Meeting of the Trust Board
Tuesday 26 May 2020

Dear Members

There will be a public meeting of the Trust Board on Tuesday 26 May 2020 at 2:10pm by video conferencing.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**2:10pm**
Declarations of Interest All members 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 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 1 April 2020**	Chair	**I**	**2:15pm**
3.	**Matters Arising/ Action Checklist**	Chair	**J**	
4.	**Chief Executive Update**	Chief Executive	**K**	**2:20pm**
	ANNUAL REPORT AND ACCOUNTS			
5.	**GOSH Foundation Trust Annual Financial Accounts 2019/20 and Annual Report 2019/20 Including:** o **the Annual Governance Statement** o **the Audit Committee Annual Report** o **Draft Head of Internal Audit Opinion** o **Draft Representation Letter**	Chief Finance Officer Company Secretary Audit Committee Chair	**Li and Lii** **Liii**	**2:30pm**
6.	**Compliance with the Code of Governance 2019/20**	Company Secretary	**M**	**2:45pm**
7.	**Compliance with the NHS provider licence – self assessment 2019/20**	Company Secretary	**N**	**2:50pm**
8.	**Draft Quality Report 2019/20**	Medical Director	**O**	**2:55pm**
	STRATEGY and RISK			
9.	**CQC Always Improving Update**	Medical Director	**P**	**3:05pm**
10.	**Safety Strategy**	Medical Director	**Q**	**3:15pm**
11.	**Quality Strategy**	Medical Director	**R**	**3:25pm**
	PERFORMANCE			

12.	**Integrated Quality and Performance Report – Month 1 2020/21** **Update on Data Kite Marking for Board Reports**	Medical Director/ Chief Nurse/ Interim Chief Operating Officer Interim Chief Operating Officer	**S** **7**	**3:35pm**
13.	**Month 1 2020/21 Finance Report**	Chief Finance Officer	**T**	**3:50pm**
14.	**Learning from Deaths Mortality Review Group - Report of deaths in Q2 and Q3 2019/2020**	Medical Director	**U**	**4:00pm**
15.	**Safe Nurse Staffing Report (April 2020)**	Chief Nurse	**V**	**4:10pm**
	ASSURANCE			
16.	**Annual Reports** • **Annual Freedom to Speak Up Report 2019/20** • **Annual Health and Safety and Fire Report 2019/20** • **Gender Pay Gap Report 2019/20** • **Guardian of Safe Working Annual Report 2019/20**	Freedom to Speak Up Guardian Director of HR and OD Director of HR and OD Medical Director	**W** **X** **Y** **Z**	**4:20pm**
17.	**Board Assurance Committee reports** • **Audit Committee update – April 2020 meeting and May 2019 (verbal)** • **Quality, Safety and Experience Assurance Committee update – April 2020 meeting** • **Finance and Investment Committee Update –March 2020** • **People and Education Assurance Committee – February 2020**	Chair of the Audit Committee Chair of the Quality and Safety Assurance Committee Chair of the Finance and Investment Committee Chair of People and Education Assurance Committee	**1** **2** **3** **4**	**4:40pm**
18.	**Council of Governors' Update – April 2020**	Chair/ Company Secretary	**5**	**4:55pm**
	GOVERNANCE			
19.	**Declaration of Interest Register**	Company Secretary	**6**	**5:00pm**
20.	**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.)			**5:05pm**
21.	**Next meeting** The next confidential Trust Board meeting will be held on Wednesday 15 July 2020 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			

Attachment P

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2020

CQC Update **Submitted by:** Sanjiv Sharma, Medical Director	**Paper No: Attachment P**

Aims / summary

This report provides an overview of progress to address the recommendations in the CQC report (published Jan 2020) including action to address the two enforcement notices.

- More than 50% of actions are already complete
- The remaining actions are all in progress, and within timescale except for one action
- The one overdue action relates to the implementation of a trust wide process for monitoring temperature in medication rooms. This was discussed in detail at the May Always Improving meeting, and remedial action with a view to completion by the end of the month has been instigated. This is a 'Must Do' action, and linked to our Regulation 12 Enforcement Notice so action has been prioritised in the context of the pandemic.
- Action for Regulation 17 Enforcement notice is on track for a completion date of June 2020.
- The timescales for a number of actions have been extended to allow for work to respond to the pandemic. These include recommendations relating to our RTT, financial position and roll out of our Diversity and Inclusion strategy.
- Two changes were made to our CQC licence to support activities during the pandemic – including provision of treatment to patients who are over 18 and the management of patients detained under the Mental Health Act.
- A draft workplan for 2020-21 has been developed to ensure a balance between responding to the CQC recommendations, assurance that changes have been embedded and proactive identification of areas for improvement.

Action required from the meeting

- To note the progress which has been made since January 2020 to address the report recommendations
- To be aware of the timescale extensions which have been applied to a number of the agreed actions in light of the pandemic response.

Contribution to the delivery of NHS Foundation Trust strategies and plans

- Delivery of high quality care in line with the requirements of our regulators.

Financial implications

- Failure to take action to address enforcement notices may result in regulatory action including the potential for fines.

Who needs to be told about any decision?

- Head of Special Projects for Q&S
- Company Secretary

Attachment P

Who is responsible for implementing the proposals / project and anticipated timescales? Head of Special Projects for Q&S
Who is accountable for the implementation of the proposal / project? Sanjiv Sharma, Medical Director

Care Quality Commission

May 2020

Context

The Trust received the Care Quality Commission Report on 21st January 2020 following the inspection in October – November 2019.

- The Trust retains its overall rating of *Good*.
- All services provided by the hospital are now rated as either *Outstanding* or *Good*.
- The effectiveness of our care, and the caring attitude of our staff have been rated as *Outstanding* again.
- Many fantastic examples of outstanding practices by our teams were highlighted including patient experience and engagement work, innovative and world leading research and our Play Streets.
- Our Well Led rating has improved to *Good* at Trust level and in critical care and surgical core services which is a welcome reflection on the work at all levels in the organisation to improve.
- The safety of the care we provide has reduced to *Requires Improvement.* This is linked primarily to medicines management within the hospital specifically the storage and disposal of medicines.

Enforcement Notices

The CQC issued 2 enforcement notices following their inspection:

- **Regulation 12: Safe Care and Treatment**

Relates to the robustness of access control measures in PICU medication room; the safe storage of IV fluids in theatres, interventional radiology and on one of the surgical wards; the process for denaturing controlled drugs on wards; and the temperature monitoring arrangements for medication rooms.

- **Regulation 17: Good Governance**

Relates to: the articulation of the breadth of the medicines risk on the board assurance framework; and the need to ensure that the EPR system fully meets the needs of the staff in the CAMHS service to deliver safe care.

Significant progress has been made to respond to these notices since January 2020. In relation to regulation 12 we have completed the actions relating to the PICU medication room and the storage of fluids. A 'Medication Safety Must Dos' audit undertaken in April 2020 has confirmed that the agreed actions had been effectively implemented. The appropriate denaturing sachets have now been sourced and rolled out across the hospital, and their use will be checked in the next 'Mediation Safety Must Dos' audit. Arrangements for temperature monitoring in medication rooms is behind target but following the Always Improving Meeting on 13th May 2020 actions are being taken to ensure that this is completed by the end of the month.

In relation to regulation 17 the Trust Board's Assurance Framework has been updated to more clearly articulate the medication safety risks, and this is being updated in line with our risk management strategy. The CAMHS team and the Epic team initiated a working group to identify and work through the medical record issues identified in the inspection. The work to make these changes

has been completed on the Epic system, and the effectiveness of the changes for the staff using the system will be evaluated over the course of the next few months (accounting for the impact of responding to the Covid-19 pandemic).

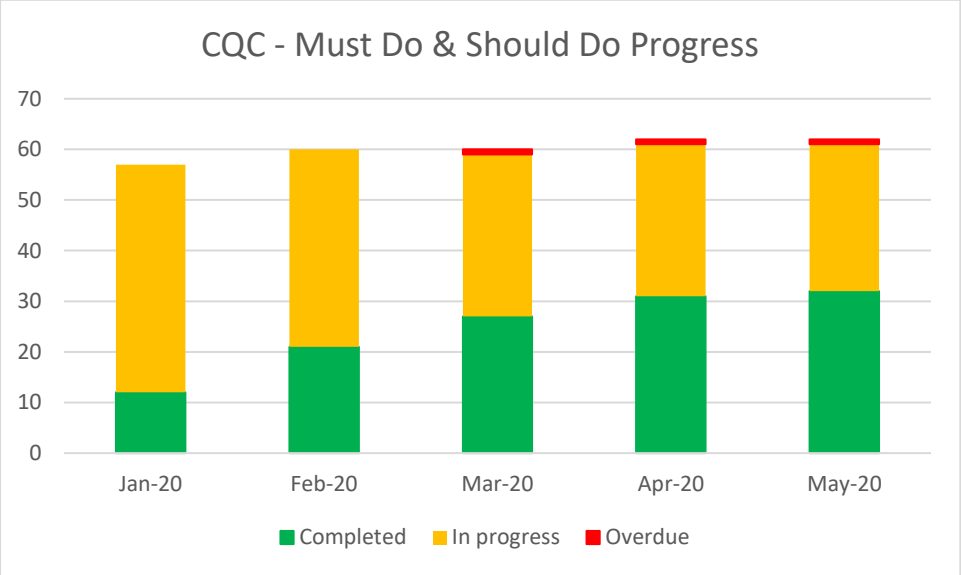
Must Dos

There were 4 Must Do actions for the Trust for which we have identified 13 actions to ensure that we effectively address the issues. These are described in detail in the Always Improving Plan. Of the 13 actions, 11 are now complete and 2 are still in progress:

- Monitoring of ambulatory temperature in medication rooms (overdue)
- Ensure the EPR system meets the need of the mental health service (due in June 2020)

Should Dos

There were 18 Should Dos actions, for which we have identified 49 associated actions. The timescales for several of these actions have been extended due to the impact of the Covid-19 pandemic. These extensions were discussed and agreed at the Always Improving meeting in April 2020 and May 2020. There are no overdue 'Should Do' actions at the time of reporting.



	Total Actions	Completed	In progress	Overdue
Jan-20	57	12	45	0
Feb-20	60	21	39	0
Mar-20	60	27	32	1
Apr-20	62	31	30	1
May-20	62	32	29	1

Impact of COVID-19

The progress of the organisation in addressing the key issues outlined in the report is shown in the chart below. There had been steady progress between January and March, but the speed has slowed

over March and April, understandably. However, now that the main peak appears to have passed, it's important that we continue to focus on clearing all of the agreed actions within the newly identified timescales to ensure that we are confident the care we are providing is of the best quality.

The key actions which have been impacted by the COVID-19 response include:

- **Should Do relating to RTT performance**

The RTT position has been severely affected by the Covid pandemic. All elective patients have been cancelled and restarting elective work will be done slowly in order to protect patients and staff. The Clinical Prioritisation Group is developing a prioritisation framework to help identify cohorts of patients should be operated on first based on clinical need. It is important to recognise that this may not always be in an order to help the RTT position as the clinical necessity is the key driver. Our RTT performance has slipped from 86% to 75% between mid-March and the end of April and we expect that it will continue to deteriorate over the next 4 months.

This affects 5 of our Should Do actions. We will liaise with the CQC during our stakeholder meetings to understand what actions would be reasonable in response to these recommendations in the current context.

- **Should do relating to WRES performance**

The people strategy has been developed and work has started on implementation. It was identified that there was a need for a separate Diversity and Inclusion strategy. The consultation on the strategy was due to take place in April 2020 wilt a delivery plan published in July 2020. These dates have been extended to June 2020 and September 2020 respectively.

- **Should Do relating to Financial Sustainability**

The CQC recommended that that the Trust should take action to develop and assure itself about financial sustainability going forward. When the action plan was developed in January 2020 actions were agreed in relation to delivery of control target; collaborative with colleagues in Children's Alliance to review and agree paediatric tariffs; timely identification and delivery of Better Value Schemes; and the use of PLICS data to drive efficiency changes. The impact of the ongoing Covid-19 pandemic on the financial performance of the organisation is, as it is for all NHS organisations, unclear. Work continues internally and in collaboration with appropriate NHS agencies to clarify pathways for funding and the impact on the Trust's financial position. We will liaise with the CQC during our stakeholder meetings to understand what actions would be reasonable in response to these recommendations in the current context.

- **Regulatory changes**

Several changes have been made to our registration in response to the Covid-19 pandemic including:

- The ability to accept and treat adult patients
- The ability to accept and treat patients detained under the MHA
-

We are adapting governance models to ensure our management of these patients is safe and appropriate. In relation to Mental Health patients in particular we have sought early review by local experts within the STP to help identify areas where we can improve.

2020 Work plan

A draft work plan for the Always Improving Group for 2020/21 and has been agreed in principle at the May 2020 meeting. This will include deep dives into each KLOE over the course of the next 12 months as well as ongoing checks on compliance with actions we have implemented in response to the report and proactive Quality Rounds.

Roisin Mulvaney
Head of Special Projects – Quality and Safety
15th May 2020

Our Always Improving Plan

Our Ref	Report Ref	Power	KLOE	Report Recommendation		Exec Lead	Operational Lead	Agreed Timescale	Progress update	Current Status
1	Trust Well Led	Must Do	Well Led	Ensure the Board Assurance Framework reflects all known medicine risks including the storing, administration and destroying of medicines in line with the legislation and the trust medicines management policies	1. Review of all medication risks in the Trust at the Medication Safety Committee. .	Mat Shaw	1. Sophie Varadkar & Steve Tomlin	Jan-20	All medication risks have been collated for review and circulated to the the Medication Safety Committee ahead of the meeting on the 28th January 2020. They weren't reviewed in detail at the meeting due to time constraints, but were used in the review of the medication BAF risk.	Complete
					2. Revise baf risk 14 (Medication Management) based on the outcome of the review of all medication risks, and the feedback from the CQC report.		2. Anna Ferrant, Sophie Varadkar & Steve Tomlin	3.2.2020	The BAF risk will be reviewed following reivew of Trust wide medication risks at the medicaion safety committee on the 28.1.2020. BAF risk review completed 5.2.2020.	Complete
					3. Present revised BAF risk statement and controls/assurances to RACG.		3. Anna Ferrant & Steve Tomlin	12.02.2020	BAF risk has been revised andwas presented to the Risk Assurance and Compliance Group on the 12.2.2020	Complete
					4. Revise annual plan of medication safety audits in line with risk profile		4. Andrew Pearson and Rasha Samsha	28.2.2020	Annual plan of medication audits has been devised with the support of the Clinical Audit Manager. This schedule has been approved by the Chief Pharmacist on 25.2.20. The results of each audit will be reviewed at the medication safety committee.	Complete
					5. Amend TOR for Medication Safety committee to ensure that there is regular review of all medication risks in the Trust alongside the results of the medication safety audits and that this is used to support changes to the BAF periodically.		5. Salina Parkyn & Sophia Varadkar	28.1.2020	The amended TOR were reviewed on the 28.1.2020 and subject to changes agreed at the committee have been approved. New Safety Pharmacist is now receiving all incidents relating to medication safetly to analyse trends with a medication safety dashboard and identify new risks. This will be reported at the meeting on a monthly basis along side the risk register review.	Complete
					6. Deliver updated BAF with recommendations for amendments to Board on 1 April 2020		6. Anna Ferrant	1.4.2020	Updated BAF was presented to April Trust Board.	Complete
2	Critical Care	Must Do	Safe	Ensure medicines are stored safely in line with legislation and the trusts medicines management policies	1. Review Access control to PICU clean utility room.	Sanjiv Sharma	Dagmar Gohil	13.2.2020	There is auditable swipecard access to the PICU medication room. This list needs to be cleansed to ensure that it is restricted to the groups agreed in the hospital's policies. A full list of all staff with access to the PICU medication room is being generated by the Security Team and the PICU Nursing team will review and identify those who can be removed. This work was completed on 13.2.2020. A further trust wide action has been identified. See Always Improving Plan Tab 2.	Complete
3	Surgery	Must Do	Safe	Ensure medicines are stored safely in line with legislation and the trusts medicines management policies	1. Ensure that IV fluids are stored securely and in line with best practice in theatres.	Sanjiv Sharma	Ciara McMullin	Jan-20	1. IV fluids in theatres were moved from the corridor enclave to a swipe access controlled store room on the day of the inspection. This was completed on 5.10.2019	Complete
					2. Ensure that IV fluids are stored securely and in line with best practice in interventional radiology		Ciara McMullin	Jan-20	2. IV fluids in interventional radiology were moved to a swipe access controlled store room on the day of the inspection.	complete
					3. Ensure that IV fluids are stored securely and in line with best practice in Sky ward.		Carly Vassar	Jan-20	3. The clean utility room was expanded in December 2019. Now all the IV fluids are stored in cupboards in that swipe access controlled room.	Complete
					4. Ensure that temperatures in rooms used to store medicines are monitored and recorded.		Andrew Bell	Feb-20	Jan: 1.Request submitted to estates to compile a list of all medication rooms and arrangements for temperature monitoring. 2. Trust wide risk assessment and action plan to be developed. April: Risk assessment and new SOP were reviewed at Medication Safety Committee in April 2020. Roll out anticipated in May 2020.	overdue

					5. Ensure that the service is denaturing CDs in line with policy		Stephen Tomlin	Feb-20	Discussed at Medication Safety Committee 28.1.2020. The key actions: 1. identify and source denaturing gel 2. confirm location for storage following review of CAS alert (should be behind a swipe card access door) 3. communicate change out to the matrons and ward sisters. Aim for full compliance by End of Feb 2020. Request was submitted to NHSSC in February, but supplies are not due to arrive until 5.3.2020. THe sachets were rolled out to all clinical areas from the 6/3/2020. **Paper outlining evidence of implementation will be reviewed at the Always Improving meeting.**	Complete
4	Children and Adolescent Mental Health Services	Must Do	Well Led	Ensure that the electronic patient record system meets the needs of the service so staff can record, update and find patient records promptly. This includes further development of, and staff adherence to, electronic patient record storage protocols.	Establish a formal Speciality Level Optimisation process to support the CAMHS service in making the necessary changes to Epic.	Richard Collins	Helen Vigne	Jun-20	Formalised process began in December 2019. There is an associated action log which tracks progress. At least 19 issues have been addressed and closed. 05.02.2020: meeting with CAMHS and Epic team, and agreed that key work to address this work was on track and would be likely to be completed by end of March 2020. April: Work has been completed, but final meeting which was due to take place in March was postponed due to Covid-19.	in progress
5	Trust Wide	Should Do	Well Led	Continue to develop and implement a formal board development programme	1. Consult on drafting a Board Development Plan	Mat Shaw	Anna Ferrant	01/01/2020	AF Held meeting with Mat Shaw and Louisa Desborough to discuss framework for programme and possible external input to the development of the Board.Programme under development following comments	Complete
					2. Draft a version for consultation with EMT and update following comments		Anna Ferrant	29/04/2020	April update: on track	Complete
					3. Circulate to all Board members prior to Board for consultation		Anna Ferrant	12/05/2020	April update: on track	In progress
					4. Present at Board for approval		Anna Ferrant	26/05/2020	April update: on track	In progress
6	Trust Wide	Should Do	Well Led	Take action to develop and assure itself about financial sustainability going forward	Deliver control target for 19/20	Helen Jameson	Helen Jameson	01/06/2020	April 2020 - accounts sign off is due at the end of June, so an update on performance will be included then.	In progress
					Work collaboratively with the Children's Alliance to review and agree paediatric tarriffs	Helen Jameson	Helen Jameson	TBC	Ongoing.	In progress
					Identify all the better value schemes for 2020/21	Richard Collins	Richard Collins	TBC	Impacted by COVID-19. Actions and timescales to be reconsidered in due course.	In progress
					Using plics information to drive efficiency changes	Richard Collins	Richard Collins	TBC	Impacted by COVID-19. Actions and timescales to be reconsidered in due course.	In progress
7	Trust Wide	Should Do	Well Led	Continue to promote the role of the FTSUG, taking proactive action to identify and address themes from staff contacts with the FTSUG	**Role promotion** 1. Survey of staff to see why they haven't used the service Feb 2020) and analysis of results included in the annual report (April 2020) 2.Role Promotion strategy: Aligned to the change in the FTSU (after feb 2020)	Sanjiv Sharma	1. Luke Murphy 2. FTSUG in collaboration with Comms	May-20	April update: note 88 contacts with service in Feb and 10 in March.	In progress
					Proactive Action: 1. Launch Speak up for our values, and Peer Messengers roles	Sanjiv Sharma	Karen Panesar & Andrew Long	Nov-20	The launch of this project has been paused given the current pandemic. The programme Board have agreed to being work on the PRAISE component of the project ahead of the summer, with a view to Speak Up for Values in the Autumn, but this will be conditional on the situation with Covid at that time.	In progress

					Address Themes 1. Share (anonymised) FTSUG case outcomes within the organisation to ensure staff are aware. 2. Themes from FTSUG and Speak Up to be integrated into one report to provide comprehensive insights for the Trust. 3. Actions identified through FTSU and Speak Up must be specifically followed up through PSOC	Sanjiv Sharma	1. Luke Murphy 2. FTSUG & Karen Panesar 3. Salina Parkyn	May-20	April 2020- Annual report being compiled for committees in May/June 2020	In progress
8	Trust Wide	Should Do	Well Led	Raise staff awareness of the safe and respectful behaviour policy and improve access to conflict resolution training	1. Seek views from staff on support needed to enact the Safe and Respectful behaviour policy specifically in relation to: - policy - training - communication	Alison Robertson	Luke Murphy & Zoe Berger	Feb-20	1. Short survey sent out with Trust Brief on 17.1.2020 and a reminder at SLT. Face to face feedback sessions have taken place. Survey due to close on 3rd February 2020. Meeting scheduled with Chief Nurse to agree plan based on feedback. 2. Safe and REspectful working group meeting took place 5.2.2020. Action plan agreed. 3. Safe and Respectful policy presentation at SLT on 20.2.2020 4. Survey completed in March 202, and feedback collated.	Complete
					2. Arrange listening events with specific areas requiring additional support.	Alison Robertson	Luke Murphy & Zoe Berger	Jan-20	5 completed in January	complete
9	Trust Wide	Should Do	Well Led	Continue to improve the quality of WRES data to enable this to be used to inform areas for development.	1. people strategy	Caroline Anderson	Caroline Anderson	Jan-20	The People Strategy was launched at the Open House in November 2019	complete
					2. Consult and engage with forums and other stakeholders on the development of the D&I strategy.	Caroline Anderson	Sarah Ottoway	Jan-20	Completed December 2019	complete
					3. Publish strategy for consultation across the organisation	Caroline Anderson	Sarah Ottoway	Jun-20	Dates have been adjusted to allow for impact of COVID from April to June 2020	In progress
					4. Prepare and publish the delivery plan for D&I strategy	Caroline Anderson	Sarah Ottoway	Sep-20	Dates have been adjusted to allow for impact of COVID from July to Septmeber 2020	In progress
10	Trust Wide	Should Do		Raise staff awareness of the role of the accredited safety champions	1. Speak Up for safety champions 2. Peer Messengers 3. Set out plans and strategy for Speak Up in the Quality Strategy Refresh.	Sanjiv Sharma	Andrew Long/Karen Panesar	Jun-20		in progress
11	Trust Wide	Should Do	Well Led	Clarify the role and expectations of governors in interview stakeholder groups, including for which roles they will be invited to participate in groups for	Clarification to be included in the Governance Update for the Council in February 2020	Mat Shaw	Paul Balson	05/02/2020	Papert has been written and submitted to the Council outlind the roles and expectations of governors in interview stakeholder groups. Will be discussed on 5.2.2020	complete
12	Trust Wide	Should Do	Well Led	Improve the oversight of delivery of services by the pharmacy department by identifying and reporting key performance indicators via the directorate performance process to the board.	1. Introduce Qpulse to support the QMS and enable effective KPI reporting. STAGE 1: Qpulse for Deviations	Phil Walmsley	Attia Hasnain	15/06/2020	The QMS has been built in Qpulse and is currently being tested. Then staff will be trained in the new system. April: The training has been provided. An SOP to support delivery was being developed, but due to issues with staffing (COVID and staff leaving) this has not yet been completed. Delays discussed at the April CQC Always Improving Meeting. It was agreed that the deadline could be extended to Mid June (from MArch 2020) in light of current challenges, but it was felt this was an important action which also links to the MHRA action plan.	in progress
					Qpulse Stage 2: Use of qpulse for CAPAs		Attia Hasnain	31/07/2020	Workflow will be developed on Qpulse, alongside training and SOP	in progress
					Qupulse Stage 3: use of Qpulse for Change Control		Attia Hasnain	30/09/2020	Workflow will be developed on Qpulse, alongside training and SOP	in progress
					2. Ensure agreed KPIs are included in the monthly directorate performance pack for Medicines, Tests and Therapies.		Chris Longster	01/01/2020	This has been in place since November 2019.	complete

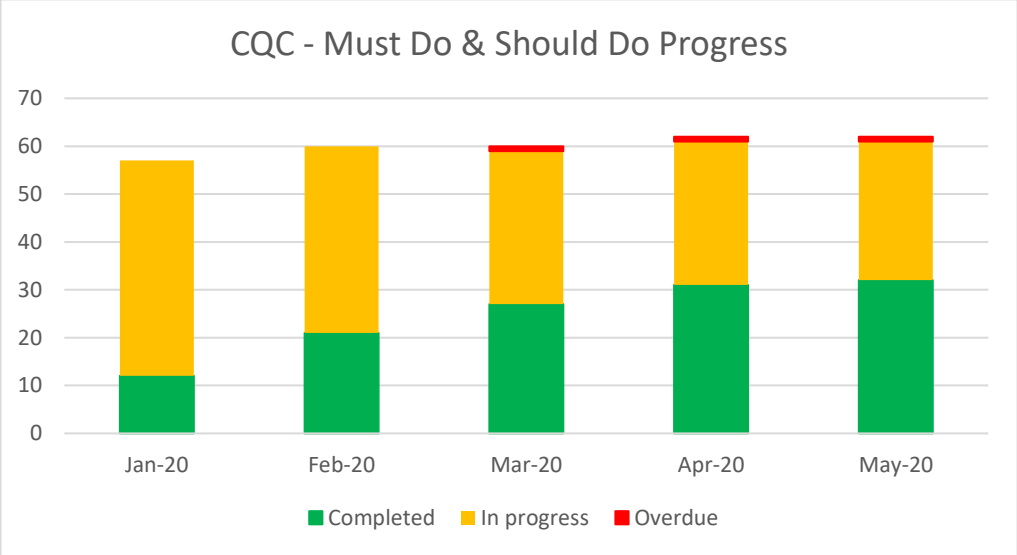
					3. Monthly reporting of the KPIs through to the Always Improving Compliance group.		Chris Longster & Salina Parkyn	Feb-20	KPI dashboard has been shared with the Head of Quality and Safety. March 2020 - Compliance group TOR updated and approved.	complete
13	Trust Wide	Should Do	Safe	Take action to improve the number of incidents closed with the trust's 45 working day target	1. Weekly monitoring of open incidents-compliance with investigation timescales and closure timescales with compliance shared monthly at SLT and via IQPR	Sanjiv Sharma	Salina Parkyn & Diane Jones	ongoing	ongoing. The imapct on timescales due to COVID-19 should be considered.	in progress
					2. Datix Action Module refresh		Datix Manager	Jan-20	Completed December 2019	Complete
					3. Cleanse of users from the Datix system to ensure that the right people are receiving the right incidents for investigation		Datix Manager	Feb-20	User cleanse completed December 2019. Leaver notification reports re-instated to ensure that these are maintained. Collaboration on-going. Lists circulated to teams January 2020. March - advised that this is complete.	Complete
					4. Incident module rebuild in consultation with end users and management.		Diane Jones	Sep-20	Incident module rebuild commenced Jan 2020.	in progress
					5. Investigation policy refresh in line with the new rebuild		Diane Jones	Sep-20		in progress
					6. Training and education for staff in Systems Analysis (previously RCA)		Salina Parkyn & Diane Jones	TBC	Due to be started in March 2020 - but postponed due to COVID-19. New date TBC Meetings taking place in April and May 2020 to assess how this can be delivered in house.	in progress
14	Trust Wide	Should Do	Well Led	Improve the accuracy of the trust's information asset register	1. Develop pilot register in order to test methodology for use in the rest of the Trust.	Phil Walmsley (SIRO)	Joseff Enyon-Freeman & Peter Hyland	Jan-20	Pilot register has been developed.	Complete
					Launch Pilot in 2 Trust Departments	Phil Walmsley (SIRO)	Joseff Enyon-Freeman	Feb-20	Currently being piloted in Information team and HR with plan to report outcome of trial to IGSG on 19th February 2020. **Feb 2020:** Shared at IGSG. The update confirmed that HR and Information Services had completed their IARs. Research, Finance, ICT, IPP and CAMHS had shared their assets for update. A total of 152/556 assets had been assigned.	Complete
					Assign all known assets to initiate roll out.	Phil Walmsley (SIRO)	Joseff Enyon-Freeman	Mar-20	Feb 2020: It was agreed at IGSG that all 556 known assets would be assigned by the March IGSG and evidence of this produced for the DSP Toolkit. March 2020: The known assets were assigned.	Complete
					Roll out to the remaining deparments across 2020.	Phil Walmsley (SIRO)	Joseff Enyon-Freeman	Dec-20		in progress
15	Critical Care	Should Do	Well Led	Consider developing a divisional clinical strategy for critical care areas	1. Develop 1 year strategy as part of standard business planning. 2. Develop longer term strategic vision following publication of hospital strategy refresh.	Phil Walmsley	Daniel Lutman, Katherine Joel & Dagmar Gohil	TBC	February: 2020 business plan is in draft, and will be refreshed monthly ahead of year end. March: this will be impacted by COVID-19 response, and therefore due date will need to be revised.	In progress
16	Critical Care	Should Do	Safe	Provide consistent checks in relation to all in-use resus equipment in the critical care areas, in line with guidance from the Resus Council.	1. Remove Trolley from Flamingo as it has only been retained for training purposes. There are patient need specific resus trolleys in each of patient bays.	Sanjiv Sharma	Denise Welsby	Jan-20	Trolley has been relocated from the clinical area to the simulation suite on Alligator so that it can still be used for training	Complete
	Surgery	Should Do	Responsive	Continue to work to improve referral to treatment times	Reduce 52 week breaches to a position 32 or less by the end of March 2020	Phil Walmsley	Peter Hyland	Mar-20	Feb 2020 update: Current predicted position is 26 X 52 week breaches by end of March. April 2020: Target was reached, but noted that this will be impacted by COVID-19 and the reduction of essential activity. The ongoing work to address this will be covered as part of the Trust's Covid Recovery plan.	Complete

17					Deliver a compliant diagnostic position within year.	Phil Walmsley	Peter Hyland	TBC	The RTT position has been severely affected by the Covid pandemic. All elective patients have been cancelled and restarting elective work will be done slowly in order to protect patients and staff. The Clinical prioritisation Group is deciding on which cohorts of patients should be operated on first and this may not always be in an order to help the RTT position as the clinical necessity is the key driver. Our RTT performance has slipped from 86% to 75% between mid-March and the end of April and we expect that it will continue to deteriorate over the next 4 months. The actions listed here were developed pre-pandemic. We will liaise with CQC collegaues in our stakeholder meetings to consider how best to respond to this recommendation given current climate.	in progress
					Work with commissioners to develop a recovery plan for RTT to improve delivery against the RTT standards as part of contracting process	Phil Walmsley	Peter Hyland	TBC		in progress
					Increase capacity for our SDR service to reduce the volume fo long waiting patients	Phil Walmsley	Peter Hyland	TBC		in progress
					develop and implement a plan to reduce long waiters in the Dental service	Phil Walmsley	Peter Hyland	TBC		in progress
					Patient Redesign in specific specialities. Flow Programme. Outpatient Transformation to improve methods and utilisation Theatre Utilisation Group Fortnightly performance meetings with GMs.	Phil Walmsley	Various	TBC		in progress
18	Surgery	Should Do	Safe	Improve the timeliness of discharge summaries sent to the patient's GP	Reduce backlog of discharge summaries to less than 100	Phil Walmsley	Peter Hyland	Mar-20	As of 15th April, the outstanding discharge summaries was 59.	Complete
					Review the quality of discharge summaries to ensure they are meeting the needs of the GPs and referrers	Phil Walmsley	Peter Hyland	Aug-20	April 2020- extension requested in context of pandemic information returns. Extended to August 2020.	in progress
19	Surgery	Should Do	Safe	Review and improve systems for equipment maintenance in theatres so that staff are assured it is fit for use	1. Review system for tagging equipment in theatres which is managed under contract (rather than via biomed).	Sanjiv Sharma	Ciara McMullin	May-20	Initial discussions between Head of Nursing for Theatres, GM for MTT and Head of BME.Meeting due to take place in 1st week of Feb. Plan and timescales to be agreed at that meeting. May 2020: work had not progressed on this, but is now being picked up between Theatres and BME.	in progress
20	Children and Adolescent Mental Health Services	Should Do	Responsive	Continue to take action so that staff, patients, family members and carers are not negatively affected by the lack of disabled access to the roof terrace	Access for disabled patients is not possible currently, but patients can access other outdoor gardens and spaces in the hospital. Incident forms will be raised when when patients are unable to access the roof terrace.	Phil Walmsley	Carly Vassar	Feb-20	All MCU staff have been advised to complete incident forms in the event that children are unable to access the room for any particular group activity, noting alternative arrangemetns made.	Complete
21	Children and Adolescent Mental Health Services	Should Do	Effective	Provide training and support to all relevant staff so that they are competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years	1. Develop a new training programme based on capacity and competence	Caroline Anderson	Carly Vassar, John Forrester, Jonathan Goldin,	2020 (and ongoi	Capacity and competence is on the teaching list for 2020 and will be annual topics. Jon Goldin did some teaching for the team on competency and consent on 29.1.2020. This will be a monthly one hour Gillick competency workshop going forward (moving to 2 monthly in due course), supported by the Practice Educator who will be keeping a log of attendance.	Complete
22	Children and Adolescent Mental Health Services	Should Do	Well Led	Provide timely administrative support for the service so audits and document scanning are not delayed.	1. Identify administrative support	Phil Walmsley	John Forrester	Dec-19	1. There is now an administrator in place, processes in place for scanning and accurate process and audit for consent forms.	Complete
					2. Develop annual audit plan for MCU.		Andrew Pearson and John Forrester	Feb-20	Clinical Audit manager meeting with Ward Manager on 27.1.2020 to develop audit plan. 04.02.2020: Annual Audit plan now agreed.	Complete

Always Improving Work Plan (Draft May 2020)												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Medication Safety Must Do Audit	X				X				X			
Honarary Contracts update	X	X	X	X	X	X	X	X	X	X	X	X
Safe Deep Dive		X										
Caring Deep Dive				X								
Effective Deep Dive						X						
Responsive Deep Dive									X			
Well Led Deep Dive							X					
Quality Rounds				X			X			X		
Datix Cleanse Quarterly update	X			X			X			X		
Compliance update												
Notice Board Refresh			X			X			X			X
De-Clutter				X				X				

Always Improving Action Plan Tracking

	Total Actions	Completed	In progress	Overdue
Jan-20	57	12	45	0
Feb-20	60	21	39	0
Mar-20	60	27	32	1
Apr-20	62	31	30	1
May-20	61	32	29	1



Attachment Q

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2020

GOSH Safety Strategy 2020 **Submitted by:** Dr David De Beer Associate Medical Director for Safety	**Paper No: Attachment Q**

Aims / summary

The GOSH Safety Strategy 20020 describes the road map to development of the organisational approach to improving the safety of care for children and young people with complex health needs within the Trust over the next five years. It focuses on cultivating a just, kind and civil culture where safety is always given top priority, learning is shared locally and with our partners and solutions are implemented proactively.

Underpinning principles include:

- Building system safety
- Meeting all regulatory, compliance and governance requirements
- Provision of education and training to all staff to build safety skills
- Supporting local ownership of safety
- Commitment to openness and transparency in investigating when things go wrong
- Learning from incidents (Safety 1) and excellent practice (Safety 2)
- Supporting of patients, families and staff an partners through safety improvement processes

This Strategy is aligned with the GOSH 'Above and Beyond' Strategy, NHS Patient Safety Strategy and addresses the concerns raised within the GOSH Care Quality Commission report (2019).

Action required from the meeting

Agreement of strategic approach

Contribution to the delivery of NHS / Trust strategies and plans

The Safety Strategy reinforces the Trust's commitment to Always Learning, Always Improving and Always Involving

Financial implications

None

Legal issues

None

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

Associate Medical Director for Safety
Head of Quality and Safety

Who is accountable for the implementation of the proposal / project

Medical Director

GOSH Safety Strategy 2020 - 2025:
Keeping our Children and Young People Safer

Our five-year strategy to continuously improve the safety of care for children and young people with complex health needs

Our Context

Patient safety is one of the cornerstones of high-quality healthcare. Despite considerable investment and good intentions to reduce the risks inherent in healthcare, patient safety problems and preventable harm continue to occur in every hospital. The Berwick Report on patient safety, '*A promise to learn – a commitment to act*' (2013), argued that the NHS should become "… more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end". The report's recommendations included the cultivation of an NHS culture in which learning, and improvement are core to organisations through:

- Provision of education and training to all staff, including executive teams, in patient safety theory and practice
- Renewed emphasis on our duty of candour and the transparent reporting of data on quality of care in general and safety in particular
- Greater involvement of patients and their carers at all levels of healthcare organisations.

The Care Quality Commission (CQC) report, '*Opening the door to change – NHS safety culture and the need for transformation*' (2018), recognised that while there was a strong commitment to safety, NHS staff were not supported by sufficient training in the principles of safety and that Trusts had limited capacity to keep them in touch with current best practice. The complexity of the current patient safety system made it difficult for staff to ensure that safety was an integral part of everything they did. Based on its findings, the CQC called on the NHS and its partners to promote a change in safety culture across the NHS so that safety was given the highest priority it deserved. Recognising that we all make errors, everything should be planned with this in mind to create a just culture where learning is shared, and risk is managed proactively. These risks should be identified

and managed with a greater understanding of team dynamics, situational awareness and human factors, and with safety protocols followed consistently.

The recently published '*NHS Patient Safety Strategy',* (2019) proposes a fundamental shift from talking about harm and individual blame, to developing safer systems that consistently deliver the right care for all our children and young people with complex health needs. The importance of harnessing valuable learning from what works and not just from what does not is also emphasised.

Our Safety Strategy has been developed in consultation with key stakeholders. Our purpose, our principles and our priorities are aligned with the strategic aims of:

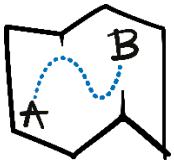
- Trust's five-year 'Above and Beyond' strategy to advance care for children and young people with complex health needs
- NHS Improvement 'Patient Safety Strategy'
- Care Quality Commission (CQC) report 'Opening the door to change – NHS safety culture and the need for transformation'
- Trust's Care Quality Commission (CQC) recommendations from the 2020 inspection report

Our intention is to cultivate and nurture a just, kind and civil safety culture that supports the reduction of avoidable harm to children and young people with complex health needs and empowers our staff to continuously and consistently learn and improve our care processes.

Our Challenge

In the most recent Care Quality Commission (CQC) report published in January 2020, the Trust retained its overall rating of 'Good', with all services being rated as either 'Outstanding' or 'Good'. The Trust was rated 'Requires Improvement' for being safe, with the two main areas of concern cited as medicines management and infection control. The Trust has also undergone a considerable amount of public scrutiny and criticism around transparency of safety issues and the management of serious incidents.

In our most recently published staff survey (2019), there was a clear indicator that staff perceived an improvement in the safety culture within the Trust, but benchmarking indicates we lag behind other high performing organisations.



Our Purpose

To provide the safest, kindest and most effective care for our children and young people with complex health needs

Our statement of purpose places the ethos of learning at the heart of everything we do for everyone that works at GOSH, with a commitment to provide the safest, kindest and most effective care possible for children and young people with complex health needs. Establishing safer care will involve working in partnership at every level of the healthcare system, from local NHS and patient experience teams to national and international research collaborations. It will also involve the adoption of a more responsive and forward-thinking approach to safety with a core principle of learning, both when things go wrong but also when things go right.

It is our intention to foster a safety culture that empowers and enables our patients, families and staff to routinely act in the service of learning and safety across the organisation with a value system of being just, kind and civil. This will need to be supported by a robust learning network that disseminates key messages for improvement.

Our Principles

We have identified seven principles that are aligned to key national safety strategies to guide our priorities, set our desired outcomes and achieve our purpose

ALWAYS LEARNING – *gaining insight and understanding*

We are committed to continuously improve our understanding of patient safety by drawing intelligence from all available safety sources and acting on them to deliver the safest, kindest and most effective care for our children and young people with complex health needs. Key to this will be cultivating a just, kind and civil patient safety culture and building system safety and learning capability.

1 Putting safety first - building system safety and learning capability

This will be achieved by:

- Building upon and embedding a culture where all our staff are treated equally, without bias or judgement, and with kindness and compassion to facilitate the creation of safety and learning capability
- Learning from the wide variety of patient and family feedback opportunities including PALS queries, formal complaints, FFT, PREMs, YPF, annual surveys and focus groups
- Increasing the involvement of patients, families, carers and other lay people as 'patient safety partners' in the provision of safer care
- Redesigning and streamlining processes for reporting and managing incidents to increase learning capability. In particular, rebuilding the Trust incident reporting system so that it is easy to use, fit for purpose and provides timely feedback, supported by digital technologies to expedite the dissemination of the messages for learning and improvement
- Learning from colleagues within the hospital, regionally, nationally and internationally so that we are better aware of the key safety challenges that face us in healthcare and are therefore in a better position to prepare for and mitigate against emerging risks

2 Getting the basics right - meeting all regulatory, compliance and governance requirements within specified timescales

This will be achieved by:

- A renewed emphasis on our duty of candour and the transparent reporting of data on quality of care in general and safety in particular
- Ensuring that all staff receive role specific training on key safety principles and practices to enable them to confidently deliver the safest, kindest care at all times
- Improving the response to, and investigation of serious incidents and red complaints to expedite learning and inform improvement
- Responding to new and emerging risks as well as implementing safety recommendations from external bodies in a timely manner, with the provision of assurance and completion of actions (e.g. National Patient Safety Alerts and initiatives, Healthcare Safety Investigation Branch [HSIB] safety notices)
- Embedding robust processes for the scrutiny of childhood deaths to optimise learning (Medical Examiner role, Child Death review) to optimise learning

ALWAYS INVOLVING – *making safety everyone's business*

Everyone, from ward to board, needs to be involved in the Trust's safety agenda. In order to deliver our strategy, we will focus on equipping, empowering and supporting our patients, families, staff and other lay people with the necessary skills and opportunities to continuously improve patient safety throughout the Trust.

3 Providing our patients and staff with the necessary skills and opportunities to improve patient safety

This will be achieved by:

- Normalising a culture in which 'safety is everyone's business'. Key to this will be empowering our staff to openly discuss safety concerns and challenge behaviours by providing the necessary framework, support and tools to 'Speak up for Safety', 'Speak up for our Values' and feel comfortable using the safety C.O.D.E.
- Designing an achievable multidisciplinary patient safety syllabus so that all staff receive high quality training on the key principles of patient safety at the appropriate level (e.g. RCA/ systems analysis, learning from incidents, human factors, Safety 1 and 2)
- Supporting our staff to respond appropriately and have open conversations with patients and their families when things have gone wrong and to be kind and supportive to each other in the process
- Actively participating in paediatric research with translation of evidence into practice

4 Being more proactive with regard to patient safety through specialty ownership built on local expertise

This will be achieved by:

- Building the capability within Directorates to effectively manage safety incidents. This will help to cultivate a more forward looking, proactive and timely approach to patient safety issues within the Trust, while at the same time providing assurance of consistent patient safety and risk management across the Trust, underpinned by good governance and management
- Establishing patient safety champions within each specialty to lead on risk management and improving safety across the specialty
- Supporting the Deputy Chiefs of Service to lead the directorate patient safety agenda in partnership with the Patient Safety team and Heads of Nursing and Patient Experience
- Building consistent and effective patient safety and risk management processes across the Trust

SPECIALTY LEVEL

Specialty
Administered by: Safety champion
Supported by: Speciality lead

DIRECTORATE LEVEL

Directorate Quality & Safety meetings
Administered by: Deputy Chiefs of Service (DCoS)
Supported by: Heads of Nursing, Patient Experience and Q&S team

EXECUTIVE LEVEL

Patient Safety and Outcomes Committee (PSOC)
Lead: Medical Director/Associate MD for Safety / Head of Q&S
Supported by: Deputy Chiefs of Service
Administered by: Q&S team

TRUST LEVEL

Quality Safety and Experience Assurance Committee (QSEAC)
Lead: Non-Executive Director (Quality & Safety)
Supported by: Medical Director/ Associate MD Safety /Head of Q&S/ DCoS

ALWAYS IMPROVING – *delivering effective improvement initiatives*

We recognise the importance of developing safer systems. We will focus on designing programmes that deliver effective and sustainable change in key areas within the Trust, and in partnership with the Quality Improvement, Patient Experience and Transformation teams.

5 Exploring patient safety incidents and complaints using a fair, transparent and supportive approach focused on 'learning' rather than 'blame'

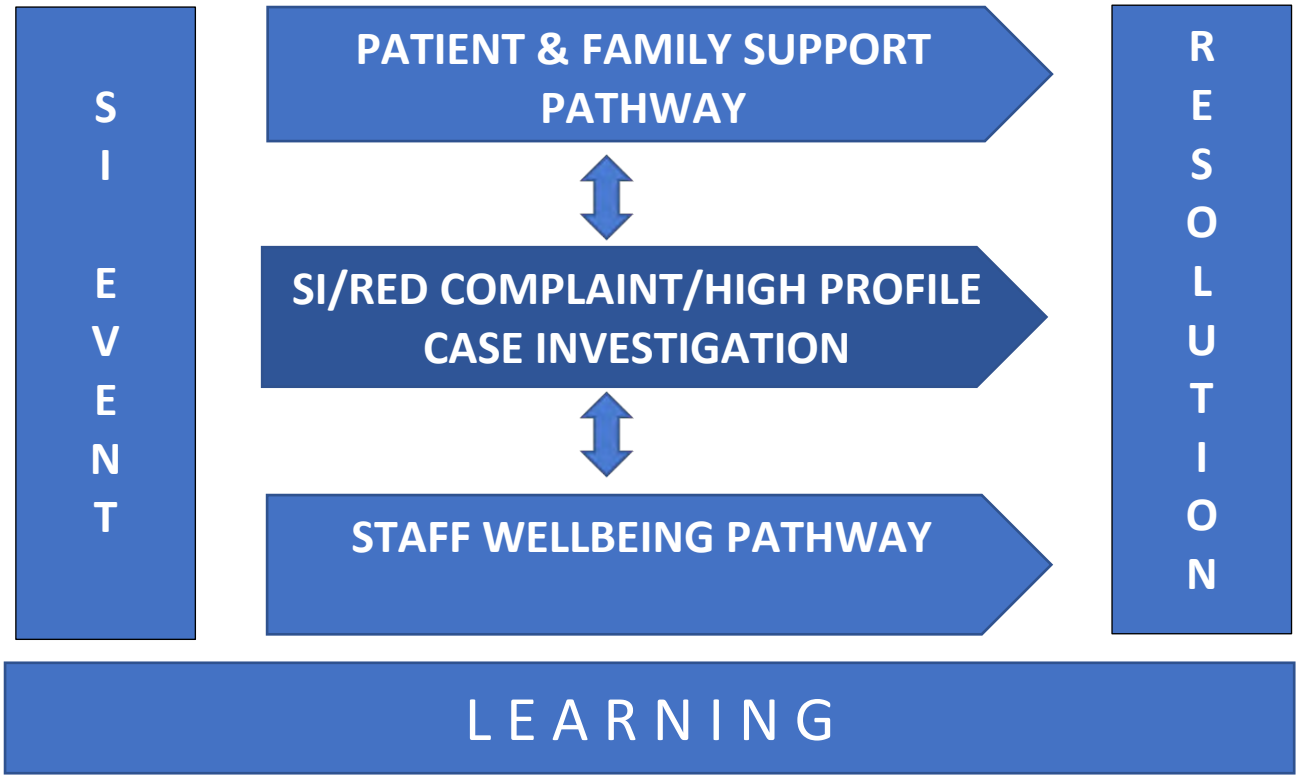
This will be achieved by:

- Developing a framework to help identify the correct level of patient safety incident investigation and response required (Safety 1). Integral to this will be the development of a new tri-parallel learning and wellbeing framework for the investigation of serious incidents, red complaints and high profile cases to provide ongoing support to our patients/families as well as our staff (2nd victim support) as shown below

- Supporting specialties and directorates to produce SMART action plans in response to serious incidents and red complaints and ensuring that the actions required to embed lessons learnt when things go wrong are completed and communicated appropriately to 'close the loop'
- Renewed focus on learning from when things could have gone wrong (near misses or 'good catches') and using patient experience and other feedback to identify and learn from when things go right (e.g. exemplar or new practices where adjustments in processes or behaviours improved outcomes – Safety 2)
- Providing appropriate support (immediate and ongoing) to patients, families and staff when things go wrong to ensure that they understand that the focus is on transparency and 'learning' rather than 'blame'

Tri-parallel learning & wellbeing management system for the investigation of Serious Incidents (SIs), red complaints and high profile cases.

In its simplest form this is a learning & wellbeing management system for serious incidents, red complaints and high profile cases. This will comprise three parallel pathways that will be activated as soon as we identify an SI, red complaint or high profile case. In the centre is the existing investigation pathway that will produce a high-quality review of the case. Working alongside this is a patient support pathway with a specific aim of managing the wellbeing of the families, updating them regularly about the progress of the review, listening to their concerns and anxieties and signposting them to targeted well-being support or psychological support where necessary. The final pathway is staff wellbeing pathway designed to support our staff during and after the investigation. Resolution and closure will be reached within timescales with all learning from the process being translated into action plans that are disseminated throughout the Trust and onward to local paediatric networks.



6 Ensuring the appropriate analysis of, and timely response to clinical outcome metrics, trends and vulnerabilities

This will be achieved by:

- Benchmarking our safety outcomes against national and international peers and making them publicly available on our website (e.g. ward accreditation programme)
- Developing a framework for clinical outcomes and safety dashboards (e.g. 'safety hotspots')
- Developing the Medication Safety Improvement Programme (MSIP) to reduce avoidable, medication-related harm within the Trust, focusing on high-risk drugs and situations (e.g. ITU)
- Working to ensure that research and innovation support an improvement in safety outcomes
- Developing metrics to evaluate our progression to a just and 'learning' culture

7 Working in collaboration with our partners to deliver continuous safety improvement

This will be achieved by:

- Ensuring that up-to-date evidence based clinical guidelines and protocols are easily accessible in a central repository and are being used to guide decision making in clinical practice
- Working with patients, families and regional and international partners to co-design the safest clinical pathways of care that work best for children and young people with complex health needs
- Sharing data and benchmarking regionally (North Thames Paediatric Network), nationally (UK Children's Hospital Alliance) and internationally to advance safety in paediatric specialised services
- Working collaboratively with Camden Borough Council and North London Partners to deliver the Sustainability Transformation Plan (STP) and improve the health outcomes and wellbeing of our local population
- Partnering with academia and industry to accelerate research and innovation into clinical practice to save and improve more children's lives

Partnerships

INTERNAL

We appreciate the value in harnessing information from all safety sources within the Trust and acting on it to deliver the safest, kindest and most effective care for our children and young people with complex health needs. We are committed to working closely with:

- All members of the wider Trust safety team, including those at Directorate and Executive level responsible for safety, to learn from incidents
- The Patient Experience team to better capture learning from complaints, PALS contacts and Friends and Family test submissions when things have not gone well (Safety 1) and from feedback and appreciative enquiry when things have gone well (Safety 2)
- The Quality and Transformation teams to collaboratively deliver on work streams that are closely aligned to safety
- The GOSH Learning Academy to translate learning into action and safer patient care

EXTERNAL

We recognise the importance of working collaboratively with our partners locally, nationally and internationally to achieve our purpose of continuously improving the safety of care for children and young people with complex health needs. We will focus on building and nurturing relationships and networks with our external partners.

North Thames Paediatric Network

The North Thames Paediatric Network brings together 24 providers of paediatric services across the North London region of which 18 are acute care and 6 specialist providers. It provides a unique opportunity to build relationships, share practice and develop integrated care pathways that benefit our children and young people.

UK Children's Hospitals Alliance (CHA)

The Children's Alliance is a strategic group of 10 children's hospitals in the UK that collaborate on models of care and benchmarking through shared knowledge, expertise and learning.

Making it Safer Together (MiST)

The Making it Safer Together (MiST) Paediatric Patient Safety Collaborative is an alliance of 18 children's healthcare providers in the UK. MiST's goal is to continually reduce healthcare associated harm, through a process of sharing areas of concern, safety data, and providing mutual support to learn from one another's practice.

European Children's Hospitals Organisation (ECHO)

The European Children's Hospitals Organisation is a network of many of the leading paediatric hospitals across Europe that advocates for children's health and their access to the best quality and safest care through the collaborative work of the member hospitals. GOSH is a founder member and co-chairs the working group of the Quality, Safety, Outcomes and Value work stream, where the focus is currently benchmarking and the fostering of ERN (European Research Networks) links.

Paediatric International Patient Safety and Quality Community (PIPSQC)

The Paediatric International Patient Safety and Quality Community is an informal, international community of professionals who share a passion for patient safety and quality in paediatrics, and who interact together across organizational and geographic boundaries, to advance learning and improvements in these areas.

International Society for Quality in Health Care (ISQua)

The International Society for Quality in Health Care is dedicated to promoting improvements in the quality and safety of healthcare through education, knowledge sharing, supporting health systems worldwide and connecting people through healthcare networks.

Post Covid-19 Recovery Plan

"I can't change the direction of the wind, but I can adjust my sails to always reach my destination" **Jimmy Dean**

The Covid-19 pandemic has led to extraordinary changes in the way that GOSH functions and has impacted on day-to-day working practice. While the Trust is prepared to accommodate a significant increase in clinical demand with a changing patient demographic and potentially reduced staffing levels, staff in both clinical and support services have been asked to work outside of their normal roles to meet this clinical demand.

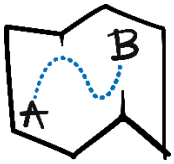
Through these changes, patient safety must be maintained, and we must maintain the necessary processes and support for when things go wrong. The pandemic will impact on the delivery of some of the safety priorities set out in our Safety Strategy and once the pandemic has come to an end, there will need to be a period of reflection, refocusing and planning before we are in a position to carry on with 'business as usual' delivering our priorities. During this new steady state, the main areas of focus will be:

1. **Acknowledging success**
   An important consideration during this time will be the acknowledgment and demonstration of appreciation for all contributions made during the crisis and celebration of the successes along the way.

2. **Reviewing safety team capacity and capability**
   A review of safety team capacity and capability to deliver the new safety strategy will be conducted. Consideration of the extent to which team dynamics and processes have changed during the crisis and assessment of any new challenges that may have arisen will be crucial.

3. **Reviewing safety strategy priorities and deliverables**
   A review of our priorities will take place, allowing incorporation of unanticipated challenges and issues that require urgent action. The year 1 priorities will describe the actions during the pandemic recovery phase, respond to outstanding CQC recommendations and establish the firm foundations for a new normal.

   Timeframes for delivery of programmes of work will also be reviewed and be responsive to those things outside of our control in our environment. It is likely that as a result, should a further increase in COVID-19 cases occur, timeframes will need to put back by up to 12 months (i.e. programmes of work due to be completed in year 1 will now become priorities for year 2, etc.).



Our Priorities for 2020 - 2025

We will deliver the following programmes of work over the next 5-years to help us deliver safer care for children and young people with complex health needs

Year 1 Post COVID-19 Recovery Plan

- Review of patient safety team capacity, capability, priorities and deliverables
- Facilitated reflections within the patient safety teams at specialty and Directorate level
  - What are the current and expected work streams and deliverables?
  - What urgent issues or priorities have arisen as a result of COVID-19?
  - What priorities set out for Year 2 in the new Safety Strategy need addressing?
  - What are our safety priorities as the Trust moves to a new 'Steady State', with consideration of timings in preparation for a possible second surge?
- Delivery of the necessary actions to meet the CQC recommendations with implementation plans to mitigate against the risk raised. The CQC report recommendations include

Medicines management

- Ensuring that systems and processes are in place to store, record or destroy medicines in line with current legislation and the Trust's medicines management policies
- Ensuring that pharmacy provision on the critical care wards meets the recommendations of the Society of Critical Care Medicine

Infection Risk Control

- Ensuring the consistent use of infection control measures across all services
- Ensuring consistent compliance with Infection Prevention Control (IPC) best practice guidance in relation to hand hygiene, particularly when entering or leaving wards or moving between patient bays
- Ensuring that all equipment and premises are kept visibly clean

Equipment

- Ensuring effective systems are in place so that all medical equipment is maintained and safe and that national guidance is always followed so that staff feel assured it is safe to use
- Providing consistent checks in relation to all in-use resuscitation equipment in the critical care areas, in line with guidance from the Resuscitation Council

	Y 1	Year 2	Year 3	Year 4-5
Building system safety and learning capability	POST COVID-19 RECOVERY PLAN	▪ Identify appropriate tools to assess safety culture ▪ Review our current processes to assess their effectiveness on creating a just, kind and civil safety culture ▪ Build understanding around safety concerns from patient experience metrics, and the development of safety specific patient surveys ▪ Design processes for greater lay person engagement in safety initiatives ▪ Design and test methods to recruit and train patients and families as 'patient safety partners' ▪ Work in partnership with the performance team to establish electronic integrated performance dashboards to support safety learning. Benchmark against best practice nationally and internationally ▪ Redesign and streamline processes for reporting and managing incidents in consultation with operational teams to increase learning capability ▪ Implement training around the new processes, including an update of the incident management policy ▪ Ensure that all incident actions have an agreed monitoring plan ▪ Improve timeliness of incident action completion with review via Closing the Loop to embed learning throughout the Trust	▪ Regularly assess GOSH safety culture ▪ Continuously review and refine processes and behaviour to cultivate a just, kind and civil safety culture ▪ Integrate patients, families and lay representatives into safety projects and processes ▪ Create a training support package for patients, families and lay representatives recruited into GOSH safety work ▪ Evaluate functionality of validated integrated dashboards. Identify gaps and implement appropriate solutions to address these gaps ▪ Evaluate and continuously refine the enhanced incident reporting system with further training to consolidate module use and easier access to reports ▪ Work with our partners to set up learning forums across specialist paediatric centres nationally and internationally	▪ Continuously review and refine processes and behaviour to cultivate a just, kind and civil safety culture ▪ Evaluate impact of patient, family and lay representative involvement in GOSH safety processes ▪ Evaluate and continuously refine the enhanced incident reporting system with ongoing end user support and training ▪ Host a paediatric safety conference to showcase safety learning
Getting the basics right	POST COVID-19 RECOVERY PLAN	▪ Identify or recruit a duty of candour lead to provide advice and monitor training and compliance ▪ Develop a robust training methodology for duty of candour	▪ Monitor duty of candour compliance with key candour metrics; demonstrate a continued high level of compliance	▪ Deliver exemplary duty of candour practices ▪ Take a leadership role in duty of candour conversations within paediatrics ▪ Ensure a robust system of learning from incidents, both

		▪ Explore methods of capturing and disseminating learning from incidents, complaints, PALS contacts and other feedback ▪ Establish local and national networks to capture learning and share insights ▪ Review and establish robust processes to ensure timely responses to safety recommendations from external bodies with assurance and completion of actions	▪ Assess staff competence and confidence in exercising their duty of candour ▪ Establish local safety and learning networks ▪ Build upon networks nationally and internationally ▪ Ensure timely responses to safety recommendations from external bodies with assurance and completion of actions	locally and nationally, has been embedded. Consolidate networks nationally and internationally ▪ Ensure that learning is embedded within clinical areas with ongoing monitoring of compliance
Equipping all staff	POST COVID-19 RECOVERY PLAN	▪ Continue to support and further embed the 'Speak Up for Safety' programme ▪ Support the launch of the 'Speak up for Values' programme ▪ Design and deliver a patient safety training programme for our senior leadership teams in collaboration with the GLA ▪ Design a patient safety training programme for all staff based on the NHS Patient Safety Strategy in collaboration with the GLA ▪ Further develop and enhance patient safety capability with the safety & risk teams ▪ Complete review of current infrastructure (staff, digital technology) available to support resuscitation training in the 'classroom' and at the bedside	▪ Continue to embed the 'Speak up for Safety' and 'Speak up for Values' programmes ▪ Develop metrics to monitor impact and effectiveness of the 'Speak up' programmes ▪ Continue to upskill senior leadership, patient safety & risk teams ▪ Deliver patient safety training to all clinical staff ▪ Recruit and train a team of patient safety champions within the Clinical Directorates ▪ Develop and implement solutions to address identified gaps in available infrastructure for resuscitation training	▪ Continue to support and embed the 'Speak up' programmes ▪ Ensure that patient safety training is embedded across the Trust with ongoing monitoring of quality and effectiveness ▪ Review role of safety champions within the Clinical Directorates
Adopting a more proactive approach	POST COVID-19 RECOVERY PLAN	▪ Create new patient safety structures to create a greater degree of accountability within specialties and Directorates, supported by validated performance metrics ▪ Explore and introduce more robust quality assurance processes within Directorates and Trust wide	▪ Evaluate the impact of the revised safety structure assessing effectiveness, performance and accountability ▪ Deliver consistent patient safety and risk management processes underpinned by good governance and management	▪ Ensure that revised safety structures embedded across all specialties and Directorates ▪ Continue to monitor and evaluate patient safety and risk management processes

Exploring incidents - 'Learn not Blame'	POST COVID-19 RECOVERY PLAN	▪ Develop a framework that identifies the appropriate level of investigation, response and depth of actions required to mitigate against repeat incidents or new risks ▪ Evaluate and build a portfolio of Safety 2 built on good practice ▪ Explore and develop the Learning and Wellbeing management system for Serious Incidents (SIs), red complaints and high profile cases ▪ Develop a "Learn not Blame" programme	▪ Demonstrate learning from Safety 1 and 2 embedded into daily clinical practice ▪ Establish the Learning and Wellbeing management system for Serious Incidents (SIs), red complaints and high profile cases ▪ Launch the "Learn not Blame" programme	▪ Monitor and evaluate effectiveness of embedded safety learning ▪ Review the Learning and Wellbeing management system for Serious Incidents (SIs), red complaints and high profile cases ▪ Evaluate effectiveness of patient/ family support (Patient Experience) and peer support networks in helping staff to feel safer ▪ Embed the "Learn not Blame" programme
Outcome metrics, trends and vulnerabilities	POST COVID-19 RECOVERY PLAN	▪ Expand and embed metrics of safety and learning ▪ Develop safety dashboards linking audit and clinical outcomes data ▪ Explore the development of metrics to evaluate patient experiences with safety practices within the Trust	▪ Continue to expand safety metrics ▪ Create national benchmarking opportunities to discuss safety outcomes and practices ▪ Launch safety dashboards ▪ Evaluate patient experiences with safety practices within the Trust	▪ Share and benchmark safety practices and outcomes ▪ Ensure continued presence at national and international safety forums ▪ Evaluate safety dashboards and monitor effectiveness ▪ Evaluate effectiveness of programmes to support an improved safety culture using developed safety culture metrics
Working with partners	POST COVID-19 RECOVERY PLAN	▪ Collaborate specialties and Directorates to ensure that local protocols and guidelines are up to date and have been ratified by the Clinical Guidelines group ▪ Build on new and established networks to share experiences, data and lessons learnt locally (North Thames Paediatric Network) and nationally (UK Children's Hospitals Alliance) ▪ Strengthen and expand current internal and external working partnerships as per strategy (e.g. Child Death Overview panels and National Child Mortality database)	▪ Ensure that up-to-date, evidence-based local and national protocols and guidelines are easily available in a central repository ▪ Build upon these new networks and share best practice ▪ Continue to widen and strengthen both internal and external working partnerships	▪ Review processes to ensure that protocols and guidelines are up to date and easily available ▪ Build on networks and communities of practice ▪ Ensure on-going strengthening of partnerships

Monitoring and Assurance

The Medical Director will have overall executive responsibility, on behalf of the Board, for the delivery of this strategy. The Associate Medical Director for Safety and Head of Quality & Safety will have devolved responsibility for overseeing the delivery of the work set out in this strategy. Each work stream will be underpinned by robust systems of clinical and corporate governance to ensure that there is appropriate oversight of progress during the year. The safety team will report on progress through the directorate quality & safety meetings and our work will be presented at the Quality Safety and Experience Assurance Committee (QSEAC).

Outcome Measures and Key Performance Indicators

Our work is directed towards providing the safest, kindest and most effective care for our children and young people with complex health needs. We have created a portfolio of outcome measures by which we will assess our progress and success in delivering the priorities laid out in this strategy.

	Key Performance Indicator (KPI)	Y 1	Year 2	Year 3	Year 4-5
PROCESS MEASURES	**Incident reporting**	POST COVID-19 RECOVERY PLAN			
	- Percentage of incidents closed within 45 days		80%	90%	100%
	Duty of Candour compliance				
	- Percentage compliance with Stage 1		100%	100%	100%
	- Percentage compliance with Stage 2		90%	95%	100%
	- Percentage compliance with Stage 3		75%	85%	100%
	Serious Incidents (SIs)				
	- Percentage of SIs closed within 60 days		90%	95%	100%
	Complaints				
	- Percentage of red complaints (12m rolling)		<10%	<10%	<10%
	- Percentage of re-opened complaints (12m)		<10%	<10%	<10%
	- Percentage of complaints closed within timeframes agreed with complainants		95%	95%	95%
	- Percentage of action plans completed within timeframes specified with complaint response		90%	95%	95%
	CAS alert compliance				
	- Percentage of alerts completed on time		95%	100%	100%
	WHO Surgical Safety Checklist compliance				
	- Percentage compliance in theatres		95%	100%	100%
	- Percentage compliance out of theatres		90%	95%	100%
	Clinical guidelines				
	- Percentage of guidelines updated every 3 years		75%	90%	100%
	Patient Safety training				
	- Percentage of senior leadership team trained		95%	100%	100%
	- Percentage of clinical staff trained		50%	75%	90%
	'Speak up for Safety' training				
	- Percentage of staff trained		90%	100%	100%
	Establish a tool and/or expand staff survey to measure safety culture		Design	Implement	Refine
	Create a tool for assessing patients experiences with our safety practices		Design	Implement	Refine
	Enhanced engagement of patients, families and lay representatives in safety processes		Design	Implement	Refine
	Develop and/or refine Safety 1 & 2 Practices				
	- New incident management process		Design	Implement	Refine
	- Learning & Wellbeing Management system		Design	Implement	Refine
	- Safety 2 practices		Design	Implement	Refine
	- Safety & Learning Network		Design	Implement	Refine

OUTCOME MEASURES	**Safety culture** ***a) Perception of a Safety Culture*** ** Continuously improving Staff Survey results Q16a *"In the last month have you seen any errors, near misses or incidents that could have hurt staff?"* **Target 12%** Q16b *""In the last month have you seen any errors, near misses or incidents that could have hurt patients/service users?"* **Target 20%** Q16c *"The last time you saw an error, near miss or incident that could have hurt staff or patients/service users, did you or a colleague report it?"* **Target 100%** Q17a *"My organisation treats staff who are involved in an error, near miss or incident fairly"* **Target 75%** Q17b *"My organisation encourages us to report errors, near misses or incidents"* **Target 95%** Q17c *"When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again"* **Target 85%** Q17d *"We are given feedback about changes made in response to reported errors, near misses and incidents"* **Target 75%** Q18a *"My organisation encourages us to report errors, near misses and incidents"* **Target 95%** Q18b *"I would feel secure raising concerns about unsafe clinical practice"* **Target 85%** Q18c *"I am confident that my organisation would address my concern"* **Target 75%** Q18d *"My organisation acts on concerns raised by patients/ service users"* **Target 90%** *b)* ***Assessment of Patient safety Culture & Effectiveness*** e.g. Manchester Patient Safety Framework (MaPSaF)	POST COVID-19 RECOVERY PLAN			
	Incidents - Total number of incidents reported - Rate of incidents per 1000 bed days - Percentage of 'no harm/'near miss' incidents - Percentage of action plans completed within agreed timeline				
	Never events Compliance with Never Event criteria				
	Medicines Management Compliance with best practice and 'No Medicines Must Do's' identified through our Medicines Clinical Audit plan		100%	100%	100%
	CQC - 100% of clinical areas engaging in routine quality/safety rounds		Achieved		Achieved
	- 100% of directorates self-assessed as 'Good' or 'Outstanding' through quality/ safety rounds		Achieved	Achieved	Achieved
	- Trust most recent assessment to have been 'Good' or 'Outstanding'				

PATIENT EXPERIENCE MEASURES	**Friends and Family Test (FFT)** - Experience rating – inpatient - Experience rating – outpatient **Patient and Family feedback** - Annual completion by each Directorate of one additional initiative to collect patient feedback (outside of FFT and including but not limited to focus groups, listening events, additional surveys, Patient Reported Outcome Measures) - Action plan arising from additional patient feedback completed on time and reported through the Patient Experience and Engagement Committee **Staff Friends and Family Test (FFT)** *"How likely are you to recommend this organisation to friends and family if they needed care or treatment?"* **Bereavement Experience Measurement** Completion of annual survey and action plan in agreed timeframes **Volunteers** - Checks and DBS up to date - Compliance with mandatory training	POST COVID-19 RECOVERY PLAN	>95% >95% Achieved Achieved 95% 100% 95% 95%	>95% >95% Achieved Achieved 95% 100% 95% 95%	>95% >95% Achieved Achieved 95% 100% 95% 95%

Attachment R

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2020

GOSH Quality Strategy 2020 **Submitted by:** Dr Daljit Hothi Associate Medical Director for Well-Being, Leadership and Improvement	**Paper No: Attachment R**

Aims / summary

This 5 year Quality Strategy sets out the direction in which GOSH will develop their staff and their services with a common purpose of continuously delivering high quality clinical care, experiences and outcomes for children and young people with complex health needs. It has been developed in consultation with key partners across the organisation and outlines the six principles to deliver high quality clinical care. These include:

- Translating learning from safety and experience into practice
- Building knowledge across all hospital groups
- Providing assurance
- Supporting local teams with improvement activity
- Encouraging innovation
- Building QI capacity

This Strategy is aligned with the GOSH 'Above and Beyond' Strategy and the GOSH Transformation Strategy. The work streams undertaken will complement the Safety and Patient Experience Teams and there will be close collaboration with the GOSH Learning Academy.

Action required from the meeting
Agreement of strategic approach

Contribution to the delivery of NHS / Trust strategies and plans
The Quality Strategy outlines the Trust's commitment to Always Learning, Always Improving and Always Involving

Financial implications
None

Legal issues
None

Who is responsible for implementing the proposals / project and anticipated timescales
Associate Medical Director for Well-Being, Leadership and Improvement
Head of Quality and Safety

Who is accountable for the implementation of the proposal / project
Medical Director

GOSH Quality Strategy 2020 – 2025:

'Taking action to improve the health and care of children everywhere'

AMBITION

Our ambition is to support and nurture GOSH in its quality journey, advancing improvement and innovation for exemplary patient care and experiences.

Our aim is to produce a Quality profile that further enhances our world-class clinical services with a commitment to staff wellbeing and development.

This strategy sets out our direction and establishes the means by which GOSH intends to develop their staff and their services with a common purpose of continuously striving to deliver higher-quality clinical care, experiences and outcomes for children and young people with complex health needs.

OUR CONTEXT

There are six established domains of Health Care Quality *(adapted from World Health Organisation)*:

- **Effective:** delivering health care that is adherent to an evidence base and improved health outcomes for individuals and communities, based on need, avoiding underuse and misuse, respectively
- **Person-centered**: Providing care that is respectful of and responsive to an individual viewing the patient as a person, wherever possible meeting their individual preferences, needs, and the cultures of their communities; ensuring that our clinical decisions are guided by and consider the holistic needs of the individual

- **Timely**: delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to the medical need; reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficient**: delivering health care in a manner which maximises resource use and avoids waste of equipment, supplies, ideas, and energy
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

This decade a sixth dimension has been described as prioritising resources to **share principles and techniques** that enable the workforce to truly thrive, not just persevere *(Institute of Healthcare Improvement).*

Internationally, the methods, tools, concepts and evidence base for Quality Improvement continue to build and gain recognition within Healthcare. Safety issues and catastrophic failures in care have triggered a renewed commitment to learning from safety events. In the 2000s this prompted setting a national priority for the sustained translation of learning to advancing patient care, extending work from safety and risk management to quality assurance and quality improvement. Both the Francis Enquiry and Berwick Report, '*A promise to learn - a commitment to act' (2013)*, were clear in their message that *'more than ever before, we need a system devoted to continual learning and improvement of patient care, top to bottom and end to end.'* The Berwick Report's key recommendations included the cultivation of an NHS culture in which learning and improvement are core to organisations by:

- Providing education and training to all staff (including executive teams) in quality improvement and patient safety theory and practices
- Transparent reporting of data on quality and safety
- Greater attention to the views and voices of patients and carers
- Support for improvement from leaders at all levels of an organisation

There has been a drive within the NHS to create a new ethos of delivering greater value care with a lower demand on resources. The Carter review on efficiency, operational productivity and performance in English NHS acute hospitals was uncompromising in its message that the NHS must optimise its resources to remain sustainable, by reducing unwarranted variation, improving clinical outcomes and productivity, improving use of modern digital technology, and refining its real-time monitoring and reporting. '*Getting it right, first time'* (GIRFT) is a national programme that launched with an ambition to improve the quality of care within the NHS by reducing unwarranted variations.

The Care Quality Commission (CQC) report, '*Quality improvement in Hospital Trusts',* (2018) recognised that the increasing demand on the health and social care systems put quality of care at risk. Despite this, some hospital Trusts were still able to focus and deliver on a programme of continuous quality improvement that resulted in higher quality care. Trusts rated by the CQC as outstanding were successful in embedding a culture of quality improvement throughout the organisation that could be felt by all. Their staff were engaged and focused on the quality of patient care; they were confident in their ability to make positive changes; and the Trust performed well in staff and patient satisfaction surveys. The Report acknowledges that embedding this culture is not easy. In Trusts that are still on their journey to outstanding, they caution them to not to underestimate the challenge or the speed at which this could be achieved. Changing behaviours in

complex organisations and developing an effective leadership and organisational culture is an enduring process that requires commitment at all levels, particularly senior leaders, resilience and a supportive culture that enables curiosity and humility in the context of improvement. In recognition of the importance of Quality Improvement infrastructures within organisations, Quality Improvement is one of the main domains of the CQC assessment.

OUR CHALLENGE

The Trust CQC inspection in 2019 retained an overall rating of *Good* and all services provided were rated as either *Outstanding* or *Good*. However, within the domain of safety our rating reduced to *Requires Improvement*. This was linked primarily to medicines management within the hospital, specifically the storage and disposal of medicines.

Internal data from sources such as Serious Incidents, morbidity and mortality reviews; patient and family feedback mechanisms such as complaints, Friends and Family Test data and self-reported patient outcomes; in combination with benchmarking data from Civil Eyes, Dr Foster's Data and the National Model Hospital continues to show unwanted variation in practice and care. These indicators have sign-posted areas for Trust wide transformation as well as the need for localised clinical pathway and service improvements. However, as a central London quaternary hospital with the most complex patients, our referral pattern is national and our staff are younger with lower staff retention rates than the national average. The corollary of this is the increased challenge of implementing and embedding known solutions or interventions to improve care, and places a greater reliance on having to use innovative ideas and solutions to secure successful change. This requires a more collaborative and integrated approach to improving care, connecting with regional and national patient and professional networks. In order to deliver high quality services we must create diverse work spaces that invite, nurture and embrace shared wisdom from multiple teams within GOSH and key partners.

This year GOSH produced its first People Strategy. This denotes an important milestone, with a message that we at GOSH are committed to the needs and welfare of the staff that work for us. The content and strategic aims are forward-looking and carve out our intentions to improve the experiences and well-being of our staff. We all have a responsibility to support the delivery of this plan; particularly relevant for the Quality team because without happy, healthy staff our aspirations to improve the care of our patients will be compromised.

In 2020 people all over the world woke up to a new virus that was highly contagious and for some was lethal. The Coronavirus has spread across the world putting healthcare systems under unprecedented pressures as they attempt to limit the mortality and morbidity of the COVID-19 pandemic. Although primarily this is not a paediatric disease, at GOSH as we have worked to support

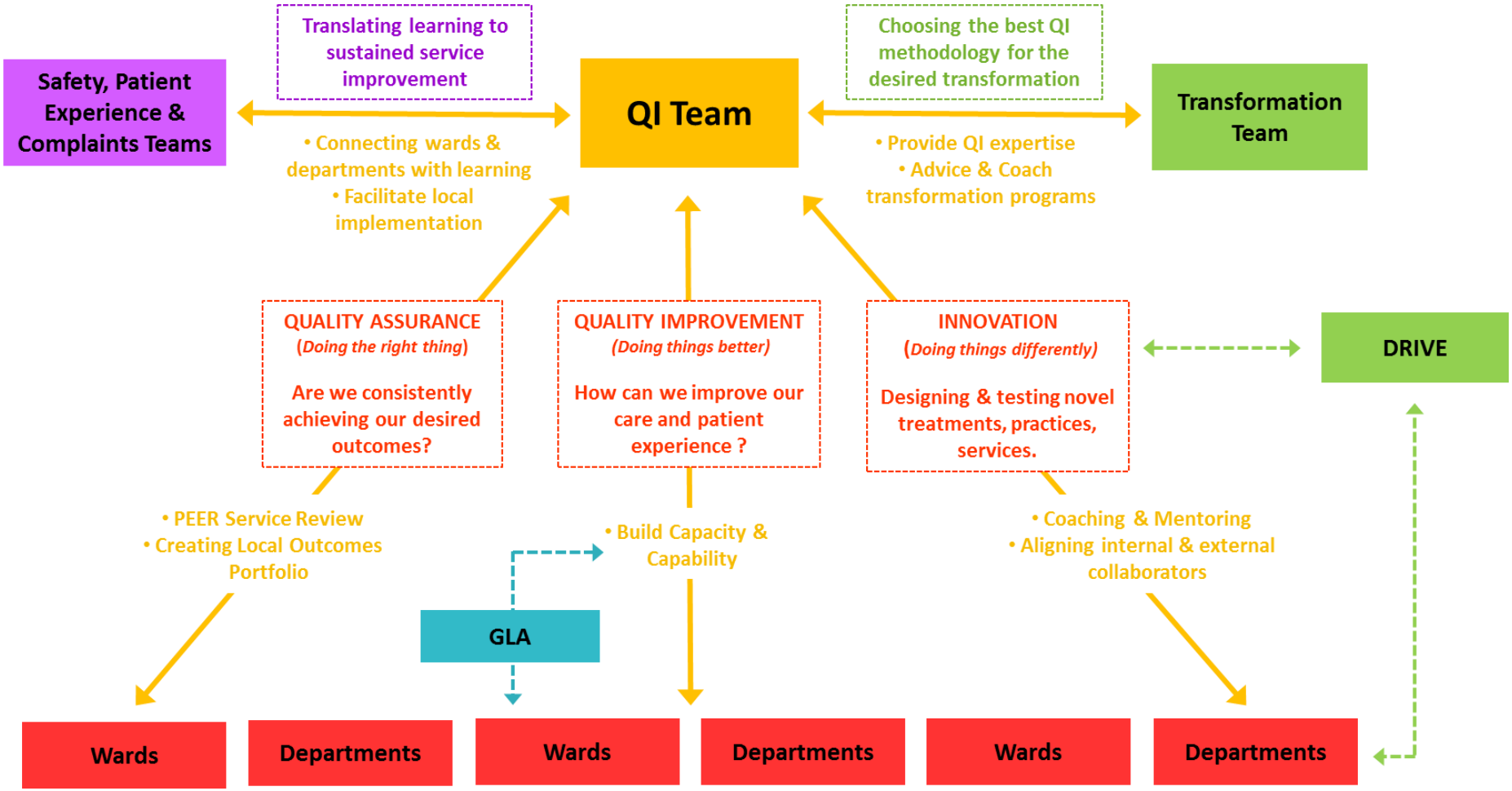
the wider NHS system, and we have experienced a protracted period of volatility, change and uncertainty. At an organisational level in the spirit of our values '*Always Welcoming, Always Expert, Always Helpful & Always One Team',* we extended our services to children and young people across London to free up capacity for adults at other hospitals, we provided support in the establishment of the Nightingale Hospital, and deployed staff to assist in other London hospitals. At department level, clinical and non-clinical staff have undertaken new roles and responsibilities, and developed new ways of working in order to ensure they continue to provide a high standard of care and experience for their patients and families. Supporting all of this work is a growing network of *well-being* provision that is caring for all our staff. In our state of *'emergency',* the hospital has been agile, responsive and creative; across the organisation, our sense of '*normality*' will undoubtedly change.

STRATEGIC FRAMEWORK

To deliver on our strategy, the ambition is underpinned by a framework, which describes our overall approach and priorities. The framework demonstrates our intention to link across to other services and teams, working collaboratively to maximise our ability to fulfil our aims whilst supporting the wider organisation to achieve goals and objectives.

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Quality Framework



OUR PRINCIPLES

Six principles will guide our team priorities and delivery plan:

1. Translating learning from safety events and patient experiences into routine care and practices

Nearly 20 years after the publication of the Institute of Medicine's report, '*To Err Is Human'*, a number of publications and frameworks have been produced with a common ambition of making healthcare safe and reliable. At the Trust, a significant proportion of safety and care issues only come to our attention from serious and critical incidents, mortality and morbidity reviews, complaints and near misses. We will improve our processes for bridging the gap between our 'learning' both from excellence in care and adverse outcomes, and embedding this into routine practices. The QI Team will do this by working in partnership with the Safety, Complaints and Patient Experiences Teams:

- Increasing the reach of important messages and learning from adverse events and experiences by utilising more creative methods and platforms
- Facilitating teams in translating key recommendations from adverse events and experiences into change actions
- Creating a process to help identify trust specific safety themes to enable us to prioritise improvement work from safety and care events

We are increasingly aware of the complexity of our clinical cases and the high degree of media scrutiny we attract. Staff involved in serious incidents, high profile cases and complaints are particularly vulnerable and undergo a high level of stress. Working with the safety team, we will design, develop and implement a novel Learning & Well-Being Management System for serious incident and high profile cases. This will comprise three parallel pathways:

i) designed to support the patient and their families
ii) actioned to investigate and provide a high quality review of the case
iii) designed to provide peer and emotional support for the key professionals involved in the case. (For further detail, please refer to the Safety Strategy.)

2. Choosing the most effective QI methodology for the desired transformation

Quality Improvement (QI) has become a constantly evolving portfolio of principles, concepts, tools and methods designed to improve the quality of healthcare worldwide. In parallel to this, the evidence base for the effectiveness of QI practices has been building. The Health Foundation (2020) has written that in planning change, not only should we consider 'what' we wish to improve but also 'how' we do it to ensure that we have the best chances of achieving the desired outcomes.

At GOSH, developing expertise in QI is essential to ensure that we maximise the value from our improvement efforts. In recognition of this, the QI team are committed to the pursuit of developing

our knowledge and expertise across existing and emerging QI practices. With our advancing knowledge we will able to adopt an enabling role in the larger Trust wide transformation projects, offering coaching, mentoring and facilitation in accordance with the needs of individual projects. We will also extend the existing transformation support provided with the aim of improving the flow of patients through the hospital.

3. Quality Assurance…. *'Doing the right thing'*

We know from benchmarking data, adverse events and local audits that we are not consistently delivering the same standard of care for every patient, every time. Reliably implementing best practice remains a challenge across the NHS, triggering a number of initiatives, including audits and peer reviews, inspection and mandated monitoring, and most recently the National GIRFT programme.

Aligned with this, we will aim to improve the care of our patients by reducing unnecessary variations in practice. Initially this will be through support to services within GOSH to define the standards against which work can be judged. These standards may arise from regional, national or international practice guidelines and will include clinical outcomes, patient reported and patient experience outcomes, and staff related outcomes. We will then support services in establishing an all-encompassing one-stop dashboard where they can transparently display every aspect of their work, including outcomes, audit data and project repository, quality assurances, QI projects, key Safety metrics, lessons learnt, excellence, patient narratives, feedback and staff related data alongside internal and external benchmarking data. We will design and deliver self and peer assessment processes to help services appreciate their successes but also understand areas for improvement. Finally, we will advise, mentor and facilitate services on projects and plans to continuously improve their outcomes and support displaying these externally.

4. Quality Improvement….. *'Doing things better'*

Quality Improvement is an approach to improving service quality, efficiency and morale simultaneously *(CQC, 2018)* and is achieved by systematically enabling staff and leaders to continuously improve their daily work, drawing upon methodologies and tools from improvement science.

At GOSH, the QI team will utilise various improvement methodologies such as the IHI Model for Improvement, Lean, Flow Coaching, Microsystems, Co-production and Person-centred to enable staff, teams and services lead effective and lasting change in caring for children with complex healthcare needs.

The QI team will deliver three core functions to enable GOSH to *'do things better'*:

- Educate, facilitate and mentor front-line staff and services to successfully engage, design, deliver and embed local quality improvement initiatives
- Advise and coach groups of teams delivering larger Trust-wide transformation projects
- Deliver an education strategy to build capacity and capability for quality improvement across all staff groups

After consulting broadly we have identified a number of quality improvement priorities for the next 3-5 years:

- The content, quality and timeliness (as perceived by the receivers) of clinic letters and discharge summaries
- Medication optimisation: The right medicine, delivered to the right patient at the right time.
- Improving the consent process through using different education platforms such as digital learning, patient stories, simulated training sessions
- Spreading and sustaining good practices such as
  - reduction in unnecessary blood testing
  - increasing the well-being and lived experiences of work by staff
- Maintaining and advancing situational awareness in the midst of an environment placing a greater reliance on electronic and digital solutions
- Person centred digital care pathways; supporting clinical teams and Epic to standardise, where possible, components of patient pathways and effectively translate that to Epic optimisation; standardising care pathways through the translating clinical pathways into Epic workflow code. In parallel identifying sections of the pathways that require individualisation.
- Co-designing and enabling new ways of working such as virtual clinics, telemedicine and off-site patient monitoring and care whilst maintaining patient safety, positive patient experiences and exemplary clinical outcomes.

5. Innovation….. *'Doing things differently'*

The QI team has been in a unique position of having analytical team who also have the capability to develop software. This has helped us deliver a great deal of innovation within improvement projects including over 40 applications to date. The team plan to continue with this creativity and innovation, with a renewed emphasis on:

- Development of new data visualisation tools to support QI
- Interface with DRIVE and the Future Hospital Group:
  - Develop applications
  - Support interchange ideas between QI and DRIVE
- Leverage of Epic data to develop new tools for patients and staff
- Thinking creatively about how the rich Epic dataset can be used to drive improvement work.
- Roll out of the internally developed Survey Tool outside the Trust; we will need to help develop a channel for accessing Trust servers from outside the Trust.

6. Building Capacity & Capability

Increasingly' Nursing, Medical and Allied Health Professional bodies are describing Quality Improvement knowledge and capability as a desirable skill and for some groups it has become a core skill. NHS Improvement (NHSI) developed a national framework for action on improvement and leadership development across the NHS *(NHS Improvement, 2019)* and advised that team leaders at every level of the NHS develop a critical set of improvement and leadership capabilities among staff and those in leadership positions. Despite these clear directives from national groups, many NHS

staff report having little or no training in QI and therefore they lack the confidence to apply QI tools and methodology in their workplaces.

At GOSH we have pockets of QI expertise but our organisational capacity is limited and this has in part reduced the pace of change that has been possible. It is important that every staff member understands what QI is and how it fits into healthcare settings. In order to achieve this, every service will have at least one trained QI staff members that with mentoring support is capable of leading and delivering on local improvement plans. To further support this, every Directorate will have an expert in QI who is confident to coach and mentor several QI projects. We aim to deliver a practical and comprehensive approach for building QI capability by:

- Instilling QI skills into daily work from Board to Ward, through face-to-face teaching, virtual learning and active participation in projects
- Link QI development into existing clinical and non-clinical courses
- Create a spectrum of QI training as part of the Leadership and Management System that is available to all staff across the organisation
- Develop QI training to groups participating and active in Trust wide programmes of work, e.g. EASI Flow
- Create a QI mentoring and coaching scheme
- Celebrating, spreading and sharing exemplar quality initiatives through in-house recognition programmes and external submissions to national/international healthcare awards and conferences
- Building capacity and capability for improvement across the healthcare system by engaging and collaborating with other QI and paediatric networks

Once we have embedded QI capability across the organisation our aim is to start exploring the commercial potential of our courses in partnership with GLA.

In addition to developing Staff, it is absolutely imperative that we commit time and resources to our own development to ensure that we have the ability to offer expertise in a wide portfolio of QI tools, methods and concepts and can advise and direct on evidence based practice. This will be supplemented with further training on coaching, mentoring and facilitation.

PARTNERSHIPS

INTERNAL

We recognise the importance of utilising QI expertise and resources for patients and families treated in the hospital, to help achieve the Trust's strategic aims, and to advance the work of our colleagues in teams across the hospital. With this in mind:

- We are committed to working collaboratively with the Safety, Patient Experience and Transformation teams, creating the essence of 'one team' to meet the demands of the work that is closely aligned between us.
- The GOSH strategy '*Above and Beyond*' has made a commitment to innovation through digital technology. The QI team will continue to work in close collaboration with the DRIVE team and front line staff.
- The QI team will support the training and development of colleagues across the hospital; mentoring front line staff with improvement work, to build confidence and ability towards delivering positive change.
- Both the QI team and the GLA recognise the importance of improvement practices and methodology across healthcare. Together we will explore the potential of how we can commercialise the taught and consultancy work delivered by the QI team.

EXTERNAL

We recognise the need to work collaboratively with partners to ensure the greatest possible opportunities for quality improvement. We need to increase our efforts to build relationships and nurture networks with our external partners.

Quality Improvement Networks

The QI team attend quarterly NHS Improvement 'Improvement Director Network' meetings. This meeting links us with all of the other main hospitals who are actively engaging in Quality Improvement using not only Model for Improvement, but an array of other QI tools and methodologies.

The European Children's Hospital Organisation (ECHO)

This is a collaborative of leading paediatric hospitals across Europe, which aims to support improvement in quality of care, collaboration in research and innovation, and influence policy through advocacy. GOSH is a founder member and co-chairs the working group of the Quality, Safety, Outcomes and Value work stream, where the focus is currently benchmarking and the fostering of ERN (European Research Networks) links.

The Children's Hospital Alliance (CHA)

The CHA involves ten paediatric hospitals in the UK, initially working together for better tariffs but in recent years to also collaborate on models of care and benchmarking. GOSH is leading on establishing with NHS commissioners the pilot access of the 10 hospitals to each other's Specialised Services Quality Dashboard reports.

The North Thames Paediatric Network

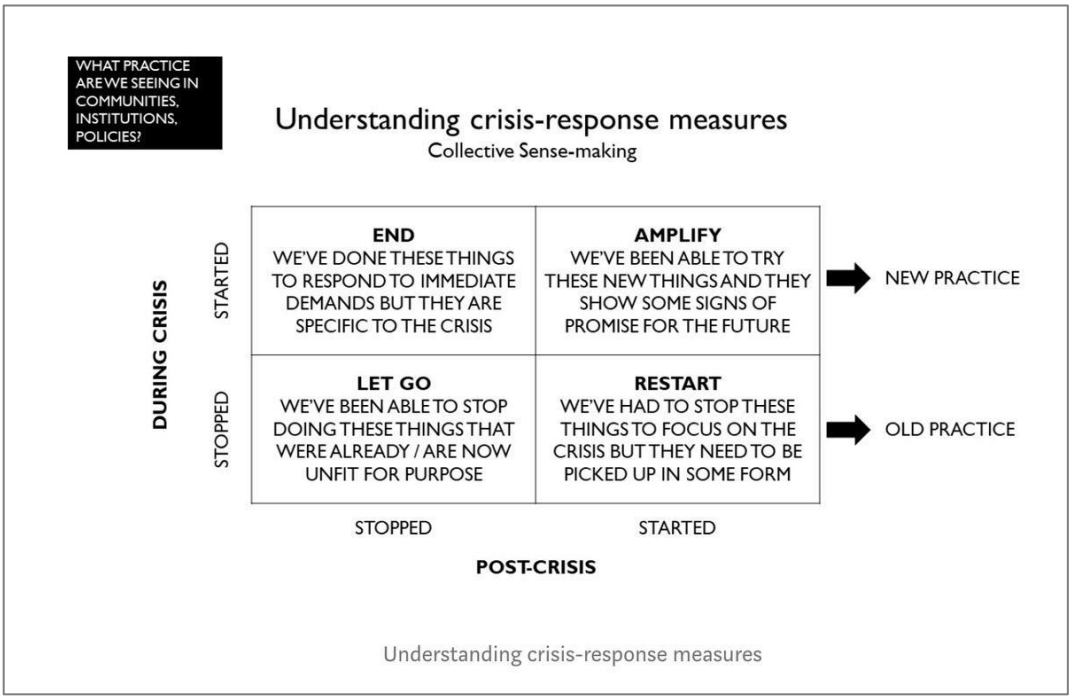
The North London Paediatric Network provides a unique opportunity to build QI relationships, share practices and develop integrated care pathways that benefit our patients and their families.

POST COVID-19 RECOVERY

"We do not learn from experience…
we learn from reflecting on the experience" *John Dewey*

As the hospital emerges from the COVID-19 pandemic we will also emerge from a period of creativity, innovation and change. We know from experience that all of us will need time to absorb what has transpired; create opportunities to share experiences; and formulate plans to heal from this crisis. Not affording our staff this time, will affect our organisational well-being, and slow pace at which we will be able to deliver against the ambitions set out in the GOSH strategy.

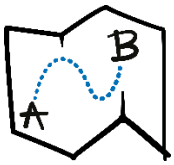
The QI team can support teams, divisions and corporate services in this recovery stage. We will commit time and resources to structure and facilitate practical and proportionate plans that will enable individuals, groups and teams to understand what has changed for them and how best to move forward, creating individualised recovery plans.



- Signpost and celebrate successes, helping draw attention to the learning and how to build and embed that into routine work

- Gain an understanding of how team dynamics, processes and procedures have changed and appraise what needs to be abandoned, further developed and implemented immediately.
- Acknowledge and appreciate what issues and challenges have surfaced and will need to be prioritised
- Identify how we can support the organisation to move from recovery to *'business as usual'*, emotionally and cognitively restoring staff energy, appetite and commitment for continuous improvement and innovation to advance our services and care.

The QI team will also need to undergo a similar process of self-reflection. We will need to make time to appraise our team's capacity and capability; our team dynamic and processes; and then define our personal opportunities to increase our performance and relationships.



OUR PRIORITIES

We will deliver the following programmes of work over the next 3-5 years (2020 - 2025) to help us produce a Quality profile that further enhances our world-class clinical services with a commitment to development and wellbeing.

Year 1 **Post Covid-19 Recovery Plan**

Review of QI team capacity, capability, team dynamic and team processes

Facilitated reflections within departments, divisions and corporate services

- What are our successes that we wish to build on?
- What needs to be developed or refined further?
- What issues have surfaced that we wish to prioritise?
- What do we need to be ready, to be willing and able to invest in our tomorrow? Our future? To return to our Quality journey?

Clinical Prioritisation Group is a is a subgroup of the Executive Management Team with delegated authority to authorise decisions on the delivery of clinical services including programmes of work and actions required to return the Trust to a new 'steady state'

- Create datasets that provide the intelligence for decision making and capture risks
- Develop processes that help translate decisions made by the group to operational processes and outputs

Our Quality Priorities for Years 2-5 have been summarised in the table below:

	Y 1	Year 2	Year 3	Years 4-5
Translating learning into routine care and practices	POST COVID-19 RECOVERY PLAN	▪ Developing a process for identifying the largest safety concerns in the trust ▪ Building more creative methods to disseminate learning from safety events ▪ Enable teams to translate recommendations from Serious Incidents into change actions ▪ Design and develop a Learning & Well-Being Management system for Serious Incident, Complaints & High Profile Cases that investigates and adequately supports patients and staff	▪ Identify and improve processes and practices related to the trust's highest safety concerns ▪ Building more creative methods to disseminate learning from safety events ▪ Enable teams to translate recommendations from Serious Incidents into change actions ▪ Implement a Learning & Well-Being Management system for Serious Incident, Complaints & High Profile Cases	▪ Identify and improve processes and practices related to the trust's highest safety concerns ▪ Building more creative methods to disseminate learning from safety events ▪ Enable teams to translate recommendations from Serious Incidents into change actions ▪ Embed and publish outcomes from the Learning & Well-Being Management system for Serious Incident, Complaints High Profile Cases
Choosing the most effective QI methodology for the desired improvement	POST COVID-19 RECOVERY PLAN	▪ Dedicate time and energy to expand the QI team's knowledge and expertise across a wider portfolio of improvement methodologies. ▪ Enhance the success of trust transformation projects by providing QI coaching, mentoring or facilitation ▪ Providing QI expertise for Patient Flow Project	▪ Dedicate time and energy to expand the QI team's knowledge and expertise. Advance their ability to direct and deliver evidence based QI practice. ▪ Enhance the success of trust transformation projects by providing QI coaching, mentoring or facilitation. ▪ Enabling clinical teams to translate clinical pathways into EPIC work-flow	▪ Dedicate time and energy to expand the QI team's knowledge and expertise. Advance their ability to direct and deliver evidence based QI practice. ▪ Enhance the success of trust transformation projects by providing QI coaching, mentoring or facilitation.

Quality Assurance	POST COVID-19 RECOVERY PLAN	▪ Develop a framework to enable services to continually assess themselves against recognised best practices & CQC standards ▪ Support services to establish their standards of work; support regular assessment of their work; creation of a local dashboard to present outcomes ▪ Enable services to translate recommendations from internal and external reviews into service improvements.	▪ Creation of a one stop Service dashboard where there is visibility of service outcomes, staff metrics, improvements, lessons learnt, excellence, patient & staff stories & feedback ▪ Establishing a more proactive approach to assessing standards of work compared to a reactive approach that follows adverse events or mandated changes. ▪ Increased national and international partnerships to benchmark clinical outcomes paediatric specialised services ▪ Develop a process for internal peer review	▪ Aim that 100% of our clinical specialties have defined their standards of work, regularly assess & present outcomes ▪ Every Service has co-designed their one stop dashboard visible to colleagues and the public ▪ Developed innovative ways of co-producing & collaborating with patients and families in our clinical audit, clinical outcomes, and compliance work streams. ▪ Enable services to translate recommendations from internal, external & peer reviews into service improvements.
Quality Improvement	POST COVID-19 RECOVERY PLAN	▪ Improve clinic letters and discharge summaries ▪ Reduce unnecessary blood testing ▪ Improving situational awareness within our digitalised environments ▪ Improving clinical care pathways with better integration into EPIC ▪ Medicines optimisation ▪ Improving the consent process	▪ Improving situational awareness within our digitalised environments ▪ Improving clinical care pathways with better integration into EPIC ▪ Medicines optimisation ▪ Improving the consent process ▪ Co-designing and enabling new ways of working in collaboration with Patient Experience	▪ Improving clinical care pathways with better integration into EPIC ▪ Medicines optimisation ▪ Improving the consent process ▪ Co-designing and enabling new ways of working collaborating with teams across the organisation

Innovation	POST COVID-19 RECOVERY PLAN	▪ Develop the Digital Quality Hub ▪ Develop the network with DRIVE and provide mentorship & supervision to trainees ▪ Continue to translate data into meaningful narrative ▪ Extend use of the survey tool (survey Marky) to enable data to be collected from outside of the trust ▪ Design and develop apps ▪ Support local innovation proposals ▪ Establish digital networks	▪ Enable the utilisation of digital technology such as YouTube, WebEx, Netflix within GOSH ▪ Support EPIC optimisation ▪ Support Data Scientists to build data platforms ▪ Explore and create apprenticeships and placements for degree students ▪ Gamification to support and /or activate our patients and their families ▪ Create an annual innovation competition ▪ Present successes at international conferences	▪ Engaging patients and families in digital health and app development ▪ Continue to support EPIC optimisation ▪ Support Data Scientists to build data platforms ▪ Establish apprenticeships and placements for degree students ▪ Gamification to support and /or activate our patients and their families ▪ Create an annual innovation competition ▪ Publish successes and present at international conferences
Building Capacity & Capability	POST COVID-19 RECOVERY PLAN	▪ Educate and embed the IHI Model for Improvement at Executive team and Senior Leadership team levels ▪ Design and deliver QI training within the Trust Management suite ▪ Create processes for QI focused mentoring & coaching ▪ Develop a portfolio of QI courses delivered through GLA ▪ Develop & nurture networks with regional, national and international QI groups ▪ Attend international conferences for continued QI team development	▪ Extend the IHI Model for Improvement training to all other staff groups ▪ Deliver QI training within the Management Suite and through GLA ▪ Design a QI focused coaching & mentoring scheme ▪ Attending courses & conferences for continued professional development for the QI team ▪ Explore avenues to commercialise QI development programmes ▪ Building QI communities of practice. ▪ Hosting first North London Paediatric Network QI Symposium	▪ Deliver QI training within the Management Suite & the GLA portfolio ▪ Establish a GOSH QI focused coaching & mentoring suite ▪ Attending courses & conferences for continued professional development for the QI team ▪ Establish & generate revenue through QI courses within GLA portfolio ▪ Host National Children's QI Symposium ▪ Further development of QI networks and communities of practice
Partnerships	POST COVID-19 RECOVERY PLAN	▪ Creating a QI community of practice within the North London Paediatric Network ▪ Consolidating working relationships with ECHO, CHA	▪ Working with GLA to build a portfolio of commercial products ▪ Organising a North London Paediatric Network QI Symposium	▪ Delivering a QI consultancy and training portfolio with GLA nationally & internationally ▪ Organising a National Children's Alliance QI Symposium

OUR OUTCOMES & KEY PERFORMANCE INDICATORS

Our work is directed towards continuously striving to deliver higher-quality clinical care, experiences and outcomes for children and young people with complex health needs.

We have created a portfolio of outcome measures by which we will assess our progress and success in delivering the priorities laid out in this strategy.

MONITORING & ASSURANCE

Robust systems of clinical and corporate governance are crucial in underpinning the organisational approach to quality improvement. Each of the selected projects will be structured in line with the appropriate governance structures within the organisation, to ensure that there is appropriate oversight of progress through the year. We will report on our progress at the Quality Safety and Experience Assurance Committee (QSEAC).

Attachment R

	Key Performance Indicator (KPI)	Y 1	Year 2	Year 3	Year 4-5
Translating learning into routine care and practices	▪ Safety Action Plans - SMART, measurable actions - Delivered & audited within timescales ▪ Safe Practice learning events ▪ Safety& Patient Experience Dashboard ▪ Learning & Well-Being Management system for Serious Incident, Complaints and High Profile Cases	POST COVID-19 RECOVERY PLAN	100% 50% Departmental 50% Design	100% 75% Organisational 75% Implement	100% 100% National 100% Refine
Choosing the most effective QI methodology for the desired improvement	▪ Transformation projects supported by the QI team ▪ PDR for QI team, including plans to expand QI skills, tools, methods ▪ QI team trained in facilitation & coaching ▪ QI team becoming members of the Health Foundation Q community	POST COVID-19 RECOVERY PLAN	25% 75% 75% 100%	50% 100% 100% 100%	75% 100% 100% 100%
Quality Assurance	▪ Wards/departments undertaking monthly Quality Rounds as routine practice ▪ Clinical specialties have defined standards of work, regularly assess their work & present outcomes ▪ Speciality/ward led clinical audits - Numbers completed - Number submitted to annual Clinical Audit & QI prize	POST COVID-19 RECOVERY PLAN	50% 25%	75% 50%	100% 80%
Quality Improvement	▪ Directorate/Pan-organisation QI projects delivered by QI team - Numbers completed per year ▪ Ward/service level QI projects supported by QI Manager - Number of mentored projects per year ▪ Projects presented at meetings/conferences - Number of projects presented - Number of conferences attended ▪ Number of QI publications per year	POST COVID-19 RECOVERY PLAN			
Innovation	▪ Design GOSH Quality Hub ▪ Innovations - Number attempted - Number completed - Number presented/published	POST COVID-19 RECOVERY PLAN	Design	Implement	Refine
Building Capacity & Capability	▪ GOSH staff trained in Model for Improvement ▪ Monthly QI training delivered through GLA ▪ QI focused coaching & mentoring programme ▪ Attendance at QI conference/training event - Number of staff per year	POST COVID-19 RECOVERY PLAN	25% 75% Design	50% 100% Implement	80% 100% Refine
Partnerships	▪ GLA teaching portfolio for QI ▪ Annual NCL QI Meeting/Symposium ▪ National Paediatric QI Symposium ▪ QI Communities of Practice - Number of networking visits with regional/national counterparts - Number of established communities of practice ▪ QI Consultancy within GLA infrastructure	POST COVID-19 RECOVERY PLAN		Implement Implement Implement Implement	Refine Refine Refine Refine

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 26 May 2020	
Integrated Quality & Performance Report **Submitted by:** Sanjiv Sharma, Medical Director Alison Robertson, Chief Nurse Phil Walmsley, Interim COO Caroline Anderson, Director of HR & OD	**Paper No: Attachment S**

Aims / summary

To provide a 3 month snapshot of hospital performance in key metrics relating to quality (safety, experience, effectiveness, responsiveness and whether we are well led)

To provide a qualitative analysis of trends and themes and learning within the organisation. This now includes upcoming inquests with their links to other incidents and complaints.

To provide assurance regarding the plans to address non-compliance.

Are we safe?

- There were 4 serious incidents reported in April 2020. One of these SIs relates to care provided 9 years ago which was identified following a claim, one relates to the cyber security event, and the other two are complex clinical cases involving a number of directorates.
- There was improvement in incident management with large numbers of incidents closed in February and March, but the position deteriorated in April with only 255 incidents closed and 48% within policy timescale. Incident trajectories for each directorate have now been developed and additional agency support for incident closures has been brought in. In house Training support for RCAs and investigations is currently being developed.
- There are currently 2 Safety Alerts overdue. One has been delayed due to difficulties in accessing equipment on a Covid-19 ward and the other has been due to staffing constraints in the procurement team. It is anticipated that both will be closed by the end of May 2020.
- WHO checklist documentation compliance remains low at 93%, although this is a small increase from February and March at 91%. This appears to be driven by gaps in documentation on Epic rather than a failure to undertake the checks. Consultant level details is being reviewed by the GOSH SSIPs group and targeted training will be provided.
- StatMan training – particularly Resuscitation and Level 3 safeguarding are below target for April at 89% and 86% respectively. Additional resuscitation sessions have been running through April and May in response to COVID-19.

Are we caring?

- FFT performance in March has been excellent with 99% experience rating for inpatients and 96% experience rating for outpatients. Feedback was overwhelmingly positively with families commenting on the professionalism and expertise of staff.
- The FFT response rate was 19% which is below the Trust target. However, FFT has not been actively promoted in the usual ways during the Covid-19 period.
- We have seen low numbers of complaints in March and April 2020 which is in line with national trends.
- The significant reduction of **Pals cases** in April is attributed at least in part to the Trust's on line information hub (which has had unprecedented high numbers of 'hits') and proactive contact to families providing further information about shielding. Some families contacted Pals requesting further assurance and some non-patients requested advice about Covid 19.

Are we effective?

- We are 100% compliant with NICE guideline reviews including all new Covid-19 guidance.
- The Q&S team have launched a new Clinical Hub has been launched to centralise local and national guidance relating to COVID-19.
- Discharge summaries are at 67.9% compliance for April which is a deterioration from the position last month. Backlog has been significantly reduced with only 29 discharge summaries predating April 2020.
- Clinic letter turnaround within 7 days has improved from 51.8% to 61.36% in April. Targeted work with specific specialties is underway and this has the potential to reduce the backlog by 25%

Are we responsive?

- There has been a 44% reduction in external referrals since March 2020, and 65% reduction in volume compared to February.
- Diagnostics 6 week waits sit at 40.34% for April 4.77% with the number of breaches in month up to 818 (compared to 387 in March and 112 in February)
- We achieved 76.2% against the RTT target of 92% with 1636 patient waiting longer than 18 weeks. This represents a deterioration of 6.7% from March.
- There are 53 52 week breaches with Dental patients accounting for approximately 50%.
- A Clinical Prioritisation Group has been set up to set priorities for admissions, diagnostics and outpatients as clinical services are restored in a phased away over the next weeks and months.

Are we well Led?

- Compliance with Duty of Candour for initial conversations is 100% for May 2020. Timescales for completing investigations remains low for March and April 2020. Additional training is being arranged for directorate staff.
- All actions associated with red complaints are either complete or within timescale. There are 105 overdue Serious Incident actions (according to data held on datix). The improvement plan has a target of closing all these action by the end of July.
- Policy performance remains low at 72% of policies currently in date, but safety critical policy performance as improved to 78% in April following the resumption of the Policy Approval Group via Zoom.

- PDR performance has reduced to 86%, reminders to staff have been reduced during the pandemic preparations. Consultant appraisal sits at 89%, but all overdue appraisals have been suspended by GMC given 'special circumstances', so our reported performance is 99%.

Action required from the meeting
To note the report, and the actions identified to improve compliance with key quality metrics.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Delivery of high quality care.

Financial implications
None.

Who needs to be told about any decision?
Head/Deputy Head of Quality & Safety

Head of Patient Experience

Head of Special Projects for Quality & Safety

Head of Performance

Associate Director of HR Operations

Who is responsible for implementing the proposals / project and anticipated timescales?
This varies depending on the action outlined.

Who is accountable for the implementation of the proposal / project?
Sanjiv Sharma, Medical Director

Alison Robertson, Chief Nurse

Phil Walmsley, Chief Operating Officer

Caroline Anderson, Director of HR & OD

Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality & Performance Report May 2020 (April data)

Sanjiv Sharma	Alison Robertson	Phil Walmsley	Caroline Anderson
Medical Director	Chief Nurse	Chief Operating Officer	Director of HR & OD

Data correct as of 21st May 2020

Hospital Quality Performance – May 2020 (April data)

Are our patients receiving safe, harm-free care?

	Parameters	Feb 2020	Mar2020	Apr 2020
Incidents reports (per 1000 bed days)	R<60 A 61-70 G>70	82 (n=598)	64 (n=447)	54 (n=376)
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	1648	755	255
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	33%	51%	48%
Average days to close	R ->50, A - <50 G - <45	57.7	62.9	74
Medication Incidents (% of total PSI)	TBC	23.6%	24.3%	26.3%
WHO Checklist (overall)	R<98% G>98-100%	90.9%	91%	93.06%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	3.7%	3.6%	6.1%
New Serious Incidents	R >1, A -1 G – 0	2	0	4
Overdue Serious incidents	R >1, A -1, G – 0	0	0	0
Safety Alerts overdue	R- >1 G - 0	0	1	2
Serious Children's Reviews Safeguarding children learning reviews (local)	New	0	0	0
	Open and ongoing	7	7	7
Safeguarding Adults Board Reviews	New	0	0	0
	Open and ongoing	2	2	2

Are we delivering effective, evidence based care?

	Target	Feb 2020	Mar 2020	Apr 2020
Specialty Led Clinical Audits on Track	R 0- 60%, A>60-75% G>75-100%	80%	77%	76%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	130	135	9
NICE guidance overdue for assessment of relevance	R=1+, G=0	0	0	0
Relevant NICE national guidance without a gap analysis	R=1+, G=0	0	0	0
Participation in mandatory relevant national audits	G=100%	100%	100%	100%

Are our patients having a good experience of care?

	Parameters	Feb 2020	Mar 2020	April 2020
Friends and Family Test Experience rating (Inpatient)	G – 95+, A- 90-94, R<90	98%	98%	99%
Friends and Family Test experience rating (Outpatient)	G – 95+, A-90-94,R<90	94%	97%	96%
Friends and Family Test - response rate (Inpatient)	25%	26%	25%	19%
PALS (per 1000 combined pt episodes)	N/A	6.71	11.42	5.41
Complaints (per 1000 combined pt episodes)	N/A	0.27	0.28	0.38
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	6%	5%	5%
Re-opened complaints (% of total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	10%	10%	10%

Are our People Ready to Deliver High Quality Care?

	Parameters	Feb 2020	Mar 2020	Apr 2020
Mandatory Training Compliance	R<80%,A-80-90% G>90%	94%	93%	93%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	88%	86%	86%
PDR	R<80%,A-80-89% G>90%	88%	86%	85%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	89.7%	Reported: 99% Actual: 88%	Reported: 100% Actual: 89%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	86%	83%	86%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	96%	95%	95%
Resuscitation Training	R<80%,A-80-90% G>90%	88%	88%	89%
Sickness Rate	R -3+% G= <3%	2.6%	3.2%	3.8%
Turnover - Voluntary	R>14% G-<14%	16.25%	15.8%	15.4%
Vacancy Rate – Contractual	R- >10% G- <10%	7.2%	6.2%	5.76%
Vacancy Rate - Nursing		6.1%	5.8%	4.67%
Bank Spend		5.4%	5.4%	4.1%
Agency Spend	R>2% G<2%	0.7%	0.7%	0.4%

Hospital Quality Performance – April 2020 (March data)

Is our culture right for delivering high quality care?

	Target	Feb 2020	Mar 2020	Apr 2020
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	92%	82%	77.2%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G-0	133	132	105
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G-0	1	1	0
Duty of Candour Cases	N/A	8	8	10
Duty of Candour Conversation (Stage 1)	R<75% A 75-90% G>90%	100%	100%	100%
Duty of Candour Letter (Stage 2) Has a letter been sent?	R<75% A 75-90% G>90%	75%	80%	71%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	62.5%	40%	57%
Duty of Candour - Stage 3 Total sent out in month	Volume	2	3	7
Duty of Candour – Stage 3 Total (%) sent out in month on time	R<50%, A 50-70%, G>70%	100%	0%	14.3%
Duty of Candour – Stage 3 Total overdue (cumulative)	G=0 R=1+	5	8	6
Policies (% in date)	R 0- 79%, A>80% G>90%	73%	72%	72%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	69%	68%	78%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	100%	100%	100%
Inquests currently open	Volume monitoring	8	9	14
Freedom to speak up cases	Volume monitoring	82	11	31
HR Whistleblowing - New	Volume monitoring	0	0	0
HR whistleblowing - Ongoing	12 month rolling	1	1	1
New Bullying and Harassment Cases (reported to HR)	Volume	0	1	0
	12 month rolling	2	2	1

Are we managing our data?

	Target	Feb 2020	Mar 2020	Apr 2020
FOI requests	Volume	48	48	38
FOI Closures: % of FOIs closed within agreed timescale	R- <65% A – 65-80% G- >80%	100%	94%	87%
No. of FOI overdue (Cumulative)		2	3	5
FOI - Number requiring internal review	R>1 A=1 G=0	1	1	1
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	13	4	7
IG incidents reported to ICO	R=1+, G=0	0	0	0
SARS (Medical Record) Requests	volume	116	105	56
SARS (Medical Record) processed within 30 days	R- <65% A – 65-80% G- >80%	96%	92%	93%
New e-SARS received	volume	1	0	0
No. e-SARS in progress	volume	4	4	4
E-SARS released	volume	1	0	0
E-SARS released past 90 days	volume	1	0	0

	Target	Feb 2020	Mar 2020	Apr 2020
52 week + breaches reported (ticking at month end)	Volume	39	36	53
52 week + harm reviews to be completed (for treatment completed)		27	0	3

Do we deliver harm free care to our patients?

Central Venous Line Infections

GOS acquired CVC related bacteraemias ('Line infections')

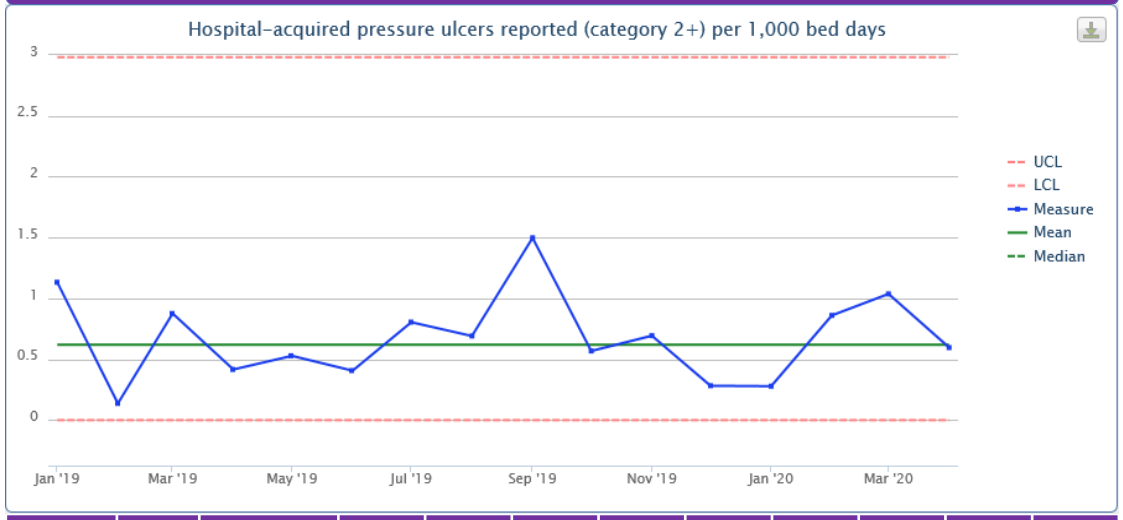
Period	GOSACVCRB_No	DaysRecorded	Rate	Rate_YtD
Year 15/16	75	51976	1.4	1.4
Year 16/17	87	52679	1.7	1.7
Year 17/18	82	50732	1.6	1.6
Year 18/19	82	52929	1.5	1.5
Year 19/20	73	51520	1.3	1.3
Apr-20	8	4811	1.5	1.7

*During the initial covid surge, the blood culture assessment was not completed for March of year 2019/20. 4098 line days were removed from the total year days recorded, so this figure is for 11 months data.

Infection Control Metrics

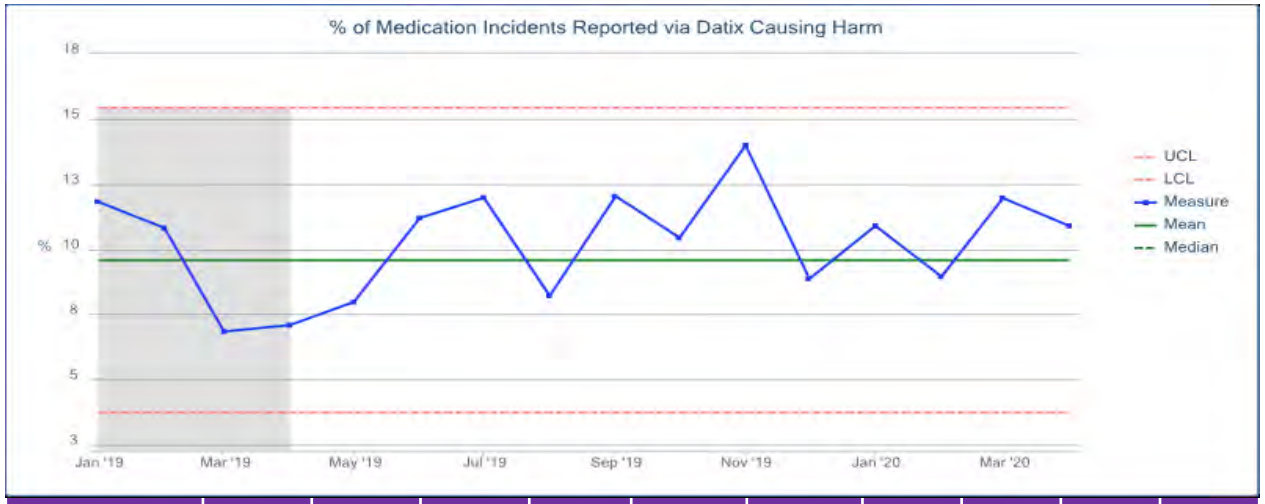
Care Outcome Metric	Parameters	Jan 2020	Feb 2020	Mar 2020	April 2020
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	5	12	3	6
	YTD (financial year)	69	81	84	6
C Difficile cases - Total	In month	0	0	0	3
	YTD (financial year)	7	7	7	3
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	0	0	0	3
	YTD	2	2	2	3

Pressure Ulcers



			Augu st	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20
Hospital Acquired Pressure Ulcer (2+)	Volu me	R – 12+, A 6-11 G =0-5	5	11	4	5	2	2	7	7	4
	Rate	R=>3 G=<3	0.67	1.45	0.54	0.66	0.27	0.27	0.97	1.04	0.6

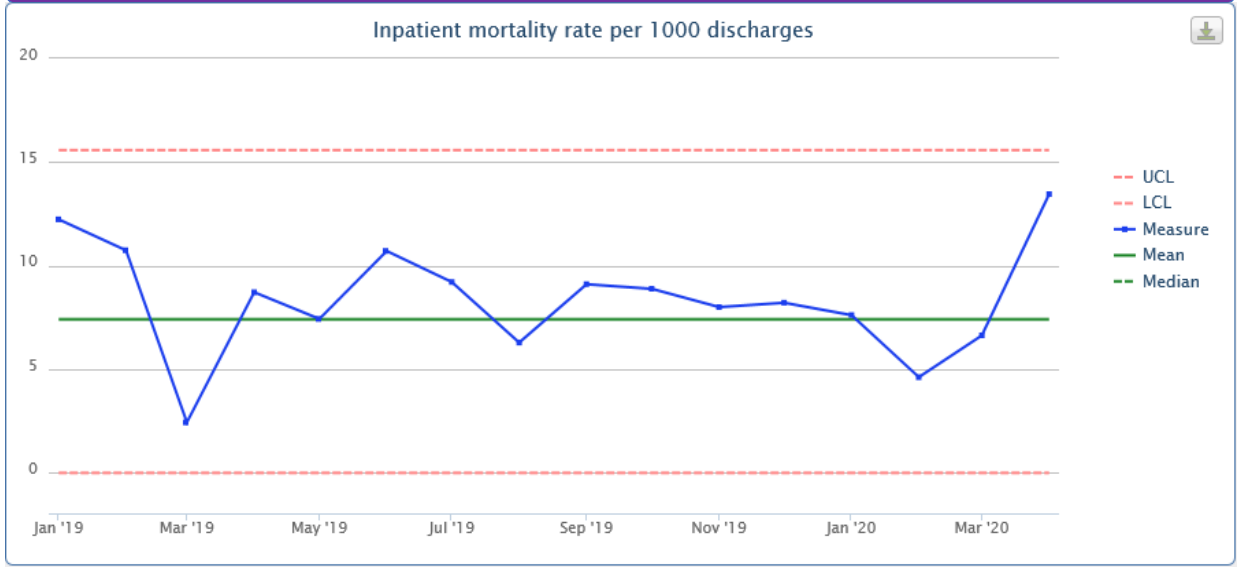
Medication incidents causing harm



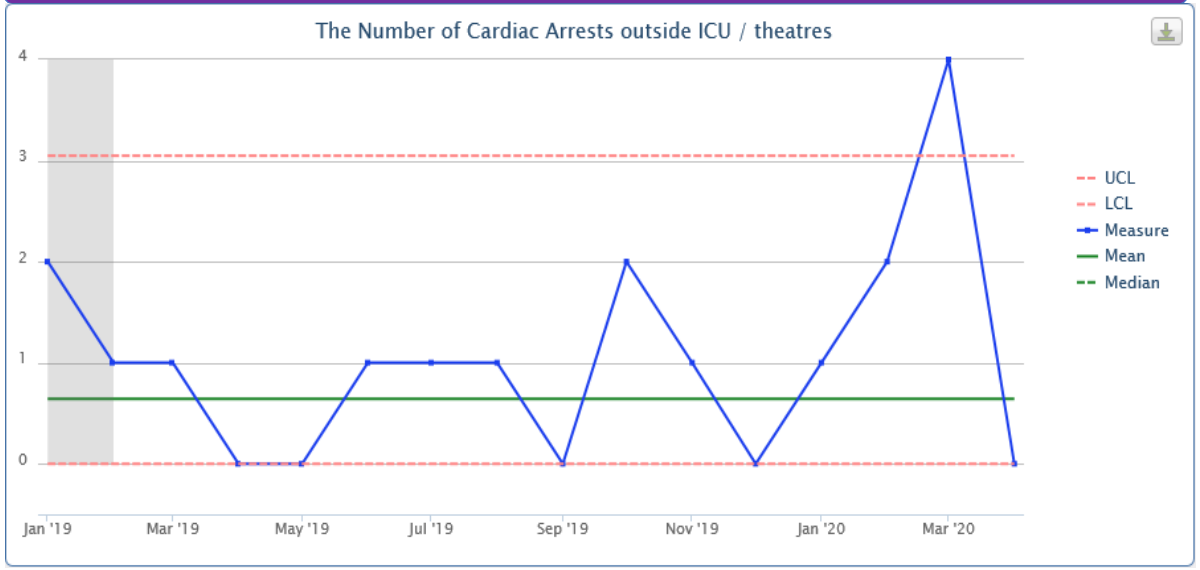
	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20
% medication incidents causing harm	12%	8%	13%	10%	14%	9%	11%	11%	12%	11%

Does our care provide the best possible outcomes for patients?

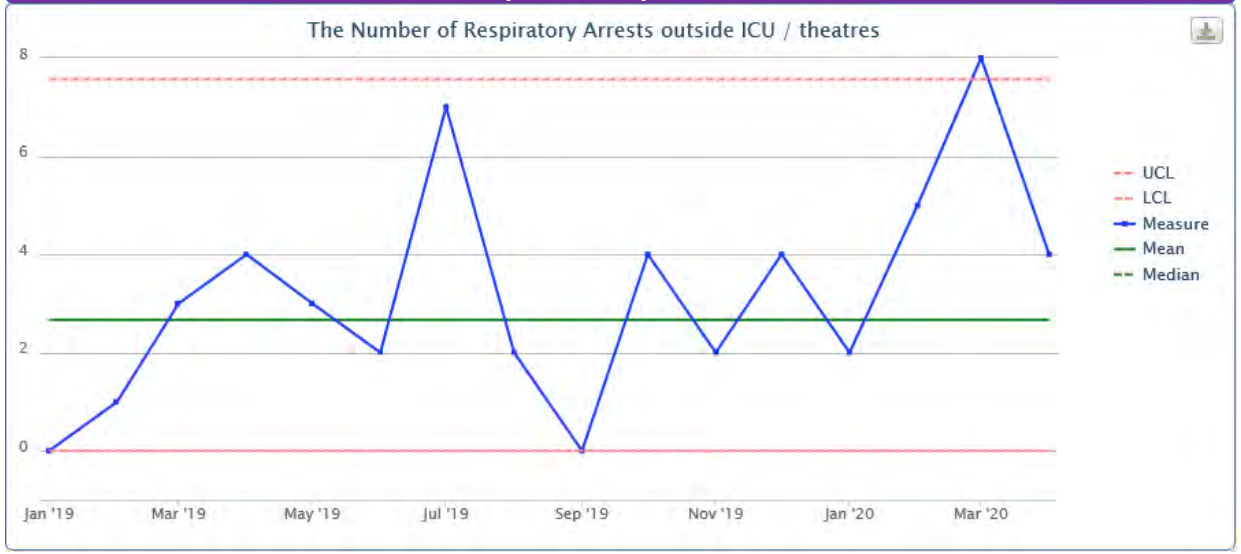
Inpatient mortality



Cardiac Arrests



Respiratory Arrests



The spike for March 2020 was due to a high number of calls to support one patient on Leopard ward over the course of the month. This has led to an additional MDT for the patient to consider longer term management options. There was also a high number of cases in which the clinical emergency team were stood down on arrival to the crash call – primarily because the local team had been able to deliver effective resuscitation interventions prior to their arrival. High levels of stand down calls are considered positive in terms of understanding that staff know to ask for help in the case of patient deterioration, and also shows that they are able to deliver effective interventions in the immediate response.

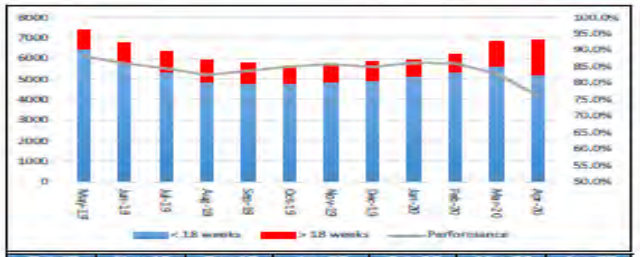
In April there were no cardiac arrests outside of ICU/theatres (4 in March) and there were 4 respiratory arrests outside of ICU/Theatres (compared to 8 in March). Both figures are now within the agreed limits and appear consistent with previous months

Are we responsive to the needs of our patients?

Patient Access
Great Ormond Street Hospital for Children NHS Foundation Trust

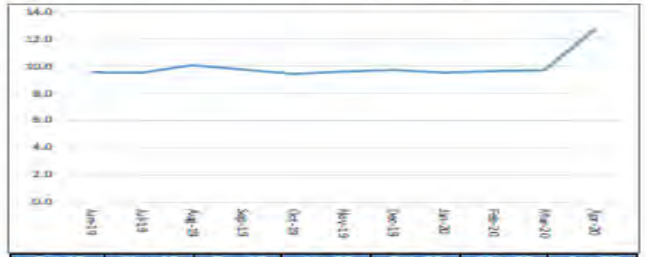
NHS Great Ormond Street Hospital for Children NHS Foundation Trust

RTT incomplete pathways: % of patients waiting <18 weeks	Period	Target	Actual
	Apr-20	92.0%	76.2%



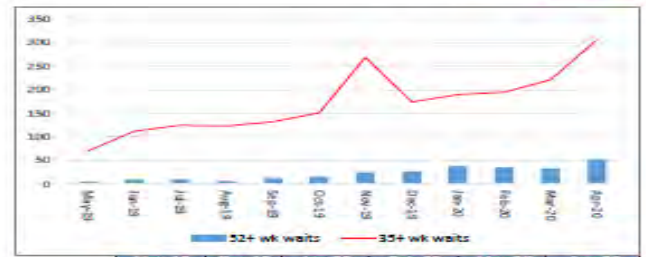
Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
85.0%	83.7%	83.0%	86.1%	86.0%	82.9%	76.2%

RTT: Average waits for open pathways	Period	Target	Actual
	Apr-20	8.1	12.7



Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
9.4	9.6	9.7	9.5	9.7	9.7	12.7

RTT: Incomplete pathways 52 weeks or more	Period	Target	Actual
	Apr-20	0	33

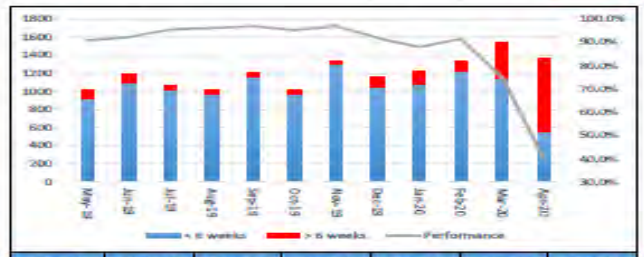


	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
52 wks+	23	27	38	36	33	33
35 wks+	269	174	190	195	221	306

RTT: Total unknown clock starts	Period	Actual
	Apr-20	321

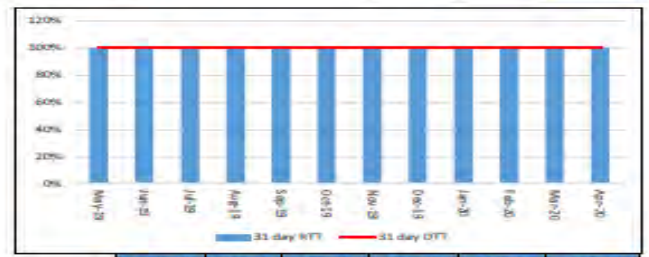
Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
314	360	415	413	386	274	321

Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Period	Target	Actual
	Apr-20	99.0%	40.3%



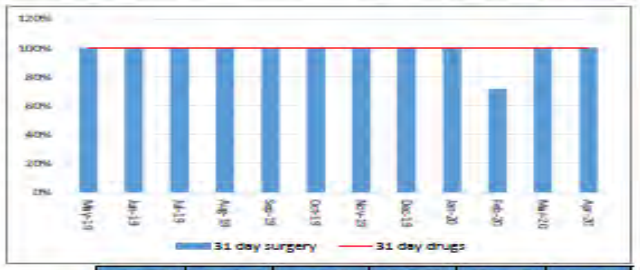
Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
93.2%	97.0%	91.8%	87.9%	91.6%	74.8%	40.3%

	Period	Target	Actual
Cancer: 31 day referral to treatment	Apr-20	85.0%	100%
Cancer: 31 day decision to treat	Apr-20	96.0%	100%



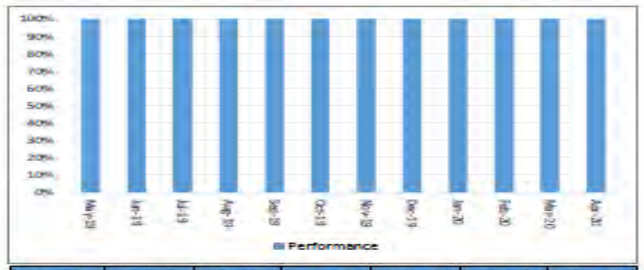
	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
31 day RTT	100%	100%	100%	100%	100%	100%
31 day DTT	100%	100%	100%	100%	100%	100%

	Period	Target	Actual
Cancer: 31 day subsequent treatment	Apr-20	94.0%	100%
Cancer: 31 day subsequent treatment	Apr-20	98.0%	100%



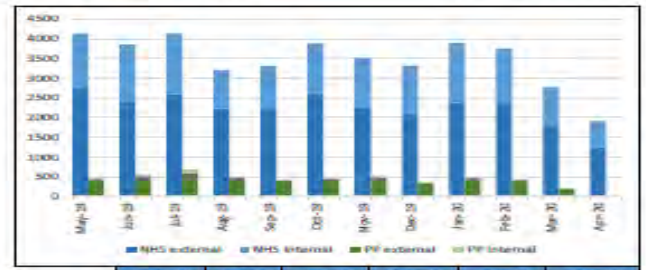
	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Surgery	100%	100%	100%	71%	100%	100%
Drugs	100%	100%	100%	100%	100%	100%

Cancer: 62 day consultant upgrade	Period	Actual
	Apr-20	100.0%



Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
91.7%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%

	Period	Actual
External Referrals (NHS & PP)	Apr-20	1285
Internal Referrals (NHS & PP)	Apr-20	663

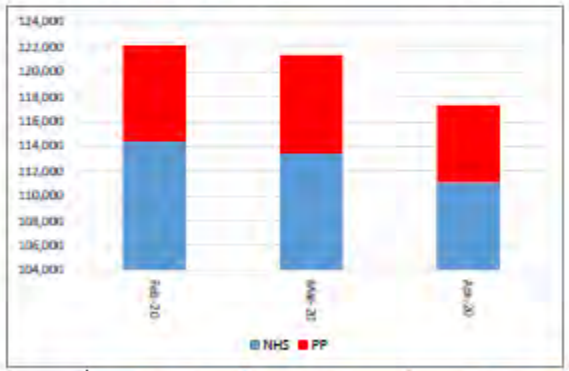


	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
External	2759	2414	2841	2798	1972	1285
Internal	1275	1268	1542	1396	1009	663

Are we responsive to the needs of our patients?

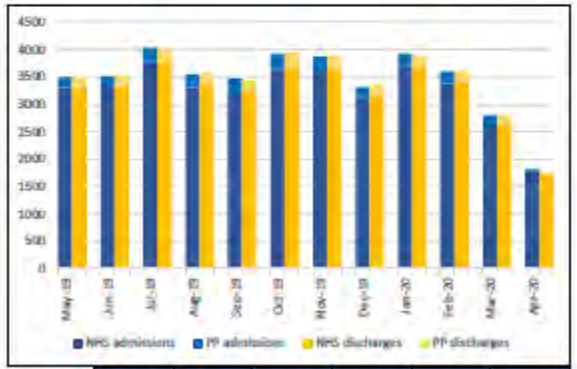
Patient Access
Great Ormond Street Hospital for Children NHS Foundation Trust

	Period	Actual
Open referrals at month end (NHS & PP)	Apr-20	117,295



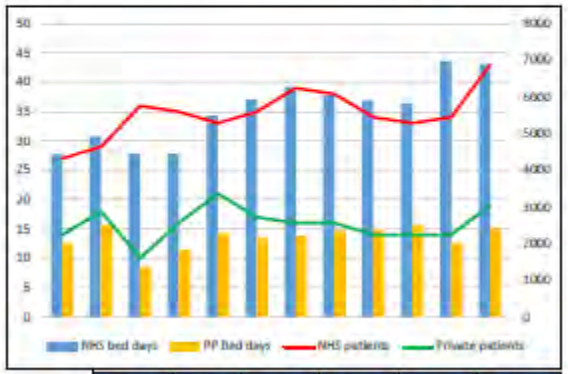
	Feb-20	Mar-20	Apr-20
NHS	114,406	113,459	111,085
PP	7,703	7,906	6,210

	Period	Actual
Admissions (NHS & PP)	Apr-20	1819
Discharges (NHS & PP)	Apr-20	1762



	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Admissions	3870	3314	3925	3601	2801	1819
Discharges	3892	3360	3880	3613	2793	1762

	Period	Actual
Patients not yet discharged with LOS >50 days	Apr-20	53
Bed days	Apr-20	9,321



	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Patients	54	50	47	48	57	53
Bed days	8471	8409	8273	8349	8996	9321

	Period	Actual
Patients with an estimated date of discharge		
Patients beyond their date of discharge		

Under construction

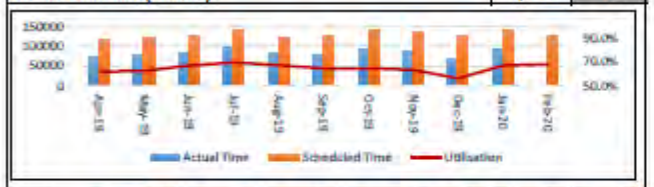
EDD						
> EDD						

Are we responsive to the needs of our patients?

Productivity & Efficiency

Great Ormond Street Hospital for Children NHS Foundation Trust

	Period	Actual
Theatre Utilisation (Main)	Apr-20	TBC
Theatre Utilisation (Outside)	Apr-20	TBC



Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Main	64.81%	63.78%	56.40%	67.15%	68.31%	TBC	TBC
Outside	TBC	TBC	TBC	TBC	TBC	TBC	TBC

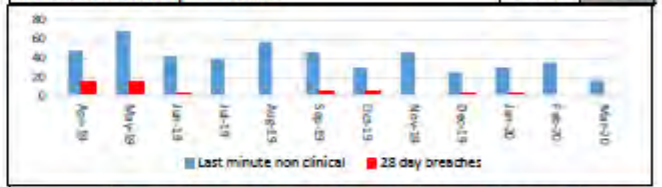
*Theatre session utilisation data is currently being investigated for March and April 2020

Emergency theatre utilisation	Period	Actual
	Apr-20	TBC

Under Construction

Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Cases	TBC	TBC	TBC	TBC	TBC	85.00	217.00
Utilisation	TBC	TBC	TBC	TBC	TBC	TBC	TBC

	Period	Actual
Last minute hospital cancelled ops for non clinical reasons	Mar-20	17
Last minute hospital cancelled ops - breaches of 28 day standard	Mar-20	2
Last minute cancelled ops - all reasons	Mar-20	TBC



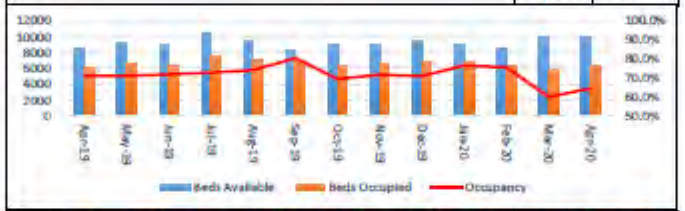
Month	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Non clinical	46	30	46	25	30	35	17
Breaches	4	5	1	3	3	2	2

Average length of stay	Period	Actual
	Apr-20	TBC

Under Contruction

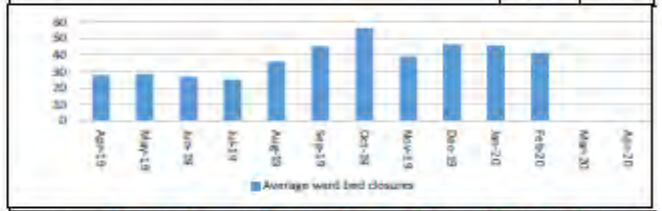
Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Main	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Bed Occupancy	Period	Actual
	Apr-20	64.45%



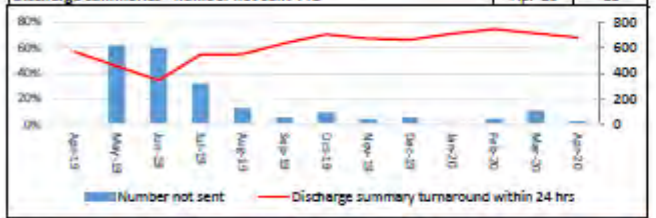
Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Main	69.58%	71.83%	71.04%	76.63%	75.63%	60.05%	64.45%

Average monthly ward bed closures (excluding weekends)	Period	Actual
	Apr-20	TBC



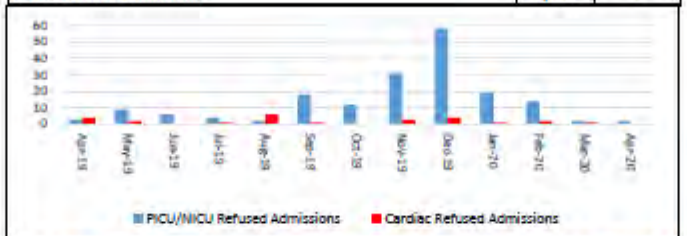
Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Av Closures	56.1	39.0	46.4	45.8	41.0	TBC	TBC

	Period	Actual
Discharge summary turnaround within 24 hours	Apr-20	68%
Discharge summaries - number not sent in month	Apr-20	23
Discharge summaries - number not sent YTD	Apr-20	23



Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Performance	70.43%	67.08%	66.15%	70.95%	74.49%	71.21%	67.91%
Not sent	96	39	51	11	42	109	23

	Period	Actual
PICU/NICU refused admissions	Apr-20	2
Cardiac refused admissions	Apr-20	0



Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
PICU/NICU	12	31	38	19	14	2	2
Cardiac	0	3	4	1	2	1	0

PICU Readmissions within 24 hours	Period	Actual
	Apr-20	2

Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Readmissions	0	2	0	1	1	0	2

Are we Safe?

There were 376 **incidents** reported in April 2020. The rate per 1000 bed days, is noted to have decreased. However, as OPD is not open there are less incidents being reported (from approx. 30 a month to approx. 4 a month) this is replicated for areas that are not at capacity. Reassuringly the ICUs and BCC haven't seen as a significant change.

Weekly numbers of reporting per directorate is currently being monitored and support by the Patient Safety Team is being offered to ensure reporting rates remain. However, it should be noted that activity is generally reduced in some areas due to the cancellation of elective cases due to the current COVID-19 pandemic. There are currently 8 open **serious incident investigations**. With 4 new SIs being declared in April 2020. One of these SIs are relating to care provided 9 years ago which was identified following a claim, one relates to the cyber security event (IG) and the other two are complex clinical cases involving a number of Directorates. The Patient Safety team are being supported by wider members of the Quality and Safety Team due to current staffing gaps as clinical staff return to clinical work to support the treatment of patients through the Pandemic.

The number of **incidents** being quality checked and closed by the Patient Safety team (PST) reduced in April which was expected due to one of the three Patient Safety Managers (PSM) returning to clinical work for half of their time and the change in process which requires all red complaints to be discussed at an Executive Incident Review meeting (EIRM) each of which requires a timeline of events that is completed by the PSMs.

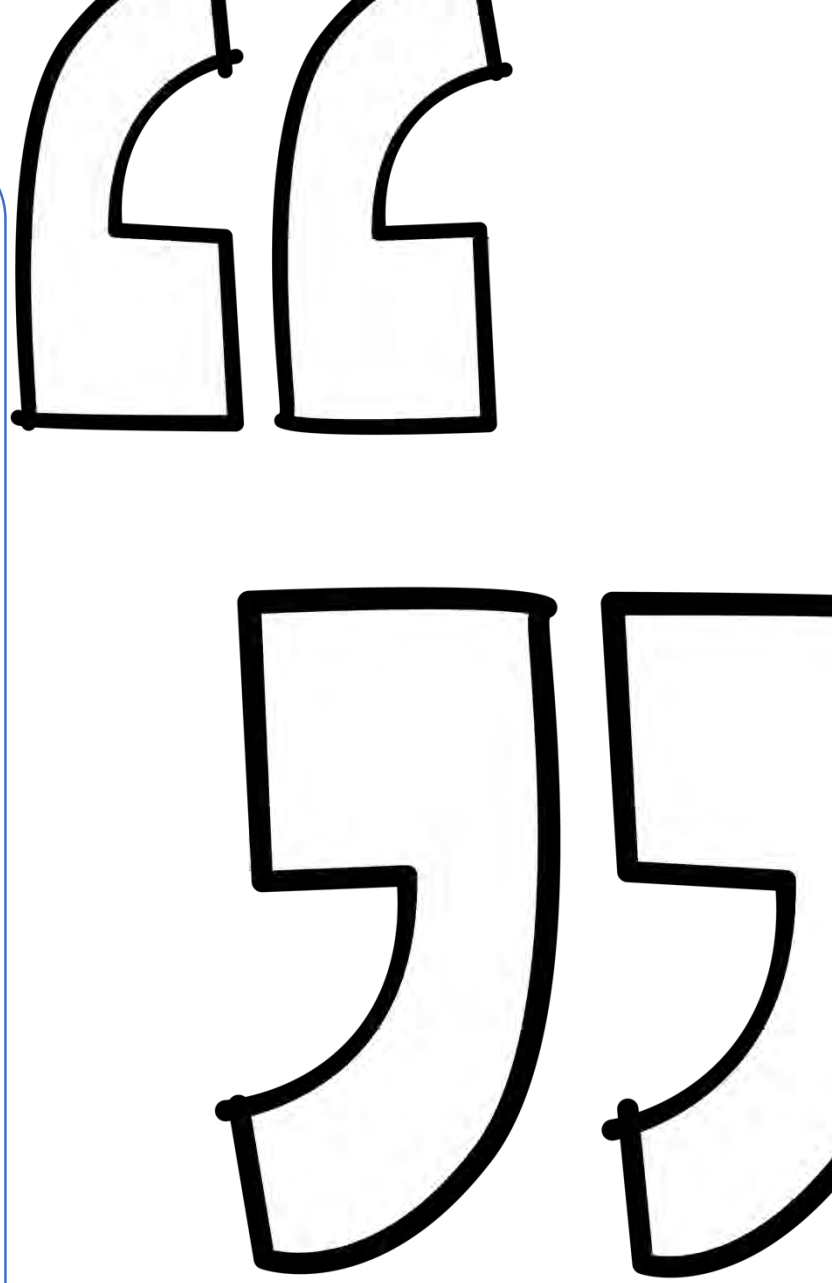
The percentage of incidents being closed within 45 working days has dipped slightly by 3% this month. As expected this is due to the numbers of incidents that are being closed that were reported in 2018 and 2019. Of the historical incidents awaiting completion of investigation, this has reduced to 400 in March with ongoing work to complete these.

The Trust currently has 14 **inquests** open, 8 of which have dates listed and 6 have dates pending. There are a further 8 cases that are currently pending a Coroner's decision as to whether there needs to be an inquest (or not). Delays with coronial processes during the pandemic may be expected.

There are currently 18 open **safety alerts** in March 2020. There are two alerts which are currently overdue. Details of these are provided later in the report (Slide 17). One alert was delayed due to locating equipment on COVID19 wards and the other is due to delays in workload for the Clinical Procurement team.

The documented compliance for **WHO safer surgery checklists** in our Theatres remains lower than we would expect at 93% in April 2020, although this is an improvement on 91% in March 2020. We have seen 100% compliance in all the MSCB Theatres, so a huge well done to these teams. The GOSH Safety Standards for Invasive Procedures (SSIPs) group are looking at ways to learn from the high performance in MSCB in other theatres. The SSIPs group reviews data at theatre, consultant and speciality level to identify teams and individuals who require additional education and support. An area of focus for this month is understanding the way in which the checklist is completed in lists involving a general anaesthetic and those that do not as this may contribute to the way in which the information is documented on Epic.

Clinical Harm Reviews are carried out for patients who have waited longer than 52 weeks for their treatment. As of 19th May 2020 there are 0 overdue harm reviews, 3 harm reviews have been sent for completion. There are 53 breaches of the 52 week pathway (at month end) for patients on a ticking pathway with approximately 50% of the breaches in the dental specialty.



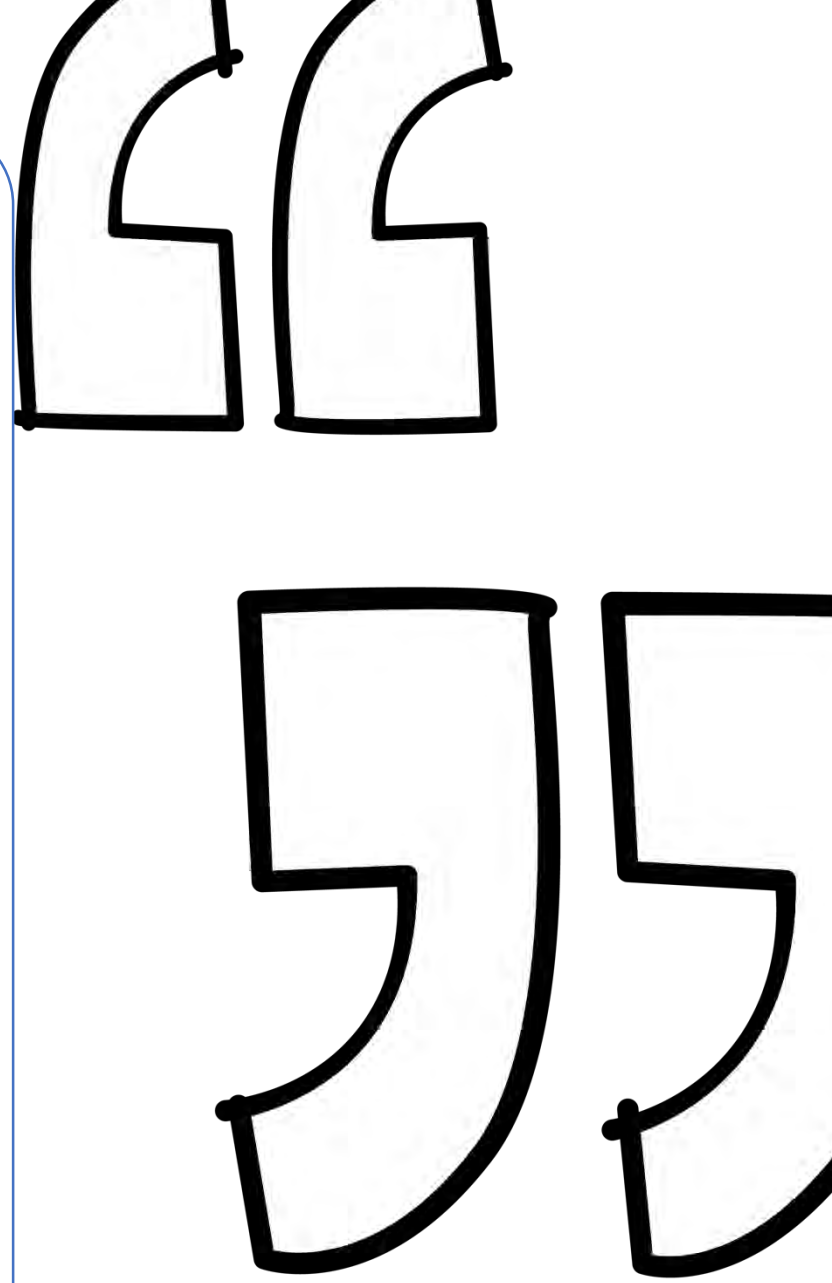
Are we Caring?

In April there were 5 new **formal complaints.** This was unchanged from March 2020 and reflects continuing national trends of lower complaint numbers. The Complaints team continue to assess complaints to identify any safety or risk issues and to determine whether the complaint can be investigated at this time. The Complaints team and services are working hard to minimise any complaints being paused (as per NHSE guidance) and to conclude current investigations as soon as possible. To date 1 complaint has been paused and there are 17 open complaints (this includes reopened complaints).
Overall patient activity has reduced across all directorates but most significantly in IPP. As a result of this, the IPP complaint rate by patient activity was at its highest (3) despite having received only one complaint.

Responding to recommendations outlined in a national report on hospital complaints published by Healthwatch, information about learning from complaints is outlined in slide 28 and will be reported in all future reports. This month learning related to communication and clarification of services, invoicing and actions to monitor cleaning in a ward area. The Complaints team are reviewing other learning from the report to improve the Trust's complaints process.

The Complaints team are working with the Patient Safety team to finalise a process for red/ high risk complaints to be reviewed at an Executive Incident Review Meeting. The purpose of this is to determine if they should be investigated as a serious incident under the NHSE Incident Reporting Framework. Information about any such reviews will be shared with complainants at the outset of the process.
The significant reduction of **Pals cases** in April is attributed at least in part to the Trust's on line information hub (which has had unprecedented high numbers of 'hits') and proactive contact to families providing further information about shielding. Some families contacted Pals requesting further assurance and some non-patients requested advice about Covid 19.

The **Friends and Family Test** response rate in April was 19.3%. Whilst this was below the Trust target, this was a better response rate than expected as FFT has not been actively promoted during the Covid-19 outbreak. The experience rating (formerly the recommendation rate) exceeded the Trust target of 95% for both Inpatients and Outpatients (99% and 97% respectively). Feedback was overwhelmingly positive with patients and families commenting on the professionalism and expertise of staff and praising the NHS as a whole. Within outpatients staff were praised for their efficiency and for alleviating parent and patient fears about their visit.



Are we Effective?

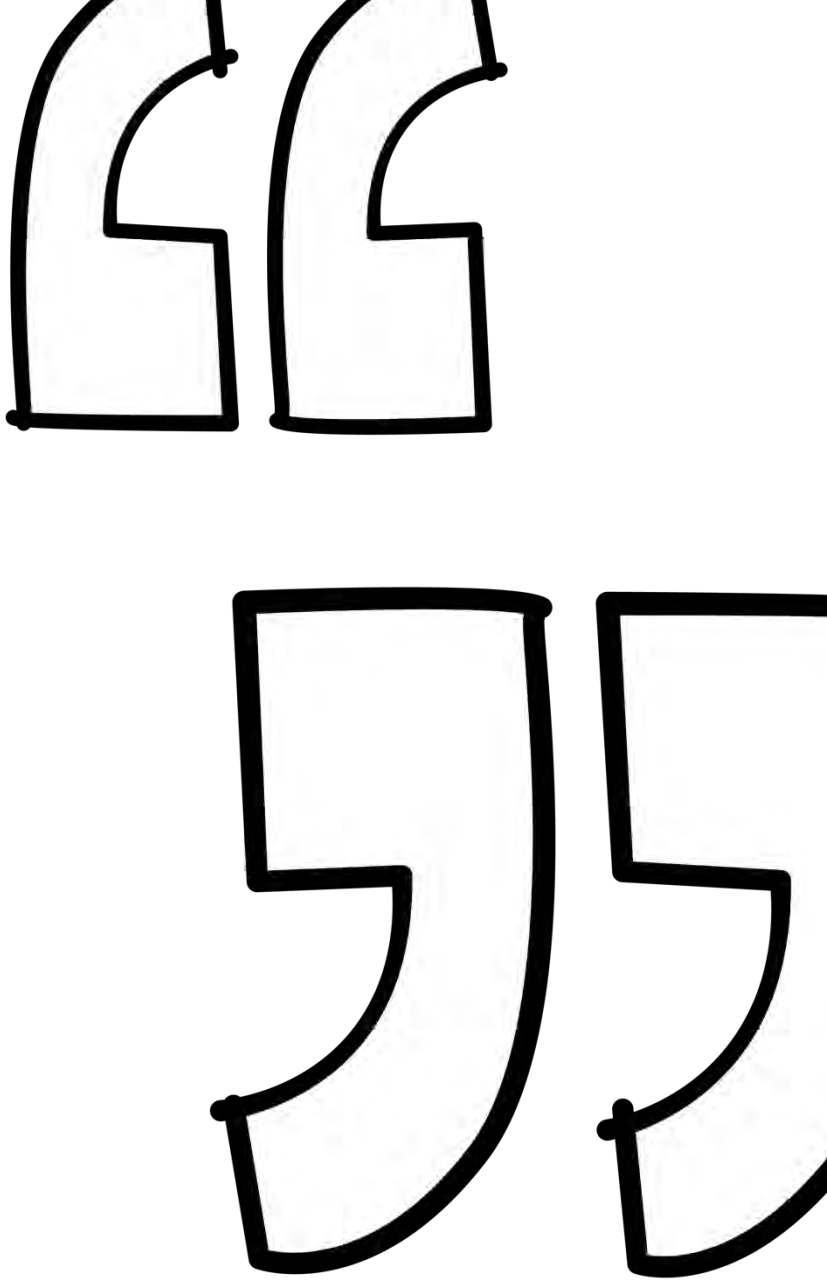
We are on track for 76% of our **speciality led clinical audits** in April 2020. This is within target, and will help to ensure we are encouraging and sustaining a culture of completing and sharing the outcomes of specialty led clinical audit . We saw a decrease in the number of new audits being started around the initial lockdown period. Activity appears to be normalising as some clinical teams may have capacity to focus on audit as some clinical activity has been paused. We have seen a number of specific clinical audits started in response to COVID. Clinical teams have been quick to use clinical audit to review service delivery now, and to support care in the future. Some of these pieces of work are collaborative across the North Central London hospitals.

We have identified through **priority audit** that specific actions relating to medicines storage identified on our **CQC action plan** have been completed .This audit has highlighted the need to further review, clarify and communicate a reasonable policy of swipe access control to medicines storage rooms. As a result of this audit there will be a revision to policy which will be communicated to staff .The action plan in response to this audit was agreed at the April Medicine Safety Committee (MSC) . The MSC will oversee and monitor progress with the action plan. The revised policy will be re-audited later in the year.

NICE have developed rapid COVID-19 guidelines. These guidelines have been quickly developed to maximise patient safety whilst making the best use of NHS resources and protecting staff from infection, and are based on the latest evidence. An SOP has been developed to ensure all COVID-19 NICE guidance is reviewed quickly. All NICE COVID-19 guidelines have been reviewed at GOSH.

For the month of April, 67.91% of patients who were discharged from GOSH received a **discharge summary** within 24 hours, a decrease from the March position of 71.21%. Focussed work on this to date includes backlog clearance of discharge summaries and the embedding of the completion of discharge summaries in real time into clinical practice. We now have a backlog of 29 discharge summaries up to April 2020 and the Directorates continue to work to reduce this further.

For April 2020, performance has improved in relation to 7 day turnaround for **clinic letters**; 61.36% compared to 51.87% in March. The EPR team have now rolled out the ‘clinic letter not required’ button within Epic, to specific services at a clinic level which can be used for specific patient appointments where a clinic letter will not be required for clinical reasons. In addition, additional training is being provided. Focused work is also looking at those areas by speciality where patients have multiple letters within the same service which have not been sent, to understand if some of the earlier letters can be closed off. This has the potential to reduce the backlog by up to 25%.



Are we Responsive?

As expected during the Covid-19 situation the Trust continues has underachieved against the 99% national standard for **Diagnostic pathways** reporting 40.34% of patients waiting within 6 weeks for the 15 diagnostic modalities. There was a significant increase in the number of breaches reported in April (818) compared to the number of breaches reported in March (387).Of the 818 breaches, 606 are attributable to modalities within Imaging (334 of which are MRI), 96 in Sleep Studies, 35 in ECHO, 32 in Clinical neuro-physiology, 30 in Gastroscopy, 6 in Audiology, 8 in Cystoscopy, 3 in Urodynamics, and 2 in Colonoscopy.

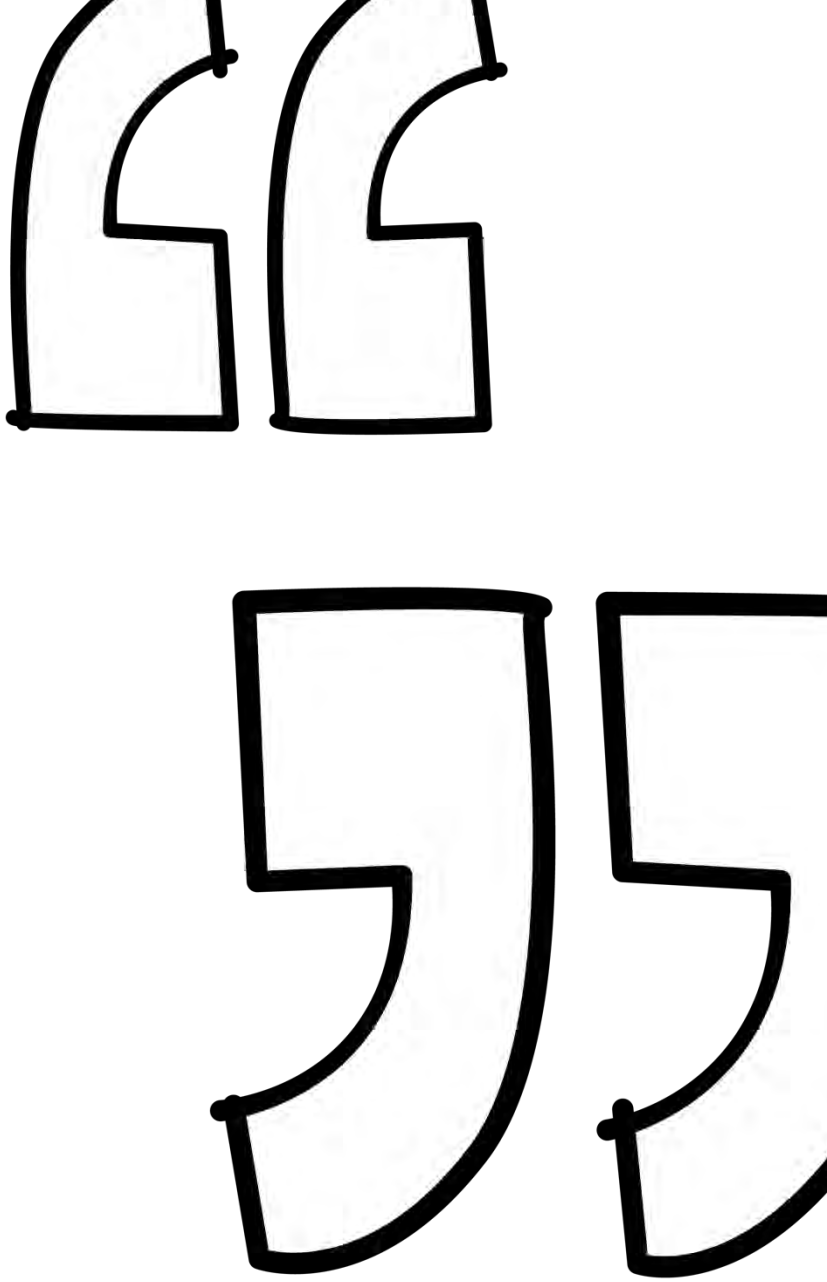
The patients are currently being managed by clinical prioritisation with patients requiring a scan within 6 – 72 hours being booked as previous, patients within 2 weeks are being assessed by Radiologist and/or Radiographers and booked accordingly. Routine scans have been on the whole postponed accept for patients requiring a scan with a face to face appointment, or surgery planning and the surgery is booked. Planned patients are being assessed on a weekly basis by the clinical teams.

The Trust did not achieve the **RTT** 92% standard, submitting performance of 76.2%, with 1,636 patients waiting longer than 18 weeks, this is a significant deterioration of 6.7% from the previous month.

The worsening position has been as a result of the Trust significantly reducing non-essential elective workload since the middle of March 2020, with up to 70% of the focus across admissions and outpatients being on urgent cases and utilising virtual appointments across outpatients. The average reduction in performance over the Covid-19 period has been 1.6% per week, with a further deterioration projected over the coming months as activity levels remain below planned levels due to the need for social distancing, the additional clinical time required as a result of the need to use PPE and the reluctance of parents to attend appointments.

A **Clinical Prioritisation Group** has been established led by the Medical Director to access all patient who require to be seen across outpatients and admissions to ensure they are reviewed and prioritised according to clinical need. Any patient who experiences an extended wait will need to have a harm review completed.

The Trust has seen almost a 44% decrease in external **referrals** since March 2020 and a 65% decrease compared to the volume received in February. Equally, internal referrals in the Trust as a whole have also decreased by approximately 50%.
Similarly the volume of **admissions** in April was significantly lower compared to previous months', a decrease of nearly 1,000 admissions compared to March and 1,700 less than the level of admissions in February.



Are we Well Led?

There were 10 incidents that were identified as requiring **duty of candour** in April 2020. Being Open/Duty of Candour conversations took place in 100% of incidents. Stage 2 Duty of Candour Letter compliance increased to 57% within 10 days, and 71% in total. Two of the stage 3 investigation reports were shared with families in April 2020. However, none of these were shared within the required timeframe due to the delays in completing the investigations. There are currently 6 RCA investigations which are overdue their completion deadline. A meeting was held with the Deputy Chiefs of Service, Heads of Nursing and the Quality and Safety Team in May to address the delays and a training plan has been agreed.

Risk Register: High risk monthly review performance decreased in April at a compliance rate of 77%. Due to the current COVID-19 pandemic, a number of RAG meetings were postponed within the month which has delayed the review of risks at this time. RAG reports for directorate continue to be produced and it is intended the RAG meetings will be re-instated, albeit in a slightly different/shortened format until resolution of this pandemic has occurred This continues to be monitored monthly. Extra support is being offered by the Patient Safety Team to ensure compliance is being maintained.

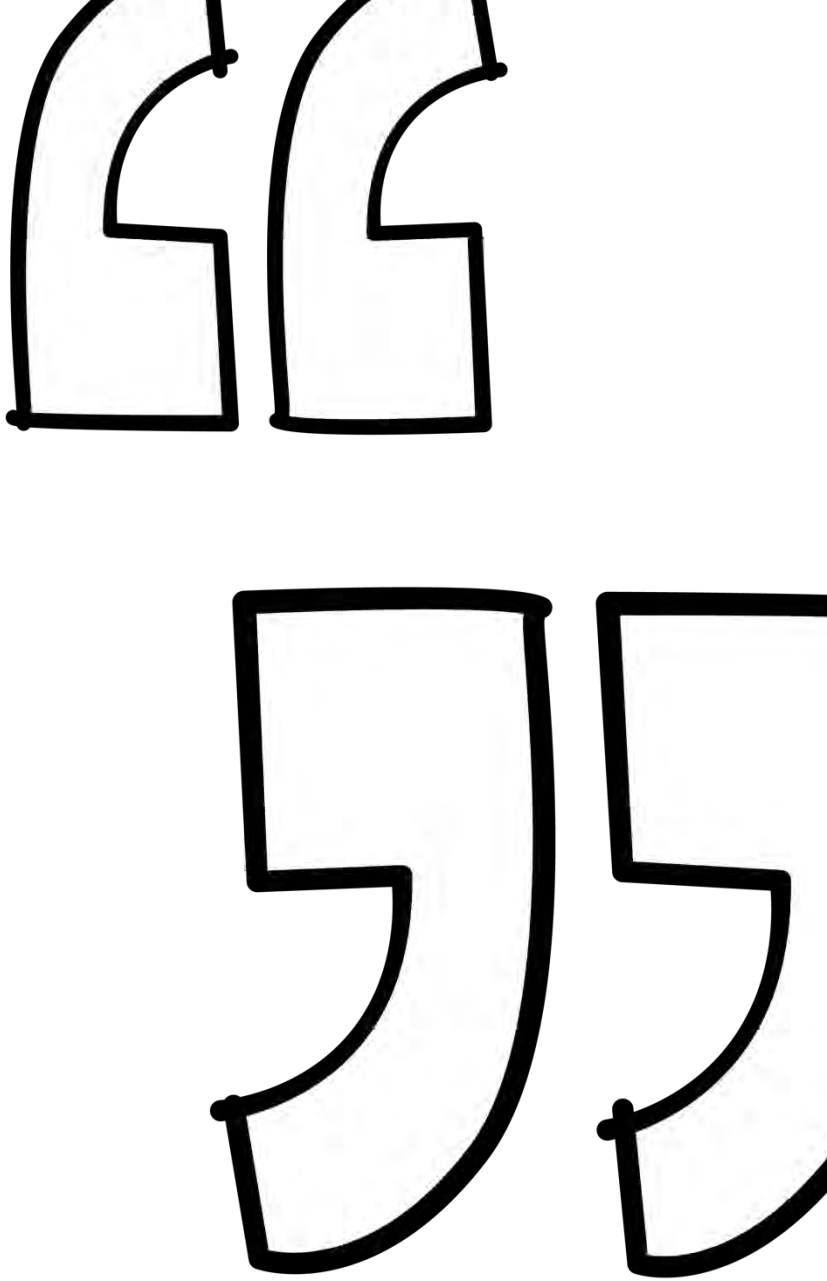
The Trust saw a decline of **FOI** requests in April (a decrease of 10) and a reduction in compliance with timescale noted for April. The FOI team is currently one staff member short with interim arrangements for cover to start in June 2020. One internal review has been requested and this was responded to within deadline.

With regard to overdue documented **Serious Incident actions**, there are currently 105 open SI actions with a trajectory to close these by the end of July 2020.

The **Freedom to Speak Up** service has seen a significant rise in cases through April and this appears to be continuing into May 2020. Several covid-19 related concerns have been raised, which have related predominantly to concerns about the annual leave, working from home arrangements and support from line managers.

Policy performance, remains static at 72% of policies currently in date, compliance in updating of safety critical policies has increased to 78%. Due to the current COVID-19 crisis, Policy Approval Group meetings have been suspended, but virtual meetings are now taking place.

Appraisal/PDR completion The non-medical appraisal rate for April was below target at 85%. Again, while establishing COVID readiness, reminders were reduced, the expectation remains that PDRs should be completed remotely if necessary. Consultant appraisal rates have increased to 100%. (The GMC have advised nationally that Drs with overdue appraisals should be recorded as having special circumstances due to COVID19.) Without this exemption, Consultant appraisals sit at 89%



Workforce Headlines

Contractual staff in post: Substantive staff in post numbers in April were 4741 FTE which is an increase from March (22 FTE), this is slightly higher than the same month last year.

Unfilled vacancy rate: Vacancy rates for the Trust are currently being established following the loading of Month 1 budgets.

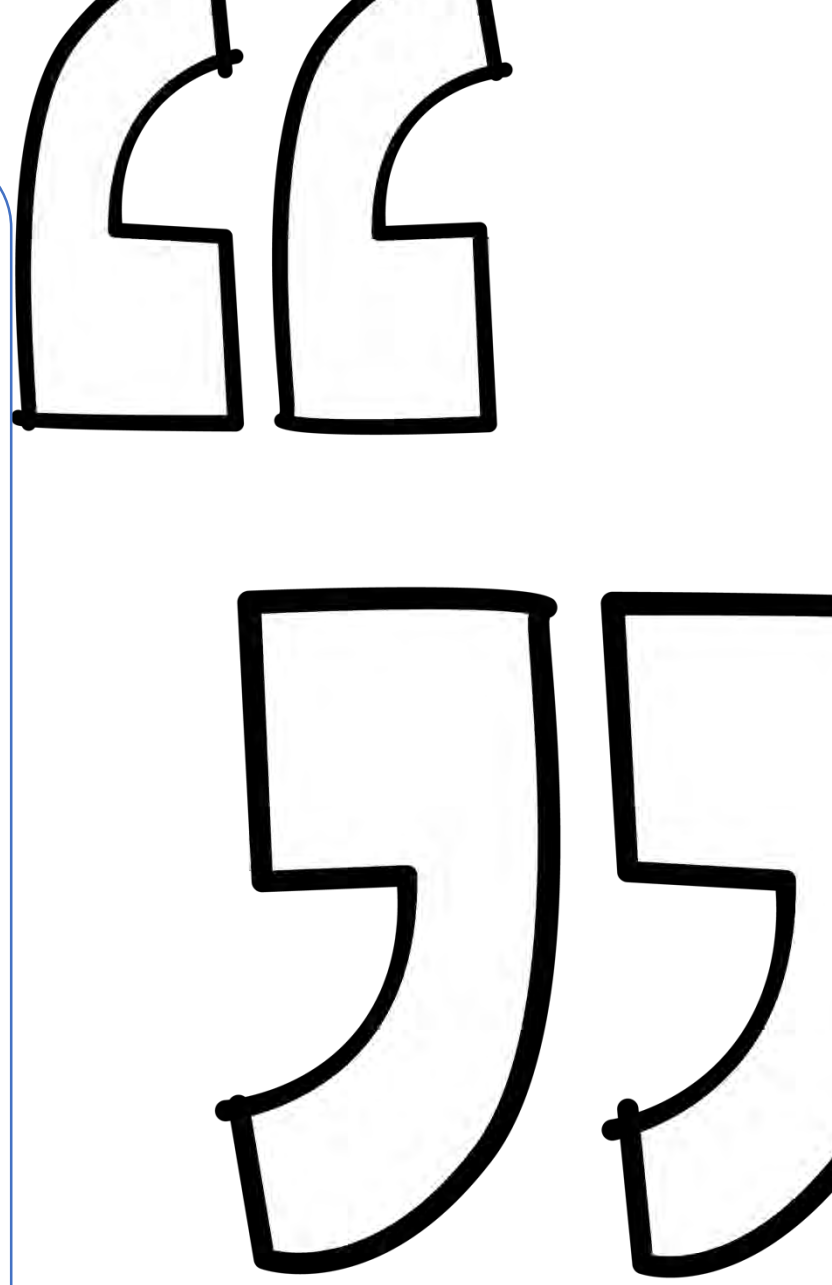
Agency usage for April 2020 was 0.4% of total paybill, which is below the local stretch target, and is also well below the same month last year (0.9%). The target for 2020/21 remains 2% of total paybill. Bank % of paybill was 4.1%

Turnover is reported as voluntary turnover. Voluntary turnover reduced to 15.4%, it's lowest level since August 2019, although remains above target (14%). Total turnover (including Fixed Term Contracts) also reduced to 18.3%.

Statutory & Mandatory training compliance: In April the compliance rate across the Trust remained at 93%, which remains above the target with all directorates achieving target. Across the Trust there are 9 topics below target including Information Governance where the target is 95%. With COVID preparations, managers have been receiving less reminders about overdue training, but there has been clear messaging that with staff should continue to use available time to ensure that any online training (all bar Resus training) is completed once due.

Appraisal/PDR completion The non-medical appraisal rate for April was below target at 85%. Again, while establishing COVID readiness, reminders were reduced, the expectation remains that PDRs should be completed remotely if necessary. Consultant appraisal rates have increased to 100%. (The GMC have advised nationally that Drs with overdue appraisals should be recorded as having special circumstances due to COVID19.) Without this exemption, Consultant appraisals sit at 89%

Sickness absence . The sickness KPI has been amended in 2020/21 to reporting in month sickness rather than annual rate as before, this is to be able to monitor peaks and troughs more effectively . As expected April saw in increase in sickness absence levels due to COVID, with in month sickness rate of 3.8%, well above the target and long term average for the trust. Reported together with self-isolation and shielding absences, the Trust is reporting an impact of 6% COVID related absences, which is over double our normal reported sickness absence rate. Whilst high this is significantly lower than other trusts in our STP are reporting who are experiencing rates of over 15%. Daily absence reporting is being fed in to national reports.



Covid–19 at GOSH

We have changed the way that we work at GOSH in March in order to ensure that we play our part in supporting the NHS to respond effectively to Covid-19. This is an overview of some of the changes we made in March & April, and what that means for Quality and Performance at GOSH.

The national and international evidence to date suggests that COVID19 is an asymptomatic or very mild illness for almost all children, including those with underlying illnesses.

In March 2020 we stopped all non-essential treatments and procedures at the hospital beginning with Cardiac. This then extended to all specialities within the hospital in line with Government advice.

We discussed our care provision with the CQC and with their approval we have added the care of adult patients to our registration. This means that in the event of emergency GOSH would be able to help care for this group. We anticipate that we would limit this to adults under 25 years old. We have also added an additional regulated service to ensure that we can look after children and young people suffering from significant mental health issues. Following a recent inspection the Body, Bones and Mind team have been commended for all of their hard work and efforts in managing this new patient set.

There were 39 COVID 19 related incidents in April:

NCL had the highest number of incidents (8) closely followed by Heart and lung (7) and BBM, MTT and Ops and Imaging all had (5). Access to clinical services was the category that had that highest number of incidents (7), followed by PPE (5). 27 were no harm incidents, 11 minor harm and 1 moderate harm for which an RCA is being completed.

FFT feedback suggested that patients were happy about the care they received both inpatients (99%) and outpatients (96%) with many positive comments about management during the pandemic. There were no complaints relating to Covid-19 in April 2019.

Following the high number of contacts in March the Pals contacts in April dropped significantly. The contacts received primarily related to further clarification and assurance sought regarding 'high risk' conditions/ shielding.

The Trust is 100% compliant with the review of NICE rapid COVID-19 guidelines.

There are 37 Risks on the COVID 19 risk register. Issues include infrastructure (including staffing, facilities and environment) which was the most common risk type with 9 risks, information governance with 8 risks and clinical assessment (including diagnosis, tests and assessments) with 5 risks.

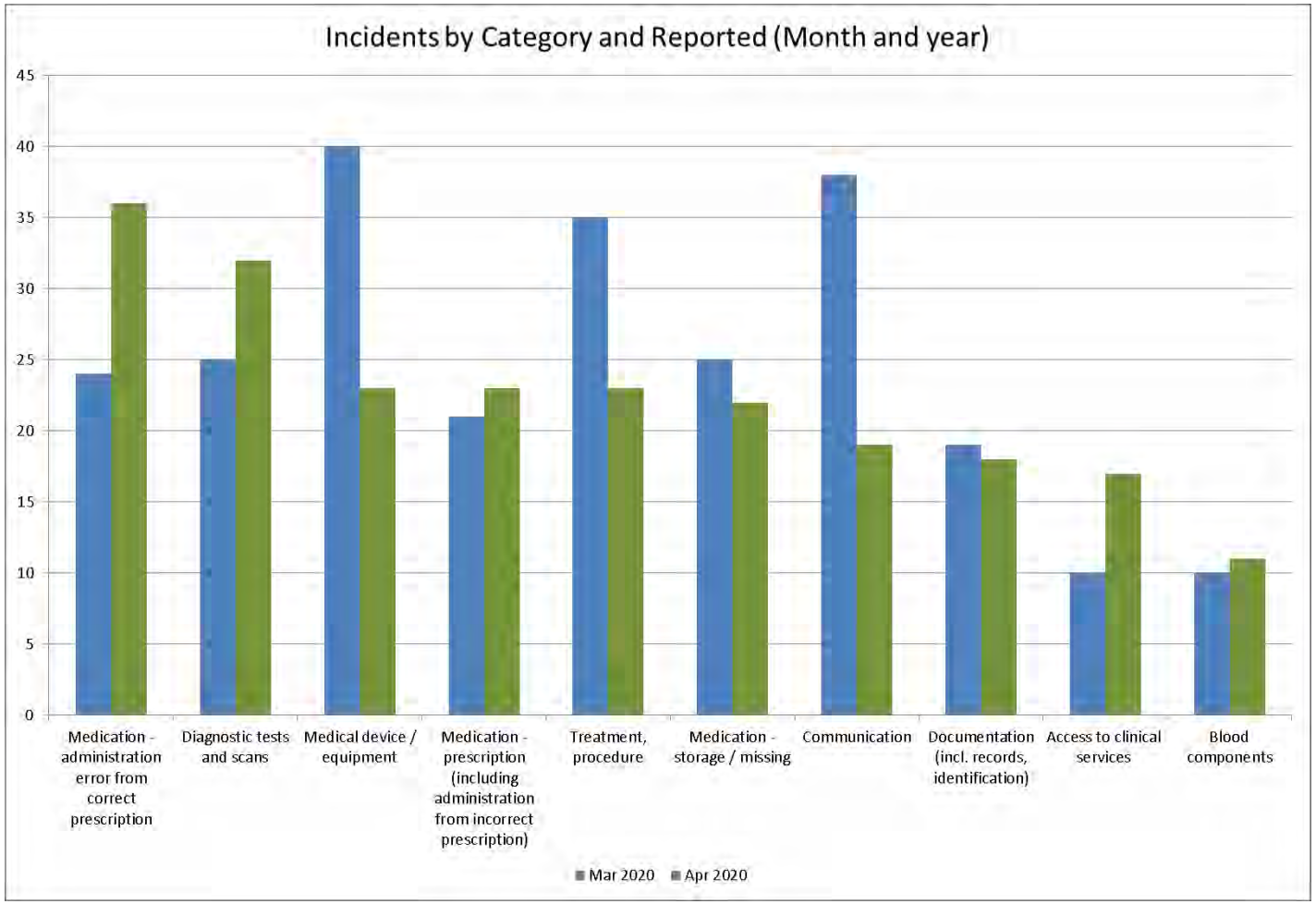
When the risks were first reported most were reported as either medium (16 risks) or low (12 risks) and 9 risks were initially reported as high. The current risk levels have changed slightly with 10 risks currently graded as high, 13 as low and 14 as medium.

The Trust has launched a variety of mechanisms to support staff in caring for patients and caring for - themselves during this time. This includes:

- Daily updates to staff on Covid-19 issues within the hospital
- Creating a clinical hub collating Covid-19 clinical guidelines (local and national) and other resources
- Developing a health & wellbeing hub to support staff
- Regularly updated FAQ for staff, managers and for patients and families
- Publishing specialty/disease specific covid-19 guidance

The Trust is reporting an impact of average 6% of COVID related absences in April 2020, which is over double our normal reported sickness absence rate. The Trust is currently providing staff testing including antibody testing.

Understanding our Patient Safety incidents



Covid-19 continued to cause a drop in incident reporting across the hospital, with 376 incidents reported overall in April (447 in March, 582 in April 2019). We also began the process of identifying new risks around Covid-19, as well as tagging existing risks whose risk level was changed by the pandemic. There are currently 37 risks related to Covid-19.

Medication administration incidents rose from 24 in March to 36 in April. 6 were on PICU, 5 on CICU and 3 each on NICU and Robin Ward. Five incidents were relating to too much drug being either drawn up or given, with two being potential 10x overdoses of cyclosporine on Robin Ward that were fortunately noticed before administration. Some teaching is taking place on the ward around this and all doses are to be double checked. There were 3 incidents where a possible double dosing took place because doses were given too close together, and 2 incidents where doses were missed. There were 3 incidents where drugs were run at the wrong rate. Overall, 4 incidents were graded as minor harm with 32 as no harm.

Diagnostic tests and scans saw a rise this month, mainly in genetics where 15 of the 32 incidents were reported (9 in molecular genetics and 6 in cytogenetics). All of the genetics related incidents were no harm, and most involved processing errors or delays.

Access to clinical services also saw a slight rise from 10 to 17 incidents. There were no specific themes in this category though the general theme was around communication between GOSH and various partner hospitals who referred patients. In particular, communication and handover around Covid-19, and in some cases insufficient information being provided which impacted planning at GOSH.

Patient Safety – Serious Incident Summary

New & Ongoing Serious Incidents

Directorate	Ref	Due	Headline	Update
H&L	2019/26856	30/04/20	Semi elective procedure rescheduled due to capacity issues, patient deteriorated and resus was unsuccessful	Extension agreed. Draft report circulated to panel and awaiting feedback
O&I S&S	2020/3609	18/05/20	Patient arrested unexpectedly in theatre following a dental case	Investigation underway. Extension requested
BCC	2020/3840	21/05/20	Misdiagnosis of tumour	Investigation commenced
H&L (with O&I and S&S input)	2020/6276	30/06/20	Femoral line placed prior to admission inadvertently in artery. Ischaemic injury to leg	Investigation commenced
BCC and H&L	2020/6535	03/07/20	Failure to treat Sepsis in line with the sepsis protocol	Investigation commenced
ICT	2020/7656	21/07/20	Incident contributing to cybersecurity breach	Investigation commenced
H&L	2020/8027	22/07/20	Retained surgical wire following post procedural identification	Investigation commenced

Learning from Serious Incidents: 2020-913: Gross paraphimosis requiring surgical intervention

What happened?

On 6 January 2020 the patient attended the Trust for a procedure to separate the fatty filum and complete spinal untethering. Following the procedure the patient's mother identified that the patient's penis looked sore and different to expected, the recovery nurse assured her that this was not a concern and that some soreness was common following catheterisation. Over the following two days the patient was cared for on a specialist Neurosciences ward. The nursing staff identified no concerns with the penis. On the evening 8 January the patient complained of discomfort and itchiness around his penis and it was examined by the nurse in charge. The Urology Fellow identified the problem as gross paraphimosis and attempted to treat on the ward using approved techniques for reducing swelling and replacing the foreskin. Unfortunately this was not successful, and at 03.00 on 9 January the patient had surgery to allow the foreskin to return to the correct position.

Learning and recommendations

- Standardised training course for catheterisation produced for medical and nursing staff which will be available on the Trust's e-learning system in line with other competencies.
- The Practice Educator team will complete a 'train the trainer' program across the Trust to increase urinary catheterisation skills amongst doctors and nurses.
- The guideline Insertion and management of urinary catheters will be updated with the learning identified.
- Informative materials will be produced to remind staff on the process for carrying out catheter hygiene and maintenance.
- A review will be undertaken of the catheter elements of the Electronic Patient Record system to ensure that they are clear and understandable, are gender specific, and that the language reflects the tasks staff are expected to carry out.

Patient Safety Alerts/ MHRA/ EFN Alerts

NatPSA/2020/003/NHSPS: Blood control safety cannula & needle thoracostomy for tension pneumothorax

Date issued: 02/04/2020

Date due: 09/04/2020

NatPSA/2020/002/NHSPS:Interruption of high flow nasal oxygen during transfer

Date issued: 01/04/2020

Date due: 08/04/2020

NatPSA/2019/003/NHSPS: Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices

Date issued: 13/12/2020

Date due: 11/09/2020

NatPSA/2019/002/NHSPS: Risk of death and severe harm from ingesting superabsorbent polymer gel granules

Date issued:28/11/2020

Date due: 01/06/2020

MDA/2020/014: Pilling Clear Advantage aortic punch – risk of infection due to packaging failure

Date issued: 20/04/2020

Date due: 03/06/2020

FSN-004 Stellar 100/150 Ventilators: Stellar 100/150 Ventilators – Device failure may lead to alarm malfunction

Date issued: 05/12/2019:

Date due: N/A

FSN/FA902: Medtronic Heartware HVAD System Battery Charger AC Adapter Controller Power Port Incompatibility

Date issued: 03/02/2020

Date due: N/A

FSN/002 021720: Advanced Bionics HiRes Ultra / HiRes Ultra 3D - impedance drops and hearing performance degradation

Date issued: 25/02/2020

Date due: N/A

EFA/2020/001: EFA/2020/001 Allergens Issues - Food Safety in the NHS

Date issued: 29/01/2020

Date due: 12/08/2020

EFA/2019/005: Issues with doorstops / door buffers

Date issued: 31/12/2019

Date due: 31/12/2021

CEM/CMO/2020/021(R): Tiger Eye Protector Product – Removal from the Supply Chain in respect of Covid-19 use

Date issued: 10/05/2020

Date due: N/A

NHSE/I – 2020/001: NHSE/I – 2020/001 Use of high flow Oxygen therapy devices (including wall CPAP and high flow face mask or nasal oxygen) during the Coronavirus epidemic

Date issued: 31/03/2020

Date due: N/A

Clinical Audit – current work plan

A clinical audit plan prioritises clinical audit work related to incidents, risk, complaints, and areas for improvement in quality and safety. These items are facilitated by the Clinical Audit Manager who engages with relevant staff as appropriate.

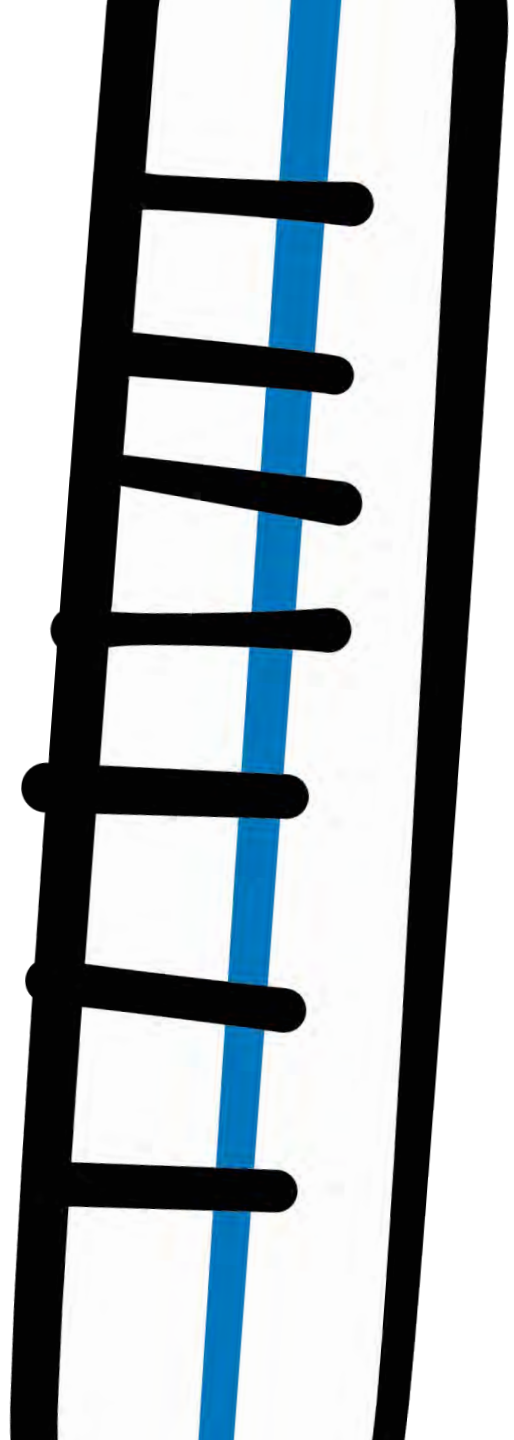
All items of work have been assessed in light of the COVID 19 pandemic based on

- Current and predicted staff capacity to complete the work and act on results
- minimisation of any staff activity which may increase their exposure to patient areas which they may not routinely work in
- the degree to which the work is an essential regulatory requirement.
- Work that is important – which makes a wide contribution to quality and safety , but not critical is being postponed where it cannot take place.

Audit	Why are we doing this audit?	Status
Review of compliance with Mental Capacity Act for procedures (re-audit)	To review our progress with ensuring that mental capacity act assessments are taken where necessary as part of our consent process.	**Improvement required** We haven't seen progress with the completion of mental capacity assessments as part of our consent process. In order to be compliant with the Mental Capacity Act changes maybe required in EPIC to support the process. An action plan will be delivered by the Mental Capacity Act group/Operational Safeguarding Group .To support this the audit will be on the agenda for the June Patient Safety and Outcomes Committee.
Learning from complaint (18/093)	To determine if we have changed our practice on PICU for documenting updates given to families, as recommended following a complaint.,	Completed in December 2019. The complaint action plan committed to a specific change of practice to document the update given to the patient's family in the evening PICU ward round. This change was evident in 35% of admission days reviewed in the audit. **Improvement required** The limiting factor to meeting this was the availability of devices to document ward round. The equipment has now arrived on PICU . A re-audit is underway and will be reported to Closing the Loop in June 2020.

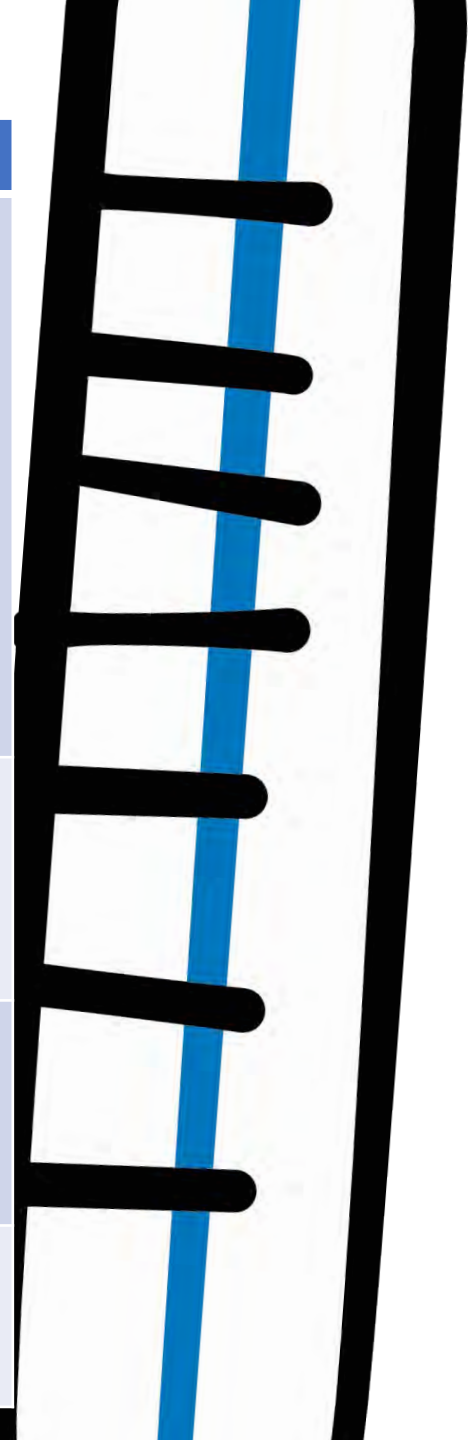
Clinical Audit – current work plan

Audit	Why are we doing this audit?	Status
Storage of Medicines Must Do Audit	This audit has been designed to look at some of the basics of medicines storage that we want to get right, and which were flagged by the CQC. This will help assess compliance and provide some baseline to measure future improvements	The audit has helped provided assurance that specific actions relating to medicines storage identified on our CQC action plan have been completed • No IV fluids were found insecurely stored in theatres. • Access to the storage room had been restricted to clinical staff in PICU This audit has highlighted the need to further review, clarify and communicate a reasonable policy of swipe access control to medicines storage rooms. As a result of this audit there will be a revision to policy which will be communicated to staff The action plan in response to this audit was agreed at the April Medicine Safety Committee (MSC) . The MSC will oversee and monitor progress with the action plan. The revised policy will be re-audited later in the year.



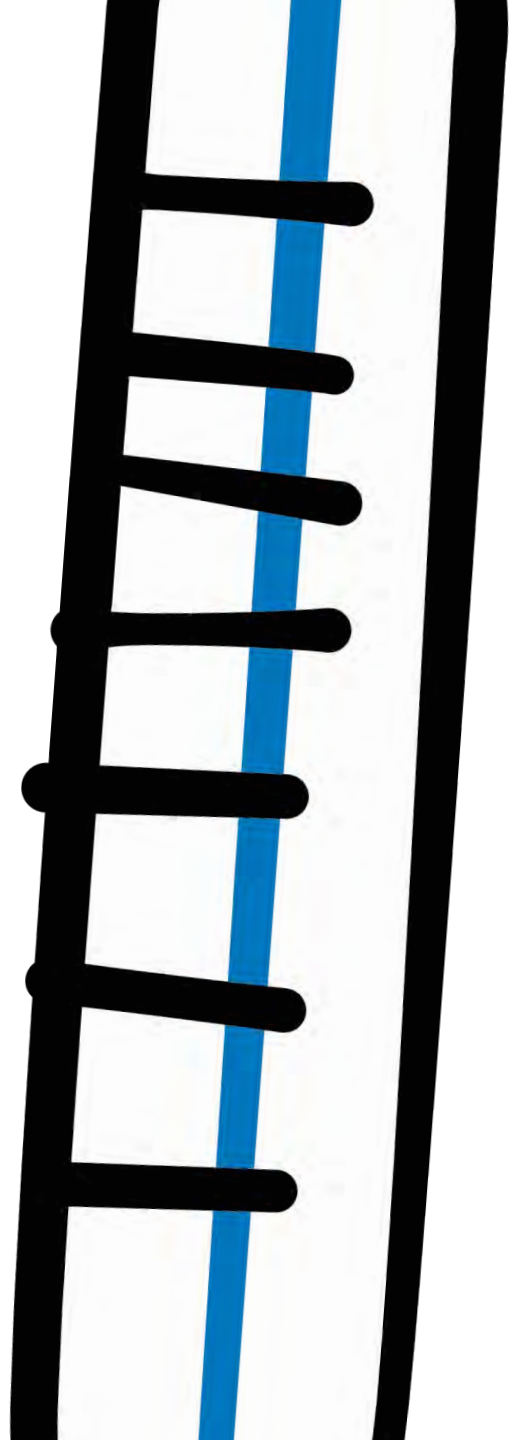
Clinical Audit – current work plan

Audit	Why are we doing this audit?	Status
Safeguarding –survey on learning from Serious Case Reviews	Review our awareness of some of the key learning from recent serious case reviews that GOSH have been involved with	The audit was presented at the Operational Safeguarding Group in March 2020. The key findings of this piece of work are positive, 100% of respondents were clear on the need to escalate if concerns were not listened to and who to escalate to. Staff who had been involved in a safeguarding case felt they had been listened to when raising safeguarding concerns. Areas for improvement 1. Awareness of the need for staff to immediately and directly refer to social work/safeguarding when presented with a patient with unexplained bruising. 2. Understanding of the concept of safeguarding supervision. 3. 53% of respondents had seen the Safeguarding newsletter An action plan was to be agreed by the April 2020 Operational Safeguarding Group. This meeting was cancelled, and a further update will be provided by the Named Nurse for Safeguarding on the process for acting on the findings of the audit
Learning from incidents -CVL insertion in Interventional Radiology	7 MSSA infections following CVL insertions placed in Interventional Radiology have been reviewed as root cause analyses since June 2018. It has therefore been recommended by Infection Control that an audit of best practice to minimise the risk of infection pre, during, and post CVL insertion takes place	This has been delayed due to capacity to complete the audit. A draft report was planned for March 2020 , but it is estimated this will now not be possible to be completed until July 2020.
Learning from incidents-ECHO machines audit	The audit determines whether key processes to minimise risk of infection associated with ECHO machine are being followed. This is following learning from a MRSA outbreak within cardiac services between Feb and June 2019.	Audit in November 2019 highlighted that the learning from the MRSA outbreak around the adequacy of cleaning of ECHO machines had not been implemented. This was re-audited in January 2020. There have been improvements in the cleanliness of the ECHO machines following the action plan resulting from the first audit. A follow up audit was scheduled for March 2020 , and has been postponed due to the impact of COVID 19 on IPC team.
Actions from SI 2017/13562 Retained foreign object in theatres	To check if we have implemented changes to minimise the risk of an incident. The audit applies to the surgical count process for cases where metallic reduction heads attached to screws are used.	Audit plan agreed with Spinal Team Leader .Data collection to take place when relevant cases meeting the inclusion criteria occur (these are low volume cases)



Clinical Audit – current work plan

Audit	Why are we doing this audit?	Status
Learning from an inquest- GOSH MDT meetings –re-audit	Learning from an inquest has highlighted the need to ensure appropriate attendance and documentation at GOSH multidisciplinary team (MDT) meetings. Standard terms of reference are being introduced for MDTs to support best practice and ensure that appropriate attendance and clear decision making is recorded.	A re-audit to measure progress was planned to take place in Q4 19/20. This has been deferred and timeframes will be reviewed in July 2020. This has been deferred as improvement in performance depends on EPIC optimisation work and some Trust wide communications which won't take place until post COVID
Learning from incidents. Quality of the Surgical Count	To look at how effectively we are using the surgical count to minimise the risk of retained foreign objects. This audit will focus on engagement and the ability to complete a surgical count that is respected and listened to. The audit considers learning points raised from two retained foreign objects SI.	Data collection commenced in March 2020.This work has had to be paused due to the cancellation of elective surgery and capacity of staff to engage in the audit. This has been deferred and timeframes will be reviewed in July 2020
Documentation of consultant updates to families on CICU	Audit identified by Closing the Loop to provide assurance that learning from a red complaint/inquest has been implemented.	Audit has been completed and highlighted that improvements are required in the documentation of updates given to the families by the medical team on CICU. It has been agreed with the CICU Specialty Lead that some Quality Improvement work will be scheduled to address this in September 2020. This will be monitored by Closing the Loop.
Urology documentation	To assess the implementation of documentation recommendations made for the Urology Service by the Royal College of Surgeons.	Data collection was planned to be completed in March 2020. The data from this audit is being reviewed at the time of writing.

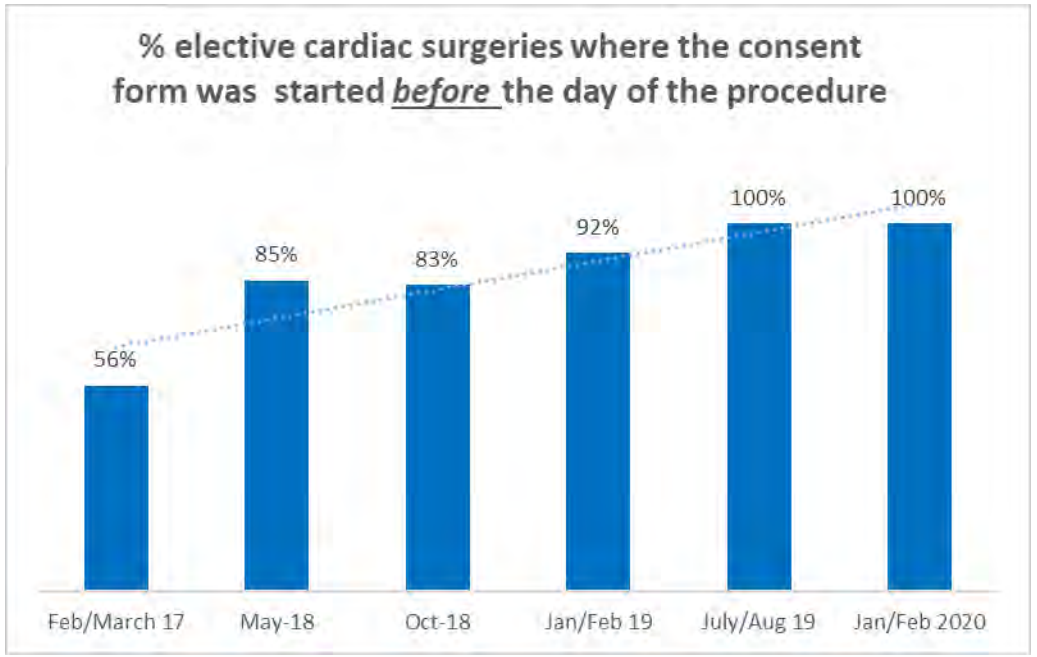


Avoidance of on the day consent for elective cardiac surgery

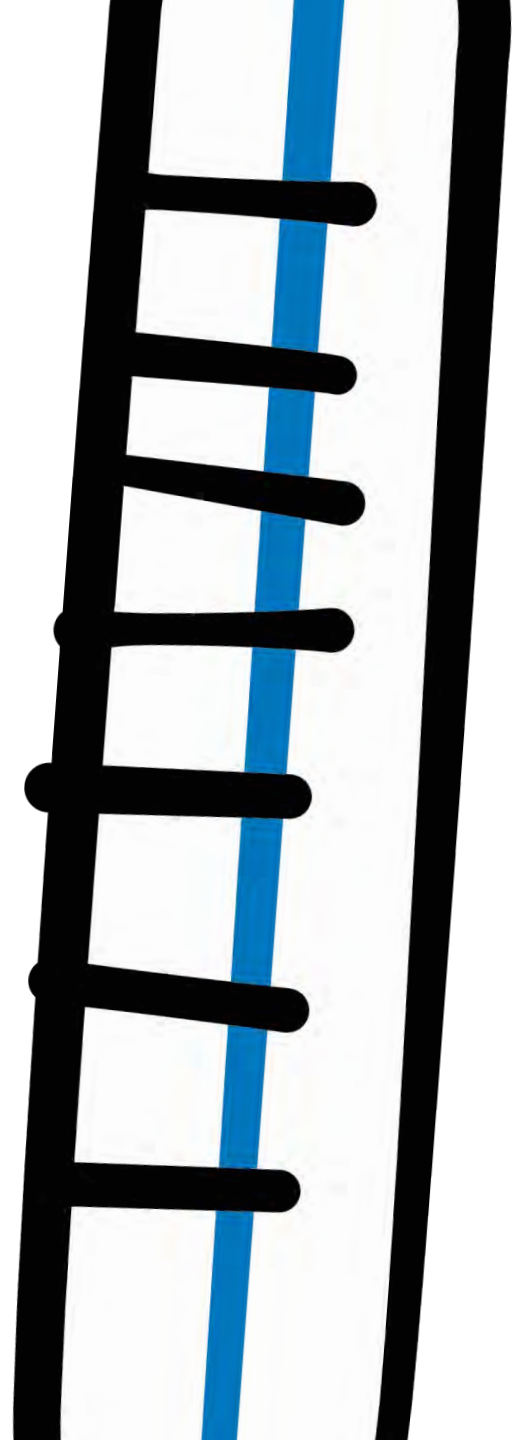
Learning from incidents in 2017 prompted this audit, an example of an incident reported
"*The Surgical Consultant was contacted and came to the ward to do the consent for the procedure 5 minutes before the patient was taken to theatre*"

Repeat audit and feedback was used to help drive improvement and had shown progress had been sustained in avoiding on the day consents for elective cardiac surgery .

One incident was reported in January 2020 where consent was started on the morning of the procedure . Because of this an action plan was agreed to minimise the risk and an additional audit took place to monitor any further incidence.



The audit data helped provide assurance that the incident did not reflect a trend , and that the actions taken following the incident in January 2020 had been effective



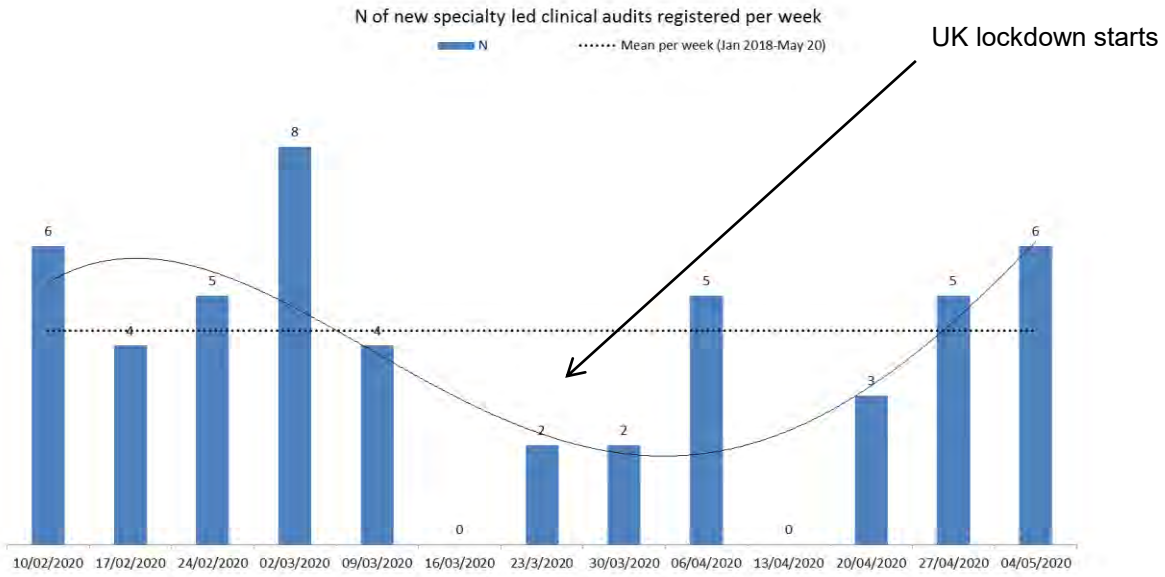
COVID clinical audit

The Infection Control Prevention and Control team are leading a **priority** Trust audit to look at COVID

Audit Title	Why do this audit
Prevalence of SARS CoV2 in paediatric patients and their primary carers	This work will, in line with NHS England/Improvement guidance, determine the rate of asymptomatic carriage of SARS CoV2 (COVID-19) in our patient population alongside their primary carers. Understanding the level of asymptomatic carriage in both of these groups will enable us to ensure that the infection prevention and control measures we are instigating are fit for purpose, as well as supporting early detection of clinical transmission risks. Aim :to ensure fitness for purpose of current infection prevention and control measures for SARS CoV2 in line with NHS E/I guidance by understanding levels of asymptomatic carriage

Specialty Led Clinical Audit

We saw a decrease in the number of new audits being started around the initial lockdown period. Activity appears to be normalising as some clinical teams may have capacity to focus on audit as some clinical activity has been paused



Specialty led clinical audit and COVID

We have seen a number of specific clinical audits started in response to COVID, Clinical teams have been quick to use clinical audit to review service delivery now, and to support care in the future. Some of these pieces of work are collaborative across the North Central London hospitals. Some examples are listed below.

Audit Title	Why do this audit
Acute paediatric mental health presenting via emergency departments in North Central London hospitals during COVID-19:	To determine the volume, nature and severity of recent acute paediatric mental health presentations in the NCL region during COVID-19 compared to previously and the implications this presents currently and in the future for service delivery, quality and safety.
Management of Febrile Neutropenia	The new CCLG management pathway will be introduced for UCLH CYPCS patients at GOSH and this audit will evaluate; duration of admission, clinically important infection, representation, ICU admission and mortality.
Audit of investigation and management of Paediatric Inflammatory Multisystem Syndrome – Temporally associated with SARS-CoV2 (PIMS-TS)	A newly emerging inflammatory syndrome has been identified in the UK in the last 2 weeks. A rapid case definition and investigation plan has been published by the RCPCH. We are auditing practice relative to this guidance and to inform future practice within GOSH
Neuroimaging findings in COVID-19 children	To enable earlier detection of findings and accurate reporting
Comparison of neurological non-accidental injuries during COVID-19 with an historic control group	To establish referral patterns of non-accidental injury patients to the neurosurgical department in a 6 week period during the COVID-19 pandemic.
ICU COVID-19 testing audit	Understanding of practices to inform COVID testing in ICU patients
The Rising Incidence of Abusive Head Trauma During The COVID-19 Pandemic	To establish whether or not we are seeing an increase in the incidence of abusive head trauma during the COVID-19 pandemic..
Cystic fibrosis lung function remote monitoring	To evaluate the success of set-up and monitoring of children with cystic fibrosis using a home spirometry device, app and portal for video conference

NICE guidance and COVID

Background

NICE have developed rapid COVID-19 guidelines. These guidelines have been quickly developed to maximise patient safety whilst making the best use of NHS resources and protecting staff from infection, and are based on the latest evidence.

An SOP has been developed to ensure all COVID-19 NICE guidance is reviewed quickly**. All NICE COVID-19 guidelines have been reviewed at GOSH.**

Relevant guidance reviewed and assessed as compliant, and no actions needed

Reference number	Name of Guideline	Specialit reviewed
NG160	COVID-19 rapid guideline: dialysis service delivery	Nephrology
NG164	COVID-19 rapid guideline: haematopoietic stem cell transplantation	BMT
NG167	COVID-19 rapid guideline: rheumatological autoimmune, inflammatory and metabolic bone disorders	Rheumatology
NG166	COVID-19 rapid guideline: severe asthma	Respiratory
NG170	COVID-19 rapid guideline: cystic fibrosis	Respiratory
NG169	COVID-19 rapid guideline: dermatological conditions treated with drugs affecting the immune response	Dermatology
NG172	COVID-19 rapid guideline: gastrointestinal and liver conditions treated with drugs affecting the immune response	Gastroenterology

COVID-19 rapid guideline: children and young people who are immunocompromised

NICE recommended
Healthcare workers with known or suspected COVID-19 should self-isolate and not return to working directly with patients who are immunocompromised until they:
•show no symptoms for 1 week and
•test negative for COVID-19.”

The Trust position prior is that
In line with PHE policy, that staff DO NOT need to have tested negative for COVID-19 before returning to work.
This NICE guidance has been reviewed by the IPC team and communicated to the Silver COVID Command on the 4th May.

Silver approved the decision that GOSH continue to operate its current policy, and staff do not require a negative test before returning to work. This has been added to the COVID risk register as a derogation

This information is correct as of the 11th May 2020 .

Quality Improvement

1. Mentoring QI Projects

The team provides a mentoring service, offering QI support to staff who are interested in starting projects.

Project Commenced	Area of work	Project lead:	Expected completion date	Project Support
Dec 2018	**Improve handover** quality and continuity of care for outlying patients in the cardiology service	Craig Laurence (Cardiac Fellow)	March 2020	**Project closed (March 2020)**
Jun 2019	To reduce the number of **unnecessary blood tests**, when ordered in sets/ bundles, in Brain Division	Spyros Bastios (Metabolic Consultant)	April 2020 **(adjusted to August 2020)**	Diagnostics
Aug 2019	To **improve patient satisfaction of the consenting process** in cardiac anaesthesia	Marc Cohen	Aug 2020	Diagnostics
Nov 2019	To **reduce unnecessary fasting** of patients re-procedure on Safari Ward	Elena Stanton (Trainee-Anaesthetics)	July 2020	PDSA cycle support
Nov 2019	To ensure all **Haem/Onc TTO medication** is ready at time of planned discharge	Anupama Rao (Consultant, Haematology/Oncology)	April 2020 **(adjusted to August 2020)**	PDSA cycle support
Jan 2020	To **improve the provision of Play** for Inpatient wards	Laura Walsh (Head of Play Services)	June 2020 **(adjusted to September 2020)**	Diagnostics

Project Commenced	Area of work	Project lead:	Expected completion date
Sept 2019	To reduce variation in the pre-op processes undertaken by **Orthopaedic CNS service**	Claire Waller (Matron)	June 2020
Oct 2019	To improve staff satisfaction through redesign of the **Palliative Care on-call service**	Julie Bayliss (Clinical Lead)	April 2020 **(adjusted timeframe August 2020)**
[Recommenced] Feb 2020	To improve IR theatre utilisation by implementing **ZAPPP** (zero acceptance of poor patient preparation) policy	Sam Chippington (Cons)	Sept 2020

Local / Directorate QI Work, Training and Trust Wide Projects

Project Commenced	Area of work	Project lead:	Expected completion date
Sept 2019	To reduce variation in the pre-op processes undertaken by **Orthopaedic CNS service**	Claire Waller (Matron)	June 2020
Oct 2019	To improve staff satisfaction through redesign of the **Palliative Care on-call service**	Julie Bayliss (Clinical Lead)	April 2020 **(adjusted timeframe August 2020)**
[Recommenced] Feb 2020	To improve IR theatre utilisation by implementing **ZAPPP** (zero acceptance of poor patient preparation) policy	Sam Chippington (Cons)	Sept 2020

Activity Commenced	QI Activity (Ad-hoc teaching/facilitation)	Project lead:	Expected completion date
Feb/March 2020	Development of a GOSH guide to clinical pathway redesign	Richard Collins	Complete
All QI training was paused in March 2020 as per Trust policy during the COVID-19 response period			

Project Commenced	Area of work	Project Lead (PL) Exec Sponsor (ES)	Expected completion date
Oct 2019	Supporting the **medication safety work stream** of the Hospital Pharmacy Transformation Programme Board (HPTPB): Uncollected Medications	PL: Stephen Tomlin ES: Sophia Varadkar	30th September 2020
Jun 2019	Improving safety and standardisation of **urethral catheterisation**	PL: Nicola Wilson / Claire Waller ES: Sanjiv Sharma	30th June 2020 (extension agreed)
Jun 2018	Reducing rejected **laboratory samples**	PL: Christine Morris ES: Sanjiv Sharma	1st June 2020 (extension agreed)

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QI Support for COVID-19 Response- April 2020

Staff COVID-19 Testing Clinic:

- Established clinic design through process mapping and PDSA cycle testing
- Development of clinic bookings and lab results tracker

FIT Testing Process Redesign:

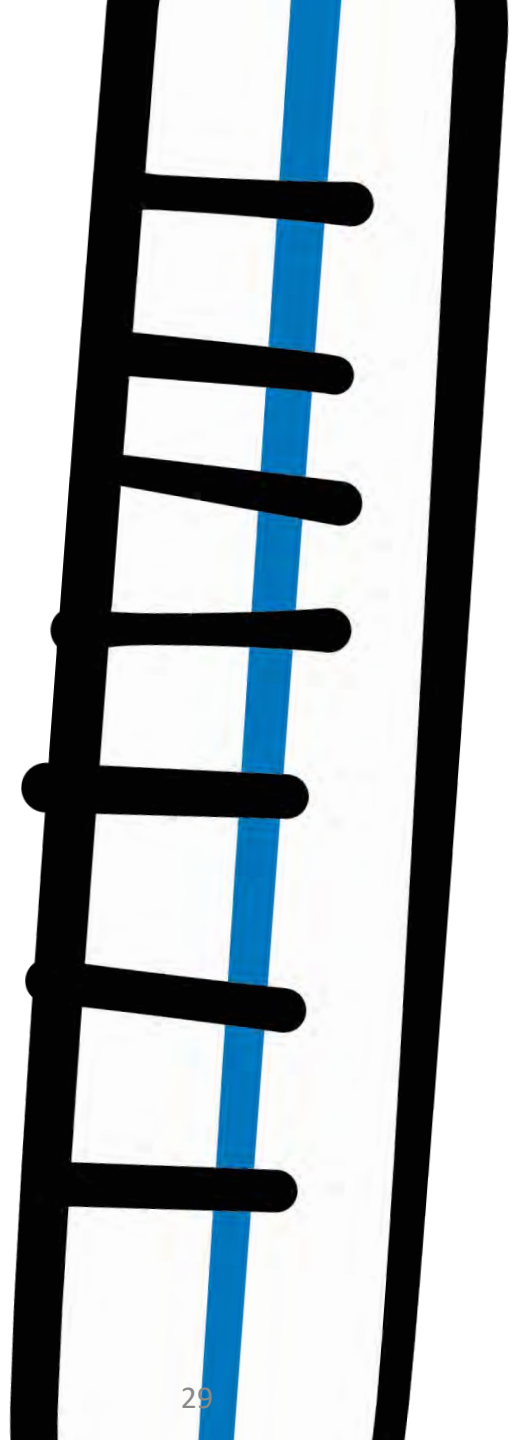
- Established clinic design through process mapping
- Development of FIT testing management app to record accurate testing figures for IP&C against available equipment and feed information back into HealthRoster

COVID-19 Antibody Testing:

- Established clinic design through process mapping
- Development of clinic bookings and lab results tracker

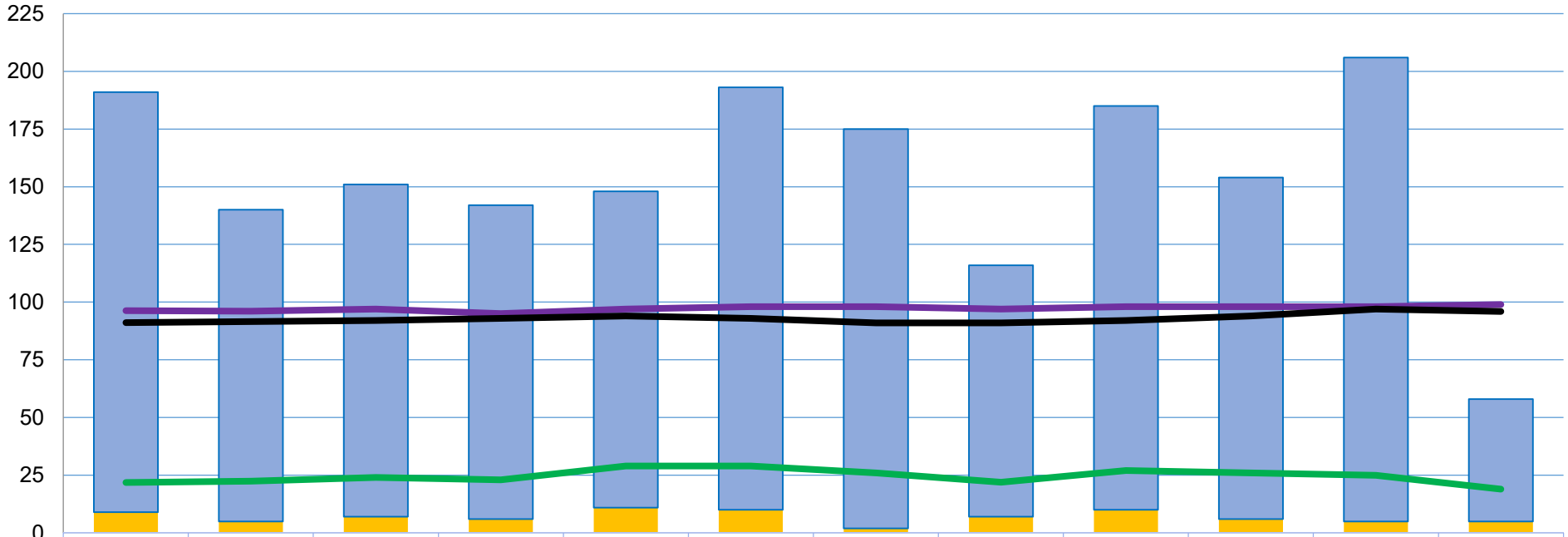
Bereavement Services:

- Supporting the development of off-site Child Death Helpline service



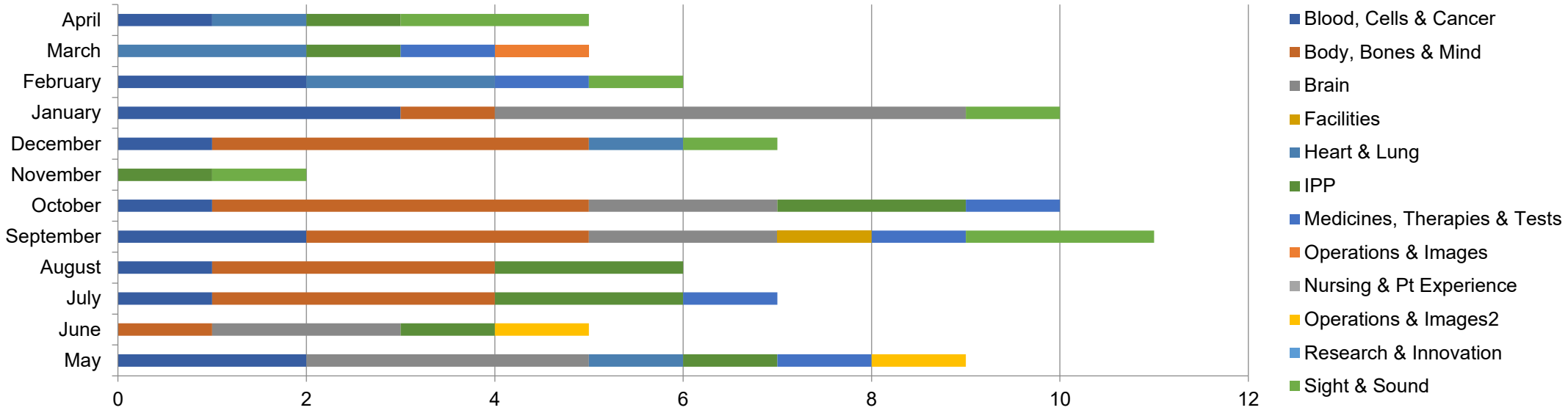
Patient Experience Overview

Are we responding and improving?
Patients, families & carers can share feedback via Pals, Complaints & the Friends and Family Test (FFT).



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Pals	182	135	144	136	137	183	173	109	175	148	201	53
Formal Complaints	9	5	7	6	11	10	2	7	10	6	5	5
FFT recommendation rate - Inpatients %	96	96	97	95	97	98	98	97	98	98	98	99
FFT recommendation rate - Outpatients %	91	92	92	93	94	93	91	91	92	94	97	96
FFT % response rate	22	22	24	23	29	29	26	22	27	26	25	19

Complaints: Are we responding and improving?



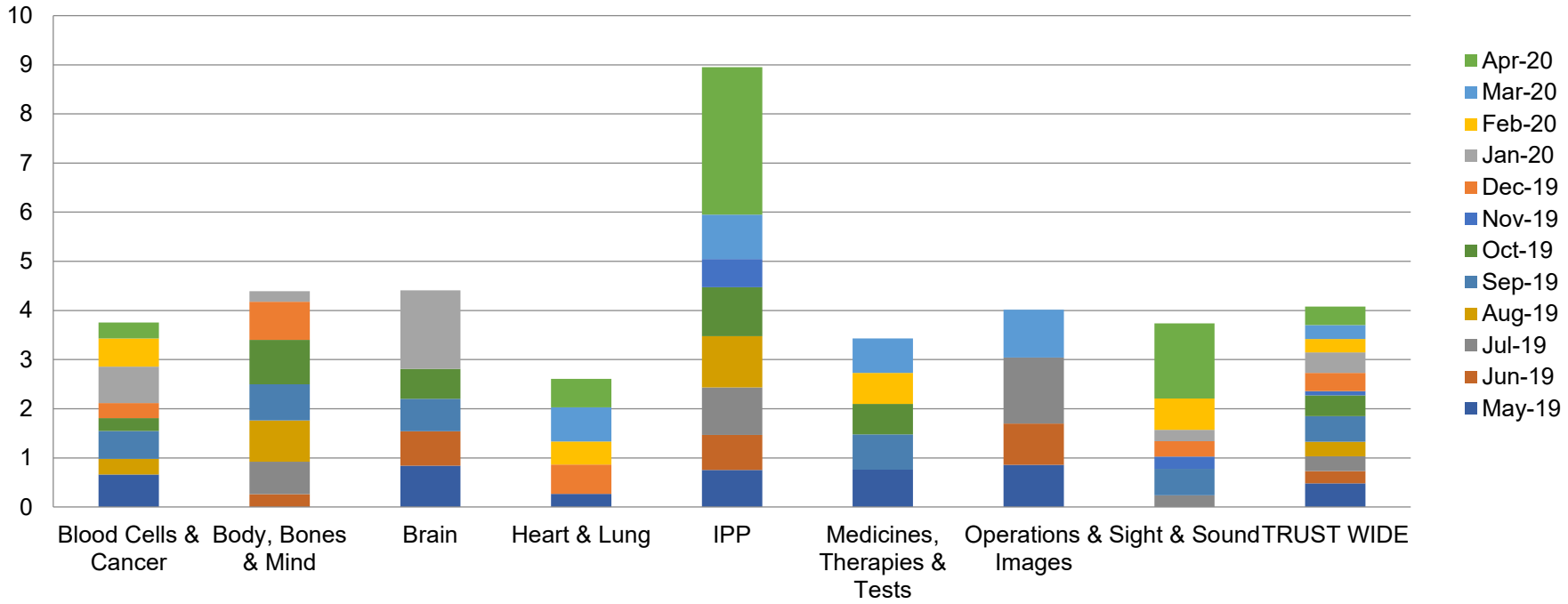
There were 5 new formal complaints received in April 2020 which is a decrease compared to April 2019 (n=7). This is the same number of complaints as the previous month and reflects a continued decrease in the number of complaints received per month since the COVID-19 pandemic.

Within complaints this month families reported concerns regarding:

- The risk of bringing their child to the hospital during the current pandemic. Concerns also raised regarding a lack of communication and strained relationships with the team.
- Failure to identify a cleft palate when the patient was admitted to GOSH days after birth. This happened in 2016 but the cleft palate was diagnosed towards the end of 2019.
- Post-operative complications and aspects of the care on the ward. Concerns were also raised about the patient being discharged too quickly (within 48hours after surgery) and feel that this contributed to the complications and re-admission.
- Lack of communication between the clinical teams which they feel resulted in their child's procedure being cancelled, after the child was given food whilst nil by mouth.
- The diagnosis given and query if it is correct.

Complaints by patient activity*

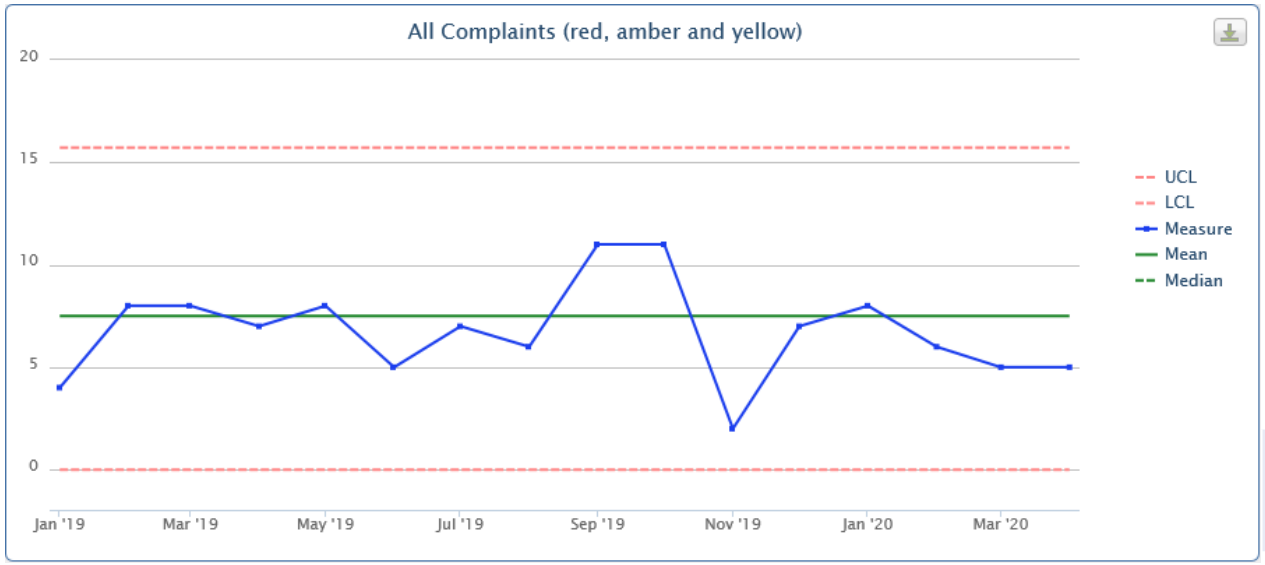
**Combined patient activity (CPE) = the number of inpatient episodes + the number of outpatient appointments attended*



The overall complaints rate in April was 0.38 complaints per 1,000 combined patient episodes. This was a slight increase from March. Despite the number (n=5) of complaints remaining the same as last month, this slight increase is reflective of the decrease in the patient activity within the Trust in April. Following the cancellation of procedures and appointments, the Trust's patient activity fell to its lowest this financial year.

IPP received one complaint. However, due to the very low combined patient activity this stood as an outlier at 3 complaints per 1,000 combined patient episodes, which is the highest it has ever been.
Similarly, Sight and Sound attained its highest complaint rate (1.53 complaints per 1,000 CPE) and is also reflective of the low patient activity. Of note, Sight and Sound were the only directorate to receive more than one complaint this month (n=2).

Red Complaints: Are we responding and improving?



No of new red complaints this financial year 2020/21 (as of 27/04/ 2020):	1
New Red complaints opened in April 2020	1
No of re-opened* red complaints this year (from April 2020):	0
Open red complaints (new and reopened) as of 30/04/2020:	3

Opened red complaint in April 2020

Ref	Directorates Involved	Background	Update
20/004	Sight and Sound	Concerns raised about post-operative complications and care, discharge within 48hours (felt to be too soon) and care on the ward when readmitted.	Investigation underway

Open red complaints (including reopen red complaints)

Ref	Directorates Involved	Description of Complaint	Next Steps:
19-084	Heart and Lung	Father raised concerns regarding care and treatment prior to his child's death. He feels that should not have died when she did and how she did.	Investigation underway
18-095R	Blood, Cells and Cancer	Further questions raised regarding care and treatment and action taken. Request for further information including some records and evidence of learning from complaint.	Complaint investigation paused due to being unable to investigate appropriately at this time (COVID)

There are no overdue red complaint actions currently. Complaint Actions continue to be monitored at the Closing the Loop meetings and in the Patient Family, Experience and Engagement Committee.

Are we responding and improving to complaints?

You Said: The pathway is unclear for patient being seen under the Vascular Anomalies Service. This included uncertainties on who is leading on care.

We did: A new 'Vascular Anomalies' protocol has been devised and a named consultant has agreed to take over as lead for this group of patients. Families were informed of this.

You Said: The bed sheets were not changed daily and there were issues surrounding the cleanliness of the rooms on the IPP ward.

We did: Regular walkrounds on the ward now take place with the OCS supervisor to monitor standards of cleaning.

You Said: IPP invoice letters are confusing.

We did: A review of the invoice paperwork. We changed the terminology, layout and added clearer breakdown of charges.

You Said: You were unsure what to expect from one of our multi-disciplinary specialist services (HAEGRO) and feel that families could be better prepared for these sensitive appointments.

We did: A new and detailed leaflet about what to expect from the service was created and is now sent to all families prior to their first appointment. The leaflet aims to address frequently asked questions and explain the sensitive nature of the discussions and how best children and young people can cope with these.

Pals – Are we responding and improving?

Cases – Month	04/19	03/20	04/20
Promptly resolved (24-48 hour resolution)	89	162	53
Complex cases (multiple questions, 48 hour+ resolution)	44	37	13
Escalated to formal complaints	3	2	2
Compliments about specialities	1	0	3
Total:	**137**	**201**	**71**
Themes for the top six specialties			
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families, transport)	47	71	30
Admission/Discharge /Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation; waiting times to hear about admissions; lack of communication with families, Accommodation)	4	5	1
Staff attitude (Rude staff, poor communication with parents, not listening to parents, care advice)	11	0	0
Outpatient (Cancellation; Failure to arrange appointment; poor communication, franking of letters)	39	28	1
Transport (Eligibility, delay in providing transport, failure to provide transport)	5	7	0
Information (GOSH information, Health information, care advice, advice NHS, access to medical records, incorrect records, missing records, support/listening)	31	90	39

There has been a considerable decrease in the volume of Pals cases received in April in comparison to the preceding month, with 71 cases reported in April compared to 201 in March.

Contributory factors for this 64% decline include trust activity due to COVID-19 and the Coronavirus information hub on the GOSH website which has seen unprecedented ‘hits’. This includes specialty/ condition specific information related to COVID-19. Information relating to Pals contacts has also been shared daily with the Communications team to inform a Frequently Asked Questions section within the hub.

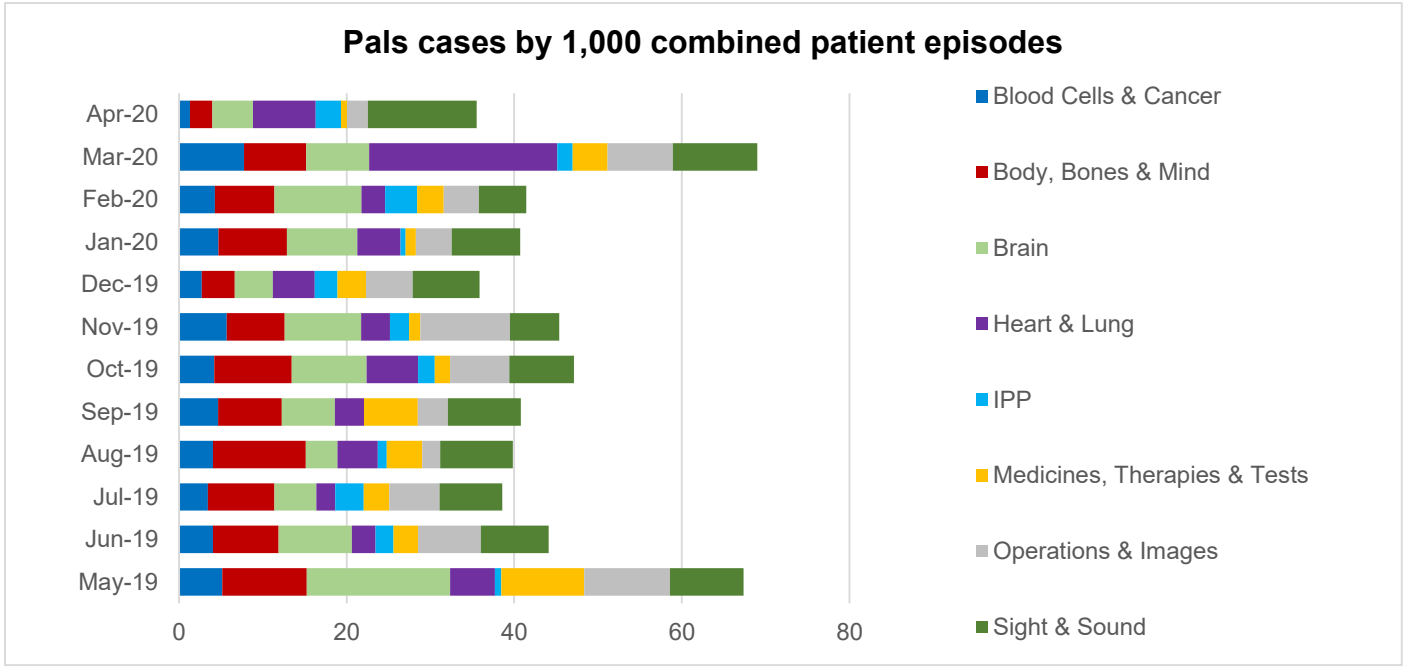
Families have found the FAQs very helpful. Specialties have also contacted families of patients who have “high risk” conditions (according to national guidance) and also sent letters to families to explain “shielding”. The resources and proactive communication to families have seen Pals contacts regarding COVID-19 reduce to 23% compared to 51% in March.

Nevertheless, communication continues to be a major theme for Pals. The majority of contacts centre around requests for additional clarity on social distancing policies employed by the Trust, with a particular focus being placed on the ‘one parent rule’.

Pals received three compliments praising staff for their exceptional levels of patient-centred care and wishing them well during this challenging time.

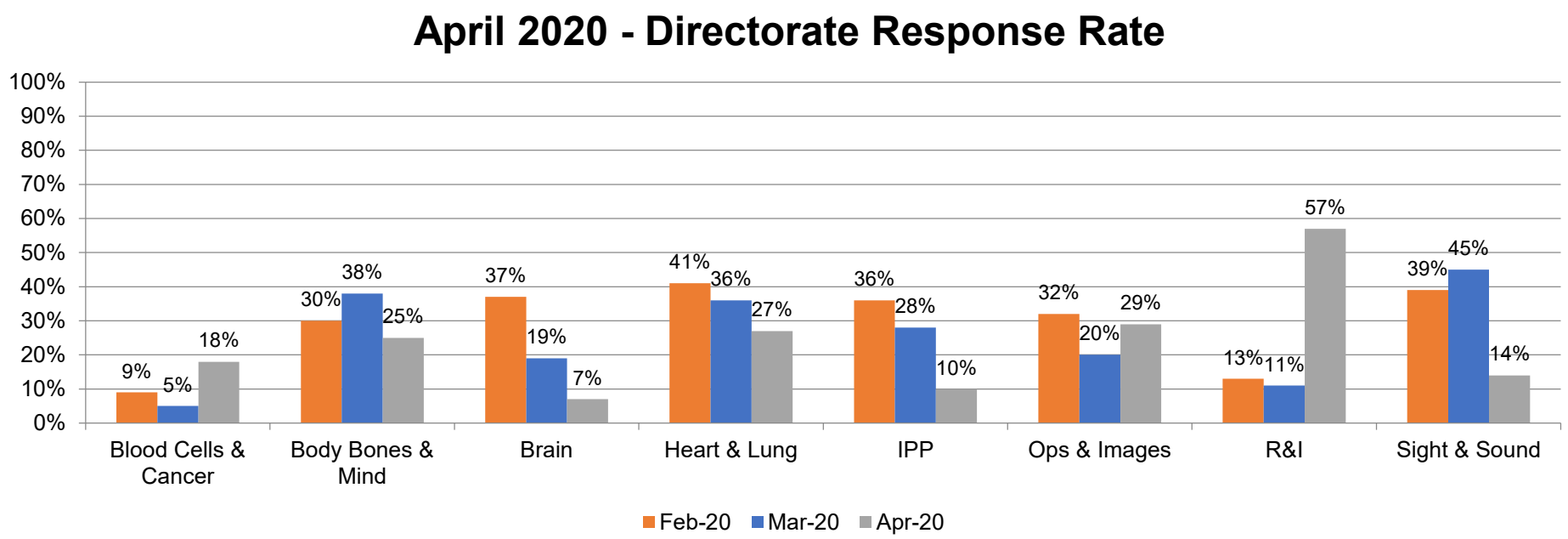
Pals cases by directorate

Following the high number of H&L cancellations in March, the Pals contacts in April dropped significantly. The contacts received primarily related to further clarification and assurance sought regarding ‘high risk’ conditions/ shielding.
Sight and Sound contacts primarily related to requests for test results/ information and difficulties in contacting some reams including Health Records.



	BCC	BBM	Brain	H&L	IPP	MT&T	O&I	R&I	S&S
May-19	16	36	41	20	1	13	12	1	30
Jun-19	13	30	25	11	3	4	9	0	30
Jul-19	13	36	17	10	7	5	9	0	31
Aug-19	13	34	10	18	2	6	3	0	34
Sep-19	16	31	19	15	0	9	5	0	32
Oct-19	16	41	29	25	4	3	11	2	36
Nov-19	21	32	30	15	4	2	17	0	24
Dec-19	9	15	12	17	4	4	7	0	25
Jan-20	19	39	27	23	1	2	7	0	35
Feb-20	15	31	32	12	6	5	6	0	21
Mar-20	25	27	21	65	2	6	8	2	25
Apr-20	4	8	11	13	1	1	1	2	17
YTD	**180**	**360**	**274**	**244**	**35**	**60**	**95**	**7**	**340**

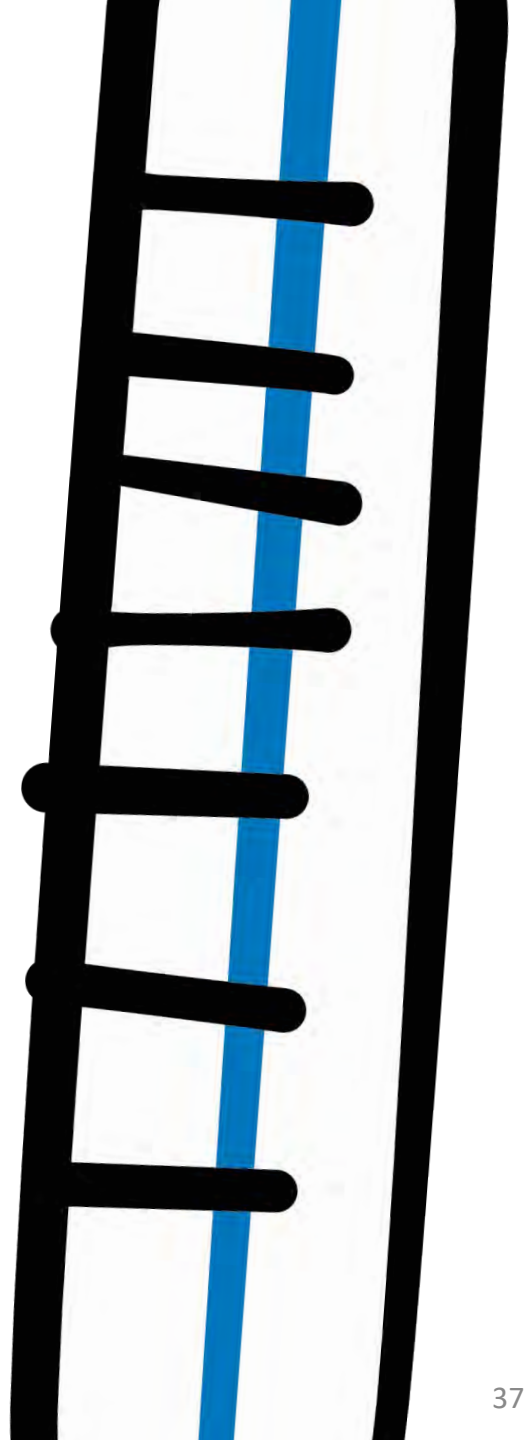
FFT: Are we responding and improving?



The response rate for inpatients is **19.3%** and the experience measure is **98.5%. This** is positive as FFT has not actively been promoted during Covid-19. Body Bones and Mind, Heart & Lung, Ops & Images, Research and Innovation have all scored above the Trust Target. R&I achieved the highest response rate in April, **57%.**

Five directorates achieved a100% experience rate, Blood Cells and Cancer, Body Bones and Mind, Brain, Ops & Images, and Research & Innovation.

Responses were overwhelmingly positive, praising staff and their professionalism and the NHS as a whole. Negative comments related to the environment and catering.



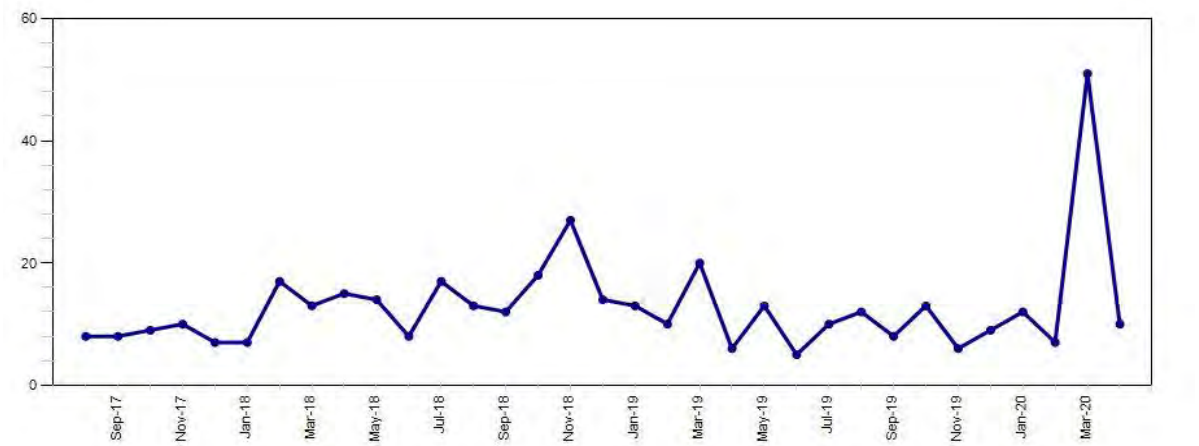
Pals – Are we responding and improving?

Top specialities - Month	04/19	03/20	04/20
Cardiology	6	51	10
Outpatients	10	12	8
Metabolic Medicine	2	8	4
Gastroenterology	9	8	3
Neurology	6	7	3

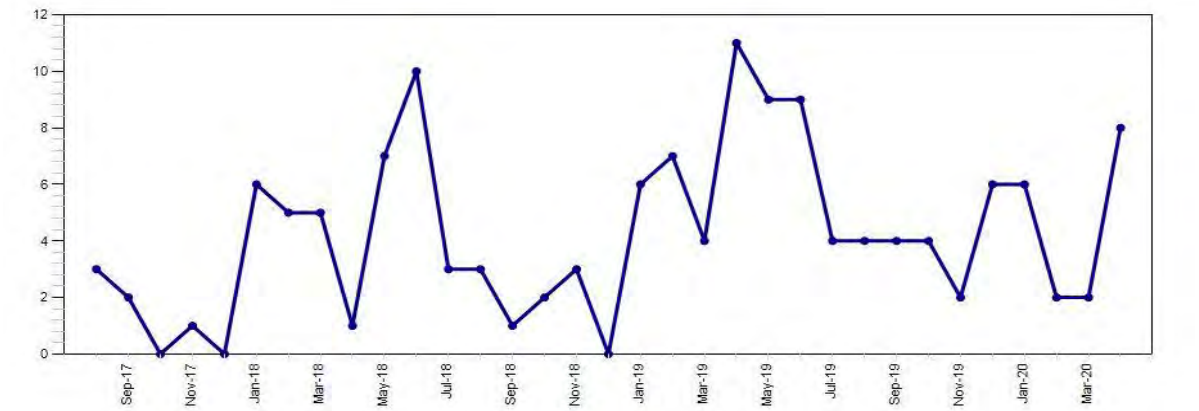
Cardiology- Following the spike of cases in March due to cancelled procedures and appointments, Pals contacts in April reduced significantly. Cases related to requests for further clarification about risks of corona virus and shielding for Cardiology patients. The corona virus information hub and speciality information sheets is deemed to be a key contributory factor to the reduction of contacts across the Trust. Pals continue to signpost patients/carers to this information, whilst also ensuring that complex and patient specific concerns are appropriately escalated to the relevant clinical teams within the specialty.

Outpatients- There has been a decrease in the volume of Outpatient cases. Common themes include requests for additional clinical and administrative information regarding appointments; including examination results and assistance with booking follow ups. In addition to this, Pals were contacted by a parent who expressed concerns about the infection control measures employed by the trust. Pals continue to work alongside the relevant teams to provide support for patients and carers whilst ensuring that the concerns raised are efficiently and appropriately escalated when required.

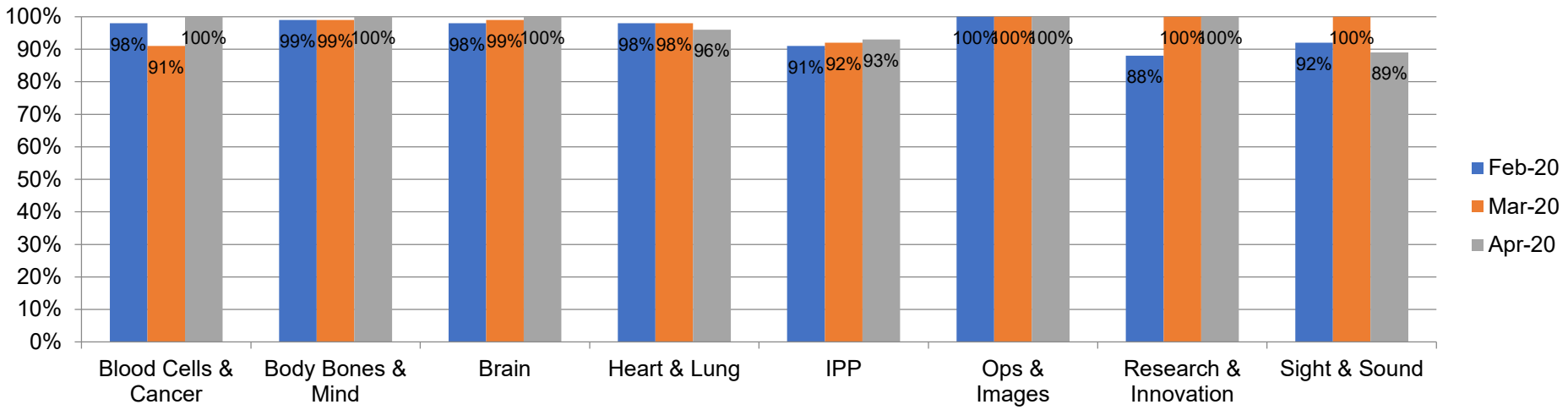
Cardiology cases by patient activity- (total cases excluding formal complaints)



Outpatient cases by patient activity- (total cases excluding formal complaints)



FFT: Are we responding and improving?



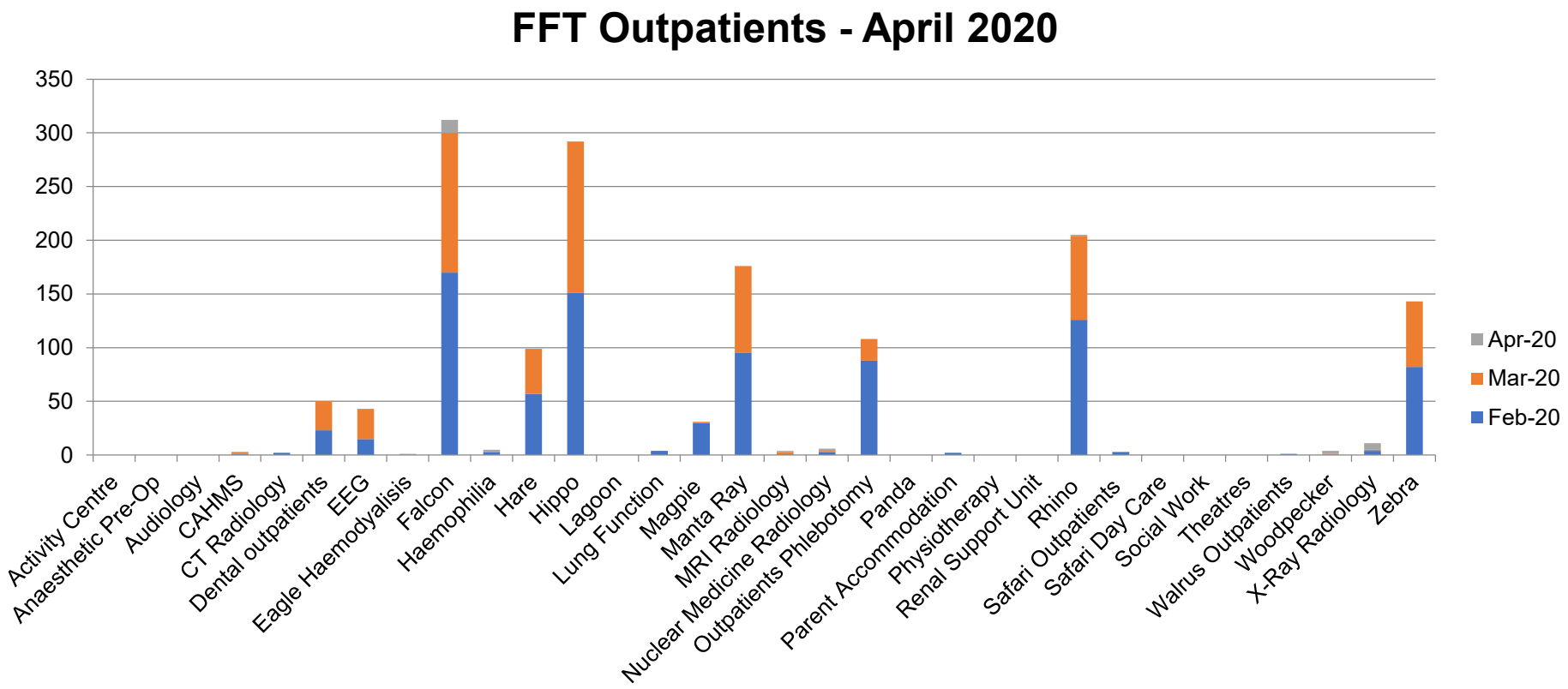
	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Oct 19	1008	1116	67	**2191**	**81.7%**
Nov 19	897	659	55	**1611**	**83.5%**
Dec 19	642	404	38	**1084**	**83.9%**
Jan 20	945	650	61	**1656**	**81.5%**
Feb 20	875	860	47	**1782**	**70.1%**
Mar 20	500	617	24	**1141**	**81.5%**
Apr 20	195	28	15	**238**	**85.7%**

The volume of feedback received this month has reduced significantly as expected during the Covid-19 outbreak.
Inpatient response rate = **19.3%.**
The experience measure for inpatients = **98.5%.**

The qualitative comments were higher than last month at **85.7%.**

Positive comments related to the professionalism and friendliness of the staff. There were a very small number of negative comments this month. These related to the closure of the playrooms on wards and the lack of showering facilities on Koala ward. There was also a comment related accessibility for wheelchair users.

FFT: Are we responding and improving?



The outpatient areas which remain open have seen a significant drop in FFT responses as expected in line with reduced onsite clinics (2940*). Many clinics are taking place virtually and while there has been an increase in the number of online FFT submissions, this has not been representative of the number of virtual clinics held (7073*). The FFT link has been added to the after visit summary on MyGOSH, so we are hopeful the number of online submissions will improve.

The recommendation rate was above the Trust target at **96.4%,** just a slight reduction from last month.

Comments praised the efficiency of the Phlebotomy services and clinics during the Covid-19 outbreak and commended staff for alleviating patient and family concerns about their visit.

*Data provided by Information Services

FFT: Are we responding and improving?

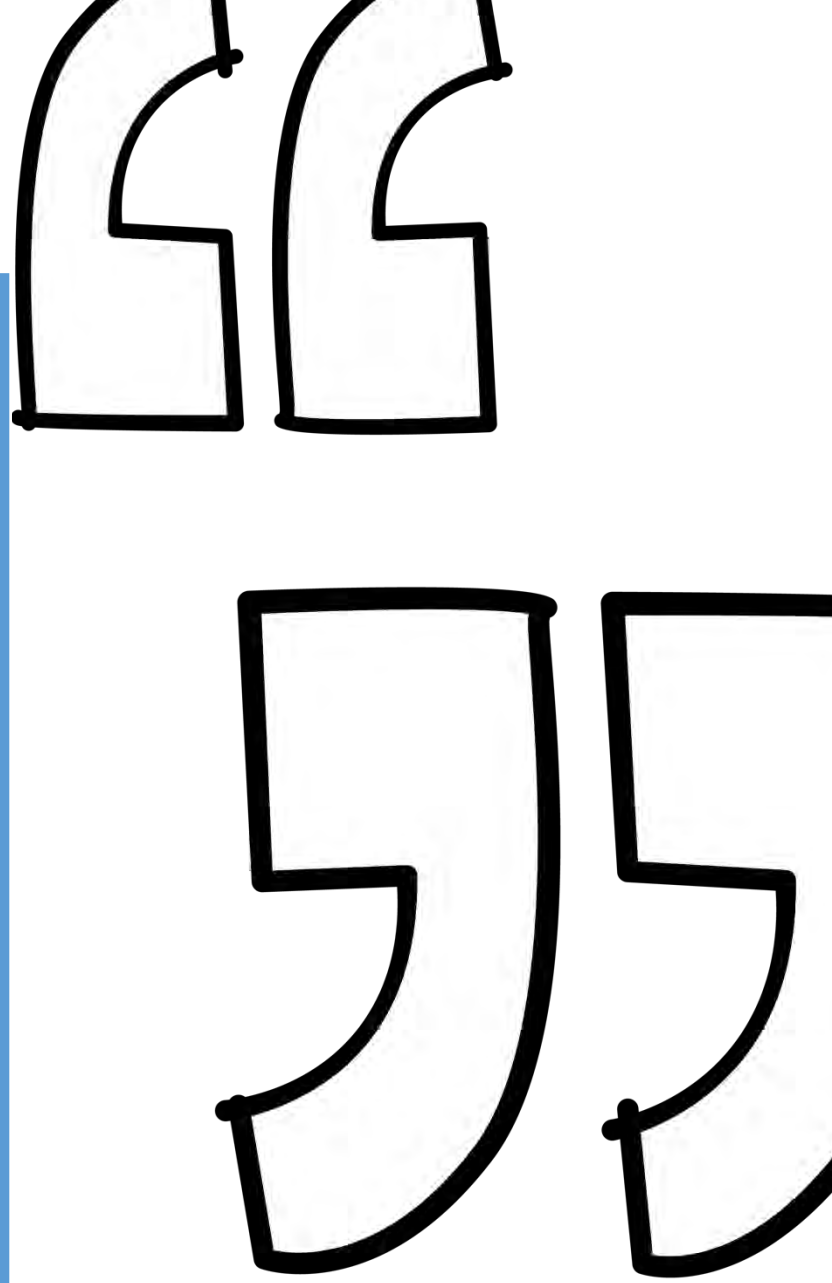
Qualitative Comments

"*The atmosphere here in GOSH is mind blowing, legendary led patient care. You have the most amazing staff who are super gifted in positivity affecting healing into their patients*" –
Panther Ward

"We come to the hospital on many occasions as my son has undergone an operation here. Your staff every time exceed our expectations. Thank you to all of them, they are amazing!" –
Hare Outpatients

"We clapped for the NHS last night, but especially for GOSH. Thank you to everyone!" –
Giraffe Ward

"Brilliant team, very well looked after especially during this pandemic. Staff remained calm and professional and kept us at ease and happy to help and answer all our questions" –
Squirrel Gastroenterology Ward



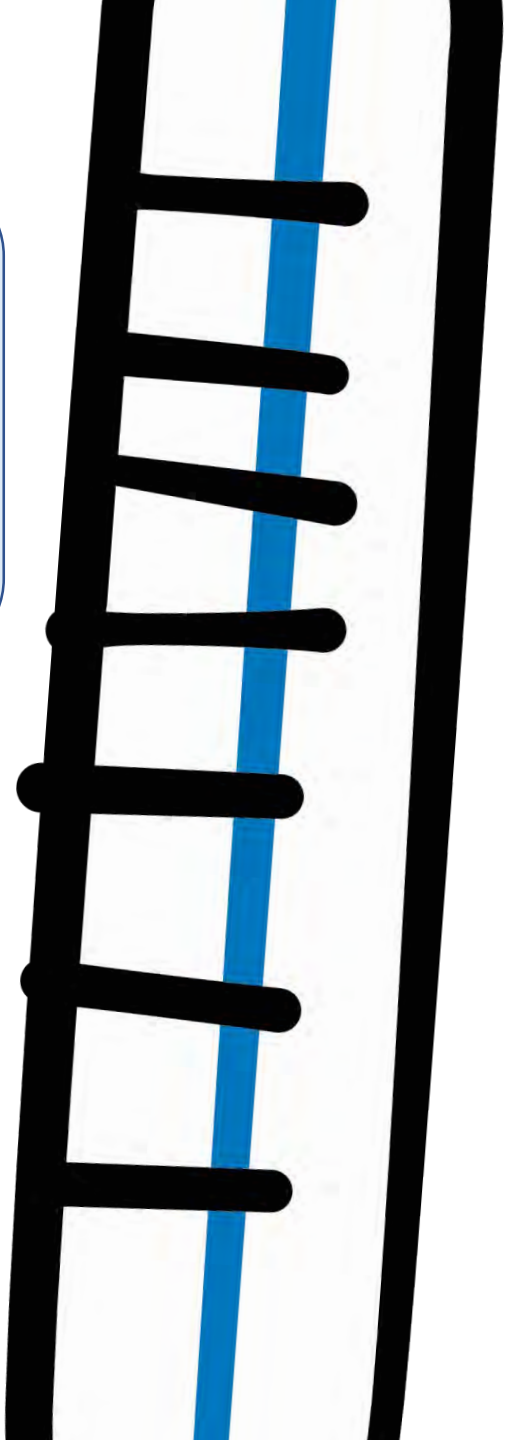
Patient Access – Diagnostic waiting times

April 2020 Summary

- As expected during the Covid-19 situation the Trust continues has underachieved against the 99% national standard, reporting 40.34% of patients waiting within 6 weeks for the 15 diagnostic modalities. There was a significant increase in the number of breaches reported in April (818) compared to the number of breaches reported in March (387).
- Of the 818 breaches, 606 are attributable to modalities within Imaging (334 of which are MRI), 96 in Sleep Studies, 35 in ECHO, 32 in Clinical neuro-physiology, 30 in Gastroscopy, 6 in Audiology, 8 in Cystoscopy, 3 in Urodynamics, and 2 in Colonoscopy.
- The patients are currently being managed by clinical prioritisation with patients requiring a scan within 6 – 72 hours being booked as previous, patients within 2 weeks are being assessed by Radiologist and/or Radiographers and booked accordingly. Routine scans have been on the whole postponed accept for patients requiring a scan with a face to face appointment, or surgery planning and the surgery is booked. Planned patients are being assessed on a weekly basis by the clinical teams.

We are still working with services to confirm the breach reasons, however as expected a high proportion of the 818 breaches are connected with Covid-19 (unable to book due to Covid19 or attendance cancelled due to Covid9)

The Trust is working on plan on how to safely increase activity for diagnostics through the Clinical Prioritisation Group, however Covid-19 is having a significant impact on the Trust ability to deliver against the standard and therefore it is projected that performance will worsen further in the coming months.



Cancer Wait Times

Although at the time of writing April 2020 cancer waiting times data had not been submitted, provisional performance suggests that, the Trust achieved 100% across all five of the standards we are required to report on. Please note during the current national Covid-19 situation Cancer patients have been accessing services as normal and the Trust has been supporting UCLH paediatric cancer patients. However, over the last 8 weeks the Trust has seen an approximate 50% decrease on cancer referrals into the Trust due to the and are planning for the potential increase with the change in government guidance to the public.

Patient Access – Referral to Treatment

April 2020 Summary

- The Trust did not achieve the RTT 92% standard, submitting performance of 76.2%, with 1,636 patients waiting longer than 18 weeks, this is a significant deterioration of 6.7% from the previous month.
- The worsening position has been as a result of the Trust significantly reducing non-essential elective workload since the middle of March 2020, with up to 70% of the focus across admissions and outpatients being on urgent cases and utilising virtual appointments across outpatients. The average reduction in performance over the Covid-19 period has been 1.6% per week, with a further deterioration projected over the coming months as activity levels remain below planned levels due to the need for social distancing, the additional clinical time required as a result of the need to use PPE and the reluctance of parents to attend appointments.
- A Clinical Prioritisation Group has been established led by the Medical Director to access all patient who require to be seen across outpatients and admissions to ensure they are reviewed and prioritised according to clinical need. Any patient who experiences an extended wait will need to have a harm review completed.
- The Trust continues to experience extended waits in some sub-speciality areas including Dental/Maxfax and SDR, and continue to work with Commissioners around the best way to treat these patients in a timely way, in line with their clinical priority.
- The Trust is currently reviewing all under achieving specialties and working with services to produce recovery plans and trajectories in light of the Covid impact. This will include working on the capacity element of services to understand how many patients we can see across outpatients and theatres in a safe environment, as well as the demand for such services.
- The Trust continues to monitor the volume of RTT pathways with an unknown clock start (both referred to us externally and internally) and the current position stands at 321 pathways, all of which were referred to us by external providers.

Referrals, Admissions and Discharges

The Trust has seen almost a 44% decrease in external referrals since March 2020 and a 65% decrease compared to the volume received in February. Equally, internal referrals in the Trust as a whole have also decreased by approximately 50%.

Similarly the volume of admissions in April was significantly lower compared to previous months', a decrease of nearly 1,000 admissions compared to March and 1,700 less than the level of admissions in February.

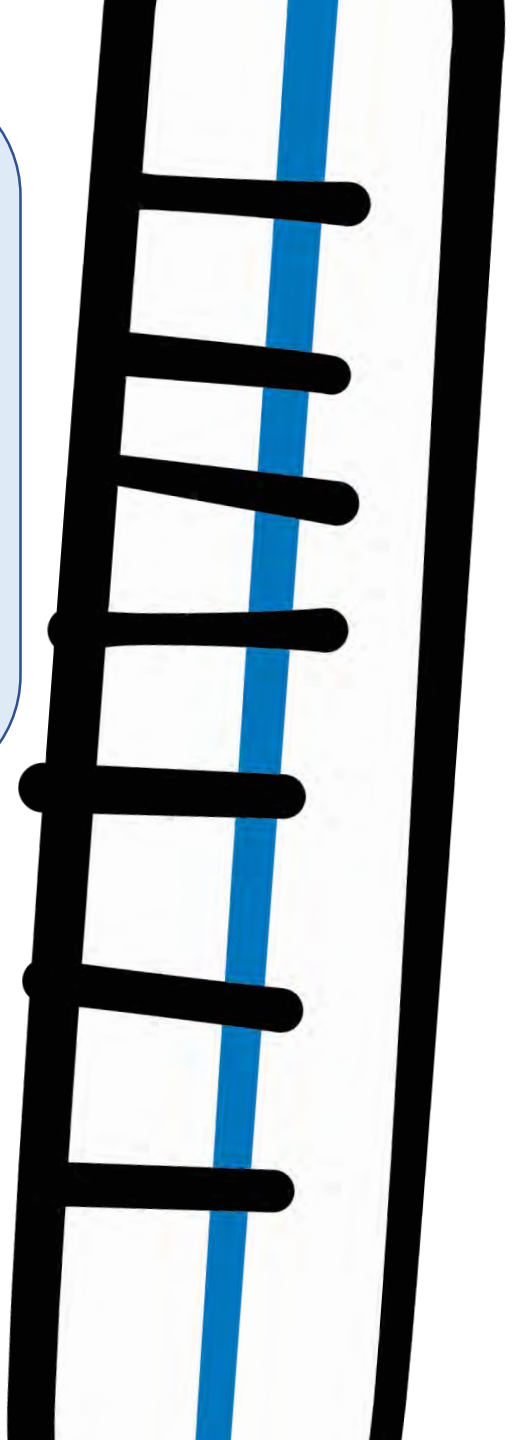
Long stay patients:

This looks at patients with a LOS over 50 days and currently not discharged as well as the combined number of bed days accumulated during their stay. For the month of April, there were 53 patients (both NHS and PP) whose LOS was more than 50 days, accumulating 9,321 bed days in total.

52+ Week Waits: Incomplete pathways

As at the end of April, the Trust reported a total of 53 patients waiting 52 weeks or more. The specialty breakdown is given below:

Specialty	>52 wks
Dental	26
Plastic Surgery	6
Orthodontics	4
Neurosurgery	3
Craniofacial	3
Neurodisability	2
Urology	2
Ear Nose and Throat	2
Maxillofacial	2
General Paediatrics	1
Ophthalmology	1
Cochlear Implant	1



Productivity & Efficiency – Theatre Utilisation

To meet the Trusts operating requirements during Covid-19 the way in which operating theatres were scheduled significantly changed mid-March 2020 to no longer hold scheduled list but run lists as urgent/emergency as non-essential elective work ceased. The number of emergency cases operated on during April were 217. However, work continues on targeting fully utilising lists for patients requiring treatment.

We are also working to understand if there are any data quality issues associated with sessions remaining open when they were cancelled during the Covid-19 period

Last minute non-clinical hospital cancelled operation

Reported in the dashboard are the monthly breakdowns for this quarterly reportable indicator, with the latest available position for March 2020.

For March, there were 17 patients cancelled compared to 35 in February, however, the lower number of elective admissions will directly correlate to the March position. The areas contributing most to the monthly position are Cardiac Surgery (3), Neurology (3), Neuromuscular (3), SNAPS (2), Gastroenterology (2), Cystic Fibrosis (2), Cardiology (1), and Ophthalmology (1). The top three reasons recorded for the month are : Ward bed unavailable (5), Emergency/Urgent patient taking priority (5) List overrun(4).

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

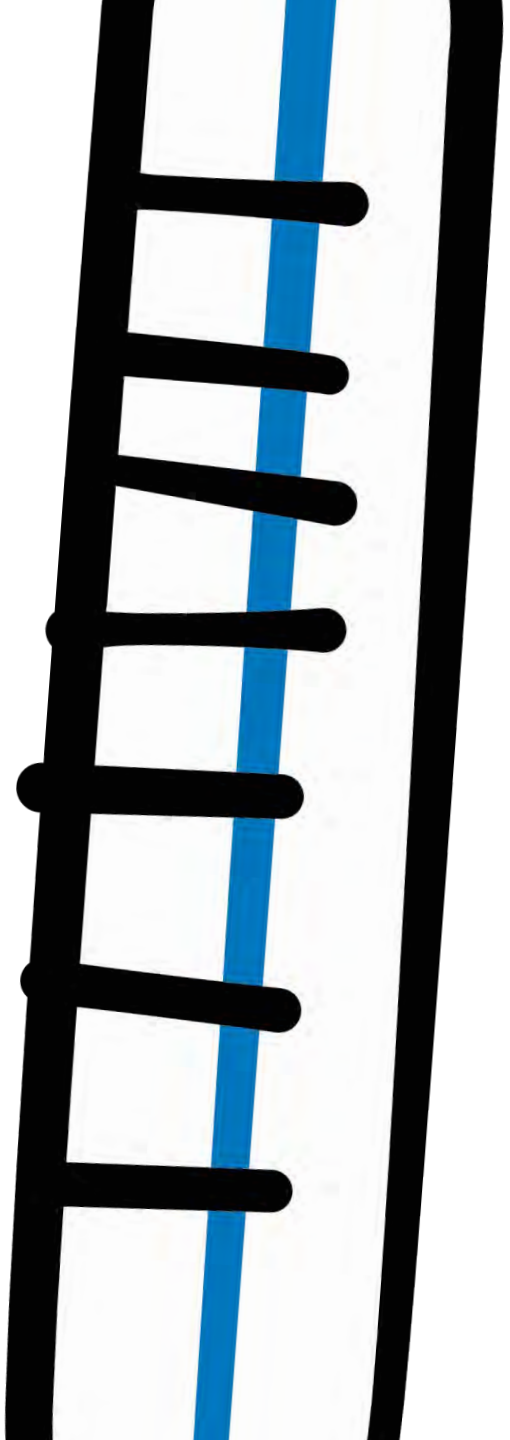
The Trust reported 2 last minute cancelled operations not readmitted within 28 days in March. The areas of breach was Neurosurgery with both patients cancelled due to COVID-19.

Bed Occupancy and Closures

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

Occupancy: For both the months of March and April, bed occupancy was lower than previous months at, 60% and 64% respectively, however this is impacted by all beds being counted as being open for the Covid period, therefore a baseline of 495 beds across the organisation.

Bed closures: Throughout the Covid-19 period, the Trust assumed that all beds across the organisation were open, and therefore a position of zero has been reported. Examining February, an average of 41 beds were classed as closed compared to 46 in January. This impact was mainly due to Dragonfly, Butterfly and Bumblebee having an average of 4-5 beds closed over the month mainly due to staffing. NICU/PICU/CICU have experienced an average of 5 beds closed due to staffing issues.



Productivity & Efficiency – PICU metrics

The KPIs have been agreed collaboratively with the Trusts PICU consultants and are designed to provide a triangulated picture of the service. Further analysis and intelligence will be added in future reports.

CATS referral refusals to PICU/NICU: The number of CATS referral refusals into PICU/NICU from other providers has remained the same as March (2) which is significantly lower than previous months and is a direct response to supporting NCL organisations by transferring paediatric patients to GOSH and releasing beds for adult care. This is reflected with the activity for Paediatric Critical Care which is mainly inline with the plan.

PICU Emergency Readmissions:

There were two readmissions back into PICU within 48 hours for the month of April compared to none in March.

Outpatient DNA rates and cancellations

For the month of April, the Trust reported a DNA rate of 4.65%, a slight decrease to the rate reported in previous months, which was around 6% in January and February and 5% in March.

In contrast the number of outpatient appointments that were cancelled either on the day or day before (both by hospital and patient) was significantly lower at 396 in April compared to 1,105 in March, although, this is reflective of the reduced outpatient activity due to Covid-19, which was operating at approximately 30% of normal levels.

Trust activity: April activity for both day case and overnight stays remains below plan due to the Covid19 pandemic . Critical care bed days are above plan but lower than last month's activity. The Trust continues to work on recovery plans to return to planned levels in light of the Covid-19 activity reductions, together with other impacts on activity.

Productivity & Efficiency – Discharge Summaries

April 2020 Summary

Although not at the required standard of 100% compliance, considerable focus has been placed on this indicator by both the operational and clinical teams to improve compliance. For the month of April, 67.91% of patients who were discharged from GOSH received a discharge summary within 24 hours, a decrease from the March position of 71.21%.

This focus includes backlog clearance of discharge summaries and the embedding of the completion of discharge summaries in real time into clinical practice. We now have a backlog of 29 discharge summaries up to April 2020 and the Directorates continue to work to reduce this further. Focus going forward is around timely completion of discharge summaries in real time, including reviewing the weekend resource that is available across the organisation to complete this task.

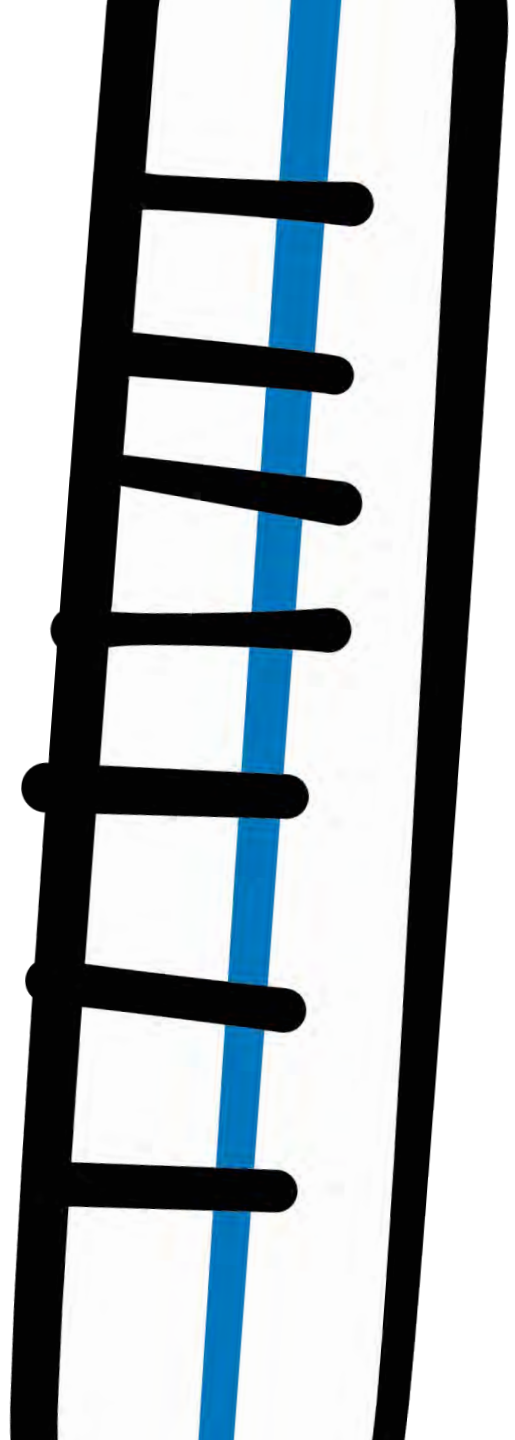
Working groups have been initiated to focus on specific challenges experienced by services and ensure resolutions are agreed and transacted. Training materials and courses have been reviewed and the workflow has been clearly communicated. Targeted support will be offered to individuals/services with poor metrics. The EPR team in conjunction with Service Managers will approach clinicians with additional training and guidance.

Clinic Letter Turnaround Times

For April 2020, performance has improved in relation to 7 day turnaround; 61.36% compared to 51.87% in March.

The EPR team have now rolled out the ‘clinic letter not required’ button within Epic, to specific services at a clinic level which can be used for specific patient appointments where a clinic letter will not be required for clinical reasons. In addition, additional training is being provided for Clinicians and Operational Managers around the process to ensure that everyone is aware of the process.

Focused work is also looking at those areas by speciality where patients have multiple letters within the same service which have not been sent, to understand if some of the earlier letters can be closed off. This has the potential to reduce the backlog by up to 25%.



Trust Workforce KPIs: April 2020

Metric	Plan	April 2020	3m average	12m average
Voluntary Turnover	14%	15.4%	15.8%	15.6%
Sickness (1m)	3%	3.8%	3.2%	3.0%
Vacancy	10%	5.8%	6.4%	7.7%
Agency spend	2%	0.4%	0.6%	0.7%
PDR %	90%	85%	86%	87%
Consultant Appraisal %	90%	100%	96%	90%
Statutory & Mandatory training	90%	93%	93%	94%

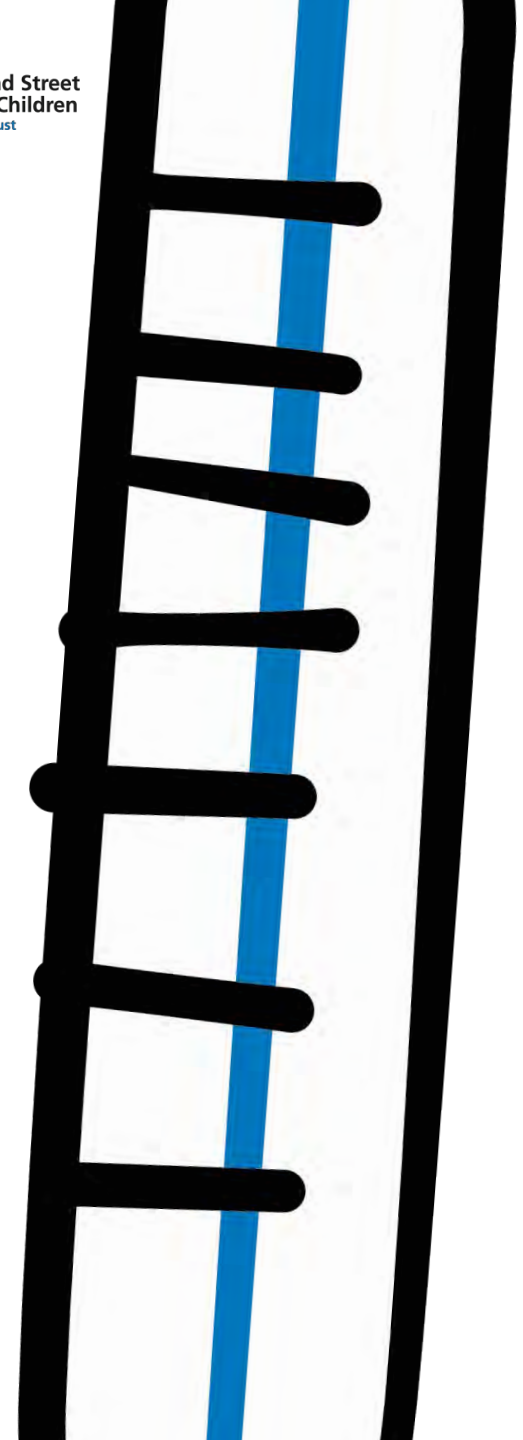
Key:

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

Directorate (Clinical) KPI performance April 2020

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP
Voluntary Turnover	14%	15.4%	12.2%	16.0%	14.9%	15.6%	16.4%	12.2%	10.7%	18.0%
Sickness (1m)	3%	3.8%	7.6%	4.9%	3.2%	4.0%	0.6%	9.1%	2.1%	6.7%
Vacancy	10%	5.8%	-0.6%	-4.9%	6.4%	1.5%	-0.8%	2.8%	0.5%	9.3%
Agency spend	2%	0.4%	0.0%	0.0%	0.0%	0.0%	1.8%	0.2%	-0.4%	0.6%
PDR %	90%	85%	83%	84%	92%	88%	80%	79%	95%	88%
Stat/Mand Training	90%	93%	92%	91%	94%	90%	93%	94%	98%	95%



Key:

Achieving Plan Within 10% of Plan Not achieving Plan

Directorate (Corporate) KPI performance April 2020

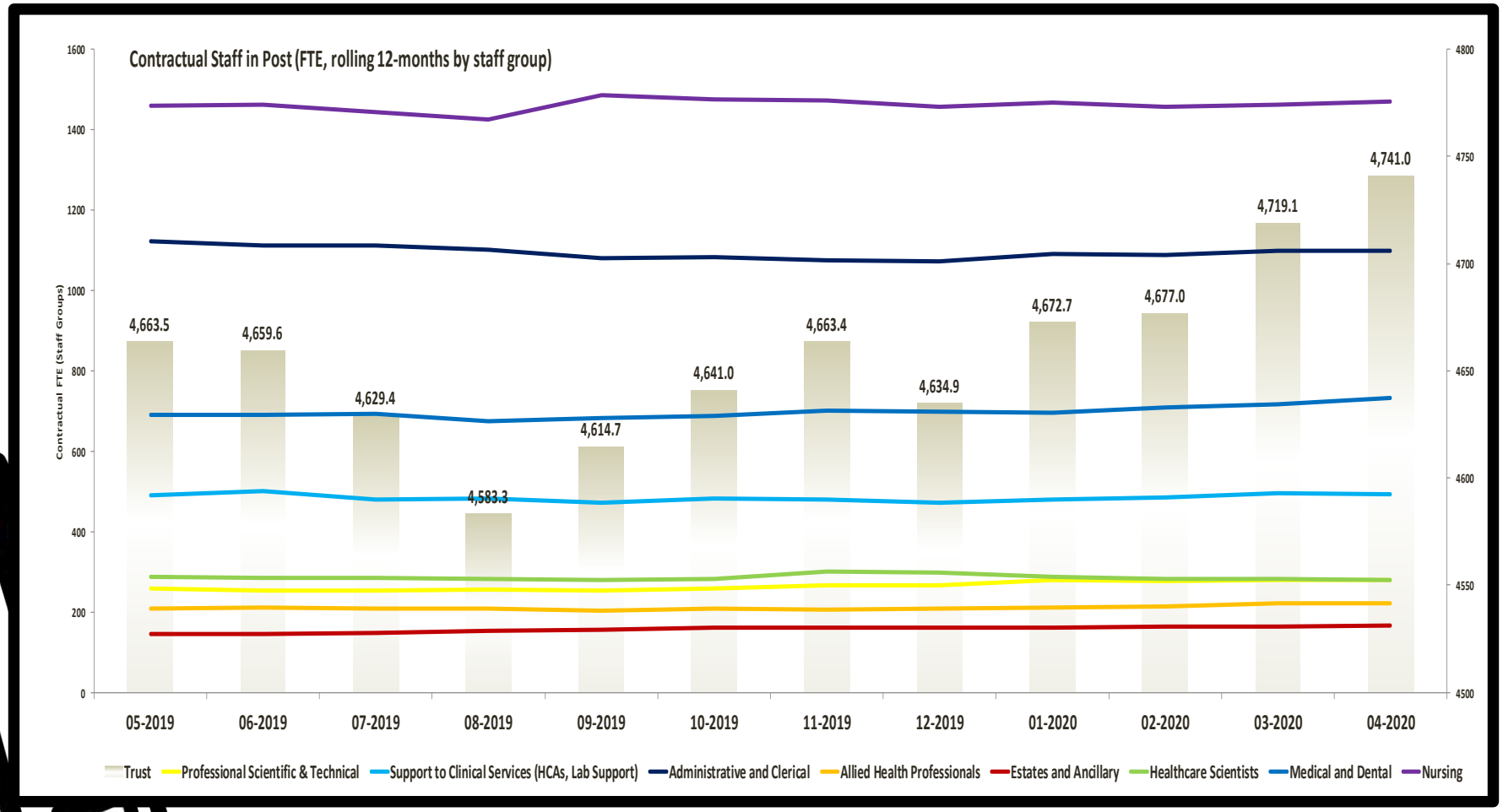
NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Metric	Plan	Trust	Clinical Operations	Corporate Affairs	DPS	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation
Voluntary Turnover	14%	15.4%	8.7%	31.7%	13.1%	23.3%	19.2%	37.9%	14.8%	25.4%
Sickness (1m)	3%	3.8%	8.4%	0.0%	10.8%	2.4%	2.7%	0.6%	2.9%	2.4%
Vacancy	10%	5.8%	-10.5%	16.7%	8.4%	25.7%	5.9%	13.5%	2.6%	51.8%
Agency spend	2%	0.4%	1.9%	0.0%	1.3%	9.2%	0.0%	0.0%	0.0%	0.0%
PDR %	90%	85%	80%	56%	83%	69%	83%	58%	85%	86%
Stat/Mand Training	90%	93%	97%	95%	94%	96%	98%	97%	98%	97%

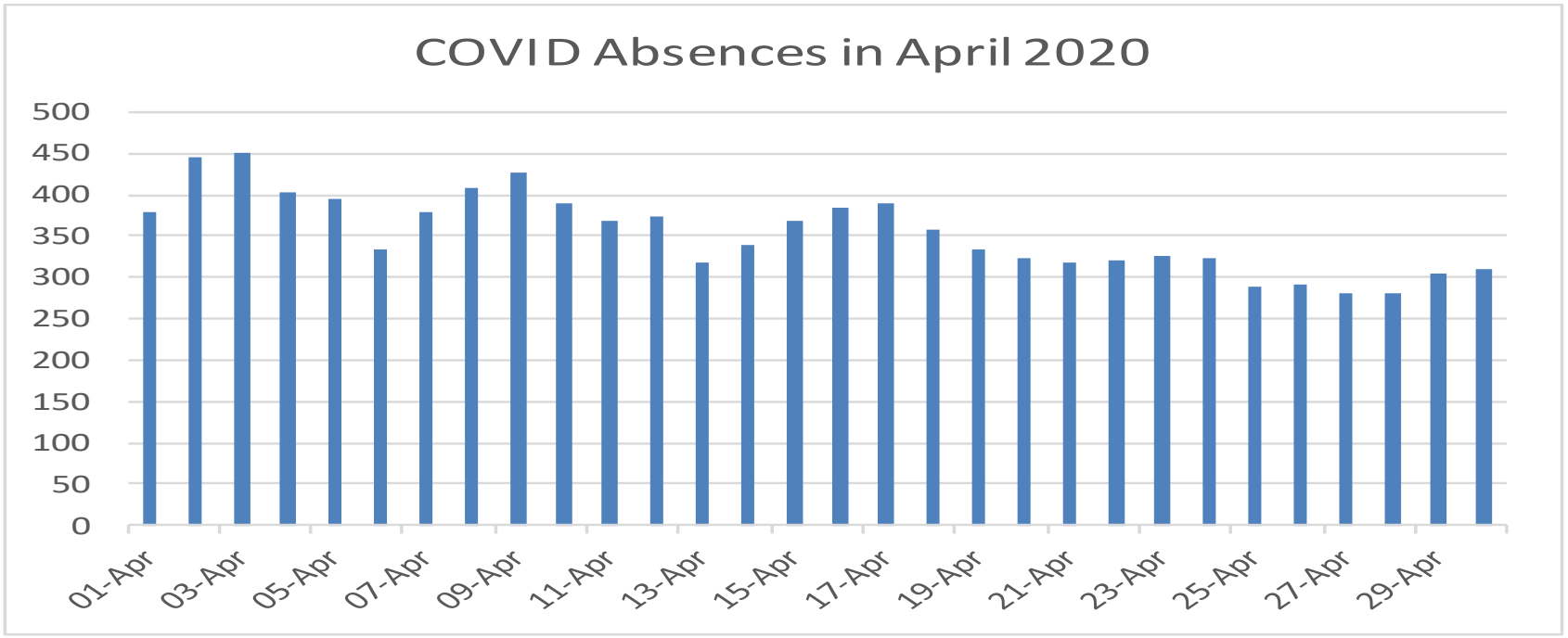
Key:

Achieving Plan Within 10% of Plan Not achieving Plan

Substantive staff in post by staff group



Absences: Impact of COVID-19



The COVID pandemic continued to impact the trust as absences peaked in early April before reducing. Average COVID absence rates were 6% in April peaking at 7%. At 6%, the impact of COVID-19 is twice the standard rate of sickness absences. However this is considerably lower than many other Trusts with reported absence rates of above 15%.

Most absences relate to forms of self –isolation, either due to mild COVID symptoms, a household member with symptoms, or requiring shielding due to a higher risk of complications with COVID-19. Many of these shielded staff will be working from home where possible

Attachment 7

Data Quality Kite Marking for Board Reports

1. Headline Issues

Within the NHS Improvement document Well-led framework for governance reviews: guidance for NHS Foundation Trusts, NHS Improvement recommends that the Trust Board seeks assurance that the board receives appropriate, robust and timely information and consideration as to whether it supports the leadership of the trust.

A recognised way of seeking this assurance around the first element is through the use of a Data Quality Kite Mark.

2. Background

The Trust needs to be working towards compliance of this framework and adoption of a Data Quality Kite Mark (DQKM) will provide greater visibility and ownership of data that is being published to Trust Board via the Integrated Quality and Performance Report (IQPR).

The DQKM is also fundamental as part of our agreed programme of work to achieve the Trust's data quality plan, having been introduced in 2016 following the previous data quality review and has recently been updated.

3. Consultation

The DQKM approach has been reviewed and approved through the following groups Data Quality Review Group, Information Governance Steering Group, Executive Management Team meeting and Audit Committee.

DQKM Development and Application

Roll out of the Data Quality Kite Marking was made on the following basis:

1. Collaborative approach was taken in the development of the self-assessment tool with each department lead responsible for producing data that feeds into IPQR metrics. The self-assessment criteria measures dimensions of data quality that include: accuracy, validity, reliability, timeliness, relevance and audit.

2. Each indicator has an Executive lead and the final measure reflects the lead has signed off the Kite Mark for the specific KPI.

3. Adopt a standard approach to consider, review and assurance in line with this process for all other returns and internal reports that are produced across the Trust, regardless of which department produces the output.

For each metric:

- A score of 1 means the metric data quality element is sufficiently assured
- A score of 0 means the metric data quality element is not sufficiently assured

- For the overall total which includes Executive Judgement – A score of 7 means that a metric is sufficiently assured and a score of < 7 means elements of the kitemark are not met.

4. Attachments

Appendix 1 –DQKM Process and Monitoring

Appendix 2 – Trust Board Data Quality kite mark

Appendix 3 – Elements and Assessment Criteria of the proposed DQ Kite Mark

Appendix 1

DQKM Process and Monitoring

a. The kite-mark is included with KPIs on Trust Board Report, providing assurance on quality of a performance indicator (see Figure 1).

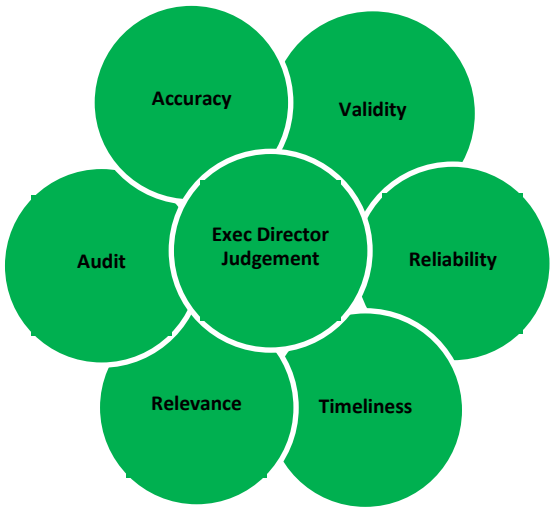
b. The Executive Team can request that the kite-mark be applied to any other indicator within the trust's performance assurance framework in addition to those reported through the Board.

c. The kite-mark will be a visual indicator that acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based.

d. Each measure will be assessed as 'sufficient' or 'insufficient' on seven distinct elements. For each element a colour code shows the strength of assurance. Each measure will have an equal weighting.

e. The elements and assessment of the criteria of the kite-mark are detailed in Appendix 3.

Figure 1 – The Kite Mark



Key

Sufficient Assurance

Insufficient Assurance

f. Each indicator should be assessed as 'sufficient' or 'insufficient'. The assessment is based on a positive response to the criteria in Appendix 3 Table 2. Where an attribute is marked as 'insufficient' the KPI owner should explain the issue, why it exists and the remedial action to be taken including the time frame in which the action will be completed.

g. Blank kite-marks should be added to appropriate performance reports containing the KPIs to be assured but not yet reviewed.

h. The KPI owner should clarify the sources of assurance required to enable a rating for each attribute of the kite-mark to be assessed.

i. Actions to address any element assessed as "insufficient" will be developed by the KPI owner. Progress in delivering the actions will be reported to the Executive Committee on a quarterly

basis through the Board Report. Once all actions have been completed in relation to an element, the kite-mark will be updated to show that element is now assessed as “sufficient”.

j. A schedule of indicator testing by internal and external audit will be developed by the Head of Performance each year in relation to the current Board Report indicators. Each indicator subject to the kite-mark will require independent audit on a three yearly basis. The prioritisation process is as follows.
    1. Priority 1 (High) – The indicator has been introduced by a national body e.g. NHS Improvement.
    2. Priority 2 (Medium) – The indicator has been introduced by commissioners.
    3. Priority (Low) – The indicator has been introduced locally.

k. Where an indicator subject to the kite-mark is not identified as requiring audit through the schedule, this will be clearly identified within the audit schedule document and the reason detailed.

l. The Audit Committee will receive the agreed schedule of audits on an annual basis and receive updates on progress against this on a quarterly basis.

Attachment 7

Appendix 2: Trust Board Data Quality Kite Mark

The Trust Board Data Quality Kite Mark shows an in-progress self-assessment against KPI metrics using the dimensions of kite mark.

Trust Board Data Quality Kite Mark

			Accuracy	Validity	Reliability	Timeliness	Relevance	Audit	Executive Director	Executive Director Judgement	Score
Caring	Access to Healthcare for people with Learning Disability		1	1	1	0	1	0	Alison Robertson	1	5
	% Positive Response Friends & Family Test: Inpatients		1	1	1	0	1	1	Alison Robertson	1	6
	Response Rate Friends & Family Test: Inpatients		1	1	1	0	1	1	Alison Robertson	1	6
	% Positive Response Friends & Family Test: Outpatients		1	1	1	0	1	0	Alison Robertson	1	5
	Number of complaints open at month end (including re-opened)		1	0	0	1	1	0	Alison Robertson	1	4
	Number of open RCAs		0	0	0	0	0	0	Alison Robertson	1	1
Safe	Number of incidents	Reported	1	1	-	1	1	-	Sanjiv Sharma	-	4
		Open	1	1	-	1	1	-	Sanjiv Sharma	-	4
	Number of overdue incidents		1	1	1	1	1	-	Sanjiv Sharma	-	5
	Serious Patient Safety Incidents (date reported on STEIS)	In-month	1	1	1	1	1	-	Sanjiv Sharma	-	5
		YTD	1	1	1	1	1	-	Sanjiv Sharma	-	5
	Never Events	In-month	1	1	1	1	1	-	Sanjiv Sharma	-	5
		YTD	1	1	1	1	1	-	Sanjiv Sharma	-	5
	Incidents of C. Difficile	In-month	1	1	1	1	1	1	Alison Robertson	1	7
		YTD	1	1	1	1	1	1	Alison Robertson	1	7
	C.Difficile due to Lapses of Care	In-month	1	1	1	0	1	0	Alison Robertson	1	5
		YTD	1	1	1	0	1	0	Alison Robertson	1	5
	Incidents of MRSA	In-month	1	1	1	1	1	1	Alison Robertson	1	7
		YTD	1	1	1	1	1	1	Alison Robertson	1	7
	CV Line Infection Rate (per 1,000 line days)		0	1	1	1	1	0	Alison Robertson	1	5
	WHO Checklist Completion (Main Theatres)		-	1	-	1	1	1	Sanjiv Sharma	-	4
	WHO Checklist Completion (Outside Theatres)		-	1	-	-	1	1	Sanjiv Sharma	-	3
	WHO Checklist Completion		-	1	1	-	1	1	Sanjiv Sharma	-	4

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			Accuracy	Validity	Reliability	Timeliness	Relevance	Audit	Executive Director	Executive Director Judgement	Score
	Arrests Outside of ICU	Cardiac Arrests	1	1	1	1	1	-	Sanjiv Sharma	-	5
		Respiratory Arrests	1	1	1	1	1	-	Sanjiv Sharma	-	5
	Total hospital acquired pressure / device related ulcer rates grade 3 & above		1	1	1	1	1	1	Alison Robertson	1	7
Responsive	Diagnostics: Patients Waiting <6 Weeks		0	1	0	0	1	1	Philip Walmsley	1	4
	Cancer 31 Day: Urgent GP Referral to First Treatment		1	1	1	1	1	1	Philip Walmsley	1	7
	Cancer 31 Day: Decision to Treat to First Treatment		1	1	1	1	1	1	Philip Walmsley	1	7
	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		1	1	1	1	1	1	Philip Walmsley	1	7
	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		1	1	1	1	1	1	Philip Walmsley	1	7
	Cancer 62 day: Consultant Upgrade of Urgency of a referral to first treatment		1	1	1	1	1	1	Philip Walmsley	1	7
	Last Minute Non-Clinical Hospital Cancelled Operations		1	0	1	0	1	1	Philip Walmsley	1	5
	Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		1	0	1	0	1	1	Philip Walmsley	1	5
	Same day / day before hospital cancelled outpatient appointments		1	1	1	0	1	1	Philip Walmsley	1	6
	RTT: Incomplete Pathways (National Reporting)		1	0	1	0	1	1	Philip Walmsley	1	5
	RTT: Average Wait of all RTT Pathways		1	0	1	0	1	1	Philip Walmsley	1	5
	RTT: Number of Incomplete Pathways (National Reporting)	<18wks	1	0	1	0	1	1	Philip Walmsley	1	5
		>18wks	1	0	1	0	1	1	Philip Walmsley	1	5
	RTT: Incomplete Pathways >52 Weeks - Validated		1	0	1	1	1	1	Philip Walmsley	1	6
	RTT: Incomplete Pathways >40 Weeks		1	0	1	1	1	1	Philip Walmsley	1	6
	Number of unknown RTT clock starts	Internal Referrals	1	0	1	0	1	1	Philip Walmsley	1	5
		External Referrals	1	0	1	0	1	1	Philip Walmsley	1	5
	RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	1	0	1	0	1	1	Philip Walmsley	1	5
		>18 weeks	1	0	1	0	1	1	Philip Walmsley	1	5
Data Completeness	Mental Health Identifiers: Data Completeness		1	1	1	1	1	0	Philip Walmsley	1	6
	Mental Health Ethnicity Completion - %		1	1	1	1	1	0	Philip Walmsley	1	6
	% of Patients with a valid NHS number	Inpatients	1	1	1	0	1	0	Philip Walmsley	1	5
		Outpatients	1	1	1	0	1	0	Philip Walmsley	1	5

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				Accuracy	Validity	Reliability	Timeliness	Relevance	Audit	Executive Director	Executive Director Judgement	Score
Well Led	Sickness Rate			1	1	1	-	1	-	Caroline Anderson	-	4
	Turnover	Total		1	1	1	-	1	-	Caroline Anderson	-	4
		Voluntary		1	1	1	-	1	-	Caroline Anderson	-	4
	Appraisal Rate	Non Consultant		1	1	1	-	1	-	Caroline Anderson	-	4
		Consultant		1	1	1	-	1	-	Caroline Anderson	-	4
	Mandatory Training			1	1	1	-	1	-	Caroline Anderson	-	4
	% Staff Recommending the Trust as a Place to Work: Friends & Family Test			1	1	1	1	1	-	Caroline Anderson	-	5
	Vacancy Rate	Contractual		1	1	-	-	1	-	Caroline Anderson	-	3
		Nursing		1	1	-	-	1	-	Caroline Anderson	-	3
	Bank Spend			1	1	1	1	1	-	Caroline Anderson	-	5
	Agency Spend			1	1	1	1	1	-	Caroline Anderson	-	5
Effective	Discharge Summary Turnaround within	24 hours		1	1	1	0	1	1	Phillip Walmsley	1	6
		Number of letters not sent	In-month	1	1	1	0	1	1	Phillip Walmsley	1	6
			YTD	1	1	1	0	1	1	Phillip Walmsley	1	6
	Clinic Letter Turnaround within	7 days		1	1	1	0	1	0	Phillip Walmsley	1	5
		Number of letters not sent	In-month	1	1	1	0	1	0	Phillip Walmsley	1	5
			YTD	1	1	1	0	1	0	Phillip Walmsley	1	5
	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)			1	1	1	0	1	0	Phillip Walmsley	1	5
Productivity	Main Theatres	Theatre Utilisation		1	1	1	0	1	0	Phillip Walmsley	1	5
	Outside Theatres	Theatre Utilisation		1	1	0	0	1	0	Phillip Walmsley	1	4
	Trust Beds	Bed Occupancy		1	1	0	0	1	0	Phillip Walmsley	1	4
		No of available beds		1	1	0	0	1	0	Phillip Walmsley	1	4
	Average number of trust beds closed	Wards		1	1	0	0	1	0	Phillip Walmsley	1	4
		ICU		1	1	0	1	1	0	Phillip Walmsley	1	5
	Refused Admissions	Cardiac refusals		1	1	1	1	1	0	Phillip Walmsley	1	6
		PICU / NICU refusals		1	1	1	1	1	0	Phillip Walmsley	1	6

			Accuracy	Validity	Reliability	Timeliness	Relevance	Audit	Executive Director	Executive Director Judgement	Score
Activity (NHS & PP)	Number of PICU Delayed Discharges	Internal 8 - 24 hours	1	1	1	1	1	0	Philip Walmsley	1	6
		Internal 24 hours+	1	1	1	1	1	0	Philip Walmsley	1	6
		External 8 - 24 hours	1	1	1	1	1	0	Philip Walmsley	1	6
		External 24 hours+	1	1	1	1	1	0	Philip Walmsley	1	6
		Total 8 - 24 hours	1	1	1	1	1	0	Philip Walmsley	1	6
		Total 24 hours+	1	1	1	1	1	0	Philip Walmsley	1	6
	PICU Emergency Readmissions < 48 hours		1	1	1	1	1	0	Philip Walmsley	1	6
	Daycase Discharges (YOY comparison)	In-month	1	1	0	1	1	0	Philip Walmsley	1	5
		YTD	1	1	0	1	1	0	Philip Walmsley	1	5
	Overnight Discharges (YOY comparison)	In-month	1	1	0	1	1	0	Philip Walmsley	1	5
		YTD	1	1	0	1	1	0	Philip Walmsley	1	5
	Bed Days >=100 Days	No. of patients	1	1	0	1	1	0	Philip Walmsley	1	5
		No. of beddays	1	1	0	1	1	0	Philip Walmsley	1	5
	Outpatient Attendances (All) (YOY comparison)	In-month	1	1	1	0	1	0	Philip Walmsley	1	5
		YTD	1	1	1	0	1	0	Philip Walmsley	1	5
	Trust Debtor Days		1	1	1	1	1	1	Helen Jameson	1	7
	Quick ratio (Liquidity)		1	1	1	1	1	1	Helen Jameson	1	7
	NHSI KPI Metrics		1	1	1	1	1	1	Helen Jameson	1	7

Key

	Sufficient Assurance Score = 7
	Insufficient Assurance Score 3 - 6
	Insufficient Assurance Score < 3
-	Not yet assessed

Appendix 3 – Elements and Assessment Criteria of the DQ Kite Mark

Table 1: Elements of the Kite Mark

Element	Definition
Accuracy	All recorded data must be correct the first time it is input, but updated as appropriate thereafter and must accurately reflect what actually happened to a patient. The Trust must take every opportunity to check patient's demographic details with the patient or their representative themselves.
Validity	This is the extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements. For example, correct application of rules and definitions. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk. Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.
Reliability	This is the extent to which the data is generated by a computerised system, with automated IT controls, or a manual process. It also relates to the degree of documentation outlining the data flow, i.e. documented process with controls and data flows mapped. Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.
Timeliness	This is the time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Relevance	This is the extent to which the data is captured for the purposes for which it is used. This entails periodic review of the selection of key performance indicators to reflect changing

Element	Definition
	needs, such as new strategic objectives. For example, is this indicator the right indicator by which to measure performance against a strategic objective?
Audit	This is the extent to which the integrity of data (accuracy, validity, reliability, relevance, and timeliness) has been audited by someone independent of the KPI owner (for example, Internal Audit, External Audit, Clinical Audit or Peer Review) and the extent to which the assurance provided from the audit is positive.
Executive Director Judgment	This recognises that each KPI should have a lead executive director that has responsibility for ownership and that all other elements of the data quality kite mark have been considered as to the overall quality of the reporting of the metric.

Table 2: Assessment Criteria

Element	Sufficient	Insufficient
Accuracy	Fewer than 3% blank, invalid or inconsistent data fields in expected data set. This standard applies unless a different standard is explicitly stated for a KPI within commissioner contracts or through national requirements. KPI owner can provide assurance that effective controls are in place to ensure that 100% of records are included in population.	More than 3% blank or invalid fields in expected data set Inadequate assurance or no assurance that effective controls are in place to ensure that 100% of records are included within the total population
Validity	The trust has agreed upon procedures in place for the validation of data for the KPI and that the data has been validated	There are no validation procedures in place or the data has not been validated
Reliability	Process is fully documented with controls, quality assured and data flows mapped. Process is stable and consistent over the last 6 months unless the change in reporting was necessary to reflect a change in operational / statutory requirement.	Process is not documented and / or, for manual data production, does not adequately detail controls, quality assurance and validation procedures. Process has changed during the last 6 months therefore there is an increased risk that data is not consistent between
Timeliness	Where data is available within the same timescales as it is produced. i.e. Daily, available	Where data is not available within the same timescales as it is produced. i.e. Daily, not

Element	Sufficient	Insufficient
	next day, Monthly, available next month, etc.	available next day, Monthly, not available next month, etc.
Relevance	This indicator is relevant to the measurement of performance against the: -Performance area -Performance question -Strategic objective	This indicator is no longer relevant to the measurement of performance against the: -Performance area -Performance question -Strategic objective
Audit	The data quality of the KPI has been audited in the last 3 years and either: positive assurance was received; or Recommendations have been completed and successfully followed up by audit.	The data quality of the KPI has not been reviewed by audit in the last 3 years; or the data quality of the KPI has been reviewed by audit in the last 3 years but: -negative assurance was received; and - recommendations have not yet been followed up by audit
Executive Director Judgment	Reviewed all other DQ Kite mark measures and is satisfied that sufficient steps have been taken to assure that the metric is accurate	No review carried out. Not satisfied that sufficient steps have been taken to ensure that the metric is accurate

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2020

Month 1 2020/21 Finance Report **Submitted by: Helen Jameson** **Chief Finance Officer**	**Paper No: Attachment T**

Aims / summary

This report shows the Trust's finance position against the plan set by NHSE for the first 4 months of the year as these reflect the assumptions made by NHSE/I on income flows and expenditure.

1. The Trust position at Month 1 is a £6.4m deficit. This has been offset by an accrual for the NHS top up payment (£6.4m) which, in line with NHS Guidance, give the trust a breakeven position for Month 1.

2. NHSE have set the Trust a plan based on the average income and expenditure in M08 to M10 for 2019/20. NHS clinical income is under a block that reflects this plan, this includes high cost drugs and devices.

3. The key driver of the Trust deficit is the income position which is below plan. Private patient income is £2.2 below plan due to reduced levels of activity associated with the Trust stopping referrals in March to facilitate Covid-19 capacity. Other non-clinical income is £3.2m below plan due to research studies not linked to Covid-19 being suspended, reduced E&T programmes and reduced charitable donations due to projects being put on hold.

4. Pay and non-pay are above plan (£0.8m and £1.0m respectively). This is driven by additional staffing costs to support the Covid-19 response which includes additional medical and scientific staff from UCL. The Trust high cost drug spend has increased due to the need to support battens treatments and 2 Car-T patients in April. The Trust has also seen an increase in the credit loss allowance in line with the Trust policy due to reduced payments. These costs have been partly offset by low levels of clinical supplies spend linked to reduced non-urgent elective activity.

5. Previous SLA payments have been replaced by a Block arrangement. The cash held by the Trust increased by £41.9m in April. This was mainly due to receiving £38.4m cash in advance from NHSE.

6. A revised version of the Trusts capital plan was submitted to the STP on the 13 May with the final capital envelope expected to be agreed by 31st May. Capital expenditure for April was £2.0m for Trust funded and £0.4m for charity funded.

The key movement s to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust increased £41.9m in April to a closing cash balance of £103.2m. This increase was mainly due to SLA block payment (£31.5m) being received a month advance and a top up payment (£6.9m).
NHS Debtor Days	NHS Debtor days decreased from 23 to 20 days which is in line with the plan. SLA payments have been replaced by block arrangements as of a result of Covid-19. The block payment for April was received on the 1st April with Mays block being received on the 15th April resulting in a reduction in NHS debtor days.
IPP Debtor Days	IPP debtor days decreased from 247 days to 273 days due to lower than average receipts from embassies.
Creditor Days	Creditor days decreased in month from 39 days to 38 days.

Action required from the meeting

- To **note** the Month 1 Financial Position

Contribution to the delivery of NHS Foundation Trust strategies and plans
The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.

Financial implications
Changes to payment methods and expenditure trends

Who needs to be told about any decision?
Chief Finance Officer

Who is responsible for implementing the proposals / project and anticipated timescales?
Chief Finance Officer / Executive Management Team

Who is accountable for the implementation of the proposal / project?
Chief Finance Officer / Executive Management Team

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance and Workforce Performance Report Month 1 2020/21

Contents

Trust Performance Summary for the 1 month ending 30 Apr 2020

KEY PERFORMANCE DASHBOARD

Great Ormond Street Hospital for Children NHS Foundation Trust

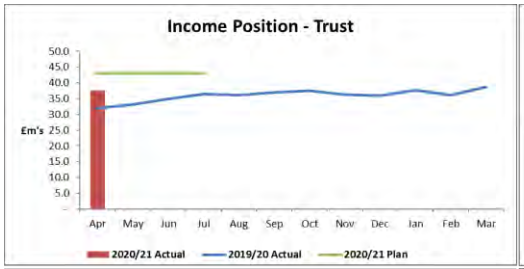
ACTUAL FINANCIAL PERFORMANCE

	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	£43.1m	£37.5m	🔴	£43.1m	£37.5m	🔴
PAY	(£24.1m)	(£24.8m)	🔴	(£24.1m)	(£24.8m)	🔴
NON-PAY inc. owned depreciation and PDC	(£18.2m)	(£19.0m)	🔴	(£18.2m)	(£19.0m)	🔴
Surplus/Deficit excl. donated depreciation	£0.8m	(£6.4m)	🔴	£0.8m	(£6.4m)	🔴
Top up	£0.0m	£6.4m		£0.0m	£6.4m	
Surplus/Deficit excl. donated depreciation	£0.8m	£0.0m	🟢	£0.8m	£0.0m	🟢

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

AREAS OF NOTE:

The Trust position at Month 1 is a £6.4m deficit, a NHS top up (£6.4m) has been accrued ,in line with NHS guidelines, which gives the Trust a breakeven position for Month 1. The Trust plan has been set by NHSE up to the end of July 2020 based on income and expenditure in 2019/20. NHS income is on a block contract while Private patient and Non-Clinical income have fallen in Month 1. Private patient income is £2.2m below the NHSE plan due to the Trust stopping referrals in March to expand Covid-19 capacity. Non-Clinical income is below the NHSE plan due to UCL stopping all research not associated with Covid-19, Charitable projects being put on hold and Education and training income reducing due to some being included in the NHS block and courses being cancelled. In addition to this the NHS changed the genetics contract so that P2P could no longer be billed but has not increased the block to reflect this policy change. Pay is above plan (£0.8m) due additional staffing costs to support the Covdi-19 response. Non Pay is above plan due to additional high costs drugs to support long term conditions and Car-T treatments in April, increase in the credit loss allowance associated with non-payment of private patient bills and these are partly offset by reduced clinical supplies linked to reduced non-urgent activity.

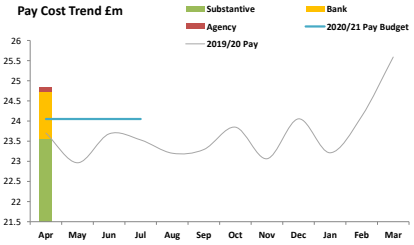


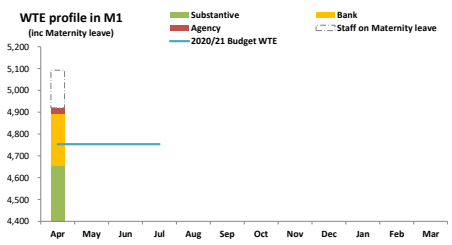
PEOPLE

	M1 Plan WTE	M1 Actual WTE	Variance
PERMANENT	4,516.9	4,657.4	(140.4)
BANK	215.3	238.2	(22.9)
AGENCY	21.2	24.2	(3.0)
TOTAL	**4,753.4**	**4,919.7**	**(166.3)**

AREAS OF NOTE:

NHSE has set a plan that is equivalent to 4,753 WTE. which shows a 166 WTE over establishment. If this was set at the average pay spend for M9-11 2019/20, which is more representative of the Trust normal pay spend, then the WTE over establishment would have been 94 WTE. The remaining variance is due to additional medical and scientific staff from UCL brought into the Trust to support the Covid-19 response, additional backfill for Covid-19 related sickness and staff that were previously funded through capital being deployed to support the Trust infrastructure.



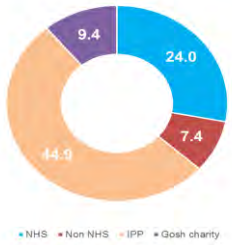


CASH, CAPITAL AND OTHER KPIs

Key metrics	Mar-20	Apr-20
Cash	£61.3m	£103.2m
IPP Debtor days	247	273
Creditor days	39	38
NHS Debtor days	23	20

Capital Programme	Plan M1	Actual M1	Full year plan
Total Trust-funded	£2.0m	£2.0m	£15.6m
Total Donated	£0.4m	£0.4m	£18.0m
Grand Total	£2.4m	£2.4m	£33.6m

Net receivables breakdown (£m)



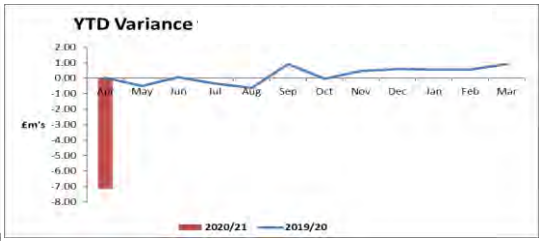
AREAS OF NOTE:

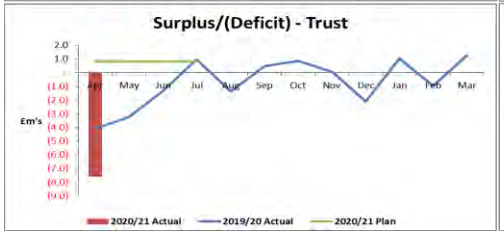
1. Cash held by the Trust increased by £41.9m. This was largely as a result of the receipt of SLA block payments a month in advance (£31.5m) and a top up payment of £6.9m under the new financial framework.
2. A revised capital plan was submitted to the STP in May; this has yet to be agreed. Actual capital expenditure in April was £2m in repsect of donated expenditure and £0.4m in respect of Trust-funded expenditure.
3. IPP debtors days increased in month from 247 days to 273 days. This was caused by an increase in debtors of £3.2m as well as a reduction in income.
4. Creditor days decreased slightly in month from 39 days to 38 days.
5. NHS debtor days fell from 23 to 20 days.
6. NHSI metrics are not currently being measured

Trust Income and Expenditure Performance Summary for the 1 month ending 30 Apr 2020

Great Ormond Street Hospital for Children NHS Foundation Trust

2020/21 Board Approved plan (£m)	Income & Expenditure	Month 1 NHSE Plan (£m)	Month 1 Actual (£m)	Month 1 Variance (£m)	Month 1 Variance %	Year to Date NHSE Plan (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	Rating YTD Variance	Notes	2019/20 Actual M1 (£m)	2020/21 NHSE Plan M1 (£m)	2020/21 Board Approved Plan M1 (£m)
414.52	NHS & Other Clinical Revenue	31.97	31.75	(0.22)	(0.69%)	31.97	31.75	(0.22)	(0.69%)	A	1	27.82	31.97	33.03
73.24	Private Patient Revenue	5.59	3.41	(2.17)	(38.94%)	5.59	3.41	(2.17)	(38.94%)	R	2	4.95	5.59	5.85
64.15	Non-Clinical Revenue	5.53	2.35	(3.17)	(57.45%)	5.53	2.35	(3.17)	(57.45%)	R	3	4.62	5.53	5.23
551.91	**Total Operating Revenue**	**43.08**	**37.51**	**(5.57)**	**(12.93%)**	**43.08**	**37.51**	**(5.57)**	**(12.93%)**	R		**37.39**	**43.08**	**44.10**
(303.12)	Permanent Staff	(22.76)	(23.56)	(0.80)	(3.50%)	(22.76)	(23.56)	(0.80)	(3.50%)			(22.18)	(22.76)	(24.69)
(0.21)	Agency Staff	(0.15)	(0.10)	0.05	32.14%	(0.15)	(0.10)	0.05	32.14%			(0.21)	(0.15)	(0.03)
(2.55)	Bank Staff	(1.14)	(1.18)	(0.04)	(3.45%)	(1.14)	(1.18)	(0.04)	(3.45%)			(1.31)	(1.14)	(0.22)
(305.88)	**Total Employee Expenses**	**(24.05)**	**(24.84)**	**(0.79)**	**(3.29%)**	**(24.05)**	**(24.84)**	**(0.79)**	**(3.29%)**	R	4	**(23.70)**	**(24.05)**	**(24.94)**
(107.60)	Drugs and Blood	(6.76)	(8.03)	(1.26)	(18.69%)	(6.76)	(8.03)	(1.26)	(18.69%)	R		(5.93)	(6.76)	(8.18)
(39.93)	Supplies and services - clinical	(3.11)	(1.68)	1.43	46.07%	(3.11)	(1.68)	1.43	46.07%	G		(2.72)	(3.11)	(3.33)
(79.16)	Other Expenses	(6.68)	(7.82)	(1.15)	(17.19%)	(6.68)	(7.82)	(1.15)	(17.19%)	R		(6.68)	(6.68)	(6.74)
(226.69)	**Total Non-Pay Expenses**	**(16.55)**	**(17.53)**	**(0.98)**	**(5.92%)**	**(16.55)**	**(17.53)**	**(0.98)**	**(5.92%)**	R	5	**(15.33)**	**(16.55)**	**(18.24)**
(532.57)	**Total Expenses**	**(40.60)**	**(42.37)**	**(1.77)**	**(4.36%)**	**(40.60)**	**(42.37)**	**(1.77)**	**(4.36%)**	R		**(39.03)**	**(40.60)**	**(43.18)**
19.34	**EBITDA (exc Capital Donations)**	**2.48**	**(4.86)**	**(7.34)**	**(296%)**	**2.48**	**(4.86)**	**(7.34)**	**(295.65%)**	R		**(1.64)**	**2.48**	**0.92**
(19.34)	Owned depreciation, Interest and PDC	(1.68)	(1.50)	0.18	10.65%	(1.68)	(1.50)	0.18	10.65%		7	0.26	(1.68)	(1.54)
0.00	**Surplus/Deficit (exc. PSF/Top up)**	**0.81**	**(6.36)**	**(7.16)**	**(888.65%)**	**0.81**	**(6.36)**	**(7.16)**	**(889%)**			**(1.38)**	**0.81**	**(0.62)**
0.00	PSF/Top up	0.00	6.36	6.36		0.00	0.00	0.00					0.00	0.00
0.00	**Surplus/Deficit (incl. PSF/Top up)**	**0.81**	**0.00**	**(0.80)**	**(99.56%)**	**0.81**	**(6.36)**	**(7.16)**	**(888.65%)**	R		**(1.38)**	**0.81**	**(0.62)**
0.00	PY PSF post accounts reallocation	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
(13.70)	Donated depreciation	0.00	(1.25)	(1.25)		0.00	(1.25)	(1.25)				(2.72)	0.00	(1.09)
(13.70)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**0.81**	**(1.25)**	**(2.05)**	**(254.63%)**	**0.81**	**(7.61)**	**(8.41)**	**(1,043.71%)**			**(4.10)**	**0.81**	**(1.71)**
0.00	Impairments	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
18.36	Capital Donations	0.00	2.02	2.02		0.00	2.02	2.02			6	4.07	0.00	2.20
4.66	**Adjusted Net Result**	**0.81**	**0.77**	**(0.03)**	**(4.26%)**	**0.81**	**(5.59)**	**(6.39)**	**(793.34%)**			**(0.03)**	**0.81**	**0.48**





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

Summary

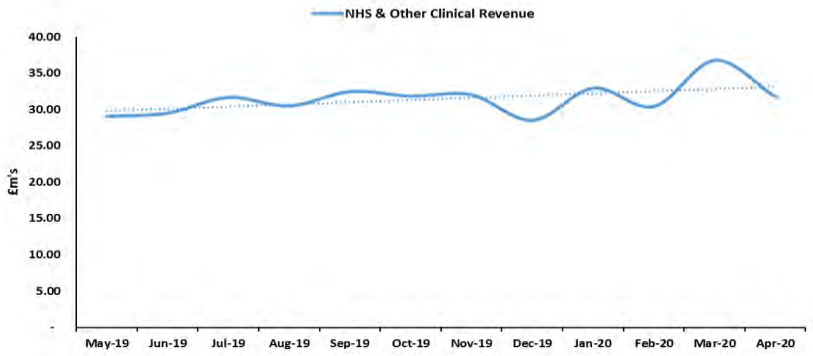
- The month 1 deficit is £6.4m which is then offset by an accrual for the NHS top up which brings the Trust to a breakeven position.
- The NHS is no longer issuing PSF payments and instead providing top up payments. The top up payment for the Trust at month 1 is £6.4m.

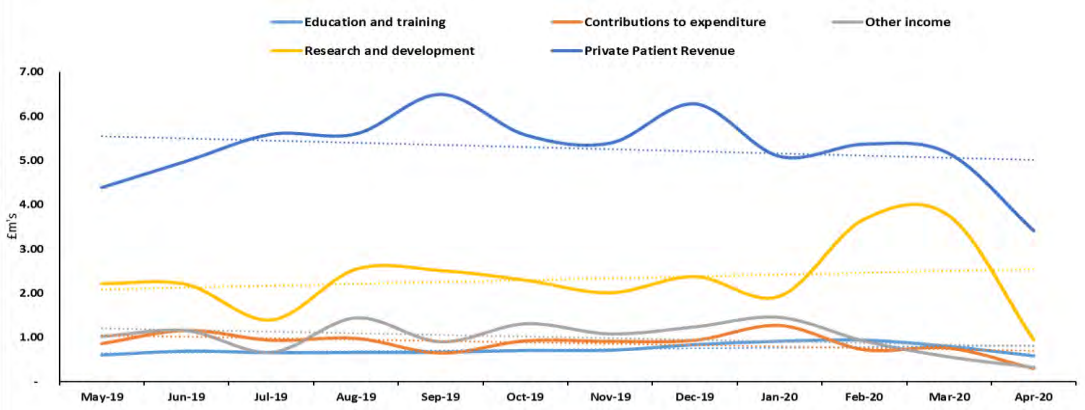
Notes

1. NHS & other clinical revenue plan has been set centrally by NHSE for M1-4 and is comparable to the 2019/20 average income. NHS Clinical income is under a block contract including high cost drugs and devices.
2. Private Patient income is £2.2m adverse to the NHSE pan. This income represents those long stay patients that were in the Trust before the Trust stopped accepting referrals in March. The Trust stopped accepting referrals in order to expand capacity for Covid-19 patients and has not changed this policy as at the end of April.
3. Non-clinical income is £3.2m adverse due to UCL stopping research studies which are not linked to Covid-19, reduced E&T programmes and reduced charitable donations as projects on hold during the Covid-19 response.
4. Pay is adverse to the NHSE plan by £0.8m. as the plan is lower that the Q4 average combined with the additional staff from UCL to support the Covid-19 response and the staffing redeployed from capital projects that are on hold.
5. Non pay is £1.0m adverse to the NHSE plan due to higher drug associated with ongoing treatment of patients with new high costs drugs and two Car-T patients in April. The Trust has also seen an increase in the credit loss allowance (£1.7m). These are partly offset by reduced supplies and healthcare purchases due to the changes in patient mix and reduced non-urgent elective activity.
6. The plan set by NHSE does not include a plan for capital donations.

2020/21 Income for the 1 month ending 30 Apr 2020

Great Ormond Street Hospital for Children NHS Foundation Trust





Summary

- The income plan has been set centrally by NHSE/I for the period to the end of July as a result of the impact of Covid-19. This plan is comparable to the 2019/20 average monthly income on a straight line basis.
- Block payments will be paid for NHSE England and the main contract CCGs based on the average 2019/20 income to December uplifted by 2.308%.
- The plan for other income streams is based on the average income for Nov 2019-Jan 2020 uplifted to 2020/21 values. It was recognised that these estimates may be undeliverable in the current climate. This has been borne out in month 1 where there is a £2.4m adverse variance that is largely driven by the £2.19m under-performance for private patient income.
- **Private Patient income** has fallen in months and is £2.2m below the NHSI plan. In March 2020 the Trust stopped accepting referrals in order to free up bed capacity in the sector for Covid-19 patients. The income recognised in Month 1 is for those patients admitted prior to Covid-19. 7 of these are currently ready to fly and with no new referrals income is expected to fall further.
- **Research income** has fallen significantly as is £1.2m below the NHSI plan. This is due to research studies having stopped after UCL closed all its buildings and suspended all research projects except those on Covid-19.
- **Other income** is £1.0m below the NHSI plan. The key driver of other income is associated with the National change in the rules governing Genetics billing. The new policy states the Genetics service can no longer charge for P2P testing as the plan was to include this in the new tariff. However the income is now part of the block and so has not been uplifted to offset this lost income. Within other income both catering and accommodation are below historic trend due to reduced activity within the hospital and due to changes to support staff social distance.
- **Charitable income** is £0.7m below the NHSI plan. This is caused by the projects that were being funded having put on hold due to the Trusts response to Covid-19. With these

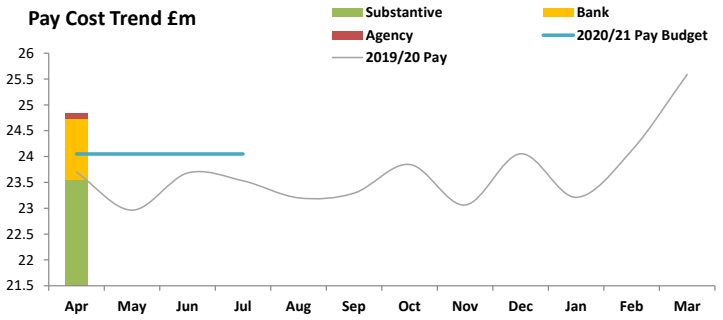
Workforce Summary for the 1 month ending 30 Apr 2020

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

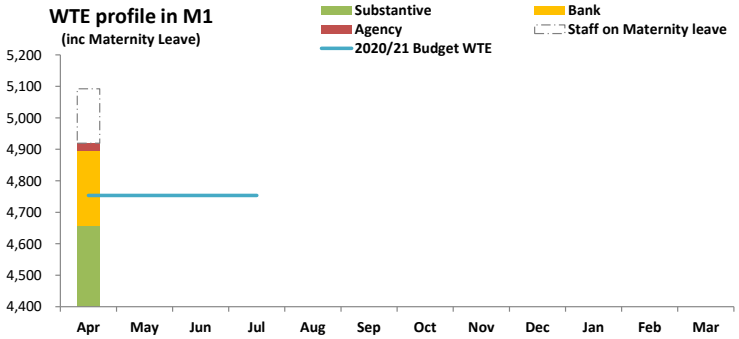
Great Ormond Street Hospital for Children NHS Foundation Trust

£m including Perm, Bank and Agency	2019/20 actual			2020/21 actual			Variance			RAG
Staff Group	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	50.3	1,110.6	45.3	4.5	1,180.3	46.0	(0.3)	(0.3)	(0.1)	A
Consultants	54.5	352.1	154.7	4.7	388.3	145.8	(0.2)	(0.5)	0.3	A
Estates & Ancillary Staff	4.6	137.9	33.2	0.4	137.9	33.1	0.0	(0.0)	0.0	G
Healthcare Assist & Supp	9.1	281.7	32.2	0.8	277.7	33.2	(0.0)	0.0	(0.0)	G
Junior Doctors	28.4	347.1	81.9	2.7	390.7	81.7	(0.3)	(0.3)	0.0	A
Nursing Staff	80.7	1,526.0	52.9	6.9	1,529.0	54.4	(0.2)	(0.0)	(0.2)	A
Other Staff	0.5	9.1	53.3	0.0	8.8	45.7	0.0	0.0	0.0	G
Scientific Therap Tech	52.1	945.3	55.1	4.6	982.8	56.6	(0.3)	(0.2)	(0.1)	A
Total substantive and bank staff costs	**280.2**	**4,709.7**	**59.5**	**24.7**	**4,895.5**	**60.4**	**(1.3)**	**(0.9)**	**(0.4)**	R
Agency	2.0	28.8	68.8	0.1	24.2	48.8	0.1	0.0	0.0	G
Total substantive, bank and agency cost	**282.1**	**4,738.6**	**59.5**	**24.8**	**4,919.7**	**60.4**	**(1.2)**	**(0.9)**	**(0.3)**	R
Reserve*	2.1	0.0	0.0	0.1	0.0	0.0	0.1	0.2	(0.1)	G
Additional employer pension contribution by NHSE	11.6	0.0	0.0				1.0	1.0	0.0	G
Total pay cost	**295.8**	**4,738.6**	**62.4**	**24.8**	**4,919.7**	**60.6**	**(0.2)**	**(0.9)**	**0.8**	A
Remove maternity leave cost	(3.6)			(0.3)			(0.0)		(0.0)	G
Total excluding Maternity Costs	**292.2**	**4,738.6**	**61.7**	**24.6**	**4,919.7**	**59.9**	**(0.2)**	**(0.9)**	**0.7**	A

*Plan reserve includes WTEs relating to the better value programme



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

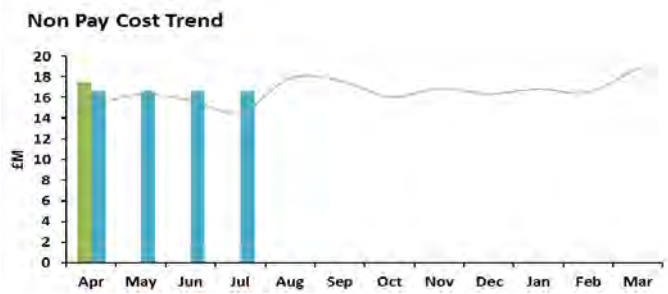


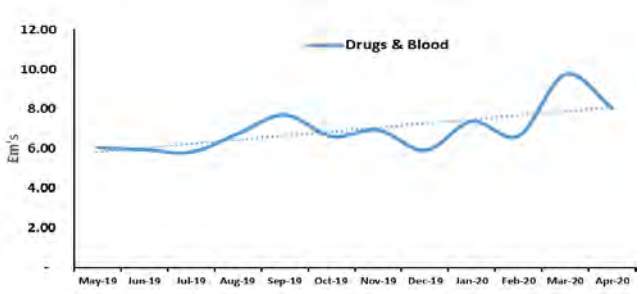
Summary

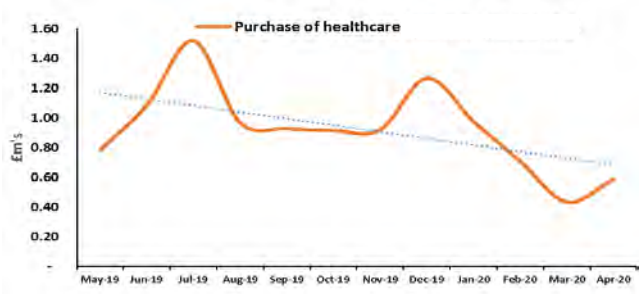
- Pay costs in the NHSI plan have been calculated lower than the Trusts 2019/20 Q4 average pay plus inflationary uplift. The NHSE plan is £0.4m lower than the inflated Q4 would have been creating a variance. This would mean the Trust over establishment is 94 WTE.
- Staffing associated with reduced private patient activity and research activity have been redistributed to support the additional Covid-19 capacity leading to the Trust needing less temporary staff to meet the Covid-19 response than would have been required by extra capacity.
- Medical staffing is higher than then plan due to additional university doctors that have joined the Trust in order to support the Covid-19 response.
- Admin staffing has increased due to the number of capital projects that have stopped during the Covid-19 response meaning that capitalised staff now form part of the Trust revenue costs.
- The trust pay costs include £0.1m of staff that were assigned to Nightingale.
- The Trust has had 80 staff working at other Trusts to support them in providing expanded ITU capacity which have prevented GOSH saving from the reduced non–urgent elective work but has prevented additional sector costs.
- WTE have increased from last year due to the increased staffing from UCL to support Covid-19 and the capitalised staff in the revenue position due to capital projects stopping.

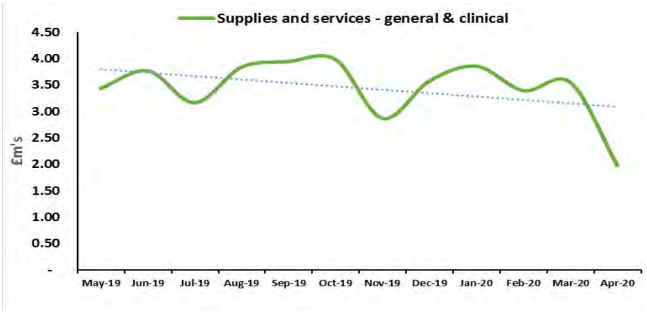
Non-Pay Summary for the 1 month ending 30 Apr 2020

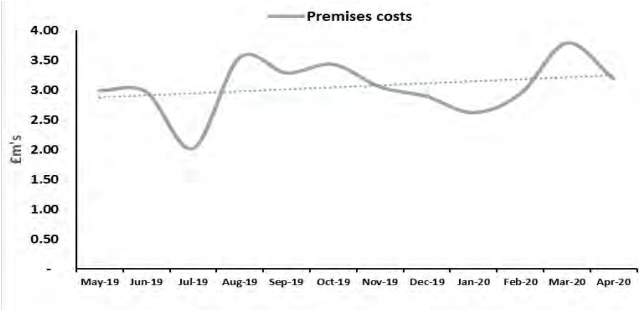
Great Ormond Street Hospital for Children NHS Foundation Trust











Summary

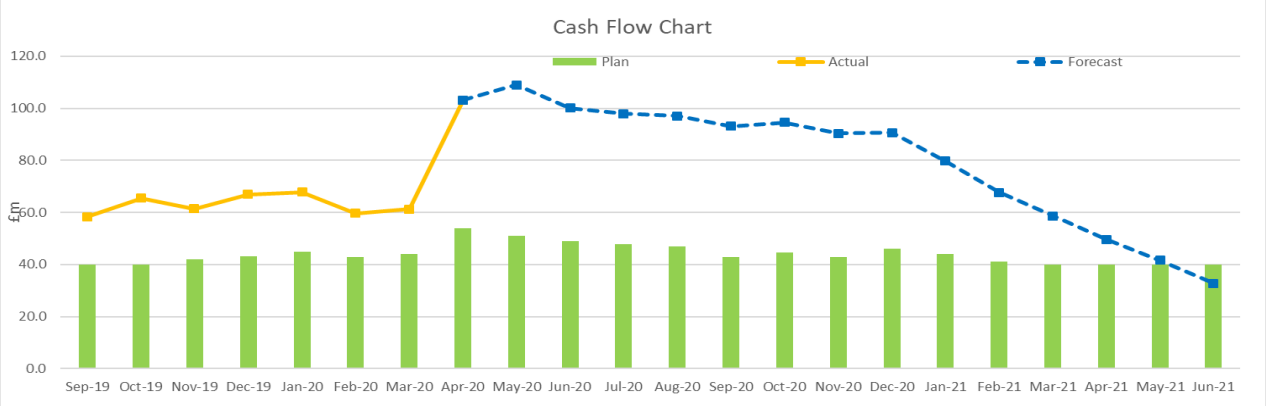
- Drugs are £1.3m higher than the NHSI plan as the Trust is paying for ongoing treatment with new high cost drugs that weren't being issued and accounted for in the plan – this includes Battens drugs and 2 Car-T (£0.5m) treatments in April. These new high cost treatments can be seen in the drug trend which has seen significant increase in the last 12 months, the income associated with these drugs is now part of the NHS block contract.
- Supplies and services along with the purchase of healthcare have remained fairly steady over 12 months with a significant decrease in April. This decrease is due to the change in patient mix that the Trust is treating, reduced non-urgent elective patients and the variable cost savings associated with reduced Research, charitable projects and private patients.
- The Trust has seen a £1.7m increase in the credit loss allowance due to non-payment of private patient debt. This has been calculated in line with IFRS9 and the Trust's policy.
- Depreciation is £1.1m higher than the NHSI plan as donated depreciation and capital donations were excluded from the plan. .

31 Mar 2020 Unaudited Accounts £m	Statement of Financial Position	YTD Actual 29 Feb 2020 £m	YTD Actual 31 Mar 2020 £m	*YTD Actual 30 Apr 2020 £m*	In month Movement £m	*Plan 30 Apr 2020 £m*
542.65	Non-Current Assets	522.29	542.65	542.93	0.28	*631.40*
116.44	Current Assets (exc Cash)	115.71	116.44	117.03	0.59	*95.13*
61.31	Cash & Cash Equivalents	59.59	61.31	103.21	41.90	*54.01*
(103.54)	Current Liabilities	(102.13)	(103.54)	(145.60)	(42.06)	*(85.09)*
(5.54)	Non-Current Liabilities	(5.24)	(5.54)	(5.48)	0.06	*(66.11)*
611.32	**Total Assets Employed**	**590.22**	**611.32**	**612.09**	**0.77**	**629.34**

31 Mar 2020 Unaudited Accounts £m	Capital Expenditure	Plan 30 Apr 2020 £m	YTD Actual 30 Apr 2020 £m	YTD Variance £m	Forecast Outturn 31 Mar 2021 £m	RAG YTD variance
21.84	Redevelopment - Donated	1.51	1.64	(0.13)	13.34	G
7.43	Medical Equipment - Donated	0.51	0.38	0.13	2.28	G
1.95	ICT - Donated	0	0.00	0.00	0.00	G
31.22	**Total Donated**	2.02	**2.02**	**0.00**	**15.62**	G
6.78	Redevelopment & equipment - Trust Fur	0	0.06	(0.06)	10.15	G
1.90	Estates & Facilities - Trust Funded	0.11	0.14	(0.03)	3.37	G
11.95	ICT - Trust Funded	0.26	0.17	0.09	4.48	G
0.00	Contingency	0	0.00	0.00	0.00	G
20.63	**Total Trust Funded**	0.37	**0.37**	**(0.00)**	**18.00**	G
51.85	**Total Expenditure**	2.39	**2.39**	**0.00**	**33.62**	G

31-Mar-20	Working Capital	31-Mar-20	30-Apr-20	RAG	KPI
23.00	NHS Debtor Days (YTD)	23.0	20.0	G	< 30.0
247.00	IPP Debtor Days	247.0	273.0	R	< 120.0
34.80	IPP Overdue Debt (£m)	34.8	38.9	R	0.0
109.00	Inventory Days - Non Drugs	109.0	132.0	R	30.0
39.00	Creditor Days	39.0	38.0	R	< 30.0
0.41	BPPC - NHS (YTD) (number)	40.9%	46.6%	R	> 90.0%
70.4%	BPPC - NHS (YTD) (£)	70.4%	69.0%	R	> 90.0%
85.0%	BPPC - Non-NHS (YTD) (number)	85.0%	86.7%	A	> 90.0%
89.2%	BPPC - Non-NHS (YTD) (£)	89.2%	93.4%	G	> 90.0%

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



Comments:

1.A revised version of the Trust's capital plan was submitted to the STP on 13 May; a final capital envelope is expected to be agreed by 31 May. Actual capital expenditure for April was £2.02m for Trust-funded expenditure and £0.37m for Charity-funded expedniture.
2.Cash held by the Trust increased by £41.9m in April. This was largely as a result of SLA block payments (£31.5m) being received a month in advance. In addition a top up payment of £6.9m was received in month.
3.Total Assets employed at M01 increased by £0.8m in month.

- Non current assets totalled £542.9m, an increase of £0.3m in month as result of capital expenditure net of depreciation and amortisation.
- Current assets excluding cash totalled £117m, an increase of £0.6m; this includes an accrual for the April top up payment of £6.4m, an increase in IPP debtors of £3.2m and reductions in NHS Receivables (£3.6m), capital receivables (£2m) and Charity receivables (£1.9m). Provision for doubtful debt incrased by £1.7m.
- Cash held by the Trust totalled £103.2m, an increase of £41.9m in month. This included £38.4m of payments received in advance under the new financial framework brought about by Covid-19.
- Current liabilities totalled £145.6m, an increase of £42m in month. This includes the £38.4m cash received in advance mentioned above and an increase in accrued expenditure of £1.9m.

4.Overdue IPP debt increased in month to £38.9m (£34.8m in M12).
5.IPP debtor days decreased from 247 days to 273 days in month.
6.The cumulative BPPC for NHS invoices (by value) decreased slightly in month to 69% (70.4% in M12). This represented 46.6% of the number of invoices settled within 30 days (40.9% in M12)
7.The cumulative BPPC for Non NHS invoices (by value) increased in month to 93.4% (89.2% in M11). This represented 86.7% of the number of invoices settled within 30 days (85% in M12).
8.Creditor days decreased in month from 39 days to 38 days.

Attachment U

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26th May 2020

Learning from Deaths. **Mortality Review Group - Report of deaths in Q2 2019/20** **Submitted by:** Dr Sanjiv Sharma, Medical Director. Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews Andrew Pearson, Clinical Audit Manager.	**Paper No: Attachment U**

Aims / summary

The Mortality Review Group (MRG) was established in 2012 to review the deaths that occur at Great Ormond Street Hospital (GOSH).

This report meets the requirements of the National Quality Board by

- Outlining the Trusts approach to undertaking case reviews
- Including data and learning points from case reviews.

This report describes the findings from MRG reviews of GOSH inpatient deaths that occurred between 1st July and 30thSeptember 2019.

Case record reviews have been completed for all cases by the Mortality Review Group. There were two cases that had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death. This report highlights the learning points and actions to be taken in response.

The MRG reviews highlight the excellent care provided by the multidisciplinary teams at GOSH for children, young people and their families, including at the end of life. The MRG review process identified particular positive aspects of care and communication in eleven cases.

Action required from the meeting

The board is asked to note the content of the paper.

Contribution to the delivery of NHS Foundation Trust strategies and plans

This report meets the requirements of the National Quality Board to report learning from deaths to a public board meeting.

Financial implications- none.

Who needs to be told about any decision?

n/a

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

The Medical Director is the executive lead with responsibility for learning from deaths.

Who is accountable for the implementation of the proposal / project?

Learning from Deaths: Report of deaths in Q2 2019/20

Background

The Mortality Review Group (MRG) was established in 2012 to review the deaths of inpatients at Great Ormond Street Hospital (GOSH). The purpose of the MRG is to provide a Trust level overview of all deaths to identify any learning points, themes and risks and take action as appropriate to address any risks. This process is linked with local case reviews undertaken by specialty teams and provides an additional oversight of inpatient deaths in the Trust.

Child Death Review Statutory Guidance

The guidance outlines the statutory NHS requirements for child death reviews for all deaths on or after the 29th September 2019. This requires a Child Death Review Meeting (CDRM) that must be "a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death." This includes clinicians or professionals from external providers. To support this a CDR lead has been appointed (2 PAS) and a Child Death Coordinator role has been recruited within the Bereavement Services Team to coordinate the process.

Deaths that occurred prior to the 29th September have continued to be reviewed by the MRG.

On 29th September 2019 new statutory guidance came into force for the review of childhood deaths. This guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in 'Working Together to Safeguard Children' and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews.

The guidance sets out the process in order to:

- improve the experience of bereaved families, and professionals involved in caring for children
- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths

A detailed update will be included in the next learning from deaths report.

Aim of report

The purpose of the report is to highlight any deaths where there were identified modifiable factors and any learning from case record reviews. Modifiable factors are defined as factors, which by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

This report describes the findings from MRG reviews of GOSH inpatient deaths that occurred between 1st July and 30thSeptember 2019

Headlines

Twenty seven children died at GOSH between 1st July and 30th September 2019. Case record reviews have been completed for all cases by the Mortality Review Group.

Of the twenty seven cases reviewed:

There were two cases that had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death (influence score 2[1]).

1. The review (MRG398[2]) highlighted a potential failure to recognise clinical deterioration of the patient. This case was subsequently referred to the Executive Incident Review Meeting (EIRM) and a Root Cause Analysis investigation (DATIX ref 64613) was completed on the 15th November 2019. The RCA report concluded that "Two lessons have been identified for Trust wide learning during this investigation although these did not contribute to the patients collapse or the outcome of the incident".
2. One review (MRG436) highlighted that there could have been better implementation of the Sepsis 6 protocol. This case was reviewed by the MRG on the 13th January 2020, and was referred to the Executive Incident Review Meeting (EIRM) and been declared as a Serious Incident. The learning from the review, including any actions required, will be identified via that investigation and an update will included in the next learning from deaths report

The MRG also highlight the excellent care provided by the multidisciplinary teams at GOSH for children, young people and their families, including at the end of life. The MRG review process identified particular positive aspects of care and communication in eleven cases.

The table below provides a summary of the deaths that occurred during the quarter using NHS England reporting guidance.

Total number of inpatient deaths at GOSH between 1st July and 30th September 2019	27
Number of those deaths subject to case record review by the MRG	27
Number of those deaths investigated declared as serious incidents	2
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2	2
Number of deaths of people with learning disabilities	2
Number of deaths of people with learning disabilities that have been reviewed	2
Number of deaths of people with learning disabilities where a modifiable factor was identified at GOSH with an influence score of 2 or more	0

One death was declared as a serious incident following the MRG review and is outlined above. In one case an SI (2019/8273) investigation took place prior to the patient's death. The incident was not related to the care provided around the time of death, and the MRG review found no modifiable factors relating to the child's death. The incident was retained arterial line tubing. The learning and action plan are being monitored by Closing The Loop.

Learning Disability Mortality Review notifications

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by NHS England to review the deaths of people with learning disabilities. All NHS Trusts are required to notify LeDer of deaths of a patient with a learning disability over the age of four. The Clinical Nurse Specialist for Learning Disabilities is the lead at GOSH for notifying deaths and coordinating requests for information.

Period of deaths covered	No. of notifications required by GOSH	No. of notifications made	No. of notifications requiring submission
May 2017 to 30th September 2019	13	13	0

[1] The Child Death Review Analysis form outlines an influence score which offers an interpretation of the extent to which the factor may have contributed to the death of the patient.
0 - Information not available
1 - No factors identified, or factors identified but are unlikely to have contributed to the death
2 - Factors identified that may have contributed to vulnerability, ill health or Death
This information should inform the learning of lessons at a local level.

[2] The MRG case number is a unique number that is assigned to each case reviewed, and allows queries to be tracked back to the case. The MRG case number is indicated in this report by using the format (MRGnnn) after referencing a specific case.

Learning points from deaths occurring in Q2 2019/20

Learning from cases where there were modifiable factors at GOSH

Modifiable factor identified	Learning	Action taken /action to take
Failure to recognise clinical deterioration of patient and escalate care	The RCA highlighted "Two lessons have been identified for Trust wide learning during this investigation although these did not contribute to the patients collapse or the outcome of the incident. • The importance of completing a full set of observations to enable the CSP team to be aware of children at risk of clinical deterioration across the Trust. This is due to a change in hospital practice following the introduction of EPIC and the PSAG boards no longer being used to give a general overview of patients across the trust. • Staff to be aware of the functionality in EPIC to allow for overview of emerging trends in patient observations."	The RCA and learning points were reviewed at the February 2020 Closing the Loop. It was agreed that this would be highlighted and reviewed at Nursing Board. Progress with implementation of this learning is being monitored by Closing the Loop.
Sepsis 6 protocol was not initiated. No blood cultures done prior to starting enteral Co Amoxiclav No evidence of Consultant input following the gastrostomy insertion (12/8), particularly not the day before death when she was already unwell	Implementation of Sepsis 6 protocol	This case was reviewed by the MRG on the 13th January 2020, and was referred to the Executive Incident Review Meeting (EIRM) This has been declared as Serious Incident(2020 /1310) The learning from the review, including any actions required, will be identified via that investigation and an update will included in the next learning from deaths report

The learning points in this report were shared with Closing the Loop in February 2020 to support any actions required to implement them.

Additional learning points identified

The MRG also highlight the excellent care provided by the multidisciplinary teams at GOSH for children, young people and their families, including at the end of life. It is important to identify positive practice and learning from excellence.

The MRG review process identified particular positive aspects of care and communication in eleven cases.

- Good service delivery
- Very good team work and symptom management. Good communication with parents and family closely involved.
- Parents expressed that they were very happy with the care they received

- Excellent liaison with the family and their wishes were respected. The family felt listened to and treated as equals given the fact they brought up the issue of withdrawal of life sustaining treatment. Parents were present at the time of death after support from family liaison team.
- Collective team working. Mother was in agreement for organ donation.
- During admission the family received support from chaplaincy, CICU family liaison nurse and social worker.
- Good MDT work during resuscitation. Extensive debrief
- Death well managed and excellent communication of likely symptom development to ward staff from palliative care team.
- Palliative care well managed. Good documentation around advice and facilitating transfer of body to the mosque.
- Good communication with the family, especially in last few days of life and after death. Communication and decision making well documented.
- Death well managed including facilitation of organ donation

The learning points in this report will be shared with Closing the Loop to support any actions which made be required to implement them.

Monitoring of modifiable factors.

The table below provides a summary of the number of cases with modifiable factors with an influence score of 2 over the last five calendar years:

		Cases with a modifiable factor at GOSH that may have contributed to vulnerability, ill health or death (influence score two).	
Calendar Year	Inpatient deaths	N	%
2015	103	6	5.8%
2016	86	7	8.1%
2017	110	10	9.1%
2018	86	5	5.8%
2019 (to 30th September)	87	4	4.6%
Total	**472**	**32**	**6.8%**

5th March 2020
Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews
Andrew Pearson, Clinical Audit Manager

Attachment V

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2020

Safe Nurse Staffing Report for reporting period February/March 2020 **Presented by: Alison Robertson, Chief Nurse.** **Prepared by: Marie Boxall, Head of Nursing-Workforce**	**Paper No: Attachment V**

Aims / summary

This report provides the Board with an overview of the Nursing workforce during the month of February 2020 and March 2020 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018.

It provides assurance that arrangements are in place to safely staff the inpatient wards with the right number of nurses with the right skills and at the right time.

Action required from the meeting

To note the information in this report on safe nurse staffing which highlights actions taken by the nursing teams to assure readiness in March for any increases in activity due to COVID-19 and in response to changes in admission pathways to include general paediatrics (including mental health) from our North Central London partner organisations.

There have been no reported safe staffing datix incident reported in February and March

The Trust operated within nationally recommended parameters for safe staffing levels in February. Reporting was suspended in March (appendix one).

Contribution to the delivery of NHS Foundation Trust strategies and plans

Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.

Financial implications

Already incorporated into 19/20 Directorate budgets.

Who needs to be told about any decision?

Directorate Management Teams
Finance Department
Workforce Intelligence

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

Chief Nurse, Director of Nursing and Heads of Nursing

Who is accountable for the implementation of the proposal / project?

Chief Nurse; Directorate Management Teams

Attachment V
Safe Nurse Staffing Report for reporting period February/March 2020

1. Summary

This report on GOSH Safe Staffing contains information from the months of February and March 2020.This paper provides the required assurance that GOSH had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage the demand for nursing staff. The report also includes measures taken to ensure safe staffing throughout the Trust and during Phase 1 of the Covid 19 pandemic up to the 8th May 2020, during which time the trust also hosted general paediatric and mental health patients from our North Central London (NCL) partner organisations the North Middlesex, Royal Free, Whittington and University College Hospital. The national reporting process for safe staffing was suspended in March 2020 due to the COVID-19 pandemic.

2. Safer Staffing during Covid 19 Pandemic

The coronavirus pandemic has required GOSH nursing staff to work in new ways and in different wards, departments and organisations. At times, it has also required nursing staff to work in environments and with patient groups that may be unfamiliar. We followed NHSE/I principles and Nursing and Midwifery Council (NMC) regulatory guidance to support our response and maintain safe staffing measures.

2.1 Early deployment

GOSH nursing staff were deployed early into unfamiliar clinical areas in a super-nummary capacity prior to any surge in demand. This was to ensure staff received the right training, induction and familiarisation to the new environment and set of processes should they be required to work in a different area.

2.2 Building competence and confidence

All nursing staff have a responsibility to work within their competence, however team-based capability is more important than individual capability. Senior nurses and ward managers were encouraged to think in terms of competences rather than roles. This information was collected at an early stage via an online survey and health rosters updated to enable appropriate redeployment of nursing staff as necessary. As part of the Covid-19 response it was helpful to align the directorates into three main groups – General Paediatrics, Specialist and ICUs. Team and directorate nurse leaders were identified to ensure clear lines of reporting and accountability were in place.

Although nurses brought transferable skills with them into new clinical areas they were also offered upskilling and refresher sessions via the education teams to ensure clinical competence.

2.3 Supervision

All nursing staff working in a new clinical setting are being appropriately supervised by staff experienced in that field e.g. ICUs when delivering clinical care. They all have access to a clearly identified supervisor who is competent to act in that role. The intensity of supervision has been tailored to individual needs (i.e. direct or remote)

2.4 Health and Well-being

A significant raft of measures have been put in place via the Health and Well-being Hub to ensure nursing staff receive support and have access to tools to ensure they

are best able to maintain good health and wellbeing. Local support mechanisms are readily available and resources were also created specifically for those working from home.

As our nursing staff has also spent long periods wearing personal protective equipment (PPE), ward and unit areas have been sufficiently staffed to ensure regular breaks to remove equipment, rehydrate and eat. Skin care packs have also been provided by our Tissue Viability Teams to ensure staff well-being. Nursing staff sickness was well managed throughout February (3.5%) and March (3.6%).

2.5 Rosters

Working patterns were redesigned at an early stage in some directorates with the co-operation of nursing staff to ensure an increased presence of staff at night and out of hours but also to ensure adequate down time. Rosters also factored in the assumption that a proportion of nursing staff might be unavailable due to sickness or self-isolation. In addition to this we have continued to promote adherence to the principles of good rostering and the application of the Working Time Regulations (1998) during the coronavirus pandemic.

2.6 Tracking

The Heads of Nursing have ensured their nursing staff are maintaining up to date rosters and encourage their team leaders to make regular contact with all nursing staff to ensure they are identified and contactable, and their attendance/absence is tracked appropriately and recorded in ESR.

2.7 Returners

The Coronavirus Act 2020 has provided the nursing professional regulator, the NMC with emergency powers to establish a temporary register to those who have left the professional register. In March 2020 this applied to nurses who left the register within the last three years, in April it was extended to overseas nurses who had completed all parts of their NMC registration process except their OSCE and nurses who have left the register within the last four and five years. We did have some enquiries from nurses who had joined the temporary register however as we did not see the surge in demand that was anticipated and these enquiries were redirected to the Bring Back Bureau to redirect this support to our North Central London (NCL) partners where the need was greater. We did however recruit nurses who were returners to GOSH who had previously left for various reasons. Details of these are listed later in the report.

2.8 Aspirant nurses

Nursing students in their final six months of training have been invited to opt into joining the workforce in a paid capacity. On the 4th May GOSH welcomed 61 aspirant nurses all of whom have Newly Qualified Nurse (NQN) conditional offers with us for September 2020. This means we will be able to supplement the workforce over these challenging months of the pandemic, while supporting a smooth transition into their NQN roles in the autumn.

2.9 General Paediatric Patients

Our response included supporting the wider system by accepting general paediatric patients and Covid-19 positive patients. To ensure safe staffing additional support

was put in place for the areas admitting these patients including senior staff with general paediatrics experience, flexing and deployment of staff from other areas to supplement and support existing staff, full provision and fit testing of personal protective equipment (PPE), completion of risk assessments with mitigation put in place as appropriate and twice daily nursing operational huddles to ensure rapid identification and escalation of issues as required.

2.10 Mental Health Patients

The transfer of NCL patients to GOSH bought a new cohort of patients with acute mental health presentations and the use of the Mental Health Act. Working within the NCL network a cohort of Registered Mental health Nursing (RMNs) staff were identified and deployed to GOSH. These nurses in collaboration with the Mildred Creek Unit (MCU) staff are leading on the mental health care of patients with physical health care being provided by registered Children Nurses in a similar model to general paediatrics. Staffing and acuity levels are constantly reviewed, and capacity is determined on the supervision needs of those patients. The nursing staff caring for our mental health patients have a rolling programme of de-escalation training, common law and emergency situation training. Debriefing and staff support are offered each shift and nursing planning meetings allow nurses to raise concerns regarding staffing numbers and patient acuity. Out of hours safety was mitigated through the merger at night of Kingfisher and MCU allowing a senior MCU nurse to oversee the ward, lead on restraint and offer expertise in case management.

3. Temporary Staffing

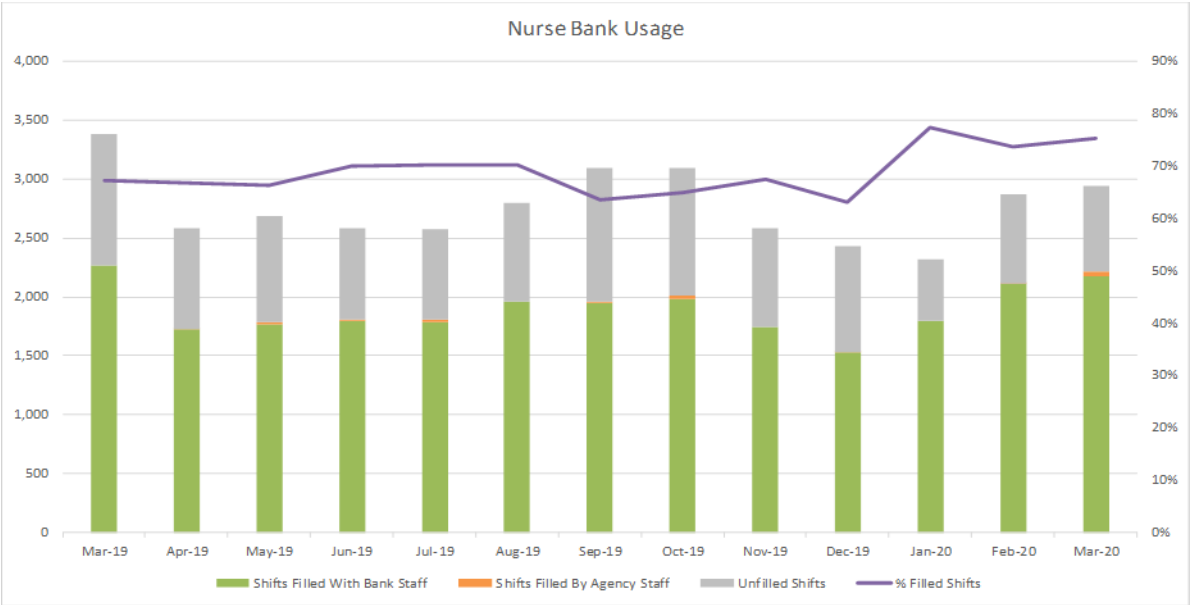


Fig. 4 Temporary staffing fill rate 12 month view

Requested shifts for February increased to 2,866 and further increased in March to 2,940. The fill rate for February was 74% increasing to 75% in March, both of which are above the 12 month average of 69%. In February, there were no agency nursing shifts, however in March; there were 45 agency shifts, all on Koala Ward to provide

specialing support to patients. Agency nursing usage in the Trust remains well controlled. There has been increased scrutiny and review of requested bank shifts since March and it is anticipated that there will be a significant drop in the number of requests over the following months.

4. Incident Reporting

During the reporting period of February and March there were no datix incidents in relation to safe staffing.

5. Nursing Establishment Review

The Children's & Young People's Safer Nursing Care Tool (C&YP SNCT) is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013 which has been used successfully implemented in many trusts across England. The tool is used to determine nursing establishments based on the acuity of patients.

As an organisation we commenced testing of the tool with the first phase completed in January and the second phase commenced in March however was paused at any early stage due to planning for Covid-19 response taking priority. As teams are currently deployed elsewhere, and wards and new activity aligned to new temporary directorates we will look to defer the next phase of the SNCT scoring to July 2020 once the new ways of working has been established.

The biannual staffing establishment reviews which were due to take place in March were also deferred due to prioritisation of Covid-19 response planning, and will be resumed through May and June, with a report due to go to the next Trust board.

6. Nursing Workforce Assurance Group (NWAG)

The NWAG meeting was paused in March to allow prioritisation of Covid-19 response planning. This meeting will be resumed in virtual form in May 2020.

7. Accuracy of Data

As previously reported in the last Trust Board report, there are concerns over the accuracy of data which is derived from the budget statement provided by Finance and includes SIPS, reserves, recharges, bank and agency. These additional elements are responsible for the current contrasts in vacancy rate reporting, as this is how the vacancy rate has historically been calculated at GOSH. The proposal to resolve these discrepancies and provide a more accurate picture is to adjust to a simpler methodology using Electronic Staff Record (ESR) budgets instead of finance budgets as of April 2020. Unfortunately due to the Covid-19 planning response this work had been slightly delayed but has now recommenced and we have been advised by the Head of Workforce Information that the new methodology for reporting workforce related data should be implemented by June 2020.

Appendix 1

Workforce utilisation

1. Actual vs Planned

Actual vs Planned (AvP) Hours shows the percentage of Nursing & Healthcare Assistant (HCA) staff who worked (including bank) as a percentage of planned care hours in month. The National Quality Board recommendations are that the parameters should be between 90-110%.

In February 2020 the overall fill rate of AvP was 102.1% which is within the recommended range and an improvement on the same month last year. During the day nursing shifts were 109.3% of plan, while HCA shifts were 99.7%. At night nursing shifts were 113.6% while HCA shifts were slightly below the lower range at 89.7% of plan.

At a directorate level, Sight and Sound were the only directorate to exceed the 90-110% range at 113.3% of plan, the Head of Nursing (HoN) has highlighted that this is not an accurate reflection due to an increase in the number of phlebotomy shifts requested with distorts the figures. Blood, Cells & Cancer and the Brain directorate were the only directorates below 100%. The HoN for these directorates has confirmed that this was as a result of reduced activity in BCC which led to the cancellation of bank shifts and redistribution of staff to support other areas. In Brain there was an outbreak of Norovirus and increased demand due End of Life (EoL) care which was mitigated through the closure of beds which maintained safe staffing levels. All other directorates were between 100-110% of plan.

In March, as part of a review of national readiness for COVID-19, the Unify return was suspended. Due to this, and the number of ward and team moves, there is no data available for March 2020. However the Trust implemented a number of planning changes to assure itself of its ability to safely staff wards and meet any expected increase in demand.

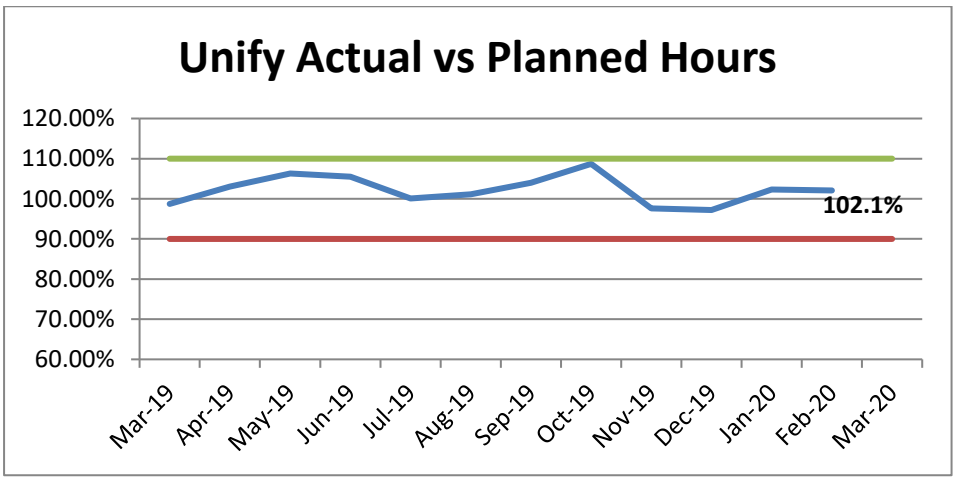


Fig. 1 Actual vs Planned Hours 12 month view

2. Care Hours Per Patient Day (CHPPD)

CHPPD is calculated by adding the hours of registered nurses and healthcare assistants available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported as a total and split by registered nurses and HCAs to provide a complete picture of care and skill mix and uploaded onto the national Unify system which is published on NHS Choices on a monthly basis.

The reported CHPPD for February 2020 was 13.6 hours, made up of 11 registered nursing hours and 2.6 HCA hours. This is slightly lower than the 12 month average CHPPD of 13.7 hours. The ICUs are excluded from the figures.

As with Actual versus Planned there is no CHPPD data available in March.

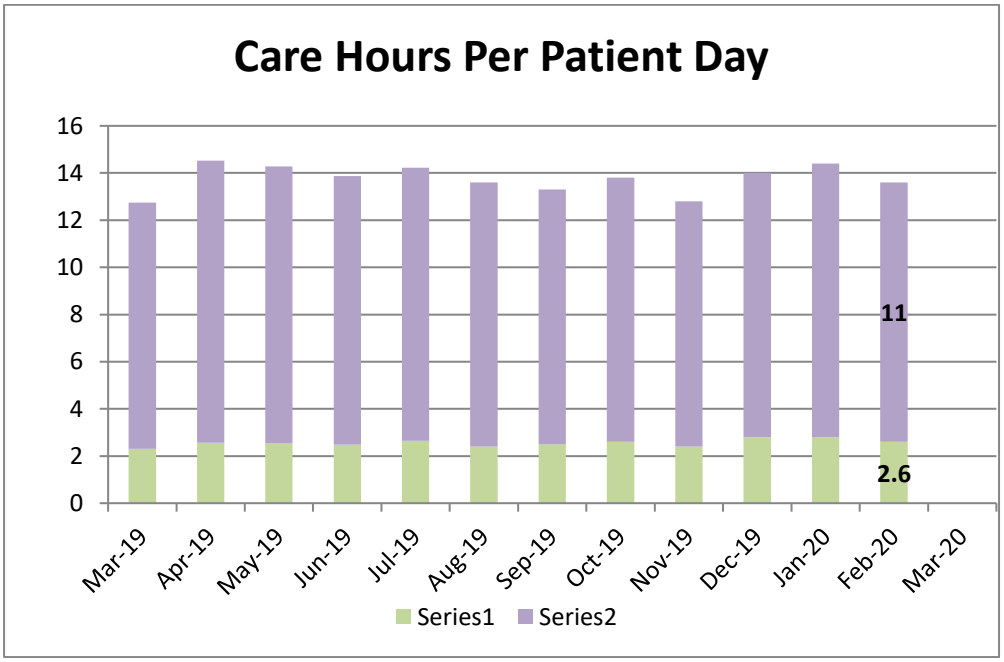


Fig. 2 Care Hours Per Patient Day 12 month overview

Attachment V
Safe Nurse Staffing Report for reporting period February/March 2020

3. February & March Workforce metrics by Directorate

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover* %	Sickness %	Maternity %
Blood, Cells & Cancer	95.6%	15.7	16.1	6.9%	12.0%	2.7%	5.7%
Body, Bones & Mind	107.8%	12.3	28.4	11.3%	18.0%	3.0%	7.5%
Brain	92.3%	12.6	7.1	5.6%	12.1%	2.8%	4.8%
Heart & Lung	103.8%	14.0	27.1	5.2%	21.1%	3.9%	5.4%
International & PP	108.9%	14.7	32.4	28.5%	25.1%	5.2%	4.7%
Operations & Images	-	-	11.2	5.5%	12.7%	4.6%	4.8%
Sight & Sound	113.3%	10.6	2.7	4.7%	15.6%	3.2%	3.2%
Trust	102.1%	13.6	100.1	6.2%	16.9%	3.5%	5.4%

February Nursing Workforce Performance
**Relates to all RN grades*

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover * %	Sickness %	Maternity %
Blood, Cells & Cancer	Unavailable	Unavailable	17.1	7.4%	11.5%	2.7%	3.7%
Body, Bones & Mind	Unavailable	Unavailable	25.0	10.0%	17.2%	3.0%	7.7%
Brain	Unavailable	Unavailable	5.9	4.7%	12.2%	2.9%	5.6%
Heart & Lung	Unavailable	Unavailable	24.7	4.7%	21.8%	3.9%	5.7%
International & PP	Unavailable	Unavailable	29	25.5%	23.9%	5.2%	4.5%
Operations & Images	Unavailable	Unavailable	11.1	5.5%	12.0%	4.9%	4.8%
Sight & Sound	Unavailable	Unavailable	1.5	2.6%	13.6%	3.2%	4.9%
Trust	Unavailable	Unavailable	90.8	5.6%	16.6%	3.5%	5.5%

March Nursing Workforce Performance
**Relates to all RN grades*

Attachment W

Trust Board 26 May 2020	
Freedom to Speak Up Guardian's Report **Submitted by:** **Luke Murphy, Freedom to Speak Up Guardian**	**Paper No: Attachment W**
Aims / summary To share the frequency and themes of the contacts to the Freedom to Speak Up Service	
Action required from the meeting To note the work of the service	
Contribution to the delivery of NHS Foundation Trust strategies and plans People Strategy and the Speak Up for Safety and Speak Up for Values Programmes.	
Financial implications NA	
Who needs to be told about any decision? NA	
Who is responsible for implementing the proposals / project and anticipated timescales? Freedom to Speak Up Guardian	
Who is accountable for the implementation of the proposal / project? Medical Director	

Freedom to Speak Up Guardian's Report: 14/05/2020

Introduction

The Freedom to Speak Up (FTSU) Guardian role is one of the recommendations from Sir Robert Francis' FTSU review in February 2015 into whistleblowing in the NHS, which identified very poor experiences for NHS staff who raised concerns. All trusts are required to appoint Guardians to support their staff raising concerns at work.

Service Provision and Resource

- The FTSU service in the Trust is provided by a FTSU Guardian and a range of FTSU ambassadors.
- The Guardian post is a remunerated 0.4WTE post.
- There are 4 staff members who volunteer as FTSU Ambassadors. The Ambassadors come from a range of roles and professions across the Trust and help to raise awareness in the organisation.
- The FTSU Guardian reports directly to the Medical Director.
- The FTSU Guardian regularly meets with the Chief Executive to provide updates and an overview on thematic concerns.
- There is a non-executive director who is responsible for FTSU and for Whistleblowing.

The role of the Guardian:

- support our staff to raise concerns at work;
- promote awareness of the FTSU pathways to staff at GOSH
- listen and keep a brief record of concerns raised (confidential if desired);
- where appropriate, ensure that an investigation is arranged through the appropriate channels
- stay in contact with the individual during the process and ensure they are kept updated, and are supported;
- report regularly to the Trust Board, identifying thematic areas for improvement and providing challenge where appropriate
- escalate concerns to the executive lead, Dr Sanjiv Sharma, Medical Director, or to Matthew Shaw, Chief Executive, and the nominated Non-Executive Director as may be appropriate.

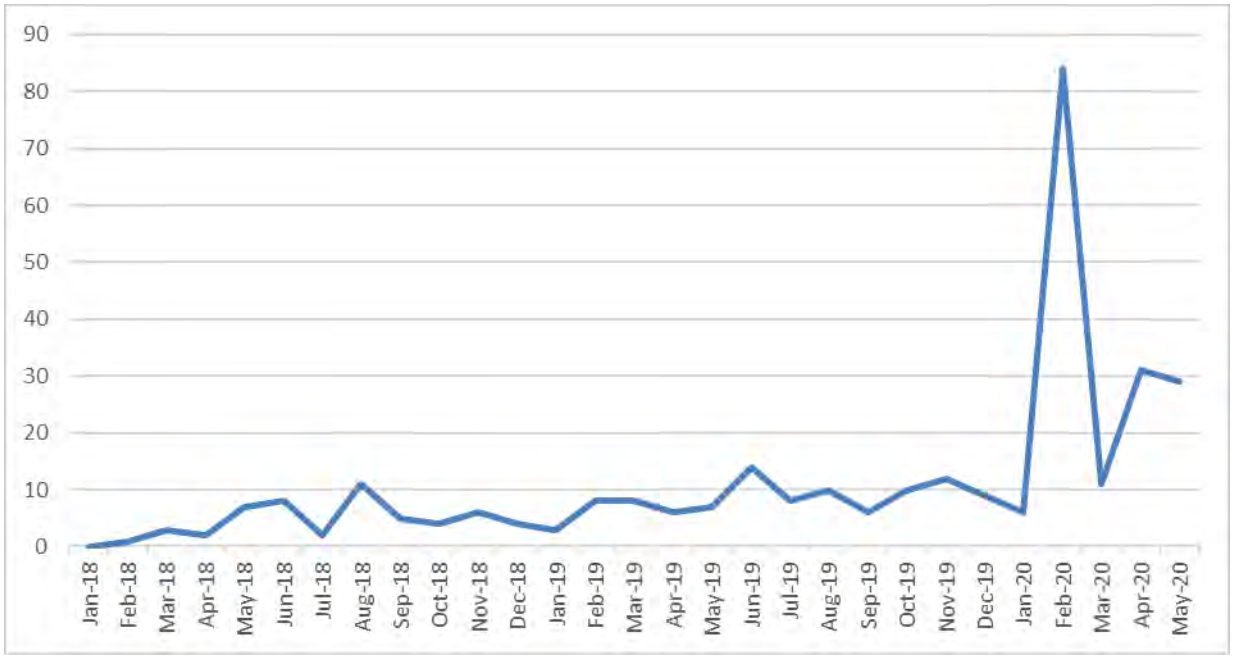
Accessibility

Following the appointment of the FTSU Guardian in March 2018, several steps have been taken to improve accessibility to the service including:

- A dedicated email account
- A dedicated mobile phone number
- Intranet page updates (including pictures of the Guardian and Ambassador)
- Open house promotional events shared with the other two "Speak Up" programmes for Safety and Values

There has been ongoing high level support from the management team for the FTSU Guardian in his other Trust role which has enabled flexibility in responding to cases and staff Monday to Friday.

FTSU Contacts up to 14/05/20



Contact Numbers and Themes:

In 2018/19 the FTSU service received 68 contacts of GOSH staff and sub-contractors. In 2019/20 the service received 183 contacts from GOSH staff and sub-contractors. This reflects ongoing work to raise awareness of the role, and is likely to also be linked to the Trust Wide Speak Up training programme in 2019.

In 2019/20 the FTSU contacts have been significantly increased by the contact numbers related to the two special themes detailed below. This makes direct comparisons with the preceding year difficult. The table below shows the changes in themes between 2018/19 and 2019/20.

Theme	2018/19	2019/20
Behaviour/Bullying/Performance	42%	54%
Safety	26%	14%
Process	32%	30%

Behavioural concerns about colleagues or managers: 54.9%

Issue: the service has received contacts about racism, sexism and about poor communication or aggression from managers.

Actions: GOSH will be launching “Speak Up for Values” campaign to promote professional accountability and enable staff to challenge inappropriate behaviour in the moment or to report concerns so that staff have an opportunity to reflect on the impact of their behaviour.

This is a non-punitive approach that should encourage more open communication about staff to staff behaviour and its impact.

The Trust is also launching the “Praise” module that will enable staff to share their good experiences of staff to staff communication and behaviour. This should help foster positive appreciation of the benefits of being kind to each other.

The roll out of the People Strategy through 2020 will provide additional support and training for managers throughout the organisation to support more professional communication particularly in the context of performance management.

Safety concerns: 14.6%

Issue: Issues raised have included availability of protective wear for cleaning staff and an investigation in the cleaning process of some pieces of clinical equipment. From March 2020 some concerns were also raised about working from home (see below).

Actions: The “Speak Up for Safety” programme continues to empower staff to speak up about safety concerns when they arise. The Trust has committed to continue to invest in this programme and when coupled with the new “Speak Up for Values” programme both together should enable more staff to be open about any safety concerns.

Process concerns 30.4%

Staff have raised concerns with the FTSU about staff consultations, external service reviews and about access to Muslim prayer facilities.

Actions: the FTSU data contributed to the development of the new People Strategy and is now shared with the new People and Education Assurance Committee. Relevant cases are raised with the Assistant Director of HR who has helped allocate appropriate advice and or support for each case. The Trust has improved access to Muslim prayer facilities and appointed a new Imam as well as continuing to provide a Muslim chaplain to better support Muslim staff and sub-contractors.

Special issues

OCS: In February 2020 two petitions were submitted by a group of OCS staff representing 82 OCS staff. The two petitions were about 1) poor relationship with their managers and 2) lack of access to prayer facilities during their working day. OCS staff are not employed by Great Ormond Street Hospital but are rightly recognised as playing a key role in the provision of safe and effective care for our patients. It is for this reason that I have included them into this report but it is important to distinguish the responsibilities of OCS as an employer and Great Ormond Street Hospital. OCS staff did not raise specific safety concerns.

Action: OCS staff who have raised concerns have been supported to better articulate their concerns. OCS Management encouraged their staff to be represented by a Trade Union and the FTSU service has worked with trade union colleagues to support this. OCS staff now have better representation and have access to prayer facilities at work.

CV19: In March/April and May only three staff members have contacted the FTSU service about PPE and each have had positive outcome to their concerns. In the same period 34 staff have contacted the FTSU service about other CV19 issues such as working from home, differences in workload at home and on site, and perceived differences within teams about how some staff are treated.

Actions: Trust guidance has been updated repeatedly to provide the most up to date national guidance about Coronavirus. This has meant that some have perceived that the Trust has changed its advice and is inconstant. Staff contacting the FTSU service have discussed their anxiety but with reading through of the Trust advice, staff have felt assured and better able to raise concerns with their managers. Other contacts have been opportunities to remind staff that colleagues' medical conditions are private and managers cannot articulate why some colleagues must work remotely and others do not.

Future plans: The current FTSU Guardian ended their term in February 2020. In order to support the continuity of the FTSU service, the current Guardian has been asked by the Medical Director to continue in the role until the new Guardian role can be appointed. This recruitment has been delayed due to the Coronavirus.

Care Quality Commission

The CQC inspected the hospital in October – November 2019. In the report, published in January 2020, they recognised that the Trust had increased its focus on the Freedom to Speak Up, noting in particular the events to celebrate 'Speak Up' month in October 2019. They recognised the positive increase in FTSU contacts since their previous visit, and acknowledged the regular meetings which the FTSU guardian had with the Medical Director, Chief Executive and the Non-Executive Director responsible for FTSU with regular reports to QSEAC and Trust Board. They indicated that while much progress had been made, there was some scope to raise awareness further to ensure that all staff knew how to access the service. Once the new Guardian is appointed there will be a communications plan to support even greater awareness of the role.

Luke Murphy, Freedom to Speak Up Guardian: 14/05/2020

Attachment X

Trust Board 26th May 2020	
Fire Health and Safety Annual report **Submitted by: Chris Ingram, Fire, Health and Safety Manager**	**Paper No: Attachment X**
Aims / summary To inform the Trust Board of the on-going work streams, themes and priorities faced by the Trust and the progress and problems in relation to fire, health and safety.	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust strategies and plans Zero Harm	
Financial implications A serious incident could result in very large fines if we were found to be at fault.	
Who needs to be told about any decision? Not Applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? Fire, Health and Safety Manager	
Who is accountable for the implementation of the proposal / project? Fire, Health and Safety Manager	

Fire, Health and Safety Annual Report 2019 - 2020

The Fire, Health and Safety team support the Trust management and employees to meet their statutory duties in relation to controlling the risks and precluding the chance of harm to patients, visitors and staff.

The table below highlights work that has been completed by the team during the year:

Description of work	Progress and lead	Timescale	Original RAG rating	Current RAG rating
The Trust reports health and safety incidents on Datix.	828 (852 last year) health and safety incidents were reported from 1/4/19 – 31/3/20. This included 98 patient safety accidents. **Fire, Health and Safety Team**	The team aims to reply to each H&S incident within 1 working day.		
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - Any incident that involves a staff member being away from the Trust for more than 7 days or results in a serious injury must be reported under RIDDOR.	8 incidents were reported under RIDDOR. A more detailed breakdown is included below. **Fire, Health and Safety Team**	Incidents must be reported under RIDDOR within 15 days		
Train 90% of staff in Health and Safety. Training is completed through E-Learning and has not been affected by COVID 19.	On the 1st April 2020 compliance with Health and Safety training was 96% (93% in 2019) **Health and Safety Team**	Monitored monthly. Email sent out to all those who are not compliant on the 1st of each month.		
Safer Sharps - The Trust is required to comply with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 (the regulation), which is monitored by the Health and Safety Executive (HSE). Progress has been halted due to COVID 19. A paper will be presented at the Health and Safety Committee (25.6.20) about how to take this forward.	A working group has met over the reporting period to discuss and implement actions relating to safer sharps. The group is currently reviewing the following products: • Butterfly Needles • Hypodermic Needles • Port-a-caths • Insulin Pens • Scalpels • Stitch Cutter **Health and Safety Team**	Monitored at the Health and Safety Committee (Bi-monthly)		
Risk Impact Assessments	Projects that have been	As and when		

are undertaken when a project is ready to begin. The Fire, H&S team will review them. Local staff will receive training prior to taking over the area.	completed this year include: • ZCR • The Physiotherapy Gym • IMRI • Cath Labs/ MR4 • MEDU **Fire, Health and Safety Team**	required		
All Control of Substances Hazardous to Health (COSHH) information has been updated across the clinical areas. All relevant non-clinical areas such as Estates have also been completed.	An audit to ensure staff are aware of their duties and resources are in place was completed in June 2019. This was presented at the Health and Safety committee in August 2019. **Health and Safety Team**	Assessments are updated and audited on an annual basis.		
Fire Risk Assessments - A new more comprehensive assessment tool is now being used. This has been agreed with the London Fire Brigade. (LFB)	100% of fire risk assessments have been completed in clinical areas. 100% of fire risk assessments have been completed in non clinical areas. **Fire, Health and Safety Team**	Monitored monthly at the Estates Performance Meeting. Monitored at the H&S Committee bi-monthly		
Fire Safety Training -– Trust standard is to be above 90% compliance.	As of 1st April 2020 levels of compliance are: Fire Safety Training is currently at 92 (94) % compliance for bi-annual training and 90 (90) % for annual training **Fire, Health and Safety Team**	Monitored monthly. Email sent out to all those who are not compliant on the 1st of each month.		
Incidents and Unwanted fire signals. The LFB were called out to the Trust 4 times over the reporting period.	WEB66728 – Incident on Walrus caused by a staff member putting a metal cup in a microwave. No fire but a large amount of smoke. Issue resolved by removing power to microwave. 3 unwanted fire signals where LFB attended false alarms. **Fire, Health and Safety Team**	Monitored at the Health and Safety Committee (Bi-monthly)		
Scheduled visits from LFB.	The LFB have attended the Trust 15 times over the reporting period. They have had a series of	LFB are invited into the Trust whenever a		

	familiarisation visits to ZCR and the Southwood Courtyard Building (Gym and IMRI), have been educated in fire safety in an MRI Department and have completed a fire safety inspection in Octav Botnar Wing. **Fire, Health and Safety Team**	new building is commissioned. They are also free to attend at any time to inspect.		

Impact of COVID 19

- Fire Safety Training is now being completed online. The team are investigating if the training can be done face to face over Zoom.
- The team are part of the Returning to Work Safely Group to ensure staff return to working on-site in a safe manner.
- The team are part of the Home Working Task and Finish Group to explore opportunities to increase working at home.
- Potential increased reporting under RIDDOR.
- Safer Sharps Working Group has not met since March. This is because procurement resources have been used to source Personal Protective Equipment.

Number and severity of incidents reported (Pan Trust)

GOSH employees reported 828 (852 – last year) health and safety incidents in the year from April 2019 to March 2020. These included including 98 patient safety incidents. 1 incident was reported as catastrophic.

- **WEB58363** – OCS contractor collapsed in the hospital. Was reviewed, asked to break his fast and went home with a colleague. Was advised to attend Accident and Emergency. He passed away later that night. This has been reported as a Serious Incident to NHS England – STEIS No. 2019/10699

- **STEIS No. 2019/25710 –** A second incident was also reported to NHS England. This involved a bed bugs infestation on one of our wards. This caused interruption to service delivery, impacted on patient experience and caused additional working challenges for staff.

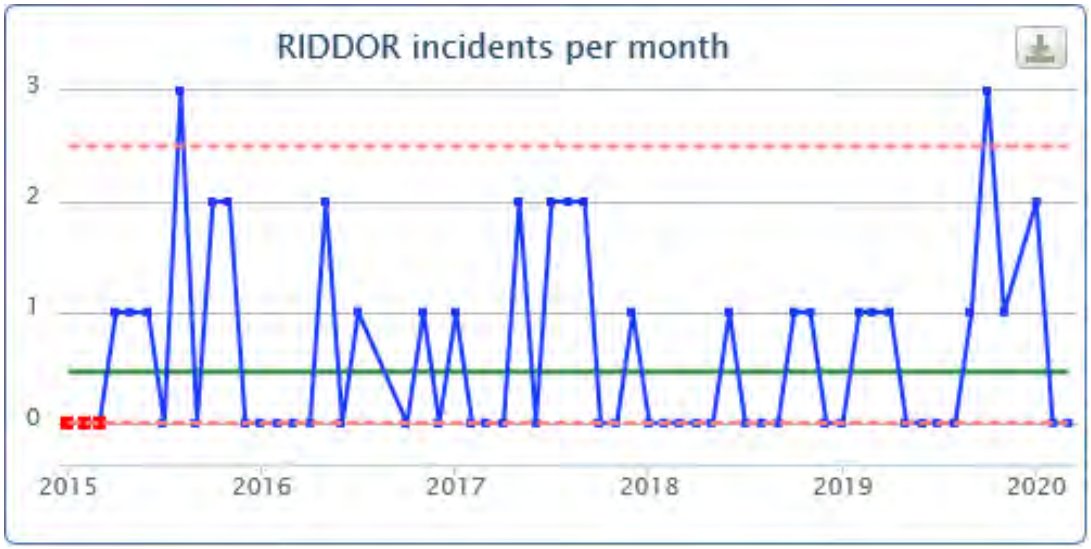
Reporting of Injuries, Diseases and Dangerous Occurrence Regulations

The Trust is required by law to report specified workplace incidents, such as work-related deaths, major injuries, over 7-day injuries, work related diseases, and dangerous occurrences (near miss accidents)

8 incidents were reported to the Health and Safety Executive (HSE) under RIDDOR.

- **WEB61313** – Nurse shut thumb inside filing cabinet resulting a fracture. Staff member was away from the Trust > 7 days.
- **WEB63601** – Nurse suffered needlestick injury which led to her being exposed to a biological agent.
- **WEB59129** – Staff member fell off foot stool resulting in shelving falling on them. Staff member was away from the Trust > 7 days.
- **ID - 87136** – Staff member ran upstairs and tripped up resulting in a fractured wrist. Major injury.

- **WEB64577** – Nurse bitten on hand causing infection. Staff member was away from the Trust > 7 days.
- **WEB64906** – Staff member was walking upstairs when she tripped over and fractured their foot. Major injury.
- **WEB66236** – Nurse banged head in staff kitchen. Staff member was away from the Trust > 7 days.
- **WEB66406** – Staff member fell down stairs and bumped head. Staff member was away from the Trust > 7 days.



Main aims for 2020/2021

- The team will play a vital role in ensuring that the Trust adapts safely to working under conditions imposed by COVID 19.
- Complete COSHH Audit in all clinical areas. This is scheduled for June.
- Maintain Health and Safety training compliance above 90%.
- Increase compliance with fire safety training to above 90%.
- Respond to all Health and Safety incidents within 1 working day.
- Ensure compliance with the HSE's Safer Sharps Directive.
- Ensure that our new buildings meet high safety standards and are safe for our staff and patients to move into before they are used.
- Maintain 100% compliance in regard to fire risk assessments.

Attachment Y

Trust Board 26th May 2020	
Gender Pay Gap Board paper **Submitted by:** Sarah Ottaway, Associate Director of HR&OD	**Paper No: Attachment Y**
Aims / summary To update Trust Board with information on the 2019 Gender Pay Gap, which was reported in March 2020 in line with statutory requirements.	
Action required from the meeting For information and noting	
Contribution to the delivery of NHS / Trust strategies and plans Understanding our gender pay gap and the reasons behind it, as well as well as putting in place actions to address it – contributes to promoting GOSH as an open and inclusive employer of choice	
Financial implications None	
Legal issues No legal issues	
Who is responsible for implementing the proposals / project and anticipated timescales Director of HR & OD	
Who is accountable for the implementation of the proposal / project Director of HR & OD	

Gender Pay Gap Report 2019

1.0 Introduction

1.1 As with all other employers with more than 250 staff, since 2018, the Trust has been required to report data relating to the Gender Pay Gap. The data reported in this paper shows the pay gap as at 31st March 2019, as required by the Regulations. The Trust has reported its Gender pay gap data on the Government portal ahead of the deadline of 31st March 2020.

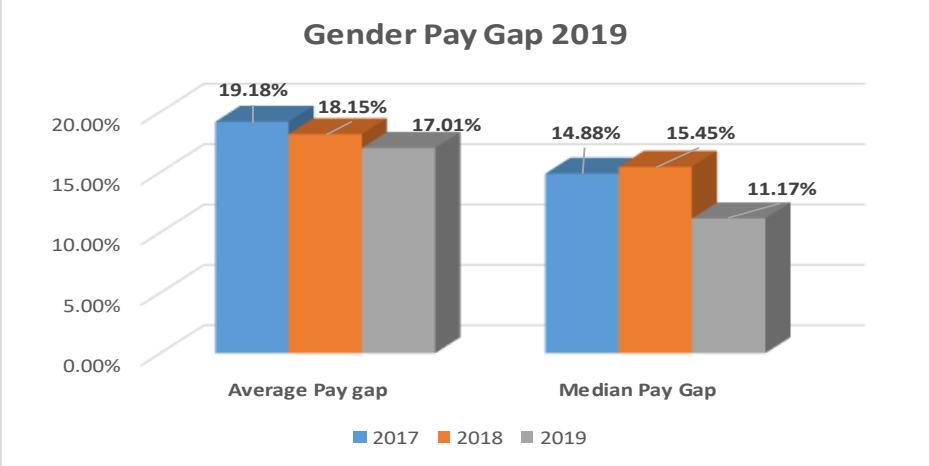
1.2 The GOSH People Strategy has the creation of an integrated Diversity & Inclusion Strategy as a key output in the first year of delivery,. The D&I strategy will develop a more embedded holistic response to the issues raised by the existence of a Gender Pay Gap.

1.3 Whilst both equal pay and the gender gap deal with the disparity of pay women receive in the workplace, they are two different issues:

- Equal pay means that men and women in the same employment performing equal work must receive equal pay, as set out in the Equality Act 2010.
- The gender pay gap is a measure of the difference between men's and women's average earnings across an organisation. It is expressed as a percentage of earnings and represents the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees

2.0 Gender Pay Gap

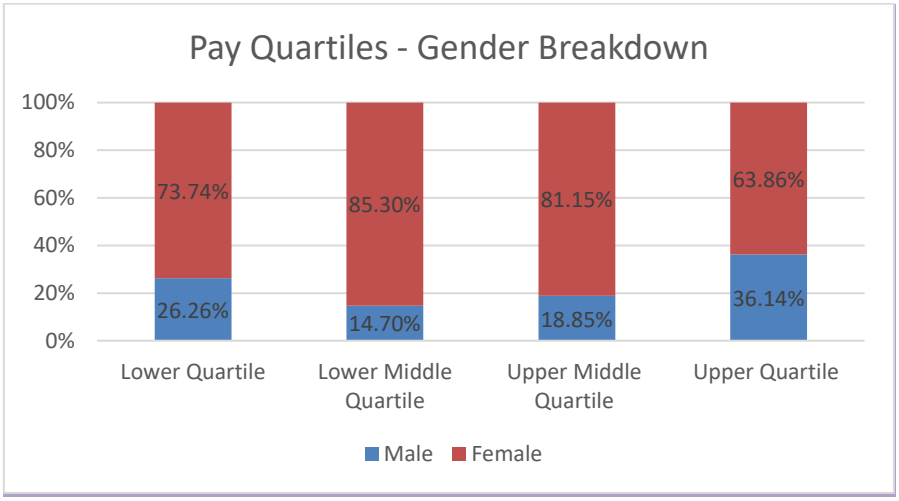
2.1 In common with many organisations (including NHS Trusts) GOSH has a gender pay gap. In 2019 the average pay for a male employee was £4.35 (17.01%) higher than the average female hourly rate. The median hourly rate gap was lower at £2.40 (11.17%) per hour. Both the average and median gap saw a reduction on the previous year.



2.2 Reasons for a pay gap are complex and driven by the traditional demographics of the healthcare workforce. For example the Nursing and Administrative & Clerical professions are predominately female, and women make up 77% of the overall Trust workforce.

	Female Headcount	Male Headcount	Total	Female	Male
Add Prof Scientific & Technical	218	72	290	75%	25%
Additional Clinical Services	412	109	521	79%	21%
Administrative & Clerical	789	410	1199	66%	34%
Allied Health Professionals	219	18	237	92%	8%
Estates & Ancillary	70	79	149	47%	53%
Healthcare Scientists	221	82	303	73%	27%
Medical & Dental	398	327	725	55%	45%
Nursing	1421	86	1507	94%	6%
Grand Total	**3748**	**1183**	**4931**	**76%**	**24%**

2.3 Whilst the GOSH pay quartile data shows that the highest percentage of staff across all pay quartiles are females, the highest proportion (relatively) of male staff are to be found in the highest pay quartile:



3.0 Medical vs. Non-Medical Gender Pay Gap

3.1 When considering the data at a more granular level it is clear the main driver for the gap at GOSH is the difference our consultant workforce makes on pay levels across the organisation.

3.2 Whilst we have a fairly equal number of men and women consultants (51% and 49% respectively), female consultants form part of a much larger population of women when looking at the gap at the organisational level (as the Trust is 77% female). Consequently their effect on female average pay is less than male consultant pay is on male average pay:

Gender pay gap (non-medical)		Gender pay gap (medical/dental)	
Mean	**Median**	**Mean**	**Median**
Men on a mean average earn 31p per hour more than women.	Women on a median average earn 75p per hour more than men.	Men on a mean average earn £3.51 per hour more than women.	Men on a median average earn £6.74 per hour more than women.
1.55%	-4.36%	8.52%	15.65%

Attachment Z

Trust Board 26 May 2020	
Guardian of Safe Working report **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment Z**

Aims / summary

This report is the fourth quarter report of 2019/20 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1st January to 23rd March 2020 inclusive.

Action required from the meeting

The Board is asked to note the report and the issues influencing junior doctor's working, including the change to COVID rotas on March 23rd 2020. The challenges in monitoring compliance with the TCS 2016 through the exception reporting system should also be noted.
Requirement for data cleansing with respect to understanding bank payments.

Contribution to the delivery of NHS Foundation Trust strategies and plans

The Guardian of Safe Working (GOSW) supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.

Financial implications

Publication of Amendments to the 2016 TCS which requires increased costings

- Due to the 5th nodal point addition to salary scale in 20/21 and estimated on costs
- Additional clinical workforce requirement due to limitation in hours

Continuing payment for overtime hours documented through the exception reporting practice

Who needs to be told about any decision?

n/a

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

Dr Renee McCulloch, Guardian of Safe Working, Associate Medical Director: Workforce
Mr Simon Blackman Deputy Medical Director for Medical & Dental Education

Who is accountable for the implementation of the proposal / project?

Dr Sanjiv Sharma, Medical Director

Guardian of Safe Working
Fourth Quarter: 1st January 2020 – 23rd March 2020

1 Purpose

To inform the board on issues arising relating to the junior doctors working at GOSH and the work of the Guardian of Safe Working (GOSW). The GOSW is directly accountable to the trust board.

2 Background

See Appendix 1

3 COVID Rotas

3.1 Rotas were switched to emergency COVID rotas on March 23rd 2020. See Appendix 2.

3.2 COVID rotas supported absence cover for 30% predicted reduction in junior doctor workforce, provided medical support for new cancer and general paediatric work and expansion in critical care capability.

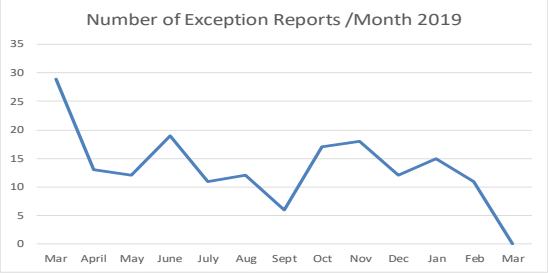
3.3 Involved:

- Rapid on boarding of 27 doctors (academics/ bank doctors)
- 17 doctors provided from across NCL

3.4 All rotas were compliant with TCS 2016 with 12.5 hour shift patterns; banded 1a.

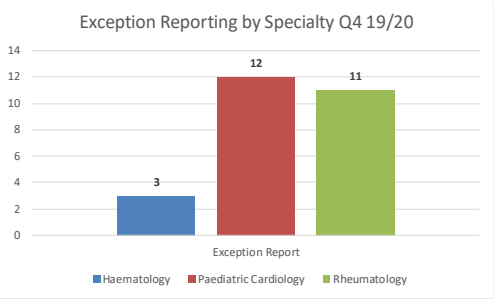
4 High Level Data

Number of exception reports (ER) at GOSH remain low reflecting cohort a) senior trainees b) non UK Trust doctors c) poor engagement with ER system



5 Numbers of doctors submitting reports down this quarter.

- 26 ERs submitted in this quarter
- 26 ERs are for extra hours worked.
- No reports submitted in March Likely due to focus on COVID pandemic



6 Exception Report Outcomes:

Outcome ERs January to March 2020	
Financial Compensation	26

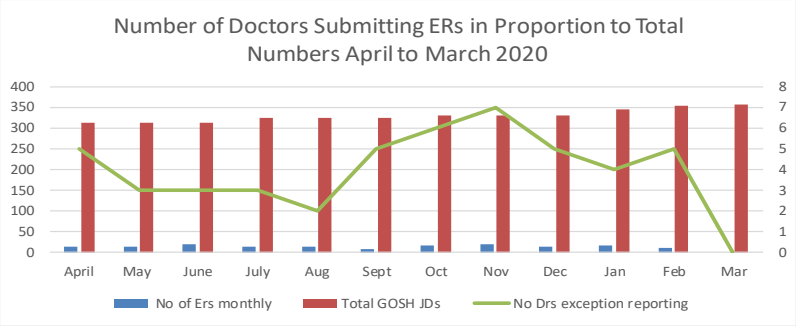
No fines have been levied – no known breaches for Health Education England (HEE) trainees

7 Exception Report Narratives:

- *'Covering Pelican ward inpatients, had to stay longer to finish jobs: arrange investigations for patients, chase results, document and prepare discharge summaries'.*
- *'Usual overtime. Short of one registrar in the pulmonary hypertension team for the last 3 months. First exception report'*
- *'Understaffed. One registrar instead of 2'.*
- *'Busy ward day with arranging multiple investigations and reviews, admission and the other inpatients'*

8 Exception Reporting Patterns:

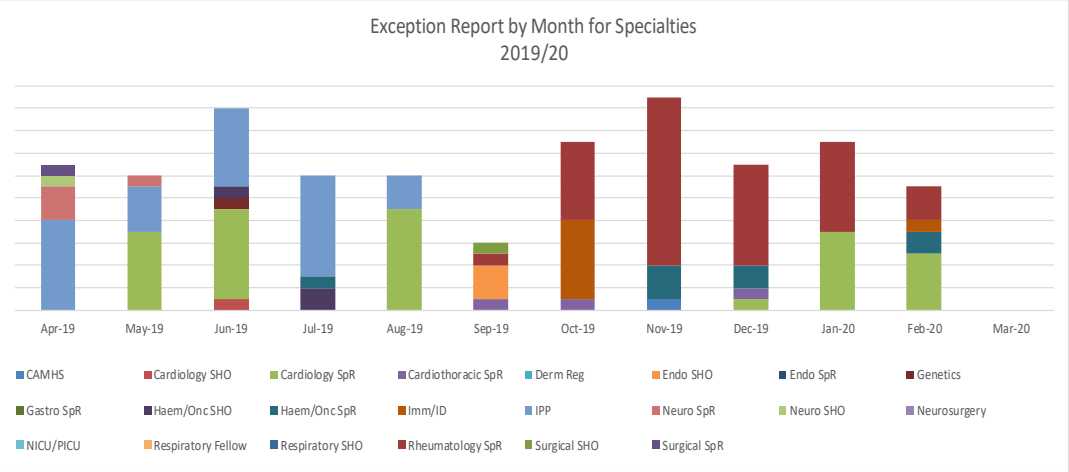
8.1 Six doctors used the exception reporting system between Jan and March



8.2 'Cluster reporting' is easily identifiable

Rheumatology reporting after discussions about work flow with the GOSW. Work schedule review requested. Business case in development for extra staff.

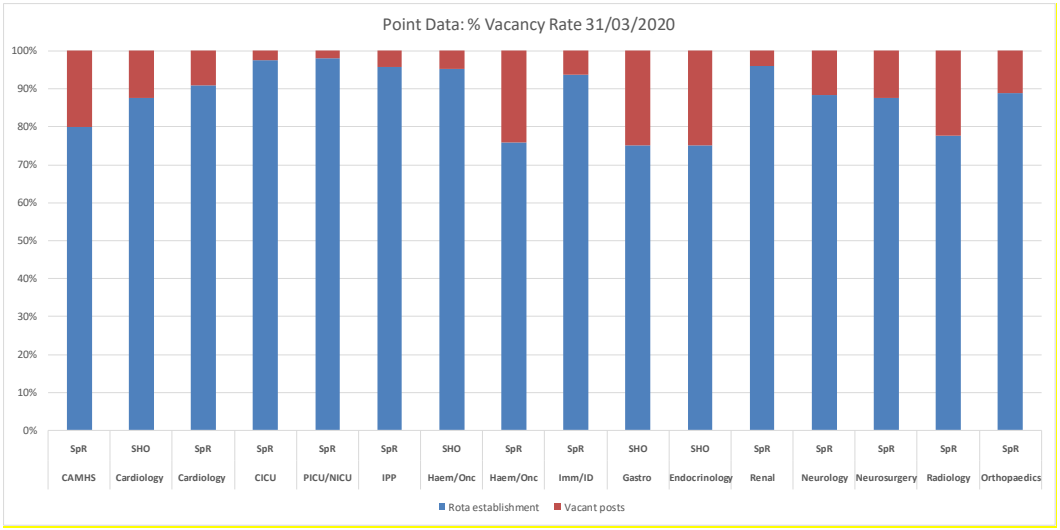
Pulmonary hypertension (cardiology) have one out of two fellows. Considering for advanced clinical practice post.



9 Vacancy Rates

9.1 Vacancy rates: overall vacancy rate across junior doctor rotas as of 22nd March 20 is 6.1% with 18.7 FTE vacant out of a total of 307 rota slots.

- Trust Doctors FTE as of 22nd Mar 20 = 223.6
- Training Doctors FTE as of 22nd Mar 20 = 118.3



9.2 GOSH vacancy rates fluctuate but in general remains less than the national average

9.3 32% rota gap in HaemOnc SpRs resulted from delays in the Medical Training Initiative (MTI) scheme via the Academy of Medical Colleges.

9.4 HaemOnc gaps have impacted directly on access to training and education opportunities and a significant bank spend.

9.5 Pulmonary hypertension (cardiology) remains a persistent gap

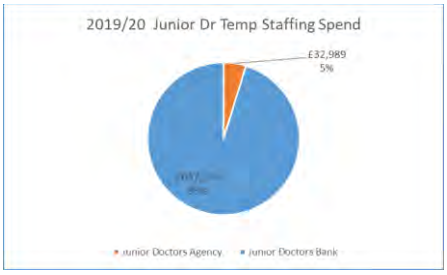
9.6 Radiology SpR gaps have required consultants to 'act down' to cover service requirements

9.7 Endo/ Gastro SHO reduced numbers result from lack of Health Education England placements.

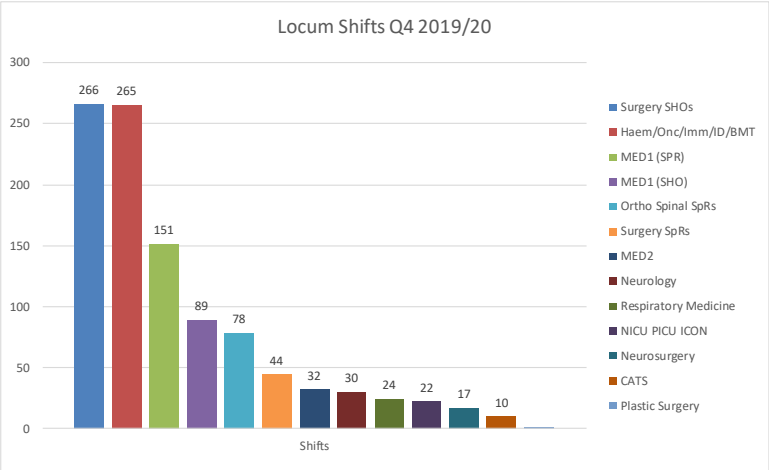
10 Vacancy Spend –with reference to rota

10.1 According to Finance data, the Trust spent £690,222 on Junior Doctor temporary staffing shifts in Quarter 4. Of this £32,989 (5%) related to agency shifts while the remaining £657,233 (95%) was for Bank hours.

10.2 Year to Date spend is £2.75 million (of which Agency spend was £90,049 (3.2%)



10.3 Whilst Finance data reports spend against cost centres rather than rotas, when looking at shifts booked across the rotas, the Surgery SHO rota accounted for the largest number at 266 (25.6% of the total) followed by Haem/Onc/Imm/ID/BMT at 265 (25.5%). Vacancy was given as the most common reason (80%) of bookings followed by Study Leave (7%), however further validation of the accuracy of booking reasons is required and will be addressed in 2020.



11 Exception Reporting Survey Dec 19 to Jan 202

11.1 64/ 330 (19.4%) Junior doctors responded to the survey which was open for 3 weeks.
11.2 50% of responders are employed on the 2016 contract
11.3 11 doctors had completed an ER at GOSH, 8 in other hospitals; the majority of ERs had been about hours worked.
- 48% were unfamiliar with the ER process; 21% quite or very familiar
  - 48/64 (75%) knew they could report when hours worked vary from agreed rota
  - 39/64 (61%) reported working extra hours on a daily or weekly basis
  - 36/64 (56%) reported having missed breaks
  - 31/64 (48%) reported missing educational opportunities

11.4 Issues that prevented reported included:
- 31/64 (48%) concern re negative impact on career or reputation
- 25/64 (39%) think ER will not lead to any change
- 18/64 (28%) ER creates too much work for others

11.5 Qualitative Comments:

- *I have never done an exception report as I don't feel supported by the team to do a report when we stay back for more hours. It is seen as a part of the job*
- *Breach most days but not daily (more than once weekly). Mostly clinical admin - letters, documentation.*
- *Whilst my Consultant are supportive in principle, Consultants cannot report and everyone stays late due to workload, not just the SpRs, so it feels unfair complaining about it when all my consultants had to work the same hours or more. If the SpR workload is cut this will only increase the load on the Consultant who are already overworked.*
- *I am not sure that the culture in the department actively encourages filling one*
- *Have actually never been shown where to do the exception reporting and the non-respect of hours is so common in our team, while exception reporting is never discussed.*
- *I expect to sometimes need to come in early or leave late - nobody puts pressure on me to do this, I choose to do so because I feel it is part of being a doctor*
- *I feel like unconsciously I assume the position of to some extent "sacrifice" my time because it is "accepted", also to "please" but mainly because I feel it is "my fault" that I have not finished my work load on time because I spend a lot of time talking and listening to families as well as playing with the kids. I think this is my responsibility but at the same time this is the kind of doctor I want to be*
- *Role modelling from seniors - they all stay late so it's the norm that we do; there was some talk initially when we started about leaving on time etc., but it's not backed up by action. Actually, we're increasingly being told that "we have it easy" compared to previous rotations and that "things are usually much worse"*
- *I don't think it's realistic to expect to clock off at a certain time every day. It doesn't happen in other jobs and I don't see why we should expect to drop everything and leave when someone is unstable and we need to stay to ensure safe care. I think it's ridiculous to complain about staying a bit late and prioritising patient care.*

11.6 On average 75% felt supported by consultants in their current role
11.7 Satisfaction with current role: 43/64 (67%) felt role was as good as or better than expected.

12 Compliance with 2016 TCS: Implementation of the New Amendments October 2019 – August 2020:

12.1 The implementation of the '5th nodal salary point' will result in a cost pressure at GOSH due to the seniority of many of our junior doctors. Cost pressure calculated at -£69,538.60 for 2020-21 and estimated at £570,232.95 from implementation 2020 to year end 2023
12.2 PICU/ CATs rotas are currently non-compliant for weekend frequency with planning to increase establishment for September 2020
12.3 Current rest facilities provide 'minimum standard' accommodation; costings for linen change has been addressed.
12.4 It is likely that new changes to safety and rest limits will attract GOSW fines if they are reported in the future
12.5 No fines have been levied with current ERs to date. Fines would only apply for the doctors on the 2016 TCS on formal training programs

13 Junior Doctors Forum

13.1 There have been two JDF meeting this quarter. March meeting was cancelled due to COVID meeting restrictions in place at the time. Prior to this JDF has been very well attended. The JD rep system is working well.
13.2 Communication systems (contact lists; ability to identify doctors on call and collaborate as teams out of hours) are the main area of concern.

14 Summary

14.1 The exception reporting process continues to be a challenge for monitoring the 2016 contractual obligations of the Trust as doctor's struggle with many aspects of reporting system including poor incorporation into medical culture and structures.
14.2 ER process requires more integration. Systems enabling regulation of response completion and payment time scales are currently being addressed by the GOSW and medical HR.
14.3 Exception reporting is currently highlighting issues relating to working hours in rheumatology and pulmonary hypertension.
14.4 Cost pressures will result from junior doctor salary rises in 20/21
14.5 Restrictions placed on rotas from contract refresh requiring establishment increases will also incur costs
14.6 Rota gaps continue to impact on working conditions for junior doctors.
14.7 Vacancy rates are directly impacted by the MTI and overseas medical recruitment 'pipeline' challenges.
14.8 Junior doctors are well engaged and the JDF invites the Board members to continue to attend its meetings.

Appendix 1 Background Information for Trust Board

In 2nd October 2017 all junior doctors in training transferred to the new contract with 2016 Terms & Conditions (TCS).

The 2016 TCS clearly indicate the importance of appropriate working hours and attendance at training and education for junior doctors. Both issues have a direct effect on the quality and safety of patient care.

The statutory role of 'Guardian of Safe Working' (GOSW) was introduced in the 2016 and includes;

- overseeing the safeguards outlined in the 2016 contract
- ensuring that issues of compliance with safe working hours are addressed by the doctors and/or the employer
- facilitating the reporting structures
- overseeing the wellbeing of the junior doctors
- a requirement to provide quarterly reports to Trust board.

Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

Exception reports are submitted electronically by doctors to their educational supervisor. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The outcome of an exception report may be compensation, in the form of time off in lieu or payment for additional hours worked, or an adjustment to the work schedule of the post.

Whilst exception reporting is a mechanism of the 2016 contract for doctors in training, GOSH has elected to extend the use of the system to doctors employed under local (non-training) TCS, in order to encourage safe working practices for all doctors, provide equity and obtain a more comprehensive view of junior doctors working hours across the Trust.

The 2016 contract requires that a Junior Doctors Forum (JDF) is established in every Trust. The JDF primarily represent trainees and offers a forum for addressing concerns pertaining to working hours and conditions and education and training. This is in place and meets every month.

There are 45 different rota patterns currently in place within the Trust.

The Trust uses 'Allocate' software for rota design and exception reporting. There have been issues with navigation of software and consistency of use (wide range of inputs for the same exception reports). There are no automated ways to identifying breaches. This must be done manually.

Allocate have improvement updates due in 2019 to include:

- Ability to close exception when trainee fails to respond (Jan 2020)
- Guardian quarterly board data report (not yet available)
- Simplify the adding of overtime hours
- Process for tracking time of in lieu and overtime payments
- Allow supervisor and Guardian role for the same user
- Standardised themes for breach types.

Publication of Amendments 2016 TCS September 2019:
Context for 2018 contract review

The new junior doctor contract was introduced in England without the BMA's agreement in 2016. The intention of the negotiations on this new contract was to introduce for doctors in training new, improved safe working arrangements, more support for their education and a new modernised pay system. The BMA and NHS Employers agreed during negotiations on this contract to jointly commission in August 2018 a review of its efficacy, to identify any areas for improvement to the contract terms. In 2019 a new referendum of the BMA Junior Doctor membership accepted the 2016 contract, including the amendments that have been negotiated.

TCS contract includes but is not limited the following amendments:

a. Weekend frequency allowance maximum 1:3
b. Too tired to drive home provision
c. Accommodation for non-resident on call
d. Changes to safety and rest limits that will attract GoSW fines.
e. Breaches attracting a financial penalty broadened to include:
    1) Minimum Non Resident overnight continuous rest of 5 hours between 2200-0700
    2) Minimum total rest of 8 hours per 24 hour NROC shift
    3) Maximum 13 hour shift length
    4) Minimum 11 hours rest between shifts
f. Exception Reporting
    1) Response time for Educational Supervisors - must respond within 7 days. GoSW will also have the authority to action any ER not responded to
    2) Payment must be made within 1 month of agreement or on next available payroll. No extra admin burden should occur
    3) Conversion to pay - 4 week window from outcome agreed to identify a shift before the end of the placement for TOIL to be taken. If this doesn't happen, payment should automatically be given. At the end of a placement, any untaken TOIL should be paid
g. Time commitment and administrative support for GOSW.

Implementation of New Amendments 2016 TCS

The 'refresh' requirements for the 2016 contract is in progress at GOSH –a staggered timeline is in place for implementation to be completed between October 2019 and August 2020.

Attachment Z

Appendix 2:

COVID – 19 Medical Rota Proposal

GUIDING PRINCIPLES
• **Maintain safety of patients and staff**
• **Collaborative working across departments**
• **Wider situational awareness for risk assessment allowing informed and timely decisions**
• **Prioritisation of patient need**
• **Prioritisation of 24/7 clinical cover – pan Trust oversight**
• **Deployment based on clinical capability rather than current role**

The underlying approach to the COVID 19 clinical workforce planning has included:

- Planning must accommodate an unknown patient and staff demographic; we must be responsive and adaptable with structures in place to support rapid change
- Staff wellbeing is paramount – all rotas will have contingency staffing factored in to provide 30-50% back up on days and nights should someone call in sick/ be unable to work. Rotas will also have rest days that will be respected.
- All rotas will run 12.5 hour day and night shifts
- Depth and breadth of clinical workforce will need to be activated to ensure sharing of responsibilities
- Education and training will be delivered in parallel with upskilling /refreshing of staff skills and as an ongoing programme.
- We are ready to review, change and refine these plans as needed

In order to safely staff the trust in the face of potential staff shortages Workforce Bronze proposes the following structure.

Classification of Medical Staff

Doctors in the trust will be classified into the following categories:

Tier 3: Expert Clinical Decision Makers	Clinicians who have overall responsibility for patient care: consultants as well senior registrars / fellows who can 'act –up'
Tier 2: Senior Clinical Decision Makers	Medical & surgical registrars/CSPs/ ACPs: clinicians who are capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatments

Tier 1: Competent Clinical Decision Makers	Clinicians who are capable of making an assessment of the patient: includes SHOs (ST1-3); ANPs; CNS; ACPs*; redeployed clinicians

Note that these categories are context specific; so surgical registrar may, for example, be able to work at Tier 2 in their own specialty but at Tier 1 whilst covering medical patients. Following a review of ACP competencies in the trust by the Education Team, we have concluded that ANPs not currently on medical rotas will not be able to act above Tier 1. Some CNSs may be able to work at Tier 1 in their clinical areas, but this must be balanced against the potential need for them to support the nursing workforce.

The trust will have 5 rotas to maintain critical services and provide emergency provision

1. Specialist Medicine
2. Acute Surgery
3. Haematology, Oncology and BMT
4. Critical Care
5. Pelican (COVID-19), whilst these patients remain cohorted

All junior doctors on these rotas will be asked to work 12.5 hour shifts. We have used a survey to identify those doctors with critical care skills who could be offered training to move into critical care roles. The junior doctor workforce will then be classified into the following categories:

- Tier 2 Medical
- Critical care competent or competent following training
- Haem/Onc/BMT with EPIC Beacon training
- Tier 2 Acute Surgery
- High dependency Competent
- Tier 1

The individual rotas will be run as follows

Medicine - Clinical Leads tbc

This rota will provide staffing for critical inpatient work which needs to continue despite restrictions to elective activity, for example critical inpatient infusions. Please note that we think this work will continue to delineate a weekday vs. weekend day differentiation which has been accommodated. Most of the inpatient specialist medicine work will be provided by specialty consultants with support from the tier 2/1 pool.

This rota will provide:

Weekday	12 x Tier 2
	12 x Tier 1
Weekend day	8 x Tier 2
	8 x Tier 1
Nights	4 x Tier 2

4 x Tier 1

This rota is designed with 4 x doctors on backup days and 2 x doctor on backup nights, which provides 50% contingency at night and 30% during the day. This rota will require 42 doctors to run from our current establishment of 48.7 at Tier 2, leaving us some contingency and the opportunity to redeploy some doctors to other areas.

Acute Surgery – Clinical Lead Simon Blackburn

The emergency surgery service will be staffed by Tier 2 Acute Surgery doctors, who will principally be those with general paediatric surgery experience, on the basis that reduced elective activity will significantly reduce patient numbers, in plastics, orthopaedics, urology and ENT.

The rota will provide:

Daytime	2 x Tier 2 Acute surgery
	2 x Tier 1
Nights	2 x Tier 2 Acute surgery
	1 x Tier 1

Additional cover will be required to run any elective lists which will be operating during this period. It is recommended that any elective lists are staffed by two surgical consultants

Specialty cover will be provided at Tier 3 by the Consultants.

Neurosurgery and Cardiothoracic Surgery represent critical urgent care services and their rotas will remain as they currently run. Contingency arrangements will need to be made to allow for potential staff sickness on these rotas.

Haematology, Oncology, Immunology, ID & BMT (Blood Cells Cancer rota) – Clinical Lead Lynne Riley

An increase in demand for these services is anticipated. Current staffing numbers are low. In order to meet the demand of this rota given the reduction in staff due to sickness, doctors from the Tier 2 pool will be redeployed and trained to deliver services via EPIC Beacon. These doctors will be offered additional induction and training during the week beginning 16th March.

This rota will provide:

Weekday

Haem	2 x Tier 2, 1 x Tier 1
Onc	2 x Tier 2, 1 x Tier 1
BMT	4 x Tier 2. 1 x Tier 1
Safari	2 x Tier 2, 3 x Tier 1

Weekend day	3 x Tier 2, 3 x Tier 1

Nights	2 x Tier 2
	2 x Tier 1

Pelican (COVID – 19) – Lead Karyn Moshal

This rota will be supported by the BCC rota and offered whilst patients with COVID-19 continue to be cohorted on Pelican. This rota will require

Day	1 x Tier 2 1 x Tier 1
Night	1 x Tier 21 x Tier 1

Critical Care – Clinical Lead Andrew Jones

Staffing to allow 70 critical care beds to be achieved according to PICC standards can be delivered from existing staffing without allowing for sickness. This rota will be supported by provision from anaesthesia, with middle grade staff released by a decrease in elective activity. This workforce will be supplemented by other doctors with critical care experience who can act at Tier 2 with additional training.

The cardiology registrars will remain on their current rota with the cardiology fellows who are not on the current rota being drafted onto a 12.5 hour rota pattern.

Education Needed

ITU induction & training for doctors new to the system.

EPIC training for anaesthetic doctors rotating to ITU

EPIC Beacon training for those doctors joining Haem/Onc BMT

Staffing Hub

A staffing hub is being established by HR. This will need significant oversight by the clinical teams within each area. Success depends on knowledge of the skill set of the clinicians and a clear administration and communication process.

We suggest that the hub convenes on a daily at the end of the working day in order to confirm plans for the following 24 hours

Staff Wellbeing

The wellbeing of the clinical staff is paramount to the delivery of sustainable, quality care. We want to develop and deliver a wellbeing strategy which includes: a process that checks in on our staff who are self-isolating or are unwell; those who are far away from home and those who are feeling most vulnerable. This is the first time our generation have been faced with a work related mortality risk and we need to listen and respond to their fears and concerns.

Attachment Z

Executive Summary

- This paper summarises progress to the year end 31 March 2020 in providing assurance that junior doctors at Great Ormond St Hospital (GOSH) are safely rostered and enabled to work hours that are safe and support training and education opportunity. It describes the exception reporting (ER) experience, rota gaps and vacancies for junior doctors across the Trust and some of the actions taken to address them.

- There is an ongoing need to evolve robust medical workforce data on absence rates, rota gaps and vacancy rates alongside financial tracking of bank spend. Without improved data intelligence the Trust risks being unable to fully understand the dependencies and requirements of the junior medical workforce.

- Compliance with 2016 TCS: Implementation of the New Amendments October 2019 is underway.

    - Critical care rotas breach compliance on weekend frequency and will require an increase in establishment to achieve compliance.

    - Rest facilities have improved in 2019/20 with increased number of rooms available and financial support with enhanced furnishings from Department of Health rest and facilities grant

    - The implementation of the 5th nodal salary point' will result in a significant cost pressure at GOSH due to the seniority of many of our junior doctors.

- Exception reporting (ER) requires more integration and is a risk for monitoring assurance and compliance with 2016 contractual obligations of the Trust as doctor's struggle with many aspects of the reporting process. Integration into medical culture and systems enabling process regulation are currently being addressed by the GOSW and medical HR.

- GOSH vacancy rate has varied between 6.8 and 12.7% over 2019/20 and continue to be below the national average

- No fines have been levied with current ERs to date. Fines would only apply for doctors on the 2016 TCS on formal training programs (35% of GOSH junior medical workforce). All doctors at GOSH can ER.

- Junior Doctor 24/7 (JD24/7) task finish group (Feb to Sept 2019). Interdisciplinary group led by the GoSW reviewed models of out of hours working and rota systems in GOSH with a focus on specialist medicine to improve patient and doctor safety. The report published in July 2019 made several recommendations and implemented whole system rota structure changes across eleven specialities.

- The modernising clinical workforce committee is delivering ongoing improvement recommendations made by the JD24/7 group including developing medical workforce dashboard and an advanced clinical practice and Shape of Training strategy

Attachment Z

GOSH Guardian of Safe Working Annual Trust Board Report April 1st 2019 to March 23rd 2020

1. Purpose

This paper provides assurance to the Board on progress being made to ensure that doctors working hours are safe for the year ending March 2020.

The Board is asked to report information on rota gaps and the plan for improvement in the Trust's Quality Account and publish the details of Guardian fines in the Trust's annual accounts.

2. Introduction

2.1. The 2016 Terms and Conditions of Service (TCS) clearly indicate the importance of appropriate working hours and attendance at training and education for junior doctors. Both issues have a direct effect on the quality and safety of patient care. There is increasing recognition on the effect of rota gaps on junior doctor training and wellbeing.

2.2. The 2016 TCS set firm limits to the number of hours trainee doctors can spend on duty and provided a process for:

- reporting safety concerns in the workplace which reach senior management level
- trainees to record if they worked beyond their scheduled hours
- fining departments directly for the most serious breaches of working hours
- providing work schedules to doctors before starting a job and in more detail than previously
- trainees to inform if they are not able to attend education and training opportunities
- the establishment of a junior doctors forum (JDF) to discusses work and training issues

2.3. The contract also requires that every Trust has a Guardian of Safe Working (GoSW), a senior appointment who ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and provides assurance to the Board of the employing organisation that doctors' working hours are safe.

3. Publication of Amendments 2016 TCS September 2019:

The British Medical Association and NHS Employers agreed during negotiations on the 2016 contract to jointly commission (in August 2018) a review of its efficacy, to identify any areas for improvement to the contract terms. In 2019 a new referendum of the BMA Junior Doctor membership accepted the 2016 contract, including new amendments that have been negotiated.

4. Implementation of 2019 New Amendments to 2016 TCS: Headlines

4.1. The contract 'refresh' requirements for the 2016 contract is in progress at GOSH –a staggered timeline is in place for implementation to be completed between October 2019 and August 2020. Every rota has been checked and amended for compliance to new regulations. It is likely that safety and rest limits, and the challenges for taking leave, will impact on the requirements for medical staffing in 2020/21.

4.2. All GOSH rotas have been line checked and updated for compliance with new amendments

4.3. PICU/NICU/CATS rotas are now non-compliant following the 2016 TCS refresh. This is due to the change in weekend frequency allowance (now a maximum of 1:3 PICU/NICU/ CATS are 1:2.5- 1:2.7). GOSW and JDF have approved the rotas on the basis that rota compliance is achieved by September 2020

4.4. Access to rest facilities have been improved however a more permanent solution is required

4.5. The implementation of the '5th nodal salary point' will result in a significant cost pressure at GOSH due to the seniority of many of our junior doctors.

4.6. It is likely that changes to safety and rest limits will attract GOSW fines

4.7. GOSW is restructuring the current exception reporting (ER) process with the amendments from 2019 refresh. These will be rolled out by August 2020. Areas for improvement are educational supervisor response time and time to payment.

5. Patient Safety

5.1. During 2019/20 there have been no actual and immediate safety concerns reported directly through the exception reporting ER system (several have been created in error).

5.2. The Junior Doctors 24/7 'round-the-clock' (JD24/7) task and finish group was commissioned by Medical Director in response to issues raised through the Guardian of Safe Working in December 2018. The interdisciplinary group reviewed models of working and rota systems in GOSH with a focus on out of hours work to improve patient and doctor safety. The report published in July 2019 made several recommendations and implemented whole system rota structure changes across eleven specialities.

5.2.1. Positive changes included:

- New medical rotas: increased registrar night cover
- Increased establishment numbers in Haematology/ Oncology rota
- Rotas designed to accommodate junior doctors annual and study leave however flexibility remains limited on some rotas
- New general manager supporting cross organisational rota support
- Definition and implementation of an escalation pathways for known and unknown rota gaps in medicine.

5.2.2. JD24/7 recommendations integrated into a wider Trust project delivered through the modernising medical workforce committee:

- Improving communication platforms (specifically out of hours) and handover systems
- Consideration of centralisation of rota coordinators
- Rota gap escalation processes to be formalised across all specialities.
- Future proofing: accurate and up to date data dashboard within governance and performance pathways to enable the medical workforce to be optimally managed in a responsive and safe way
- Developing an advanced clinical practice and Shape of Training strategy

5.3. It is known that basic administrative and clinical tasks can negatively affect patient safety and quality of experience by detracting from time available for tasks that specifically require doctors. Implementation of an electronic patient record 'Epic' introduced in April 2019 may have improved some of the burden of administrative tasks undertaken by Junior Doctors although the impact of Epic on Junior Doctor working is yet to be fully evaluated.

5.4. **Rest provision** contributes to safe patient care by ensuring staff are making safe effective decisions. The 2016 TCS mandates the provision of adequate rest facilitates or alternative arrangements for safe travel home and includes provision of accommodation for non–resident on call and those 'too tired to drive home'. GOSH has increased bed availability on site from 12 to 21 beds. Rest facilities are currently housed on an unused ward. The facilities have received some upgrading supported by the 2019 Department of Health facilities fund (£60k) to support the BMA/ NHS 'Fatigue and Facilities Charter'.

Current rest facilities provide adequate accommodation although costings and logistics to develop permanent rest facilities for junior doctors are required.

5.5. **Reconfiguration of the JDF** to include junior doctor's representative role in each directorate management team and access to leadership training has improved engagement. Engagement of doctors is directly linked to improved quality and safety outcomes, reducing clinical error and mortality rates.

6. COVID-19 Medical Workforce Preparedness

6.1. GOSH COVID-19 pandemic response included all junior doctor rotas being switched to emergency COVID rotas on March 23rd 2020. GOSH COVID rotas accommodated the requirement for a flexible, sustainable workforce to ensure patient safety during rapid change.

6.2. Rapid on boarding of 27 doctors (academics/ bank doctors) and 17 doctors provided from across NCL (supported through memorandum of understanding) was undertaken. All COVID rotas were compliant with TCS 2016 with 12.5 hour shift patterns; banded 1a.

6.3. COVID rotas were devised on the following principles:

- Maintain safety of patients and staff
- Collaborative working across departments
- Wider situational awareness for risk assessment allowing informed and timely decisions
- Prioritisation of patient need
- Prioritisation of 24/7 clinical cover – pan Trust oversight
- Deployment based on clinical capability rather than current role

6.4. The underlying approach to the COVID-19 clinical workforce planning included:

- Planning must accommodate an unknown patient and staff demographic; we must be responsive and adaptable with structures in place to support rapid change
- Staff wellbeing is paramount – all rotas will have contingency staffing factored in to provide 30-50% back up on days and nights should someone call in sick/ be unable to work. Rotas will also have rest days that will be respected.
- All rotas will run 12.5 hour day and night shifts
- Depth and breadth of clinical workforce will need to be activated to ensure sharing of responsibilities
- Education and training will be delivered in parallel with upskilling /refreshing of staff skills and as an ongoing programme.

6.5. All doctors in the Trust were reclassified into:

- *Tier 3: Expert Clinical Decision Makers* Clinicians who have overall responsibility for patient care: consultants as well senior registrars / fellows who can 'act –up'
- *Tier 2: Senior Clinical Decision Makers* Medical & surgical registrars/ CSPs/ ACPs: clinicians capable of making a prompt clinical diagnosis and deciding the need for specific investigations/ treatments
- *Tier 1: Competent Clinical Decision Makers*: Clinicians capable of making an assessment of the patient: includes SHOs (ST1-3); ANPs; CNS; ACPs*; redeployed clinicians

6.6. Support, adaptation and responsiveness from the junior doctors to accommodate rapid rota and role change has been exceptional.

7. Work Schedules

7.1. NHS employers mandate that doctors in training should receive schedules of work that are safe for patients and safe for doctors and should be finalised and available 8 weeks prior to commencement of the new post. Med1 and Med2 work schedules were delayed for two weeks for September 2019 medical registrar cohort due to rota improvement work. Formal notification of deferment was sent from GoSW.

7.2. Notification of the essential information regarding rotational posts can be delayed from Health Education England and impact on work schedule deadlines.

7.3. Working patterns of doctors in training are significantly influenced by rota gaps and changes in service requirements which in turn effects access to training and educational opportunities. This has been the case with the impact of delayed international medical graduate recruitment due to issues relating to Medical Training Initiative scheme causing rota gaps in haematology and oncology September 2019-March 2020 with trainees reporting missed educational opportunities.

7.4. Content of work schedules is not standardised and can be highly variable, often not reflecting the reality of the post. GOSW aims to work with PGME to improve work schedules for junior doctors across the Trust. Intention is that work schedules will accurately reflect work flow across departments accounting for clinical administrative time, patient facing clinical work and education and training opportunities.

7.5. Currently work schedule review is requested for rheumatology specialist registrar trainees.

8. High level Data* as of 22nd March 2020 (pre COVID rotas)

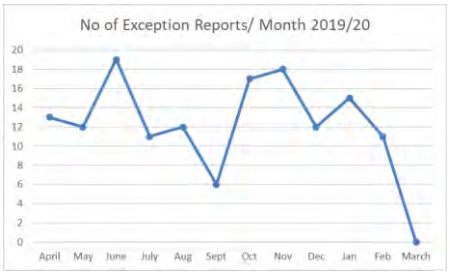
Number of trust doctors	223.6
Number of training doctors	118.3
Number of vacant unfiled posts	18.7 out of a total of 307 rota slots (6%)

*Numbers indicate full time equivalent posts

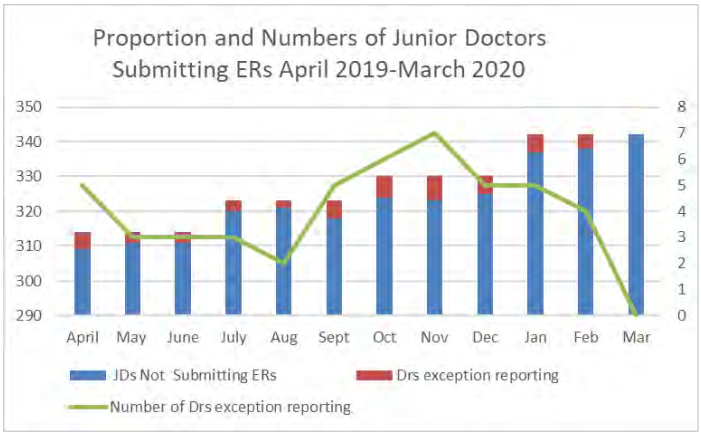
9. Exception Reporting

9.1. Exception reporting (ER) is the mechanism by which doctors are able to report safety concerns in the workplace and as such GOSH enables both Health Education England (HEE) trainees and non-training (trust) grade doctors to exception report at GOSH. All GOSH junior doctors can receive either financial compensation or time off in lieu for additional work performed if either preauthorised or when validated by a clinical manager.

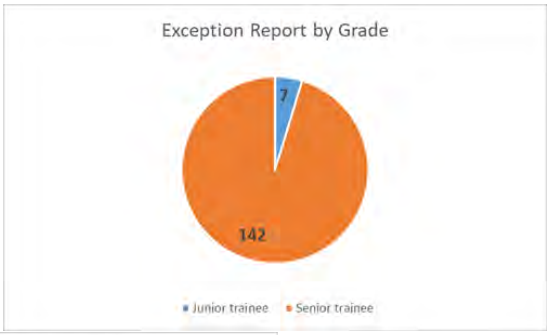
9.2. In 2019/20 GOSH received 149 exception reports submitted by a total of 31 individual doctors. There are no ERs from March 2020, likely due to COVID pandemic disruption, however there is an overall reduction from 227 reports submitted by 46 doctors in 2018/19

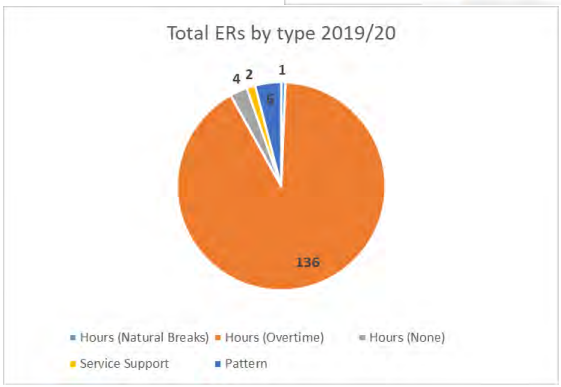


9.3. Presented monthly less than 2% of the junior doctor workforce are submitting ERs. This is a very small proportion of doctors but aligns with the national knowledge and our local ER survey in January 2020.

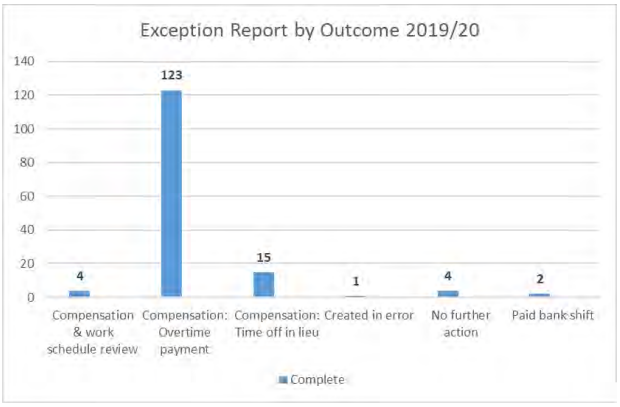


9.4. The majority of ERs are related to additional hours work and submitted by senior Trust grade (non-training) doctors.



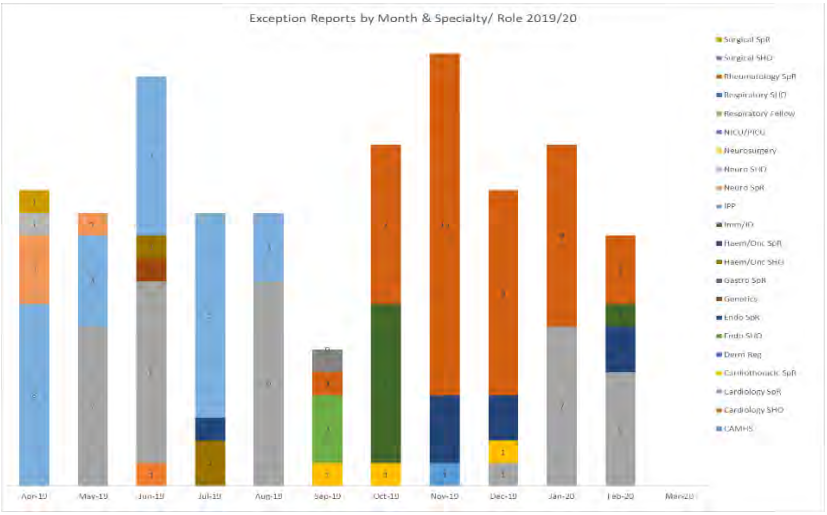


9.5. Most ERs resulted in financial compensation. One doctor has an outstanding work schedule review



9.6. No fines have been levied with current ERs to date. Fines would only apply for the doctors on the 2016 TCS.

9.7. ERs have been presented by multiple specialties. Variation in reporting patterns are seen through the year. Incidence of reporting can be seen in some specialities that have experienced vacancies (IPP and cardiology/ pulmonary hypertension) with subsequent high volume work flow resulting in additional hours. Rheumatology experience high work volume and after consultation with GoSW agreed to submit exception reports to formally record additional working hours and understand work flow. Rota gaps do not necessarily correlate with reporting – for example a 30-40% reduction in baseline establishment in haematology/oncology is not reflected in ER.



9.8. In **January 2020 an exception reporting survey** of GOSH junior doctors received a total of 64 responses

- 64/ 330 (19.4%) Junior doctors responded to the survey which was open for 3 weeks.
- 50% of responders are employed on the 2016 contract
- 11 doctors had completed an ER at GOSH, 8 in other hospitals; the majority of ERs had been about hours worked.

- 48/64 (75%) knew they could report when hours worked vary from agreed rota
- 39/64 (61%) reported working extra hours on a daily or weekly basis
- 6/64 (56%) reported having missed breaks
- 31/64 (48%) reported missing educational opportunities

Things that prevented reported included:

- 31/64 (48%) concern re negative impact on career or reputation
- 25/64 (39%) think ER will not lead to any change
- 18/64 (28%) ER creates too much work for others

9.9. The themes of these results mirror the JD survey in 2018 (with 131 respondents; 48% JD response rate) although the number of respondents is significantly reduced.

9.10. In line with the 2018 survey, the recent January 2020 survey and GOSH ER data strongly suggests that overworking is common and is an element of reporting that only a few doctors are comfortable with. The survey and data also indicates that junior doctors are missing breaks and education and training opportunities and do not report these issues through the ER system.

9.11. GOSH 2018 and 2010 survey results reflect described patterns of ER across the country. There is generally less recording from senior doctors in training. The majority of the GOSH JD workforce is senior (>ST6) and has proportionally less training doctors than most hospitals (currently 35% training grade doctors).

9.12. GOSH experience and 2018 and 2020 survey results strongly indicate that the ER system is not being used for reporting lack of rest and natural breaks and poor access to education and training opportunities.

9.13. As doctors who have trained under the new contract move through the system, higher levels of exception reporting are anticipated with improved engagement in the process

9.14. Tracking ER process and outcomes has been challenging but is now mandated within strict timeframes within the 2019 contract refresh. A structured and responsive system, including rapid escalation for those doctors on rotas with known gaps and monitoring of TOIL, is being implemented by GoSW for August 2020.

9.15. Welcome software updates include the ability to edit and close the ER by the GoSW were introduced from January 2020.

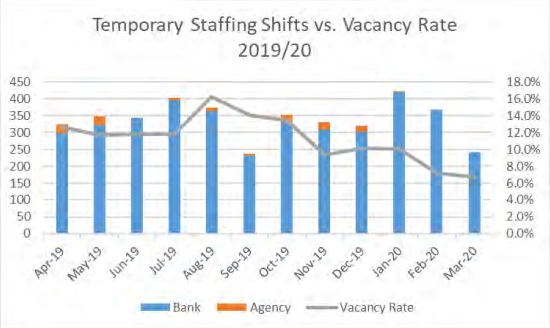
9.16. GoSW or deputy attends induction of junior doctors to discuss ER process. Ongoing education of educational supervisors and junior doctors is required to embed ER in medical culture.

10. Rota Gaps and Vacancy Rates

10.1. GOSH vacancy rate has varied between 6.8 and 12.7% over 2019/20 (slightly increased from 2018/19; range 5.3-11.4%) but continues to sit below the national average. According to the Royal College of Paediatrics and Child Health national vacancy rates are 14.6% on senior (registrar) rotas and 11.1% at junior (SHO) level [Workforce census overview 2017 (published 2019)] https://www.rcpch.ac.uk/resources/workforce-census-uk-overview-report-2019#introduction

10.2. Vacancy rates and rota gaps reflect the end point of multiple workforce issues including:
- short term unplanned absence

- delays in recruitment process, particularly timeframes for on boarding international medical graduates
- long term structural rota problems and complex interdependencies
- variations in numbers of trainees sent to the Trust by the deanery
- national reduction in the medical paediatric workforce.



10.3. Rota gaps have been highlighted as an organisational pressure. Measures are being taken to mitigate the situation at GOSH include:

- disbanding a rota that had significant gaps as it was difficult to recruit to and retain doctors on
- applying equitable out of hours working principles to the medical workforce, increasing the number of doctors who are able to provide out of hours support
- establishing minimal numbers of doctors required to safely staff speciality areas
- devising new rotas that factor in minimum doctor numbers and hours for annual and study leave
- definition and implementation of an escalation pathways for known and unknown rota gaps in medical specialities
- allocating managerial oversight providing cross organisation rota coordination and support
- monthly organisational monitoring of recruitment time frames and anticipation of/ planning for rota gaps

11. Fines

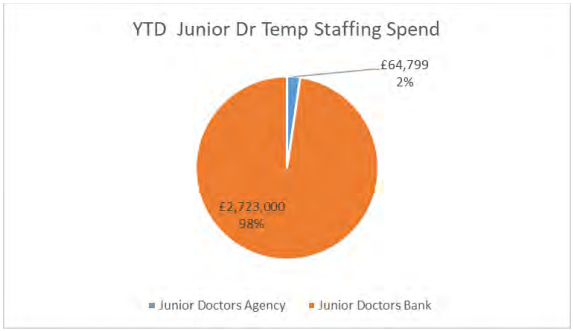
11.1. To date the GoSW has not levied any fines. Fines only apply to training grade doctors. ERs in 2019/20 have been mostly submitted by Trust doctors.

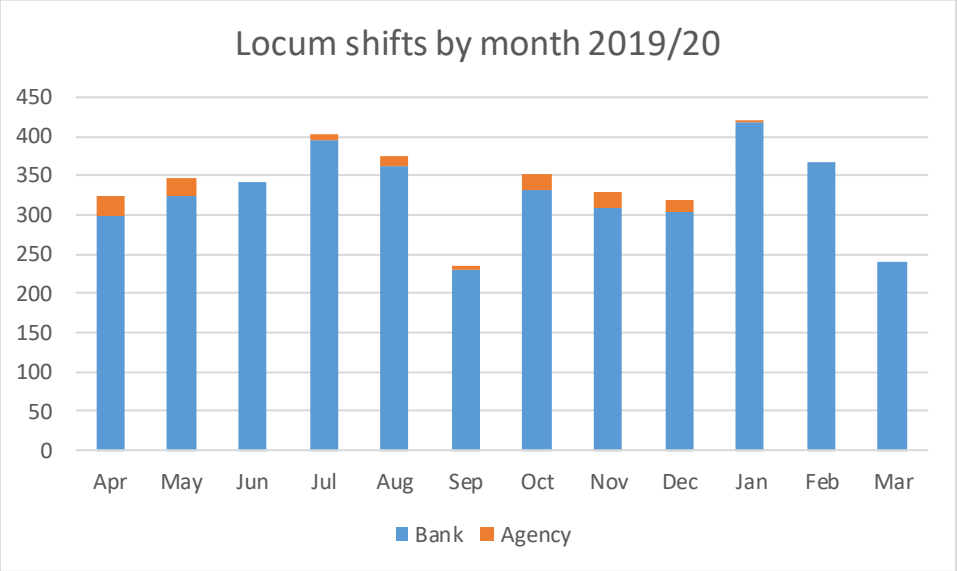
11.2. Current ER system does not automatically identify breaches as the system is dependent on the doctors to report breaches which, as seen from the survey and the ER data, they are often reluctant to do.

12. Bank Hours

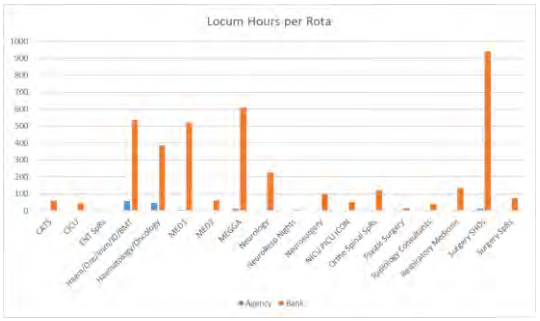
12.1. Bank shifts are filled 'in house' as opposed to locum agencies. There is significant reliance on internal 'bank' locums to cover both short and long term gaps in junior medical staff rotas across the Trust.

12.2. Year to Date spend is £2.79 million (of which Agency spend was £64,799 (2%)



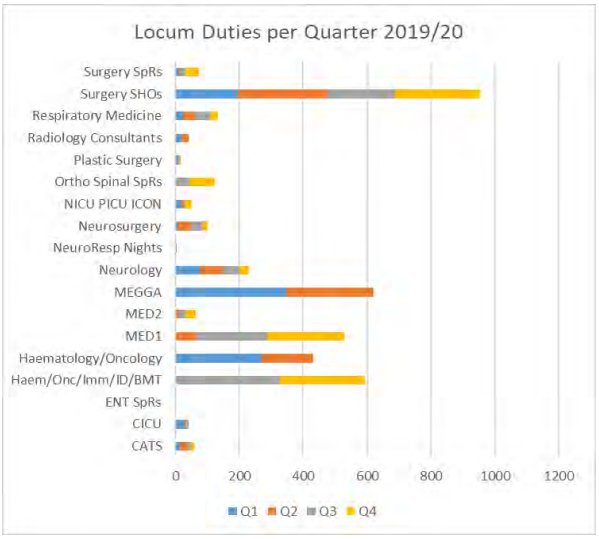


12.3. NHS employers are offering ongoing work to enable greater clarity within the 2016 terms and conditions of service to reflect process for undertaking locum work. If trainees wish to do work additional to their work schedule they must be aware of breaching safe working hours. Doctors themselves have a responsibility and duty of care for regulating their own hours of working, in addition to the organisation. Some organisational oversight is achieved through the rota coordinators. However, more robust systems and guidance are required.



12.4. Whilst Finance data reports spend against cost centres rather than rotas, when looking at shifts booked across the rotas, the Surgery SHO rota accounted for the largest number (25.6% of the total) followed by Haem/Onc/Imm/ID/BMT at (25.5%). Vacancy was given as the most common reason (80%) of bookings followed by Study Leave (7%), however validation of the accuracy of booking reasons is required and will be addressed in 2020.

12.5. Further analysis of speciality areas requiring locum shifts is required. Consideration for innovative ways to provide clinical support is being considered.



13. Junior Doctors Forum (JDF)

13.1. The JDF was first established in spring 2017. Theoretically there is a requirement for every speciality rota to be represented at each meeting. In 2018 a new monthly JDF was created, merging the DocsReps Committee and the statutory JDF to improve attendance. The meeting is currently split into two sections: the first being related to junior doctor events and discussions, the second attended by senior colleagues including the Director of Medical Education, Post Graduate Training Centre representatives; Local Negotiating Representatives and co-chaired by the GoSW and the JDF President.

13.2. Junior medical staff are now represented as 'JDF Reps' in each directorate attending management meetings and having access to extended leadership training.

13.3. Junior medical staff also played a key role in the EPIC launch, April 2019 with many shaping clinical functionality and acting as 'EPIC super-users' supporting and training others.

13.4. General engagement with the junior doctors across the organisation is good. Improvement in new messaging platforms, such as the new Office 365 teams is likely to reach more junior medical staff and enable better communication.

14. Matters for the Board:

14.1. Significant achievements to date with respect to collaborative working between the junior doctor workforce and the GoSW/ PGME team.

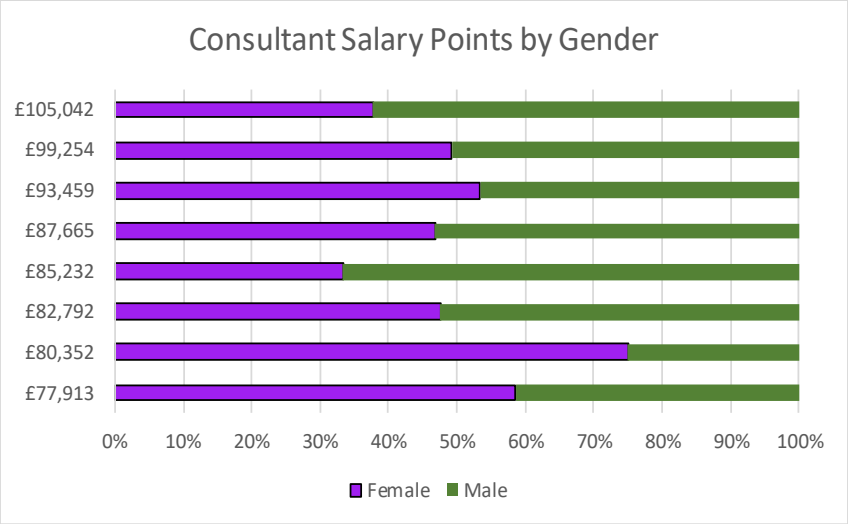
14.2. Ongoing consideration of financial risk associated with junior medical workforce costings including 5th nodal point and likely requirement to increase clinical workforce to ensure rota compliance.

14.3. Understanding of risk related to poor compliance assurance offered by the exception reporting system

14.4. Awareness of requirement for better data intelligence to support clinical workforce planning

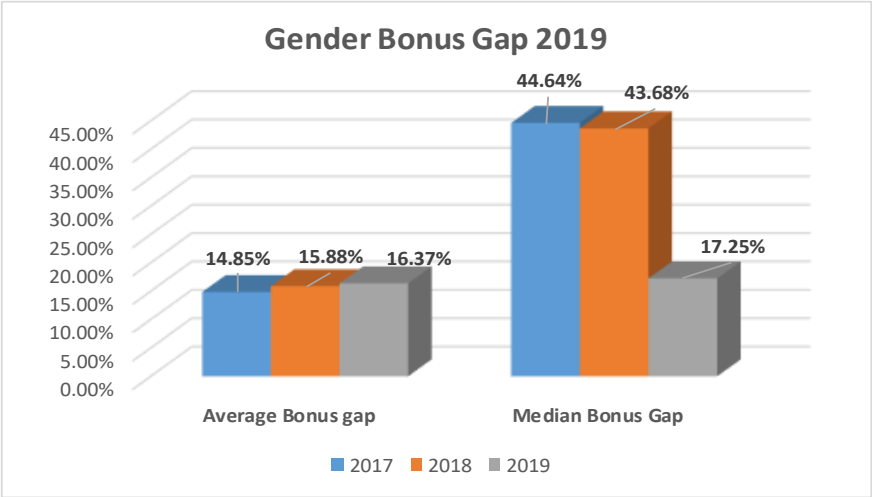
14.5. Consideration of a Junior Doctor representation at Executive and Board level.

3.3 Within the consultant workforce the distribution of men and women along the consultant payscale broadly represents the traditional demographic of the medical workforce (i.e. predominately male). Over time, as the demographic shift within the trainee medical workforce (currently approximately 60% female) filters through to the consultant workforce, and female consultants' progress up the payscale, the ratio of female consultants at higher points of scale will increase and contribute to a reduction in gender pay gap at GOSH.



4.0 Bonus Gender Pay Gap

4.1 Earnings in the calculation for bonus payments relate to Clinical Excellence Awards (CEAs) for consultant medical staff. The average gender pay gap currently stands at £2,410 (16.37%), and the median £1,257 (17.25%). It should be noted that while there has been a small increase in the average bonus payment, the median gap has reduced significantly since 2018.



4.2 The proportion of staff receiving bonus pay was 6.32% (male) and 1.37% (female) – based on the total workforce at GOSH. It should be noted only Consultant medical staff are eligible to receive CEAs – 44% of the consultant workforce hold a CEA. This breaks down to 37% of female consultants and 51% of male consultants holding a CEA.

	Consultant Headcount	Award holders	Award Holders
Male	186	94	51%
Female	171	65	37%
Total	**346**	**145**	**44%**

4.2 Local clinical excellence awards are decided by a GOSH panel which consists of a diverse range of participants, representing the diversity the consultant workforce at GOSH including ethnicities, gender and specialities. Applications and allocation of awards are monitored against a range of protected characteristics including Gender.

5.0 Pay Measures in Place

5.1 GOSH uses the following pay systems to ensure pay is equal and consistent regardless of gender:

- Agenda for Change: National pay system which covers all job roles excepting those given below:
  - Trust contracts - for senior managers and directors
  - National Junior Doctors' contract.
  - National Consultants' contract.

5.2 Under Agenda for Change, NHS Foundation Trusts have the ability to negotiate local terms and conditions. In common with all other NHS Foundation Trusts GOSH has chosen to remain with Agenda for Change rather than move to locally created pay systems due to the protection it affords in terms of ensuring work of equal value is paid equally. Agenda for Change was designed to evaluate the job rather than the person in it and by doing so, ensuring equity between similar jobs in different areas.

6.0 Future actions

- Continue to support development of the GOSH Women's Forum (launched March 2019) and work closely with the forum to address relevant issues, support policy development and culture change as well as promoting positive discussion and develop further awareness of the issues around the gender pay gap.
- The Trust will continue to encourage training and career pathways as well as ensuring our processes around local CEAs remain fair and equitable.
- Embed the recently launched GOSH career mentoring programme by developing more mentors and encouraging staff to request a mentor, particularly those from protected groups where career progression may be more difficult.
- Continue to support all staff including those returning from time away from the workplace for carer responsibilities. We offer childcare vouchers and an onsite nursery in order to help staff remain in work after having children. We also have a variety of family friendly policies, open to both genders.
- Continue to provide training and education to managers to address issues related to unconscious bias in recruitment and selection, Personal Development reviews (PDR) and clinical excellence award decisions.

Attachment 1

Summary of the Audit Committee
held on 9th April 2020

Deep dive: Cyber security
Although GOSH already had a number of mitigations in place, the cyber security risk profile had changed as a result of COVID-19 and NHS Trusts had been urged to be vigilant to scams and phishing attacks. The team had prioritised resources as a result of the increased need for remote working and there had been upgrades to the Trust's systems. The Committee welcomed the work that was underway.

Year End Update 2019/20
A key area for GOSH would be confirmation of the level of COVID-19 funding the Trust will receive on 16th April. It was possible that the control total would also change as part of this process. Two key areas of concern were likely to impact the audit opinion: the stock take and valuation of land and buildings. As the auditors could not be present at the stock take they would be unable to validate the existence of stock. It was confirmed that there was an extended deadline for the Quality Report.

- Covid-19 Capital Funding and related Cash Flows

The importance of continuing to operate under robust financial controls, ensuring evidence was in place was emphasised. The Department of Health and Social Care had agreed to fund all appropriate COVID-19 related capital expenditure. Spend in excess of £250,000 required prior approval however 'reasonable' projects under £250,000 would be approved retrospectively. The rate of PDC dividend was being reviewed and it was possible there would be some relief related to assets under construction which were paused as a result of COVID-19. PDC dividend would also not be payable on COVID related capital assets.

- IFRS 9 Update

It was proposed that outstanding debts over a three year period by classes of debtor was used as an indicator and Committee approved this amendment to the provisioning policy.

- IFRS 16

The introduction of IFRS 16 to the NHS had been delayed by one year. The Trust would continue to work on processes. During this work it had been identified that number of leases included dilapidations clauses which require the Trust to hold a provision. The Committee approved the provision.

- Accounting Treatment of Intangible Assets not yet in use at 31 March 2020

The EPR programme board had reviewed the status of the EPR and concluded that the clinical modules continued to be developed and therefore were not yet complete as at 31st March 2020. The underlying database software was not being developed and was therefore considered complete and in use since go-live in April 2019. It was agreed that the completeness assessment schedule would be provided to the Committee going forward and the committee approved the proposed approach.

External Audit: Interim update report to the Audit Committee for the year ended 31 March 2020
Including update on interim report on Trust Quality Report
The key matters were around the changes to the Quality Report and potential and potential impact of the stock take and valuation of assessment judgement. GOSH continued to work to the original timetable however there was a risk around this in the case of sickness in either the GOSH or Deloitte team.

Internal Audit Progress Report, Technical Update and Draft Head of Internal Audit Opinion for 2019-20
Additional work was required to conclude the Head of Internal Audit Opinion which would also require the conclusion of the final review. The Committee emphasised the importance of considering whether the number of reports received in 2019/20 with a rating of partial assurance did collectively reflect a weakening of controls in the Trust.

The Committee discussed the Trust's position in terms of data quality. It was noted that through the introduction of Epic the inputting of data had been increased from a very controlled number of staff to a much wider group and it was vital that these individuals received training and support to be aware of the implications of RTT for the patients they were seeing. Work continued to identify poor practice and provide additional training. The Committee agreed that discussion would take place with the Chair around how greater oversight could be provided on this matter. The Director of Operational Performance and Information said that he was clear that the current situation in terms of data quality was very different to the issues in 2017 when the GOSH had paused reporting due to the absence of assurance around data quality. He said that current issues were primarily around the training of staff.

Internal Audit Strategic and Operational Plan: 2020-21
Following agreement between Executive and Non-Executive Directors, as a result of the COVID-19 pandemic, internal audit input would be removed in the first quarter of 2020/21 and following this the team would reflect on the content and timings of the plan. Three areas of review related to the pandemic had been suggested as additions to the plan. It was confirmed that GOSH's financial controls process related to the pandemic had been discussed with other Trusts across the STP and had been acknowledged as robust.

The Committee noted the discharge planning report which had provided a rating of 'partial assurance with improvements required' and suggested that little progress had been made in this area. It was confirmed that best practice was now being implemented.

Internal audit recommendations – update on progress
The Committee welcomed the progress made to complete recommendations and emphasised the importance of ensuring that the revised timelines were deliverable.

Counter Fraud progress report annual self-review toolkit (SRT) and Counter Fraud Workplan 2020/21
The team had begun to collate evidence towards the Trust's NHS Counter Fraud Authority Self-Review Tool and proposed an overall green return with some areas where the Trust would achieve partial compliance. The Committee delegated approval and submission of the final version of self-assessment tool to the Audit Committee Chair and Chief Finance Officer.

The workplan for 2020/21 was presented and the CFO confirmed she was satisfied with the content. The NHS Counter Fraud Authority (NHSCFA) had set additional requirements for work to undertake a national exercise for procurement however this work had not been able to add value to the example contracts the Trust had provided. The Committee requested that feedback was provided to the NHSCFA about the considerable pressures that Trust were currently facing and the prioritisation that was required.

Draft Annual Governance Statement 2019/20
The Committee requested that changes were made to the inclusion of IPP as part of the finance risk including the threat to continuing global fragmentation as a result of the pandemic. They requested that

the EPR risk incorporated data quality issues and that further emphasis was given to the time taken in year on the governance of the EPR implementation and other major capital projects.

Update on Procurement Waivers
The Committee approved the list of waivers.

Write Offs
The Committee approved the list of write offs in relation to bad debt.

Any other business
The Committee considered whether further review of emergency planning and business continuity was required. It was agreed that the Chief Operating Officer would consider this further.

Attachment 2

Summary of the Quality, Safety and Experience Assurance Committee (QSEAC) held on 2nd April 2020

Quality, Safety and Experience Assurance Committee Effectiveness Survey Results 2019/20: Findings and Recommendations

The respondents to the survey had broadly agreed that improvements were being made in ensuring the committee was a more assurance focused committee. Responses did not indicate a need to change the Committee's Terms of Reference however the work-plan and on-going agenda would be reviewed. The Committee approved the recommendations arising from the survey responses.

Emerging Significant Risks (Quality Update)

Sanjiv Sharma, Medical Director said that the COVID-19 pandemic had filled the Executive Team's capacity in the previous six weeks. He said that it was vital that previous ongoing priorities continued to receive focus once the Trust was able to move back to business as usual. The urology team had been made excellent progress and it was vital that this could become embedded. A piece had been aired in the media alleging GOSH had not been open with four families. Going forward teams would be clearer with families about the reasons for issues being investigated as complaints or serious incidents and the committee requested that information was provided in the complaints report about the reason for one investigation being undertaken over the other.

Covid-19 – Impact on quality and safety at GOSH

The landscape was rapidly changing however safety remained the overriding priority for the Trust. Discussion took place around the risks around safeguarding given the changing circumstances for families and it was confirmed that daily meetings continued between the social work and safeguarding team and the interim named doctor was being supported by the named doctor from UCLH. Pharmacy had seen increased demand due to additional haematology/oncology patients being onsite and it was important to be mindful of this notwithstanding the improvements that had been made in the team.

Safety Strategy 2020-2025

The Committee reviewed the strategy for the first time and welcomed its development. It was confirmed that a set of KPIs would be developed in each category of the strategy to measure improvement.

Quality Strategy 2020-2025

The importance of developing innovative practice and working with teams throughout the Trust was emphasised. The Committee welcomed the development of the strategy.

Always Improving Action Plan (CQC actions update)

It was reported that almost all actions were either complete or in progress within the initial timescales set out in the action plan, however deadlines were likely to require amendment in light of COVID-19 and the CQC were supportive of this. It was important to review each actions to ensure that work continued where possible.

Internal Audit Progress Report (January 2020 – February 2020)

It was confirmed that that internal audit was keeping interactions with the Trust to a minimum to support the additional capacity required during the pandemic.

Draft Internal Audit Annual Operational Plan (2020/21)
It was not proposed that any audits were undertaken in the first quarter of 2020/21 and following a discussion with assurance committee chairs the plan had been amended to allow capacity for the addition of reviews related to COVID-19.

Health and Safety Update
Safer sharps work had been paused as a result of the pandemic. Two RIDDORS had been reported during the period and the members of staff involved had since returned to work.

Overview of actions arising from the Patient Family Experience and Engagement Committee (PFEEC)
Work continued where possible, however many of the workstreams arising from PFEEC had been paused due to COVID-19. On-going work was focusing on actions arising from patients stories.

Discussion took place around the delay to patients' treatment as a result of the pandemic and the Trust's ability to only carry out emergency work. The Trust had worked hard to reduce the number of long waiting patients over 52 weeks to 9 and this had since increased to 29. Discussions were based on clinical decisions and those patients who required treatment would receive it. Outpatient appointments were continuing in a virtual capacity where possible.

Horizon Scanning – quality and safety issues
The IPP directorate had reviewed the recommendations arising from the Paterson Inquiry and an action plan had been presented at the IPP Directorate Board on 30th March 2020. It was agreed that a fuller update would be provided at the next meeting.

Update on Annual Quality Report
There would no longer be a requirement to include a Quality Report in the Annual Report however a report would continue to be published with an extended deadline.

Report from the RACG on the Board Assurance Framework
The BAF had been updated in line with the refreshed strategy and it was noted that a full update had been provided at Trust Board.

Compliance Update
The committee noted the compliance update.

Attachment 3

Trust Board Wednesday 29 May 2020	
Board Assurance Committee reports: Finance and Investment Committee (March and May 2020) **Submitted by:** Helen Jameson, Chief Finance Officer Paul Balson, Deputy Company Secretary **Item presented by:** James Hatchley, Chair of the Finance and Investment Committee	**Paper No: Attachment 3**

Aims / summary

This report summarises the work of the Finance and Investment Committee (FIC) since its last report to the Trust Board on 1 April 2020.

At the 1 April 2020 Trust Board meeting, the FIC Chair provided a verbal update on the highlights of the 23 March 2020 meeting. The highlights and points of discussion are reported below.

This report also provides a summary of the key highlights and points arising from the 1 May 2020 meeting.

Action required from the meeting

Board members are asked to note the key issues highlighted by the Committee and pursue any points of clarification or interest.

Contribution to the delivery of NHS Foundation Trust strategies and plans

The Finance and Investment Committee reports on financial strategy and planning, financial policy, investment and treasury matters and reviewing and recommending for approval major financial transactions. The Committee also maintains an oversight of the Trust's financial position, and relevant activity data and productivity metrics.

Financial implications

None

Who needs to be told about any decision?

N/a

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

N/a

Who is accountable for the implementation of the proposal / project?

N/a

Key issues for the Trust Board's attention

At the March and May meetings of FIC, the Chair requested that due to COVID-19, the meetings focus on essential issues to allow the Executives to focus on the management of COVID-19. At the May meeting, the Chair received assurance that the deferred agenda items did not present any risk to the Trust and that the deferred items would be covered at the July meeting.

Kathryn Ludlow, Non-Executive Director observed at the May meeting.

Corona Virus – Reformation plan

The Committee reviewed the local, regional and national status of the NHS as it moved to restoring operations.

The Trust Strategy would be analysed to identify any areas where it needed strengthening post COVID-19. A detailed reformation plan would be presented to the May Trust Board.

Finance and Better Value report Month 12

<u>Finance</u>

It was reported to the March meeting that due to COVID-19, NHSE/I had suspended operational planning and changed the way funding would be provided to NHS bodies in 2020/21.

At the May meeting it was reported that the model of NHS funding for COVID-19 could not continue indefinitely. The Chief Finance Officer was working with other stakeholders in the STP to model how funding the 'New NHS' would function.

Pending further guidance, the Committee approved the proposal to load the draft plan into the ledger for 2020/21 and use it as a baseline to measure COVID-19 spends and other variance against. The Finance and Investment Committee endorsed the 2020-21 budget and approach to the Trust Board.

Key highlights from Month 12 included:

- The Trust submitted draft accounts for 2019/20 showing an end position £0.9m favourable to the control total; this was principally due to a one off royalty payment.
- The Trust recognised £11.6m of income from NHSE to cover the central pension uplift which was offset by equal costs. Once this is excluded, the Trust was behind its income target by £0.7m (excluding pass through). This included £1.6m for COVID-19 related costs and £0.3m for lost income.
- Private patient income was below plan in month and the year to date deficit increased to £4.9m. NHS Clinical Income not on block contract was ahead of plan by £1.8m.
- Pay was underspent year to date by £5.0m due to the high number of vacancies across the Trust that were not being covered by equivalent Bank or Agency and reduced research costs (offset by income) despite additional costs associated with the COVID-19 response.
- Non-pay was £5.0m above plan year to date (excluding pass through). This was due to increased computer software costs, premise costs associated with the new buildings and additional COVID-19 response costs.
- Cash held by the Trust was higher than plan by £17.2m which included £8.2m received earlier in the year related to Provider Sustainability Fund (PSF), for 2018/19.

Better Value

Although COVID-19 meant that better value had become less of a priority, the Trust remained committed to improving financial performance through Directorate performance reviews.

COVID-19 has resulted in a number of efficiencies being implemented across the Trust e.g. teleconferencing. The next step was to embed them and ensure they became part of business as usual.

Integrated Performance Report (IPR) for Month 12

The Committee received the Integrated Performance Report (IPR) for Month 12. Key highlights included:

- COVID-19 necessitated cancellation of all elected work, which has adversely affected performance metrics.
- Quality metrics for the period had remained similar or improved.
- One area of slippage was the 'Discharge summary within 24 hours' metric. The Trust would focus on improving this as the threat of COVID-19 reduced.
- The Committee noted that as patients would be prioritised on the urgency of their case, rather than the length of their wait, a new suite of performance metrics were required to effectively measure performance in a post-COVID-19 NHS.

Patient Level Costing 2019/20 national cost collection pre-submission

The Committee noted that NHSE/I did not require GOSH to submit a return for 2019/20.

Cyber Fraud – Impact on business continuity and financial risk

At the May meeting, the Committee received a report from the Interim Chief Information Officer on cyber security and fraud at the Trust. The report included an overview of recent incidents, the immediate remedial action taken and the Trusts long-term strategy to reduce the likelihood of future attacks.

NHS Resolution member contribution notice

At the March meeting, the Committee noted the increase in contribution from £6.8m to £7.2m, which was a result of inflation on the cost of settling claims.

Major projects update

The Committee received an update on the Sight and Sound Centre and Zayed Centre for Research into Rare Disease in Children.

Annual effectiveness review report

At the March meeting, the Committee conducted a review. The Chair thanked all members and attendees for the 100% response rate, valuable feedback and recommendations. Key areas for the Committee to focus on and further improve effectiveness in 2020/21 included:

- The length of papers and the allocation of time given to key topics at meetings.
- Reduction in the duplication of papers between Trust Board, FIC and the FIC confidential meetings.
- Consideration of additional teams, groups and committees that could report to the Committee.

End of report

Attachment 4

Summary of the People and Education Assurance Committee held on 18th February 2020

Minutes of Meeting Held on 2nd December 2019

Minor amendments to the minutes were made.

Staff Stories

Ms Rachel Watson, Secretary of the GOSH Women's Forum and Ms Kate Plunkett-Reed, Deputy Chair of the Women's Forum joined the People and Education Assurance Committee (PEAC) to speak to the committee about their stories at Great Ormond Street Hospital and provided a presentation. Ms Watson and Ms Plunkett-Reed said their experiences of time spent in the Women's Forum had been positive though highlighted that women within the organisation receive varying levels of support and noted there is a need for culture change. PEAC were advised the Women's Forum Board has doubled since October 2019 and all are members of the Diversity and Inclusion working group. It was agreed that committee members would advocate open conversations across the organisation in order to raise awareness of the Women's Forum. It was noted the Women's Forum have planned to hold Annual General Meetings and yearly report including a summary of achievements.

Update Terms of Reference and Committee Workplan

Comments were received and the terms of reference and workplan updated and approved.

People Strategy Delivery Plan

Ms Anderson presented and summarised the progress of the People Strategy Delivery Plan. Work has continued across the organisation to establish the structure and the People Strategy which will align with the GOSH Strategy. Work streams continue to progress including the commission of the new employee brand, nursing recruitment and core HR processes. The management advisory service work has begun and there has been a focus on culture and engagement, health and wellbeing and the internal comms framework. The Diversity and Inclusion Strategy will sit alongside the Health and Wellbeing Strategy. Work is being undertaken to connect the streams of reward and recognition with the organisation. The committee would like to focus on specific issues in future meetings. It was agreed workforce metrics will be reported to PEAC twice yearly and will be included in the workplan. PEAC will be informed on specific pieces of work.

Update on Learning Academy

Ms Lynn Shields, Director of Education submitted updated papers to PEAC and advised the Learning Academy will be hosting a roadshow in March 2020 as part of the year one delivery plan. Recruitment has been successful and is ongoing. Space was noted to be a risk and conversations are ongoing to resolve. The programme is on plan for year one and the Leadership and Management Framework document and toolkit is due to be finalised on 26th February.

Update on Board Assurance Framework

Deep Dive into BAF Risk 4 Recruitment and Retention

Ms Alison Hall, Deputy Director of HR and OD provided an update on the Board Assurance Framework culture risk, updated in January 2020. The risk had been structured around the four pillars of the People Strategy and linked to the Delivery Plan. Ms Hall answered specific questions from the Non-Executive Directors on recruitment and retention and noted work is continuing to focus hot spot areas.

Staff Survey Update

Ms Sarah Ottaway provided an update detailing initial analysis of the 2019 NHS staff survey results, used to inform commitments and priorities and impact of activities of the GOSH People Strategy. The results were due to be discussed at Trust Board and noted it was too early to draw conclusions between NHS and GOSH results but assurance was given that the organisation is continuing to move in the right direction.

Update on staff focused Freedom to Speak Up cases

Mr Luke Murphy provided a paper and update and noted the Values programme is a long-term investment for the organisation and believes there will be an increase in conversations but does not anticipate rapid changes. Mr Murphy highlighted careful consideration will be required not to exclude contracted staff.

Safe Staffing Report

Mr Darren Darby, Director of Operations - Nursing presented the report. Key issues highlighted during the meeting included nursing workforce, safe staffing and challenges. The recruitment and retention target has not been met however the committee were assured there is confidence this will improve. Month six had the highest turnover of newly qualified staff and budget setting is focused on patient safety. Indicative budget for directorates has rolled over from month six, with some directorates coming up short, however it was highlighted the issue is greater for nursing. Recruitment from the Philippines was successful. Safe staffing will be based on patient's needs.

Attachment 5

Summary of the Council of Governors
held on 22nd April 2020

Chair's update
The Non-Executive Directors had agreed to apply the newly published guidance on the remuneration of Chairs and NEDs from 1st April 2020. The Council approved this proposal.

Matters Arising and action log
GOSH had been focusing on providing system support by accepting paediatric patients from other North London Trusts in order to create capacity for adult hospitals which were under significant pressure. Work was now taking place to consider how COVID-19 would be managed as business as usual while existing projects resumed. An update was received on pharmacy, the progress of the urology team and the impact of the pandemic on long waiting patients.

Prior to the pandemic the Trust was reported that it would achieve the Control Total of breakeven and it had been indicated that this would be exceeded and a surplus delivered. This was now subject to the agreement to reimburse substantial COVID costs which had been submitted. The planning process for 2020/21 had been paused and payments were being made on a block contract. Work was taking place with the Children's Alliance to highlight that the tariff was not sufficient to cover costs which had been acknowledged.

Update on planning for COVID -19: Question and Answer Session
The Trust had been sharing both staff and equipment with other Trusts in North Central London and approximately 1200 staff had received additional training to enable them to undertake different roles. A large number of virtual outpatient consultations were taking place and it was important to be able to continue this way of working. An operational hub had been established and this would be embedded going forward to ensure that GOSH was making best use of its bed base. The Trust was communicating with staff on an ongoing basis and a well-being hub had been established. This period was extremely challenging for adult services and it was likely that transition would be delayed for many young people. Families were being directed to MyGOSH in order to receive advice from their clinical teams. Internal and external audit teams had established new ways of working and counter fraud had increased vigilance due to the environment.

It was agreed that discussion would take place outside the meeting between the Lead Governor and Chair about practical ways in which Governors could support GOSH.

An update was provided on research. The laboratory team had been instrumental in the Trust's efforts to bring staff testing online and over the course of a week the number of approved COVID-19 related studies running at GOSH had doubled from 8 to 16. Existing grants were being reviewed on a weekly basis to ascertain whether they were active to ensure that this could be appropriately reflected and income maximised.

Update on Lead Governor Appointment
The process for appointment had been approved but had not gone ahead due to the pandemic. Discussion took place about whether the Lead Governor should stay in post until the election and it the Council confirmed that it was supportive of this approach as long as a Deputy Lead Governor was also in post. The Chair, Company Secretary and Lead Governor agreed to discuss a way forward outside the meeting.

Update from Council of Governors' Nominations and Remuneration Committee

- Appointment of the UCL nominated NED on the GOSH Board

The Council approved the appointment of Professor Russell Viner as a Non-Executive Director on the GOSH Board as recommended by the Council of Governors' Nominations and Remuneration Committee. The Council welcomed the appointment, noting his relevant experience in research, policy and the clinical area in which he worked.

- Nominations for members of the Committee

It was proposed that membership of the committee continued until the election. It was agreed that Governors would contact the Company Secretary with alternative proposals if they would prefer.

Compliance with the NHS provider licence – self assessment

The Trust is required by NHS Improvement to annually declare compliance or otherwise with four key areas of the Foundation Trust licence conditions plus one requirement under the Health and Social Care Act around the training of Governors. The evidence had been reviewed by the Executive Team which had recommended that the Trust was able to 'confirm' all four areas of the licence conditions plus the Health and Social Care Act requirement.

Discussion took place around the completion rate of the actions arising from the CQC report and it was confirmed that approximately 75% of the 'should do' and 'must do' actions were also complete and work would take place to collate the negative commentary into an action plan. Governors requested an update on cyber security during a period when an increased number of staff had been working from home and it was confirmed that this had been discussed in depth by the Audit Committee.

Any other business

It was reported that GOSH's CQC licence had been amended and the Trust was now able to accept paediatric patients who had been sectioned at other Trusts. GOSH was also able to accept young adults in some specialties however this had not yet taken place. Discussion took place around the staffing for young adult patients and it was confirmed that paediatricians were able to treat adults up to 25 years. In terms of nursing, GOSH was clear that liability for this care was with the Trust and the NHS rather than the individual. A number of nursing staff had already agreed to support work in adult centres during the pandemic.

Trust Board 26 May 2020	
Declaration of Interest Register – Directors and Staff **Submitted by: Dr** Anna Ferrant, Company Secretary	**Paper No: Attachment 6**

Aims / summary

This paper provides a summary of the management of declarations of interest, gifts and hospitality at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH).

NHS staff have long been obliged to declare their interests and the Trust has maintained systems to record these declarations in line with previous good governance requirements. Guidance released by NHS England in 2018 brought additional consistency and transparency to the way in which interests are managed across the NHS.

The GOSH policy was revised in line with NHS England's model Conflict of Interest Policy. The policy explains that some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. These people are referred to as 'decision making staff.' All decision making staff are required annually to review declarations they have made and, as appropriate, update them or make a 'Nil' return. All other non-decision making staff are reminded of the importance of making declarations or make a nil return.

Decision-making staff at GOSH have been determined to be:

- Executive and Non-Executive Directors
- Governors on the GOSH Council of Governors
- Members of the Senior Leadership Team
- All Consultants and Honorary Consultants

In order to support up to date reporting of declarations in the public domain, the Trust implemented DECLARE - an online portal to make the process of both declaring and managing these declarations as efficient as possible. Once declarations have been made (declarations of interest, gifts and hospitality), the Company Secretary reviews them, seeks further information/ provides advice on matters where required and publishes them.

After expiry of an interest, the interest/ gift/ hospitality remains on the register for a minimum of 6 months and a private record of historic interests retained for a minimum of 6 years.

All declarations are published to the GOSH website. The register is available here: https://gosh.mydeclarations.co.uk/home. A link to DECLARE is provided on the Trust website to allow members of the public to view the register of interests on a live basis: https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board

Under the new electronic system, staff receive automated reminders to make

declarations. Work continues to ensure that all decision makers have made annual declarations and that all staff are reminded of their duty to do so on a regular basis. The Trust confirms that the register is published on the website in the Trust's Annual Governance Statement in the annual report.
Action required from the meeting To note the content of the register of interests, gifts and hospitality for 2019/20 and that the register is updated on a live basis.
Contribution to the delivery of NHS Foundation Trust strategies and plans The public rightly expect the highest standards of behaviour in the NHS, effective management of conflicts of interest provides greater transparency.
Financial implications None
Who needs to be told about any decision? N/a
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary
Who is accountable for the implementation of the proposal / project? The Chief Executive