Great Ormond Street Hospital for Children
NHS Foundation Trust

Meeting of the Trust Board
Wednesday 16 September 2020

Dear Members

There will be a public meeting of the Trust Board on Wednesday 16 September 2020 at 1:15pm on Zoom and in Barclay House, 37 Queen Square, Great Ormond Street, London WC1N 3BH.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Author	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**1:15pm**
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 15 July 2020**	Chair	**J**	
3.	**Matters Arising/ Action Checklist**	Chair	**K**	
4.	**Chief Executive Update**	Chief Executive	**L**	**1:20pm**
5.	**Patient Story**	Chief Nurse	**M**	**1:30pm**
	STRATEGY			
6.	**Diversity and Inclusion Strategy and Health and Wellbeing Strategy**	Director of HR and OD	**N**	**1:55pm**
7.	**Directorate Presentation: Sight and Sound Directorate**	Interim Chief Operating Officer/ Chief Finance Officer	**O - Presentation**	**2:05pm**
	RISK			
8.	**Board Assurance Framework Update**	Company Secretary	**P**	**2:25pm**
	PERFORMANCE			
9.	**Update on data quality assessment framework**	Interim Chief Operating Officer	**Q**	**2:30pm**
10.	**Integrated Quality and Performance Report – Month 4 (July) 2020 and Patient Safety Metrics**	Medical Director/ Chief Nurse/ Acting Chief Operating Officer/	**R**	**2:40pm**
11.	**Finance Report - Month 4 (July) 2020**	Chief Finance Officer	**S**	**2:50pm**
12.	**Safe Nurse Staffing Report (June and July 2020) and Six monthly staffing review**	Chief Nurse	**T** **4**	**3:00pm**
	ASSURANCE			
13.	**Update with completion of CQC recommendations**	Medical Director	**U**	**3:15pm**

14.	**Infection Control Annual Report 2019/20**	Chief Nurse	**V**	**3:25pm**
15.	**Workforce Equality** • **Workforce Race Equality Standard 2020** • **Workforce Disability Equality Standard 2020**	Director of HR and OD	**X**	**3:45pm**
16.	**Emergency Planning Annual Report 2019/20**	Interim Chief Operating Officer	**Y**	**3:55pm**
17.	**Board Assurance Committee reports** • **People and Education Assurance Committee Update –September 2020** ***Note: There have been no meetings of the Quality, Safety and Experience Assurance Committee, the Finance and Investment Committee or Audit Committee since the last Trust Board meeting.***	Chair of the People and Education Assurance Committee	**Verbal**	**4:05pm**
18.	**Council of Governors' Update – July 2020**	Chair	**Z**	**4:15pm**
	GOVERNANCE			
19.	**Trust Board Terms of Reference and Workplan**	Company Secretary	**1**	**4:20pm**
20.	**Schedule of Matters Reserved for the Board and Council of Governors**	Company Secretary	**2**	
21.	**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.)			**4:30pm**
21.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 25 November 2020 (location to be determined).			

Attachment J

Great Ormond Street Hospital for Children
NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 15th July 2020

Present

Sir Michael Rake	Chair
Lady Amanda Ellingworth	Non-Executive Director
James Hatchley	Non-Executive Director
Chris Kennedy	Non-Executive Director
Kathryn Ludlow	Non-Executive Director
Akhter Mateen	Non-Executive Director
Matthew Shaw	Chief Executive
Phillip Walmsley	Interim Chief Operating Officer
Sanjiv Sharma	Medical Director
Professor Alison Robertson	Chief Nurse
Helen Jameson	Chief Finance Officer
Caroline Anderson	Director of HR and OD

In attendance

Cymbeline Moore	Director of Communications
Dr Shankar Sridharan	Chief Clinical Information Officer
Stephanie Williamson	Interim Director of Built Environment
Richard Collins	Director of Transformation
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Renee McCulloch*	Associate Medical Director and Guardian of Safe Working
Grace*	GOSH Patient and Chair of the Young People's Forum
Toby*	GOSH Patient and member of the Young People's Forum
Claire Williams*	Head of Patient Experience and Engagement
Adeboye Ifederu*	Chair of the BAME Forum
Lakiesha Ward*	Member of the BAME Forum
Musfira Bukht*	Member of the BAME Forum
Renee Barrett*	Member of the BAME Forum
Helen Vigne*	Head of EPR Programme
Nick Martin*	Head of Sustainability and Environmental Management
Andrew Long*	Associate Medical Director and Responsible Officer

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

68	**Apologies for absence**
68.1	Apologies for absence were received from Professor Russell Viner, Non-Executive Director.
69	**Declarations of Interest**
69.1	No declarations of interest were received.

69	**Patient Story**
69.1	Grace, Chair of the Young People's Forum had been a GOSH patient for 6 years. She had been involved in a number of GOSH activities during lockdown but had felt that it was difficult to be involved at the same level when meetings and workshops took place over video conference. Grace said that she was due to transition to adult services however the COVID-19 pandemic had made progress with this uncertain. She had noticed that there had been improved communication between teams during the pandemic which she welcomed.
69.2	Toby said that he had been a GOSH patient since 2005 under a number of different teams. He said he felt that in terms of the work of the YPF the group had been able to achieve most of its required business over videoconference. Toby had visited the hospital for appointments during lockdown as well as having appointments via videoconference. He said that initially there had been some challenges with online appointments however they now worked well.
69.3	Grace said that it had been important to keep busy over lockdown and she felt that this had been beneficial to her mental health. Toby said that his physical health had improved throughout lockdown and he was now able to be more active than in previous day to day life and had found new ways to socialise with friends and families.
69.4	Sir Michael Rake, Chair asked whether Grace and Toby had recommendations for the Trust irrespective of the pandemic. Grace said that it was vital to begin conversations around transition at an earlier stage to ensure sufficient time was available to discuss the matter. Grace said that her discussions about transition had been inconsistent between specialties and had begun at the age of 17 which she felt was too late. She said that MyGOSH was helpful to support communications and it was important that this was used to the best of its ability consistently across specialities.
69.5	Toby said that in previous discussions with the YPF prior to the pandemic members had not been keen to move forward with online consultations however having experienced these appointments the benefits were clear to members and they recommended continuing with them particularly for patients who lived elsewhere in the country.
69.6	Amanda Ellingworth asked for a steer on the way in which the Board could better engage with the YPF and Grace recommended that members of the Board attend a meeting. She said that many teams had found the YPF's input valuable on many different matters.
69.7	Alison Robertson, Chief Nurse said that transition was a key issue for young people and work continued to be required on this complex area. She said that it was important that teams took responsibility for carrying out discussions at the appropriate time and added that it was vital to recruit to the Clinical Nurse Specialist for Adolescent Medicine or utilise the post in a different way to actively support the directorates to introduce and embed transition arrangements into their services..
69.8	**Action:** Sir Michael Rake said that the use of videoconferencing meant it was more practical for Board members to attend additional meetings such as this and recommended that Board members attend a meeting of the YPF where possible.

70	**Minutes of Meeting held on 26 May 2020**
70.1	The Board **approved** the minutes of the previous meeting.
71	**Matters Arising/ Action Checklist**
71.1	Actions take since the last meeting were noted.
72	**Chief Executive Update**
72.1	Matthew Shaw, Chief Executive said that Zoe Asensio-Sanchez, Director of Estates and Facilities and the Built Environment would be joining the Trust on 3rd August. He thanked Stephanie Williamson, Interim Director of Built Environment for her work with the Trust over seven years.
72.2	The Trust had undergone an inspection to assess its digital maturity. GOSH had been HIMMS accreditation at level 6 which was an excellent achievement. It was anticipated that within a fortnight the Trust could achieve level 7 for outpatients which would be the first such achievement for a UK Trust. Matthew Shaw, Chief Executive thanked Helen Vigne, EPR Programme Manager and Sarah Newcombe, Chief Nursing Information Officer who had been instrumental in this achievement.
73	**Integrated Quality and Performance Report – May 2020 including focus on clinical outcomes**
73.1	Sanjiv Sharma said that the paper had been considered at the QSEAC and Council of Governors. He highlighted that work was taking place to improve the position of open incidents and there had been an improvement shown in June data. It was anticipated that all pre-2020 incidents would be closed by the end of July.
73.2	A national report on Freedom to Speak Up (FTSU) had been published which showed GOSH was in the top ten in terms of most improved use of the FTSU service. As planned the Freedom to Speak Up Guardian had left the role at the end of the fixed term contract and interviews were taking place in the week beginning 20th July.
73.3	James Hatchley welcomed the reduction of PICU and NICU refusals to zero and queried whether, notwithstanding the reduction in activity, there was learning which would support this position going forward. He noted there had been an increase in mortality and asked for a steer on the drivers. Sanjiv Sharma said that the demand for PICU had reduced through the pandemic which had enabled the Trust to develop an approach of 'never say no' to a patient which required a paediatric environment. A combination of factors had led to the increase in deaths including receiving very unwell patients from other Trusts whose deaths were expected but would ordinarily having taken place in a different hospital. Late presenting patients had also died at GOSH. Sanjiv Sharma said that there did not appear to be any themes.
73.4	Akhter Mateen, Non-Executive Director highlighted that training metrics were deteriorating and asked for a steer on the drivers. Sanjiv Sharma said that training was moving to digital platforms but in some cases this was challenging and modifications were required to enable this.

73.5	Phillip Walmsley, Interim Chief Operating Officer said that GOSH's RTT performance was higher than the national average, however diagnostic performance was lower but was in line with that of other paediatric hospitals as there were specific paediatric diagnostic issues. Length of stay over 50 days had increased largely as a response to COVID-19 and the difficulties in repatriating patients internally. A substantial improvement in discharge summaries had been achieved.
73.6	Average theatre utilisation was 90% as a result of limited available lists, some of which were overrunning considerably.
74	**Infection Control Board Assurance Framework (NHS England)**
74.1	Helen Dunn said that the Infection Control Board Assurance Framework had been developed by the CQC and commissioners in response to COVID-19. It was being monitored by the Infection Control Committee which reported to the Patient Safety and Outcomes Committee and was split into ten key required standards.
74.2	Key risks were around PPE and fit testing and these issues had been managed throughout the pandemic but had been challenging. Testing is a key area for focus and ensuring laboratory resources were available was vital. The way in which the built environment was managed would be key going forward, particularly in terms of ventilation and the Infection Control team was working with the estates team.
74.3	Akhter Mateen noted that there were some instances in which the Trust's cleaning contractor was required to provide evidence of staff training and Helen Dunn said that many contracted staff had been trained by GOSH however evidence was required to be provided by the contractor. Alison Robertson, Chief Nurse said that the Infection Control Team were disciplined in ensuring the appropriate evidence was in place and the required information was managed.
73.4	**Action:** It was agreed that the Board would send a letter of thanks to Dr John Hartley who had recently stepped down as DIPC.
74	**BAME Forum Discussion**
74.1	Adeboye Ifederu, Chair of the BAME Forum said that he had met with Sir Mike Rake and had an open discussion. Given the on-going Black Lives Matter protests and the raised profile of inequality experienced by people of colour in many countries including the UK people had been provided with the opportunity to reflect. Adeboye Ifederu said that it was important for the Board to consider the real changes that could be made in the Trust as issues of inequality impacted staff and patients. He challenged the Board to take action given that this matter was core to GOSHs principles.
74.2	Renee Barrett, Member of the BAME Forum highlighted the challenge of understanding the day to day experiences of people of colour if this was not an individual's own experience. She suggested that Board members and members of the Senior Leadership Team develop a buddying system and buddy with a person of colour. Renee Barrett welcomed the nurse listening events which were helping to drive the diversity and inclusion agenda.

75.3	Adeboye Ifederu said that the magnitude of the issue was clear but he was assured that moving forward together would lead to positive changes. Lakiesha Ward agreed that collective effort was required to work on an agreed set of actions to create the most effective change. Adeboye Ifederu said that although BAME forum meetings were productive and collaborative and showed a good appetite for this work, this was not always in line with people's day to day experience at GOSH.
75.4	Alison Robertson, executive sponsor of the BAME forum encouraged Board members to influence within their roles and use their position to speak about the importance of diversity and inclusion. Three listening events for nurses had been held and feedback was being presented to the Nursing Board in September. Themes would be developed into an action plan which would be monitored as part of the overall nursing workforce development plan. She said that it was important to begin to move ahead with actions. Caroline Anderson, Director agreed and said that preparatory discussions had been taking place over recent months and work was now taking place to draft the diversity and inclusion strategy 'Seen and Heard' which would focus on ensuring that all staff had the same leadership focus and opportunities.
75.5	Akhter Mateen asked for a steer on the barriers to becoming an antiracist organisation which valued diversity and inclusion. Adeboye Ifederu said from discussions with BAME colleagues that there was a clear theme of issues with career development and the recruitment process. Renee Barrett said that it was important for GOSH to be more vocal and visual about its support for these issues and Lakiesha Ward said that it was important to normalise these types of conversations. Musfira Bukht, Member of the BAME Forum said that all GOSH staff had their individual strengths from which the Trust could benefit.
75.6	Chris Kennedy, Non-Executive Director asked how GOSH could ensure that there was representation of diversity of lived experience at points where real decision making took place. Adeboye Ifederu said that the BAME forum was becoming involved with policy setting but said that day to day it was important that individuals did not accept being involved in meetings, projects and workshops where there was a lack of diversity.
75.7	**Action:** It was agreed that members of the BAME forum would be invited back to the Board to discuss progress before Christmas.
75.8	Matthew Shaw said that despite the constructive discussions there remained poor experiences for some staff from a BAME background at GOSH. He emphasised the importance of being clear with staff about expectations.
76	**Finance Report Month 2 2020/21**
76.1	Helen Jameson, Chief Finance Officer said that as a result of the COVID-19 pandemic the NHS had moved to a new commissioning systems in which block payments were made along with top up payments retrospectively covering additional COVID costs. The block contract had been based on the requirements of acute Trusts taking into account winter pressures and GOSH required a substantial top up to this payment. At month two year to date, £10million had been requested of which £8.6 million had been approved and the remaining £1.4million was based on the changes to bad debt provision. Cash remained strong. As a considerable proportion of the Trust's drugs were associated with home care this had not reduced in line with the reduction in activity.

76.2	Akhter Mateen asked whether any additional payments associated with IPP debt had been received since the Finance and Investment Committee and Helen Jameson confirmed that it had and further receipts were anticipated.
77	**Electronic Patient Record (EPR) Programme Update**
77.1	Helen Vigne, Head of EPR Programme said that since go-live the Trust had continued to work to maintain the momentum and develop user experience. Some challenging areas such as pharmacy had received considerable focus and were now in a more stable position. Shankar Sridharan, Chief Clinical Information Officer said that prior to the introduction of Epic GOSH's digital maturity had been poor however the Trust had become the first in Europe to have been assessed at level 6 in both inpatients and outpatients in terms of digital maturity and it was anticipated and outpatients could move to level 7 which was a significant achievement.
77.2	The optimisation phase of the EPR programme had been on-going for approximately one year and 64% of Epic usability had now been turned on which was the joint highest in Europe. The team were able to quickly turn on usability during the pandemic to support continued activity.
77.3	Alison Robertson emphasised the importance of MyGOSH and its consistent use throughout the specialties. She said that discussion around this would be a standing item at the Patient and Family Engagement and Experience Committee going forward and would be driven through directorate performance reviews. She asked for a steer on the improvements made in pharmacy and Helen Vigne said that the majority of issues had been solved and the team's use of Epic was now in a stable position. Work was taking place with the Epic team to implement new software developments to further improve the position.
77.4	Sir Michael Rake said that overall the implementation of Epic had been a considerable success however during Non-Executive Director walkrounds some staff had expressed concern about its use. Shankar Sridharan said that many staff who were challenged by beginning to use Epic had welcomed its benefits throughout the pandemic as it had enabled them to work differently.
77.5	Chris Kennedy welcomed the EPR yearbook but expressed some concern that the benefits of Epic were proving difficult to quantify and were likely to be underperforming. He said it was important to capture all benefits even where they were not financial. Shankar Sridharan said that work was showing that Epic was reducing length of stay and unnecessary tests which was being quantified.
77.6	Kathryn Ludlow, Non-Executive Director highlighted strong concerns which were raised by a member of nursing staff on a walkround to CICU and asked if they had been alleviated. Richard Collins, Director of Transformation said that Epic involved a change in practice in some areas which had been challenging for some staff to adapt to. Alison Robertson said that in response to that walkround she had followed up with the member of staff. A number of Epic users across critical care met with the Nursing Information Officers to discuss and work through issues. She said that it was important that staff had faith in the system and used it as designed rather than implementing workarounds.
78	**Safe Nurse Staffing Report (April/ May 2020)**
78.1	Alison Robertson said that staff who had been redeployed around the Trust throughout the reporting period were now returning to their usual specialties in

	order to resume activity which had been paused due to the pandemic. A large number of staff had been upskilled throughout the period and it was important to maintain those competencies going forward. The health and wellbeing of nursing staff remained a key consideration and Alison Robertson said that it would be important to maintain the measures which were put in place via the Health and Well-being Hub to ensure nursing staff received ongoing support.
78.2	GOSH had welcomed 62 aspirant nurses all of whom had Newly Qualified Nurse (NQN) conditional offers of employment for September 2020. Health Education England had reported that funding for these posts would end on 31st July 2020 and a funding proposal had been submitted to the Operational Board and Executive Management Team to bridge the gap and support a smooth transition in the NQN roles in September. A larger proportion of this group had declared themselves as being from a BAME background which indicated more positive results from increased efforts to recruit from local feeder universities.
78.3	The nursing establishment review would be considered by the Board in September 2020 and work continued through the Nursing Workforce Assurance Group to use data in order to understand and plan the workforce.
79	**Learning from Deaths Mortality Review Group - Report of deaths in Q4 2019/2020**
79.1	Sanjiv Sharma presented the report and highlighted the addendum which had been added which spoke to a recent spike in crude mortality data.
79.2	James Hatchley asked whether work took place to review comparable data with other paediatric Trusts and Sanjiv Sharma said that GOSH was part of a national group looking at PICU mortality and 96% of deaths at GOSH occurred within PICU. In the event that GOSH was an outlier in mortality in any area this would be highlighted by PICANET which provided a very early warning where mortality in a clinical area fell outside confidence intervals. GOSH had not triggered this warning even when taking into account the increase in deaths.
80	**Safeguarding Annual Report 2019/20**
80.1	Alison Robertson confirmed that the report had been considered by the QSEAC. She said that the volume and complexity of work was considerable. The Named Doctor had retired and an interim was in place with interviews taking place in week beginning 20th July 2020. The job description had been amended and advertised internally after a round of unsuccessful external recruitment.
80.2	The Named Nurse had expressed her intention to retire and a strong and diverse pool of applications had been received.
81	**Sustainability Annual Report 2019/20**
81.1	Nick Martin, Head of Sustainability and Environmental Management said that the Trust continued to work towards a goal of carbon neutrality by 2030. A patient centred approach was being taken in terms of working towards declaring a climate emergency. The GOSH Children's Charity were supportive of this and were discussing approaching donors to develop a funding plan.

81.2	Work had taken place with the Young People's Forum who had a clear commitment to support the Trust in this area and were considering how best to become involved.
81.3	**Action:** Sir Michael Rake requested that sustainability was discussed by the Board again at a time which was more appropriate to declare a climate emergency.
81.4	James Hatchley highlighted the positive environmental impact of patients being treated remotely and without the need to travel and the probable large reduction in the use of paper due to staff working from home. He suggested that these new behaviours could be capitalised upon to promote good sustainability practices.
81.5	Stephanie Williamson, Director of Development noted that there had been a 43% reduction in the CO_2 produced by the Trust which was primarily as a result of phase 2 which had been planned as the most sustainable building. She highlighted the potential scale of progress with sustainability that could be made in the Children's Cancer Centre.
82	**Guardian of Safe Working report Q1 2020/21**
82.1	Renee McCulloch, Associate Medical Director and Guardian of Safe Working said that the as part of the major incident planning for the pandemic a rota was built in order that the hospital could be flexible and responsive to patient need whilst providing a 'stand by system' for absence cover of 30%. Junior doctors had worked extremely hard over this time and had supported the Trust by working in other specialties and not taking annual leave over a six week period.
82.2	Throughout the process it had become clear that improved data and monitoring of staff was required and a new system for monitoring doctor absences had been established which had not previously been in place. A new senior medical officer post had been developed which was a leadership role which would support the distribution of work overnight in the event of absences. Work was taking place to ensure that a team approach was in place at night.
82.3	PICU and CATS rotas remained non-compliant in respect of 2016 terms and conditions and plans were in place to increase establishment for September 2020. The CAMHS rota which was extremely complex was under review. The doctors on this rota worked across a number of Trusts and activity was increasing.
82.4	Sir Michael Rake welcomed the support and flexibility provided by junior doctors throughout the pandemic.
83	**Responsible Officer Annual Report 2019/20**
83.1	Dr Andrew Long, Associate Medical Director and Responsible Officer said that he would be retiring at the end of 2020 and welcomed the appointment of Dr Phil Cunnington, Consultant Anaesthetist who would take over the role in 2021.
83.2	As a result of the COVID-19 pandemic NHS England had confirmed that medical appraisals should be cancelled from March 2020 and no Annual Organisational

83.3	Audit was required for 2019/20. Prior to the pandemic GOSH's medical appraisal rate had been over 90%. Good and clear guidelines for revalidation were in place and the system gave good notice of approaching revalidation dates. Individuals who did not yet meet the standard were provided with advice about additional requirements. The most frequent cause of referral was as a result of delays in receiving 360 degree patient feedback which had been particularly challenging over lockdown. Andrew Long said he felt that a robust process had been developed and the majority of appraisers were leading good quality appraisals. Those who did not meet this standard were undertaking refresher training.
83.4	The Board thanked Andrew Long for his work at GOSH.
84	**Annual Quality Report 2019/20**
84.1	Sanjiv Sharma presented the Quality Report which had been presented to the Council of Governors and was recommended for approval by the QSEAC. Due to the COVID-19 pandemic the report was not required however it had been developed in order to maintain focus on the quality agenda. There was also no requirement for inclusion in the annual report or external audit. Sanjiv Sharma reported that the Quality Report 2019/20 had been shortlisted for an HSJ Patient Safety Award.
84.2	The Board **approved** the Quality Report 2019/20.
85	**Board Assurance Committee reports**
85.1	<u>Audit Committee update – May 2020 meeting</u>
85.2	The Board noted the update.
85.3	<u>Quality, Safety and Experience Assurance Committee update – July 2020 meeting</u>
85.4	It was noted that an update had been provided at the Council of Governors' meeting. The Board noted the update.
85.5	<u>Finance and Investment Committee Update –July 2020</u>
85.6	The Board noted the update.
85.7	<u>People and Education Assurance Committee Update – June 2020</u>
85.8	**Action:** The Board noted the update. It was agreed that a summary of the confidential PEAC session would be presented to the confidential Board where appropriate.
86	**Council of Governors' Update – July 2020 (Verbal)**
86.1	Sir Michael Rake said that a positive meeting had taken place and Governors were keen to continue to engage with the Non-Executive Directors. A revised buddying system had been approved.
87	**Revision to the Trust Constitution**

87.1	Anna Ferrant, Company Secretary said that it had been agreed in principle by the Council of Governors in 2018 that the constituency boundaries would be changed to ensure they aligned with current electoral boundaries and that the proportion of Governors on the Council was in line with the distribution of GOSH outpatients throughout England and Wales. The Council had also agreed in 2018 to implement phasing of elections and the next election, beginning in November 2020.
87.2	In order to enact the changes the Trust's constitution was required to be updated and the Constitution Working Group met on 1st July 2020 to discuss these changes. It was agreed that the changes would be recommended to the Board and Council for approval along with the recommendation to provide for the flexibility to hold an AGM and AMM virtually including any required virtual membership voting at a meeting to ensure essential business can be maintained under social distancing rules. When a mapping exercise had taken place it had shown that one new constituency, 'Patients from the Rest of England and Wales', had a gap of only 17 members between the minimum number required and actual members. The Constitution Working Group had proposed that the minimum number of members in this class was reduced to 100 from 150. The Membership Engagement Recruitment and Representation Committee (MERRC) would also focus on recruiting and engaging with members in this class.
87.3	The Board **approved** the following proposals made by the Constitution Working Group: • Changes to the way public and patient/carer members are allocated to classes to align with current electoral boundaries through approval of the following annexes of the constitution: o Annex 1 – public constituency o Annex 3 – Patient/carer constituency o Annex 4 – Composition of the Council of Governors • Temporary transition arrangements for implementing phased elections through approval of annex 11 – composition of the Council of Governors – transitional period • Amendment to annex 10 to allow the Trust to hold a virtual AGM and AMM including virtual voting. • Revision of the minimum number of members in 'Patient – GOSH rest of England' to 100.
88	**Register of Seals**
88.1	The Board **endorsed** the use of the company seal.
89	**Any other business**
89.1	There were no items of other business.

Attachment K

TRUST BOARD – PUBLIC ACTION CHECKLIST
September 2020

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
69.8	15/07/20	Sir Michael Rake said that the use of videoconferencing meant it was more practical for Board members to attend additional meetings such and recommended that Board members attend a meeting of the YPF where possible.	All	On-going	Connections made between NEDs and the YPF administrator
73.4	15/07/20	It was agreed that the Board would send a letter of thanks to Dr John Hartley who had recently stepped down as DIPC.	MR	September 2020	In progress
75.7	15/07/20	It was agreed that members of the BAME forum would be invited back to the Board to discuss progress before Christmas.	AF	November 2020	Not yet due – planned for November Trust Board
81.3	15/07/20	Sir Michael Rake requested that sustainability was discussed by the Board again at a time which was more appropriate to declare a climate emergency.	ZAS	Q1 2021	Not yet due: Executive Team to review in November 2020
85.8	15/07/20	It was agreed that a summary of the confidential PEAC session would be presented to the confidential Board where appropriate.	CA	On-going	Noted

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 16 September 2020	
Chief Executive Report **Submitted by:** Matthew Shaw, Chief Executive	**Paper No**: **Attachment L**
Aims / summary Update on key operational and strategic issues.	
Action required from the meeting For noting.	
Contribution to the delivery of NHS Foundation Trust strategies and plans • Compliance with CQC Well-Led framework • Delivery of trust strategy: Above and Beyond	
Financial implications • None (business as usual)	
Who needs to be told about any decision? Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? CEO and executive colleagues	
Who is accountable for the implementation of the proposal / project? CEO	

Part 1: COVID-19 response and recovery

1.1 STP system-wide planning for pandemic resilience

After a period of review and reflection on the resilience of paediatric services across North Central London during the first surge of the pandemic, the NCL Gold group has agreed to implement temporary changes to paediatric services over the autumn and winter period.

To minimise the disruption to paediatric services that may be caused by a second wave, and to expedite ongoing recovery and resilience of services across the NCL system, the Whittington Hospital will become the southern hub for paediatric emergency services and GOSH will accept a broader range of elective and day case services from the Royal Free Hospital.

There will be a further review in the coming months to assess the effectiveness and impacts of these temporary arrangements. In the meantime, we are pleased to continue working with our partners across the STP to ensure that children and young people on waiting lists are seen as quickly as possible and in planning ahead to help ensure that access for children and young people is not adversely impacted by any second surge of Covid in the adult population.

1.2 Recovery position at GOSH

GOSH is performing at 8 per cent below our activity from last year, which benchmarks well against other trusts across the STP. There is still a great deal of work to do to recover our backlog, but our teams have achieved an impressive throughput for elective work, day cases and outpatients in very challenging circumstances.

Our Clinical Prioritisation Group is working to mitigate the risk of harm that patients may suffer as a result of delay in treatment from the suspension of elective work and reduced capacity within the hospital to treat the numbers of patients we were previously able to treat. The group has developed and agreed surgical and medical prioritisation frameworks and a process for managing International and Private Patient referrals and external requests for support and an impact assessment tool to evaluate the impact of any delays on our patients. In August the prioritisation process went live on Epic enabling real time update and review of patient prioritisations throughout the organisation.

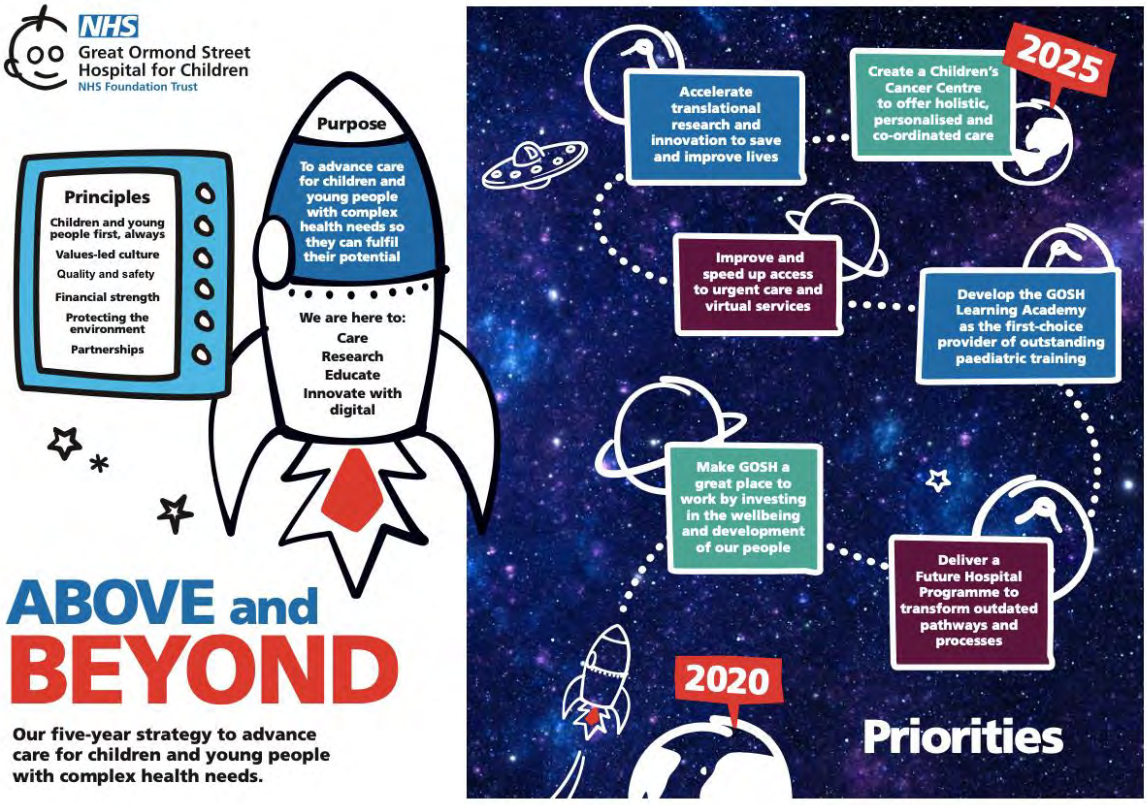
Over 5,000 of the patients on our current waiting list have been prioritised by our clinical teams – this figure does not include all those patients who have already been prioritised and admitted since April 2020. This represents 55% (up from 42% in July 2020) of our current patient waiting list. The figure fluctuates weekly as patients are admitted, and referrals continue to increase (albeit not yet at pre-pandemic levels). The roll out of clinical prioritisation on Epic in August has helped to make the process of prioritisation easier and more efficient. As of the first week in September there are 1,347 Priority 2 patients (i.e. patients who must be admitted/treated within 4 weeks) on the waiting list, of which 733 patients require a procedure during the admission. Based on current projections, there is a Priority 2 gap of 7,940 theatre minutes, which is equivalent to approximately 14 all day lists. Additional theatre capacity is being opened in September with Project Apollo aiming to improve flow and utilisation.

The NHS England Phase 3 letter (31st July 2020) signals a need to ensure that patients who have experienced lengthy waits (i.e. 52 week waits) for procedures are considered within Clinical Prioritisation frameworks. As our 52 week wait position deteriorates (>200 breaches) this presents a further challenge to our capacity and ability to deliver timely treatment for

patients who have been assessed at Priority 2. The CPG continues to work through this, collaborating closely with clinical teams to ensure that the most clinically urgent patients are being seen first.

1.3 Above and Beyond Strategy launch

The original launch of Above and Beyond was planned for March 2020 and derailed by the COVID-19 crisis. With the first wave of the pandemic behind us the executive team reviewed the launch plans and concluded that launching the strategy this month in a sensitive and appropriate way would give a clear sense of direction and purpose.



During summer, we have trailed the strategic priorities (planets) above in a series of Zoom sessions with the Senior Leadership Team. The Board will note that this version of the 'strategy on a page' has been updated to reflect the importance of safety in our post-Covid context within the principles. An updated version of the strategy leaflet is also provided, which has the textual changes outlined in my previous report.

Attachment: Above and Beyond strategy leaflet, post-Covid update

We will launch the strategy to all staff in a special 45 minute Zoom briefing on Thursday 22 September at 2.30pm, which happens to be the September equinox. The launch will be professionally produced and streamed live, with a recording available afterwards. Given the technical issues of showing video over zoom, panellists will appear live.

The focus of the briefing will be purpose, priorities and principles – bringing these to life for people in a series of talks that are inspiring, high level and thought provoking. We are delighted that British astronaut Tim Peake will join the event to introduce the strategy and reflect on the importance of teamwork and shared purpose.

The Restoration Strategy Design Group (a time-limited group established to oversee the complex pieces of work needed to recover activity and maintain oversight on our strategy) has identified a series of priority activities for year one of the strategy. A portfolio manager has been put in place to work with GOSH leaders to develop and articulate the organisational change proposition (including organisation-wide objectives, key performance indicators etc.) and put in place systems to monitor strategy delivery, balance priorities and track benefits.

Meanwhile, the strategy is being embedded into the business planning process for 2021/22 to ensure that corporate departments and directorates all establish their own service objectives that respond to the strategy. We recognise that we will need to provide support to help teams lock the strategy into their business plans for the financial year so our post launch plans will involve the development of Zoom learning modules on priorities and principles. These will run throughout the rest of this calendar year alongside the business planning process.

The post launch activities will be staged as follows:

Year one phasing – launching and embedding the strategy

Phase 1: Launch (August – October 2020)
Raise awareness and interest, educate and share information on the strategy and enabling strategies, stimulate discussion and understanding of how local teams will deliver against the strategy in 2021/22.

Phase 2: Map (November 2020 – January 2021)
Define objectives that support delivery of the strategy into local business plans, the operational plan and a new corporate plan. Identify the skills and support required for strategy delivery and build Above and Beyond organisational development activities into the 2021-22 staff development plan.

Phase 3: Embed (February – April 2021)
Communicate 2021-22 objectives to staff and roll-out organisational development and training activities to support strategic delivery and transformational change during 2021-22. Establish Portfolio office and connection into existing committees, commence portfolio delivery cycles, live progress monitoring and benefits realisation activities.

Phase 4: Sustain (May – September 2021)
Regular check-ins on progress to deliver against the strategy and establish the review and reframing activities that will link into business/corporate planning for 2021/22. Planning for the strategic review and business planning processes that will take place during Q3 2021.

1.4 Post-Covid financial position

There is ongoing financial uncertainty with regards to the financial settlement that trusts will receive until the end of the year. Given GOSH's reliance on research income and international private patients, the uncertainty around a second surge of Covid and the ongoing impact on international markets, there is significant risk that the trust will be facing a substantial deficit position for the first time in a number of years. Current projections estimate this could be in the region of £38m. We are working hard to mitigate this by working with system partners and exercising financial cost control, but the impact of lost activity, lost income and unplanned expenditure will naturally be extremely significant.

Part 2: People

2.1 Appointment of the new Chief Operating Officer

We are delighted that John Quinn will join us as COO at the end of the calendar year. John is currently the COO at Moorfields Eye Hospitals NHS Foundation Trust.

A pharmacist by background, he's also worked at UCLH and Buckinghamshire Healthcare NHS Trust. He is a very experienced operational leader, who is actively involved in regional conversations about improving care across North Central London and has a great track record in overseeing the development of research and commercial portfolios.

Being a clinical pharmacist, he will also be help us with issues around medicines safety and make sure when we move in to the new facility as part of the Children's Cancer Centre it really works for both staff and patients.

Phil Walmsley has agreed to stay with us as our interim COO until John starts. I would like to thank him for how he has helped and continues to help lead the organisation in these unusual and challenging times.

2.2 Diversity and Inclusion and Health and Wellbeing Frameworks

I am delighted that these two documents are being shared with the Board for approval at today's meeting and I look forward to hearing your views. Thank you to Caroline Anderson, her team and the colleagues across the organisation for their support to develop these core frameworks, which support our People Strategy and provide a clear roadmap for our Above and Beyond strategic priority to Make GOSH a Great Place to Work.

2.3 The Impact of Covid on our people and the new *In Touch* Survey

I continue to be inspired by the dedication and commitment of our fantastic staff across the organisation, not only in working so hard to make sure we are seeing as many children and young people as possible, but in continuously raising the bar to advance care, share what they are learning and improve the experience of patients and families.

At the same time, we are very mindful of the fact that these are very difficult times for our staff and we are working hard to make sure people get the support they need. Our In Touch survey results from August have been more positive across all of the categories that ask whether staff felt safe and supported in various ways. They indicate that people are generally feeling safer on site than they were in June and that communication between staff and senior management is effective. Interestingly, the result for the general question about how people are coping with life at the moment has remained stable.

Significantly, the metrics for the small proportion of shielding staff are not as good as they were in June. We have set up engagement forums for them to run through September to ensure we have a better understanding of what they need and can provide tailored support as required.

InTouch staff survey results August 2020

Question	Response	Working onsite	Home working (not shielding)	Shielding	All
How do you feel you are coping with life at the minute?	Very Well/Pretty Well	66%	**70%**	55%	66%
Do you know where you would go for wellbeing help and advice, if you needed support?	Yes	80%	87%	**85%**	82%
If you are working on-site, how safe do you feel?	Very Safe/Safe	73%	78%	N/A	73%
My immediate manager is taking a positive interest in my health and wellbeing	Strongly Agree/Agree	68%	81%	**73%**	72%
Communication between senior management and staff is effective at the moment	Strongly Agree/Agree	63%	72%	**68%**	69%
Senior managers are acting on feedback	Strongly Agree/Agree	53%	65%	**46%**	56%
I am involved in deciding on changes introduced that affect my work/team	Strongly Agree/Agree	42%	51%	**46%**	45%
Respondents		644	356	56	1200

Key

Improved since June
Deteriorated since June
No change

Part 3: Service quality

3.1 GIRFT review into neurosurgery

An outstanding Getting It Right First Time (GIRFT) review on our neurosurgery services has confirmed that GOSH is a true centre of excellence. I would like to congratulate the team on being recognised for their skill and commitment towards patient safety and outcomes. Our Medical Director Sanjiv Sharma will present the outcome of the review to the board at today's session.

3.2 Planning for Outstanding – the GOSH Well Led Assessment

The Executive Team wish to agree and implement a plan of action to achieve 'Outstanding' at the next CQC Well Led Inspection (inspection expected around 2022). Board members will recall that we have also approved holding an external Well Led assessment in Q1 2021/22 (approximately half-way between the last and next CQC inspection). The external assessment will be used as an opportunity to understand where the Trust sits in its Well Led developmental journey and seek external assurance of our understanding of our gaps and the focus of our plan.

The Board is asked to note the following:

- Work is underway to develop a plan to assess gaps in GOSH's preparation to attain 'Outstanding' for Well Led at the next CQC inspection. A gap analysis and associated plan will be drafted and will consider all of the Well Led recommendations and negative commentary presented by the CQC during its last inspection as well as any learning/top tips available from other Trusts who have already attained 'Outstanding' for Well Led. A dashboard for monitoring progress with this plan will also be produced. This plan will be presented for discussion at the October 2020 Strategy Board. Progress with the plan will be monitored by the *Always Improving* Group and regularly reported to Trust Board.

- At the October 2020 Strategy Day, the Executive Team will use this gap analysis to recommend to the Board where they think GOSH currently sits in relation to the Well Led criteria. On the back of this, it is proposed that the Board discuss and agree the possible areas of focus for the external Well Led assessment, noting that the areas selected should be those where the most benefit can be extracted from the assessment in preparing the Trust for its next CQC inspection.

- The agreed areas of focus for the external Well Led assessment will be included in the draft procurement document, requesting evidence of the bidders' staff expertise in assessing these focus areas.

- It is proposed that that the external assessor is sought from an NHS procurement framework and that a small short-life working group is set up to consider and recommend the final procurement document to the November 2020 Trust Board. Two NEDs are asked to be involved in this short-life working group, plus the CEO and Company Secretary. It is proposed that members of this group will also sit on the appointment panel (sometime in January/ February 2021).

Part 4: Partnerships

4.1 GOSH participation in NHS Net Zero Expert Panel and National Clean Air Day

I have been approached by Dame Jackie Daniel, Chief Executive of Newcastle upon Tyne Hospitals NHS Foundation Trust, to participate in a discussion group later this month with Dr Nick Watts, chair of the NHS Net Zero Expert Panel as part of *'The Greener NHS'* programme. The programme was launched in January 2020 and sets out action to reduce the environmental impact of the NHS, including:

- Immediate action to cut emissions, including new measures in the Standard Contract
- Development of a plan for how the NHS can reach net zero as fast and safely as possible overseen by the NHS Net Zero Expert Panel
- A campaign to engage staff, stakeholders and the public

The invitation recognises GOSH's focus on this agenda. The discussion group will explore opportunities for trusts to go further and faster to delivering net zero, by identifying and sharing best practice in delivering on the net zero agenda and exploring opportunities and enablers that have supported them in achieving this success.

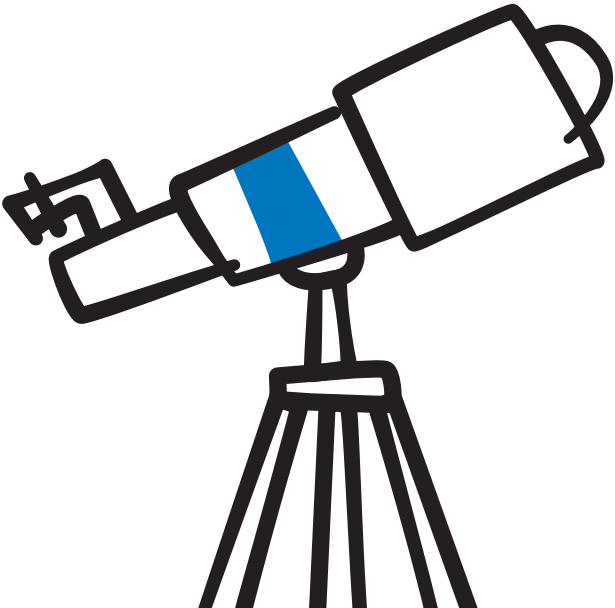
In early October I will be contributing to an evidence-sharing session for health leaders to contribute to a report for government, policy and political leaders on how to build clean air measures into the UK health sector recovery from COVID-19.

Ends

ABOVE and BEYOND

Our five-year strategy to advance care for children and young people with complex health needs.

Our vision for 2025



Every day, here at Great Ormond Street Hospital (GOSH), I see people who go above and beyond. All across the hospital and in all sorts of roles, our people are really going the extra mile to make things better for our patients and families. This strategy recognises that commitment and will make sure every bit of that effort counts for something.

To help us shape our hopes for the future, patients, families, staff and partners have told us what they think of our hospital. What we do well and what we could improve. What we should do more of so that we're always improving, and what we should do less of so we can focus on what matters most. This strategy is the result of that helpful advice.

It is launched as this country comes out of the first wave of the coronavirus pandemic. The crisis has shown how key elements of this strategy such as partnership, the wellbeing of our people, research and virtual care have never been so vital.

As the world continues to shift around us our purpose is clear – to advance care for children and young people with complex health needs so they can fulfil their potential. We'll do this by focusing time and energy on a limited number of priorities. And we'll stay on track by embracing some simple principles to guide our decision making.

This way we'll do right by our patients and right by our staff. More children will fulfil their potential and the GOSH of 2025 will be truly out of this world.

Matthew Shaw, Chief Executive

Our Purpose

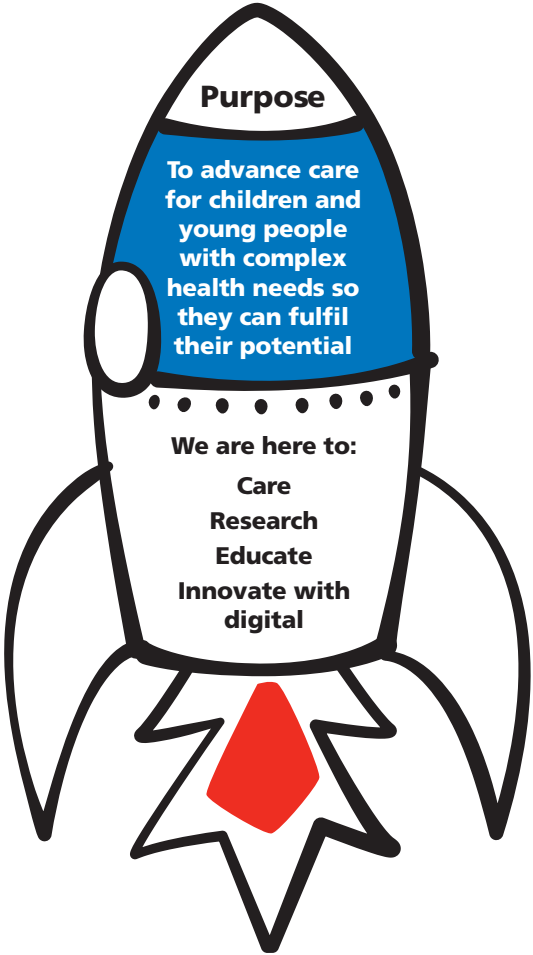
At GOSH we advance care for children and young people with complex health needs so they can fulfil their potential.

We are here to **CARE** – to meet the physical, emotional, social, educational and spiritual needs of children, young people and their families.

We are here to **RESEARCH** – to learn from all we do, collaborate with the global child health community, and develop treatments, cures and holistic approaches to care that will offer children and young people a brighter future.

We are here to **EDUCATE** – to be a stimulating place for children and young people, to help colleagues build rewarding careers and to provide outstanding training to drive improvements in paediatric care.

We are here to **INNOVATE WITH DIGITAL** – to embrace and master digital technologies that will help us save and improve lives and make support available to children and families around the clock.

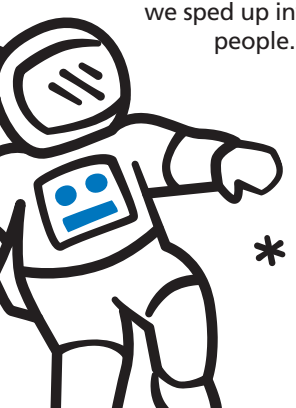

Purpose
To advance care for children and young people with complex health needs so they can fulfil their potential
We are here to:
Care
Research
Educate
Innovate with digital

Our Priorities

We will complete six bold and ambitious programmes of work to help us deliver better, safer, kinder care and save and improve more lives.

PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people

As a GOSH community, we must value and respect each other, work together as one team, and put in place the support, education and development opportunities to help us be at our best, every day. In November 2019 we launched our new People Strategy, with a three-year plan to create an inclusive organisation where our people are valued for who they are, as well as what they do.



During the first wave of the COVID-19 pandemic, we sped up investment in the wellbeing of our people. We will build on this momentum by continuing to address our most urgent workforce issues; deliver clear, shared expectations to help our people learn and thrive; and develop the skills we need to respond to a changing NHS – embracing new ways of working at GOSH and beyond.

PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes

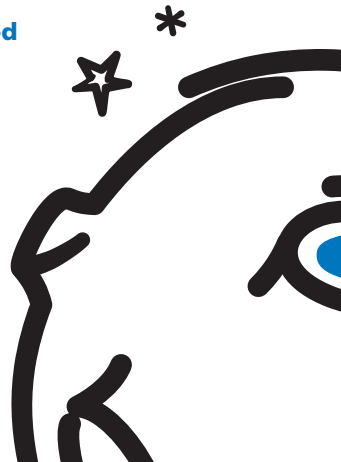
GOSH is brilliant at so many things – from making patients and families feel welcome and safe to developing new treatments, pioneering surgery and world-leading research. However, there are some longstanding issues like medicines management and patient flow we really need to improve on. The concept of the 'Future Hospital' was developed in conversation with the GOSH community and the roadmap for the journey is outlined in our new Transformation Strategy. Ultimately, our ambition is to become the most digitally enabled hospital in the world. By creating slick operational processes, optimising our Electronic Patient Record (EPR) and using data to drive more personalised approaches to care, we can really make things better for our patients and for our staff.

PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training

Staff education and training influences every stage of the patient journey. From the teams caring for children and young people on the ward; the facilities staff who make their stay more comfortable; the leaders directing resources for their care; and the administrators planning their transport home – each member of staff needs up-to-date knowledge and skills to provide our patients with exceptional care. The GOSH Learning Academy's mission is clear – for GOSH to become the first-choice provider for multi-professional paediatric healthcare education, training and development. By developing the Learning Academy and investing more in education, we will help ensure that all GOSH staff receive the best support, education and specialist training at every stage of their career.

PRIORITY 4: Improve and speed up access to urgent care and virtual services

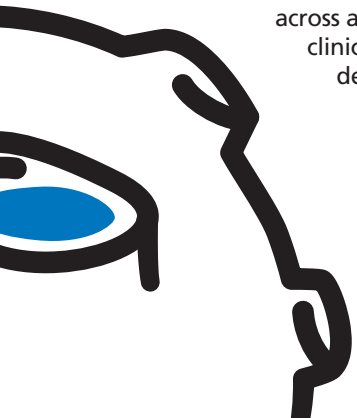
It's so important that children and young people with complex health needs have access to the right specialist teams quickly, so they can get expert advice, the right care and the best outcomes for their treatment. Having to do things virtually



during the pandemic has catapulted us forward in developing new ways of caring for children and we will expand and improve in this area. We want to work together with patients and families, referring partners and commissioners to understand how we can best support and improve the whole patient pathway, so we can be more accessible and responsive.

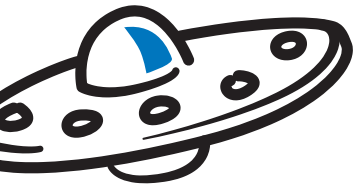
PRIORITY 5: Accelerate translational research and innovation to save and improve lives

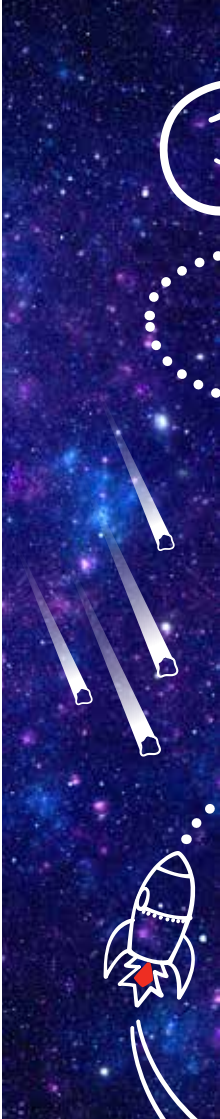
GOSH, together with the UCL Great Ormond Street Institute of Child Health, are world-renowned for translational research activities. In recent years, we've made significant progress in developing our data infrastructure – putting in place an EPR, the DRE (Digital Research Environment) and DRIVE (Digital Research, Informatics and Virtual Environment) to enable us to collect data and insights to refine new approaches to care. Going forward, we want to make sure that research and innovation is fully integrated across all areas of the hospital. All our clinical directorates and services are developing their own research agenda to improve treatment options, outcomes and experience for our patients, and our senior leaders will develop strategies to support and recognise staff involved in research and innovation.

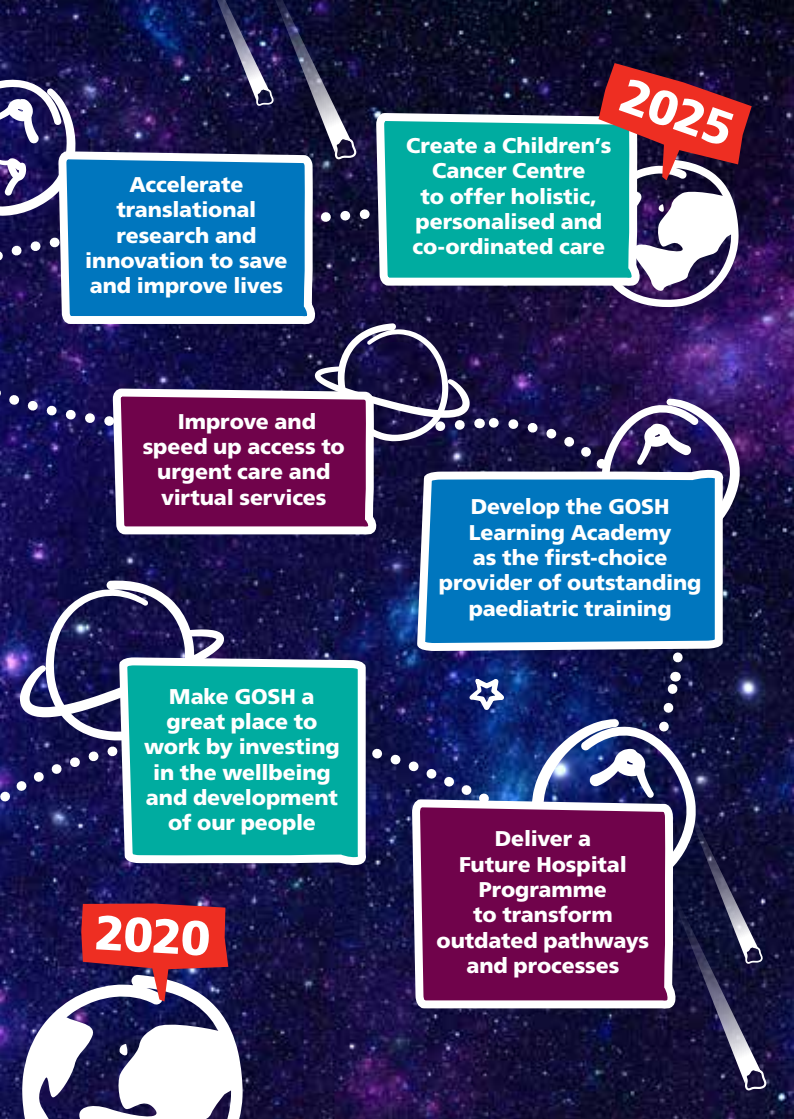


PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care

Building a Children's Cancer Centre will create a national resource for children with rare and difficult-to-treat cancers. Our expert teams will be able to care for even more patients, providing holistic, personalised and co-ordinated care, advancing our understanding of these diseases and developing new and better treatments. The new facility will replace the outdated Frontage Building, providing an inspiring new main entrance, improved facilities for pharmacy, imaging, the GOSH School and flexible clinical spaces that enable us to adapt to rapid advances in cancer care.






2025
Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care
Accelerate translational research and innovation to save and improve lives
Improve and speed up access to urgent care and virtual services
Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training
Make GOSH a great place to work by investing in the wellbeing and development of our people
Deliver a Future Hospital Programme to transform outdated pathways and processes
2020

Our Principles

Six clear principles will guide our planning, decision making and day to day work. Sticking to our principles gives us the best chance of achieving our purpose and delivering our priorities, while doing the things that matter most to the GOSH community.

This is what we see for GOSH in 2025.

Above and beyond for CHILDREN

PRINCIPLE 1: Children and young people first, always

Over the coming years, GOSH will be very different to the hospital established in 1852. But while our founders would marvel at our progress and wonder at our technology, our ethos would be quite familiar. Fulfilling the potential of children and young people has always, and will always, drive us on to achieve great things.

Above and beyond in our CULTURE
PRINCIPLE 2: Always Welcoming, Helpful, Expert and One Team

GOSH will be a tolerant, inclusive, open and respectful place where staff are valued for who they are as well as what they do. Our people will enjoy their work and will live the GOSH Always Values. We will have strong, supportive teams where everyone has the freedom to learn, contribute and no one is afraid to speak up.

Above and beyond for SAFETY AND QUALITY
PRINCIPLE 3: Safe, kind, effective care and an excellent patient experience

We will be world leading in clinical outcomes and service design that puts patients first. Patients and families will be confident in their care because clinical outcomes across all our services will be scrutinised, internationally benchmarked and made publicly available. Our staff will feel confident about their own safety, and that of their patients, whether they are working on site or from home.

Above and beyond for FINANCIAL STRENGTH

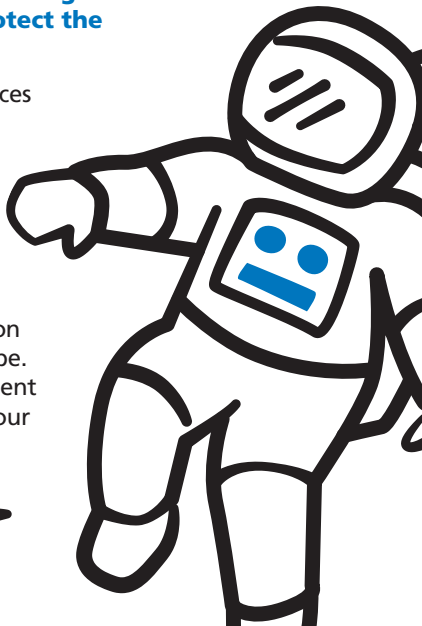
PRINCIPLE 4: Stronger finances support better outcomes for more children and young people

We will be a more efficient, resourceful and resilient organisation. We will develop strong partnerships and look for opportunities to create secure and varied income streams. Through the generosity of donors, we will go over and above what is possible through the NHS – extending our reach and influence to help more children who need complex care.

Above and beyond for the ENVIRONMENT

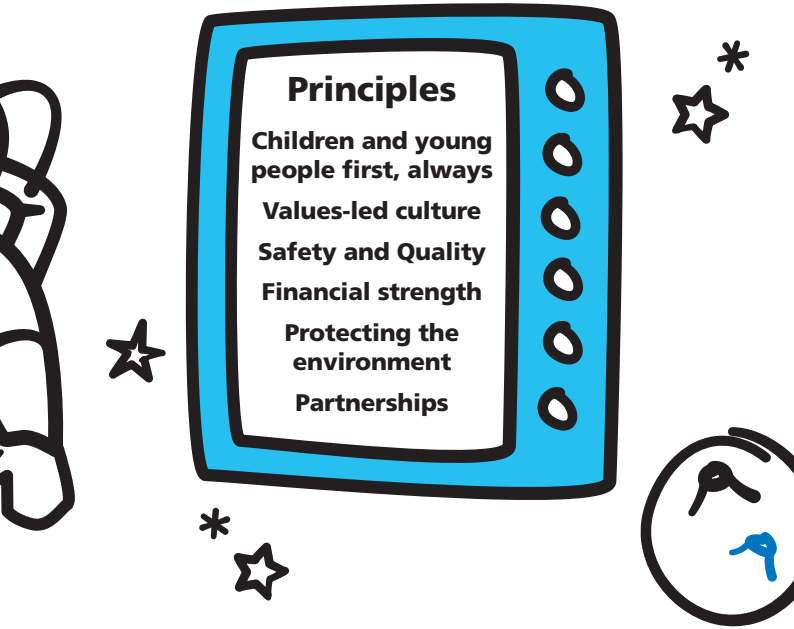
PRINCIPLE 5: We aren't caring for children if we don't protect the environment

Sustainable business practices will be put in place so that our people find it easier to make the right choices. Sustainability will be central to our purpose, given the widely acknowledged impact of climate change on child health across the globe. Our Sustainable Development Action Plan will underpin our commitment to planetary health, every day.



Above and beyond in our PARTNERSHIPS
PRINCIPLE 6: Together we can do more

We will never work in isolation if we can better achieve our goals by working with others. We will be proactive in asking for help from policy makers and challenge barriers to progress. We will work with regional and national partners, as well as our patients and families, to design care pathways together. By partnering with academics and industry, we will make even faster progress to improve practice and more children's lives.



Read more about how we're going above and beyond:
Visit **GOSHWeb > Corporate > Strategy and planning**
Email **StrategyAndPlanning@gosh.nhs.uk**

Attachment M

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
16 September 2020

Patient story- Experiences at GOSH from Samih, a patient with sight impairment **Submitted by:** Claire Williams, Head of Patient Experience & Engagement and Carolyn Akyil, Head of Nursing & Patient Experience for Sight & Sound	**Paper No: Attachment M**

Aims / summary

The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories for the Trust Board. Stories which are selected represent a range of experiences across a variety of wards and service areas across the divisions, ensuring that the experiences of patients and families are captured.

The story to be shared on 16 September has been pre-recorded via Zoom and outlines:

- Samih's experiences of GOSH as a patient with a severe visual impairment;
- What is important to Samih when he attends GOSH; and
- Areas for improvement based on Samih's experiences

In collaboration with the Sight & Sound directorate, we will also provide a summary of how feedback has informed the design of the new Sight & Sound building and action being taken to meet the needs of those patients. This includes:

- Focus on clear signposting for rooms and areas using bold colours and large graphics;
- Light, airy, uncluttered areas with quiet spaces and a sensory garden
- Work is also underway to achieve a Deaf Aware Quality Mark for the building and also working with Communication Access UK to create an accredited paediatric programme. Both will lead to a bespoke programme of training for staff working in the new Sight & Sound Building and improved communication for the patients and families using these services.

Action required from the meeting
For information

Contribution to the delivery of NHS / Trust strategies and plans

- The Health and Social Care Act 2010
- The NHS Constitution for England 2012 (last updated in October 2015)
- The NHS Operating Framework 2012/13
- The NHS Outcomes Framework 2012/13
- Trust Values and Behaviours work

Great Ormond Street Hospital for Children
NHS Foundation Trust

• Quality and Safety Strategies • The Patient Experience and Engagement Framework
Financial implications None
Who needs to be told about any decision N/a
Who is responsible for implementing the proposals / project and anticipated timescales Claire Williams, Head of Patient Experience & Engagement and Carolyn Akyil, Head of Nursing & Patient Experience for Sight & Sound
Who is accountable for the implementation of the proposal / project Alison Robertson, Chief Nurse
Author and date Claire Williams, Head of Patient Experience & Engagement

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
16 September 2020

Diversity & Inclusion Strategy And Health & Wellbeing Strategy **Submitted by:** Caroline Anderson, Director of HR & OD	**Paper No: Attachment N**

Aims / summary

The People Strategy was formally published in November 2019 and has been used to drive and underpin our approach to people management across the Trust. As part of the People Strategy we committed to developing a Diversity & Inclusion (D&I) strategy and an integrated and joined up approach to Health and wellbeing (H&W), supported by programmes of work to ensure that those commitments could be delivered.

The development of these two pieces of work commenced in the Autumn last year and while the finalisation of the strategies was delayed by the pandemic, the work and supporting arrangements implemented in response, has provided the opportunity to accelerate and consolidate much of the work expected to be included and has created a much stronger foundation on which to deliver this work. Two strategies have been developed in consultation with staff groups drawn from across the Trust. They have been subject to formal consultation with the Trade Unions and were reviewed and endorsed by the People and Education committee on 10th September 2020. These are now presented for approval prior to their formal publication as part of the GOSH Above and Beyond strategy launch. In order to differentiate between these new sub strategies and the People Strategy they will be publically referred to as frameworks.

The 2 new frameworks are :

Seen and Heard : Diversity and inclusion

The purpose of this framework is to ensure that all our people in all their roles, are SEEN and HEARD, have EQUAL ACCESS to promotion, education and training and the OPPORTUNITY to be themselves and do their best work.

It focuses on recruitment, promotion and progression, creating an inclusive work place and providing and amplifying the employee voice.

Mind, Body and Soul :Health and Wellbeing

To ensure that every member of staff at GOSH feels cared for and cared about, supported to be healthy in mind and body, feel safe while working, whether at home or on site and connected to the GOSH community.

It focuses on promoting and supporting physical and mental wellbeing, providing effective support infrastructure and ensuring that all staff feel, safe secure and connected.

Both the D&I and H&W frameworks represent the practical expression of our commitment to all staff to make GOSH a great place to work for everybody. Transparency and progress will be essential to building trust in the organisation and to building credibility and belief in the ability of the organisation to change. Collecting and publishing data and information on progress will be essential. Both frameworks include a set of metrics which will be used to track progress and monitor impact.

Where progress will be measured via staff survey responses, the stated targets are based on bringing GOSH in line with the average for Acute Specialist trusts. It should be noted that this is typically a high performing benchmark group – achieving average performance against peers in this group would represent above average performance compared with London trusts generally. For metrics derived from WRES and WDES reporting, targets for improvement have been determined based on bringing GOSH to above average when benchmarked against other London trusts in year 1, and progressing to the upper quartile in year 2.

Oversight of the delivery of the programmes of the work will be overseen by a new staff forum who will review progress on the individual programmes of work, with formal assurance provided through the People and Education and Assurance Committee (PEAC) using the agreed metric to track progress and impact. A mid-year and annual review report will be presented to the public Trust Board.

Action required from the meeting

The Diversity and Inclusion (D&I) and Health and Wellbeing (H&W) frameworks are submitted to the Trust Board for formal approval

Contribution to the delivery of NHS / Trust strategies and plans

Both the D&I and H&W strategies represent the practical expression of our commitment as part of the GOSH Above and Beyond Strategy and the People Strategy and directly contribute to delivery of the obligations set out for Trusts in the NHS People Plan

Financial implications

Legal issues

n/a

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

Executive management team

Who is accountable for the implementation of the proposal / project

Caroline Anderson, Director of HR & OD

Great Ormond Street Hospital for Children
NHS Foundation Trust

Seen and Heard

Above and Beyond Diversity and Inclusion

Contents

Version Control

Title	Seen and Heard – Above and Beyond Diversity and Inclusion
Strategy	Diversity and Inclusion
Executive Sponsors	Director of Human Resources
Date	25/08/2020
Version	10
Status	Draft

Foreword

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Our people are the head, the heart, the hands and the face of Great Ormond Street Hospital (GOSH). They make us who we are and allow us to do extraordinary things. We value and respect them individually and collectively for who they are, as well as what they do. As a Trust we are committed to ensuring all our people are well led and well managed, but also, supported, developed and empowered to be, and do, their best.

The People Strategy

1. Introduction and Purpose

"Diversity is a fact, inclusion is a choice"

Helen Snowball,
Chief Human Resources Officer,
Asia Pacific at JLL

Each and every day, our people come together to do extraordinary work. Often providing unique solutions to complex health needs and working to deliver the highest standards of care, emotional and physical support to our patients and their families, as well as to each other. As an international research and teaching hospital, the work we do at GOSH touches the lives of hundreds of thousands of children and young people across the country and the world. Our patient base is diverse and to continue to do our best work, we must be too. Evidence shows that diversity of skills, knowledge, background, and experience brings: different insights and perspectives; creates challenge and encourages change and innovation; supports more effective decision making; and delivers better outcomes. Diverse workforces are key to driving the success, effectiveness and relevance of an organisation.

Diversity is a fact. We are all different and the harnessing of that difference has inherent value. As an organisation we embrace it as concept in much of our work, with the use of Multi-Disciplinary Teams (MDTs) and mixed skilled, project and research teams being the norm. But we are less proactive and accepting of diversity in our people management practice and decisions. So, despite increasing awareness, recognition and legislation on the need to support equality and diversity in the workplace, it remains underdeveloped in many organisations including here at GOSH.

If diversity is a fact, for its benefits to be realised at an organisational level and felt at a personal level, it requires a commitment to inclusion. Inclusion occurs when people feel valued and accepted in their teams and wider organisation without having to conform, in order to fit in, or progress. Inclusive organisations support employees, regardless of their background and circumstances to thrive and this requires the creation of an environment where differences of thought, experience and outlook are not only respected, but expected, and are supported by enabling policies, processes and systems, reinforced by a culture of positive values and behaviour which allows inclusion to become a reality.

We want all our people at GOSH to feel that they can be themselves at work, valued for the distinct perspective that they bring, and be able to go as far as their ambitions and talents will take them – irrespective of their sex, gender identity, ethnicity, sexual orientation, disability, faith, age or socio-economic background. Feeling included is good for us as individuals. It's good for teams and team working and it is good for the patients and families we care for. Being fulfilled at work allows us as individuals and a community to be and do our best.

The purpose of this Strategy is to ensure that all of our people in all their roles, are **SEEN** and **HEARD**, have **EQUAL ACCESS** to promotion, education and training and the **OPPORTUNITY** to be themselves and to do their best work.

2. National and Local Drivers for Change

The People plan for 2020/21 *'We are the NHS – action for us all'* was published in August 2020.

The Plan sets out what the people of the NHS can expect – from their leaders and from each other – for the rest of 2020 and into 2021. It sets out actions to support transformation across the whole NHS. It states how much we must all *'continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care'*.

It recognises that '*our NHS people have been under increasing pressure since the response to COVID-19 began, and there will be further challenges ahead. Workload remains a pressing concern and we have all been reminded how critical it is to look after our people – and that we need to do more. To address this now, and for the future, the NHS needs more people, working differently, in a compassionate and inclusive culture'.*

The Plan sets out practical actions that employers and systems should take, as well as the actions that NHS England and NHS Improvement and Health Education England will take over the remainder of 2020/21. It focuses on:

- **Looking after our people** particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically
- **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong
- **New ways of working and delivering care** emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care
- **Growing for the future** particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer.

Above and Beyond – A strategy for GOSH

The first priority of the Trust's five year strategy 'Above and Beyond' commits to **making GOSH a great place to work by investing in the wellbeing and development of our people.** It states that as a GOSH community, we must value and respect each other, work together as one team, and put in place the support, education and development opportunities to help us be at our best, every day.

In November 2019 we launched our new People Strategy, with a three-year plan to create an inclusive organisation where all our people are valued for who they are, as well as what they do.

This **Diversity and Inclusion Strategy (D&I)** will sit alongside a new **Health and Wellbeing Strategy (H&WB)**. Together they will provide the foundations to reinforce the commitments set out

in the People Strategy and create the environment and a work programme to ensure they are delivered and, in doing so, help us meet the expectations set out in the NHS People Plan.

The Impact of COVID-19 on the Workforce

Our current context is not one that we could have imagined a year ago. The COVID-19 pandemic has impacted significantly on the whole organisation and will continue to do so for the foreseeable future. It has already changed the way we organise, deliver and support patient care, and how and where we do that from.

Both the virus and subsequent lockdown has had a disproportionate impact on individuals and whole communities with elevated and cumulative risks associated with age, gender, ethnicity, disability, and certain health conditions. Even before the events which led to the galvanisation of the' Black Lives Matter' movement, it was clear that 2020 would be seen through a lens of inequality.

But there have also been some unexpected positives from this challenging period, which we would wish to protect and build on going forward.

Despite the immense challenges, our staff have been flexible, creative and supportive of each other, despite high levels of anxiety. They have worked at pace, rolling out and accommodating new services, colleagues and ways of working, while continuing to deliver high standards of patient care and maintaining essential support services, going Above and Beyond and truly living the value of 'One Team'.

Our response to COVID-19 has provided a unique opportunity to reposition our relationship with our people as the impact on staff and their welfare has been central to our planning, decision making and response. From the very beginning, we have worked proactively as a community, in partnership with staff and their representatives to keep our people safe, informed and supported. We have introduced new and flexible ways of working and communicating and are having more open and honest conversations about the things that matter. We have been able to accelerate work towards some of the priorities set out in our Above and Beyond Strategy and in doing so, provided a stronger foundation on which to take forward the commitments set out in the People Strategy 2019-22. The work of the D&I and H&WB strategies allow us to turn the commitments into action.

3. Our People and Processes

As with all Trusts, GOSH collects a significant amount of information on our workforce through our HR process, systems and surveys. Some of it we publish, such as the staff survey, the gender pay gap and race and disability data but all as individual data sets. What we have never done before, is to triangulate all that information to understand not just what the data says, but what it is telling us about what it is like to work here, or to use it to inform decision making and planning. An essential part of developing this strategy has been the opportunity to bring together a group of people from across the Trust to critically evaluate all the data and provide insight on what that means in practice for individuals and groups. Their collective work has provided a more robust evidence base and additional insight and has been used to inform the content of this strategy and the work programme it supports.

Key findings:

- We employ circa 5,000 staff from over 100 nations
- BAME staff make up 30% of our workforce. This is significantly lower than many other London Trusts
- In common with the rest of the NHS, ¾ of our staff are female
- Our age profile is significantly younger than the NHS average with over half of our staff aged under 40

- 2.7% of staff are disabled, however we know from the Staff Survey this is likely to be an under-estimate
- 2.9% of our staff identify as LGBT+, but again, the Staff Survey suggests this is closer to 6%
- At least 9 major faiths are represented, however nearly a third of staff declined to disclose this information
- BAME staff are 2.5 times more likely to be disciplined than White staff
- 63% of job applicants were BAME, but made up only 36% of appointments
- In the 2019 Staff Survey 24% of disabled respondents said they had experienced discrimination at work
- 58% of BAME staff felt the Trust acted fairly in regard to career progression whilst 84% of White staff agreed
- As well as a Gender Pay Gap of 17%, BAME staff earn 13% less than White staff per hour, while Disabled staff earn 15% less
- Declaration rates for some equality themes are under reported and inconsistent with NHS and national statistics
- Non-Declaration rates for protected characteristics range form 0-30%.

Ethnicity

BAME representation at GOSH is much lower than many other London Trusts at 30%. Within the Allied Health Professional and Nursing staff group this is lower still at 11% and 16% respectively while the Estates and Ancillary and Additional Clinical Services staff are highest at 48% and 43%. As both of these groups tend to have lower banded roles within them, it is perhaps unsurprising that Bands 2 & Band 3 have the highest BAME representation at 51% and 50%. For the group of staff at Band 8a and above this reduces to 15%, while our BAME Medical staff represent a third of the workforce.

Since 2015, NHS organisations have been required to publish data against the NHS Workforce Race Equality Standard (WRES). WRES data publication is an annual requirement and is included in the NHS standard contract for provider organisations and also features in the CQC Assessment of the 'Well Led' domain. The 2019/20 return shows that White applicants were more than twice as likely to be shortlisted than BAME candidates. BAME staff were also more than 2.5 times more likely to be disciplined. However the 2019 results did indicate a slight improvement in the gap between White and BAME staff accessing non-mandatory training.

The most recent Staff Survey results showed a clear gap between the experience of BAME and White staff with the Equality, Diversity & Theme score for BAME staff reported at 8.1 (out of 10) while for White staff it was higher at 9.2. This basket of survey questions looks at fairness of career progression, experience of discrimination and responsiveness of the organisation to respond to needs for reasonable adjustments for disabled staff. Whilst 84% of White staff said the Trust did act fairly, only 58% of BAME staff agreed. BAME staff felt they received less respect from colleagues than White staff (65.3% and 75.4% respectively). This result worsened for BAME staff in 2019 from the previous year and improved for White staff.

All our current data tells us that opportunities for staff from diverse backgrounds are far from where they should be and that is not acceptable. Our BAME representation is significantly below that of other London Trusts which would indicate issues with our pipelines and our employer brand. There is an identified need to address the 'race pay gap' (WRES 2020) and more work we could and should be doing to promote GOSH as an open and inclusive employer of choice, with a wide range of careers, roles, training, education opportunities and people.

Sex / Gender

Most NHS organisations are predominantly female and GOSH is no exception. Within the staff groups, 95% of nurses and 92% of Allied Health Professionals are female, while 40% of Estates and Ancillary and 55% of Medical and Dental staff are female. By pay group, female staff make up 85% of Bands 5-7 but 73% of Band 8 and above. In the medical pay grades, female staff make up 49% of Consultants but 62% of Junior Doctors indicating future positive movement in that cohort.

Since 2018 the Trust has been required to report on its Gender Pay Gap. The most recent report for 2019 showed an improvement in the previous year, however there was still a gap of £4.35 per hour (17%) between a male and female staff member's hourly wage. The key factor for this is the impact of the Consultant workforce on overall pay levels. Whilst we have a fairly equal number of male and female consultants (51% and 49% respectively), female consultants form part of a much larger population 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.

Disability

According to ESR reports 2.7% of our workers have declared they have a disability. But the 2019 Staff Survey results said 12% of respondents identified that they were disabled or living with a long term health condition. (It should be noted that this is a slightly different question which will in part explain the variance.) GOSH is required to report on the experience of disabled staff in the national Workforce Disability Equality Standard (WDES) which looks at the representation of disabled staff in the workforce, likelihood of disabled applicants to be appointed, experience of performance management processes and Staff Survey results. The 2019 WDES show disabled staff to be under-represented in the higher bands of the workforce, applicants less likely to be appointed and poorer staff survey results.

Age

The GOSH workforce is much younger than the NHS average, with over half aged under 40. The majority of our youngest staff (those under 25) are in Nursing, HealthCare Assistant or Administrative roles. The 2019 staff survey results show a lower score for Equality Diversity & Inclusion, Team working & Immediate Managers themes indicating a different working experience for this group.

LGBT+ and Other Protected Characteristics

The Trust gathers equality monitoring data from its new recruits for sexual orientation and religion. However, both of these areas tend to have high rates of non-declaration, making the data less useful. 2.9% of staff identify as LGBT+, while 54.2% say they have a faith, but over a quarter of both categories have "not disclosed" as one of their largest responses. Marital status, pregnancy and gender re-assignment data is not routinely gathered. However, the Trust retains an obligation to ensure staff in these groups are seen and heard and that their experience at work is a positive one as with all staff. Improving our declaration rates across all categories will be an important first step.

Intersectionality

We use the categories above to identify groups that might have characteristics and therefore experiences in common. However, the reality is that many people will have characteristics that cross over and this may lead to increased marginalisation.

This crossover is referred to as 'intersectionality' and is why a focus on inclusion for all is such an important theme for this strategy and the work it will support.

4. Delivering change through Education, Learning and Ally-ship

Creating a diverse and inclusive organisation can be complex but at its heart is a desire to do better and a commitment to work differently, including providing a broader range of work opportunities for a wider range of people.

Education and learning are key to the delivery of the change we seek. Understanding that access to opportunities for some, have been restricted by the structures, processes and systems we have in place and sometimes, by the actions, both conscious and unconscious, of others is vital. Acknowledging that about the organisation and ourselves is an important starting point. Education, learning and the development of new knowledge and skills is an essential part of the change process and for some that will require a commitment to unlearn what we think we know, in order to learn something different. There are already some existing resources, workshops and initiatives which promote good practice examples, but these are not yet coordinated so lose the opportunity to be mutually reinforcing.

The Role of Leaders and Managers

In January 2020, we published, the GOSH Leadership and Management Framework. Its purpose is to ensure GOSH has leaders and managers who are able to contribute towards the delivery of our strategic ambition and commitment and act as role models who embody and uphold the values of the Trust.

It sets out our expectation of leaders and managers as follows:

Our leaders should be self-aware and recognise their impact on others, empowering and nurturing their colleagues to be and do their best. They will ensure they are a trusted positive influence in their services, our Trust and embody our organisational values. They are also seen as inclusive, compassionate and competent. As a group, they will be connected to each other and the priorities of the wider organisation, acting as conduits for their staff, with that responsibility, supported and reinforced by organisational infrastructure (policies, processes, systems and ways of working) which maximises joined up, collaborative and inclusive working. Our leaders should be willing to be self-taught in areas of social justice, systematic discrimination and endeavour to broaden their leadership competence around culture shift.

Investment in the development of inclusive leadership, and an understanding of unconscious bias and cultural intelligence will help us build the knowledge, skills and the connectivity we need to create a more trusted and inclusive work place for us all.

The Role of all GOSH staff

There is a role for all of us in supporting and promoting diversity and inclusion. For some it will be as members of marginalised groups in sharing their knowledge and experience, to help others understand and learn – but for all of us there is an opportunity to become the best Allies we can be.

The role of allies can be very powerful. In recognition that that real change only occurs through the collective action and commitment of the majority, adding their voice to that of the minority, we will proactively support the development of Ally-ship at GOSH.

What Ally-ship means in practice

Ally-ship is the process through which people in a position of influence or in a dominant group, work to develop empathy towards another marginalised group's challenges or issues. The goal of ally-ship is to create a culture in which an individual feels valued, supported, and heard. Being an ally is not a label -- it is about what you do and should be celebrated.

Being a good Ally also means **stepping up and stepping in** when you see something going on that undermines the values that we should all uphold, **proactively learning** and increasing your understanding of diversity and inclusion, the experience of others and, **stepping alongside** to add your voice to support change.

At GOSH we want to build relationships of trust, consistency and accountability with individuals and our forums that represent those who are marginalised. Anyone has the potential to be an ally and although they may not be a member of that community they support, they make a concerted effort to better understand the lived experiences and make the effort to understand the challenges they face using their own voice to increase understanding for others.

More information and resources are available on the NHSE website.

"Being an Ally is a privilege but also a duty to use my position to stand side by side with my forum colleagues to learn, listen and act in whatever capacity in can."

Marie Boxall, BAME Staff Forum Ally

5. The Role of Staff Forums

In 2018, GOSH undertook its first whole organisation staff survey which identified a range of issues in relation to the culture of the Trust and how staff felt about working here. It resulted in a programme of work which ultimately led to the creation of the People Strategy 2019-22. Part of that initial response was a commitment to invest in four staff forums to ensure that staff voices could be heard. Each forum is overseen and managed by a dedicated staff group and is sponsored by a member of the Executive Management Team, who acts as advocate and ally to the forum they sponsor. We have seen the value of the forums over the last year and particularly during the pandemic when they worked across to support their members.

We now want to extend the use and influence of the staff networks and will invest in their development through ensuring their leadership are given time and remuneration rather than relying on just their good will.

The Black, Asian and Minority Ethnic (BAME) Forum

Launched in October 2018, this forum was first established to support the interests of Black, Asian and Minority Ethnic members of staff, as well as to help the Trust build a more inclusive, reflective and diverse environment. In its first year, the forum focused on three key priorities: Career Development, Social and Networking opportunities, and Leadership.

Going forwards, the forum will focus more specifically on:

1. Empowering BAME staff members by sharing their stories and experiences, celebrating their successes and making them aware of development opportunities at the Trust and within the wider NHS
2. Acting as a resource for BAME staff members in order to offer crucial peer-to-peer support, recognising the impact of systemic racism on the wellbeing of the BAME community
3. Leading conversations about anti-racism and ally-ship that drive cultural change within GOSH, encourage BAME staff to speak up about their experiences and encourage non-BAME staff to understand how they can better support their BAME colleagues
4. Connecting and networking with BAME colleagues and allies outside of GOSH and help to drive change in the wider community.

Email: BAME@gosh.nhs.uk

The Women's Forum

This forum aims to improve the working lives of everyone at GOSH. It promotes equality and supports anyone who identifies as a woman at GOSH.

The mission of the forum is to act as a place for discussion and consultation for all issues affecting women at work. The aim is to help the organisation hear that voice, and understand where we can improve the experience of women working at GOSH. In it's first year, the Women's Forum identified three key work streams:

- Progression and skills focus (mentoring, coaching opportunities, finding role models, exploring personal impact)
- Supporting women working at GOSH (maternity and return to work, menopause support, progression and understanding the pay gap)
- Inspirational speaker series

Email: Womens.Forum@gosh.nhs.uk

The LGBT+ and Allies Forum

This inclusion forum is dedicated to supporting and celebrating our staff and volunteers who are lesbian, gay, bisexual, transgender, non-binary, queer, intersex, asexual, and relationship diverse, so they feel comfortable to bring their whole selves to work. The Forum also honours and supports our LGBT+ allies. The overall aim is to ensure that LGBT+ people (staff, volunteers, patients, families and visitors) feel welcome and 'safe' being who they are at GOSH.

Through surveys, focus groups and other feedback, Forum members identified a number of priority areas:

Visibility of LBGT+ staff and families –The Forum increases visibility through celebration of LGBT History Month within the hospital, and participation in the annual Pride March and Pride in London under the GOSH NHS banner. There's also a 'GOSH We're Proud' badge – and more recently the NHS Rainbow badge – for staff and volunteers to wear, to show their support for LGBT+ people and to signal 'You can talk to me' with any concerns or questions. Due to interest, for families and members of the public. the charity-branded rainbow badge was established.

Policy and management advice – Supporting the organisation in its diversity and inclusion goals, the forum input on policy from LGBT perspectives, and provide advice to the executive and senior leadership team to continue to develop GOSH as a welcoming organisation.

Mentoring, training and education – Providing information on terminology and behaviours to help people understand better how to foster team spirit in an inclusive way.

Inclusive, varied and publicised events – Running a range of events including social drinks, pub quizzes and an annual Christmas party to grow our GOSH community of LGBT+ staff, volunteers and allies.

Links with other forums and groups – Actively supporting our colleagues in the other GOSH inclusion forums and participating in joint events as often as possible. Through Twitter and other means, the forum also foster links with other NHS and public sector LGBT+ forums.

Sharing experience and support – The forum are available as a point of contact and support for any individual within the organization.

Email: lgbtstaff@gosh.nhs.uk

Disability and Long-term Health Conditions and Friends (DLHC&F) Forum

Launched in 2019, this forum aims to create a safe, inclusive and diverse working environment that supports staff with disabilities and/or those who have a long-term health condition. Members have the opportunity to connect with their colleagues, influence GOSH policies and engage with the Trust to shape the development of both the Diversity and Inclusion Strategy as well as the Health and Wellbeing Strategy. Members have been actively involved in the valuable work that the Trust has undertaken during COVID-19 and continue to be closely involved with the COVID-19 Recovery Plan. All activities for this forum are based around our three main aims:

- Being Connected
- Being Heard
- Being Seen.

Email: DLTC@gosh.nhs.uk

6. Our Diversity and Inclusion Themes and Programme of Work

There is a lot we could do, should do and want to do but we will need to prioritise in order to provide a meaningful and deliverable programme. We have reviewed the evidence, data, and information and had input and advice from colleagues from across the Trust, to develop this Strategy and more importantly to establish the work programme it will drive. We will focus on the things that our people have told us really matter and will have the most impact, based on our commitment to make sure that all our people in all their roles are seen and heard, and have equal access and opportunities to jobs, education and training.

As a consequence our work will be built around four key themes:

1. **Opening-up external recruitment**, promoting GOSH as a creative, diverse and inclusive employer of choice
2. **Creating internal career paths and opportunities** for progression and ensure fair and transparent access to jobs, training and education
3. **Creating a more inclusive work culture for all** to build understanding and connectivity and support value-based people management practice
4. **Creating channels and safe spaces which amplify the employee voice**, ensuring that we listen, hear and take action as a consequence.

Theme 1: Opening up external recruitment, promoting GOSH as a creative, diverse and inclusive employer of choice

We will:

- Ensure that we are seen as a diverse and inclusive employer by introducing a new Employee Brand that articulates the diverse and inclusive culture we want to create as well as our welcoming, helpful, expert and one team values
- Follow best practice standards in our recruitment and promotion policies, always
- Update our recruitment channels, attraction strategies and processes to ensure they are open and accessible
- Roll-out fairer selection training and introduce diverse and ethnicity recruitment and stakeholder panels to promote fair recruitment and selection processes
- Appoint recruitment ambassadors and mentors to showcase and promote careers, people and opportunities in GOSH (including those with a disability and long term health conditions)
- Work with local organisations to promote local recruitment to jobs, education and training opportunities
- Establish GOSH as a local employer of choice, supporting individuals living in the locality to work and be trained at GOSH, improving workforce retention and ensuring that GOSH is representative of the diverse community of patients that it cares for
- Explore flexible working opportunities to ensure a balance between service delivery and home-life to support recruitment and retention, team dynamics and team working.

Theme 2: Creating internal career paths and opportunities for progression and ensure fair and transparent access to jobs, education and training

We will:

- Open up and be transparent about our decision making processes to make sure that we hold ourselves to account for following our own high standards of fairness, equality and inclusion
- Review the internal recruitment process to provide a more standardised, transparent and consistent processes accessible to all
- Create an internal vacancy portal to advertise ALL opportunities and publicise results

- Mandate the use of diverse panels for all internal recruitment and decision making processes, including for development opportunities, secondments and acting up
- Design and implement a framework to develop non-clinical career and training paths
- Introduce career coaching and mentoring. We will nurture and support staff through training, coaching and mentoring, giving every member of staff the opportunity to reach their potential
- Promote and extend access to the aspiring and development leadership programmes with a focus on under-represented groups.

Theme 3: Create a more inclusive work culture for all to build understanding and connectivity and support value-based people management practice

We will:

- Prioritise wellbeing and D&I for delivery in the leadership and management development programme
- Develop the cultural knowledge and understanding of the organisation to ensure that it becomes culturally aware and rich in cultural intelligence. To do this we will develop and roll-out an unconscious bias and cultural intelligence training for all staff
- Establish a set of principles to govern the fair and transparent application of HR polices and processes
- Review and update the key ER HR policies and establish a programme of ongoing review to reflect and embed those principles to include sharing and learning from outcomes
- Implement a 'stop and think' point into ER processes, prior to a decision to investigate, to promote informal resolution before, or as an alternative to formal process
- Develop training and resources to promote and support the role and impact of Ally-ship.

Theme 4: Creating channels and safe spaces which amplify the employee voice – ensuring that we listen, hear and take action as a consequence

We will:

- Create an internal communications framework which extends the channels and promotes two-way engagement and feedback including pulse surveys and capturing the voices of our people
- Invest in the extension, influence and impact of the staff forums and the promotion of Ally-ship
- Create an annual calendar of staff events which promote D&I and celebrates the Trust and its workforce
- Create staff listening events as standard practice across the Trust with the compulsory attendance of management, leadership and key staff
- Ensure that we are a civil and kind organisation, where individuals interact respectfully and politely, acknowledging different personal backgrounds, cultures, expectations and preferences
- Support the continued roll-out of the Speak Up for Safety and Speak Up for Our Values programmes as a means of checking our behaviours against our standards and holding ourselves to account when we fall short
- Develop a reverse mentoring scheme for senior leaders to enhance exposure and understanding of the lived-experiences of under-represented or marginalised groups
- Review and extend the influences and contribution and impact of our staff networks, recognising that the inclusion forums are currently under-resourced.

7. Measuring and Monitoring success

"Transparency is a vital first step towards harnessing the power of a diverse workforce at all levels."

A Model Employer – increasing black and minority ethnic representation at senior levels across the NHS

The Diversity and Inclusion Strategy is the practical expression of our commitment to all staff to make GOSH a great place to work for everybody. Oversight for the delivery of the programme of work will be overseen by a newly established staff forum with assurance provided by the People and Education Assurance Committee (PEAC), and an annual and mid-year review report presented to The Trust Board.

We will measure our improvement progress and publish it to demonstrate we are an organisation that is open and accountable for its progress. We will present the data regularly and action all areas where we need to get better, involving staff from all areas in developing ideas and proposals for improvement.

Proposed metrics

Many of the metrics listed below are current data points available to the trust, however some of the metrics require further work to be developed or expanded. It will be a first year priority to establish these and enable regular reporting to monitor progress.

Theme	Measure	Source	Current Performance	Targets	
				Year 1	Year 2
External Recruitment	A more diverse and representative workforce	Workforce demographics	29% BAME which is significantly below the London average of 45%		
	Greater diversity at Board and Senior Leadership levels	WRES Indicator 9	BAME representation at Board level is 8% lower than Trust workforce		
	Improvement in recruitment outcomes for BAME applicants	WRES Indicator 2, Recruitment data	White applicants are 2.03 times more likely to be appointed than BAME applicants.		
	Improvement in recruitment outcomes for disabled applicants	WDES Indicator 2, Recruitment data	Non-disabled applicants are 1.3 times more likely to be appointed than disabled applicants		
	Improvement in "Equality & Diversity" staff survey theme	NHS Staff Survey	2019 Staff Survey Themes score was 8.9 (out of 10). National average for Acute Specialist trusts was 9.2		
	Improvement in demographic pay gap	Gender Pay Gap reporting, GOSH pay data	The reported Gender pay gap for 2019 was 17% between male and female staff. There was a 13% gap between BAME and white staff, as well as a 15% gap between disabled and non-disabled staff		

Internal Career Paths	More internal applicants being promoted to role at GOSH	Recruitment data			
	Increased access to training and development opportunities	WRES indicator 4, Training data	White staff were 1.18 times more likely to access discretionary training		
	Improvement is staff feeling GOSH acts fairly regarding career progression	Staff survey	76% of respondents felt that GOSH acted fairly with regard to career progression		
	Number of career development events held	Organisational Development data			
Inclusive Culture	Reduction in relative likelihood BAME staff entering formal HR processes (e.g. disciplinary, capability)	WRES indicator 3, ER data	BAME staff were 2.74 more likely to be in a formal disciplinary process		
	Number of senior managers completing inclusive leadership training	Training data			
	Proportion of staff recommending GOSH as a place to work	NHS Staff Survey	67% of respondents would recommend GOSH as place to work		
Employee Voice	Increase in membership of GOSH staff forums	Staff Forum data			
	Improved staff declaration rates against protected characteristics	HR data	34% of staff have opted to not disclose at least one protected characteristic		
	Number of listening and staff engagement events held	HR and Forum data			
	Number of trained in Speak up for Safety and Speak up for Our Values	Training data			
	Number of staff trained in reverse mentoring scheme	HR data			

8. Summary and Conclusion

The purpose of this Diversity and Inclusion Strategy was always to support delivery of some of the key commitments set out in the People Strategy. Through this Strategy and programme of work we are committed to addressing the systemic issues we have identified through a joined-up and integrated approach. It scales up action to increase the representation of under-represented groups at all grades across the trust; and it establishes a more robust approach to inclusion and building a culture that attracts, retains and nurtures the best and most diverse talent. Ensuring accountability through greater transparency to staff and stakeholders.

We have listened to staff across the Trust, including our highly engaged and hardworking staff inclusion forums about the barriers they still face and the further actions required to make a real difference to their experience. We have taken a strong, evidence-based approach, adopting best practice and learning from research on what works to improve diversity and inclusion. We have used this evidence to help shape our approach and produce a platform for further and faster progress on which we can all stand.

There is a role for everyone to play in achieving our ambition to become a diverse and inclusive employer of choice and where everyone feels able to bring their whole self to work and perform at their best. Openness, honesty, challenge, and a commitment to listen, learn and take action rests with all of us.

We would urge all staff to read this strategy and reflect on what each of us can do to help deliver its ambitious objectives.

The Diversity and Inclusion Strategy is the practical expression of our commitment to all staff to make GOSH a great place to work for everybody. Oversight of the delivery of the programme of the work will be overseen by a newly established staff forum with assurance provided by the People and Education Assurance Committee (PEAC), and an annual and mid-year review report presented to The Trust Board.

References

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NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Mind, Body and Soul

Our Health and Wellbeing Strategy

Contents

Version Control

Title	Mind, Body and Soul: our Health and Wellbeing Strategy
Strategy	Wellbeing Strategy
Executive Sponsors	Director of Human Resources
Date	28 08 20
Version	14
Status	Draft

Foreword

----------TEXT TO BE ADDED----------

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Matthew Shaw
Chief Executive

Our people are the head, the heart, the hands and the face of Great Ormond Street Hospital (GOSH). They make us who we are and allow us to do extraordinary things. We value and respect them individually and collectively for who they are, as well as what they do. As a Trust we are committed to ensuring all our people are well led and well managed, but also, supported, developed and empowered to be, and do, their best.

People Strategy
2019-22

1. Introduction and Purpose

Here at GOSH, every member of staff should feel cared for and cared about. They should be supported to be healthy in mind and body, feel safe and secure while working – whether on site or at home – and feel part of the GOSH community. That's what this strategy is all about.

Responding to the COVID-19 crisis has been an incredible collective endeavour. But the pressure on individuals, at work and at home, has been immense. Never has compassionate and inclusive leadership been more important. Never has there been such need for wellbeing and support services to keep people healthy, well, engaged, supported, motivated, and safe.

GOSH rose to the challenge of the pandemic with a positive culture and a wealth of new initiatives to support wellbeing (see page 7). Now it's time to embed those initiatives and deliver on the commitment set out in our People Strategy – to provide a more holistic approach to managing health and wellbeing across the organisation.

> **"Working with seriously ill children and their families, many of whom have complex conditions and uncertain futures, is physically and emotionally challenging. It places huge demands on our staff day in and day out. While there are a wide range of support arrangements in place for staff, they have been introduced over time and are therefore uncoordinated and sometimes difficult to navigate. The situation is further exacerbated by a lack of organisational infrastructure, and strategies which promote trust, respect, inclusion and health and wellbeing.**
>
> People Strategy 2019-22

This Health and Wellbeing Strategy covers the period from September 2020 to December 2022 and will be overseen by the People and Education Assurance Committee. It will be delivered by the Trust and supported by both NHS funding and charitable donations from the GOSH Children's Charity, without whose generous support many of the health and wellbeing services needed to support staff simply could not happen.

The first year's activity will focus on reviewing existing health and wellbeing services to ensure they are connected, integrated and accessible. We will roll out enhanced support services to staff, including counselling, coaching and revised Occupational Health services. We will also establish a Health and Wellbeing Steering Group to co-design health and wellbeing interventions.

In the second year, we will build on external partnerships and develop capacity and capability internally, implementing a different way of working which embeds health and wellbeing into our DNA.

At the end of 2022, we will review progress against the Strategy and revisit the vision for the future to ensure that it aligns with the People Strategy and Above and Beyond, the organisation's overarching strategy which takes us to 2025.

Board and Executive involvement in this strategy will ensure a 'Board-to-ward' approach and we will learn from the best practice of our partner organisations at a local, regional, national and international level. Our approach will be cohesive and consistent to bring together a range of mutually reinforcing initiatives, new and existing, that support health and wellbeing in the widest sense.

2. Priorities and Beliefs

We have identified three health and wellbeing priorities:

1. **Our Mind:** focusing on mental health and wider wellbeing
2. **Our Body:** focusing on our physical health while working, whether at home or on site
3. **Our Soul:** focusing on safe travel to and from sites; safety and security while we are working; and focusing on the GOSH community and how we work together as #OneTeam.

Our approach to, and programme of work in each of these areas is described in section 6.

Our work will be based on **five core beliefs** about health and wellbeing:

1. That staff health and wellbeing and sense of belonging have a positive impact on patient experience and patient outcomes
2. That staff who feel cared for and cared about, will be able to deliver high quality services
3. That individual staff have different risks and different needs for health and wellbeing support, so resources should be tailored to meet those needs
4. That managers play a vital part in identifying and discussing aspects of health and wellbeing both in the moment and at structured touch points
5. That the impact of health and wellbeing interventions should be measured by using both quantitative (sickness absence, staff survey results) and qualitative (listening events, themes) data

3. Drivers for Change

3.1 Above and Beyond – a strategy for GOSH

Wellbeing is at the heart of our first priority in the Trust's five-year strategy, Above and Beyond.

In this the Trust commits to **making GOSH a great place to work by investing in the wellbeing and development of our people**. It states that, as a GOSH community, we must value and respect each other, work together as one team, and put in place the support, education and development opportunities to help us be at our best, every day.

3.2 Our People Strategy

In November 2019 we launched our new People Strategy. We set out a three-year plan to create an inclusive organisation where our people are valued for who they are, as well as what they do. Through our People Strategy we will look at our most urgent workforce issues; ensure clear, shared expectations to help our people learn and thrive; and develop the skills we need to respond to a changing NHS – embracing new ways of working at GOSH and beyond.

This **Health and Wellbeing Strategy (H&WB)** will sit alongside a new **Diversity and Inclusion Strategy (D&I)**. Together they will provide the foundations to reinforce the commitments set out in the People Strategy and create the environment and a work programme to ensure they are delivered and, in doing so, help us meet the expectations set out in the NHS People Plan (see section 3.5).

3.3 NHS Workforce Health and Wellbeing Framework (2018)

This framework provided a guide for organisations in developing and improving their staff support programmes and activities. It listed leadership and management, data and communication, and a

healthy working environment as organisational enablers and mental health, musculoskeletal (MSK) health and healthy lifestyles as health interventions.

3.4 The NHS Long Term Plan (2019-2029)

This brought together learning about staff health and wellbeing from the previous ten years and made a commitment to make the NHS a consistently great place to work.

"We will seek to shape a modern employment culture for the NHS – promoting flexibility, wellbeing and career development, and redoubling our efforts to address discrimination, violence, bullying and harassment."

3.5 The NHS People Plan (August 2020)

The People plan for 2020/21 *'We are the NHS – action for us all'* was published in August 2020.

The Plan sets out what the people of the NHS can expect – from their leaders and from each other – for the rest of 2020 and into 2021. It sets out actions to support transformation across the whole NHS. It states how much we must all *'continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care'*.

It recognises that '*our NHS people have been under increasing pressure since the response to COVID-19 began, and there will be further challenges ahead. Workload remains a pressing concern and we have all been reminded how critical it is to look after our people – and that we need to do more. To address this now, and for the future, the NHS needs more people, working differently, in a compassionate and inclusive culture'.*

The Plan sets out practical actions that employers and systems should take, as well as the actions that NHS England and NHS Improvement and Health Education England will take over the remainder of 2020/21. It focuses on:

- **Looking after our people** particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically
- **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong
- **New ways of working and delivering care** emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care
- **Growing for the future** particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer.

3.6 The Health and Well-being at Work report from the Chartered Institute of Personnel and Development (March 2020)

This report said that presenteeism (people coming to work when they were not well) and leaveism (people working beyond their contracted hours or using annual leave for work or illness) were critical indicators of the health of an organisation's culture. These unhealthy work practices have serious implications for the physical and mental health of employee, and for organisational productivity.

3.7 The Impact of COVID-19 on the Workforce

COVID-19 has changed the way we work, maybe forever. During the pandemic staff at GOSH responded quickly to set up a number of new Health and Wellbeing Services (see below). We will take the good practice implemented during this time and put it in place for the long term. This means focusing on things like personal protective equipment and social distancing in a way that we have not had to consider before.

Psychological Support: Ensuring staff get access to wellbeing services, providing signposting and psychological first aid. CareFirst providing information services and counselling.	**Occupational Health Service:** Providing specific individual guidance and support to keep people well and safe based on their risk. Undertaking fitness to return to work assessments following COVID-19 symptoms.	**Track and Trace:** Identifying staff who have had contact with infected individuals, offering testing to staff with symptoms, and offering antibody testing for COVID-19. Providing appropriate advice and support including self-isolation.	**Personal Protective Equipment:** Supplying and fitting staff with appropriate PPE to carry out their roles safely. Advising on face coverings and other measures to facilitate a safe commute to work.
Social Distancing: Assessing all wards, offices, corridors etc in the Trust to ensure the appropriateness of their use and ability to social distance. Identifying all COVID-19 secure areas.	**Safer Travel:** Working with staff to consider ways of getting to and from work safely, such as working different hours and using alternative modes of transport.	**Risk Assessments:** Assessing and reassessing the risks to our staff and making reasonable adjustments where practicable to do so.	**Remote Working:** Continuing to support remote working where possible and ensure staff have what they need to work safely in the office or at home.

4. Our People and Processes today

The environment of the NHS is stressful and we know that here at GOSH, caring for critically ill children is emotionally challenging yet incredibly rewarding. As an organisation it is important to us to understand the stresses and challenges faced by staff in order to help us decide what services we need. We use the data we collect about the health and wellbeing of our people to plan future support.

What we know about our organisation:

Our Organisation

- We employ around 5,000 staff
- Around 75% of our staff are female and over half of our staff are aged under 40.

Our Health and Wellbeing

- Sickness related to psychological and mental health challenges accounted for nearly 15% of reported sickness in 2019-20
- We had 85 referrals to Occupational Health in 2019-20 related to work-based stress
- Our highest rate of sickness is amongst our Estates and Ancillary staff (4.6%), closely followed by Additional Clinical Services (4.4%).

Our Staff Survey (2019-20)

- 22% of staff felt that the organisation took positive action on health and wellbeing
- 71% felt that their immediate line manager took a positive interest in their health and wellbeing
- 51% of staff were satisfied with flexible working opportunities
- 74% felt that their line manager was supportive in a personal crisis
- 44% of staff felt that communication between senior management and staff was effective
- 67% of staff would recommend GOSH as a place to work.

During COVID-19, the ability of the organisation to understand its data and use it for the benefit of staff became crucially important. In June 2020 we ran our first In Touch pulse survey to gauge how people were feeling as we managed the difficult challenges posed by COVID-19. This short survey had a specific emphasis on staff wellbeing and communications. Over 1,500 (30%) staff responded, 61% of which were based on site and 39% were at home. We found that:

- 18% of respondents were finding it hard to cope
- Most people (80%) knew where to get health and wellbeing support
- 64% of on-site workers felt safe or very safe being on site
- 71% of respondents felt their manager was taking an interest in their wellbeing (which is the same as the annual staff survey)

Our In Touch Pulse Survey (June 2020)

Over the next two years we will improve our data collection and our data analysis so that we are better able to prioritise our efforts and provide appropriate health and wellbeing support in the areas of most need.

5. Building on Good Practice

Health and Wellbeing Projects 2019/20

Across the Trust, a number of Directorates have implemented local projects and practices to improve staff health and wellbeing. Some examples are below.

Body Bones and Mind:

- Have a daily debrief
- Use a going home checklist
- Run sisters' wellbeing check-ins twice a week
- Run recharge hubs on the wards to help staff move from COVID-19 ways of working to business as usual
- Plan to continue running staff support groups that were set up during COVID-19 because of the positive response received from staff.

Bear Ward:

A shielding member of staff set up 'Zoom Health and Well-being clinics' in which they organised a one-to-one catch up session with each member of staff. The lead nurse conducting the sessions provided staff with up-to-date information taken from the Health and Wellbeing Hub on GOSHWeb. The lead nurse downloaded, tried and tested the mindfulness apps in order to give an honest, informed opinion. The team used recurring themes from staff conversations to guide what help and support information they sent out to all members of the team.

Nursing Workforce:

- Improved implementation and access to flexible working and flexible retirement
- Improved use, ownership and understanding of Health Rostering
- Offer equitable access to unsocial hours, bank shifts
- Share good practice around pastoral care and improved provision currently in place in H&L and education on this through NWAG and matron meetings
- Created a new wider staff recognition awards at both local and trust wide level
- Use a going home checklist and staff huddles following success in BBM
- Proactively signpost to support including financial, health and wellbeing, staff benefits and career clinics
- Established five day access to support and advice via the nursing workforce team.

Activities and Incentives at GOSH

The organisation provides a number of additional health and wellbeing activities and incentives for staff, such as yoga, pedometer challenges, netball, football, walking tours, a choir and much more. More information is available on GOSHWeb.

6. Our Health and Wellbeing Priorities and Programme of Work

Cross Cutting Priorities: Our Mind, Our Body, Our Soul

A number of programmes of work will help us deliver on all three of our priority areas. They are:

A Responsive and Ready Wellbeing Hub: During the COVID-19 pandemic, the Trust developed a number of Health and Wellbeing support services, at pace, in order to respond to the immediate needs of staff dealing with high stress, both in work and at home. We at GOSH set out a pan-trust wellbeing service that was predominantly delivered through digital and virtual platforms, interspersed with targeted, face-to-face interventions for higher risk groups. To support us to continue the valuable work of the Hub and bring it in to mainstream operation, extending its accessibility, we will:

- Develop a network of trained Peer Support & Wellbeing Practitioners
- Deliver and implement, REACTMH, a recognised wellbeing awareness programme for new clinical staff that join the organisation
- Recruit and train Wellbeing Coaches to support staff to better regulate their emotions and build their coping strategies and resilience muscle
- Recruit and train Trauma Risk Management (TRiM) practitioners.

Full Roll Out of HealthRoster: The roll out of HealthRoster commenced in 2018 and is now live across 87% of services at GOSH. By October 2020, all staff members across GOSH will be live on HealthRoster and this will be the main web-based electronic tool to monitor staff members' working patterns and ensuring they are based on fairness and equity. This is such an exciting opportunity for GOSH to modernise our systems and business processes, inevitably resulting in some of us doing things differently, but in a positive and cohesive way. During the pandemic, the use of HealthRoster has become the fundamental platform for monitoring staff attendance and absences. There are many benefits of this new system including:

- Streamlining the monitoring of staff attendances and absences by providing full visibility and analysis of staff availability
- Ensuring compliance with working time regulations and supports health and wellbeing of both staff and service users
- Monitoring staff members working patterns to improve staff wellbeing and retention rates
- Managing sickness across teams and ensuring it is documented correctly, monitored and followed-up appropriately
- Fast, efficient rostering which improves quality, and meets the needs of staff and service users.

Developing GOSHWeb for the Digital Future: The COVID-19 crisis has shown just how important it is to share accurate information as quickly as possible in a clear and compelling way. To support anxious staff, worried families and nervous patients, the hospital has invested time and resource in communications and engagement. COVID-19 will be with us for years to come, and what we now know is that the hospital intranet – our repository for guidance, support and advice – is not fit to meet the challenge of our continued response to the virus. A new, innovative intranet with focus on communication and information and will:

- Be fully searchable, so people can find important information
- Be accessible on site and off site, taking mobile access into consideration
- Host media formats like videos so that we can share guidance about things like how to use personal protective equipment (PPE) safely and effectively
- Host our new leadership and management network to support GOSH leaders to lead through and manage future demands
- Provide easy access to Care First advice and guidance, e.g. financial support and counselling.

Priority 1: Our Mind – ensuring that wellbeing is considered right across the organisation

The emotional impact that caring for sick children has on individuals is recognised across the organisation.

At GOSH, good mental health is essential to good leadership, a positive culture, inclusive team dynamics and excellent performance. We need to make changes at both an organisational level and an individual level to ensure that mental health is considered right across the organisation.

Experience during the COVID-19 pandemic has shown us that we need to:

- Monitor the wellbeing needs of staff
- Provide relevant teaching and training to ensure staff are competent
- Identify vulnerable staff groups
- Ensure support services are accessible to staff who need them
- Ensure that the Trust is responsive and flexible in meeting changing healthcare demands and addressing the impact this has on the workforce.

High sickness absence is linked to high patient mortality

Prof Sir Bruce Keogh. NHS England, 16 June 2013

Staff experience has a direct impact on patients' experience

Maben et al., National Institute for Health Research, 1 November, 2012

Safe, effective patient care is intimately linked to good staff health, wellbeing and engagement. Research has found that doctors who feel more engaged are significantly less likely to make mistakes, while a study of nursing practice similarly found that higher staff engagement was linked to improved patient safety. Better staff wellbeing is even associated with reduced MRSA infection rates and lower standardised mortality figures.

Work and wellbeing in the NHS: why staff health matters to patient care, Royal College of Physicians, March 2015

In Year One we will:

- Continue to develop a sustainable package of support to ensure that emotional wellness is a fundamental element of our culture. This package will include Wellbeing Coaches, Peer Support and Wellbeing Practitioners
- Develop the new Health and Wellbeing Hub to reflect the new strategy and become a 'one stop shop' for support, continuing the good practice established during COVID-19
- Ensure that mental health first aiders are networked and accessible to staff at the right time and with the right skills

In Year Two we will:

- Extend and support line managers' capability to identify stress and distress in staff and understand how best to support them
- Embed staff health and wellbeing into new HR policies and guidance
- Build health and wellbeing of staff into the way that we monitor quality and performance as a Trust.

Priority 2: Our Body – Providing occupational health and support services that meet the needs of our changing context

Health and wellbeing is crucial to performance at work and home and to living the best life you can. Increasingly, research is being conducted on the impact of lifestyle behaviours on mortality. Smoking, excessive alcohol consumption, poor nutrition and physical inactivity are important modifiable risk factors.

Here at GOSH our Occupational Health service aims to promote, maintain and protect the health of everyone throughout their working life in the organisation.

In Year One we will:

- Undertake a full independent review of the Occupational Health Services being provided at GOSH to ensure they meet the needs of our changing landscape
- Work with our staff forums to adapt and personalise health and wellbeing support for hidden and specific staff groups
- Rewrite our Sickness and Absence Policy to reflect a positive wellbeing focus
- Develop a Physical Wellbeing platform to raise awareness, improve knowledge and provide opportunities to enhance wellbeing. This will include education and advice about nutrition, hydration, sleep, physical activity, smoking cessation and alcohol consumption
- Signpost staff to the wide variety of services to support good health choices.

In Year Two we will:

- Build the ability of managers to hold health and wellbeing discussions and signpost to healthy choices
- Develop specific health and wellbeing support, reflecting the greater reliance on digital technologies and remote working self-assessments to set individual health goals dependent on ability, with improvements along a personal, physical wellbeing journey.

Research with employers found that informal meetings between employees and line managers with a good understanding of the employee's condition(s) are useful in dealing with employment-related health issues. The success of OH interventions by employers was considered to be highly dependent on how accommodating managers and companies are, as well as how interested they are in helping employees.

Understanding the provision of occupational health and work-related musculoskeletal services, IFF Research for DWP and DHSC, May 2020

Happiness is contagious: Our happiness influences the people we know and the people they know. Research shows that the happiness of a close contact increases the chance of being happy by 15%. The happiness of a 2nd degree contact (e.g. a friend's spouse) increases by 10% and the happiness of a 3rd-degree contact (e.g. a friend of a friend of a friend) increases by 6%.

Action for Happiness, Happiness Fact 03/06/20

Priority 3: Our Soul – Ensuring staff feel safe and secure while working and building a strong community for GOSH

It is important that staff feel safe and secure at work. We know that the way staff feel at home impacts the way they feel in work, in the same way that thoughts about work impact on life at home. Communities are adaptive and changing and we seek to ensure that we build a strong community at GOSH where everyone feels connected, valued and unique.

In Year One we will:

- Promote practical support for staff who want to travel using sustainable methods
- Review how we can be flexible in our approach to work, to see it as a function rather than a location, to support staff during COVID-19 and beyond, and to promote wellbeing
- Develop specific support for staff with higher health risks, by working with our wider forum groups and Staff Partnership Forum
- Maximise our support to people in financial hardship and those seeking financial advice
- Raise the profile of health and wellbeing in our appraisal policy and process
- Use our In Touch pulse survey to shape the way we respond and adapt to the changing health and wellbeing needs of our staff
- Increase the ways that we communicate as a GOSH community, taking into account 'Smarter Working'
- Launch our 'Speak Up for our Values' programme with support for peer messengers and managers
- Encourage and promote staff 'Praise' and opportunities to provide positive feedback.

Engaged staff are significantly less likely to make mistakes.

Royal College of Physicians, 12 October 2015

In Year Two we will:

- Build our connections with the local community to support integrated working and a sense of belonging
- Monitor the ongoing impact of COVID-19 and develop responsive and adaptive plans
- Review staff policies with the key aspects of the Health and Wellbeing Strategy in mind to ensure consistency
- Extend our community to work with our contracted services, volunteers and honorary contract holders to ensure they have access to health and wellbeing support
- Put in place advice surgeries linked to development opportunities and career progression, ensuring improved job satisfaction across the workforce and improving job security
- Embed the 'Speak up for Safety' programme into policies and guidance
- Set up a variety of engagement mechanisms regarding personal safety to ensure that everybody's voice can be heard, including contracted staff.

2019 NHS Staff Survey:
Humans have three core needs and it is particularly important these are met in the workplace. They are the needs for belonging, competence and autonomy.

Belonging:
- bullying and harassment from staffs has shown little or no decrease – 18.1% in 2015 to 19% in 2019
- 53.4% report strained relationship at work

Competence:
- Is undermined by chronic excessive workload and 77% report unrealistic time pressures
- 31.5% do not believe they are able to deliver the care they aspire to

Autonomy:
- 52% say they are involved in changes affecting their team, the same as 2015
- 34.5% say that senior managers act on staff feedback

7. Measuring and Monitoring Success

This Strategy sets out how we will support staff health and wellbeing for the next two years. We intend that at the end of the first year we will have taken the good wellbeing practices developed during the COVID-19 pandemic, learnt from them and further developed them to ensure that the health and wellbeing support available to staff across the organisation is high quality, responsive and flexible. At the end of the second year we will have invested in staff training and development to ensure that caring for staff health and wellbeing is business as usual and embedded within our culture.

To help us achieve these goals, we will develop an implementation plan through which we can be held to account for delivering on our actions.

This implementation plan will be developed and overseen by a core Health and Wellbeing Steering Group with representation from different professions. We will develop sub-groups to act as challenge and critical friends in each of the three themes, and ask these to co-design the right solutions and uphold our key principles.

Reporting and monitoring of our implementation plan and impact on outcomes for staff will take place through the People and Education Assurance Committee.

Proposed Metrics

Theme	Measure	Source	Current Performance	Targets (to be agreed)	
				Year 1	Year 2
Mind	Does your organisation take positive action on health and wellbeing? (Q11a)	Staff survey	22%		
	Number of Peer Support Workers trained	Training records			
	Number of staff accessing the Health and Wellbeing Hub	Hub activity data			
	Staff satisfaction of Health and Wellbeing Hub	TBC			
	Number of staff accessing Mental Health First Aiders	Mental Health First Aiders contact numbers			
	My immediate manager...is supportive in a personal crisis. (Q8e)	Staff survey	74%		
	HR policies include reference to health and wellbeing	Policy audit			
	Quality and performance monitoring to include reference to health and wellbeing	TBC			
Body	Review of Occupational Health services	Review document			
	Implementation of Occupational Health services review recommendations	Implementation plan and performance reports			

	Adapt and personalise health and wellbeing support for hidden and specific staff groups	TBC			
	Develop a Physical Wellbeing platform	User access/hits			
	My immediate manager takes a positive interest in my health and wellbeing. (Q8f)	Staff survey	71%		
	Health and wellbeing support reflecting the greater reliance on digital technologies	TBC			
Soul	Number of staff taking up the Cycle to Work scheme	TBC			
	How satisfied are you with the opportunities for flexible working patterns? (Q5h)	Staff Survey	51%		
	Number of staff accessing financial advice service	Care First			
	Roll out of Speak Up for our Values	Speak Up activity data			
	Number of staff, contracted services, volunteers and honorary contract holders engaged in personal safety activities	HR data			
	Improvements in In Touch pulse survey results	In Touch pulse survey			
	Communication between senior management and staff is effective. (Q9b)	Staff survey	44%		
	Number of Praise submissions	HR data			
	Number of community events	Partnership data			
	I would recommend my organisation as a place to work. (Q21c)	Staff survey	67%		
	Take-up of health and wellbeing support by contracted services, volunteers and honorary contract holders	HR data			
	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (Q14)	Staff survey	76%		

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Attachment O

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
16 September 2020

Directorate Presentation: Sight and Sound Directorate **Submitted by:** Elizabeth Jackson, Chief of Service, Sight and Sound Directorate	**Paper No: Attachment O**

Aims / summary

- A review of Directorate performance – this is provided for information and background only
- Progress made towards meeting the objectives of the new Trust strategy 'Above and Beyond'

A short presentation will be delivered at the Board meeting with time for questions

Action required from the meeting

- For noting

Contribution to the delivery of NHS Foundation Trust strategies and plans

- Delivery of trust strategy

Financial implications

- None

Who needs to be told about any decision?

- Not applicable

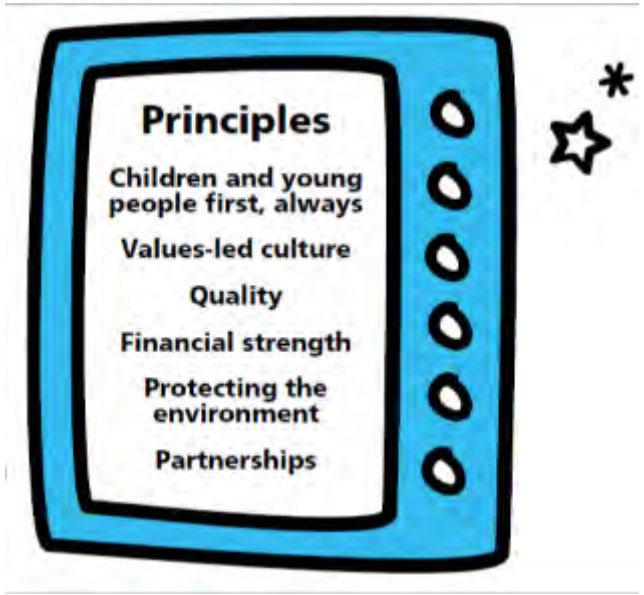
Who is responsible for implementing the proposals / project and anticipated timescales?

- Not applicable

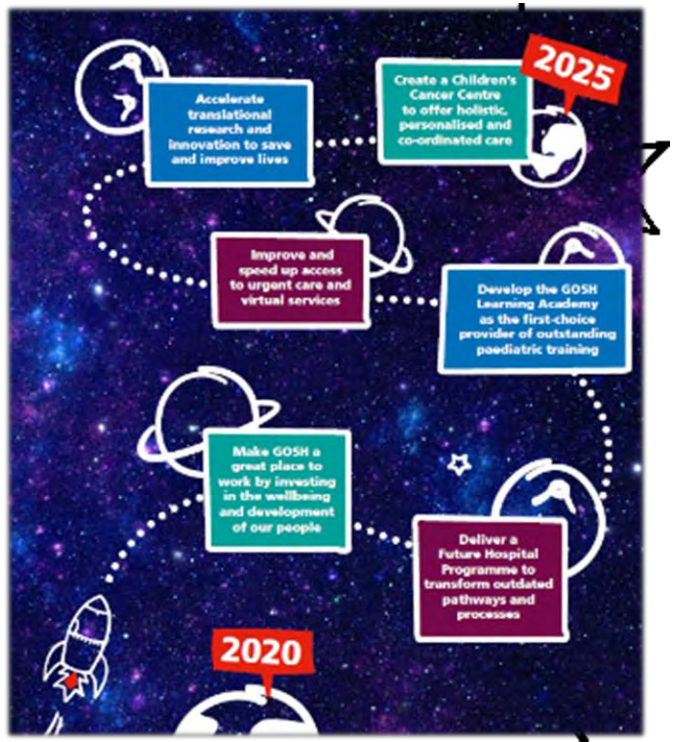
Who is accountable for the implementation of the proposal / project?

- Not applicable

Sight and Sound
DIRECTORATE REVIEW



Trust Board
16 September 2020



Liz Jackson – Chief of Service
Daniella Soar – General Manager
Carolyn Akyil – Head of Nursing and Patient Experience
Chris Jephson – Deputy Chief of Service

Team Organogram

Chief of Service

Elizabeth Jackson

Deputy Chief of Service

Christopher Jephson

Head of Nursing and Patient Experience

Carolyn Akyil

General Manager

Daniella Soar

Specialty Lead

ENT, Audiology, Cochlear Implant

Michelle Wyatt

Specialty Lead

Ophthalmology

Chris Lloyd

Specialty Lead

Dental and Maxillofacial

Simon Critchlow

Specialty Lead

Cleft Lip and Palate, Craniofacial and Plastic Surgery

Neil Bulstrode

Staff Group	WTE
Add Prof Scientific and Technical	28
Additional Clinical Services	37
Administrative and Clerical	126
Allied Health Professionals	6
Estates and Ancillary	2
Healthcare Scientists	11
Medical and Dental	57
Nursing and Midwifery Registered	47
Grand Total	**314**

Top three successes and challenges in the last year

Top three successes

- Opened Falcon; new, state of the art outpatient facilities in the Zayed Centre for Research
- Response to COVID-19; partnership working with NCL General Paediatrics, staff redeployment to other centres and internal departments, delivering outpatient care virtually (slides 6 and 15)
- Improved workforce and safety metrics; regular monthly risk action groups, improved incident management, consistent statutory/mandatory training compliance (slides 9,13 and 14)

Top three challenges

- Dental service; shortage of consultant cover, growing number of 52 week waits and Operation Tooth Fairy (slide 15)
- Recruitment; Outpatient HCAs, Paediatric dental consultant, lead Audiologist, Craniofacial consultant
- COVID-19 recovery; growing waiting list including patients transferring as a result of NCL paediatric reconfiguration, access to theatre lists and surgical bed capacity (slide 5)

Top three priorities

- Restoration of services; prioritising clinical need, long waiters and ensuring equitable access to care (slide 5)
- Successful commissioning and opening of the new Sight and Sound Centre at the Italian Hospital
- Leading on Outpatient Transformation and delivering benefits of virtual consultations and self-service appointment bookings

Principle 1: Children and young people first, always

Activity

- Restoring elective activity to 19/20 levels within current capacity constraints is a major challenge.
- Effort required to clinically prioritise admitted, non-admitted and planned waiting lists.
- Increased proportion of outpatient visits taking place via video and telephone; up to 52% in July 2020.

Slides 5 and 6

Clinical outcomes

- Newly commenced outcome reporting on implantable hearing aids for Microtia, BAHA and Middle Ear Implants;
- Cleft; great improvement in Orthodontics and Speech.
- Facial palsy; plan in place to resolve gap in provision of specialist physiotherapy.

Slide 7

Research and Innovation

- Newly commissioned gene therapy being delivered in partnership with Moorfields.
- NIHR fellowship for Lola Solebo, Ophthalmology
- First few cases of laryngeal re-innervation surgery completed.
- Remote programming of cochlear implants
- Orthodontic intra-oral scanner business case being prepared.

Principle 1: Children and young people first, always

Restoring elective activity and clinical prioritisation

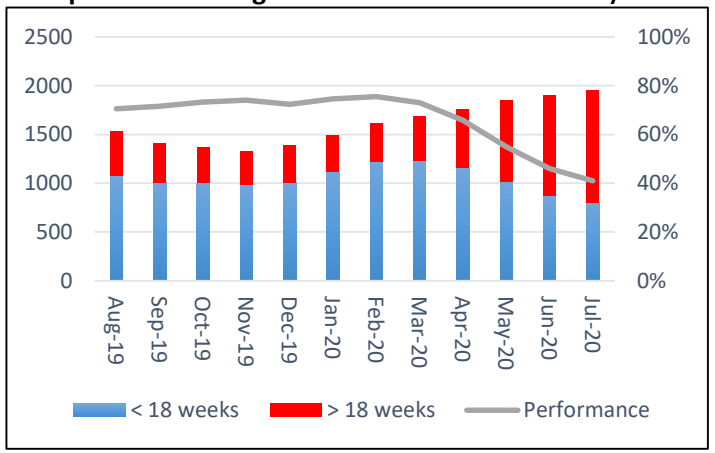
Situation:

- 2,009 patients were waiting for their first appointment or treatment* at the end of July 2020; 1,953 are on RTT pathways and a growing number are waiting more than 35 weeks for treatment.

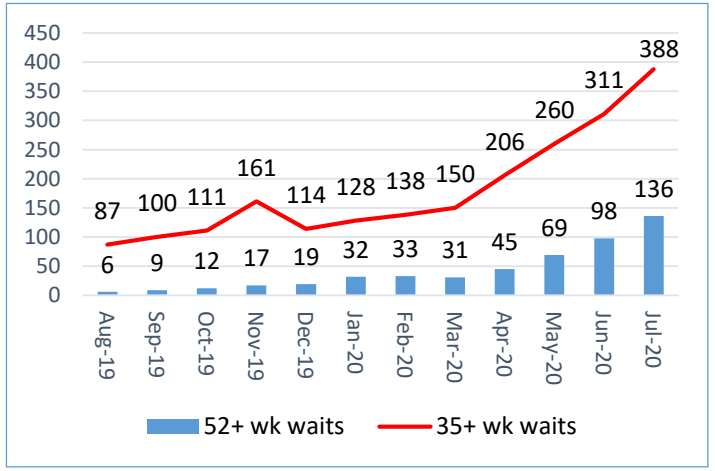
Actions being taken:

- Continue to treat the most clinically urgent patients; those with airway issues, risk of vision loss, suspected cancer (priority 1a or 1b)
- Continue to clinically prioritise those on the waiting list and categorise as priority 2, 3 or 4
- In reply to NHSE's third phase response to COVID-19, those patients expected to breach 52 weeks by March 2021 will be prioritised for treatment once the priority 2s have been treated.

RTT incomplete pathways:
% of patients waiting < 18 weeks = 41% July 2020



Number of RTT patients waiting:
35 weeks + and also 52 weeks +



Challenges:

- The number of priority 2 patients continues to exceed the theatre capacity we have been offered for the next 4 weeks.
- The number of patients waiting over a year continues to rise. Currently standing at 136 (July 2020).
- 50% of all patients waiting for Plastic Surgery are deemed clinically low priority (category 4) yet majority have been waiting over 18 weeks.
- Agreement to transfer NCL Plastics patients from the Royal Free will result in a further deterioration of the waiting list.
- Seeking agreement of families to come in for procedures and/or pre-admission COVID testing is a daily challenge.
- Current air changes in Dental and Outpatient clinic rooms is a constraint on increasing activity until remedial works are completed.

Principle 1: Children and young people first, always

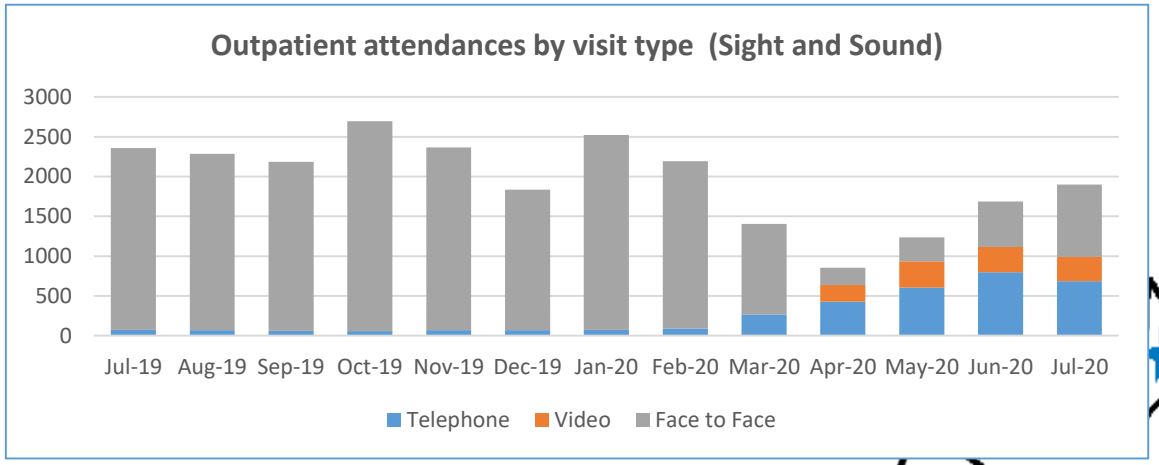
Delivering outpatient care virtually

Situation:

- The 2019 NHS Long Term Plan set a target for all Trusts to reduce traditional face to face outpatient activity by a third and while progress was being made towards this goal, the COVID-19 outbreak accelerated delivery of the solution.

Actions taken:

- Established principle that video should be used to deliver outpatient care where clinically appropriate.
- Supported rapid delivery of fully integrated Epic MyGOSH and Zoom solution resulting in improved experience for the clinician.
- Stood up team to sign patients up to MyGOSH and support them with technology set up.
- Reviewed governance policies, processes and guidelines to ensure new ways of working were compliant and safe.
- Exploring ways to improve the patients experience for video consults; i.e. using reception staff to manage the virtual waiting room and keep patients informed of any delays.



Outcomes:

- In July 2020, 52% of all outpatient activity was delivered via telephone and video, rather than face-to-face, compared to 3% at the same point last year.

Challenge:

- While the aim is to continue to deliver at least 35% of all OP activity virtually going forward, services such as Audiology, Dental, Ophthalmology require a high proportion of physical examinations.

Principle 1: Children and young people first, always

Clinical outcomes

Service	How we perform	What we want to improve
Dental and Maxillofacial	Consistently low surgical site infections and no non-elective readmissions (exception: Jan 2020)	Improve communication with families.
Audiology, Cochlear Implant and ENT	We're consistently excellent on avoiding implant failure of hearing aids according to the SSQD data	Reduce non-elective spike in readmissions as seen this Summer.
Ophthalmology	Paediatric cataract and inflammatory eye disease; leading establishment of evidence based guidelines for national	Improving the routine capture of patient generated and reported outcomes, and integrating them into our management – we are currently working on grants to support the work needed for this.
Cleft Lip and Palate	Comprehensive benchmarked data. GOSH achieves high levels of normal speech in our patients compared to peers (exception In 19/20, 16 patients were not screened for psycho-social issues before their 6th birthday)	To resolve issue with patients not being screened, continue to offer another appointment to those who do not attend audit clinic and follow up with phone call.
Craniofacial	Patient-Reported Outcome Measure (PROM) and a Patient-Reported Experience Measures (PREM) completed before and after surgery show excellent outcomes for concern ratings, shape improvement and also psycho-social measures such as reduced bullying.	PREM data says we could do better preparing patients for their operation. Need to also publish more up to date data (nothing post 2018)
Plastic surgery	PROMs show significant increase in patient satisfaction and function. Where hand surgery is concerned, thumb strength was reported to have the lowest level of satisfaction (64%).	Facial palsy; plan in place to resolve gap in provision of specialist physiotherapy
Beckwith Wiedermann Syndrome (BWS) and specifically treatment of macroglossia through tongue reduction surgery	Leading the world in evidence base for the treatment of macroglossia associated with BWS. Only highly specialised service in the UK. For example, across 3 clinical measures for immediate surgical outcomes (oral feeding start, surgical complications and length of stay) patients showed marked improvement over the last 4 years.	Sharing our learning with other Centres.

Principle 2: A values led culture

Top workforce issues

- Ensuring staff who are in the high/severe risk category feel confident to return to work or are supported to continue home working.
- Stress felt by admin staff as a result of increasing workload in response to COVID-19. 20% of all sickness episodes are stress/anxiety related.
- Turnover amongst admin and continuous recruitment cycle to fill vacancies in the Central Booking Office in particular. Many however are moving because of internal promotion.

Slide 9

Culture, engagement, health and wellbeing

- Support for home working; during COVID-19 and onwards.
- Leadership walkarounds, 'tea at three' feedback sessions and first Directorate webinar with 70 attendees have all provided opportunities for staff to engage directly with the leadership team.
- Launch of Sight and Sound Health and Wellbeing Ambassadors Programme in August 2020.
- 85% of staff reported knowing how to access health and wellbeing advice and support from the Trust.

Key staff survey results and actions

- Improved score for 'morale' and 'quality of care' ranking in top quartile compared to the organisation.
- Feeling safe from violence at work is serious area of concern.
- Deteriorated score for 'health and wellbeing', 'quality of appraisals', 'immediate managers' and 'team working'.
- Service level action plans focused on local issues.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement	Team Working
	improved	worsened	worsened	improved	worsened	improved	no change	worsened	improved	worsened	improved
Directorate Score	8.8	5.6	6.8	6.2	5.4	7.7	7.8	9.6	6.8	7.2	6.4
Trust Score	8.8	5.8	7	6	5.7	7.5	7.9	9.8	6.9	7.3	6.6
Rank (of 21)	12	14	14	3	14	6	14	16	11	11	14
National Average	9.2	6.3	7.1	6.4	5.8	7.9	8.3	9.8	7	7.5	6.9

2018 to 2019 comparison:

- Improvement in 5 themes
- Deterioration in 4 themes
- No change in 1 theme

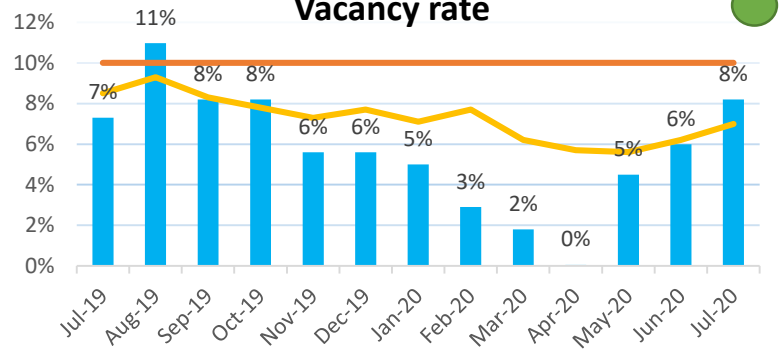
Slide 10

Principle 2: A values led culture

Workforce headlines

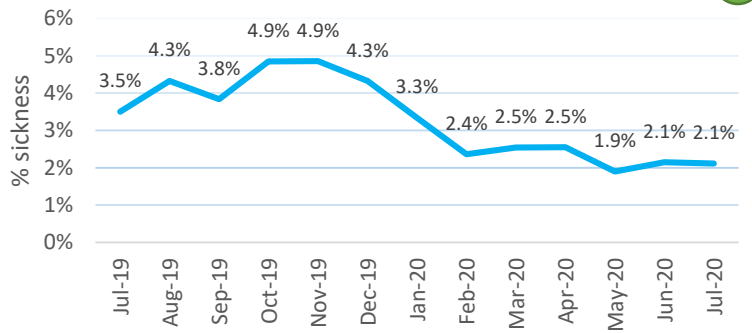
Key
- Trust target
- Trust performance
- Directorate performance

Vacancy rate



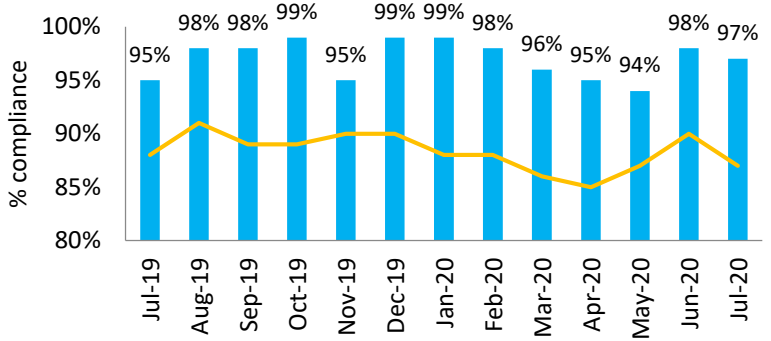
- **Successful recruitment to long standing vacant posts in 19/20 financial year.**
- Leavers not replaced during Apr/May while activity was down i.e. in outpatient reception and central booking office. Recruitment however has now resumed.
- Bank spend is 5.4% in July compared to 7.2% last year

Sickness rate



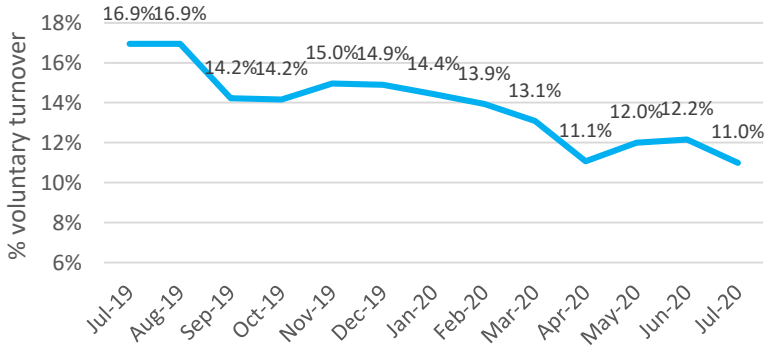
- **Improving trend** 2.% in July compared to 4.3% at same time last year.
- !! Stress/anxiety related conditions commonly makes up 20% of all sickness reported
- Line managers are reporting that homeworking has reduced number of sickness episodes

PDR



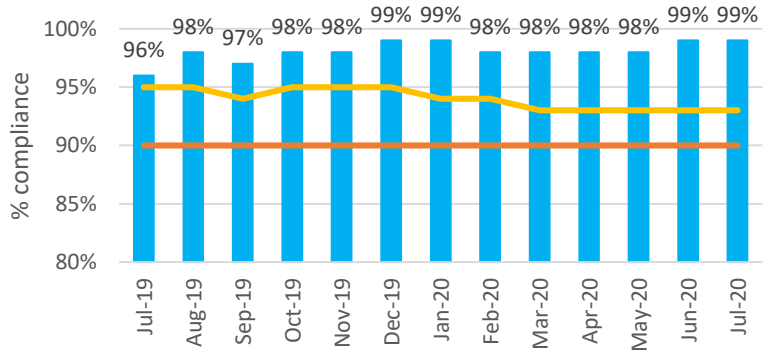
- **Consistently outperforming 90% target and Trust**
- PDR compliance dropped between March and May 2020 due to prioritising COVID management but is recovering now as we return to business as usual.

Voluntary turnover



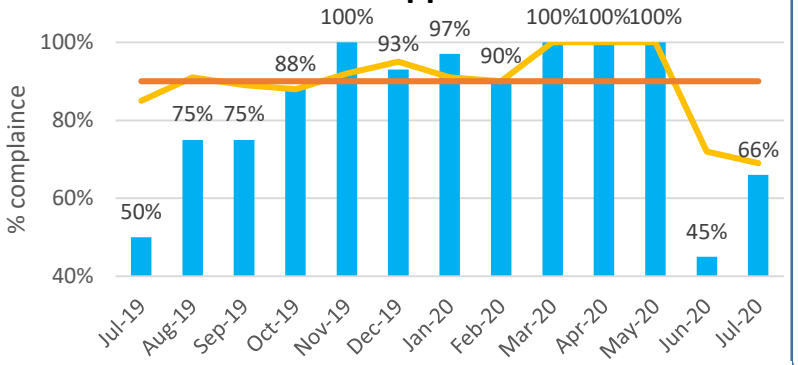
- **Improving trend** 11% compared to Trust target of 14%
- Total turnover (including fixed term contracts) is 14.5%
- Highest % voluntary turnover over the year has been across audiologists, service managers, ward and outpatient nursing.

Statutory mandatory training



- **Consistently outperforming 90% target and Trust**
- Weekly monitoring and chasers by Chief of Service are the contributing factor to maintaining compliance even throughout COVID crisis period.

Consultant appraisals



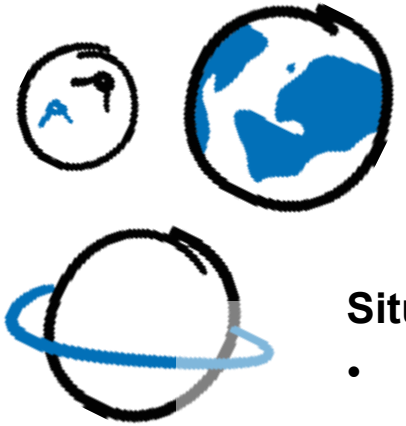
- Consultant appraisals are at 100% (due to current GMC COVID exemption). Without exemption, the Directorate is sitting at 66% compliance.
- Target is 80% compliance by October 2020.

Principle 2: A values led culture

Key staff survey results and actions

How Sight and Sound local results compare to that of the Trust in 19/20 and actions being taken

Staff survey question	Trust	S&S	Worst performers	Best performers	Actions taken
Morale: I have a choice in deciding how to do my work (Yes)	56%	44%	29% Ophthalmology 31% Main Reception	58% ENT 57% Central Booking Office	Line managers in teams with issues asked to explore underlying reasons via 1:1s
Quality of appraisals: It helped me agree clear objectives for my work (Yes, definitely)	35%	25%	13% Dental/Maxfac 14% Ophthalmology	45% Main Reception 38% ENT	All line managers asked to complete Trust PDR refresher training by October 2020. Peer reviews to be organised before end of the year.
Safe environment: In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from ***patients / service users, their relatives or other members of the public?*** (% of staff saying they experienced as least one incident)	23%	34%	57% Outpatients 44% Audiology/Cochlear 43% Main Reception 41% Ophthalmology 38% Dental/Maxfac	0% Health Records	DATIX incidents raised following every incident and local RCA completed to understand trigger or themes. Breakdown in communication is a common trigger and happens for example when an appointment is cancelled and the patient unware.
Team working: The team I work in has a set of shared objectives.	71%	61%	32% Outpatients	75% ENT 71% Central Booking Office	Outpatient matron and charge nurses to communicate objectives of flow improvement work at weekly huddles. Looking to see how an away day can be arranged.
Reporting culture: The last time you experienced physical violence at work, did you or a colleague report it? (% of staff saying they, or a colleague, reported it)	59%	43%	0% Audiology and Cochlear 0% Central Booking Office 0% ENT 0% Health Records	67% Main Reception	Staff are regularly reminded of the importance of reporting incidents of abuse or violence at work to their manager as and when it is occurring so support can be offered / correction action taken.
Learning: Have you had any training, learning or development in the last 12 months? (not including mandatory training)	75%	63%	46% Health Records 46% Main Reception	80% Dental/Maxfac	Aim to ensure that at least one PDR objective relates to training, learning or development for every member of staff.
Environment: I have a clean work space.	72%	60%	33% Health records	85% Main reception 79% Central Booking Office	The health records team have acted on feedback and worked hard to declutter the space and tackle pest issues.
Equality, diversity and Inclusion: On which grounds have you experienced discrimination? Averaged across all types i.e. religion, race	44%	22%	43% Audiology	14% Central Booking Office 14% ENT 14% Main Reception	Line managers directed to complete training modules on unconscious bias. Local survey to be carried out in Audiology to draw out any remaining issues.
Morale: I often think about leaving this organisation.	33%	27%	45% Outpatients 41% Ophthalmology	6% Dental/Maxfac 9% ENT	Ophthalmology service review conducted. Regular listening events for Outpatient teams and anonymous feedback boxes.



Principle 2: A values-led culture

Staff survey action plan: Health Records and Scanning Bureau

Situation:

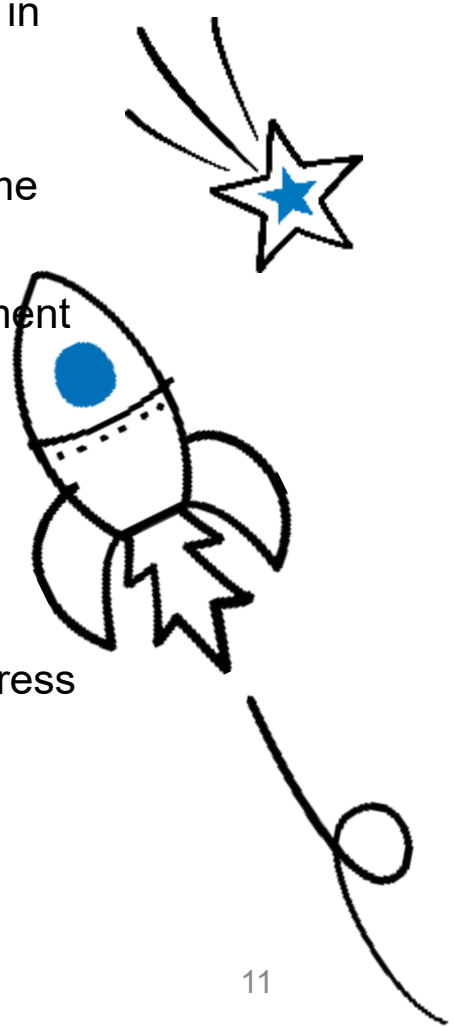
- 98% of staff in the Health Records and Scanning Bureau team responded to the 2019 staff survey. This provided rich data from which we could learn and generate targeted actions.
- Themes identified as areas for improvement were ‘quality of appraisals’, ‘career development’, ‘work environment’ and ‘wellbeing’
- In response, the management and staff have worked collaboratively to put a number of interventions in place.
- The aim is to improve staff engagement, improve work life balance and reduce staff turnover.

Actions taken to date:

- The following interventions are now all in place:
  - Weekly ‘social’ reflective huddles
  - Support for staff to work from home
  - Upgraded office rest facilities
  - Quarterly 1:1s between management and every staff member

Actions planned:

- Additional management training
- DISC profile awareness training
- Appraisal training
- Additional ‘pulse’ survey to check progress



My immediate manager takes a positive interest in my health and well-being

Only 58% of staff agreed with this statement

Principle 3: Quality

Compliance

- 3 long standing red risks closed:
  - delay to treatment from lack of paediatric dentist,
  - risk of elective cancellation due to failure of ophthalmic microscope and
  - inadequate infection control management in outpatients
- Proportion of incidents closed within target of 45 days has improved from 59% (April 19) to 84% (July 20).
- WHO checklist completion rate is 99% (July 20).
- 63% of clinic letters are sent within 7 working days; average turnaround time has improved month on month to 6.8 days (July 20).
- 2 serious incidents reported in the last 12 months.
- Sustained improvement for FFT inpatient response and recommendation rate, currently 98%. Outpatients recommendation rate is 95%.
- All complaints in the last 18 months have been closed within the agreed timeframe. In the same period, we have had one red complaint (Apr 20) which is now closed.

Slides 13 and 14

Epic ePR

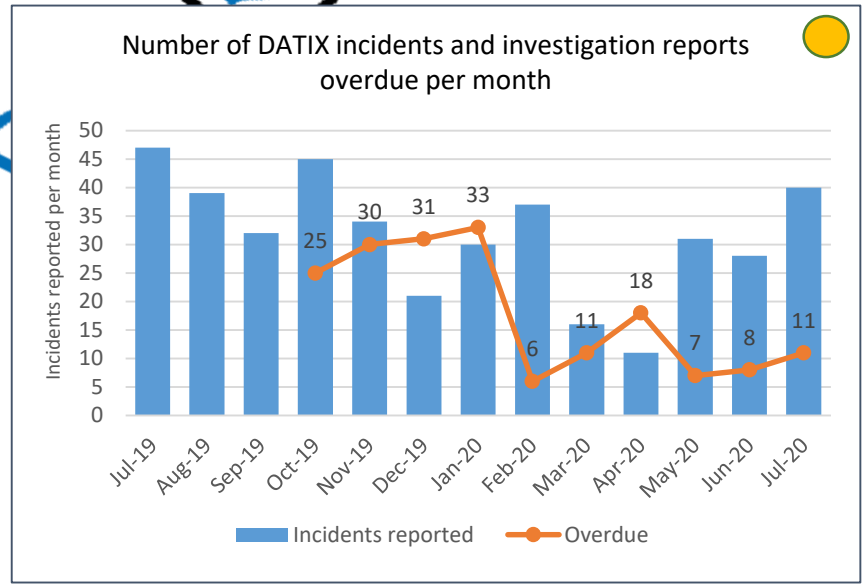
- Directorate taking the lead on a number of clinical and admin Epic optimisation projects
- Reduction of paper records has meant that staff in Health Records and the Scanning Bureau could fulfil new roles of MyGOSH helpdesk and support the set up of video clinics.
- With the implementation of Epic and personalisation, clinic letter turnaround in ENT has reduced from 5-6 days to 1-2 days.

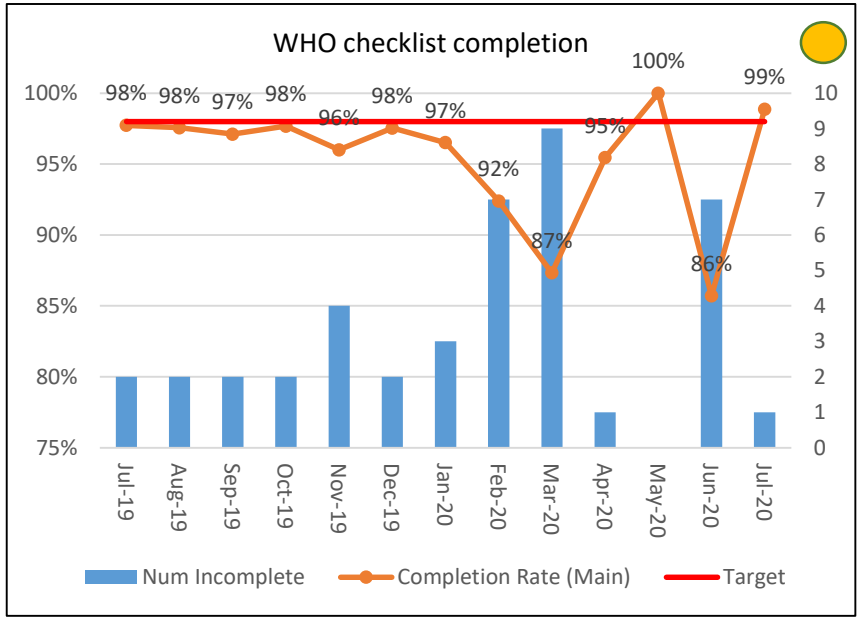
Transformation

- Directorate leading on Trustwide Outpatient Transformation Programme
- Focus on clinical pathway re-design including successful shift from consultant to more audiologist led clinics
- In final stages of information governance checks before starting new initiative of cochlear implant remote programming

Principle 3: Quality

Compliance





DATIX incidents

- DATIX incident reporting was lower in March/April 20. Believe this is correlated with reduced inpatient and outpatient activity due to COVID.
- Decline in number of overdue DATIXs is a direct result of increased levels of monitoring and leadership support to investigate and close incidents.
- !! Number of overdue incidents has risen in last 3 months. Action being taken now to close these.

WHO checklist

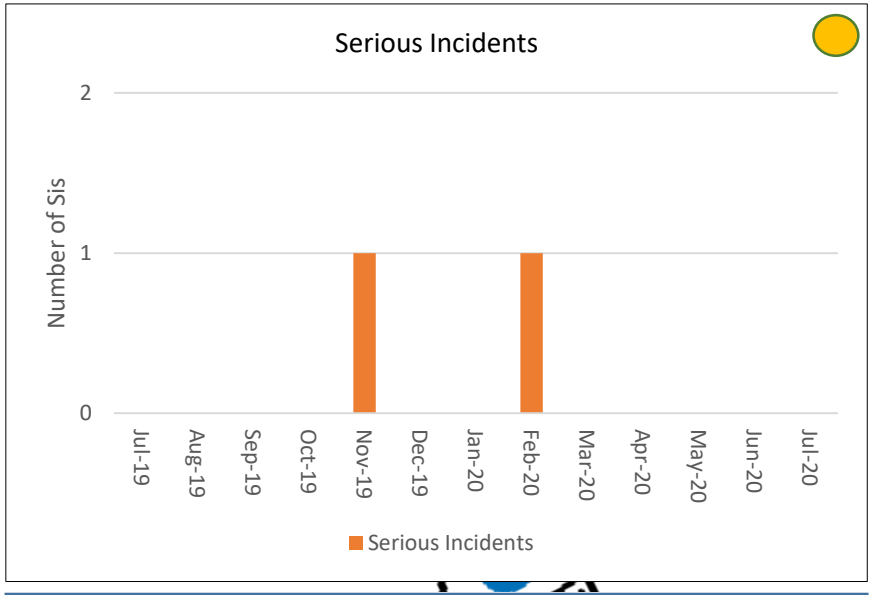
- Deputy Chief of Service has confirmed that WHO checklists are being completed in practice but there are documentation gaps on Epic. Surgeons have been reminded to seek verbal confirmation that is has been completed on Epic.

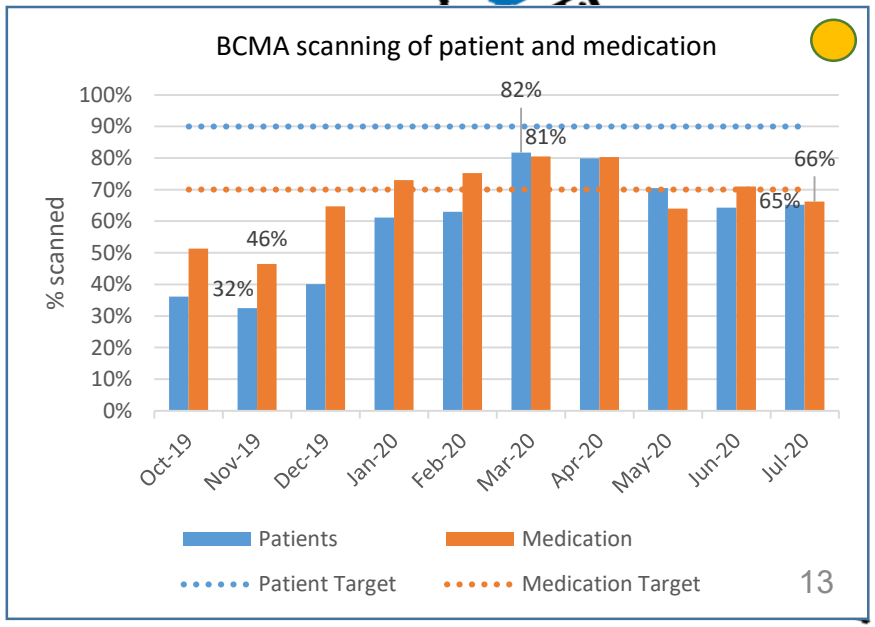
Serious Incidents

- 2 SIs in last 12 months; one relates to procedure carried out without a valid consent. Learning was shared at surgeons forum. This has now been signed off by NHSE. The second relates to an unexpected death following a Maxillofacial procedure. Learning included recommendations for APOA, Dental/Maxillofacial, Anaesthetics and for the Trust to review management of and guidelines for high BMI patients.

BCMA scanning compliance

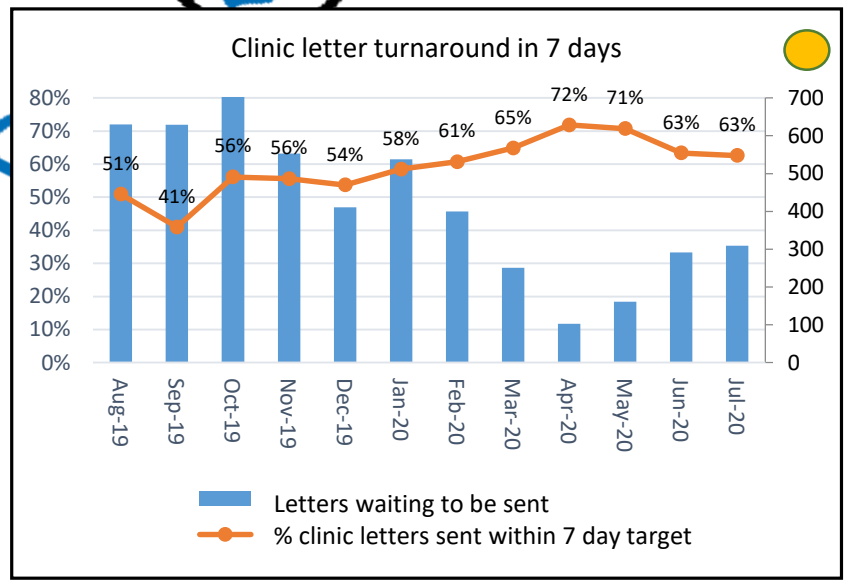
- !! Area of concern and something that the charge nurse on Panther ward is actively working to improve. Best performance was achieved in March 2020 pre-COVID. July performance was 66% in comparison. Action plan in place.

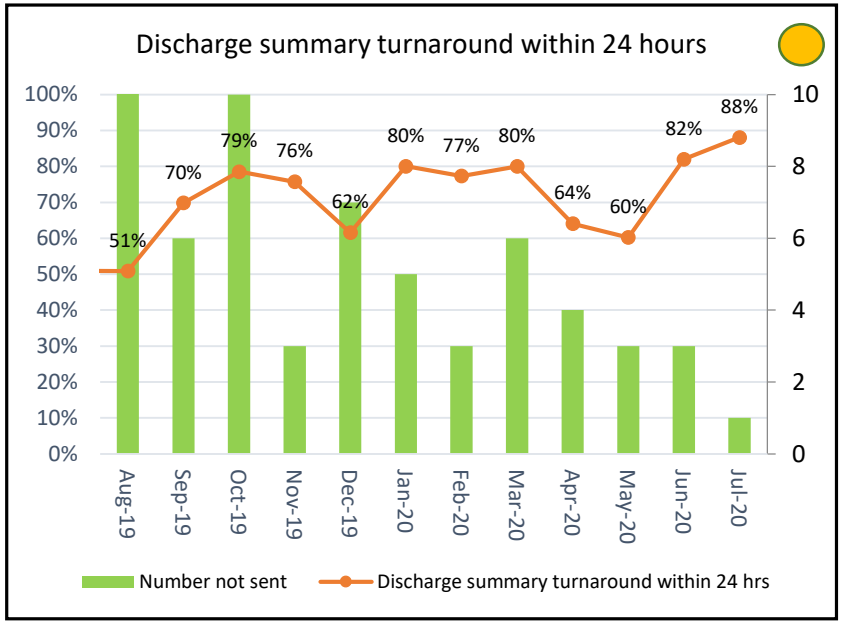




Principle 3: Quality

Compliance





Clinic letter turnaround in 7 days

- **Improving.** Each service has worked hard to overcome the challenges that followed the implementation of the new electronic patient record system and reduce their backlog. Average turnaround time is now 6.8 days compared to 25 days in April 2019.
- While percentage compliance with the 7 day turnaround target has worsened over the last couple of months, attendances have increased significantly at the same. [an increase of 800 between June and July 2020].
- Individualised actions plan are in place for consultants who are struggling with performance.

Discharge summary turnaround

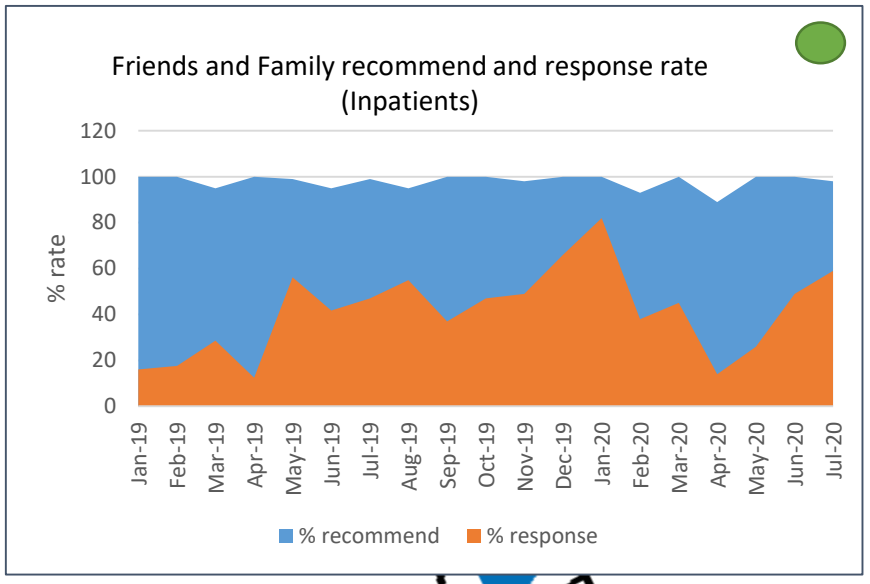
- **Improving.** Since the introduction of Saturday cover and increased team supervision, performance has improved and is expected to be maintained going forward.

Friends and Family Test (FFT)

- The inpatient response rate improved from May 2019 when the charge nurse on Panther ward took direct responsibility for speaking to families each morning and handing out FFT cards. This took a dip during April and May when interaction with families was restricted under COVID prevention measures.

Complaints

- For the review period 19/20, Sight and Sound ranked second best when comparing the ratio of complaints to combined patient activity (*outpatient attendances + inpatient episodes) with other Directorates. The trend of normally receiving 1-2 new complaints per month has continued in to 20/21.



Complaints per 1000 combined patient activity * (FY 19/20)

Directorate	Number of Complaints	Patient activity	Complaints per 1000 CPA	% of Complaints per 1000 CPA
Blood Cells & Cancer	13	42947	0.30	12%
Body Bones & Mind	22	49095	0.45	18%
Brain	13	35360	0.37	14.8%
Heart & Lung	8	50471	0.16	6.4%
IPP	10	19855	0.50	20%
Medicines Therapies & Tests	5	17760	0.28	11.2%
Operations & Images	4	15251	0.26	10.4%
Sight & Sound	8	43939	0.18	7.2%

Principle 3: Quality

52 week waits: Paediatric dentistry

Situation:

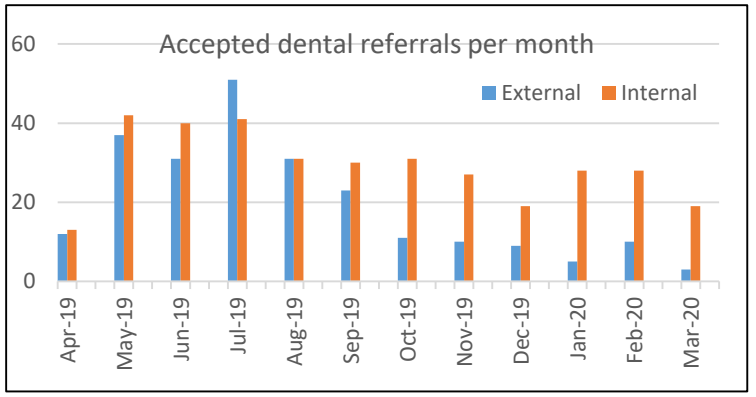
- Increasing demand for services compounded by a shortage of paediatric dentists resulted in 52 week waits

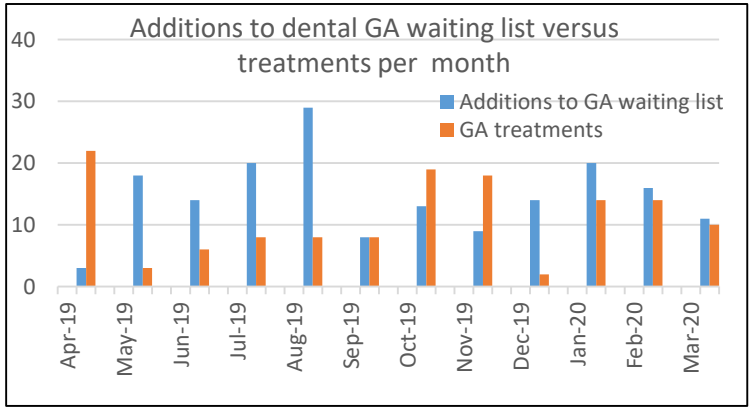
Actions taken:

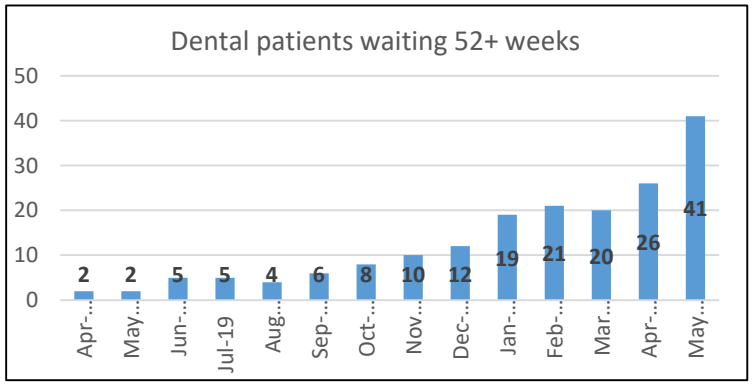
- Rigorous application of acceptance criteria and closure of service to external new patient referrals in October 2019
- With patients' consent, arranged treatment of 13 less complex patients at Chelsea and Westminster NHS Trust (25 offered treatment)
- Agreed additional lists with existing consultant dentist to maintain activity and clear 52 week waits by the end of March
- Recruitment of a new consultant dentist (started in post June 2020)

Outcome:

- Harm reviews carried out on all patients waiting 52 weeks+. No harm found.
- Reduction in new patients accepted with priority given to complex patients known to GOSH.







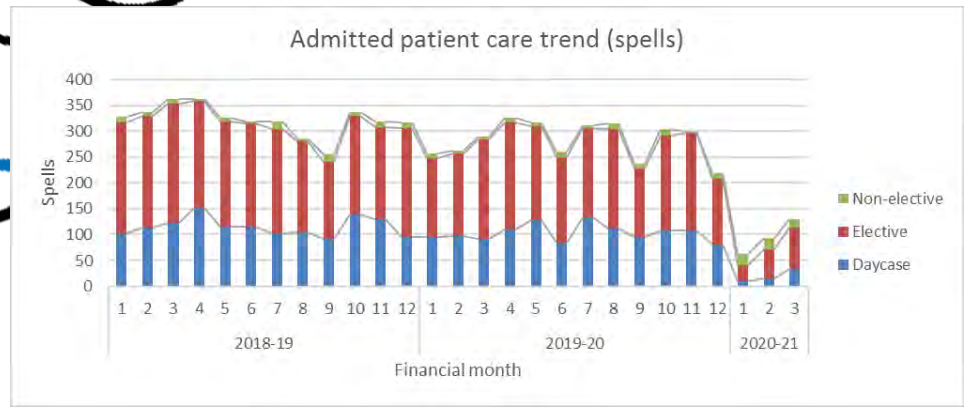
New challenges:

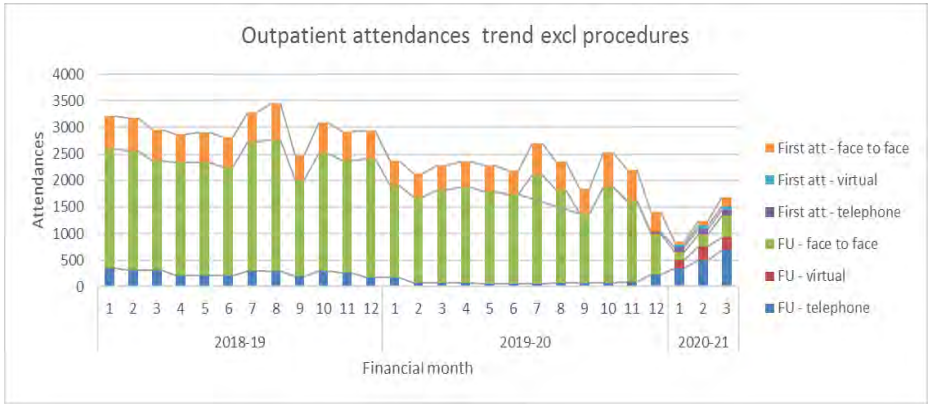
- COVID-19 led to patients requesting to delay their treatment on top of our own list cancellations. This has meant increasing numbers of 52 week + waits in Dental. Now standing at 75 (July 2020).
- Following updated infection control guidelines for aerosol generating procedures (AGPs), clinic rooms need to be left for up to 4 hours in between treatments due to current air exchange capability.

Actions taken:

- Works to upgrade air handling. Will see fallow time between appointments reduce to 20 minutes in 4 out of the 6 rooms. This is the best outcome that can be achieved.
- Exploring partnership with UCLH with the aim of maximising capacity/capability across 2 centres and ensure children with greatest clinical need receive care first, and long waiters are prioritised.
- In line with clinical prioritisation group that long waiting patients should be treated as highest priority 3s.

Principle 4: Financial strength

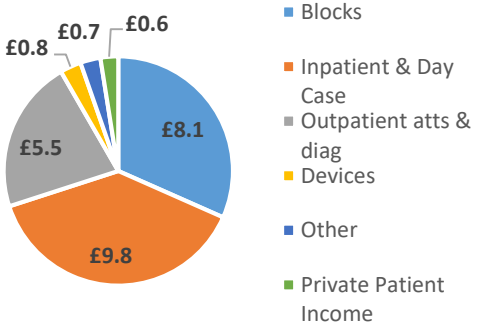




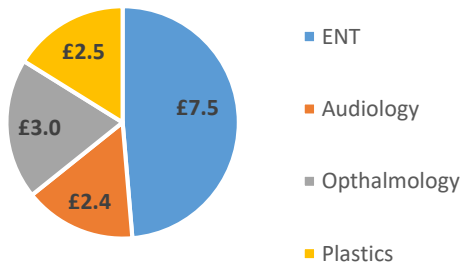
- Admitted patient care spells for Sight & Sound significantly reduced since M12 2019/20 due to Covid.
- Mix of care has also changed; elective/day case work reducing significantly and non-elective rising (including transfer of patients from local Trusts to facilitate their Covid response), all based on clinical priority.
- Activity has grown between M1 and M3 2020/21; referrals are returning with a continued strong pipeline of cases.

- Volume of outpatient attendances significantly reduced since M11 2019/20 due to Covid, but seeing a continued improvement in M2/M3 2020/21.
- The mix of care delivery method has changed due to Covid; the directorate has seen substantial growth in the number of virtual and telephone appointments and reduction of face-to-face appointments.

Patient Care Income 2019/20 (£m)



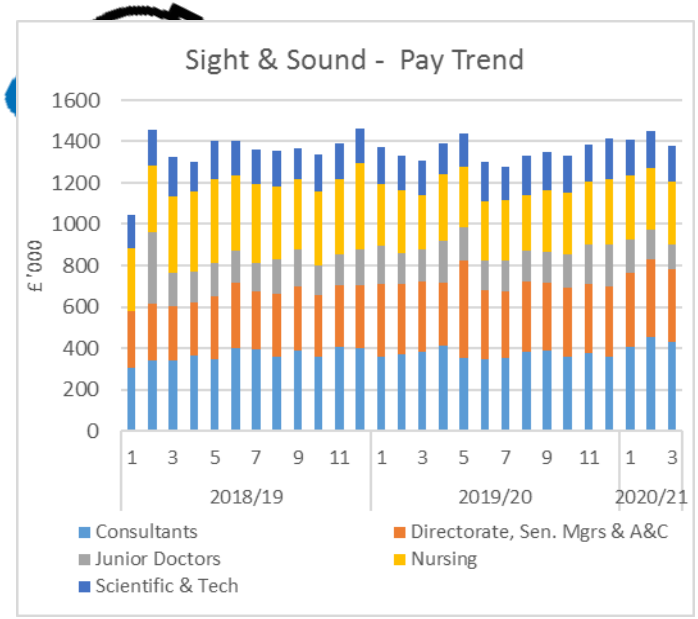
Top 4 specs by income (excl block & devs)



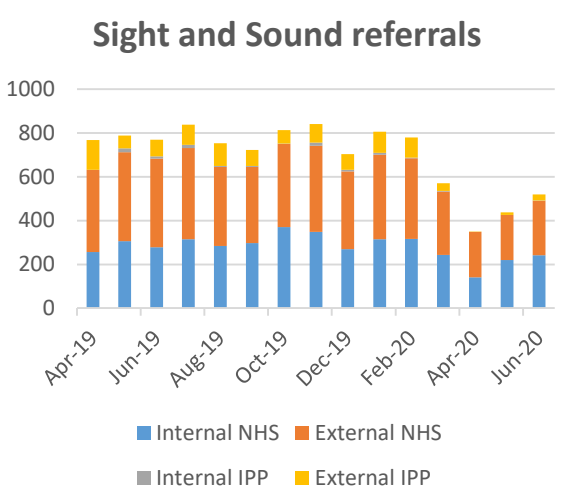
**cochlear assessments and bilaterals incl. in ENT*

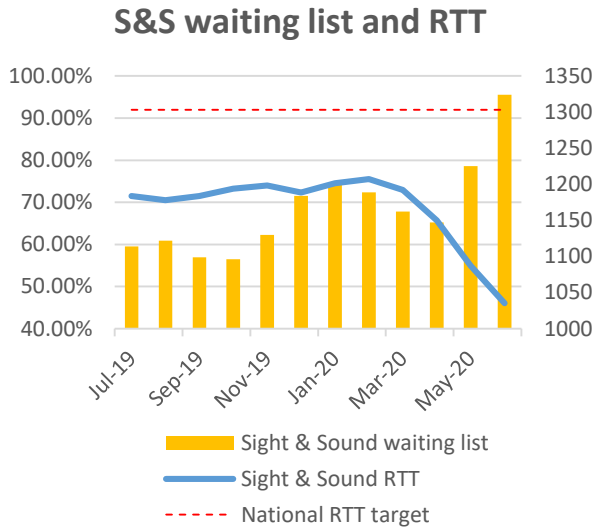
- Activity within Sight & Sound is almost entirely NHS work, with private patients generating only between 1%-2% of income.
- Inpatient and day cases generated the largest proportion of income (£9.8m) in 2019/20, whilst outpatients generated £5.5m. It is likely that this mix will change in 2020/21; expect fewer inpatient procedures given Covid and infection control changes, and greater outpatient volumes given advances in virtual appointments.
- ENT generates the most significant income for S&S with c. £6.0m coming from inpatient procedures in 2019/20. Audiology (£2.1m) and Ophthalmology (£1.1m) generate the majority of outpatient income currently (2019/20).

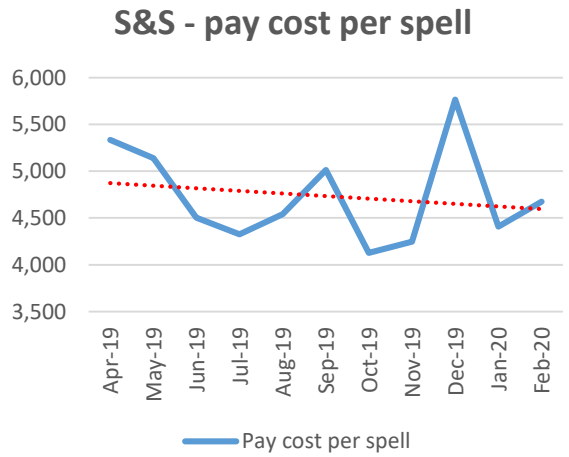
Principle 4: Financial strength



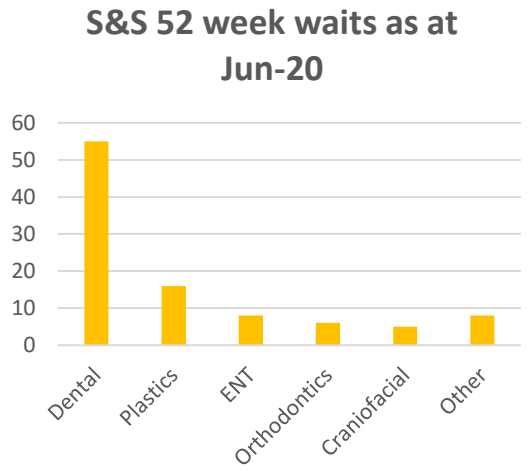
- S&S pay in 2019/2020 totalled £16.2m which is 5.5% of Trust total pay (£295.8m) and 67% of S&S annual expenditure. Non-pay totalled only £6.0m (of which £1.5m was pass-through).
- Pay spend has maintained throughout 2019/20 into 2020/21 with headcount remaining broadly stable.
- Referrals remained strong throughout 2019/20; whilst lower during Covid, a gradual return towards normalised levels can be seen.
- Given Covid, waiting lists have grown significantly; a growing waiting list and returning growth of referrals suggests a strong future pipeline. RTT continues to suffer given this backlog, creating potential future pressures in delivering care.

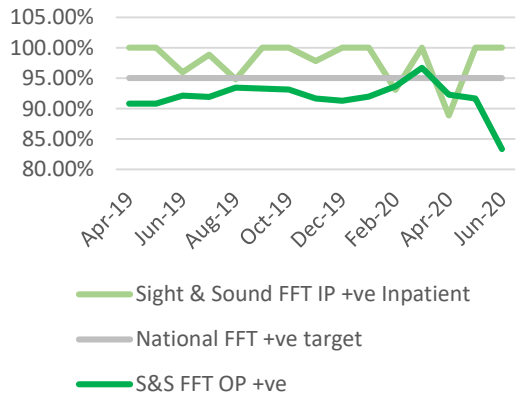






- Until Covid, S&S showed a reducing pay cost per spell which suggests directorate efficiency improvement through 2019/20.
- The directorate face challenges with their 52 week waits with particular pressure in dental and plastics; reduction will remain a challenge given infection control guidelines.
- S&S has continued to deliver a high quality service according to the positive FFT feedback. Outpatient feedback would usually be based on 500-600 responses each month but has been based on a much smaller sample (10-15).





Principle 5: Protecting the Environment

Sustainability

- Epic electronic patient record instead of paper
- Reducing patient travel through virtual consultations
- Reducing staff travel through home working

Current space and environment

- Space for aerosol generating procedures; number of air changes.
- Magpie, Southwood Building: old, outdated
- Social distancing in offices
- Outpatient cleaning frequency in response to COVID

Capital developments

- Falcon Outpatients; opened Oct 2019
- Sight and Sound Centre; due to open April 2021
- Rolling replacement programme for dental chairs
- Explore opportunity to create more in-chair capacity

Case Study: Moving from paper to digital

Situation:

- MyGOSH allows patients/carers to access their own health records online. One of the key benefits is that correspondence is uploaded to a patient's MyGOSH account, avoiding the need to print and post letters.

Action taken:

- The Outpatients reception and Central Booking Office team have been promoting the benefits of MyGOSH and encouraging sign ups
- Following COVID outreak, we stood up a further team of ten staff to prospectively sign patients up to MyGOSH.

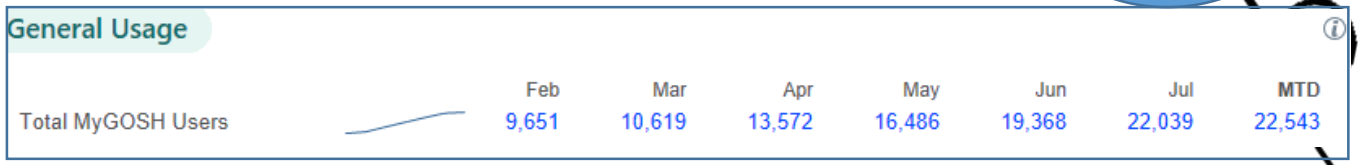
Outcome:

- 22,500 patients now receiving digital communication from the Trust which to date is estimated to have saved the equivalent of 18 trees.

22,500 patients signed up

c.£34,500 saving on printing contract

120,000 letters sent via MyGOSH rather than print and post



Principle 6: Partnerships

System working

- Worked with NCL partners to deliver general paediatric service during COVID-19 pandemic – surge plan and restoration
- Partnership with Moorfields to deliver new ocular gene therapy
- Partnership with Chelsea & Westminster to operate on Dental long waiters
- Optimising Audiology pathway of cleft patients at Mid Essex
- Potential partnership with UCLH on Dental to maximise capacity and capability to treat clinically urgent patients first across 2 sites.

Charity

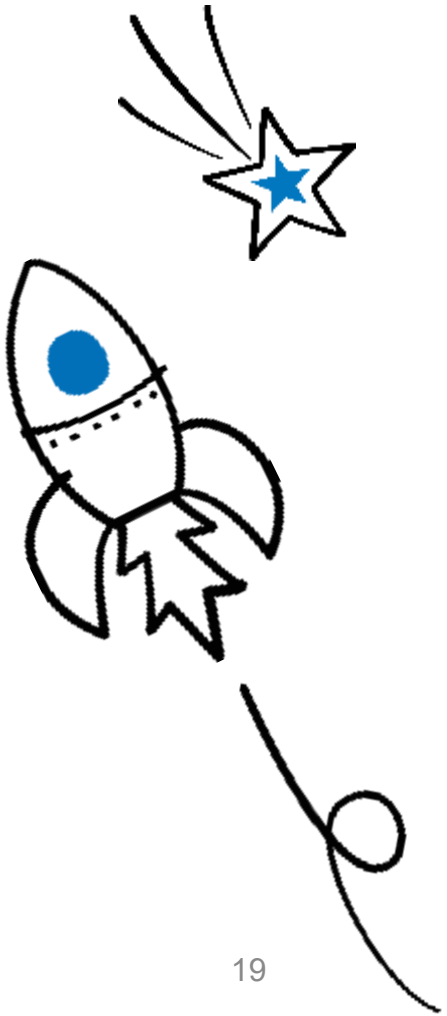
- £25m investment in specialist outpatient facility – The Sight and Sound Centre
- Support for capital equipment replacement including ophthalmic surgical microscope and vestibular chair
- Support for proleptic consultant appointments
- Opportunity to support case for purchase of intra-oral scanners
- Opportunity to support outpatient transformation programme projects

Commercial

- Opportunity to deliver outpatient advice and guidance service
- Continuously explore research opportunities
- Future of private patient work uncertain in current climate

Research

- Capacity is currently focused on treating NHS patients but need to balance needs of our research partners at the same time.



Focus for next 6 months

Where we are now	Where we aim to be in 6 months' time
• Only treating patients who are priority 1 or 2. Growing list of priority 3 and 4.	• To have access to enough capacity to be able to treat patients in category 3 and 4.
• 136 patients waiting 52 weeks or more for treatment	• 52 week position halved and a plan in place to treat the remainder
• Outpatient activity for 20/21 is down 35% when compared to 19/20	• Outpatient activity returned to 19/20 levels
• Deteriorated across 4 out of 10 staff survey categories	• Improvement across all staff survey categories and in particular health and wellbeing
• Sight and Sound Hospital revenue business case; currently revising activity and pay/non-pay spend projections	• Revenue business case approved, budget allocated and posts filled
• Clinic letter backlog stands at 309 with turnaround performance within 7 days at 63%	• Clear letter backlog and deliver clinic letter turnaround within 7 days of 90%

Trust Board
16 September 2020

Update on the Board Assurance Framework **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment P**

RACG review of the Board Assurance Framework (BAF)

The purpose of this paper is to provide an update on the Board Assurance Framework (BAF) and to remind Board members of the current status of risks on the BAF. A summary of all risks is presented at **Appendix 1**. All BAF risks were updated in August 2020 following a review of all the risks on the BAF against the refreshed Trust strategy. A copy of the full BAF is provided for information.

The Director of HR and OD is the risk owner for the recruitment and retention risk. At the RACG meeting in September 2020, the RACG considered the net score for the risk (L3 x C5). On the basis of the healthy pipeline of nursing staff, the high number of applications for clinical and non-clinical positions at GOSH and the reduced staff turnover rate (currently 14%), the Group agreed that the likelihood of the risk being realised is reduced. The Group recommends that the net score for this risk is recorded as L2 x C5.

Action required from the meeting
Committee members are asked to note the update to the BAF and approve the recommended reduction in score for the recruitment risk.

Financial implications
None

Legal issues
None

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

Who is accountable for the implementation of the proposal / project
N/A

Great Ormond Street Hospital for Children NHS Foundation Trust: Board Assurance Framework (August 2020)

No.	Short Title	Risk type and description		Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee
				L x C	T	L x C	T						
1	Financial Sustainability	Strategic & Operational	Failure to continue to be financially sustainable	5 x 5	**25**	5 x 5	**25**	**Low (1-6)**	1-2 years	Chief Finance Officer	**Helen Jameson, Chief Finance Officer**	19/08/2020	Audit Committee
2	Recruitment and Retention	Operational	The risk that the organisation will be unable to recruit and retain sufficient highly skilled staff	4 x 5	**20**	~~3 x 5~~ 2 x 5	~~**15**~~ **10**	**Med (8-10)**	1-2 years	Director of HR and OD	**Caroline Anderson, Director of HR and OD**	20/08/2020	People and Education Assurance Committee
3	Operational Performance	Operational	Failure of our systems and processes to deliver efficient and effective care that meets patient/carer expectations and supports retention of NHS statutory requirements and the FT licence.	4 x 5	**20**	3 x 5	**15**	**Low (1-6)**	1 year	Interim Chief Operating Officer	**Phil Walmsley, Interim Chief Operating Officer/ Anna Ferrant, Company Secretary**	19/08/2020	Audit Committee/ QSEAC
4	GOSH Strategic Position	Strategic	The risks to delivery of the GOSH strategy as approved by the Board in February 2020 are Financial, Political, Social, Existential.	3 x 4	**12**	2 x 4	**8**	Med (8-10)	5-10 years	Chief Executive	**Matthew Shaw/ Louisa Desborough**	26/08/2020	Audit Committee
5	Unreliable Data	Operational	Failure to establish an effective data management framework:	4 x 4	**16**	4 x 4	**16**	**Low (1-6)**	1-2 years	Interim Chief Operating Officer	**Phil Walmsley, Interim Chief Operating Officer**	19/08/2020	Audit Committee
6	Research infrastructure	Strategic	The risk that the Trust is unable to accelerate and grow research and innovation to achieve its full Research Hospital vision due to not having the necessary research infrastructure.	3 x 4	**12**	3 x 4	**12**	Med (8-10)	1-2 years	Director, Research & Innovation	**Jenny Rivers, Dep Dir, R&I**	11/08/2020	Audit Committee
7	Cyber Security	Operational	The risk that the technical infrastructure at the Trust (devices, services, networks etc.) is compromised via electronic means.	5 x 5	**25**	4 x 5	**20**	Low (1-6)	1-2 years	Interim Chief Operating Officer	**Joanna Smith, Interim Chief Information Officer**	18/08/2020	Audit Committee
8	Electronic Patient Records	Operational	The risk that the Epic system is not fully adopted by staff; successfully optimised within a defined governance framework; does not realise the benefits for the organisation (as outlined in the EPR Business Case); has a detrimental impact on the quality, safety and experience of patients, families and carers and on staff experience.	4 x 4	**16**	4 x 4	**16**	**Low (1-6)**	1-2 years	Interim Chief Operating Officer	**Phil Walmsley, Interim Chief Operating Officer/ Richard Collins, Director of Transformation**	19/08/2020	Audit Committee/ Trust Board
9	Business Continuity	**Operational**	The trust is unable to deliver normal services and critical functions during periods of significant disruption. Due to: Gaps in planning, logistical challenges or unexpected events causing difficulties for staff and patients. Impact: An adverse effect on the trust's operational performance	4 x 5	**20**	3 x 5	**15**	**Low (1-6)**	1 year	Interim Chief Operating Officer	**Camilla McBrearty, Emergency Planning Officer/ Phil Walmsley, Interim COO**	30/07/2020	Audit Committee
10	Redevelopment	**Operational**	Inadequate maintenance of the estate and planning of redevelopment programmes will result in an unsatisfactory environment for provision of quality and efficient care, VFM and failure to deliver expected business benefit.	4 x 3	**12**	3 x 3	**9**	**Med (8-10)**	1-5 years	Director of Estates, Facilities and Built Environment	**Zoe Asensio-Sanchez, Director of Estates, Facilities and Built Environment**	19/08/2020	Audit Committee
11	Information Governance	**Operational**	Personal and sensitive personal data is not effectively collected, stored, appropriately shared or made accessible in line with statutory and regulatory requirements.	4 x 5	**20**	3 x 5	**15**	**Low (1-6)**	1 year	Interim Chief Operating Officer	**Phil Walmsley, Interim COO/ Anna Ferrant/ Joseff Eynon- Freeman**	18/08/2020	Audit Committee
12	Medicines Management	**Operational**	Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.	5 x 5	**25**	4 x 5	**20**	**Low (1-6)**	1-2 years	Interim Chief Operating Officer	**Steve Tomlin, Chief Pharmacist/ Chris Longster, GM/ Phil Walmsley, Interim Chief Operating Officer**	22/07/2020	Quality, Safety and Experience Assurance Committee

No.	Short Title	Risk type and description		Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee
				L x C	T	L x C	T						
13	Inconsistent delivery of safe care	**Operational**	Patients are not consistently cared for within a comprehensive safety system which ensures they are protected from avoidable harm and focuses on openness, transparency and learning when things go wrong.	4 x 4	**16**	3 x 4	**12**	**Low (1-6)**	1-2 years	Medical Director	**Sanjiv Sharma, Medical Director, Roisin Mulvaney, Head of Special Projects**	27/08/2020	Quality, Safety and Experience Assurance Committee
14	Political Instability	**Strategic**	The recent political instability caused by Brexit and the ongoing reconfiguration of the health economy will have an adverse impact on the ability of Trust to ensure continuity of effective patient care.	4 x 5	**20**	3 x 5	**15**	**Med (8-10)**	1-5 years	Interim Chief Operating Officer	**Anna Ferrant, Company Secretary/ Phil Walmsley, Interim Chief Operating Officer**	18/08/2020	Trust Board
15	Service Innovation	**Operational**	Failure to embrace service transformation and deliver innovative, patient centred and efficient services.	4 x 4	**16**	3 x 4	**12**	**Med (8-10)**	1-5 years	Director Of Transformation	**Richard Collins, Director of Transformation**	19/08/2020	People and Education Assurance Committee
16	Culture	**Strategic**	There is a risk that GOSH fails to develop its culture and levels of staff engagement and motivation in alignment with its strategy and values,	4 x 4	**16**	3 x 4	**12**	**Low (1-6)**	1-5 years	Chief Executive	**Caroline Anderson, Director of HR and OD**	20/08/2020	Trust Board/ People and Education Assurance Committee

GOSH BAF Risks – Gross Scores August 2020

Likelihood		Consequences				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain					1. Financial Sustainability; 12. Medicines Management
	4 Likely			10. Redevelopment	5. Unreliable data; 16: Culture; 13. Consistent delivery of services; 8. EPR; 15. Service Innovation	2. Recruitment & Retention; 14. Political Instability; 7. Cyber Security; 11. Information Governance; 5. Operational Performance
	3. Possible				9. Business Continuity; 4. GOSH Strategic Position; 6. Research Infrastructure and resourcing	
	2. Unlikely					
	1.Rare					

GOSH BAF Risks – Net Scores August 2020

Likelihood		Consequences				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain				7. Cyber Security	1. Financial Sustainability
	4 Likely				5. Unreliable data	12. Medicines Management
	3. Possible			9. Business Continuity; 10. Redevelopment	16: Culture; 8. EPR; 6. Research Infrastructure and resourcing; 15. Service Innovation; 13. Consistent delivery of services	2. Recruitment & Retention; 11. Information Governance; 14. Political Instability; 3. Operational Performance
	2. Unlikely				4. GOSH Strategic Position	
	1.Rare					

QSEAC & Audit Committee

QSEAC

Audit Committee

Trust Board

People and Education Assurance Committee

Attachment Q

Trust Board

16 September 2020

Data Quality Kite Mark for Board Reports: Update **Submitted by:** Phil Walmsley – Interim Chief Operating Officer	**Paper No: Attachment Q**

Aims / summary

Within the NHS Improvement document, Well-led Framework for Governance Reviews: Guidance for NHS Foundation Trusts, NHS Improvement recommends that Trust Boards 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.

1. The purpose of this paper is to provide an update on the data kite mark scoring in key metrics as presented in the Integrated Quality and Performance Report (Caring, Safe, Responsive, Data Completeness, Well-led, Effective, Productivity and Activity)

2. The paper notes changes to the data kite mark scoring over the last three months and includes comments from KPI owners.

3. This is now an ongoing project that will be brought back to EMT on a quarterly basis. Where key indicators are seen to be non-compliant the KPI lead and where necessary lead executives, will get support to deliver a compliant indicator. Until the indicator is compliant then data related to that indicator will be flagged as not fully compliant with an explanation for the non-compliance

4. The internal KPMG audit reviewing "data kite mark methodology and operational controls" is currently in its final stages and recommendations will form part of the project plan to continue to maintain assurance and improve areas on non-compliance.

Action required from the meeting

To note contents of the report and recommendations

Contribution to the delivery of NHS Foundation Trust strategies and plans

Supports the overall improvement in data quality against the framework of governance and leadership, policies, systems and processes, people and skills and data use and reporting.

Financial implications

None

Who needs to be told about any decision?

Director of Operational Performance and Information
Head of Performance
Data Assurance Manager

Attachment Q

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? Phil Walmsley, Chief Operating Officer

Attachment Q

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 Trust Boards 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

GOSH needs to be working towards compliance against 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.

3. Consultation

The DQKM approach has been reviewed and approved through the following groups: Data Quality Review Group, Information Governance Steering Group, EMT and Audit Committee.

DQKM Development and Application

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

1. A 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 how the item will be audited.
2. Each indicator has an Executive lead, and the final element of the process is the lead signing off the Kite Mark for the specific KPI.
3. For the trust to 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 scoring:

- "1" means the metric data quality element is sufficiently assured
- " – " means not yet assessed
- "0" means the metric data quality element is not sufficiently assured

- "7" means that a metric is sufficiently assured and a score of < "7" means elements of the kite mark are not met and therefore not sufficiently assured.

Changes since April update:

- There is now an internal KPMG audit in progress to review Trust's data quality kite mark process

  The domains that have been selected for testing are Safe, Well-Led and Caring. Recommendations from the internal audit will be considered as part of the Data Kite Mark Project Plan.

The data kitemark scorings have now been reviewed by the individual KPI owners and significant changes in scoring are noted by CQC domain (safe and responsiveness):

- **Safe**
  - WHO checklist completion - **Reliability** has changed from sufficiently assured to not yet assessed
  - WHO checklist completion outside theatres. **Timeliness** has changed from not yet assessed to sufficiently assured

  Comment from KPI owner
  A lot of work has been done between Performance, EPR and Information Services to ensure that this KPI is accurate and reliable, however work on this indicator is still ongoing. There is now an indicator in place within the snap board which tracks completeness of WHO checklist.

  There are processes in place for validation and audit. There are still gaps in terms of data completeness. Where this is not due to data fields requiring completion from users, we are expecting improvement as the reporting script has been handed over to a different team.

  Where this is due to user practise, clinicians from the SSIPs committee are leading on educational work to raise awareness amongst the teams on the completion of the checklist on Epic.

  - Arrests Outside of ICU. **Audit** has now changed from not yet assessed to sufficiently assured

  Comment from KPI owner
  All numerical values are correct as of September 2020 with the addition of 1 in the audit column as the Resuscitation team collaboratively work with the Clinical audit manager and PSOC committee within GOSH

- **Responsiveness**

  The **Accuracy** scoring for the following KPIs has now changed from sufficiently assured to not sufficiently assured.
  - Last Minute Non-Clinical Hospital Cancelled Operations
  - Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard
  - RTT: Incomplete Pathways (National Reporting)
  - RTT: Incomplete Pathways >40 Weeks
  - RTT: Total Number of Incomplete Pathways Known/Unknown

Attachment Q

Comment from KPI owner

Accuracy in recording inpatient cancellations varies between teams and work is in progress to review the end to end workflow of cancelled operations particularly where the patient has already been admitted. There is a wider piece of work in progress as well to review inpatient admissions across directorates to tackle data quality issues as source.

RTT validation and accuracy – Due to the urgent operational response to the COVID pandemic, we have seen an increase in un-validated RTT pathways and this has impacted on the accuracy of RTT reporting. This was also reflected in the output of the national diagnostic PTL.

North of England Commissioning Support Unit analysed a snapshot of the Trust's live RTT PTL in August 2020 to identify invalid pathways that require validations across themes of validation priority, capacity and data quality. The report highlighted areas of validation work needed to reduce data quality against active RTT waits but also showed data quality issues such as un-validated pathways, duplicate pathways and potential pathways which should have a clock stop.

Recommendations

This is now an ongoing project that will be brought back to EMT on a quarterly basis. Where key indicators are seen to be non-compliant the KPI lead and where necessary lead executives, will get support to deliver a compliant indicator. Until the indicator is compliant then data related to that indicator will be flagged as not fully compliant with an explanation for the non-compliance.

4. Attachments

Appendix 1 – Trust Board Data Quality kite mark (September 2020)

Appendix 2 – DQKM Process and Monitoring

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

Attachment Q

Appendix 1: Trust Board Data Quality Kite Mark (September 2020 update)

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

Attachment Q

Trust Board Data Quality Kite Mark

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

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

				Accuracy	Validity	Reliability	Timeliness	Relevance	Audit	Assessed by	Executive Director	Executive Director Judgement	Score
Well Led	Sickness Rate			1	1	1	-	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	4
	Turnover	Total		1	1	1	-	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	4
		Voluntary		1	1	1	-	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	4
	Appraisal Rate	Non Consultant		1	1	1	-	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	4
		Consultant		1	1	1	-	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	4
	Mandatory Training			1	1	1	-	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	4
	% Staff Recommending the Trust as a Place to Work: Friends & Family Test			1	1	1	1	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	5
	Vacancy Rate	Contractual		1	1	-	-	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	3
		Nursing		1	1	-	-	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	3
	Bank Spend			1	1	1	1	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	5
	Agency Spend			1	1	1	1	1	-	Matt Guilfoyle Michael Nwosu	Caroline Anderson	-	5
Effective	Discharge Summary Turnaround within	24 hours		1	1	1	0	1	1	Rebecca Stevens	Philip Walmsley	1	6
		Number of letters not sent	In-month	1	1	1	0	1	1	Rebecca Stevens	Philip Walmsley	1	6
			YTD	1	1	1	0	1	1	Rebecca Stevens	Philip Walmsley	1	6
	Clinic Letter Turnaround within	7 days		1	1	1	0	1	0	Rebecca Stevens	Philip Walmsley	1	5
		Number of letters not sent	In-month	1	1	1	0	1	0	Rebecca Stevens	Philip Walmsley	1	5
			YTD	1	1	1	0	1	0	Rebecca Stevens	Philip Walmsley	1	5
	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)			1	1	1	0	1	0	Rebecca Stevens	Philip Walmsley	1	5
Productivity	Main Theatres	Theatre Utilisation		1	1	1	0	1	0	Rebecca Stevens	Philip Walmsley	1	5
	Outside Theatres	Theatre Utilisation		1	1	0	0	1	0	Rebecca Stevens	Philip Walmsley	1	4
	Trust Beds	Bed Occupancy		1	1	0	0	1	0	Rebecca Stevens	Philip Walmsley	1	4
		No of available beds		1	1	0	0	1	0	Rebecca Stevens	Philip Walmsley	1	4
	Average number of trust beds closed	Wards		1	1	0	0	1	0	Rebecca Stevens	Philip Walmsley	1	4
		ICU		1	1	0	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
	Refused Admissions	Cardiac refusals		1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	6
		PICU / NICU refusals		1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	6
		Internal 8 - 24 hours		1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	6

			Accuracy	Validity	Reliability	Timeliness	Relevance	Audit	Assessed by	Executive Director	Executive Director Judgement	Score
Activity (NHS & PP)	Number of PICU Delayed Discharges	Internal 24 hours+	1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
		External 8 - 24 hours	1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	6
		External 24 hours+	1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	6
		Total 8 - 24 hours	1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	6
		Total 24 hours+	1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	6
	PICU Emergency Readmissions < 48 hours		1	1	1	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
	Daycase Discharges (YOY comparison)	In-month	1	1	0	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
		YTD	1	1	0	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
	Overnight Discharges (YOY comparison)	In-month	1	1	0	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
		YTD	1	1	0	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
	Bed Days >=100 Days	No. of patients	1	1	0	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
		No. of beddays	1	1	0	1	1	0	Rebecca Stevens	Philip Walmsley	1	5
	Outpatient Attendances (All) (YOY comparison)	In-month	1	1	1	0	1	0	Rebecca Stevens	Philip Walmsley	1	5
		YTD	1	1	1	0	1	0	Rebecca Stevens	Philip Walmsley	1	5

Key

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

Appendix 2

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).

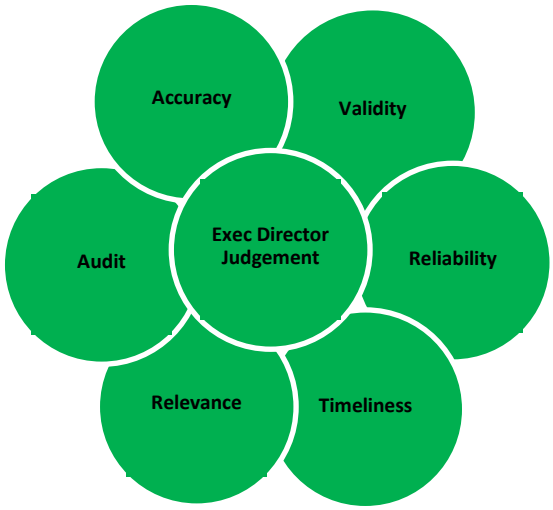
b. The Executive Team can request that the kite-mark be applied to any other indicator within the trust's performance assurance framework in addition to those reported through the Board.

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, working with the Director of Operational Performance & Information and Head of Performance, should clarify the sources of assurance required to enable a rating for each attribute of the kite-mark to be assessed.

i. The Director of Operational Performance & Information and Head of Performance will work with the KPI owner to populate the kite-mark and identify whether each element should be assessed

as “sufficient” or “insufficient”. The outcome of the kite-mark process for each indicator will be reported to the Executive Committee at least annually or as required e.g. when new indicators are added to the Board report or are amended significantly.

j. 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”.

k. A schedule of indicator testing by internal and external audit will be developed by the Director of Operational Performance & Information and 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 or Monitor.
    2. Priority 2 (Medium) – The indicator has been introduced by commissioners.
    3. Priority (Low) – The indicator has been introduced locally.

l. 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.

m. 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

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

Element	Definition
	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 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.	More than 3% blank or invalid fields in expected data set Inadequate assurance or no assurance that effective

Element	Sufficient	Insufficient
	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.	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 next day, Monthly, available next month, etc.	Where data is not available within the same timescales as it is produced. i.e. Daily, not 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

Element	Sufficient	Insufficient
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

Attachment R

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
16 September 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 R**

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 was 1 serious incidents reported in July 2020. This relates to a delay in monitoring which is believed to have resulted in the loss of renal function. There were two further serious incidents declared in August 2020. One relating to inadequate patient monitoring and another relating to a lack of clinical information on admission which impacted patient care.
- Consistently high levels of incident closures noted from May through to August which have considerably reduced the backlog of incidents, so we are starting to see improvements in the % of incidents closed within timescale. As of 9th September all pre-2020 incident have been closed. There are less than 50 incidents overdue from the period January – June 2020.
- WHO checklist documentation compliance within Main Theatres improved in July to its highest level during 2020 with performance documented at 95.9% for cases done under general anaesthetic (93.1% for all cases in theatres). August performance is reported as 94.5% for GA (93.1% for all cases in theatres). Improvements have been in response to the rapid improvement plan initiated at the end of June 2020 by the GOSHSSIPS group. This plan was extended to include areas outside the traditional theatre environment and in July this has resulted in an improvement from 51.3% in July to 79.8% in August. There is still a lot of work to do, but progress towards better recording is positive.
- Stat & Man training cumulatively across the Trust remains at 93% which is above target but Resuscitation and Level 3 Safeguarding are below target for July at 84% and 85% respectively. These rates have been consistently below target over the last 3 months.

Are we caring?

- FFT performance in July has been excellent with 98% experience rating for inpatients and 98% experience rating for outpatients. Feedback was overwhelmingly positively with families commenting on the professionalism and expertise of staff as well as their caring and welcoming nature. Performance for August has not yet been

validated but review of the early data looks promising in terms of maintaining a high response rate and a high patient experience rating.

- The FFT response rate has been consistently above 30% through May, June and reaching 37% in July which is well above the Trust target.
- There have been no new red/high risk complaints in July. A BBM complaint received in June was declared as an SI in August 2020. This relates to delays in patient follow up and monitoring which may have contributed to reduced kidney function. No further red complaints in August.

Are we effective?

- We remain fully compliant with all NICE national guidance gap analysis completion.
- 80% of specialty led clinical audits are on track in July which is a positive position in light of the pressures faced in recent months. The overall volume of clinical audits completed remains slightly lower than anticipated based on previous year's performance. The August data suggests we have now recovered this position, but we need to be mindful of the ongoing challenges faced by the clinical teams at this time.
- Discharge summaries are at 74% compliance within 24 hours for July which is a deterioration from the position in June. This rises to 84.9% within 48 hours.
- Clinic letter turnaround within 7 days has dipped slightly from 68.36% in June to 65.03% in July. Targeted work with specific specialties is underway for clinic letters and discharge summaries to support further improvement.

Are we responsive?

- Diagnostics 6 week waits sit at 66.33% for July 2020 with the number of breaches in month up to 670 (compared to 973 in May and 818 in April).The position for August is still being validated.
- We achieved 55.6% against the RTT target of 92% with 2968 patients waiting longer than 18 weeks. The position for August is still being validated.
- At the end of July we were reporting 189 breaches of the 52 week wait with Dental patients accounting for approximately 50% of these breaches. At the end of August, this position had deteriorated further with >200 breaches reported.
- 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?

- The Trust launched the nationally mandated covid-19 staff risk assessment process in June. As of mid-August 2020 96% of staff have had a risk assessment completed.
- The second In Touch survey ran at the end of July 2020, with a good response rate from staff. Improvement was noted in communication between senior management and staff, action on feedback, and staff feeling involved in decision making.
- Compliance with Duty of Candour for initial conversations is 100% for July and August 2020. 86% of stage 2 were completed in July with 43% going out within 10 working days. In August 78% of stage 2 letters were sent with 56% going on time. A proposal for a weekly duty of candour catch-up with the directorates to help address obstacles is being worked up.
- Although 4 investigations were shared with the families in July, none of these met with policy timescales. In August 6 investigations were shared with families, but only one of these was within timescale. An RCA training programme led by the Head of Quality and Safety has commenced to support more timely investigation completion.

- All actions associated with red complaints are either complete or within timescale. As of 7th September 2020, we are reporting that there are 23 overdue Serious Incident actions (according to data held on Datix).
- Policy performance has been consistently at 77-79% over the last 3 months, with improvements in compliance with safety critical policy performance has improved to 87% in July (up from 68% in March) following the resumption of the Policy Approval Group via Zoom and real time policy updates during the meeting.
- PDR performance sits at 87% and Consultant appraisal has further reduced to 69%. NB All overdue appraisals have been suspended by GMC given 'special circumstances', so our externally reported performance is 100%.

Patient Safety Metrics

At the Trust Board on the 15th July 2020 concerns were raised about the performance of the following metrics:

- Timeliness of Patient Safety Incident closures
- Timeliness of SI action plans closures
- Timeliness of Duty of Candour letter/investigation completion
- WHO safety checklist performance

In light of this, there has been regular executive level scrutiny of the performance of these metrics and, more importantly, the progress of the improvement plans which have been implemented to address the low performance. The paper tracks the progress of the work since July 2020, but also reflects the last year's performance to provide a sense of the context for these performance metrics.

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 August 2020 (July 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 July 2020

Hospital Quality Performance – August 2020 (July data)

Are our patients receiving safe, harm-free care?

	Parameters	May 2020	June 2020	Jul 2020
Incidents reports (per 1000 bed days)	R<60 A 61-70 G>70	71 (n=536)	71 (n=516)	78 (n=568)
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	628	695	713
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	54%	62%	64%
Average days to close	R ->50, A - <50 G - <45	58	55	58
Medication Incidents (% of total PSI)	TBC	20.5%	16.4%	22.7%
WHO Checklist (overall)	R<98% G>98-100%	92.72%	92.07%	95.9%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	5.8%	3.7%	8.6%
New Serious Incidents	R >1, A -1 G – 0	2	0	1
Overdue Serious incidents	R >1, A -1, G – 0	0	0	0
Safety Alerts overdue	R- >1 G - 0	0	0	0
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	May 2020	Jun 2020	Jul 2020
Specialty Led Clinical Audits on Track	R 0- 60%, A>60-75% G>75-100%	76%	84%	80%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	14	24	31
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	May 2020	Jun 2020	Jul 2020
Friends and Family Test Experience rating (Inpatient)	G – 95+, A- 90-94, R<90	98%	98.6%	98%
Friends and Family Test experience rating (Outpatient)	G – 95+, A-90-94,R<90	95%	92.6%	98%
Friends and Family Test - response rate (Inpatient)	25%	30%	35.3%	37%
PALS (per 1000 combined pt episodes)	N/A	6.63	7.93	8.08
Complaints (per 1000 combined pt episodes)	N/A	0.35	0.40	0.34
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	6%	6%	8%
Re-opened complaints (% of total complaints since April 2020)	R>12% A- 10-12% G- <10%	0%	0%	0

Are our People Ready to Deliver High Quality Care?

	Parameters	May 2020	Jun 2020	Jul 2020
Mandatory Training Compliance	R<80%,A-80-90% G>90%	93%	93%	93%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	86%	86%	86%
PDR	R<80%,A-80-89% G>90%	87%	89%	87%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	Actual: 77%	Actual: 71%	Actual: 69%
Honorary contract training compliance	R<80%,A-80-90% G>90%	61%	72%	93%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	84%	84%	85%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	94%	93%	94%
Resuscitation Training	R<80%,A-80-90% G>90%	88%	83%	84%
Sickness Rate	R -3+% G= <3%	2.5%	2.2%	2.4%
Turnover - Voluntary	R>14% G-<14%	14.9%	14.7%	14%
Vacancy Rate – Contractual	R- >10% G- <10%	5.57%	6.2%	7%
Vacancy Rate - Nursing		5.03%	5.4%	7.1%
Bank Spend		4.1%	4.1%	5.2%
Agency Spend	R>2% G<2%	0.4%	0.4%	0.6%

Hospital Quality Performance – August 2020 (Jul data)

Is our culture right for delivering high quality care?

	Target	May 2020	Jun 2020	Jul 20220
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	87.3%	91.6%	74.1%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G-0	84	31	19
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G-0	0	0	0
Duty of Candour Cases	N/A	9	11	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%	80%	43%	86%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	60%	100%	43%
Duty of Candour - Stage 3 Total sent out in month	Volume	3	3	4
Duty of Candour – Stage 3 Total (%) sent out in month on time	R<50%, A 50-70%, G>70%	66%	33%	0%
Duty of Candour – Stage 3 Total overdue (cumulative)	G=0 R=1+	7	5	2
Policies (% in date)	R 0- 79%, A>80% G>90%	77%	79%	77%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	84%	87%	87%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	100%	100%	100%
Inquests currently open	Volume monitoring	13	10	8
Freedom to speak up cases	Volume monitoring	29	6	6
HR Whistleblowing - New	Volume monitoring	1	0	0
HR whistleblowing - Ongoing	12 month rolling	1	1	1
New Bullying and Harassment Cases (reported to HR)	Volume	0	0	0
	12 month rolling	1	1	1

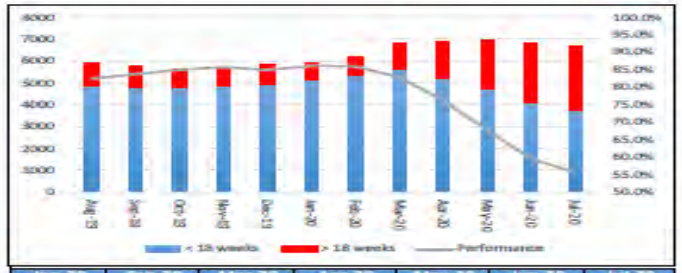
Are we managing our data?

	Target	May 2020	Jun 2020	Jul 2020
FOI requests	Volume	35	28	43
FOI Closures: % of FOIs closed within agreed timescale	R- <65% A – 65-80% G- >80%	52%	85%	89%
No. of FOI overdue (Cumulative)		3	3	3
FOI - Number requiring internal review	R>1 A=1 G=0	0	0	0
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	13	12	16
IG incidents reported to ICO	R=1+, G=0	0	0	0
SARS (Medical Record) Requests	volume	64	97	107
SARS (Medical Record) processed within 30 days	R- <65% A – 65-80% G- >80%	97%	91%	97%
New e-SARS received	volume	0	0	1
No. e-SARS in progress	volume	3	3	4
E-SARS released	volume	0	0	0
E-SARS released past 90 days	volume	1	0	0

	Target	May 2020	Jun 2020	Jul 2020
52 week + breaches reported (ticking at month end)	Volume	88	133	189
52 week + harm reviews to be completed (for treatment completed)	Volume	2	13	13

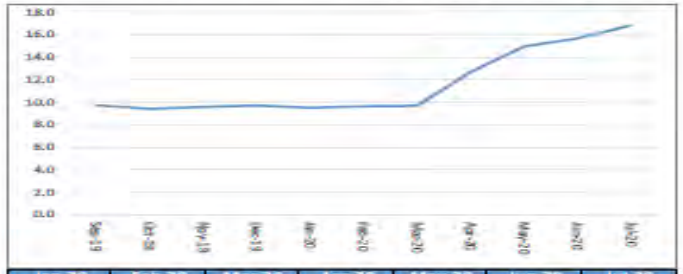
Patient Access
Great Ormond Street Hospital for Children NHS Foundation Trust

RTT incomplete pathways: % of patients waiting <18 weeks	Period	Target	Actual
	Jul-20	92.0%	55.6%



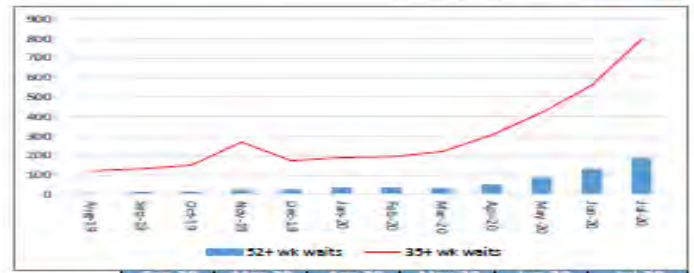
Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
86.1%	86.0%	82.9%	76.2%	67.7%	59.6%	55.6%

RTT: Average waits for open pathways	Period	Target	Actual
	Jul-20	8.1	16.8



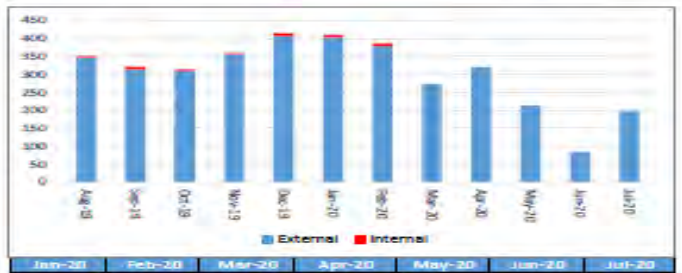
Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
9.5	9.7	9.7	12.7	15.0	15.7	16.8

RTT: Incomplete pathways 52 weeks or more	Period	Target	Actual
	Jul-20	0	189



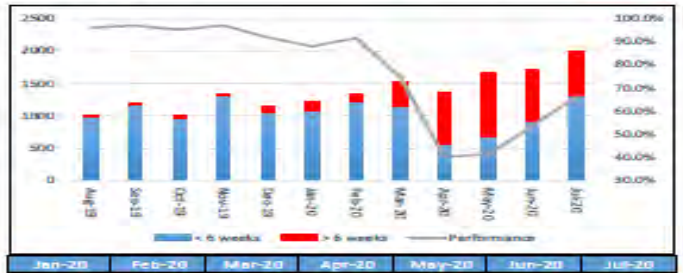
	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
52 wks+	36	33	53	88	133	189
35 wks+	195	221	306	420	561	797

RTT: Total unknown clock starts	Period	Actual
	Jul-20	197



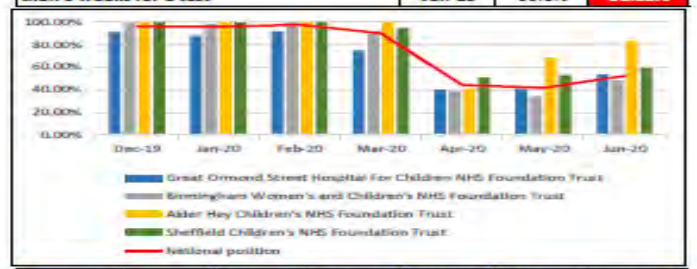
Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
413	386	274	321	213	83	197

Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Period	Target	Actual
	Jul-20	99.0%	66.33%



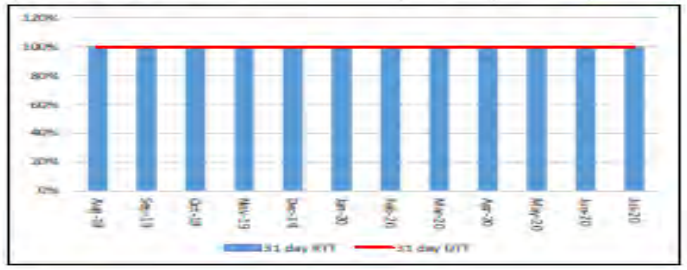
Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
87.94%	91.57%	74.77%	40.34%	41.39%	53.65%	66.33%

Diagnostics: National % patients waiting less than 6 weeks for a test	Period	Target	Actual
	Jun-20	99.0%	52.18%



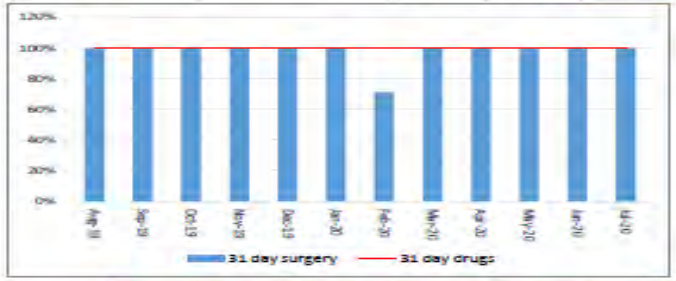
Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
95.83%	95.58%	97.24%	89.81%	44.26%	41.54%	52.18%

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



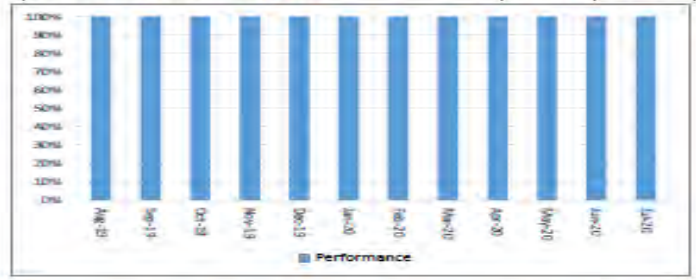
	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
31 day RTT	100%	100%	100%	100%	100%	100%
31 day DTT	100%	100%	100%	100%	100%	100%

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



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Surgery	71%	100%	100%	100%	100%	100%
Drugs	100%	100%	100%	100%	100%	100%

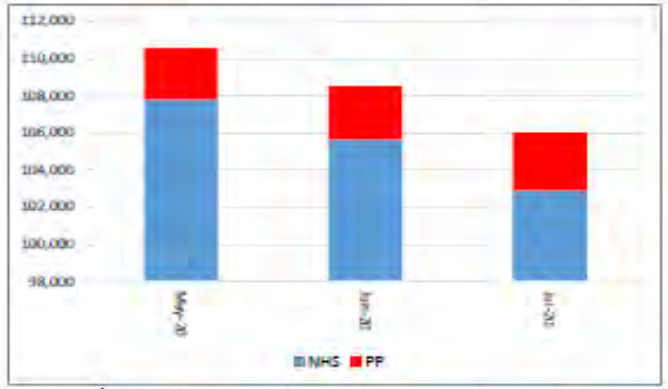
	Period	Actual
Cancer: 62 day consultant upgrade	Jul-20	100.0%



Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	100.0%

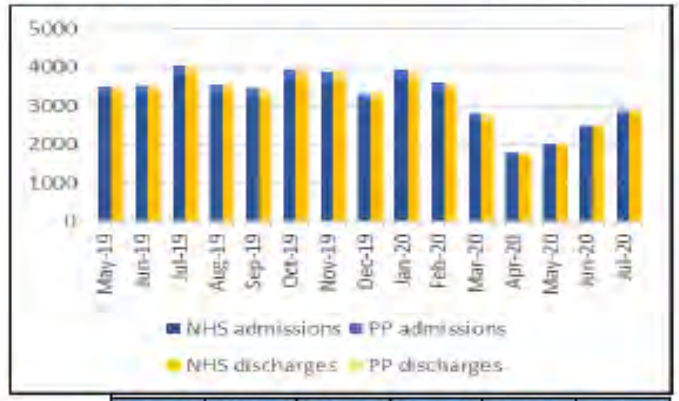
Patient Access
Great Ormond Street Hospital for Children NHS Foundation Trust

	Period	Actual
Open referrals at month end (NHS & PP)	Jul-20	106,012



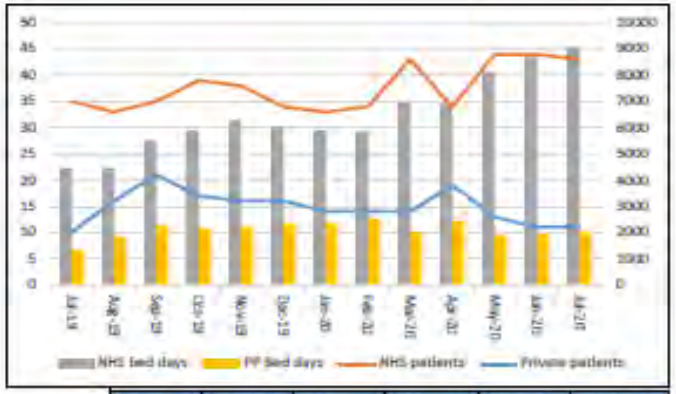
	May-20	Jun-20	Jul-20
NHS	107,787	105,631	102,873
PP	2,783	2,878	3,139

	Period	Actual
Admissions (NHS & PP)	Jul-20	2873
Discharges (NHS & PP)	Jul-20	2882



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Admissions	3601	2801	1800	2025	2490	2873
Discharges	3613	2772	1773	2025	2485	2882

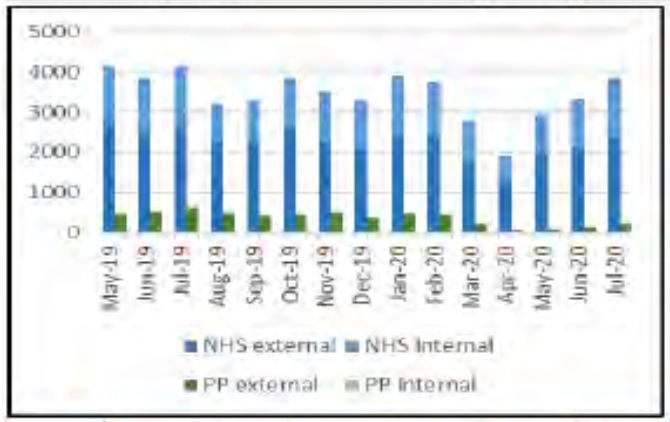
	Period	Actual
Patients not yet discharged with LOS >50 days	Jul-20	54
Bed days	Jul-20	11,119



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Patients	48	57	53	57	55	54
Bed days	8349	8996	9321	10026	10621	11119

-72

	Period	Actual
External Referrals (NHS & PP)	Jul-20	2536
Internal Referrals (NHS & PP)	Jul-20	1557



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
External	2798	1972	1285	1989	2223	2536
Internal	1396	1009	663	970	1241	1557

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

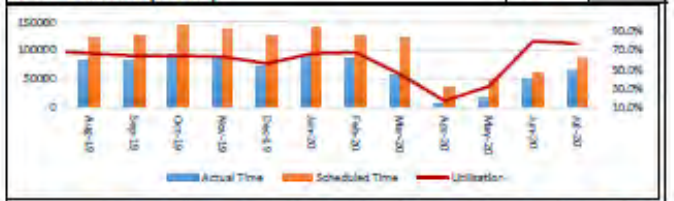
Under construction

EDD						
> EDD						

Productivity & Efficiency

Great Ormond Street Hospital for Children NHS Foundation Trust

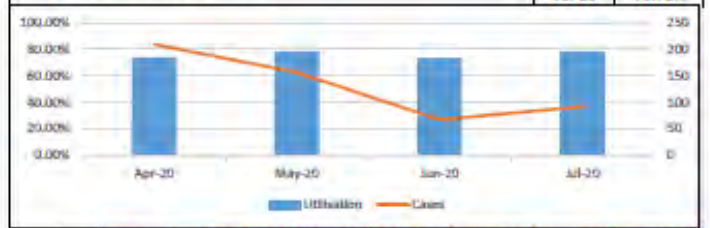
	Period	Actual
Theatre Utilisation (Main)	Jul-20	77.31%
Theatre Utilisation (Outside)	Jul-20	TBC



Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Main	67.15%	68.31%	45.30%	17.10%	32.45%	80.07%	77.31%
Outside	TBC	TBC	TBC	TBC	TBC	TBC	TBC

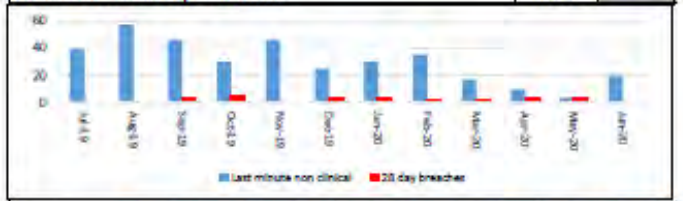
*Theatre session utilisation data is currently being investigated for March and April 2020

	Period	Actual
Emergency main theatre utilisation	Jul-20	78.72%



Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Cases	TBC	TBC	TBC	209	156	67	91
Utilisation	TBC	TBC	TBC	73.89%	78.43%	73.52%	78.72%

	Period	Actual
Last minute hospital cancelled ops for non clinical reasons	Jun-20	20
Last minute hospital cancelled ops - breaches of 28 day standard	Jun-20	0
Last minute cancelled ops - all reasons	Jun-20	TBC



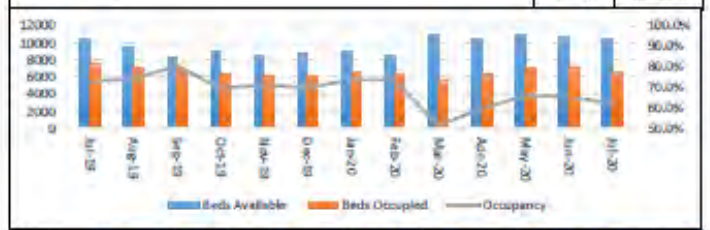
Month	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Non clinical	25	30	35	17	10	4	20
Breaches	3	3	2	2	4	3	0

	Period	Actual
Average length of stay	Jul-20	TBC

Under construction

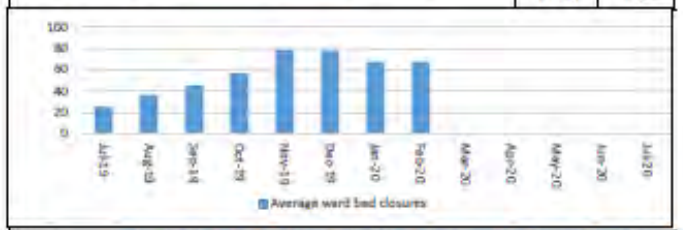
Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Main	TBC	TBC	TBC	TBC	TBC	TBC	TBC

	Period	Actual
Bed Occupancy	Jul-20	62.05%



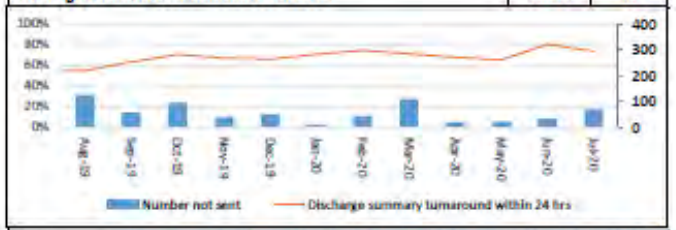
Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Main	73.83%	73.48%	51.52%	59.65%	65.95%	65.51%	62.05%

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



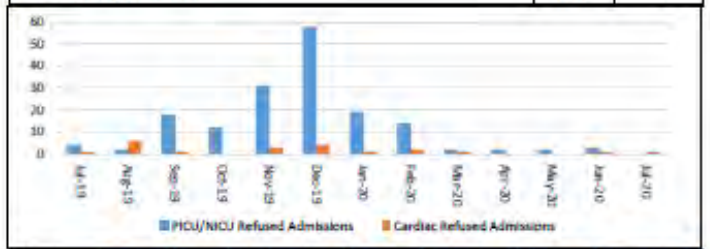
Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Av Closures	67.1	66.8	66.8	0.0	TBC	TBC	TBC

	Period	Actual
Discharge summary turnaround within 24 hours	Jul-20	74.03%
Discharge summaries - number not sent in month	Jul-20	69
Discharge summaries - number not sent YTD	Jul-20	89



Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Performance	70.95%	74.49%	71.21%	68.05%	65.24%	80.53%	74.03%
Not sent	11	42	109	19	21	34	69

	Period	Actual
PICU/NICU CATS refused admissions	Jul-20	0
Cardiac refused admissions	Jul-20	1



Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
PICU/NICU	19	14	2	2	2	3	0
Cardiac	1	2	1	0	2	1	1

	Period	Actual
PICU Readmissions within 24 hours	Jul-20	0

Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Readmissions	1	1	0	2	1	4	0

Productivity & Efficiency
Great Ormond Street Hospital for Children NHS Foundation Trust

	Period	Actual
Clinic letter turnaround within 7 days	Jul-20	65.03%
Clinic letters- number not sent in month	Jul-20	1216
Clinic letters - number not sent Financial YTD	Jul-20	1922

Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Performance	51.41%	53.56%	51.87%	61.36%	68.24%	64.04%	65.03%
Not sent	2636	2217	1266	726	755	1226	1216

DNA/Was Not Brought rate	Period	Actual
	Jul-20	4.81%

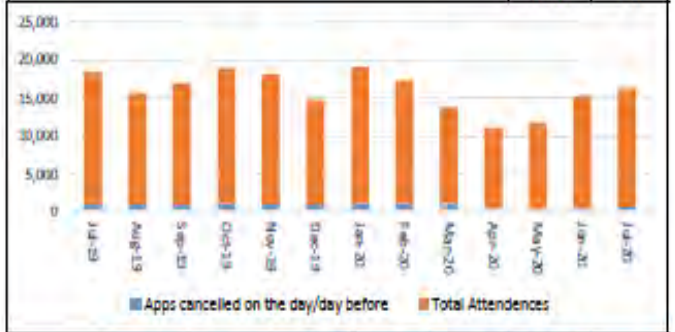
Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Rate	6.05%	6.11%	5.59%	4.65%	4.92%	4.75%	4.81%
DNAs	1246	1134	802	483	551	675	851

Outpatient Clinic Utilisation	Period	Actual
	Jul-20	TBC

Under Construction

Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Rate	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Outpatient appointments cancelled on the day/day before	Period	Actual
	Jul-20	639



Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Cancellations	1009	1033	1105	396	392	473	639
Attendances	18112	16266	12698	10617	11401	14671	15628

Outpatients past review date	Period	Actual
	Jul-20	TBC

Under Construction

Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
# of Patients	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Do we deliver harm free care to our patients?

Central Venous Line Infections

GOS acquired CVC related bacteraemias ('Line infections')

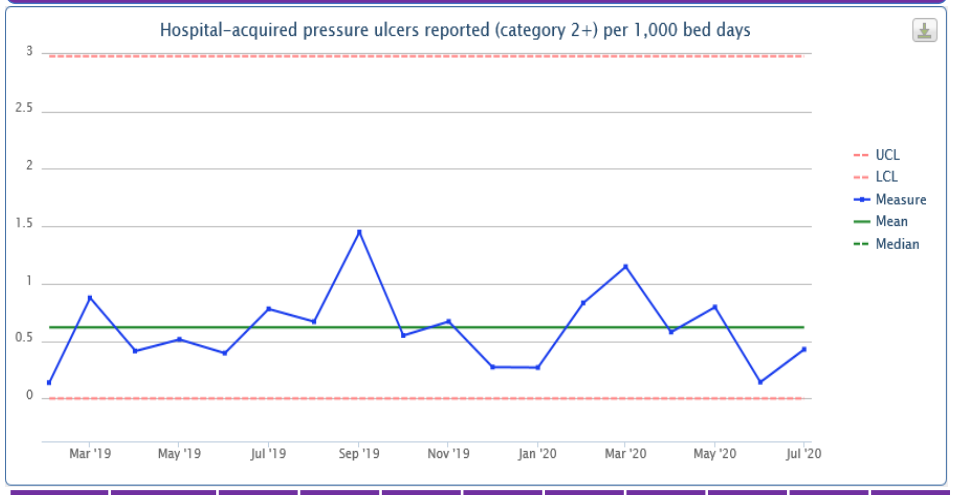
Period	GOSACVCRB_No	DaysRecorded	Rate	Rate_YtD
Year 15/16	75	51976	1.4	1.4
Year 16/17	87	52679	1.7	1.7
Year 17/18	82	50732	1.6	1.6
Year 18/19	82	52929	1.5	1.5
Year 19/20	73	51520	1.3	1.3
Apr-20	8	4779	1.7	1.7
May-20	9	4468	2	1.8
Jun-20	4	4389	0.9	1.5
Jul-20	7	4561	1.5	1.5

*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

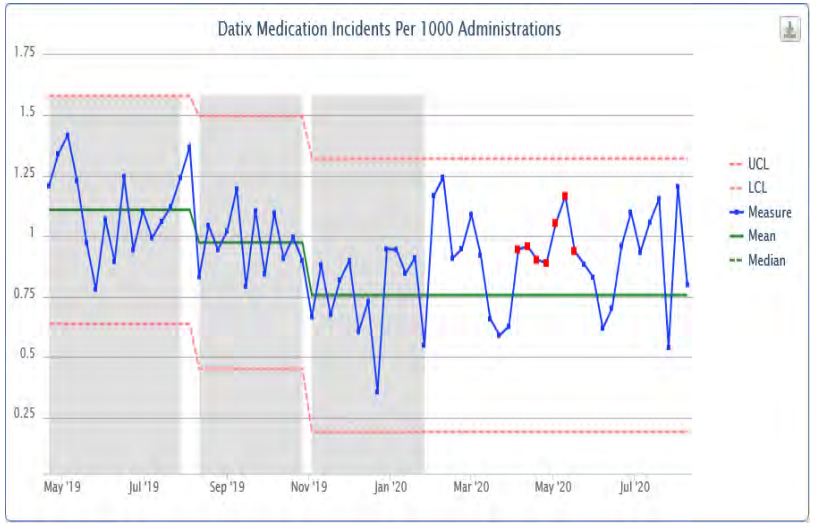
Care Outcome Metric	Parameters	April 2020	May 2020	June 2020	Jul 2020
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	6	11	6	9
	YTD (financial year)	6	17	23	32
C Difficile cases - Total	In month	3	1	0	0
	YTD (financial year)	3	4	4	4
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	3	0	0	0
	YTD	3	3	3	3

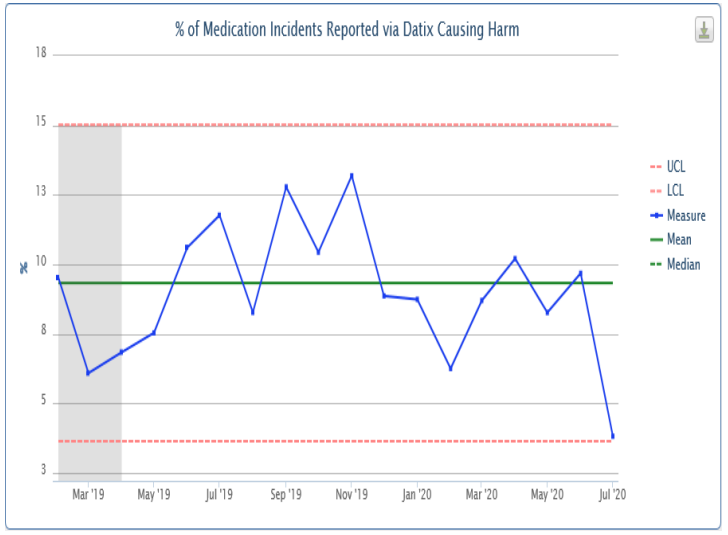
Pressure Ulcers



		Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Volume	R – 12+, A 6-11 G =0-5	5	2	2	6	8	4	6	1	3
Rate	R=>3 G=<3	0.66	0.27	0.27	0.83	1.15	0.6	0.79	0.14	0,43

Medication Incidents

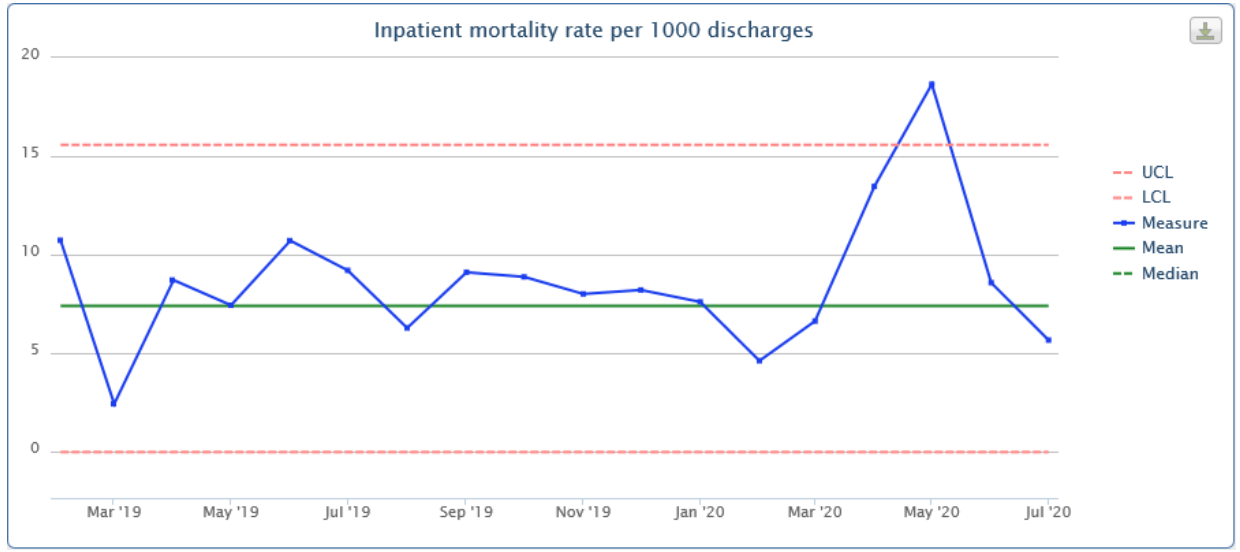




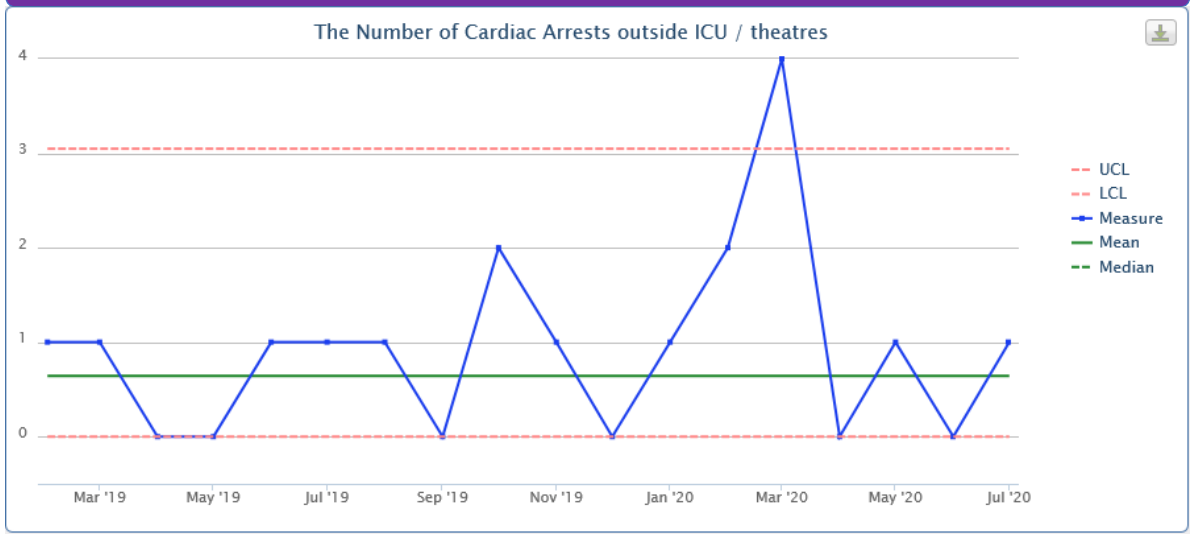
	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
% medication incidents causing harm	13%	10%	14%	9%	11%	11%	12%	11%	10%	10%	4%

Does our care provide the best possible outcomes for patients?

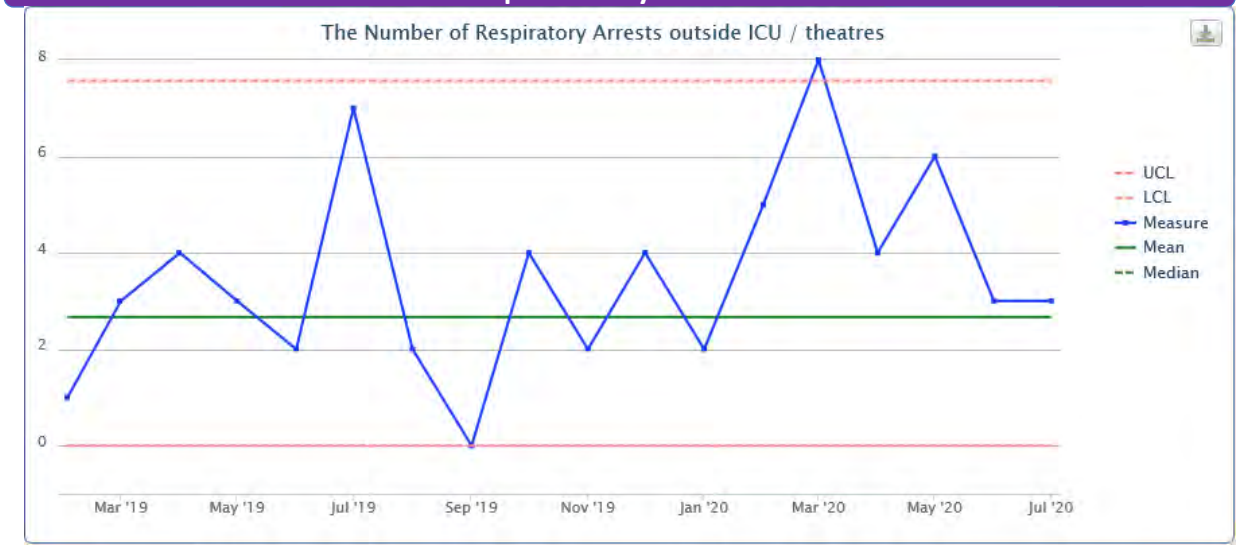
Inpatient mortality



Cardiac Arrests



Respiratory Arrests



An increase in the mortality rate in May 2020 prompted a pro active internal review to identify trends and understand the reasons for this

- This report has been summarised in the July IQPR, reported to PSOC , QSEAC, CQRG and summarised in the Learning from Deaths Report to Trust Board.
- The crude mortality rate has returned to within normal variation for June and July

There have been no outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths

Are we Safe?

The incident reporting rate has increased slightly at 78 per 1000 bed days (n=568) which means we continue to show high levels of incident reporting.

There are currently 8 open **serious incident investigations**. There was 1 new SI declared in July 2020.

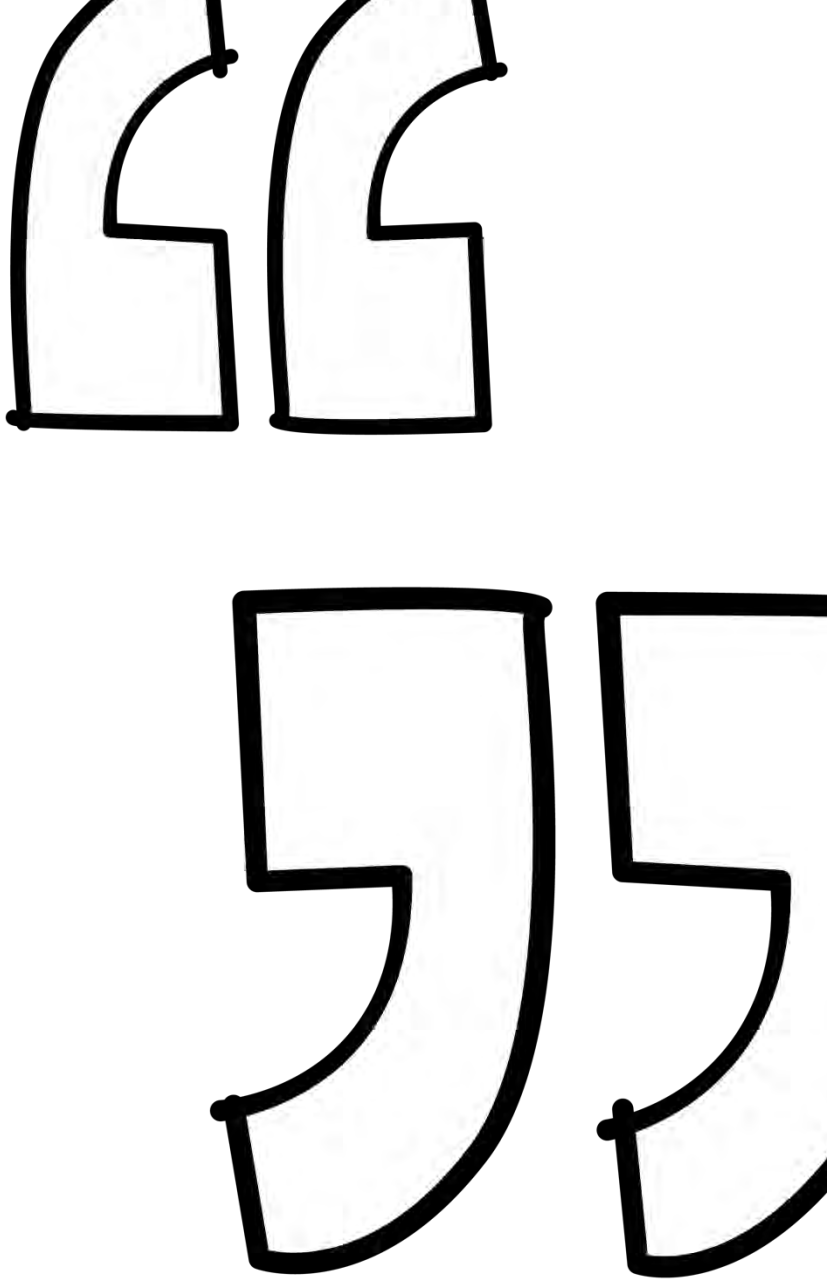
The number of **incidents** being quality checked and closed has increased to 713. This process continues to be supported by a bank member of staff who had previously worked within the PST who has been able to focus on quality checking these completed incident investigations to ensure that that all the appropriate safety actions have been taken ahead of closure.

The percentage of incidents being closed within 45 working days has increased slightly by 2% this month. With the average days to closure recorded as 58 days. As previously reported, although an improvement is observed, this is due to the numbers of incidents that are being closed that were reported in 2019. Of the historical incidents awaiting completion of investigation, we are able to confirm that all incidents from the first 2 quarters of 2019-2020 have been completed as per trajectory (ie the end of July). Work is ongoing to complete these and the rest of 2019 (n=58). With a set trajectory in place, it is likely that the days to closure will decline in the next 1-2 months data as more of the historical/delayed investigations are completed and the incidents closed.

In terms of **infection control** (please refer to slide 4) there were 9 mandatory bacteraemias reported for July including 2 Ecoli, 2 Klebsiella, 1 MRSA, 2 MSSA and 2 pseudomonas. There were no c.Difficile infections. Our line infection rate for the year to date is 1.5 which is in line with previous years' reporting. This will continue to be monitored via the Infection Prevention and Control Committee using the new infection control assurance framework.

The documented compliance for **WHO safer surgery checklists** in our Theatres has increased significantly in July 2020 in response to a rapid improvement plan initiated by the GOSH SSIPs group in June 2020. While improved to 95.9%, this remains below our target of 98% documented compliance. The documented compliance for WHO safer surgery checklist outside of Theatre remains under 50%.

Clinical Harm Reviews are carried out for patients who have waited longer than 52 weeks for their treatment. As of 21st July 2020 there are 0 overdue harm reviews, 13 harm reviews have been sent for completion. There are 133 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?

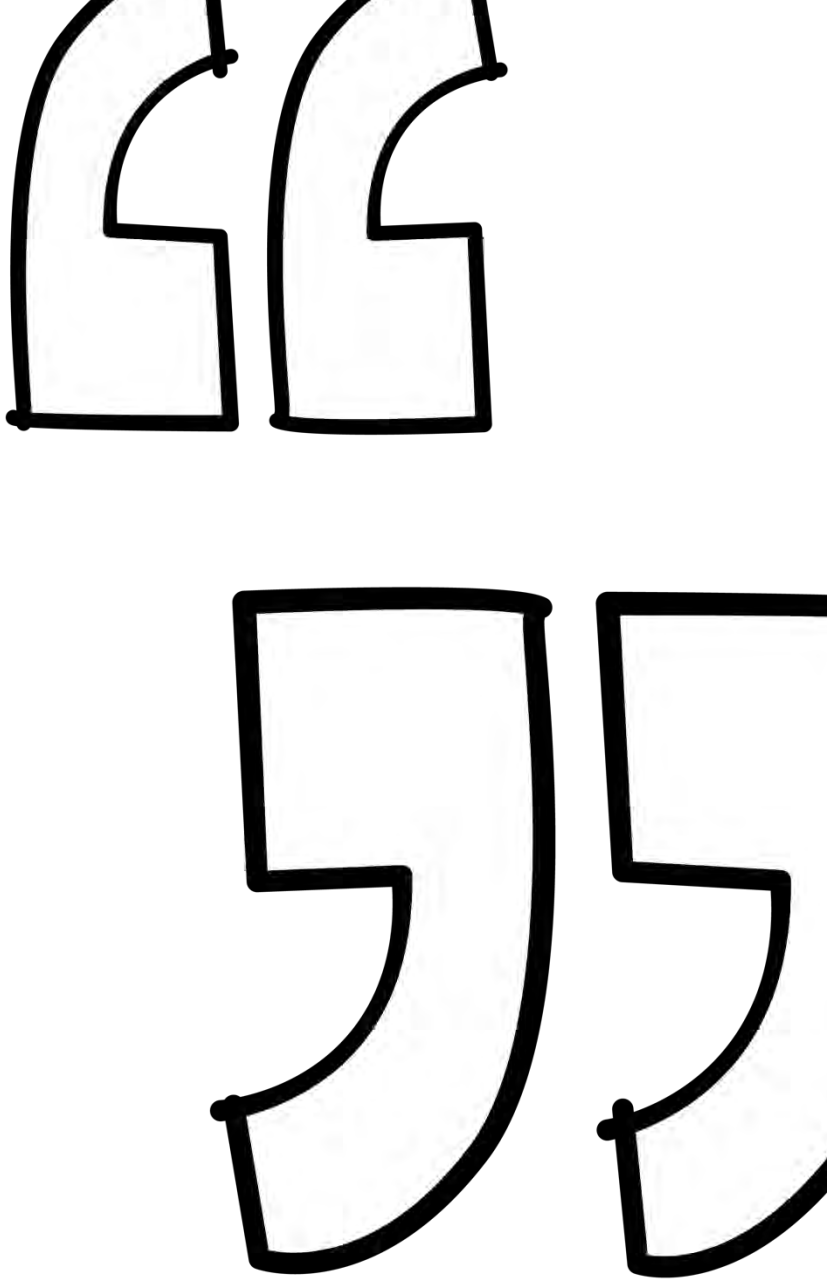
The **Friends and Family Test** response rate in July increased again reaching 37%. Inpatient submissions are almost back to pre-Covid levels and there was a significant increase in Outpatient feedback from 27 in June to 260 in July. Online submissions remain low (n=29) in July despite links being sent to families via MyGOSH after virtual clinics and promotion via social media. Sign up to MyGOSH currently exceeds 23,000 and will be monitored at directorate level via PFEEC to increase sign up and therefore links to the FFT being sent following every appointment..

Formal Complaints- 7 formal complaints were received in July with one (relating to IPP) later withdrawn following successful local resolution. This month complaints related to aspects of care and communication. One complaint related to the one carer visitor policy applied within the Trust in line with national guidance. The Patient Experience team are reviewing further feedback about this (outside of the complaints and Pals processes) to identify further learning.

IPP saw increases in Pals cases (n=6) and complaints (n=2- one complaint later withdrawn). While the FFT response rate also declined this month, the rating of experience was 100%. The Patient Experience team will liaise with IPP to monitor this.

Whilst there were no new red/ high risk complaints, a Body Bones and Mind Complaint (opened in June 2020) has been declared a Serious Incident following an Executive Incident Review Meeting. This is the first complaint confirmed as meeting the Incident Reporting Framework since the new process started in April 2020.

Pals contacts increased again in July 2020. The key theme related to requests for information and in particular to queries about Medical Records. Improvements to the GOSH website enabling families to telephone the Medical Records team directly should enable a more accessible service and reduce queries via Pals. Increased Neurology contacts (n=11) relating to communication about care plans, referrals and admissions have been quickly resolved following successful collaboration with Pals and administration and clinical teams.



Are we Effective?

Our long term data suggests we are encouraging a culture of sharing our specialty led clinical audit activity. To support this further we aim to have as a minimum >100 completed **specialty led clinical audits per** year. At the end of July we are slightly off track for achieving this (31 audits completed (target =33 by end of July) A number of specialty audits have delayed completion due to the impact of COVID .It is likely that there will be a reduction in the number of completed clinical audits this year due to the impact of the pandemic.

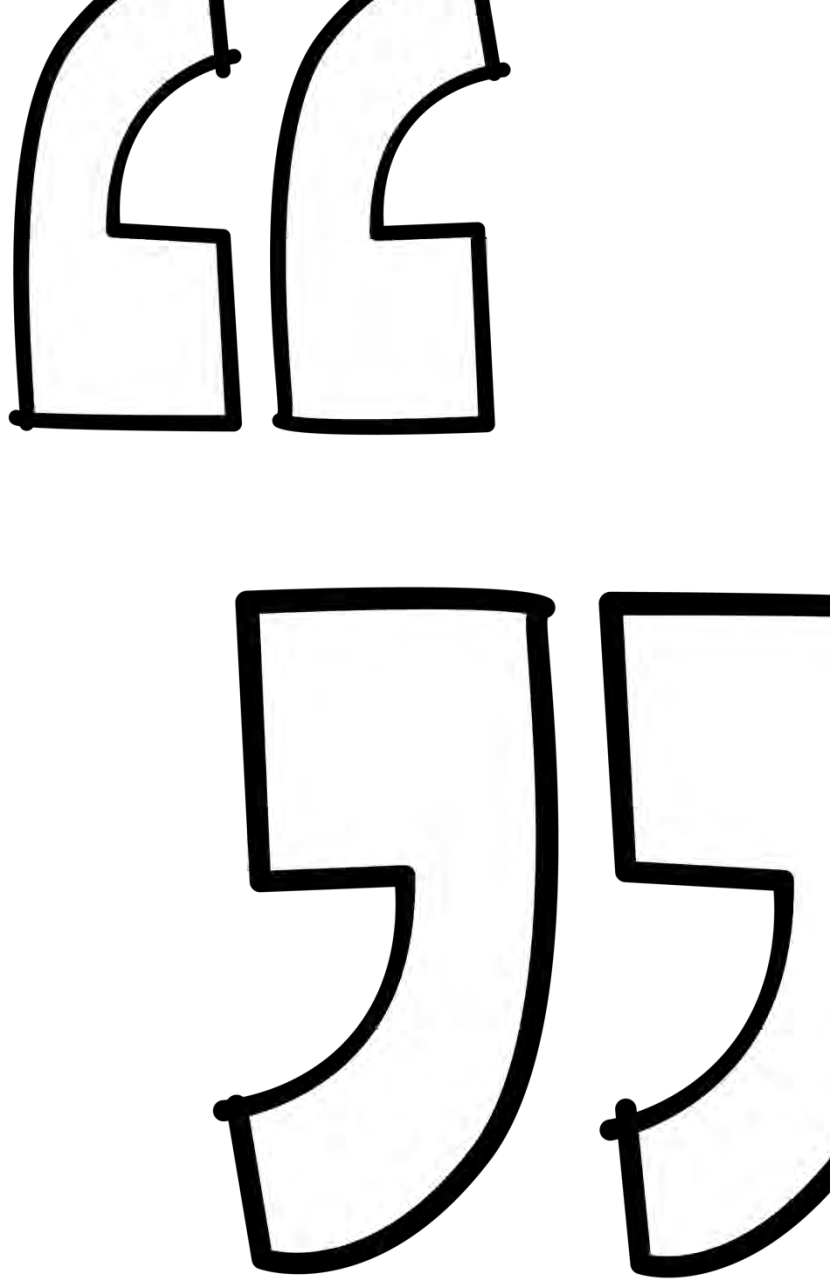
There were a number of **priority audits** completed in July 2020. Key learning from these includes:

- A re-audit of practice in July 2020 highlights an improvement in **documentation in the Urology department** against required documentation standards following the recommendations made to the service by the Royal College of Surgeons. Compliance was 100% for the two standards assessed in this audit. Urology Consultants have taken individual responsibility for ensuring that their postoperative same day reviews are documented.

- Audit shows significant improvement in compliance with GOSH standard and national standards for the **content of a discharge summary,** when compared to an audit of discharge summaries from 2016/17. The audit found 100% compliance with all mandatory national standards for the content of a discharge summary. Recommendations were made to the RACG to clarify Trust standards and add value to the discharge summary process to ensure key information is handed over to support ongoing care.

Although not at the required standard of 100% compliance for discharge summaries turnaround times considerable focus has been placed on this indicator by both the operational and clinical teams to improve compliance. For the month of July, 74% of patients who were discharged from GOSH had a letter sent to their referrer or received within 24 hours. This is a slight decrease from the June position of 80.5%.

For July 2020, performance has slightly increased in relation to 7 day turnaround for **clinic letters**; 65.03% compared to 64.04% in June. At the point of writing the report, a backlog of 1521 letters not yet sent was reported for this financial year of which 921 are in July 2020.



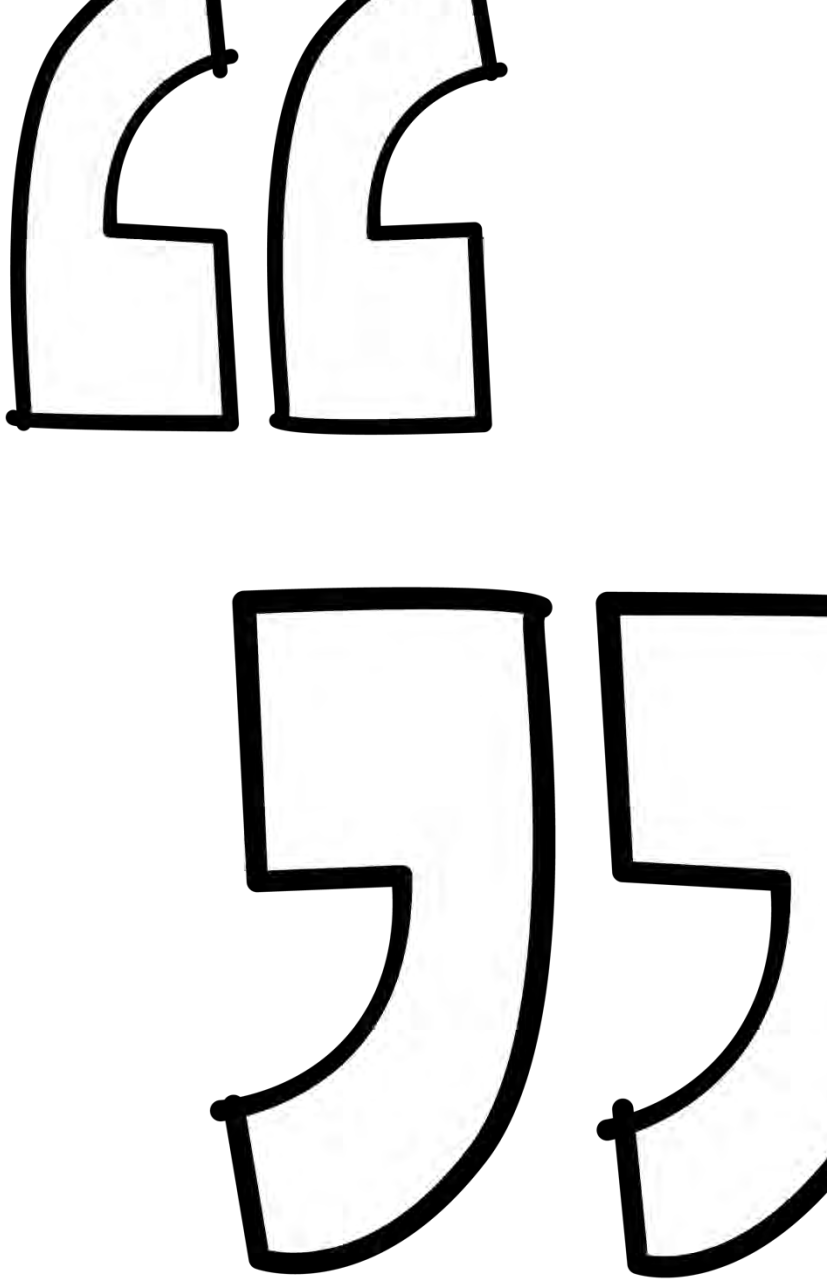
Are we Responsive?

As the national Covid-19 situation continues the Trust has not delivered against the 99% national standard for diagnostic waits. We are currently at 66.33% of patients waiting less than 6 weeks for the 15 diagnostic modalities. This is an improvement on last month's position where we reported 53.65%. The number of breaches reported in July (670) compared to the number of breaches reported in June (793) has declined inline with increased activity in July.

Patients continue to be seen according to their clinical prioritisation with patients requiring a scan within 6 – 72 hours being booked as previously, patients within 2 weeks are being assessed by Radiologist and/or Radiographers and booked accordingly. Routine scans have largely been postponed except for patients who require a scan as part of a face to face appointment, or have surgery planned and the surgery is booked. Through the Clinical Prioritisation Group the diagnostic teams are working closely with outpatient and inpatients teams to ensure capacity is opened at appropriate and safe levels. 650 of the breaches are connected with Covid-19 (unable to book due to Covid-19 or attendance cancelled due to Covid-19), 10 are a booking process issue, 8 are tolerance and 2 are Trust process issues (No beds, admin error, investigations needed).

Our RTT Performance for July sits at 55.6% against a target of 92%. This is a deterioration from June's position (59.6%) as anticipated. Patient continue to be clinically prioritised to ensure that those children and young people who most need our care can access it.

There as been a 14% increase in external referrals in July, compared to June 2020. Overall the Trust received 9% less referrals than in the month preceding the pandemic. The volume of admissions has also increased in July 2020. There were 60% more admissions in July than in April. There was an increase of 383 patient admissions between June and July 2020.
At the end of July the Trust reported a total of 189 patient waiting 52 weeks or more. The is an increase of 56 patients from the June 2020 position. The majority of breached are within Dental (55) Plastic Surgery (16), Urology (9), ENT (8), SDR (6) and Orthodontics (6).



Are we Well Led?

There were 10 incidents that were identified as requiring **duty of candour** in July 2020. Being Open/Duty of Candour conversations took place in 100% of incidents. With regard to stage 2 compliance only 43% were within the 10 days from initial conversation. The delays observed were predominantly due to clarity as to who was responsible in completion of the letter. Four investigation reports were shared with families in July 2020. Unfortunately due to the length of time in completing these investigation, none were shared within the expected timeframe. There are currently 2 RCA investigations which are overdue their completion deadline. Requests for updates with predicted timeframes for completion continue to be sent to the directorates to address the delays and a training plan has been agreed. A review of escalation processes is underway.

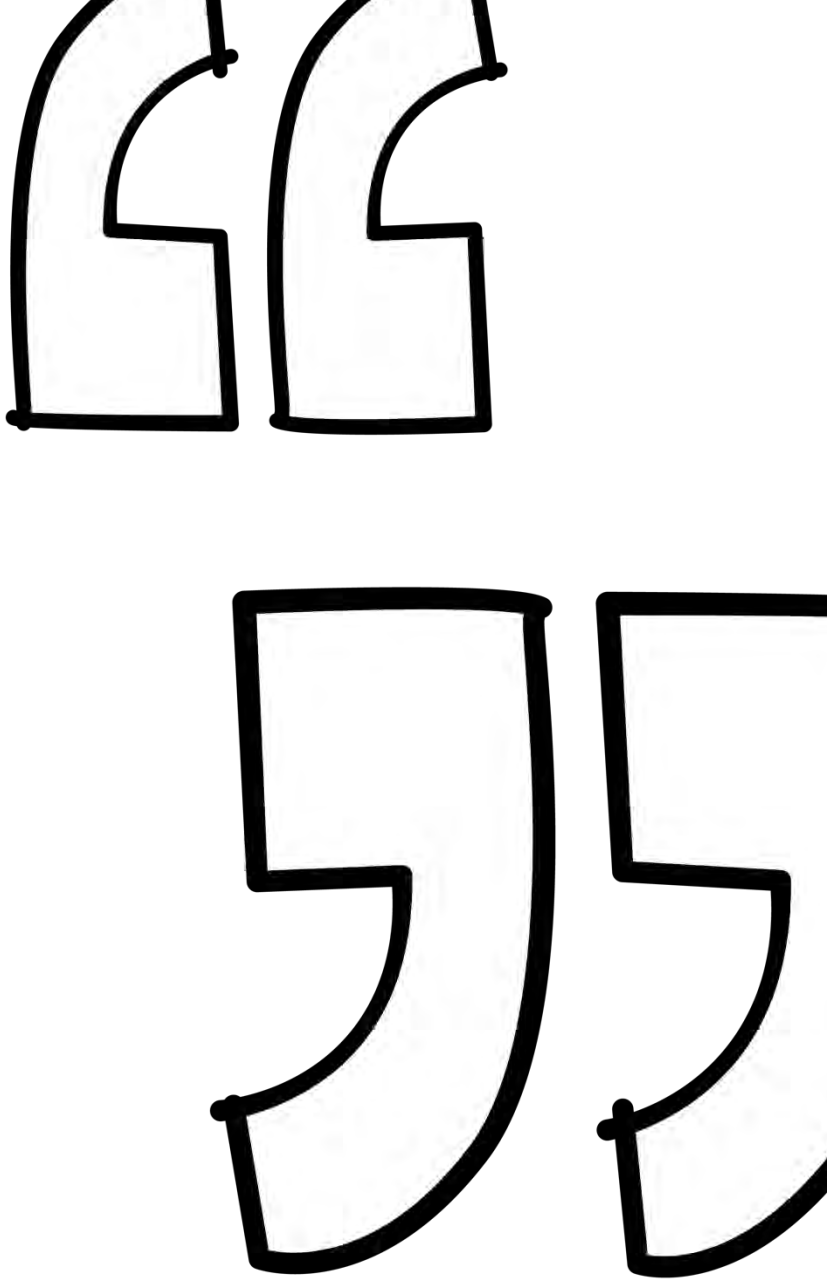
Risk Register: High risk monthly review performance decreased to 74% in July 2020. This related predominantly to the cancellation of RAG meetings due to annual leave commitments during July and August 2020.

The Trust saw an increase of **FOI** requests in July 2020. There was also a positive increase in the timeliness of FOIs being completed. 89% were completed within timescale. There are currently 3 FOI requests that are overdue. These are predominantly due to the complexity of the requests and the information required from a number of departments and linked Trusts/departments. .

There are currently 19 **open** Serious Incident actions in July, with 12 SI actions remaining from 2019. The Patient Safety Team continue to work with the directorate leadership teams to ensure completion and closure of these actions by the end of August 2020.

The **Freedom to Speak Up** service received 6 contacts in July 2020. This is comparable to the 6 cases previously reported in June 2020. The main theme of contacts was bullying or inappropriate behaviours exhibited by other members of staff. Topics were similar to those raised on Slido at recent Big Briefs. Only 1 of the 6 cases related to patient safety concerns and this was signposted and dealt with by the appropriate team.

Policy performance, has decreased from 79% to 77% of policies currently in date. The change has been driven by a number of new policies which have been identified as required for the organisation and are currently in development. Compliance in updating of safety critical policies has remained steady at 87%.



Workforce Headlines

Contractual staff in post: Substantive staff in post numbers in July were 4807.4 FTE, an increase of 8 on last month, and 181 FTE higher than the same month last year.

Unfilled vacancy rate: Vacancy rates for the Trust remain below target at 7%, an increase on June (6.2%) but a reduction on the previous year. A review of corporate areas was undertaken in August to improve reliability of Finance & HR vacancy data. This has led to an improved Month 4 position for Clinical Operations, Nursing & Patient Experience, Research & Innovation & Transformation.

Turnover: is reported as voluntary turnover. Voluntary turnover continued to reduce to 14%, it's lowest level since April 2019, and meets the Trust target (14%). Total turnover (including Fixed Term Contracts) also reduced to 16.8%, again it's lowest rate for over a year

Agency usage: for July 2020 was 0.6% of total paybill, which is below the local stretch target, and is also well below the same month last year (0.8%). The target for 2020/21 remains 2% of total paybill. Bank % of paybill was 5.2%

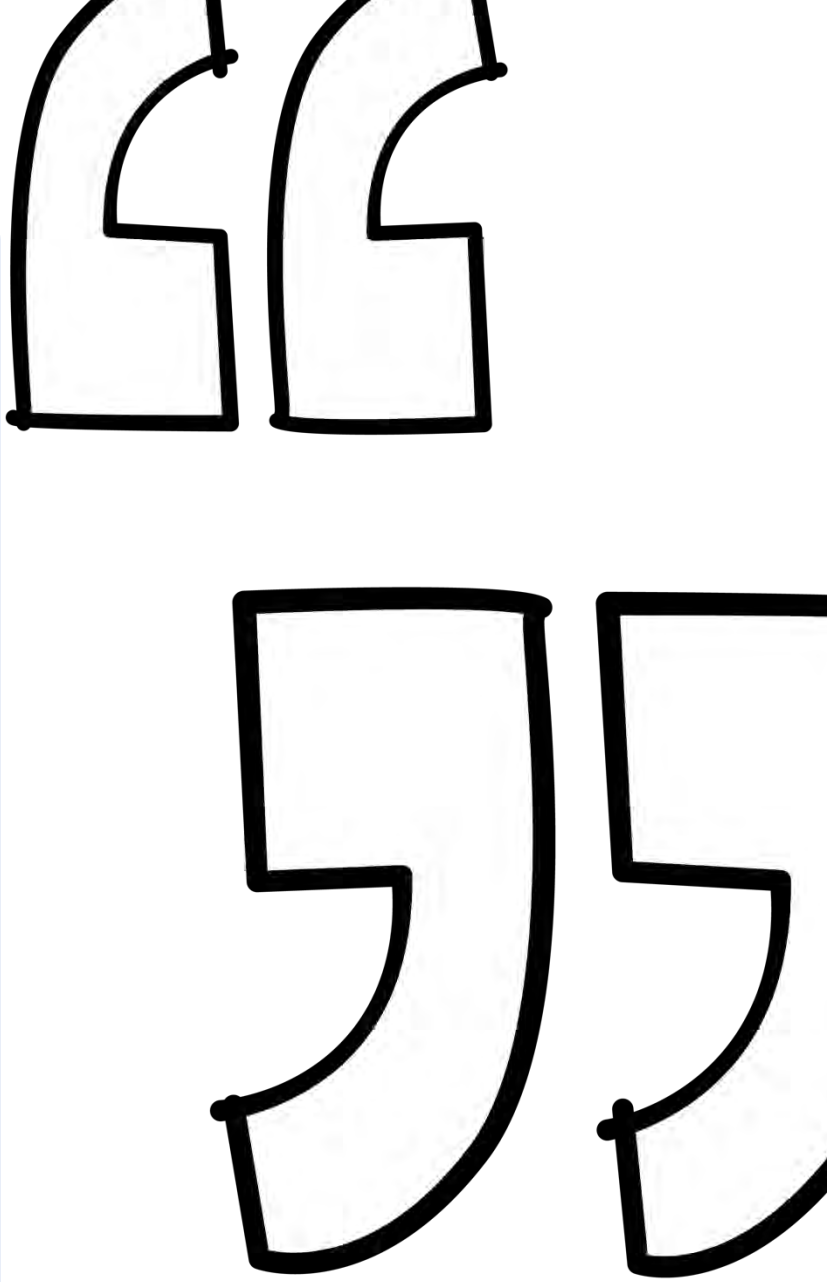
Statutory & Mandatory training compliance: In July the compliance rate across the Trust remained at 93%, which remains above the target with all directorates achieving target. Across the Trust there are 9 topics below target including Information Governance where the target is 95%.

Appraisal/PDR completion: The non-medical appraisal rate for July was 87%, below the 90% target. Consultant appraisal are reported at 69%. The Medical Appraisal and Revalidation Committee is establishing processes to address levels of medical appraisals that will commence from August.

Sickness absence: The sickness KPI has been amended in 2020/21 to reporting in month sickness rather than the previous annual rate. This is to be able to monitor peaks and troughs more effectively . Sickness rates have reduced since the beginning of the year which saw an increase as the pandemic took hold in London. Sickness rates for July were 2.4%, well below the 3.8% April peak and 3% target. There are still a group of staff who are shielding due to pregnancy or long term health conditions, some of these staff are working remotely where possible. Daily absence reporting which is being fed in to national reports show we have an average of 120 staff shielding during July.

Covid-19 staff risk assessment: The Trust launched the nationally mandated risk assessment process in June. As of mid-August 2020 96% of staff have had a risk assessment completed.

In Touch survey: The second survey ran at the end of July 2020, with a good response rate from staff. Improvement was noted in communication between senior management and staff, action on feedback, and staff feeling involved in decision making.



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.

There were 38 COVID 19 related incidents in July 2020 which is an increase of 10 when compared with the previous month. Access to clinical services was the category that had that highest number of incidents (13), followed by clinical assessment (investigations, images & lab tests (5). 10 were categorised as minor harm, with the remaining categorised as no harm.

FFT feedback suggested that patients were generally satisfied with the care they received both inpatients (98%) and outpatients (92%) with many positive comments about management during the pandemic.

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

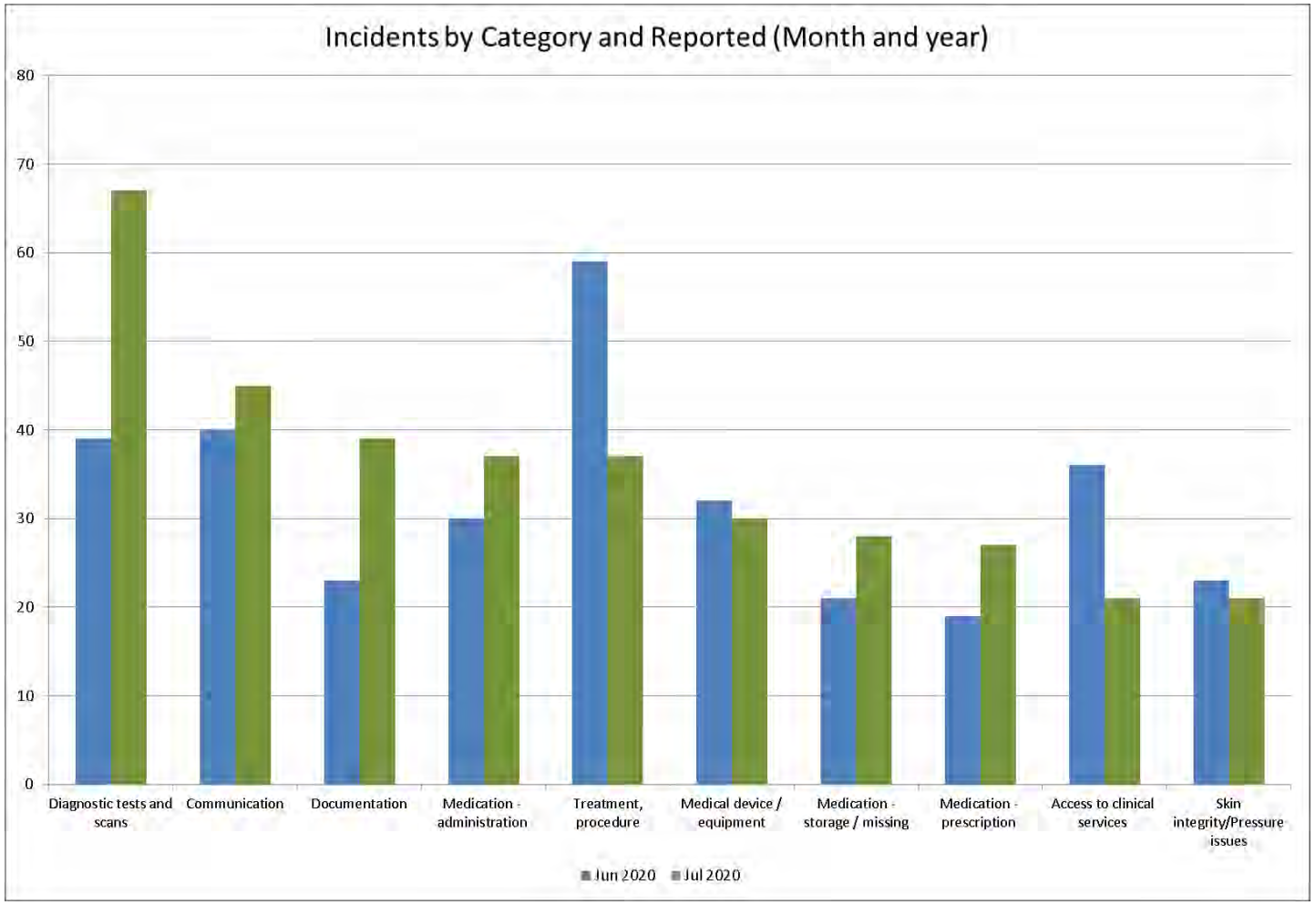
There are currently 48 open Risks on the COVID 19 risk register. Issues include infrastructure (including staffing, facilities and environment) which was the most common risk type.

The current risk levels have changed slightly with 15 risks currently graded as high, 19 as low and 14 as medium.

In July the Health and Safety team, supported by the DIPC and Patient Safety reviewed 1 COVID related incident that was assessed as reportable to the Health and Safety Executive (HSE) under the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 2013 (RIDDOR) that was:

- The database used by the IPC team to receive alerts about new infections (RL feed) did not pick up a SARS-CoV2 equivocal result. The initial result was negative which was then amended to be equivocal. There was the potential exposure to 1 staff member.

Understanding our Patient Safety incidents



Diagnostic tests & scans was the most common incident category in July 2020 with 67 incidents. 13 incidents were recorded in Molecular Genetics, 7 in x-ray and 5 in CICU. Breaking the data down further, the most common sub-category was *'tests – failure/delay to undertake'* (14) followed by '*Test results – failure/delay to record'*. 21 incidents were minor harm and 2 incidents graded as moderate harm. Of these harm incidents, 4 were related to delays in covid swabs being processed or received, and 5 were related to unnecessary or accidental exposures to radiation. Of the two moderate harm incidents, one involved an incident where two samples were inadvertently swapped during the initial phases. This was later discovered and rectified, but not before the parents had been told an incorrect result. The other moderate harm incident relates to x-ray planning for a spinal patient and this harm level is still under review.

Documentation also saw a significant rise in July 2020 to 39 incidents in total. These were spread through the clinical specialties, with Oncology (5), CICU (4) and PICU (4) recording the most. The most common sub-category was incorrect information recorded with 17 incidents. Only one incident was recorded as causing minor harm. Reviewing the 39 incidents qualitatively, there were no significant themes amongst the incidents to suggest a single cause behind this rise in reported incidents. 4 incidents were related to drug documentation, mainly controlled drugs. 4 incidents were related to patient information being accidentally recorded to the wrong record.

Patient Safety – Serious Incident Summary

New & Ongoing Serious Incidents

Directorate	Ref	Due	Headline	Update
H&L (with O&I and S&S input)	2020/6276	26/08/2020	Femoral line placed prior to admission inadvertently in artery. Ischaemic injury to leg	Report drafted, panel being organised
BCC and H&L	2020/6535	04/09/2020	Failure to treat Sepsis in line with the sepsis protocol	Investigation commenced
ICT	2020/7656	18/08/2020	Incident contributing to cybersecurity breach	Report drafted, panel being organised
H&L	2020/7770	19/08/2020	Retained surgical wire following post procedural identification	Investigation commenced
H&L, O&I, BBM	2020/8287	26/08/2020	Concerns regarding the treatment plan following thoracic surgery in H&L	Investigation commenced
H&L	2020/9488	17/08/2020	Cardiac condition not identified on fetal echocardiogram	Investigation commenced.
BBM	2020/13894	16/10/2020	Delay in monitoring resulting in loss of renal function	Investigation commenced.
BBM	2020/14532	27/10/2020	Lack of nephrology input for child with poor kidney function	Investigation commenced.

Learning from Serious Incidents: 2020/3840

What happened?

The patient underwent a biopsy of a brain lesion in April 2018 and following diagnosis was placed on an 18-month course of chemotherapy. In October 2019, it was identified that the tumour had started to grow. A further biopsy was arranged and this confirmed that the patient had a different type of brain tumour. This led to the conclusion that there had been a misdiagnosis of the original tumour and that the patient required a different course of treatment.

Lessons Learned

- For the MDT to recognise that the diagnosis should be based on data from as large a patient cohort as possible which reflect and quantify the risk of error in each diagnostic modality and for that risk of error to be balanced against the possible harm caused by further interventions.

- The level of uncertainty relating to the pathology result and the accuracy of the methylation array was open to interpretation when communicated to the clinical team

Recommendations

- To have a higher index of suspicion about diagnoses based on a small sample of tissue and seek external opinions in such circumstances.
- The communication of test results from the laboratories to the clinical teams, using more robust and clearer language, when communicating the degree of diagnostic uncertainty.
- Duty of Candour training to be more accessible to all staff so as to ensure a clearer process for communicating with families in the event of an incident occurring

Patient Safety Alerts/ MHRA/ EFN Alerts

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

NatPSA/2019/004/NHSPS: Risk Of Death From Unintended Administration Of Sodium Nitrate

Date issued: 06/08/2020

Date due: 06/11/2020

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

FSN – Product recall – BD PosiFlushT XS 10mL syringe

Date issued: 20/07/2020

Date due: N/A

FSN – Fannin pre-filled N/Saline Syringe 10ml

Date issued: 27/07/2020

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

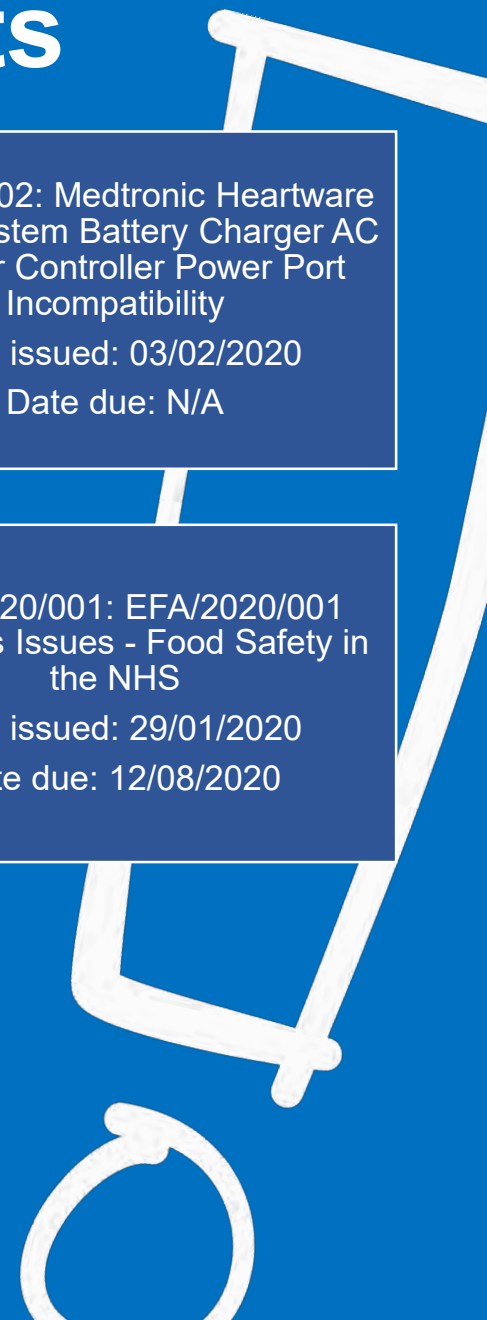
Date issued: 31/12/2019

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



Clinical Audit –priority plan

Audit	Why are we doing this audit?	Timeframes for audit
Content of clinic letters	To review the content of our clinic letters against best practice standards	September 2020
Learning from a complaint (19-070)	To establish implementation of learning within BMT service that “All vital information regarding the patient and their treatment plan will be discussed at ward round .”	Timeframes to be agreed with BMT
GOSH/IPP response to Patterson Inquiry	To provide assurance that recommendations that are relevant to GOSH have been implemented.	Audit plan and timeframe is waiting for approval from the Deputy Director, International & Private Patients Service.
Quality of medical clinical documentation-are we EPIC	To review the clinical quality of our documentation to ensure we are providing a medical record that supports patient care and meets best practice standards. The audit was requested as a priority by the Chief Clinical Information Officer	Clarification required from Chief Clinical Information Officer on plan for finalising data collection
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	August/September 2020
Learning from complaint (18/093)	Learning from complaint (18/093) re-audit to determine if we have changed our practice on PICU for documenting updates given to families	August 2020
Learning from complaint and inquest	To establish sustained implementation of recommendation made for Spinal MDT	September 2020
Controlled Drugs audit	To review best practice and progress from previous audits.	August 2020
Infection Prevention and Control (IPC) audits	Audit of national guidance to support management of COVID-19 to inform the IPC Assurance Framework	August 2020
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. The audit considers learning points raised from two retained foreign objects SI.	Paused due to impact of Covid 19. This will resume when there is capacity to complete the audit . This is being monitored by SSIPS
Learning from Incidents (SI 2020/3609)	Audit to be undertaken to assess compliance with the Trust’s Height & Weight Policy.	September 2020
Chaperone Policy	Review of implementation of key principles of the Policy	Scope and timeframes to be agreed with Safeguarding in August 2020

Clinical Audit –key learning from priority audit

Implementation of documentation recommendations made for the Urology Service by the Royal College of Surgeons.

Audit of cases from February 2020 highlighted that improvement was required in the documentation of a same day post-op consultant ward round for each patient on the day of surgery as per the Urology team standards. The results were shared within the Urology team, and it was clarified that the data reflected an absence of documentation, rather than practice.

A re-audit of practice in July 2020 highlights an improvement in documentation in the Urology department against required standards. Compliance was 100% for the two standards assessed in this audit. Urology Consultants have taken individual responsibility for ensuring that their postoperative same day reviews are documented.

All priority clinical audits completed in 2020/21 to date

Key - High level of compliance

Some improvements required and plan in place

Improvements required and plan

Medicines Storage of Medicines “Must Do” Audit
Safeguarding –survey on learning from Serious Case Reviews
Learning from complaint (18/093)To determine if we have changed our practice on PICU for documenting updates given to families
Learning from incidents -CVL insertion in Interventional Radiology
Duty of Candour Audit
Content of discharge summaries
Urology documentation
Mental Capacity Act re-audit

Content of discharge summaries

This audit shows significant improvement in compliance with GOSH standard and national standards for the content of a discharge summary, when compared to an audit of discharge summaries from 2016/17. (Mean compliance with key standards in 2016/17 =76%, July 2020 = 91%).

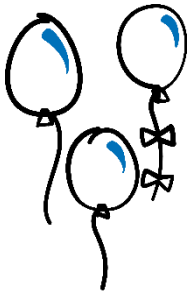
There were many clear examples of good practice enabled by Epic, including clear instructions on next steps for the patient and family, which were written directly to the family and in a clear and noticeable way. This included detailed next steps and arrangements for future appointments and links to MY GOSH.

100% compliance with all mandatory national standards for the content of a discharge summary. There are two GOSH policy standards which exceed those requirements and where there could be improvement, or alignment of the standard to national expectation.

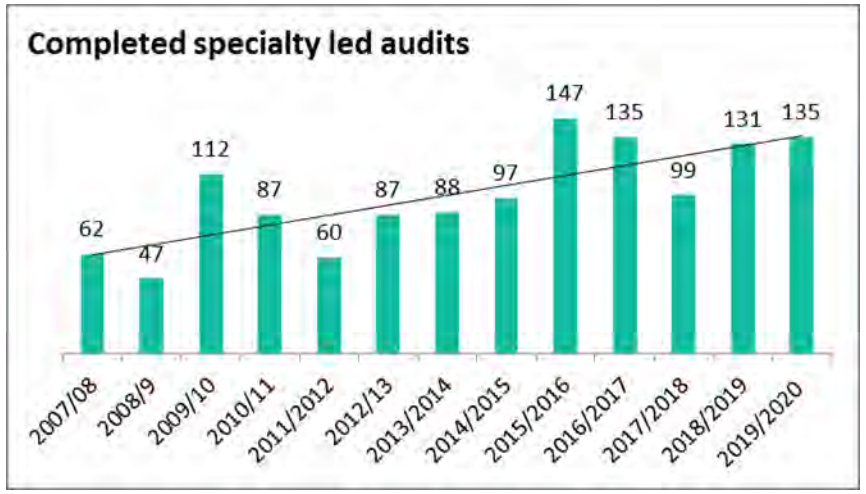
Recommendations were made to the RACG to clarify Trust standards and add value to the discharge summary process to ensure key information is handed over to support ongoing care.

Specialty led clinical audit

There are **245** specialty led audits currently registered at GOSH.



Our long term data suggests we are encouraging a culture of sharing our specialty led clinical audit activity



We aim to have to have over 100 completed specialty led clinical audits per year. At the end of July we are slightly off track for achieving this (31 audits completed (target =33 by end of July) A number of specialty audits have delayed completion due to the impact of COVID.
It is anticipated that there will be a reduction in the number of completed clinical audits this year due to the impact of the pandemic.

Specialty audits on track

Why does it matter?

It is important to have timely oversight of the outcomes of specialty led clinical audit in order to be assured that teams are engaging in reviews of the quality of care provided, and that the outcomes of those can be monitored. The Trust is expected to provide evidence to regulators, including the CQC, that specialty led clinical audit activity takes place.

Specialities with the most overdue audits

Anaesthetics 9
Gastroenterology 5
PICU 5
Neuroradiology 4

These are clinical audits where no update has been given to the clinical audit dept. as to whether the audit is on progress, requires support or more time, or has been completed. Reminders are sent each month by the Clinical Audit team.

The specialty and audit leads for the above have been contacted with details of outstanding audits and offered support. Anaesthetics and PICU are now updating their audit portfolios.

Quality Improvement - support the QI framework outlined in the Trust Quality Strategy ("doing things better")

1. Trust Priority Projects

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 & TPN	PL: Stephen Tomlin ES: Sophia Varadkar	30th September 2020
June 2020	Implementing an effective trust-wide system and process for temperature monitoring of fridges and drug rooms	PL: Salina Parkyn ES: Sanjiv Sharma	30th September 2020
May 2020	Design and implementation of a Ward Accreditation Programme trust-wide.	PL: Darren Darby ES: Alison Robertson	31st January 2021

2. QI Education/Training

In line with the 2020-25 Quality Strategy, QI training will be offered to all staff groups from Board to Ward and an expanded coaching programme launched across the Trust.

Current education priorities are:

- Launch of virtual six-part QI training programme for all GOSH staff- August 2020 [on track for completion]
- QI training sessions delivered to all nursing teams in preparation for Ward Accreditation programme- sessions to commence between August- October 2020 [on track for completion]

3. Local / Directorate QI Work- coaching and data analytical support provided by the QI Team

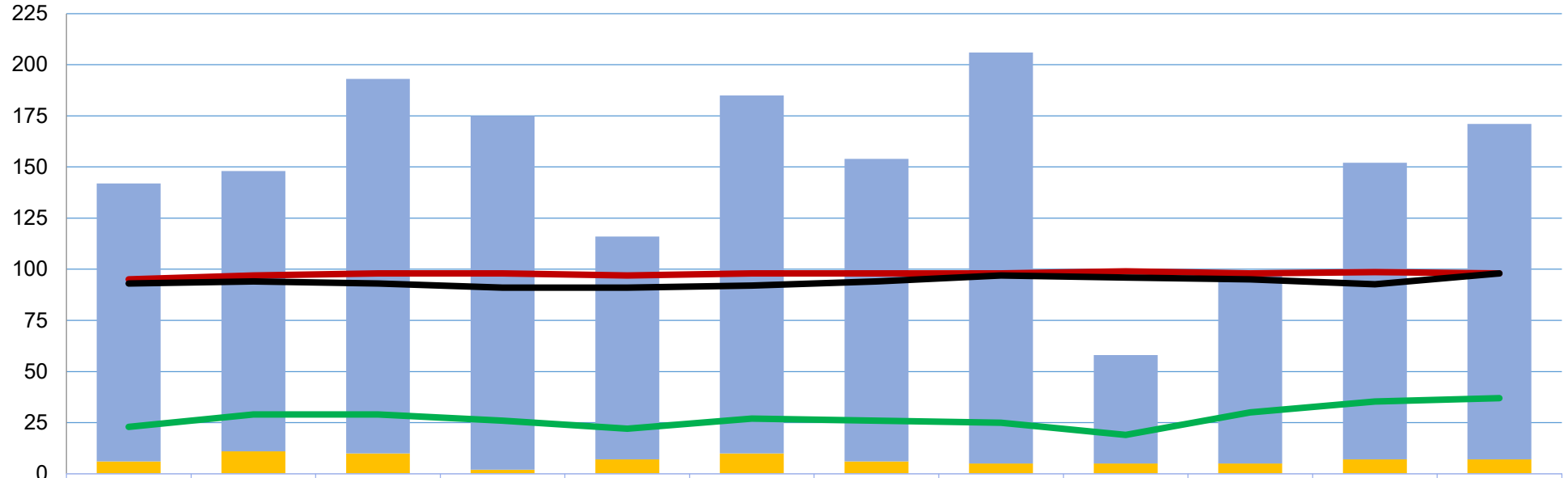
*some projects have been paused during COVID-19 response and therefore completion dates adjusted

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 **(adjusted timeframe August 2020)-on track for completion**
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))-on track for completion**
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))-on track for completion**
April 2020	**Improving access** to the chaplaincy service during COVID-19 response	Jim Lithicum (Lead Chaplain)	August 2020
Nov 2019	To **reduce unnecessary fasting** of patients re-procedure on Safari Ward	Elena Stanton (Trainee-Anaesthetics)	July 2020 (project on hold)
Aug 2019	To **improve patient satisfaction of the consenting process** in cardiac anaesthesia	Marc Cohen (Consultant Anaesthetist)	August 2020)
May 2020	To increase opportunities to **empower and enable children and young people** to register their complaints	Claire Williams (Head of Patient Experience)	August 2020
July 2020	To reduce the number of patients with normal intraocular pressure seen in the uveitis clinic, **increasing throughput** of patients requiring treatment	Natalia Arruti (Clinical Fellow)	September 2020
June 2020	To **improve staff understanding** of children and young people's Mental Health and Wellbeing across the Trust by March 2021	Shauna Mullarkey (Clinical Psychologist & Practice Educator)	March 2021

Patient Experience Overview

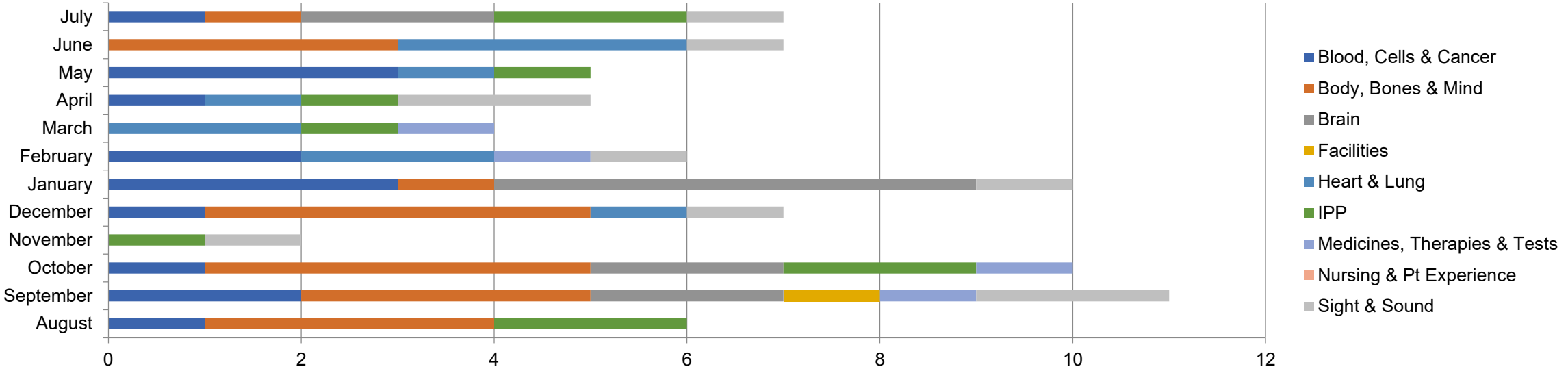
Are we responding and improving?

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



	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Pals	136	137	183	173	109	175	148	201	53	94	145	164
Formal Complaints	6	11	10	2	7	10	6	5	5	5	7	7
FFT recommendation rate - Inpatients %	95	97	98	98	97	98	98	98	99	98	99	98
FFT recommendation rate - Outpatients %	93	94	93	91	91	92	94	97	96	95	93	98
FFT % response rate	23	29	29	26	22	27	26	25	19	30	35	37

Complaints: Are we responding and improving?

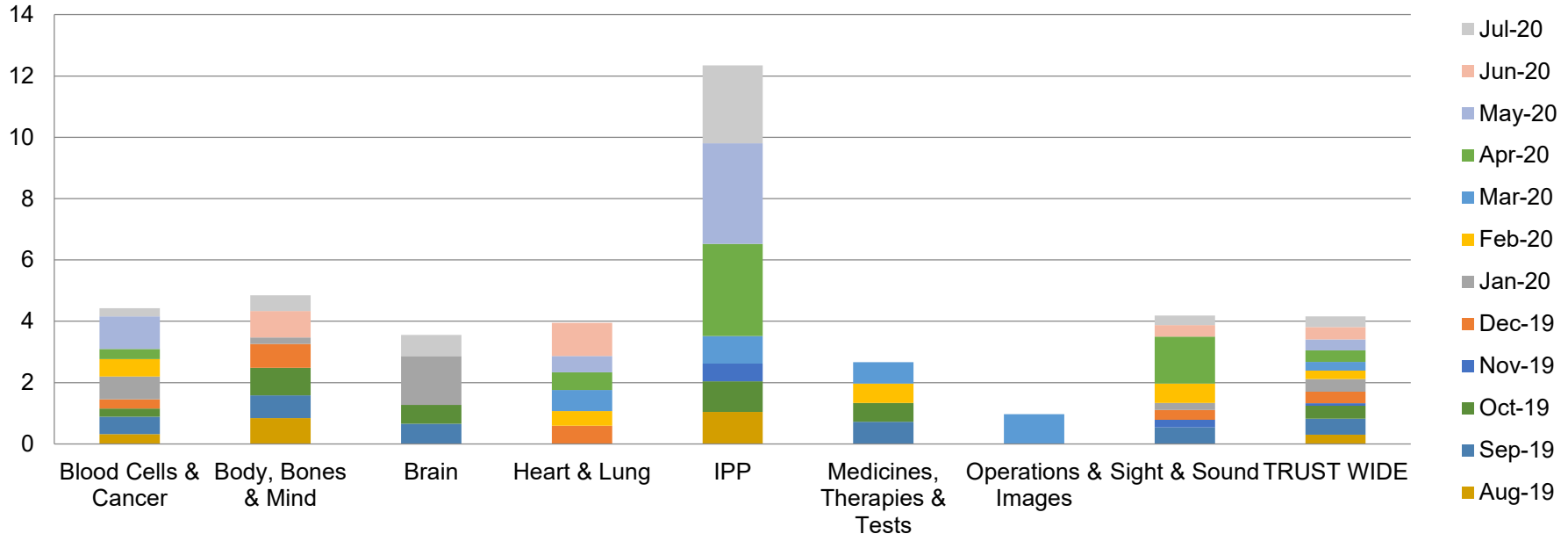


There were 7 new formal complaints received in July 2020 (one complaint about IPP was later withdrawn following a successful meeting with the clinical team). This month families raised concerns:

- about the care received and the 'watch and wait' monitoring approach that was chosen by the clinical team
- that treatment and medication required was not given. Also, that emails were not responded to by the clinical team
- about a lack of dignity given to a patient and a lack of communication between the treating and ward teams
- regarding the one parent/carer rule and lack of consideration to individual circumstances
- around aspects of care on the ward including the management of bowel preparation. Concerns were also raised about a delay in arranging for a cannula insertion and a lack of communication between medical and nursing staff
- that the family were required to restrain the child in order to apply eye drops
- regarding a last minute admission and the lack of information provided in regards to pre operative testing for COVID (Withdrawn).

Complaints by patient activity*

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



Patient activity increased overall by around 10% this month. In IPP activity increased by almost 70% from June and was the highest since March 2020. As shown above, IPP had the highest complaint rate by patient activity (2.53 per 1,000 CPE) in July having received two complaints. However, one of those complaints was later withdrawn by the family following successful local resolution with the clinical team.

Blood Cells & Cancer, Body, Bones & Mind, Brain, and Sight & Sound all had reduced complaints rates. Sight & Sound had its lowest complaints rate since January 2020.

Red/ High Risk complaints: Are we responding and improving?

NEW red complaints opened in **JULY 2020**	**NEW** red complaints **since APRIL 2020**	**REOPENED** red complaints **since APRIL 2020**	**ACTIVE** red complaints (new & reopened) as of **31/07/20**	**OVERDUE** red complaint actions
0	4	0	3	0

No New Red Complaint (July 2020)

Active Red Complaints (including new & reopened complaints July 2020)

Ref	Directorate	Description of Complaint	EIRM Outcome:	Update:
19-084	Heart & Lung	Father's concerns that care and treatment contributed to and hastened patient's death.	N/a- prior to change in process.	Father has recently raised new concerns. A draft response to original complaint has been received from the investigator.
20/011	Blood, Cells & Cancer	Parents have raised concerns that soiled sheets may have caused the fungal lung infection which contributed to the patient's death.	EIRM on 21/05/20 concluded this did not meet SI criteria.	Draft response received from the investigator. Extension required due to complexity of complaint.
20/012	Blood Cells & Cancer	Concerns that actions not taken by the team resulted in further kidney damage.	SI confirmed at EIRM on 03.08/20	Case reviewed at 2 EIRMs and SI declared. Family informed and further information being collated.

Closed Red Complaints

Ref	Directorate	Description of Complaint	Outcome
18-095 Reopen	Blood Cells & Cancer	Further questions about care; request for further information including a response to an external opinion; and evidence of learning from complaint.	Complaint response sent providing further clarification of decisions reached, action taken and evidence of learning, The investigation could not conclude that aspergillus was contracted in GOSH.
20/004	Sight & Sound	Concerns raised about post-operative complications and care, premature discharge and care on the ward when readmitted.	Full complaint response was sent. A meeting to discuss the content of the response and questions was offered and the mother will be in contact when she is able to meet (either via zoom or in person).
20/007	Blood, Cells & Cancer	Concern that delays, aspects of care and insufficient imaging/reporting resulted in the patient's very poor prognosis.	Response has now been shared with the family as per their request. A meeting was offered to discuss the response (which was clinically technical) and any questions they may have.

Are we responding and improving?

What you told us:

You were not fully informed of the potential problems with an audiology magnetic attract system (MAS). You are concerned that you had never physically been shown a MAS prior to the procedure.

What we did:

The Audiology team have committed to improving the information they give to patients and families regarding a MAS. These improvements include:

- Reviewing and updating the audiology patient information leaflet to ensure patients and parents are fully informed about any potential issues that can occur with the MAS. This will also provide a better understanding of what to expect during appointments and following surgery.
- A dummy device showing the external part of the MAS is now shown to all patients and parents in clinics.

A review of the way that we train audiologists to fit external magnets is also taking place. This will ensure that there is a consistent approach within the department .

Pals – Are we responding and improving?

Cases – Month	07/19	06/20	07/20
Promptly resolved (24-48 hour resolution)	113	108	128
Complex cases (multiple questions, 48 hour+ resolution)	29	35	34
Escalated to formal complaints	0	1	1
Compliments about specialities	2	0	1
Total:	**144**	**145**	**164**
Top Six Themes			
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families).	56	70	57
Admission/Discharge /Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation).	10	0	4
Staff attitude (Rude staff, poor communication with parents, not listening to parents, care advice)	6	0	0
Outpatient (Cancellation; Failure to arrange appointment).	36	7	15
Transport Bookings (Eligibility, delay in providing transport, failure to provide transport)	4	4	6
Information (Access to medical records, incorrect records, missing records, GOSH information, Health information, care advice, advice, support/listening)	32	64	82

Pals have recorded a 13% increase in the number of contacts received in July in comparison to the previous month.

50% of all contacts received by Pals in July centre around requests for information. These contacts typically involve assistance with obtaining additional guidance and knowledge on care plans, general hospital information and request for medical records, the latter of which making up approximately 1 in 5 of all information contacts received in the month.

Pals received a glowing compliment from a parent regarding the positive experience and exemplary levels of care and attention received by both her and her daughter whilst they were admitted for an admission under the SNAPS team. Mum particularly wished to highlight the professionalism and positive attitude of everyone involved who, even with the added pressures of Coronavirus, created the '*least stressful admission they have ever had.'*

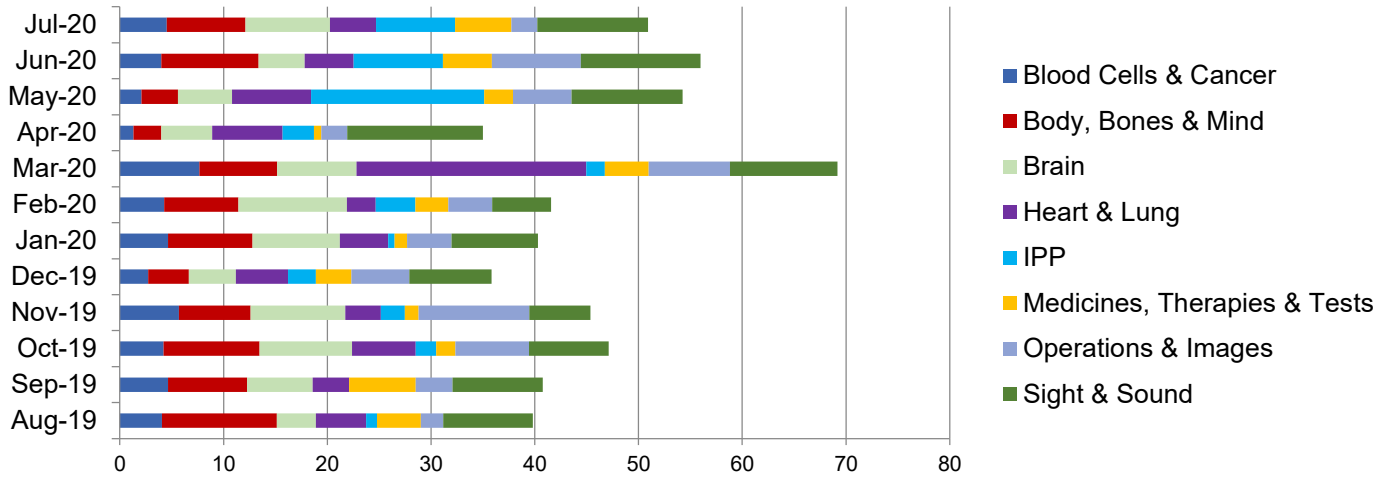
Pals presented a report at PFEEC in August which analysed communication issues across a range of services. The report, produced in collaboration with the Heads of Nursing and Patient Experience, identified the various causes of communication challenges and highlighted positive actions from the services to improve this. Actions included better staff coordination, improved access to 'soft phones' (enabling telephone calls to be answered remotely) and clarifying roles and responsibilities within some clinical teams.

Pals cases by directorate

Following increases in contacts about Medical Records (part of Sight & Sound) the directorate attained it's highest number of Pals contacts since January 2020. (10.6 cases per 1,000 CPE). The Brain directorate also had its highest Pals case rate since March 2020. Further details about the contacts can be found on the following slide.

Medicines, Therapies and Tests also saw an increased contact rate (5.40 cases per 1,000 CPE). 5 of those cases related to Clinical Genetics and requests for information/ test results.

Pals cases by 1,000 combined patient episodes



	BC&C	BB&M	Brain	H&L	IPP	MT&T	O&I	R&I	S&S
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
May-20	6	11	12	16	5	4	3	0	19
June-20	14	33	13	14	4	8	8	0	31
July-20	17	30	24	15	6	9	3	0	35
YTD	**175**	**332**	**240**	**248**	**39**	**59**	**79**	**6**	**334**

Pals – Are we responding and improving?

Top specialities - Month	07/19	06/20	07/20
Medical Records	1	12	15
Neurology	3	2	11
Gastroenterology	5	14	10
Ophthalmology	10	2	8
General Surgery (SNAPS)	12	1	7

Medical Records- For the second consecutive month there was an increase in the contact about accessing patient records (with 2 contacts received in May compared to 12 in June and 15 in July). Pals have also noted a significant rise in contacts from former patients (with these forming 40% of the total amount received).

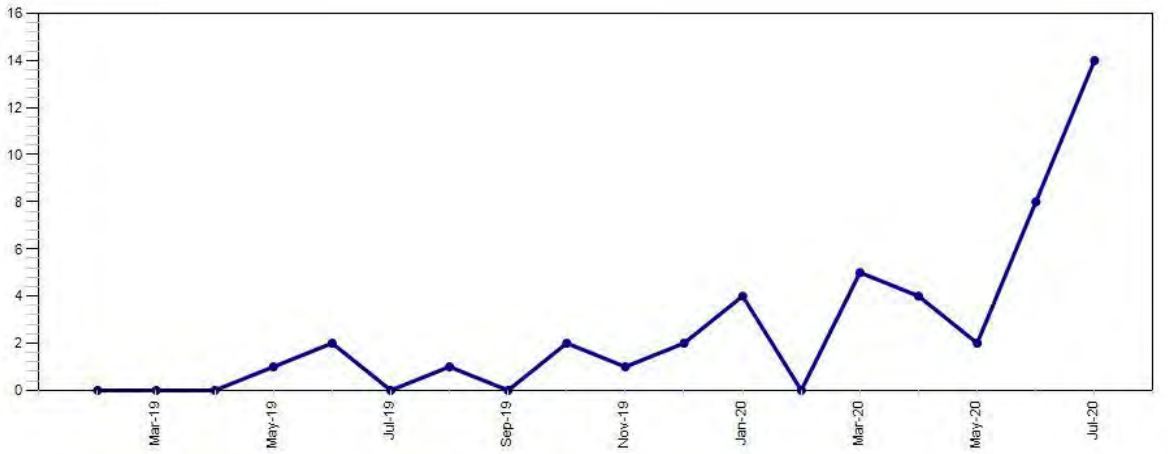
.

Pals continue to explain the process of requesting records to patients and carers, providing the option to assist them in completing relevant paperwork if they are on site. When this is not possible Pals work alongside the Medical records team by escalating requests and monitoring cases and any associated trends.

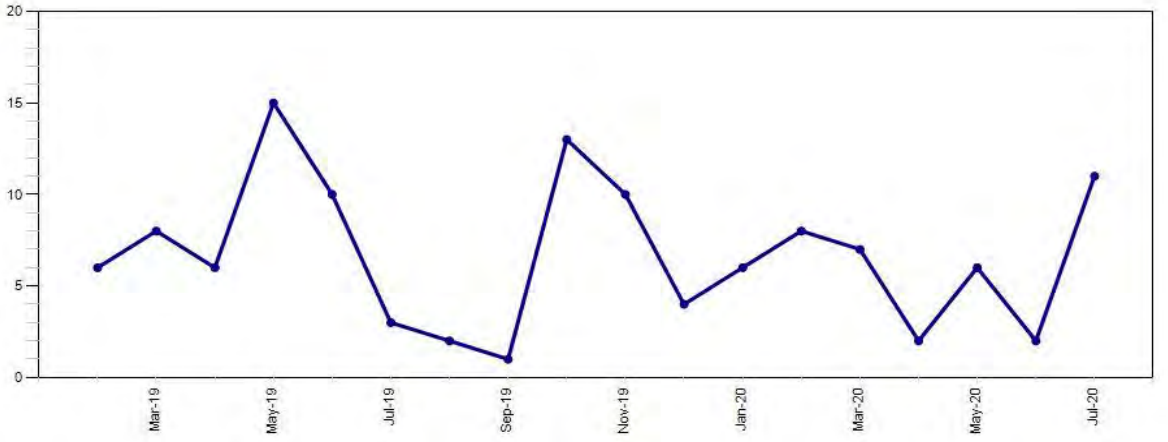
Pals established that the Medical Record team's contact details are currently absent from the GOSH website with only an online submission form available. The website will be updated enabling Medical Records to be the primary point of contact with queries about this process and become a more accessible service.

Neurology-There has been a rise in the volume of Neurology contacts received in July (11) compared to the preceding month June (2). Common themes for contacts involve assistance with updates regarding the timeframes of referrals to the Trust and requests for additional information and clarity on care plans and inpatient admissions. In collaboration with the administrative and clinical teams, it has been possible to provide prompt responses with the majority of contacts being resolved within 72 hours.

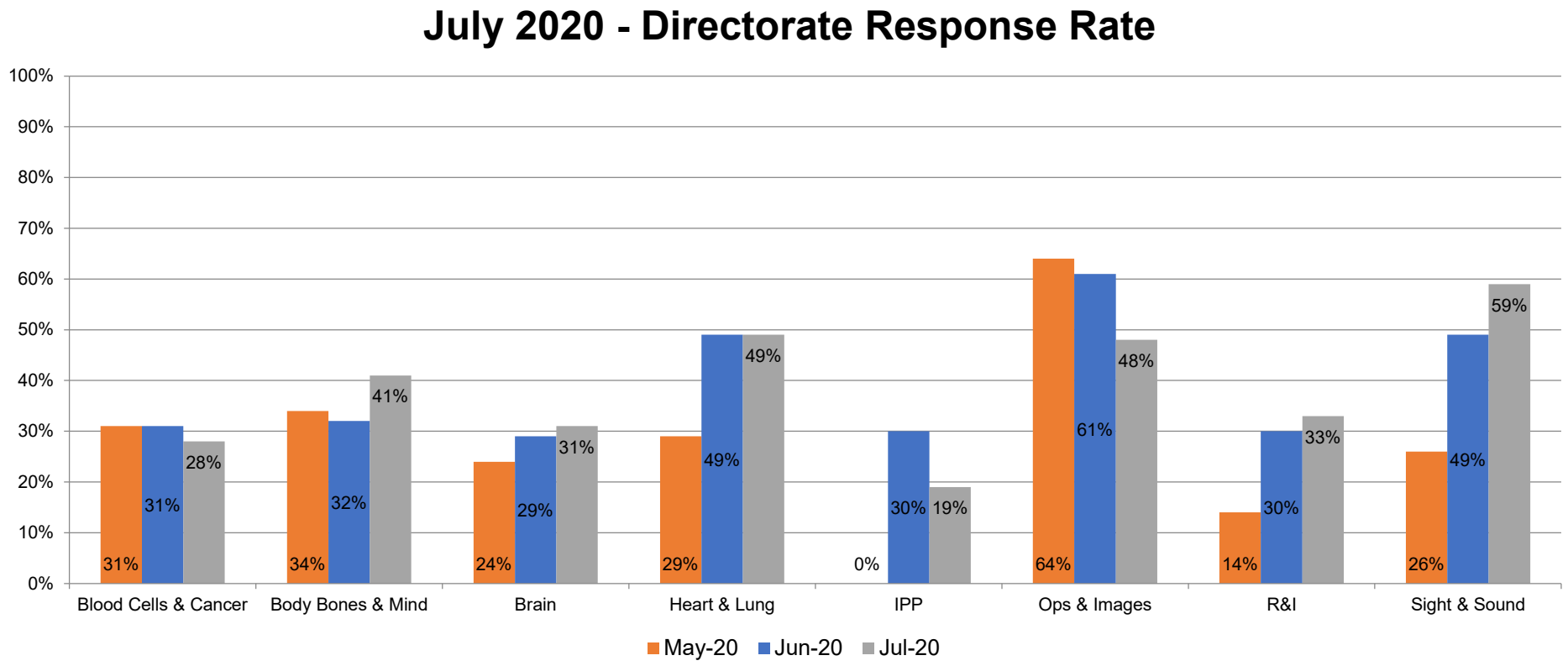
Medical Records cases by patient activity- (total cases excluding formal complaints)



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



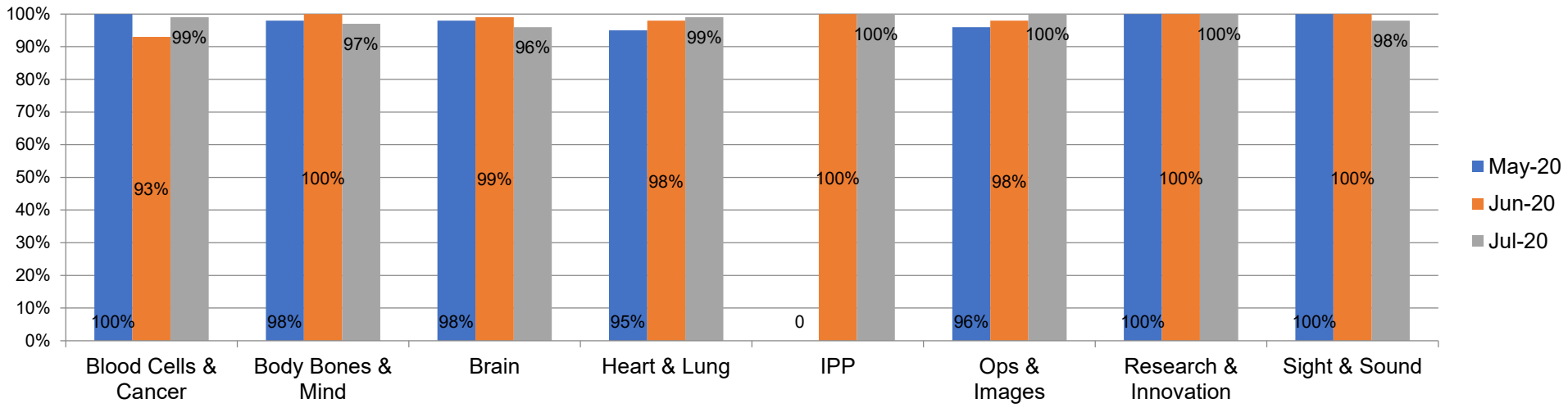
FFT: Are we responding and improving?



Seven directorates achieved above the Trust target response rate of 25%. There were a low number of comments where families scored their experience as ‘poor’ or ‘very poor’.

Staff expertise and friendliness was praised. There were many positive comments relating to the entire ward teams and how they work together, including cleaners, housekeepers, administrative team, nurses, consultants and allied health professionals. The negative comments related to food, parent beds and communication issues with the medical teams and staffing turnover.

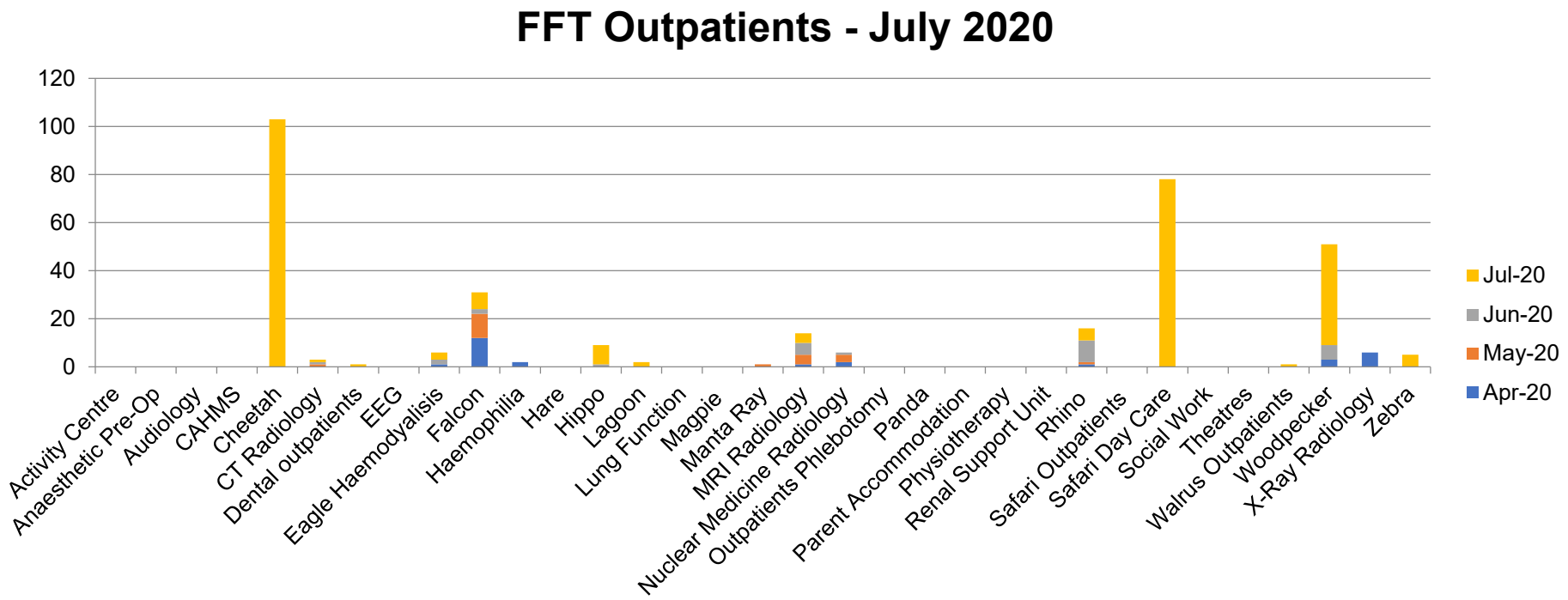
FFT: Are we responding and improving?



	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Feb 20	875	860	47	**1782**	**70.1%**
Mar 20	500	617	24	**1141**	**81.5%**
Apr 20	195	28	15	**238**	**85.7%**
May 20	349	20	12	**381**	**86.9%**
Jun 20	514	27	32	**573**	**89.7%**
Jul 20	701	260	28	**989**	**86.0%**

- Overall the experience measure for inpatients = **98%**
- 72% increase in responses compared to June 2020.
- Consistently high number of qualitative comments= 86%
- Very low number of negative responses = 14. Some comments related to noise and the lack of hot water or a kettle in the room.
- High number of comments commending individual members of staff.

FFT: Are we responding and improving?



The Outpatients areas have increased substantially this month (n=260), however they are still below pre Covid-19 levels (n=860 in February 2020). The travel reimbursement desk (added as Cheetah) contributed to the increase this month by obtaining 103 responses. A high number of clinics being held virtually but despite the FFT link being added to the after visit summary, we have not yet seen a significant increase in online responses which totalled 10 for Outpatients in July.

The recommendation rate was above the Trust target at **98%.**

FFT: Are we responding and improving?

Fantastic hospital and ward. My child's care was excellent. All appointments and treatments were done professionally. The staff were very good and we received the best treatment. Thank you so much" – **Bumblebee Ward**

The new precautions in place are excellent. All staff are kind and friendly. We are so pleased that our son is care for by the staff at GOSH – they do an amazing job!" – **Magpie Ward**

"My baby's transfer to GOSH for treatment was quite scary seeing that he needed surgery. It was truly an emotional time for us. Asides the exceptional care from the medical team, I would in particular like to commend two nurse from GOSH Neonatal unit - they both demonstrated a high level of professionalism, passion, confidence and excellence at their jobs. Their performance put our minds at rest as they ensured they delivered beyond our expectations. When providing feedback they communicated with empathy and soundness and were willing to help in the best ways possible. I will not forget their duty of care to my son" – **Dolphin Ward**

"*I was transferred to GOSH early hours of Friday morning. All staff that we came in contact with were AMAZING and couldn't do enough to make us as safe and comfortable as possible. They were so friendly, polite and nothing was ever an inconvenience for them, Thank you to everyone for looking after our little girl with the best care EVER!"* - **Chameleon Ward**

"The staff are great and caring.

At night is very loud. Staff chatting, doors banging constantly. Don't think staff realise their conversations can be heard at night when everything else is quiet." - **Bear Ward**

This issue has been raised with all staff via team meetings and followed up in email. Staff are aware of the need to be considerate at night time and this will be monitored via feedback received.

"*Excellent care, nurses are affable and build rapport with patients – trust competence and expertise" –* **Walrus Day Ward**

"Staff all lovely, kind and warm, made a difficult time much easier to manage and made my son smile even though he was having not nice things done. They made him comfortable and less scared" **– Woodpecker Ward**

Patient Access – Diagnostic Waiting Times

- As the national Covid-19 situation continues the Trust has not delivered against the 99% national standard. We are currently at 66.33% of patients waiting less than 6 weeks for the 15 diagnostic modalities. This is an improvement on last month's position where we reported 53.65%. The number of breaches reported in July **(670)** compared to the number of breaches reported in June **(793)** has declined inline with increased activity in July.
- Of the **670** breaches, 413 are attributable to modalities within Imaging (**167** of which are MRI), 93 in Sleep Studies, 38 in ECHO, 24 in Clinical neuro-physiology, 44 in Gastroscopy, 25 in Audiology, 9 in Cystoscopy, 19 in Urodynamics, and 6 in Colonoscopy.
- Patients continue to be seen according to their clinical prioritisation with patients requiring a scan within 6 – 72 hours being booked as previously, patients within 2 weeks are being assessed by Radiologist and/or Radiographers and booked accordingly. Routine scans have largely been postponed except for patients who require a scan as part of a face to face appointment, or have surgery planned and the surgery is booked. Through the Clinical Prioritisation Group the diagnostic teams are working closely with outpatient and inpatients teams to ensure capacity is opened at appropriate and safe levels.

- 650 of the breaches are connected with Covid-19 (unable to book due to Covid-19 or attendance cancelled due to Covid-19), 10 are a booking process issue, 8 are tolerance and 2 are Trust process issues (No beds, admin error, investigations needed).
- Covid-19 is having a significant impact on the Trust's ability to deliver against the standard and therefore it is projected that performance will not improve significantly over the coming months. The national diagnostic position for June 2020 performance stood at 52.2%, a 38% deterioration from March 2020. GOSH saw a 21% reduction in performance over the same period. Currently at a national level there are 540,593 patients were waiting 6 weeks and over at the end of June.
- Comparative children's providers have seen similar movements. GOSH, Sheffield Children and Birmingham Women's and Children's reported performance between 48-58% for June 2020 whilst Alder Hey was higher at 83.1%.

Cancer Wait Times

- June 2020 cancer waiting times data has now been submitted nationally and the Trust achieved 100% across all five of the standards we are required to report on. The Trust is projecting full compliance in July.
- The Trust continued to provide services for GOSH Cancer patients as normal. The Trust previously had seen an approximate 50% decrease on cancer referrals into the Trust, however, both June and July has seen an increase into Haematology and Oncology services.

Patient Access – Referral to Treatment

- The Trust did not achieve the RTT 92% standard, submitting a performance of **55.6%** with **2968** patients waiting longer than 18 weeks. This is a deterioration from **59.6**% from the previous month, as predicted.
- The worsening position has been as a result of the Trust significantly reducing non-essential elective workload since the middle of March 2020. Continued deterioration is 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 bring patients to attend appointments.
- The Clinical Prioritisation Group assesses all patients who require outpatients, diagnostics or admission to ensure they are prioritised according to clinical need. At the 29th July **49%** of patients on the elective waiting had been prioritised, with **472** identified for surgery within 4 weeks. During July, 439 patients were operated on. Any patient who experiences an extended wait has 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 on the best way to treat these patients in a timely way.
- The Trust is working with The Portland (Private Hospital) who have offered two all day lists commencing from July. At the point of writing 40 Urology patients have been identified who could access this service
- 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 197 pathways, all of whom were referred to us by external providers.

National Position

At the end of June 2020, 52.0% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks, thus not meeting the 92% standard

Referrals, Admissions and Discharges

- The Trust has seen an 14% increase in external referrals in July 2020, compared to June. This is only a 9% decrease compared to the volume received in February (Pre-covid). Internal referrals in the Trust as a whole have increased and are getting back to pre-covid levels. The volume of internal referrals received in July was 11.5% greater than the volume in February 2020.
- The volume of admissions in July 2020 increased by 60% since April but is still lower compared to previous months'. July saw an increase of 383 more admissions than June.

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 July there were 55 patients (both NHS and PP) whose LOS was more than 50 days, accumulating 11,119 bed days in total.

52+ Week Waits: Incomplete pathways

As at the end of July, the Trust reported a total of **189** patients waiting 52 weeks or more; this is an increase of 56 patients (42%). The majority of breaches are within Dental (55), Plastic Surgery (16), ENT (8), SDR (6), Orthodontics (6), and Urology (9).

National Position

June 2020 indicates a significant increase of over 360% (compared to April) of patients waiting over 52 weeks (50,536 patients).

Comparative children's providers Sheffield Children (58.5%) and Birmingham Women's and Children's (65.2%) and Alder Hey (46.1%) reported on average 83 52-week breaches in June.

Productivity & Efficiency

Theatre Utilisation

- To meet the Trusts operating requirements during Covid-19, main operating theatres scheduling significantly changed mid-March 2020. Scheduled lists for Covid-19 positive patients were formed, along with scheduled lists, emergency and urgent/emergency. Theatres remain running a significantly lower number of lists than the pre-Covid period.
- Scheduled main theatres in July saw utilisation of 77.31%, out of 248 sessions. 49 were ring fenced for Covid-19 positive patients and 10 patients were operated on during July in those theatres. Emergency theatre utilisation was 78.72% with the number of emergency theatre cases during July being 91.
- From July, we have access to two theatre sessions a week at the Portland hospital for treating our Urology patients.
- A weekly task and finish group has been formed to review Theatre Constraints which includes reviewing consenting and clerking, late theatre starts, theatre list lockdown and allocation of lists.
- Data presented at clinical prioritisation group for activity during August indicates that to meet the volume of category 2 patients requires an additional 10,250 minutes. Further theatre sessions are commencing from 7th September 2020, however, this will not fully cover the gap.

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 being June 2020.

In June, 20 patients were cancelled compared to 4 in May. The areas contributing most to the monthly position are Cardiac Surgery/Cardiology (8), Cystic Fibrosis (3) and Rheumatology (3), Diagnostic Imaging (2), SNAPS (1). Neurology (1), ENT (1) and Ophthalmology (1). The top reasons recorded for the month are: Emergency/Urgent patient taking priority (6), Ward Bed unavailable (5) and List Overrun (3).

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

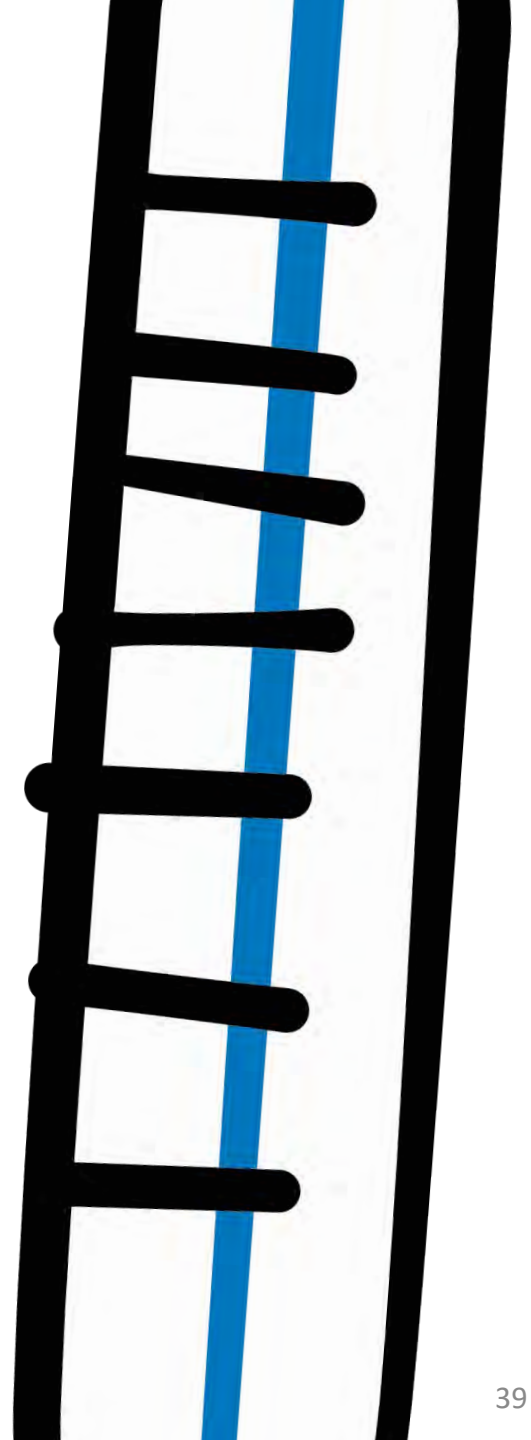
The Trust reported 0 last minute cancelled operations not readmitted within 28 days in July.

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 June and July, bed occupancy was lower than previous months at, 65% and 62% respectively, however, this is impacted by all inpatient beds being counted as being open for the Covid period, therefore a baseline of 350 beds across the organisation (excluding day-case).

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



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 Trust did not report any CATS referral refusals into PICU/NICU from other providers in July. This the first instance of no CATs refusal in over 12 months

PICU Emergency Readmissions:

The Trust did not have any readmissions back into PICU within 48 hours for the month of July.

Trust Activity

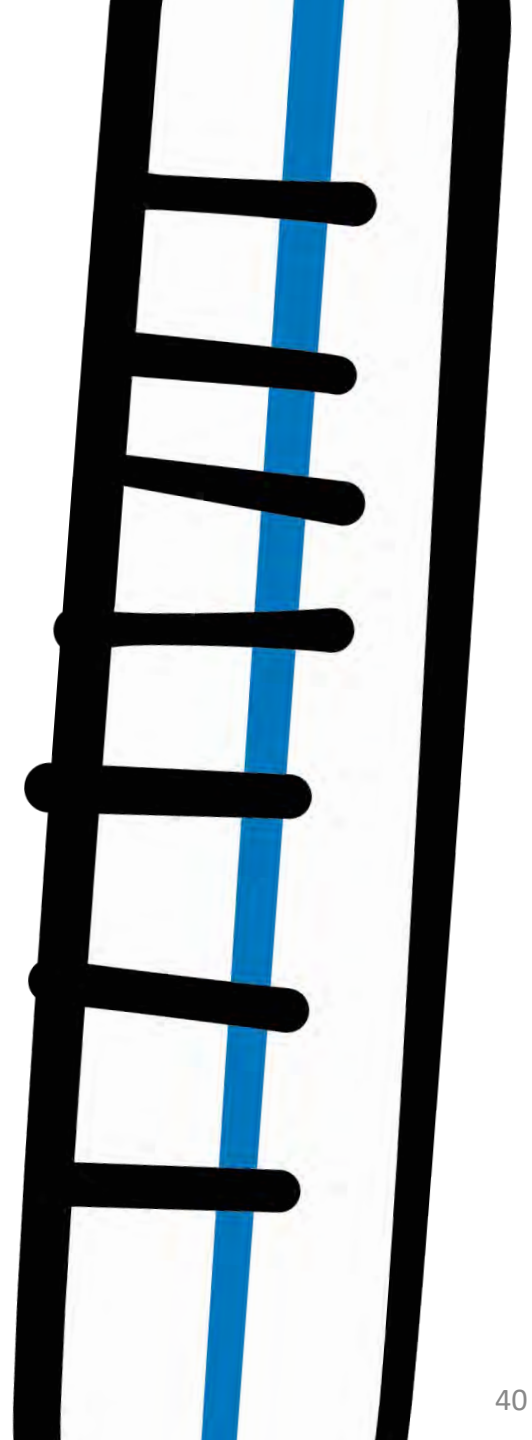
Outpatient DNA and Cancellation Rates

For the month of July, the Trust reported a DNA rate of 4.81%, a slight increase to the rate reported in June of 4.75%, but remains lower that previous months

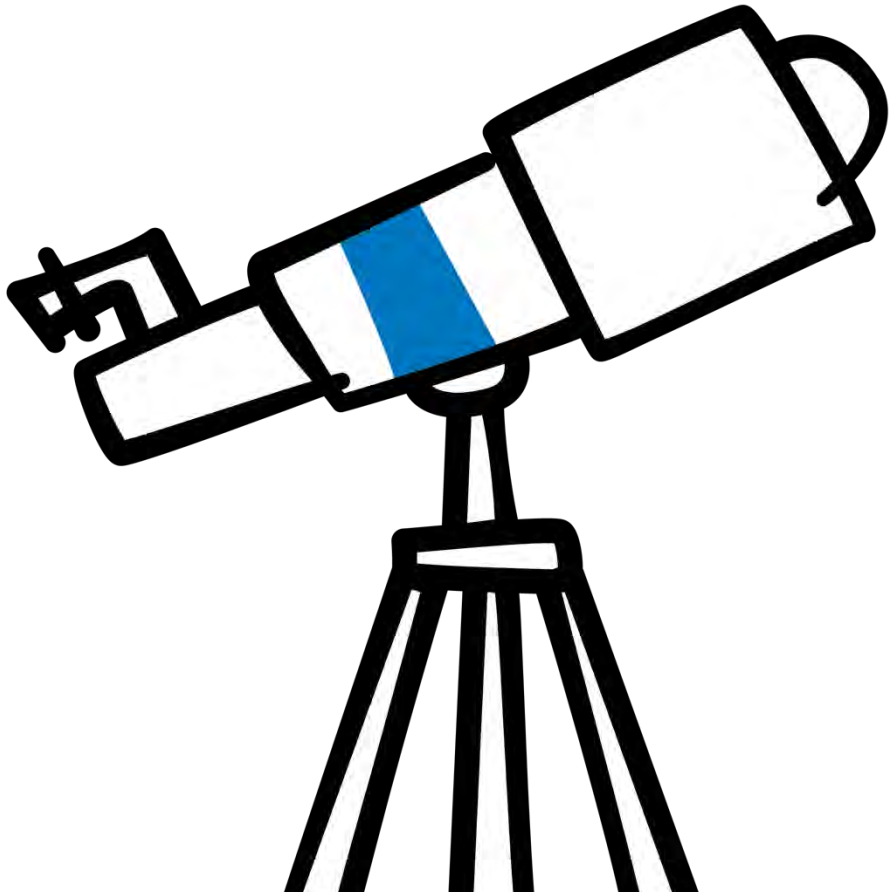
The number of outpatient appointments that were cancelled either on the day or the day before (both by hospital and patient) increased in July compared to June but still significantly lower at 639 in July compared to 1,105 in March. However, this is reflective of the reduced outpatient activity due to Covid-19, which was operating at approximately 30% lower than normal levels.

Trust activity

July 2020 activity for both day case and overnight stays remains below plan due to the Covid19 pandemic at circa 53%. Critical care bed days are 12% lower than YTD plan. 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. Please refer to the Activity Monitoring Summary for further details.



Productivity & Efficiency – Discharge Summaries & Clinic Letters



- 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 July, 74% of patients who were discharged from GOSH had a letter sent to their referrer or received within 24 hours. This is a slight decrease from the June position of 80.5%.
- 84.9% of letters were sent within 2 days of discharge, on average for July letters were sent 1.6 days following discharge compared to 1.3 days in June.
- 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 89 discharge summaries up to July 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 July 2020, performance has slightly increased in relation to 7 day turnaround; 65.03% compared to 64.04% in June. At the point of writing the report, a backlog of 1521 letters not yet sent was reported for this financial year of which 921 are in July 2020.
- The EPR team have now rolled out the 'clinic letter not required' button within Epic, to specific specialties 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.

Workforce Headlines

Contractual staff in post: Substantive staff in post numbers in July were 4807.4 FTE, an increase of 8 on last month, and 181 FTE higher than the same month last year.

Unfilled vacancy rate: Vacancy rates for the Trust remain below target at 7%, an increase on June (6.2%) but a reduction on the previous year. A review of corporate areas was undertaken in August to improve reliability of Finance & HR vacancy data. This has led to an improved Month 4 position for Clinical Operations, Nursing & Patient Experience, Research & Innovation & Transformation.

Turnover: is reported as voluntary turnover. Voluntary turnover continued to reduce to 14%, it's lowest level since April 2019, and meets the Trust target (14%). Total turnover (including Fixed Term Contracts) also reduced to 16.8%, again it's lowest rate for over a year

Agency usage: for July 2020 was 0.6% of total paybill, which is below the local stretch target, and is also well below the same month last year (0.8%). The target for 2020/21 remains 2% of total paybill. Bank % of paybill was 5.2%

Statutory & Mandatory training compliance: In July 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%.

Appraisal/PDR completion: The non-medical appraisal rate for July was 87%, below the 90% target. Consultant appraisal are reported at 69%. The Medical Appraisal and Revalidation Committee is establishing processes to address levels of medical appraisals that will commence from August.

Sickness absence: The sickness KPI has been amended in 2020/21 to reporting in month sickness rather than the previous annual rate. This is to be able to monitor peaks and troughs more effectively . Sickness rates have reduced since the beginning of the year which saw an increase as the pandemic took hold in London. Sickness rates for July were 2.4%, well below the 3.8% April peak and 3% target. There are still a group of staff who are shielding due to pregnancy or long term health conditions, some of these staff are working remotely where possible. Daily absence reporting which is being fed in to national reports show we have an average of 120 staff shielding during July.

Trust Workforce KPIs: July 2020

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Metric	Plan	July 2020	3m average	12m average
Voluntary Turnover	14%	14.0%	14.6%	15.4%
Sickness (1m)	3%	2.4%	2.4%	3.0%
Vacancy	10%	7.0%	6.8%	7.0%
Agency spend	2%	0.6%	0.5%	0.6%
PDR %	90%	87%	88%	88%
Consultant Appraisal %	90%	69%	80%	90%
Statutory & Mandatory training	90%	93%	93%	94%

Key:

Achieving Plan Within 10% of Plan Not achieving Plan

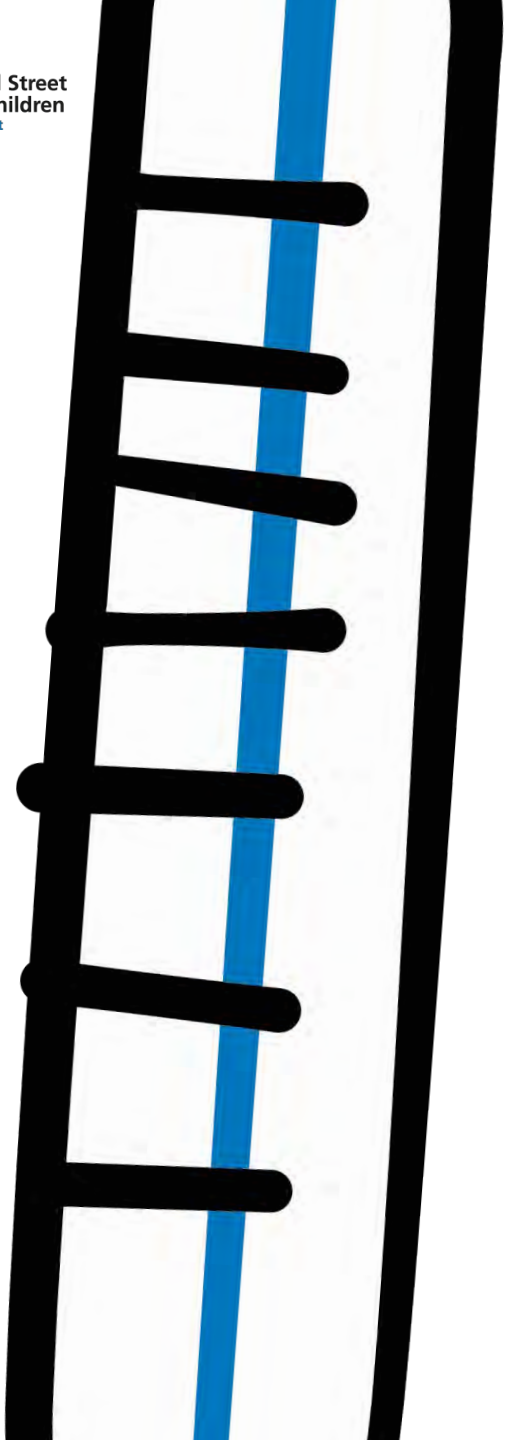
Directorate (Clinical) KPI performance July 2020

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	Genetics
Voluntary Turnover	14%	14%	10.9%	**18.0%**	12.6%	14.1%	14.7%	11.5%	11.0%	14.7%	9.3%
Sickness (1m)	3%	2.4%	3.0%	2.2%	2.2%	2.5%	2.2%	3.1%	2.1%	3.4%	1.1%
Vacancy	10%	7.0%	0.5%	2.7%	5.5%	0.3%	-1.9%	7.9%	5.8%	**12.3%**	8.2%
Agency spend	2%	0.6%	0.0%	0.0%	0.0%	0.0%	1.3%	1.0%	0.5%	0.2%	0.0%
PDR %	90%	87%	85%	88%	90%	89%	88%	89%	97%	92%	82%
Stat/Mand Training	90%	93%	91%	92%	94%	91%	93%	94%	99%	96%	99%

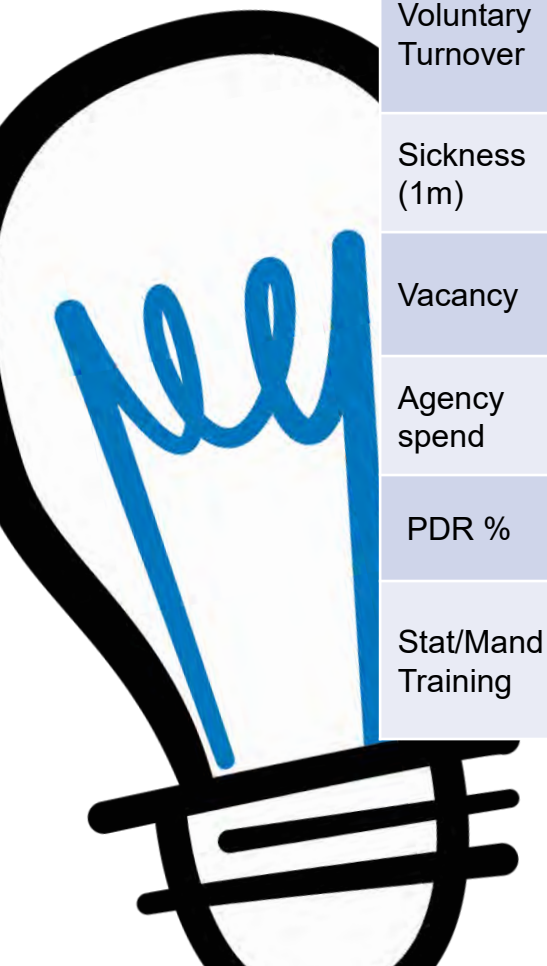
Key:

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



Directorate (Corporate) KPI performance July 2020

Metric	Plan	Trust	Clinical Operations	Corporate Affairs	ICT	Property Services	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation	Transformation
Voluntary Turnover	14%	14%	10.3%	**33.1%**	13.0%	10.7%	**18.5%**	12.6%	**24.9%**	10.2%	**20.9%**	**27.6%**
Sickness (1m)	3%	2.4%	1.5%	0.0%	0.8%	**4.8%**	0.1%	3.1%	0.0%	1.1%	3.0%	3.3%
Vacancy	10%	7.0%	0.7%	**22.3%**	**15.2%**	0.6%	**18.7%**	8.0%	**18.6%**	6.5%	8.9%	**13.8%**
Agency spend	2%	0.6%	**2.4%**	0.2%	**6.2%**	**3.2%**	**7.3%**		0.0%	0.0%	0.0%	0.0%
PDR %	90%	87%	**77%**	**79%**	**70%**	91%	93%	87%	90%	86%	81%	**80%**
Stat/Mand Training	90%	93%	97%	97%	98%	97%	96%	99%	96%	97%	97%	97%



Key:

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

In Touch Survey: July 2020

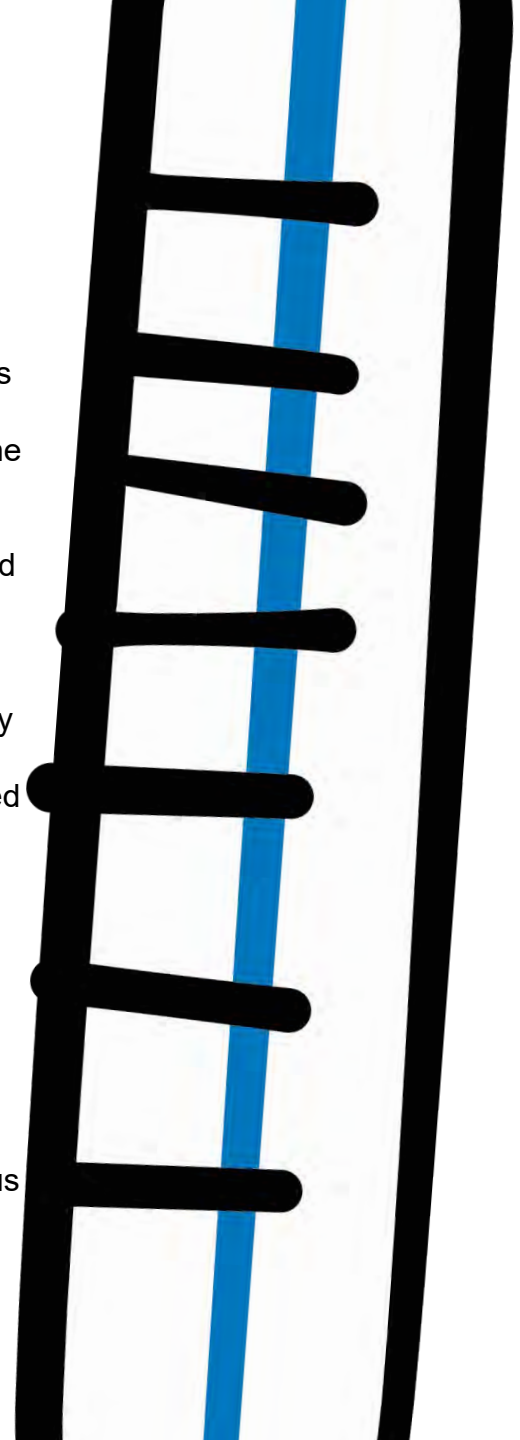
Directorate	How do you feel you are coping with life at the minute?	Do you know where you would go for wellbeing help and advice, if you needed support?	If you are working on-site, how safe do you feel?	My immediate manager is taking a positive interest in my health and wellbeing	Communication between senior management (Trust Leadership team) and staff is effective at the moment.	Senior managers (Trust Leadership team) are acting on feedback.	I am involved in deciding on changes introduced that affect my work/area/team/dept.
Blood, Cells & Cancer	58%	77%	80%	74%	67%	49%	47%
Body, Bones & Mind	67%	79%	78%	64%	71%	50%	42%
Brain	65%	78%	75%	82%	74%	62%	55%
Clinical Operations	65%	85%	87%	80%	60%	55%	50%
Corporate Affairs	76%	86%	89%	52%	79%	72%	59%
Finance	65%	84%	64%	68%	81%	65%	48%
Genetics	71%	76%	75%	71%	52%	57%	43%
Heart & Lung	65%	71%	77%	59%	52%	39%	28%
HR&OD	74%	96%	81%	85%	93%	69%	63%
ICT	51%	76%	57%	62%	57%	35%	27%
International	71%	91%	75%	77%	77%	63%	48%
Medical Directorate	79%	95%	100%	89%	84%	79%	79%
Medicines Therapies & Tests	60%	80%	62%	70%	67%	51%	39%
Nursing & Patient Experience	61%	78%	78%	84%	83%	67%	59%
Operations & Images	55%	79%	52%	66%	42%	37%	34%
Property Services	62%	74%	58%	66%	49%	53%	42%
Redevelopment	71%	82%	79%	82%	82%	59%	41%
Research & Innovation	80%	86%	71%	80%	80%	59%	34%
Sight & Sound	66%	82%	68%	71%	64%	58%	45%
Transformation	74%	88%	88%	83%	86%	76%	50%
Trust	**66%**	**81%**	**72%**	**71%**	**69%**	**55%**	**45%**

Green is always the most positive Directorate for the question, red the least positive.

The 2nd In Touch survey was run at the end of July. The results continued to show the majority of staff felt supported, able to access information for wellbeing and an improvement in the % of staff feeling safe on site.

66% of respondents felt they were coping well, however 18% of respondents reported they were finding things difficult.

Communication between senior management and staff, feedback being acted on and being involved in decisions affecting their teams all saw an improvement on the previous survey.



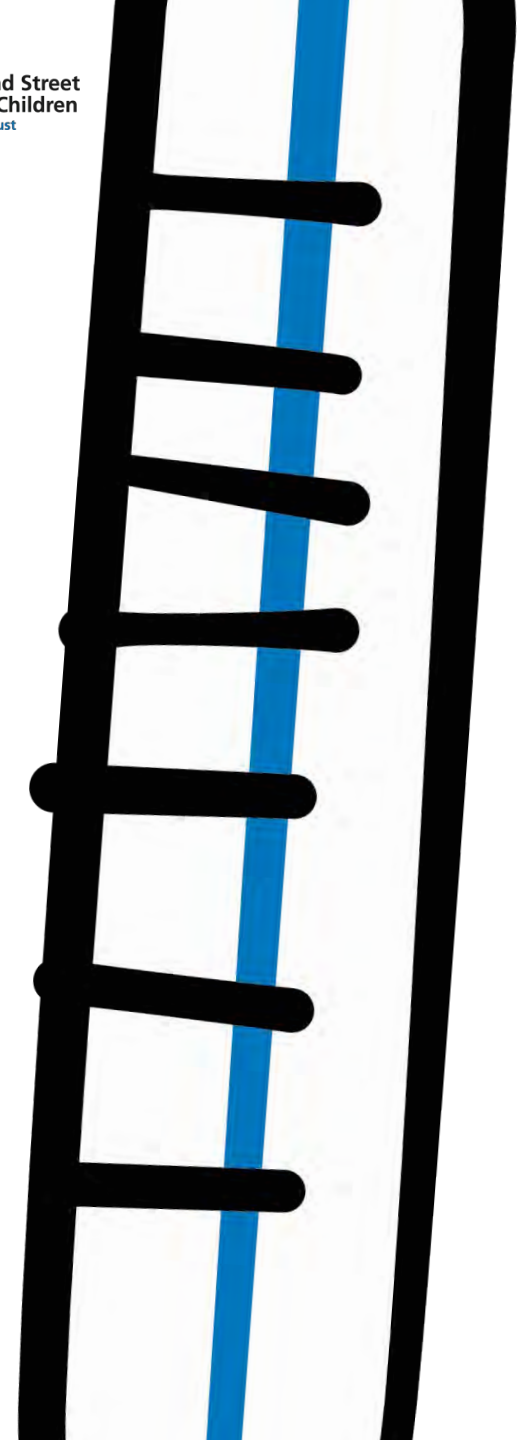
COVID-19 Impact on the workforce

Directorate	Risk Assessments	% Completed
International	227	100%
Genetics	145	100%
Finance	45	100%
Redevelopment	30	100%
Transformation	88	100%
Sight & Sound	327	99%
Nursing & Patient Experience	146	99%
HR&OD	83	99%
Medicines Therapies & Tests	625	98%
Medical Directorate	42	98%
Property Services	132	96%
Body Bones & Mind	522	96%
Brain	298	96%
Research & Innovation	114	96%
Blood Cells & Cancer	403	95%
Clinical Operations	171	93%
Corporate Affairs	13	93%
Heart & Lung	812	92%
Operations & Images	396	91%
ICT	61	85%
Grand Total	4680	96%

Although the impact of COVID on sickness absence has reduced since the April peak, the pandemic continues to impact a number of staff in many ways, from those shielding to staff who need to work on-site or those learning to adapt to new ways of agile working at home. Shielding as a category was due to end at the start of August so directorates have been identifying ways in which to support staff with higher risk profiles.

The Trust launched a nationally mandated risk assessment process in June, which required managers to have a conversation with their team members are their specific risk factors and if needed how those risks could be mitigated against.

Progress has been significant, with a final reported progress by mid August of 96% (shown opposite). Directorates & HR Business Partners are continuing to engage staff who have yet to have a risk assessment.



Great Ormond Street Hospital for Children NHS Foundation Trust

Patient Safety Indicators

September 2020

Introduction and overview

At the Trust Board on the 15th July 2020 concerns were raised about the performance of the following metrics:

- Timeliness of Patient Safety Incident closures
- Timeliness of SI action plans closures
- Timeliness of Duty of Candour letter/investigation completion
- WHO safety checklist performance

This is the third EMT update paper focussed on these metrics. This paper provides an update which includes the August 2020 performance data and an update on progress with the action plans.

Timeliness of Patient Safety Incident closures

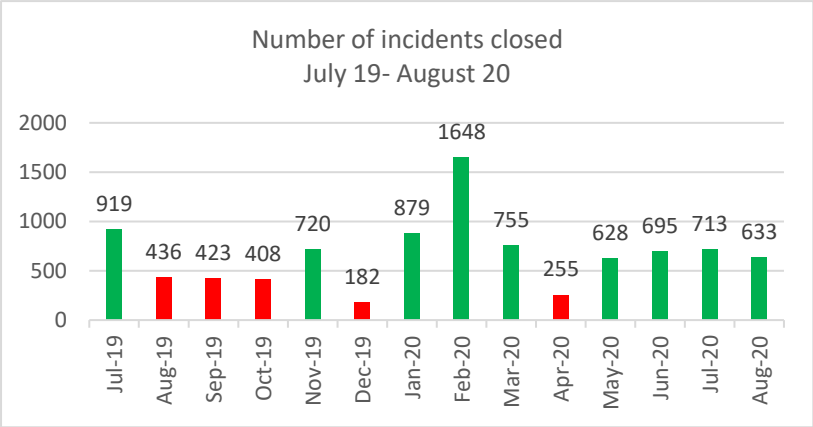
Performance over the last 12 months

The CQC report includes a Should Do recommendation that the Trust should take action to improve the number of incidents closed within the Trust's 45 working day target. Timely incident closures are indicators of a system and culture which is focussed on identifying and implementing learning from incidents in a timely way. It should be noted that our measures are based on the use of the datix system, and therefore are a measure of the documentation that investigations and actions have been completed, rather than necessarily the timeliness of this occurring in real time.

In order to understand the incident closure performance, there are a number of metrics one should consider collectively. These are shown, and explained, below:

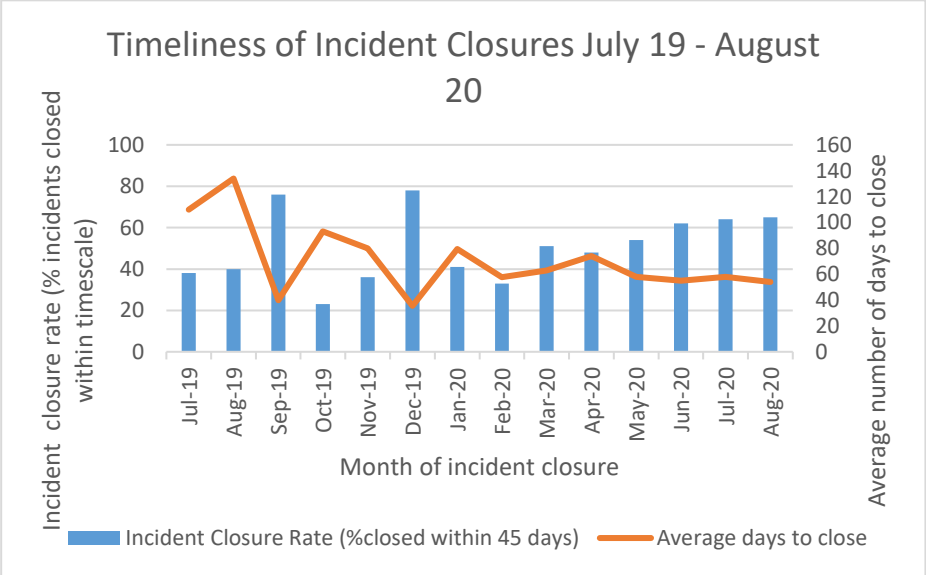
Indicator	Sep -19	Oct -19	Nov-19	Dec -19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul 20	Aug-20
Number of incidents closed	423	408	720	182	879	1648	755	255	628	695	713	633
Incident closure rate	76%	23 %	36%	78%	41%	33%	51%	48%	54%	62%	64%	64%
Average days to close	40	93	80	35	79.5	57.7	62.9	74	58	55	58	54

The **number of incidents closed** metric provides the volume of incidents closed on Datix in that month. Where the volume of incidents closed is less than the number of incidents received in the month, this is considered underperformance as it leads to a backlog accumulation. It should be noted that in any given month, incidents from a variety of preceding months will also be closed.



The chart on the left demonstrates that there has been a fairly consistent improvement in performance through 2020. In this chart the months in which we have closed more incidents than the total of new incidents in month are shown in green. Red indicates a month where there were less closures than new incidents. Following the decline in performance in April 2020, additional support was sourced from a previous team member given the staffing challenges in the Patient Safety team due to vacancies and staff seconded to support response to the pandemic. Performance has been sustained well over the past 4 months.

The **incident closure rate** is the percentage of incidents in that month which were closed within 45 working days (our policy requirement). This is a measure of the timeliness of incident closures. It should be reviewed in tandem with the **average days to close** metric which tells us how close we are (or not) to the 45 day target.



During 2019 there was erratic performance. There are two months (September and December 2019) when it appears that there was significant improvement in the incident closure rate (76% and 78% compliance with 45 days) and the average number of days to close was below 45 days. Analysis suggests that in those months the team focussed on closing newer incidents, rather than those held in the backlog.

The data in 2020 does show a much more consistent picture of improvement with a sustained increase in the % of incidents closed within 45 days and correlating improvement in the average days to close. This is suggestive of better control and a gradual move towards compliance in line with the CQC recommendations. Through June, July & August the incident closure rate has been improving gradually (62% - 64%) after the significant improvement between April (48%) and May (54%). There remains an acceptable level of variation in the average number of days taken to close as this will be driven to a large part by the closure of older incidents which will naturally skew the average. However, we should start to see the impact of the work to close off all pre-2020 incidents very soon.

Attachment R

In June 2020, the following actions were agreed to help support further improvement, and the current progress update is included in the final column. It is of note that all pre-2020 incident has now been closed. As of 9th September 2020, there are less than 50 incident left which are overdue. In context this is equivalent to the number of incidents we would receive over the course of two days. Some of the deadlines which were set in June were exceeded (as shown below) and this has been attributed to a number of risk action groups being cancelled during July/August as staff were encouraged to take annual leave.

Milestone	Completed by	Action Owner	Update	Open Incidents	Urgent revised deadline
All incidents from Jan 2019 – December 2019 to be closed	Friday 31st July 2020	Directorate Management Teams / Corporate Teams	**Complete**		
All incidents due to closed January 2020 – March 2020	**Friday 21st August 2020**	Directorate Management Teams / Corporate Teams	**OVERDUE**	15	**18th September 2020**
All incidents due to be closed by April 2020 –May 2020	**Friday 28th August 2020**	Directorate Management Teams/ Corporate Teams	**OVERDUE**	26	**18th September 2020**
All incidents due to be closed by June 2020	**Friday 4th September 2020**	Directorate Management Teams/ Corporate Teams	**OVERDUE**	2	**18th September 2020**
All incidents due to be closed by July 2020	**Friday 11th September 2020**	Directorate Management Teams/ Corporate Teams	In progress	27	
All incidents due to be closed by August 2020	**Friday 18th September 2020**	Directorate Management Teams/ Corporate Teams	In progress	50	

Attachment R

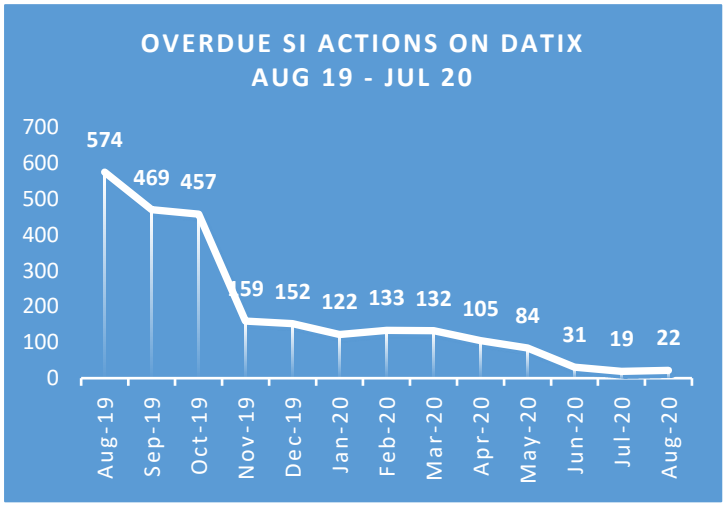
The chart below shows the directorate breakdown of overdue incidents:

Milestone	Completed by	BBC	BBM	Brain	Clini Ops	Corp S	Est & Fac	Finance	Genomics	H&L	HR	ICT/EPR	IPP	MTT	Nursing	O&I	R&I	S&S	Trust
All incidents from January 2020 – March 2020 to be closed	**Friday 21st August 2020**	1		1				1	2	1	2			4		2		1	
All incidents from April 2020 –May 2020 to be closed	**Friday 28th August 2020**	4	1					2	2	3	2	1		4		3	3	1	
All incidents from June 2020 to be closed	**Friday 4th September 2020**													1		1			
All incidents from July 2020 to be closed	**Friday 11th September 2020**	4	1	1							2	4		6		6		3	
All incidents from July 2020 to be closed	**Friday 18th September 2020**	10	2	5	1				4	5		3		10		2	2	4	2

Timeliness of SI action closures

Performance over the past 12 months

In 2019, it was identified that there was a significant number of actions relating to serious incidents on the Datix system which remained open. These actions extended to serious incidents over a 10 year period. It was understood that the actions for many of these incidents had been taken, but this has not been effectively updated on the Datix system, and the evidence to confirm action had been taken had not been captured. In August 2019 the metric was added to the monthly IQPR to provide oversight of the progress being made to address this historical backlog. This chart demonstrates the significant progress which has been taken over the last 12 months to address this problem.



In August 2019 there were 574 open historical SI actions on the datix system. As of 8th September 2020, this number has reduced to 22. This includes 12 actions which were due to be completed before 2020, and 10 which have completion dates in 2020. The performance will remain under monthly review through the IQPR, with actions being followed up directly through the relevant Risk Action Groups and through Closing the Loop.

The Quality and Safety Team are reviewing potential areas for improving the way in which discussions at Closing the Loop can be effectively updated in Datix to ensure there is a better flow of evidence and documentation, and which removes any duplication of effort.

Timeliness of Duty of Candour letter/investigation closures

Performance over the past 12 months

Duty of candour for incidents causing significant harm comprises three stages:

1. Conversation with patient and family including apology (as soon as possible)
2. Duty of candour letter summarising conversation and apology within 10 working days
3. Provision of the outcome of the investigation (in line with timeframes set out in policy)

Indicator	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug - 20
Duty of Candour - stage 1	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100%	100 %	100 %	100 %
Duty of Candour - stage 2	66%	50%	100%	40%	100%	75%	80%	71%	80%	43%	86%	78%
Duty of Candour - stage 3 (on time)	0%	62%	100%	75%	20%	100%	0%	14%	66%	33%	0%	17%

Our performance with undertaking the duty of candour conversations with families has been consistently excellent throughout the year, with 100% compliance reported each month.

Performance for both stage 2 and stage 3 has been variable over the past 12 months, although there does appear to have been a more consistently positive performance in 2020 (with the exception of June 2020) in relation to sending out the stage 2 duty of candour letter. However, compliance with meeting the 10 day timescale for this letter remains quite variable. Of those letters sent out in July, less than half (43%) were sent out on time. This has improved slightly to 58% in August, however there is still significant room for improvement.

Completion of stage 3 (sharing the investigation) has not seen any significant or sustained improvement. There were 4 investigations shared with the families in July, but none of these were shared within the policy timescale (45 days). There were 6 investigations shared with families in August, but only one of these was shared within the 45 day target. An action plan (below) to support improvement was developed in July 2020 and has been supplemented following further consideration in September 2020.

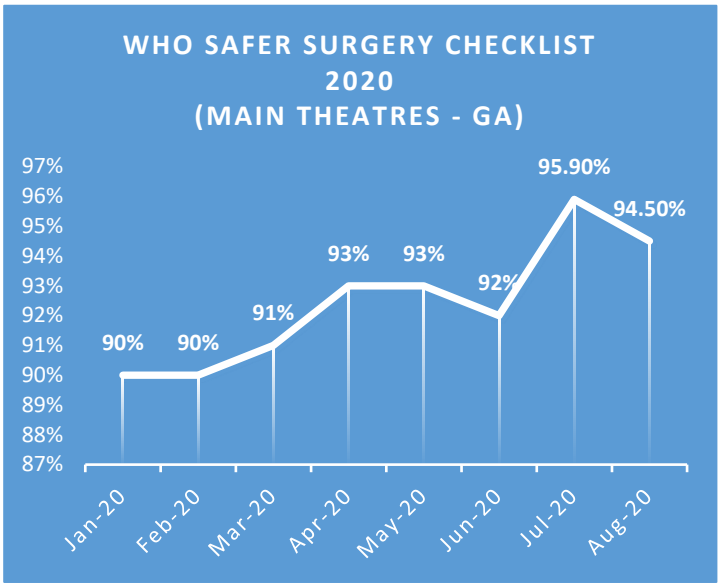
Action	Responsible	Due Date	Update
Development and roll out of additional RCA training (which incorporates duty of candour process training) to support staff in completing the investigations in a timely way.	Salina Parkyn Head of Quality and Safety	October 2020	Training has already started with sessions being scheduled in through the next few months.
Completion of a Duty of Candour Survey of staff to understand level of understanding and need for support	Roisin Mulvaney, Head of Special Projects	August 2020	Survey completed (189 respondents). Themes compiled and included as part of the full duty of candour audit which was presented to PSOC on 13th August

			2020. Recommendations agreed by committee and additional action plan has been developed and approved at PSOC
Development of online training package for Duty of Candour	Roisin Mulvaney, Head of Special Projects	September 2020	First draft has been produced by training department. Feedback and change requests have been submitted by subject matter experts. Second version completed on 6.7.20. Further changes may be made dependent on feedback from survey. Three videos to be completed for inclusion with a view to go live in September.
Added September 2020 Patient Safety Report template to be revised to ensure that the directorate leadership team have the data they need to manage Duty of Candour in a timely way	Salina Parkyn, Head of Quality & Safety and David de Beer, Associate Medical Director for Safety	October 2020	Several drafts have been developed and are being reviewed by key stakeholders
Added September 2020 Datix duty of candour fields to be updated to enable easy monitoring for directorate leadership team and PST.	Diane Jones, Deputy Head of Safety & Quality	October 2020	Changes are being developed by Datix manager.
Added September 2020 Weekly meeting with Deputy Chiefs of Service to review current lists and help troubleshoot and support timely completion	Roisin Mulvaney, Head of Special Projects	September 2020	A proposal has been developed and shared with the Deputy Chiefs of Service. Expecting to go live in week commencing 14th September.

It has further been agreed that the duty of candour compliance data should be reviewed as part of the monthly directorate performance review as of July and this information has been shared with the COO.

WHO Safety Checklist performance

Since April 2019 when Epic was launched it has been possible to collect real time information on the performance of the WHO checklist as staff are required to document completion of the various checks and stages in their record. There is however no hard stop which means that there are times when the check may not have been documented.



The initial reports from Epic suggested a very high level of compliance (typically 99% in main theatres, and 95-98% outside main theatres), which was in line with the feedback we had received from our observational audits of WHO checklist performance. However, in January 2020 some issues with the way in which the report had been set up were identified, and monthly performance has typically been reported as between 90% and 93% for the first half of 2020. Epic documented performance has improved to 95.9% in July 2020 and 94.5% in August 2020. This is likely to be in response to the Rapid Improvement Plan developed by the SSIPs group in June 2020. It is recognised that there is still further work to do.

The metric shown above only captures compliance in main theatres. The documentation of checklist completion in areas outside theatres has been poor and inconsistent. More work and support is required to support a better checklist culture in some areas outside the traditional theatre environment e.g. MRI, CT and Laser. Engagement and Improvement work, led by the Associate Medical Director for Safety, in conjunction with the GOSH Safety Standards for Invasive Procedures (SSIPs) group has already started on this. There is recognition of the need to improve rapidly, but an acknowledgement that quick improvement will not necessarily lead to sustainable change. There is a need to ensure that rapid change is underpinned by robust process. We are already starting to see improvement based on the interventions and support from this group. The August performance data shows a very significant improvement from 45.3% for all cases in July (excluding imaging not under general anaesthetic) to 79.8%. While this is a very welcome improvement, it is clear that there is still work to do.

In August 2020 a working group was convened to identify the actions required to support improvement in non-traditional theatre environments. This includes practical steps such as updating laminates in the relevant areas, and revisiting Epic workflows to ensure they facilitate and promote effective documentation, but it also includes engagement work with the radiographers, ODPs and anaesthetic teams in those areas to ensure they are identifying the improvements, monitoring performance, supporting colleagues and helping to embed the changes in practice. Work will focus on MRI in the first phase, then moving to CT and laser theatres. The work will be subject to audit organised by the Clinical Audit Manager.

A need for additional staffing resource has been identified. This is to support continuous improvement not just in the quality of documentation that the checks have taken place, but also in maintaining the quality of the checks and the culture in which the checks are undertaken. A joint

role between the Medical Directors office and the Ops and Images directorate is currently being scoped.

It has further been agreed that one of the targets during Project Apollo in October 2020 will be complete compliance with WHO checklist documentation. This will help us to support staff who are struggling with the documentation of the checklist on Epic, and identify any ways in which we can improve the system to make it easier for staff to document the checks that they are completing.

Roisin Mulvaney
Head of Special Projects – Quality and Safety
9th September 2020