Attachment W

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27 November 2019

Integrated Quality & Performance Report **Submitted by:** Sanjiv Sharma, Medical Director Alison Robertson, Chief Nurse Phil Walmsley, Interim COO	**Paper No: Attachment W**

Aims / summary

- To provide a 3 month snapshot of hospital performance in key metrics relating to quality (safety, experience and effectiveness)
- 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 specifically:

Incident closure rate/number of incidents closed and average days to close:
These metrics are closely aligned so are dealt with together. There is currently a central backlog of incidents awaiting closure, due to staffing challenges in the Risk Team. Recruitment has been completed and staff expected to be in place by the **end of November 2019**. (See Slide 8 for more details)

Serious Incident Actions
The Closing the Loop meeting is now in place to proactively manage action plan completion following serious incidents and red complaints. There is however a backlog of actions linked to serious incidents which are currently open on Datix (n=457). It is understood that in the main these actions have been taken, but the evidence has not been uploaded onto datix to allow closure. The patient safety team are working with the directorates to support timely closure. (See slide 3 & 8 for more details)

Complaints and Pals.
For a second month we have received more complaints (n=10) than usual (average of 7.25 based on previous 12 months). There is no discernible common theme emerging, but this is being kept closely under review. October also saw a significant increase in Pals cases, but very few of these converted to formal complaints reflecting good levels of collaboration to facilitate prompt resolution.

Speak Up in the Moment
There is an update on the progress which has been made by the Speak Up programme which launched in June 2019. Staff attendance at workshops currently sits at 76%, and it is anticipated that we were reach the 85% target by end of December 2019. (See slide 10 for more details).

Diagnostic waits
The Trust did not achieve the RTT 92% for diagnostic waits – submitting performance of 85.05% with 842 patients waiting longer that 18 weeks. This represents an improvement of 1.3% from September.

52 week waits
The Trust reported 16 patient waiting over 52 weeks (details in slide 34)

Attachment W

Action required from the meeting To note the report which has also been submitted to QSEAC, and the actions identified to improve compliance with key quality metrics
Contribution to the delivery of NHS / Trust strategies and plans Delivery of high quality care.
Financial implications None
Legal issues No specific legal issues, but the report now includes an update on upcoming inquests.
Who is responsible for implementing the proposals / project and anticipated timescales Head/Deputy Head of Quality & Safety Head of Patient Experience Head of Performance
Who is accountable for the implementation of the proposal / project Medical Director Chief Nurse Chief Operating Officer

Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality &Performance Report November 2019 (October data)

Sanjiv Sharma
Medical Director

Alison Robertson
Chief Nurse

Phil Walmsley
Interim Chief Operating Officer

Hospital Quality Performance – November 2019 (October data)

Are our patients receiving safe, harm-free care?

	Parameters	August 2019	September 2019	October 2019
Patient Safety Reporting	R<60 A 61-70 G>70	622	505	588
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	40%	76%	23%
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	436	423	408
Average days to close (2018 -2019 incidents)	R ->50, A - <50 G - <45	134	40	93
Medication Incidents (% of total PSI)	TBC	26.2%	23.2%	18.5%
WHO Checklist (overall)	R<98% G>98-100%	99.3%	99.0%	99.1%
WHO Checklist (Theatres)	R<98% G>98-100%	99.6%	99.4%	99.5%
WHO Checklist (non-theatres)	R<98% G>98-100%	98.5%	98.1%	98.1%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	8%	7.1%	5.8%
New Serious Incidents	R >1, A -1 G – 0	0	1	2
Overdue Serious incidents	R >1, A -1, G – 0	0	0	0
Safety Alerts overdue	R- >1 G - 0	1	2	2
Serious Children's Reviews Safeguarding children learning reviews (local)	New	0	1	0
	Open and ongoing	6	7	7
Safeguarding Adults Board Reviews	New	1	0	0
	Open and ongoing	1	2	2

Are we delivering effective, evidence based care?

	Target	Aug 19	Sept 19	Oct 2019
Specialty Led Clinical Audits on Track	R 0- 60%, A>60-75% G>75-100%	86%	87%	81%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	60	77	89
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	August 2019	Sept 2019	Oct 2019
Friends and Family Test Recommend rate (Inpatient)	G – 95+, A- 90-94, R<90	95%	97%	98%
Friends and Family Test Recommend rate (Outpatient)	G – 95+, A-90-94,R<90	93%	94%	92.7%
Friends and Family Test - response rate (Inpatient)	25%	23%	29%	29%
PALS (per 1000 combined pt episodes)	N/A	6.39	6.48	7.76
Complaints (per 1000 combined pt episodes)	N/A	0.3	0.52	0.42
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	7%	7%	7%
Re-opened complaints (% of total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	14%	13%	14%

Are our People Ready to Deliver High Quality Care?

	Parameters	Aug 19	Sept 19	Oct 2019
Mandatory Training Compliance	R<80%,A-80-90% G>90%	95%	94%	95%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	89%	87%	89%
PDR	R<80%,A-80-89% G>90%	91%	89%	89%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	91%	89%	88%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	89%	89%	94%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	96%	95%	95%
Resuscitation Training	R<80%,A-80-90% G>90%	87%	89%	93%
Sickness Rate	R -3+% G= <3%	2.5%	2.6%	2.7%
Turnover - Voluntary	R>14% G-<14%	15.2%	15.5%	15.7%
Vacancy Rate – Contractual	R- >10% G- <10%	9.9%	10%	8.3%
Vacancy rate - Nursing		8.6%	8.3%	8.3%
Bank Spend		4.8%	4.5%	5%
Agency Spend	R>2% G<2%	0.7%	0.7%	0.7%

Well Led Dashboard

Is our culture right for delivering high quality care?

	Target	August 2019	September 2019	October 2019
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	84%	87%	76.1%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G- 0	574	469*	457
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G- 0	2	3	8
Duty of Candour Cases	N/A	2	6	11
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%	50%	66.6%	50%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	50%	66.6%	50%
Duty of Candour - Stage 3 Total sent out in month	Volume	2	2	5
Duty of Candour – Stage 3 Total (%) sent out in month on time	R<50%, A 50-70%, G>70%	50%	0%	60%
Duty of Candour – Stage 3 Total overdue (cumulative)	G=0 R=1+	5	8	6
Policies (% in date)	R 0- 79%, A>80% G>90%	80%	81%	83%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	88%	88%	90%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	97%	100%	100%
Inquests currently open	Volume monitoring	5	5	5
Freedom to speak up cases	Volume monitoring	10	6	10
HR Whistleblowing - New	Volume monitoring	0	0	0
HR whistleblowing - Ongoing	12 month rolling	1	1	0
New Bullying and Harassment Cases (reported to HR)	Volume	0	0	0
	12 month rolling	2	2	2

Are we managing our data?

	Target	August 2019	Sept 2019	Oct 2019
FOI requests	Volume	67	54	52
FOI % responded to within timescale	R- <65% A – 65-80% G- >80%	79%	100%	95%
FOI - Number requiring internal review	R>1 A=1 G=0	0	1	0
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	6	20	13
IG incidents reported to ICO	volume	0	0	1
SARS (Medical Record) Requests		104	141	141
SARS (Medical Record) processed within 30 days	R- <65% A – 65-80% G- >80%	100%	100%	99.2%
New e-SARS received	volume	0	0	3
No. e-SARS in progress		2	0	3
E-SARS released	volume	2	3	0
E-SARS released past 90 days	volume	3	0	0

* This is the corrected figure for SI actions only. The previous month's numbers included local actions as well as SI/Never event actions

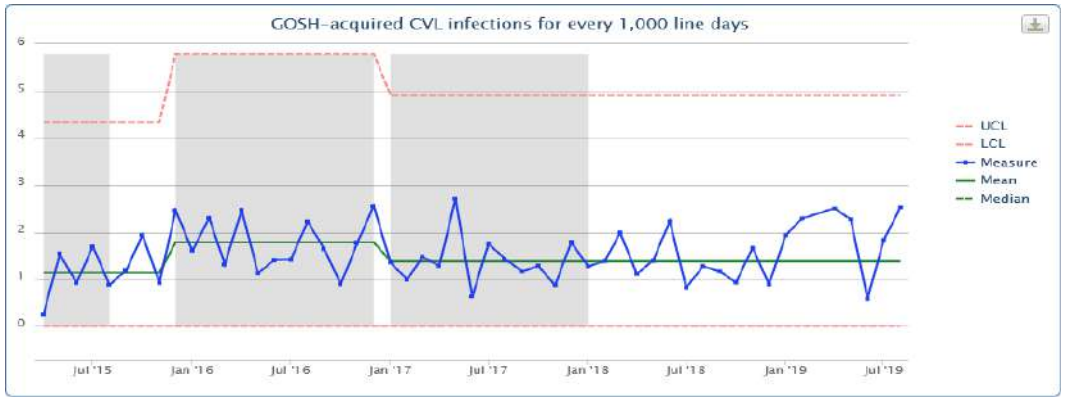
Are we delivering effective and responsive care for patients to ensure they have the best possible outcomes?

Responsive Hospital Metrics		Aug-19	Sep-19	Oct-19
Diagnostics: patient waiting <6 weeks	R<99% G -99-100%	96.04%	96.92%	95.19%
Cancer 31 day: referral to first treatment	R<85% G 85%-100%	No Patients	No patients	No patients
Cancer 31 day: Decision to treat to First Treatment	R<96% G 96-100%	100%	100%	*100%*
Cancer 31 day: Decision to treat to subsequent treatment - surgery	R<94% G94-100%	100%	100%	*100%*
Cancer 31 day: decision to treat to subsequent treatment - drugs	R<98% G 98-100%	100%	100%	*100%*
Cancer 62 day: Consultant upgrade of urgency of a referral to first treatment	-	91%	100%	*92%*
Theatre Cancellation for non-clinical reason	-	57	46	TBC
Last minute non-clinical hospital cancelled operations - breach of 28 day standard		1	4	TBC
Urgent operations cancelled for a second time.	R 1+ G=0	0	0	0
Same day/day before hospital cancelled outpatients appointments	-	1.76%	1.66%	1.89%
RTT Incomplete pathways (national reporting)	92%	82.42%	83.72%	85.02%
RTT: Average Wait of All RTT Pathways		10.06	9.75	9.42
RTT number of incomplete pathways <18 weeks	-	4858	4810	4778
RTT number of incomplete pathways >18 weeks	-	1036	935	842
RTT Incomplete pathways >52 weeks Validated	R - >0, G=0	7	13	16
RTT incomplete pathways >40 weeks validated	R - >0, G=0	74	76	84
Number of unknown RTT clock starts – Internal Ref	-	4	8	4
Number of unknown RTT clock starts – External Ref	-	347	314	310
RTT: Total number of incomplete pathways known/unknown - <18 weeks	-	5188	5151	5110
RTT: Total number of incomplete pathways known/unknown - >18 weeks	-	1045	948	857

Effective & Productivity Hospital Metrics		Aug-19	Sep-19	Oct-19
Discharge summary 24 hours	R=<100% G=100%	58.05%	66.34%	71.88%
Clinic Letter– 7 working days	R=<100% G=100%	64.55%	61.64%	75.86%
Was Not Brought (DNA) rate		8.85%	7.03%	6.10%
Theatre Utilisation – Main Theatres	R<77% G>77%	Data under review		
Theatre Utilisation – Outside Theatres	R<77% G>77%			
Trust Beds	Bed Occupancy	Data under review		
	Beds available	396	396	396
	Avg. Ward beds closed	49	47	62
	ICU Beds Closed	5	6	7
Refused Admissions	Cardiac	6	1	0
	PICU/NICU	2	18	12
PICU Delayed Discharge	Internal 8-24 hours	1	1	0
	Internal 24h +	2	3	0
	External 8-24 hr	0	0	1
	External 24h+	1	1	0
	Total 8-24h	1	1	1
	Total 24h +	3	4	0
PICU Emergency Readmission <48h	-	2	1	0
Daycase Discharges	In Month	2,056	2,074	2,399
	YTD	10,615	12,689	15,088
Overnight Discharges	In Month	1,511	1,393	1,558
	YTD	7,179	8,572	10,130
Critical Care Beddays	In Month	1,295	1,296	1,163
	YTD	6,480	7,776	8,939
Bed Days >100 days	No of Patients	6	2	8
	No of Beddays	773	257	1,479
Outpatient attendances (All)	In Month	15,604	16,837	18,560
	YTD	88,168	105,005	123,565

Do we deliver harm free care to our patients?

CVL Infections



2019	April	May	Jun	Jul	Aug	Sept	Oct
Central Venous Line infections (per 1000 bed days)	1	1.7	1.3	1.4	1.6	1.6	1.8

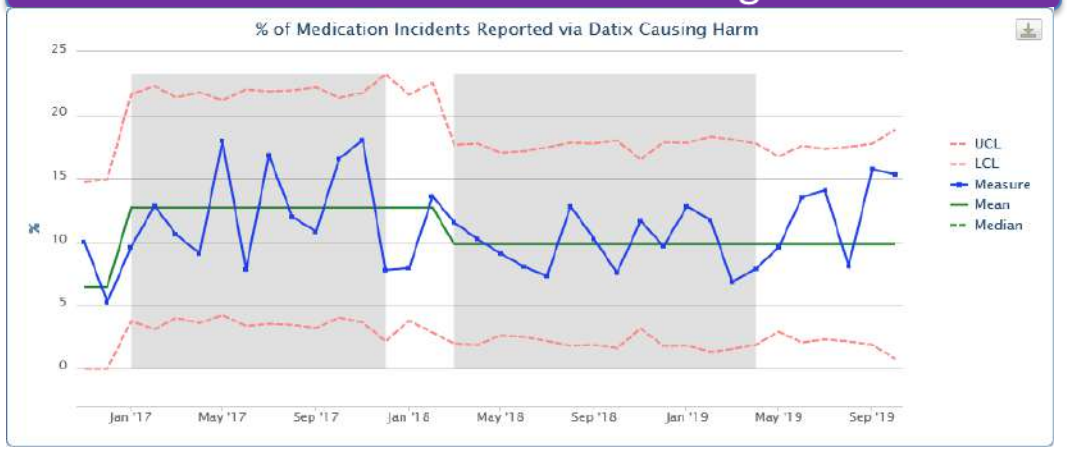
Infection Control Metrics

Care Outcome Metric	Parameters	Aug 2019	Sept 2019	Oct 2019
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	8	8	7
	YTD	35	43	50
C Difficile cases - Total	In month	1	0	0
	YTD	4	4	4
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	0	0	0
	YTD	2	2	2

Pressure Ulcers

			April 19	May 19	Jun 19	July 19	August	Sept 19	Oct 19
Hospital Acquired Pressure Ulcer (2+)	Volume	R – 12+, A 6-11 G =0-5	3	4	3	6	5	11	4
	Rate	R=>3 G=<3	0.41	0.52	0.4	0.78	0.67	1.45	0.55

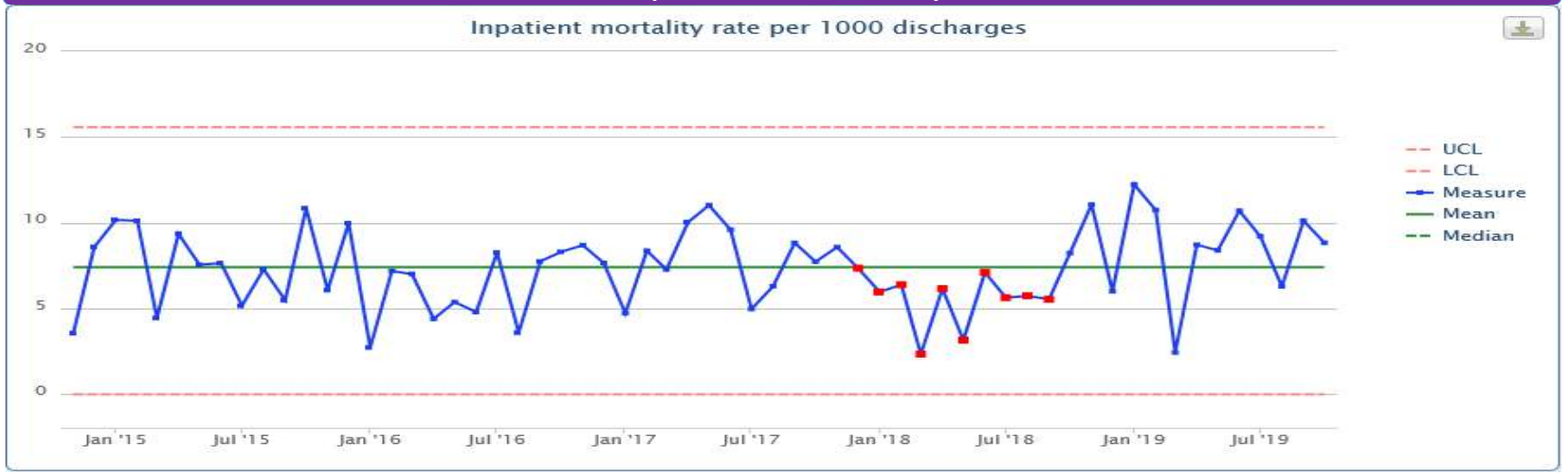
Medication incidents causing harm



		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19
% of reported medication incidents causing harm	Mean-12.5 %	8%	11%	14%	15%	18%	20%

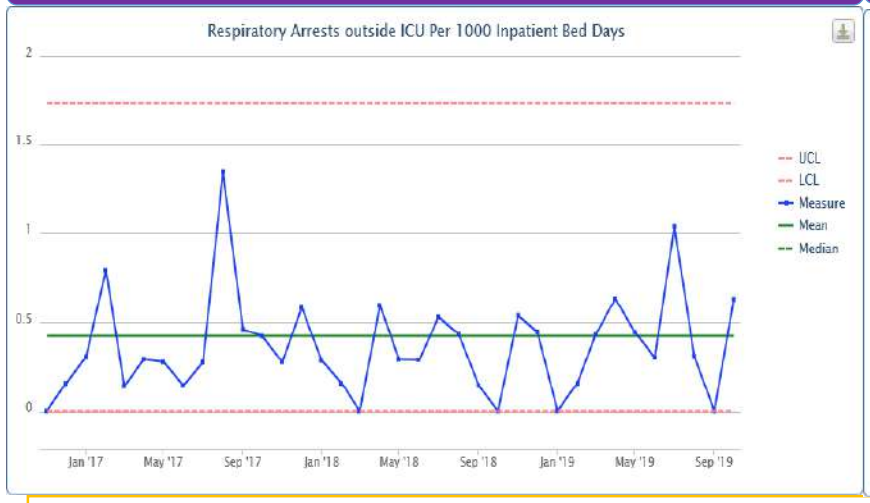
Does our care provide the best possible outcomes for patients?

Inpatient mortality

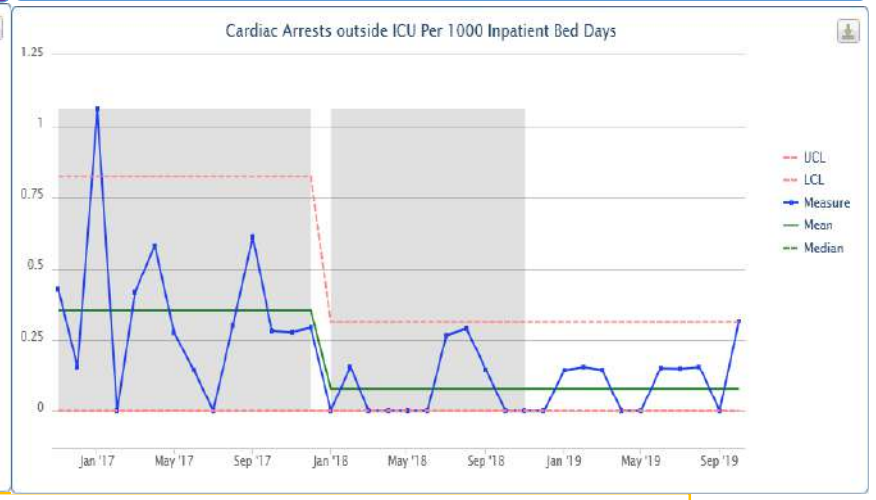


In October, we were notified that our PICANet data was showing mortality was higher than expected. The submitted data is currently being reviewed.

Respiratory Arrests



Cardiac Arrests



No concerns noted in current data trends for mortality rates, or rates of respiratory and cardiac arrest

Well Led Overview

Duty of Candour
There were 6 cases identified within the month of October 2019 that had achieved 100% compliance in terms of stage 1 of **duty of candour (DoC)**. Of these 6, 50% (3) that achieved the 10 day deadline. Of the remaining 3, the central team are informed that a letter was sent, however, a copy of this has not been received as evidence of completion and therefore will appear as outstanding until a copy is received. The remaining 2 are in process of review by the clinical teams to establish whether they fulfil criteria for DoC and investigation. With regard to stage 3 compliance, 6 cases are overdue completion of the RCA reports. 3 of these 6 are confirmed as completed but 1 is awaiting translation into another language and 2 require directorate sign-off prior to sharing with the patients/parents.

High risk monthly review performance saw a decline from September (87%) with compliance recorded at 71%. When broken down to clinical; non-clinical and Trust wide risks, compliance is as follows: Trust wide n=2 with 100% compliance; non-clinical risks n=13 with 23% compliance and clinical risks n=50 with 78% compliance. This decline appears to be due to a lag in the upload of updates within the timescale as well as a number of RAG meetings postponed due to availability of key staff over the half term period. As described earlier, the Patient Safety team capacity has been reduced over October 2019. New team members have been recruited and will be commencing mid-late November 2019. This continues to be monitored monthly. It should also be noted that the Patient Safety team monitor compliance within the Directorate boards.

52 FOI requests were received in October. Of these, 21 have been closed, 20 of which were within the allocated timescale. Of the remaining 31, 13 x requests are being processed within 20 working days (compliant); 5 x requests for clarification sent to the FOI applicants (compliant); 4 x responses drafted/or approval pending (compliant); and 9 x requests pending validation by the FOI applicants (before processing) to comply with either Section 8(1) and/or Section 45 (code of practice) within different deadlines up to **27/11/2019.**

SARS performance remains positive in October. Three requests were received in month and are being processed. There are no SARS currently overdue.

An information governance incident was reported to the ICO and to NHS England in October 2019 (2019/22539). This related to a letter containing sensitive medical and social information being sent to the wrong address. The investigation is underway, and the panel meeting is takin place mid- November 2019.

The one recorded HR **whistleblowing** case was closed at Audit Committee in October 2019. No new cases have been reported. 10 Freedom to speak up cases were recorded in October 2019.

There are 5 inquests currently open for the Trust. Two inquests were concluded in October/Early November. Two new inquests were opened in October 2019. These are currently rated as low risk. Statement timescales set by the coroner are notably short for both inquests.

Safety Overview

The number of **incidents being closed** month on month is static with closure each month being in excess of 400. Directorates have completed their investigations and reviewed and are awaiting central review and closure. Due to staffing capacity over the past 6 months, a central backlog is observed. Work is underway to prioritise closure of the incidents that have not yet breached, with ongoing work to ensure that this closure backlog is cleared. A large number have been closed but the numbers of overdue incidents awaiting closure continue to increase so this is not yet reflected in the numbers seen. The percentage of incidents being closed within 45 working days has decreased this month to 23%, but this is due to the number of completed investigations that were overdue being closed off. Since the 17th October 2019, a weekly report is prepared and disseminated around all directorates/departments. This is separated by the numbers still awaiting completion of the investigations as well as the investigations that are sitting with the central team requiring quality checking and closure of the incidents. The central team are aiming to close approximately 150 incidents per week which will increase once the team are up to full capacity. The directorates and departments have been asked to provide a workplan and trajectory as to when they are aiming to complete their outstanding investigations. A weekly report will continue to be circulated in order to monitor progress.

There was 1 **open SI investigation** from September 2019 with a new SI declared in October, so 2 SI's are currently in progress. The SI from August was submitted by deadline mid-October. A summary of this SI is provided later in the report. There are no overdue SIs.

With regard to overdue SI actions, over the past one month, these have been reviewed and the data cleansed (ie relocated to the correct directorates; actions categorised as local amended to SI and visa versa). Also actions from recently Trust approved SI's were uploaded. There are currently 457 overdue actions. Due to the cleansing and the upload of further SI actions, the number recorded does not reflect the actual number closed with uploaded evidence of completion. Work is continuing to obtain the evidence and close. This will be monitored monthly via PSOC and the MD & DCOS meetings.

In October 2019, 2 **CAS alert** are recorded as overdue. The one related to the *Zebra printer* power supply units with a recall due to the risk of fire. This was due a response by the 17th October 2019 but there is an audit still underway to establish the number of power units affected with the intention that these will be returned and replacements provided. To date a small number have been identified. With regard to the other alert (from the Energy networks association, an update is required from estates (AB). This was due for a response by the 31st October 2019.

Patient Experience Overview

For a second consecutive month complaints (n=10) were higher than usual (based on the average of 7.25 per month over the last 12 months). Since April 2019 there have been 57 complaints and in the context of approximately 100 complaints received annually, the Complaints team are closely monitoring numbers.

Pals cases also increased this month (n=183- the highest number since April 2018) but there was a marked reduction in complex cases and in escalation to formal complaints. This reflects the collaboration between specialties and the Pals team to facilitate prompt and effective resolution for patients and families.

The main theme of complaints and Pals cases again related to all aspects of communication. A planned MyGOSH training day has been rescheduled for December and is intended to focus on promotion and sign up to MyGOSH as well as encouraging effective communication with clinical teams. In addition and in response to the CCQ Inpatient Survey, a working party is being set up to look at improving communication with patients and families particularly regarding post discharge advice.

In October Body, Bones and Mind (BBM) received the highest number of complaints (n= 4 which equates to 0.90 complaints per 1,000 CPE). This was replicated in Pals where BBM cases totalled 41 (9.24 per 1,000 CPE). However, BBM exceeded both the Trust's FFT response rate (28%) and inpatient recommendation rate (98%).

There was also an increase in IPP complaints (n= 2) which when reviewed against patient activity represents 0.99 complaints per 1,000 CPE. As shown in slide 16, IPP Pals cases (n=4) also increased this month. While IPP achieved a 36% FFT response rate, the recommendation rate fell to its lowest (79%) in the last 12 months. Families expressed concern about rudeness of some staff, noise and difficulties in sleeping, medication delays, communication (no interpreter), access to the Play Room and cancellation/ delays.

The Research and Innovation FFT recommendation rate rose from 71% in September to 93% in October narrowly missing the Trust target. Negative comments received related primarily to the preferred less clinical environment of the Somers CRF following the temporary move to Hedgehog. Consistent with the reported improvements, only one comment related to medication delays.

Overdue red complaint actions increased this month to 8 and are being monitored through PFEEC and Closing the Loop. Plans are in place to complete overdue actions as soon as possible and no later than mid December.

Speak Up Programme

Speak Up for Safety

In June 2019 GOSH commenced the roll-out of Speaking Up for Safety training Trust-wide.

Staff attendance at Speaking Up for Safety workshops now sits at 76%*. It is anticipated that we are well on our way to achieving the 85% target by the end of December 2019.

Attendance at workshops continues to be good with the majority of sessions running at maximum capacity. A further20 SUFS sessions are scheduled to end December 2019.

As we go into 2020 workshops will continue to run at Induction and online refresher training is in planning in order to ensure the sustainability of the programme going forwards.

To further enhance this work GOSH, as a centre of excellence have been approached by the General Medical Council (GMC) to pilot the GMC's Professional Behaviours and Patient Safety programme (PBPS) with a pilot workshop scheduled for December 2019.

Speak Up for Our Values

Following on from the successful launch of Speaking Up for Safety GOSH prepares to implement Speak Up for Our Values in 2020.

Speak up for Our Values is based on an evidence-based framework that builds a high-performance culture of safety and reliability, while addressing individual behaviours that undermine it.

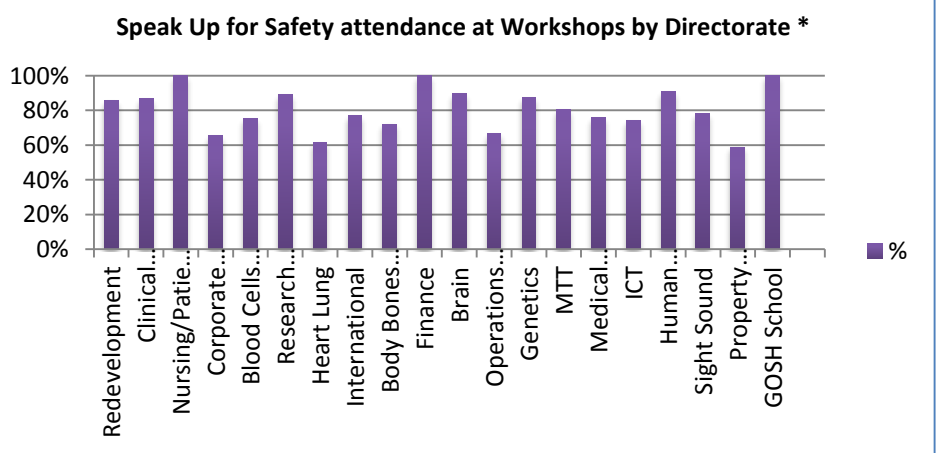
The programme builds on the professionalism and commitment of the overwhelming majority of staff, while ensuring the actions of no one individual can undermine a culture of safety and quality.

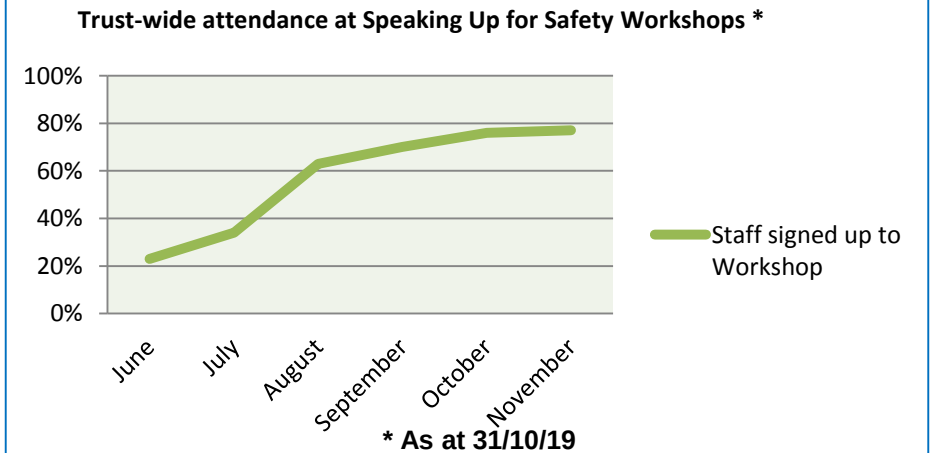
In preparation for the launch the team are working closely with HR to ensure the programme and associated training is aligned to the planned Management Development training .

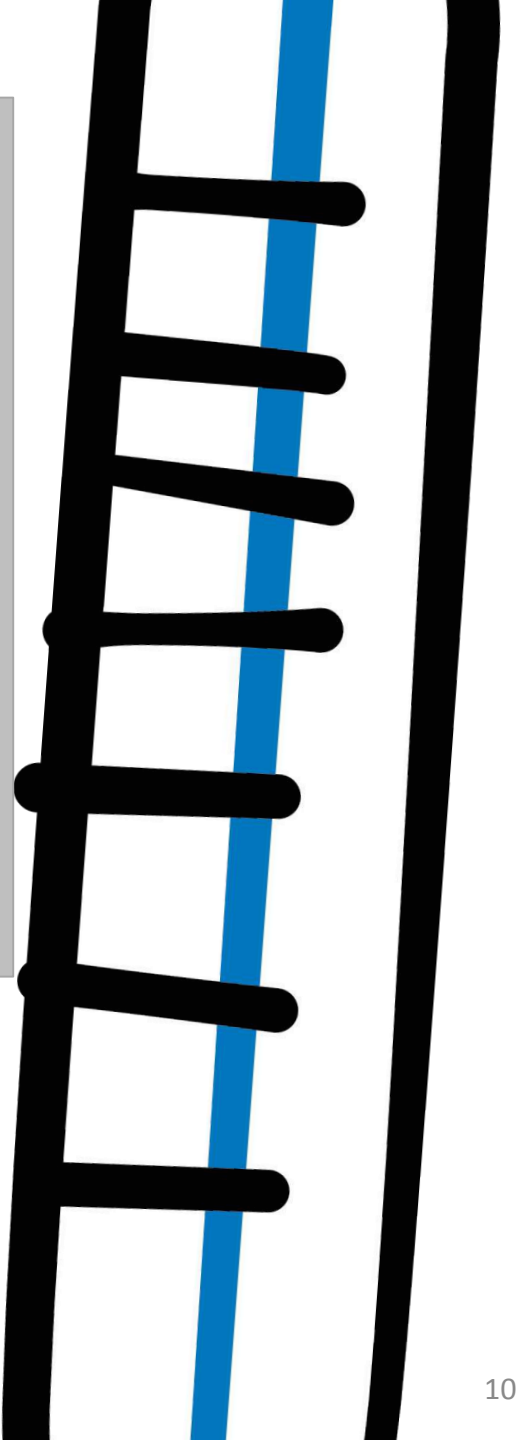
In October we invited expressions of interest for Peer Messengers

Training for Peer Messengers and Senior Leadership Intervention workshops are scheduled for January 2020.

Work in relation to a prototype reporting tool is underway internally.







Emerging trends in Patient Safety

EPIC- Foetal patients

- There has been a number of reported incidents where infants have been double registered. There are a number of reasons why this has occurred, for example, when a mother is seen ante-natally and has known that the infant will be referred to GOSH post delivery or on receipt of a post-natal referral. The patient may be registered on the system by the specialty team. In several cases the infant has then been retrieved and has been registered a second time. The protocol is to register a neonate as male infant or female infant but some teams are registering as “baby” and not using the “soundex” function on Epic. This has resulted in duplicate registrations which has an inherent risk. This has largely affected cardiology and CATS patients and there has been bespoke training with the admin teams to reinforce the protocol. Epic admission processes will be reviewed as part of the optimisation phase. The admin and medical records team support the clinical areas to merge any duplicate records.

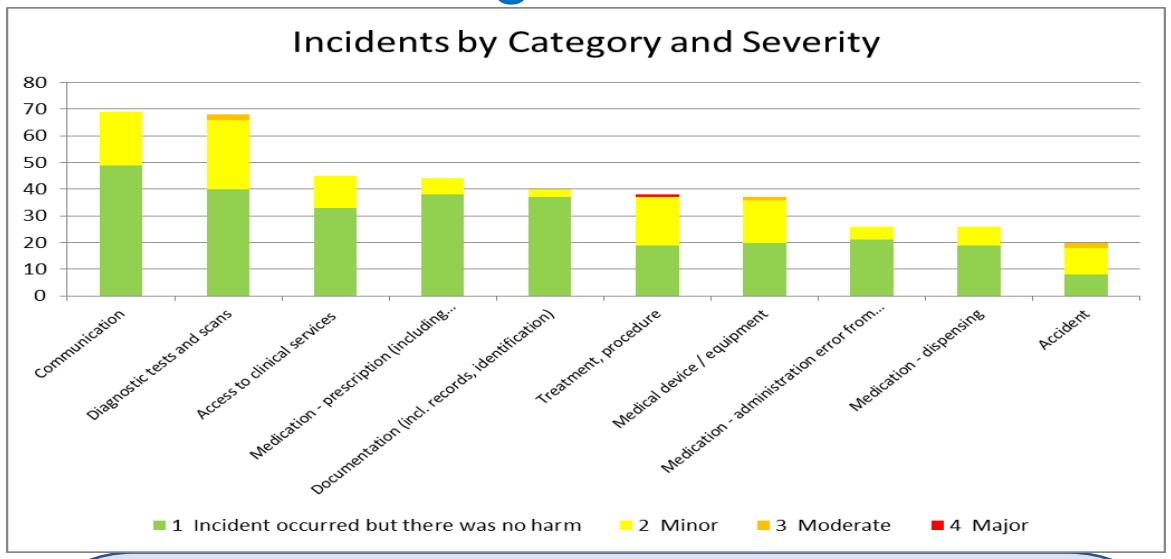
Medication configuration errors

- There continue to be incidents submitted citing medication configuration errors on Epic. Incorrect medication limits increase the risk of a prescription and/or an administration error. “Guardrails” are not currently in place on the system. These issues are particularly prevalent across critical care areas (eg 50 configuration errors) reported from PICU/NICU in October 2019. Currently these have not resulted in patient harm but there have been a number of near miss events. The pharmacy team are working with Hornbill, to address these issues.

ZCR

- The new Zayed Centre for Research opened this month. There have been some incidents relating to the ZCR opening and some challenges for the team there. This includes ensuring that cleaning schedules are amended so infectious patients can be seen in any room, ensuring that there is a safe method of bringing patients back to the hospital in event of a collapse, and ensuring that there is a way to transfer non-ambulant patients between the two sites. In order to understand the risk and operational issues, a clinical emergency team exercise was undertaken. This highlighted a number of process issues and in order to resolve this, a SOP which was written in liaison with the London Ambulance Service, OCS has been completed. This exercise will be repeated later in November 2019 in order to test the revised SOP.

Understanding incidents

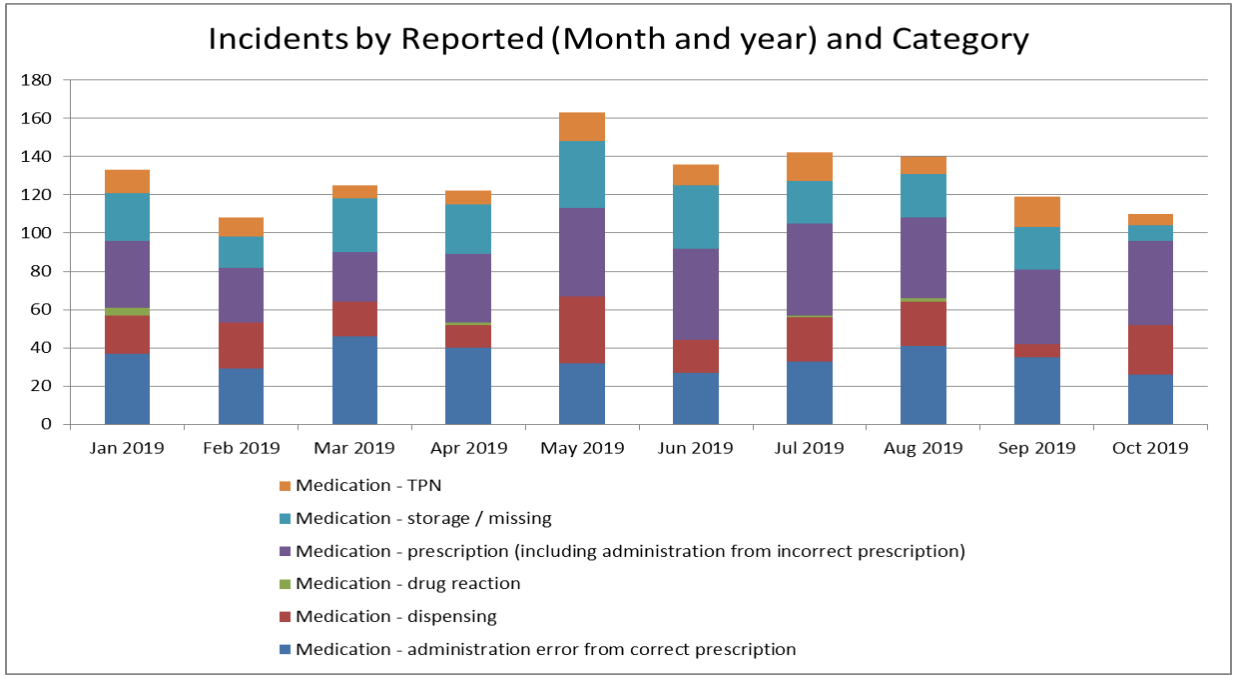


Access to clinical services – there are significant issues with visibility of internal and external referrals to the Trust on the Epic system. This impacts Trust-wide. This is compounded by an inability to cap the number of referrals received and inability to see the date of referral. There is ongoing work with the Epic team to develop a clear referral module. A neonatal tracker has recently been introduced whereby a ante-natal referral details can be put onto Epic and then released once the infant has been delivered.

Medication incidents are closely monitored by both Patient Safety and Pharmacy. A new medication safety pharmacist started in October who will be looking at any trends in medication incidents going forward.

The dashboard data continues to report on open and closed incidents. As stated in last months report, the level of harm may not have been amended, pending the investigation. It should be noted that the definition of low harm includes events whereby an additional procedure, eg a blood test, is required to determine whether any additional care or escalation of care is required. In many incidents, this confirms no harm from the medication but remains classified as low harm because of additional interventions required.

In October 2019 a decrease in medication storage incidents was observed. This is attributed in part to removal of oromorph and sildenafil from the mandated Controlled Drug (CD) count.



Patient Safety Alerts

Alerts open in the Trust: 2

Overdue Alerts: **2**

Zebra printer Power Supply Units (PSUs): fire risk – product recall expanded

Date issued: 19/09/2019

Date due: 17/10/2019

Update: Audit underway to establish PSU's effected. Action plan for replacements to follow when numbers obtained.

ENERGY NETWORKS ASSOCIATION (ENA) Various DINs, SOPs and NeDERs, issued since May 2018

Date issued: 12/07/2019

Date due: 31/10/2019

Update: Awaiting update from

Patient Safety – Serious Incident Summary

New & Ongoing Serious Incidents				
Directorate	**Ref**	**Due**	**Headline**	**Update**
O&I R&I	2019/20382	10/12/2019	Subarachnoid Haemorrhage	Report drafted
BBM	2019/22539	Mid-November	ICO Reportable Breach	Report drafted- early due date to comply with complaint timescales

2019/22539 ICO Breach Incident

An incident was reported to both the Information Commissioner's Office (ICO) and NHS England in October 2019. The incident occurred when a report compiled by the Child and Adolescent Mental Health Service (CAMHS) was inadvertently sent to the wrong address. This was the result of a typo during the report drafting process where the wrong house number was inputted into the address field.

As an immediate action, all report writing was moved into EPIC where addresses are auto-completed. This will ensure that the address in EPIC will be the address where the report is sent.

The parents of the patient involved also raised concerns via the formal complaints process and a copy of the final report will be sent to them with a letter from the CEO.

Learning from Serious Incidents: 2019/3785

The SI investigated the cancellation of three patients due to the non-sterility of the sets planned to be used. The report also looked more broadly at the provision of sterile services at GOSH.

Recommendations:

- To establish a quoracy for the fortnightly customer liaison meetings to ensure that at least one member of the Theatres clinical management team attends the meeting.
- To ensure that all new concerns raised during meetings are documented. To ensure that any updates provided around service delivery are documented.
- To ensure that an action plan is created which follows SMART best practice (Specific, Measureable, Appropriate, Realistic, Time), with a clearly defined action owner and associated timescale for completion. Ensure that there is an escalation plan in place for when timescales are not met and that this is followed.
- To continue to monitor contract compliance through monthly contract review meetings, and to escalate any concerns appropriately.
- To utilise the Trust's electronic patient record system to conflict check and ensure that theatre time is planned with available sets in mind. Using this system the Trust will ensure that backup/alternative sets are available for all procedures – in particular those using rare sets such as the TrueLok Orthofix system.
- To review available sets with a view to purchasing additional sets to provide backup cover for when sets are not able to be used.
- To recruit into a band 7 decontamination /infection control/ environmental theatre link post. This post would support discussions with the sterilisation company and ensure a reliable clinical single point of contact to manage any ongoing concerns.
- To review the Theatres uniform policy to bring it in line with national best practice and submit this to the Policy Approval Group (PAG) for approval.

Patient Safety – Serious Incident Summary

Learning from Serious Incidents: 2019/16723

The SI investigated an Incident where a patient suffered an oesophageal perforation after ingesting food and a subsequent acute kidney injury (AKI stage 3) nine days after the initial incident

Recommendations:

- The implementation and Trust wide dissemination of agreed food substances, textures and terminology for patients who do not require input from the dietetics or SALT teams following surgical procedures.
- The development of a refeeding protocol after Heller Myotomy that benchmarks processes and protocols with other centres undertaking this rare condition.
- The implementation and Trust wide dissemination of a guideline to support risk assessment of patients who are most at risk of acquiring an Acute Kidney Injury.
- The implementation and Trust wide dissemination of an guideline to support identification and management of patients who have acquiring an Acute Kidney Injury.
- Clear guidelines on the dosages in the Trust of Vancomycin in the paediatric population.

Clinical Audit priorities – current work plan

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

Source	Subject/context	Status
SI/Area where support is required	Controlled Drugs audit	Re-audit planned for December 2019
NICE guidance	Review of compliance with Mental Capacity Act for procedures	Audit completed and summarised on next page of this report
Patient Safety Alert/prevention of Never Event	Reducing the risk of oxygen tubing being connected to air flowmeters	Re-audit to take place to assess implementation of the action plan that was agreed at the May 2019 PSOC.
Patient Safety Alert	Re-audit to assess improvement in documentation post EPIC in NG Tube Testing	Audit completed and summarised on next page of this report
NHS England 7 Day Services Self-Assessment	Audit of compliance with NHSE standards is a mandatory requirement.	Completed .An audit of GOSH unplanned ICU admissions demonstrates compliance with the 90% target required by the NHS England Priority Standards for 7 Day Services for emergency admissions.
Lessons Learned audit plan– Potential missed diagnosis of bowel obstruction(SI2019/442)	Audit of recommendation from the SI	Gastroenterology Specialty Lead to finalise audit plan with Clinical Audit Manager.
Safeguarding –survey on learning from Serious Case Reviews	Aim - review our awareness of some of the key learning from recent serious case reviews that GOSH have been involved with.	Data collection period extended until the end of October. Report to be produced in November 2019
Learning from RCAs	7 MSSA infections within a month of a CVL insertion placed in Interventional Radiology have been completed as root cause analyses since June 2018. It has therefore been recommended by Infection Control that an audit of best practice to minimise the risk of infection pre, during, and post CVL insertion takes place.	Data collection to be completed in November 2019
Learning from incidents	The audit will determine whether key processes to minimise risk of infection associated with ECHO machine are being followed. This is following learning from a MRSA outbreak within cardiac services between Feb and June 2019.	Data collection to be completed in November 2019

Clinical Audit priorities – completed

Mental Capacity Act

This audit focused on the application of the key principle of the Mental Capacity Act to procedures performed on patients aged sixteen and over.

This audit highlights that improvements are required in order to comply fully with the Mental Capacity Act.

This will require amending the process of documenting consent to support the completion and documentation of a mental capacity act assessment, specifically requiring demonstration of practicable steps that have taken place to help the person give consent without success and clarification of how impairments cause the patients to be unable to consent for themselves at the time of decision making.

The audit was presented to the Mental Capacity Act Group and an action plan approved by Strategic Safeguarding Committee . A re-audit was requested to take place in Q3.

Actions agreed include

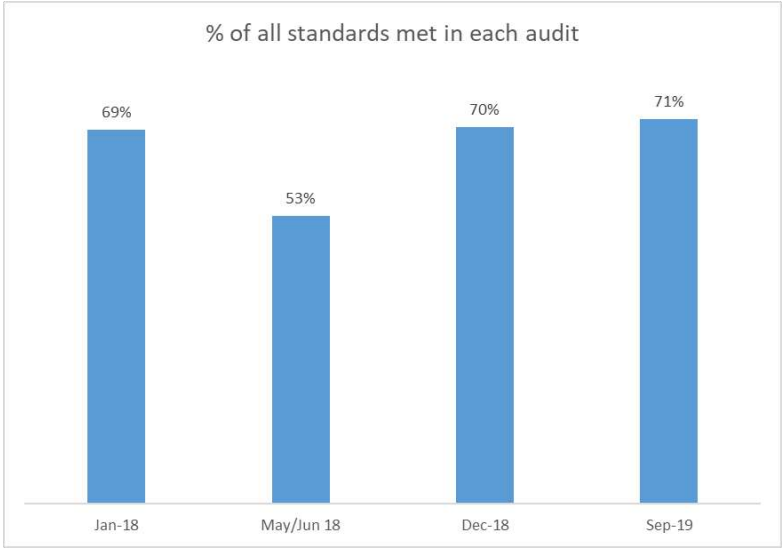
- Mental capacity assessment form to included in EPIC.
- Ongoing MCA training to be incorporated into Safeguarding mandatory training.

Naso-gastric tube documentation Re-audit

Repeat audits in 2018 showed there could be improvement in documentation . It was agreed that further audit takes place post EPIC implementation, to help assess whether the system facilitates an improvement in the documentation of practice.

Key findings

There have not been any improvements in documentation since the first audit, and following the launch of EPIC



Areas for improvement and ward level action plans have been agreed)
The audit highlighted a limiting factor to documenting all aspirate results was how some specific sections are located in EPIC .

The audit was shared at the October 2019 Matron Meeting and an action plan agreed. This including an action for the Matrons to raise this at the next EPIC meeting with Chief Nursing Information Officer .

How further items for audit will be identified

Further items will be established following requests made by Directorate Management, PSOC, and via SI and Complaint processes. Rapid Response Alerts which require confirmation of clinical practice, will be identified by the Patient Safety team, and audit will then be added to establish compliance . Specific audits may be identified as required through Closing the Loop.

The following audits have been identified as *recommended from reviews of previous SIs and RCAs* to help close the loop on learning from past incidents.

Learning	Steps taken to agree audit
Si2017/13562 Retained foreign object in theatres	The SI highlighted specific key recommendations made for the surgical count for spinal surgery .Audit plan agreed with Spinal Team Leader , data collection to take place in November and December 2019 .
2017/26155 Wrong tooth extraction RCA Miscommunication between Dental and Maxillofacial teams resulting in a different procedure being listed.(WEB61553)	Clinical Audit Manager to meet with the Maxillofacial Consultant to finalise audit plan
2018/7762 Retained foreign object during surgery *.Ensure that the 'count' is a protected part of the procedure in the same way that for example the 'time out' part of the WHO checklist is. All staff present in theatre should be aware that the count is being carried out and there should be no unnecessary talking, interruptions etc (unless needed for patient care)*	Reviewed with Theatre Matrons Audit to take place looking at quality of the surgical count process following update of policy.
2018/10554 Patient fall "Ensure risk assessment is used effectively and acted upon for patients at risk of falls."	Clinical Audit Manager to undertake audit to check three key standards . • whether falls care plans are completed following admission to an inpatient ward • to identify if assessments are completed on a weekly basis for long term admissions • determine if patients are being re-assessed following a fall
2018/10796 prescription of morphine look at whether dose prompt calculators and preventative warnings are present to minimise the possibility of a prescribing error for oral morphine	Clinical Audit Manager working with PICU fellow on audit

Quality Improvement

The QI Team support, enable and empower teams, to continuously improve the quality of care provided to patients across GOSH.

1. Mentoring QI Projects

The team provides a mentoring service, offering QI support to staff who are interested in starting projects. Mentorship provides 1:1 QI support and advice, with a time commitment between 1-6 hours per month.

Project Commenced	Area of work	Project lead:	Expected completion date
Dec 2018	**Improve handover** quality and continuity of care for outlying patients in the cardiology service	Craig Laurence (Cardiac Fellow)	Nov 2019
Sept 2019	To reduce variation in the pre-op processes undertaken by **Orthopaedic CNS service**	Claire Waller (Matron)	Dec 2019
Sept 2019	To provide daily debrief sessions to staff on the renal unit to improve moral and reduce stress	Sarah Owens	Dec 2019
Jun 2019	To reduce the number of **unnecessary blood tests**, when ordered in sets/ bundles, in Brain Division	Spyros Bastios (Metabolic Consultant)	April 2020
Oct 2019	To **reduce unnecessary blood sampling** post-operative neurosurgical HDU patients	Orla Hayes (Staff Nurse)	June 2020
Aug 2019	To **improve patient satisfaction of the consenting process** in cardiac anaesthesia	Marc Cohen	Aug 2020
Oct 2019	To improve staff satisfaction through redesign of the **Palliative Care on-call service**	Julie Bayliss (Clinical Lead)	April 2020

2. Local / Directorate QI Projects

The QI Team also provides QI support and expertise to local or divisional improvement work. The following graphics, maps where registered QI activity is taking place across the Trust:

GI Bleeds Pathway

Reduce unnecessary coagulation testing in SNAPS

ZAPPP

BMT Patient/ Family Info

Pelican ward Q&S

Mobile App Group

Datix (DRM)

Discharge Sum

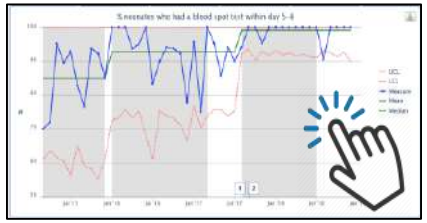
PN Administration

Project Commenced	Area of work	Project lead:	Expected completion date
May 2019	Supporting the development of a joined up, pan-trust approach to the **management of acute gastro-intestinal haemorrhage** for inpatients	Sian Pincott (DCOS-BBM)	Aug 2019 **Closing soon- delay to policy approval**
Dec 2018	To improve IR theatre utilisation by implementing **ZAPPP** (zero acceptance of poor patient preparation) policy	Sam Chippington (Cons)	Dec 2019
Jun 2019	To implement Datix Review Rounds to **improve the culture of learning from incident reporting** in IPP	Deborah Zeitlin (Cons IPP)	Dec 2019
May 2019	Revising the **provision of Discharge Summaries** in IPP since EPIC.	Sian Pincott (DCOS - IPP)	Dec 2019
Jul 2018	Mobile App Development Project. Develop **a framework and process to oversee the development of Mobile Applications** in the Trust	Louis Grandjean (ID Cons) / Sue Conner (DRIVE)	Jan 2020
Oct 2019	To implement a **nursing PGD in Haem/Onc** to **reduce unnecessary delays in administering Pip/Taz** to patients developing sepsis	Vicki Villalobos- Lopez	Jan 2020

**Click links to open project dashboard*

3. Trust wide QI Projects

Trust-wide projects are commissioned and governed by the Quality Improvement Committee, with an Executive Sponsor and a MDT steering group.



All Trust-wide project data is available on the QI dashboard

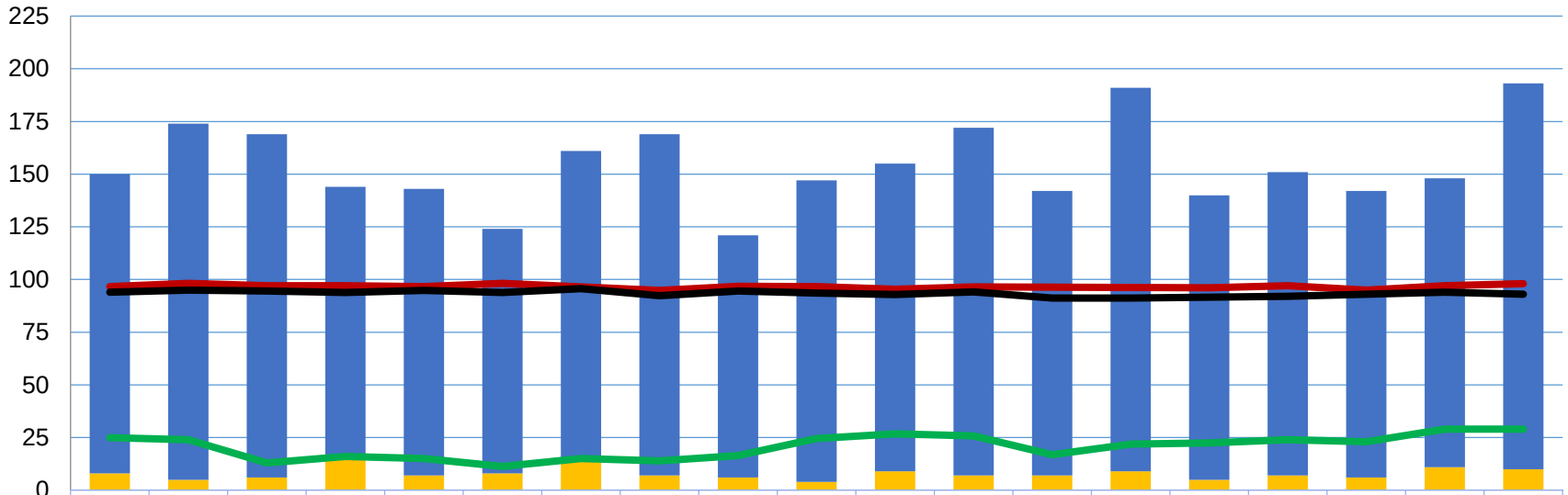
Project Commenced	Area of work	Project Lead (PL) Exec Sponsor (ES)	Expected completion date
Oct 2019	Supporting the **medication safety work stream** of the Hospital Pharmacy Transformation Programme Board (HPTPB): **Uncollected Medications**	PL: Stephen Tomlin ES: Andrew Taylor	April 2020
Jun 2019	Improving safety and standardisation of **urethral catheterisation**	PL: Nicola Wilson / Claire Waller ES: Sanjiv Sharma	Dec 2019
Jun 2018	Reducing rejected **laboratory samples**	PL: Christine Morris ES: Sanjiv Sharma	Nov 2019 (extension to be agreed- Mar 2020)

**Click links to open project dashboard*

Patient Experience Overview

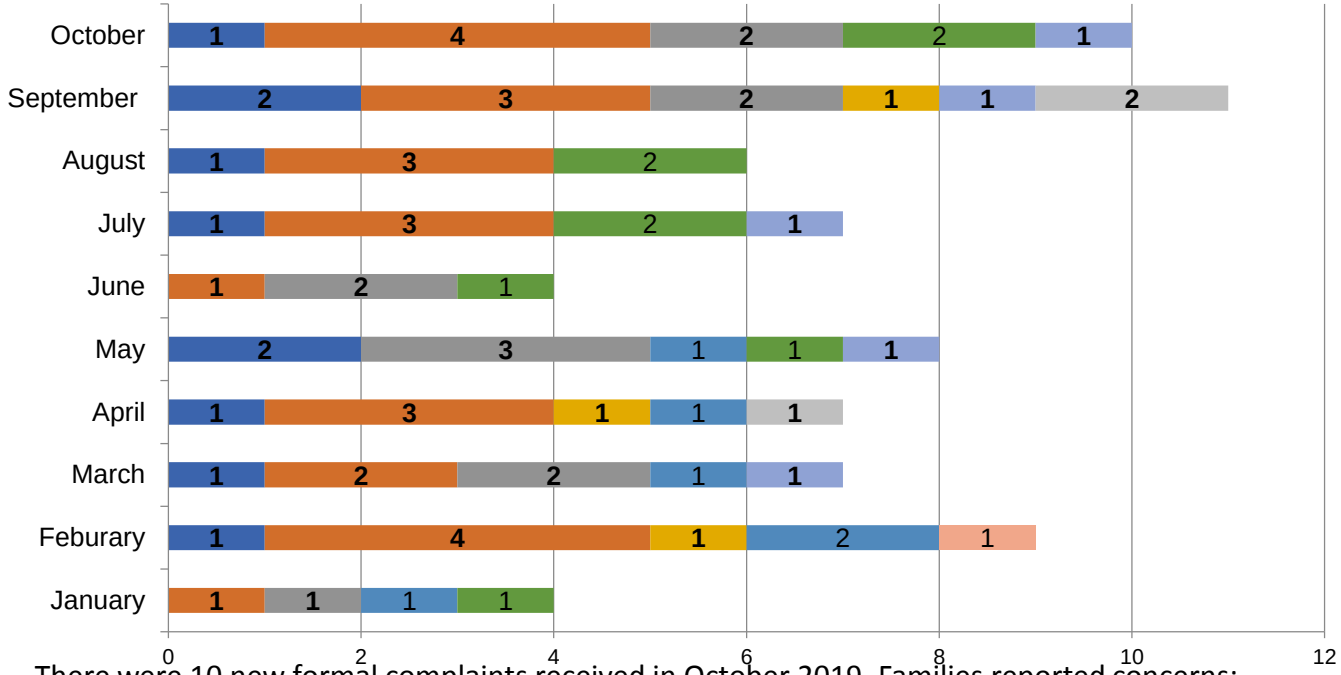
Are we responding and improving?

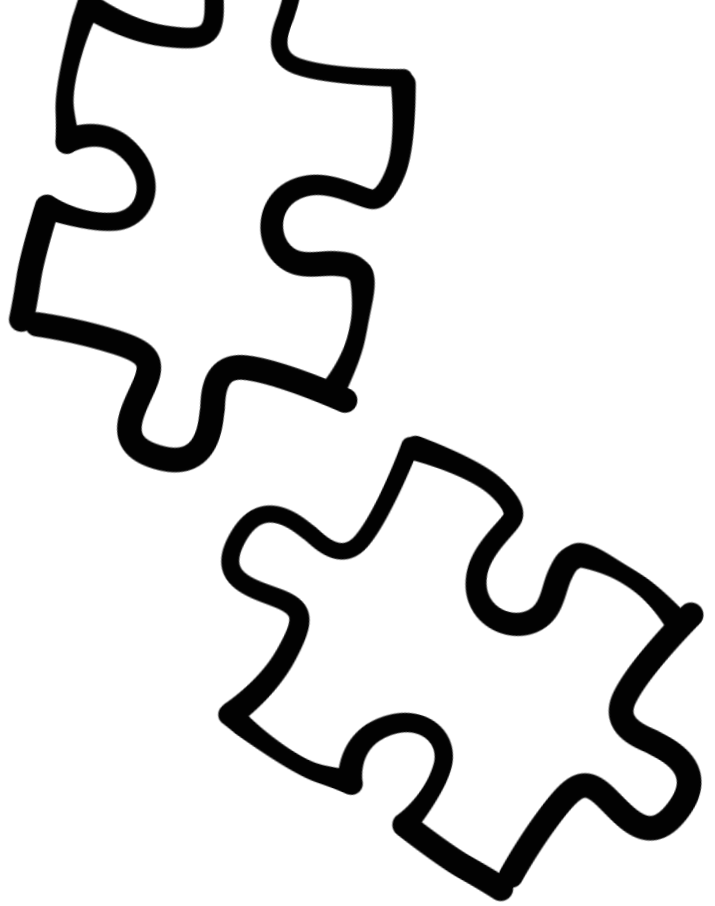
Patients, families & carers can share feedback via PALS, Complaints & the Friends and Family Test (FFT).



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
PALS	142	169	163	129	136	116	146	162	115	143	146	165	135	182	135	144	136	137	183
Formal Complaints	8	5	6	15	7	8	15	7	6	4	9	7	7	9	5	7	6	11	10
FFT recommendation rate - Inpatients %	97	98	97	97	97	98	97	95	97	97	95	97	96	96	96	97	95	97	98
FFT recommendation rate - Outpatients %	94	95	95	94	95	94	96	92	95	94	93	94	91	91	92	92	93	94	93
FFT % response rate	25	24	13	16	15	11	15	14	17	25	27	26	17	22	22	24	23	29	29

Complaints: Are we responding and improving?

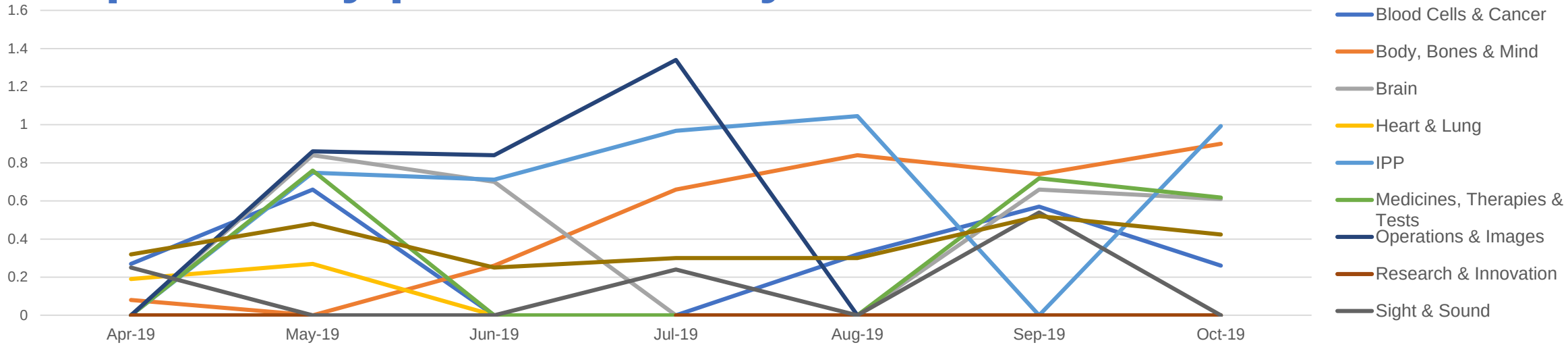


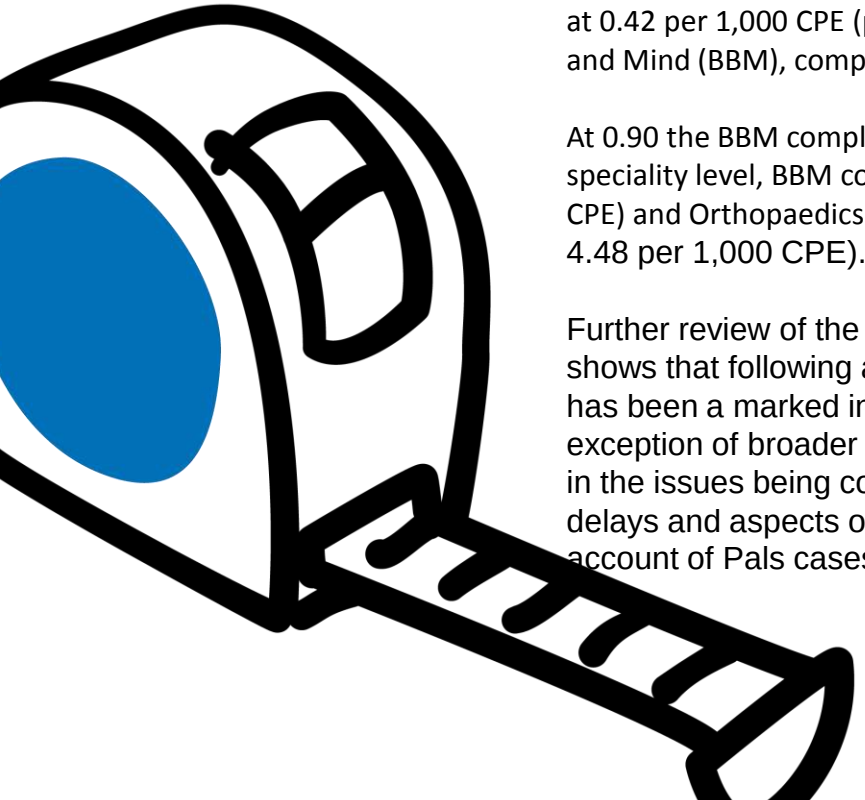


There were 10 new formal complaints received in October 2019. Families reported concerns:

- that a report containing highly sensitive personal patient identifiable information was sent to the wrong address and that subsequent email communication was not sufficiently secure
- about delays in medication being administered and information recorded in the patient's clinical records
- about aspects of care including differing diagnoses, approaches, medication and communication in particular regarding the patient's fitness to attend school
- regarding communication about the patient's condition, diagnosis, future treatment, cancellation of an appointment at short notice, and management of a referral
- delays and a lack of responsiveness to changes in the patient's condition, and cleanliness within the ward
- continuity of care given frequent changes of consultants, poor communication, delays and no diagnosis made
- delays in responding to another hospital's request for a tumour sample and the implications of this
- poor communication and delays
- inappropriate and unhelpful communication and the discharge of the patient from GOSH
- communication regarding a delayed lumbar puncture and prolonged fasting for the patient, and cancellation of an appointment the next day

Complaints by patient activity*



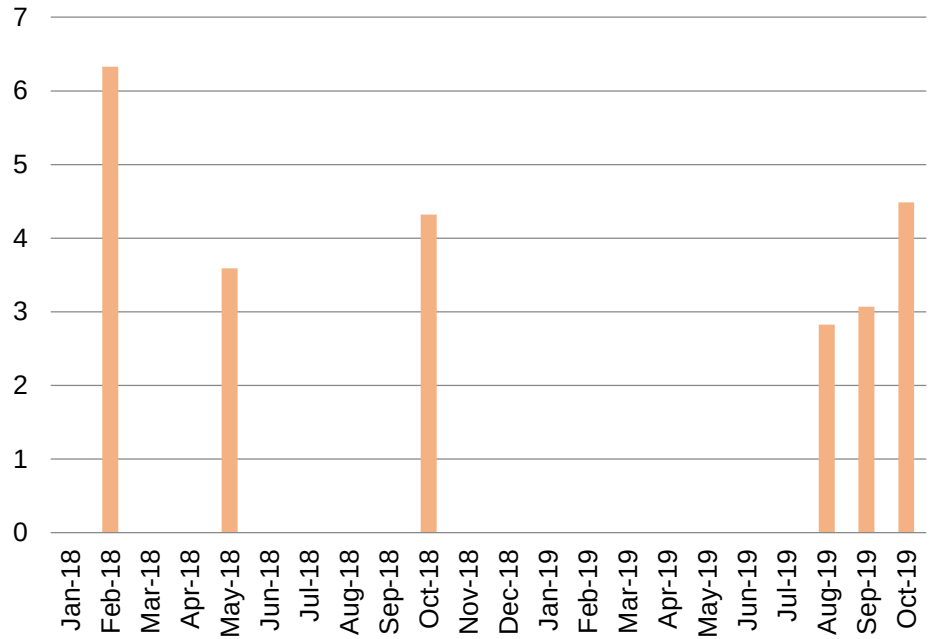


Complaints by patient activity across the Trust slightly decreased in October at 0.42 per 1,000 CPE (previously 0.52). With the exception of Body, Bones and Mind (BBM), complaint rates for all directorates fell this month.

At 0.90 the BBM complaint rate is the highest since February 2019 (0.96). At speciality level, BBM complaints in October related to CAMHS (n=1, 2.83 by CPE) and Orthopaedics (n=1, 1.28 by CPE) and Gastroenterology (n=2, 4.48 per 1,000 CPE).

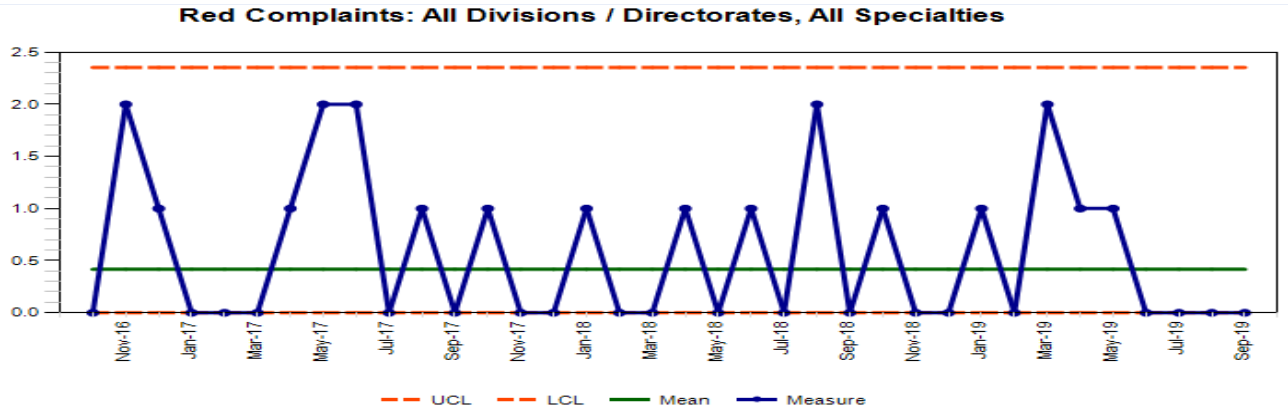
Further review of the Gastroenterology complaints since January 2018 shows that following a 9 month period of no complaints at all, there has been a marked increase (4 complaints) since August. With the exception of broader communication issues, there is no apparent trend in the issues being complained about which related to cancellation, delays and aspects of care. This will remain under close review taking account of Pals cases, FFT response and recommendation rates.

Gastroenterology Complaints per 1,000 CPE



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

Red Complaints: Are we responding and improving?



No of new red complaints this financial year 2019/20:	3
New Red complaints opened in October 2019	1
No of re-opened red complaints this year 2019/20:	1
Open red complaints (new and reopened) as at 08/11/2019:	2*

New or Open Red complaint

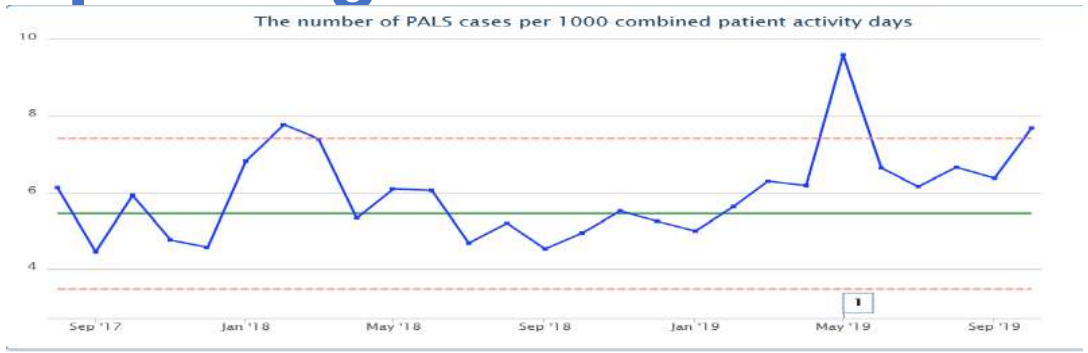
Ref	Due Date	Divisions Involved	Background	Next Steps:
19/046	20/11/19	CAMHS	Information governance breach- report containing highly sensitive information was sent to the wrong address. This is being investigated as a Serious Incident.	Under investigation

Ref	Reopened Date	Divisions Involved	Background	Next Steps:
*18/081	17/06/19	IPP	Parents are concerned that there was a delay in identifying sepsis . Investigation concluded patient's presentation was complex/ unusual and sepsis protocol was followed appropriately.	Complaint resolution meeting and follow up actions have taken place. A meeting has been offered with the Sepsis Lead at the end of 29/11/19

There are eight overdue Red Complaint actions (five of which became overdue on 31/10/2019). One outstanding action for 18/056 has been updated following inquest and is being monitored via QSEAC. Complaint 19/010 has four outstanding actions regarding processes for management of IPP patients and escalation and will be discussed at Closing the Loop in December. 18/095 has one outstanding action with a third party provider and a further action regarding a cleaning audit. 18/093 has two actions relating to documentation regarding communication with families which will be audited and discussed at the next Closing the Loop meeting before being closed.

PALS – Are we responding and improving?

Cases – Month	10/18	09/19	10/19
Promptly resolved (24-48 hour resolution)	120	78	144
Complex cases (multiple questions, 48 hour+ resolution)	26	56	36
Escalated to formal complaints	5	2	1
Compliments about specialities	0	1	2
*Special cases (e.g. large volume of contact following media interest)	0	0	0
Total	**151**	**137**	**183**
Themes for the top five specialties			
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families)	49	46	66
Admission/Discharge /Referrals (waiting times; advice on making a NHS/ IPP referral; cancellations; waiting times to hear about admissions; lack of communication with families, accommodation)	15	9	4
Staff attitude (rude staff, poor communication with parents, not listening to parents)	15	11	15
Outpatient (cancellation; failure to arrange appointment; poor communication, franking of letters)	35	45	50
Transport (eligibility, delay in providing transport, failure to provide transport)	8	5	9
Medical records and access to information (GOSH information, Health information, care advice, advice NHS, access to medical records, incorrect records, missing records, support/listening)	29	20	39



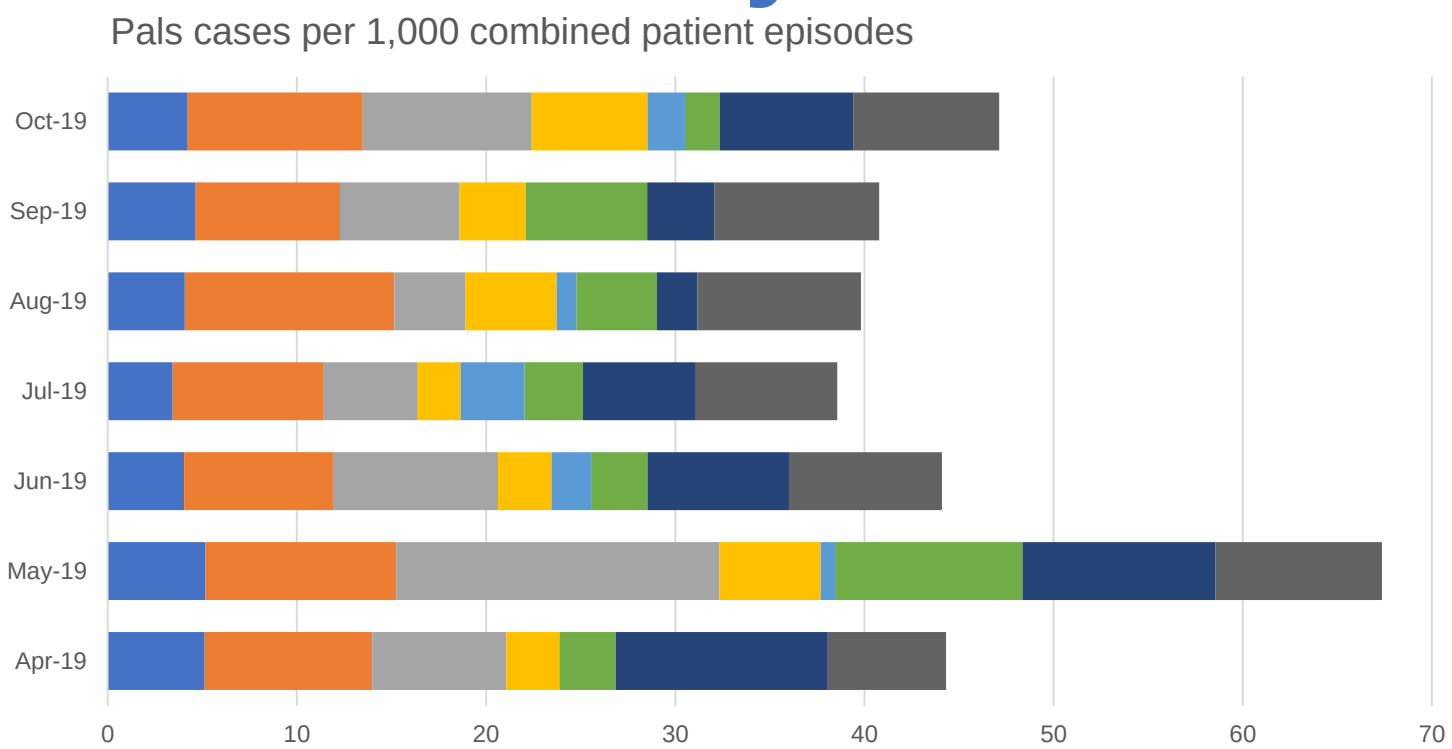
There was a significant increase in the number of Pals cases received in October (n= 183). This is the highest number since April 2018 and is under close review particularly in the context of combined patient activity (shown above), which shows a breach of the upper control limit. Contributory factors include a slight increase in patient activity (approx. 10%) but also continued focus in Pals on data quality and recording (particularly following a recent return to full staffing levels). Of note, the percentage of complex cases reduced significantly from 41% of all Pals cases in September to 20% this month.

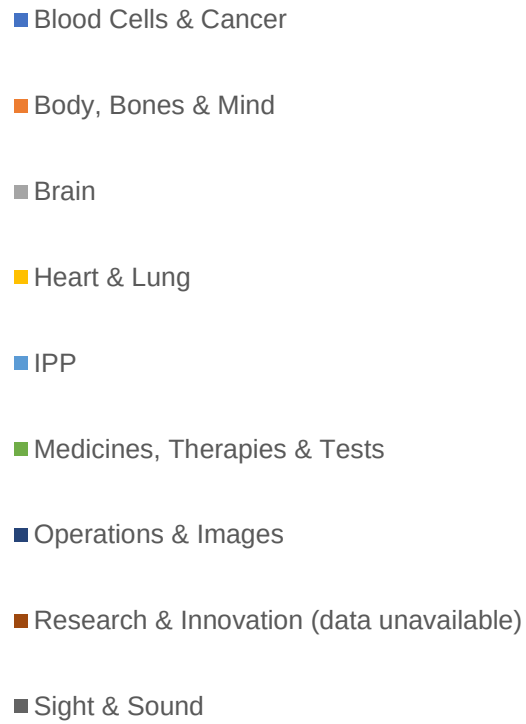
Communication cases increased for the third successive month and equated to 2.75 cases per 1,000 combined patient episodes (the highest rate since March 2019). Concerns related to issues including difficulties in obtaining responses to queries, poor communication which necessitated additional appointments, lack of follow up and families not feeling listened to.

Pals cases regarding access to information and medical records encompassed a wide range of requests for treatment advice (prompted in part by the Zayed Centre for Research), fundraising, general information. For existing patients cases related to requests for medical records and clarification about aspects of care and treatment.

Pals cases by directorate

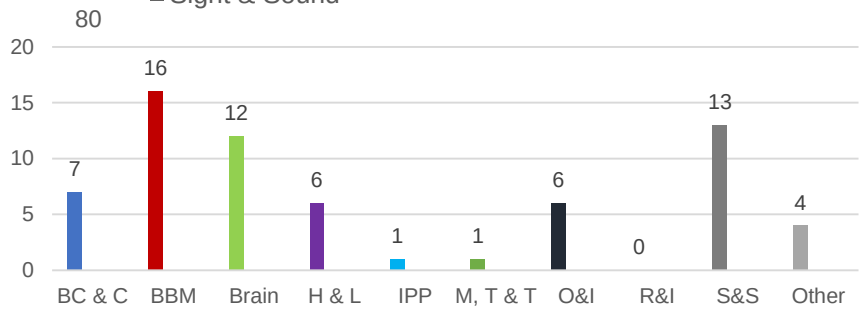
Pals cases per 1,000 combined patient episodes





Pals case numbers

	Blood Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	IPP	Medicines, Therapies & Tests	Operations & Images	Research & Innovation	Sight & Sound
Apr-19	19	33	20	15	0	4	8	0	25
May-19	16	36	41	20	1	13	12	1	30
Jun-19	13	30	25	11	3	4	9	0	30
Jul-19	13	36	17	10	7	5	9	0	31
Aug-19	13	34	10	18	2	6	3	0	34
Sep-19	16	31	19	15	0	9	5	0	32
Oct-19	16	41	29	25	4	3	11	2	36



In October a number of directorates received higher than usual numbers
of Pals cases in particular in Body, Bones and Mind and Brain (the highest since May at 8.91 cases per 1,000 CPE). IPP Pals cases were at their highest since July 2019 at 1.95 complaints per 1,000 CPE. As mentioned in the preceding slide, the main issue related to aspects of communication (shown at directorate level below).

Pals – Are we responding and improving?

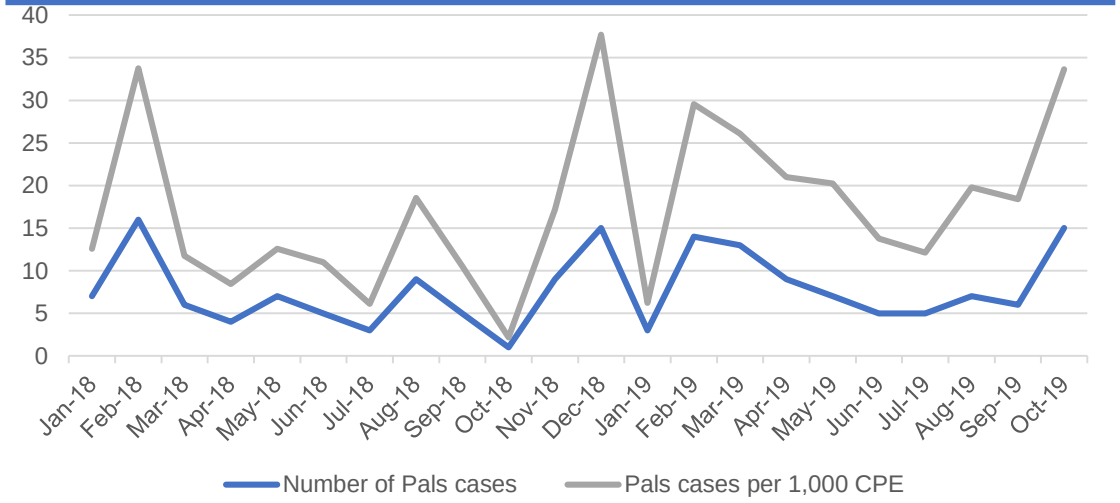
Top specialties - Month	10/18	09/19	10/19
Gastroenterology	1	6	15
Cardiology	19	7	13
Neurology	12	1	12
General Surgery (SNAPS)	7	6	10
Radiology	2	4	8

In response to the Pals team's request for any further feedback/ insight about cases and any contributory factors, the top specialties provided the following information:

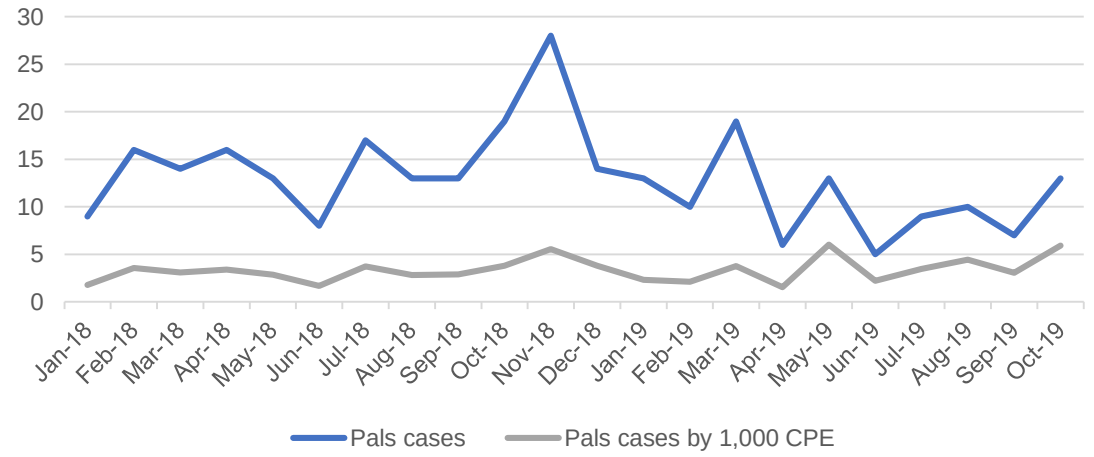
Gastroenterology- As shown above, cases in October 2019 were significantly higher than September 2019 (6) and October 2018 (1). Common themes for October 2019 typically centre around a lack of communication between parents/patients and both administrative and clinical teams (including concerns regarding an absence of replies to calls and an inability to reach teams). Other themes involve concerns about staff attitude, nursing care and requests for clinical and non-clinical information (including tests results and information about transport services for admissions).

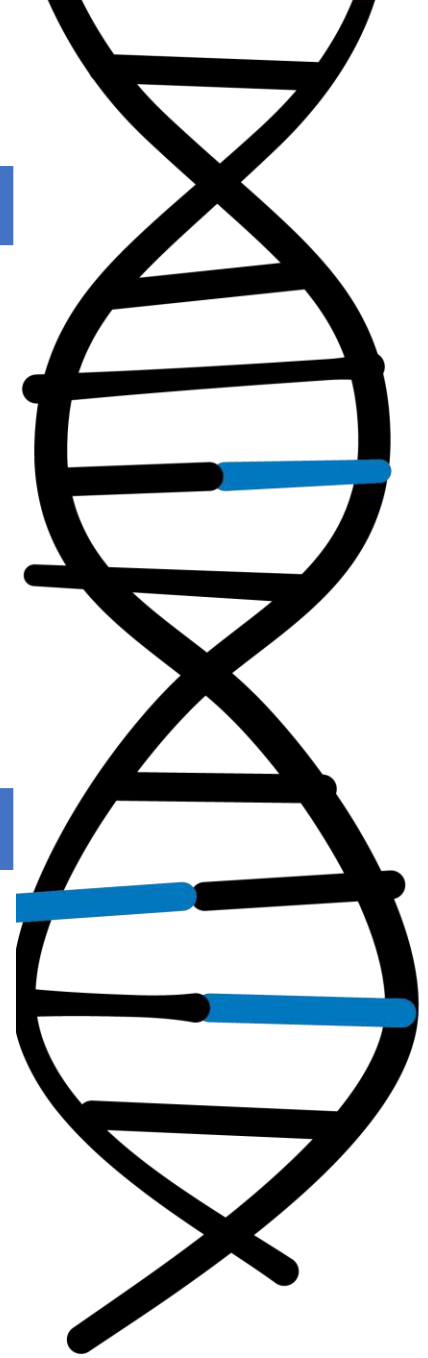
Cardiology- There has been an increase in cases received in October 2019 (13) in comparison with the previous month of September (7). However in October 2018 there were 19 cases so the number of cases has decreased over the year. The volume of PALS contacts about admissions is similar to previous month with similar requests for reimbursement for cancellations.

Gastroenterology cases

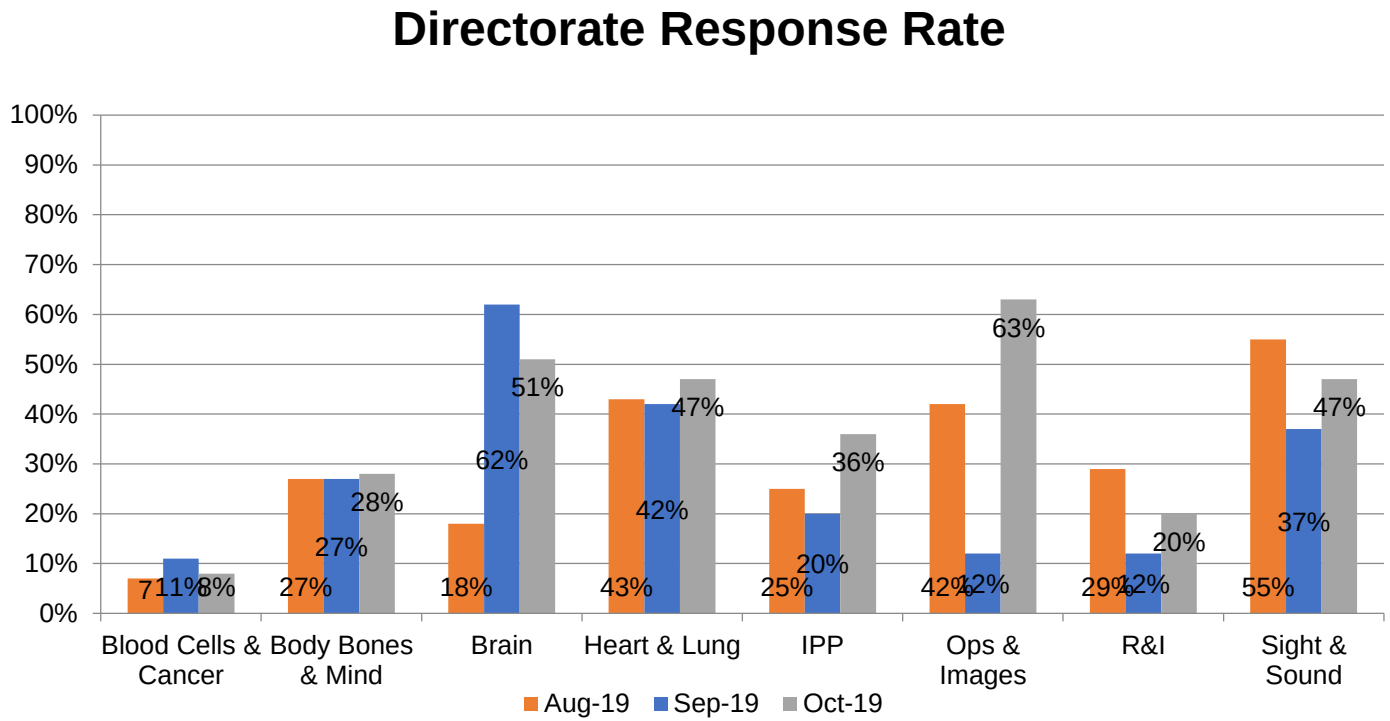


Cardiology cases



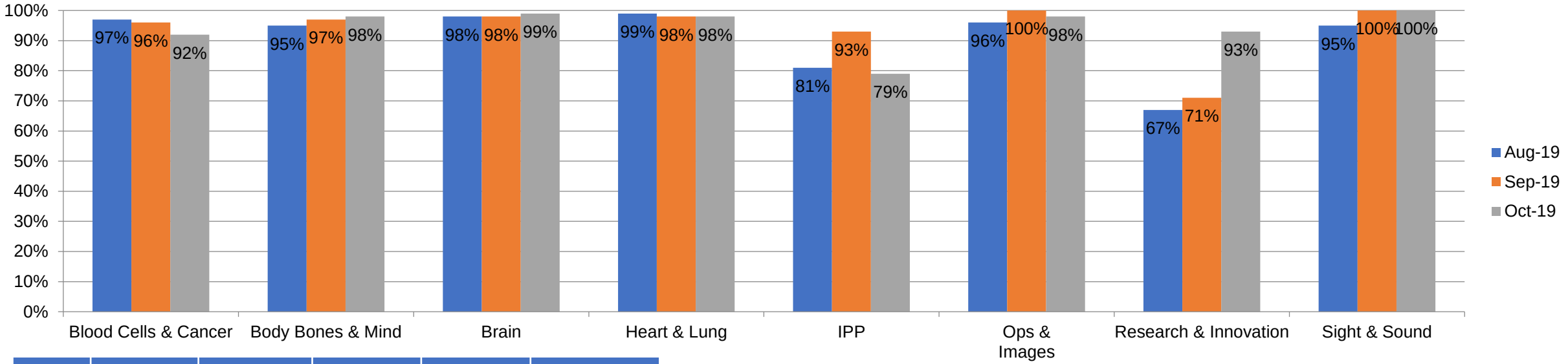


FFT: Are we responding and improving?



The overall FFT response rate reached 29% for the second consecutive month. In addition, the number of individual pieces of feedback increased by more than 500 to a total of 2,191. This is the highest volume of feedback received so far in 2019/20.
Two directorates scored below the Trust Target of 25%, Blood Cells and Cancer and Research and Innovation. Within Blood Cells and Cancer they still have extremely high discharge numbers from Pelican Ambulatory and Safari and this has been escalated to the EPR team and will be followed up via the Patient Family Experience & Engagement Committee.

FFT: Are we responding and improving?



	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Apr 19	516	399	40	**955**	**85.3%**
May 19	667	701	51	**1419**	**79.4%**
June 19	714	836	40	**1590**	**80.4%**
July 19	922	865	77	**1864**	**79.1%**
Aug 19	732	945	42	**1719**	**81.4%**
Sep 19	874	761	30	**1665**	**84.1%**
Oct 19	1008	1116	67	**2191**	**81.7%**

Five directorates achieved the Trust target of 95% to recommend. International Private Patients and Research and Innovation both fell below this target.

Blood Cells & Cancer

The negative comments related to Pelican and Safari. For Safari the negative comments related to the environment and waiting times for medication. Negative comments for Pelican related to written communication about admissions.

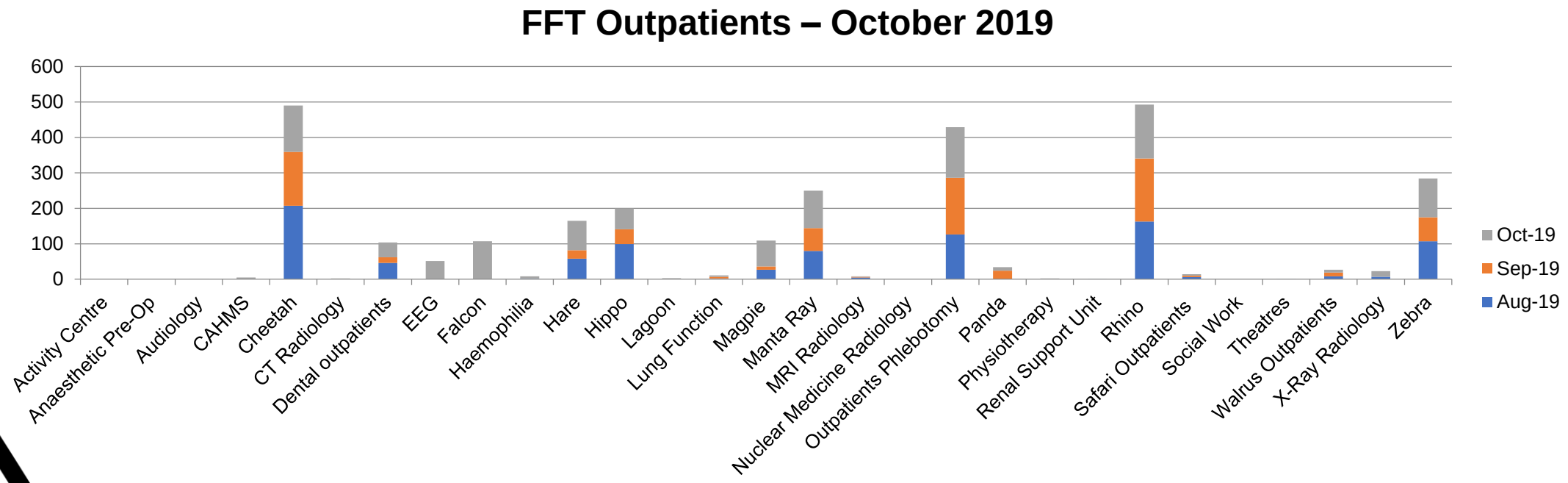
International Private Patients

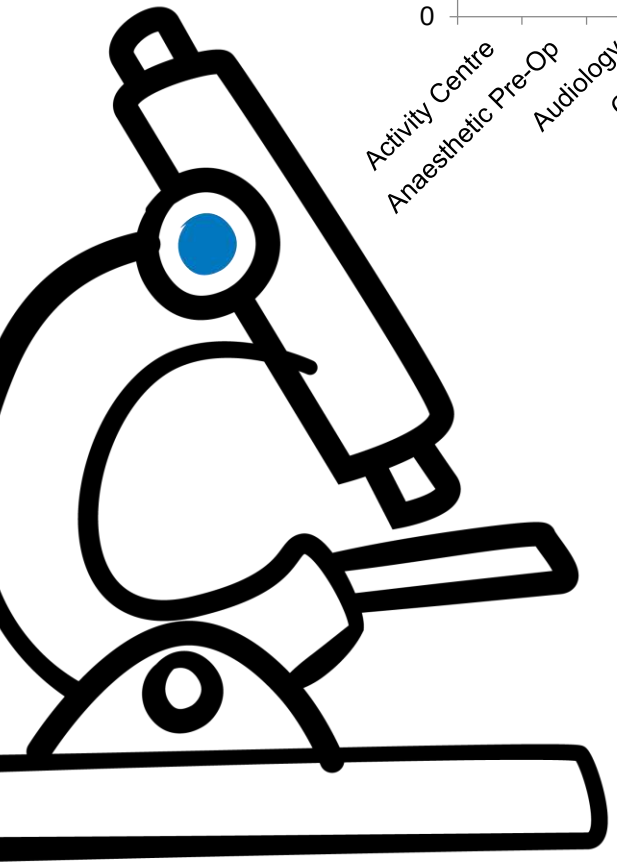
The negative comments received related to the hospital environment, nursing Care and poor communication about admissions.

Research & Innovation.

The negative comments received this month were mostly related to the environment and the recent move to Hedgehog. The majority of families prefer the welcoming environment of the Somers CRF and the less clinical surroundings. There was only one negative comment received this month related to drug delays which is a vast improvement on previous months.

FFT: Are we responding and improving?





The above chart outlines the number of the FFT responses within Outpatients. The amount of feedback received in outpatients has increased to 1116 with Falcon (in the Zayed Centre for Research) receiving a large amount of feedback since it opened on 21 October. The feedback received about Falcon Outpatients has been very positive. The only negative comments received related to wayfinding to the new building and appointment letters / text directing families to the incorrect building for their appointments.

EEG started FFT in October and have collected more than 50 pieces of feedback within their first month.

The percentage to recommend score has reduced very slightly to 92.7%, this remains under the Trust target of 95%.

FFT: Are we responding and improving?

Qualitative Comments

'I would recommend GOSH because they are keeping my baby brother alive which I truly respect. I am very interested to see what future brings and with GOSH's help, it is going to be great.' **Falcon Outpatients.**

'I would recommend GOSH because they have helped my younger brother with all of his heart conditions and are trying to make him all better. They support my family when my brother is having any sort of operation. I appreciate GOSH so much its unbelievable. GOSH is an incredible hospital.' **Falcon Outpatients.**

'*I was welcomed from start to finish and felt comfortable at all the times. Our nurse was a god send for my daughter and she will not be a nurse that we will forget. Well done team!'* **Nightingale Ward.**

'The communication is poor particularly the appointment system. I visited the hospital for a pre-assessment appointment for my son in October and was told by the nurse that he was scheduled for surgery later that month and an appointment letter will be sent through the post as confirmation within a week. No letter has been received and I have no means of contacting anyone as I have rung the hospital several times and all that seems to happen is getting transferred to various departments and eventually speaking to a voicemail which results in nothing.

At one point I got transferred to the Hippo department before I could say anything at all, the receptionist asked was which consultant is your son under and that she was a receptionist that doesn't deal with queries. Ringing the appointments line is just as unhelpful as the advisors do not have any other information apart from the appointments on their booking system. Right now I have no idea as whether this surgery will be taking place. As a working parent written confirmation is required as evidence to take time off from work.'

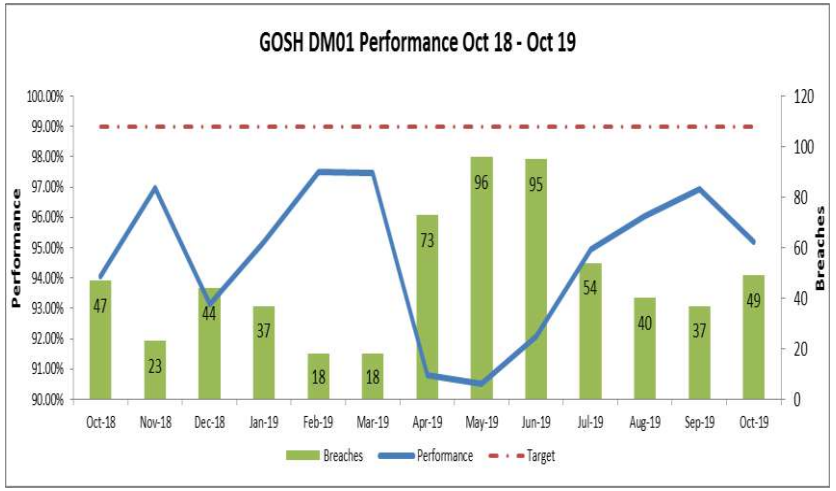
Assistant Service Manager contacted the family to apologise and confirmed the admission date. She also advised the parent about MYGOSH and registered them while on the call.

Feedback is shared with the teams concerned. All negative comments are followed up with the families (subject to contact details being available).

Responsive – Diagnostic Waiting Times

October 2019 Summary

- The Trust continues to underachieve against the 99% national standard, reporting 95.19% of patients waiting within 6 weeks for the 15 diagnostic modalities
- Unfortunately there was an increase in the number of braches for the month of October to 49, compared to the reported 37 in the month of September.
- The increase in the volume of breaches was mainly due to the number of booking process issue breaches that were experienced across the various modalities, which has been predicated due to the number of new / bank staff employed within these areas. Focused training work is underway within these areas to improve the position.



Of the 49 breaches, 36 are attributable to modalities within Imaging (23 of which are MRI), 2 in Audiology, 2 in Barium Enema, 1 in Cardiology, and 8 in Gastroscopy.

Breaches fall in four distinct themes: 26 due to booking process issues (Booked past breach date with no reasonable offers, patient cancelled and not booked in time), 4 due to lack of capacity (sedation, complex list, MR5 and cubicle capacity), 10 due to tolerance (cancelled due to patients unfit on the day) and 9 due to Trust process issue (hospital cancellations not rebooked within time, protocol delays)

The Trust continues to monitor the diagnostic recovery plan which has been shared with NHSI. The current trajectory forecasted compliance by end of September 2019 which the Trust failed to meet and a revised plan is being finalised and agreed with NHSI which will detail compliance against the standard towards the end of the year.

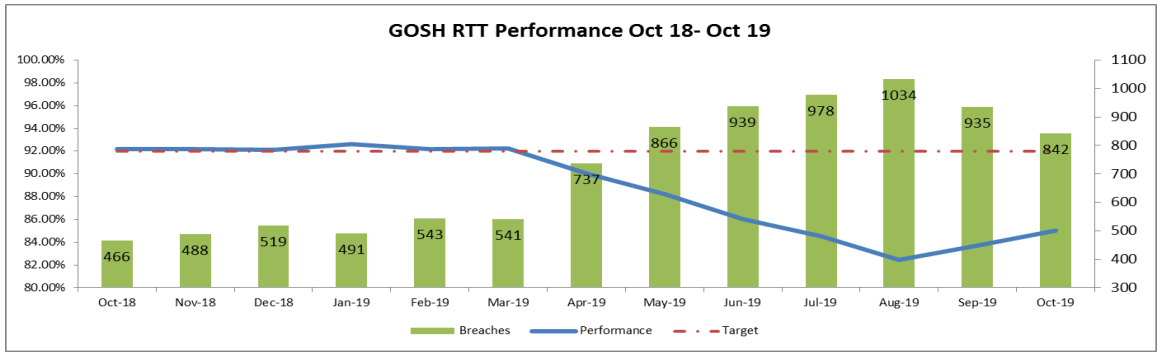
Cancer Wait Times

At the time of writing the report for the month of September 2019, no breaches against the cancer standards attributable to the Trust were reported, with performance being at 100%. Indicative performance for October projects compliance against all standards except 62 day consultant upgrade which currently being validated.

Responsive – Referral to Treatment

October 2019 Summary

- The Trust did not achieve the RTT 92% standard, submitting performance of 85.05%, with 842 patients waiting longer than 18 weeks, however an improvement of 1.3% from the previous month. EPIC of course is a contributing factor to this position at a speciality level, with the new processes in place but there are also other specialty specific issues affecting RTT performance. At the point of the EPIC go-live a decision was taken to reduce activity across outpatient services and theatres for patient safety reasons to ensure a smooth EPIC implementation, this has impacted future capacity availability.
- Dental/Maxfax relates to the loss of two consultants (retirement and maternity leave) leaving only one consultant within the service who can complete GA work. Plastic Surgery has also experienced a loss of consultant within a highly specialised service. Cardiac Surgery has experienced bed capacity issues due to the increase in volume of complex non-elective patients requiring 2:1 nursing. Orthopaedics is linked to utilisation, future loss of a consultant and specialisation. Also, the SDR service within Neurosurgery, which became NHS commissioned in July 2018 has resulted in significantly more demand than we have capacity to provide and as such has impacted on our RTT position.
- The Trust is currently reviewing all under achieving specialties and working with services to produce recovery plans and trajectories. The number of patients waiting 40 weeks+ has again increased to 84 patients in October (from 76 patients in September), primarily driven by the 52 week position.



52 Week Waits:

The Trust reported 16 patients waiting over 52 weeks in the following specialties:

Dental (9)- 3 patients are dated in November, 1 treated at Chelsea and Westminster and 4 require a date to be agreed.
ENT (1)- Joint surgery with the dental team, provisional TCI is being agreed.
Plastic surgery (2) – One patient booked for November, however, the family cancelled the TCI and have requested to be seen in January 2020. The second patient has also requested a January 2020 date
Neurosurgery (3)- One patient has TCI in February 2020 and 2 have TCI dates in March 2020
Endocrinology (1)- Patient has requested a date in January 2020

National Average Performance

GOSH is participating in the national pilot for RTT reporting which is proposing a shift to an average based standard.

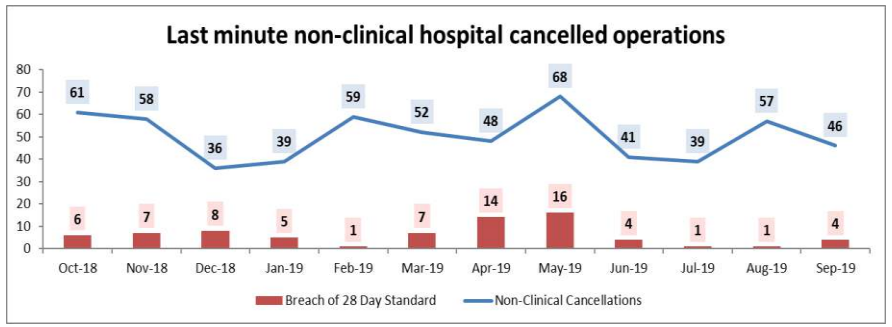
In terms of this standard for the month of October, the Trust has an average wait for an incomplete pathway of 9.41 weeks against a GOSH average standard of 8.1 weeks. This is an improvement from commencing the pilot in July, where the average wait for an incomplete pathway was 9.55 weeks.

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

Last minute non-clinical hospital cancelled operations:

Reported in the dashboard are the monthly breakdowns for this quarterly reportable indicator, with the latest available position for Q2.

For Q2, the Trust reported a decrease in the number of patients cancelled, with 142 patients cancelled compared to 157 in Q1 19/20. The areas contributing most to the monthly position are ENT (18), Dental & Max Fax (18), Surgery (17), Cardiac Surgery (16), Orthopaedics (14) and Plastic Surgery (9). The top three reasons recorded for the month are theatre list over run (43), ICU bed unavailable (25) and ward bed unavailable (22)



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

The Trust reported 6 last minute cancelled operations not readmitted within 28 days in Q2, a significant reduction compared to 34 in Q1 19/20). The areas contributing to the largest number of breaches are Cardiology (3), SNAPS (1), Rheumatology (1), Surgery (1) and Endocrinology (1).

Urgent operations cancelled for a second time

- This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.
- Since the start of the new financial year the Trust has reported no patient being cancelled for an urgent operation for the a second time.

Data Completeness – Mental Health Identifiers

Mental Health Identifiers: Data Completeness

The Trust is nationally required to monitor the proportion of patient accessing Mental Health Services that have a valid NHS number, date of birth, postcode, gender, GP practice and commissioner code. Within this area the Trust met the 97% standard with 97.84% of patients having valid data in October. However this was a slight decrease from September when the trust reported 95.66%. Work is ongoing with administrative teams to improve this position and implementing a more robust process for reconciling against nationally held records.

Mental Health: Ethnicity Completion - %

This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

The Trust has seen a significant improvement in collating ethnicity for patients accessing mental health services, with 69.94% in October having a valid ethnic code. This continues to be addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work. Capture of this data is now completed within the EPIC system.

Patients with a valid NHS Number

% of patients with a valid NHS Number Inpatients and Outpatients

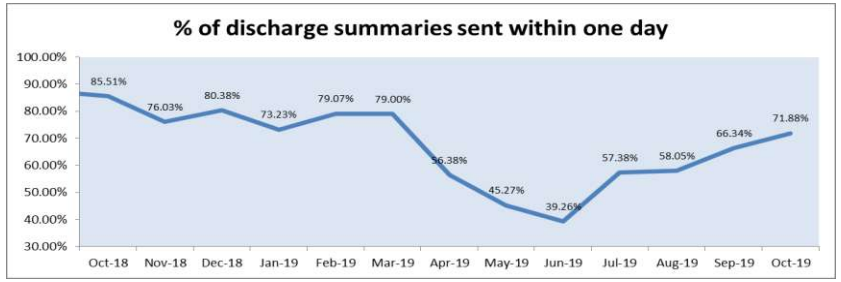
This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

Nationally the Trust is monitored against achieving 99% of patients having a valid NHS Number across all services being accessed. As the report depicts for both Inpatients and Outpatients this is below the standard, nationally the average for both indicators is above 99%. Work is continues to improve collating our patient's NHS number.

Effective – Discharge Summaries

October 2019 Summary

- Although not at the required standard of 100% compliance, considerable focus has been placed on this indicator by both the operational and clinical teams to improve compliance. For the month of October, 71.88% of patients who were discharged from GOSH received a discharge summary within 24 hours, a further improvement from the September position of 66.34%..
- This focus includes backlog clearance of discharge summaries and the embedding the completion of discharge summaries in real time into clinical practice. Compliance against the standard continues to be reported on a weekly basis though SLT and the weekly General Managers meeting. Significant improvement has been made in reduction of the backlog also, with no discharge summaries pre-dating September.
- 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

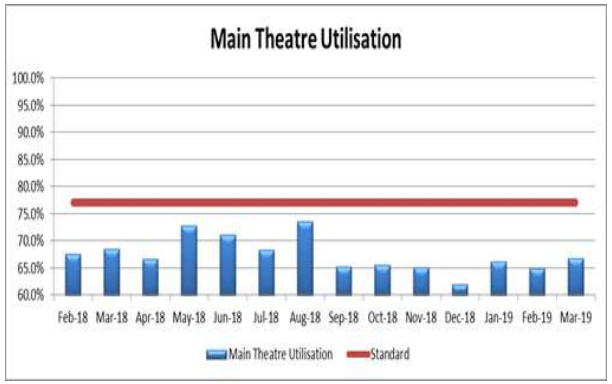
For October 2019, performance has significantly improved in relation to 7 day turnaround; 75.86% compared to 61.64% in September and 42.65% in May.

The EPR team have now rolled out the 'clinic letter not required' button within Epic, to specific services at a clinic level which can be used for specific patient appointments where a clinic letter will not be required for clinical reasons. In addition, additional training is being provided for Clinicians and Operational Managers around the process to ensure that everyone is aware of the process, presentation of the performance and backlog figures at the weekly at the Senior Leadership Team (SLT) meeting and targets set for improvement week on week and to be managed and flagged through the weekly PTL meetings, targeted support will be offered to individuals/services with poor metrics.

Productivity – Theatre Utilisation

The first cut of the theatre utilisation data has now been provided to the Directorate team and the outputs of this are currently in the process of being validated. Work continues on the development of a theatres dashboard which will allow the teams to track performance against a range of appropriate theatre indicators.

Work continues on targeting fully utilising lists and addressing delays with clerking and consenting of patients. However, it is expected that theatre utilisation will be impacted as EPIC stabilises and throughput returns to normal levels.



Bed Occupancy and Closures

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

Occupancy: Q2 occupancy was reported as 78.4%, a slight improvement from Q1 occupancy which was reported as 74.8%. Work is underway to produce the monthly breakdown for occupancy.

Bed closures: The average number of beds closed in October (61) was significantly higher than the number reported in September (47). The reasons for closures are linked to staffing and infestation on Sky. This was mainly due to Sky having an average of 9 beds closed over the month, Kingfisher having 8 beds closed and Hedgehog having 10 beds closed. NICU/PICU have experienced an average of 6 beds closed.

Trust Activity

Trust activity: October activity for day case remains below plan, while the level of activity for over night stays continues to track above the plan, although the level of activity across spells was more than last month. For outpatients the volume of attendances continues to track below plan although again there was a notable increase in activity compared to last month, reflecting the focus across teams to return outpatient activity to pre-Epic levels. Critical care bed days continue to track behind both plan and the previous month of activity.

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For the month of October, there were eight patients whose stay in hospital at point of discharge was over 100 days, accumulating 1,479 bed days in total.

Productivity – PICU Metrics

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

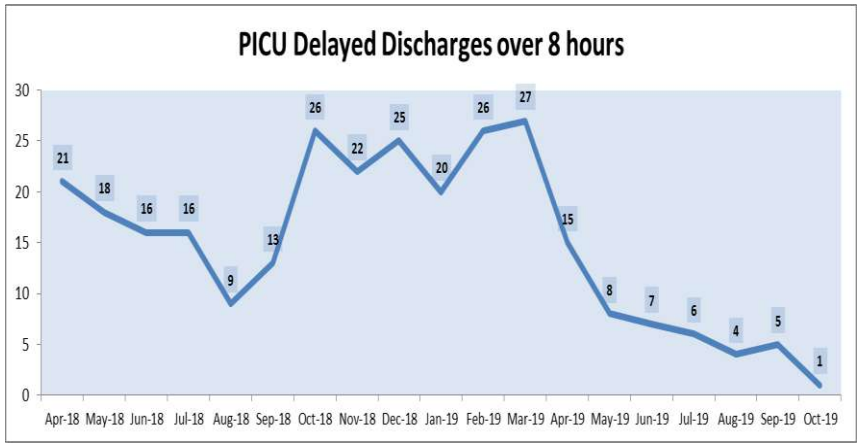
CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during September has increased to 18 from an August position of 2.

It should be noted that although The Trust has seen an improvement in the number of refusals, the Trust remains a national outlier. As part of the specialised services Quality Dashboard, a KPI is monitored on emergency admission refusals. It clearly shows the Trust refuses a higher percentage of patients than the national average, as demonstrated in the table below

Quarter	GOSH PICU/NICU/ CICU refusals	GOSH admission requests	GOSH % refused	National % refused
Q1 19/20	27	228	11.8	10.5
Q4 18/19	63	271	23.2	10.0
Q3 18/19	79	234	33.8	16.9
Q2 18/19	45	127	35.4	8.09
Q1 18/19	27	112	24.1	6.27

PICU Delayed Discharges:

Delayed discharges over 8 hours from PICU can demonstrate the challenges being faced internally and externally with regards to capacity issues on accessing beds. October has seen one patient delayed over 8 hours compared to 5 in September.



PICU Emergency Readmissions:

There were no readmissions back into PICU within 48 hours for the month of October, compared to one in September.

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Workforce Headlines

- **Contractual staff in post:** Substantive staff in post numbers in October were 4625.8 FTE which is a slight increase from September (4659 FTE), however this is 10 WTE lower than the same month last year.
- **Unfilled vacancy rate:** The Trust vacancy rate for October fell slightly to 8.1% from an August peak of 9.3% however while below target is well above the long term average. This is due to an increase in the budgeted establishment as well as a change to reporting of some unidentified Better Value costs. Trust vacancy rates have been below target since July 2017.
- **Turnover** is reported as voluntary turnover. Voluntary turnover has increased to 15.6%, which is above target and the same month last year. HR has established a Recruitment & Retention group, linking in with colleagues across the Trust to develop a retention plan, aligned to the existing Nursing retention collaborative work. The most common leaving reasons are Relocation and promotion. Total turnover (including Fixed Term Contracts) increased to 18.5% which is slightly above target and the highest since December 2017.
- **Agency usage** for October 2019 was 0.7% of total paybill, which is below the local stretch target, and is also well below the same month last year (1.1%). Human Resources Business Partners continue to work with the Directorates and corporate areas to address local pockets of agency usage. The target for 2019/20 remains 2% of total paybill. Bank % of paybill was 5%
- **Statutory & Mandatory training compliance:** In October the compliance rate across the Trust was 94%, which is well above the target with all directorates achieving target. Across the Trust there are 3 topics below target including Information Governance where the target is 95%. These non-compliant topics continue to be a focus of improvement.
- **Sickness absence** remains at 2.7%, and remains below target, and below the London average figure of 2.8%. The 2019/20 target remains 3%.
- **Appraisal/PDR completion** The non-medical appraisal rate has reduced slightly to 89% in October, achieving target for the first time this financial year. 8 of the 17 Directorates have achieved target. Consultant appraisal rates remain at 88% since August.

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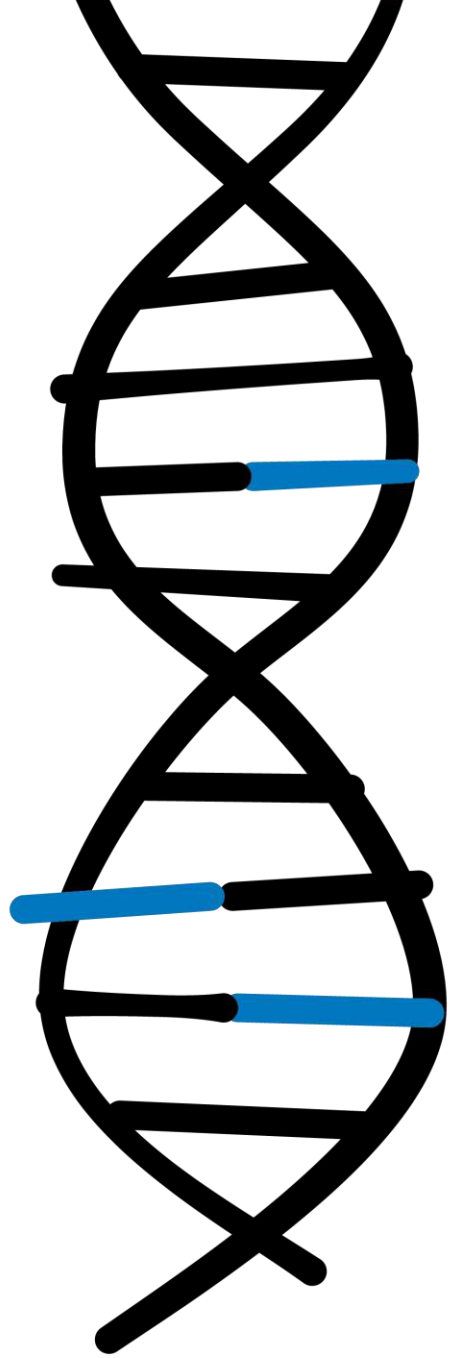
Trust KPI performance October 2019

Metric	Plan	October 2019	3m average	12m average
Voluntary Turnover	14%	15.6%	15.4%	15.0%
Sickness (12m)	3%	2.7%	2.6%	2.5%
Vacancy	10%	8.1%	8.5%	4.8%
Agency spend	2%	0.7%	0.7%	0.8%
PDR %	90%	89%	90%	85%
Consultant Appraisal %	90%	88%	89%	85%
Statutory & Mandatory training	90%	94%	94%	93%

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



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Directorate (Clinical) KPI performance October 2019

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP
Voluntary Turnover	14%	15.6%	12.2%	15.5%	15.6%	17.1%	15.0%	13.0%	14.2%	16.6%
Sickness (12m)	3%	2.7%	2.4%	2.4%	2.1%	3.0%	2.2%	3.3%	3.8%	5.4%
Vacancy	10%	8.1%	-6.0%	4.2%	4.2%	3.7%	-1.5%	-1.4%	9.1%	15.8%
Agency spend	2%	0.7%	0.0%	0.1%	0.0%	0.2%	1.4%	-0.4%	0.8%	0.0%
PDR %	90%	89%	89%	88%	90%	89%	83%	89%	99%	89%
Stat/Mand Training	90%	94%	92%	93%	95%	92%	95%	96%	98%	93%

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

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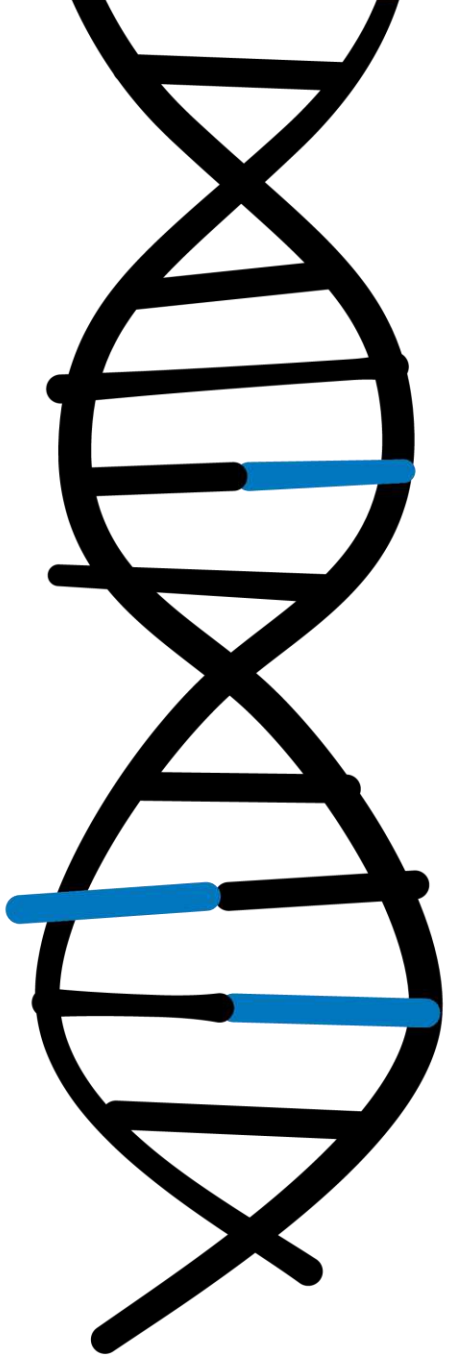
Directorate (Corporate) KPI performance October 2019

Metric	Plan	Trust	Clinical Operations	Corporate Affairs	DPS	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation
Voluntary Turnover	14%	15.6%	14.1%	32.3%	12.5%	20.3%	19.5%	32.4%	16.9%	28.7%
Sickness (12m)	3%	2.7%	1.3%	0.0%	3.0%	1.1%	5.4%	1.1%	2.2%	1.9%
Vacancy	10%	8.1%	35.5%	3.3%	4.2%	27.4%	2.1%	25.7%	9.3%	62.6%
Agency spend	2%	0.7%	1.4%	0.0%	4.1%	12.0%	3.8%	0.0%	0.0%	0.3%
PDR %	90%	89%	89%	100%	96%	91%	91%	78%	89%	91%
Stat/Mand Training	90%	94%	98%	100%	94%	98%	99%	96%	97%	97%

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



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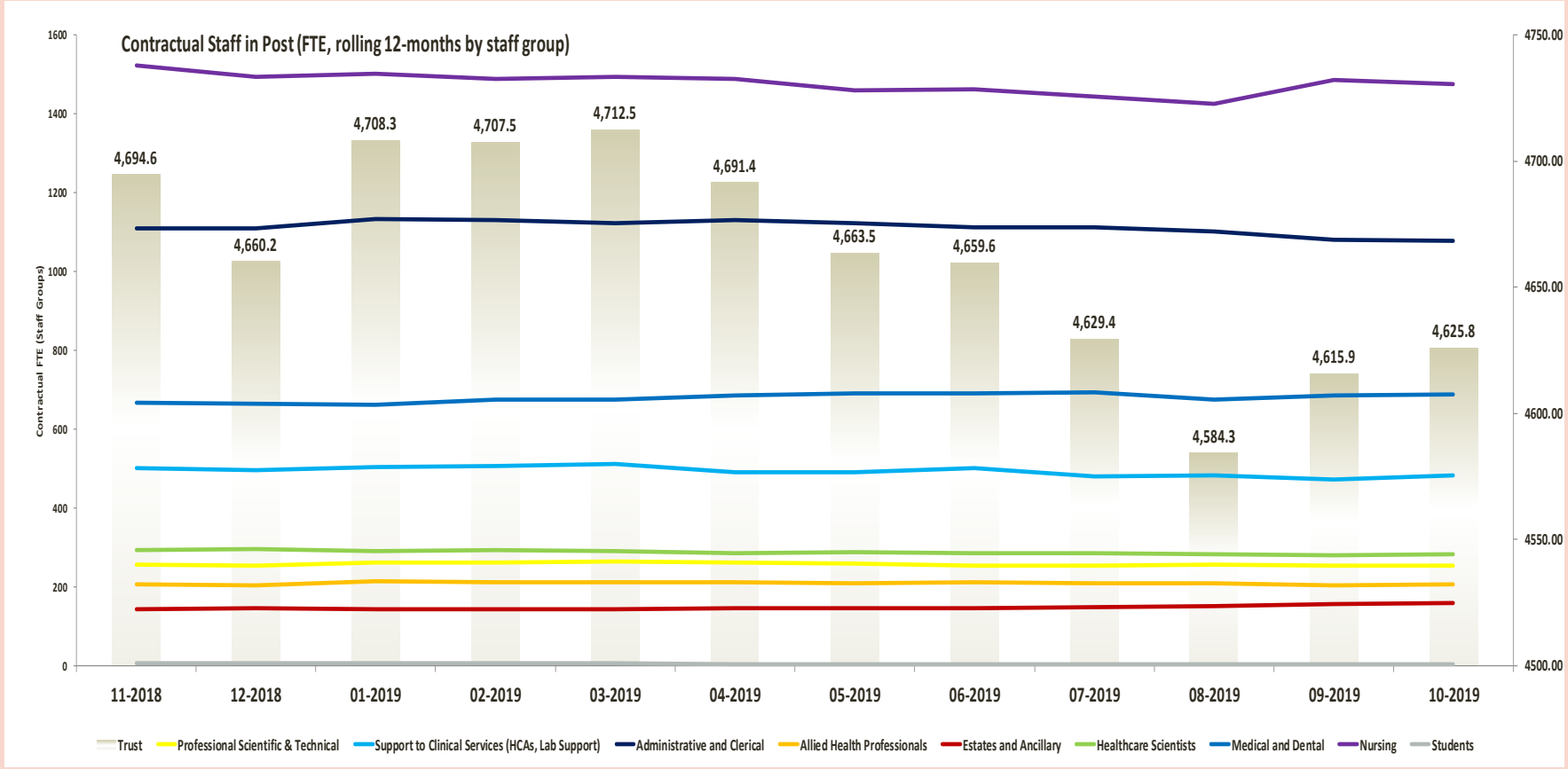
Substantive staff in post by staff group



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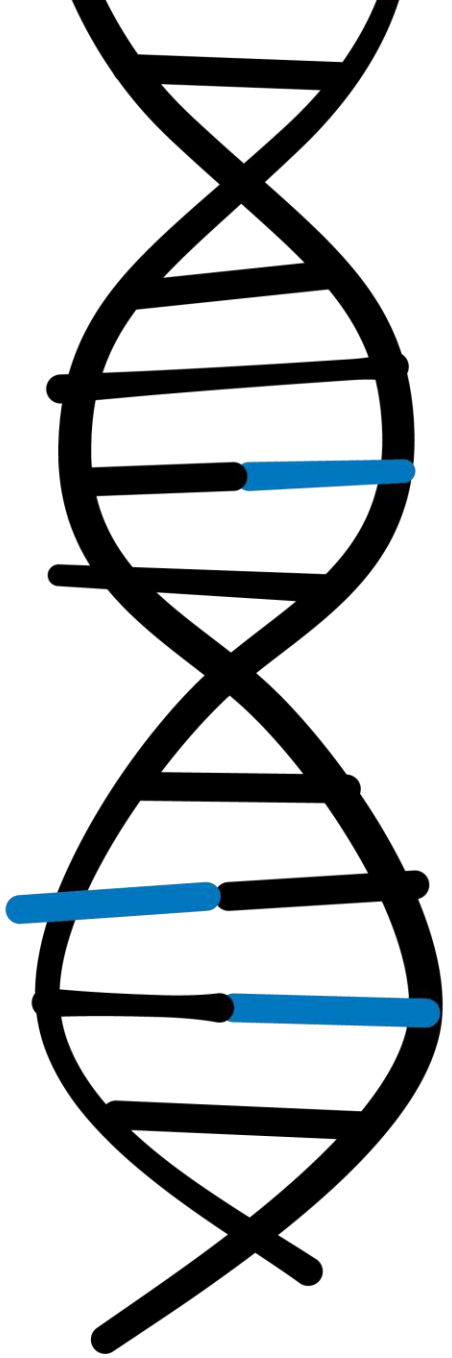
Workforce: Stat Mand Training Focus

- The Trust continues to perform well with Statutory & Mandatory training with rates of 94%
- Across the 30 topics, 27 (90%) are achieving target with 3 not yet achieving target although 2 of the 3 topics are within 10% of compliance.
- All Directorates are achieving at least 90% compliance, with 2 corporate areas at 100% compliance.
- Only the Medical and Dental staffgroup is below 90% compliance although more recently the rate of compliance has improved towards target.
- Safeguarding Children L3 and Resuscitation have been an area of focus in recent months and training rates for these topics are currently at 93% compliance.

Staffgroup	StatMand Training %
Add Prof Scientific & Technical	95%
Additional Clinical Services	95%
Administrative & Clerical	97%
Allied Health Professionals	97%
Estates & Ancillary	94%
Healthcare Scientists	97%
Medical and Dental	88%
Nursing & Midwifery Registered	94%

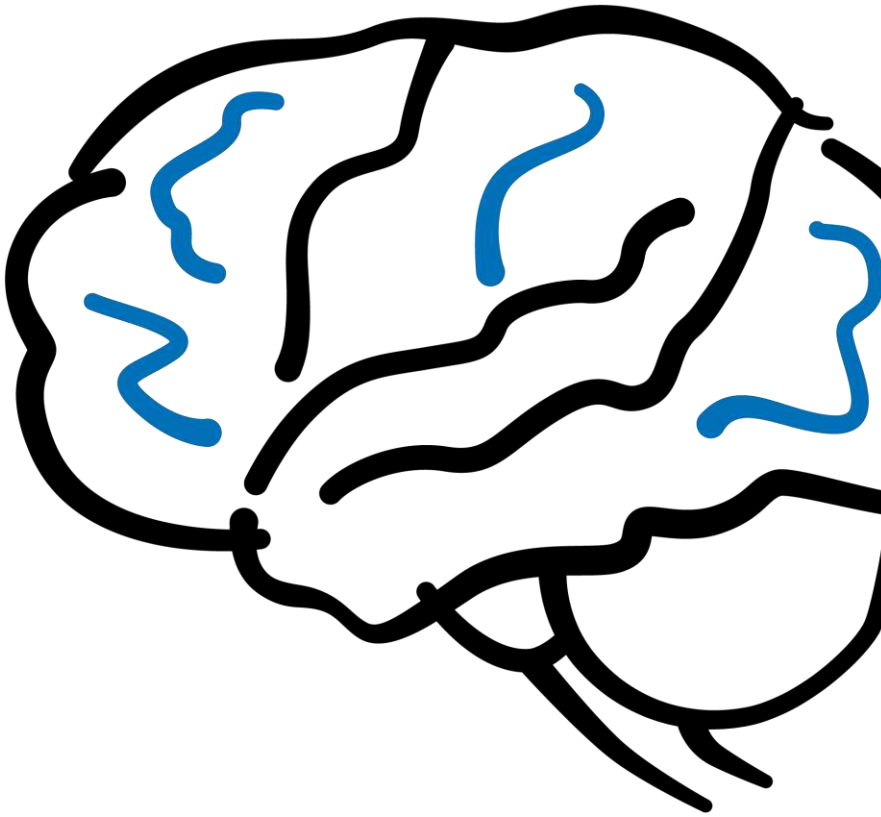


Our Money

Summary

This section of the IPR includes the position for October 2019 (Month 7). In line with the figures presented, the Trust has a Month 7 Control Total deficit of £0.6m which is £0.1m behind plan, this includes £1.7m of 2019/20 PSF funding. The Trust is generating a Month 7 net deficit of £97.8 which is £0.2m ahead of plan and includes an additional PSF payment relating to 2018/19 of £0.4m.

- Clinical Income (exc. International Private Patients and Pass through Income) is £0.5m lower than plan
- Non Clinical revenue is £0.8m lower than plan
- Private Patients income is £3.2m lower than plan
- Staff costs are £5.1m lower than plan
- Non-pay costs (excluding pass-through costs) are £0.8m above plan



Attachment X

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27 November 2019

Update on Children's Alliance Specialised Services Quality Dashboard (SSQD) benchmarking pilot **Submitted by:** Meredith Mora, Clinical Outcomes Development Lead	**Paper No: Attachment X**

Aims / summary
The Children's Alliance is a group of 11 hospitals in England that provide specialist paediatric care. This executive member group is self-organising, with a range of evolving work streams, including paediatric healthcare tariffs, models of care, and benchmarking.

GOSH has led on a benchmarking initiative involving Children's Alliance hospitals sharing their Specialised Services Quality Dashboard (SSQD) reports with one another, with the technical support of NHS England.

This paper provides an update on the progress of this benchmarking initiative.

Action required from the meeting

None – for information and comments.

Contribution to the delivery of NHS Foundation Trust strategies and plans
This document describes progress on a pilot in national paediatric benchmarking that is taking place in line with the Trust's strategic aim of excellence through the pursuit of peer benchmarking for improvement.

Financial implications
None

Legal issues
None

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
Specialty leads of the three specialties initially focused on have been consulted for their views on the most useful measures to compare from the dashboards. As the pilot expands, more staff will be consulted with as relevant to optimise the benefit of the initiative.

Who needs to be told about any decision?
Children's Alliance attending members of the GOSH executive team are updated on progress.

Who is responsible for implementing the proposals / project and anticipated timescales?
The coordination of the project is the responsibility of the Clinical Outcomes Development Lead, in partnership with relevant clinicians, and staff from each of the participating hospitals.

Who is accountable for the implementation of the proposal / project?
The identified leads of the project at each Trust are accountable for delivery locally.

Attachment X

Great Ormond Street Hospital for Children NHS Foundation Trust

Update on Children's Alliance SSQD Benchmarking Pilot Project

Background

The Children's Alliance (CA) is a group of 11 hospitals[1] in England that provide specialist paediatric care. The chair of the CA rotates and attendees are usually executive team members, in particular: CEOs, Chief Finance Officers, Chief Nurses and Medical Directors. The group is self-organising, with a range of evolving work streams, including paediatric healthcare tariffs, models of care, and benchmarking.

In 2016, GOSH led on a questionnaire of members about their data collection and reporting, to better understand what kind of benchmarking opportunities the CA could pursue as a group. Results from 100% completion by member showed that the one area of robust commonality that included outcomes data was submissions to the NHS England Specialised Services Quality Dashboards (SSQDs). All (at the time 10) member hospitals agreed to share their SSQD reports with one another.

GOSH worked with NHSE to achieve a technical solution to this, to ensure a sustainable electronic approach via its central portal.

Progress this year

May 2019

NHSE granted access to the SSQDs of the Children's Alliance Hospitals for staff identified within each organisation, coordinated by GOSH. Designated staff began to navigate the portal to view results.

August 2019

NHSE agreed a total of **three** staff per CA organisation can have access to CA hospitals' SSQDs during the pilot period of the project. Eight hospitals have three staff able to access the dashboards; two hospitals have two staff assigned.

On 30th August, GOSH hosted a national meeting attended by CA hospital staff members with access to the dashboards and by NHSE staff. The meeting covered the background of the pilot and practical aspects including process and key elements of an ideal benchmarking framework. A live

[1] Alder Hey Children's NHS Foundation Trust, Birmingham Women's and Children's NHS Foundation Trust, Central Manchester University Hospitals NHS Foundation Trust, Great Ormond Street Hospital for Children NHS Foundation Trust, Guy's and St Thomas's NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, Sheffield Children's NHS Foundation Trust, The Newcastle upon Tyne Hospitals NHS Foundation Trust, University Hospitals Bristol NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust, and recently, Oxford University Hospitals NHS Foundation Trust

demonstration was also given by NHSE, which allowed for more detailed questions about the portal interface.

The group agreed to focus on Rheumatology and one other dashboard (to be voted on) to begin to develop an ideal benchmarking framework. They also agreed to exclude 'All Ages' dashboards as these will not be comparable when viewing paediatric centres, and hospitals that provide both adult and paediatric care.

October 2019

By majority, the Neurosurgery dashboard is confirmed by the group to initially compare. PICU has also been added as it is reported by 10/10 hospitals (Rheum & Neurosurgery are reported by 9/10).

	Alderhey	Birmh'm	Mancs	GOS	Evelina	Leeds	Sheff	Newcas	Bristol	S'hampt	Notes
Rheumatology	Y	Y	Y	Y	Y	Y	Y	Y	Y		Agreed as a first dashboard to test benchmarking.
Neurosurgery	Y	Y	Y	Y		Y	Y	Y	Y	Y	Useful process measures as well as core outcomes and patient experience.
PICU	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	This data is quarterly and includes a summary version of what's submitted to PICANet, so useful to compare.

Next steps

Each hospital representative to ask their Rheumatology, Neurosurgery and PICU clinical leads to:

- identify the measures in their SSQD that they find most meaningful
- seek confirmation from our clinical leads / data managers of how they interpret any unclear measures, to understand more any differences in reporting we may find
- Share this information within the group for GOSH to coordinate next steps and for NHSE to have this key information from providers that may be useful in clarification of any operational definitions of measures

The next pilot working group meeting will take place at Evelina in mid-December.

Meredith Mora, Clinical Outcomes Development Lead, GOSH
15 November 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27 November 2019

Month 7 2019/20 Finance Report **Submitted by:** **Helen Jameson, Chief Finance Officer**	**Paper No: Attachment Y** **Attachment Finance Report M07**

Key Points to take away

1. The Trust is required to achieve an overall control total that is agreed with NHSI annually. The Trust is £0.1m adverse to the control total YTD at Month 7; this is principally due to underperformance in private patient income being partially offset by vacancies across the organisation.

2. The Trust is behind its income target by £4.5m (excluding pass through) at Month 7. Private patient income has improved since the start of the year but fell in month compared to Month 6 and is now £3.2m behind plan YTD. NHS Clinical Income that is not on block contract is behind plan by £1.0m.

3. Pay is underspent YTD by £5.1m due to the high number of vacancies across the Trust that are not being covered by equivalent Bank or Agency and reduced research costs (offset by income)

4. Non pay is £0.8m above plan YTD (excluding pass through). This is due to increased expenditure on clinical supplies, increased computer software costs and premise costs associated with the new buildings. These costs are being partly offset by reduced private patient debt releasing impairment to receivables.

5. Cash held by the Trust is higher than plan by £25.3m which included £6.7m received in month from GOSH charity (of which £3.7m related to ZCR and £2.3m related to Capital projects) and £8.2m received earlier in the year which related to PSF for 2018/19.

Introduction

This paper reports the Trust's Financial Position as at the end of October 2019 (Month 7). The Trust is required to achieve an overall control total breakeven (excluding PSF) for the year which is a decrease from 2018/19. Due to reductions in income tariffs and additional costs associated with new buildings the Trust must deliver a Better Value program of £20m.

The Trust is currently £0.1m behind its YTD control total of a £2.3m deficit in M7 (excluding PSF payments). In Month 7 the Trust delivered a financial position that was £1.0m behind the in month control total of a £2.6m surplus. The Trust is forecasting that the control total will be met and therefore the PSF of 3.8m will be achieved.

The Trust delivered £6.1m (£3.7m recurrently) YTD of the Better Value programme target of £8.9m with the remainder being covered by non-recurrent pay vacancies. Work is being undertaken to review how these non-recurrent savings can be maintained throughout the year.

Financial Position – Summary Points

NHS & other clinical revenue (excluding pass through) is adverse to plan by £0.5m YTD. The majority of services are under a block contract arrangement so the underperformance relates to those services remaining on a cost and volume contract and is due to a

combination of lower levels of activity and depth of coding. The Trust is working through the impact of the coding changes brought about via the implementation of EPIC.

Private patient income is behind plan by £3.2m due to reduced activity from reduced levels of demand across Q1. Private patient income has risen in Q2 but fell again in Month 7 and was £0.8m below a target of £6.3m. The Trust agreed to an increase to the PICU/NICU activity in the IPP plan for 2019/20. While this is being implemented, demand has not emerged in line with plan.

Non-clinical income is £0.8m behind plan YTD relating to the timing of spend on approved charity funded projects and research grants. The improvement in month has been due to increased income from research grants which is offset by expenditure.

Pay is underspent by £5.1m YTD and £0.2m in month. The key contributors to this underspend are the number of vacancies across the organisation that not currently being backfilled by agency and bank. The Trust is currently below the NHSI agency cost ceiling that it agrees as part of its annual plan and is forecasting to be below this by year end. Some of the pay underspends relate to the delays in charitable funded projects and reduced research costs; both of these are offset by reduced income. In month pay increased due to pension auto-enrolment which put staff who had opted out of the pension scheme back in increasing the Trust pension contributions. The Trust also saw a one off cost from a change in the treatment of local CEAs.

Non-Pay expenditure (excluding pass through) is £0.8m behind pan YTD. The increased expenditure in month is driven by increased clinical supplies and IT costs associated with EPIC implementation. These are being partly offset by work undertaken by the Trust which has resulted in payment of private patient debt which has resulted in the reduction for the provision for the impairment of receivables of £1.4m YTD

Financial Forecast – Summary Points

The Trust is currently forecasting to deliver plan. Private patient income is forecast to be £5.5m below plan and non-pay is forecast to be above plan by £1.9m being. These are being offset by forecast underspends of £7.7m on pay. These numbers are driven by reduced levels of activity across the organisation continuing into the second half of the year. NHS Clinical income not on block is forecast to improve in the second half of the year and end the year £0.4m above plan, this is due to changes to service provision agreed in year. The achievement of the Trust forecast is dependent on an increase in private patient income in the later months of the year and the achievement of additional better value schemes, without these the forecast breakeven position would be at risk.

Statement of Financial Position – Summary Points

<table>
<tr><th>Indicator</th><th>Comment</th></tr>
<tr><td>NHSI Financial Rating</td><td>The Trust overall metric score is a two which is in line with plan and an improvement on last month which was a three. One metric is now rated a three and is forecasted to improve throughout the year as the Trust moves from a deficit to a surplus position. The annual plan is for an overall score of one.</td></tr>
<tr><td>Cash</td><td>
<table>
<tr><th>Variance/movement</th><th>Cash variance vs plan YTD (£m)</th></tr>
<tr><td>EBITDA higher than plan</td><td>0.1</td></tr>
<tr><td>Interest Receivable – higher than plan</td><td>0.1</td></tr>
<tr><td>Inventories – higher than plan</td><td>(0.4)</td></tr>
<tr><td>Trade and Other Receivables – lower than plan</td><td>4.8</td></tr>
<tr><td>Trade and Other Payables - higher than plan</td><td>15.6</td></tr>
<tr><td>Other liabilities – lower than plan</td><td>(2.3)</td></tr>
<tr><td>Capital expenditure – lower than original plan</td><td>7.4</td></tr>
<tr><td>Cash variance to plan</td><td>25.3</td></tr>
</table>
</td></tr>
</table>

NHS Debtor Days	NHS Debtor days in month are 16 days which is in line with the plan. This is because the majority of the Trust's NHS invoices by value relate to contractual monthly SLA payments which are settled on the 15th of each month.
IPP Debtor Days	IPP debtor days increased from 198 to 203 days due to lower than average receipts from embassies; however, the payments that were received related to older debt. This led to a reduction in bad debt provision.
Creditor Days	Creditor days remained at 35 days as work is still being undertaken to settle the pharmacy invoice backlog.
Inventory Days	Drug inventory days cannot be calculated as the value of the pharmacy inventory is not available. Non-Drug inventory days decreased from 54 days to 74 days.

Action required from the meeting

- To **note** the Month 7 Financial Position

Contribution to the delivery of NHS Foundation Trust strategies and plans

The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.

Financial implications

The Trust has not achieved its control total in month by £0.9m and is £0.1m adverse to the YTD control Total. The Trust is forecasting to receive the Q3 PSF this will not occur if the control total is not met. The PSF is back ended with increased amounts owing each Quarter. The Trust has released £0.4m of the £1.0m contingency.

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

Chief Finance Officer / Executive Management Team.

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

Chief Finance Officer.

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance and Workforce Performance Report Month 7 2019/20

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Cash, Capital and Statement of Financial Position Summary	10

Trust Performance Summary for the 7 months ending 31 Oct 2019

KEY PERFORMANCE DASHBOARD

Great Ormond Street Hospital for Children NHS Foundation Trust

ACTUAL FINANCIAL PERFORMANCE

	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME incl. pass-through	£43.7m	£43.1m		£285.2m	£286.2m	
PAY	(£24.0m)	(£23.8m)		(£169.3m)	(£164.2m)	
NON-PAY incl. pass-through, owned depreciation and PDC	(£17.1m)	(£17.7m)		(£118.2m)	(£124.3m)	
CONTROL TOTAL excl. PSF	£2.6m	£1.6m		(£2.3m)	(£2.4m)	

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

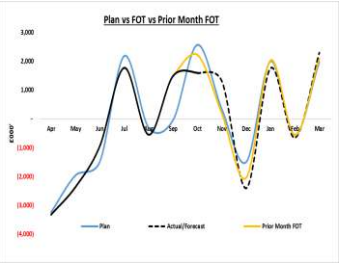
AREAS OF NOTE:

As at the end of Month 7, the Trust position is adverse to the planned control total (£0.1m). NHS and other clinical income is favourable (£0.6m) in month associated with activity not covered by the block and pass through activity is above plan (£2.0m) due to new drugs approved in year. Pay costs in month increased due to the Trust Pension auto-enrolment which has put staff who had opted out of the pension back in increasing the Trust pension contribution payment. Pay YTD (£4.9m) is behind plan due to the vacancies across the organisation not being covered by bank or agency staff. Non-pay is adverse to plan (£0.4m) due to write offs associated with capital project scoping costs and increased costs of supplies. Private patient income was down in month (£0.8m) which is offset by payment of private patient debt that has resulted in the reduction in month for the provision for the impairment of receivables (£0.7m). The Trust has received £0.4m of PSF monies relating to a 2018/19 PSF reallocation post accounts. This was not included in the annual plan and does not contribute to the control total.

FORECAST FINANCIAL PERFORMANCE

	Plan (£m)	Forecast (£m)	Var (£m)	RAG
INCOME incl. pass-through	£488.4m	£496.0m	£7.6m	
PAY	(£289.2m)	(£281.5m)	£7.7m	
NON-PAY incl. pass-through, owned depreciation and PDC	(£199.2m)	(£214.5m)	(£15.3m)	
CONTROL TOTAL excl. PSF	£0.0m	£0.0m	£0.0m	

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



AREAS OF NOTE:

The Trust is forecasting a year end position that breaks even with the Trust control total. The forecast is compiled from each individual directorate forecast from across the organisation. The forecast incorporates an improvement in the private patient income for the later part of the year to a total respective outturn of £64.3m. Pay is forecast to continue to underspend throughout the rest of the year ending the year £7.1m underspent. This is due to continued vacancies across the organisation and vacancy control processes that ensures posts are recruited to as appropriate. The forecast is being updated on a monthly basis and a review is undertaken each month to look at how the forecast has moved each month. The in month position excluding the reduction of the impairment for receivables is £0.6m behind the month 6 forecast for October.

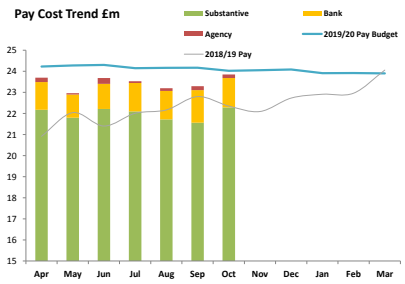
PEOPLE

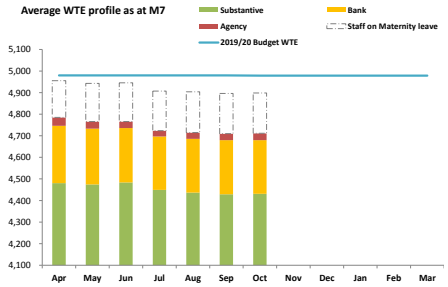
	M7 Plan Av. WTE	M7 Actual Av. WTE	Variance
PERMANENT	4,630.3	4,430.9	199.4
BANK	292.8	249.0	43.8
AGENCY	56.5	31.6	24.9
TOTAL	**4,979.6**	**4,711.5**	**268.1**

AREAS OF NOTE:

The pay costs have risen in absolute terms from last year due to the AfC and medical pay awards along with the one-off non-consolidated AfC payments in Month 1. As part of budget setting, the establishment was reviewed and set in line with the Trust bed base.

Pay is up in month due to the auto-enrolment to the pension this month which increased the Trust pension contribution. The Pay bill YTD is still below plan due to the vacancies across the organisation. The WTE excludes 190.6 average contractual WTE's on maternity leave within the Trust. The actual bank and agency usage is currently below plan (and below the agency ceiling set by NHSI).



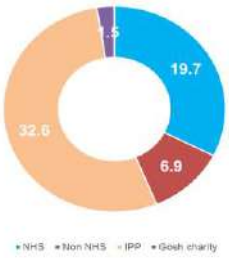


CASH, CAPITAL AND OTHER KPIs

Key metrics	Plan	Actual
Cash	£40.0m	£65.3m
IPP Debtor days	120	203
Creditor days	30	35
NHS Debtor days	30	16

Capital Programme	YTD Plan M7	YTD Actual M7	Full year plan	Full Year F'cst
Total Trust-funded	£8.4m	£9.7m	£17.5m	£20.7m
Total Donated	£29.8m	£20.6m	£44.8m	£32.2m
Grand Total	£38.2m	£30.3m	£62.3m	£52.9m

Net receivables breakdown (£m)



NHSI metrics	Plan M7	Actual M7
CAPITAL SERVICE COVER	2	2
LIQUIDITY	1	1
I&E MARGIN	3	3
VAR. FROM CONTROL TOTAL		1
AGENCY	1	1
TOTAL	2	2

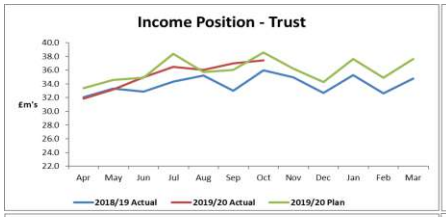
AREAS OF NOTE:

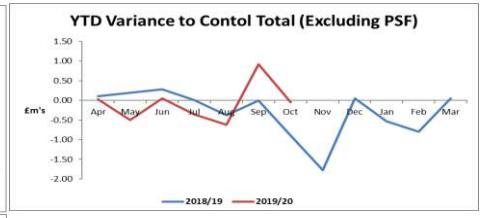
1. Cash held by the Trust is higher than plan by £25.3m which included £6.7m received in month from GOSH charity (of which £3.7m related to ZCR and £2.3m related to Capital projects) and £8.2m received earlier in the year which related to PSF for 2018/19.
2. The capital programme is behind the plan by £7.9m at M07; of this Trust-funded is £1.3m ahead of plan and donated £9.2m behind. Trust-funded is ahead due to recognition of EPR licence charges payable in future periods. There is slippage on the Trust-funded Estates and IT programmes; and on the donated Redevelopment and Medical Equipment programmes.
3. IPP debtors days increased in month from 198 days to 203 days. IPP receipts in month were lower than the previous month at £5.8m (£7.8m in M06). Total IPP debt increased in month to £32.6m (£31.0m in M06), however overdue debt decreased in month to £25.3m (£26.7m in M06).
4. Creditor days remained the same as the previous month at 35 days.
5. NHS debtor days remained the same as the previous month at 16 days.
6. NHS metric are overall rated at a 2 which is on plan.

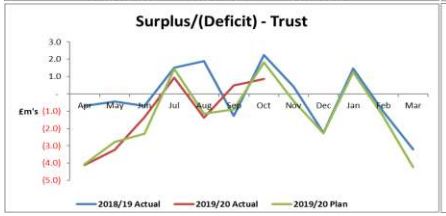
Trust Income and Expenditure Performance Summary for the 7 months ending 31 Oct 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

2019/20											Notes	2018/19	CY vs PY	
Annual Budget	Income & Expenditure	Month 7				Year to Date				Rating		YTD Actual	Variance	
		Budget	Actual	Variance		Budget	Actual	Variance		YTD Variance				
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			(£m)	(£m)	%
296.47	NHS & Other Clinical Revenue	26.43	25.83	(0.60)	(2.27%)	172.75	172.23	(0.52)	(0.30%)	R	1	164.70	7.53	4.57%
59.94	Pass Through	5.49	6.05	0.56	10.20%	35.34	40.80	5.46	15.45%			36.60	4.20	11.48%
69.76	Private Patient Revenue	6.33	5.57	(0.76)	(12.01%)	40.79	37.57	(3.22)	(7.89%)	R	2	37.50	0.07	0.19%
62.25	Non-Clinical Revenue	5.46	5.65	0.19	3.48%	36.37	35.58	(0.79)	(2.16%)	R	3	38.60	(3.02)	(7.82%)
488.42	**Total Operating Revenue**	**43.71**	**43.10**	**(0.61)**	**(1.40%)**	**285.25**	**286.18**	**0.93**	**0.33%**	G		**277.40**	**8.78**	**3.17%**
(272.88)	Permanent Staff	(22.76)	(22.28)	0.48	2.11%	(158.81)	(153.85)	4.96	3.12%			(142.70)	(11.15)	(7.81%)
(3.48)	Agency Staff	(0.29)	(0.17)	0.12	41.38%	(2.03)	(1.12)	0.91	44.83%			(1.60)	0.48	30.00%
(12.81)	Bank Staff	(0.98)	(1.39)	(0.41)	(41.84%)	(8.47)	(9.24)	(0.77)	(9.09%)			(9.30)		0%
(289.17)	**Total Employee Expenses**	**(24.03)**	**(23.84)**	**0.19**	**0.79%**	**(169.31)**	**(164.21)**	**5.10**	**3.01%**	G	4	**(153.60)**	**(10.61)**	**(6.91%)**
(13.80)	Drugs and Blood	(1.24)	(1.13)	0.11	8.87%	(8.09)	(7.75)	0.34	4.20%	G		(7.50)	(0.25)	(3.33%)
(44.13)	Other Clinical Supplies	(3.70)	(4.11)	(0.41)	(11.08%)	(26.23)	(26.15)	0.08	0.30%	G		(24.40)	(1.75)	(7.17%)
(62.50)	Other Expenses	(5.09)	(5.15)	(0.06)	(1.18%)	(37.70)	(38.88)	(1.18)	(3.13%)	R		(37.90)	(0.98)	(2.59%)
(59.94)	Pass Through	(5.49)	(5.69)	(0.20)	(3.64%)	(35.34)	(40.81)	(5.47)	(15.48%)			(36.40)	(4.41)	(12.12%)
(180.37)	**Total Non-Pay Expenses**	**(15.52)**	**(16.08)**	**(0.56)**	**(3.61%)**	**(107.36)**	**(113.59)**	**(6.23)**	**(5.80%)**	R	5	**(106.20)**	**(7.39)**	**(6.96%)**
(469.54)	**Total Expenses**	**(39.55)**	**(39.92)**	**(0.37)**	**(0.94%)**	**(276.67)**	**(277.80)**	**(1.13)**	**(0.41%)**	R		**(259.80)**	**(18.00)**	**(6.93%)**
18.88	**EBITDA (exc Capital Donations)**	**4.16**	**3.18**	**(0.98)**	**(24%)**	**8.58**	**8.38**	**(0.20)**	**(2.30%)**	A		**17.60**	**(9.22)**	**(52.38%)**
(18.88)	Owned depreciation, Interest and PDC	(1.60)	(1.59)	0.01	0.81%	(10.85)	(10.71)	0.14	1.31%		7	(9.52)	(1.19)	(12.50%)
0.00	**Control Total (exc. PSF)**	**2.56**	**1.60**	**(0.97)**	**(37.71%)**	**(2.28)**	**(2.33)**	**(0.05)**	**(2.39%)**					
3.76	PSF	0.38	0.38	0.00	(200.00%)	1.69	1.69	0.00	(100.00%)					
3.77	**Control total**	**2.94**	**1.97**	**(0.97)**	**(32.89%)**	**(0.58)**	**(0.64)**	**(0.05)**	**(9.33%)**	R		**8.08**	**(8.72)**	**(107.89%)**
0.00	PY PSF post accounts reallocation	0.00	0.00	0.00		0.00	0.35	0.35						
(13.07)	Donated depreciation	(1.13)	(1.11)	0.02	1.50%	(7.34)	(7.46)	(0.12)	(1.67%)			(6.48)	(0.98)	(15.12%)
(9.30)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**1.81**	**0.86**	**(0.95)**	**(52.49%)**	**(7.92)**	**(7.75)**	**0.17**	**2.15%**			**1.60**	**(9.70)**	**(606.06%)**
(5.50)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%			0.00	0.00	0%
46.72	Capital Donations	3.82	2.17	(1.65)	(43.19%)	33.54	20.59	(12.95)	(38.61%)		6	21.90	(1.31)	(5.98%)
31.92	**Adjusted Net Result**	**5.63**	**3.03**	**(2.60)**	**(46.18%)**	**25.62**	**12.84**	**(12.78)**	**(49.88%)**			**23.50**	**(11.01)**	**(46.84%)**







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

Summary

- The Trust in month position is adverse to plan (£1.0m) with a YTD adverse position to the control total (£0.1m). Private patient income is below plan YTD (£3.2m). Pay is underspent (£5.1m).
- The Trust position includes PSF funding for months 1-7 (£1.7m) and an additional bonus payment relating to 2018/19 of £0.3m (excluded from the control total).

Notes

1. NHS & other clinical revenue (excluding pass through) is adverse to plan YTD (£0.5m).
2. Private Patient income in month is adverse to plan (£0.8m) due to a fall in activity, income has fallen £0.9m compared to M6. The YTD position is behind plan (£3.2m) which is due to lower demand across a number of specialities.
3. Non-clinical income is adverse to plan (£0.8m) due to timing of research studies against plan.
4. Pay is favourable to plan (£5.1m) due to vacancies across the Trust. The Trust use of agency is forecast to be £2.6m which is below plan and the agency ceiling set by NHSI. In month pay has increased due to pension auto-enrolment which put all staff into the pension and increased the Trust pension contribution.
5. Non pay (excluding pass through) is adverse to plan YTD (£0.8m) due to the IT spend within relating to the EPIC implementation partially offsets by drugs costs. In month Private patient debt was paid in month which resulted in the reduction for the provision for the impairment of Receivables (£0.7m)
6. Income from capital donations is lower than plan YTD due to slippage in capital projects (£12.9m).

Trust Income and Expenditure Forecast Outturn Summary for the 7 months ending 31 Oct 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

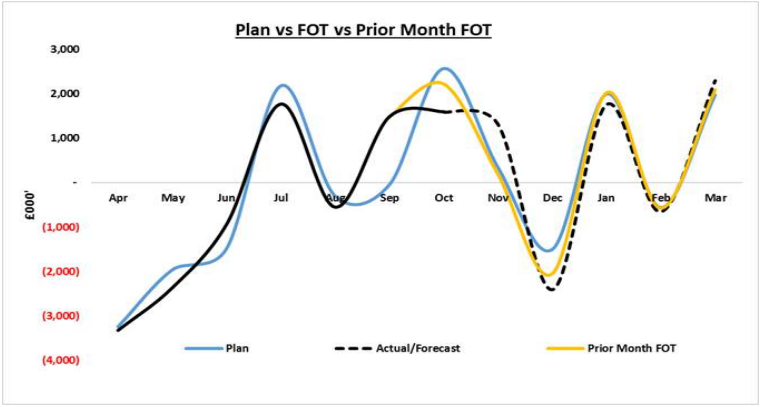
Full Year Actual 2018/19 (£m)	31 Oct 2019 Income & Expenditure	Annual Budget (£m)	Internal Forecast Full-Yr (£m)	Variance to Plan (£m)	Variance to Plan %	Rating Forecast Variance to plan	Notes
288.61	NHS & Other Clinical Revenue	296.47	296.91	0.44	0.15%	G	1
62.40	Pass Through	59.94	73.44	13.50	18.39%		
62.19	Private Patient Revenue	69.76	64.29	(5.47)	(8.51%)	R	2
74.43	Non-Clinical Revenue	62.25	61.40	(0.85)	(1.38%)	R	
487.63	**Total Operating Revenue**	**488.42**	**496.04**	**7.62**	**1.54%**		
(250.05)	Permanent Staff	(272.88)	(264.59)	8.29	(3.13%)		
(2.74)	Agency Staff	(3.48)	(2.55)	0.93	(36.58%)		
(15.84)	Bank Staff	(12.81)	(14.38)	(1.57)	10.89%		
(268.63)	**Total Employee Expenses**	**(289.17)**	**(281.51)**	**7.66**	**(2.72%)**	G	3
(11.88)	Drugs and Blood	(13.80)	(13.56)	0.24	(1.80%)	G	
(43.37)	Other Clinical Supplies	(44.13)	(43.01)	1.12	(2.60%)	G	
(66.77)	Other Expenses	(62.50)	(65.79)	(3.29)	5.00%	R	
(62.92)	Pass Through	(59.94)	(73.44)	(13.50)	18.38%		
(184.94)	**Total Non-Pay Expenses**	**(180.37)**	**(195.79)**	**(15.42)**	**7.88%**	R	4
(453.57)	**Total Expenses**	**(469.54)**	**(477.30)**	**(7.76)**	**1.63%**	R	
34.06	**EBITDA (exc Capital Donations)**	**18.88**	**18.74**	**(0.14)**	**(0.77%)**	A	
(16.69)	Owned Depreciation, Interest and PDC	(18.88)	(18.73)	0.15	(0.79%)		
17.37	**Control Total (exc. PSF)**	**0.00**	**0.00**	**0.00**	**80.00%**		
0.00	PSF	**3.76**	**3.76**	**0.00**			
17.37	**Control total**	**3.76**	**3.76**	**0.00**	**0.11%**	G	
0.00	PY PSF post accounts reallocation	0.00	0.35	0.35	100.00%		
(11.39)	Donated depreciation	(13.07)	(13.08)	(0.01)	0.11%		
5.98	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(9.30)**	**(8.97)**	**0.34**	**(633.33%)**		
(7.90)	Impairments	(5.50)	(5.50)	0.00	0.00%		
32.78	Capital Donations	46.72	32.17	(14.55)	(45.25%)		5
30.86	**Adjusted Net Result**	**31.92**	**17.70**	**(14.22)**	**(80.33%)**		

Summary

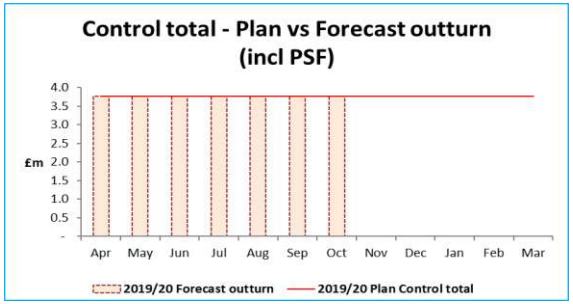
- The Trust is forecasting a year end position that breaks even with the Trust control total. This forecast is based a number of Better Value programmes coming online in the later part of the year including additional payment of private patient debt releasing impairment of receivables. if these do not come online there would be a risk in achieving the Forecast.
- A block contract has been agreed with NHSE for 2019/20 and is included in the NHS Clinical income and non clinical income numbers of the forecast.
- The current forecast shows the Trust position holding steady into November and deteriorating in December and remaining close to plan for the remainder of the year.

Notes

1. NHS Clinical income is forecast to be £0.4m favourable to plan which is driven by the additional activity agreed in year offset by lower than planned CCG activity and depth of coding following the implementation of EPIC. This is an improvement on the YTD position as newly commissioned services come on line in the second half of the year.
2. Pass through income is above plan (£13.5m) due to additional drugs agreed in year, this is offset by expenditure but is a significant increase and is a significant risk to the Trust if this over performance is not paid.
3. Private patient income is forecast to be £5.5m adverse to the plan which is a 2.4% growth from 2018/19 an improvement on last months forecast..
4. Pay is forecast to be £7.7m favourable to plan due to a number of vacancies across the organisation that are not currently being covered by temporary staffing. Vacancy control process is in place to ensure posts are recruited to as appropriate.
5. Non-pay (excluding pass through) is forecast to be £1.9m adverse at the year. This is related to additional ICT costs offset by additional better value and the release of impairment to receivables.
6. Capital Donations are forecast to be £14.6m below plan at the year end linked to the Trust Capital program.



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



2019/20 NHS Income for the 7 months ending 31 Oct 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

Organisation	Contract type	Annual plan (£m)	Income plan (£m)	Income actual (£m)	Income variance (£m)	RAG YTD Variance
NHS England	Block	274.25	159.84	159.84	0.00	G
	Pass through drugs	51.75	30.51	35.96	5.45	G
	Cost & volume	0.80	0.46	0.49	0.03	G
Total NHS England		326.79	190.82	196.29	5.47	G
CCG contracts	Block	13.01	7.57	7.82	0.26	G
CCG non contract activity	Cost & volume	6.26	3.64	2.04	(1.60)	R
All CCG	Pass through	5.05	2.98	3.41	0.44	G
Total CCGs		24.31	14.18	13.28	(0.91)	R
NHS Trusts	Cost & volume	0.13	0.07	0.12	0.06	G
Total NHS Clinical Income		351.23	205.07	209.69	4.62	G
Non NHS	Cost & volume	4.45	2.61	2.78	0.17	G
	Pass through	0.29	0.17	0.27	0.10	G
Overseas	Cost & volume	0.43	0.25	0.30	0.05	G
	Pass through	0.00	0.00	0.00	0.00	G
TOTAL CLINICAL INCOME		**356.41**	**208.09**	**213.04**	**4.94**	G

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

Summary

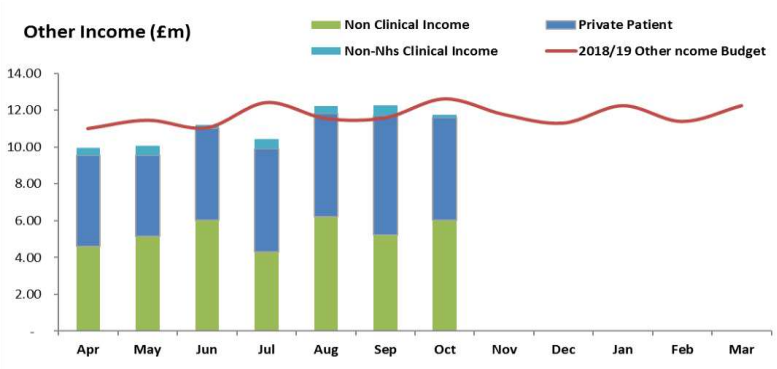
- Block contracts for activity have been agreed with NHS England for specialised commissioning and are in the process of being agreed with contracted CCGs, 91% of the CCGs have agreed their contracts this equates to £17.2m . This approach was adopted to mitigate the risk from the implementation of the new patient administration system, EPIC.
- Pass through income is being charged on a cost and volume basis for all commissioners except NHS England where drugs are on a cost and volume basis while pass through devices form part of the block contract.
- Income is favourable to plan by £4.94m that is largely due to increased pass through income (£5.45m for NHSE). The in month drugs value for October is based on an estimate (whilst the new reporting system is optimised) and may be subject to change when refreshed in November.
- The increased drugs costs for NHSE particularly from newly approved drugs increases the risk of non-payment owing to financial pressures in the system.
- There is a £1.6m year to date adverse variance for non contract activity. Due to the implementation Epic there are currently higher volumes of uncoded activity that is being priced at a historical average price and therefore the value for non contract and non NHS activity may increase or decrease when refreshed in November. Uncoded activity has however reduced on working day 1 by 36% between September and October and is expected to return to historic levels by the end of November.
- Analysis of the actual performance to the end of August versus the block for NHS England show the key area of underperformance is outpatients activity that is partially offset by increased non elective activity. The estimated impact of coding changes at the end of August post-Epic implementation for daycase, elective and non-elective activity for NHSE is c£1.4m. There is ongoing work to improve coding including detailed review and updates.

2019/20 Other Income for the 7 months ending 31 Oct 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

Other Income Summary

		Current month			Year to date			
	Annual plan (£m)	Plan (£m)	Actual (£m)	Variance (£m)	Plan (£m)	Actual (£m)	Variance (£m)	RAG YTD Variance
Private Patient	69.76	6.33	5.57	(0.76)	40.79	37.57	(3.22)	R
Non NHS Clinical Income	4.89	0.45	0.17	(0.28)	2.85	2.70	(0.15)	A
Non-NHS Clinical Income	**74.65**	**6.78**	**5.74**	**(1.04)**	**43.63**	**40.27**	**(3.36)**	R
Education & Training	8.01	0.73	0.80	0.07	4.65	4.90	0.25	G
Research & Development	26.28	2.22	2.25	0.03	15.37	15.48	0.11	G
Non-Patient Services	1.00	0.09	0.12	0.03	0.59	0.58	(0.01)	G
Commercial	1.61	0.15	0.12	(0.02)	0.94	0.81	(0.14)	A
Charitable Contributions	10.72	0.96	0.97	0.01	6.24	5.88	(0.36)	A
Other Non-Clinical	18.40	1.70	1.76	0.06	10.28	9.98	(0.29)	A
Non Clinical Income	**66.01**	**5.84**	**6.03**	**0.18**	**38.06**	**37.62**	**(0.44)**	A



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

Summary

- Private patient income YTD it is below plan by £3.2m due to lower than expected bed occupancy in earlier months of the year, caused by referrals rates into the Trust. The month 7 private patient income is £0.9m lower than month 6 and is £0.1m higher than was forecasted last month.
- Non-Clinical income is £0.4m behind plan YTD. Charitable contributions are £0.4m below plan in month due to the timing of costs associated with EPR optimisation and vacancies associate with posts funded by the charity.
- Other Non-Clinical income is £0.3m below plan in YTD due to reduced income from NHSE for clinical excellence awards.
- Within the month Research and Development income is above plan by £0.1m due to timing of research studies. This is offset by expenditure.

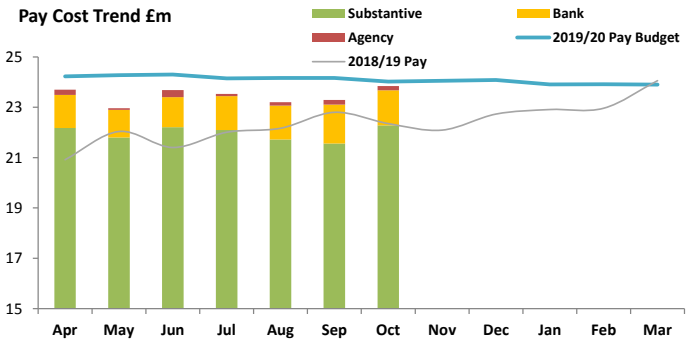
Workforce Summary for the 7 months ending 31 Oct 2019

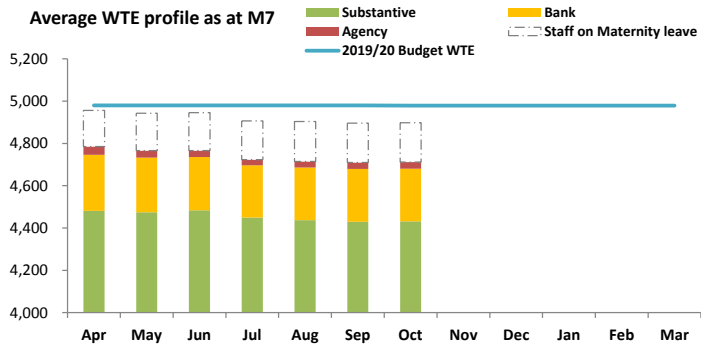
*WTE = **Worked WTE**, Worked hours of staff represented as WTE

Great Ormond Street Hospital for Children NHS Foundation Trust

£m including Perm, Bank and Agency	2019/20 plan			2019/20 actual			Variance				RAG
Staff Group	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Average WTE Vacancies	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	34.1	1,214.0	48.2	29.5	1,110.7	45.5	4.6	103.3	2.9	1.7	G
Consultants	31.6	368.0	147.2	31.5	349.4	154.4	0.1	18.7	1.6	(1.5)	G
Estates & Ancillary Staff	2.9	146.8	33.5	2.6	133.4	33.9	0.2	13.4	0.3	(0.0)	G
Healthcare Assist & Supp	5.8	305.9	32.3	5.3	280.9	32.1	0.5	25.0	0.5	0.0	G
Junior Doctors	16.2	381.9	72.7	16.3	341.5	81.8	(0.1)	40.4	1.7	(1.8)	A
Nursing Staff	48.3	1,623.6	51.0	46.7	1,524.7	52.5	1.6	98.9	2.9	(1.3)	G
Other Staff	0.3	10.0	55.5	0.3	9.2	52.5	0.0	0.8	0.0	0.0	G
Scientific Therap Tech	29.8	948.4	53.8	30.3	930.2	55.8	(0.5)	18.2	0.6	(1.1)	R
Total substantive and bank staff costs	**169.0**	**4,998.6**	**57.9**	**162.4**	**4,679.9**	**59.5**	**6.5**	**318.7**	**10.8**	**(4.2)**	G
Agency	2.0	56.5	61.6	1.1	31.6	60.9	0.9	24.9	0.8	0.1	G
Total substantive, bank and agency cost	**171.0**	**5,055.1**	**58.0**	**163.5**	**4,711.5**	**59.5**	**7.4**	**343.6**	**11.6**	**(4.2)**	G
Reserve*	(1.7)	(75.5)	0.0	0.7	0.0	0.0	(2.4)	(75.5)	(2.5)	0.2	R
Total pay cost	**169.3**	**4,979.6**	**58.3**	**164.2**	**4,711.5**	**59.7**	**5.1**	**268.1**	**9.1**	**(4.0)**	G
Remove Maternity leave cost				(2.2)			2.2			2.2	G
Total excluding Maternity Costs	**169.3**	**4,979.6**	**58.3**	**162.1**	**4,711.5**	**59.0**	**7.2**	**268.1**	**9.1**	**(1.9)**	G

*Plan reserve includes WTEs relating to the better value programme





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

Summary

- YTD pay spend is £164.2m which is £5.1m favourable to plan. The key contributor to the underspend is the number of vacancies across the organisation that are currently not being backfilled by bank or agency; this can be seen by the volume variance (£9.1m).
- The Trust has put in a bank and agency budget alongside the permanent workforce budget in line with the NHSI reporting requirements. The agency budget has been set below the agency ceiling and is currently underspent (£0.9m).
- The table above does not include 190.6 average contractual WTE for staff on maternity leave which have cost £2.2m YTD. If this cost is excluded then the average cost per WTE is higher than plan by £0.4k per WTE.
- The increased price variance is mainly being caused by the higher than planned cost of consultants and junior doctors. This is being offset by reduced numbers of staff.
- We are not expecting to breach the agency ceiling set by NHSI and the Trust is currently below the agency ceiling.
- Staff costs are forecast to end the year £7.7m below plan due to continued vacancies across the organisation not being filled by temporary staffing. In month costs are £0.6m higher than was forecast in M6.
- October pay costs are higher than previous months due to the Pension auto-enrolment for all staff that increased the Trust pension payments. The Trust also saw a one off hit from the local CEA awards due to the change in allocation of these awards form previous years.

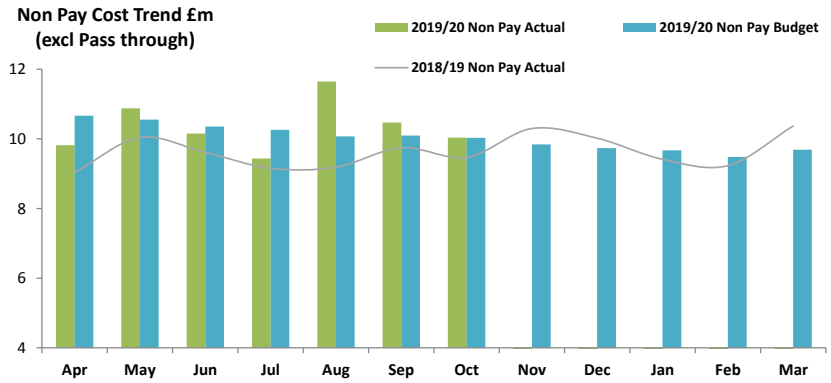
Non-Pay Summary for the 7 months ending 31 Oct 2019

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

Non-Pay Costs (excl Pass through) YTD	Budget (£m)	Actual (£m)	Variance	RAG YTD Actual variance
Drugs Costs	6.9	6.6	0.3	G
Blood Costs	1.2	1.1	0.0	G
Business Rates	2.4	2.5	(0.1)	A
Clinical Negligence	4.0	4.0	0.0	G
Supplies & Services - Clinical	26.2	26.2	0.1	G
Supplies & Services - General	3.2	2.7	0.5	G
Premises Costs	18.8	20.1	(1.3)	R
Other Non Pay	9.3	9.6	(0.3)	A
Total Non-Pay costs	**72.0**	**72.8**	**(0.8)**	R
Depreciation	13.7	13.8	(0.1)	A
PDC Dividend Payable	4.7	4.7	(0.0)	G
Total	**90.4**	**91.2**	**(0.9)**	R

Top 5 YTD Clinical* Non Pay overspends by Speciality (£m)	YTD 2019/20 Budget (£k)	YTD 2019/20 Actual (£k)	Variance (£k)	Trend
Medical Endocrinology	598	861	(263)	↑
Ent	41	282	(240)	↑
Haematology/Oncology	1,836	2,064	(228)	↑
Bone Marrow Transplant	1,640	1,807	(166)	↑
Audiology	881	1,022	(142)	→

Top 5 YTD Clinical* Non Pay underspends by Speciality (£m)	YTD 2019/20 Budget (£k)	YTD 2019/20 Actual (£k)	Variance (£k)	Trend
Cardiac Serv & H&L Central Bud	3,128	2,525	602	↑
Nephrology	1,920	1,517	403	↑
Cardiac Critical Care	1,306	946	360	↑
Picu Nicu	2,511	2,201	310	↑
Medical Metabolics	579	449	129	→



Clinical non-pay excludes pass through

Summary

- YTD non-pay excluding pass through is £0.9m adverse to plan. The key drivers behind this variance are the overspends in the IT spend within premises costs relating to the EPIC implementation which are partially offset on clinical supplies and drugs underspends.

Top 5 clinical over/under spends

The key areas with Non-pay overspends are:

- **Haematology/Oncology** – Non Pay budget is overspent due to activity related costs across the service.
- **Medical Endocrinology -** Mainly due to the overspend on chemical pathology for recharges and drugs.
- **ENT -** Non Pay spend is driven by clinical supplies and additional lab tests linked to activity.
- **Bone Marrow Transplant -** Driven by higher Blood costs which is due to additional CAR-T patients
- **Audiology -** Due to additional Cochlear implants outside the block plus increased cost of supplies.

The key areas of Non-pay underspends are:

- **Cardiac Serv & H&L Central bud** - Driven by reduction in clinical supplies and drugs linked to activity
- **Nephrology** - Outpatient drugs underspent due to lower than expected activity.
- **PICU NICU -** Driven by low clinical supplies expenditure owing to shortfall in activity particularly for IPP.
- **Cardiac Critical Care** - Is mainly driven by Internally recharged costs are lower than planned.
- **Medical Metabolics** - Due to the underspend within Chemical pathology recharges.

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

Better Value summary for the 7 months ending 31 Oct 2019

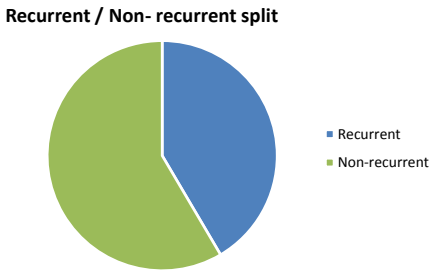
Great Ormond Street Hospital for Children NHS Foundation Trust

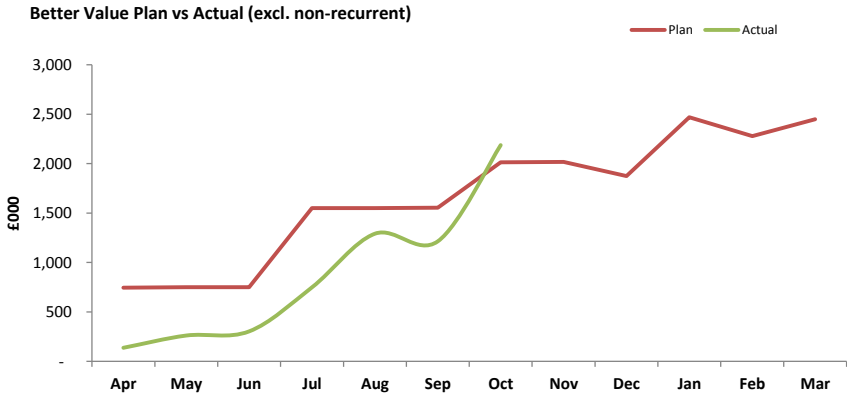
Better Value Summary						
DIRECTORATE	YTD performance £000's			Better Value Total £000's		
	Better Value target YTD	YTD delivery	YTD variance	Better Value target	Unidentified target	Schemes identified
Blood Cells & Cancer	1,060	161	(899)	1,817	(1,515)	297
Body Bones & Mind	1,112	253	(859)	1,906	(1,456)	428
Brain	803	255	(547)	1,376	(915)	474
Clinical & Medical Operations	172	126	(46)	295		292
Corporate Affairs	74	82	8	127	29	155
Finance	169	262	94	289		441
Genetics Laboratory Hub	257	257	(0)	440		440
Heart & Lung	2,221	424	(1,797)	3,808	538	4,347
HR	169	156	(14)	290		298
ICT	391	321	(70)	671	(38)	632
IPP	551	99	(452)	944	84	1,029
Medical Director	101	0	(101)	173	(168)	0
Medicines Therapies & Tests	1,465	208	(1,256)	2,511	(2,117)	382
Nursing and Patient Experience	88	118	30	150	(14)	152
Operations & Images	1,327	297	(1,030)	2,275	(1,763)	524
Estates and Facilities	820	180	(639)	1,405	(546)	707
Built Environment	29	24	(5)	50		50
Sight & Sound	598	231	(367)	1,025	(583)	443
Central	261	2,687	2,426	447	2,441	2,888
Better Value phasing	(2,755)	0	2,755	0		0
Total	**8,911**	**6,142**	**(2,769)**	**20,000**	**(6,023)**	**13,978**
Vacancies		2,769	2,769	0	0	0
Total Better Value	**8,911**	**8,911**	**(0)**	**20,000**	**(6,023)**	**13,978**

Summary

- The Better Value program is currently delivering £6.1m of the £8.9m YTD target at month 7. The rest of the delivery is being covered by Pay vacancies across the organisation.
- The increase in Better Value deliver in month is due to the work undertaken reduce private patient debt, this has resulted in the reduction for the provision for the impairment of receivables (£1.4m).
- The Trust has identified better value savings (£14.0m) that have been removed from the Trust budgets. Additional saving plans have been worked up which require further work to remove from the Trust plans on a recurrent basis.
- Without the Trust vacancies supporting the Trust better value program the program would be £2.8m behind target. With the staffing posts in the Trusts plans these savings can only be recognised on a non-recurrent basis which will add pressure onto the 2020/21 finances of the Trust. In order to meet the Better Value program these vacancy levels will need to be maintained throughout the rest of the year.
- The Better Value program phasing can be seen in the graph below. This shows that the Better Value target increases significantly each quarter. It is therefore important that the savings across the organisation increase to cover the increased targets in later months.

Recurrent / Non-recurrent	
	YTD 2019/20 Actual (£k)
Recurrent	3,700
Non-recurrent	5,211
Total Better Value	**8,911**



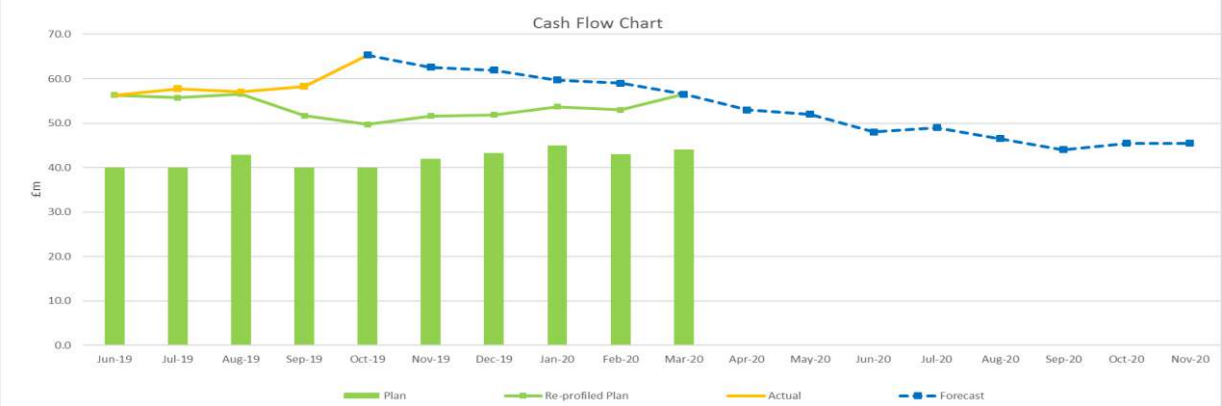


31 Mar 2019 Audited Accounts £m	Statement of Financial Position	Plan 31 Oct 2019 £m	YTD Actual 31 Oct 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2020 £m	YTD Actual 30 Sep 2019 £m	In month Movement £m
499.04	Non-Current Assets	532.82	515.72	(17.10)	522.40	515.41	*0.31*
103.55	Current Assets (exc Cash)	90.73	98.42	7.69	95.26	101.06	*(2.64)*
48.61	Cash & Cash Equivalents	40.00	65.33	25.33	56.49	58.34	*6.99*
(74.89)	Current Liabilities	(65.04)	(90.80)	(25.76)	(80.27)	(89.13)	*(1.67)*
(5.01)	Non-Current Liabilities	(4.50)	(4.53)	(0.03)	(4.87)	(4.57)	*0.04*
571.30	**Total Assets Employed**	**594.01**	**584.14**	**(9.87)**	**589.01**	**581.11**	**3.03**

31 Mar 2019 Audited Accounts £m	Capital Expenditure	YTD Plan 31 Oct 2019 £m	YTD Actual 31 Oct 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2020 £m	RAG YTD variance
5.81	Redevelopment - Donated	21.27	13.22	8.05	21.19	A
9.06	Medical Equipment - Donated	6.37	5.24	1.13	8.81	A
9.78	ICT - Donated	2.17	2.13	0.04	2.17	G
24.65	**Total Donated**	**29.81**	**20.59**	**9.22**	**32.17**	A
6.99	Redevelopment & equipment - Trust Funded	1.87	2.13	(0.26)	5.26	A
1.61	Estates & Facilities - Trust Funded	0.69	0.26	0.43	2.94	R
4.73	ICT - Trust Funded	5.80	7.28	(1.48)	11.87	A
0.00	Contingency	0.00	0.00	0.00	0.67	A
13.33	**Total Trust Funded**	**8.36**	**9.67**	**(1.31)**	**20.74**	A
37.98	**Total Expenditure**	**38.17**	**30.26**	**7.91**	**52.91**	A

31-Mar-19	Working Capital	30-Sep-19	31-Oct-19	RAG	KPI
20.00	NHS Debtor Days (YTD)	16.0	16.0	G	< 30.0
253.00	IPP Debtor Days	198.0	203.0	R	< 120.0
36.70	IPP Overdue Debt (£m)	26.7	25.3	R	0.0
5.00	Inventory Days - Drugs	N/A	N/A		7.0
94.00	Inventory Days - Non Drugs	54.0	74.0	R	30.0
34.00	Creditor Days	35.0	35.0	A	< 30.0
43.6%	BPPC - NHS (YTD) (number)	42.0%	42.8%	R	> 90.0%
80.3%	BPPC - NHS (YTD) (£)	66.9%	65.2%	R	> 90.0%
85.5%	BPPC - Non-NHS (YTD) (number)	86.4%	85.4%	A	> 90.0%
91.1%	BPPC - Non-NHS (YTD) (£)	90.4%	90.1%	G	> 90.0%

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



Comments:

1. Capital expenditure is behind plan by £7.9m at M7; of this, Trust-funded is ahead of plan by £1.3m, and donated £9.2 behind. The Trust-funded position is due to slippage on the Estates programme (£0.4m) and IT (£0.4m) offset by the accrual of future year licence payments on EPR on EPR (£1.9m). Donated projects which have slipped include Sight and Sound Hospital (£5.5m), Southwood Courtyard (£0.9m), and equipment purchases (£1.3m).
2. Following the NHSI request to reduce the Trust-funded plan, the plan was amended/rephased in June/July. Although the NHSI reduction requirement has been removed, the Trust cannot return to the original timing due to the delays imposed to meet the target reduction. Therefore this report now shows the plan as rephased in June/July as this provides a better indicator of performance.
3. Cash held by the Trust is higher than plan by £25.3m. This includes £8.2m relating to Provider Sustainability Funding for 2018/19 which was received in Q1; £6.7m received in month from GOSH charity (of which £3.7m related to ZCR and £2.3m related to Capital projects). The cashflow forecast was reprofiled in Quarter 1 and at M07 the cash held by the Trust was £15.6m higher than the revised plan profile, this is shown in the Cash Flow chart above.
4. Total Assets employed at M07 was £9.9m lower than plan as a result of the following:
   - Non current assets totalled £515.7m (£17.1m lower than plan)
   - Current assets excluding cash less Current liabilities totalled £7.6m (£18.1m lower than plan).
   - Cash held by the Trust totalled £65.3m (£25.3m higher than plan which includes £8.2m of PSF bonus and incentive relating to 2018/19 as well as £6.7m received from GOSH charity).
4. Overdue IPP debt decreased in month to £25.3m (£26.7m in M06).
5. IPP debtor days increased from 198 days to 203 days in month. This is largely as a result of the increase in debt which is not yet due (£2.8m higher than M06).
6. The cumulative BPPC for NHS invoices (by value) decreased in month to 65.2% (66.9% in M06). This represented 42.8% of the number of invoices settled within 30 days (42.0% in M06)
7. The cumulative BPPC for Non NHS invoices (by value) decreased in month to 90.1% (90.4% in M06). This represented 85.4% of the number of invoices settled within 30 days (86.4% in M06).
8. Creditor days remained the same as the previous month at 35 days.
9. Non-drug inventory days increased in month to 74 days (54 in M06). This is largely as a result of the increase in the level of Berlin Heart stock held. Inventory days (drugs) cannot be calculated at M07 as the valuation requires further refinement following the August 2019 stocktake.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27 November 2019

Better Values update	**Paper No: Attachment Z**
Submitted by: Richard Collins – Director of Transformation	**For Information**

Aims

The aim of this paper is to provide the Board with an update on the latest position related to the Better Value programme as at M6 and the developing plans for the transformation programme which will seek to support more fundamental change (either through more efficient working practices, better / different use of systems & technology, or new ways of working) as the Trust moves towards developing comprehensive plans to address an equally challenging (forecast) financial gap in 2020 / 2021.

Year to date Better Value position

Delivery of the Better Value target is currently behind plan but the gap has been largely filled with non-recurrent savings (primarily underspend on pay). The focus of the Trust is on closing the current forecast gap to achieve the control total (currently c£4.5m as at M6).

- The operating plan anticipated that by M6, Better Value schemes of £6.9m would be required in order to achieve the planned trajectory towards the £20m target by year-end
- By M6, £4.0m was achieved through Better Value, with the remaining £2.9m being covered by pay vacancies across the organisation
- Of the £6.9m, £3.2m was recurrent and £3.7m non-recurrent (largely vacancies as noted above)
- The rate of Better Value delivery has remained in-line with M5, delivering £1.3m in each of M5 and M6, compared to £1.4m cumulatively for M1 to M4
- During October, an additional £500k saving was signed into directorate budgets related to the rollout of materials management

Full year plan

Directorates are currently projecting that the year-end position will be in aggregate £4.5m adverse to the Trust's control total. In order to reach that position, they have assumed continued benefit from establishment control and vacancy reduction, although this has always been anticipated to be at a lower level than the first half of the year due to planned recruitment of new nurses coming online in September.

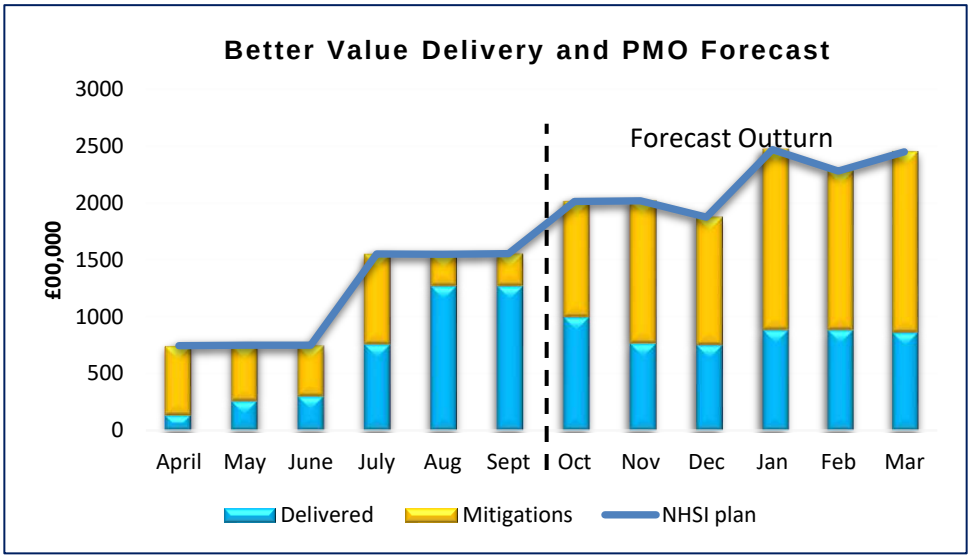
In addition there remain a range of procurement schemes yet to be signed off into budgets. Our procurement shared service partners have reduced the likely year-end position for this programme to c.£1.7m from a previously reported plan of c.£2m. The CFO-chaired Procurement Transformation Board is overseeing these savings and following an increased on-site presence from our procurement partners, a series of meetings with clinical directorates has begun in order to identify areas where opportunities exist to reduce costs through greater standardisation.

In sum, the total value of all potential identified schemes including the pipeline is £22.1m. However, a significant proportion (£10.3m) are non-recurrent, and after applying risk adjustments to the programme, the PMO currently predicts the programme would be challenged to deliver more than a maximum of £16.9m in-year.

As the Better Value programme is not currently predicting sufficient new schemes 'in year' to close the current forecast gap, other mitigating actions continue to be required to meet the Trust's control total. These include:

- Non-recurrent savings related to the delayed opening of the Zayed Centre for Research
- Release of £0.4m from the CEO contingency funds
- Continued assumptions regarding non-recurrent pay underspend
- Recovery of debt

The Better value requirement becomes much harder through to year end due to the phasing of the programme in the Operating plan, as shown in the chart below (the higher figure for October compared to following months reflects materials management catch-up following incorporation into budgets). However, the current plan does assume that the Better Value programme and other mitigations will enable the Trust to achieve the control total in FY 19/20.



Further mitigations

The overall financial position, including Better Value delivery, forms part of the discussion at each of the clinical and corporate directorate monthly performance review meetings and the PMO team are working with all directorates to identify further schemes.

The development of the 'GOSH Narrative' (see below) provides an opportunity to identify potential in-year savings as well as support a broader change programme as part of the delivery of efficiency savings next financial year.

A targeted communication and engagement programme is being developed with the support of the Communication Team to raise and maintain awareness, gain support for upcoming projects and empower staff to develop their own local initiatives. Recent focus group work is leading to the finalisation of a 'call to action' to be launched during December with the aim of encouraging all staff to come forward with ideas on things that we can do differently over the coming year.

Preparing for 2020 / 2021

Better value projects form part of a larger transformation agenda which will be delivered by a wide-ranging portfolio of significant enabling projects and programmes. The current range of larger enabling work programmes covers a range of areas such as:

- creating a culture, together with the capability and capacity, that enables us to learn and thrive (including the development of the People Strategy, our work with the Cognitive Institute and development of the GOSH Learning Academy);
- transforming care through harnessing technology (including realising the benefits from Epic, as well as making the most of the innovation that can come from DRIVE);
- providing the most effective and efficient care (through the development of pan and intra Trust pathway and service redesign initiatives as well as through a Better Value programme which enables us to use our existing resources in the most efficient way); and
- creation of new spaces (for example the development of the Sight and Sound Centre and as well as smaller initiatives such as the development of an Operational Hub).

The transformation team are currently recruiting to a number of new fixed term roles with a particular focus on staff with experience of managing complex patient flow and clinical pathway redesign programmes (including change analysts, informaticists and programme / project managers). The team will work closely with Clinical Operations and with members of the Medical Director's team, particularly those engaged with monitoring and measuring patient outcomes, to ensure changes introduced through the Transformation Programme are appropriately assessed for any potential impacts on patient outcome and experience.

Lessons learned from the EPR Programme show that engagement with clinical staff is critical to adoption of new systems and processes. The Chief Nursing Information Officer (CNIO) has established a group of nurses (in excess of 70 ward staff) and a group of Allied Health Professionals (AHPs) to act as links between the Transformation Programme and key staff groups. The Transforming Care Link Nurses have met twice to fully establish the group and to determine the best approach to collaboration and engagement. The first meeting of the AHP group has also now taken place and plans are in place to establish similar forums for other staff groups.

The Programme Management Office, now part of the Transformation Directorate, is undertaking detailed benchmarking work to develop the 'GOSH Narrative' which delivers an empirical assessment of GOSH against peer organisations both within the paediatric specialist network and across London. It is recognised that GOSH can learn from other organisations and through that learning identify ways to deliver care in a more effective and efficient manner, improving patient outcomes, patient and staff experience and positively contribute to our overall financial sustainability.

The benchmarking data is being shared with directorate leadership teams to support understanding of why GOSH might vary from its peers but also to identify further opportunities to transform the organisation, either through simple efficiencies (which will be supported and monitored through the Better Value programme) or through service redesign (which will be managed through one of our other existing transformation programmes or the establishment of a new programme).

The Transformation team is also working closely with the Chief Operating Officer to support delivery of improvements / adherence to existing processes which will be governed through operational groups (and through to the Operations Board) but which will also enable efficiencies and savings.

The following key enablement programmes are planned to be in place by April 2020 (recognising that a number of them are already underway).

- Flow – covering the whole patient journey with specific projects designed to support improvements and / or process change within the following four core areas:
    - Pre-admission
    - Hospital Stay
    - Discharge
    - Overarching process
- Clinical pathway redesign (closely linked to Flow) - which will support:
    - The design of new or re-design of existing clinical pathways
    - Efficient use of space and infrastructure
    - Design and adoption of new ways of working
- EPR Optimisation – which will look to build on the baseline configuration deployed at go-live as well as introduce additional functionality
- DRIVE – there are a number of projects currently being delivered through the Digital Research Environment (DRE) and in association with DRIVE partners such as Samsung and Microsoft. It is expected that DRIVE will provide a test bed for cutting edge technology (or the application of existing technology into the health space) and advanced data analytics

NB. The provision of meaningful data will be key to maximising the opportunity for improvements in the other programmes as well as providing assurance in terms of patient safety, experience and outcomes associated with potential changes

Whilst in many cases, individual projects are still being scoped and will require approval through appropriate governance groups, the following have currently been identified as specific pieces of work which may be delivered within the enablement programmes:

- Operational Hub
- Patient Acuity / Dependency (linking with existing initiatives being led by the Chief Nurse)
- Development of specialty content (within Epic)
- Extension of MyGOSH (including consideration of data input from wearable / personal devices and questionnaires)
- Telemedicine (which will likely be delivered to initially support 'video visits' but expand to include options for remote monitoring and more complex shared care)
- Omnicell (drug cabinet) and Infusion Pump integration

Action required from the meeting

The Trust Board is asked to:

- **Note** the current position of the Better Value programme and the contribution to the Trust delivering the control total
- **Note** the programmes of work which will be developed (in line with the refreshed Trust Strategy and in partnership with workplans underpinning the People Strategy) which will support a financial plan for 2020 / 2021 in line with our financial principles

Financial implications

There remains risk associated with full delivery of all of the Better Value programme but the current plans indicate that the Trust will achieve the 2019 / 2020 control total. Lack of recurrent savings in 2019 / 2020 will create a larger savings target for 2020 / 2021.

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th November 2019

Safe Nurse Staffing Report for August/September 2019 **Presented by Alison Robertson, Chief Nurse.**	**Paper No: Attachment 1**

Aims / summary

This report provides the Board with an overview of the Nursing workforce during the month of August and September 2019 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018.

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

Action required from the meeting

To note the information in this report on safe staffing including:

1. That the Trust operated within recommended parameters for staffing levels in both August and September.
2. The adoption of rostering metrics included in this report to ensure maximum benefit is derived from the implementation of HealthRoster & SafeCare.
3. Work continues to establish an accurate picture of Bank demand.
4. Actual versus planned care hours available are within recommended parameters
5. Care Hours Per Patient Per day continue to be higher than the 2018/19 average
6. Agency utilisation remains very low, overall bank fill rates have increased slightly, although are reduced in the critical care areas due vacancies, skill mix issues and rises in acuity.
7. In August and September there were 4 Datix reports which raised concerns in relation to nurse staffing levels –appropriate escalation and actions were put in place and no harm was recorded.
8. A successful recruitment Open Day was held in October
9. 84 newly registered nurses commenced in September.
10. The mid-year safe staffing establishment review was conducted in October
11. A new safe staffing establishment tool will be piloted in November and implemented in January 2020

Contribution to the delivery of NHS Foundation Trust strategies and plans

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

Financial implications

Currently incorporated into 19/20 Directorate budgets.

Who needs to be told about any decision?

Directorate Management Teams
Finance Department
Workforce Intelligence

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

Chief Nurse, Director of Nursing, Director of Education and Heads of Nursing

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

Chief Nurse; Directorate Management Teams

1. Summary

This report on GOSH Safe Staffing contains information from the months of August & September 2019.This paper provides the required assurance that GOSH had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage the demand for nursing staff. The report also includes measures taken to ensure safe staffing throughout the Trust.

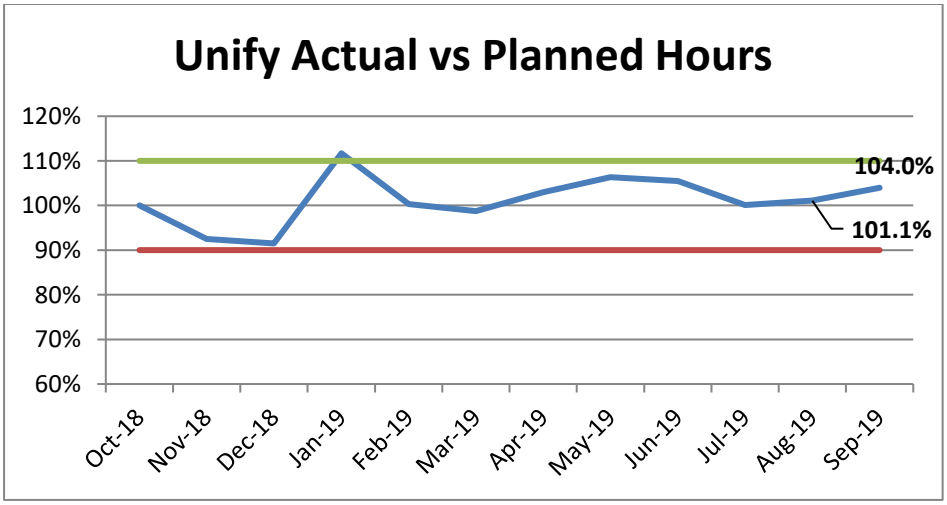
2. Safer Staffing.

2.1 Actual vs Planned

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

In August 2019 the overall fill rate of AvP was 101.1% which is within the recommended range and an improvement on the same month last year. In September the rate was 104.4%. In both months HCA fill rates at night were lower than the recommended minimum %, however Heads of Nursing have verified that despite these lower rates no shifts were unsafe, and local management of available staff resolved any staffing issues.

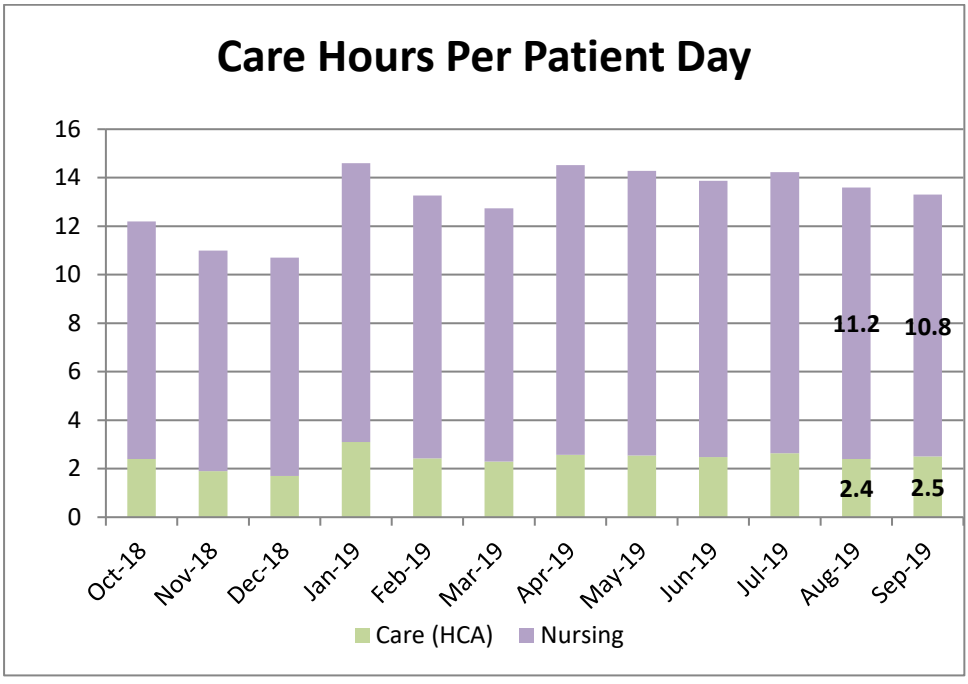
At a Directorate level, only the International & Private Patients directorate was outside of the recommended parameters in both months, exceeding the 110% upper range.



2.2 Care Hours Per Patient Day (CHPPD)

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

When we report CHPPD we exclude the 3 ICUs to give a more representative picture across the Trust. The reported CHPPD for August 2019 was 13.6 hours, made up of 11.2 registered nursing hours and 2.4 HCA hours. In September, the figure was slightly lower at 13.3 hours (10.8 RN and 2.3 HCA) however both months are higher than the 12 month average of 13.1 total hours. With effect from 1 August 2019 national CHPPD guidance was updated to include a new requirement for Nursing Associates and Allied Health Professionals (AHPs) who are rostered to the in-ward establishment to be included as part of the CHPPD daily data return.



2.3 SafeCare

PANDA assessment on EPR continues to improve with a compliance average of 96% in August and September across inpatient wards. We are working with the EPR team to create a report that shows where PANDA was not complete and work with the senior nursing team to improve this. All outpatient areas will be live on SafeCare by the end of the year – this will include the ability for areas to input patient numbers and task types. The aim is to get SafeCare fully operational by March 2020 and to include all ITUs and Theatres. Working Groups will be organised with the clinical ops team to ensure it is being used operationally in trust bed meetings as a way of supporting safer staffing across the wards by using the feature professional judgement when PANDA acuity is not accurate.

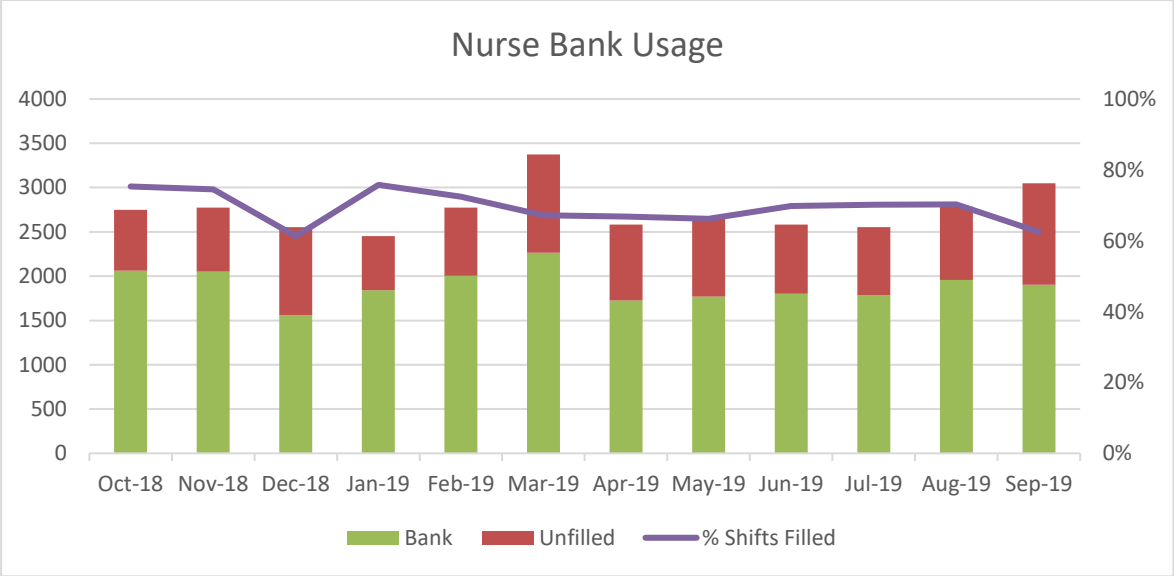
3. Workforce Utilisation.

3.1 Rostering

The Rostering Scorecard measures are shown below. Publication of Rosters in advance was a major focus for Rostering managers in July and August, which is expected to show results from autumn onwards. The reduction in variances between demand templates (amount of nurses to be scheduled to a shift) and the budgeted establishment continues to be addressed with the Heads of Nursing (HoNs) and this metric continues to show improvements. The newly appointed Director of Nursing (Corporate) and HoN for Workforce will be working with senior nurses to improve compliance with the rostering rules and therefore staff experience.

Metric	Target	April Roster	May Roster	June Roster	July Roster	August Roster	September Roster
Advance Publication of a Roster	42 + days	27	28	32	29	42	37
Time Balances in Hrs	Below 12 hours	7.5	8.7	8.1	8.1	9.9	6.4
% Annual Leave Unavailability	15-20%	11.20%	12.20%	11.70%	12.40%	11.70%	12.70%
Demand vs Budget (WTE)	0	116	171	235	109	76.7	31.8
% Staff working fair proportion of night and weekend duties	50%+	46%	43%	43%	40%	42%	38%
Additional Shifts Created	0	991	892	773	843	454	704
SafeCare Utilisation	90-100%	tbc	tbc	99%	100%	100%	99%

3.2 Temporary Staffing



Requested shifts increased in both months to above the long term average with 2,786 shifts during August and 3,055 in September (over 200 more than the previous September). Filled shifts in both months were broadly similar to the 12 month average at 1,958 and 1,910 respectively. ICU requests continued to be higher than in previous years which has an impact on their fill rate which is lower than the Trust average at 60% and 50% respectively. The Director of Nursing (Corporate) and HoN for Workforce will be working with senior ICU nurses and bank partners to explore how this may be managed more effectively going forward.

Agency nursing usage in the Trust remains very low. There was no usage in August while there were 8 agency shifts in September, 7 of these in IPP to support short term safe staffing and maintain quality while long term solutions are being sought to address some vacancies.

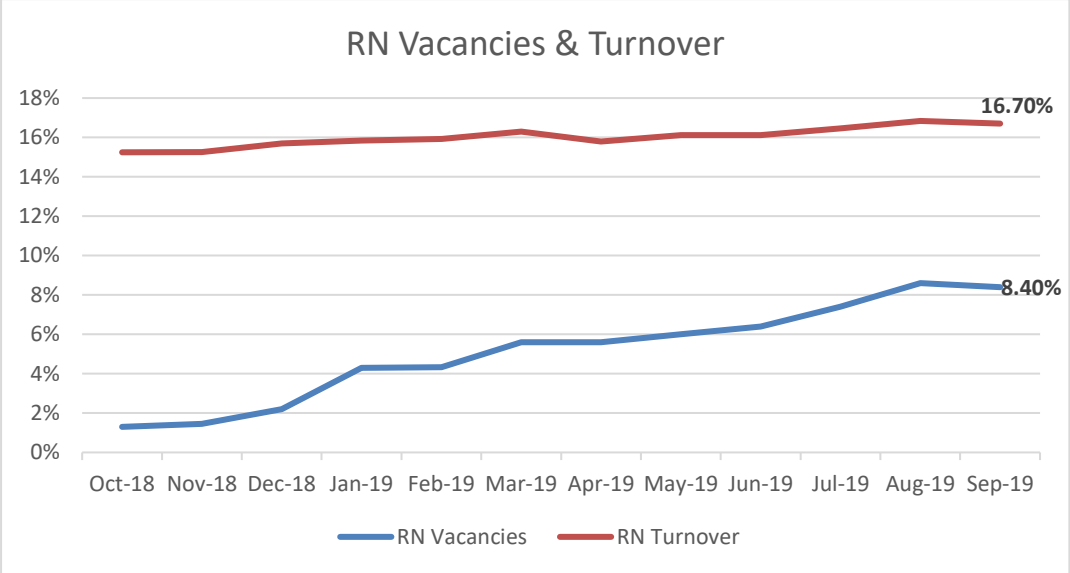
3.3 Vacancies & Recruitment

The Trust Nursing Vacancy rate for August was 8.6% (140.5 WTE) and had reduced slightly to 8.4% (136.7 WTE) in September. The highest number of vacancies was in IPP (32.5 WTE, 28.7%), Heart & Lung (36.6 WTE, 7.0%) and Body, Bones & Mind (28.8 WTE, 11.5%).

Band 6 vacancies remains above the Trust target and average at 74.3 (13.4%). One of the drivers of the Nursing retention plan is a refresh of strategies around career development which aim to support Band 5 Nurses to progress in their career at

GOSH.

Healthcare Assistants vacancies remain above target (33.49 10.9% in September) The Nursing Workforce team will be reviewing the approach to recruiting HCAs, with a rejuvenated local recruitment drive and clear career progression plans in place to support a 'grow your own' approach to our nursing workforce and make the role more attractive to prospective candidates.



3.4 Retention

As part of the Retention initiative, a proactive approach was taken by the nursing workforce leads, education leads and some Heads of Nursing by supporting Retention Week (28 Oct – 1st Nov inclusive) at the trust. This involved visiting all clinical areas over a four-day period followed by an early morning breakfast to capture night staff on the fifth day. The aim was to engage with a variety of staff in order to gain insight into the what retains them and to build on this and what might risk them leaving and to address this where possible. We also wanted to promote visible leadership and a message of valuing our nursing staff. In addition to gathering useful feedback we also took the opportunity to highlight what benefits, opportunities and support was available to staff which they were not fully aware of. Staff sighted team spirit as their main reason for working at GOSH followed by good work/life balance, internal transfer opportunities, specialist knowledge and career development opportunities. Areas identified for improvement included equity of rostered shifts, career breaks opportunities, childcare and accommodation. The Nursing Workforce Team will incorporate these findings into their future plans and work with GOSH colleagues to explore how we mitigate against these risks.

4. International & Private Patients

Vacancies and Turnover in this area remain high, with a range of measures to support the Directorate having been agreed. These include the appointment of 5 nursing associates (NAs) due to commence in November, followed by an international recruitment campaign in January 2020 to create a pipeline of experienced nurses joining the trust later in the year. During the interim period safe staffing levels will be supported through established lines of agency nurse usage and staff redeployment as necessary.

5. Incident Reporting

5.1 Patient Safety and DATIX

In August there were two reported Datix incidents (NICU and Butterfly) and in September there were two Datix incidents (Butterfly and Panther) all of which identified concerns around nurse staffing levels.
The Heads of Nursing and Patient Experience have reviewed these incidents and have confirmed that there was appropriate escalation with remedial actions put in place to manage the situation. No harm came to any patients in relation to the reported incidents.

6. Bed Closures

GOSH monitors the number of beds that are closed on a daily basis due to poor staffing levels. This can be attributed to a number of reasons; high vacancy factor, short term sickness, increases in acuity/dependency.
In August there were between 24 – 36 beds and in September there were between 27 – 52 beds, closed on a temporary basis. It should be noted that in these two months 10 beds were closed on Hedgehog Ward (IPP) and 6-8 on Sky Ward (Body, Bones and Mind).
In both months between 0 – 9 beds were temporarily closed in critical care (CICU, PICU, NICU).

7. Nursing Establishment

7.1 Safe Staffing Establishment Review

In May 2019 a nursing establishment exercise was completed to identify each of the ward requirements based on the number of established beds, acuity and activity plan

for 19/20 in order to identify the nursing requirements to deliver safe high standards of care, quality care and staff and patient experience. We conduct a review of this establishment at a mid-year point to provide assurance that we are maintaining safe levels and also to review progress against the implementation of recommendations since the last report. A full report has been submitted to the board for assurance.

7.2 Safe Staffing Tool

The Children's & Young People's Safer Nursing Care Tool (C&YP SNCT) is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013 which has been used successfully in many organisations. The tool is used to determine nursing establishments based on the acuity of patients. As an organisation we are looking at introducing this evidence based and validated tool to GOSH with a pilot planned for November 2019 and testing of the tool alongside the existing method in January and June 2020 to analysis and validate results prior to full implementation. The tool is described in greater detail within the Safe Staffing Establishment Review Paper which has been submitted to the board.

8. Recruitment

9.1 Newly Qualified Nurses (NQN)

84 NQNs commenced in post in September across a number of clinical areas. They have now completed their induction and will be included in the establishment numbers for our next Trust Board meeting in January 2020.

9.2 GOSH Recruitment Open Day 23rd Oct 2019

The Nursing Workforce Team led a successful and vibrant recruitment day which saw all clinical areas well represented and generated great interest. Over 90 candidates registered an interest of working at GOSH will be followed up by the recruitment lead. Nurse Bank too used the opportunity to recruit a possible 24 candidates who will also be followed up and assessed. A social media campaign promoting the event achieved high engagement levels of over 2,000 views per tweet and reached high profile figures including the Chief Nurse of England who re-tweeted the event. The Nursing Workforce Team plan to actively promote the next Recruitment Open Day Event scheduled for February 2020 from mid-November 2019 to ensure greater attendance and allow for potential candidates to plan ahead. The social media campaign will actively target experienced nurses with a strong emphasis on promoting diversity and inclusivity.

9.3 Capital Nurse Graduate Nurse Guarantee

In addition to our own trust led recruitment we are also participating in the Capital Nurse Graduate Nurse Guarantee initiative which ensures we are working in collaboration with our STP partners and widens our scope to capture the interest of other potential NQNs from additional universities in and around London.

9. Future Governance Arrangements

Following the appointment of the new Head of Nursing for Workforce in October, she and the Director of Nursing (Corporate), plan to establish a Workforce Committee to provide oversight, co-ordination and to provide assurance to the board that safe staffing is being maintained. Sub groups of this committee will include a workforce data task and finish group and a workforce challenge and scrutiny group to assist with monitoring activity and to ensure robust plans are in place to maintain a secure recruitment pipeline and improve retention rates. Further details of proposed plans will be provided to the next trust board in January 2020.

Appendix 1: August & September Workforce metrics by Directorate

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover* %	Sickness %	Maternity %
Blood, Cells & Cancer	93.6%	15.0	17.2	7.4%	15.3%	2.7%	3.5%
Body, Bones & Mind	98.1%	12.4	29.2	11.7%	15.9%	2.7%	7.1%
Brain	98.4%	13.1	5.3	4.3%	15.0%	2.5%	6.4%
Heart & Lung	108.8%	16.2	36.5	7.0%	18.7%	3.8%	5.2%
International & PP	115.8%	12.4	31.3	27.6%	27.2%	4.4%	7.2%
Operations & Images	-	-	15.7	7.8%	9.5%	4.7%	2.4%
Sight & Sound	90.9%	11.2	8.2	14.0%	10.7%	3.2%	5.4%
Trust	101.1%	13.6	140.5	8.6	16.8%	3.3%	5.0%

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

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover* %	Sickness %	Maternity %
Blood, Cells & Cancer	93.8%	14.7	19.5	8.4%	13.3%	2.8%	3.9%
Body, Bones & Mind	101.7%	12.3	28.8	11.5%	15.1%	2.9%	6.7%
Brain	100.0%	13.2	7.3	5.8%	13.7%	3.4%	7.3%
Heart & Lung	112.3%	14.5	36.6	7.0%	20.1%	3.8%	5.6%
International & PP	130.1%	13.2	32.5	28.7%	23.6%	4.8%	6.6%
Operations & Images	-	-	13.2	6.5%	11.6%	4.7%	4.5%
Sight & Sound	85.2%	9.1	5.6	9.6%	11.9%	3.2%	6.6%
Trust	104.0%	13.3	136.7	8.4%	16.7%	3.4%	5.5%

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th November 2019

Safe Staffing Nursing Establishment Mid-year Review **Presented by:** Alison Robertson, Chief Nurse	**Paper No: Attachment 2**

Aims / summary
This report provides the Board with an overview of the Mid-Year Safe Staffing Establishment which was conducted in Oct and Nov 2019 in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018.
It provides assurance that arrangements are in place to review the establishments which determine if inpatient wards are safely staffed with the right number of nurses with the right skills and at the right time.

Action required from the meeting
To note the information, recommendations and future actions planned to ensure safe staffing establishments are maintained

Contribution to the delivery of NHS Foundation Trust strategies and plans
Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.

Financial implications
Currently incorporated into 19/20 Directorate budgets.

Legal issues
None

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
Directorate Management Teams
Finance Department
Workforce Intelligence

Who needs to be told about any decision?
Directorate Management Teams
Finance Department
Workforce Intelligence

Who is responsible for implementing the proposals / project and anticipated timescales?
Chief Nurse, Directors of Nursing, Director of Education and Heads of Nursing

Who is accountable for the implementation of the proposal / project?
Chief Nurse, Directors of Nursing

Safe Staffing Nursing Establishment Mid-Year Review (2019/20)

Purpose

In May 2019 a nursing establishment exercise was completed to identify each of the ward requirements based on the number of established beds, acuity and activity plan for 19/20 in order to identify the nursing requirements to deliver safe high standards of care, quality care and staff and patient experience. We conduct a review of this establishment at a mid-year point to provide assurance that we are maintaining safe levels and also to review progress against the implementation of recommendations since the last report.

Introduction

Great Ormond Street Hospital (GOSH) has a responsibility to ensure a safe and sustainable workforce and all Trusts have to demonstrate compliance with the 'triangulated approach' to deciding staffing requirements described by the National Quality Board (NQB) guidance in the recent 'Developing Workforce Safeguards' by NHS Improvement (2018).This combines evidence based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

The NQB guidance states that providers:

1. must deploy sufficient suitably, competent, skilled and experienced staff to meet the care and treatment needs safely and effectively
2. to have a systematic approach to determining the number of staff and range of skills required to meet the needs of the people using the service and to keep them safe at all times
3. must use an approach that reflects current legislation and guidance where it is available

This most recent nursing establishment review is able to demonstrate that the Trust is aligning with the outlined recommendations in order to provide assurance to the Board that the nursing workforce decisions regarding the establishments are designed to promote patient safety and quality.

Methodology for Calculating Nursing Numbers

The staffing ratios have been determined using the Royal College of Nursing (RCN 2013) and Paediatric Intensive Care Standards (PICS 2016) for guidance; these include the percentage uplift that supports annual leave, sick leave, study leave etc. The ratios of nurses per patients will vary depending on the type of patient and their dependency. The ratios used by the Trust are:

Intensive Care 1:1, High Dependency 1:2, Ward 1:3

Enhanced Intensive Care - 2 Nurses: 1 Patient (this includes children requiring ECMO or renal replacement therapies).

Whilst using national tools to work out establishments it is also key to note that the nursing professional judgement is also factored into the equation.

Throughout October and November, each directorate had their nursing establishments reviewed ward by ward with the directorate Heads of Nursing, the Director of Nursing (Corporate), the Director of Nursing (Operational) and the Head of Nursing for Workforce.

The staff establishment exercise in May 2019 included validation of the funded bed base for each ward and the type of patients nursed within those beds regarding dependency as mentioned above. The dependency information is obtained from the Paediatric Acuity and Nurse Dependency (PANDA) Tool which is also widely used across GOSH to determine patient acuity which helps to inform safe staffing levels. (It should be noted that the nurse numbers calculated within PANDA are not used to inform the nurse establishments as the algorithms used within the system over estimate the nursing requirements).

Each ward area nursing requirements were based at 100% capacity to ensure the safety and quality of care could be delivered in this highly specialised Trust providing tertiary and quaternary services. The Intensive Care areas have had the figures recalculated at 90% capacity in order to achieve cost savings with regards to staffing requirements. Monies saved were redistributed to other areas such as the Zayed Centre for Research (ZCR), Operations and Images, and Body Bone and Mind **(**BBM) due to the shortfall in their budgets.

A new tool, the Children's & Young People's Safer Nursing Care Tool (C&YP SNCT), will be introduced and piloted in November and implemented in January and June 2020, to assist with determining future nursing establishments. The C&YP SNCT is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013 which has been used successfully in many organisations. It has been developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing in Children's and Young People's in-patient wards. The tool, when used with Nurse Sensitive Indicators (NSIs), will also offer a reliable method against which to deliver evidence-based workforce plans. The Children's and Young People's (C&YP) wards included in the study cared for children and young people aged 0-19 years across many specialties.

Safe Staffing Nursing Establishment Mid-Year Review (2019/20)

Conclusion

Each ward staffing requirements was reviewed and cross referenced with directorates own information. It is important to note that the establishments reviewed only reflect patient facing staff, to ensure that it is transparent what the nursing requirements are to provide direct nursing care based on the number of funded beds and patient acuity. Roles such as Practice Educators, Advanced Care Practitioners and Nurse Practitioners were not included.

We have clarified the different types of beds with the wards and the numbers which then determines the staff requirements such as the exact number of High Dependency (HD) beds versus ward beds, what days the beds are open, etc.

Review outcomes

Below is an overview of the actions taken, the status of current establishments and future plans identified as a result of the review:

1. **Blood Cells and Cancer (BCC)** - There were no requirements within BCC and staffing was appropriately balanced across all the ward areas. Staffing costs were within budget, with equity of staffing across all wards has been addressed and therefore the demand for bank reduced.
2. **Body Bone and Mind (BBM) –** Staffing establishment within the BBM directorate was considered to be safe, and although Chameleon currently has three Band 6s vacancies due to previous reconfiguration of wards, these may be utilised in a business case for Possum Ward and therefore have not been recruited to. Further work needs to be considered regarding the effectiveness of the current staff mix across the wards within this directorate which will be reviewed.
3. **Brain –** There were no requirements to overall establishments within Brain and staff are deployed as required to support the directorate function as a whole. **Koala ward** were 3 Band 6 nurses over establishment due to funding arrangements for HDU beds, however these posts will be also be factored into the business case for Possum Ward.
4. **Heart and Lung –** PICU, NICU and CICU are currently working with staffing requirements at 90% occupancy to align the staffing within the available budget. **Neonates (NICU) and Paediatric Intensive Care (PICU)** both have vacancies however 15 Newly Qualified Nurses (NQN) are being recruited to Band 5 posts between January and March 2020 and 8 Band 6s have just been appointed which will be reflected in the numbers over the next few months. Safe staffing has been maintained across the directorate through temporary redeployment of staff across

Bear, Leopard and Kangaroo as required and through use of bank budget to support; this will be kept under review and is expected to be reduced as new staff come on board. It has also been identified through the review that senior nursing staff feel the acuity of their patients is increasing and although this is currently being mitigated will be reflected through the use of the new SNCT staffing establishment tool when implemented in January 2020.

5. **Sight and Sound –** outpatients (OPD) staffing requirements have been addressed for ZCR which opened last month however are yet to be addressed for Sight and Sound which is due to open next year 20/21. The rest of outpatients will also be reviewed in the next establishment review which will be timed to coincide with the next round of business planning and we are exploring the availability of a staffing establishment model which specifically supports the OPD setting.
6. **International and Private Patients (IPP) –** Following a focused staffing review carried out in Aug 2019 to align current staffing numbers with the bed pool**, Bumblebee** bed capacity was increased from 16 to 18 beds and **Butterfly** bed capacity to 12 -15 beds as Hedgehog Ward has closed to enable a 1:3 ratio as per guidance. In the short term we are also utilising three lines of agency nurses to maintain safe levels. Ongoing work to provide long term solutions to support the pipeline of staff supply include the appointment of five Nursing Associates who commenced in post in November, and international recruitment to the Philippines in January 2020.
7. **Operations and Images** – since the establishment exercise in May the bank spend has significantly reduced following the appointment of an additional 6 WTE staff following changes made in collaboration with Nightingale Ward.

Recommendations implemented since the last report

1. A live document documenting all changes to the Ward establishments is now available and maintained.
2. We continue to work with nursing staff of all levels to ensure they have the appropriate understanding of staffing establishments and budgets, especially at Ward Manager level and above. This is also being supported by the Head of Nursing Workforce through participation in the Band 6 and Band 7 stepping up development programme.
3. The introduction of a new validated and approved safe staffing establishment tool as from November 2019 will enable benchmarking with similar hospital trusts and provide greater assurance to the board.

Future plans to ensure continuous improvement

1. The roll out of the Nursing Associates roll will be monitored and evaluated to assess impact and impact of quality safety and costs.
2. Scoping on the introduction of a pharmacy technician role to support nursing staff by addressing skill mix requirements to enable the delivery of the right care at the right time to patients.
3. External review of the nursing establishments conducted by Birmingham Sick Children's Hospital to ensure that GOSH is benchmarked against other similar Paediatric Hospital, awaiting report.
4. To review other nursing staff cohorts (Practice Facilitators, Practice Educators, Clinical Nurse Specialists, Advanced Nurse Practitioners)across the Trust.
5. Review the nursing model of practice in the Outpatient setting where the Clinical Nurses Specialists could run a clinic with the medical team in its entirety which may address shortfalls in Outpatient staffing numbers.
6. To include an analysis of quality measures against any areas of staffing concern in the next establishment review.
7. To establish a Workforce Committee in December which will provide greater scrutiny and oversight of all workforce related activity including appropriate and effective use of Healthroster and triangulation of workforce intelligence and quality metrics to ensure safe staffing and optimum skill mix.

Author: Herdip Sidhu-Bevan – Director of Nursing (Operations), Darren Darby- Director of (Corporate) and Marie Boxall - Head of Nursing (Workforce)

13 November 2019

Attachment 3

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 November 2019	
Transparency in Healthcare **Submitted by:** Sanjiv Sharma, Medical Director	**Paper No: Attachment 3**
Aims / summary This paper sets out the context for promotion of transparency in healthcare. It notes the necessity and advantages of working to improve transparency, particularly in light of regulatory, statutory and cultural reasons. It considers the arrangements we currently have in place, with a specific focus on those we have sought to improve and enhance in the last 12-18 months. It highlights recent criticisms of the organisation's openness, and considers whether there is more that we can do to promote openness with all key stakeholders: patients & their families, staff, other NHS providers, commissioners & regulator; and the public.	
Action required from the meeting Note the report and offer support for recommended actions	
Contribution to the delivery of NHS Foundation Trust strategies and plans Supporting the discharge of professional and organisational responsibilities to be open which are included in our Always Expert values.	
Financial implications Financial implications will depend on support for recommended actions.	
Who needs to be told about any decision? Medical Director Head of Special Projects for Quality and Safety	
Who is responsible for implementing the proposals / project and anticipated timescales? Medical Director	
Who is accountable for the implementation of the proposal / project? Medical Director	

Transparency in Healthcare

Background & Context

One of the over-riding lessons from the Mid Staff enquiry was the need for a consistent culture of openness and candour in the NHS. The report advocated that the healthcare system must move away from previous closed and defensive responses to mistakes; recognising the importance of being transparent about mistakes so that errors can be addressed and lessons learnt. The report recognised that it was crucial to help rebuild full public trust in the NHS following the revelations of the enquiry. To this end many of the recommendations supported greater transparency about key safety metrics including safe staffing, and exercising a duty of candour when patients have been harmed in NHS care.

Following the publication of the Mid-Staffordshire public inquiry, the Prof. Don Berwick was invited to undertake a review of patient safety in the NHS. In 2013 he published A Promise to Learn; a Commitment to Act. The opening paragraph in the executive summary states:

'Place the quality of patient care, especially patient safety, above all other aims.

Engage, empower and hear patients and carers at all times.

Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.

Embrace transparency unequivocally and everywhere, in service of accountability, trust and the growth of knowledge'

The first three points in this paragraph -patient safety, patient experience and staff development - are topics which have become part of the operational day to day management of hospitals. They are measured, surveyed, benchmarked and inspected. At GOSH, we have committees designed to focus our organisational attention on these issues: Patient Safety & Outcomes Committee; Patient and Family Experience and Engagement Committee; and most recently the GOSH Learning Academy.

Yet the governance and structure regarding the last topic - the need for transparency - is slightly less tangible. This is not specific to GOSH. What is it that we can measure, benchmark and improve in relation to transparency? How do we determine what 'good' and 'outstanding' looks like?

What does transparency mean in healthcare?

Transparency supports the basic principles of professionalism. It is consistent with, and reinforces the clinical view of professionalism: to put the patient's interests first and improve quality of care.

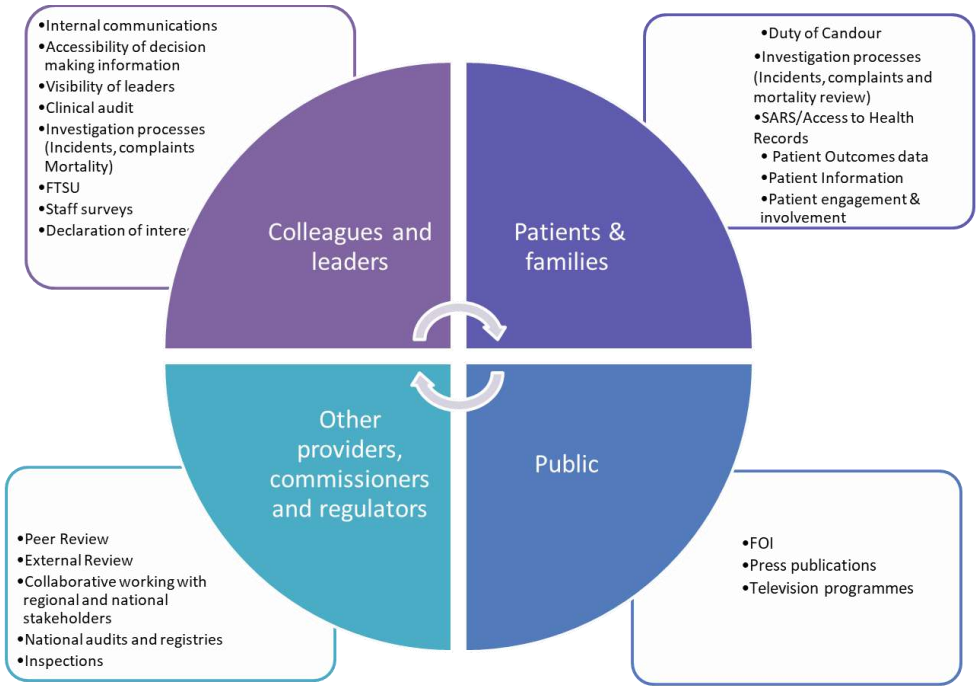
Transparency is not a one off thing we do. It's not an end in itself. It's better understood as a process (or range of processes) which enable us to build, maintain and increase trust.

There are four key stakeholder groups with whom we must cultivate a relationship of trust:

- **Patients and their families** trust hospital to always provide high quality care and be forthcoming and open about things that have gone wrong
- **Staff** trust colleagues and leaders to always make decisions in an open and accountable way
- **NHS Colleagues including Commissioners and Regulators** trust the organisation to always work effectively as a system player and leader, acknowledging strengths and weaknesses

- The **public** trust the hospital to always deliver world leading care for the sickest children and to be open and honest about their performance standards

There are a range of different processes which support us to be transparent with each of these groups of stakeholders. These include:



What are the benefits of improving transparency?

Transparency lies at the heart of the relationship between patient and clinician, but it is also central to the effective management of healthcare organisations. Transparency:

- Facilitates patient choice and informed decision making
- Promotes accountability with the hospital and the broader regulatory system
- Supports learning and development in an open culture
- Catalyses improvements in quality and safety at local, regional and national level
- Promotes trust and ethical behaviour between colleagues
- Enables healthcare professionals to be recognised for excellence in performance and allows others the opportunity to learn from and emulate that excellence

What are the Barriers to Transparency

Although the value and benefits of transparency are understood, it's important to recognise that there can be barriers to transparency, and consider how they may impact decision making at a range of different levels in the organisation. Understanding these barriers helps us to identify the areas in which we can focus our improvement efforts in future:

- Fear
  - Concerns about being treated unfairly if they are transparent
  - Concerns about conflict, humiliation or shame (individual/hospital)
- Lack of leadership and organisational will to create a culture of safety
- Stakeholders with a strong interest in maintaining the status quo
- Lack of reliable definitions, data and standards for reporting
- The need to protect Safe Spaces

Are we getting it right?

There are a number of ongoing cases being managed by the hospital where it is clear that families feel that they have not been provided with full information when requested via the SARS (and other) process.

In the last staff survey, our colleagues raised concerns, amongst other things, about the openness of our culture.

There have also been a number of media stories over the last few years which have questioned the Trust's commitment to transparency.

In September 2019 the organisation has faced criticism in the media from the family of Amy Allen who were concerned that the Trust had not been forthcoming regarding failings in her care.

In November 2019 the organisation faced further criticism in the media which alleged that differences between the first and final draft of a report on the RCPCH review of the Gastroenterology service pointed to a lack of transparency.

What have we done/are doing to enhance transparency?

In order to be transparent, it's imperative that we know and understand the truth. This relies on professional curiosity to help establish the truth through our reviews and investigations. It also relies on the quality of the data that we hold, how it is stored and how it is accessed. With the introduction of Epic in the organisation, our information is growing exponentially. Understanding it, and using it, effectively is crucial.

Attachment 3

- Speak up for Safety in the moment & Speak Up for the Values (staff)
- Freedom to Speak Up Guardian – March 2018 (staff)
- Duty of Candour policy and monitoring – April 2019 (patients &families)
- People Strategy (Staff)
- Internal: MBB (250 attending on average each month (staff)
- Visible Leadership Walk-rounds (staff)
- Proactive engagement with teams involved in external reviews/media interest (staff)
- FOI Log – April 2019 (public)
- Feedback Friday on twitter (patients & public)
- Declaration of Interest processes changes (staff, regulators & commissioners)
- EPIC/My GOSH (staff, patients & families)
- Child Death Overview process changes – Sept19 (families, regulators & commissioners, public)
- Q&S boards – July 2019 (patients and families)
- Integrated Quality and Performance – March 2019 (staff, regulators and commissioners)
- Closing the loop – June 2019 (staff, regulators and commissioners)
- Ethics committee (staff, patients and families)
- Publication of clinical outcomes (patients, and families, public)

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27th November 2019	
Royal College of Surgeons Urology Service Review Summary and Action Plan **Submitted by:** Dr Sanjiv Sharma, Medical Director	**Paper No: Attachment 4**
Aims / summary This paper provides context to a recent Royal College of Surgeons (RCoS) invited review of the GOSH Urology Service. An Executive Summary with recommendations from this report and action log outlining the developmental plan for the department are attached.	
Action required from the meeting For noting	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Trust is committed to reviewing the quality of the service that is provided to our patients and to work with our external partners to ensure we are always improving.	
Financial implications None identified at present	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? The report has previously been shared with QSEAC and with the clinical team. Further discussion will take place through two more scheduled team days as outlined in the action log.	
Who needs to be told about any decision? Feedback to the RCoS of delivery against the action plan will be provided early in 2020. The action plan will continue to be monitored through Patient safety and Outcomes committee (PSOC) and Operational Board.	
Who is responsible for implementing the proposals / project and anticipated timescales? The Specialty Lead will be responsible for implementing proposals and supported by the Chief of Service for Body, Bones and Mind.	
Who is accountable for the implementation of the proposal / project? Chief of Service for Body, Bones and Mind	

Background

In March 2019 the Medical Director commissioned a Urology Service Review from the Royal College of Surgeons (RCS) asking for a review of team dynamics, quality and performance data, departmental leadership, and future opportunities for subspecialisation.

RCS reviews are commissioned through the RCS Clinical Review Service. Terms of reference for the review are agreed with the commissioning organisation and are strictly regulated through an RCS governance process that cannot be influenced by any interested parties.

Quality Safety and experience Assurance Committee (QSEAC) and Trust Board have been kept informed about this review, and we have also discussed the review with CQC and NHS England.

The Executive Summary for the RCS report is attached as Appendix 1. An initial action plan was submitted to the RCS in September 2019 and in response to this, the RCS wrote:

The review team were encouraged by the by the apparent willingness by the Trust and the department to move things forward and make the following specific comments/observations:

The planned department away day.

1. *This appears to be a key milestone on enabling progress going forward; it may be helpful to agree:*
    - *The key objectives;*
    - *The agenda;*
    - *The Chairing arrangements, perhaps considering an external chair from Trust senior management.*
    - *How decisions agreed (and still to be agreed) will be audited.*
2. *It may be helpful to aim for agreement on how the team needs to operate to deliver the service to the standards required. This could consider a behavioural code of conduct, formally agreed by all team members and agreement regarding any infringements which may occur. A clear chain of accountability in place, should any issues not able to be resolved amongst the team, may help to ensure the Code remains meaningful.*
3. *A follow up/review meeting, within six months after the away day and regular follow ups every 6-12 months may help keep things on track and keep momentum.*

Mediation

An external mediator is advised. If an internal mediator is used, it may be preferable for them to be from outside of the department and trained in mediation skills.

Report recommendation 4b

The review team reiterate the recommendation of appointing an external chair for the nephron- urology radiology MDT. They note that the Trust's consideration of rotation monthly would be acceptable and suggest consideration is given to a rotation of radiologists.

Next Steps

Subsequent to this submission a team away day has been held and a further two dates are booked for 03/12/2019 and 10/01/2020. An action log is attached to this paper as Appendix 2 and this will be tracked through Patient Safety Outcomes Committee (PSOC), learning cascaded via the Closing the Loop Group and assurance provided to QSEAC against completion of actions.

Invited Service Review Report

Report on the Paediatric Urology Surgical Service

Great Ormond Street Children's Hospital NHS Foundation Trust

Review visit carried out on: 23rd & 24th May 2019

Report issued: 11th July 2019

A service review on behalf of:

The Royal College of Surgeons of England

British Association of Paediatric Surgeons

Review team:

[redacted]

[redacted]

[redacted]

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1. Executive summary

On 18th March 2019 [redacted] for Great Ormond Street Hospital NHS Foundation Trust (referred to hereafter as "the Trust"), wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the healthcare organisation's paediatric urology surgical service. The request was prompted by: concerns raised by staff, serious untoward incident, internal review and audits/outcomes data. In particular, the request highlighted: standards of team working, multi-disciplinary team (MDT) processes, clinical workload, clinical leadership, protocols and patient pathways and interactions with management.

The request was considered by the Chair of the RCS IRM and a representative of the British Association of Paediatric Surgeons and it was agreed that an invited service review would take place.

A review team was appointed and an invited review visit was held on 23rd and 24th May 2019. The appendices to this report list the members of the review team, the individuals interviewed, the service overview information and the documents provided to the review team.
It should be noted that an invited Clinical Records Review of seven specific cases within the paediatric urology service was commissioned by the Trust alongside this service review.

Overview of Trust and Department

There are currently six consultant surgeons within the paediatric urology surgical service (referred to hereafter as "the consultant team"). In addition, there is: one specialist registrar[1], a deanery fellow and seven Trust fellows. The Consultants do a 1:6 emergency on call with internal cover for annual and study leave.

There were understood to be six Urodynamics Clinical Nurse Specialist (CNS) posts and 1.5 full time equivalent urology CNSs. There is one dedicated urology ward with eight beds plus two HDU beds. There are no dedicated ITU beds, the service utilises beds from a central ITU ward where needed.

In terms of elective capacity, there are fourteen sessions per week of four hour lists, covering both day case and elective operating. There are nine Trust four hour emergency sessions per week. Data from the previous two years, indicates that, there were, on average, 3,300 elective (NHS only) admissions per year.

Weekly outpatient clinics are currently twenty eight slots for new patients and 112 for follow ups, with data from the previous two years indicating the number of patients seen per year, to be in the region of 5000 – 5500.

It is understood that the service accepts referrals from anywhere in the country, although it is expected that referrals would not be accepted where there is a suitable provider closer to the patient's home.

The nephro-urology radiology multi-disciplinary team meeting (referred hereafter as the "MDT meeting") is held each Friday morning for 90 minutes, with the average consultant attendance reported as 80%. There is also, for clinical governance, a weekly consultant meeting taking place after the MDT meeting, with the same reported consultant attendance.

[1] ST8

Key Issues arising and conclusions

This section provides a summary of key issues arising and conclusions formed by the review team based on the information provided. It is noted that the Invited Clinical Records Review, conducted separately to this review, is only commented on insofar as it fits within the terms of reference.

The consultant team was widely reported to be a group of excellent dedicated surgeons who look after patients well, and have different strengths and areas of expertise. It was clear from interviews, however, that there has been and there are currently, significant difficulties in interpersonal relationships within the consultant paediatric urology surgery team (referred to hereafter as "the consultant team"), which, it seemed has resulted primarily from a fractured relationship between two individual consultant urology surgeons. The effect on the working environment for the two individuals concerned and indeed on the whole consultant team, is significant.

The difficulties in interpersonal relationships have impacted the effectiveness of the consultant team and its ability to share ideas and constructive criticism. Areas specifically identified as affected include: patient management, the development of the service, the ability of the service to adapt to changing demands, involvement in national audit and clinical outcomes. In addition, the significance of the dysfunction between the two consultants, seems to have resulted in Trust management focussing on this, at times to the detriment of the rest of the consultant team.

It seemed that previous attempts to address the team working difficulties, including mediation and agreeing a set of team rules, has been of limited effectiveness. There are some reservations amongst the consultant team as to the appropriateness of the planned further mediation, given that the problems are seen to be centred around two consultants in particular. The review team, as a result, have concerns regarding proceeding with this mediation at this time.

The interpersonal difficulties, primarily between the two consultant paediatric urologists, seem to be causing difficulties in the operational and developmental aspects of the service. This may have the potential to affect patient care and safety, if not resolved, in light of the apparent lack of trust and respect and unwillingness to work collaboratively. The potential impact and the ability of the team to work effectively, and hence on patient care, may be amplified in the context of reportedly high current workloads and by further additional stressors including: the transition to EPIC[2], the invited external reviews and the proposed mediation.

Many members of the consultant team are working together collaboratively, both inter-departmentally and intra- departmentally. However, the apparent reluctance of one consultant paediatric urologist to collaborate with the wider team and with other related services, has had an impact on multidisciplinary team (MDT) working. Of particular significance, is the reportedly inconsistency of working with paediatric surgical colleagues, considered important to enable a holistic approach to patient care.

It was also of concern to the review team that there were reports of inappropriate behaviour towards support staff and consultant colleagues by a member of the consultant team. In addition, an unwillingness of this member of the consultant team to participate in cystoplasty and Mitrofanoff audit for ERAS[3], was considered indicative of the impact on the wider team and related services of this individual's apparent reluctance to contribute towards team working.

The reportedly variable attendance at the MDT meeting and the quality of discussions appear to have been affected by the perceived atmosphere as a result of the attendance or non-attendance of a particular consultant urology surgeon. In the review team's opinion, this is

[2] EPIC is a health information technology system to access, organize, store and share electronic patient medical records.
[3] ERAS - Enhanced recovery after surgery

indicative of many of the difficulties of intra- departmental and MDT working, which appear to be attributed primarily to this member of the consultant team.

The Trust historically, appears to have had limited success in managing the departmental difficulties. Frequent changes in directorate structures are likely to have impacted the consistency of management and support for the urology surgery service within the context of the apparently ongoing and worsening difficulties within the consultant team as a whole, fuelled by the interpersonal difficulties outlined above. There were some particular areas, in which difficulties were identified in the support and management of the service. These included: management's ability to address issues raised and take action, follow through on agreed actions, taking account of the expectations of trainees and fellows, focussing on some members of the consultant team rather than the whole consultant team and processes for recruitment (both to the clinical lead and the consultant team).

It was understood that there is currently a moratorium on definitive surgery for DSD[4] cases at the Trust, yet it was not clear what process had been put in place for the surgical assessment pathway.

There did not appear to be clear guidelines or pathways for the management of external clinics and complex case referrals. There also appeared to be significant competition between some consultants for work, without clear subspecialisation being taken into account. This seemed to be adding to the conflict within the team as well as creating the potential for waiting time breaches.

The current workload, in the review team's view, has been putting the consultant team under undue pressure at times, in particular in respect of the outpatient time allocated to see and assess complex patients. The context of the recent additional non clinical demands such as the transition to EPIC, is also noted.

The structures and processes in place for the treatment and care of private patients by individual consultant surgeons were unclear and appeared to be an area which had contributed to interpersonal difficulties within the consultant team.

Regarding clinical governance, the overall structure and its operational aspects are considered insufficiently robust. There appeared to be a lack of cohesion, direction, joint accountability for decision making, joint learning and action planning. In addition, effective clinical leadership seems to be hampered by the dysfunction within the consultant team.

The outcome data provided for the review was inadequate in several respects, including there being a lack of evidence of learning in morbidity and mortality (M&M) meetings. In addition, the review team was concerned regarding the accuracy of the hypospadias outcome data provided and the service and individual consultant surgeon complication rates in terms of clarity and comparability.

It was understood that there is currently some degree of sub-specialisation within the service according to relative expertise. However, it appeared that sub-specialisation had yet to be comprehensively addressed, limiting the progression and innovation of the service. The apparent lack of trust and respect between some members of the consultant team and the need for stronger managerial leadership, appears also to have been a barrier.

In relation to succession planning, actions have been taken by individual consultants to enable this to be addressed but as with sub-specialisation, there appears to have been a lack of a comprehensive approach.

[4] Disorders of sex development (DSD) are medical conditions involving the reproductive system and refer to "congenital conditions in which development of chromosomal, gonadal, or anatomical sex is atypical.

Overview of recommendations

Two recommendations are made which are considered urgent to address patient safety risks, and, therefore are highly important actions for the Trust to take. The first of these addresses the dysfunctional relationship between two members of the consultant team and highlights the need to facilitate repair of the relationship within an appropriate time frame. The second recommends support and training to improve the effectiveness of clinical leadership. This is considered key to improving culture, communication and team working, which in turn will improve patient safety and operational efficiency.

Seven further recommendations are made, considered important for service improvement. These include building on the urgent recommendation in respect of the fractured collegiate relationship by further improving team working. In addition, these recommendations address the issues highlighted relating to: the MDT meeting, service delivery and sub-specialisation, patient referral, audit and recruitment processes.

Two additional recommendations are made for the Trust to consider as part of its future development of the service in terms of succession planning and consultant job plans.

5. Recommendations

5.1. Urgent recommendations to address patient safety risks

The recommendations below are considered to be highly important actions for the healthcare organisation to take to ensure patient safety is protected.

1. The current dysfunctional relationship amongst the two consultant surgeon colleagues needs to be addressed and attention given to ways in which support may be provided to heal the division. This may include, but is not limited to, a facilitated process to repair the relationship in an appropriate time frame agreed by those concerned.

2. The Trust should provide appropriate support for the clinical lead for the service and consider formal training programmes. Good clinical leadership is key to improving culture, communication and team working, which in turn will improve patient safety and operational efficiency. The College document “Surgical Leadership: A guide to best practice,” provides some guidance.

5.2. Recommendations for service improvement

The following recommendations are considered important actions to be taken by the healthcare organisation to improve the service.

3. Following recommendation 1 above, once there is progress in repairing the relationship between the two consultant surgical colleagues, a facilitated process should follow to build team working. This should include re-establishing the expected code of conduct for the service and an appropriate process for managing any agreements arising from that process, including handling of infringements, and a willingness by senior management to sanction behaviours deemed to be a risk to team functioning and therefore, potentially, to safe patient care.

4. The structure of and process within the nephro-urology Radiology MDT, should be addressed and consideration given (but not limited) to:
    - Monitoring attendance by core members with low attendance addressed through the appraisal system;
    - Appointing a neutral external chair to contribute to resolving poor team working;
    - Formal documentation with minutes, decision making and action points being noted. This should be addressed for the departmental MDT, the M&M meetings, and other interdepartmental MDTs.

5. The Trust should review the present working model of service delivery and consider the development of more formal sub-specialisation to enable the service to meet present and future demands and to ensure the skill mix within the team is well utilised. This may include, but is not limited to a model whereby two consultants jointly perform exstrophy surgery and other complex surgery. The consultant team should gradually learn to respect and support colleagues’ specific clinical interests. However, the review team strongly advise that no significant condition should be regarded as the sole property and interest of any single consultant.

6. Reduce the number of patients with complex cases to be seen in each clinic and/or increase the time allocated to see each patient.

7. The process for patient referral to the consultant team should be established in a framework agreed by all individuals involved in the process.

8. There should be a comprehensive approach to audit, including, but not limited to:
    - Audit of outcome and complications for all areas of work;
    - Submitting to national databases, including for hypospadias;
    - Acceptance of departmental data of the exstrophy service and presentation of such annually at the national BAPU meeting;
    - Cooperation with the national hypospadias database.

9. The selection and appointment of new consultants and other team members should be made in accordance with a standardised process. This should include the way in which the panel members are appointed, the way questions are asked, and the way the final choice of candidate is made. This should be in full accordance with existing Trust policy and process which, in turn, should follow accepted best practice in selection and recruitment.

5.3. Additional recommendations for consideration

The following recommendations are for the healthcare organisation to consider as part of its future development of the service.

10. The Trust should review the current activity in terms of succession planning and consider building on this as part of a strategic approach. This should be carried out with robust, regular job planning and consultant appraisal.

11. The clinical lead and management should review consultant job plans with colleagues, in order to ensure equal distribution of work, or at least that colleagues are satisfied with their own job plan, in comparison to others.

5.4. Responsibilities in relation to this report

This report has been prepared by The Royal College of Surgeons of England and British Association of Paediatric Surgeons under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the content of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[13]

5.5. Further contact with the Royal College of Surgeons

Where recommendations have been made that relate to patient safety issues the Royal College of Surgeons will follow up with the healthcare organisation that commissioned the invited review to ask it to confirm that it has taken to action to address these recommendations.

[13] The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made

If further support is required by the healthcare organisation The College may be able to facilitate this. If the healthcare organisation considers that a further review would help to assess what improvements have been made the College's Invited Review service may also be able to provide this assistance.

ACTIONS LOG - Urology Review

Last updated: 05.11.19

Great Ormond Street Hospital for Children NHS Foundation Trust

Ref	Action	Date identified	Owner	RAG	Due Date	Status	Comments / Notes	Closed Date
A001	Mediation between 2 identifed consultants	05-Nov	Allan Goldman	Green	01/01/20	Open	Provisional date identified 28/11-29/11	
A002	Clinical leadership guidance for HOCS to improve culture, communication and team working	05-Nov	Allan Goldman	Green	31/03/20	Open	A coach and mentor have been agreed and have both already met with IM and myself. We have away days booked for 03/12/19 and 10/01/20 to improve teamwork & go through actions of RCoS report	
A003	Repair team working and consider code of behaviour and escalation of behaviours thought to impact on service development	05-Nov		Green		Open		
A004	Improvements to be delivered in nephro-urology radiology MDT	05-Nov	Zoe Hallett/Carly Vassar	Green	31/01/20	Open	This should include appointing a neutral chair, setting core team, TOR, monitoring attendance. Formal minute taking including decision making and action setting.	
A005	Develop formal sub-specialisation of service in order to meet present and future demands of service	05-Nov	Allan Goldman	Green	31/03/20	Open	To be discussed as part of consultant away days above	
A006	Review clinic provision in order to provide a better patient experience for complex patients	05-Nov	Zoe Hallett	Closed	30/11/19	Closed	Reduction of patients in clinic. Additional ad hoc clinics arranged as an interim solution. Plan is to also appoint a locum consultant to assist with clinical workload.	13/11/19
A007	Appointment of locum to provide additional capacity for outpatients	05-Nov	Zoe Hallett	Green	31/03/20	Open	IM finalising job plan before taking to panel and EMT	
A008	Patient referral framework to be developed and embedded in practice by entire team	05-Nov	Cristina De Rossi	Green	31/03/20	Open	Accptance criteria has been reviewed. New referral process to be developed on away date. First step is to agree subspecialisation and then for those teams to work out referral pathway and outcomes audit. On agenda for the 3rd away day after agreement sub specialisation at next one.	
A009	All areas of work should have audit data for outcomes and complications collected	05-Nov	Allan Goldman	Green	31/03/20	Open	To be discussed at away day. Also see A008 above	
A010	Audit data should be available to be submitted to national databases this should include hypospadius data	05-Nov	Allan Goldman	Green	31/03/20	Open	Agree, to discuss at 3rd away day in Jan.	
A011	Data collected for the bladder extrophy service should be shared annually at the BAPU conference	05-Nov	Allan Goldman	Green	31/03/20	Open	Data has been presented at BAPU 2019. Further audit and presentation as above and refined following agreement on subspecialisation.	
A012	Recruitment processes will be inline with the trust standard HR processes	05-Nov	Allan Goldman	Closed	31/03/20	Closed	Previous recruitment has followed trust guidelines. Future shortlisting will be done with all Urology Consultants as per request.	13/11/19
A013	All consultant and CNS job plans to be reviewed ensuring equity of work distribution	05-Nov	Allan Golsman/ Carly Vassar	Green	31/03/20	Open	Principles of group job planning of consultants to be discussed and agreed at away day. Individual job plans to be done annually. Have been completed for 2019 in past 6 months for all but one consultant. To complete job plan after agreement of principles of job planning and subspecialisation above.	
A014	Current activity should be reviewed and sucession planning considered	05-Nov	Allan Goldman/Zoe Hallett	Green	31/03/20	Open	To be undertaken at away days, this is very much part of subspecialisation agreement. Small sub specialist teams with succession planning included.	
A015								
A016								

A017								
A018								

RAG Rating Key:
Action is on track
Action up to 2 weeks behind due date
Action is more than 2 weeks over due

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 November 2019	
Guardian of Safe Working report **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment 5**
Aims / summary This report is the second quarter report of 2019/20 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1st July to 30th September 2019 inclusive.	
Action required from the meeting The board is asked to note the report and the issues influencing junior doctor's working, the challenges in monitoring compliance with the TCS 2016 and the achievements to date.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working (GOSW) supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications Continuing payment for overtime hours documented through the exception reporting practice Publication of Amendments to the 2016 TCS which requires GOSW administrative support and may result in additional clinical workforce requirements	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working Mr Simon Blackman Deputy Medical Director for Medical & Dental Education	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Medical Director	

Attachment 5

Guardian of Safe Working
Second Quarter: 1st July – 30th September 2019

1. Purpose

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

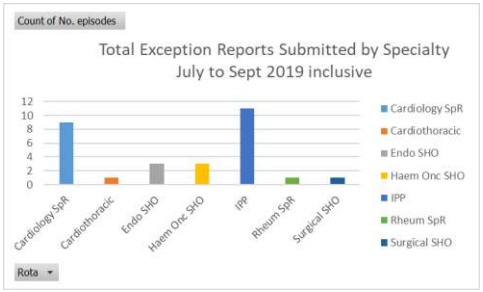
2. Background: See Appendix 1

3. High Level Data:

3.2. Number of exception reports (ER) at GOSH remain relatively low but reflect cohort a) senior trainees b) non UK Trust doctors.

3.3. Numbers of doctors submitting reports as a proportion of total remains very low.

- 29 ERs in this quarter are for extra hours worked.
- All 29 ERs submitted by a total of 7 doctors



International private patient (fellow) and cardiology/ pulmonary hypertension (fellow) are the two main specialties submitting the majority of ERs 7-9/19

3.4. Exception Report Outcomes:

Outcome ERs July to Sept 2019	
Financial Compensation	21
Time off in Lieu	7
Paid bank shift	1

- Financial compensation has been paid to most doctors submitting ERs.
- No fines have been levied – no known breaches for trainees

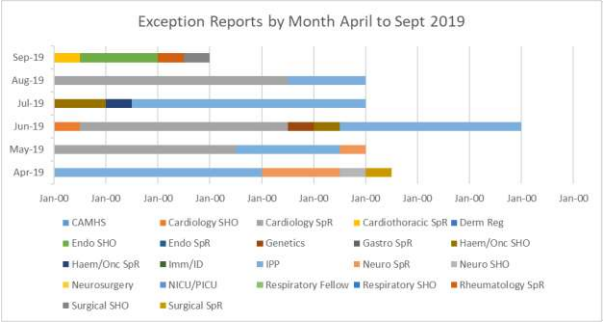
3.5. Exception Report Narratives:

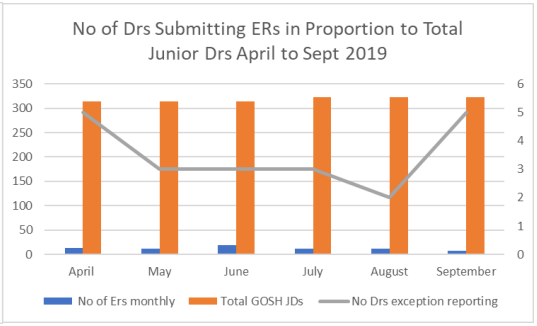
- *'The long day registrar was busy sorting out a sick child. There was a new private patient admitted to Kingfisher who needed urgent clerking. We have discussed that all hand over should happen at 5:00 p.m. and the job should be taken over by the long day registrar. This will be discussed in our junior- senior meeting so that we can identify any issues and rectify them'.*
- *'We acknowledged that there has been a chronic understaffing within the PH team. X has been working hard and consistently staying at work beyond his contracted hours'*

3.6. Exception Reporting Patterns:

- There is spread of reporting across specialities but few junior doctors submit ERs

Dr Renée McCulloch 16/11/2019

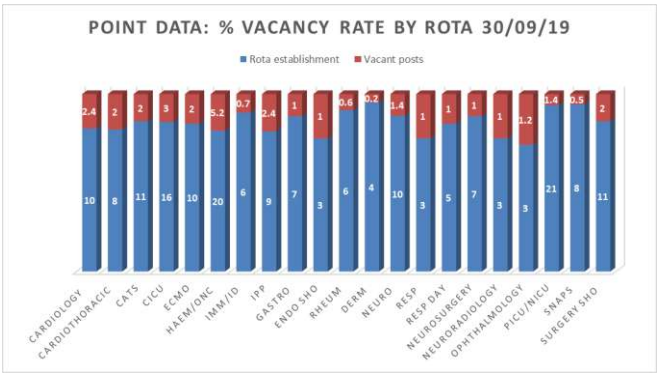




4. **Vacancy rates:** overall vacancy rate across junior doctor rotas as of 30/09/2019 **is 11% with 33 FTE vacant out of a total of 299 rota slots.**

4.2. Number of Trust Doctors as of 30 Sept 2019 = 185.56

4.3. Number of Training Doctors as of 30th Sept 2019 = 137.71



4.4. Although GOSH vacancy rate is less than the national average (approx.15% in paediatrics) the impact of rota gaps on a department is significant when:

- the gaps persist over time (e.g respiratory; CATS)
- they involve both SHOs and SpRs in the same department
- they occur in smaller departments (Immunology; Rheum; Derm) and impact on flexibility to take leave.

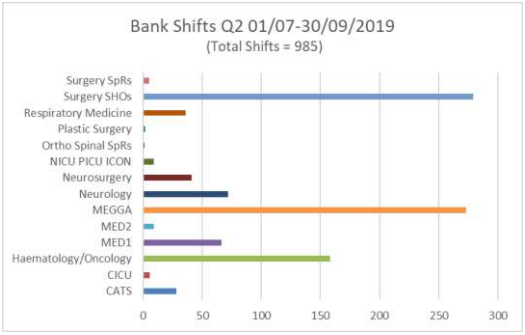
5. **Vacancy Spend –with reference to rota**

5.2. Total Bank Spend Q2 = £379,763.58

5.3. MEGGA rota (now disbanded; MED1 and MED2 established in Sept 2019. MEGGA spend for July & August £99,658.

5.4. National delays in recruitment of overseas doctors in September created rota gaps, particularly in HaemOnc.

5.5. Surgical SHO had significant rota gaps in July/ Aug. From Sept 2019 now almost at full complement



6. **Junior Doctors Forum**

6.2. JDF has been very well attended. Junior doctor's representatives are now integrated within each directorate management team. They have access to the MILE leadership program. This development route has resulted in excellent engagement.

7. **Compliance with 2016 TCS**

7.2. GOSH rotas are compliant with the 2016 TCS. Both trainees and non-training grades can exception report at GOS

7.3. No fines have been levied with current ERs to date. Fines would only apply for the doctors on the 2016 TCS on formal training programs On introduction of 2016 TCS, doctors below ST3 in 2016 moved onto the new system.. GOSH has 141 doctors in training on the 2016 TCS with increasing numbers expected over coming years.

7.4. GoSW intends to restructure the current ER process with the 2019 updated 2016 TCS below.

8. Publication of Amendments 2016 TCS September 2019:

8.2. Context for 2018 contract review

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

9. TCS contract includes but is not limited the following amendments:

9.2. Weekend frequency allowance maximum 1:3

9.3. Too tired to drive home provision

9.4. Accommodation for non-resident on call

9.5. Changes to safety and rest limits that will attract GoSW fines.

Breaches attracting a financial penalty broadened to include:

1) Minimum Non Resident On Call overnight continuous rest of 5 hours between 2200-0700
2) Minimum total rest of 8 hours per 24 hour NROC shift
3) Maximum 13 hour shift length
4) Minimum 11 hours rest between shifts

9.6. Exception Reporting

1) Response time for Educational Supervisors - must respond within 7 days. GoSW will also have the authority to action any ER not responded to
2) Payment must be made within 1 month of agreement or on next available payroll. No extra admin burden should occur
3) Conversion to pay - 4 week window from outcome agreed to identify a shift before the end of the placement for TOIL to be taken. If this doesn't happen, payment should automatically be given. At the end of a placement, any untaken TOIL should be paid

9.7. Time commitment and administrative support for GOSW

10. Implementation of New Amendments 2016 TCS

The 'refresh' requirements for the 2016 contract is in progress at GOSH –a staggered timeline is in place for implementation to be completed between October 2019 and August 2020. Every rota is being checked and amended for compliance to new regulations. It is likely that safety and rest limits, and the challenges demonstrated by the JD24/7 project for taking leave, will impact on the requirements for medical staffing in 2020.

11. JD 24/7 Task Finish Group

The Junior Doctors 24/7 'round-the-clock' (JD24/7) task and finish group was commissioned by Medical Director in response to issues raised through the Guardian of Safe Working in December 2018. The interdisciplinary group reviewed models of working and rota systems in GOSH with a focus on out of hours work. The report published in July 2019 made several recommendations. These are being integrated into a wider Trust project to be delivered through the modernising medical workforce committee.

Table to outline work streams resulting from JD 24/7 Recommendations:		
Objective	**Task**	**Milestone to date**
Trust wide rota restructure to support safe working and better staff experience to deliver excellent outcomes including formal centralisation of Trust wide rota coordination incorporating key successful elements identified through our engagement with peers	Megga rota remodel	New MED1 and MED2 rotas: increased night cover for 11 specialities. Integrated IPP fellows into NHS rotational post.
	Centralisation of rota coordinators	New general manager supporting cross organisational rota support;
	Rota review in cardiology, neuro-respiratory	
	Ensuring that our rotas are designed to enable junior doctors to take annual and study leave appropriately	In process- work plan in place
Delivering clinical excellence out of hours	Ensure we have safe and effective handover out of hours	Plan to run 'pop-up' workshop Jan 2020
	Delivery of the clinical operations hub facilitating effective triage, allocation and completion of tasks out of hours, working as one team OOH	Define milestones through MMW committee
To ensure that GOSH is the best hospital for junior doctors to work and learn Future proofing: make sure that we have accurate and up to date information flowing within our governance and performance pathways to enable us to manage the medical workforce in a responsive and safe way.	Fatigue and facilities charter	Action plan in place
	Develop dashboards with appropriate KPIs	Define milestones through MMW committee
	Define and implement escalation pathways for unsafe staffing	In progress SOP draft re escalation planning for rota gaps
	Develop Advanced Clinical Practice& Shape of Training strategy	Define milestones through MMW committee

12. Rest Facilities

12.2. Temporary bed rest facilities remain on Penguin ward. Costings and logistics to develop permanent rest facilities are now needed to meet requirements for out of hours working.

12.3. The Junior Doctor Forum has been awarded £60,000 from the Department of Health to contribute towards improving out of hours rest facilities. Monies have been allocated for furniture and fittings.

13. Summary

13.2. ER numbers are remain low but despite this are used as indicators of issues within departments that may require further attention and review, facilitating change management

13.3. The ER system and process is being evaluated and refined as required for the new terms of the 2016 contract.

13.4. Rota reviews are occurring across GOSH to ensure compliance with amended TCS 2016 contract – this may have implications for medical workforce staffing.

13.5. Vacancy rates fluctuate across departments but remain less than the national average. Rota gaps continue to impact on working conditions for junior doctors.

13.6. Temporary rest facilities provide adequate accommodation however costings and logistics to develop permanent rest facilities for junior doctors are required.

13.7. The JD 24/7 task finish group have been actively working to identify issues relating to JD working. Remodelling of the MEGGA rota has been implemented in September 2019. A project plan incorporating recommendations is in progress,

13.8. Junior doctors are well engaged and the JDF invites the Board members to attend its meetings.

Appendix 1 Background Information

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

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

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

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

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

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

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

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

There are 45 different rota patterns currently in place within the Trust. All are compliant with 2016 TCS.

The Trust uses 'Allocate' software for rota design and exception reporting. There have been issues with navigation of software and consistency of use (wide range of inputs for the same exception reports). There are no automated ways to identifying breaches. This must be done manually. Allocate have improvement updates due in 2019 to include:

- Ability to close exception when trainee fails to respond
- Guardian quarterly board report
- Simplify the adding of overtime hours
- Process for tracking time of in lieu and overtime payments
- Allow supervisor and Guardian role for the same user
- Standardised themes for breach types

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 November 2019	
Emergency Preparedness, Resilience and Response Assurance 2019 **Submitted by:** Camilla McBrearty & Phil Walmsley	**Paper No: Attachment 6**
Aims / summary This report sets out to the Board the level of compliance reached by the Emergency Planning function at Great Ormond Street Hospital for the 2019 NHS England & NHS Improvement core standards for Emergency Preparedness, Resilience and Response. The report also sets out some of the minor recommendations made to further enhance the EPRR capability of the Trust.	
Action required from the meeting For the Board to agree the level of compliance awarded to Great Ormond Street Hospital for the 2019 core standards for Emergency Preparedness, Resilience and Response Assurance by NHS England & NHS Improvement.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Zero Harm	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision? NHS England & NHS Improvement	
Who is responsible for implementing the proposals / project and anticipated timescales? Emergency Planning Officer and Accountable Emergency Officer (C.O.O.)	
Who is accountable for the implementation of the proposal / project? Emergency Planning Officer and Accountable Emergency Officer (C.O.O.)	

Attachment 6

Report name:	**Great Ormond Street Hospital's level of compliance against the NHS England and NHS Improvement Emergency Preparedness Resilience & Response (EPRR) assurance process, 2019**
Purpose:	**Board approval and agreement with compliance awarded**
Meeting date:	**24th November 2019**
Author:	**Camilla McBrearty, Emergency Planning Officer (EPO)**
Exec lead:	**Phil Walmsley, Accountable Emergency Officer (AEO)**

The annual NHS England and NHS Improvement (NHS E&I) assurance process aims to seek assurance that both NHS organisations in England and NHS E&I are prepared to respond to emergencies and have arrangements to ensure resilience to allow continuation of provision of safe patient care in the event of disruptions.

The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against the NHS Core Standards for EPRR.

To enable a national-level overview of EPRR capability, each organisation is asked to provide a single self- assessed overall level of compliance, approved by the AEO. This is intended to summarise whether organisations believe they are fully, substantially, partially or non-compliant against the core standards as a whole. The definitions of these ratings for the 2019-20 process and are detailed below:

Compliance levels	Criteria to achieve this level of compliance
Fully compliant	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is less than 76% compliant with the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action

Following the assurance visit on 15th October 2019, it was confirmed that the Trust scored 100% and was therefore fully compliant for all EPRR core standards. This is the first time the Trust has secured this level of compliance, and particular note was made of the success of 100% coverage for business continuity plans across the Trust, the implementation of new training for specific roles to improve our capability during major incidents, and the improvement to the EPRR Policy document.

There were several minor recommendations which will form the basis of the EPO's workplan for the next 6 months:

- enhanced information and clarification of wording to be incorporated in some Action Cards within the Critical & Major Incident Plan and the Cold Weather Plan

- adding hyperlinks to the Critical & Major Incident Plan and Trust Business Continuity Plan for ease of cross referencing when utilising plans during an incident.

- Adding information in line with new guidance regarding mass counter measures in cases of public vaccination, and the role GOSH may need play in such circumstances

- enhanced information regarding Mutual Aid to be added to the Trust Business Continuity Plan.

All organisations participating in the 2019-20 EPRR assurance process have been asked to ensure their Boards (or equivalent) are sighted on the overall level of compliance achieved, the results of the assessment and the action/work plan for the forthcoming period. A report detailing London's overall assurance outcomes will be tabled at the Spring 2020 London Local Health Resilience Partnership (LLHRP) meeting, and concludes with a submission to the NHS England and NHS Improvement Board in March 2020. Once this has been accepted by the Board, NHS England and NHS Improvement will be in a position to provide national EPRR assurance for 2019-20 to the Department of Health and the Secretary of State for Health.

Attachment 7

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27 November 2019

Learning from Deaths. **Mortality Review Group - Report of deaths in Q1 2019/20** **Submitted by:** Dr Sanjiv Sharma, Medical Director. Dr Finella Craig, Palliative Care Consultant, Chair of the Mortality Review Group. Andrew Pearson, Clinical Audit Manager	**Paper No: Attachment 7**

Aims / summary

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

This report meets the requirements of the National Quality Board by:

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

This an executive summary of a report that was reviewed at the November 2019 Patient Safety and Outcomes Committee.

- In Q1 19/20 there were no deaths that had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death.
  The report highlights learning highlighted by the reviews undertaken by the Mortality Review Group, and actions taken.

- This report is focused on learning from deaths that occurred between 1st April and 30th June 2019. One death has been reviewed by the MRG after this period that highlighted modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death. The review highlighted a potential failure to recognise clinical deterioration of the patient. This case was referred to the Executive Incident Review Meeting (EIRM) and a Root Cause Analysis investigation is being facilitated by the Patient Safety Team. The RCA will identity if there was a failure to recognize the clinical deterioration of the patient. The learning from that case, including any actions required, will be identified via that investigation and an update will included in the next learning from deaths report. The planned end date for the conclusion of the investigation is December 2019.

- This report includes an update on actions taken following publication of a Prevention of Future Deaths Report

Action required from the meeting

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

Contribution to the delivery of NHS Foundation Trust strategies and plans

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

Financial implications

none**.**

Attachment 7

Who needs to be told about any decision? n/a
Who is responsible for implementing the proposals / project and anticipated timescales? The Medical Director is the executive lead with responsibility for learning from deaths.
Who is accountable for the implementation of the proposal / project?

Attachment 7

Learning from Deaths: Report of deaths in Q1 2019/20

Background

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

Child Death Review Statutory Guidance

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

Aim of report

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

This report describes the findings from MRG reviews of GOSH inpatient deaths that occurred between 1st April and 30th June 2019 so precedes the 29th September requirement for a CDRM.

Headlines

Thirty one children died at GOSH between. 1st April and 30th June. Case record reviews have been completed for all cases.

Of the 31 cases reviewed:

- There were no cases that had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death (influence score 2[1]).
- Two cases where the review team felt that there had been a modifiable factor in the child's care *outside* of GOSH that that may have contributed to vulnerability, ill health or death (influence score two).
    - One case identified that there may have been missed opportunities for earlier septic screen and treatment in the community.
    - One case highlighted the advancement of a naso gastric tube which caused pneumothorax. The Child Death Review Co-coordinator is to liaise with the local team regarding this and to establish if a patient safety investigation has taken place.

These cases and the learning points are summarized in Appendix 1 of this report.

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

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

Total number of inpatient deaths at GOSH between 1st April and 30th June.2019	31
Number of those deaths subject to case record review by the MRG	31
Number of those deaths investigated declared as serious incidents	0
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2	0
Number of deaths of people with learning disabilities	3
Number of deaths of people with learning disabilities that have been reviewed	3
Number of deaths of people with learning disabilities where a modifiable factor was identified at GOSH with an influence score of 2 or more	0

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

This report is focused on learning from deaths that occurred between 1st April and 30th June 2019. One death has been reviewed by the MRG after this period and highlighted modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death .

The review (MGR398) highlighted a potential failure to recognise clinical deterioration of the patient. This case was referred to the Executive Incident Review Meeting (EIRM) and a Root Cause Analysis investigation (DATIXref 64613) is being facilitated by the Patient Safety Team. The RCA will identity if there was a failure to recognize the clinical deterioration of the patient. The learning from that case, including any actions required, will be identified via that investigation and an update will included in the next learning from deaths report. The planned end date for the conclusion of the investigation is December 2019.

Update on actions taken following Prevention of Future Deaths Report.

An inquest into the death of Amy Allan was heard between the 2nd and 5th September 2019. The coroner determined that Amy had died as a result of multi-organ failure and that an elective operation on the 4th September 2018 set in train a sequence of events which led to her death. During the inquest evidence was presented which gave rise to concerns for the coroner and he issued a Prevention of Future Deaths Report.

- Lack of awareness and sharing of information between departments. In particular the PICU had not been given any advance warning of Amy's complex medical background.
- There was no clear plan or instruction for the management of Amy post operation in relation to extubation and ECMO support on the PCIU.
- The handover between clinicians involved in Amy's operation and those taking over her care in the PICU was poorly executed with vital information either not properly conveyed or recorded or simply missed.
- Delay in commencing ECMO support
- No single properly informed clinician appeared to be coordinating Amy's post operative care in such a complex and high risk case.

Following the inquest the complaints action plan has been updated and expanded to include the learning from the inquest and the issues identified in the PFD. A submission must be made to the coroner by the 27th November 2019 to provide details of actions taken, or proposed to be taken, setting out the timetable for action. The actions are being followed up through Closing the Loop and QSEAC.

Learning Disability Mortality Review notifications

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

Period of deaths covered	No. of notifications required by GOSH	No. of notifications made	No. of notifications requiring submission
May 2017 to 30th June 2019	12	12	0

Learning points from deaths occurring in Q1 2019/20

The following general learning points have been identified from case note reviews. This does not imply that any factors were directly linked to the death of the child, rather that an awareness of these points will help us to continuously improve the care provided in the Trust for children and their families. These learning points will be shared with Closing the Loop to support any actions which made be required to implement them.

Context	Learning point and any actions taken
The child had multiple long term health needs following a bone marrow transplant. The child was admitted to PICU from their local hospital with widespread pulmonary Graft Versus Host Disease and referred to palliative care on this admission. The patient died in PICU with ceiling of care in place, but remained ventilated. (MRG374)	Many children attending GOSH have a poor long term prognosis. We need to identify children within this group who may benefit from parallel planning with the palliative care team. Parallel planning is now included in consultant update talk by the palliative care team.
The MRG review (MRG375) highlighted learning from one death where an incident was reported but no harm occurred to the patient. The patient had a cardiac arrest and the adrenaline minijet was reported as non- functional on DATIX (ref. 82859)	The learning from this incident was to highlight that mini jet pre filled syringes are not compatible with smart site connectors, and that a 3 way tap must be attached to connect them. A laminate to alert staff to this was introduced in 2017 and placed in emergency trolleys. Since 2017 the Resus team have included using a 3 way tap with a smart site and the prefilled syringe in the Level 3 resuscitation courses for nurses and medics. Following this incident •This incident happened on PICU, and staff were reminded , in posters and via email about using a 3 way tap when using a prefilled syringe. Staff were reminded about this as a top tip prior to every handover in the month following the incident. •The Practice educators have completed extensive training to re advise staff in PICU to remember that the prefilled Syringes cannot be attached directly to a smart site which was the

	cause of this datix •Additional posters have been issued across the hospital to remind others.
This child arrested peri-insertion of a central line on a background of severe circulatory instability. The central line was inserted as safely as possible using the gold standard technique of US guided insertion but the approximation to the time of arrest means it is impossible to say that this has nothing to do with the arrest; no procedure in a critically ill child is without risk. Whilst the complications of pneumothorax and haemopneumothorax were ruled out, it is possible that an arrhythmia may have been precipitated by line insertion. Just a small haemodynamic disturbance on the background of severe circulatory instability may have been enough to precipitate the arrest. There is nothing that could have been done to avoid this on review of the case(MRG376).	This is a an opportunity for teaching and preparedness within teams for cardiac arrests that do occur in haemodynamically unstable children, undergoing procedures, which are not risk free, despite adherence to gold standards, when undertaken PICU have devised a check-list for the insertion of central venous lines in critically ill children As a teaching point it is a reminder to ICU teams that unexpected complications can occur and should be anticipated and prepared for. This will be further reinforced by the use of the check-list. Caring for a critically ill child does necessitate undertaking procedures for stabilization; occasionally multiple procedures in sequence. During these times, parents are given the option of waiting in the relatives waiting area and are then invited to return to the bedside upon completion of the procedure/s. From review of this case, our learning has been to ensure we allow parents time at the bedside, with their seriously ill child, albeit briefly, in between procedures. We are cognizant that this might not always be practically achievable

4th November 2019
Dr Finella Craig, Palliative Care Consultant Chair of MRG;
Andrew Pearson, Clinical Audit Manager

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 November 2019	
Regular report on Infection Prevention and Control **Submitted by:** Dr John Hartley Director of Infection, Prevention and Control (DIPC)	**Paper No: Attachment 8**
Aims / summary: To update the Board on Infection Prevention and Control issues and current plans	
Action required from the meeting : Board support for actions and feedback.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Minimising infection is a central component of the Trust goal of zero harm	
Financial implications Failure to prevent or control infections leads to harm and cost.	
Legal issues No specific issues	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? Infection prevention and control is responsibility of all staff, patients and carers	
Who needs to be told about any decision?	
Who is responsible for implementing the proposals / project and anticipated timescales? Clinical and Corporate Directorates Infection Prevention and Control Team. Ongoing.	
Who is accountable for the implementation of the proposal / project? Dr John Hartley Director of Infection, Prevention and Control (DIPC)	

Great Ormond Street Hospital for Children NHS Foundation Trust

Regular DIPC Infection Prevention & Control Report to Trust Board
Update at 14/11/2019 (previous report was presentation of Annual Report on 18/07/2019)

Three top achievements since last report:

1. Completed 1 year of new audit process; providing good data on compliance
2. Establishment of Directorate IPC committees and outcome dashboards
3. Successful implementation of the 2nd phase of the 'gloves are off' campaign

Directorate risk registers - High risk items involving IPC - mitigation plans are in place

1. E&F - Non-compliant environment for medical equipment decontamination unit
2. O&I - Quality of off site sterile services resulting in cancellations and delays
3. S&S - Risk of cross infection to patients attending outpatient due to lack of isolation rooms
4. BBM – Risk of service disruption and patient harm due to quality of water on the haemodialysis unit
5. E&F – Quality of off site sterile services

(E&F - Estates and Facilities; O&I - Operations and Images; S&S - Sight and Sound; BBM - Body, Bones and Mind)

IPC Top risks

1. Trust: Failure to implement standard and transmission based infection prevention and control procedures at all times
2. IPC Team: long term maintenance and development of IPC information management systems (RL Solutions and EPIC)

Ongoing issues from IPC Committee (last meeting 17 October) – action plans are in place

1. Establishment of FFP3 respiratory (face mask) 'fit testing' process for all staff and modification of mask use in isolation precautions.
2. Final collation of records of baseline immunity for all staff held in OH
3. Implementation of alternative isolation policy in outpatients
4. Play and toy strategy
5. Agreeing schedule of periodic cleans
6. Acceptability of alternative waste stream
7. Monitoring gloves of campaign
8. Inconsistent quality of cleans in clinical area
9. EPIC - Need for new tip sheets for care bundles; Isolation orders
10. Awaiting audit of line insertion in IR triggered by RCAs of S. aureus bacteraemias
11. Further actions and communication on flu immunization campaign
12. Confirmation of appointment letters for Responsible Persons in water and ventilation
13. Theatre ventilation annual verification behind schedule, in part related to flight boards.

Closed actions this financial year

1. Urinary catheter care – guidelines
2. Policy for siblings of infectious patients
3. Duty of candour grading with respect to IPC
4. Antimicrobial Stewardship TOR and reporting
5. Quality of sterile services – incorporate in regular facilities report
6. Agreement that new Trust audit day procedure should continue
7. Reestablishment of Directorate IPC management (committee structure)
8. Specialist Ventilation Committee recommenced
9. Creation of IPCC Risk register for review in IPCC
10. Agreement to remove gloves from contact precautions

Attachment 8

Report

1. **Infection Prevention and Control (IPC) team**

Issue: **Long term maintaining data and electronic infection prevention management system**
Control process– Seek to ensure long term funding.

Issue: **Insufficient staff to maintain input in to all development projects**
Control process – Advertising 0.6 wte new IPC nurse agreed through Built Environment

2. **Health care associated infection (HCAI) statistics : Apr – Oct 2019/10**

HCAI Mandatory national reporting:

Mandatory bacteraemias with *S. aureus* (MRSA and MSSA), E. coli bacteraemias, Pseudomonas aeruginosa, Klebsiella spp.

Period	ECOLI	Klebsiella	MRSA	MSSA	Pseud	Total
18/19	21	19	2	28	17	87
2019-20						
Apr-Oct	5	18	1	13	14	51

Mandatory *C. difficile* infection reporting

Period	Notified	Assigned
Year 18/19	7	7
2019-20		
Apr-Oct	4	2

More detailed investigation of increase in Klebsiella infections needed

HCAI non-mandatory internal reporting – infection and significant colonisation:

GOSACVCRB (GOS acquired CVC related bacteraemias ('Line infections')*

Period	GOSACVCRB_No	DaysRecorded	Rate
Year 18/19	82	52924	1.5
2019-20			
Apr-Oct	43	33417	1.3

HCAI non-mandatory internal reporting – infection and significant colonisation:

	2019/20 after 7 months		Last financial year 2018/19	
Infection:	**Developed in hospital**	**Admitted with**	**Developed in hospital**	**Admitted with**
Respiratory virus	**142**	**214**	**220**	**441**
Enteric virus	**63**	**92**	**266**	**260**
MRSA colonisation	**7**	**81**	**22**	**109**
MDR GN- nonCPO	**40**	**75**	**43**	**120**
CPO	**2**	**6**	**0**	**14**
VRE	**2**	**16**	**21**	**27**

MDR GN = Multi antibiotic resistant gram negative 'alert' organism ; CPO = carbapenemase producing organism
VRE = Vancomycin resistant enterococci MRSA = Meticillin resistant Staphylococcus aureus
CPO = Carbapenemase producing organism

Issue: Children, their families and staff, are a frequent reservoir of viral infections and antimicrobial resistant organisms. Cross-colonisation and cross-infection is not fully controlled.
Control activity: Maintaining a clean environment; compliance with individual risk assessment and implementation of standard and transmission based precautions.

Achievement: Noticeable reduction in VRE acquisition with new cleaning strategy.

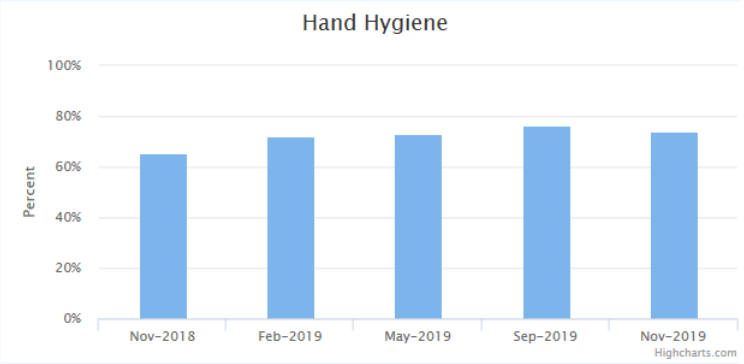
3. Infection prevention and control regular audits and data display

The new three monthly audit process now has 5 collection points. Audit shows:

Hand hygiene compliance audit is realistic and improvement plans are underway across clinical areas. Since the implementation of gloves off (April 2018) hand hygiene compliance has increased.

Hand Hygiene

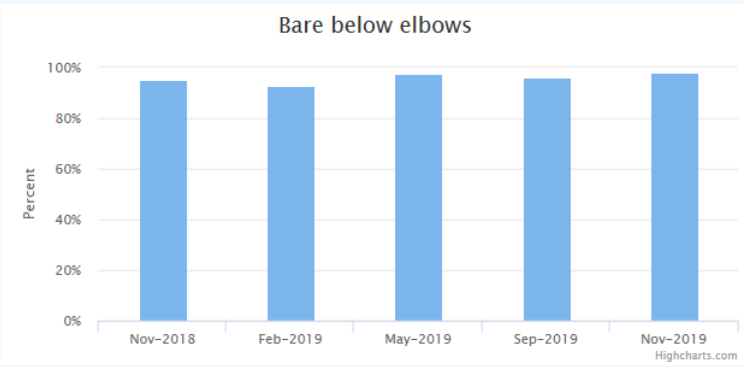
Date	Observed	Compliant	Percent
Nov-2018	821	537	65%
Feb-2019	822	592	72%
May-2019	748	546	73%
Sep-2019	860	654	76%
Nov-2019	640	471	74%



Compliance with bare below the elbows remains high- focus for improvement sits with pharmacy, play workers and other visitors to clinical areas rather than medical and nursing staff.

Bare below elbows

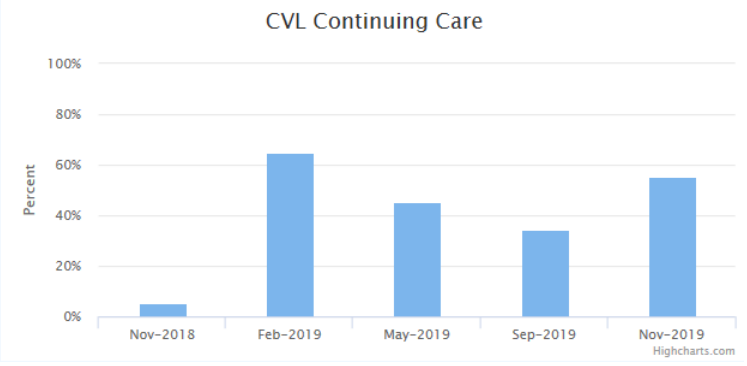
Date	Observed	Compliant	Percent
Nov-2018	801	761	95%
Feb-2019	842	781	93%
May-2019	748	730	98%
Sep-2019	860	827	96%
Nov-2019	640	629	98%



CVL on going care compliance audit – initially issues with documentation. Changes have been made to the way this information is recorded (Nov 19) on. Improvement has been noted in the Nov 19 audit days but we would like higher compliance. Education is ongoing.

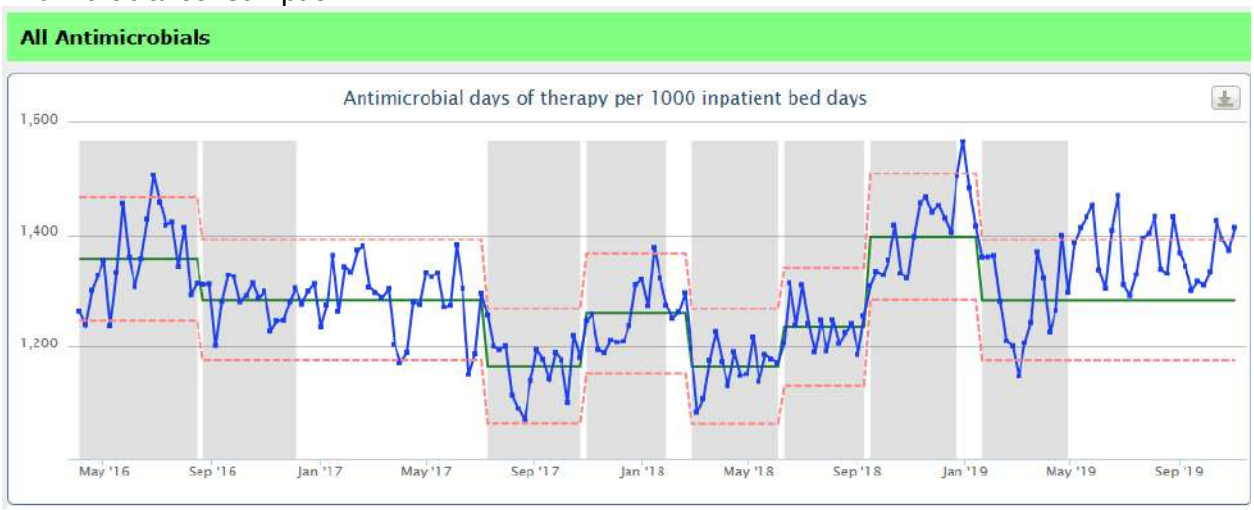
CVL Continuing Care

Date	Observed	Compliant	Percent
Nov-2018	112	6	5%
Feb-2019	99	64	65%
May-2019	151	68	45%
Sep-2019	119	41	34%
Nov-2019	101	56	55%



4. **Antibiotic stewardship** –

Antimicrobial consumption:



Reduction remains a challenge, although we have achieved the national target of >1% reduction from 2016 baseline; most use is to policy or on ID/micro advice (confirmed in recent antifungal use audit).

5. Major outbreaks and complaints including IPC issue 2019/20

Date	Organism and issue	Ward	Outcome
Mar-Apr	MRSA cross colonisation and infection	Cardiac services	Possibly related to cleaning of equipment (ECHO machines) between patients
Mar-Apr	Adenovirus cross infection	Robin/Fox	Loss of environmental control for multiple reasons; risk remains and control is onerous
Sept	Norovirus outbreak	Koala	Control required ward closure
Complaint including IPC			
Sept	Communication of colonisation status	Cardiac Services	Education on responsibilities. Possible use of My GOSH.

6. Estate and facilities – issues

a. Cleaning – continued close monitoring required; new onsite manager.
b. Decontamination – New Medical equipment disinfection unit being built; New Endoscope decontamination unit operational (final environmental upgrade needed); off site sterile services contract out for tender.
c. Ventilation and water committees meet; slippage in planned preventative maintenance for water and schedule for ventilation verification.

7. IPC Training

Trust compliance with level 1 training is at 96%
Trust compliance with level 2 training is at 92%

Actions: Compliance is within limits in both areas of training.
Directorates need to monitor and continue to improve compliance.

J C Hartley Consultant Microbiologist and DIPC
H Dunn Lead Nurse in IPC and Deputy DIPC

ATTACHMENT 9

Attachment 9

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Quality, Safety and Experience Assurance Committee (QSEAC) held on 17th October 2019

Matters arising

Discussion about sharing benchmarking of outcomes had taken place at the Children's Alliance meeting and it had been agreed that the member organisations would propose useful metrics for comparison in the three agreed specialties.

Overview and emerging clinical and risk issues – to focus the committee's attention on the areas under its remit of most concern

Medication was a theme of serious incidents both in terms of safety and optimisation and this continued to be a focus of review. Outcomes of investigations were discussed at 'Closing the Loop' meetings to ensure that learnings were embedded.

The Committee discussed the GOSH dental service staff shortages and it was confirmed that one consultant post was being advertised and the service had been paused to external referrals in agreement with NHS England. It was not always possible for GOSH patients to move to other services as they were often complex in terms of anaesthetic care.

Substantial work was taking place around Duty of Candour and almost 2000 staff had been trained with compliance being tracked through the Integrated Quality and Performance Report.

A formal process was being developed for the completion of external reviews to include the commissioning of reviews, terms of reference and communication throughout the process. It would also include the approach taken to responding to freedom of information requests. It was emphasised that it was important to also recognise non-clinical learning.

Deep dive: IPP Quality and Safety

IPP had been in a challenging position and had taken steps to close beds and review quality data which had improved matters going forward. Exit meetings took place with staff who were leaving the directorate. Some were leaving London whilst some found the variation within IPP challenging and moved to work in a particular area of interest in the Trust. Education was being provided which staff had identified as key. Engagement was taking place around the staff survey which was positive; the results had been broadly in line with the organisation as a whole.

Deep dive: Genetics

At the beginning of October 2019 67% of outstanding genetic testing reports were overdue. It was confirmed that the majority of urgent tests were delivered on time and there had been no delays which had resulted in any harm. Workstreams had been established to review how the laboratory could be more efficient however there was a national shortage of scientists. Recruitment of less senior support was taking place. Reporting took place through monthly performance reviews as well as to the Genomic Laboratory Hub meetings and NHS England. The laboratory had performed extremely well at the annual AKAS inspection in September 2019 and accreditation had been maintained. There was a trajectory of improvement which would be important to sustain.

Board Assurance Framework Update

- Risk 9: The Trust may not deliver its full Research Hospital vision if key research alliances are not fostered

Work was required to move to the next stage of becoming a research hospital and to ensure that this was recognised by patients, families and staff. It was agreed that greater focus on research was required at Board level at a strategy level including on the interrelationship between the hospital and the UCL GOS Institute of Child Health and other research partners.

Impact of the EPR on delivery of quality services at GOSH

A significant improvement had been made in the discharge summary completion rate and focus was moving to clinic letter turnaround time. Further configuration of the system had supported improvement. Families and patients reported finding MyGOSH very helpful and approximately 6000 families were signed up to the portal which was extremely positive. The 'was not brought' rate for families who were signed up to my GOSH was approximately 3% which was much lower than the data for hospital as a whole and there had been a reduction in PALS contacts around communication.

Learning from internal and external reviews

- Medicines and Healthcare Products Regulatory Agency Review

An MHRA preparedness internal review had been undertaken to provide insight into the factors contributing to the poor MHRA inspection findings in May 2019. Reports from the MHRA had not been positive over a number of years as issues were long standing and it had been found that there was a cultural contribution whereby staff accepted the issues. The team had been responding positively to the support they were receiving and some activity had been outsourced to the wards which had created additional capacity to undertake the improvement actions. The committee congratulated the team on the improvements and noted the importance of circulating the learning which was relevant to the Trust as a whole.

- External Review Learning: Ventricular Assist Device (VAD)

The review had been commissioned as a result of higher than expected observed neurological complications in patients using ventricular assist device (VAD). The team had been very complimentary about the openness of the team's approach to the review and had provided some recommendations.

- Royal College of Surgeons' Review into GOSH urology (service review and case review)

Initial feedback had been provided in response to the action plan and actions would be followed up in more detail in the coming months. There had been an increase in complaints in the service and this would be kept under review.

- Closing the loop

This new monthly meeting had been developed to ensure that learning was disseminated appropriately across the Trust and good progress was being made. Its effectiveness would be reviewed in January 2020.

Freedom to Speak Up Guardian Update

The Committee agreed that in future the detail of the HR related cases would be reviewed at the People and Education Assurance Committee but overall themes related to Quality and Safety would be shared with QSEAC.

Integrated Quality and Experience Report (August 2019) including update on issues arising from patient stories at Board

A continued upwards trajectory had been noted in medication incidents causing harm. Data was being reviewed to assess any themes. The Friends and Family Test results for IPP had remained low during the period however they had shown a recovery in September data.

Patient Experience and Engagement Framework

The framework would develop priorities for engaging with patients and families over one, two and three years. The Committee recommended that innovative including virtual methods of engagement could also be used and that consideration was given to what other organisations were doing nationally and internationally.

Horizon Scanning – quality and safety issues

Learning had been identified from the CQC inspection reports on other Trusts.

Whistle blowing update – safety related cases

The Royal College review of the one current open whistleblowing case had provided recommendations but no patient safety concerns had been identified.

Safeguarding Update Q1 2019/20

Safeguarding paediatrician cover was now in place on a 24/7 basis and data collection was taking place to review the success of the rota. GOSH was the first Trust to go live with the Child Protection Information System which helped to ensure that all child protection information was clear when a patient was admitted. Succession planning was taking place for the Named Professionals.

Compliance Update

An inspection had taken place of the mortuary by the Human Tissue Association who were complementary. Two issues had been raised and had been resolved. An inspection of nuclear medicine had taken place and the team had been positive about staff. The two amber actions for emergency preparedness were likely to be green in the coming days and the committee congratulated the Emergency Planning Officer.

Internal Audit Progress Report (July 2019 – September 2019)

Management responses were being compiled for the incident reporting review which had a number of amber actions and were in the process of being closed.

Internal and external audit recommendations update

Good progress continued to be made to reduce the number of overdue recommendations and the recommendations were now reviewed by the Risk Assurance and Compliance Group which was welcomed by the internal auditors.

Escalation of quality and safety matters from ward to board (including committee route) – how priorities are agreed and tracked

The committee noted the escalation process.

Update on quality and safety impact of the Better Value programme

A programme of post scheme implementation quality and safety reviews was proposed alongside the continued tracking of quality metrics assigned to each scheme.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18 September 2019

Board Assurance Committee reports: Finance and Investment Committee (September 2019) **Submitted by:** Helen Jameson, Chief Finance Officer **Paul Balson,** Deputy Company Secretary **Item presented by:** James Hatchley, Chair of the Finance and Investment Committee	**Paper No: Attachment 10**

Aims / summary
This report summarises the work of the Finance and Investment Committee (FIC) since its last written report to the Trust Board on 25 July 2019. The FIC held a formal meeting on Friday 27 September 2019.

Action required from the meeting
Board members are asked to note the key issues highlighted by the Committee and pursue any points of clarification or interest.

Contribution to the delivery of NHS Foundation Trust strategies and plans
The Finance and Investment Committee reports on financial strategy and planning, financial policy, investment and treasury matters and reviewing and recommending for approval major financial transactions. The Committee also maintains an oversight of the Trust's financial position, and relevant activity data and productivity metrics.

Financial implications
None

Who needs to be told about any decision?
N/a

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

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

Key issues for the Trust Board's attention

- Since July 2019, the Committee allocates the first section of the meeting to discuss key issues and developments arising from Committee members' review of the papers.
- The Committee requested assurance that progress was being made to meet the 92% RTT target by March 2020.
- The Committee reviewed Directorate reviews from: Sight and Sound, Blood, Cells and Cancer, Estates and Corporate Directorate. It was agreed that more work was required on the review template to ensure that the most relevant information is presented to this committee.
- The Committee received Major Project updates on the Zayed Centre for Research and the Sight and Sound Centre.

Summary of key issues and developments

Since the July meeting, the Finance and Investment Committee starts each meeting with a discussion on the key issues and developments. The following points were raised:

- Achievement of the 'Better Value' target was key and the Trust should focus on this, in particular the more challenged Directorates, in the second half of the year.
- FIC would initiate discussions on the tariff for 2020/21 including a discussion on the probability that the environment would result in the Trust remaining on a block contracts rather than a switch to cost and volume.
- FIC Members identified staffing as a recurring theme throughout the meeting papers and recommended that vacancy planning for areas with delays took place as soon as possible.
- The Committee outlined plans to rework the Directorate review template, to guide directorates in providing information aligned to the aims of directorate reviews.
- Focus was required on the Development Team, specifically the ability to deliver projects to time.

Performance & finance standing updates

<u>Finance Month 5</u>

- The Trust position was adverse to the planned control total by £0.6m.
- The Trust continued to forecast that the control total would be met albeit with a significant use of non-recurrent rather than recurring savings.
- Private patient income performance improved in month and was just below plan (£0.3m) making it £3.2m below plan YTD due to lower levels of activity mainly in previous months.
- YTD pay costs were favourable to plan (£4.0m) due to the vacancies across the organisation not being covered by bank or agency staff.
- Non-pay was breakeven excluding pass-through due to underspends relating to lower than planned activity.
- The Trust received £0.4m of PSF monies relating to a 2018/19 PSF reallocation post accounts.

<u>Productivity and efficiency (Better Value) report Month 5</u>

- The planned trajectory required to achieve the Better Value target had not been met year to date.

- The Committee was told that it was probable that the target would be met however this would be through non-recurrent savings and other methods.
- It was reported that there were potentially for significant efficiencies to be found in the way staff deliver activity and added that there were further opportunities to improve the procurement process and reduce waste.
- The Committee requested that directorates were challenged and supported to identify more transformational schemes, especially around use of EPR.

Integrated Performance report Month 5

The Committee agreed that it was vital to ensure that work to move towards compliance with referral to treatment is prioritised and requested assurance that progress was being made to meet the 92% RTT target by March 2020.

Directorate reviews

Sight and Sound

The following points were covered in discussion:

- Directorate issues raised in the staff survey mirrored the issues of the organisation.
- Research continued to be extremely important within the directorate.
- The team had adapted well to working with EPR, however clinics were taking longer as clinicians were adapting to the software.
- It was likely that the directorate would achieve c3% of expenditure which was half of the Directorate's Better Value target. The Committee discussed potential ways to support the directorate and its patients.

Blood, Cells and Cancer

The following points were covered in discussion:

- It was noted that there were no 'Better Value' schemes specific to the Directorate. It was reported that opportunities in the directorate were limited, but work was ongoing to identify new opportunities.
- Work was taking place to challenge practice to become more efficient on wards and increase leadership visibility through regular meetings with lead nurses.
- The Directorate leadership team was encouraged to visit other Trusts to learn about different methods of practice and to consider a greater level of buy-in in terms of the challenge all the directorates face on better value

Estates

The following items were covered in discussion:

- Approximately £800,000 in Better Value savings had been achieved against a target of £1.4million.
- Work was taking place to agree the standard to which different areas of the hospital should be cleaned and identify efficiencies.

The high level of contract activity and management of contract spend was discussed

- The Committee discussed whether it was possible to increase the catering revenue and provide high quality patient food at the same time.

- The Committee requested a follow up report on staff accommodation and occupancy rates.

Corporate Directorate

It was reported that there was a high vacancy rate in informatics and some areas such as data validation had a high turnover rate.

Annual Business / Performance review

Treasury Management update

The Committee endorsed the policy to the Policy Approval Group with one amendment.

Electronic Patient Record update

The Committee received an update and discussed the potential impact of agreed data entry in the records and EPR team members moving to other organisations. Pharmacy issues are a continuing area of focus but it was noted that these had been discussed at length at the recent trust Board

Major Project updates: Zayed Centre for Research

Discussions were taking place with the contractor about taking possession of the building. It was estimated that saving was from the delays in the opening were estimated at c£800,000 but may rise.

Major Project updates Sight and Sound Centre

There were issues with non-performance of the contract, which had led to substantial delays in the project. A further revised programme of delivery was anticipated at the end of September and it was predicted that the total delay time would be 24 weeks with a completion around July 2020. There was a continuing focus on the contractor's performance and financial viability. The drivers for this delay were not clear and the committee was disappointed to note that this is another major Project with issues; this will be a continuing area of focus for the Committee.

Post implementation review: Multi-Faith Room

The Committee noted that the project had been completed successfully and was well received by staff.

Evaluation of papers

the Non-Executive Director members of the Committee, the Chief Executive and Chief Finance Officer would follow-up with a discussion on how to capture the most relevant and valuable information for the directorate reviews and to consider how other committees/NEDs can see this level of directorate information.

End of report

ATTACHMENT 12

Attachment 12

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the People and Education Assurance Committee held on 11th September 2019

Minutes of Meeting held on 10th July 2019:
Actions from the last meeting were noted. It was agreed that there should be a rolling rota of staff attendance in line with staff voice and that two people from Pharmacy should be invited given the current problems apparent in Pharmacy.

Revised Terms of Reference / Membership:
The Terms of Reference will reflect the headings of the People Strategy. A more detailed work plan will be presented next time. The committee requested a regular review of the impact of the People Strategy. It was agreed that there would be separate strategies and plans for staff engagement and equality diversity and inclusion. The Committee would also receive reports about progress against plan of the GOSH Learning Academy. It was agreed to look at standard assurance questions to ensure the committee is asking the right questions and viewing the right information in order to be provided with assurance.

Update on Board Assurance Framework and HR Specific Risks:
The risks relevant to the committee are Recruitment and Retention, Culture and Transformation. This Committee is responsible for overseeing, on behalf of the Board, these specific workforce risks and reporting back to Board. Richard Collins was asked to present a deep dive on the Transformation risk at the December PEAC and further deep dives would be arranged at future committee meetings.

Draft People Strategy:
Ms Anderson presented the draft People Strategy which will go to Board in September 2019. There will then be a period of consultation across a wide range of staff groups followed by a further draft to Board in November. The strategy is constructed around 4 key themes: capacity and workforce planning, developing skills and capability, modernising and reshaping HR and OD, culture engagement health and wellbeing. Staff support needs to improve as well as internal communications.

The Nursing Recruitment Retention Plan:
The Trust has joined the NHS improvement programme with the aim of reducing voluntary turnover by 1%.
The retention plan is split into four work streams, with the aim of reducing band 5 and 6 turnover of nurses; career pathway opportunities, achieving nursing work life balance, providing a supportive ward environment and newly qualified nurse support.

Review of Bank Rates:
This report was presented in order to show the current bank rates and that no change will be undertaken this year. There will now be an annual review to ensure that we remain competitive.

Safe Staffing Report:
The report was previously reported to Board but will now be presented to PEAC prior to the relevant Board. This report lists safe staffing in relation to patient acuity and actions undertaken to address any issues identified. Staffing in International and Private Patients is an issue and there is now a workgroup and action plan.

Update on Learning Academy:

Attachment 12

The business case has been approved and the governance structure is being set up. Posts are being recruited to and this committee will receive regular reports on progress. The aim will be to income generate and become sustainable by year 3. This is a fantastic investment of funds for staff development and education.

WRES and WDES Update:

The Trust is required to report on these indicators to Board and based on the findings, develop action plans including Equality Objectives. The committee agreed on review of the data that there is a lot of work to do. The Committee will receive the HR and OD Workplan next time around and there after regular reports on progress. Equality, Diversity and Inclusion will be a key focus the Trust in the People Strategy and there needs to be greater transparency on these figures and visible work to address the issues much like there has been around Bullying and Harassment. The reshaping of the Employee Relations function will be key as will management development.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th November 2019

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 14**

Aims / summary
Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since 18th September 2019.

Date	Description	Signed by
30/09/2019	Estate Rental Charge deed GOSHFT and Executive Affairs Authority	MT
30/09/2019	Lease relating to the Zayed Centre for Research into rare Disease in Children at the Great Ormond Street Hospital 20 Guilford Street London GOSHCC (Landlord) and GOSH (Tenant)	MT, HJ
22/10/2019	Children's Cancer Centre Pre-Construction Services Agreement	MT, HJ
24/10/2019	Deed – Lease for Zayed Centre for Research	MT, HJ
24/10/2019	Consultant Warranty: BDP Ltd, Sisk & Son Ltd and GOSH – CCC	MT, HJ
24/10/2019	Consultant Warranty: Turley Associates Ltd, Sisk & Son Ltd and GOSH - CCC	MT, HJ
24/10/2019	Consultant Warranty: McBains Ltd, Sisk & Son Ltd and GOSH - CCC	MT, HJ

Action required from the meeting
To endorse the application of the common seal and executive signatures.

Contribution to the delivery of NHS / Trust strategies and plans
Compliance with Standing Orders and the Constitution

Financial implications
N/A

Legal issues
Compliance with Standing Orders and the Constitution

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

Who is accountable for the implementation of the proposal / project
Anna Ferrant, Company Secretary oversees the register of seals