Meeting of the Trust Board
Wednesday 15 July 2020

Dear Members

There will be a public meeting of the Trust Board on Wednesday 15th July 2020 at 1:30pm via Zoom

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**1:15pm**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	**Patient Story**	Chief Nurse	**I**	**1:15pm**
3.	**Minutes of Meeting held on 26 May 2020**	Chair	**J**	**1:30pm**
4.	**Matters Arising/ Action Checklist**	Chair	**K**	
5.	**Chief Executive Update**	Chief Executive	**L**	**1:35pm**
6.	**BAME Forum Discussion**	Chair/ Chair of the BAME Forum	**Verbal**	**1:50pm**
7.	**Electronic Patient Record (EPR) Programme Update**	Chief Clinical Information Officer/ EPR Programme Director	**N**	**2:05pm**
	PERFORMANCE			
8.	**Integrated Quality and Performance Report – May 2020 including focus on clinical outcomes**	Medical Director/ Chief Nurse/ Acting Chief Operating Officer	**O**	**2:20pm**
9.	**Finance Report Month 2 2020/21**	Chief Finance Officer	**P**	**2:30pm**
10.	**Safe Nurse Staffing Report (April/ May 2020)**	Chief Nurse	**Q**	**2:40pm**
	ASSURANCE			
11.	**Infection Control Board Assurance Framework (NHS England)**	Chief Nurse/ Director of Infection Prevention and Control	**3**	**2:50pm**
12.	**Learning from Deaths Mortality Review Group - Report of deaths in Q4 2019/2020**	Medical Director	**R**	**3:00pm**
13.	**Guardian of Safe Working report Q1 2020/21**	Medical Director	**S – to follow**	**3:10pm**
14.	**Responsible Officer Annual Report 2019/20**	Responsible Officer – Dr Andrew Long	**T**	**3:20pm**

15.	**Safeguarding Annual Report 2019/20**	Chief Nurse	**U**	**3:30pm**
16.	**Sustainability Annual Report 2019/20**	Director of Development	**V**	**3:40pm**
17.	**Annual Quality Report 2019/20**	Medical Director	**2**	**3:50pm**
18.	**Board Assurance Committee reports** • **Audit Committee update – May 2020 meeting** • **Quality, Safety and Experience Assurance Committee update – July 2020 meeting** • **Finance and Investment Committee Update – July 2020** • **People and Education Assurance Committee Update – June 2020**	 Chair of the Audit Committee Chair of the Quality, Safety and Experience Assurance Committee Chair of the Finance and Investment Committee Chair of the People and Education Assurance Committee	 **W** **X** **Y** **Z**	**3:55pm**
19.	**Council of Governors' Update – July 2020 (Verbal)**	Chair	**Verbal**	**4:10pm**
	GOVERNANCE			
20.	**Revision to the Trust Constitution**	Company Secretary	**M**	**4:15pm**
21.	**Register of Seals**	Company Secretary	**1**	**4:25pm**
22.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			**4:30pm**
23.	**Next meeting** The next confidential Trust Board meeting will be held on Wednesday 16 September 2020 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			

Attachment I

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
15 July 2020

Patient story- YPF members' experiences during lockdown **Submitted by:** Claire Williams, Head of Patient Experience & Engagement	**Paper No: Attachment I**

Aims / summary

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

The story to be shared on 15 July will be live via Zoom and details the experiences of two members of the Young People's Forum (YPF), Grace and Toby, during lockdown.

The story highlights:

- Grace's experience of the changes made to the YPF during lockdown
- How lockdown has affected Grace and Toby's experiences of the hospital and their feedback in relation to virtual appointments and clinics
- How lockdown has affected their health and wellbeing

Action required from the meeting

For information

Contribution to the delivery of NHS / Trust strategies and plans

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

Financial implications

None

Who needs to be told about any decision

N/a

Attachment I

Great Ormond Street Hospital for Children
NHS Foundation Trust

Who is responsible for implementing the proposals / project and anticipated timescales Claire Williams, Head of Patient Experience & Engagement
Who is accountable for the implementation of the proposal / project Alison Robertson, Chief Nurse
Author and date Claire Williams, Head of Patient Experience & Engagement

Attachment J

Great Ormond Street Hospital for Children
NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 26th May 2020

Present

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

In attendance

Cymbeline Moore	Director of Communications
Dr Shankar Sridharan	Chief Clinical Information Officer
Professor David Goldblatt	Director of Research and Innovation
Stephanie Williamson	Interim Director of Built Environment
Richard Collins	Director of Transformation
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Daljit Hothi*	Associate Medical Director for Well-Being, Leadership and Improvement
David de Beer*	Associate Medical Director for Safety
Renee McCulloch*	Associate Medical Director and Guardian of Safe Working
Luke Murphy*	Freedom to Speak Up Guardian
Chris Ingram*	Fire, Health and Safety Manager

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

31	**Apologies for absence**
31.1	No apologies for absence were received.
32	**Declarations of Interest**
32.1	No declarations of interest were received.
33	**Minutes of Meeting held on 1st April 2020**
33.1	The Board **approved** the minutes of the previous meeting.
34	**Matters Arising/ Action Checklist**
34.1	Actions take since the last meeting were noted.

35	**Chief Executive Update**
35.1	Matthew Shaw, Chief Executive said that as part of the response to the COVID-19 pandemic GOSH had been playing a broader role in supporting the local care system. Non-urgent activity had been paused and the majority of outpatient activity had become virtual, as well as accepting patients who would usually have been admitted to other North Central London hospitals.
35.2	Matthew Shaw welcomed Professor Russell Viner to the Board and welcomed his valuable input into GOSH's ambition to improve child health and ascertain its place in the STP.
35.3	The annual Risky Business conference would be taking place online as a three hour learning event entitled 'Lessons from COVID-19 – making sense of the pandemic.'
35.3	Sir Michael Rake, Chair congratulated GOSH on its work throughout the pandemic. He said that he attended a virtual meeting of Chairs in the STP and there had been recognition of the support provided by the Trust.
36	**GOSH Foundation Trust Annual Financial Accounts 2019/20 and Annual Report 2019/20**
36.1	Helen Jameson, Chief Finance Officer thanked the finance team for their hard work to complete the accounts and year end remotely. She said that GOSH had ended the year c£~~98~~00~~,000 k~~ahead of the control total and had therefore secured provider sustainability funding (PSF) for the year. This position included £1.6million of COVID-19 costs which had been agreed by NHS England. Due to the pandemic the valuers of the Trust's land and buildings included a 'material uncertainty' clause in its valuation which had led to a note from the auditors. The auditors had not yet completed their work but did not anticipate any material changes and expected to issue a clean opinion subject to completion of their work.
36.2	Akhter Mateen, Chair of the Audit Committee said that the Audit Committee had reviewed the year end documents and recommended them to the Board for approval subject to the completion of the auditors' work. An area of focus for the auditors had been around going concern in the current environment and the committee had discussed this and were satisfied that the Trust would continue to operate as a going concern for the next 12 months. The Quality Report would not be subject to external audit~~ and would not be included in the Annual Report for 2019/20~~.
36.3	The internal auditors had provided a Head of Internal Audit Opinion of 'partial assurance with improvements required' partly as a result of the number of partial assurance reports received throughout the year including the review of access and activity data which had been considered at the May Audit Committee meeting. The team had identified some breaches which had contributed to the overall opinion.
36.4	Sir Michael asked to what extent the assumptions around the going concern statement had recognised the shortfall in IPP income and the availability of government funds to close the gap. Helen Jameson said that the modelling assumed that the Trust would be reimbursed until the end of October and IPP

	income was assumed to continue at its current, lower rate. The modelling also assumed that research activity did not increase and that there was an increase in costs related to activity being brought back online. Akhter Mateen said that the Audit Committee had been satisfied that the modelling was appropriately prudent.
36.5	The Board **approved** the following documents: • Annual Accounts and Annual Report 2018/19 • Annual Governance Statement • Audit Committee Annual Report • Draft Head of Internal Audit Opinion • Representation letter.
37	**Compliance with the Code of Governance 2019/20**
37.1	Anna Ferrant, Company Secretary said that Foundation Trusts were required to report against NHS Improvement's Code of Governance each year in the Annual Report on the basis of compliance with the provisions or an explanations where there were areas on non-compliance. A review of the provisions had found that the Trust had met all the requirements of the Code of Governance during 2019/20 and within the report explained the reduction in the number of Non-Executive Directors following Professor Rosalind Smyth stepping down from the Board.
37.2	The Board **approved** the statement for inclusion in the Annual Report.
38	**Compliance with the NHS provider licence – self assessment 2019/20**
38.1	Anna Ferrant said that the Foundation Trust Boards were required to declare annually to NHS Improvement that it was compliant with a small number of licence conditions and one requirement under the Health and Social Care Act. As a result of the COVID-19 pandemic, no guidance had been released by NHS Improvement for 2019/20 however the work had continued to be undertaken in order to assure the Board. The Executive Team had recommended that compliance could be confirmed for all required areas.
38.2	The document had been reviewed by the Council of Governors at the meeting in April 2020. Governors had asked for clarity about the progress with work to close recommendations arising from the CQC inspection and the implementation of the cyber strategy. The Council had agreed the responses recommended by the Executive Team for all conditions.
38.3	The Board **agreed** the Trust's responses to all required conditions taking into account the views of the Governors.
39	**Draft Quality Report 2019/20**
39.1	Sanjiv Sharma, Medical Director presented the draft Quality Report and said that it had been agreed by the Audit Committee that the final version would be considered by the QSEAC at its July meeting and approved by the Board in July. He said that the Chair of the Joint Health Overview and Scrutiny Committee had provided positive feedback having reviewed the draft report.
39.2	

39.3	Sir Michael requested an update on progress with the EPR programme and Richard Collins, Director of Transformation said that there remained some data challenges and work on this continued however it was clear that many of the adjustments made by the Trust in order to continue as much activity as possible during the pandemic would not have been possible without an EPR. This had been recognised by staff and good feedback had been received on this. **Action:** It was agreed that an EPR update would be presented at the July meeting of the Trust Board which would set out the current status of the programme and the benefits realisation thus far.
40	**CQC Always Improving Update**
40.1	Sanjiv Sharma said that work related to CQC requirements continued to take place as part of 'business as usual' and more than 50% of actions arising from the CQC report had been closed. There was one overdue action related to the enforcement notice that had been received around medication rooms and remedial action had been instigated with a view to completion by the end of May.
41	**Integrated Quality and Performance Report – Month 1 2020/21**
41.1	Sanjiv Sharma said that there had been a deterioration in the incident closure rate during April. Incident trajectories had now been developed for each directorate and additional support had been provided. Individuals in the quality and safety team had returned from clinical duties and sick leave which would also support improvement.
41.2	WHO checklist documentation compliance remained low and targeted training would take place. Sanjiv Sharma said he that anticipated that improvement would be reported at the next meeting.
41.3	James Hatchley, Non-Executive Director queried whether any additional KPIs required monitoring in the context of restarting elective services and Matthew Shaw said that the Executive Team would be considering the metrics which were most appropriate for focus and the first draft of this was likely to be available at the July meeting.
41.4	Alison Robertson, Chief Nurse said that there had been a reduction in the number of complaints and PALS contacts received which reflected the success of the information hub. The Patient and Family Engagement and Experience Committee had been re-established as had monthly meetings with Heads of Nursing to review patient experience within the Directorates.
41.5	Phillip Walmsley, Interim Chief Operating Officer thanked the information team and emergency planning officer for their work to respond to information requests which were being managed seven days a week. He said that there had been a 50% reduction in activity and work was taking place to model a later potential surge in activity. Chris Kennedy, Non-Executive Director asked whether there would be regulatory implications resulting from the Trust's failure to meet waiting targets such as RTT and Phillip Walmsley said that he was in contact with NHS England to clarify the expectations in this regard. Matthew Shaw said that it was likely to take some considerable time to begin to meeting waiting list standards and it was important to be clear about the reasons for the priorities which were set and to build good relationships with NHS England.

42	**Quality Strategy**
42.1.	Daljit Hothi, Associate Medical Director for Well-being, Leadership and Improvement said that the strategy set out the direction in which GOSH would develop staff and services with the common purpose of continuously delivering high quality clinical care. She said that focus was being placed on quality assurance and innovation along with collaboration. Staff were witnessing the impact of delivering change at pace through the COVID-19 pandemic and it was important to capitalise on this.
42.2	Akhter Mateen, Non-Executive Director expressed some concern about some of the timeliness included in the strategy and suggested that some of the work such as clinical teams having defined standards of work should be in place as soon as possible. He noted that this action was scheduled for 80% completion in five years' time. Daljit Hothi said that timelines had been modified to take into account work on the pandemic and therefore strategic timelines began at year 2. She said that staff would be encouraged to develop their own outcome measures and be innovative in the way that they moved forward with quality assurance. Sanjiv Sharma said that as part of this and other related strategies there was significant work for the Trust and it was important to balance this work and prioritise the key areas.
42.3	The Board **approved** the strategy**.**
43	**Safety Strategy**
43.1	David de Beer, Associate Medical Director for Safety said that the safety strategy was aligned with the Trust's overall strategy and also with the NHS patient strategy and focused on developing a just and kind culture with safety as the top priority. Learning also required pro-active sharing and implementation. The strategy aimed to support the cultivation of a safety culture and to ensure that role specific education was available for all staff. An innovative approach to the investigation of senior incidents would be implemented involving patient, family and staff support alongside the investigation itself. David de Beer said that it was important to learn from incidents as well as share information nationally and internationally to advance safety.
43.2	David de Beer said that focus would be placed on transparency and partnership and there would be a renewed emphasis on duty of candour. James Hatchley noted the work that had been on-going with the Cognitive Institute and asked how this would be embedded into the strategy. He queried whether the infection control and clinical audit teams were sufficiently resourced in respect of the strategy. David de Beer said that embedding 'speaking up for safety' was a key part of the strategy's operational plan as well as the 'learn not blame' initiative from the Doctors' Association. The Infection Control Team had worked extremely well and it would be important to review the requirements of the team including the expectations of the CQC to ascertain whether additional resources would be required. Alison Robertson said that the team had recently received additional resources for a period of at least 12 months including a senior educator. She said that it was vital that responsibility for infection control was recognised as being held jointly with the directorates. Alison Robertson added that the Head of Patient Experience had met with David de Beer and Daljit Hothi to ensure that the strategies were aligned with the patient experience strategy.

43.3	Sanjiv Sharma said that following approval of the strategies operational delivery plans would be developed for each of the areas and these would be considered by the QSEAC with Clinical Audit involvement to ensure that work was moving ahead as anticipated. It was possible that additional clinical audit resource would be required for this.
43.4	Russell Viner, Non-Executive Director welcomed the focus on openness and transparency and working with families. He suggested that it was often challenging to develop KPIs from this type of important work and Daljit Hothi said that the team had been working with behavioural scientists to consider how surveys and narratives could be used to establish how far staff had been working with kindness and openness. Caroline Anderson, Director of HR and OD said that a number of metrics were tracked through the staff survey and could provide an annual evidence base and consideration was also being given to undertaking more regular 'pulse' surveys.
43.5	The Board **approved** the strategy**.**
44	**Update on Data Kite Marking for Board Reports**
44.1	Phillip Walmsley said that data quality kitemarking had been introduced in 2016 following the previous data quality review and had been recently updated. He said that it was fundamental to achieving the Trust's data quality plan and would provide greater visibility and ownership of the data that was being published in the Integrated Quality and Performance Report.
44.2	**Action:** Akhter Mateen noted that there was the intention to audit each indicator subject to the kite-mark on a three yearly basis and queried how this would be done. Phillip Walmsley said that both internal audit and clinical audit would be used as well as independent reviews of RTT by NHS England. Akhter Mateen said that he was supportive of the proposed way forward which if done well would restore confidence in the data. It was agreed that this would be discussed in more detail at the next meeting of the Audit Committee.
45	**Month 1 2020/21 Finance Report**
45.1	Helen Jameson, Chief Finance Officer said that the Trust's position at month 1 was a £6.4million deficit which had been offset by an accrual for the NHS top up payment related to spend as a result of the COVID-19 pandemic resulting in a breakeven position for month 1. This deficit position was a result of £0.4million increase in costs and £6million reduction in income. Pay and non-pay were above plan and these costs were partly offset by low levels of clinical supplies linked to reduced elective activity.
45.2	Previous contracting arrangements had been replaced by a block arrangement and a revised version of the capital plan had been submitted to the STP. It was anticipated that this would be agreed by 31st May.
45.3	Akhter Mateen highlighted that IPP debtor days had increased considerably in April to 273 days. He said that discussion had taken place on this at the Audit Committee and the team was working with embassies and in particular one embassy to reduce debtor days. He said that it was important to keep this under review particularly due to the extremely low current oil price. Helen Jameson

	confirmed that active discussions were taking place with the health attaché from one territory. James Hatchley said that although the NHS top up was filling the current shortfall it was important to consider how the Trust would move to business as usual.
46	**Guardian of Safe Working Annual Report 2019/20**
46.1	Renee McCulloch, Associate Medical Director said that the medical workforce had moved to revised rotas for COVID-19 on 23rd March which had supported absence cover for a 30% absence rate in the junior doctor workforce and had involved a considerable change in demand. She said that going forward it would be important to improve reviewing and recording data on absences, rota gaps, and vacancy and bank spend.
46.2	Following changes to junior doctors' terms and conditions in 2019 some non-compliance with rotas in ICU had materialised. This had not been due to a deterioration but as a result of changes to requirements and a review of the establishment would take place to make improvements.
46.3	It continued to be challenging to integrate exception reporting into the workforce and a survey of junior doctors had shown that they did not feel supported to report and were not clear on the value that reporting could add. Renee McCulloch said that whilst the reporting tool was not fit for use as an assurance mechanism it was helpful as a guide in terms of where there were issues that required further investigation.
46.4	The Trust's average vacancy rate was good in comparison to other Trusts' however there were areas at GOSH where the vacancy rate was significantly higher and this was having a substantial impact.
46.5	**Action:** Matthew Shaw said that it was important to work to engage the junior doctors and Sir Michael said that when he had attended the Junior Doctor Forum it was clear that they were a dedicated group however discussions had not been not been about key issues. It was agreed that representatives of the Junior Doctor Forum would be invited to the People and Education Assurance Committee.
47	**Learning from Deaths Mortality Review Group - Report of deaths in Q2 and Q3 2019/2020**
47.1	Sanjiv Sharma said that twenty seven children had died at GOSH between 1st July and 30th September 2019 and case record reviews had been completed for all cases by the Mortality Review Group. Two cases were identified as having modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death.
47.2	Both cases were reviewed by the Executive Incident Review Meeting and one was subject to a Root Cause Analysis investigation and the other was declared a serious incident.
47.3	The Mortality Review Group also highlighted excellent care provided for children, young people and their families at GOSH including at the end of life. The review process found particularly positive aspects of care in eleven cases.

48	**Safe Nurse Staffing Report (April 2020)**
48.1	Alison Robertson said that national safe nurse staffing reporting had been suspended as a result of the pandemic and therefore an incomplete data set was being reported for the period. The pandemic had required GOSH nursing staff to work in new ways and in different wards and teams and some nursing staff had volunteered to work in other organisations. The Trust had followed NHS England and Improvement principles and Nursing and Midwifery Council regulatory guidance to ensure that safe staffing measures were maintained.
48.2	Sir Michael asked for a steer on the morale of nursing staff and their views on the PPE that was being provided to them. Alison Robertson said that the infection control team and practice educators had done excellent work in staying ahead of the national guidance and in general nurses had been comfortable with the changes that were being made and understood the rationale for those changes.
49	**Annual Freedom to Speak Up Report 2019/20**
49.1	Luke Murphy, Freedom to Speak Up Guardian said that there had been an increase in contacts in recent months. This had previously been around 10 contacts per month, which was in line with other Trusts of a similar size, but had increased as a result of contacts related to subcontractor OCS as well as the COVID-19 pandemic.
49.2	OCS staff had been raising concerns and Luke Murphy said that as key colleagues it was important to continue to receive these concerns despite their not being GOSH staff. OCS had agreed to meet with staff who were now receiving improved support from their union.
49.3	Issues raised related to COVID-19 were primarily around the way in which departments were allocating staff working in the office and working at home which had also been the subject of a number of questions at the CEO 'Big Brief' all staff session.
49.4	The Board noted that the term of office for the Freedom to Speak up Guardian was coming to an end. They thanked Luke Murphy for the work he had done and queried the transition arrangements. Luke Murphy said that he believed a fixed term role was beneficial to the Trust in terms of the independence of the role from the management structure. He said that the post had been advertised as a full time role and the transition arrangements would be dependent on circumstances of the appointed individual. He added that a full time role would be beneficial in terms of the accessibility of the service.
50	**Gender Pay Gap Report 2019/20**
50.1	Caroline Anderson, Director of HR and OD said that in common with all other organisations employing more than 250 staff GOSH was required to report Gender Pay Gap data. Data showed that at 31st March 2019 GOSH had a gender pay gap whereby the average pay for male employees was £4.35 higher than the female hourly rate. Both the average and median pay gap had reduced since the previous year. The pay gap was driven by the composition of the

	workforce in which nursing and administrative and clerical professions were predominantly female and women comprised 77% of the overall workforce.
51	**Annual Health and Safety and Fire Report 2019/20**
51.1	**Action:** Chris Ingram, Fire, Health and Safety Manager said that progress with safer sharps had slowed as a result of procurement staff who would have sourced products moving to source PPE for the COVID-19 pandemic. Matthew Shaw, Chief Executive highlighted the importance of moving forward with safer sharps in order to protect staff. He requested that the project was presented to the Executive Management Team meeting within two months in order to support progress.
51.2	Discussion took place around the challenges that had been experienced in recruiting a substantive fire officer. Chris Ingram said that the Trust's former fire officer was supporting the work and he was confident that the post would be filled but this was taking time.
51.3	James Hatchley requested that consideration was given to the implication on fire evacuation of social distancing.
52	**Board Assurance Committee reports**
52.1	<u>Audit Committee update – April 2020 meeting and May 2020 (verbal)</u>
52.2	Akhter Mateen, Chair of the Audit Committee said that the May 2020 meeting had primarily been focused on year end and a detailed discussion around cyber security had also taken place in April and May. The results of the Audit Committee effectiveness survey had also been received which had been positive. Some respondents had reported that there was some overlap between the work of the Audit Committee, Board and Finance and Investment Committee. Whilst some overlap was unavoidable, this would be kept under review.
52.3	The meeting in April had discussed some amendments to the Internal Audit plan for 2020/21 and it had been agreed that there would be minimal contact in quarter 1 in order to allow sufficient capacity for work related to the pandemic. Three reviews over the year would focus on the impact of COVID-19 on the control environment.
52.4	<u>Quality, Safety and Experience Assurance Committee update – April 2020 meeting</u>
52.5	Amanda Ellingworth, Chair of the QSEAC said that work continued to ensure that the committee was focused on assurance. Acknowledgement of this work was reflected in the positive responses provided to the QSEAC effectiveness survey.
52.6	<u>Finance and Investment Committee Update –March 2020</u>
52.7	James Hatchley, Chair of the Finance and Investment Committee said that the committee had requested updates to directorate reporting and to develop a standard format for reporting and presenting. The Committee had reviewed the feedback from the effectiveness survey which had achieved a 100% response rate and valuable feedback had been provided with small findings.

52.8	<u>People and Education Assurance Committee – February 2020</u>
52.9	Kathryn Ludlow, Chair of the PEAC said that the Women's Forum had reported to the committee and highlighted that each of the staff forums would be developing an annual report.
53	**Council of Governors' Update – April 2020**
53.1	Sir Michael said that the Council continued to be a constructive and supportive group and the private pre-meetings continued to be valuable. Governors had been clear that they wanted to provide practical support to the Executive Team during the pandemic. He added that discussion had taken place around the re-appointment of the Lead and Deputy Lead Governor roles and the Council had requested recruitment to the Deputy Lead Governor role given that the same Lead Governor would remain in post until the election.
54	**Declaration of Interest Register**
54.1	Anna Ferrant, Company Secretary said that the Declaration of Interest and Gifts and Hospitality Policy had been revised in line with NHS England's model Conflict of Interest Policy. The policy requires 'decision making staff', those who are more likely to have a decision making influence on the use of taxpayers' money to annually make a declaration, whether this be an update of an existing declaration or a nil return. The Trust had identified approximately 700 decision makers and along with declarations or nil returns made by other staff, there had been approximately 900 declarations made on the online system which was a substantial increase on previous years.
54.2	All declarations were reviewed by the Company Secretary and where there was an actual or potential conflict a management plan was required.
54.3	The Board **noted** the declaration of interest register and the register of gifts and hospitality.
55	**Any other business**
55.1	There were no items of other business.

Attachment K

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 2020

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
39.3	26/05/20	It was agreed that an EPR update would be received at the July meeting of the Trust Board which would set out the current status of the programme and the benefits realisation thus far.	RC	July 2020	On agenda
44.2	26/05/20	It was agreed that data quality and kitemarking would be discussed in more detail at the next meeting of the Audit Committee.	PW	October 2020	Passed to Audit Committee for October 2020 meeting
46.5	26/05/20	Matthew Shaw said that it was important to work to engage the junior doctors and Sir Michael said that when he had attended the Junior Doctor Forum it was clear that they were a dedicated group however discussions had not been not been about key issues. It was agreed that representatives of the Junior Doctor Forum would be invited to the People and Education Assurance Committee.	CA	September 2020	Passed to PEAC for September 2020 meeting
51.1	26/05/20	Chris Ingram, Fire, Health and Safety Manager said that progress with safer sharps had slowed as a result of procurement staff who would have sourced products moving to source PPE for the COVID-19 pandemic. Matthew Shaw, Chief Executive highlighted the importance of moving forward with safer sharps in order to protect staff. He requested that the project was presented to the Executive Management Team meeting within two months in order to support progress.	CA	September 2020	Passed to EMT for review

Attachment L

Trust Board 15 July 2020	
Chief Executive Update **Submitted by:** Matthew Shaw, Chief Executive	**Paper No: Attachment L**
Aims / summary Update on key operational and strategic issues.	
Action required from the meeting For noting.	
Contribution to the delivery of NHS Foundation Trust strategies and plans • Compliance with CQC Well-Led framework • Delivery of trust strategy • GOSH recovery & service restoration strategy	
Financial implications • None (business as usual)	
Who needs to be told about any decision? Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? CEO and executive colleagues	
Who is accountable for the implementation of the proposal / project? CEO	

Part 1: COVID-19 response

1.1 Hosting general paediatrics and mental health services at GOSH

Over recent months, we've played an important role in the regional response to Covid by opening our doors to children and young people from neighbouring hospitals so that they could focus on dealing with adult patients with COVID-19. Through the North Central London STP we offered to continue to host these services for the coming 10 months. However, the home centres were not able to send sufficient staff to GOSH for us to establish a shared service in the longer term. With the pressing requirement to recover our usual activity and resolve the backlog of patients with rare and complex diseases, we were not able to staff the services alone. Therefore, from Monday 22 June 2020 general paediatric patients returned to local hospitals, who confirmed they had sufficient capacity on their own sites.

It was a pleasure to be able to provide a safe haven for these services during the first peak, and also a temporary home for Heam Onc services usually based in UCLH. We are extremely grateful to the staff from GOSH and elsewhere in NCL for being flexible and continuing to provide a great service in challenging circumstances.

1.2 Above and Beyond Strategy – launch plans

The Executive Team met in early July 2020 to review the trust strategy *Above and Beyond* in the light of our ongoing operational challenges and assess when might be the right time to proceed with plans to launch the new strategy to the organisation.

It was acknowledged that the core features of our strategy (the purpose, principles and priorities) were clearly in use through the organisation and remained relevant, particularly now that our clinical activity has re-focused on specialist care. However, the strategy materials will need to be revised to address our new context and challenges. For example, the central importance of safety can no longer be taken for granted and this will need to feature more prominently in our principles.

A plan is being developed by the communications team to work towards launch in September 2020. The EMT will review this on 12 August 2020 in the light of our organisational context at that stage. The CEO's office is developing a matrix of enabling strategies and plans which will deliver *Above and Beyond* and these will be established in a portfolio management structure with a dedicated team to working alongside EMT in support of delivery.

1.3 Post-Covid financial position

There will be a continued block contractual agreement as we move forward from August to the end of the year and the figures for this are expected from NHSE later in July. Our financial position continues to be extremely difficult to manage as we have entered entirely unchartered territory, with unexpected costs relating to Covid, unusual patterns of activity and significant changes to our baseline income that will not settle for some time to come.

We are actively working with the NHSE London region and the national team to highlight the longstanding (and now significantly more problematic) issue of placing GOSH alongside acute providers in terms of contractual modelling. The ongoing fragility of research and IPP income will limit our usual ability to bridge the NHS funding shortfall, and this position will of course be exacerbated by the pressing clinical safety requirement to recover urgent activity as well as the wider ongoing challenges of Covid Safe working, workforce resilience and limitations on productivity.

Going forwards, decisions on funding will increasingly come through the local integrated care system, which will create further challenges relating to fit.

As we advocate for a sensible approach to funding during these extraordinary times, it is more important than ever that we continue to look for efficiencies and resist unnecessary spending. Clearly a level of investment is required to ensure our staff can work safely both in the hospital and at home, and to ensure that we provide care for as many patients and families as we can, as safely as we can. We aim to achieve a pragmatic approach to balancing these two imperatives, as we continue our efforts to effect change in funding structures. At this time a sense of calm leadership is really important for the organisation – there is a lot of anxiety and uncertainty in the system and within the hospital itself.

Part 2: People

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

Attachment 1: In Touch Survey results

The GOSH response to Covid has provided a unique opportunity to reposition our relationship with our staff and our organisational culture. The impact on staff has been central to our planning, decision making and response. We have worked proactively to help keep our staff:

- **Safe** – through the provision of testing, training, retraining, PPE, equipment, amended working practices and flexible working including home working.
- **Informed** – through significantly increased levels and models of communication and engagement facilitated by technology.
- **Supported** – through infection control, amended processes, HR practice and policy, occupational health, and wellbeing support and advice. The new wellbeing hub proved crucial and the staff shop and food/gift delivery services provided practical support and a huge morale boost.

Our staff have been flexible, creative and supportive of each other, despite high levels of anxiety. They have worked at pace to accommodate new services, established new systems and ways of working and collaborated across teams and job functions to solve problems. We have learned a huge amount from each other and from our partner organisations. Many of us have been able to step beyond our usual roles and have relished the opportunity to try new things.

However, the impact on our staff of coping with these rapid changes alongside personal challenges including sickness, grief, fear and the care of dependents has inevitably taken its toll. Going forward, staff are coping with ongoing uncertainty affecting all aspects of their lives on top of the pressure to reset and recover activity at work.

Our new *In Touch* survey will provide an essential snapshot of the wellbeing on our staff every six weeks and will guide our decisions on how best to continue supporting them as we move forwards. From the results in June (detailed in the document attached) we know that most of our staff feel well supported and safe at work. But 18% are finding it hard to cope and there are some staff who feel less well supported than others: including those providing the essential clinical, scientific and technical services that are key to our recovery.

2.2 What we are doing now to support our staff

The following interdependent work streams will support the next phase of easing lockdown and increased clinical activity:

Returning to site safely – ensuring GOSH meets government guidelines on "Covid secure" workplaces e.g. social distancing, cleaning & hygiene, new working practices – and make best use of the reduced available space at GOSH.

Staff Risk Assessments – all staff will have a personal risk assessment to discuss their demographic and health status, to identify those at elevated risk of Covid, and put in place mitigating actions.

Working from Home – new policies and arrangements to establish longer term, sustainable home working – making sure the appropriate support is in place around infrastructure, health and safety, governance and contractual frameworks and productivity and effectiveness.

We will also be prioritising the following elements of the year one People Strategy Delivery plan:

- Health and Wellbeing – extending and consolidating the work and impact of the Wellbeing Hub
- Diversity and Inclusion – assessing the impact of Covid through the lens of inequality. Creating and publishing an integrated D&I strategy to ensure we embed the commitments we have articulated into our future working arrangements
- Leadership and Line Management – with a renewed focus on leading and managing in our new context
- Internal communications – to support engagement, communicate changes and decisions, create employee voice and capture the GOSH Covid journey from the perspective of our people, as part of our recovery.
- Employer brand and value proposition – to support recruitment and retention.

These activities require ongoing investment in HR processes, systems and infrastructure to provide an efficient and effective HR & OD function which adds value and contributes to the delivery of strategic aims.

2.2 Diversity and Inclusion

We are delighted to welcome Adeboye Ifederu, chair of the BAME forum for GOSH staff to the board meeting today and grateful to the Board for the support to shape our recently published organisational response to recent global focus on Black Lives Matter.

Part 3: Service quality

3.1 Patient safety and clinical prioritisation

We continue to provide care for small numbers of patients who have tested positive for COVID-19, including those with PIMS-TS (Paediatric Inflammatory Multisystem Syndrome Temporally associated with SARS-CoV-2). We have not identified any true patient to patient nosocomial transmission. In total, three patients appear to have acquired the infection in hospital – potentially from one staff member and two parents who were involved in their care and tested positive.

Overall, the data suggests that our testing, infection prevention control precautions (including PPE and fit testing) and use of appropriate cohorting has worked successfully. During the board meeting we will review a set of sensible and pragmatic recommendations for operational management of Covid pathways at GOSH, which are adapted from NHS guidance and respond to our organisational context and learnings from the first phase.

Our most pressing patient safety challenge now is ensuring that we can see as many children and young people who have experienced delays or interruptions to treatment as quickly as possible. We have established a comprehensive clinical prioritisation process to review the entire cohort of over 3,700 patients who require an admission and will bring forward cases on the basis of clinical urgency.

In line with national guidance, patients and their entire household are currently required to self-isolate for 14 days prior to admission to hospital for elective surgery. This can reduce to 7 days for interventional procedures or for a diagnostic procedure which involves an aerosol generating procedure (AGP). All elective admissions to Hospital must be swabbed for COVID-19 no longer than 72 hours before admission to Hospital, and this swab should be negative for admission to take place.

These pre-admission testing requirements are presenting significant logistical challenges. They impact on our productivity and act as a barrier to access – in particular, for families who are not in a position to self-isolate prior to admission. At today's meeting the Board will be considering the latest evidence on disease prevalence in the London region as well as paediatric transmission rates and outcomes. The data indicates that a different approach to testing will provide a more effective balance of risks to children and improve access by making sure that elective admissions are simple, safe and equitable.

3.1 Refocusing on the basics

As we emerge from the frenetic activity of recent months is it reasonable to expect to see some slippage on some of our basic underpinning metrics. However, we made some significant progress on improving some of the basics towards the end of 2019/beginning of 2020 and we should take care not to lose momentum.

We have recently re-focused on closing internal audit actions and are now starting to remind teams of their responsibility to maintain discipline on improving the basics – from driving up appraisal and statutory/mandatory training rates, to duty of candour compliance and resolution of historical incidents.

3.2 HIMMS accreditation – a sign of EPR maturity

On 7th July we were HIMSS accredited at Level 6 and we anticipate the same accreditation for outpatients this week. Within a fortnight, we hope to achieve HIMSS Level 7 accreditation for outpatients. If we achieve this, we will be the first trust in the UK to do so and this reflects the excellent work through our EPR programme to achieve digital maturity.

3.3 Patient experience through Covid

Although the Friends and Family Test (FFT) feedback was suspended by NHS England as a result of the pandemic, GOSH have continued to collect, analyse and report on this important feedback. In line with reduced patient activity, numbers of FFT responses have reduced (although Trust response rate target of 25% was achieved in all months except April 2020). However, ratings of experience (the percentage of respondents who would recommend the hospital) remain high (as shown below at Trust and directorate level) and in line with the Trust target of 95%.

Part 4: Partnerships

4.1 North Central London Sustainability and Transformation Partnership

As the board is aware, I am currently the SRO and chair of two key groups which are addressing the urgent issues for the local health and care system in the wake of Covid.

The NCL COVID-19 Operational Implementation Group is expediting the re-start of elective work and considering how to establish the role of lead providers to facilitate greater flexibility and shared working across the STP area. The Phlebotomy System Group has now set up 4 hubs to address the urgent need for shared resources to take blood and is now looking at efficiencies, capacity and workforce challenges.

As of last week I am also now participating on NCL STP's capital investment group.

Ends

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

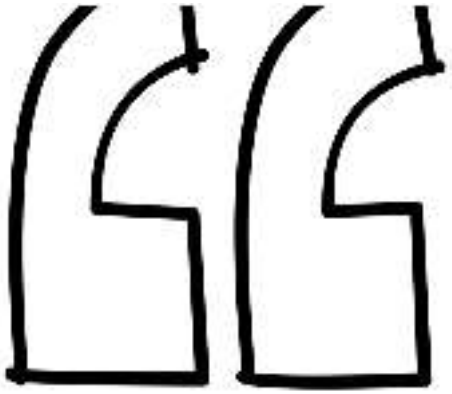
GOSH In Touch

June 2020

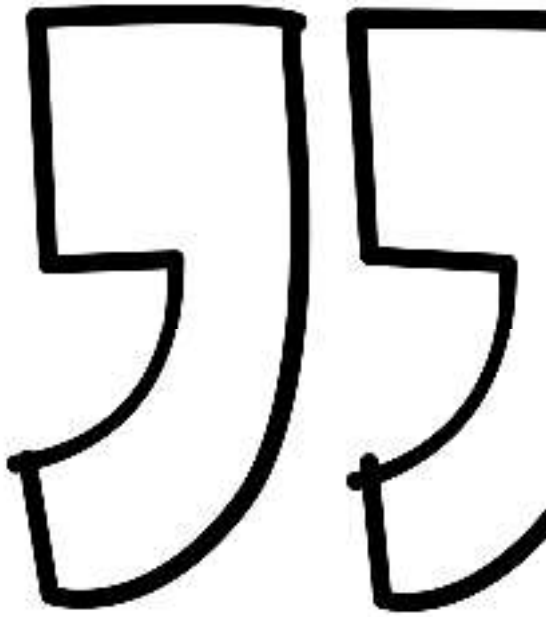
About the Survey

- Survey opened on 15th June 2020
- Ran for 2 weeks
- Promoted via Headlines, Big Brief & SLT
- 7 questions (& demographics)
- Completed in less than 2 minutes
- 1528 respondents
- 30% response rate
- More responses than regular Staff Friends & Family
- Will repeat in 6 week intervals to see trends

In Touch talking points



- 18% of respondents are finding it hard to cope (this is comparable to weekly BB poll)
- Most people know where to get support (80%)
- 64% of on-site workers feel safe or very safe being there.
- 71% of respondents feel their manager is taking an interest in their wellbeing.(No change since the staff survey.)
- There has been an improvement of 19% in how people see communication between senior management and staff.
- More respondents see senior management acting on feedback since the staff survey (+14%)
- People feel less involved in the changes happening to their team or dept. (-12% since the staff survey)
- 61% were onsite with 39% at home.



- Across all questions offsite workers were more positive than those on-site.
- Shielders are finding it harder to cope than other staff (25% not very well or difficult)
- By staffgroup, the Professional, Scientific & Technical responses were the least positive.
- Administrative staff were the most positive (this is a change from the Staff Survey comparable questions)
- Ops & Images, ICT & Genetics directorate responses were the least positive.
- Corporate areas in general responded more positively than clinical areas.
- BAME staff responses were less positive but they felt their managers were taking a positive interest in their health & wellbeing.

NHS
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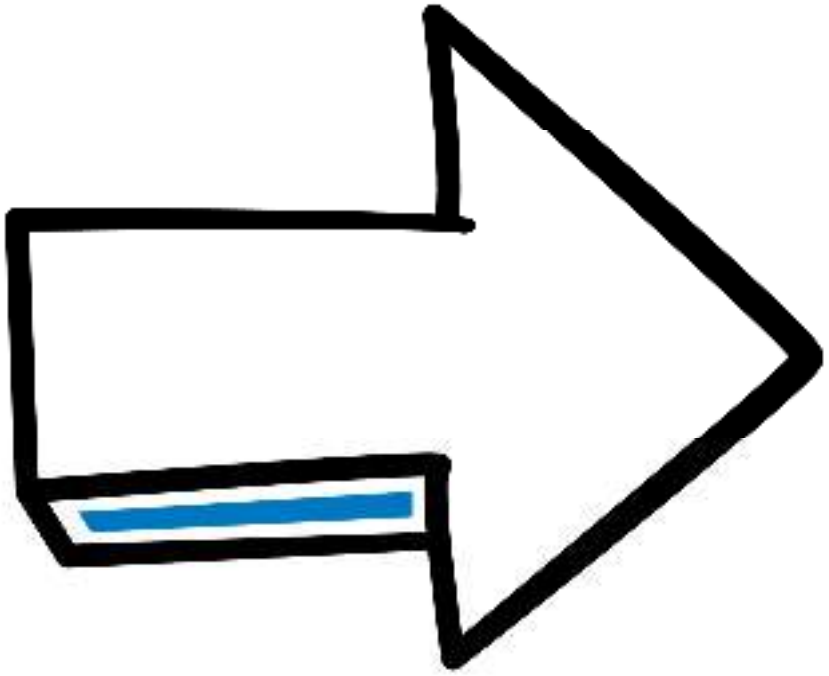
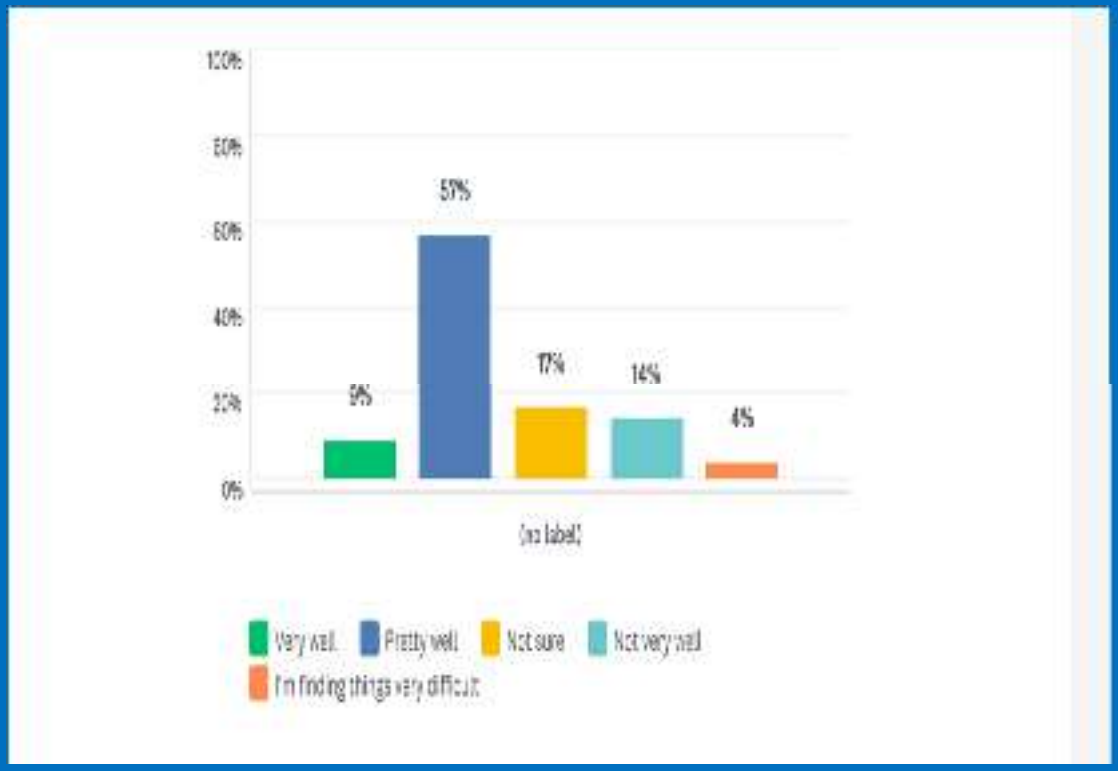
Directorate	Headcount	*NHS Staff Survey Responses*	In Touch Survey Responses	% Completed
Corporate Affairs	14	*82%*	14	100%
Medical Directorate	43	*69%*	42	98%
Finance	45	*82%*	39	87%
Redevelopment	29	*85%*	24	83%
HR&OD	85	*84%*	54	64%
Nursing & Patient Experience	155	*71%*	94	61%
Transformation	91	*66%*	54	59%
ICT	75	*62%*	37	49%
Genetics	150	*62%*	69	46%
Research & Innovation	120	*60%*	52	43%
Clinical Operations	145	*73%*	59	41%
Sight & Sound	349	*51%*	116	33%
Trust	***5,158***	***53%***	***1,528***	***30%***
Brain	331	*48%*	94	28%
International	232	*46%*	62	27%
Body Bones & Mind	600	*43%*	127	21%
Medicines Therapies & Tests	677	*52%*	138	20%
Operations & Images	469	*47%*	91	19%
Blood Cells & Cancer	454	*47%*	77	17%
Heart & Lung	933	*39%*	136	15%
Property Services	159	*52%*	21	13%
Skipped	-	-	136	-

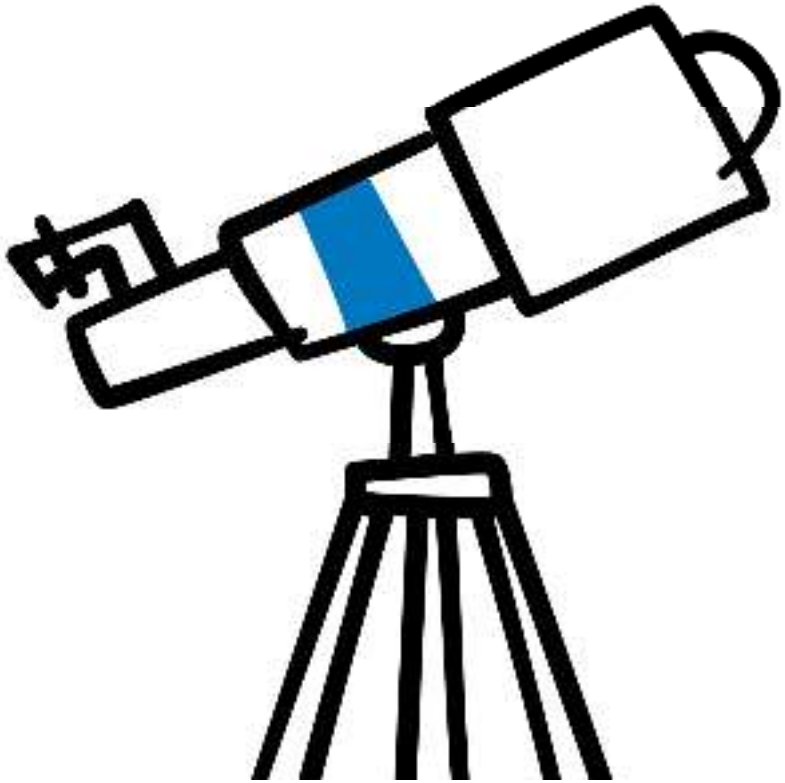


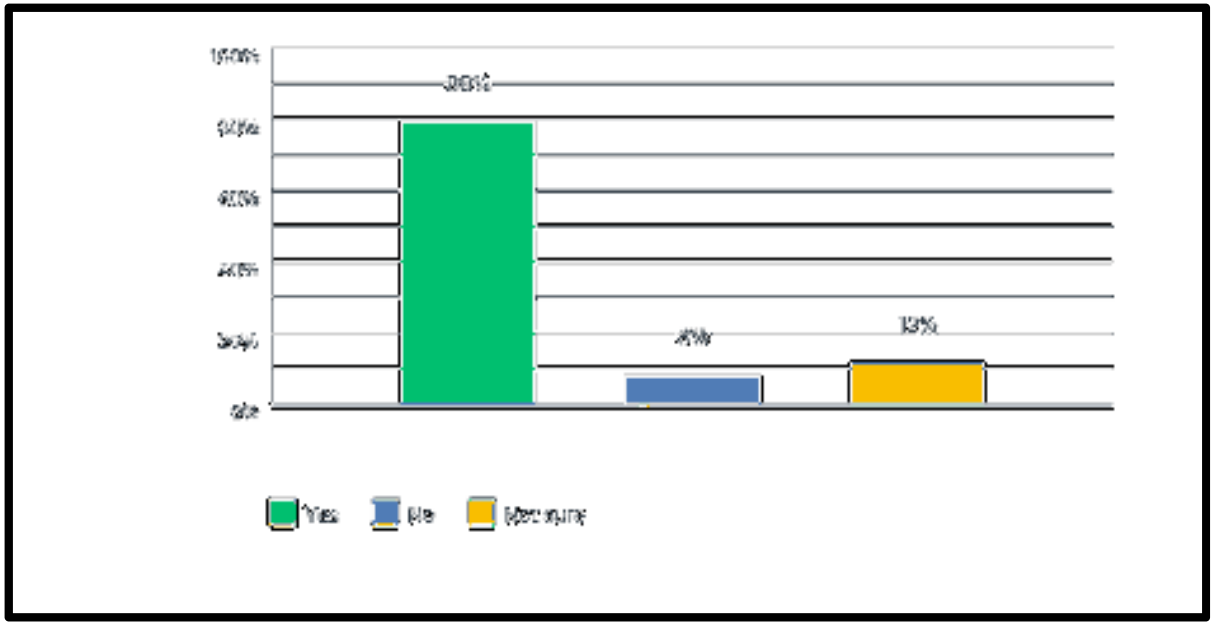
How do you are feel you are coping with life at the minute?



- Positive score 66%
- Negative score 18%

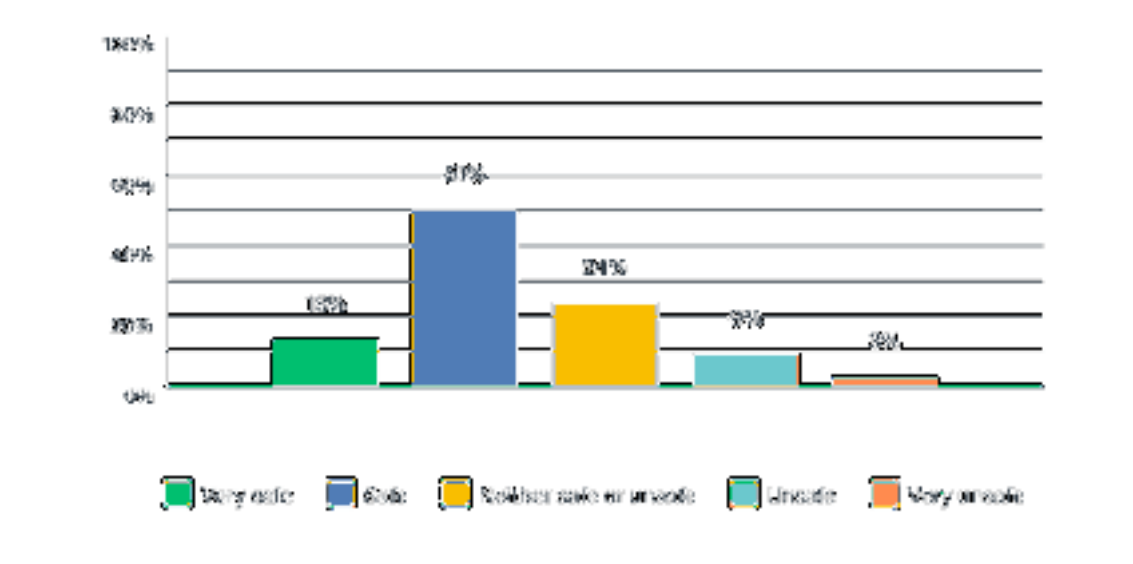
Do you know where you would go for wellbeing help and advice, if you needed support?





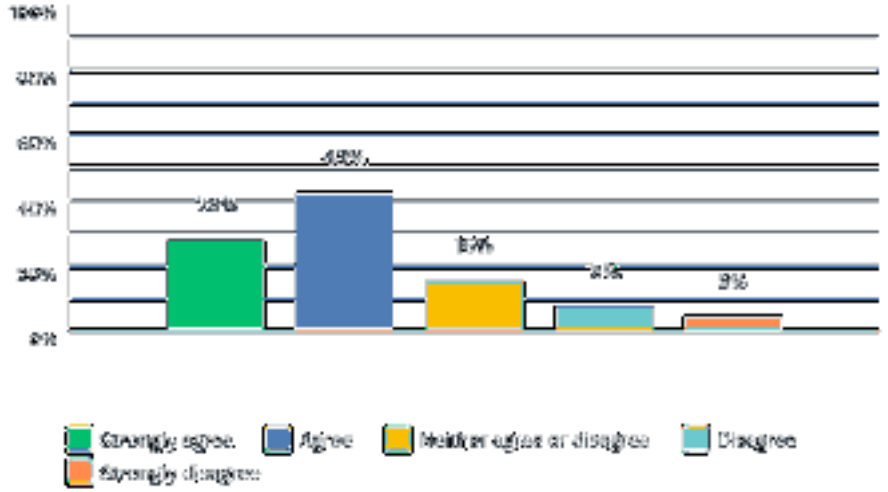
80% of respondents knew where to get support

If you are working onsite how safe do you feel?



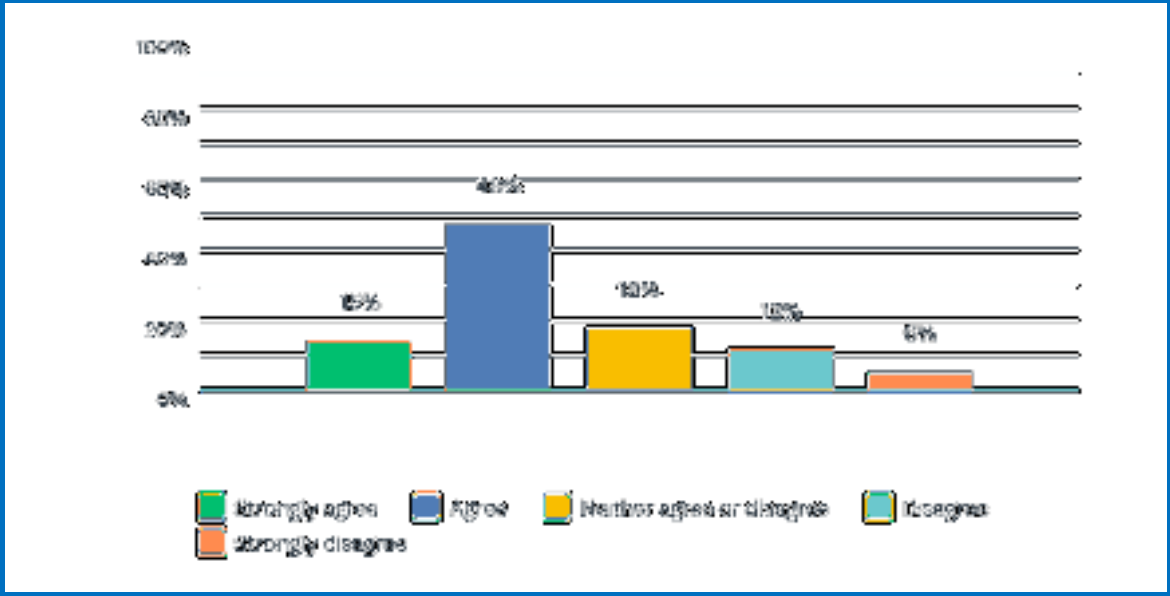
- 64% Positive score
- 12% Negative score

My immediate manager is taking a positive interest in my health and wellbeing?



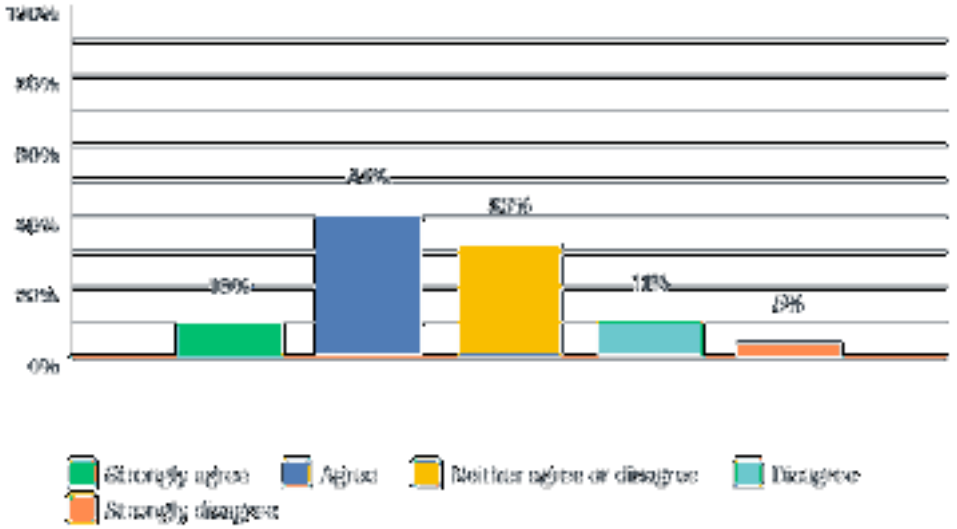
- 71% Positive score
- 13% Negative score
- Staff Survey comparison 71%

Communication between senior management and staff is effective at the moment



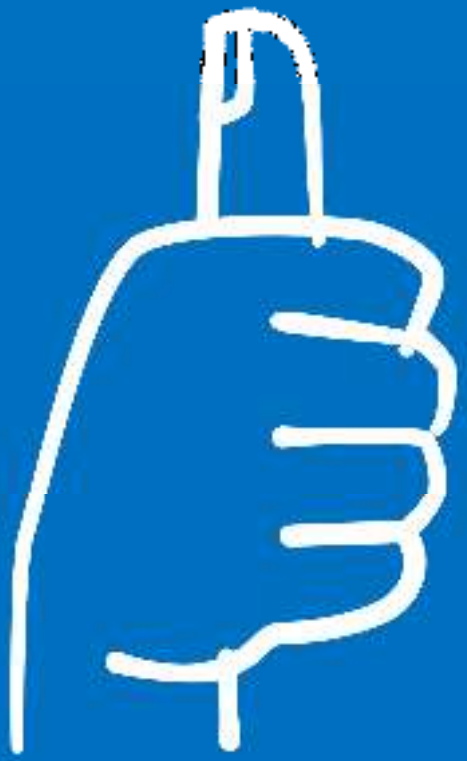
- 63% Positive score
- 19% Negative score
- Staff Survey comparison 44%

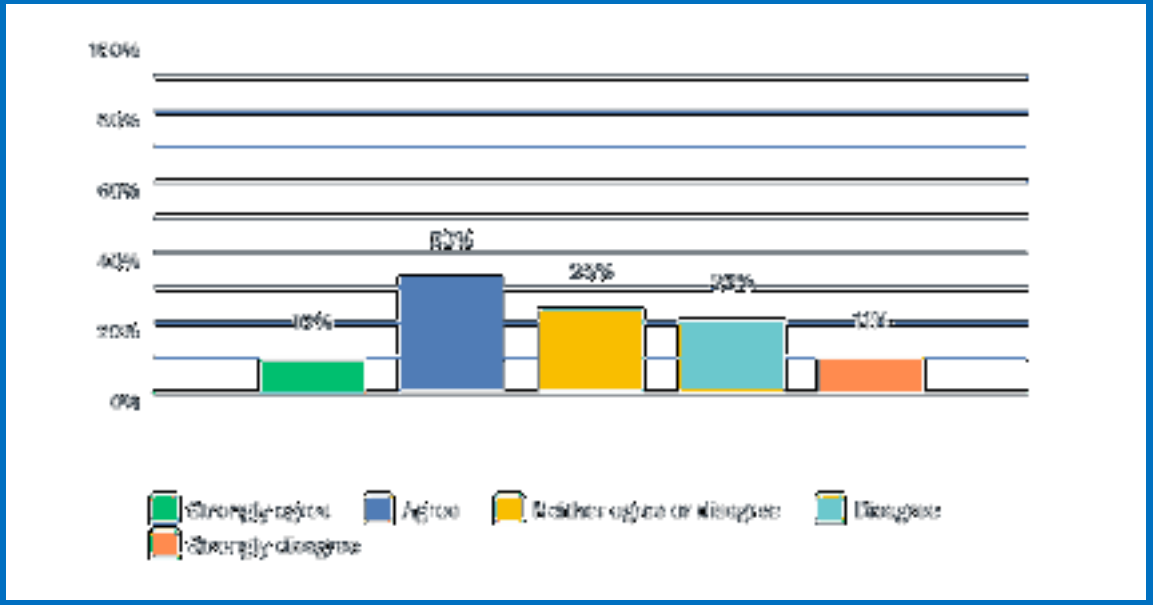
Senior managers are acting on feedback



- 51% Positive response
- 16% Negative response
- Staff Survey comparison 37%

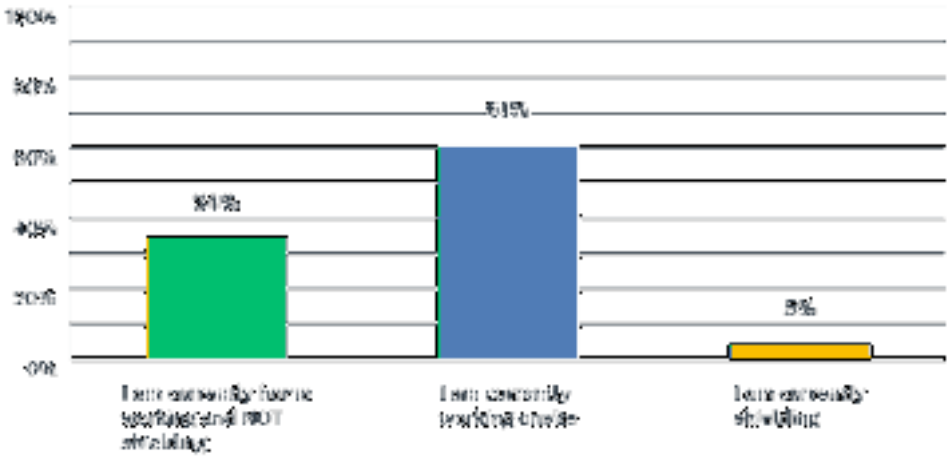
I am involved in deciding on changes introduced that affect my work/area/team/department

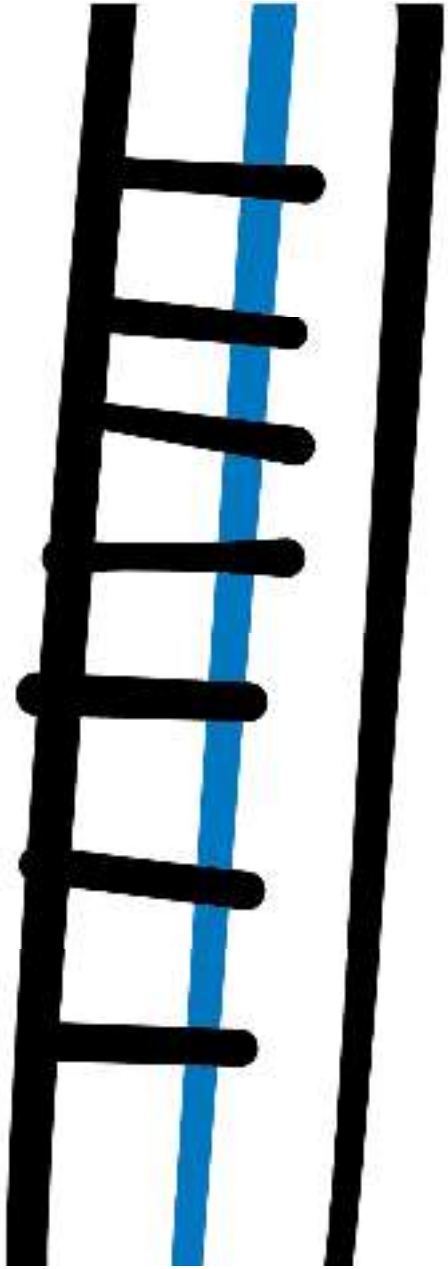




- 43% Positive response
- 33% Negative response
- Staff Survey comparison 55%

What is your current status?



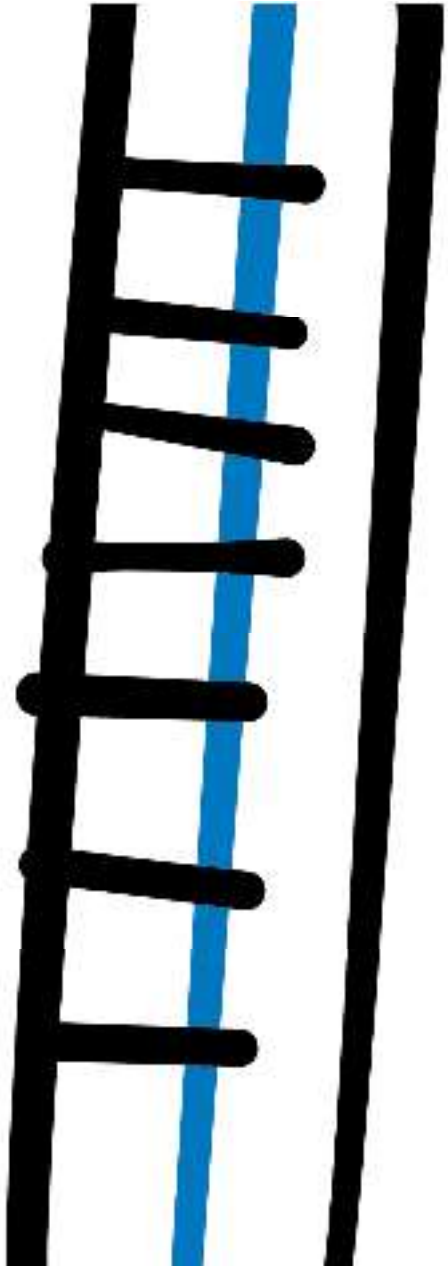


Responses by Staffgroup

In Touch question	Add Prof Scientific & Technical (eg Pharmacy)	Additional Clinical Services (eg HCA)	Administrative and Clerical	Allied Health Professional	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Nursing & Midwifery
How do you feel you are coping with life at the minute?	47%	63%	69%	64%	59%	64%	64%	67%
Do you know where you would go for wellbeing help and advice, if you needed support?	60%	80%	84%	79%	73%	79%	81%	78%
If you are working on-site, how safe do you feel?	39%	67%	55%	57%	53%	58%	70%	77%
My immediate manager is taking a positive interest in my health and wellbeing	57%	76%	73%	72%	71%	63%	61%	75%
Communication between senior management and staff is effective at the moment	48%	63%	69%	66%	48%	58%	60%	60%
Senior managers are acting on feedback	38%	57%	55%	49%	44%	52%	45%	49%
I am involved in deciding on changes introduced that affect my work/area/team/department	28%	33%	48%	42%	46%	33%	46%	41%

Responses by Directorate

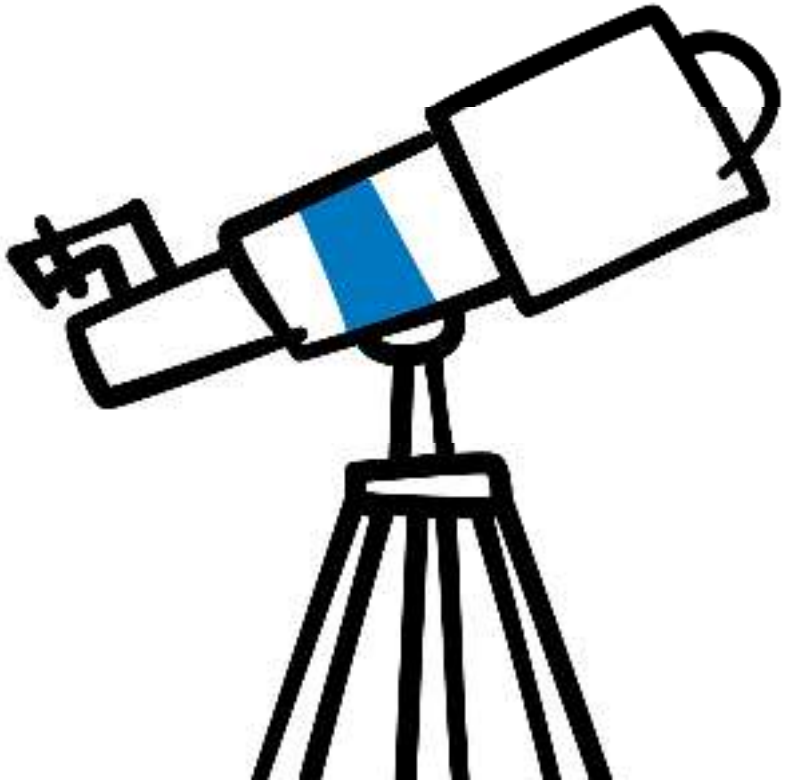
Directorate	How do you feel you are coping with life at the minute?	Do you know where you would go for wellbeing help and advice, if you needed support?	If you are working on-site, how safe do you feel?	My immediate manager is taking a positive interest in my health and wellbeing	Communication between senior management and staff is effective at the moment	Senior managers are acting on feedback	I am involved in deciding on changes introduced that affect my work/team
Blood, Cells & Cancer	64%	72%	66%	76%	64%	45%	45%
Body, Bones & Mind	62%	79%	77%	76%	59%	43%	39%
Brain	66%	83%	73%	81%	67%	55%	51%
Clinical Operations	74%	85%	68%	74%	62%	47%	44%
Corporate Affairs	77%	85%	62%	74%	72%	56%	54%
Finance	66%	78%	31%	75%	66%	59%	53%
Genetics	61%	65%	50%	62%	54%	52%	32%
Heart & Lung	73%	74%	79%	71%	63%	43%	34%
HR&OD	61%	98%	55%	87%	91%	74%	50%
ICT	49%	66%	27%	62%	57%	46%	38%
International	75%	81%	74%	65%	62%	55%	35%
Medical Directorate	74%	83%	65%	79%	83%	67%	69%
Medicines Therapies & Tests	62%	80%	59%	62%	55%	44%	34%
Nursing & Patient Experience	73%	82%	73%	80%	73%	52%	53%
Operations & Images	49%	73%	53%	63%	46%	40%	34%
Property Services	76%	91%	58%	67%	54%	57%	57%
Redevelopment	63%	83%	78%	79%	63%	42%	33%
Research & Innovation	60%	83%	70%	73%	73%	54%	40%
Sight & Sound	60%	85%	61%	58%	57%	60%	46%
Transformation	76%	83%	53%	70%	72%	67%	56%
Trust	66%	80%	64%	71%	63%	51%	43%



Response by Status

In Touch question	Onsite	Offsite	Shielding	Trust
How do you feel you are coping with life at the minute?	66%	72%	51%	66%
Do you know where you would go for wellbeing help and advice, if you needed suppor	75%	86%	87%	80%
If you are working on-site, how safe do you feel?	69%	N/A	N/A	64%
My immediate manager is taking a positive interest in my health and wellbeing	68%	76%	76%	71%
Communication between senior management and staff is effective at the moment	57%	72%	69%	63%
Senior managers are acting on feedback	46%	57%	64%	51%
I am involved in deciding on changes introduced that affect my work/area/team/depar	38%	49%	57%	43%

Responses by Ethnic Origin



In Touch question	BAME	White	Prefer not to say/Not recorded	Trust
How do you feel you are coping with life at the minute?	66%	69%	55%	66%
Do you know where you would go for wellbeing help and advice, if you needed support?	79%	82%	71%	80%
If you are working on-site, how safe do you feel?	52%	72%	50%	64%
My immediate manager is taking a positive interest in my health and wellbeing	74%	74%	56%	71%
Communication between senior management and staff is effective at the moment	62%	66%	51%	63%
Senior managers are acting on feedback	50%	54%	39%	51%
I am involved in deciding on changes introduced that affect my work/area/team/department	41%	46%	33%	43%

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 15th July 2020	
Electronic Patient Records (EPR) Programme Update **Submitted by:** Helen Vigne, Head of EPR / Richard Collins, Director of Transformation	**Paper No: Attachment N** The EPR Yearbook, Celebrating our Successes EPR Qualitative Benefits Review A Year of EPR Optimisation

Summary

The Trust switched on the Epic electronic patient record (EPR) on the 19th April 2019, nearly four years after Trust Board granted approval to proceed with a procurement, and just under two years after signing a contract with Epic. In the two years of implementation the organisation worked tirelessly to make it a success, and it was. We went live on time, £1.3m in implementation costs under budget and with the whole organisation truly behind it.

We had achieved the EPR vision, as first described in February 2016: "*Our digital hospital vision is that every member of the team caring for a child can always access the relevant information that they need rapidly and from a single place. It is also that patients, parents and carers in other hospitals and care settings can see relevant records and contribute information in-between visits to Great Ormond Street Hospital".*

As with any EPR implementation, there were teething problems. System workflows that were agreed during the build, in reality weren't quite right. Some elements of Epic, which was still relatively new in the UK market, did not always fully support our NHS workflows. However, overall we implemented a highly ambitious enterprise-wide EPR with minimal disruption. This was in part due to the hard work of the EPR and Epic teams and in part due to the significant support provided by the executive team, the senior clinical and operational leaders within the Trust and amazingly responsive and positive staff across all teams.

A year later, and our EPR turned 1 during unprecedented and highly disruptive times. As a Trust we could really understand that for the first time, we had the tools to allow us to deliver care to our patients remotely. Decisions could be made safely as the complete clinical picture could be accessed in a single place from almost anywhere. We were able to share records with clinicians from other hospitals whilst we cared for their paediatric patients, enabling them to focus on adult / Covid-19 patients. Patients and families logged into video visits with their clinicians from home and nurses shared photos when loved ones couldn't physically visit the hospital via MyGOSH.

In the year following go-live, teams across the Trust have been working alongside the EPR team to review and enhance the way the system works for them. We have continued to adopt new features and seeking to identify and showcase where improvements have been made. This document and its three appendices summarise this work and highlight what is next for our EPR.

Realising the Benefits

Benefits Realisation activities commenced prior to go-live, with our first saving achieved through a newly negotiated contract with a digital dictation supplier. Many benefits (both financial and qualitative) were

realised at the time of go-live, and others such as impact on length of stay will develop over time and be measured alongside other transformation programmes. The following is a summary of the key benefit achievements this year.

Benefits Book

A number of teams across the Trust have identified how the EPR has positively impacted on them and their patients, how it has improved efficiency, saved money or supported sustainability. These good news stories have been developed with help from the EPR Benefits and Change Team and published in the appended document *The EPR Yearbook. Celebrating our Successes*.

As we continue to realise benefits, we will further release the Yearbook annually in order to recognise the hard work of everyone across the Trust, to challenge us to ask how we can work smarter, and to provide the justification for the significant commitment required of the organisation, both financially and emotionally.

Full Business Case (FBC) Qualitative Benefits

The FBC described the difficulties that staff, patients and families and external members of the care team experienced with the old systems and processes and how implementing an EPR would improve this. These issues were categorised in 6 key themes:

- Patient safety
- Patient experience
- Quality of care
- Staff experience
- Productivity & Efficiency
- Data quality

Using Epic and DRE data, and by undertaking interviews and reviewing post-live surveys, each category and documented future state has been reviewed and the level of achievement described. The appended document *EPR Qualitative Benefits Review* highlights where qualitative benefits have been achieved as well as where there is further work to be done to ensure maximum patient and staff satisfaction.

FBC Financial Benefits

Review of financial benefit performance is undertaken monthly and reported to the EPR Programme Board, with regular updates to Finance and Investment Committee and Trust Board. The overall benefit achievement for 19/20 was approximately £1.3m against a business case target of £2.4m. Benefits linked to reduction in transcription costs and medicines usage significantly overachieved the original plan. However, benefits associated with a planned restructure with in ICT and closing a data centre were not achieved (resulting in reduction of £1.8m against the original plan). In addition, some of the key financial benefits from the FBC have since been challenged. In response to this we are re-planning future benefits, which includes using our own experiences of our first year as well as continuing to look for examples of best practice across our peers and colleagues within the wider Epic community. . This work will be overseen by the Clinical and Operational Adoption Group (EPR Programme Board sub-committee), leveraging operational leadership to help identify where savings can be made and to take more of a roll in ongoing benefits management and reporting activities.

A Year of Optimisation

The FBC set out an 18 month period of Optimisation following go-love which included a 3 month period of stabilisation. Throughout the implementation of the EPR we maintained the mantra “Inch Deep Mile Wide”, which prevented us from developing content that was too detailed and may later require unpicking. The Optimisation phase would be used to further develop features and speciality level content as users became more familiar with the system and how it could best be used.

Some key areas such as Pharmacy and Radiology needed closer attention for a longer period, however

for most areas, Optimisation commenced and a controlled process for enhancements was designed. Optimisation was divided into five x 3-month tranches, with Advisory Groups working with EPR teams to agree what was to be delivered. Each tranche contained three delivery cycles which included documentation of request, prioritisation, change management, benefit realisation and timely delivery. The controls in place during Optimisation has allowed us to process and act on over 1000 optimisation requests since go-live. The appended document *A Year of EPR Optimisation* describes the enhancements made to the system in a number of key areas:

- Nursing
- Medical
- Theatres
- Patient Portal
- Oncology
- Research
- Cardiology
- Patient Access & Administration
- Pharmacy
- Laboratories
- Interoperability
- Business Intelligence & Reporting
- Other Specialties

It outlines how staff were operating pre-EPR, what was made available at go-live and what has been developed over the first year, as well as plans for the remaining three months of Optimisation and beyond.

What is Next for EPR

Data quality

We continue working on an acute set of data/data quality issues that are due to a combination of configuration/core Epic system constraints and user error. Issues are being addressed by a combination of system configuration, user training and /or Epic development, with progress monitored by the EPR Programme Board and its subcommittee, the Data, Finance and Group chaired by the Head of Performance. A work plan is in place to see the issues stabilised by October 2020.

Closing the Programme

While the FBC detailed a 10 year investment, a programme is a temporary organisation and would usually close following delivery. The formal end of Optimisation is October 2020 as detailed within the FBC and we have commenced plans to begin preparing for the Closing a Programme stage. Following programme closure, the EPR team will transition from being a programme team to a department and deliver in a more operational state. The EPR will continue to be developed to meet the ever changing needs of the organisation, and to ensure we keep up to date with the latest enhancements and new features as Epic release them. However the nature and ownership of the projects will change as the priorities begin to be set by other change initiatives, particularly within Transformation. The Closing a Programme stage includes a review of deliverables, process and documentation. It ensures that ongoing plans for support are in place and that ownership for any outstanding risks are handed over to the organisation. The programme closure document will be submitted for approval at the November Trust Board.

Benefits Management

While some benefits have been delivered, others will continue to need management throughout the ten-year lifecycle of the FBC. This activity will be overseen by the Transformation Directorate, with the support of the operational teams responsible for them. In a number of cases, benefits associated with the implementation of the EPR (such as Theatres utilisation, reduced length of stay, and outpatient

optimisation) have already been aligned with the Flow and Outpatient Transformation Programmes being managed within the wider Transformation Directorate. The Covid-19 pandemic and the Trust's response to this (which is likely to continue throughout the calendar year) will impact the overall achievement of a number of EPR benefits.

Action required by the meeting

For information only

Contribution to the delivery of NHS / Trust strategies and plans

Delivery of the EPR programme supports improvements to the patient and staff experience as well as financial sustainability required to deliver the wider Trust strategy

Financial implications

The total value of forecast benefits in 2020/2021 is forecast to be below that forecast within the original EPR FBC. In some cases, benefits are likely to be achieved in part but difficult to measure. Further investment in being made in baselining and measuring change as part of the wider transformation programme of which EPR is now one element.

Legal issues

None

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

Helen Vigne, Head of EPR and Richard Collins, Director of Transformation

Who is accountable for the implementation of the proposal / project

Matthew Shaw, EPR Programme Senior Responsible Owner

Attachment O

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
15 July 2020

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

Aims / summary

To provide a 3 month snapshot of hospital performance in key metrics relating to quality (safety, experience, effectiveness, responsiveness and whether we are well led)
To provide a qualitative analysis of trends and themes and learning within the organisation. This now includes upcoming inquests with their links to other incidents and complaints.
To provide assurance regarding the plans to address non-compliance.

Are we safe?

- There were 2 serious incidents reported in May 2020, in addition to 4 serious incidents reported in April 2020 which means there are a total of 9 currently open. Of the 6 new Serious Incidents one relates to care provided 9 years ago which was identified following a claim, one relates to the cyber security event, and the other two are complex clinical cases involving a number of directorates. The most recent incidents relate to a cardiac condition not being identified on a fetal echocardiogram and concerns raised over a surgical treatment plan. Investigations are underway and currently on track.
- Significant improvement in the volume of incident closures was noted in May 2020. Trajectory plans have been agreed.
- WHO checklist documentation compliance remains low at 92.7%. This appears to be driven by gaps in documentation on Epic rather than a failure to undertake the checks with a particular data issue regarding cases where the patient did not have a general anaesthetic. A rapid improvement implementation plan has been requested from the Surgical Safety in Invasive Procedures group.
- There has been a rise in the number of central venous line bacteraemias. It is thought that the re-introduction of gloves (which we have found reduced hand hygiene compliance) and challenges with the supply of the correct alcohol wipes may have contributed to the increase. Close monitoring continues.
- Stat & Man training cumulatively across the Trust sits at 93% which is above target but Resuscitation and Level 3 Safeguarding are below target for May at 88% and 84% respectively.

Are we caring?

- FFT performance in May has been excellent with 98% experience rating for inpatients and 95% experience rating for outpatients. Feedback was overwhelmingly positively with families commenting on the professionalism and expertise of staff as well as their caring and welcoming nature.

- The FFT response rate was 30% which is well above the Trust target, with a significant increase in inpatient response.
- We have seen a notable rise in the number of *red* (high risk) complaints since the start of this financial year. There are 4 year to date, which is equal to the total number for 2019-20. All of these complaints are being reviewed through EIRM to ensure that serious patient safety issues are identified and investigated in line with SI requirements where appropriate.

Are we effective?

- We are 100% compliant with NICE guideline reviews including all new Covid-19 guidance.
- For the first time we have not met the target for specialty audits being completed in month. This is due to the delayed completion of a number of audits during the pandemic, and assurance is offered that the position will be recovered over the course of the year.
- Discharge summaries are at 65% compliance for May which is a deterioration from the position last month. This rises to 73.8% within 48 hours. There are currently only 39 discharge summaries predating May 2020.
- Clinic letter turnaround within 7 days has improved from 51.8% in March to 68.36% in May 2020. Targeted work with specific specialties is underway for clinic letters and discharge summaries to support further improvement.

Are we responsive?

- Diagnostics 6 week waits sit at 41.39% for May 2020 with the number of breaches in month up to 973 (compared to 818 in April and 387 in March).
- We achieved 67.73% against the RTT target of 92% with 2252 patients waiting longer than 18 weeks.
- There have been 88 breaches of the 52 week wait with Dental patients accounting for approximately 50% of these breaches.
- A Clinical Prioritisation Group has been set up to set priorities for admissions, diagnostics and outpatients as clinical services are restored in a phased away over the next weeks and months.

Are we well Led?

- Compliance with Duty of Candour for initial conversations is 100% for May 2020. Timescales for completing investigations remains low at 66%, but this is a very significant improvement on performance in March (0%) and April (14%).
- All actions associated with red complaints are either complete or within timescale. There are 84 overdue Serious Incident actions (according to data held on datix) which is a significant improvement on the position in March (132 overdue). The improvement plan has a target of closing all these actions by the end of July.
- There have been high levels of contacts with the Freedom to Speak Up guardian in April and May which have highlighted some Covid-19 related concerns in relation to medical staffing and the need for onsite working in certain staff groups.
- Policy performance has improved but remains below target at 77% (72% in April) of policies currently in date, but safety critical policy performance has improved to 84% in May (up from 68% in March) following the resumption of the Policy Approval Group via Zoom and real time policy updates during the meeting.
- PDR performance sits at 87%, reminders to staff have been reduced during the pandemic preparations. Consultant appraisal sits at 77%, but all overdue appraisals have been suspended by GMC given ‘special circumstances’, so our externally reported performance is 100%.

Attachment O

Action required from the meeting To note the report, and the actions identified to improve compliance with key quality metrics.
Contribution to the delivery of NHS Foundation Trust strategies and plans Delivery of high quality care.
Financial implications None.
Who needs to be told about any decision? Head/Deputy Head of Quality & Safety Head of Patient Experience Head of Special Projects for Quality & Safety Head of Performance Associate Director of HR Operations
Who is responsible for implementing the proposals / project and anticipated timescales? This varies depending on the action outlined.
Who is accountable for the implementation of the proposal / project? Sanjiv Sharma, Medical Director Alison Robertson, Chief Nurse Phil Walmsley, Chief Operating Officer Caroline Anderson, Director of HR & OD

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality & Performance Report June 2020 (May data)

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

Data correct as of 19th June 2020

Hospital Quality Performance – June 2020 (May data)

Are our patients receiving safe, harm-free care?

	Parameters	Mar 2020	Apr 2020	May 2020
Incidents reports (per 1000 bed days)	R<60 A 61-70 G>70	64 (n=447)	54 (n=376)	71 (n=536)
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	755	255	628
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	51%	48%	54%
Average days to close	R ->50, A - <50 G - <45	62.9	74	58
Medication Incidents (% of total PSI)	TBC	24.3%	26.3%	20.5%
WHO Checklist (overall)	R<98% G>98-100%	91%	93.06%	92.72%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	3.6%	6.1%	5.8%
New Serious Incidents	R >1, A -1 G – 0	0	4	2
Overdue Serious incidents	R >1, A -1, G – 0	0	0	0
Safety Alerts overdue	R- >1 G - 0	1	2	0
Serious Children's Reviews Safeguarding children learning reviews (local)	New	0	0	0
	Open and ongoing	7	7	7
Safeguarding Adults Board Reviews	New	0	0	0
	Open and ongoing	2	2	2

Are we delivering effective, evidence based care?

	Target	Mar 2020	Apr 2020	May 2020
Specialty Led Clinical Audits on Track	R 0- 60%, A>60-75% G>75-100%	77%	76%	76%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	135	9	14
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	Mar 2020	Apr 2020	May 2020
Friends and Family Test Experience rating (Inpatient)	G – 95+, A- 90-94, R<90	98%	99%	98%
Friends and Family Test experience rating (Outpatient)	G – 95+, A-90-94,R<90	97%	96%	95%
Friends and Family Test - response rate (Inpatient)	25%	25%	19%	30%
PALS (per 1000 combined pt episodes)	N/A	11.42	5.41	6.63
Complaints (per 1000 combined pt episodes)	N/A	0.28	0.38	0.35
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	5%	5%	6%
Re-opened complaints (% of total complaints since April 2020)	R>12% A- 10-12% G- <10%	10%	0%	0%

Are our People Ready to Deliver High Quality Care?

	Parameters	Mar 2020	Apr 2020	May 2020
Mandatory Training Compliance	R<80%,A-80-90% G>90%	93%	93%	93%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	86%	86%	86%
PDR	R<80%,A-80-89% G>90%	86%	85%	87%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	Actual: 88%	Actual: 89%	Actual: 77%
Honorary contract training compliance	R<80%,A-80-90% G>90%	N/A	N/A	61%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	83%	86%	84%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	95%	95%	94%
Resuscitation Training	R<80%,A-80-90% G>90%	88%	89%	88%
Sickness Rate	R -3+% G= <3%	3.2%	3.8%	2.5%
Turnover - Voluntary	R>14% G-<14%	15.8%	15.4%	14.9%
Vacancy Rate – Contractual	R- >10% G- <10%	6.2%	5.76%	5.57%
Vacancy Rate - Nursing		5.8%	4.67%	5.03%
Bank Spend		5.4%	4.1%	4.1%
Agency Spend	R>2% G<2%	0.7%	0.4%	0.4%

Hospital Quality Performance – June 2020 (May data)

Is our culture right for delivering high quality care?

	Target	Mar 2020	Apr 2020	May 2020
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	82%	77.2%	87.3%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G-0	132	105	84
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G-0	1	0	0
Duty of Candour Cases	N/A	5	5	9
Duty of Candour Conversation (Stage 1)	R<75% A 75-90% G>90%	100%	100%	100%
Duty of Candour Letter (Stage 2) Has a letter been sent?	R<75% A 75-90% G>90%	80%	71%	80%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	40%	57%	60%
Duty of Candour - Stage 3 Total sent out in month	Volume	3	7	3
Duty of Candour – Stage 3 Total (%) sent out in month on time	R<50%, A 50-70%, G>70%	0%	14.3%	66%
Duty of Candour – Stage 3 Total overdue (cumulative)	G=0 R=1+	8	6	7
Policies (% in date)	R 0- 79%, A>80% G>90%	72%	72%	77%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	68%	78%	84%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	100%	100%	100%
Inquests currently open	Volume monitoring	9	14	13
Freedom to speak up cases	Volume monitoring	11	31	29
HR Whistleblowing - New	Volume monitoring	0	0	1
HR whistleblowing - Ongoing	12 month rolling	1	1	1
New Bullying and Harassment Cases (reported to HR)	Volume	1	0	0
	12 month rolling	2	1	0

Are we managing our data?

	Target	Mar 2020	Apr 2020	May 2020
FOI requests	Volume	48	38	35
FOI Closures: % of FOIs closed within agreed timescale	R- <65% A – 65-80% G- >80%	94%	87%	52%
No. of FOI overdue (Cumulative)		3	5	3
FOI - Number requiring internal review	R>1 A=1 G=0	1	1	0
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	4	7	13
IG incidents reported to ICO	R=1+, G=0	0	1	0
SARS (Medical Record) Requests	volume	105	56	64
SARS (Medical Record) processed within 30 days	R- <65% A – 65-80% G- >80%	92%	93%	97%
New e-SARS received	volume	0	0	0
No. e-SARS in progress	volume	4	4	3
E-SARS released	volume	0	0	0
E-SARS released past 90 days	volume	0	0	1

	Target	Mar 2020	Apr 2020	May 2020
52 week + breaches reported (ticking at month end)	Volume	36	53	88
52 week + harm reviews to be completed (for treatment completed)		0	3	2

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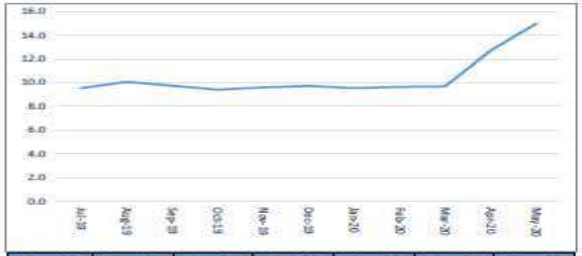
NHS Great Ormond Street Hospital for Children NHS Foundation Trust

RTT incomplete pathways: % of patients waiting <18 weeks	Period	Target	Actual
	May-20	92.0%	67.7%

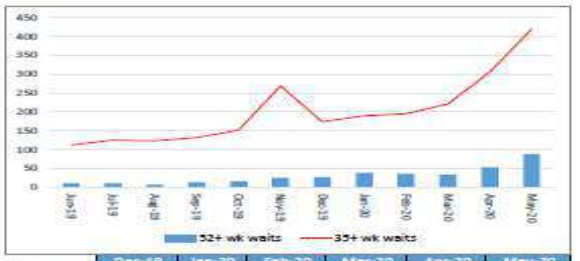
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
85.7%	83.0%	86.1%	86.0%	82.9%	76.2%	67.7%

RTT: Average waits for open pathways	Period	Target	Actual
	May-20	8.1	15.0



Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
9.6	9.7	9.5	9.7	9.7	12.7	15.0

RTT: Incomplete pathways 52 weeks or more	Period	Target	Actual
	May-20	0	88

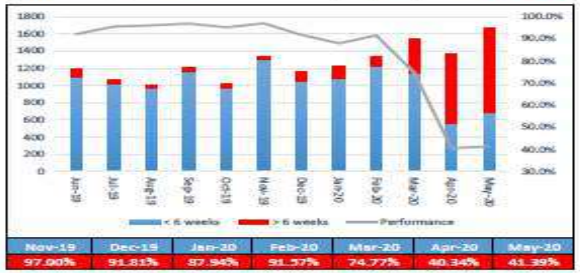


	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
52 wks+	27	38	36	33	33	88
35 wks+	174	190	193	221	306	420

RTT: Total unknown clock starts	Period	Actual
	May-20	213

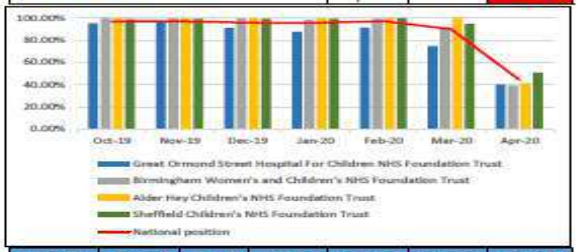
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
360	415	413	386	274	321	213

Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Period	Target	Actual
	May-20	99.0%	41.4%



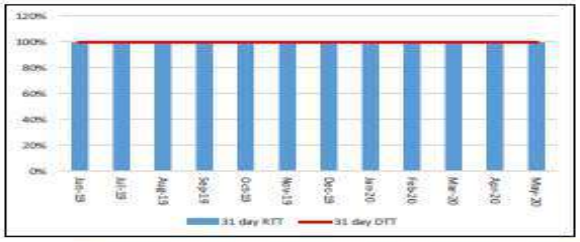
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
97.90%	91.81%	87.94%	91.57%	74.77%	40.34%	41.39%

Diagnostics: National % patients waiting less than 6 weeks for a test	Period	Target	Actual
	Apr-20	99.0%	44.3%



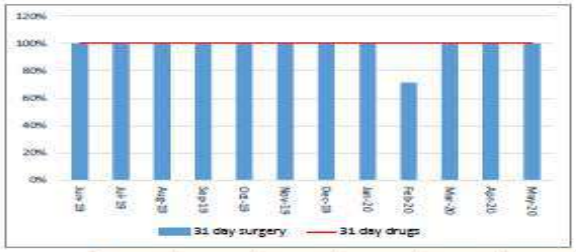
Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
96.90%	97.07%	93.83%	93.58%	97.24%	89.81%	44.26%

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



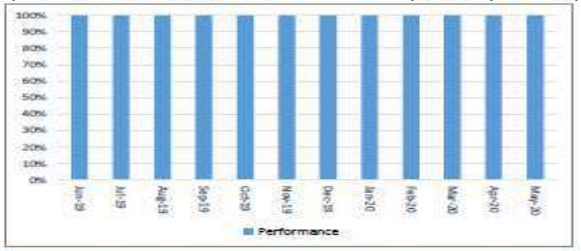
	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
31 day RTT	100%	100%	100%	100%	100%	100%
31 day DTT	100%	100%	100%	100%	100%	100%

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



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

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



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

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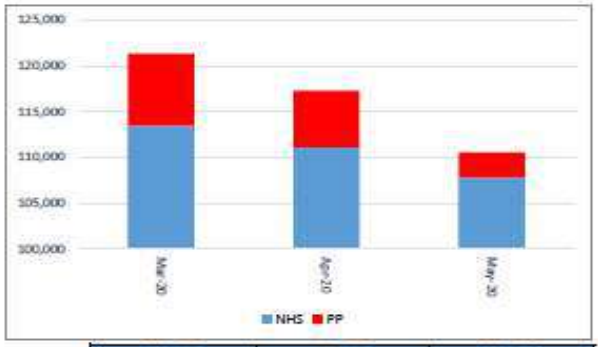
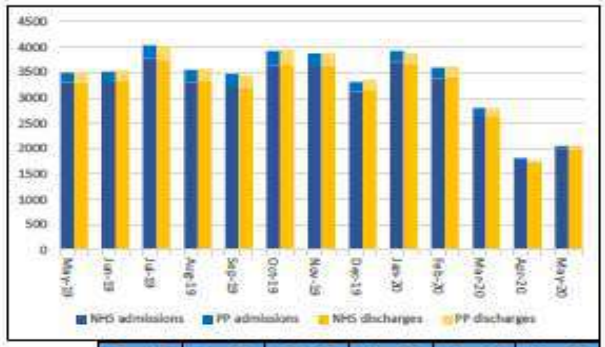
	Period	Actual
Open referrals at month end (NHS & PP)	May-20	110,570



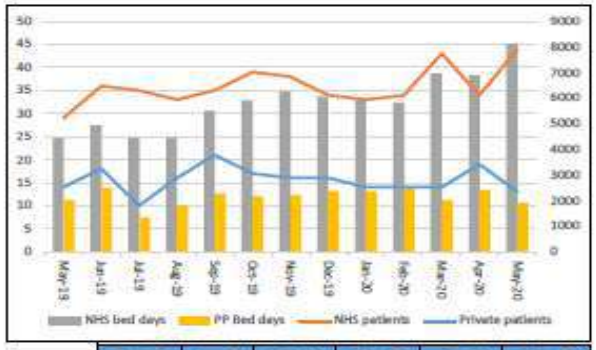
	Mar-20	Apr-20	May-20
NHS	113,459	111,085	107,787
PP	7,906	6,210	2,783

	Period	Actual
Admissions (NHS & PP)	May-20	2053
Discharges (NHS & PP)	May-20	2056



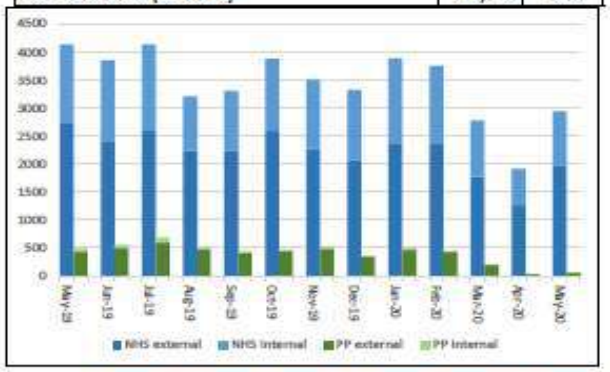
	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Admissions	3314	3925	3601	2801	1961	2053
Discharges	3360	3880	3613	2772	1796	2056

	Period	Actual
Patients not yet discharged with LOS >50 days	May-20	57
Bed days	May-20	10,026



	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Patients	50	47	48	57	53	57
Bed days	8409	8273	8349	8996	9321	10026

	Period	Actual
External Referrals (NHS & PP)	May-20	2040
Internal Referrals (NHS & PP)	May-20	970



	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
External	2414	2841	2798	1972	1285	2040
Internal	1268	1542	1396	1009	663	970

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

Under construction

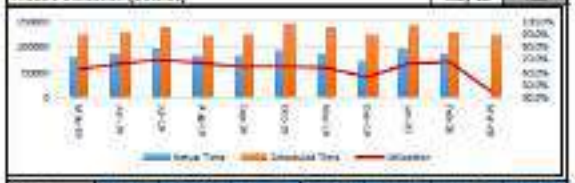
EDD						
> EDD						

Productivity & Efficiency

Great Ormond Street Hospital for Children NHS Foundation Trust

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

	Period	Actual
Theatre Utilisation (Main)	May-20	62.41%
Theatre Utilisation (Outside)	May-20	TBC



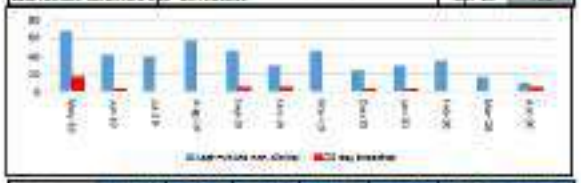
Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Main	63.75%	50.40%	57.15%	68.31%	45.93%	9.92%	62.41%
Outside	TBC	TBC	TBC	TBC	TBC	TBC	TBC

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

	Period	Actual
Emergency main theatre utilisation	May-20	78.43%

Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Cases	TBC	TBC	TBC	TBC	TBC	108.00	136.00
Utilisation	TBC	TBC	TBC	TBC	TBC	73.00%	78.43%

	Period	Actual
Last minute hospital cancelled ops for non clinical reasons	Apr-20	10
Last minute hospital cancelled ops - breaches of 28 day standard	Apr-20	4
Last minute cancelled ops - all reasons	Apr-20	TBC



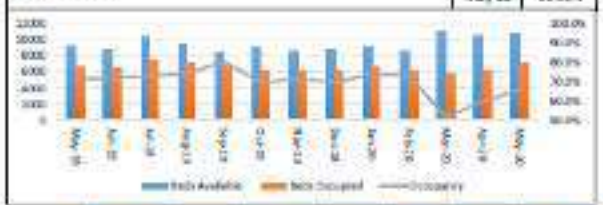
Month	May-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Non clinical	30	46	35	30	35	17	10
Breaches	5	1	3	3	2	3	4

	Period	Actual
Average length of stay	May-20	TBC

Under construction

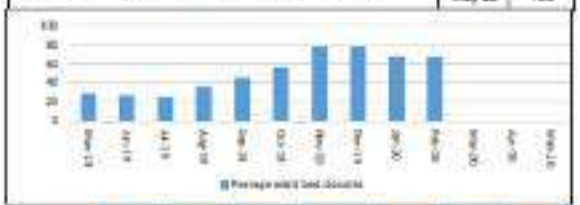
Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Main	TBC	TBC	TBC	TBC	TBC	TBC	TBC

	Period	Actual
Bed Occupancy	May-20	63.85%



Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Main	71.50%	69.74%	74.82%	73.46%	51.52%	59.60%	63.85%

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

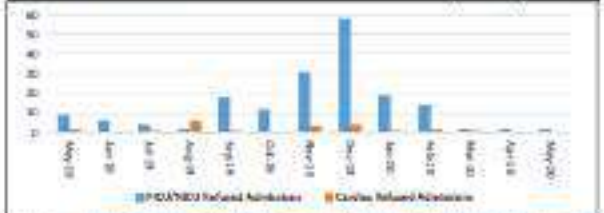


Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Av Closures	72.4	72.4	72.4	66.0	TBC	TBC	TBC

	Period	Actual
Discharge summary turnaround within 24 hours	May-20	66%
Discharge summaries - number not sent in month	May-20	21
Discharge summaries - number not sent YTD	May-20	69

Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Performance	67.06%	66.15%	70.95%	74.45%	71.21%	66.06%	65.24%
Not sent	39	51	33	42	100	19	21

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



Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
PICU/NICU	31	58	19	14	2	2	2
Cardiac	3	4	1	2	2	0	0

	Period	Actual
PICU Readmissions within 24 hours	May-20	1

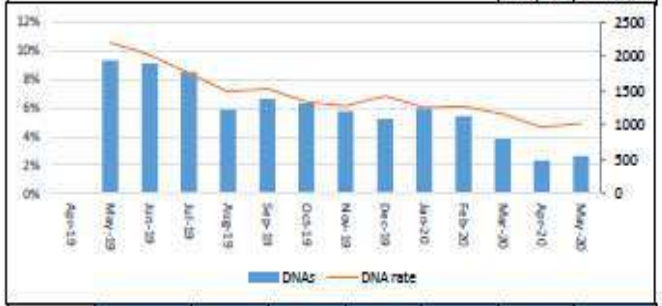
Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Readmissions	2	0	1	1	0	2	1

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

	Period	Actual
Clinic letter turnaround within 7 days	May-20	68%
Clinic letters- number not sent in month	May-20	755
Clinic letters - number not sent Financial YTD	May-20	1010

Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Performance	55.99%	54.59%	51.41%	53.56%	51.87%	61.36%	68.24%
Not sent	1854	1538	2636	2217	1266	726	755

DNA/Was Not Brought rate	Period	Actual
	May-20	4.92%



Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Rate	6.16%	6.83%	6.05%	6.11%	5.59%	4.65%	4.92%
DNAs	1202	1090	1246	1134	802	483	551

Outpatient Clinic Utilisation	Period	Actual
	May-20	TBC

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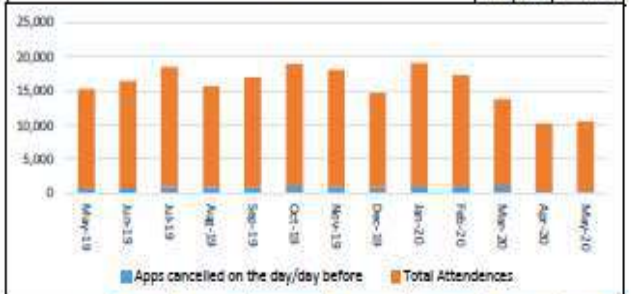
Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Rate	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Outpatient appointments cancelled on the day/day before	Period	Actual
	May-20	392



Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Cancellations	955	892	1009	1033	1105	396	392
Attendances	17106	13777	18112	16266	12698	9875	10162

Outpatients past review date	Period	Actual
	May-20	TBC

Under Construction

Month	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
# of Patients	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Do we deliver harm free care to our patients?

Central Venous Line Infections

GOS acquired CVC related bacteraemias ('Line infections')

Period	GOSACVCRB_No	DaysRecorded	Rate	Rate_YtD
Year 15/16	75	51976	1.4	1.4
Year 16/17	87	52679	1.7	1.7
Year 17/18	82	50732	1.6	1.6
Year 18/19	82	52929	1.5	1.5
Year 19/20	73	51520	1.3	1.3
Apr-20	8	4779	1.7	1.7
May-20	9	4457	2	1.8

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

Infection Control Metrics

Care Outcome Metric	Parameters	Feb 2020	Mar 2020	April 2020	May 2020
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	5	12	6	11
	YTD (financial year)	69	81	6	17
C Difficile cases - Total	In month	0	0	3	1
	YTD (financial year)	7	7	3	1
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	0	0	3	1
	YTD	2	2	3	4

Pressure Ulcers

			Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Hospital Acquired Pressure Ulcer (2+)	Volume	R – 12+, A 6-11 G =0-5	11	4	5	2	2	6	7	4	6
	Rate	R=>3 G=<3	1.45	0.54	0.66	0.27	0.27	0.83	1.04	0.6	0.79

Medication incidents causing harm

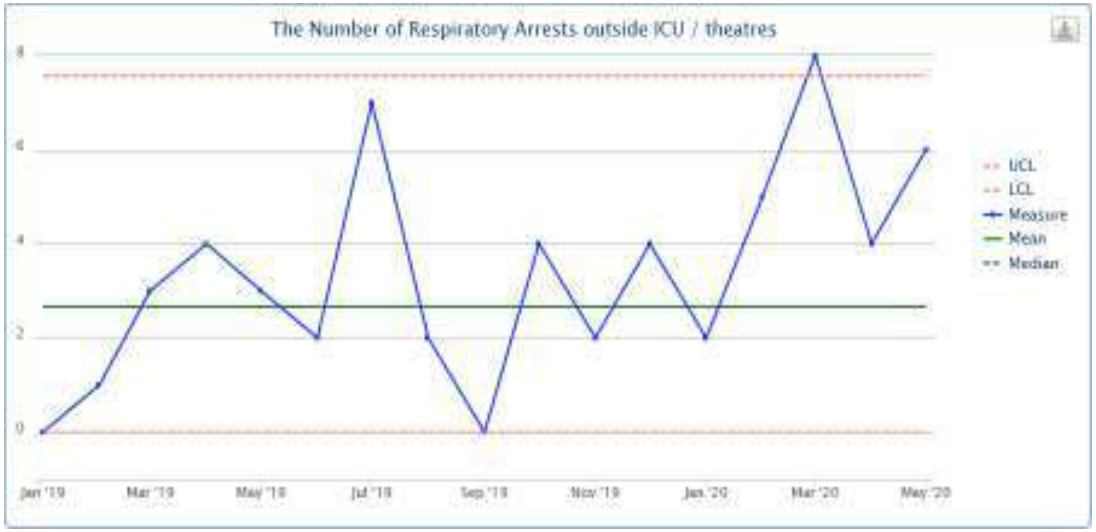
	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
% medication incidents causing harm	8%	13%	10%	14%	9%	11%	11%	12%	11%	10%

Does our care provide the best possible outcomes for patients?

Inpatient mortality

Cardiac Arrests

Respiratory Arrests



It is noted that there has been an increase in the mortality rate recently, with the mortality rate per 1000 discharges breaching the upper control limit. This is a trigger for us to review and investigate to help us understand. A full review of all the deaths in April and May is being undertaken to ascertain whether were are any common factors, including any assessment of whether the deaths are Covid-related (i.e. not specifically death due to Covid-19 but presentations which may have been delayed or impacted by Covid-19).

The total of deaths in April and May is 25. Of these, the significant majority took place in our ICUs (21). It is important to note that our internal mortality rate (as per chart above) does not include risk adjusted data. The deaths have not triggered a PICANET reset.

All of the deaths are being reviewed through the Child Death Review mechanism and a summary including the findings will be presented to the Patient Safety and Outcomes Committee in July 2020.

Are we Safe?

The incident reporting rate has increased to 71 per 1000 bed days (536 incident in total). It should be noted that activity is remains reduced in some areas due to the cancellation of elective cases to support management of patients during the pandemic.

There are currently 9 open **serious incident investigations**. There were 2 new SIs declared in May 2020. These SIs relate to concerns raised over a surgical treatment plan and the other related to a cardiac condition which was not identified following a fetal echocardiogram.

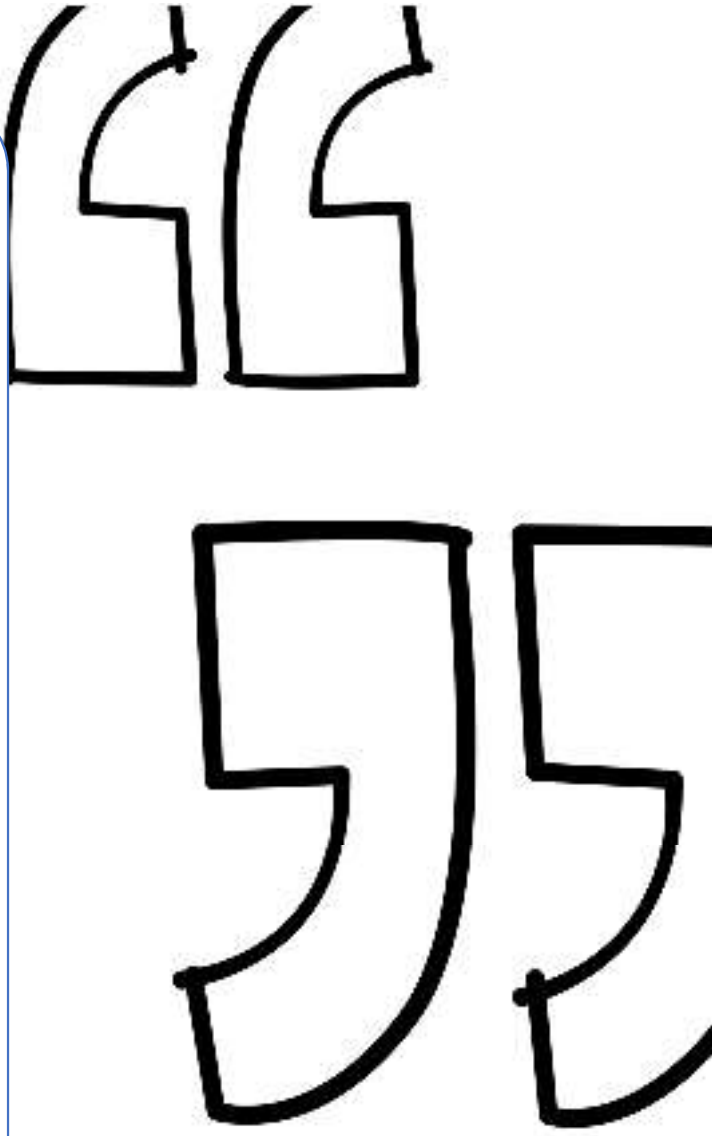
The number of **incidents** being quality checked and closed has increased to 628. This process was supported by a bank member of staff who had previously worked within the PST who has been able to focus on quality checking these completed incident investigations to ensure that that all the appropriate safety actions have been taken ahead of closure.

The percentage of incidents being closed within 45 working days has increased slightly by 6% this month. As previously reported, although an improvement is observed, this is due to the numbers of incidents that are being closed that were reported in 2018 and 2019. Of the historical incidents awaiting completion of investigation, this has reduced to 114 (from 2018-19) in May with ongoing work to complete these. With a set trajectory in place, it is likely that the days to closure will decline in the next 1-2 months data as more of the historical/delayed investigations are completed and the incidents closed.

In terms of **infection control** (please refer to slide 4) a rise has been observed in the numbers of CVC line bacteraemias when you compare the April and May YTD figures to the previous years' data. The use of PPE in sessional use and the re-introduction of gloves which know reduces hand hygiene compliance is likely to have played a part in this but there have been other challenges of note including they supply of 2% chlorhexidine 70% alcohol wipes to clean the end of needle-free connectors which we know increases the risk of CVL infection. This will be monitored via the Infection Prevention and Control Committee using the new infection control assurance framework.

The documented compliance for **WHO safer surgery checklists** in our Theatres remains lower than we would expect at 92.7% in May 2020. This is understood to be due to documentation gaps on Epic rather than gaps in practice. The GOSH Safety Standards for Invasive Procedures (SSIPs) group are looking at ways to learn from the high performance in MSCB in other theatres. The SSIPs group reviews data at theatre, consultant and speciality level to identify teams and individuals who require additional education and support. A rapid improvement implementation plan has been requested from the Surgical Safety in Invasive Procedures group.

Clinical Harm Reviews are carried out for patients who have waited longer than 52 weeks for their treatment. As of 19th June 2020 there are 0 overdue harm reviews, 2 harm reviews have been sent for completion. There are 88 breaches of the 52 week pathway (at month end) for patients on a ticking pathway with approximately 50% of the breaches in the dental specialty.



Are we Caring?

The **Friends and Family Test** response rate in May (30%) as well as the rating of experience for in and outpatients all exceeded the Trust targets, There was a significant increase in Inpatient responses and whilst negative themes reflected communication issues in Pals, feedback was very positive regarding the professionalism, efficiency, caring and welcoming nature of staff.

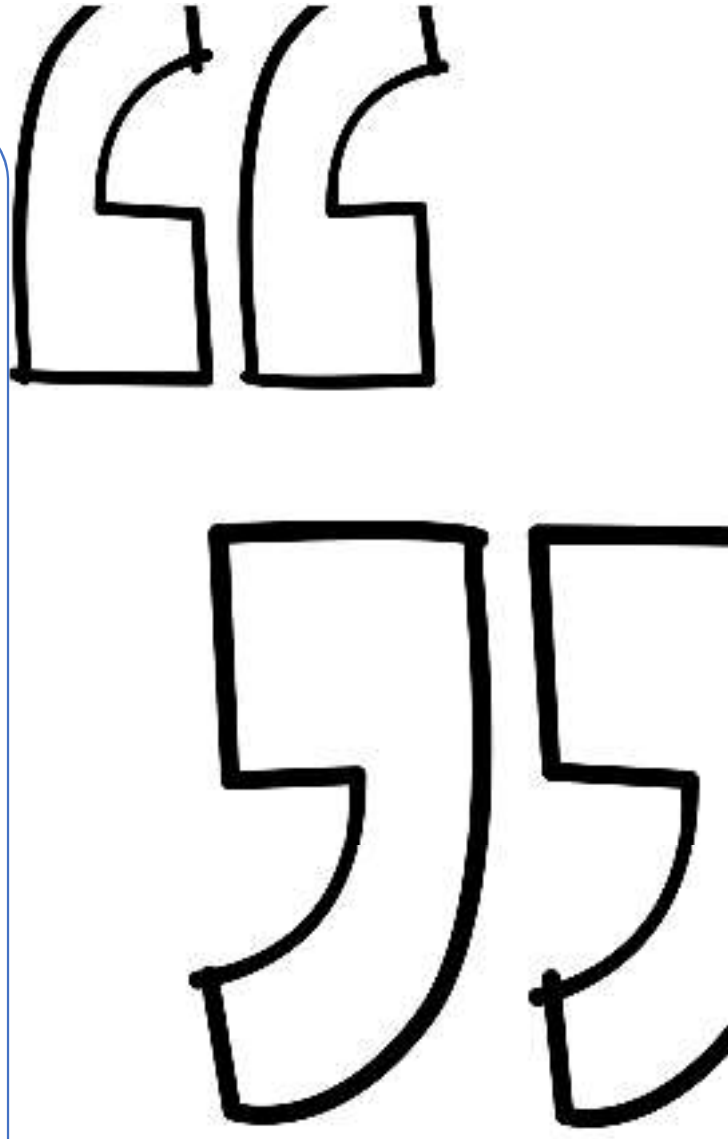
For the third successive month, there were 5 new **formal complaints.** Two related to the Blood Cells & Cancer directorate (specifically the Oncology and Bone Marrow Transplant specialties) and were graded as high risk (red). This brings the number of red complaints to 4 this financial year which equals the total number of red complaints during the whole of 2019/20. The Complaints team are closely monitoring the red complaints to identify any themes or trends. All new red complaints have been reviewed at an Executive Incident Review Meeting to determine if they should be investigated as a Serious Incident (SI) under the NHS England Incident Reporting Framework. To date, none of the red complaints have been declared as an SI.

NHSE have announced that the **pause on complaints** will be lifted at the end of June. Only one complaint was paused and the investigation has already resumed following the clinical team's increased availability.

Whilst patient activity increased in May, it remains particularly low in **IPP**. This resulted in IPP appearing as an outlier when considering complaints and pals by combined in patient activity. In fact IPP received only one complaint and of five Pals contacts, four related to prospective patients. The FFT rate for IPP was nil this month.

There was some important **learning from a complaint** relating to incorrect doses of betablockers. As a result, the team have devised a new chart to calculate the doses of oral beta blockers (propranolol and atenolol). The specially devised chart will have the correct dose for weights between 4 and 12kg. This will exclude any calculation of the doses which is person-dependent as they would only have to read the weight and the dose. The team now review medication dosage every time they have patient contact (including a day case, admission and outpatient visit). They are also trying to develop a supportive video for patients and families regarding these medications.

Pals contacts remained lower than usual in May and there was a significant reduction in COVID 19 specific concerns. Generally families raised queries about virtual appointments and some sought advice on patients returning to school. FAQs are regularly updated and are informed by Pals contacts and other feedback received. More broadly, the Pals communication cases continue to be about supporting families being in contact with busy staff and helping those families to navigate the Trust during this period of change



Are we Effective?

All **NICE** COVID guidance has been reviewed by GOSH and actions taken where required. No new COVID guidance has been published since the 15th May 2020

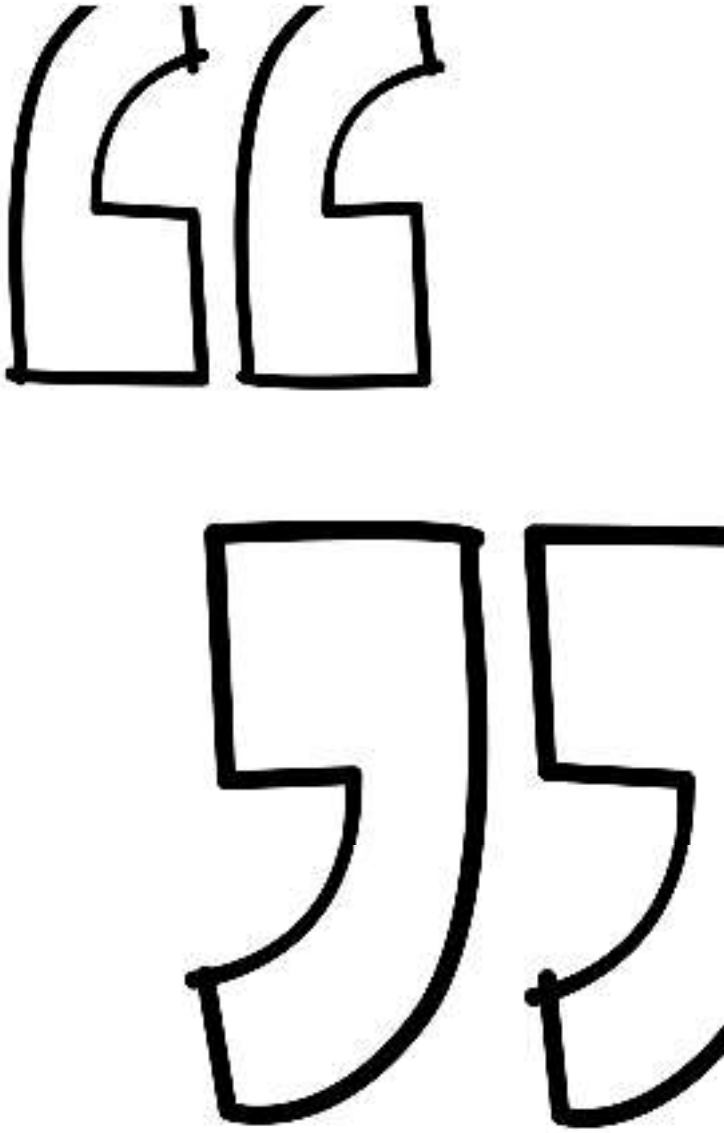
We had aimed to have as a minimum >100 completed **specialty led clinical audits** per year. At the end of May, unfortunately this timeframe is not on track for achieving this (14 audits completed (target = 17 by end of May)). A number of specialty audits have delayed completion due to the impact of COVID, some examples of the challenges reported by staff. It is anticipated that this position will be recovered by the end of the financial year.

A decrease in the number of new audits being started around the initial COVID lockdown period was also observed. Activity appears to be normalising as some clinical teams may have capacity to focus on audit as some clinical activity has been paused, and specific audits have been required in response to the pandemic. **45%** of specialty led audits commenced in April and May 2020 were initiated in response to COVID

For the month of May, 65.26% of patients who were discharged from GOSH their referrer and GP received a **discharge summary** within 24 hours, a decrease from the April position of 68.05%. 73.80% of letters were sent within 2 days of discharge, on average for May letters were sent 1.6 days following discharge compared to 1.8 days in April.

This focus includes backlog clearance of discharge summaries and the embedding of the completion of discharge summaries in real time into clinical practice. We now have a backlog of 39 discharge summaries up to May 2020 and the Directorates continue to work to reduce this further.

For May 2020, performance has improved in relation to 7 day turnaround for **clinic letters**; 68.24% compared to 61.36% in April. At the point of writing the report , a backlog of 1010 letters not yet sent was reported for this financial year of which 755 are in May 2020.



Are we Responsive?

As expected during the Covid-19 situation the Trust continues has underachieved against the 99% national standard for **Diagnostic pathways** reporting 41.39% of patients waiting within 6 weeks for the 15 diagnostic modalities. This is a slight increase from April 2020 and is due to under 6 week waits being 134 higher than in April. The number of breaches reported in May (973) compared to the number of breaches reported in April (818) has risen inline with expectations due to the reduction in activity May.

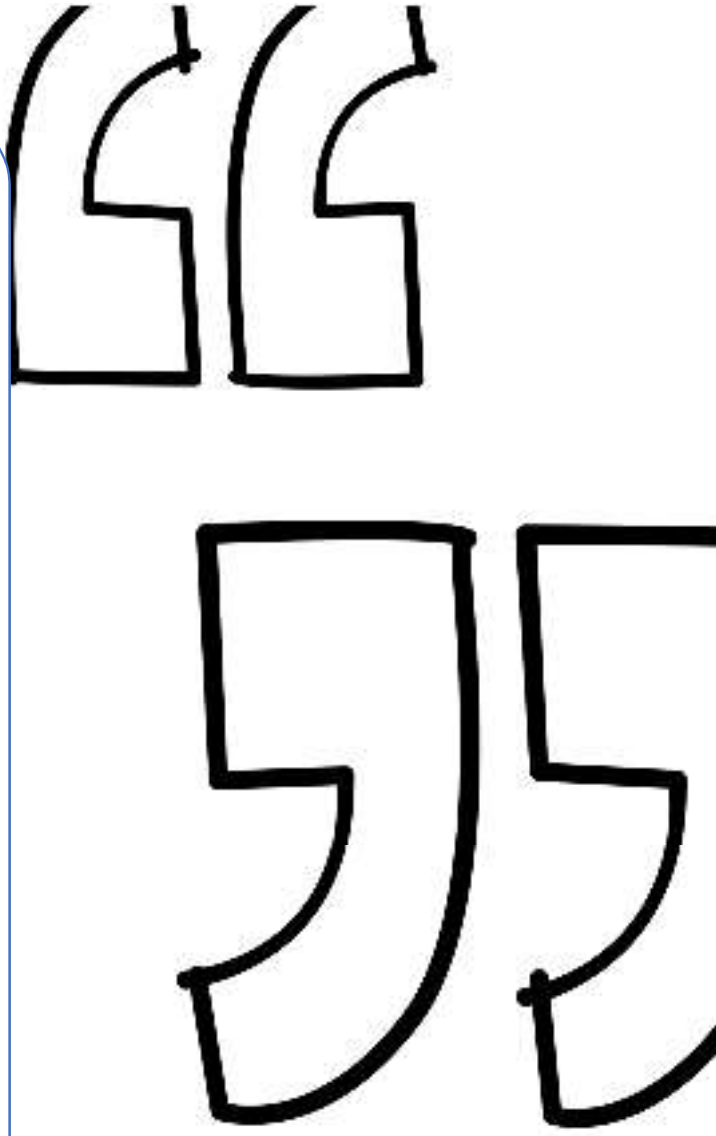
Patients continue to be seen according to their clinical prioritisation with patients requiring a scan within 6 – 72 hours being booked as previously, patients within 2 weeks are being assessed by Radiologist and/or Radiographers and booked accordingly. Routine scans have largely been postponed except for patients requiring a scan with a face to face appointment, or surgery planned and the surgery is booked. Through the Clinical Prioritisation Group the diagnostic teams are working closely with outpatient and inpatients teams to ensure capacity is opened at appropriate and safe levels.

The Trust did not achieve the **RTT 92% standard**, submitting performance of 67.73% with 2252 patients waiting longer than 18 weeks, this is a significant deterioration from 76.17% reported in the previous month, albeit expected.

The worsening position has been as a result of the Trust significantly reducing non-essential elective workload since the middle of March 2020, with up to 70% of the focus across admissions and outpatients being on urgent cases and utilising virtual appointments across outpatients. The average reduction in performance over the Covid-19 period during May 2020 has been 1.9% per week which is an increase of 0.3% average from April, continued further deterioration is projected over the coming months as activity levels remain below planned levels due to the need for social distancing, the additional clinical time required as a result of the need to use PPE and the reluctance of parents to attend appointments,

A **Clinical Prioritisation Group** has been established led by the Medical Director to access all patient who require to be seen across outpatients and admissions to ensure they are reviewed and prioritised according to clinical need. Any patient who experiences an extended wait will need to have a harm review completed. It has implemented processes for patients assessment and data capture. At the point of writing the report 68 category 2 surgical patients have been treated during May and June with 370 identified for surgery.

The Trust continues to experience extended waits in some sub-speciality areas including Dental/Maxfax and SDR, and continue to work with Commissioners around the best way to treat these patients in a timely way, in line with their clinical priority. In order to support the treatment of patients the Trust is working with The Portland who have offered two all day lists commencing from July and it is currently anticipated that Spinal, Urology and SDR patients will utilise the lists.



Are we Well Led?

There were 9 incidents that were identified as requiring **duty of candour** in May 2020. Being Open/Duty of Candour conversations took place in 100% of incidents. Stage 2 Duty of Candour Letter compliance increased to 60% within 10 days, and 80% in total. Three the stage 3 investigation reports were shared with families in May 2020. However, none of these were shared within the required timeframe due to the delays in completing the investigations. There are currently 7 RCA investigations which are overdue their completion deadline. As previously reported, a meeting was held with the Deputy Chiefs of Service, Heads of Nursing and the Quality and Safety Team in May to address the delays and a training plan has been agreed.

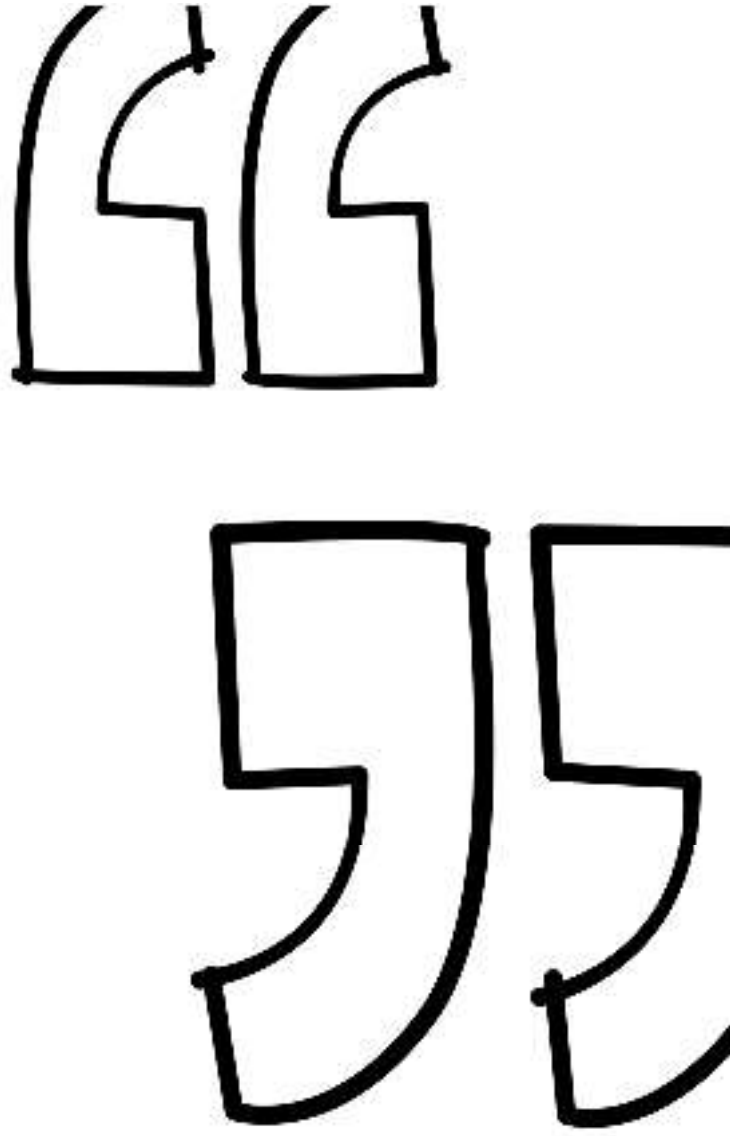
Risk Register: High risk monthly review performance increased in May at a compliance rate of 87.3%. A number are due to be reviewed in the second week of June whilst others have been updated shortly after their due review date. This delay was mainly due to delays in updating the Datix system with details of review actions/evaluation.

The Trust saw a further but slight decline of **FOI** requests in May (a decrease of 3) and a reduction in compliance with timescale of FOI responses due in May 2020. The FOI team is currently one staff member short with interim arrangements for cover to start in June 2020. Many of the responses were 1-4 days over deadline. Many of the delays were due to staff workload and the opportunity to reply to requests within the timeframes.
With regard to overdue documented **Serious Incident actions**, there are currently 84 open SI actions in May with a trajectory to close these by the end of July 2020.

The **Freedom to Speak Up** service has seen a significant numbers of cases in April and May, although contacts appear to be reducing through the first half of June. Several covid-19 related concerns have been raised, which included concerns raised by medical staff regarding the impact of changed medical staffing rotas and concerns being raised about whether onsite working was necessary for some staff groups.

Policy performance, has increased from 72% to 77% of policies currently in date, compliance in updating of safety critical policies has increased from 78% to 84%. A new process to support policy alterations in real time during the meeting has been introduced and appears to be working well.

Appraisal/PDR completion The non-medical appraisal rate for May was below target at 87%, an increase from last month. Again, while establishing COVID readiness, reminders were reduced, the expectation remains that PDRs should be completed remotely if necessary. Consultant appraisal rates have increased to 100%. (The GMC have advised nationally that Drs with overdue appraisals should be recorded as having special circumstances due to COVID19.) Without this exemption, Consultant appraisals sit at 77%.



Workforce Headlines

Contractual staff in post: Substantive staff in post numbers in May were 4741 FTE, an increase from April (45 FTE), this is slightly higher than the same month last year.

Unfilled vacancy rate: 5.6%, down slightly from 5.7% last month.

Agency usage: Remains at 0.4% of total paybill, below the local stretch target, and also below the same month last year (0.6%). The target for 2020/21 remains 2% of total paybill. Bank % of paybill was 4.1%

Turnover is reported as voluntary turnover. Voluntary turnover reduced to 15%, it's lowest level since August 2019, although it remains above target (14%). Total turnover (including Fixed Term Contracts) also reduced to 17.8%.

Statutory & Mandatory training compliance: In May the compliance rate across the Trust remained at 93%, which remains above the target with all directorates achieving target. Across the Trust there are 11 topics below target including Information Governance where the target is 95%. With COVID preparations, managers have been receiving less reminders about overdue training, but there has been clear messaging that with staff should continue to use available time to ensure that any online training (all bar Resus training) is completed once due.

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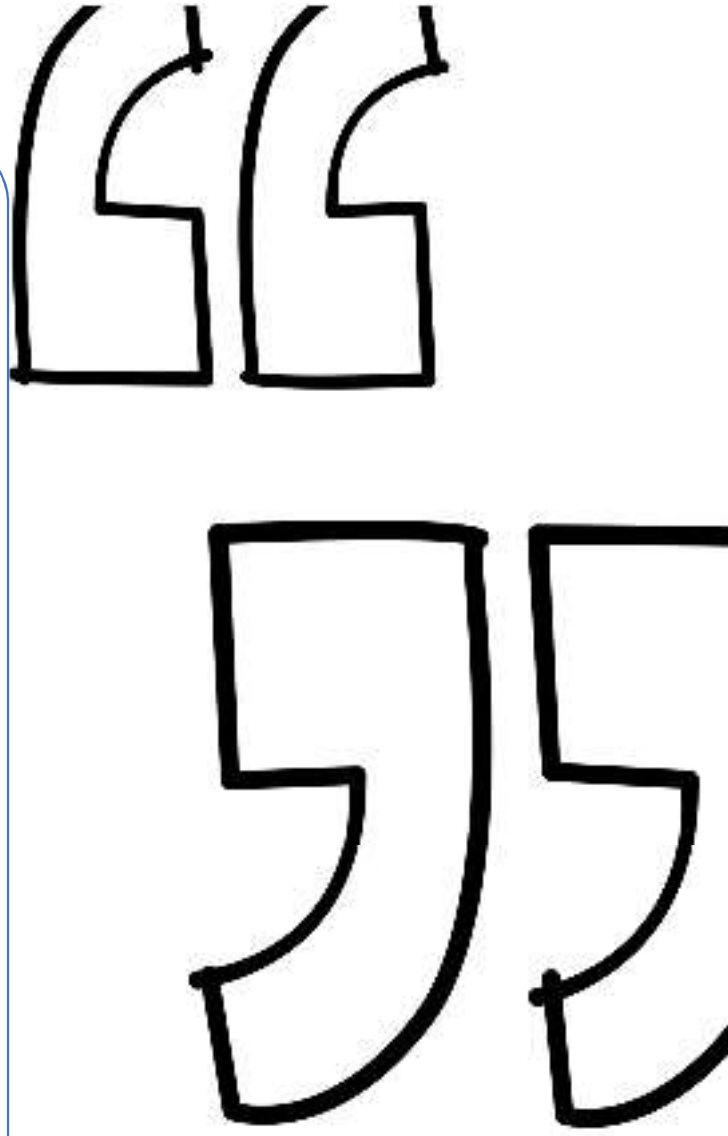
Sickness absence April sickness fell to 2.5%, below target, which seems low and may increase with revised data. The sickness KPI has been amended in 2020/21 to reporting in month sickness rather than annual rate as before, this is to be able to monitor peaks and troughs more effectively. Reported together with self-isolation and shielding absences, the Trust is reporting an impact of 4% COVID related absences. This is significantly lower than other trusts in our STP are reporting who are experiencing rates of over 15%. Daily absence reporting is being fed in to national reports.



Covid–19 at GOSH

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

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

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

There were 52 COVID 19 related incidents in May 2020:

Heart & Lung had the highest number of incidents (23) . Access to clinical services was the category that had that highest number of incidents (6), followed by communications (6) and PPE (4). 36 were no harm incidents and 16 minor harm.

FFT feedback suggested that patients were happy about the care they received both inpatients (98%) and outpatients (95%) with many positive comments about management during the pandemic.

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

There are currently 44 open Risks on the COVID 19 risk register. Issues include infrastructure (including staffing, facilities and environment) which was the most common risk type.

The current risk levels have changed slightly with 15 risks currently graded as high, 18 as low and 11 as medium.

In May the Health and Safety team, supported by the DIPC and Patient Safety reviewed 5 COVID related incidents that are reportable to the Health and Safety Executive (HSE) under the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 2013 (RIDDOR) they were:

- Nurse had been fit tested for FFP3 mask but had ward a surgical mask whilst caring for COVID 19 positive patient.
- Anaesthetics performed an aerosol generating procedure without alerting other members of staff. There were members of staff in the lab who were not wearing appropriate PPE.
- HCA staff member disclosed that she has entered the contaminated part of Dolphin wearing full PPE but having not been fit tested.
- Nurse affected had not been fit tested so only able to use surgical mask. Nurse affected carried out the Aerosol Generating Procedure without correct PPE.
- Nurse, who had not passed fit testing, entered the patient cubicle upon hearing the CRASH alarm to assist the patient. Patient was awaiting results of screening so all nursing staff allocated where wearing PPE. Patient screen was negative.

Trust Board
15 July 2020

Month 2 2020/21 Finance Report **Submitted by: Helen Jameson, Chief Finance Officer**	**Paper No: Attachment P**

Aims / summary

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

1. The Trust position at Month 2 is a £4.2m deficit. This has been offset by an accrual for the NHS top up payment (£4.2m) which, in line with NHS Guidance, gives the trust a breakeven position for Month 2. The total accrual for NHS top up payments for Month 2 YTD is £10.6m.

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

3. The key driver of the Trust deficit is the income position which is below plan. Private patient income is £4.8m below plan YTD due to reduced levels of activity associated with the Trust stopping referrals in March to facilitate Covid-19 capacity. Other non-clinical income is £5.9m below plan due to research studies not linked to Covid-19 being suspended, reduced Education & Training programmes and reduced charitable donations due to projects being put on hold.

4. Pay is adverse to plan YTD by £2.6m. This is driven by staffing requirements to support the Covid-19 response including additional medical and scientific staff from other organisations and new student nurses receiving paid placements in order to support the Trust with its Covid-19 response. There have been changes to medical staff working patterns, additional staff to support mental health services and further bank cover has been required to support sickness and rotas. Many staff costs that would have been capitalised have now become part of revenue expenditure due to charity and capital projects stopping due to Covid-19.

5. Non Pay is favourable to plan YTD by £1.2m. The Trust high cost drug spend is above plan due to the need to support battens treatments and Car-T patients in the first two months of the year. The Trust has also seen an increase in the credit loss allowance in line with the Trust policy due to reduced payments. Despite these being higher than plan, they have been offset by low levels of clinical supplies spend linked to reduced non-urgent elective activity.

6. Cash held by the Trust is £116.8m which is an increase on April of £13.6m. This was largely as a result of the collection of invoiced debt. The Trust continued to

receive block SLA payments a month in advance which contributed to the high cash balance at the end of the month.

7. Capital expenditure as at M2 YTD was £1.1m for Trust funded and £2.2m for charity funded. The Trust has also incurred £0.1m of capital spend in relation to Covid.

8. NHSE are currently reviewing the top up payment for Month 1 and have a query associated with the credit loss allowance and drugs spend of c£3.0m. This presents a risk to the Trust position.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust increased £13.6m in May to a closing cash balance of £116.8m. This increase was due to collection of invoiced debt.
NHS Debtor Days	NHS Debtor days decreased from 20 to 10 days which is in line with the plan. SLA payments have been replaced by block arrangements as of a result of Covid-19. The block payment for April was received on the 1st April, and the block for May was received on the 15th April resulting in a reduction in NHS debtor days.
IPP Debtor Days	IPP debtor days increased from 273 days to 278 days due to an increase in overdue debt.
Creditor Days	Creditor days remained the same as M1 at 38 days.

Action required by the meeting

To **note** the Month 2 Financial Position

Contribution to the delivery of NHS / Trust strategies and plans

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

Financial implications

Changes to payment methods and expenditure trends

Legal issues
N/A
Who is responsible for implementing the proposals / project and anticipated timescales
Chief Finance Officer / Executive Management Team
Who is accountable for the implementation of the proposal / project
Chief Finance Officer / Executive Management Team

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance and Workforce Performance Report Month 2 2020/21

Contents

Trust Performance Summary for the 2 months ending 31 May 2020

KEY PERFORMANCE DASHBOARD

Great Ormond Street Hospital for Children NHS Foundation Trust

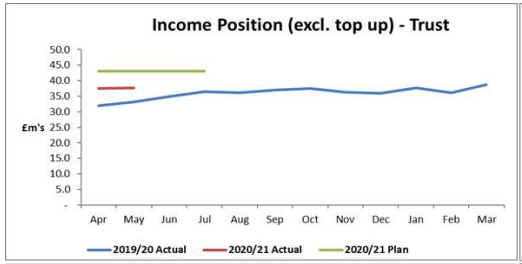
ACTUAL FINANCIAL PERFORMANCE

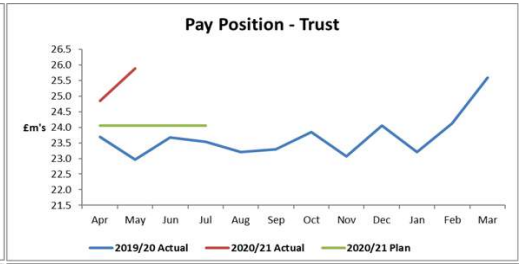
	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	£43.1m	£37.6m		£86.2m	£75.1m	
PAY	(£24.1m)	(£25.9m)		(£48.1m)	(£50.7m)	
NON-PAY inc. owned depreciation and PDC	(£18.2m)	(£15.9m)		(£36.5m)	(£35.0m)	
Surplus/Deficit excl. donated depreciation	£0.8m	(£4.2m)		£1.6m	(£10.5m)	
Top up	£0.0m	£4.2m		£0.0m	£10.5m	
Surplus/Deficit excl. donated depreciation	£0.8m	£0.0m		£1.6m	£0.0m	

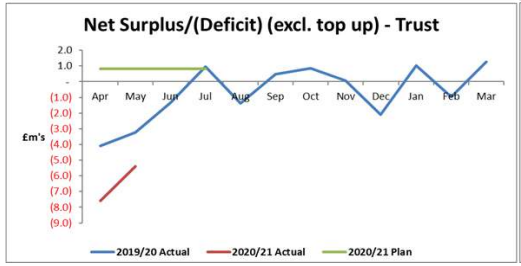
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

AREAS OF NOTE:

The Month 2 Trust position is a £4.2m deficit and YTD is a £10.5m deficit. An NHS top up has been accrued in line with NHS guidelines, which gives the Trust a breakeven position YTD. The Trust plan has been set by NHSE up to the end of July 2020 based on income and expenditure in 2019/20. NHS income is on a block contract and remains unchanged. Private patient income is below the NHSE plan YTD (£4.8m) due to the Trust stopping referrals in March in order to expand Covid-19 capacity. Non-Clinical income is below the NHSE plan due to research not associated with Covid-19 having stopped, charitable projects being put on hold and education and training income reducing due to courses being cancelled. Pay is above plan (£2.6m) due to additional staffing costs to support the Covid-19 response including staff from other organisations, changes to medical rotas, paid student nurse placements, sickness cover and additional consultant PAs. Staff previously working on capital projects have also been transferred to support the Trusts Covid-19 response. Non Pay is favourable to plan (£1.1m) due to reduced clinical supplies associated with reduced elective activity. This is partly offset by continued drugs costs associated with home delivery of high cost drugs supporting long term conditions. The Trust has also seen new drug spend linked with new services and drugs; and has seen 5 Car-T patients YTD.





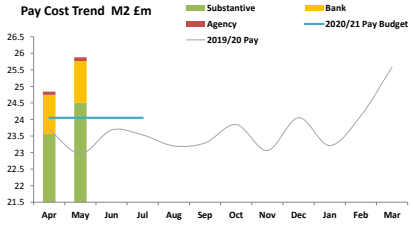


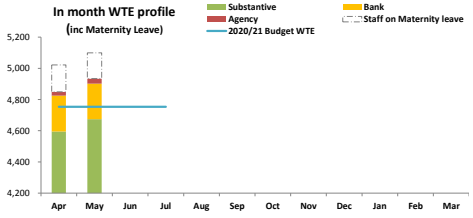
PEOPLE

	M2 Plan WTE	M2 Actual WTE	Variance
PERMANENT	4,516.9	4,674.1	(157.3)
BANK	215.3	227.5	(12.2)
AGENCY	21.2	33.1	(11.9)
TOTAL	**4,753.4**	**4,934.7**	**(181.3)**

AREAS OF NOTE:

NHSE has set a plan that is equivalent to 4,753 WTE, which shows a 181 WTE over establishment. The variance is driven by staffing requirements to support the Trust Covid-19 response. Additional medical and scientific staff from other organisations have been brought into the Trust and additional student nurses have received paid placements in order to support the Trust response. Further PA's have been provided to consultants to cover gaps left by junior doctors who have also been directed towards the Trust Covid-19 response and additional bank cover has been required to support sickness and rotas. Reduced leavers and increased starters have seen a rise in permanent staffing with bank reducing from vacancies but increased to support additional services and capacity.



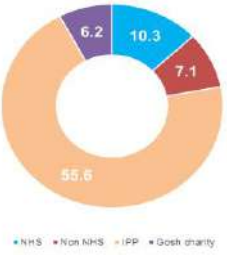


CASH, CAPITAL AND OTHER KPIs

Key metrics	Apr-20	May-20
Cash	£103.2m	£116.8m
IPP Debtor days	273	278
Creditor days	38	38
NHS Debtor days	20	10

Capital Programme	Plan M2	Actual M2	Full year plan
Total Trust-funded	£0.9m	£1.1m	£18.0m
Total Donated	£3.6m	£2.2m	£16.5m
Total Covid capital	£0.1m	£0.1m	£0.3m
Grand Total	£4.6m	£3.4m	£34.8m

Net receivables breakdown (£m)



AREAS OF NOTE:

1. Cash held by the Trust increased in month by £13.6m. This was largely as a result of the collection of invoiced debt.

2. The capital programme for the year to date is less than plan by £1.2m: Trust-funded expenditure exceeds plan by £0.1m and donated is less than plan by of £1.3m. The donated variance is largely due to the Sight and Sound project.

3. IPP debtors days increased in month from 273 days to 278 days. Total IPP debt decreased slightly in month to £48.6m (£48.7m in M1), however overdue debt increased in month to £40.1m (£38.9m in M1).

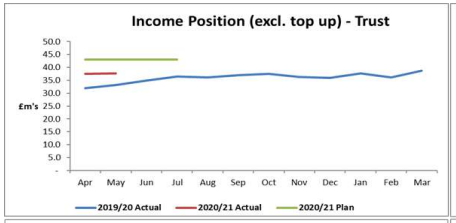
4. Creditor days remained the same as the previous month at 38 days.

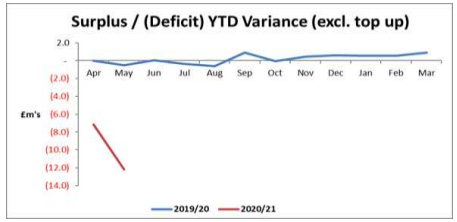
5. NHS debtor days decreased in month from 20 days to 10 days.

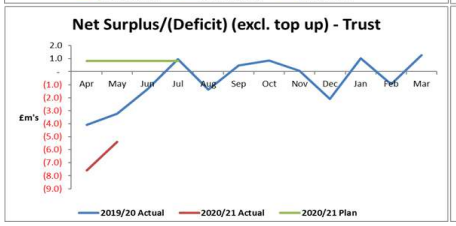
Trust Income and Expenditure Performance Summary for the 2 months ending 31 May 2020

Great Ormond Street Hospital for Children NHS Foundation Trust

2020/21 Board Approved plan (£m)	Income & Expenditure	Month 2 NHSE Plan (£m)	Month 2 Actual (£m)	Month 2 Variance (£m)	Month 2 Variance %	Year to Date NHSE Plan (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	Rating YTD Variance	Notes	2019/20 Actual M2 (£m)	2020/21 NHSE Plan M2 (£m)	2020/21 Board Approved Plan M2 (£m)
414.52	NHS & Other Clinical Revenue	31.97	31.81	(0.16)	(0.51%)	63.95	63.56	(0.39)	(0.60%)	A	1	29.10	63.95	32.02
73.24	Private Patient Revenue	5.59	3.01	(2.57)	(46.05%)	11.17	6.42	(4.75)	(42.50%)	R	2	4.39	11.17	4.92
64.15	Non-Clinical Revenue	5.53	2.79	(2.73)	(49.45%)	11.05	5.14	(5.91)	(53.45%)	R	3	5.15	11.05	5.23
551.91	**Total Operating Revenue**	**43.08**	**37.61**	**(5.47)**	**(12.69%)**	**86.17**	**75.13**	**(11.04)**	**(12.81%)**	R		**38.64**	**86.17**	**42.17**
(303.12)	Permanent Staff	(22.76)	(24.51)	(1.75)	(7.69%)	(45.53)	(48.07)	(2.55)	(5.60%)			(21.80)	(45.53)	(24.89)
(0.21)	Agency Staff	(0.15)	(0.12)	0.03	18.39%	(0.29)	(0.22)	0.07	25.27%			(0.07)	(0.29)	(0.03)
(2.55)	Bank Staff	(1.14)	(1.25)	(0.10)	(9.16%)	(2.29)	(2.43)	(0.14)	(6.31%)			(1.10)	(2.29)	(0.22)
(305.88)	**Total Employee Expenses**	**(24.05)**	**(25.88)**	**(1.83)**	**(7.60%)**	**(48.10)**	**(50.72)**	**(2.62)**	**(5.45%)**	R	4	**(22.96)**	**(48.10)**	**(25.13)**
(107.60)	Drugs and Blood	(6.76)	(6.40)	0.36	5.31%	(13.53)	(14.43)	(0.90)	(6.69%)	R		(6.06)	(13.53)	(7.79)
(39.93)	Supplies and services - clinical	(3.11)	(2.05)	1.06	34.17%	(6.22)	(3.72)	2.49	40.12%	G		(3.08)	(6.22)	(3.26)
(79.16)	Other Expenses	(6.68)	(5.97)	0.71	10.64%	(13.35)	(13.79)	(0.44)	(3.27%)	A		(7.19)	(13.35)	(6.66)
(226.69)	**Total Non-Pay Expenses**	**(16.55)**	**(14.42)**	**2.13**	**12.88%**	**(33.10)**	**(31.94)**	**1.15**	**3.48%**	G	5	**(16.33)**	**(33.10)**	**(17.71)**
(532.57)	**Total Expenses**	**(40.60)**	**(40.30)**	**0.30**	**0.74%**	**(81.20)**	**(82.67)**	**(1.47)**	**(1.81%)**	R		**(39.29)**	**(81.20)**	**(42.84)**
19.34	**EBITDA (exc Capital Donations)**	**2.48**	**(2.68)**	**(5.17)**	**(208%)**	**4.97**	**(7.54)**	**(12.51)**	**(251.83%)**	R		**(0.66)**	**4.97**	**(0.67)**
(19.34)	Owned depreciation, Interest and PDC	(1.68)	(1.51)	0.17	9.99%	(3.35)	(3.01)	0.35	10.32%		7	0.50	(3.35)	(1.53)
0.00	**Surplus/Deficit (exc. PSF/Top up)**	**0.81**	**(4.19)**	**(5.00)**	**(620.13%)**	**1.61**	**(10.55)**	**(12.16)**	**(754%)**			**(0.16)**	**1.61**	**(2.20)**
0.00	PSF/Top up	0.00	4.19	4.19		0.00	10.55	10.55					0.00	0.00
0.00	**Surplus/Deficit (incl. PSF/Top up)**	**0.81**	**0.00**	**(0.81)**	**(99.91%)**	**1.61**	**0.00**	**(1.61)**	**(99.98%)**	R		**(0.16)**	**1.61**	**(2.20)**
0.00	PY PSF post accounts reallocation	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
(13.70)	Donated depreciation	0.00	(1.20)	(1.20)		0.00	(2.45)	(2.45)				(3.08)	0.00	(1.08)
(13.70)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**0.81**	**(1.20)**	**(2.00)**	**(248.58%)**	**1.61**	**(2.45)**	**(4.06)**	**(251.85%)**			**(3.24)**	**1.61**	**(3.28)**
0.00	Impairments	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
18.36	Capital Donations	0.00	0.22	0.22		0.00	2.24	2.24			6	2.36	0.00	2.02
4.66	**Adjusted Net Result**	**0.81**	**(0.97)**	**(1.78)**	**(220.77%)**	**1.61**	**(0.21)**	**(1.82)**	**(112.76%)**			**(0.87)**	**1.61**	**(1.26)**







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

Summary

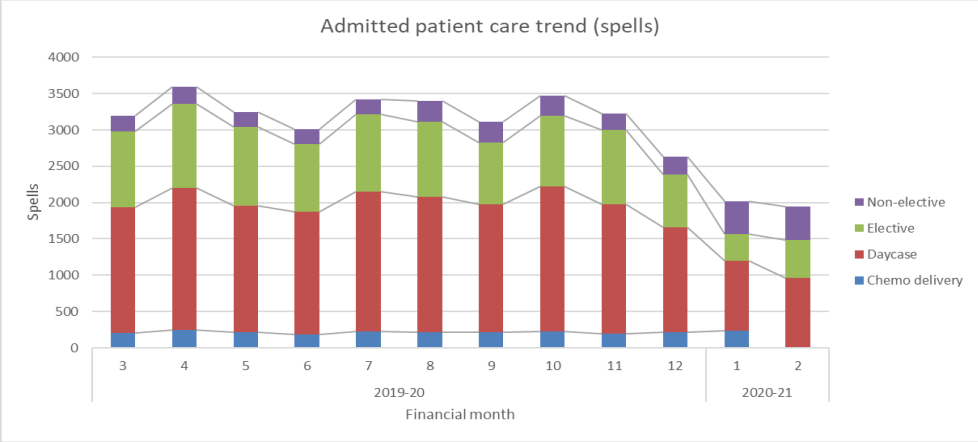
- The month 2 deficit is £4.2m, this is then offset by an accrual for the NHS top up which brings the Trust to a breakeven position.
- NHSE are currently reviewing the top up payment for Month 1 and have a query associated with the credit loss allowance and drugs spend of c. £3.0m. This presents a risk to the Trust position.

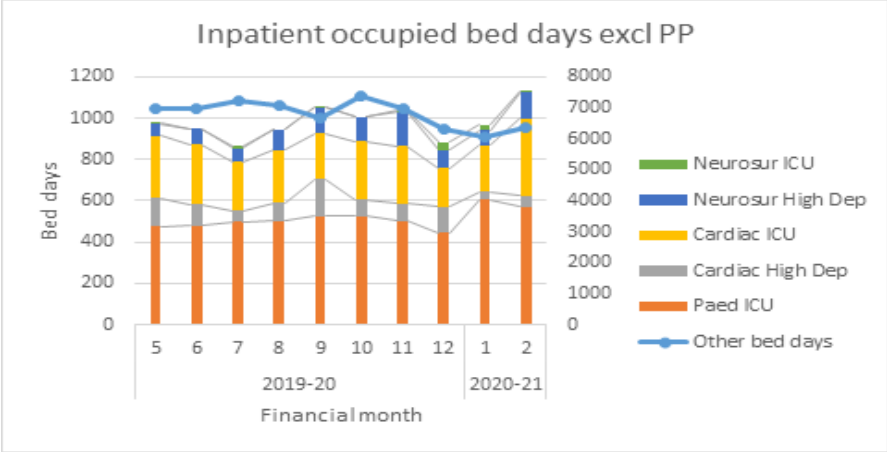
Notes

1. The NHS & other clinical revenue plan has been set centrally by NHSE for M1-4 based on the 2019/20 average income. NHS Clinical income is under a block contract including high cost drugs and devices.
2. Private Patient income is £4.8m adverse YTD to the NHSE plan. This income represents those long stay patients that were in the Trust before referrals were stopped in March. The Trust stopped accepting referrals in order to expand capacity for Covid-19 patients and has not changed this policy as at the end of May.
3. Non-clinical income is £2.7m adverse in month and £5.9m adverse YTD due to stopping research studies which are not linked to Covid-19, reduced E&T programmes and reduced charitable donations as projects on hold during the Covid-19 response.
4. Pay is adverse to the NHSE plan by £2.6m YTD due to additional staff from other organisations to support the Covid-19 response, new student nurses, staff to support mental health services, lab staffing and changes to medical staff work patterns. Staff have also been redeployed from capital projects that are on hold.
5. Non pay is £2.1m favourable to plan in month and £1.2m favourable YTD. Drug costs YTD include ongoing treatment of patients with new high cost drugs (including Car-T patients), which have been offset by reduced supplies and services due to the changes in patient mix and reduced non-urgent elective activity. The Trust has also seen an increase in the credit loss allowance YTD (£1.9m).
6. The plan set by NHSE does not include a plan for capital donations.

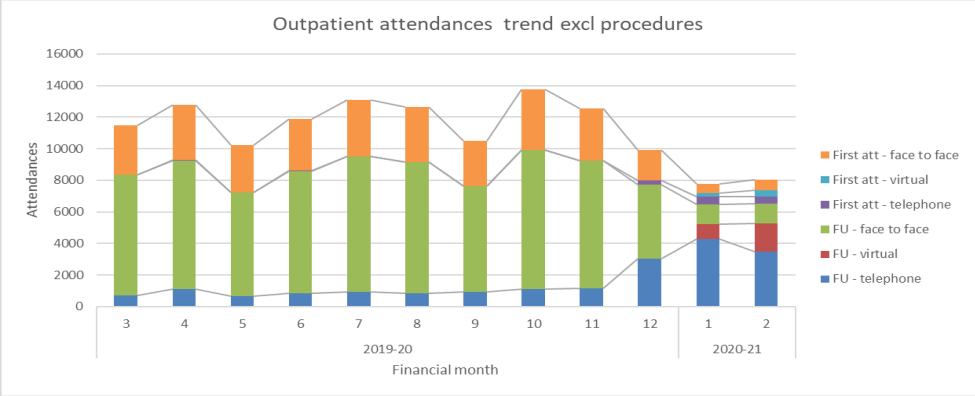
2020/21 Overview of activity trends for the 2 month ending 31 May 2020

Great Ormond Street Hospital for Children NHS Foundation Trust





NB: chemo delivery data is not available for May 2020

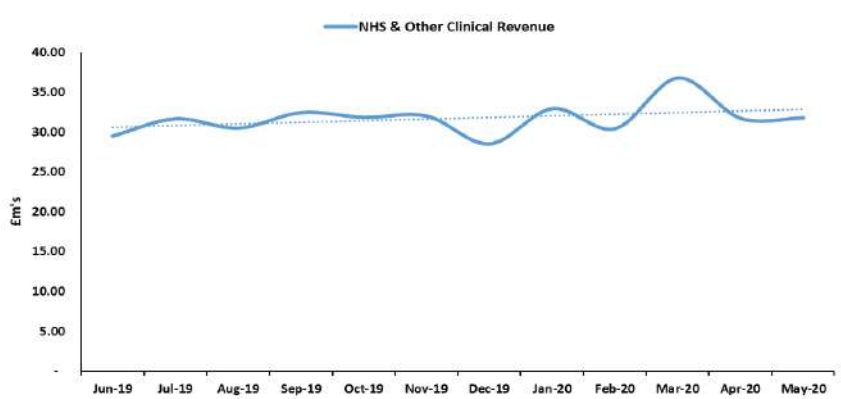


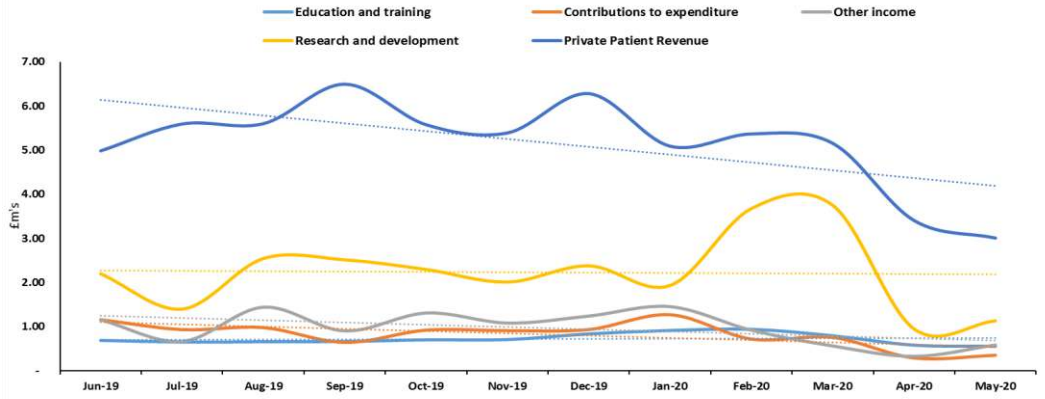
Summary

- The graphs for admitted patient care and outpatients show reduced actvity with the exception of non-elective activity and chemotherapy delivery. This correlates with the reduced spend on clinical supplies and services where the average spend per month for 2020-21 year to date is £2.0m versus an average of £2.8m for 2019-20.
- Drugs and blood product spend does not triangulate with the activity profile as year to date average spend is £7.3m per month versus £6.6m in 2019/20.
- Large volumes of drugs relate to home care and outpatient pass through that are ongoing therapies. Further to this the expected values do not take into account new drugs for e.g. cystic fibrosis, Battens disease.
- Chemotherapy delivery is 14% above the 2019/20 average in April owing to the additional activity from UCLH and this will further contribute to the drugs spend. It is expected May activity will be similar however recording is completed one month in arrears.

2020/21 Income for the 2 months ending 31 May 2020

Great Ormond Street Hospital for Children NHS Foundation Trust





Summary

- The income plan has been set centrally by NHSE/I for the period to the end of July as a result of the impact of Covid-19. This plan is comparable to the 2019/20 average monthly income on a straight line basis.
- Block payments will be paid for NHS England and the main contract CCGs based on the average 2019/20 income to December uplifted by 2.308%.
- The plan for other income streams is based on the average income for Nov 2019-Jan 2020 uplifted to 2020/21 values. It was recognised that these estimates may be undeliverable in the current climate. This has been borne out year to date with a £3.9m adverse variance that is largely driven by the £3.8m under-performance for private patient income.
- Private Patient income has reduced and is £4.8m below the NHSI plan year to date. In March 2020 the Trust stopped accepting referrals in order to free up bed capacity in the sector for Covid-19 patients. The income recognised YTD is related to patients admitted prior to Covid-19.
- Research income has fallen significantly and is £3.1m below the NHSI plan year to date. This is due to research studies having stopped after UCL closed all its buildings and suspended all research projects except those on Covid-19.
- Other income is £1.7m below the NHSI plan. The key driver of other income is associated with the National change in the rules governing Genetics billing. The new policy states the Genetics service can no longer charge for P2P testing as the plan was to include this in the new tariff. However the income is now part of the block and so has not been uplifted to offset this lost income. Within other income both catering and accommodation are below historic trend due to reduced activity within the hospital and due to changes to support staff social distance.
- Charitable income is £1.4m below the NHSI plan. This is caused by the projects that were being funded having put on hold due to the Trusts response to Covid-19. With these projects stopping the Trust has seen a saving on some variable costs but many fixed staffing and non-pay costs are still being incurred by the Trust resulting in a pressure.

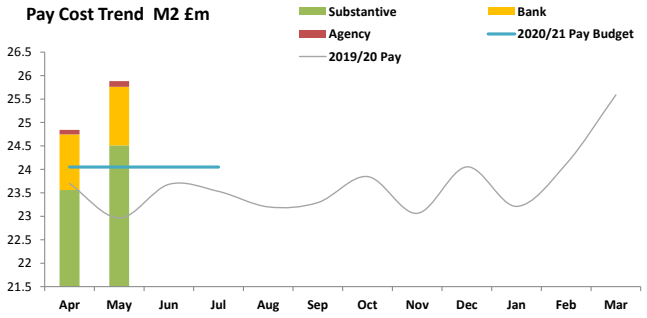
Workforce Summary for the 2 months ending 31 May 2020

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

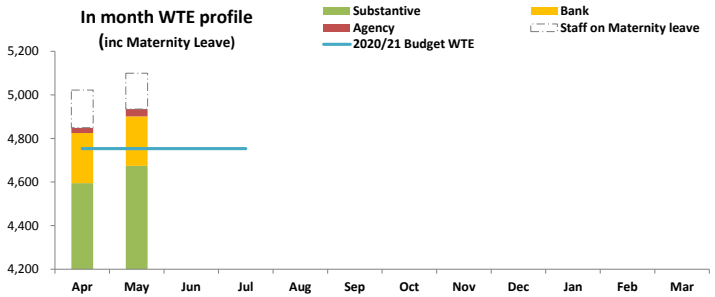
Great Ormond Street Hospital for Children NHS Foundation Trust

£m including Perm, Bank and Agency	2019/20 actual			2020/21 actual			Variance			RAG
Staff Group	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	50.3	1,110.6	45.3	9.1	1,151.2	47.4	(4.5)	(4.1)	(0.4)	R
Consultants	54.5	352.1	154.7	9.7	385.1	151.1	(4.7)	(5.0)	0.2	R
Estates & Ancillary Staff	4.6	137.9	33.2	0.8	138.6	34.0	(0.4)	(0.4)	(0.0)	A
Healthcare Assist & Supp	9.1	281.7	32.2	1.7	307.0	33.9	(0.9)	(0.8)	(0.1)	R
Junior Doctors	28.4	347.1	81.9	5.2	371.5	83.8	(2.6)	(2.5)	(0.1)	R
Nursing Staff	80.7	1,526.0	52.9	14.3	1,534.7	56.0	(7.0)	(6.2)	(0.8)	R
Other Staff	0.5	9.1	53.3	0.1	9.5	51.6	(0.0)	(0.0)	0.0	G
Scientific Therap Tech	52.1	945.3	55.1	9.4	965.7	58.2	(4.6)	(4.1)	(0.5)	R
Total substantive and bank staff costs	**280.2**	**4,709.7**	**59.5**	**50.3**	**4,863.3**	**62.0**	**(24.8)**	**(22.7)**	**(2.1)**	R
Agency	2.0	28.8	68.8	0.2	28.7	45.4	(0.0)	(0.1)	0.1	G
Total substantive, bank and agency cost	**282.1**	**4,738.6**	**59.5**	**50.5**	**4,891.9**	**61.9**	**(24.9)**	**(22.9)**	**(2.0)**	R
Reserve*	2.1	0.0	0.0	0.2	0.0		(0.0)	0.2	(0.2)	G
Additional employer pension contribution by NHSE	11.6	0.0	0.0	0.0	0.0		1.1	1.1	0.0	G
Total pay cost	**295.8**	**4,738.6**	**62.4**	**50.7**	**4,891.9**	**62.2**	**(23.8)**	**(24.0)**	**0.2**	R
Remove maternity leave cost	(3.6)			(0.6)			0.2		0.2	G
Total excluding Maternity Costs	**292.2**	**4,738.6**	**61.7**	**50.2**	**4,891.9**	**61.5**	**(23.6)**	**(23.7)**	**0.1**	R

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)

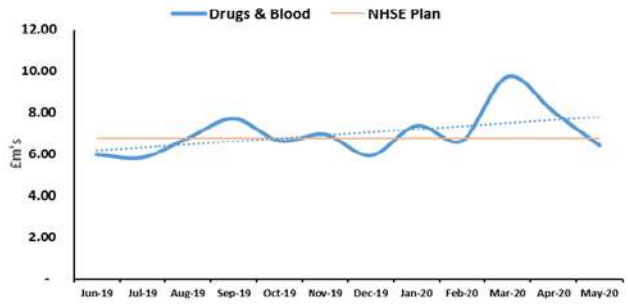


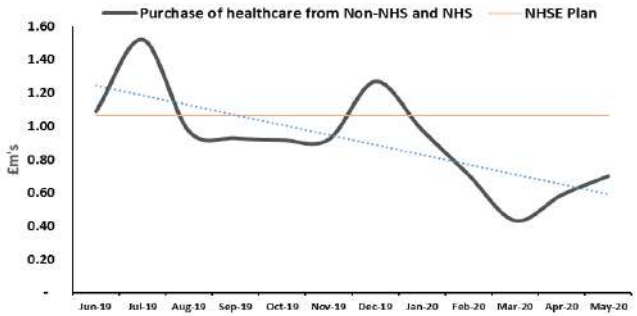
M1 WTEs have been restated due to a YTD WTE adjustment

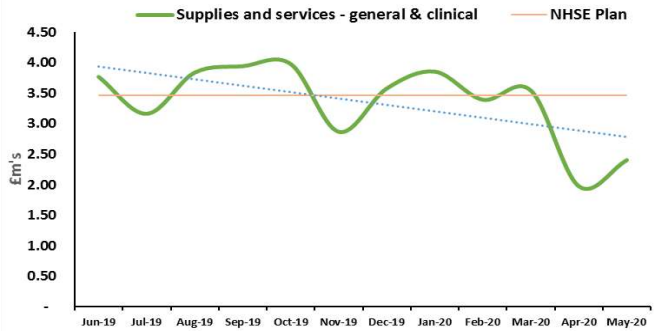
Summary

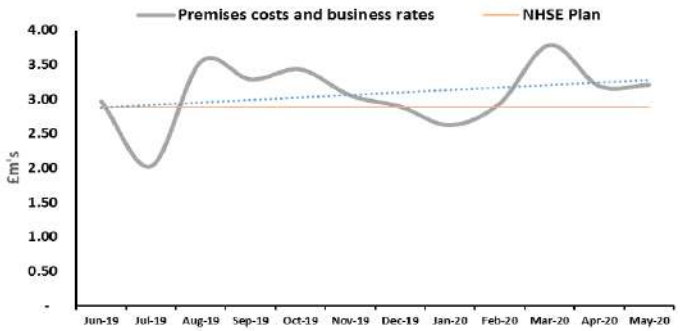
- In-month WTE's have risen from 4,849 in M1 to 4,934 in M2 (generating a higher YTD average WTE number of 4,892) and the pay cost of the Trust is £2.6m adverse to plan YTD. This is driven by staffing requirements to support the Covid-19 response.
- Additional junior doctors and scientific staff have joined the Trust from other organisations in order to support the Covid-19 response. Further PA's have also been provided to consultants largely in order to cover gaps left by junior doctors who have also been directed towards the Trust Covid-19 response. The month 2 value (£0.2m) includes back pay for these sessions.
- HCA staff have increased as 54 student nurses have received paid placements, in line with government guidelines, in order to assist with the Trust Covid-19 response and their training. These started on the payroll in M2 increasing the WTE (53 WTE) and Pay spend (£0.2m) from M1.
- Staffing associated with reduced private patient activity and research activity have been redistributed to support the additional Covid-19 capacity leading to the Trust needing less temporary staff to meet the Covid-19 response than would have otherwise been required to open extra capacity. Additional bank cover has also been required to support sickness and rotas (c. £0.3m in M2).
- Admin staffing has increased due to the number of capital projects that have stopped during the Covid-19 response meaning that capitalised staff now form part of the Trust revenue costs (c. £0.3m YTD).
- The trust pay costs include £0.1m of staff that were assigned to Nightingale and £0.2m of mental health nurses to support CAMHS transferred to GOSH.
- WTE have increased from last year due to these additional staffing requirements to support Covid-19 and the capitalised staff in the revenue position due to capital projects stopping.

Non-Pay Summary for the 2 months ending 31 May 2020









Summary

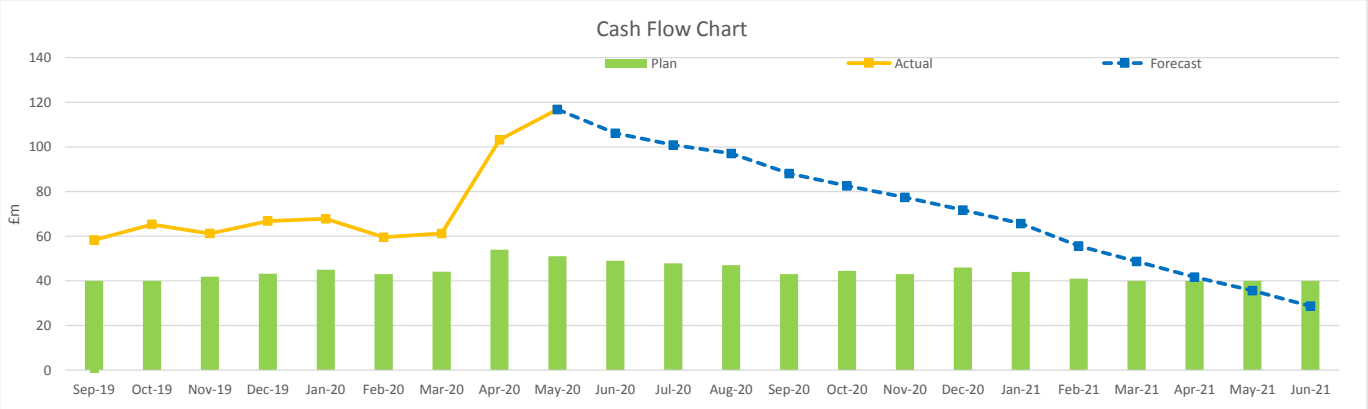
- Drugs and Blood are £0.9m higher YTD than the NHSI plan. Blood is £0.2m above plan due to the Trust treating haematology patients transferred form other organisations as part of the COovid-19 response. PbR drugs have remained on plan with high costs drugs (historically pass through) £0.7m above plan. 60% of these drugs in term of value are homecare deliveries for ongoing conditions and have therefore continued throughout M1 and M2. In addition to this the Trust has seen an increase linked to therapies that were not part of the plan including CF drugs, cannabidoil and CAR-T. The additional CAR-T drugs resulted in £0.5m additional spend and new CG drugs Orkambi and Symkevi resulted in an additional £0.3m . These new high cost treatments can be seen in the drug trend which has seen significant increase in the last 12 months, the income associated with these drugs is now part of the NHS block contract.
- NHSE are reviewing drug spend associated with the M1 top up payment. A decision to not reimburse the Trust for this spend would place the Trust in a deficit position.
- Supplies and services along with the purchase of healthcare have remained fairly steady over 12 months with a significant decrease in April. This decrease is due to the change in patient mix that the Trust is treating, reduced non-urgent elective patients and the variable cost savings associated with reduced research, charitable projects and private patients.
- The Trust has seen a £1.9m increase YTD in the credit loss allowance due to non-payment of private patient debt. This has been calculated in line with IFRS9 and the Trust's policy.
- Depreciation is £2.1m higher than the NHSI plan as donated depreciation and capital donations were excluded from the plan.

31 Mar 2020 Unaudited Accounts £m	Statement of Financial Position	YTD Actual 31 Mar 2020 £m	YTD Actual 30 Apr 2020 £m	*YTD Actual 31 May 2020 £m*	In month Movement £m	*Plan 31 May 2020 £m*
543.87	Non-Current Assets	543.87	542.93	541.93	(1.00)	*543.93*
115.21	Current Assets (exc Cash)	115.21	117.03	103.24	(13.79)	*130.19*
61.31	Cash & Cash Equivalents	61.31	103.21	116.84	13.63	*89.58*
(102.32)	Current Liabilities	(102.32)	(145.60)	(145.74)	(0.14)	*(144.83)*
(6.76)	Non-Current Liabilities	(6.76)	(5.48)	(5.16)	0.32	*(5.80)*
611.31	**Total Assets Employed**	**611.31**	**612.09**	**611.11**	**(0.98)**	**613.07**

31 Mar 2020 Unaudited Accounts £m	Capital Expenditure	Plan 30 Apr 2020 £m	YTD Actual 30 Apr 2020 £m	YTD Variance £m	Forecast Outturn 31 Mar 2021 £m	RAG YTD variance
21.84	Redevelopment - Donated	3.43	1.79	1.64	13.33	R
7.43	Medical Equipment - Donated	0.15	0.45	(0.30)	3.15	R
1.95	ICT - Donated	0.00	0.00	0.00	0.00	G
31.22	**Total Donated**	**3.58**	**2.24**	**1.34**	**16.48**	A
6.78	Redevelopment & equipment - Trust Fur	0.02	0.04	(0.02)	10.15	R
1.90	Estates & Facilities - Trust Funded	0.49	0.42	0.07	3.37	A
11.95	ICT - Trust Funded	0.40	0.61	(0.21)	4.48	R
0.00	Contingency	0.00	0.00	0.00	0.00	G
20.63	**Total Trust Funded**	**0.91**	**1.07**	**(0.16)**	**18.00**	A
	Total Covid capital	**0.13**	**0.07**	**0.06**	**0.29**	R
51.85	**Total Expenditure**	**4.62**	**3.38**	**1.24**	**34.77**	A

31-Mar-20	Working Capital	30-Apr-20	31-May-20	RAG	KPI
23.00	NHS Debtor Days (YTD)	20.0	10.0	G	< 30.0
247.00	IPP Debtor Days	273.0	278.0	R	< 120.0
34.80	IPP Overdue Debt (£m)	38.9	40.1	R	0.0
109.00	Inventory Days - Non Drugs	132.0	120.0	R	30.0
39.00	Creditor Days	38.0	38.0	A	< 30.0
0.41	BPPC - NHS (YTD) (number)	46.6%	30.8%	R	> 90.0%
70.4%	BPPC - NHS (YTD) (£)	69.0%	73.8%	R	> 90.0%
85.0%	BPPC - Non-NHS (YTD) (number)	86.7%	85.8%	A	> 90.0%
89.2%	BPPC - Non-NHS (YTD) (£)	93.4%	91.0%	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 for the two months to 31 May is less than plan by £1.2m: Trust-funded exceeds plan by £0.1m, and donated is less than plan by £1.3m. The donated projects which have slipped are Sight and Sound Hospital (£0.8m), and equipment purchases (£0.5m).
2. Cash held by the Trust increased in month by £13.6m. This was largely as a reult of the collection of invoiced debt.
3. Total Assets employed at M02 decreased by £1.0m in month as a result of the following:
   - Non current assets totalled £541.9m, a decrease of £1.0m in month
   - Current assets excluding cash totalled £103.2m, a decrease of £13.8m in month. This largely relates to reductions in NHS receivables in month (£12.9m which includes a significant settlement for outstanding debt relating to 2019/20 from NHS England); capital receivables (£1.4m); other Non NHS receivables (£4.1m) and an increase in accrued income for top up in month (£5.1m)
   - Cash held by the Trust totalled £116.8m, an increase in £13.6m in month. This includes payments received for invoiced debt as mentioned above.
   - Current liabilities totalled £145.7m, an increase of £0.1m in month
4. Overdue IPP debt increased in month to £40.1m (£38.9m in M01)
5. IPP debtor days increased from 273 days to 278 days in month. Total IPP debt decreased slightly in month to £48.6m (£48.7m in M1)
6. The cumulative BPPC for NHS invoices (by value) increased in month to 73% (69% in M1). This represented 30.8% of the number of invoices settled within 30 days (46.6% in M1)
7. The cumulative BPPC for Non NHS invoices (by value) decreased slightly in month to 91% (93% in M1). This represented 85.8% of the number of invoices settled within 30 days (86.7% in M1).
8. Creditor days remained the same as the previous month at 38 days.

Attachment Q

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
15 July 2020

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

Aims / summary

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

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

Action required from the meeting

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

During the reporting period of April and May there were six Datix incidents in relation to safe staffing.

The Trust operated within nationally recommended parameters for safe staffing levels in April and May with reporting resumed in June. (Appendices)

Contribution to the delivery of NHS Foundation Trust strategies and plans

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

Financial implications

Already incorporated into 20/21 Directorate budgets.

Who needs to be told about any decision?

Directorate Management Teams
Finance Department
Workforce Intelligence

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

Chief Nurse, Director of Nursing and Heads of Nursing

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

Chief Nurse; Directorate Management Teams

Attachment Q
Safe Nurse Staffing Report for reporting period April/May 2020

1. Summary

This report on GOSH Safe Staffing covers the reporting period for April and May 2020. The paper provides the required assurance that GOSH had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage the demand for nursing staff. The report also includes measures taken to ensure safe staffing throughout the Trust and during Phase 1 of the Covid 19 pandemic up to the 8th May 2020, and into Phase 2 during which time the trust also hosted general paediatric and mental health patients from our North Central London (NCL) partner organisations the North Middlesex, Royal Free, Whittington and University College Hospital. The national reporting process for safe staffing was suspended throughout April and May due to the COVID-19 pandemic and was reinstated on the 3rd June 2020.

2. Safer Staffing during Covid 19 Pandemic

As previously reported the coronavirus pandemic has required GOSH nursing staff to work in new ways and in different wards, departments and organisations throughout April and May. At times, it has also required nursing staff to work in environments and with patient groups that may be unfamiliar. We followed NHSE/I principles and Nursing and Midwifery Council (NMC) regulatory guidance to support our response and maintain safe staffing measures which were outlined in the previous report and updates are provided against these points for the reporting period.

2.1 Deployment

GOSH nursing staff that were deployed throughout the reporting period are now returning or have returned to their home areas and departments in order to resume activity. This has also involved debriefing, risk assessments and ensuring staff are rested and adjusted to their substantive work environment.

2.2 Building competence and confidence

Although nurses brought transferable skills with them into new clinical areas they were also offered upskilling and refresher sessions via the education teams to ensure clinical competence. We are currently working with the directorate Heads of Nursing and the education teams to explore how we maintain these skills and competencies going forward and maintain the ability to respond rapidly if we experience a second outbreak.

2.3 Health and Well-being

The longer-term effects of the pandemic on our nurses are yet to be seen and the nursing retention plan has been revised to reflect the new and urgent challenges the pandemic will bring especially over the next 12-18 months. The plan's priorities have been shaped by local intelligence, recent research findings and NHSI case studies and evidence of good practice. Therefore it will be important to maintain the significant raft of measures which were put in place via the Health and Well-being Hub to ensure nursing staff receive ongoing support and have access to tools to ensure they are best able to maintain good health and wellbeing.

2.4 Aspirant nurses

On the 4th May GOSH welcomed 62 Aspirant Nurses all of whom have Newly Qualified Nurse (NQN) conditional offers with us for September 2020. Health

Education England (HEE) advised trusts that funding for these posts would cease on the 31st July 2020. To support safe staffing and supplement the workforce over the summer months, a funding proposal has been submitted to the Operations Board and Executive Management Team (EMT) to bridge the gap between the 1st August and the 27th September in an effort to aid a smooth transition into their NQN roles on the 28th September and reducing the risk of attrition.

2.5 Mental Health Patients

The transfer of NCL patients to GOSH bought a new cohort of patients with acute mental health presentations and the use of the Mental Health Act. Working within the NCL network a cohort of Registered Mental health Nursing (RMNs) staff were identified and deployed to GOSH. All staff have now had informal de-escalation and break away training and there is a rolling programme upskilling the general paeds team with concepts relating to MH nursing. We continue to accept on a case by case system and the safety of the environment (not being purpose built) is mitigated with higher levels of supervision.

3. Temporary Staffing

In response to the pandemic preparations, annual leave and study leave requests were cancelled and bank requests reviewed and cancelled as necessary. As a result requested shifts in April reduced to 1,846 with a slight increase in May to 2,062. Both months were significantly lower than the 12 month average. The fill rate in both months was much higher than the long term average at 86%. Agency usage increased significantly to 170 shifts in April and 359 in May. However the increase was driven by requirements for RMN requirements.

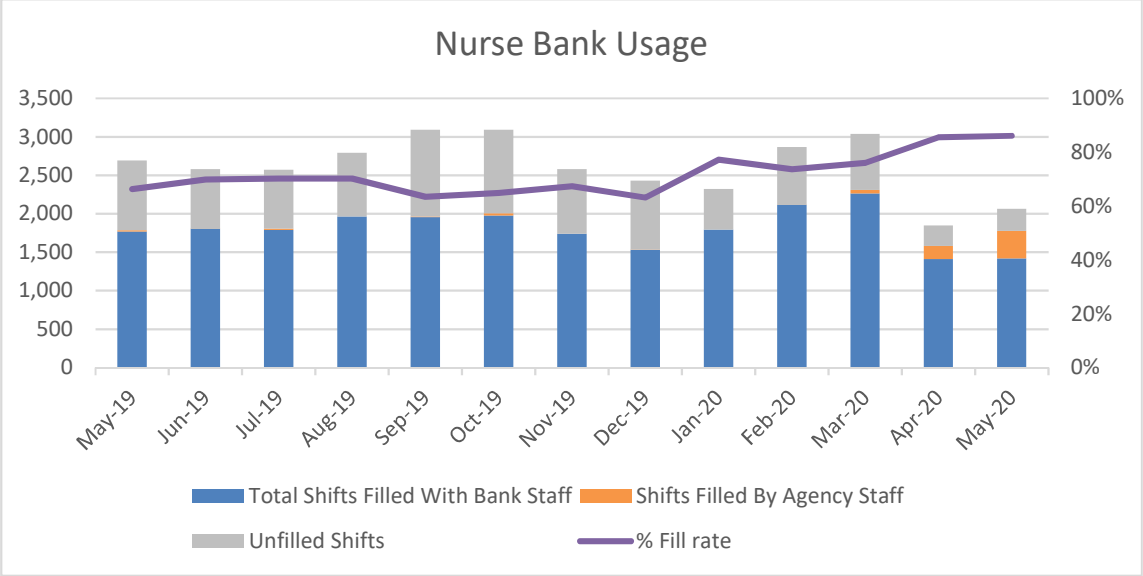


Fig. 1 Nurse Bank Usage (12 month rolling)

4. Incident Reporting

During the reporting period of April and May there were six datix incidents in relation to safe staffing.

- Heart and Lung x 2
- Ops and Imaging x 2
- Blood, Cells and Cancer x 1

The HoNs for each of these directorates have provided assurance that these incidents have been reviewed and addressed with mitigation in place to prevent reoccurrence. No patient harm occurred.

5. Nursing Establishment Review

The biannual staffing establishment reviews which were deferred from March are currently underway along with the Safer Nursing Care Tool scoring which will be conducted in July to be reported at the next Trust board meeting.

6. Nursing Workforce Assurance Group (NWAG)

The monthly NWAG meeting has resumed and is prioritising cleansing and accuracy of data in conjunction with the Workforce Information Team, Finance and the Directorate HoNs. Individual directorate meetings are currently underway, with visible improvements in the accuracy of data anticipated as we unmerge wards, cleanse data, extract ESR data and move towards restoration and recovery.

Appendix 1 : Workforce Utilisation

Actual vs Planned (AvP)

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 both months the fill rate for AvP was which is within range, April 101.9% and May 110% respectively.
The Unify return to NHS digital has now been re-instated following a pause during the active pandemic phase. Data for March, April and May 2020 will be retrospectively reported in July 2020 following directorate realignment and with caveats to reflect changes in activity during this phase.

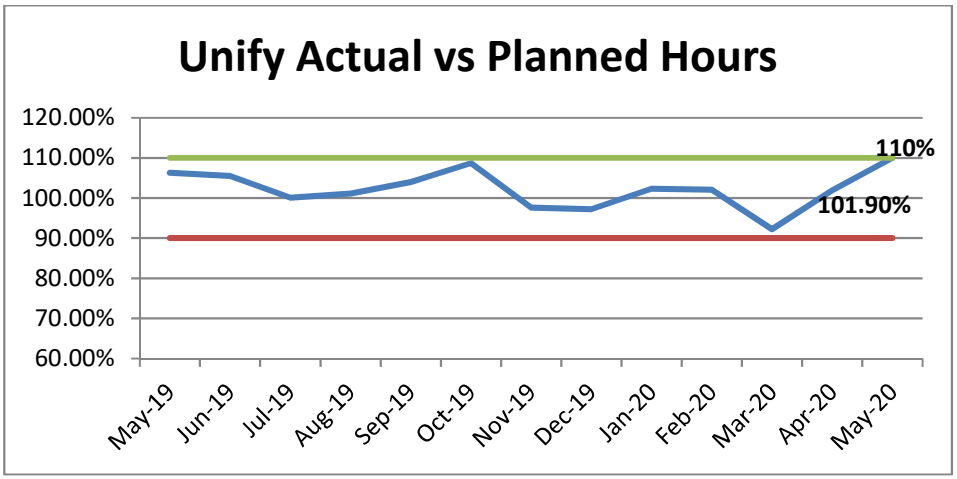


Fig. 2 AvP Hours (12 month)

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 April 2020 was 16.1 hours, made up of 13.19 registered nursing hours and 2.90 HCA hours. Higher CHPPD is attributable to higher numbers of staff available due to cancelled leave.

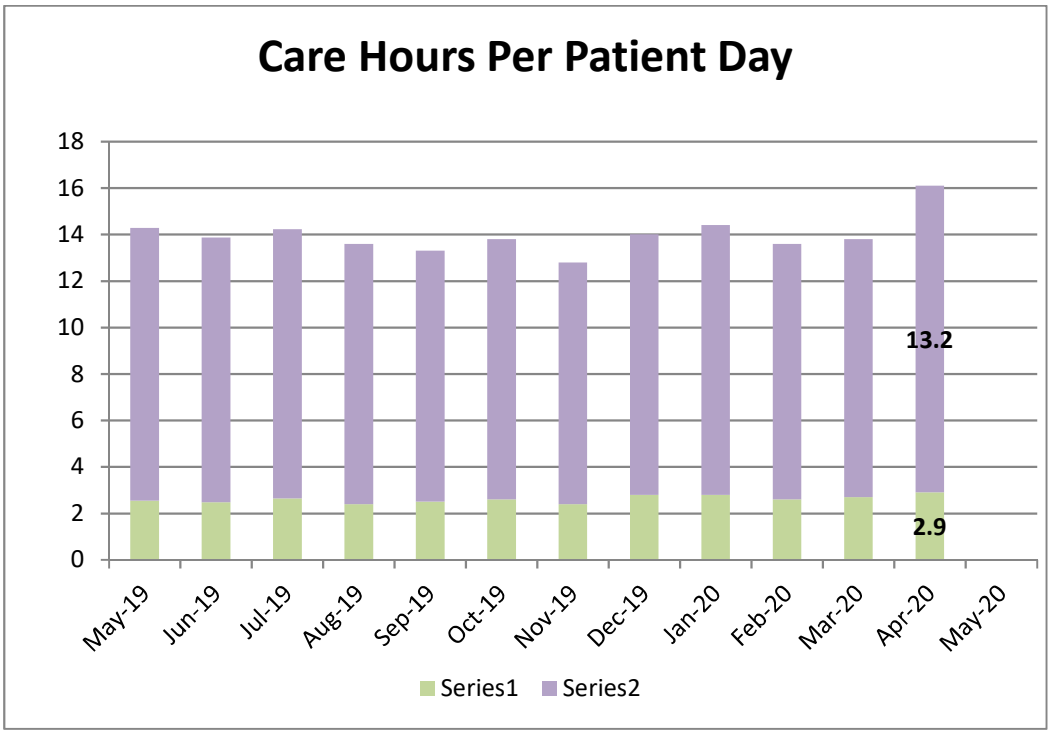


Fig. 3 Care Hours Per Patient Day (12 month)

Attachment Q
Safe Nurse Staffing Report for reporting period April/May 2020

Appendix 2: April and May Workforce metrics by Directorate

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover* %	Sickness (1 mnth) %	Maternity %
Blood, Cells & Cancer	N/A	N/A	1.77	0.8%	12.7%	7.9%	7.1%
Body, Bones & Mind	N/A	N/A	-1.53	-6.8%	17.1%	4.9%	6.5%
Brain	N/A	N/A	15.68	12.0%	13.0%	3.2%	4.8%
Heart & Lung	N/A	N/A	18.31	3.1%	19.1%	4.0%	5.3%
International & PP	N/A	N/A	12.01	12.4%	25.1%	6.7%	3.4%
Operations & Images	N/A	N/A	-6.42	-4.2%	11.9%	9.4%	5.1%
Sight & Sound	N/A	N/A	-0.82	-1.7%	10.9%	2.1%	3.7%
Trust	101.9%	15.5	61.91	4.1%	16.0%	3.7%	5.3%

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

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover* %	Sickness (1 mnth) %	Maternity %
Blood, Cells & Cancer	N/A	N/A	1.0	0.5%	11.1%	4.1%	7.5%
Body, Bones & Mind	N/A	N/A	8.33	3.6%	16.8%	1.1%	6.5%
Brain	N/A	N/A	13.9	10.6%	13.0%	1.9%	6.4%
Heart & Lung	N/A	N/A	18.3	3.6%	17.8%	3.2%	5.0%
International & PP	N/A	N/A	11.8	12.1%	21.8%	6.2%	3.3%
Operations & Images	N/A	N/A	-0.03	-1.9%	12.8%	5.9%	4.6%
Sight & Sound	N/A	N/A	0.4	0.9%	12.9%	0.4%	3.2%
Trust	110%	N/A	77.5	5.1%	15.2%	3.1%	5.3%

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

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board **15th July 2020**	
Infection Control Board Assurance Framework (NHS England) **Submitted by:** Helen Dunn, Director of Infection, Prevention and Control	**Paper No: Attachment 3**
Aims / summary The purpose of this report is to provide assurance that Infection Prevention and Control (IPC) Measures have been reviewed in light of changes in national guidance to support management of COVID-19. The report provides assurance that the Trust meets the required standards as set out in the Assurance Framework published by NHS England on the 22nd May 2020, and that where there are gaps in performance, assurance or mitigation there is a clear plan to manage this.	
Action required from the meeting Note the assurances offered, including the plans to undertake more detailed audits over the following months to help identify additional areas for improvement.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Delivery of consistently safe high quality care	
Financial implications None	
Who needs to be told about any decision? Director of Infection Prevention and Control Chief Nurse	
Who is responsible for implementing the proposals / project and anticipated timescales? Director of Infection Prevention and Control	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control Chief Nurse	

Infection Prevention and Control Assurance Framework

Introduction

Effective infection, prevention and control is fundamental to our efforts to respond to the COVID-19 pandemic. The purpose of this report is to provide assurance that Infection Prevention and Control (IPC) Measures have been reviewed in light of changes in national guidance to support management of Covid-19. The report provides assurance that the Trust meets the required standards, and that where there are gaps in performance, assurance or mitigation there is a clear plan to manage this.

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

NHS England developed and published a Board Assurance Framework to support providers to self-assess compliance with Public Health England (PHE) and other COVID-19 related IPC guidance. The use of the framework is not compulsory, but is a useful source of internal assurance to support organisations to maintain quality standards at this time.

The Assurance Framework was first published on 4th May 2020, and then updated and reissued on the 22nd May 2020.

Legislative Framework

The assurance framework is developed from the existing 10 criteria in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The other important legislation to note in this context is the Health and Safety at Work Act 1974 which places wide ranging duties on employers to protect the ' health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, visitors and the general public. The act also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others. Robust risk assessment is central to this. Where risk cannot be eliminated, it must be assessed, managed and mitigated. In the context of COVID-19 there is an inherent level of risk for NHS staff who are treating and caring for patients as well as for the patients themselves. All organisations must ensure that risks are identified, managed and mitigated effectively.

Assurance Monitoring Plan

Based on our self-assessment against the Assurance Framework, we have identified a programme of work to support further implementation and improvement in our ways of working in response to COVID-19. To support ongoing monitoring, the following plan has been developed by the Audit Manager in conjunction with the Director of Infection, Prevention and Control.

Assurance Framework category	Assurance Framework item	Audit control	Resource required	Date to be completed
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	• infection risk is assessed at the front door and this is documented in patient notes	Clinical Audit (1)	IPC Lead nurse to review 20 admissions	August 2020
	• patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission	Clinical Audit (1)	IPC Lead nurse t 0to review 20 admissions	August 2020
	• compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	Clinical Audit (1)	IPC Lead nurse	August 2020
	patients and staff are protected with PPE, as per the PHE national guidance	Clinical Audit (PPE)	IPC Lead nurse	Audit completed in May 2020
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion	• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	Patient experience feedback	Support from Patient Experience Team to analyse feedback	
	• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Clinical Audit (2)	Clinical Audit Manager	August 2020
	• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Clinical Audit (3)	Clinical Audit Manager	Clinical Audit Manager to include in Trustwide discharge summary audit due to be completed in July 2020
6Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	Clinical Audit (2) COVID clinical guideline on intranet Check guidelines are in place	Clinical Audit Manager	August 2020
	• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Clinical Incident Reporting	Health and Safety team	Ongoing monitoring via RIDDOR reporting
	• any incidents relating to the re-use of PPE are monitored and appropriate action taken	Clinical Incident Reporting	Patient Safety team	Ongoing monitoring via DATIX . Discrete C19 category
	staff regularly undertake hand hygiene and observe standard infection control precautions	Infection Control audit plan	Clinical Teams	Ongoing
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	patients with suspected COVID-19 are tested promptly patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	Visualisation of performance data	Chris Longster	Ongoing
	patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Clinical Incident Reporting	Patient Safety team	Ongoing monitoring via DATIX . Discrete C19 category
8. Secure adequate access to laboratory support as appropriate	patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance	Visualisation of performance data	Head of Performance and Information	Ongoing

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Infection risk is assessed at the front door and this is documented in patient notes	Standard admission questions are available on the IPC intranet site. Questions asked on each admission/appointment to the hospital. In and outpatients to receive a screening call the day before attending. Processes have been put in place to support screening phonecalls prior to admission and on admission.	Confirmation that these screening assessments have taken place in 100% of required cases and are documented appropriately on Epic.	
patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission	All patients are screened on admission. Patients with high probability are placed in screening cubicles within the COVID ICU (include flow chart) Ops hub to advice on patients movement. IPC team to advice on risks associated with patient movement.		Risk assessment documents to be developed to support staff in managing transfer of patients between wards where this is necessary.
compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	COVID clinical guideline on intranet		
All staff (clinical and non clinical) are training in putting on and removing PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context per national guidance	PPE guidance as per PHE advice (reference COVID clinical guideline)	Plan for PPE audit May 2020	
National IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way. Changes in guidance are board to the attention of the Board and any risks and mitigating actions are highlighted.	Dissemination pathway for CAS alerts via the patient safety team (with asscociated policy). Compliance with alerts is monitored monthly through IQPR. Dissemination pathway for emergency preparedness documents. Any guidance changes are disseminated and discussed at operational level prior to trust wide change. Changes in process and policy have been communicated to staff in all staff comms, snap comms and ward based teaching. Infection Control Committee meets regularly. This reports into Patient Safety and Outcomes Committee quarterly and to the Trust Board in line with the Board Assurance requirements.	There is no consistent national alerting system for new guidance from NHS E (not all guidance is issued via the CAS system)	Safety netting checks via Quality & Safety team.
Risks are reflected in risk registers and the Board Assurance Framework where appropriate	A Covid-19 RiskRegister has been developd and this is reviewed regularly at the Operational Board, and highlighted to the Trust Board as required through the BAF review process.		
Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC normal practice and procedures in place as set out in the IPC policies. IPC committee, RCA investigation into HCAI alert based organisms from incident list. Weekly review of infection control issues through Exec led weekly safety meeting.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Designated teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas	Standard infection control training for all staff which including information on AGPs and non-AGPS. Local Covid Training dissemination through the practice educator team. Decontamination of medical equipment policy. Covid Secure and Covid Risk Managed areas identified.	Ensure that all training records have been appropriately updated during the pandemic. Additional support for cohort and AGP areas e.g. Hedgehog, Theatres and Dolphin	
Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas	They are trained with standard infection control prevention. Using level 2 clean which is inline with national guidance. Q&A sessions provided.	Request evidence from OCS about training for staff working in covid areas.	
Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance	Staff in these areas are trained with standard infection control prevention. They are using level 2 clean which is inline with national guidance. Q&A sessions with the Trust IPC team have been run with OCS staff.	Audit of OCS isolation room cleaning. Including checking if nurses are cleaning appropriately after AGPs	
Increased frequency, at least twice a day, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	The majority of our clinical areas are specified to very high risk and therefore we provide over and above usual expectations and in line with national expectations.	Confirm that there is increased cleaning in icu and other areas like Hedgehog in line with the VHR category	
Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	The majority of our clinical areas are specified to very high risk and therefore we provide over and above usual expectations and in line with national expectations.		
Cleaning is carried out with neurtal detergent, a chlorine based disinfectant, in the form of a solution at a minimum strenght of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local IPCT whould be consulted on this to ensure it is effective against enveloped viruses	All areas of the hospital are cleaned with chlorclean or an approved alternative if it is unavaliable. This is specified within the contract.		

Manufacturers guidance and recommended 'contact time' must be followed for all cleaning/disinfectat solutions/products	They are trained with standard infection control prevention. Using level 2 clean which is inline with national guidance. Q&A sessions provided.	Request evidence from OCS about training for staff working in all areas.	
As per national guidance: - frequently touched surface e.g door/toilet handles, patient call bells, overbed tables and bed rails, should be decontaminated at least twice dailey and when known to be contaminated with secretions, excretions or body fluids - electronic equipment e.g. mobile phones, desk phones, tablets, desktops and key boards should be cleaned at least twice daily - Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	work has been undertaken with the facilities team to ensure that high touch areas in communal areas are cleaned as specified. Cleaning guidance for office areas has been developed.	Request evidence from OCS that cleaning is a specified. Review info on safe working hub re desk cleaning etc in offices.	
Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	Linen is treated as contaminated.	Floor manager audit to be undertaken to provide assurance.	
Single use items are used where possible and according to Single Use Policy	single use policy (within decontamination of medical equipment policy)	Check it has been updated in line with new guidance.	
Reusable equipment is appropriately decontaminated in line with local and PHE national policy	single use policy (within decontamination of medical equipment policy)	Check it has been updated in line with new guidance.	
Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Ventilation committee and monitoring group meets to ensure that ventilation for AGP's is in line with national guidance.	Social distancing in place in waiting areas	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Arrangements around antimicrobial stewardship are maintained	Antimicrobial rounds are taking place virtually to maintain social distancing and minimise contact whilst preserving arrangements for antimicrobial stewardship.		
Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Mandatory reporting up to date and maintained. Quarterly report to Board from Infection Control, with monthly IPC monitoring data through the IQPR		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			
Implementation of national guidance on visiting patients in a care setting	COVID clinical guideline on intranet		
Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	Dolphin is clear	Signage will be reviewed as part of the planned audit.	
Information and guidance on COVID-19 is available on all Trust websites with easy read versions	All internal guidance is available on GOSH internal and external website. Easy read versions and translated versions available.	Included in Audit for assurance	
Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Discharge summary reflects infection control status. Timeliness of completion of discharge summaries is monitored monthly.	Audit of discharge summaries to ensure that the infection status is correctly included. Continued work to improve timeliness of discharge summaries being shared outside the organisation.	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non-COVID-19 cases to minimise the risk of cross-infection as per national guidance	This standard is not applicable to the GOSH main site in the absence of an emergency department.	Check CATS triage pathway has been updated	
Mask useage is emphasised for suspected individuals	Specified within cinical guidleine if symptomatic child able to wear mask for transfer then should be encouraged but not mandatory		
Ideally segregation should be with separate spaces but there is potential to use screens e.g. to protect reception staff	Reception areas have screens in place as part of safe working group work		
For apatient with new onset symptoms it is important to achieved isolation and instigation of contact tracing as soon as possible	all children who develop new symptoms after admission have an NPA sent which is tested for the full panel of respiratory viruses.		
Patients with suspected COVID-19 are tested promptly	Patients are tested promptly with a rapid test available if clinically required. All other tests have a TAT of 48 hours.	Audit of TAT.	

Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	Patients who test negative and develop symptoms would be placed back into droplet precautions and another sample taken- COVID 19 policy. Haem/onc flow Patients are asked if symptomatic on arrival. If they are unwell but their appointment is essential they would be isolated and seen Incident reporting process		
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	If non urgent- asked to go home as per PHE guidance and rearrange when well. COVID 19 guideline sets out the process for dealing with clinically unwell patients who need to be seen.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
All staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	In addition to standard IPC training on induction and update training, there has been additional Ad hoc education through the practice education team during the pandemic. Addidional guidance and support has been delivered via the Big Briefings and All Staff Comms. An infection control covid-19 hub was quickly established on the GOSH web.	Develop a training programme online in the virtual environment to support staff.	
All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	COVID clinical guideline on intranet (pending approval at GOLD)	Audit	
A record of staff training is maintained	Staff training records are maintained on GOLD. Fit testing training database was additionally set up during the pandemic.	Audit to ensure that all training records have been appropriately updated.	
Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	The only PPE equipment we are re-using is visors and we have provided guidance on how to decontaminate it on GOSHweb. Incident reporting policy in place.	Audit & analysis of incident reporting.	
Any incidents relating to the re-use of PPE are monitored and appropriate action taken	Speak up and incident reporting processes in place. Monthly analysis of incidents, FTSU queries and complaints		
Adherence to PHE national guidance on the use of PPE is regularly audited	Infection Control Audit schedule		
Staff regularly undertake hand hygiene and observe standard infection control precautions	HH clinical guideline Quarterly Audits QI dashboards at ward level infection control link nurse		
Hand dryers in toilets are associated with a greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination.	Within clinical areas there are no hand towels in use.	monitoring for any staff or patient transmissions. Will review policy if there is an increase in these transmissions. Not easy to remove hand dryers due to blocked toilets with paper towels.	
Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas.	Starfish/octopus hand hygiene stickers/posters are up.	?DRYING	
Staff understand the requirements for uniform laundering where this is not provided for on site	Staff Uniform Policy All staff comms	Double check staff uniform policy & include in audit.	
All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household displays any symptoms	All staff comms Referral Forms Covid-19 Clinical Guideline Mat's Big Briefing HR support and OH		
7. Provide or secure adequate isolation facilities			
Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate	All patients are screened on admission. Patients with high probability are placed in screening cubicles within the COVID ICU (include flow chart) Ops hub to advice on patients movement. IPC team to advice on risks associated with patient movement Covid Secure and Covid Risk Managed Pathways identified.		
Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Air validation of ICU, theatres and Hedgehog ward and all other PPVL rooms available in the organsiation, and the SIR on Pelican.		
Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Alert on Epic with an alert mismatch flag. Standard isolation policy in place. Incidetn reporting. Weekly safety report.		
8. Secure adequate access to laboratory support as appropriate			
Testing is undertaken by competent and trained individuals	Specimen collection guideline updated in May 2020.	Confirm with Labs that we have all the correct accreditations (UCAS) and that the SOPs are on qpulse and that they have the training records for those staff.	
Patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance	Dahsboard showing screening rates withn 24 hours of admission.	Consider audit of referral time for staff to testing.	

Screening for other potential infections takes place	Full bacteriology service is running with a slighly reduced virology gastric service. The latter has been supported with guidance to clinicians to risk stratify patients.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Staff are supported in adhering to all IPC policies, including those for other alert organisms	Policy in place and available on the infection control webpage on GOSH. Udpates are included regularly as guidance changes.		
Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Updated guidance. Discussions at Silver for dissemination via Bronze. GOSH web, staff comms, practice education on the ward.		
All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with PHE National Guidance.	Category B waste guidance is followed for all suspected infections. And Categaory 3 in the Lab.	Waste Audit.	
PPE stock is appropriately stored and accessible to staff who require it	Stock levels are reviewed and circulated daily. Incident reporting and escalation pathways for staff who cannot access when they need it.		
Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is	Managerial discussions. Facilitation of staff to work from home. Occupational Health support. Risk Assessment for vulnerable staff. Well being hub. Demographic Risk	Will be rolled out W/C 18th May 2020	
Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Fit testing service with up to date records held on a central dashboards	Seek assurance that the info on dashboard filters through to health roster and that all relevant staff are using the dashboard.	
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Daily monitoring of staff sickness and isolation. Included in daily comms. Phone call service for staff who are self-isolating with peer support for medical staff who are unwell. Onsite testing is available including serology testing for all staff who want it. Access to national hubs for staff who live significant distances from the hospital.		
Staff that test positive have adequate information and support to aid their recovery and return to work	Opccupational Health Service screening prior to return to work. Safe return to site working group. Safe working checklists and risk assessments. Covid-secure areas certification. Managerial support.		

Attachment R

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
15 July 2020

Learning from Deaths. Mortality Review Group - Report of deaths in Q4 2019/20 **Submitted by:** Dr Sanjiv Sharma, Medical Director. Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews Andrew Pearson, Clinical Audit Manager.	**Paper No: Attachment R**

Aims / summary

The Child Death Review Statutory Guidance outlines the statutory NHS requirements for child death reviews for all child deaths occurring after 29th September 2019. This requires a Child Death Review Meeting (CDRM) that is 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.

Nineteen children died at GOSH between 1st January and 31st March 2020.

- Case record reviews (i.e. an MRG or a CDRM) have been completed for all cases.
- Fifteen CDRMs have taken place. Four cannot take place until the completion of necessary investigations and reviews. This in line with the Child Death Review Statutory Guidance.
- There was one death where there were modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death. Actions have been implemented.
- There is one death being reviewed as a Serious Incident.
- There was one death where a red complaint investigation is in process.
- The review process highlighted particular positive aspects of care and communication in eight cases.
- There were seven additional deaths where learning points were identified at GOSH and elsewhere.

Three deaths have occurred since July 2019 where there may have been a delay in recognition of deterioration/sepsis. This is the clearest theme to have emerged from the mortality review and incident investigation processes in 2019/20. This report was shared at the Patient Safety and Outcomes Committee (PSOC) on the 8th July. PSOC have requested an aggregation of different data concerning this theme in order to inform an appropriate response. The learning points in this report will be shared with Closing the Loop to support any actions which made be required to implement them.

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 R

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 R

Learning from Deaths: Report of deaths in Q4 2019/20

Aim of report

1. Highlight learning from deaths identified through case record reviews, this includes positive practice, but also where there were modifiable factors. 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.
2. Identify progress with the implementation of the Child Death Review Meetings (CDRM).

This scope of this report is GOSH inpatient deaths that occurred between 1st January and 31st March 2020.

Background

Case record reviews take place through two processes at GOSH:

1. **Mortality Review Group (MRG**). This was established in 2012 to provide a Trust level overview of all deaths to identify 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. This group continues to review deaths to ensure a thorough level of review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as identifying learning points and making referrals to other safety investigation processes at the earliest opportunity.
2. **Child Death Review Meetings (CDRM)** These are now in place at GOSH following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019.Child Death Review Meetings are “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.” They include clinicians or professionals from external providers. CDRM meeting should be held within 12 weeks of the child’s death, following the completion of all necessary investigations and reviews.

Completion of case record reviews

Nineteen children died at GOSH between 1st January and 31st March 2020.

- Case record reviews (i.e. an MRG or a CDRM) have been completed for all cases.
- Fifteen CDRMs have taken place. Four cannot take place until the completion of necessary investigations and reviews (Coroners (3), Post mortem (1)).This in line with the Child Death Review Statutory Guidance. This report highlights learning at the time of writing, and it is important to note that additional learning could be identified at a later stage through the coroners /CDRM process.

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

Total number of inpatient deaths at GOSH between 1st January and 31st March 2020	19
Number of those deaths subject to case record review (either by the MRG, or at a CDRM)	19
Number of those deaths declared as serious incidents	1
Number of deaths where a modifiable factor was identified at GOSH which may have contributed to vulnerability, ill health or death.	1
Number of deaths of people with learning disabilities	0
Number of deaths of people with learning disabilities that have been reviewed	0
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

Learning from case record reviews

Of the nineteen deaths in the period:

Modifiable factors at GOSH (1)
There was one case reviewed by that had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death.

Context	Action
Prior to Bone Marrow Transplant the patient was tested for toxoplasmosis and the IgG was positive but PCR negative which was suggestive of contamination from previous exposure to IVIG (as opposed to previous toxoplasmosis infection). Therefore did not receive Azithromycin prophylaxis because it was not felt to be high risk. If found to have had a previous toxoplasmosis infection (as was subsequently found to have been the case from further testing) and would have received toxoplasmosis prophylaxis.	Following the death this has been reviewed nationally and practice now is to send an additional sample to the national lab for further testing which can determine if toxoplasmosis results are from previous infection or contamination and can therefore ensure that appropriate toxoplasmosis prophylaxis in children like this is given. Of note once the diagnosis of disseminated toxoplasmosis was known (from post mortem examination) the MRI was reviewed again and there was still no evidence of toxoplasmosis on the imaging despite the post mortem findings

Deaths that are subject to an SI investigation (1)

Context	Action
Patient died (brain stem death) following cardiac arrest following dental extraction procedure in theatre. The case has been referred to the Coroner.	This was referred to the Executive Incident Review Meeting (EIRM), and is being reviewed as a Serious Incident.

There was one death where a red complaint investigation is in process

Context	Action
Parents have raised concerns that soiled sheets may have contributed to the fungal lung infection which contributed to the patient's death.	Presented at EIRM which determined that a complaint investigation is the appropriate level of investigation.

Positive practice (8)
The review process highlighted particular positive aspects of care and communication in eight cases.

This does not mean that exemplary care and communication is not practiced more widely than in those cases, but the review process has highlighted particular examples of excellence in those cases. These are summarised below.

- *Local team described very clear and helpful advice from GOSH during prolonged admission there prior to transfer to GOSH.*
- *Appreciation for the input of multiple teams making the care for this child the best it could be in the short time in a calm and structured way. The ward and staff became a family to this boy. Palliative care team were credited for their huge contribution. Prebriefs and debriefs were held for staff prior to limitation of life sustaining treatment which was well received in terms of wellbeing for staff who had developed close relationship to this child and an excellent model which should be shared throughout the Trust.*

- *Patient was facilitated to get home for 24 hours over Christmas which was hugely important for her and her family. The Play specialists and Physiotherapy team were commended for their input and support for the patient during her long admission at GOSH.*
- *Excellent collaborative care between teams. Particular gratitude to Urology team for their proactive approach to management of haemorrhagic cystitis symptoms.*
- *Very supportive bereavement service*
- *Good documentation of discussion with parents of pros and cons of BMT in this condition prior to decision to proceed. Useful input from surgeons and micro. Regular gastro/nutrition review. Mother seen by chaplain and psychologist for support. Family assisted by social work re:finances. Ot reviewed and gave plan*
- *Particular thanks to [Cardiac surgeon] for help in facilitating two open lung biopsies despite significant clinical instability which helped to guide treatment decisions. Credit also noted to BMT team as this family would normally have been referred to Bristol for BMT but chose to remain in London as a reflection of the excellent care and support they has received from the BMT team at GOSH.*
- *CICU and Cardiology teams commended for facilitating a bed when the child was born and for the surgeons facilitating insertion of pacing wires in a very small hydropic baby despite the high risk.*

Deaths where learning points were identified (7)
These were not deaths where modifiable factors were identified, but where learning points were identified around best practice which could improve safety, the co-ordination of care, or patient and family experience.

Location of learning	Learning
GOSH and nationally	Following this death the process for identification of previous toxoplasmosis exposure prior to bone marrow transplant has been reviewed nationally and practice now is to send an additional sample to the national lab for further testing which can determine if toxoplasmosis results are from previous infection or contamination and can therefore ensure that appropriate toxoplasmosis prophylaxis in children like this is given.
GOSH	Family were unable to visit the hospital regularly and [patient name] spent much of his life in a cubicle alone on the ward despite the best efforts of nursing staff. In NICU there are volunteers who will sit with babies, change nappies and provide cuddles to relieve parents. It was felt this should be provided across the Trust not just in NICU. The Bereavement Services Manager will contact the Volunteer Services Manager to determine how to provide this service across the Trust. Prebriefs and debriefs were held for staff prior to limitation of life sustaining treatment which was well received in terms of wellbeing for staff who had developed close relationship to this child and an excellent model which should be shared throughout the Trust.
GOSH	Could there have been better planning of likely prognostication with severe pulmonary hypertension on discharge home to have avoided this admission to PICU and earlier consideration of redirection (away from PICU) ie Earlier referral to palliative care.
GOSH and local	Learning Points identified from local Hospital Serious Incident Review Panel: Patient should have had a blood pressure on the initial admission to ED, and certainly before transfer to the ward [when at GOSH] This would not have changed the clinical picture, or the decisions made (as subsequently when measured it was normal); but all patients being assessed for sepsis should have a blood pressure measured.
GOSH and local	In an acute neonatal collapse there is no necessity for an echo to be done locally prior to transfer to a cardiac centre for a clinical suspicion of congenital cardiac lesion
GOSH and local	Child had very advanced malignant disease that had presented with enlargement of a 'birth mark' but had large palpable mass underneath at time of attending for biopsy, plus a history of weight loss and pain.

	Possible delayed diagnosis. Large abdominal mass not identified by GP, local dermatologist or GOSH dermatologist due to difficulties in examination of the child. Discomfort on touch, firmness beneath the birth mark and erythema picked up in dermatology clinic (and appropriate investigations organised). Unfortunately in this case (as demonstrated by diagnosis on histology of malignant rhabdoid tumour) it was felt that earlier diagnosis would not have made a difference to the outcome however had this been a treatable malignancy then the delay in detection of the abdominal mass might have contributed and therefore the learning about less common presentations of malignancy and the importance of a full clinical examination is still important. This is being reviewed as a root cause analysis.
Community	It is possible that recent immunisation may have resulted in a delay in seeking medical attention if initial symptoms overnight (prior to the seizure) were attributed to recent immunisations. This highlights the need for good signposting for parents about when to seek medical attention for children following immunisations)

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

Modifiable factors for care provided outside of GOSH (4)

The MRG/CDRM found modifiable factors in the child's care outside of GOSH in four cases.

Context
Clinical deterioration following routine immunisations: It is possible that the recent immunisation may have resulted in a delay in seeking medical attention if initial symptoms overnight (prior to the seizure) were attributed to recent immunisations. This highlights the need for good signposting for parents about when to seek medical attention for children.
Care pathways for children with suspected congenital cardiac collapse: Possibly avoidable delay in referral to cardiac centre for immediate transfer as no expert echo on site and discussed with two other centres before referring to GOSH who accepted for immediate transfer. To be explored how/if this might have been expedited in local RCA with input from the local transport team who coordinate referrals.
UVC insertion complication: extravasation injury in the liver and TPN fluid accumulation in the peritoneum on Day 7 of life resulting in abdominal compartment syndrome and TPN peritonitis. This contributed to acute kidney injury and NEC.
Unnecessary transfer from Middle East with fatal diagnosis: Baby with known confirmed genetic diagnosis of fatal condition Junctional Epidermolysis Bullosa who was transferred from the middle east unnecessarily.

Theme from 2019/20 Learning from Deaths reports –delay in recognition of deterioration/sepsis

Three deaths have occurred since July 2019 where there has been a delay in recognition of deterioration/sepsis which was identified via the learning from deaths and incident investigation process .This is the clearest theme to have emerged from the mortality review and incident investigation processes.

Two of those deaths were reviewed as Serious Incidents, and one was subject to a root cause analysis incident.

Month of Death	Learning reported in learning from deaths report/from SI
Dec 19	For one death the MRG review identified possible delays in the commencement of appropriate antibiotics both at the local hospital and GOSH. The MRG review could not conclude as to whether there were modifiable factors. This is currently being reviewed as an SI with a planned completion date of the 3rd July 2020
Aug 2019	One MRG review (MRG436) highlighted that there could have been better implementation of the Sepsis 6 protocol. This case was reviewed by the MRG on the 13th January 2020, and was referred to the Executive Incident Review Meeting (EIRM) and been declared as a Serious Incident. The learning from the review is outlined below. *"It was recognised that there was insufficient evidence at the time and leading up to the patient's cardiac arrest due to the lack of consistent sets of full observations. There is ongoing work in the Trust around patient's observations and sepsis recognition – by not undertaking routine observations in a timely fashion, one of the Trust's important safety mechanisms for the timely recognition of sepsis was removed* "
July 2019	The MRG review (MRG398) highlighted a potential failure to recognise clinical deterioration of the patient. This case was subsequently referred to the Executive Incident Review Meeting (EIRM) and a Root Cause Analysis investigation (DATIX ref 64613) was completed on the 15th November 2019. The RCA report concluded that "Two lessons have been identified for Trust wide learning during this investigation although these did not contribute to the patients collapse or the outcome of the incident The RCA highlighted *"Two lessons have been identified for Trust wide learning during this investigation although these did not contribute to the patients collapse or the outcome of the incident.* *• The importance of completing a full set of observations to enable the CSP team to be aware of children at risk of clinical deterioration across the Trust. This is due to a change in hospital practice following the introduction of EPIC and the PSAG boards no longer being used to give a general overview of patients across the trust.* *• Staff to be aware of the functionality in EPIC to allow for overview of emerging trends in patient observations."*

Increase in mortality rate

It has been noted that there was an increase in our crude mortality rate in May, above the upper control limit. The data is not risk adjusted to account for the sickness of the patient on admission, and it cannot be used in itself as a clinical outcome measure. The data does represents an event that we should investigate .This had been promptly noted and highlighted within our governance structure at GOSH .An expedited review of April and May deaths to understand was led by the Medical Lead for

Child Death Reviews. This trend was noted at the June PSOC, and a report on the reviews will be received at the July PSOC.

The report concludes

"*There are two reasons why the GOSH data shows a crude mortality outlier for May 2020*
1. Two deaths following admission to GOSH from another Trust because of COVID 19 who would otherwise have died in a local hospital , and where death occurred at GOSH due to natural disease progression.
2. One death where there was a COVID impact in terms of delayed presentation in the community.
Excluding those deaths from the GOSH mortality rate for May 2020 would indicate a mortality rate of 14.9 per 1000 discharges which is (just) inside the upper control limit of (15.58) from the statistical process control chart which indicated this outlier. It is important to note that there are four deaths in May 2020 where it is not possible to definitively conclude at the time of writing that the death occurred at GOSH due to the impact of COVID. From the available information it is likely that these may not have been deaths at GOSH without COVID. To definitively understand those deaths and causes, would require completion of the CDRM process and any coroners outcomes.

- *The reviews do not indicate care or service delivery problems provided at GOSH which account for increased deaths.*
- *There are no triggers noted in risk adjusted data for this period. There has been no reset noted the in the RSPRT this period. 16/24 deaths in April and May 2020 were on PICU/NICU.*
- *The crude mortality rate for June has returned to within normal variation.*
- *In a number of deaths it is highlighted that the families experience was particularly difficult because of limitations of the visiting policy which was necessitated due to C-19. The inability to provide bereavement follow up face to face has also been mentioned in all cases as another consequence of Covid."*

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 31st March 2020	14	14	0

Monitoring of modifiable factors.

The table below provides a summary of the number of cases with modifiable factors at GOSH that may have contributed to vulnerability, ill health or death over the last six calendar years:

		Cases with a modifiable factor at GOSH that may have contributed to vulnerability, ill health or death	
Calendar Year	**Inpatient deaths**	**N**	**%**
2015	103	6	5.8%
2016	86	7	8.1%
2017	110	10	9.1%
2018	86	5	5.8%
2019	114	4	3.5%
2020 (to 31st March)	19	1	5.3%
Total	**518**	**33**	**6.4%**

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

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 15th July 2020	
Responsible Officer's Annual Report **Submitted by:** Dr Andrew Long, Associate Medical Director and Responsible Office	**Paper No: Attachment T**
Aims / summary This report is presented to the Board to provide assurance that the statutory functions of the Designated Body and Responsible Officer are being appropriately discharged; to report on performance in relation to those functions; to update the Board on progress since the 2019 annual report; to highlight current and future issues; to present action plans to mitigate potential risks.	
Action required from the meeting The Board is asked to note the contents of the update.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Revalidation is an essential part of clinical governance.	
Financial implications	
Who needs to be told about any decision? Higher Level Responsible Officer	
Who is responsible for implementing the proposals / project and anticipated timescales?	
Who is accountable for the implementation of the proposal / project? Dr Andrew Long, Associate Medical Director and Responsible Officer	

Annual Responsible Officers' Board Report

2020

1. Purpose of the Paper

The purpose of this paper is to inform Board members of Medical Appraisal and Revalidation arrangements within GOSH, to provide assurance that the Responsible Officer and the Designated Body are discharging their statutory responsibility and to highlight current and future issues with action plans to mitigate potential risks.

This report describes the progress against last year's action plans, issues during the reporting year and sets out actions on further developing the quality of appraisals and support.

2. Summary

In March 2019 the Medical Appraisal and Revalidation Committee (MARC) commenced, and has worked well throughout the year. This group acts as a Decision Making Group to support the Responsible Officer in making reliable and robust revalidation decisions for doctors connected with the organisation. The group was productive throughout the year in assisting with a large number of recommendations prior to the COVID changes.

Due to the COVID pandemic, NHS England have stated that Medical Appraisals should be cancelled from March 2020 and that no Annual Organisational Audit (AOA) is required for 2019/20, therefore no AOA is attached to this year's report. In addition the GMC took the decision to defer all Revalidations due between 19th March 2020 and 16th March 2021 for 12 months, although these doctors will remain "Under Notice" to allow recommendations to be made where appropriate. The report below reflects the appraisal and revalidation figures as close as possible to that required in an AOA.

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) had 640 doctors connected to it as a Designated Body, of which 563 were eligible for an appraisal in 2019/20. There were 462 appraisals completed in the appraisal year.

2.1 Medical Appraisal

Category	2019/20 Appraisal Status	%
1	Completed Appraisal	462
2	Approved Incomplete or Missed Appraisal	178

No doctors fall into AOA Category 3 (Unapproved Incomplete or Missed Appraisal) as it was agreed that all incomplete appraisals would be approved due to the inability to hold the meetings from the outset of COVID.

There were 178 doctors (28%) classed as having an Approved Incomplete or Missed Appraisal (AOA Category 2) and the reasons are shown below:

- 77 joined the Trust from abroad and had been employed for less than 12 months on 31/03/20 and were therefore not yet due an appraisal;
- 3 had an agreed postponement due to long term sick leave or compassionate leave;
- 12 had an agreed postponement due to maternity leave;
- 2 had an agreed postponement due to sabbatical leave;

- 84 appraisals were cancelled or postponed due to COVID, of these 17 appraisals have since taken place (appraisal meeting date after 01/04/2020).

Directorate Breakdown of Appraisals due 1st April 2019 – 31st March 2020

	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	IPP	Medicine, Therapies & Tests	Ops & Images	Sight & Sound	Corp	Total
Cat 1	**79**	**75**	**68**	**97**	**4**	**31**	**70**	**33**	**5**	**462**
Cat 2	**24**	**30**	**30**	**61**	**10**	**1**	**8**	**12**	**2**	**178**
Cat 3	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**103**	**105**	**98**	**158**	**14**	**32**	**78**	**45**	**7**	**640**

2.2 Appraisers

The Trust had 160 trained appraisers at 31st March 2020. During the reporting period we held 2 new appraiser training sessions

Appraisers were supported by an Appraiser Forum in October led by the RO, and attended by the GMC ELA. A further Forum was planned for March 2020 with Premier IT representatives in attendance but this was cancelled due to COVID. The Trust has also implemented the regular use of the Appraisal Summary and PDP Audit Tool (ASPAT) from NHS England, feeding back to appraisers how their summaries may be improved.

2.3 Revalidation

Between 1st April 2019 and 19th March 2020 a total of 175 doctors for whom GOSH is the Designated Body have had Revalidation Recommendations made to the GMC. 116 have been revalidated and 59 were deferred – 58 due to insufficient evidence and 1 due to an ongoing process. Of these 59, 16 were recommended later in 2019/20, 43 were deferred to 2020/21. A record has been maintained showing the reasons for insufficient evidence:

Appraisal Activity	Colleague Feedback	Compliments and Complaints	CPD	Interruption to Practice	Patient Feedback	QIA	Significant Events

43	**32**	**16**	**20**	**5**	**33**	**31**	**14**

All doctors due to be revalidated between 19th March 2020 – 30 September 2020 were automatically deferred by 12 months by the GMC to ease the burden on those doctors during COVID. This was further extended to include all doctors due revalidation up to 16th March 2021. All of the affected doctors have been placed "Under Notice" which does allow for positive revalidation recommendations to be made if appropriate, however it has been advised that deferral recommendations are not made until closer to their revised submission date.

2.4 Quality Assurance

The Medical Appraisal and Revalidation Committee (MARC) has met regularly throughout the year. Those doctors due for revalidation have a complete review of all appraisal input forms, output forms and related supporting evidence. This is fed back to MARC and both the RO and the Revalidation Manager provide constructive feedback to appraisees and appraisers where the requisite standard has not been reached even if this doesn't result in deferral.

Outside of the revalidation review, a random selection of appraisal output forms are reviewed as part of the ASPAT process (Appraisal Summary PDP Audit Tool). Some reports have been released to the appraiser for their reflection during their own appraisal, others have been held back during the COVID issue. Once discussion has taken place regarding appraisal "re-start" these reports will be released to the appraisers.

Appraisers are scored by their appraisees, this is done anonymously at the end of their appraisal following acceptance of their Appraisal Output Form. To maintain anonymity a report will be produced for the appraiser once they have completed a minimum of 3 appraisals. The report is attached to their portfolio for reflection in their own appraisal. The report covers nine different aspects of appraisal and also includes areas for free typed comments.

2.5 Responding to Concerns and Remediation

In the past year there have been no completed Maintaining High Professional Standards (MHPS) investigation reports and there are no ongoing MHPS investigations.

During the past year 2 doctor has had sanctions imposed by the GMC and these include warnings and undertakings.

Annex A

Designated Body Annual Board Report
2020

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year is cancelled.

Action from last year: Continuing support and guidance to be given to appraisers; GMC and PremierIT to attend appraiser forums; PReP to attend appraiser/appraisee "Drop In" session; GOSHWEB to be updated. ASPAT to be introduced more regularly. Comments: The GMC ELA attended the Appraiser Forum held in October, PReP were due to attend the Forum in March, however this was cancelled. GOSH Web has had some updates to the information particularly regarding timeliness of appraisals. ASPAT is now a regularly activity. Action for next year: Look into the possibility of holding a virtual Appraiser Forum with PReP attending once appraisers are able to resume normal activity.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: To maintain expertise using RO Network meetings Comments: The Responsible Officer, Andrew Long (Associate Medical Director), completed RO training in November 2016 and was appointed as RO 1 January 2017. He is now retiring from this post, and following advert Philip Cunnington was proleptically appointed to the role. He has completed RO training and is looking to take the role on fully from January 2021, after a handover period commencing July 2020. Action for next year: Support the new Responsible Officer in maintaining expertise

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: None Comments: None Action for next year: None

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Maintain process for accurate prescribed connections and transfer of information. Comments: The process is threefold for maintaining an accurate list. Starter and Leaver reports are received monthly from Workforce, emails are received from the GMC when a doctor connects or leaves our Designated Body list, should a doctor not add themselves to our Designated Body list and are not yet listed on the Starter/Leaver lists they are captured when omitted from the monthly compliance data. Transfer of information requests are checked with Risk and Complaints teams and the RO before returning to the requestor.

Action for next year: Continue maintaining accurate records.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: To continue to update policies as appropriate

Comments: The Medical Appraisal Policy was updated, forwarded to Chiefs of Service for their comment, and passed through MARC. It is currently with HR before going to PAG/LNC. The delay is due to increased work volume within HR.

Action for next year: Continue with policy update and publish.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None

Comments: None

Action for next year: None

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Improve the information on the GOSHWEB to assist short-term/locums etc and continue to provide support.

Comments: Slides have been introduced into the induction meetings detailing what is required by the doctors and who to contact. The Revalidation Manager was attending some of the inductions prior to COVID. The PGME pages were updated with relevant appraisal and revalidation information.

Action for next year: To continue to update the information as needed.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Investigate the possibility of centrally uploading SI/Complaint information on to the PReP system for use in appraisals; Include information regarding timing of appraisal meetings in the appraisal policy when reviewed in line with NHS England requirements.

Comments: Appraisal timeliness flow chart developed and added to GOSH Web, the revised policy and referred to in the updated appraisal reminder emails.

Action for next year: Continue with investigating possibility of centrally uploading SI/Complaint information to PReP.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: The Trust have developed a local process which identifies doctors that have failed to complete their appraisal without reason. These doctors are discussed at the Medical Appraisal and Revalidation Committee, and recent GMC guidance advises that all those more than 3 months overdue are discussed with the ELA to decide next steps. Doctors are made aware of this before they reach this milestone. Continue with the process and review its success, with the aim of reducing the number overdue. Comments: Revised appraisal reminders and appraisal timeliness flowchart devised to assist with appraisees understanding of process and potential outcomes. Action for next year: Once appraisals and MARC restart the process will be required to restart with understanding of delays from 2019/2020.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Review appraisal policy by December 2019 to incorporate new guidance. Comments: Policy updated, Chiefs of Service have reviewed and is now with HR for their comment. Action for next year: Finalise policy, submit to PAG/LNC and publish on GOSH Web.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Consider appraiser allocation following a quality review of appraisers Comments: Preliminary work has started. The number of appraisees allocated to an appraiser has been reviewed, and where necessary advice has been given to appraisers not to take on further appraisees for the year. This has allowed those appraisers with low numbers/no appraisees to be approached to help balance allocation. Action for next year: Continue with this work, and further develop a process to monitor allocation.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: Develop appraiser refresher training in-house Comments: Work has started on a refresher course. Action for next year: Continue with the course preparation with input from MARC and look into having this online.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None identified Comments: Internal assurance is provided by the following sources: - RO reports to Board - RO and Appraisers continue to update their skills in Revalidation and Appraisal matters. Action for next year: None

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Review revalidation portfolio within 1 month of "Going Under Notice" to provide greater time to resolve any issues ahead of submission date. Comments: This was possible during the majority of the year, and was an ongoing process however since March 2020 all doctors until March 2021 are now Under Notice. Action for next year: Review all those Under Notice with a view to submitting recommendations as soon as possible, paying particular attention to those who were revalidation ready and their original submission date has passed (prior to the GMC deferring submission dates).

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None identified Comments: All revalidation recommendation decisions (positive and deferral) are emailed to the doctor. If it is likely that a doctor will be deferred they are pre-warned of this and the reasons to allow time to resolve if possible. Action for next year: Maintain process

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: The Trust's approach to Medical Governance is undergoing an evaluation, to determine effectiveness and efficacy, following which the Trust intends to put actions in place to further strengthen its approach to Medical Governance. Comments: The Medical Directorate team have been strengthened during the past year, with additional support provided for governance functions within the organisation Action for next year: Continue to develop robust medical governance within the organisation

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To develop the competency of senior management through a formalised training programme. Comments: Further work is required with the HR&OD Directorate to improve this area of activity Action for next year: Work with Medical Employee Relations team to develop senior management

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To continue to work closely with NHS Resolution and the GMC; and to continue to develop the Trust's approach to collective leadership when responding to concerns. Comments: Close relations continue with GMC ELA and the Practitioners Performance Advisory Service (NHS Resolution) Action for next year: Continue to develop good working relations

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: None Comments: Working closely with the GMC, we are developing training for all consultants within the organisation on Professional Behaviour and Patient Safety. This is an intrinsic part of our Speak Up for Values programme and has been highly commended Action for next year: Run regular workshops for medical staff

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: To continue to ensure that there is a robust process for the timely transfer of information. Comments: Further work has been undertaken in developing timely systems for Transfer of Information with other organisations

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Continue to develop this work

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: To continue to develop this approach, coupled with the implementation of a senior management programme to increase the levels of competency in managing doctors in difficulty. Comments: We are working closely with Medical ER and the LNC to ensure that our internal processes are transparent and fair Action for next year: Continue to develop this work

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: TRAC to be implemented, which will allow better visibility of pre-employment checks. Comments: A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitable skilled and knowledgeable to undertake their professional duties. TRAC was implemented in May 2019. Action for next year: None

Section 6 – Summary of comments, and overall conclusion

The majority of the action plan from the 2019/20 is complete, ongoing or looking to be adapted in line with new working practices. **Overall conclusion:** Having introduced new systems at GOSH in early 2019 to improve robustness in appraisal and revalidation systems and having achieved well over 90% compliance with medical appraisal among the medical staff the COVID pandemic has had a significant impact. The interruption in the appraisal and revalidation cycle has offered the opportunity to revisit the key components of the current system and refresh the emphasis within appraisal as well as offering some greater flexibility on the part of the Responsible Officer recommendations. This will hopefully have a positive benefit in reinforcing the positive aspects of regular appraisal (supportive and facilitatory) while discouraging some of the more negative views of revalidation requirements expressed by some doctors within the organisation

Section 7 – Statement of Compliance:

There is no requirement for a Statement of Compliance for 2019/20.

Attachment U

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
15 July 2020

Safeguarding Annual Report (2019/20) **Submitted by:** Alison Robertson, Chief Nurse **Prepared by:** Jan Baker, Named Nurse Alison Steele, Named Doctor Elleni Ross, Acting Team Manager for Social Work	**Paper No: Attachment U**

Aims / summary
The Children Act 2004 places a duty on all NHS provider services to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The Trust is expected to ensure that it's arrangements are robust and that safeguarding practice is integral to its clinical governance frameworks.

Action required from the meeting
To note the contents of this report and consider if adequate assurance has been given to meet the required duties described above. In particular progress made.

Progress made (slides 2-5):
- Supervision activity has increased due to more accurate recording and data collection.
- 24/7 safeguarding rota led by general paediatric consultants has been established
- Time has been allocated to one general paediatrician to provide oversight and leadership to those children and young people with Perplexing Presentations
- A full programme of audit has been maintained
- A safeguarding risk register has been established with scheduled regular reviews
- The national Child Protection Information Sharing system has been implemented which enables those children coming into GOSH to be identified if they are subject to a Child Protection Plan or are 'Looked After'
- A multidisciplinary Mental Capacity Act Group has been established
- A safeguarding group was established to ensure best practice and information sharing following the decision to admit all general paediatrics from surrounding NCL hospitals in response to the COVID pandemic
- The CQC inspected GOSH in 2019 and commented that '*staff understood how to protect patients from abuse and the service worked well with other agencies to do so'*

Challenges
- The Named Doctor retired in March (interim arrangements are in place) with interviews planned for mid July.
- The Named Nurse will retire in October (with interviews scheduled for end of July)
- The Head of Social Work is currently in an acting capacity – post scheduled to be advertised in July.
- Safeguarding training compliance dropped in Q4 (trust staff) - the safeguarding

training strategy is currently under review - Compliance with Level 3 training amongst honorary consultant holders has remained an issue – a new policy has recently been approved and those who are not compliant will have their contract terminated Priorities for 2020/21 are outlined on slide 18 and will form our action plan for this year
Contribution to the delivery of NHS Foundation Trust strategies and plans Safeguarding children and young people is integral and aligned to the GOSH guiding principle of the 'Child First and Always'
Financial implications Nil
Who needs to be told about any decision? The Safeguarding agenda and work plan is monitored via the Strategic Safeguarding Committee, The Operational Safeguarding Committee and the Mental Capacity Act Steering Group. GOSH is an active member of the Camden Adult and Children Partnership Boards
Who is responsible for implementing the proposals / project and anticipated timescales? Safeguarding and Social Work teams in partnership with the clinical and corporate directorates
Who is accountable for the implementation of the proposal / project? Chief Nurse, Named Nurse, Named Doctor

Great Ormond Street Hospital for Children
NHS Foundation Trust

S A F G U A R D I N G

M A T T E R S

Annual Report 2019 – 2020

Prepared by Named Safeguarding Professionals and Social Work Manager

Presented by Alison Robertson, Chief Nurse and Executive Lead for Safeguarding

Contents

The five core elements of safeguarding at GOSH aim to provide assurance on our safeguarding arrangements to our External Regulators, Commissioners, Trust Board and Quality, Safety, Experience and Assurance Committees.

Introduction:

Great Ormond Street Hospital (GOSH) is an international centre of excellence striving to provide the very best care for children with rare and complex conditions to enable them to achieve their full potential.

We receive 237,908 outpatient visits and 43,218 inpatient visits every year and have a workforce of 5,025 employees. There are 63 different clinical specialities at GOSH; the UK's widest range of specialist health services for children on one site. More than half of our patients come from outside London being referred from other hospitals throughout the UK and overseas.

The Safeguarding Children, Young People and Adults Annual Report relates to the period from 01/04/2019 – 31/03/2020, and seeks to provide high level assurance to the Trust Board of the responsibilities and value delivered by the Trust Safeguarding Team and Social Work Service.

The Children Act 2004 (Section 11) places a duty upon all NHS Provider Services to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The Trust is expected to ensure that its provider arrangements are robust and that safeguarding and promoting the welfare of children is integral to clinical governance and audit arrangements.

The Care Act 2014 sets out the statutory principles which apply to all health and care settings to safeguard vulnerable people over the age of 18 years.

The report updates on progress on work streams agreed within the work plan for 2019/ 2020.

Regulation

Care Quality Commission (CQC):

The Trust was inspected by CQC in October – November 2019. They concluded that;

'Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff had training on how to recognise and report abuse, and they knew how to apply it. '

Safeguarding was considered across the services that were inspected and in addition the Named professionals were interviewed as part of the Well Led inspection with no concerns raised.

Safeguarding progress at GOSH during 2019 – 2020

The past year for Safeguarding has been a time when long-term projects have come to fruition but also where we have adapted our traditional ways of working to meet the challenges that have presented towards the end of the year.

Like other trusts, GOSH has adapted during the COVID-19 pandemic. Likewise, the Safeguarding and Social Work Services have worked closely with our partners mainly across the North Central London region, to ensure that we we are able to safeguard those children who required a hospital admission but would not normally be admitted to a tertiary centre. A Safeguarding group was established with other Named Professionals from hospitals within NCL to ensure that there were safe processes and practice in place to safeguard children, young people and adults up to the age of 25 years who were transferred from other hospitals during the extraordinary circumstances resulting from the pandemic.

The ethos of our organisation has been to 'Always say Yes' to others so that we can support our partners effectively as they too have embraced the extra demands that the pandemic has placed on adult services across the region. GOSH is the only specialist hospital in the UK that does not have an accident & emergency necessitating a transfer from the presenting hospital.

Our workforce within safeguarding has seen a number of changes over the past year.

Significantly;

- The Named Doctor has retired from the post in March 2020 and will be returning in a different role; leading the Perplexing Presentations Service.
- The Head of Social Work resigned in May 2019 to take up a post closer to home.
- The Deputy Named Doctor will be retiring at the end of April 2020 as will the Head of Safeguarding in the latter part of the year.
- Additional specialist nurse resource has been provided by the Chief Nurse for a fixed term period until March 2021. This cover was provided to backfill an extended period of sick leave within the team and to support the work of the Leads for the Perplexing Presentation Service, and Mental Capacity Act (MCA) in the light of the introduction of the Deprivation of Liberty Safeguards (DOLs) to be implemented at the end of 2020, lowering the age of consent from 18 to 16 years which will impact on Children's Safeguarding.

The Trust currently has an Interim Named Doctor until a further recruitment process is completed. The Trust was unable to appoint a suitable candidate to the position from previous attempts to recruit. It is hoped that the position will be filled in the near future.

The Named Doctor has successfully established the 24/7 safeguarding general paediatric medical rota which commenced in March 2019, with five Consultant General Paediatricians (GPs) providing the cover. The GPs were supported by regular Peer Review, and undertook supported attachments in community child protection assessment clinics in Camden to consolidate and refresh their child protection skills. The service ensures that a GP is always available when there are urgent child protection issues arising out of hours, predominantly involving children admitted with injuries to the Paediatric Intensive Care Unit.

Safeguarding progress at GOSH during 2019 – 2020 (Continued)

The past year at GOSH has seen the successful completion of the long-term Child Protection Information Sharing Project (CP-IS). Teams from Safeguarding and Information Technology have worked extensively with NHS Digital, culminating in an agreement to become the first trust in the country to integrate the system for scheduled care visits of children as well as unscheduled care. This has led to a prompt notification of those vulnerable children who are subject to a Child Protection Plan or 'Looked After', which is imperative for ensuring that the management and communication with the wider professional team caring for the child is appropriate.

The launch of the electronic patient record (EPR) in April 2019 has led to an enhanced collaboration between Safeguarding and Social Work Services at GOSH by sharing more processes and data collection, as well as providing a more robust link with clinical teams across the Trust. Work is ongoing to refine the data collected from EPR to reflect accurately the service provision to the Trust and identify areas that require additional support, in addition to those who demonstrate good practice.
There have been a number of challenges during the implementation phase of EPR, but these are being addressed during the optimisation phase and have led to improved working arrangements between the clinical and support services at GOSH.
Referrals to the Safeguarding and Social Work duty team have increased significantly and include those made to the CLIC Sargent Social Work Team who support children with cancer.

There has been significant work undertaken to embed the MCA role more robustly within the Trust, following the Safeguarding Adults Lead incorporating the role into their post. An interdisciplinary MCA Group has been established to develop the governance and support for staff around capacity issues. Training on MCA and DOLs has been strengthened and preparation begun for the implementation of Liberty Protection Safeguards which will be introduced in 2020/2021.

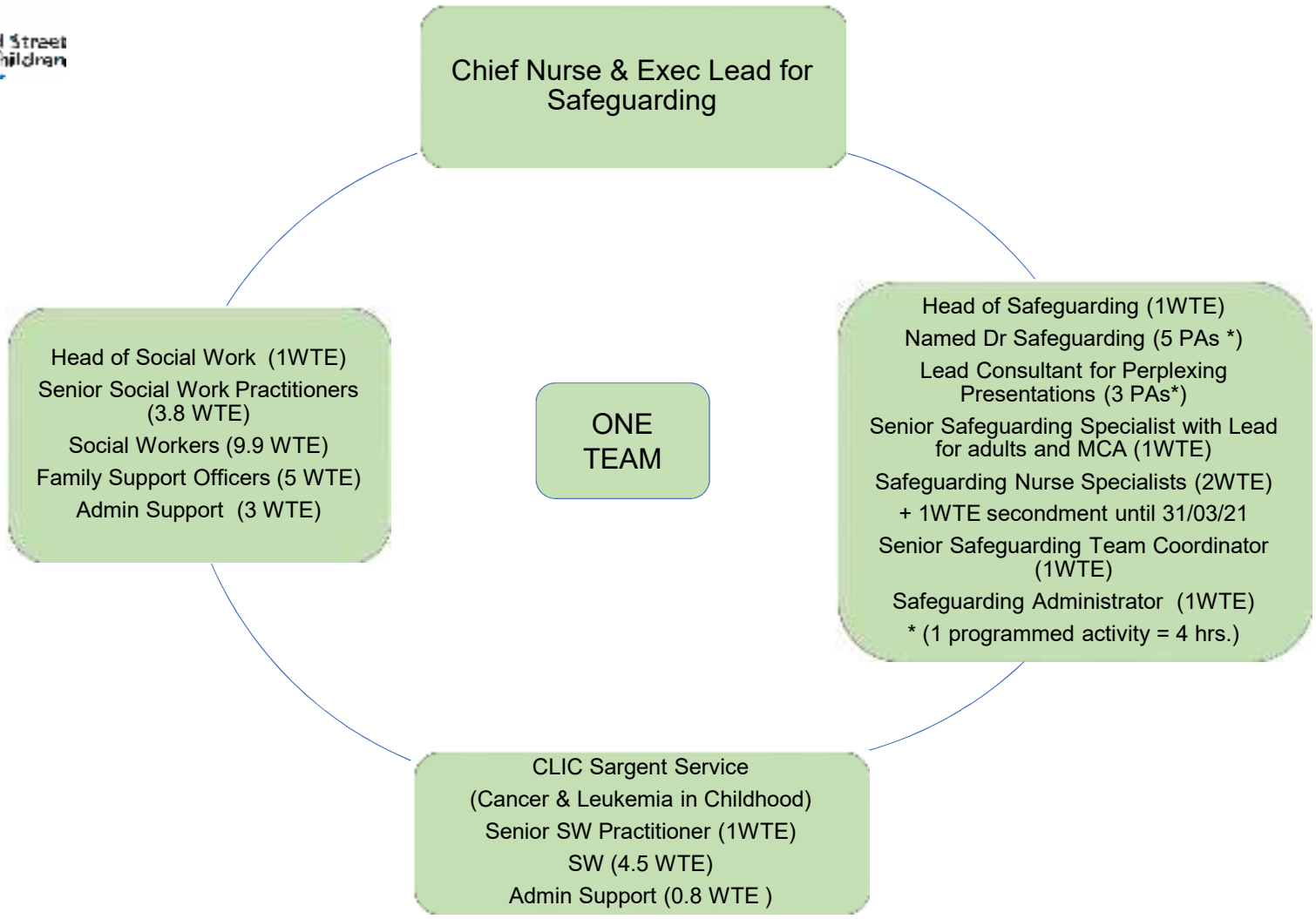
Safeguarding Training at Level 3 competence achieved the Trust Gold Standard of 95% at the end of 2019, but has dropped with the impact of COVID-19. The Safeguarding Team were unable to deliver face to face sessions in line with Trust guidance at the time but are reintroducing those sessions in a virtual environment. The training for Honorary Contract holders remains below target and tighter boundaries are being set which will be outlined in a new policy developed by Human Resources. Staff are able to achieve their competencies in an increased variety of learning models and practical applications.

Supervision is being captured more accurately with the introduction of EPR and is reflected in the increased numbers for both staff attendance and consideration of cases.

Safeguarding Audit activity has provided reassurance that staff understand their responsibilities towards identification of child maltreatment but in some cases could act in a more timely manner. Ensuring that we capture the Child's Voice more effectively is a priority for the next year.

We are working with colleagues in Neuro-radiology to consider an increase in abusive head traumas since the start of the COVID-19 period and this work will carry on into the next year attempting to identify thematic predisposing factors.

The Safeguarding Team has maintained its' links with the National Named Professional Network as well as establishing a pan European safeguarding group to share good practice across a broader spectrum.


Chief Nurse & Exec Lead for Safeguarding
Head of Safeguarding (1WTE)
Named Dr Safeguarding (5 PAs *)
Lead Consultant for Perplexing Presentations (3 PAs*)
Senior Safeguarding Specialist with Lead for adults and MCA (1WTE)
Safeguarding Nurse Specialists (2WTE)
+ 1WTE secondment until 31/03/21
Senior Safeguarding Team Coordinator (1WTE)
Safeguarding Administrator (1WTE)
* (1 programmed activity = 4 hrs.)
CLIC Sargent Service
(Cancer & Leukemia in Childhood)
Senior SW Practitioner (1WTE)
SW (4.5 WTE)
Admin Support (0.8 WTE)
Head of Social Work (1WTE)
Senior Social Work Practitioners (3.8 WTE)
Social Workers (9.9 WTE)
Family Support Officers (5 WTE)
Admin Support (3 WTE)
ONE TEAM

External Assurance

NHSE

North Central London (NCL) Clinical Commissioning Group (CCG)

Commissioner Requirements

The Trust provides quarterly metrics to its commissioners from North Central London (NCL) reporting on four key areas:

- Involvement in Child Protection Conferences (See slide 8)
- Supervision (See slide 14)
- Training (See slide 13)
- Audit (See slide 15)

Partnership working

Following the publication of Working Together (2018), Camden Safeguarding Children Board became known as Camden Safeguarding Children Partnership (CSCP) from 1st June 2019.

The Executive Lead and Named Professionals attend CSCP and its subgroups namely Quality Assurance and Health to ensure that the Trust is actively involved with local multi-agency developments and provision of assurance at all levels. During the past year there has been attendance by the member or their deputy at all meetings.

People in a position of trust

The Trust has a clear policy aligned with national and local guidance for dealing with allegations against people who work with children. Support is provided by the Local Authority Designated Officer (LADO). In the past year there have been 18 such allegations.

Local and national child safeguarding practice reviews

Following the changes to the way in which serious child safeguarding cases are considered; either a national or local level, the Trust has been asked in 2019/20 to contribute to 1 new Serious Case Review (SCR) involving 1 child. There are 6 active cases with independent overview reports in progress or delayed due to ongoing police investigations or criminal proceedings.

The past year has seen a reduction in the number of new cases meeting the threshold for an SCR with a greater number of cases potentially being considered in a shorter time frame at local level.

There have been contributions provided to local partnerships for 1 Child Safeguarding Practice Learning Review and 2 Adult Reviews.

Learning is disseminated to staff through the Patient Safety Outcomes Committee, and from June 2019 the 'Closing the Loop' group. The learning is included in training and supervision.

Serious cases of physical maltreatment, both external and internal are selected for discussion and learning at the Child Abuse Pathology (CAP) Meeting.

Mandatory Reporting

Area	Legal Requirement	No. of cases reported in 19-20
Female Genital Mutilation (FGM)	Serious Crimes Act 2015	0
Prevent	Counter Terrorism and Security Act 2015	0
Modern Day Slavery	Modern Day Slavery Act	0

There have been no cases for mandatory reporting in each of the 3 areas.

Staff are made aware of each of these forms of abuse, information which is included in Safeguarding Training.

Internal assurance

- The Strategic Safeguarding Committee (SSC) meets quarterly, with Camden's designated safeguarding professionals in attendance. The Operational Safeguarding Group (OSG) meets twice between each SSC. The aims of both groups are to provide assurance that the Trust promotes the safeguarding of children young people and vulnerable adults at all times.
- A quarterly report is compiled for the Quality Assurance, Experience and Safeguarding Committee (QSEAC), and an annual report for Trust Board.
- The Clinical Quality Review Group (CQRG) meets quarterly with commissioners from NHSE and receives safeguarding updates as required.

Risks

The Disclosure and Barring Service (DBS)

The Trust undertakes checks at recruitment of all staff carrying out regulated activity, which was 100% as of 31.03.2020. The Trust changed its DBS policy in 2019, removing the requirement for rechecks, however it committed to ensuring that any staff that had not been checked against the Adults barred List at recruitment would be rechecked once their current DBS would have been up for its 3 yearly renewal. To date 56% of current staff have been checked against the Adults Barred list. The program to recheck the remaining staff will be complete by March 2022.

Persons Who Pose a Risk

The Safeguarding Team works closely with the Risk, Social Work, Security and Directorate Nursing Teams to ensure a safeguarding perspective is included in the risk assessment where there are concerns about a person who may pose a risk to others.

GOSH

Requests for contributions to Local Authority Assessments

The safeguarding team have coordinated a total of 122 (29 assessments relating to child protection and 93 relating to child in need) requests for information from clinical professionals. The clinical teams are supported by the safeguarding team to ensure comprehensive information is provided to the local authority. The GOSH Social Workers contribute to those cases where they have had involvement.

Involvement in Child Protection (CP) Conferences

The Trust has received a total number of 305 invitations in 2019/20 for involvement in CP conferences. This is a 78% increase on 2018/19. This is most likely due to the Child Protection Information Sharing System (CP-IS) which is providing additional data of children who are subject to a CP Plan.
Professionals contributed to 286 conferences with either a report, linking in by teleconference or attending in person. Where compliance has not been achieved this is mainly due to late or non receipt of invites from the Local Authority.

Risk Register

A dedicated Safeguarding Risk Register is overseen by SSC.

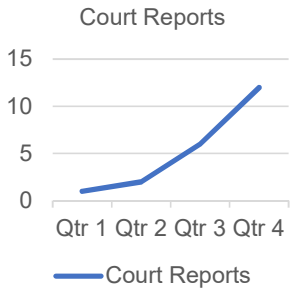
- The register currently has risks in relation to migration of reporting systems, the retirement of the Named Doctor, and increasing compliance with MCA requirements.

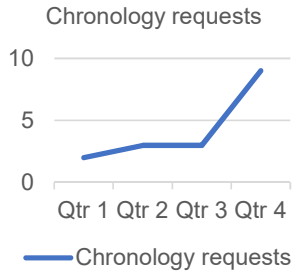
National Independent Inquiry into Child Sexual Abuse

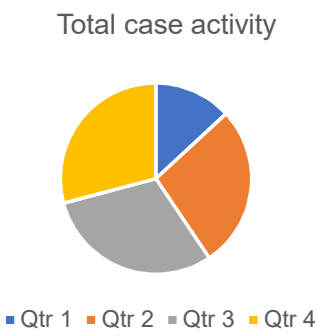
This was set up due to serious concerns that some organisations had failed and were continuing to fail to protect children from sexual abuse.

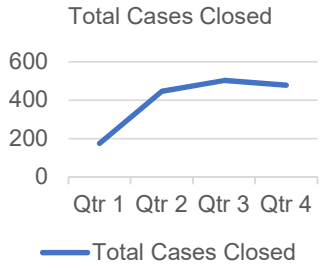
- There have been no cases identified to the Trust from the Inquiry to date. The Trust is compliant with the Action Plan which is updated annually.

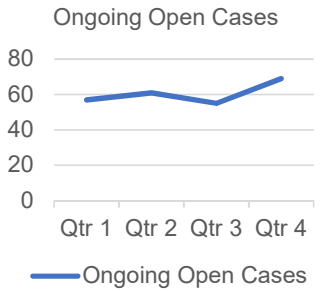
Safeguarding Team Activity











- Over the year 2019/2020 referrals to the safeguarding team have significantly increased, most evident between Q1 and Q2. This can be attributed to a number of factors. In April 2019 the Trust introduced an EPR system which made data collection more precise and ensured that all cases with involvement from the safeguarding team were referred via one route.
- Additionally from November 2019, Child Protection Information System (CP-IS) alerts have been integrated into EPR and processes have been agreed between the safeguarding and social work teams for information gathering from Local Authorities which has resulted in increased information sharing. Managing CP-IS alerts has led to an increase in workload which will be ongoing. However, the current issues around COVID-19 mean that CP-IS checks will not be carried out as staff are working remotely without smart card access so we may see a disproportionate surge in these as outpatient services recommence in the coming year. Discussions are taking place as to how best to mitigate this risk.
- Due to arrangements made to comply with COVID-19 guidance, there has been a significant reduction of outpatient appointments on site and planned procedures towards the end of Q4 in line with COVID-19 guidance and it can be interpreted from this that there may be some changes in the data going from Q4 in to Q1 of 2020/2021.
- There is an expectation that we will see inpatient referrals increase and this presumably will be due to the increase in our general medical inpatient cohort transfers from within the North Central London Hospitals. Further understanding around this data and change of safeguarding concerns within the hospital will be further understood in 2020/2021.
- The safeguarding team are now leading on safeguarding patients admitted from the NCL region as some of the NCL hospitals safeguarding teams have been redeployed. GOSH are co-ordinating all issues with GOSH social work and the NCL discharge co-ordinators and then informing the local hospitals and teams as appropriate..
- The NCL has also brought a number of new categories of concern to the hospital that would not normally be seen at GOSH and the safeguarding team are attending weekly psychosocial meetings for these new wards and supporting staff with safeguarding updates and supervision on a weekly and ad-hoc basis.
- Work is ongoing with the EPR team regarding the reporting of safeguarding data. There are a number of processes required in optimisation to accurately capture the level of safeguarding concerns within GOSH. A new activity data collection system will hopefully commence in June 2020 and will mean that the activity within the safeguarding team will be more robust. For the coming year we plan to further amend the parameters of data collection to reflect more accurately the data within the hospital.

GOSH Social Work Service

The main GOSH Social Work service

This service is jointly funded by the GOSH Charity and NHS. Since May 2019, the Head of Social Work post has been vacant, but a senior practitioner has been acting up in the role of Interim Team Manager to ensure operational management support continues while the new Head of Social work role is finalised. During this period a social worker has acted up into the vacant Senior Practitioner role to ensure sufficient management cover is in place.

Historically, qualified social workers were employed by London Borough of Camden, then given GOSH honorary contracts to deliver the social work service. This form of employment has ceased in 2019/20. In March 2020, three new social workers were directly employed by GOSH at Band 6. Towards the end of March 2020, due to COVID-19, many staff are working off site but there has been a minimum team of social worker, duty manager and admin support on site through the pandemic period. New ways of working are being devised so that all referrals are being actioned despite the pandemic.

CLIC Team

In 2019 / 2020, the CLIC Sargent team structure has remained stable although there have been individual staff changes, meaning that the team has not been fully staffed more than 2 months at any one time. CLIC Sargent has been affected by COVID-19 impacting on fundraising. In an effort to ensure longer-term continuity of service, Social Work teams across CLIC Sargent will have to reduce their hours by 20% from mid-April 2020. Additionally, COVID-19 has led to all CLIC Sargent staff having to work from home from mid-March 2020. Despite these significant pressures, the CLIC Sargent team at GOSH has continued to provide a service for all families of cancer patients treated at GOSH. We have also continued to facilitate our weekly parent/carer support group - previously held on the ward but now via virtual meeting.

Managing Safeguarding referrals at GOSH

The Social Work and Safeguarding Teams continue to work closely together. All referrals are now sent via EPR to Social Work and Safeguarding. There is a Social Work and Safeguarding Hub Meeting (SWASH) to discuss any child protection level referrals. The duty social work manager and duty social worker along with the duty safeguarding nurse make an initial decision to agree initial tasks required. Operational delivery of services remains largely completed by the social work staff. Information gathered in SWASH and the planning decisions are recorded on the EPR for each child. For complex cases, there can be several joint safeguarding and social work discussions per day.

2014/15	2015/16	2016/17	2017/18	2018/19	2019/2020
1183	945	1510	1392	1261	1840

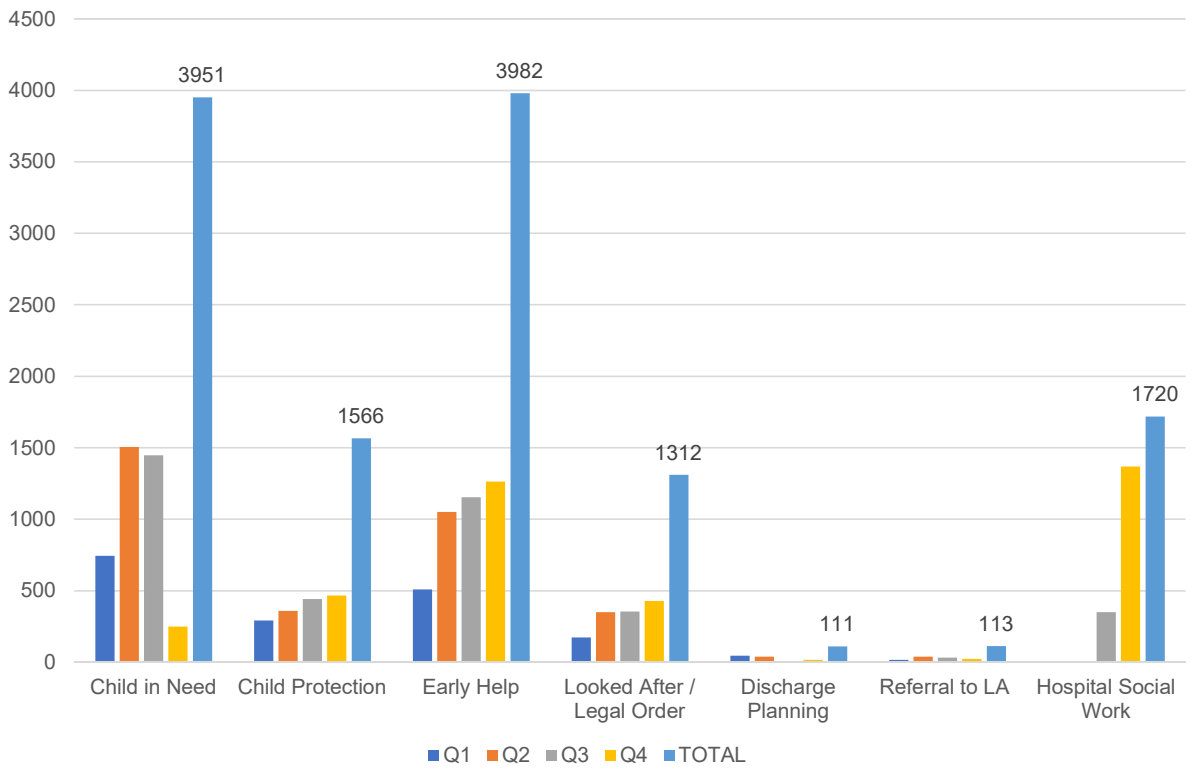
Referrals to GOSH social work department are based on data from EPR. This is shown in the table above and shows the total referrals for the year is 1840. This is a 76% increase with social work now responding to over 500 referrals per quarter since Epic was fully embedded in Q3. CP-IS notifications account for a large proportion of this increase as we are now notified of every single patient who is in care of the Local Authority or is subject to a Child Protection plan via this automated system.

Local Authority referrals

GOSH social workers have referred 113 patients to Local Authority social services. There is a separate section on EPR to record referrals.
CLIC referrals: CLIC Sargent introduced a new duty system in September 2019. All new referrals are now received via EPR. However, we also received referrals for closed cases where families require additional support or a safeguarding concern has arisen. In 2019 / 2020, we received a total of 345 referrals to the CLIC Sargent team. Most of these referrals came via EPR, although others were received via drop-in or to CLIC Sargent Live Chat service.

GOSH Social Work Service

Social Work Activity by Intervention 2019 / 2020



In 2019 we created a new category of Hospital Social Work for work that has safeguarding elements or high social needs but does not meet threshold for Local Authority Safeguarding input whether that be Child in Need plans or Child Protection plans. Consequently Child in Need recording in Q4 declined substantially as recording moved across to Hospital Social work. Henceforth, Child in Need will be the category of activity used only for cases with Safeguarding issues. What was previously logged as disability will fall under Hospital Social work.

Child protection includes work carried out for children who are subject to a Child Protection plan or have current concerns that meet the threshold for a Section 47 Child Protection investigation.
Early Help refers to work undertaken primarily by Family Support Officers to assist families with practical matters such as debt, housing matters, welfare advice and making charity applications.
The total number of interventions for social work is 12,755.

Safeguarding Adults & Mental Capacity

Adult patients seen at GOSH in 2019/20:

Type of contact	Numbers	
	2019/2020	2018/2019
Admitted as an inpatient. (this includes cardiac MRI) *	582	671
Outpatients (2017/2018)	5600	6392
TOTAL	**6182**	**7063**
Top 5 admitting specialties:		
Cardiology	332	553
Urology	6	32
Dental & Maxillary Facial	13	25
Neurology	33	9
Plastic Surgery		
Spinal		7
Rheumatology	6	7
Immunology	13	
Neuromuscular	19	
Gastroenterology	19	
Oncology	6	

- Current data available does not distinguish between day cases and overnight inpatient stays.
- The reduction in the overall number of adult patients seen at GOSH is partly explained by the COVID-19 pandemic which resulted in a reduction in non-urgent cases at the end of the year. It is also the first year that EPIC has been the main source of data, which may also have had an impact.

Training

- Level 2 Safeguarding Adults training is mandatory for all qualified staff at GOSH. This is currently a 30 minute assessed e-learning module.
- Compliance with Safeguarding Adults Training: Level 1 = 95% Level 2 = 93%
- Additional Safeguarding Briefings have been delivered to the specialties with the most adult patients.

Supporting the local safeguarding system

- GOSH attends the Camden Safeguarding Adults Partnership Board meetings and the Quality and Performance Sub-group. A representative from GOSH has attended 100% of Board Meetings and 75% of Sub-group meetings.
- Quarterly reports are provided to Camden CCG to demonstrate our compliance with the North Central London Sustainability and Transformation Partnership's Safeguarding Adults Quality Assurance Framework.
- The Senior Nurse Specialist for Safeguarding Adults and Children/MCA Lead represents GOSH at the London Safeguarding Adults Provider Forum and MCA/DoLS Network. 75% of these meetings have been attended.

Safeguarding Adult Reviews (SARs)

GOSH has not been asked to contribute to any new Safeguarding Adult reviews in 2019/20.

Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS)

- The Senior Nurse Specialist is the Trust MCA Lead and works closely with the Learning Disabilities Team.
- An interdisciplinary MCA Group meets quarterly to develop policy/strategy; provide pragmatic advice to decision makers; and, provide co-supervision, support and agreement around capacity issues.
- Training on MCA and DoLS is included in Level 2 Safeguarding Adults training and a training package has been developed to provide further training for key staff.
- Preparation for the implementation of Liberty Protection safeguards, in accordance with the Mental Capacity (Amendment) Act 2019 has taken place. The Code of Practice to accompany this legislation is awaited.

Policy and procedures

- The Safeguarding Adults Policy remains up to date
- The MCA Policy has been updated to reflect a Supreme Court ruling relating to the deprivation of liberty of young people aged 16 & 17 years.

Training

Substantive Contract Holders

- Staff are required to complete 2 hours of Safeguarding Children Level 3 training each year to maintain compliance. This is achieved through either attending a face to face course or completing an online module.
- Staff must attend a face to face session at least once over a 3 year period. In May 2019, the compliance level was 77%. In May 2020 compliance is sitting at 84%, continuing to show good improvement
- The Safeguarding Team and the Learning and Development team are reviewing the existing training model for Safeguarding Children Level 3, considering options of how staff can achieve the required level of competence and increase the levels of compliance.
- All face to face training for Safeguarding Children Level 2 and Level 3 is being delivered using internal resource.
- Compliance for Prevent Level 3 now stands at 91%, an increase from 88% in May 2019.
- Compliance for Safeguarding Adults Level 2 in May 2020 is 94%, an increase from 89% in May 2019.

Staff compliance as of 31 March 2020

Safeguarding Children	Staff compliant	%
Level 1	1459	95%
Level 2	492	95%
Level 3	2287	84%
Level 4	2	100%

Commentary:

At the time of the CQC inspection the Safeguarding compliance for staff at Level 3 reached 95% This required a concerted effort at all levels in The Trust.

The current figures are disappointing but need to be considered within the context of COVID-19.

The Safeguarding Team are working to develop different models for staff to follow to achieve their compliance.

A clear pathway for Honorary Contract Holders to adhere to, will be incorporated into the policy by Human Resources.

Honorary Contract holders

- Honorary Contract Holders compliance for Safeguarding Children level 3 remained below that of substantive staff despite regular efforts to address non-compliance during 2019/20
- As part of the CQC inspection during the year, increased focus on medical staff completions on the topic increased compliance levels to the 90% target in November 2019, however these have since fallen back again to below target and as of May 2020 stand at 61%.
- Safeguarding Adults Level 2 for honorary contract holders is 69% as of May 2020.
- Compliance for Prevent Level 3 now stands at 69%.
- The Honorary Contracts policy is currently being rewritten and is expected to be approved in June 2020. The new policy sets out more clearly the roles of Honorary Contract Holders, Hosting depts. and the trust in ensuring that honorary contract holders play in remaining compliant in statutory and mandatory training together with the consequences for non-compliance.
- Under the new policy, non-compliant individuals will have their contract terminated if they have not completed the relevant training or provided evidence of completion elsewhere within 6 weeks. This automatic termination process will be supported by increased monitoring of training supplied to the Directorates by the HR team.

Supervision

The importance of safeguarding supervision is a recurrent finding in the analysis of Serious Case Reviews.

The Trust recognises that clinical supervision is essential to professional development and helps the supervisee develop confidence in decision making.

Supervision is delivered in various formats to ensure that clinical experts can benefit from bespoke models applied alongside educational opportunities within their own highly specialised area such as the monthly Child Abuse Pathology Meeting.

The Planned Supervision data now provides a more accurate reflection of the work undertaken across the Trust and includes,

- Safeguarding individual and group sessions
- Social Work Supervision data
- Complex Gastro MDT sessions
- General pediatrician peer review
- Leadership, supervision and safeguarding sessions for GOSH Staff who have undertaken the London South Bank University (LSBU) post-graduate safeguarding module to assist with embedding the learning from the course.
- Attendance at psychosocial meetings in wards and departments to strengthen and standardise the model employed across the Trust, complementing the presence of social work colleagues who currently provide a level of safeguarding oversight and ensure that safeguarding concerns are identified and responded to in a timely and appropriate manner.
- Two members of the safeguarding team were able to complete the safeguarding supervision course in January 2020 meaning that 5 staff within the team have now completed a recognised safeguarding supervision training.

	Planned sessions	Planned Staff No.	Planned Case No.	Unplanned Sessions	Unplanned Staff No.	Unplanned Case No.
2018-19	67	801	264	134	165	164
2019-20	498	1153	1549	659	653	707

- There has been an increase in cases and staff numbers for both planned and unplanned supervision across the year, even though in line with Trust Guidance we have had to suspend group supervision since the start of the COVID-19 pandemic.

- The unplanned supervision figures have increased in keeping with further supervision we are providing to staff working in the increasing general paediatric patient population and liaison with other hospitals in the NCL network.

Future developments in supervision are planned in the following areas:

- Integration of supervision documentation in EPR has been requested.

- Capture of Psychological and Mental Health Service (PAMHS) supervision data.

- Continue to target team days and newly qualified preceptorship programmes.

- Lunch time drop-in supervision sessions for CNS and ANP's were due to commence in March 2020. These have currently been postponed due to COVID-19 but will be rescheduled as soon as the situation allows.

Audit

Internal:

Learning from Serious Case Reviews and Experiences of Supervision
The audit sought to provide assurance that professionals are embedding the learning into practice from recent SCRs that the Trust has contributed to. The response rate had increased from the previous audit.
Key findings were overall positive with the vast majority demonstrating an awareness of best practice through the scenarios, but there were 3 areas for improvement identified for which an action plan has been developed to address the issues.

1. Awareness of staff to make timely referrals to safeguarding and social work when presented with a patient with unexplained bruising.
2. Understanding of the concept of safeguarding supervision
3. 53% of respondents had seen the Safeguarding Newsletter,.

Voice of the Child
The learning from the audit demonstrated a low level of documentation of The Child's Voice.
The impact is Trust wide and not limited to Safeguarding alone.
The template for reporting to Child Protection Conferences will be amended to ensure capture of the The Child's Voice, and key messages to be included in safeguarding training and dissemination via Trust wide communication systems.

Mental Capacity Act (MCA)
The audit was initially completed which demonstrated that there is scope for improvement in understanding the MCA.
The compliance with the MCA was re-audited in Q4. This demonstrated that there continues to be scope for improvement in understanding the MCA.
This will be addressed by a) implementation; b) Increased training on the MCA.
Further audit to be competed later in the year.

Current audits in progress

Was Not Brought Audit (WNB)
Data is now being collected regularly around WNB.
The audit was delayed due to COVID-19.
However we will now also be capturing those patients who are due to be admitted electively for procedures. There will need to be careful consideration of the risks that may be posed to the child from non attendance against widespread parental anxiety existing across the country to bringing children to hospital following the impact of COVID-19.

External:
Safeguarding Children Boards undertake a schedule of multi-agency audits as part of their statutory function under Section 14 Children Act 2004 to monitor the effectiveness of safeguarding practice.

The Trust has participated in 1 multi-agency audit requested by Local Safeguarding Children Partnerships:

Hackney - Thematic Audit of Children and Young People living with mental health issues. We are awaiting the learning from Hackney.

Camden – Thematic audit in relation to older children in need of help and protection. Even though one child was known to GOSH, they had only been seen once. As this date fell outside of the scoping period, we were not required to contribute.

GOSH actions:
Each area of learning is included in core safeguarding training and reinforced through supervision.

Safeguarding across the Trust

Directorates

- The Named Professionals link with the Deputy Chiefs of Service to ensure that key safeguarding information is embedded into practice within each of the directorates, including any learning from Serious Case Reviews.
- The Safeguarding Team links various disciplines across the Trust.
- The Specialist Nurses attend Practice Educators meetings regularly.
- Safeguarding Newsletters are produced 6 monthly to provide an update to all staff.

Named Doctor Activity

- The year has been very busy supporting clinical teams to reflect on and address a range of safeguarding and child protection issues that have necessitated referral to local children's social care departments. The role is vital to promote trusting relationships with clinicians in order to progress the concerns they may have about the welfare of children in a constructive manner.
- Supporting colleagues to write reports for child protection conferences or court, or producing overview reports on behalf of all the clinical teams involved.
- Key role in supporting colleagues to deliver the new 24/7 safeguarding general paediatric medical rota which commenced in March 2019, being one of five consultant general paediatricians on the rota .
- Regular Peer Review sessions with the general paediatricians took place, with supported attachments of a number of the general paediatricians to community child protection assessment clinics in Camden to consolidate and refresh their child protection skills. This new service ensures that there is a consultant general paediatrician to advise and assess children when there are urgent child protection issues arising out of hours and in the main involves children admitted with injuries to the Paediatric Intensive Care Unit.
- Bespoke training continues to be offered to specialist medical and nursing teams across The Trust.
- The current Named Doctor retired in March and will be returning to develop a Perplexing Presentations Support Service in May 2020.

Early recognition and management of Perplexing Presentations

- Discussion and advice regarding complex cases involving perplexing presentations are led by either the Named Doctor or Deputy Named Doctor who also liaise extensively with health teams outside the Trust.
- Perplexing presentations are defined as the presence of alerting signs (in the child or in caregiver behaviour) suggesting the possibility of FII, when there is no risk of immediate serious physical harm to the child's physical health or life.
- The essence of the work is encouragement of recognition of alerting signs by all professionals within GOSH a) through training and consultation and b) formulated steps in response to reports of alerting signs.
- The work has been led by a consultant with 2 PAs (deputy named doctor for safeguarding) and supported by skilled and dedicated, but ad hoc, involvement of the GOSH safeguarding team.
- In the year April 2019 – 2020 there have been 35 new cases referred to the safeguarding team and continued involvement with approximately 20 previous referrals. A detailed database of the cases and their management has been constructed and is being 'populated'. The time taken to consult to the management of these complex cases varies from a few hours to several days (not consecutively).

Psychological and Mental Health Service

- Safeguarding remains an important issue within the newly merged Psychological and Mental Health Service (PAMHS).
- PAMHS Clinicians continue to liaise with the GOSH Social Work and Safeguarding Teams as needed, when safeguarding issues arise, as well as with external agencies and social services as appropriate.

Since March 2020, as a result of the COVID-19 pandemic, paediatric services across North and Central London have been reconfigured. GOSH has admitted significantly more acute general paediatric presentations. A significant number of these have mental health and safeguarding issues. The existing structures in place at GOSH regarding safeguarding have helped us to manage such cases safely and appropriately.

Practice Development

Safeguarding policy development

Safeguarding continues to be a rapidly changing and growing area of work.

Work has been underway to review and update all safeguarding guidance with the development of new areas for example safe usage of cannabinoid oil within medicine.

Safeguarding Links

- The Safeguarding Links are health professionals across the Trust who provide an important and effective means of disseminating information and good practice across the organisation.
- They act as role models to front line practitioners and be champions of safeguarding within their local areas.
- The Senior Safeguarding Nurse Specialist co-ordinates quarterly meetings with the links, with support from the Safeguarding Nurse Specialists and Senior Practitioners from the Social Work team.
- A system of 7 minute briefings on a range of safeguarding topics are disseminated to help the links cascade information to update staff within their areas and to support staff in identifying concerns early and referring these appropriately.
- Topics covered in 2019/20 include: Learning from Serious Case Reviews, Domestic Abuse, Criminal Exploitation and Neglect.

Child Protection Information Sharing System (CP-IS)

- In conjunction with NHS Digital The Trust became the first health organisation in England to implement in August 2019 CP-IS for scheduled patients as well as those patients receiving unscheduled care.
- The system has been developed and supported by ICT and the Safeguarding Team to alert clinical professionals who are managing the patient, being automatically embedded into the patient's electronic record.

National Named Professionals Tertiary Network

GOSH hosted a day which brought together Named Professionals from across the country to discuss the challenges faced by tertiary hospitals.
The Network has grown and now includes representation from 11 trusts.

European Children's Hospitals Organisation (ECHO)

The Safeguarding Team have undertaken a exercise, using an international research tool which was disseminated amongst the 13 members of ECHO in order to further understand the challenges encountered in different cultures and benchmarking best practice in safeguarding.

Although the structure of safeguarding is diverse many of the challenges faced are similar. We hope to hold our inaugural virtual meeting in July 2020 which has been delayed due to COVID-19.

Performance Priorities 2020/21

1. Recruit to the substantive Named Doctor post.

2. Develop the functionality within EPR to capture data to more accurately reflect the work undertaken across the Trust in relation to Safeguarding, and identify where there are challenges as well as the existence of good practice.

3. Seek agreement and implement the new training strategy. Expanding training opportunities to meet the needs of the workforce and provide greater flexibility in the programme for those staff who are require Level 3 core and specialist competencies.

4. In addition to the Strategic Safeguarding Committee (SSC), regular monthly meetings will be established to monitor the Safeguarding Risk Register along with any cases that involve allegations against staff and volunteers.

5. Complete the business case for supporting resources for the Perplexing Presentation Support Service.

6. Continue to promote the safeguarding supervision agenda and explore further ways of increase access to more staff.

7. Increase compliance across the Trust with the MCA and prepare for the introduction of Liberty Protection Safeguards.

8. Support the Camden Children Safeguarding Partnership priorities:
    - Domestic Violence & Abuse
    - Transitional Safeguarding (for young people aged 14-24 years)
    - Vulnerable parents and safeguarding in the first 1001 days (following birth)
    - Safeguarding Children during COVID-19

Attachment V

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
15 July 2020

GOSH Sustainability pages: Annual Report 2019/20 **Submitted by:** Nick Martin, Head of Sustainability and Environmental Management	**Paper No: Attachment V**

Aims / summary:

Paper includes suggested pages for inclusion in the 2019/20 annual report 'Sustainability Section'. Aims to outline GOSH's progress in regard to our Sustainability activity and ambitions across the year and going forward.

It includes a number of sections covering work completed across the year including;

- a quote from the CEO outlining the view reached by GOSH of the current Climate & Health situation
- detail on GOSH 'Play Street' activity and links between improving air quality & the benefits of children's play
- GOSH's Strategy 2020-2025 that formally outlines our commitment to prioritising a long term, embedded and ambitious approach to 'protecting the environment' within the strategy.
- Planning around the Climate & Health Emergency and adopting a carbon neutrality goal
- Staff action and involvement through our new digital 'environmental & wellbeing behaviours app/platform'.
- The role of our new Sustainable Development Management Plan
- Great Ormond Street Public Realm and the integral link into our sustainability and well-being goals
- Energy & associated Carbon summary and data
- Waste & Recycling summary and data
- Green Champions activity summary
- Other Green achievements for the year

Action required from the meeting

To assess the submitted sustainability pages in advance of them being used within the 2019/20 GOSH annual report

Contribution to the delivery of NHS Foundation Trust strategies and plans

Measuring, monitoring and reporting on sustainability through the annual report supports the assurance process for meeting legal, reputational and policy requirements.

Annual Sustainability Reporting is mandated for CCGs and Trusts through the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and by the Foundation Trust Annual Reporting Manual (FT ARM); and from Arm's Length

Bodies through the Greening Government Commitments. Along with regularly updated Sustainable Development Management Plan, annual reporting on sustainability is mandated by the NHS Standard Contract (Service Condition 18).
Financial implications **N/A**
Who needs to be told about any decision? Nick Martin/ Steph Williamson/Andy Bowman
Who is responsible for implementing the proposals / project and anticipated timescales? Nick Martin/Magali Thomson
Who is accountable for the implementation of the proposal / project? With Steph Williamson leaving the Trust and being replaced by Andy Bowman (interim) and Zoe Asensio Sanchez (permanent) accountability looks like: July: Steph Williamson August: Andy Bowman August/September ongoing: Zoe Asensio Sanchez

Sustainability Annual Report 2019-2020

This has been a big year for GOSH in terms of building on previous sustainability achievement, through consolidating and broadening our activities, reaching out to wider partners, involving more GOSH people and embracing an increasingly ambitious agenda. We believe we have set the foundations for a ground breaking 2020-2021 and decade to come! However now, we'd like to take this chance to reflect on the past year in sustainability at GOSH.

Mat Shaw our CEO wrote in the forward of our new Sustainable Development Management Plan:
"At GOSH we work hard to create a healthier future for children and young people. Climate change is widely acknowledged as the most significant global health issue and our patients, families and staff have told us that minimising our collective impact on the planet is something they really care about.
Becoming an environmentally sustainable organisation starts with sending a clear and unequivocal message that this stuff *really* matters. We need to declare our intentions, spell out what sustainable behaviours at GOSH look like, commit to taking action individually and collectively every day, and stay accountable to each other and to the children and families we serve. The Sustainable Development Management Plan (SDMP) is the tool that helps us to do this.

As a clinician I know how difficult it can be to make sustainable choices in a hospital, especially when you're dealing with the immediate needs of a sick patient and their family. Clinical and non-clinical – all our staff are working hard to play their part in providing the best possible services. We need to embed sustainable business practices across the organisation to help make it as easy as possible for them to make the right choices in the moment.

The revised Trust strategy reflects the increasing importance of collaborating with the wider healthcare system as a force for good in children's health. Partly, this is about contributing the expertise of our clinicians and research teams towards efforts on population health – playing our part in preventing the causes of ill health as well as treating and eradicating disease. By working with other public services and our contractors to become a clean air hospital, we will improve the air quality for our patients and the local community – and lead the way as an example for other hospitals looking to do the same".

A holistic approach to the Air Pollution challenge

GOSH Play Street: Play and Sustainability teams creating together

We believe that the sustainability of our ecological systems is integrally connected to people and children. It reaches globally and into our communities, as well as being deeply individual and personal. On an organisational level it involves leadership and decision making that prioritises both immediate and longer term mental, emotional and physical health & wellbeing benefits to people. We want our sustainability vision to be led by and for the children in our care and to support finding solutions to broad climate and ecological challenges and associate health impacts.

A great example is through GOSH Play Streets. Play is a priority at GOSH, the Play Service consists of 43 staff, both Play Specialists using playful techniques to support the therapeutic interventions and Play workers, building relationships with Patients, reducing boredom and facilitating opportunities to play with mess and risk and follow their desires and whims. They reduce anxiety around strange environments and mysterious procedures. They remind families that fun is still possible even in the most terrifying times.

Play is a human right, but what does this mean if one can't access play opportunities? In an environment that is polluted and surrounded by heavy traffic not play and community interaction is shown to be reduced as spaces are dominated by vehicles. In the same way that GOSH strive to humanise the clinical environment we can also extend this outside of the walls of the hospital and bring play outside, giving an opportunity Children and young people being treated at GOSH and those living in the local community to occupy the same spaces and play together.

As a children's hospital, GOSH has paid particular attention to engaging their many young patients. Patients have been engaged through the GOSH school on clean air messaging. Play specialists and play workers have been engaging with children about clean air and its benefits, including activities where children design their own clean air superheroes. A cross Trust team worked on piloting a 'Play

Street' event on Great Ormond Street in June to redraw some of the power relationships between cars-people, adults-children, sick-well, hospital-local community. GOSH's Young People's Forum continue to discuss why they think it is important for hospitals to take action on air quality.

Clean Air and Car Free Day 'Play Streets'!

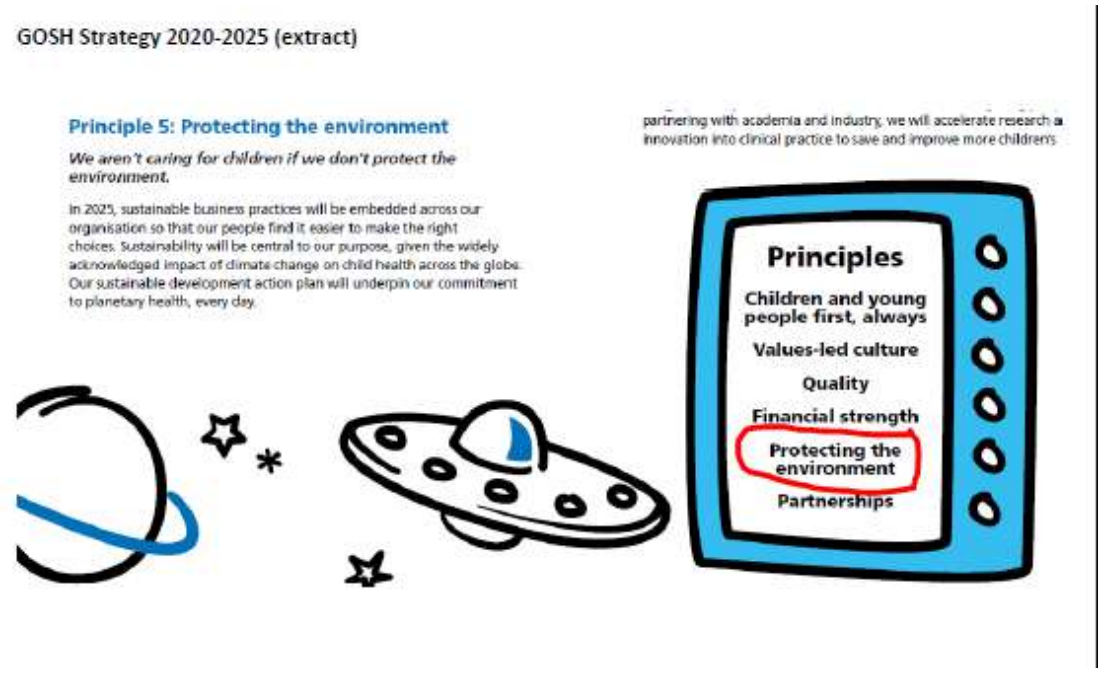
Our Play Street events are not a spectacle, festival or fundraising event. The essence of Play Streets are that they reclaim space for interactions to happen. Comments received after the last Play Street were 'everything feels so calm', 'the atmosphere throughout the hospital is amazing', 'I feel so proud to work here today'. Taking a Playwork approach to a Play Street outside Great Ormond Street Hospital felt quite radical, we let play happen here and made it as inclusive as we possibly could.

Our 2 Play Street events – run in June & September – achieved various key things that we plan to build on next year. They brought the local community and children together in design and delivery of the Play Streets and transformed a more hostile environment into a calm and welcoming one for staff, patients, neighbours and local businesses. We brought together diverse people including the Dep Mayor of London, Walking & Cycling Commissioner & CQC Inspector with patients, school children and staff members to play. Whether it was hopscotch, dancing a ceilidh, building towers from cardboard boxes, penalty shoot outs or plant potting, fun was had by all and a seed was sown for a better Great Ormond Street in the minds of all.

Commitment to a long term sustainability vision

GOSH Strategy 2020-2025

GOSH has committed to a long term vision, putting the need to 'protect the environment' at the forefront of its activity acknowledging that, "We aren't caring for children if we don't protect the environment".



As one of the 6 key principles that will guide the organisation this attitude and practice will become normalised and embedded in all we do both operationally and culturally. This high level ambition will be met through delivering on many lower level goals and activities as well as creating new business practices across the Trust. Exciting times ahead!

The Climate & Health Emergency

As well as working towards being part of the solution GOSH has spent much of the year planning our broader strategic approach. There is a clear acknowledgement from patient to Trust Board level that Climate Change is a threat to both planetary and human health – especially children and more vulnerable people - and that GOSH has the desire to assume a leadership role in response to this Emergency. We will do this through setting an ambitious Carbon Neutrality goal, that will power our journey across the decade to come. We'll shortly complete the necessary detailed carbon analysis allowing for methodical, targeted and transparent progress towards our goal, in parallel with a programme of deep engagement and innovative collaboration and partnerships.

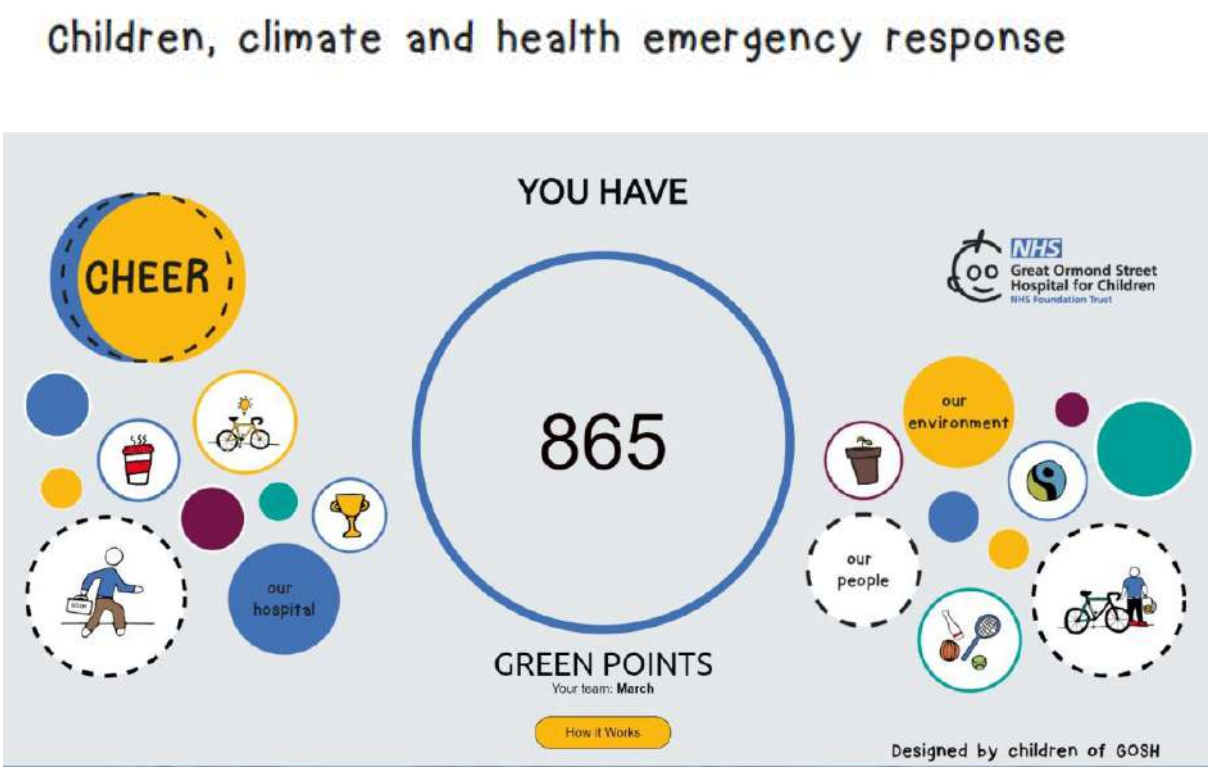
Our Young People's Forum (YPF) and patients where possible are at the centre of this. They are passionate and involved in this work and will be key to governance on the journey to come.

In a statement, backed up by her YPF peers Rose Dolan said, "*"In our planets current state, the declaration of a climate emergency is an obvious decision to make. This is the only way for Great Ormond Street to publicly show that the hospital are seriously considering the issue of climate change and are committed to holistically caring for the future generation's health, beyond the clinical terms. As a chance to showcase the hospital's work so far, and their plans for the future. It is an opportunity for the hospital, trusted by so many to use their influence and resources in a positive manner and spearhead the climate movement among similar healthcare organisations.*

The declaration of a climate emergency, in my opinion, will only serve to improve GOSH's reputation as a hospital of strong morals and an innovator that is prepared to adapt to the challenges of time".

Similarly it's vital that staff respond to this 'call to action' from across the organisation including clinically. One of our Consultant Intensivists Mark Hayden said," *"Like many other Paediatricians I find myself at a moment of crisis. Both a global and personal one. Over the course of my career a situation that will do far more harm to my patients than any good I have done has arisen. With this knowledge it is unethical for me as a doctor to continue business as usual and further damage the health and future of my patients by lifestyle choices not available to most of the planet. I feel compelled to use my understanding of the clear science around the causes of the climate emergency and air pollution, its causes and its effects on human health and nature's biodiversity to advocate for local, national and international truth telling and urgent action I believe that the candid declaration of truth that we are already in a climate emergency backed up by decisive sustainable changes at GOSH will resonate across the world where GOSH is rightly held in high regard and have a major impact".*

Staff involvement and action

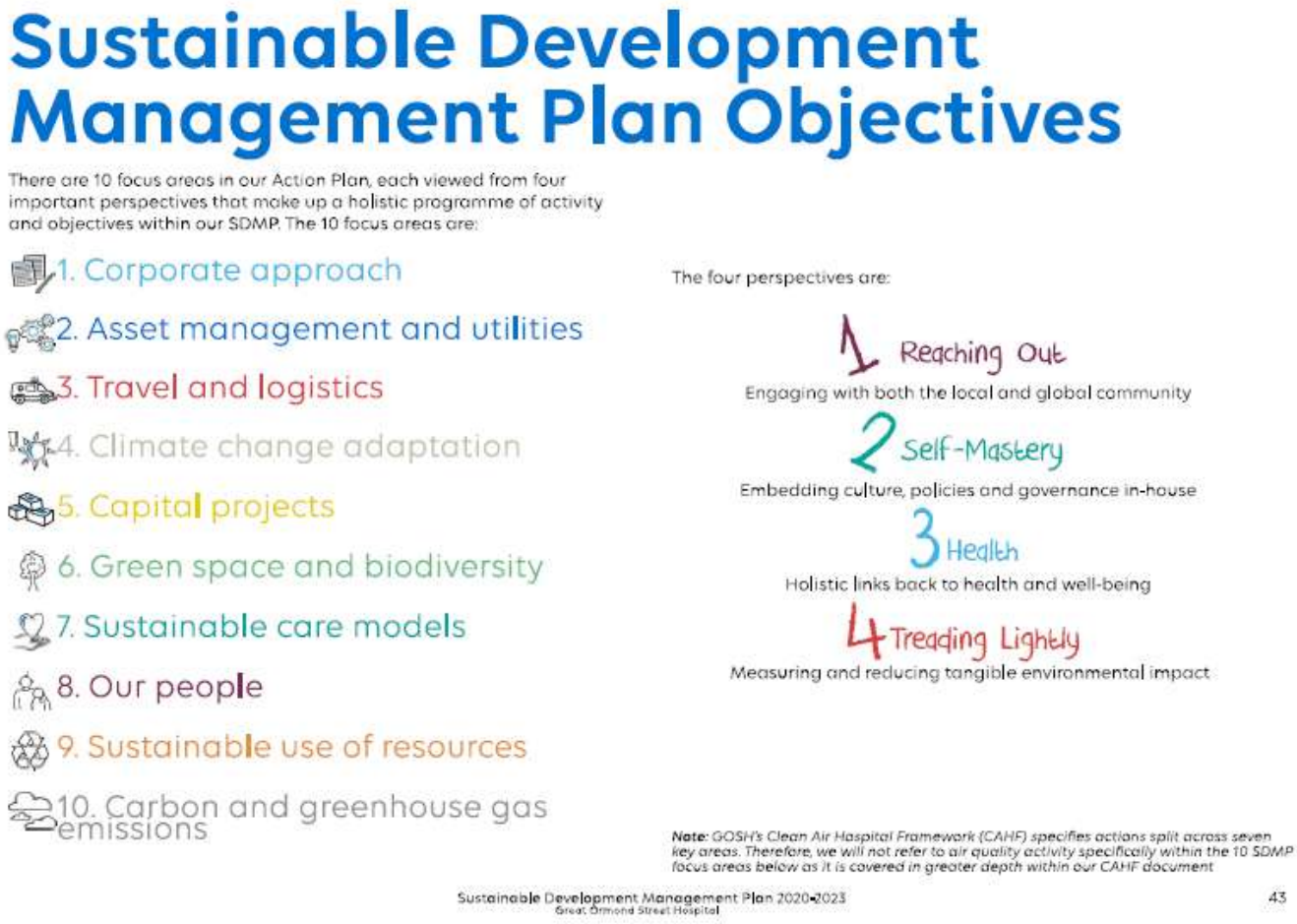


CHEER for GOSH: Working with an external partner, GOSH has designed an environmental and wellbeing behaviours platform/app to encourage, measure and add an element of fun & competition to staff behaviours that will contribute to the overarching sustainability & wellbeing goals. It will also translate actions into carbon reductions using the latest methods.

Children, climate and **H**ealth **E**m**E**rgency **R**esponse (CHEER) allows GOSH staff to become fully involved in becoming the solution. We have just begun a pilot launch of the platform with our staff champions and aim to launch fully across the organisation in the coming months. The platform has been designed in collaboration with staff – who chose the array of actions we'll be measured on – and our Young Person's Forum who designed the logos above that represent the actions we'll be taking.

Our route map underpinning our actions

Our new Sustainable Development Management Plan (SDMP) underpins and lays out a holistic road map of sustainability actions to 2023. It covers 10 key focus areas from 4 important perspectives.



This holistic approach and view – of what is a complex & multi-faceted organisation – helps us to present the challenge down into smaller parts that cut across GOSH and involve all of its people. The 10 focus areas are viewed from 4 perspectives allowing us to bring maximum benefit from the interventions we take ,in terms of how we communicate to the world, tidy our own house, demonstrate links into health & wellbeing as well as maintain a focus on Carbon and measurement. The SDMP is a key element underpinning our commitment to planetary care!

Great Ormond Street Public Realm forms an integral link into our sustainability & wellbeing goals

The creation of a dedicated role looking at public realm is a demonstration of the commitment from GOSH to address the experience of our patients, families and neighbours arriving at GOSH, and also the impact we have as an institution on our surrounding community.

Phase 4 of Great Ormond Street Hospital's Redevelopment Masterplan, the Children's Cancer Centre, will be a national resource for children with rare and difficult to treat cancers. The centre will be the physical embodiment of the aspiration to improve outcomes for children, and will replace the existing frontage buildings on Great Ormond Street.
This new building on Great Ormond Street provides us with an opportunity to address the hospital's relationship with the street, and the city beyond it, with the potential for a new, more permeable threshold, (re)integration of the hospital with its community and a healthier street environment.

The most recent additions of the Zayed Centre on Guilford Street, and the soon to open refurbished Sight and Sound Centre on Queens Square illustrate the fact that the hospital is becoming more of a campus beyond the island site, meaning the routes between the various buildings take on more significance.

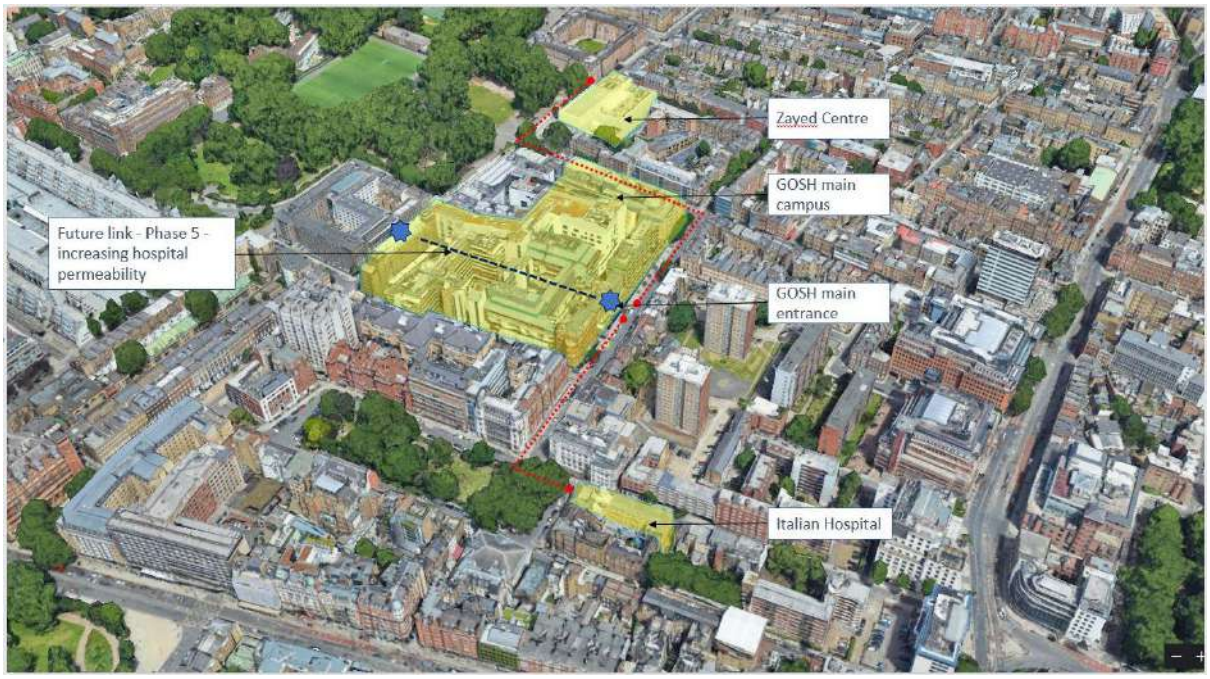


Figure 1 GOSH campus

Currently Great Ormond Street suffers from being congested, noisy, polluted, often the setting for angry scenes and not being child-friendly in any way. This is further compounded by poor way-finding from Russell Square tube station, resulting in a negative and often stressful arrival experience for newcomers to GOSH.

Figure 2 Some current issues

Our architects BDP's proposal for the Children's Cancer Centre shows an improved pedestrian experience for Great Ormond Street in a number of ways including greater activity and visual connection between the hospital and the street; the provision of a café and outdoor seating; planting; more accessible surfaces and crossing points as well as a reduction in width, which would help with safety and access and create a visually more attractive and stimulating environment.

As the design is developed with respect to the building itself, we are also working on a vision and brief for the street. The desired outcome is for a health led and child-friendly approach to the design of the street, which will result in an improved relationship between the hospital and its surrounding Bloomsbury community.

This work includes:

- Engaging with our patients, staff , families and the YPF
- Understanding who our local community are, and engaging with them with respect to the street and what they would like improved
- Collating and analysing air quality data on the street currently
- Using the Clean Air Hospital Framework to establish a key set of recommendations which will help us reduce the amount of air pollution that staff, patients, visitors and surrounding community are exposed to
- Liaising with Camden and TfL and using their Healthy Streets Strategy to inform our vision
- Also working with the Urban95 criteria which puts you in the feet of a 3 year old child (95cm tall) and asks you to understand their view of the city from this perspective. This is particularly relevant as children are this height are even more vulnerable to pollution.

Our overarching Sustainable Development Management Plan (SDMP) requires sustainability to be embedded into everything we do at GOSH, and public realm relates to all our objectives, especially travel and logistics; climate change adaptation, green space and biodiversity, our people, sustainable use of resources and carbon and greenhouse emissions.

These, alongside the UN Sustainable Development Goals, give us a framework to work towards, and are guiding our work creating a vision and brief for the public realm.

Figure 3 YPF Public Realm Workshop

Figure 4 TfL Healthy Streets

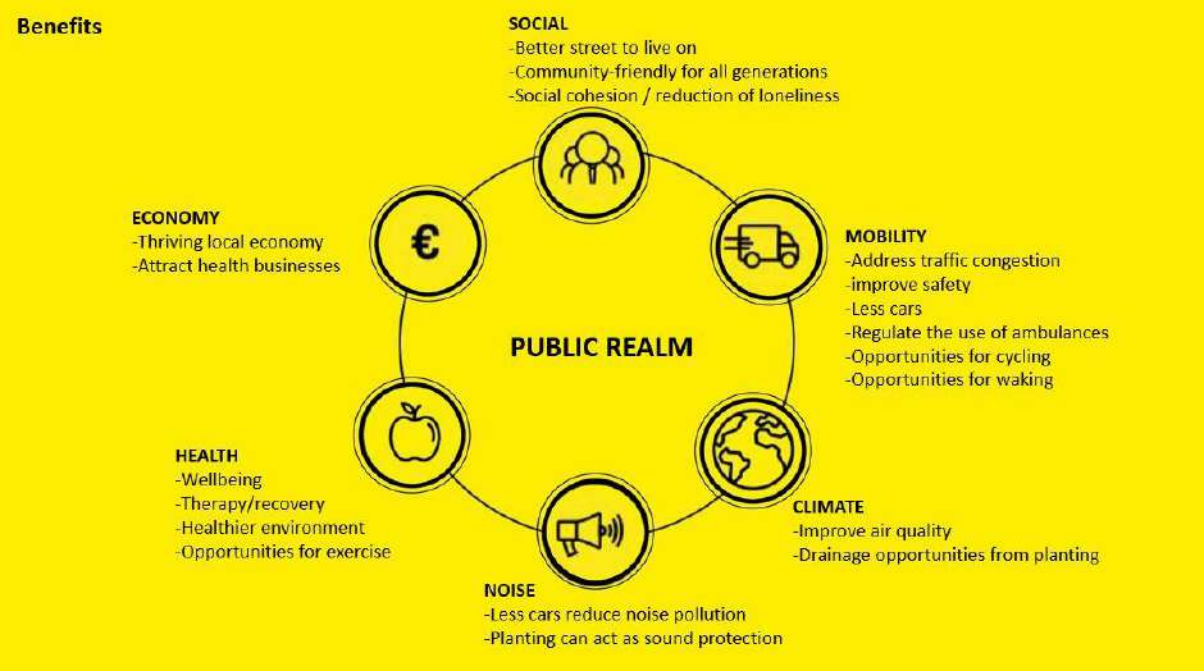


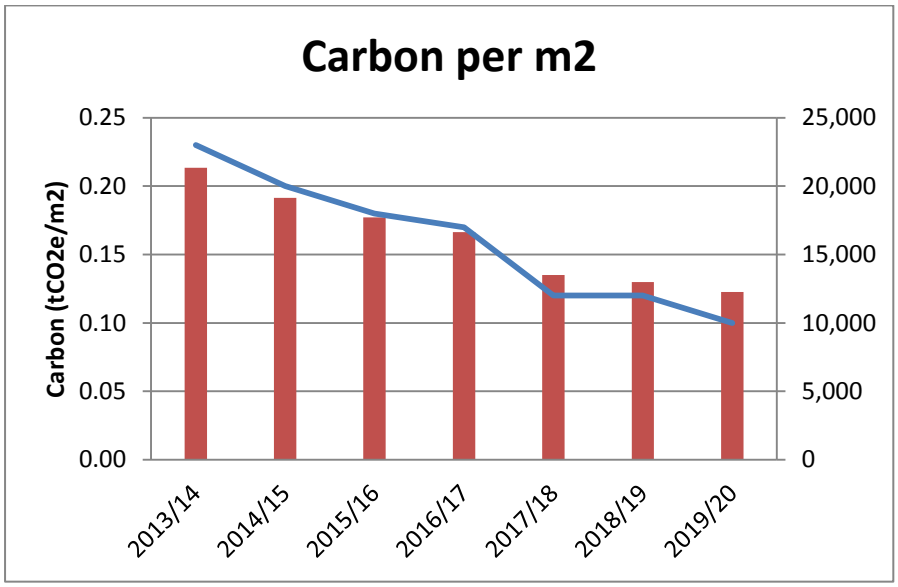
Figure 5 Benefits of an Improved Public Realm

Energy & Carbon

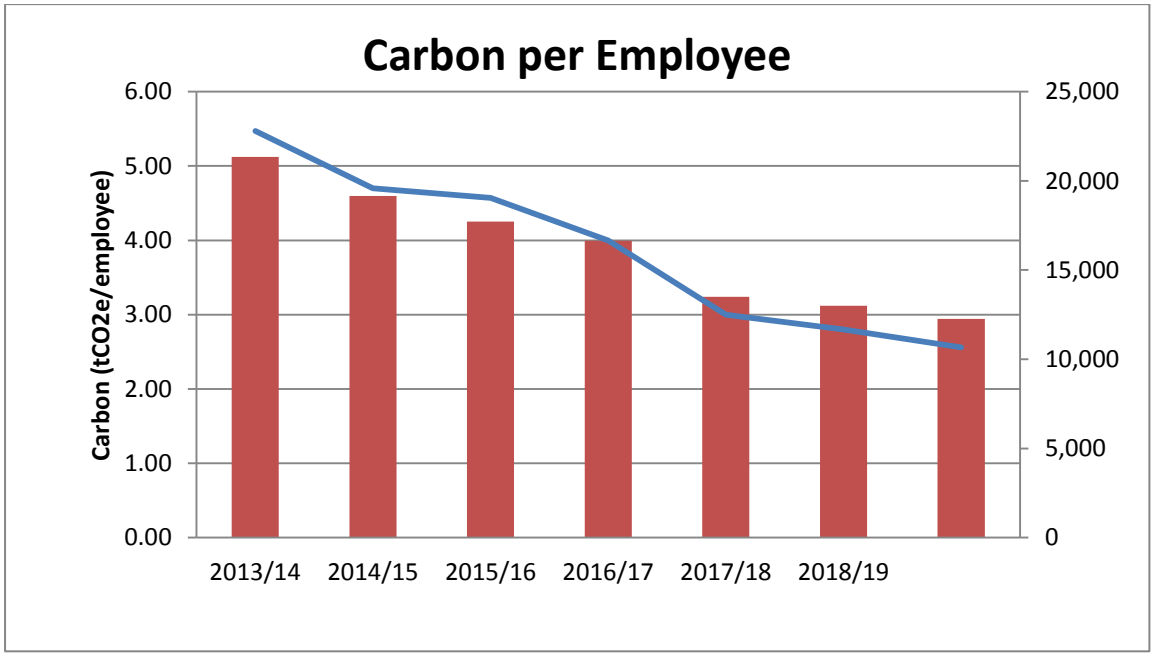
Resource		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Gas	Use (kWh)	41,492,485	39,444,385	40,657,465	38,603,045	39,587,133	42,929,340	42,134,954
	tCO2e	7,675	7,276	7,481	7,109	7,269	7,893	7,747
Electricity	Use (kWh)	27,649,236	25,675,114	24,828,164	27,087,839	22,042,240	19,961,112	19,369,669
	tCO2e	13,666	11,867	10,230	9,523	6,239	5,102	4,516
Total energy tCO2e		**21,341**	**19,143**	**17,711**	**16,632**	**13,508**	**12,995**	**12,263**

Context info	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Direct emissions (tCO2e)	**21,341**	**19,143**	**17,711**	**16,632**	**13,508**	**12,995**	**12,263**
Floor space (m2)	92,199	96,716	95,967	97,290	111,069	111,955	119,461m^2
Total number of staff (headcount)	3900	4082	3879	4127	4469	4663	4786

Context info	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Carbon (**tCO2e/m2**	0.23	0.20	0.18	0.17	0.12	0.12	0.10
Direct Emissions (tCO_2e)	21,341	19,143	17,711	16,632	13,508	12,995	12,263



Context info	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Carbon **(tCO2e/employee)**	5.47	4.70	4.57	4.00	3.00	2.80	2.56
Direct Emissions (tCO_2e)	21,341	19,143	17,711	16,632	13,508	12,995	12,263



Waste & Recycling

Overall waste volumes have seen a significant decrease this year 1,463 tonnes have been generated. This is due in part to the COVID19 pandemic.

The chart below details the waste streams and destinations. There have been some challenges with recycling which has also seen a reduction in volume as less people have been coming to the hospital. There have also been issues with the contamination of the recycling stream and an education awareness programme is being developed to address this. Other recovery waste streams which include domestic waste and food composting have also reduced for similar reasons outlined below. Landfill remains around just over 1.5 tonnes and zero to landfill target continues to be the aim. Earlier in the year the waste team had made good progress with the roll-out of the offensive waste stream which saw an increase from 7% to 14 %. This was on-hold during the pandemic and it is planned to continue with the offensive waste stream rollout in the coming months.

We have plans to further develop the online reuse platform for our successful furniture and equipment reuse scheme for internal staff reuse. Staff will now be able to go on to the platform and claim furniture and equipment items that are no longer needed by their colleagues.

During the year there has been a focus on working closely with our laboratory teams, providing auditing and training for staff and assisting with the introduction of sustainable Bio bin cardboard containers for the disposal of non-sharp items. As a result the team have reduced their use of single-use plastics and savings of £9,000 have been projected.

We are planning a significant evolution of our waste service, significantly enhancing its links into the wider sustainability agenda with a focus on operations, education and carbon targets.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Recycling	**265.8**	**283.02**	**342.03**	**390.02**	**442.67**	**458.46**	**304.64**
Other recovery	**963.4**	**1014.2**	**958.95**	**774.93**	**1144.07**	**1068.97**	**552.67**
High temp disposal	**83.52**	**91.29**	**84.39**	**147.98**	**87.71**	**96.94**	**90.51**
Landfill	**6.03**	**2.88**	**0.99**	**0.99**	**0.99**	**1.36**	**1.54**

Green Champions

Our Green Champions have evolved, with a wider membership and increased practical involvement across the sustainability programme. As well as regular idea sharing sessions, they have been involved in post COVID19 active travel solutions, GOSH gardens, office green teams, an indoor air quality pilot, play street delivery, student collaborations, exploring Electronic Patient Record links to air quality data & educational opportunities, the sustainability plans of phase 4 of our master redevelopment master plan, and the design of our new CHEER environmental & wellbeing behaviour portal. We'll be looking at fortifying this increasing confidence and enthusiasm with a more structured, consistent and formally recognised approach.

This year's other green achievements

- GOSH won the inaugural Camden & Islington Sustainability Award for *'improving air quality'* for the Clean Air Hospital Framework.
- Our Clean Air Hospital Framework – created in partnership with Global Action Plan – has been downloaded over 500 times and is being used by other hospitals
- In partnership with other members of the European Children's Hospital Organisation and our YPF, we have created and launched an ambitious 'Green Promise' to them. We'll be delivering and developing this over the years ahead.
- The Sustainability Team has been strengthened by the addition of our Public Realm Project Manager and Sustainability Manager
- The concept of Climate Emergency Physician and Multidisciplinary Teams is being explored
- Our energy use has continued to decrease
- GOSH Play Streets have been formalised and are influencing our perception of our hospital and it's relationship to Great Ormond Street , our public realm and local community interaction.
- A post COVID Safe, Active and Sustainable travel working group has been created to find solutions to ongoing commuting challenges.

Attachment 2

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 15 July 2020	
Great Ormond Street Hospital Annual Quality Report 2019/20 **Submitted by:** Sanjiv Sharma, Medical Director	**Paper No: Attachment 2**
Aims / summary Quality Report submitted for final review & approval. The report has also been presented at the Council of Governors on 14 July 2020.	
Action required from the meeting Comments or amendments prior to finalising and providing approval.	
Contribution to the delivery of NHS / Trust strategies and plans The document describes the quality improvement work that has taken place in line with the Trust's strategic aims of Fulfilling Our Potential, and in line with quality as defined in the Next Stage Review. The document will also declare and outline some of the Trust's quality improvement work for 2020/21.	
Financial implications None	
Legal issues None; the legal requirement for the Trust to produce a Quality Report was removed for due to the COVID 19 pandemic.	
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	

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Quality Report 2019 to 2020

Contents

Cover: Gabriel is eight years old and has been coming to GOSH every week since he was diagnosed with acute lymphoblastic leukaemia – a rare type of childhood cancer. He loves singing and tickles from his Mum.

What is the *Quality Report*?

The *Quality Report* is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The *Quality Report* is a mandated document, which is laid before Parliament before being made available to patients, their families, and the public on the NHS website.

What does it include?

The content of the *Quality Report* includes:

- Local quality improvement information, which allows trusts to:
  - demonstrate their service improvement work
  - declare their quality priorities for the coming year and how they intend to address them
- Mandatory statements and quality indicators, which allow comparison between trusts
- Stakeholder and external assurance statements

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has a long-standing reputation as one of the finest paediatric hospitals in the world. We are keen to share information publicly about the quality of our services and about our continuous improvement work.

Understanding the Quality Report

We recognise that some of the information provided may not be easily understood by people who do not work in healthcare. So, for clarity, we have provided explanation boxes alongside the text.

This is a 'what is' box

It explains or describes a term or abbreviation found in the report.

"Quotes from staff, patients and their families can be found in speech boxes."

What is the NHS website?

The NHS website is the UK's biggest health website. It provides a comprehensive health information service to patients and the public.

What is a Foundation Trust?

A Foundation Trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities. NHS Foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public, and staff, and are governed by a board of governors comprising people elected from and by the membership base.

Enzo is seven years old and is currently receiving treatment as part of a clinical research trial at GOSH. He loves superheroes and playing on his games console.

Our hospital

GOSH had
40,273
inpatients and
193,766
outpatient appointments
in 2019/20.

100%
of our clinical specialities
collect data on outcomes
of treatment.

GOSH has
19
highly
specialised
services.

GOSH has over 50 specialties.

Over
1,290
research studies
active in 2019/20.

GOSH employs
5,065
hospital staff including doctors
nurses, allied health professionals
and administrative staff.

96.9%
of inpatients would
recommend the hospital.

Our strategy – fulfilling our potential

Following a refresh and launch of Fulfilling Our Potential in 2017, our activities in 2019 continued to focus on creating a structure and engaging staff to embed our strategy as a plan for the Trust.

Alongside celebration of the work at GOSH to help children and young people with the most complex needs to fulfil their potential, this year's Open House was our third successful event that celebrated the amazing things we achieve as an organisation. This year's focus was on how we are using technology, providing care, developing and supporting our workforce and continue to help advance important research.

We also used 2019/20 as an opportunity to review Fulfilling Our Potential and in consultation with GOSH patients and families, staff and partners, develop a new five year strategy that will be launched in 2020/21.

We also launched a revised and improved business planning process that saw our clinical and corporate teams work even more collaboratively on their 2020/21 plans to ensure we continue to deliver our priorities.

Other key achievements include:

- Successfully separating conjoined twins, care of whom demanded a close collaboration between more than 100 experts at GOSH – one of the few places in the world with the skills and facilities for this procedure.
- Closing Great Ormond Street and turning it into a Play Street for Clean Air Day and Traffic Free Day.
- Completion of construction of the Zayed Centre for Research into Rare Disease in Children and the transfer of some outpatient services to the Centre.
- Roll out the Safety and Reliability Improvement Programme across the Trust.
- Launch of the GOSH Learning Academy providing first-choice, multi-professional paediatric education and training, available through state-of-the-art technologies and in contemporary evidence-based designed learning environments.
- Go Live of the Electronic Patient Records system, Epic and the beginning of the optimisation phase.

We continue to engage actively in a range of national and international collaborations to learn together and to share good practice across paediatric healthcare settings. For example, research is a key area where GOSH can promote clinical collaboration and benefits across clinical networks.

GOSH hosts the UK's only paediatric National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) in collaboration with University College London Great Ormond Street Institute of Child Health (ICH). Within education and training, partnership programmes across the STP will include lead employer for CYP Nursing Associate pilot, and a Darzi Fellow working with lead educator for local CCG to improve the communication and care for children with rare diseases.

During 2020/21 we will collaborate with other inpatient mental health providers in North London. Internally, we will also ensure collaboration across service areas. CAMHS and Psychology will merge into one mental health team and will work to make the liaison service at GOSH multi-professional.

What is Open House?

Open House is the annual celebration of all things GOSH. It's a time to come together, celebrate our hospital strategy and showcase our work to our colleagues.

What is a Darzi Fellow?

The Darzi Fellow is a London-wide programme run by NHS London Leadership Academy. It was started in 2009 in response to Lord Darzi's review *High quality care for all: NHS Next Stage Review (2009)*, which called for stronger clinical leadership and management roles.

Electronic Patient Records system

GOSH went live with the Epic Electronic Patient Record (EPR) system on the 19 April 2019. The Programme was delivered on time and under budget and saw the entire organisation come together to ensure the biggest transformation programme the Trust has ever seen was a huge success.

The Easter weekend was chosen for go-live so that inpatient areas would have four days to stabilise prior to outpatients and other services coming online the following Tuesday. A total of 800 GOSH super users and 150 clinicians from hospitals in the US, Australia, Canada and Lebanon came together to form a network of support for GOSH staff as they become accustomed to the new ways of working. GOSH ran the go-live using a bronze, silver, gold command structure, using clinical and operational management structures to communicate between staff on the frontline into the programme team and to the executive.

A 3-month Stabilisation period followed go-live which was designed to embed the system and highlight any key issues prior to the commencement of Optimisation. During this time some key areas were identified as in need of intensive support. In Pharmacy, the Willow Inventory module caused medication stock and cost discrepancies which had a significant impact on pharmacy purchasing, dispensing workflows and financial reporting. GOSH EPR, Epic and Pharmacy teams worked closely for eight months to refine the system, the workflows and the processes, which included some developments to the Epic system itself. In Radiology, some workflows were suboptimal and issues exacerbated by some poor user process further up the patient workflow. The key issues in Radiology have been resolved and we continue to optimise the workflows and the Radiant application for the Radiology teams. Documentation and data quality needed additional support and training so that discharge summaries and clinic letters were completed and sent in a timely fashion

The Optimisation phase commenced in July 2019. The 15-month phase is, broken into five 3-month tranches of work to further develop the system. The scope of each tranche is a mix of issue/process resolution, development of new speciality content and implementation of new functionality. Key projects have been established such as: Thrive with Epic, which uses data and follow up training sessions to improve users efficiency and therefore data quality; Integrating Infusion Pumps with Epic to reduce medication errors and wastage, and; the extension of external facing tools such as the MyGOSH patient portal and the EpicCare Link and Care Everywhere portals for clinicians with whom we carry out shared care.

The Trust has commenced Benefits Realisation work and is beginning to meet financial benefits as outlined in the Full Business Case. Patient safety and staff efficiency benefits have also started to be realised and case studies documented. Of particular note are Therapeutic dose monitoring in Paediatric Oncology Shared Care Units (POSCUs) via EpicCare Link; Patient access to records, documentation, blood results and the communication with the clinician via MyGOSH patient portal; reduction in the turnaround of clinic letters, and in the environmental impact of paper, printing and postage. It has also given some teams such as Laboratories and Radiology the space to review their skills mix and workload. The EPR team will continue to work with the organisation to realise and document these benefits.

As with many areas of GOSH, much of the optimisation work was placed on hold in March 2020 due to changing priorities in relation to the Coronavirus (COVID-19) outbreak. The team has turned its attentions to making changes to existing system configuration to support ward layout and referral pathways/admission processes for general paediatric work coming from other local hospitals and establishment of increased ITU capacity, and to add key data items for recording COVID activity. There is a focus on new functionality to support remote working such as integrated video visits (through Zoom) and extension of interoperability features such as EpicCare link and CareEverywhere. The technical team are involved in supporting the establishment and configuration of hardware to support the planned increase in beds.

Part 1:
A statement on quality from the Chief Executive

It is widely accepted that research-based organisations have a culture of learning and that learning organisations tend to have better patient outcomes and patient experience.

Great Ormond Street Hospital (GOSH) is a standalone specialist children's hospital with a very strong academic partner, University College London. We are, therefore, very fortunate to be a research hospital where an emphasis is put on learning. That is, learning from when things go well and when they don't and fostering a culture where we continually seek to improve all we do.

This *Quality Report* is one way we can provide information on how we are learning to improve our services and meeting a range of standards and expectations. While some standards are set externally, many of our quality improvement projects are informed by feedback from our patients, their carers and families, our commissioners and other stakeholders. Input from our staff is also vital as we identify and implement actions to improve the quality of the GOSH experience.

This report highlights a range of projects to improve the quality of care we provide and the patient experience. It also provides a range of information that serves as reassurance from the Board as to the quality of our services and information on how we are doing against core quality indicators and key national targets. Of note, some of the measurement on how well we were doing against improvement projects and key indicators was suspended as we reorganised ourselves to best support the wider NHS response to the COVID-19 pandemic.

Our improvement work should always link to our quality priorities. These are:
Safety – we are committed to reducing avoidable harm and improving patient safety as rapidly as possible. Our safety initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

Clinical effectiveness – we seek to provide patient care that is amongst the best in the world and work with our patients to improve the effectiveness of our care through research and innovation.

Experience – we wish our patients and their families to have the best possible experience of our treatment and care. Measurement is important and we seek feedback from our patients, their families, and the wider public to improve the services we offer.

In the area of safety, this report highlights the Speak Up for Safety programme. This programme, generously supported by our Great Ormond Street Hospital Children's Charity (GOSH Charity), is a multi-year programme of work to build and sustain an outstanding culture of safety, reliability and openness. Our objectives for the past year were to foster this culture by empowering staff to Speak Up to respectfully raise issues if they are concerned a situation is undermining patient safety. To date more than 80% of our staff have been trained and it forms part of our induction. There is ongoing work to ensure that speaking up through this programme and through the Freedom to Speak Up Guardian and Ambassadors is embedded in our culture. Culture change does not happen overnight and over the next year I look forward to this element of the programme embedding further and the rollout of the Praise platform, which encourages speaking up to appreciate others and Speak Up for our Values.

Reducing the number of rejected samples for laboratory testing was a focus for our efforts to further improve clinical effectiveness. When a laboratory sample is rejected, it usually means that the test needs to be repeated and we know this could lead to delayed diagnosis and treatment, which can have an impact on discharge and outcomes for our patients. The introduction of our Electronic Patient Records (EPR) has provided us with much better real time data. For this long-term project shows a sustained reduction in the number of rejected samples.

In the area of patient experience this year, working with children and young people we further developed our system to receive patient, parent and carer feedback in real time. This saw us respond to patient feedback by using emojis and children and young person friendly attitude scales. This would help our younger patients and patients and families with learning disabilities to give feedback and therefore a greater voice. Due to the current situation with COVID-19, we have not been able to test the surveys with patients and families but look forward to doing this during this coming year.

Continuing to look forward to the next year, following input from a wide range of stakeholders, including our Young People's Forum, three of the quality priorities we have set ourselves are: Improving medicines safety; Improvement of patient documentation in Child and Adolescent Mental Health Services (CAMHS); and an initiative to improve the hospital care and experiences of children and young people with learning disabilities (LD), autism and/or additional needs through four interconnected workstreams.

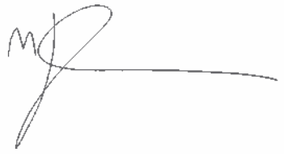
Audits are an important way we are able to gain assurance of the quality of our services. During this year we had a number of national audits and clinical outcome reviews, the results of which are found in the body of this report. GOSH staff also carried out a large number of local clinical audits. Following the introduction of our clinical audit prize in 2019, 2020 saw 20 entries – double the amount entered last year.

The quality of our services is also assured by our regulator, the Care Quality Commission (CQC). In December 2019, we were pleased to welcome the CQC to inspect three services – critical care, surgery and CAMHS – and against the well-led criteria. The Trust retains its overall rating of Good with all our services now rated as either Outstanding or Good. I was really pleased that our well-led rating has improved to Good, which reflects all the hard work done across the organisation. The overall rating for safety was reduced to Requires Improvement. This is linked primarily to medicines management and I am pleased we are making very good progress in improving this.

The healthcare targets that are set nationally are an important way we can assess whether we are delivering timely and effective care. Prior to the pandemic we had met the national standards for treatment for cancer but were falling behind in treating patients within 18 weeks and seeing them within six weeks for diagnostics. Our EPR which was launched in April 2019 gives us much better data in how we are doing against these targets. Once we are out of the pandemic phase it will be invaluable in helping us to get back on track.

Feedback from our staff, our patients and their families is also essential to monitor and improve the quality of our services. One of the principal ways our staff give feedback is through the national NHS Staff Survey. This year we had more staff complete the survey than ever before – 2,489 people or 53 per cent of our workforce. It showed we had made improvements in many areas but there was much more work to be done. The results are themed and for the most part we've done well – we have improved in seven of them compared to last year, with two staying stable. There are two themes which fell – equality, diversity and inclusion, and health and wellbeing, which we know we need to do more on, and these are two of the priorities within the GOSH People Strategy.

Of final note, the information provided in this report relies on good quality data. To this end, we have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported.



Matthew Shaw
Chief Executive

Part 2a:
Priorities for improvement

This part of the report sets out how we have performed against our 2019/20 quality priorities. These are made up of a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his 2008 NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare.

Safety

We are committed to reducing avoidable harm and improving patient safety as rapidly as possible. Our safety initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

Clinical effectiveness

At GOSH, we seek to provide patient care that is amongst the best in the world. As a major academic centre, we work with our patients to improve the effectiveness of our care through research and innovation. We use national and international benchmarks to measure our effectiveness whenever possible, and we publish this outcomes data on our website and in renowned academic journals. To measure our effectiveness from the patient's perspective, we use Patient-Reported Outcome Measures (PROMS).

Experience

We wish our patients and their families to have the best possible experience of our treatment and care. Therefore, we measure patient experience across the hospital and seek feedback from our patients, their families, and the wider public to improve the services we offer. We do this via:

- Membership, patient and member surveys
- Focus groups and events
- Social media
- Asking patients and families about their experience within 48 hours of discharge

Reporting our quality priorities for 2019/20

The six quality priorities reported for 2019/20 were:

Safety
- Implementing the Speak Up Programme to eliminate avoidable harm.
- Urethral catheterisation: Improving practice for safer care.

Clinical effectiveness
- Reducing the number of rejected samples for laboratory testing.
- Specialised Services Quality Dashboard (SSQD) benchmarking pilot.

Experience
- Implementing a system to receive patient, parent and carer feedback in real time.
- Support our staff's perception of emotional burden and resilience through the introduction of daily debriefing.

In this section, we report on our performance against each quality priority by outlining:
- What we said we'd do
- What we did
- What the data shows
- What's going to happen next
- How this benefits patients

Harvey, age three, recently had surgery to remove his tonsils and adenoids. He loves playing with dinosaurs and blowing bubbles in his bedroom.

Safety

Implementing the Speak Up Programme

At GOSH we strive for zero preventable harm and it was therefore recognised that it was a priority for the organisation to identify what within the culture at GOSH had the potential to undermine this.

What we said we would do

During the past decade, Great Ormond Street Hospital (GOSH) has aspired to zero preventable harm. It was recognised that cultural change was required to achieve this goal. In order to understand the root cause of the specific problems at GOSH we scrutinised our staff survey results and specifically those questions and responses relating to our Safety Culture.

Our aim for 2019/20 was to implement the Speak Up Programme. The Speak Up programme is a multi-year transformation programme of work to build and sustain an outstanding culture of safety, reliability and openness. Our objectives for the past year were to encourage and support our staff to feel safe in speaking up for safety and to implement processes to manage behaviours that had the potential to undermine the safety of our patients, families and colleagues.

Building on this feedback we held leadership workshops attended by 240 senior staff from across all workforce teams within the Trust aimed at increasing understanding of the environment in which we work and to gain support from our senior staff to undertake a programme to achieve cultural change at GOSH.

The aim of the Speak Up programme is to help overcome entrenched behaviours that can lead to poor patient outcomes by achieving culture change from within through supporting the right safety culture, focussed clinical leadership development and support two-way communication to prevent unintended patient harm.

The programme is Trust-wide with the goal of building a culture of safety and quality by empowering staff to support each other, raise concerns and addressing behaviours that have the ability to undermine a culture of safety and respect. This will be achieved through focused training, promoting professional accountability and addressing staff behaviours that do not align to the values of our organisation.

Speak UP
for safety in the moment

What we did

Speaking Up for Safety is delivered in house by 26 trained and accredited Safety Champions; volunteers from across all staff groups, with the aim of normalising respectful two-way communication that helps to prevent unintended patient harm. The programme teaches the Safety C.O.D.E., a graded model for standardising language when communicating concern. This model balances patient safety with respect, resulting in a culture where GOSH staff feel comfortable to 'check' each other and welcome being 'checked' by others. All staff will develop the skills and insights to respectfully raise issues with colleagues when they are concerned about a patient's safety.

Initially, we piloted Speaking Up for Safety workshops within one directorate. We invited 360 staff to undertake training and had a 93% uptake on the workshops. The directorate were highly engaged and this sparked interest from a number of other directorates keen to commence training. Through learning from the pilot we adapted our workshops, developed new materials and launched Trust-wide workshops in June 2019. The workshops were well attended with 80% of staff and volunteers having attended workshops in the six months to December 2019.

Culture change is a long-term commitment for GOSH and we have ensured that Speak Up workshops are included in the staff induction process to ensure speaking up is embedded into normal practice and that it becomes part of our culture. Speaking Up is promoted at all Trust briefings, is included in training across the Trust and is promoted as part of the Trust Open Days, Schwartz rounds and conferences. We used members of our executive team to highlight the importance of Speaking Up and provide assurance that staff choosing to Speak Up would be supported at the highest possible level to do so. We also worked with the Freedom to Speak Up (FSU) Guardian and Ambassadors at the Trust Open Day, GOSH Conference and various road shows throughout the period to promote the Speak Up message and show a united front.

What's going to happen next

Following implementation of Speak Up for Safety we have been working on the next stage of the Programme, Speak Up for Our Values. The aim was to align the launch of this work with the launch of the Trust's People Strategy however as with many areas of GOSH, much of the work was placed on hold in March 2020 due to changing priorities in relation to the Coronavirus outbreak.

How this benefits patients

The programme is aligned to the hospital strategy 'Fulfilling Our Potential' and highly sponsored by the Trust Board and Board of Governors (both of which have patient/family representation).

The overarching goals of the Programme are:

- Improved Patient Outcomes: The project will improve patient outcomes by empowering staff to respond promptly and effectively to any behaviour that may undermine patient safety.
- Better Patient Experience/Enhanced Experience for Families: This project improves patient experience by improving reliability and consistency around procedures. The project ultimately aims to improve patient safety by achieving zero preventable harm.

Staff across all professions come together for Speak Up for Safety workshops.

Urethral catheterisation: Improving practice for safer care

Across GOSH a variation in practice in urethral catheter related issues was identified in 2019, relating to the correct insertion and care of urinary catheterisation across the Trust. This lack of standardised care had unfortunately contributed to 28 patient safety incidents since January 2018.

What this means

Analysis of these incidents identified common themes, including the incorrect device/size being inserted, insufficient care of pressure areas, issues when flushing a urethral catheter and adherence to infection control standards. This project was initiated with the aim to eliminate avoidable harm to urethral catheterised patients at GOSH by 31st March 2020.

Why it is important

At GOSH the ethos of patient first and always makes this work so important in its response to where aspects of care have been suboptimal and a good patient experience compromised. The intention of this project was to reduce catheter related incidents which can lead to harm and lengthen hospital admission.

What we said we would do

The progress of this project has been measured through a number of incidents on Datix, urinary catheter audit compliance, reduction in queries directed to Urology CNS, training compliance via the staff learning and management system, and a staff skills confidence survey.

The following data definitions align with the main work streams of the project:

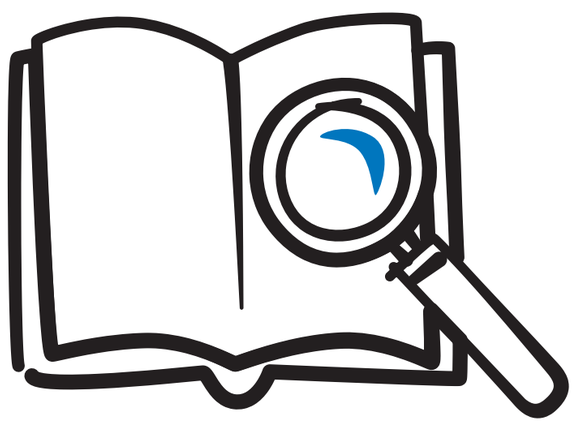
- Training: The number of staff trained as a result of the project (increased Trust wide competency).
- Devices: The number of catheter devices were reviewed within this project and the decision was made to reduce the number of devices used. We had 4 brands from 3 different suppliers of urethral catheters before we reduced to 2 main devices. Rationalising our equipment in this way improves quality by standardising practice and ensuring that staff are familiar and appropriately trained to insert and manage catheters across different wards. There is also a positive cost implication of rationalising stock and savings can be realised through bulk procurement.
- Contact: The calls received have been monitored by Urology Clinical Nurse Specialist (CNS) throughout this project. The analysis and evaluation of the impact that the project has had on the levels of catheter related contact to the Urology team will take place in September 2020, following the roll out of the education programs. This is an amended deadline due to the postponed training schedule which was created prior to COVID -19.
- Confidence: Survey from the Nursing Educator to assess the increase in competence on the wards.

What we did

The project has been delivered through three main work streams. To standardise catheter devices, a review of current devices has been conducted and an agreement made to consolidate to two preferred devices for the Trust.

This has led to streamlining the devices used between the neonatal ward and other specialty wards. In order to review and update the existing catheter pathway, a new guideline, FAQ guide and escalation pathway has been published and been made available to all staff via the Trust intranet. The new developed guidance has also been embedded into Trust Electronic Patient Record system to prompt and assist staff in their daily responsibilities with regards to catheter care.

To establish and facilitate multi-professional training, a competency booklet, training guide and resource-based intranet page has been created. Train the trainer sessions have been completed with the clinical education team who will cascade the education to their teams accordingly.



What the data shows

We used the key metrics of staff reported incidents via Datix, Staff Confidence Surveys pre and post the project interventions and the availability of standardised equipment to relevant staff to measure the impact of this quality improvement initiative. Unfortunately, the COVID 19 Pandemic has had a significant impact on the data collection of this project and timeframes have had to be adjusted for analysis of any improvement. A core intervention of this project was to develop robust 'Catheter Care and Insertion' education programmes on relevant wards and make broader resources and training material available Trust-wide. Once this enhanced education was embedded, a post-intervention staff confidence survey was planned to measure any change in capability and confidence amongst staff that are required to catheterise patients as part of their role. Whilst the education programmes have been developed and are now widely accessible to staff via an online resources hub, the face-to-face prong of the education strategy has had to be postponed until August 2020 to allow those on the frontline to focus on the COVID-19 related pressures.

Datix incidents

Comparing the Datix incidents from January 2018 to April 2020, there was been a 0.3.% increase each month in incidents (from 1.5 to 1.8 per month) and a change in the prominent incident themes from poor documentation and wrong device selection to process errors. We believe that the increase in Datix reporting could be a result of increased staff awareness of best practice surrounding catheter management however further analysis will be undertaken over the next 3 months to establish how to address these ongoing challenges.

Staff Confidence Surveys – Post Implementation

These surveys will be conducted in September 2020 as per the adjusted timeframes explained above.

Standardised Devices

The number of catheter devices were reviewed within this project and the decision was made to reduce the number of devices used.

We had 4 brands from 3 different suppliers of urethral catheters before we reduced to 2 main devices. Rationalising our equipment in this way improves quality by standardising practice and ensuring that staff are familiar and appropriately trained to insert and manage catheters across different wards. There is also a positive cost implication of rationalising stock and savings can be realised through bulk procurement.

What's going to happen next

The final stage of this project is to increase competency through training sessions and medical education bootcamp events. This will be monitored annually.

How this benefits patients

A range of benefits have been identified resulting in improved quality of care for our patients, not least the standardisation of best practice catheter care across all wards.

The project provides the following benefits:

- Reduced unwarranted variation in care and device related incidents.
- Improved identification and treatment of catheter related issues, ensuring they are addressed in a timely way with appropriate expertise.
- Standardised working practices, increased staff knowledge and expertise, and appropriate escalation will ensure children and young people requiring urethral catheterisation receive appropriate care from an appropriately trained clinician.
- Reduced patient harm and distress and the possible need for further interventions caused by catheter related incidents.
- Efficiency savings in sourcing and procuring the appropriate device.
- Improved efficiency of the Urology Team in signposting to teaching and resources, enabling expertise to be directed to appropriate queries.
- Timely and appropriate escalation of catheter related issues.
- Care delivered by appropriately trained practitioners.
- Trust-wide standardisation to improve care and outcomes for all children and young people requiring catheterisation at GOSH.

Clinical effectiveness

Reducing the number of rejected samples for laboratory testing

When a laboratory sample is rejected, it usually means that the test needs to be repeated and we know this could lead to delayed diagnosis and treatment which can have an impact on discharge and outcomes for our patients. Patient experience can also be significantly affected. This Quality Improvement project was set up to understand what leads to these rejections and introduce measures to stop them from happening.

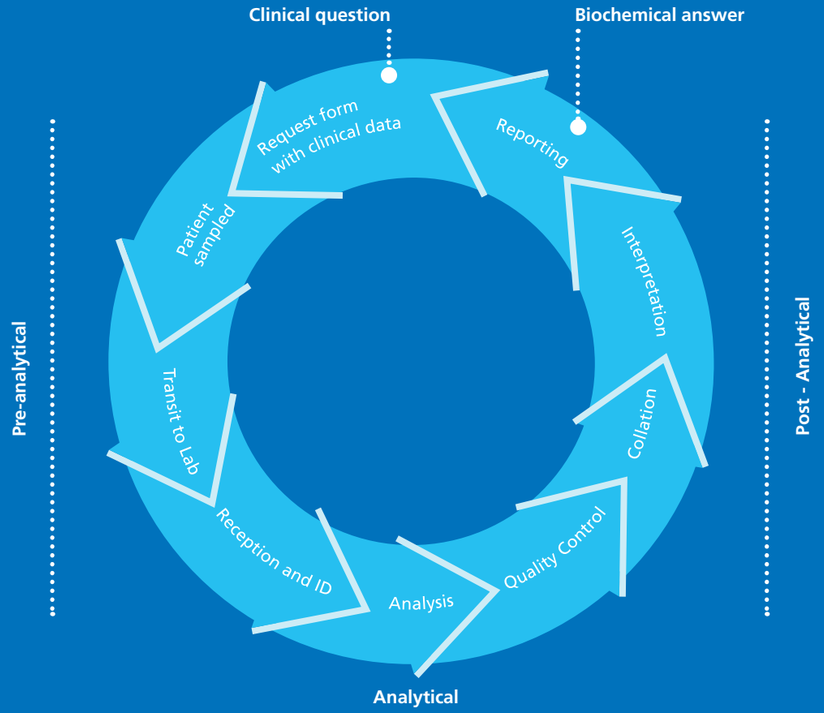
What we said we would do

Approximately 70%[1] of clinical decisions are based on information derived from laboratory test results. In 2017, GOSH received more than 400,000 samples and performed more than 1 million tests.

Through manually recorded data, GOSH laboratory identified 4900 patient samples were rejected in 2017 due to pre-analytical errors. A Quality Improvement project was set up in late 2018 with the aim of reducing laboratory sample rejections due to pre-analytical errors.

What is the pre-analytical phase?

The pre-analytical phase starts at the point of test requesting by the medical team and ends when the sample arrives in the laboratory and is evaluated for errors. The phase includes collection of the sample from the patient and transportation of the sample to the lab.



[1] Datta P (2004) Resolving discordant specimens in clinical laboratory practice. [online] https://www.mlo-online.com/articles/200411/1104LabManagement.pdf

What we did

A multi-disciplinary approach in engaging stakeholders from across the hospital was key in taking this project forward, as often rejection reasons occur as a result of process/system issues before the sample arrives in the labs and needs investigation by the clinical teams.

We created a project steering group comprising of medical, nursing, education, portering, phlebotomy, facilities and laboratory representation. Input from patients and parents were obtained where necessary.

The project was structured into four key work streams, each with focus on an integral part of achieving a quality sample:

1. **Sample Collection Resources –** focusing on the equipment and resources we use to collect patient samples to certify that they are adequate, compatible and do not hinder a quality sample being obtained.
2. **Sample Transport –** looking at the different ways in which patient samples get to the laboratory and the time it takes for samples to be transported from a patient to the lab.
3. **Training and Education –** assessing the current availability and content of education and training opportunities related to sample collection and comparing it with best practice.
4. **Policy and Guidelines –** reviewing our policies and guidelines to ensure they are evidence based and support staff to obtain adequate samples.

We developed real-time reporting on the intranet using data from the laboratory information system. The report displays statistical process control (SPC) charts including trends of rejections for specific reasons where improvement efforts are focussed. Data is available to view at Trust and ward level and is accessible by all staff.

When the Trust moved to an Electronic Patient Recording (EPR) system in April 2019, the project faced new opportunities and challenges. The availability of automated data, and therefore complete rejection numbers, will increase in its accuracy however in the short-term requires significant data quality checks. We are still working on identifying true sample rejections from all these which appear as rejections on the system. Many process errors and categorisation errors also increased at this time as a result of staff members (both wards and labs) getting used to a new EPR system.

One of the prominent successes achieved so far is the reduction of the blood culture transport time. The maximum recommended blood culture transport time (needle to incubator) is 4 hours[2]. At GOSH we set an aim to deliver these samples (needle to receipt in lab) in 120 minutes, leaving room for any other pre-analytical steps before a sample goes in to the incubator. We used different interventions including (both in wards and labs) myth busting, education, process changes at different stages to bring down the transport time.

Other key project interventions have included:

- Staff education package to avoid unnecessary clotting of blood samples.
- Improved blood collection resource and staff education in NICU.
- A study to optimise the sample transport methods available in the Trust.

What are blood cultures?

Blood cultures are blood samples performed to detect infections in the blood. If a blood culture test is positive, the bacteria causing the infection will be identified and testing will be done to find out which antibiotics would effectively treat the infection.

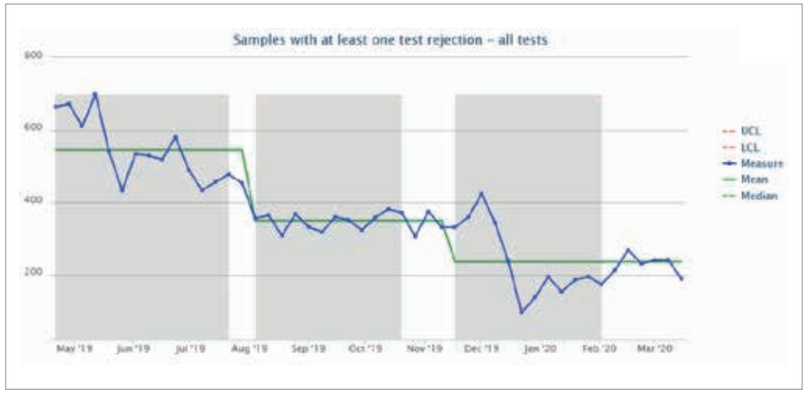
"The project has dedicated staff in all areas of expertise! This was evident when new blood bottle was recently introduced for coagulation screens. This intervention will vastly benefit our laboratory with superior plasma quality and aid improved sample quantity allowing fewer sample rejections which means less patients will need re-bleeding and consequently will help overall patient experience"
Haemostasis Lead Scientist, Coagulation Laboratory (Camellia Botnar Laboratories)

[2] L. S. Garcia (ed.), *2007 Update: Clinical Microbiology Procedures Handbook*, 2nd ed., 2007.

What the data shows

1. Number of samples with at least one test rejection

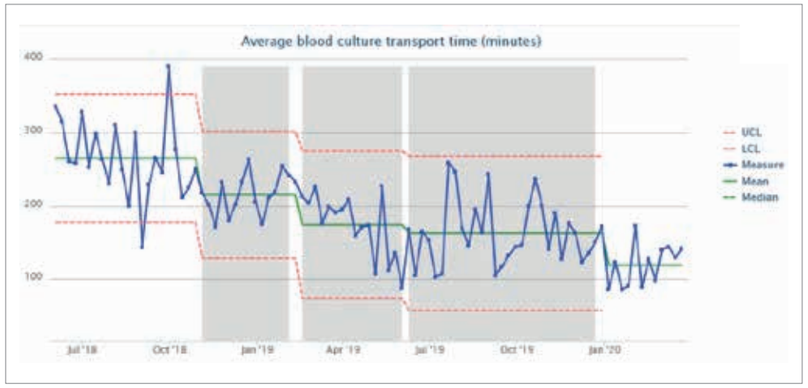
The weekly average number of samples where at least one test was rejected (a single sample can be used to do one or many tests depending on test types).



The EPR system has provided the opportunity to see all rejected samples in one graph, which was not possible previously. In part, the reduction of rejections shown in the above graph demonstrates an improvement of data quality as the project team identify and overcome various process and categorisation issues on the electronic system. The data cleaning process is ongoing to ultimately provide a true picture of real patient samples which were rejected for pre-analytical reasons.

2. Average blood culture transport time

The time between collection of a blood culture sample from a patient and the time of receipt in the laboratory, calculated as an average of all blood culture samples sent in a week.



Starting with an average time of 265 minutes at the beginning of the project, the various step changes reflect the various interventions introduced and tested at different stages. After a focussed trial in two wards, education (importance of sending samples immediately) and process change (encouraging the use of the chute system to send samples) was rolled out to the rest of the wards. This was done at various levels to capture as many staff members as possible. The final drop in the average transport time, which has allowed us to reach our aim, currently stands at 119 minutes. This reflects an extensive drive to bring down the time in the lab to receive a sample which was delivered to them. Focussing mostly on out of hours samples received to the lab, improvement in communication between main sample receiving reception and Microbiology labs and awareness of the lab staff on the urgency, supported this significant drop in time. There is still room for improvement in reducing those individual samples taking longer than 120 minutes.

What's going to happen next

- We will continue with the data cleansing efforts so that overall better visibility is available for all stakeholders.
- Lessons learnt through this project will be incorporated in to the Trust routine training programmes under the topics relevant. These will include the correct order of blood draw to collection tubes, the best practices in the techniques used to collect samples using the available resources (especially focussed on paediatric veins/ difficult access), and tips to avoid under/over filled samples to name a few.
- Relevant policies and guidelines will be updated as per the project learning and outcomes.

How this benefits patients

A reduction in rejection of samples will help avoid multiple sampling and support efficient diagnosis process. This will lead to better treatment outcomes for patients as well as have a significant impact on patient experience.

"The project has built an amazing relationship between labs and the wards across the Trust. The strong link has created baseline platform for pre analytics to embed sustainable improvements. We'll persevere to strengthen education, training, and awareness amongst staff to ascertain positive change in sample rejection rates." Quality Improvement Lead (Preanalytical), Camelia Botnar Labs

Seven-year old **Yasir** receives regular treatment at GOSH. He loves doing arts and crafts with the Play Specialists.

Benchmarking with our specialist paediatric healthcare peers

Comparing our results with other specialist paediatric hospitals is an important way that we can understand how we're doing. However, developing measures that work for everyone requires detailed work and can take a long time. Working with our fellow paediatric hospitals and NHS England, we found a way to utilise existing national measures to see how we're all doing and what we can learn from each other to improve patient care together.

What we said we'd do

After successfully proposing a benchmarking pilot to the UK Children's Hospitals Alliance (CHA), of which GOSH is a member, we said we would lead the agreed project to access and compare our results within the membership group of hospitals, to build benchmarking experience together and drive improvement.

What we did

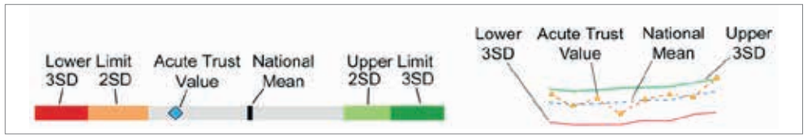
GOSH obtained agreement from the CHA executive members that as a group we would share our Specialised Services Quality Dashboard (SSQD) reports with each other. Using the nationally established SSQDs meant that we could build this initiative using existing metrics that we all reported on, thereby saving time and additional effort. We coordinated medical director sign-off from each member organisation and approached NHS England (NHSE) to explore electronic options for our benchmarking plans.

Over 2018/19, we worked with NHSE to achieve agreement for a pilot project in which they would allow three managers per CHA member organisation to access the SSQD reports[3] of the 11 member trusts. This access was provided by NHSE in May 2019.

Over the next six months, GOSH and the Evelina Children's Hospital at Guy's and St Thomas' NHS Foundation Trust each hosted a national working group to move the project forward at pace, involving clinicians and hospital managers from across the CHA member trusts, and NHSE representatives. As well as confirming practical aspects, the meetings were used to discuss and advance the commitment to an ideal benchmarking framework, which includes shared vision, clear terms of engagement, and consensus on measures.

The working group agreed to initially focus on three dashboards: Paediatric Rheumatology, Paediatric Neurosurgery and PICU. Each hospital provided input from its clinical leads to:

- Identify the measures in their SSQD that they find most meaningful.
- Confirm how they interpret each metric and how they and collect data, to understand any differences in reporting.
- Share this information within the group.
- Share this information with NHSE colleagues to provide the added value of provider feedback that could be useful in further development of operational definitions of measures.
- Each hospital continues to report its data to NHSE, review its own dashboards, and compare results across the CHA member hospitals.



NHSE's presentation of data on charts showing standard deviations (SD) allows trusts to see when they have a result that's an outlier compared to other hospitals for that reporting period.

What is the UK Children's Hospitals Alliance?

The UK Children's Hospitals Alliance (CHA) is a group of 11 hospitals[4] 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.

What are Specialised Services Quality Dashboards?

The Specialised Services Quality Dashboards (SSQDs) are NHS England (NHSE)-run dashboards of metrics agreed by Clinical Reference Groups. Specialist trusts are required to submit data for the SSQDs through an online portal, usually quarterly, to enable commissioners to monitor performance across process, safety, outcome and experience. Currently, the reports are not publicly available. Each trust receives its reports back via the portal, and each shows the specialty averages across centres for the reporting period, as well as outer limits to three standard deviations.[5]

[3] Of the Women's and Children's Programme of Care: https://www.england.nhs.uk/commissioning/spec-services/npc-crg/spec-dashboards/

[4] Alder Hey; Birmingham; Manchester; GOSH; GSTT Evelina; Leeds; Sheffield; Newcastle; Bristol; Southampton; Oxford John Radcliffe

[5] Learn more about standard deviation at: https://en.wikipedia.org/wiki/68–95–99.7_rule

What the data shows

Number of paediatric hospitals involved: **11**

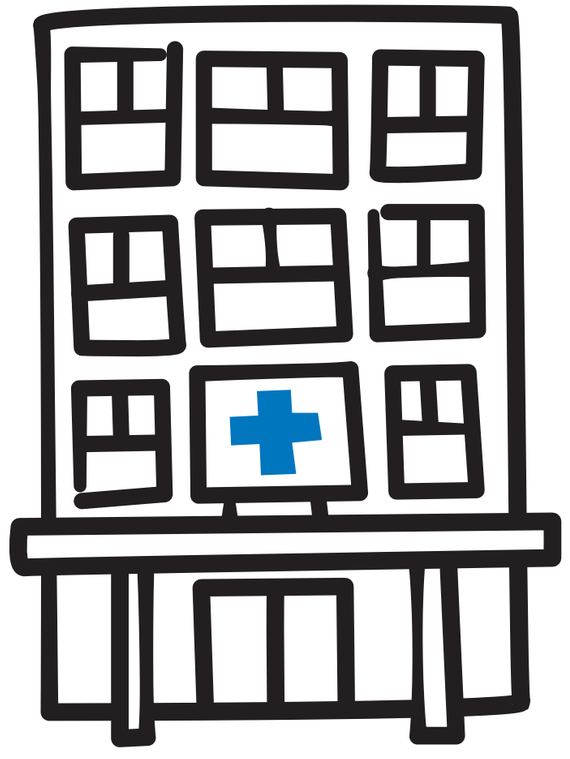
Number of metrics in the pilot: **126**

What's going to happen next?

- The next national working group is planned for July 2020, hosted by Birmingham Children's Hospital.
- Two doctors from the Evelina Children's Hospital, who are members of the working group, are preparing raw data and discussion points about what we have learned from five years of SSQD data through the lens of the benchmarking pilot. This will be presented and discussed at the next working group and will lead to a full report.
- Ongoing collaboration with NHSE.

How this benefits patients

- Collaboration with other specialist trusts opens up opportunities to share best practice in paediatric care.
- Cross-organisational comparison of relevant data helps us to identify areas of excellence and areas for improvement.



What is benchmarking?

Benchmarking is the act by organisations of comparing their business processes and outputs, and learning from the successful practices of others. In specialist healthcare, the systematic measurement and peer comparison of our processes and outcomes can provide a powerful driver for continuous improvement in care.

"While GOSH is leading on this benchmarking pilot, the strength of this project is in the peer collaboration and combined expertise. Together we are capable of using data for improvement in ways that would not be possible individually."
Clinical Outcomes Development Lead, Haemostasis Lead Scientist, Coagulation Laboratory (Camellia Botnar Laboratories)

"Benchmarking against other equivalent intensive care units at quarterly intervals allows us to see regularly how we are performing relative to our peers. Being able to see the detail of that at hospital level for the first time has been vital in better understanding our position and where we can make improvements."
Consultant Neonatalogist

Experience

Implementing a system to receive patient, parent and carer feedback in real time

We wish our patients and their families to have the best possible experience of our treatment and care, it is therefore vital we use their feedback to continually improve our services.

What we said we'd do

Patients and families told us that they would like to a choice in how they provide feedback to the Trust. In response to this, the Patient Experience Team launched new feedback software in 2018 which allowed patients and families to submit feedback online at a time that was suitable for them. During the early stages of this project, we further understood that children and young people in particular would like a more interactive way of providing their views to the Trust.

What we did

There were no existing feedback systems on the market at that time which met the Trust requirements. Our current supplier offered to work in collaboration with the Trust and our Young People's Forum (YPF) to develop the existing software to make it more interactive, thus enabling and encouraging young people to provide their feedback.

It was vital that the surveys could utilise emojis and child and young person friendly attitude scales. This would allow our younger patients, who form a large part of our patient demographic and those patients and families with learning disabilities to also be able to provide feedback.

In early 2020 the new survey module had been finalised. This allows the Patient Experience Team to use pictures and emojis rather than producing text only surveys. The original plan was to also include audio to accompany the survey, however this has not yet been possible, but we hope this will be rolled out at a later stage.

In addition, the YPF were keen that the surveys could advise patients and their families which improvement initiatives were being carried out at the Trust as a result of feedback already received at Great Ormond Street Hospital. The new module allows us to add improvement updates to each survey, so this is communicated directly to the person completing the feedback.

It was essential that the data received from these surveys could be stored alongside the other data collected by the Patient Experience Team, including the Friends and Family Test data. This allows for easier interrogation of the data, structured follow up of the negative comments, thematic analysis of all the feedback received across the Trust and comprehensive action plans as a result of the feedback. This has been successfully implemented and the full survey module went live at Great Ormond Street Hospital in April 2020.

What the data shows

Due to the current situation with Coronavirus (COVID-19), we have not yet been able to test the surveys with patients and families, however this will be carried out as soon as soon as possible.

What's going to happen next

The next phase of the project will enable the Patient Experience Team to send the surveys external to the Trust environment. This is planned for late 2020, early 2021. Furthermore, we will continue to work with the software designers to continually improve the survey module as a result of further input from the patients and families at the hospital.

"Knowing that GOSH is listening to my feedback and doing something with it will make me want to feedback more."
YPF Member

"It is really important to know my views are making a difference to the hospital."
YPF Member

"One size will not fit all, we need to create a tool that is engaging and for multiple age groups, audiences and needs."
Software designer after meeting with the YPF.

Support our staff's perception of emotional burden and resilience through the introduction of daily debriefing.

At GOSH, we are committed to improving the access and types of support available to staff recognising the emotional demands of working in an environment with complex patients.

Recognising the emotional burden being described by nurses on our long term gastroenterology ward (Squirrel Ward), combined with increasing sickness levels and voluntary turnover rates there was a clear need to offer a differing method of staff support to the monthly sessions already on offer to the team.

The Royal College of Nursing (RCN) recognise that debriefing can reduce the possibility of psychological harm by talking about what has happened; facts can be shared, misconceptions corrected, as well as fair and valid observations taken on board. It provides a valuable opportunity to share thoughts, feelings and experiences.

What we said we'd do

We said that we would be committed to supporting the staff caring for these complex patients and that we would focus on methods that could allow a separation of/and better work life balance. Recognising that daily debriefing is a well-established tool in psychiatric nursing and in GOSH on our inpatient psychiatric ward it was felt this was a potential project that we could adapt and spread to gain the known benefits across physical health wards.

What we did

We surveyed our staff across Squirrel, this was anonymised and demonstrated a clear need for debriefing. We then utilised our mental health colleagues, firstly to promote the benefits and then to support the roll out. We attended staff team days to promote our intended project and worked up an audit plan with the QI team to monitor the effects. We paused after one month to take on board suggested adjustments such as timing, location and structure. After two months we re-surveyed the team to monitor the effects.

During the project we safeguarded the staff in the recognition of when would more support be required and how to escalate this. We recognised that there were many good shifts but that even on these the momentum needed to be maintained and that missing days led to risk of returning to old practices, therefore prompts were developed for reflection and sharing of praise and gratitude.

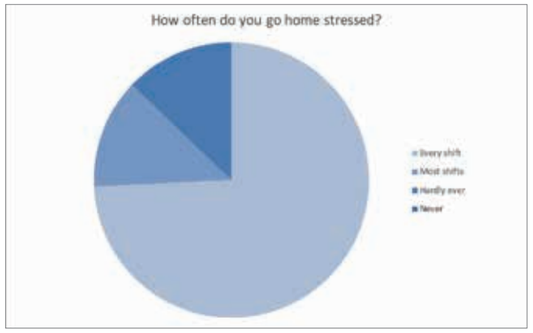
What is debriefing

Debriefing was developed as an approach for people working in environments that expose them to stressful incidents. The aims are to help in the processing of thoughts and emotions arising from their work. Debriefing is a simple yet effective tool for a team to bond, self-correct and enhance their performance.

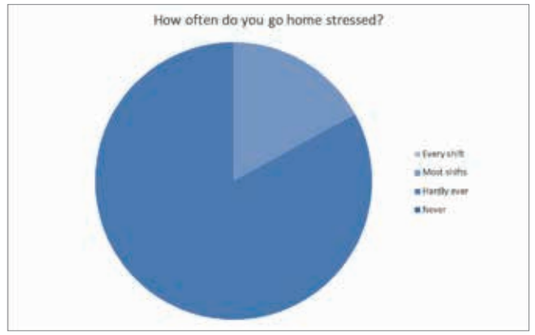
"A great way of strengthening the team and enhancing working relationships."
Staff feedback

"My favourite thing about debriefs is it allows me to keep my work and personal life separate."
Staff feedback

What the data shows



Pre-survey
75% went home after every shift stressed, 13% most shifts and 13% hardly ever.



Post-survey
83% hardly ever went home stressed and 17% went home stressed after most shifts.

Observations during the project by project team

- In general, ward staff seemed to value the opportunity to talk with their team in a private space.
- Ward staff seemed more willing to gather for a debrief when it was initiated by the Ward Sister or Nurse in Charge.
- On two occasions, ward staff gathered for a debrief but once in the room one staff member said they had nothing to discuss and the others agreed.
- Gathering for debriefs in the IV/drug room meant that it was difficult to avoid being disturbed, as doctors, pharmacists etc. could walk in.
- When concerns or issues were raised, questions asked by the NIC or Ward Sister such as; 'what could have been done differently', 'could allocation have been better', etc. appeared to prompt further discussion and appeared to be received positively by the other staff.
- Action plans initiated by the staff member leading the debrief e.g. 'I will discuss the concerns you have raised with X and will get back to you' seemed to be received positively by staff.

Suggestions occurring through the project

- Debrief 'champions' to prompt and promote gathering of the team at 4pm each day.
- Introduction of a debriefs prompt card to provide structure to the debriefs on occasions where discussion does not start naturally.
- Debriefs to be held in a room where staff can sit down and where they are less likely to be interrupted.
- Timing altered to 4pm from original 6pm.

"I find these useful. Encourages honesty about what could have been better. Able to speak openly."
Staff feedback

"A good way of reflecting on the days events."
Staff feedback

"I would say that debriefs is one of the most important spaces on MCU. The best thing I would say is that you can share the difficulties, worries and the positive things of you day with the rest of the team and feel understood and supported."
Staff feedback

What's going to happen next

Commitment to continue to share the simplicity yet positivity of this tool. Recognising that we debrief after major events is common place yet we have failed previously to acknowledge the day to day pressures contribute to stress, emotional fatigue and burnout in nursing and to provide support accordingly.

Rolled out across other medical and surgical areas in the Body, Bones and Mind group with similar results seen or expected. Provision of longer monthly support to be provided and facilitated by psychology teams who in our areas have always demonstrated dedication to allowing reflective space for the MDT. Adaptation of the MIND going home checklist as a further provision to aid separation of work and home life.

How this benefits patients

Patient care at GOSH is becoming increasing complex, the recognition of the technological and physical aspects of care are easier to quantify, more challenging is the social and emotional complexities and its impacts on teams.

Debriefing helps staff to engage in true reflective practice, to scrutinise, self-correct and seek practical solutions. It strengthens team working and supports frontline staff experiencing difficult situations. Debriefing is key to improving both patient safety and care, in creating a non-judgemental reflective workforce that are dedicated to enhancing future performance. Resilience of teams is enhanced, sickness and turnover are potentially improved and although not formally measured in this project ensuring patients access to expert practitioners at the point of care.

Four-year-old **Lillie-Anne**, is being treated at GOSH for a brain tumour. She also has a tracheostomy to help her breathe. While at the hospital, Lillie-Anne likes watching her favourite film *Frozen*.

Quality priorities for 2020/21

The following tables provide details of three of the quality improvement projects that the Trust will undertake in 2020/21.

These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including a survey, consultation, and use of established meetings such as our Council of Governors, Young People's Forum, and Patient and Family Engagement and Experience Committee.

The new quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

Safety

To eliminate avoidable harm.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improving medicines safety	Through thematic analysis of Datix, listening to our staff, and through the most recent CQC report, we are clear on the need for improvement in the safety, patient experience and efficiency of our medicines management. A multi-stranded programme of improvement is currently being finalised and initiated that will include: • Safer medicines administration. • Strengthened processes and teaching on storage, administration and disposal of controlled drugs. • Safer stock management of medication, including storage and destruction. • Reduction in the number of uncollected medications in the Pharmacy Dispensary, aiming to improve the dispense time to within 1 hour of patient 'checking in' at Pharmacy outpatients. • Optimisation of Pharmacy modules in Epic for ease of use and alignment with workflows.	• Reduced severity rating of medicine Datix reports. • An online program development covering all the specifics of the medicines policy. • Regular audit cycles of the specifics of the medicines policy. • A completed QI programme for outpatient prescribing and dispensing. • Out-patients waiting times of <1hr. Completed QI programme for ward pharmacy process in EPIC assessed against: staff satisfaction, Lean workflow modelling and reduced re-dispensing. This programme is supported by the Deputy Medical Director for direct executive team engagement and oversight.

Clinical effectiveness

To consistently deliver excellent clinical outcomes, to help children with complex health needs fulfil their potential.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improvement of patient documentation in Child and Adolescent Mental Health Services (CAMHS).	Through staff feedback and the most recent CQC report, we are aware of the need for improvement of patient documentation in our EPR system so that staff can record, update and find patient records promptly. In recent months, there have been changes to nursing documentation and flowsheets in Epic to improve fit, and the EPR link analyst for CAMHS is working with the team to arrange additional training around clinic letters. This refining work is ongoing and will have benefit not only to the Mildred Creak Unit but also across CAMHS services. We plan to: • Improve recording of consent and competence and ensure that these are accessible on the electronic record. • Improve the layout of the electronic record to make it easier to navigate e.g. a drop down tab for 'Core team minutes' • Add suitable templates for meetings eg Ward round, Review meetings, and correspondence e.g. Short and Long Discharge Summaries • Improve the recording of Risk Assessments with a suitable template, including adequate free space for documentation/comments.	Progress will be reviewed regularly over the coming 12 months. To measure the progress of the work we will review: • Staff feedback – to enable us to compare how staff felt before and after the interventions were put in place. • Staff confidence – through a confidence survey on navigating electronic patient records. We aim to collect feedback 6 months following the improvement measures being in place.

Experience

To deliver kind and compassionate care, and communicate clearly to build confidence and ease.

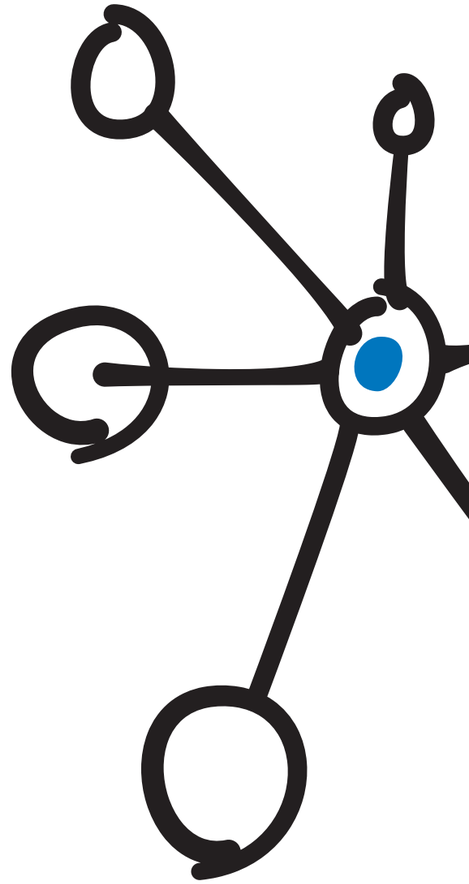
Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improving the hospital care and experiences of children and young people with learning disabilities (LD), Autism and/or additional needs through four interconnected workstreams. Unless stated otherwise, progress of each of the four LD initiatives will be monitored through Patient and Family Experience and Engagement Committee (PFEEC) and the Family, Equality and Diversity (FED) Group as well as a Disability Forum including staff and parents that will be established as part of this work.	**Workstream 1** Improve staff competence and confidence to deliver individualised care to patients with LD/Autism through a comprehensive and targeted programme of staff training. The programme will, a) Expand our existing Simulation Training, b) Co-produce with patients and/or their parents Mandatory LD Awareness Training ready for delivery from April 21, c) Source external Positive Behaviour Support Training and, d) deliver bespoke training for particular specialties, wards, and professional groups. Accompanying the training will be a programme of awareness about raising the needs of our patients with LD/Autism with the aim of developing and sustaining culture in which issues related to LD/Autism are embedded in everything that we do. **Workstream 2** Increase focus on safety of patients with LD/Autism through, a) improved processes for flagging and tracking these patients on EPIC, b) developing a risk assessment tool, c) reviewing hospital space and, d) fostering a culture of openness and honesty about their care, working with our Patient Advice and Liaison Service, Complaints Team and Patient Safety Team to ensure our recording and monitoring processes are accessible and designed to capture both incidents and near misses and facilitate shared learning and feedback to staff and families. **Workstream 3** Increase involvement of patients with LD/Autism in making decisions about their care and planning services through, a) increased availability and use of communication resources throughout the hospital and, b) increased engagement through a coordinated plan of activities and feedback sessions developed in conjunction with the Patient Experience Team.	**Workstream 1** • Numbers/range of staff completing LD Simulation Training. • Co-production of LD Mandatory Awareness Training. • Procurement of external training in Positive Behaviour Support. • Perception of staff competence and confidence captured informally through discussions with a range of staff, and formally through training evaluation forms, staff LD question box, staff survey. • Evaluate feedback from staff, parents and CYP with LD through multiple forums and mechanisms about 'our values'. **Workstream 2** • An audit of, a) the number and accuracy of LD flags applied on patient records, complaints and Datix and, b) the issues raised and the process of learning from these and reporting back to staff/parents. • An audit of staff awareness and knowledge regarding the use, documentation and reporting of restraint • Risk assessment tool development will be monitored through regular research team meetings, a study steering committee, and reports to the funders. • An audit of the number of quiet, safe spaces within the hospital and their use, including feedback from families. **Workstream 3** • Number and accessibility/ appropriateness of communication resources available. • Evaluation of staff awareness, knowledge of and confidence to use communication resources in practice. • Feedback from families about the accessibility and suitability of engagement activities in place (Year 1), with examples of changes in practice (Year 2).
Improvement initiative	**What does this mean and why is it important?**	**How will progress be monitored, measured and reported?**
	Workstream 4: Improve the hospital experience for patients with LD/Autism and their families through the use of an accessible patient reported experience measure (PREM) purposefully designed for CYP with LD to ensure their views are captured ready for Trust-Wide use in 2021. We will evaluate qualitatively whether input from the LD team, in conjunction with music therapy, can reduce pre-op anxiety and improve hospital experience for patients seen in the anaesthetic pre-op clinic. We will introduce a sensory toy library to ensure increased accessibility to sensory equipment and equitable provision to patients with LD across the Trust within and outside of 'normal working hours'. **Our training programme is responsive to:** **1. Latest Research Evidence** Data from a 3-year national study of the equality of hospital care for CYP with LD led by GOSH (Oulton et al. 2018) revealed that hospital staff a) feel less confident and capable to identify and meet the needs of CYP with LD compared to CYP without LD, b) feel that children with LD are less safe in hospital than children without LD, including in relation to the environment being safe for meeting their needs, c) feel that children with LD are significantly less involved than children without LD in decisions about their care and in planning services and, d) feel that children with LD are valued less and treated with less dignity and respect that children without LD. **2. Direct parent feedback** That the Trust could and should be doing more to ensure that staff value CYP with LD and their families equally and that their particular needs are being identified and met in a timely manner. **3. Current NHS LD Standards** - Staff having to be trained and then routinely updated in how to deliver care to people with LD/Autism. - Trusts must have mechanisms to identify and flag patients with LD/Autism from the point of admission through to discharge; and where appropriate, share this information as people move through departments and between services. - Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve people, families/carers throughout these processes. - Trusts must demonstrate that they co-design relevant services with people LD/Autism. - Trusts must have measures to promote anti-discriminatory practice in relation to people with LD/Autism. - Trusts must compare outcomes and experiences of people with LD/Autism with those of non-disabled peers. This is a Trust wide programme focused on developing and sustaining a healthcare culture that enhances safety, reduces risk and promotes equality for CYP with LD/Autism.	**Workstream 4** • a) The successful introduction of sensory toy library (Year 1) b) Evaluation of how, where, when and by whom the sensory toy library is used, as well as costs and issues (Year 2). • Development and piloting of PREM in at least one inpatient and outpatient setting, including analysis of process to identify what is working well and what improvements are needed. • Use PREM with CYP with LD attending anaesthetic pre-op clinic to assess impact of music therapy and LD Nurse input (Year 2).

Tulsi had delicate spinal surgery at GOSH within hours of being born. Her mum Laxmi says: "Tulsi is doing really great. She's crawling, standing up, and she loves going to play group."

Part 2b:
Statements of assurance from the Board

This section comprises the following:

- Review of our services
- Participation in clinical audit
- Learning from deaths
- Participation in clinical research
- Use of the CQUIN payment framework
- CQC registration
- Data quality
- Priority clinical standards for seven-day hospital services
- Promoting safety by giving voice to concerns
- Reducing rota gaps for NHS doctors and dentists in training



Review of our services

During 2019/20, GOSH provided and/or sub-contracted over 50 relevant health services. The income generated by these services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant services by GOSH for 2019/20. GOSH has reviewed all the data available to us on the quality of care in our services.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet our own quality standards and those set nationally. These processes include scrutiny by committee. One example is our Quality, Safety and Experience Assurance Committee (a committee of the Trust Board), where there is a focus on improvements in quality, safety and patient experience. Assurance is provided through reports on compliance, risk, audit, safeguarding, clinical ethics, and performance. Patient stories are often presented to this forum and to the Trust Board.

As a matter of routine, key measures relating to the Trust's core business are presented to the Trust Board. These include measures of quality and safety, patient and referrer experience, and patient access to services.

The Trust's performance framework enables clinical divisions to regularly review their progress, to identify improvements and to provide the Trust Board with appropriate assurance. Our structure can respond to our improvement needs. For example, our recent NHS Staff Survey results have prompted the development of a comprehensive People Strategy and a new committee, the People and Education Assurance Committee to monitor its delivery.

Participation in clinical audit

Participation in National Clinical Audit
During 2019/20 12 national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions have been outlined below.

Name of national audit / clinical outcome review programme	Cases submitted, as a percentage of the number of registered cases required
Cardiac arrhythmia (NICOR: National Institute for Cardiovascular Outcomes Research)	220/220 (100%)
Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular Outcomes Research)	1290/1290 (100%)
Diabetes (Paediatric) (National Paediatric Diabetes Association)	53/53 (100%)
Inflammatory Bowel Disease (IBD) Registry (British Society of Gastroenterology, The Royal College of Physicians, and Crohn's and Colitis UK via IBD Registry Ltd)	156/156 (100%)
Learning Disability Mortality Review Programme (LeDeR)	10/10 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)	16/16 (100%)
National Cardiac Arrest Audit (ICNARC: Intensive Care National Audit and Research Centre)	11/11 (100%)
National Neurosurgical Audit Programme	Data is collected from mandatory Hospital Episode Statistics rather than submitted.
National Confidential Enquiry into Patient Outcome and Death NCEPOD (Long Term Ventillation)	13/17 (76%)
Paediatric Intensive Care Audit Network (PICANet)	1760/1760 (100%)
Serious Hazards of Transfusion (SHOT) (UK National Haemovigilance Scheme)	16/16 (100%)
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	190/190 (100%)

What is clinical audit?

'Clinical audit is a way to find out if healthcare is being provided in line with standards, and lets care providers and patients know where their service is doing well and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients.'[6]

[6] https://www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/

National clinical audit reports
The following national clinical audit reports and data were published from mandatory national audits in 2019/20:

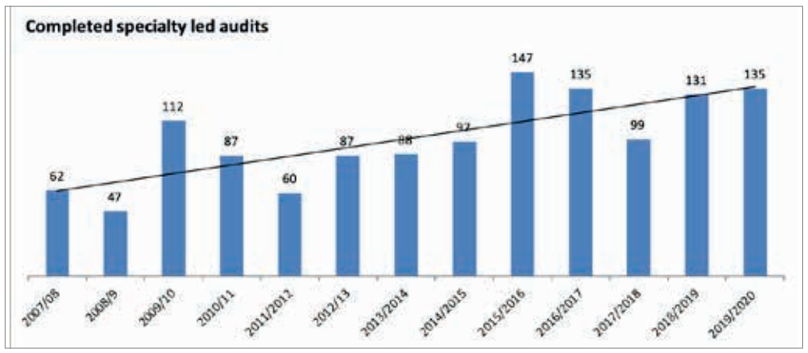
Name of national audit/clinical outcome review programme	Relevance to GOSH practice
Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular Outcomes Research)	The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes. Predicted patient survival is determined for all centres using a calculation called PRAiS2, which adjusts for procedure, age, weight, diagnosis, and co-occurring conditions (co-morbidities). GOSH perform the highest number of surgical episodes in the UK and Ireland. In the three years 2015/16 to 2017/18, there were 1,812 cardiac operations performed in our unit, of which 99.3% of patients survived to 30 days. Based on the confidence limits selected by the National Congenital Heart Audit (NCHDA), our risk-adjusted survival rates for paediatric cardiac surgery are defined as 'much higher than predicted'. More information about this can be found on the Cardiothoracic clinical outcomes page on the Great Ormond Street Hospital website.[7]
Diabetes (Paediatric) (National Paediatric Diabetes Association)	The 2018/19 NPDA national audit report was published in March 2020. It focuses on the measurement of care for type 1 diabetes. GOSH submitted data for 53 children and young people with diabetes in comparison to 48 in the previous year. GOSH does not have sufficient numbers of typical type 1 diabetes to allow comparison of data in the report. 17% of GOSH cases included in the audit have complex forms of Type 1 diabetes, this is in comparison to 97.4% of standard Type 1 and Type 2 diabetes in other centres. 83% of GOSH cases included have rare forms of diabetes.
Inflammatory Bowel Disease Registry	The IBD registry report quarterly data, the most recent report was received at the end of January 2020. There is not significant paediatric data included in the report to allow measurement of GOSH practice against the national data. The Gastroenterology Service GOSH participates in Improve Care Now, an international collaboration between Paediatric Gastroenterology centres. The collaboration benchmarks improvement in quality and monitors clinical outcomes for children with inflammatory bowel disease. As part of the Improve Care Now initiative, GOSH monitors specific IBD outcome measures and have routinely collected data since 2011. These data include outcomes relating to disease remission rates, nutrition and growth for the children we treat. More information about this can be found on the Gastroenterology clinical outcomes page on the Great Ormond Street Hospital website.[8]
Learning Disabilities Mortality Review (LeDeR) Programme report	The third LeDeR annual report was published on 21 May 2019. It gave 12 recommendations based on the evidence from deaths notified to the programme between July 2016 and December 2018. The report has been reviewed by the Consultant Nurse for Learning Disabilities. The following actions are in place which address the report recommendations **LeDeR process** 1. Continue process of identifying children/young people with LD at child mortality review meetings and reporting to LeDer. 2. Review process of flagging children with LD on EPIC to ensure it is comprehensive and accurate. **Staff training** 1. Develop and deliver Learning Disability Awareness Training for all staff and engage with NHS England regarding forthcoming mandatory LD training. 2. In conjunction with the Lead for Mental Capacity, review training about mental capacity and audit mental capacity assessments and best interest decisions. 3. In conjunction with the Pain team, review information for staff about pain assessment for children/young people with LD. **Provision of reasonable adjustments** 1. Identify children, young people and parents with LD who require reasonable adjustments. 2. Record adjustments required. 3. Audit provision of adjustments. **Palliative care** 1. In conjunction with the Palliative Care Team Review provision of end of life care plans for children/young people with LD. The LD programme at GOSH is monitored via the Patient and Family Experience and Engagement Committee. A Disability Forum, comprising parents and professionals is also in the process of being established, which will provided a further level of oversight.

[7] https://www.gosh.nhs.uk/health-professionals/clinical-outcomes/cardiothoracic-clinical-outcomes
[8] https://www.gosh.nhs.uk/health-professionals/clinical-outcomes/gastroenterology-clinical-outcomes

Name of national audit/clinical outcome review programme	Relevance to GOSH practice
National Cardiac Arrest Audit (NCAA) (ICNARC (Intensive Care National Audit & Research Centre)).	The NCCA publish quarterly reports at organisational level to support benchmarking and to identify trends to inform practice and policy on both a local, and national level. GOSH has not had sufficient cardiac arrests in the 2019/20 to allow benchmarking in the reports. The Annual Report should be published in 2020/2021. Once published this will be reviewed via the Resuscitation Committee to identity any trends and to determine any actions required in response to the report
Paediatric Intensive Care Audit Network (PICANet)	The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be 'adjusted' to consider the level of severity of the patients in respect of case mix. The most recent PICANET report compares Trusts Standardised Mortality Ratio[9] for the calendar years of 2016–18.The data in this report shows GOSH mortality as within what would be expected based around the case mix. More information about this can be found on the Intensive Care Unit clinical outcomes page on the Great Ormond Street Hospital Website.[10]
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) *Balancing the Pressures A review of the quality of care provided to children and young people aged 0-24 years who were receiving long-term ventilation.*	The report was published in March 2020 and highlights remediable factors in the care provided to people who were receiving, or had received, long-term ventilation (LTV) up to their 25th birthday. The report highlights five key areas of focus at a national level • Service Planning And Commissioning Of Integrated Care • Multidisciplinary Care • Emergency Healthcare Plans • Discharge Planning • Transition From Child To Adult Services The report has been reviewed by the Respiratory team at GOSH, and any specific actions required at GOSH will be confirmed by the team in the next six months.
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	The 2018 Cystic Fibrosis report was published in 2019/20 and includes data about individual cystic fibrosis centres, to help the centres benchmark themselves against their peers. The data shows that GOSH results for key clinical outcomes are within expected variation. More information about this can be found on the Cystic Fibrosis clinical outcomes page on the Great Ormond Street Hospital Website.[11]

Specialty led Clinical Audit

A total of 135 clinical audits led by clinical staff were completed at GOSH during 2019/20. To promote the sharing of information summaries of completed projects are published on the Trust's intranet, and reports of clinical audit activity are shared with the Patient Safety and Outcomes Committee. Our long-term data suggests we are encouraging a culture of sharing our specialty led clinical audit activity.



In this report it is not possible to list every clinical audit completed in 2019/20 that has had a positive impact on quality and safety. A summary of completed clinical audits in 2019/20 can be obtained on request by contacting the Clinical Audit Manager on 0207 405 9200 ext 5892 or at **clinical.audit@gosh.nhs.uk**.

[9] Standardised Mortality Ratio (SMR). The SMR is the ratio of observed deaths in the ICU compared to the expected number of deaths based upon the PIM3r score: the SMR is calculated periodically and is used as a method of benchmarking the outcomes between ICUs nationally via PICANET.

[10] https://www.gosh.nhs.uk/health-professionals/clinical-outcomes/intensive-care-unit-clinical-outcomes

[11] https://www.gosh.nhs.uk/health-professionals/clinical-outcomes/cystic-fibrosis-clinical-outcomes

Clinical Audit and Quality Improvement prize

This event was run to celebrating the excellent clinical audits and QI projects led by GOSH staff. This year we had 20 entries – double the amount we had last year when we first ran the prize.

Winner	Runners up	
Implementing Thromboprophylaxis Hannah Lewis, Sarah Heikal, Victoria Buswell, Helen Hume-Smith	**Can we reduce the isolation time and testing for children following acute respiratory viral infection?** Zainab Golwala, Tim Best, John Hartley	**Pelican Ward Improvements Throughout 2019** Carole Campbell/team
Date collection started in May 2019. 68% of cases reviewed had mechanical thromboprophylaxis applied when indicated. Changes made: "Guidance was simplified. Education sessions were provided for staff. A visual prompt was built into the electronic patient theatre checklist to appear when TED stockings are indicated. TED stocking length was standardised throughout the trust." Re-measurement showed 96% and 92% correct application of TED stockings.	Identified a large number of children are maintained in isolation unnecessarily. A new risk stratified policy will be written based on the learning from the audit.	Improvements in nursing handover and the ambulatory pathway. "Sepsis and PEWS escalation on the ward required improvement. We implemented a consistent programme of SIMS sessions on Pelican ward and have utilised having BMT sharing the ward to upskill the nursing team with more acute patients. Our datix numbers regarding escalation of care have significantly reduced during 2019."

The winner and runners up were announced at the Senior Leadership Team meeting in March 2020.

Andrew Pearson, Clinical Audit Manager presenting the Clinical Audit Prize to Dr Hannah Lewis at the GOSH Senior Leadership Team meeting on the 5th March 2020.

Learning from deaths

Death in childhood is a rare event. Whenever a child dies, it is important to reflect and to learn if anything could be done differently in the future.

Implementation of the Child Death Review Statutory Guidance
The guidance outlines the statutory NHS requirements for child death reviews for all child deaths occurring after 29 September 2019. This requires a Child Death Review Meeting (CDRM) that is 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. To support this GOSH a Medical Lead for Child Death Reviews has been appointed and a Child Death Review Coordinator has been recruited within the Bereavement Services Team.

Case record reviews take place through two processes at GOSH:

1. **Mortality Review Group (MRG):** This was established in 2012 to provide a Trust level overview of all deaths to identify 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. This group continues to review deaths to ensure a thorough level of review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as identifying learning points and making referrals to other safety investigation processes at the earliest opportunity.
2. **Child Death Review Meetings (CDRM):** These are now in place at GOSH.

Deaths in 2019 and case record reviews
Between 1 January 2019 and 31 December 2019, 114 children died at GOSH. All of those deaths have been subject to a case record review.

Of the 114 deaths, four had modifiable factors in the care provided at GOSH that may have contributed to vulnerability, ill health or death.

2019	Jan–Mar	Apr–Jun	Jul–Sep	Oct–Dec	Total
Number of deaths	29	31	27	27	**114**
Deaths where modifiable factors around GOSH care were identified	2	0	2	0	**4**

What are modifiable factors?

Modifiable factors are defined as those factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

What is the Child Death Overview Panel (CDOP)?

The CDOPs are statutory bodies that review the deaths of all children who die in the UK. The death is reviewed by the CDOP where the child is resident, so GOSH liaises with multiple CDOPs.

Learning from clinical case reviews
The learning points from case record reviews and actions taken are shared via quarterly Learning from Deaths reports at the Patient Safety and Outcomes Committee, and at Trust Board. The Learning from Deaths reports highlight specific learning points and actions taken and are included in the public Trust board meeting papers that can be found online.[12]

Learning from deaths in	Trust Board meeting discussed at
Oct to December 2019	Due to be reported 26th May 2020
June to Sep 2019	Wednesday 1st April 2020
April to June 2019	Wednesday 27 November 2019
Jan to March 2019	Thursday 18th July 2019

Any Trustwide learning points and actions that require implementation are monitored via the Trust Closing the Loop Group.

One of the deaths which was reviewed in 2019/20 was that of Amy Allan. Her family had raised concerns at the time, and these were the subject of a Red Complaint investigation. An inquest into her death was heard in September 2019 and was the subject of media coverage at the time.

The coroner determined that Amy had died as a result of multi-organ failure and that an elective operation in 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.

Mat Shaw, Chief Executive, has spoken about Amy's death on several occasions, both internally and externally. He has acknowledged that Amy did not get the level of care that she needed from us, and that we are deeply sorry for this. We know that we have a responsibility to learn from the mistakes in Amy's care and we take this very seriously. As a result, we have made a number of changes to the way in which we provide care, and these include:

- Ensuring we have the right people present at the right times in our multi-disciplinary team (MDT) meetings to share clinical information effectively between teams. We started with the Spinal MDT, but this is being rolled out to all MDTs in 2020.
- Ensuring that MDT outcomes are documented consistently on the new electronic patient record. This means that the outcome of the discussion is accessible in the patient record for all staff looking after the patient.
- Improving the ways we communicate between teams in the days and weeks ahead of high risk admissions as well as on the day. This will include a phased expansion of our Anaesthetic Pre-Operative Assessment (APOA) service through 2020.
- Introducing new processes for all of our surgical specialties to make sure the care of patients, like Amy, who have both complex surgical needs and heart conditions and who may need ECMO support (the use of an artificial lung located outside the body that puts oxygen into the blood and continuously pumps) are routinely considered by the hospital's specialist joint cardiac conference.

"It is very important we learn from cases like Amy's. Our patients and their families expect and deserve the best possible treatment and care. We are completely committed to providing this."
Matthew Shaw,
Chief Executive

[12] https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board/trust-board-meetings

GOSH Bereavement Survey

The purpose of the survey is to learn from the experience of bereaved parents and carers whose children died at GOSH .This is to highlight what we do well, and also to identify areas where we can improve.

Eighty six children and young people died at GOSH in 2018. Eighty one families were contacted and responses were received from the families of 27 children who died at GOSH.

Key findings

The overall findings are positive and highlight:

- Families reported being able to approach the clinical team with questions about treatment, and being given regular updates about the treatment plan.
- All respondents recall being contacted by their child's medical team and offered a bereavement follow up meeting following the death of their child.
- Responses highlight the level of emotional and spiritual support offered by the whole GOSH team, including housekeepers, volunteers, palliative care, the chaplaincy and the family liaison nurses.
- The report outlines the bereavement support provided to families and children who needed bereavement support.
- Families who identified that they had faith and spiritual needs indicated that those needs were met.
- Families were asked; "What was helpful for you during your experience at GOSH?"
  The top themes identified were:
  - Overall experience of care and expression of gratitude for all that was done (11)
  - Nursing care and compassion (5)
  - Family Liaison Nurse support (4)
  - Chaplaincy (4)

Areas for improvement

- 18/28 (64%) of families advised that there was a discussion with them about the fact that the child was dying. Five cases where this didn't happen were unexpected deaths, and five were expected. This feedback highlights the need to ensure that discussions about the fact that a child is dying take place where it is possible.
- Families were not always aware of all internal and external mortality review processes when a child dies. It should be noted that The Child Death Review: Statutory and Operational Guidance became statutory in September 2019. Families are given the NHS England information 'When a child dies' in their bereavement packs, this explains the process and their key worker's contact details.
- Families were asked "What we could have done better to improve your experience?" There were two responses that indicated they felt less secure at weekends due to fewer staff being around. Two responses expressed regret that there was no Family Liaison Nurse in place at the weekend.

The survey findings were shared at the Patient and Family Experience and Engagement Committee. A specific action plan in response to this survey will be developed by the End of Life Care Group.

Participation in clinical research

As one of the world's leading children's Research Hospitals, children are referred to GOSH from all over the world. Working in partnership with the UCL Great Ormond Street Institute of Child Health (ICH), the hospital is the largest paediatric research and training centre in the UK and one of a very small number of internationally recognised centres of excellence in the field of child health. We are focused on delivering world-leading research for patient benefit. Over recent years the major focus has been on embedding the Research Hospital initiative within the Trust.

The vision of GOSH as a research hospital is one where:

- Research is an integral part of the working lives of our staff and the patients and families we treat and see.
- Research is fully integrated into every aspect of the hospital, to improve the treatment and outcomes for our patients.
- We learn from every patient we see, using knowledge gained to improve the treatment and outcomes for our patients.
- Staff, patients and families understand the opportunity and importance of research.
- We support, value and train all those involved in research, research is considered as a core component when recruiting to leadership positions across the organisation.
- We lead the way in involving patients and families in research design, delivery and strategy and continue to develop creative ways to ensure equitable involvement.
- All clinical directorates and services develop and own their research agenda and are supported to do this.

Following the CQC inspection in 2019, Research Hospital was cited in the subsequent report as an example of how we have improved under the 'well-led framework', with Critical Care highlighted as a particular positive example.

Lacey is 13 years old, but she's been coming to GOSH since she was a baby. Because she was born without intestines, she's had to have many procedures to help her absorb nutrients.

Research activity

During 2019/20, we have run 1,290 research projects at GOSH/ICH. Of these, 377 were adopted onto the National Institute for Health Research Clinical Research Network (NIHR CRN)[13] Portfolio, a prestigious network that facilitates research delivery across the NHS.

Our already extensive research activity has grown year-on-year with the support of our most recent NIHR Clinical Research Facility (CRF) and Biomedical Research Centre (BRC) awards, which began in April 2017. The overall trend for the CRF in 2019/20 is for fewer studies to be hosted, but these are of higher intensity with a higher proportion of trials being early-phase. The occupancy of the CRF remains high, though the number of overnight visits has decreased slightly due to studies transitioning out of the CRF and onto the wards.

In 2019/20, over 2,300 patients and family members took part in research at GOSH, approved by the Health Research Authority (HRA), including Research Ethics Committee and Medicines and Healthcare products Relatory Agency (MHRA) approval as appropriate. Recruitment for 2019/20 is substantially lower than the previous year due to both the end of recruitment to the 100,000 genomes project and the overall trend for fewer studies being hosted by the CRF, but these are of higher intensity which tend to have fewer participants. In addition, this year we transitioned to recording recruitment in the Trust's electronic patient record (EPR) Epic rather than in EDGE (a cloud-based clinical trials management programme). As a result, we are investigating reporting mechanisms to ensure that recruitment is being recorded correctly and that data is not being accidently overlooked.

GOSH leads the London North Genomic Laboratory Hub (GLH)[14], one of seven regional centres that are responsible for coordinating genomic testing in the NHS, consolidating and enhancing the existing laboratory provision. This will create a world class resource for the NHS and underpin the future Genomic Medicine Service. It will also support the delivery of the Government's Life Sciences Strategy and the broader research and innovation agenda, building upon the NHS contribution to the 100,000 Genomes Project[15]. The London North GLH will deliver genomic testing for 34 Trusts and CCGs across North Thames and parts of Hertfordshire and Essex, as well as 11 specialty services. It will host the rare and inherited disease laboratory, with somatic cancer testing being largely consolidated at the Royal Marsden. The new hub gives GOSH the opportunity to continue to lead in genomics, offering an excellent service to our patients, enabling further genomic research and embedding genomics in mainstream medicine.

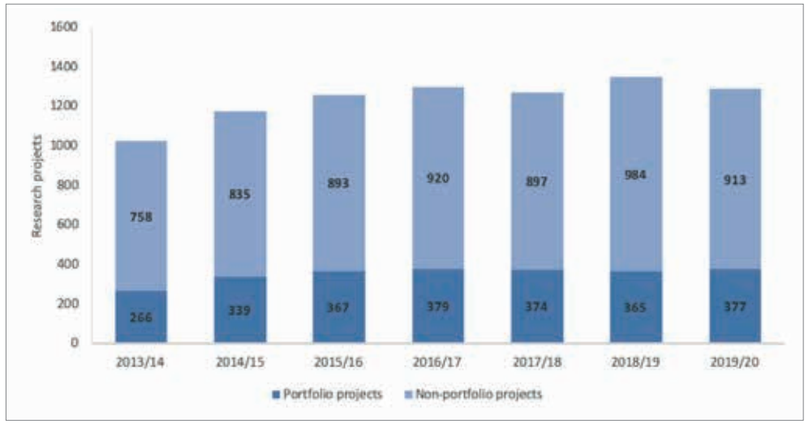


Figure 1: Number of research projects taking place at GOSH/ICH, highlighting the high-quality NIHR CRN Portfolio projects.

[13] https://www.nihr.ac.uk/explore-nihr/support/clinical-research-network

[14] https://www.england.nhs.uk/genomics/genomic-laboratory-hubs

[15] https://www.england.nhs.uk/genomics/100000-genomes-project

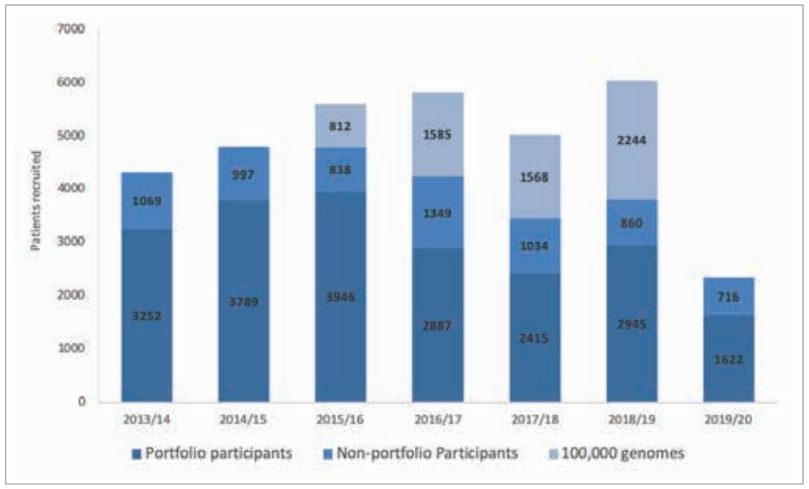


Figure 2: Number of research participants recruited at GOSH/ICH, highlighting the high-quality NIHR CRN Portfolio projects and those recruited to the 100,000 genomes project in previous years.

The Trust has made considerable progress against its objective to establish GOSH Sample Bank, a key project for achieving our Research Hospital vision. Launched to staff and patients/familes in October 2019, we are asking for consent to us retaining and storing surplus tissue, instead of these being discarded. We can then potentially use these samples, alongside associated clinical data, for future research.

The pilot completed its initial outpatient phase in September 2017, moving to the next phase (inpatients) in July 2018, with further areas beginning to consent in 2019. The pilot phase indicated that the principle for consenting to GOSH Sample Bank was generally accepted by patients and families but indicated the need for face to face discussion about the scheme.

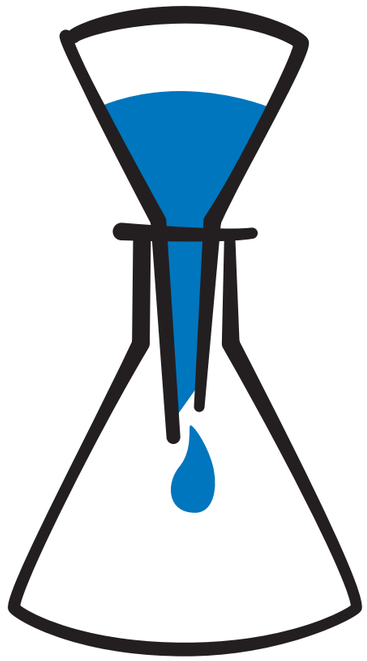
To assist our teams with this communication, our Digital team produced a short animation[16] to explain to patients what happens to their samples. We got invaluable input on this from both our Young Persons Advisory Group (YPAG) and Parent and Carers Advisory Group (PCAG), and the voiceover was provided by Sandra, a GOSH patient and member of YPAG.

Funding

This year we saw an overall 12% growth in our research income to £28 million, which supports research infrastructure and projects across the Trust. This has been in part due to a higher than anticipated growth in commercial income of 25%, through attracting an increased number and value of commercial studies to the Trust as well as extensive work to improve the effectiveness of commercial income recovery.

We have also increasingly focused on improving relationships with industry and maximising potential benefits of those relationships via commercialisation of intellectual property. We are also ensuring that we have the infrastructure to support a pipeline of new studies as existing trials transition into clinical care. 2019/20 was the third (out of five) year of our third funding term of the NIHR GOSH Biomedical Research Centre (BRC) and of our newly designated NIHR Clinical Research Facility.

In the coming year we will begin work to prepare for the BRC renewal process, a vital undertaking to ensure we can continue to maintain and progress key areas of translational research.



[16] https://www.gosh.nhs.uk/our-research/taking-part-research/gosh-sample-bank

Innovation

The Trust regularly reviews our IP portfolio and makes strategic recommendations to R&I Board for support of innovation with commercial potential. The Trust has a robust IP policy which supports the it's objective to encourage the creation and successful exploitation of innovation, ensuring that GOSH effectively manages its IP and that revenue share arrangements to incentivise employees are transparent and well managed. We have a contract with Health Enterprise East (who provide innovation management services to NHS organisations across London, South East and South West regions) for managing the Trust's IP.

The Trust also engages regularly with the BRC Translational Research and Enterprise Accelerator (TREAC) cross-cutting theme through their dedicated Business Development Manager based within the Division of R&I. This enables more regular, on-site access to our university partner and facilitates shared learning in the translational research space.

The Trust launched the Digital Research Informatics & Virtual Environment (DRIVE)[17] in October 2018; a partnership with University College London (UCL) and leading industry experts in technology, artificial intelligence and digital innovation. DRIVE aims to become a world leading clinical informatics unit focused on data analysis, accelerating research and the deployment of cutting-edge technology. With the implementation of the Trust's electronic patient record (EPR) Epic and the Digital Research Environment (DRE – which provides the technological infrastructure to facilitate research undertaken at GOSH), DRIVE will harness the powerful combination of rich health data with data science and digital innovation and develop scalable solutions to enhance health services not only for GOSH patients but across the wider NHS.

The recent appointment to the newly created Trust post of Commercial Director offers the opportunity to review current commercial processes in research, creating strategic partnerships with the commercial sector to fully maximize the benefit to the Trust.

Zayed Centre for Research into Rare Disease in Children

The Zayed Centre opened in October 2019. The facility brings together pioneering research and clinical care; patients will benefit from the latest developments in the laboratory, accelerating the progress of new diagnoses, treatments and cures for rare and complex diseases. It houses the latest technologies[18] in a flexible space that acts as a vibrant and collaborative hub.

Over the coming months, research teams will continue moving into the new centre and vital steps will progress to ready a six-room laboratory suite on the top floor. This suite adheres to the strict requirements required to manufacture therapeutic, gene-edited cells that can then be returned to patients. Facilities with this capability are extremely rare, with no comparable labs in the UK at present. One of the first patients to be treated at the Centre was Kai (pictured below). Kai has hypertrophic cardiomyopathy (HCM), a rare genetic condition, where the muscle wall of the heart becomes thickened. He is taking part in a research project aiming to discover new biological markers of inherited heart conditions, with the hope that it will result in better ways to diagnose patients and to predict how the disease will develop over time.

Below: Kai, age 10 has hypertrophic cardiomyopathy, a rare cardiac condition, and he experienced multiple cardiac arrests before receiving a donor heart earlier in 2019. Kai attends the outpatient clinic in the Zayed Centre for Research and is taking part in a research project aiming to discover new biological markers of inherited cardiac conditions.

Journal publications

In 2019/20 we pulished 660 papers, 399 of these were with our academic partner. In the five year period between 2012 and 2016, GOSH and ICH research papers together had the second highest citation impact (1.997) of comparable international paediatric organisations.

Research highlights

Successful clinical trials at GOSH and other centres resulted in NHS approval of Brineura, a novel treatment for Batten Disease. Patients given the treatment had 80% less decline in motor and language skills and reduced loss of brain tissue. The drug is administered directly into the brain via a novel intraventricular device. Since Brineura approval, GOSH has been given a leading role by NHSE in training other UK centres in managing Batten Disease patients receiving regular intracerebroventricular enzyme replacement therapy infusions.

A pioneering new stem cell gene therapy treatment, manufactured at GOSH and ICH (after being developed at the University of Manchester with funding from GOSH Charity), was used to treat the world's first patient with the severe life-limiting genetic condition MPSIIIA (Sanfilippo syndrome). The transplant was performed on a two-year old patient at the Royal Manchester Children's Hospital (RMCH).

A promising new cancer treatment (CAR-T therapy), is being offered to children with acute lymphoblastic leukaemia (ALL) through a GOSH clinical trial. GOSH also treated the first NHS patient for relapsed ALL with a similar CAR-T therapy, known as Kymriah.

GOSH researchers developed the first ever tool to identify children at risk of sudden death from a rare heart condition called hypertrophic cardiomyopathy (HCM). Children identified at high risk have the option of being fitted with an implantable cardioverter defibrillator (ICD) – a small device that can shock the heart back into a normal rhythm if they experience a life-threatening abnormal heart rhythm and could potentially save their lives.

Centre for Outcomes and Experience Research in Children's Health Illness and Disability (ORCHID)

As a Research Hospital, research is an integral part of the working lives of our staff and the patients and families we treat and see. Research is considered a core component of the work of all healthcare professionals at GOSH. Integral to maintaining that component of work is The Centre for Outcomes and Experiences Research in Children's Health, Illness and Disability (ORCHID). ORCHID is a centre for research at GOSH, bringing together non-medical professionals, to undertake their own research, as well as collaborate on multi-professional studies, within the field of child health. Professor Faith Gibson, Director of Research – Nursing and Allied Health, leads this centre, and along with Dr Paula Kelly, Dr Kate Oulton, Dr Debbie Sell and Associate Professor Jo Wray, provides leadership to the Research and Clinical Academic Faculties within ORCHID. They represent the professions of nursing and allied health with researchers undertaking time limited studies, funded through grant income, and PhD students, funded by NIHR Fellowships and NIHR GOSH Biomedical Research Centre (BRC) funds.

Our aim, within the centre, is to contribute significantly to innovation and excellence in care, to influence and help embed a research culture into the fabric of GOSH, and to foster a culture of inquiry amongst nurses and the allied health professions. One of the strategic aims of GOSH is to function as a research hospital. We contribute to this vision through firstly building nursing and allied health professions research capacity and capability and secondly through our research on experiences and outcomes of children/young people and their families: our academic and research achievements are captured in the infographic below.

The numbers 2019/20

63 Peer reviewed publications	**70** Conference presentations
37 Published abstracts	**33** Invited presentations
6 Book chapters	**1** Edited book
12 New research grants	**23** Ongoing studies
1 New PCAF award	**4** New doctoral fellowships
15 PhD students	**1** Resource
£1,116,912 Fellowship income	**£3,358,334** Research income

Our success in mentoring and supporting others was demonstrated by the recent award of a further three prestigious non-medical fellowships by the NIHR, a direct result of the internship funding we are able to offer nurses and AHPs though support from our NIHR GOSH BRC Education theme. Polly Livermore was appointed as Clinical Academic Programme Lead GOSH BRC, to support and plan for initiatives such as the internship programme. Dietitian James Evans, children's nurse, Tara Kerr-Elliott, and an optometrist Sian Handley were awarded Clinical Doctoral Research Fellowships. We have expanded our clinical academic faculty, there are now 11 NIHR Nurses and AHPs undertaking PhDs, and four further PhD students who received other grant awards.

[17] https://www.goshdrive.com
[18] https://www.gosh.nhs.uk/our-research/our-research-infrastructure/zayed-centre-research-rare-disease-children/about-zayed-centre-research

CQC registration

GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2019/20.

As of March 2020, and in response to the NHSE/I request for the Trust to support the wider NHS during the COVID 19 pandemic, the Trust has expanded its registration to:

- Treat patients up to the age of 65.
- Treat patients who have been detained under the Mental Health Act.

In December 2019, the CQC conducted a scheduled unannounced inspection of three services (critical care, surgery and CAMHS) and an announced inspection against the well-led criteria. The report was published in January 2020. The Trust retains its overall rating of *Good*. All services provided by the hospital are now rated as either *Outstanding* or *Good*.

The effectiveness of our care, and the caring attitude of our staff have been rated as *Outstanding* again. Our Well Led rating has improved to *Good*, which is a welcome reflection on the work at all levels in the organisation to improve. Although areas of good practice were noted, the overall rating of the domain safety of care was reduced to *Requires Improvement*. This is linked primarily to medicines management within the hospital specifically the storage and disposal of medicines.

The CQC issued 2 enforcement notices:

- Regulation 12: Safe Care and Treatment – This recommendation relates to the robustness of access control measures in PICU medication room; the safe storage of IV fluids in theatres, interventional radiology and on one of the surgical wards; the process for denaturing controlled drugs on wards; and the temperature monitoring arrangements for medication rooms.
- Regulation 17: Good Governance – This recommendation relates to the articulation of the breadth of the medicines risk on the board assurance framework; and the need to ensure that the EPR system fully meets the needs of the staff in the CAMHS service to deliver safe care.

A CQC action plan has been developed to address all actions. An executive led committee, Always Improving, has been established and meets monthly to review progress against this action plan, whilst supporting the ongoing work with the Trust's CQC compliance. This committee reports into the Risk, Assurance and Compliance meeting with regular reports to Board and the Council of Governors. The Trust will continue to conduct mock inspection framework (CQC Quality Rounds) in clinical directorates and review potential areas/sources of learning for example reviews of themes from other CQC reports and evaluation of CQC Insight reports.

What is the Care Quality Commission?

The Care Quality Commission (CQC) is the independent healthcare regulator for England and is responsible for inspecting services to ensure they meet fundamental standards of quality and safety.

Use of the CQUIN payment framework

A variety of CQUINs have been undertaken by the Trust in 2019/20. Some of these are national indicators, which may also be undertaken by other trusts across the country, and some were locally defined in order to improve our individual performance. Due to the specialist nature of our care, some of the national CQUINs needed to be adapted to fit with the services we provide for our patients.

CQUIN Reporting 2019/20	
CQUIN title	**Overview**
Promoting Transplantation	The aim is to increase the Organ transplantation rate by addressing barriers to organ uptake and optimising the pathway and to reduce the work up time for the live donor pathway to promote transplant rates.
Medicines Optimisation	This CQUIN scheme aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services. A number of priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office.
Paediatric Movement Therapies	The scheme aims to ensure equity of access to the pathway for all children with cerebral palsy and avoid geographical variation. There are several thousand children in England who would benefit from specialist MDT review. It also increases the focus on improving children's lives by ensuring that professionals work together across organisational boundaries.
Paediatric Movement Therapies	The aim of this local scheme is to reduce pre-analytical sample rejections and to improve pre-analytical sample transit time. For our patients there are significant consequences including delays in diagnosis and treatment, inconvenience and discomfort for the patient, and increased hospital and laboratory costs. For some of our children and neonates, it is very difficult for staff to obtain good samples, and it is not acceptable to repeat this process.

In 19/20 the total financial allocation for CQUINs was set at 1.25% for clinical commissioning groups and 0.75% for NHS England of GOSH's NHS income (activity only). This equates to circa £1.8m for the 19/20 financial year.

The value of the individual CQUINs for the Trust ranged from £14,000 for CAMHS Training to £625k for Medicines Optimisation. We have achieved 100% compliance for 2019/20 however the value for the year will be finalised by the end of June 2020 when final activity values are reported.

What is the Commissioning for Quality and Innovation framework?

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of NHS healthcare providers' income conditional upon improvement. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers, and constitutes 2.5% of the Actual Contract Value between commissioner and provider.

Data quality

Good quality data is crucial to the delivery of effective and safe patient care. Data is vital to enable us to run our services efficiently as well as to identify any care quality issues and predict trends in order to take early action.

Highlights of the work completed in 2019/20 across Information Services, Data Assurance, Information Governance, and Clinical Coding include:

Information Services

- Statutory & Mandatory Returns datasets built in the new EPR data warehouse with both internal (for validation) and external (for submission) reporting mechanisms.
- Statutory & Mandatory Returns datasets updated throughout the year as new versions and requirements released, including in-house XML translation to meet new requirements for submission in that format.
- Multiple datasets built in the new EPR data warehouse and QlikView to provide the Trust with oversight of various operational areas, from Theatre Utilisation to Patient Management, including any specific data quality issues.
- Standards for both data warehousing and reporting development consistently followed by the team and shared with other data teams across the Trust.
- Knowledge sharing with data teams across the Trust delivered via several means, including an Epic data warehouse user group established and run by the team.
- New processes developed for managing maintenance of data warehousing and reporting during system upgrades.
- Managed shutdown of warehouse data feeds from legacy systems and development of reporting on data from those systems not migrated to the new EPR, according to the requirements of diverse user groups.

Data Assurance

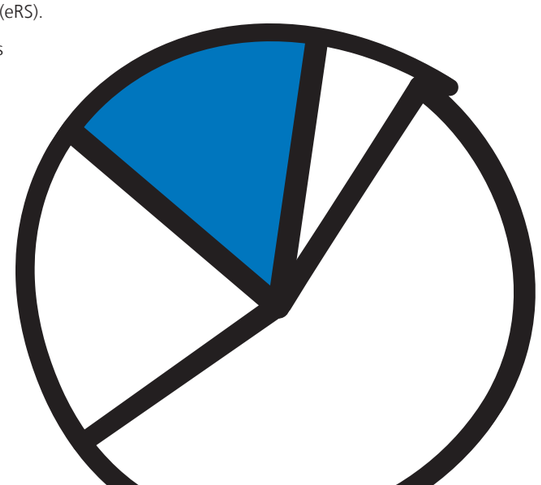
- Members of Data Assurance team were accredited Epic Credential trainers.
- Data assurance team supported the Epic go-live period and continue to provide training delivery, development of training content, standard operating procedures and data entry support to front end users.
- With successful implementation of our new Epic EPR System in April 2019 we completed a full review of our data quality governance structure. Also, reviewed Terms of Reference for weekly Data Quality Focus Groups and monthly Data Quality Review Group to ensure our work continues to be relevant and fit for purpose.
- Refreshed Data Quality Policy which also covers the Digital Research Environment Data Lake.
- Agreed programme of work for our Data Quality Plan .
- Data quality dashboards and work queues are fully integrated within the Epic and forms part of the data assurance team daily checks and Epic build review.
- Extensive validation of migrated and new epic data to ensure all dimensions of data quality criteria is met which includes full validation of all unknown RTT clock start, Statutory reporting month end submission errors (RTT, DM01, DID and SUS).
- Continuous training and user support for the Electronic Referrals System (eRS).
- Managed the transition of IPTMDS process from Central booking Services to Data Assurance Team.

What is data quality?

Data quality refers to the tools and processes that result in the creation of accurate, complete and valid data that is required to support sound decision making.

What is NHS Digital?

NHS Digital is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.



Secondary Uses Service

As required by NHS Digital, GOSH submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the National Hospital Episode Statistics. These are included in the latest published data. The table below shows key data quality performance indicators within the records submitted to SUS.

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS number	Inpatients	91.3%	99.4%
	Outpatients	91.9%	99.7%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.6%	99.7%
	Outpatients	99.6%	99.6%

Notes:

- The table reflects data from February 2020 at month 11 SUS inclusion date.
- Nationally published figures include our international private patients, who are not assigned an NHS number. Therefore the published figures are consequently lower at 91.3% for inpatients and 91.9% for outpatients.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

Information governance

The Trust is in the process of finalising its submission against the Data Security and Protection Toolkit (DSPT). This system allows us to demonstrate our position against the General Data Protection Regulations (GDPR) 2018 and other data protection legislation. The outlining of the key requirements allows GOSH to maintain status as a `Trusted Organisation' with regards to sharing NHS data with NHS bodies and other Trusted partners.

While compliant with the mandatory requirements, some areas of improvement have been identified and an action plan is underway.

Actions include:

- Ensuring the Trust is compliant with the national data opt-out so that patient wishes are respected with regard to the secondary use of data.
- The development of a continual ongoing programme to ensure an accurate and up to date list of all personal data held by GOSH.

Clinical coding

GOSH has a dedicated and highly skilled clinical coding team, which continues to maintain high standards of inpatient coding. The depth of coding continues to sit above the national average due to the complexity of our patients.

GOSH has implemented a new audit process and now carries out a continuous individual internal audit programme to ensure that accuracy and quality are maintained, that national standards are adhered to, and any training needs are identified. As a result of the audit programme, training sessions are now undertaken more regularly on either a team or individual basis, and we continue to standardise coding across the Trust.

The recent 2019/20 audit for the Data Security and Protection Toolkit showed results of over 97.5% accuracy for primary diagnostic coding, and 94.29% for primary procedure coding.

Overall results:

Area audited	Number of FCEs	Primary diagnosis accuracy	Secondary diagnosis accuracy	Primary procedure accuracy	Secondary procedure accuracy
Data Security and Protection Toolkit	200	97.50%	98.29%	94.29%	88.77%

200 FCEs were audited – the accuracy percentages were as noted above.

The findings of the audit demonstrated a very good standard of diagnosis coding accuracy.

What is the Secondary Uses Service?

The Secondary Uses Service (SUS) is a single source of specified data sets to enable analysis and reporting of healthcare in the UK. SUS is run by NHS Digital and its reporting is based on data submitted by all provider trusts.

What is an NHS Number?

Everyone registered with the NHS in England and Wales has their own NHS number, a unique 10-digit number that helps healthcare staff to find a patient's health records. The NHS number increasingly helps to identify the same patient between organisations and different areas of the country.

There were a number of areas of good practice noted – these included:

- The medical records were all accessible electronically and are available in a timely manner to the coders.
- Quality of diagnoses coding is very good.
- Histology results were checked and updated.
- The full electronic patient records were available at the time of audit.
- Evidence of good engagement between Clinicians and Coding staff.
- There are currently no vacant posts in the department.
- Encoder is in use, which allows coding 5th characters and coders can select source documents and add any relevant notes to the episode coded.

There were also a few areas that could be improved, these included:

- There were a few areas where there were inconsistencies in coding procedures – there is a need for specific polices in these areas.
- Majority of errors were coder errors.

GOSH was subject to a national Payment by Results clinical coding audit during the 2019/20 reporting period.

Priority clinical standards for seven-day hospital services

The seven-day services programme is designed to ensure patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital.

GOSH does not have an accident and emergency department and therefore our 'emergency' workload relates to non-elective patients admitted directly from other hospitals into our critical care units.

For these unplanned critical care admissions, we participate in the NHS England seven-day service audit and self-assessment framework. The audit measures whether patients admitted as an emergency are seen by a consultant within 14 hours of arrival, and whether patients are subsequently seen twice daily by a consultant. Our audit data for 2019/20 shows that we meet all required clinical standards.

Reagan is 15 years old and as she's grown, she's developed scoliosis. She recently had surgery at GOSH to straighten her spine.

Promoting safety by giving voice to concerns

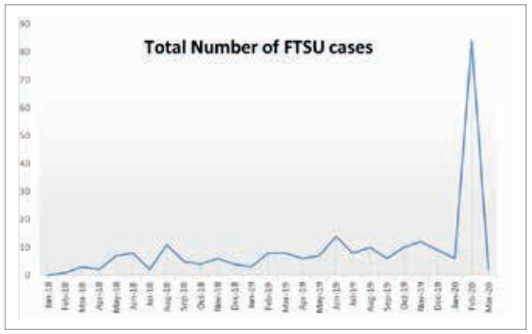
Freedom to Speak Up Guardian

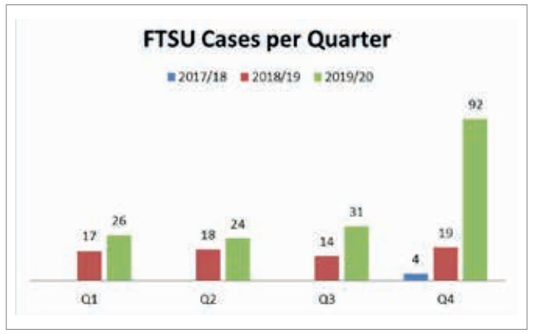
The Freedom To Speak Up service has seen a marked increase in contacts between 2018/19 and 2019/20. Nine months of the financial year saw FTSU cases increases compared to the same month the preceding year.

February 2020 saw a significant increase due to the presentation of two petitions from OCS cleaning staff. One petition was about OCS not allowing sufficient time for Muslim staff to pray but the larger petition was about poor relations between OCS managers and OCS cleaners. No safety concerns related to GOSH staff or patients were identified. OCS staff were guided to their HR teams and Trade Union for support and in addition these concerns were raised with GOSH Director of Facilities also.

Although the number of FTSU cases has increased, the proportion of staff raising concerns about bullying and about safety remain the same with bullying and harassment the most significant feature of FTSU contacts. Staff contacting the FTSU service receives advice and support to use the Trust policies and processes to raise concerns. The FTSU also aggregates the cases and anonymously reports the numbers and themes to the Quality, Safety and Assurance Committee and to the Audit Committee to alert senior Executives and Non-Executives to the experiences of staff.

Month of the financial year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	6	7	14	8	10	6	10	12	9	6	82	2	**174**
2018/19	2	7	8	2	11	5	4	6	4	3	8	8	**68**





Whistleblowing protection

Most issues raised by employees are easily resolved. However, there are times when concerns are of a more serious nature. The Trust has a policy, which has recently been updated in line with national guidance, which provides a clear and easily accessible route for raising these types of concerns which are known as qualifying disclosures (also known as whistleblowing concerns).

The policy also outlines a range of people who employees can raise concerns with even if they don't fall under the definition of a whistleblowing concern, including the Freedom to Speak Up Guardians and Speaking Up for Safety™.

The overarching aim of the policy is to demonstrate the Trust's commitment to openness and accountability through:

- The provision of a safe environment to raise concerns at work.
- Reassurance of employees that it's safe and acceptable to speak up.
- Reassurance of employees that they can raise a concern at an early stage and with clarity about the process.

Speaking Up for Safety

June 2019 saw the implementation of the Speak Up Programme.

All NHS organisations have to show they are encouraging staff to speak up with patient safety concerns. Failing to do this can harm patients and in extreme cases, may contribute to loss of life. GOSH was determined to go beyond the minimum requirement – we want to use the Speaking Up for Safety programme to create the right safety culture for our colleagues, patients and their families. The programme empowers our staff to support each other and raise concerns. Between June and December 2019 we ran in-house workshops, led by trained and accredited volunteers from across all staff groups. The purpose of the workshops were to enable staff to develop the skills and insights to respectfully raise concerns with colleagues through the use of the Safety C.O.D.E.

Reducing rota gaps for NHS doctors and dentists in training

Rota gaps for doctors' present direct risk to patient safety, affecting quality of patient care and the wellbeing of doctors.

GOSH vacancy rate has varied between 6.8 and 12.7% over 2019/20 (slightly increased from 2018/19; range 5.3–11.4%) but continues to sit below the national average. According to the Royal College of Paediatrics and Child Health national vacancy rates are 14.6% on senior (registrar) rotas and 11.1% at junior (SHO) level[19].

Vacancy rates and rota gaps reflect the end point of multiple workforce issues including:

- Short term unplanned absence.
- Delays in recruitment process, particularly timeframes for on boarding international medical graduates.
- Long term structural rota problems and complex interdependencies.
- Variations in numbers of trainees sent to the Trust by the deanery.
- National reduction in the medical paediatric workforce.

Rota gaps have been highlighted as an organisational pressure. Measures are being taken to mitigate the situation at GOSH include:

- Disbanding a rota that had significant gaps as it was difficult to recruit to and retain doctors on.
- Applying equitable out of hours working principles to the medical workforce, increasing the number of doctors who are able to provide out of hours support.
- Establishing minimal numbers of doctors required to safely staff speciality areas.
- Devising new rotas that factor in minimum doctor numbers and hours for annual and study leave.
- Definition and implementation of an escalation pathways for known and unknown rota gaps in medical specialities.
- Allocating managerial oversight providing cross organisation rota coordination and support.
- Monthly organisational monitoring of recruitment time frames and anticipation of/ planning for rota gaps .

Although organisational vacancy rates are a useful metric, understanding departmental pressures and dependencies are essential for mitigating the impact of rota gaps within specialties. When a significant rota gap is anticipated, working alongside junior medical staff and planning work flow is undertaken with support of the GoSW.

It is the experience of this Trust, and others nationally, that exception reporting is a poor assurance tool for monitoring compliance and reflecting gaps in rotas. As such the Trust is working on improving medical workforce data intelligence (absence rates, rota gaps and vacancy rates) to fully understand the dependencies and requirements of the junior medical workforce.

The modernising clinical workforce committee is responsible for delivering ongoing improvement work including developing medical workforce performance dashboard and an advanced clinical practice and Shape of Training strategy.

[19] Workforce census overview 2017 (published 2019): https://www.rcpch.ac.uk/resources/workforce-census-uk-overview-report-2019#introduction

Part 2c:
Reporting against core indicators

Performance against Department of Health and Social Care quality indicators

NHS trusts are subject to national indicators that enable the DHSC and other institutions to compare and benchmark trusts. Trusts are required to report against the indicators that are relevant to them. The table below shows the indicators that GOSH reports against on a quarterly basis to our Trust Board and also externally. Where national data is available for comparison, it is included in the table.

What is the Department of Health and Social Care?

The Department of Health and Social Care (DHSC) is a department of the UK government with responsibility for government policy for England alone on health, social care and the NHS.

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2019	2018	2017	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
				Source: NHS Staff Survey Time period: 2019 calendar year					
The percentage of staff who would be happy with the standard of care provided by the organisation if a friend or relative needed treatment.	88.7%	88.2%	86.1%	88.7%	94.8%	80.9%	90.0%	The survey is carried out under the auspices of the DHSC, using their analytical processes. GOSH is compared with other acute specialist trusts in England.	The key actions associated with addressing staff survey findings will be incorporated into the Integrated People Strategy – with its four pillars; Capacity, Infrastructure, Skills and Culture & Engagement. The survey results indicate the need to prioritise the Culture & Engagement pillar. This workstream's purpose is to ensure all our people feel well led and managed, but also supported and empowered to do and be their best. The key components of this pillar are: Visible Leadership, Corporate Strategy & Narrative, Creating an Employee Voice, Living Our Values, Creating Transparency & Promoting Dialogue, and Integrating Support Services & Networks. These are underpinned by Training & Development and Internal Communications.
Percentage of staff who agreed that care of patients is the organisation's top priority.	86.5%	84.2%	82%	86.5%	91.9%	82.9%	87.3%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from managers in last 12 months.	16.3%	17.2%	17.1%	16.3%	7.2%	16.3%	11.6%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from other colleagues in last 12 months.	24.4%	22.1%	20.8%	24.4%	13.9%	24.4%	18.7%		
Percentage of staff who consider the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.	75.9%	78.8%	81.3%	75.9%	91.4%	75.9%	86.2%		

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2019/20	2018/19	2017/18	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Friends and Family Test (FFT) - % of responses (inpatient).	24%	18.9%	24.6%	26%	41%	6%	25%	The rates are from NHS England Time period:2019/20 financial year Comparing: paediatric trusts*	We are promoting FFT at ward level, so every family is aware they can provide feedback and how. We advertise the online feedback on our weekly Feedback Friday slot on the @GreatOrmondSt Twitter feed, along with the feedback page link. Interactive feedback functions are being developed to encourage our children and young people to complete the FFT.
FFT - % of respondents who recommend the Trust (inpatient).	97%	96.7%	97.1%	96%	99%	48%	26%		
*Children's hospitals: Alder Hey, Birmingham, Bristol Royal, Evelina, Leeds, Nottingham, The Alex Brighto, Royal Manchester, Sheffield, Southampton and the Great North.									
Number of clostridium difficile (C.difficile) in patients aged two and over.	6	6	11	Data not available‡	Data not available‡	Data not available‡	Data not available‡	The rates are from Public Health England. Time period: 2019/20 financial year Comparing: Stand-alone paediatric trusts†	Continuing to test stool samples for the presence of C.difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C.difficile in patients aged 2 and over (number of hospital acquired infections/ 100,000 bed days).	2	10.3	18.8	Data not available‡	Data not available‡	Data not available‡	Data not available‡		
Note: C.difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. At GOSH, we test for C.difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported; where a request is made for enteric viruses; and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Healthcare Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report. * National report used estimated bed days at time of reporting. † www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data. ‡ Data is released by PHE and was not available at the time of publishing this report.									

Indicator	From local trust data			GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2019/20	2018/19	2017/18		
Patient safety incidents reported to the National Reporting and Learning System (NRLS):					
Number of patient safety incidents	5,069	6,751	6,345	GOSH uses electronic incident reporting to promote robust reporting and analysis of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing.	Initiatives such as: Risk Action Groups, local training in root cause analysis, and "Learning from…" events and posters, improve the sharing of learning to reduce the risk of higher-graded incident recurrence. Initiatives are reported and monitored by the Patient Safety and Outcomes Committee.
Rate of patient safety incidents (number/100 admissions)	12.6	14.9	14.2		
Number and percentage of patient safety incidents resulting in severe harm or death	4 (0.1%)	6 (0.1%)	12 (0.2%)		

Explanatory note on patient safety incidents resulting in severe harm or death

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC as part of the CQC registration process. GOSH also reports its patient safety incidents to the NRLS, which runs a national database designed to promote learning.

There is no nationally established and regulated approach to reporting and categorising patient safety incidents. Different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a lengthy investigation, which could result in the classification being changed. This complexity makes it difficult to do a formal comparison.

Part 3:
Other information

NHS Improvement uses a limited set of national mandated performance measures, described in its *Single Oversight Framework*, to assess the quality of governance at NHS foundation trusts.

Performance is measured on an aggregate (rather than specialty) basis and Trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

What is NHS Improvement?

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

Performance against key healthcare targets 2019/20

Domain	Indicator	National threshold	GOSH performance for 2019/20 by quarter				2019/20 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment***	96%	100%	100%	100%	Jan and Feb only: 100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:***							
	· surgery	94%	100%	100%	100%	89.47%	95.65%	Yes
	· anti-cancer drug treatments	98%	100%	100%	100%	100%	100%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway***	92%	Apr: 90.08% May: 88.26% June: 86%	Jul: 84.47% Aug: 82.45% Sep: 83.72%	Oct: 85.02% Nov: 85.71% Dec: 84.98%	Jan: 86.14% Feb: 85.95% Mar: 82.88%	85.47%	No
Experience	Maximum 6-week wait for diagnostic procedures***	99%	Apr: 90.79% May: 90.52% June: 92.08%	Jul: 94.93% Aug: 96.04% Sep: 96.92%	Oct: 95.19% Nov: 96.79% Dec: 91.02%	Jan: 87.94% Feb: 91.57% Mar: 74.77%	91.55%	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

*Target based on meeting the needs of people with a learning disability, from recommendations set out in Healthcare for All (Department of Health, 2008)
Capacity has also been an issue. The Trust is currently working through a recovery plan to improve performance against this standard in 2019/20. ***Source: NHS Digital

Additional indicators – performance against local improvement aims

In addition to the national mandated measures identified in the above tables, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in Part 2a. The table below sets out the range of quality and safety measures that are reviewed at each Trust Board meeting. Statistical Process Control (SPC) charts are used to measure improvements in projects over time and to identify areas that require further investigation. All measures remain within expected statistical tolerance.

Domain	Indicator	GOSH performance for 2019/20 by quarter				2019/20 mean
		Q1	Q2	Q3	Q4	
Effectiveness	Inpatient mortality rate (per1,000 discharges)‡‡†	8.97	8.20	8.38	6.26	7.99
Experience	Discharge summary completion time (within 24 hours)	47.40%	60.36%	70.07%	74.25%	62.71%
Effectiveness	PICU discharges delayed by 8–24 hours	9	6	11	14	10
Effectiveness	PICU discharges delayed by more than 24 hours	21	9	3	9	10.5
Effectiveness	Last minute* non-clinical hospital cancelled operations‡ and breaches of 28-day standard:					
	· cancellations	157	142	104	83	122
	· breaches	34	6	9	9	15
Experience	Formal complaints investigated in line with the NHS complaints regulations***	21	24	24	21	90 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge‡‡	2.55%	2.32%	2.21%	2.34%	2.36%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge‡‡	0%	0%	3.87%	4.76%	3.02%
Safety	GOS acquired Central Venous Line (CVL) related bloodstream infections (per 1,000 line days)	1.7	1.2	1.3	2.6	1.7 per 1000 line days

Note: Thirteen episodes for Squirrel gastro come from one child with a serious gastrointestinal issue who has had recurrent bacteraemias likely to have arisen from the gut but seeded the line). Removing these unavoidable 13 episodes (and the line days) gives an annual rate of 1.4.

Performance against key healthcare targets 2018/19

Domain	Indicator	National threshold	GOSH performance for 2018/19 by quarter				2018/19 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment***	96%	97.87%	100%	100%	100%	99.45%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:***							
	· surgery	94%	100%	93.33%	90.91%	100%	Indicative position: 95.65%	Yes for Q1&4. No for Q2&3
	· anti-cancer drug treatments	98%	100%	100%	100%	100%	100%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway††† ***	92%	Apr: 93.62% May: 93.64% June: 92.59%	Jul: 92.76% Aug: 92.85% Sep: 92.24%	Oct: 92.19% Nov: 92.15% Dec: 92.09%	Jan: 92.59% Feb: 92.18% Mar: 92.24%	92.60%	Yes
Experience	Maximum 6-week wait for diagnostic procedures***	99%	Apr: 97.87% May: 97.45% June: 98.43%	Jul: 97.43% Aug: 94.44% Sep: 94.53%	Oct: 94.07% Nov: 96.98% Dec: 93.14%	Jan: 95.19% Feb: 97.54% Mar: 97.48%	96.21%††	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved

*Target based on meeting the needs of people with a learning disability, from recommendations set out in Healthcare for All (Department of Health, 2008)

Additional indicators – performance against local improvement aims

Domain	Indicator	GOSH performance for 2018/19 by quarter				2018/19 mean
		Q1	Q2	Q3	Q4	
Safety	Central Venous Line (CVL) related bloodstream infections (per 1,000 line days)	1.7	1.2	1.3	2.6	1.7†
Effectiveness	Inpatient mortality rate (per 1,000 discharges)‡‡†	4.74	5.00	7.62	8.95	6.49
Effectiveness	PICU discharges delayed by 8–24 hours	19	13	16	17	16
Effectiveness	PICU discharges delayed by more than 24 hours	36	25	57	56	43
Experience	Discharge summary completion time (within 24 hours)	89.24%	87.18%	80.75%	77.32%	83.30%
Effectiveness	Last minute* non-clinical hospital cancelled operations‡ and breaches of 28-day standard:					
	· cancellations	112	135	155	150	137
	· breaches	13	17	21	13	16
Experience	Formal complaints investigated in line with the NHS complaints regulations***	18	30	27	20	95 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge‡‡	1.63%	2.72%	2.24%	1.58%	2.04%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge‡‡	0	0	1.53%	0	0.38%

† Does not include day cases †† Reported to Board from October 2017 *** Source: NHS Digital ‡‡ Source: Hospital Episode Statistics

* Last minute' is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery.

‡ Thirteen episodes come from one child with a serious gastrointestinal issue who had recurrent bacteraemias likely to have arisen from the gut but seeded the line. Removing these unavoidable 13 episodes (and the line days) gives an annual rate of 1.4.

††† Throughout the last year, the Trust continued work to improve the quality and robustness of our waiting list data, building on the work that had been completed over previous years. The principle focus for 2018/19 was maintaining compliance against the RTT standard as an organisation and focusing on speciality level compliance. In addition a significant focus has been placed on the build of the EPIC system to ensure we are able to robustly track and manage patients who are awaiting treatment, both within the EPIC system, as well as utilising Qlikview reporting to provide a patient targeting list (PTL) and booking reports for the operational teams. Throughout 2018/19, the Trust successfully delivered the 92% incomplete standard every month. This was a testament to the work completed by the clinical and operational teams. Following the completion of our audit of the Quality Accounts for 2018/19, a number of data quality issues were identified related to the small sample undertaken, although the significance of errors have reduced since last year's audit. While disappointing, the majority of the errors related to documentation management and late receipt / processing of referral information and thus were not material to the Trust's reported RTT position and as such this has led to a modified opinion by our auditor, Deloitte. This year's audit was completed using a cross section of waits on the PTL in addition to focusing on those waiting between 17 and 18 weeks. As such, the review highlighted a reduced quality of data across those pathways below 18 weeks, compared to those who have waited over 18 weeks as all of these pathways are validated as part of our RTT reporting processes in-line with processes completed. Those pathways under 18 weeks are randomly sample audited as part of our waiting times and data assurance processes on a weekly basis. Our previous patient administration system was not capable of tracking patients against an RTT pathway, so this had to be constructed and calculated outside of the system in a data warehouse environment. While much work has been completed to compensate for this, it allowed the user to enter pathway data and an outcome code regardless of the status of the pathway. The functionality provided by Epic will go some way to mitigate this, although this is unlikely to address all the issues identified as part of the audit. In addition, the initial concept of RTT was developed around the clinical model of simple surgical care, rather the complex tertiary and quaternary care that we offer at GOSH. As such, it remains a challenge to our clinicians and operational teams to apply the rules to the clinical pathways we have at GOSH. This is further compounded by the fact that 93% of the patients we receive at GOSH have been referred from another hospital setting and hence will have already waited for care at another organisation. This means that for each we have to source a minimum dataset, informing us of the current status of the patient together with their current waiting time. This vital information is often hard to source. However the Trust has completed a significant amount of work to reduce the volume of unknown clock starts from 894 in April 2018 to 231 in March 2019. Finally, although the number of errors was higher than the organisation expected, GOSH notes the context of other Foundation Trusts and their performance against this indicator. It is clear this is a significant challenge to the wider NHS.

Annex 1:
Statements from external stakeholders

Statement from Statement from NHSEI, London Region: Specialised Commissioning

NHS England and Improvement (NHSEI) would like to thank Great Ormond Street Hospital NHS Foundation Trust (GOSH) for the ongoing collaborative working relationships that remains in place. This enables us to identify areas of quality or safety improvement, for those children and young people, whose healthcare needs are managed by the Trust.

This year has presented an additional challenge and a temporary change in priority to respond to the COVID-19 pandemic. The Trust worked proactively with NHSEI, and with the Integrated Care System, to facilitate the transfer of inpatient paediatric services from across North Central London enabling these Trusts to redirect services to support adult patients. GOSH was also able to provide additional critical care capacity for children as and when required.

Following the review of the Clinical Quality Review Meetings (CQRMs) NHSEI and GOSH have agreed to continue with monthly meetings to retain a regular forum where we can critically assess and address quality and safety issues. We review feedback from several different internal and external sources including patients and families, clinical quality review meetings, the Care Quality Commission (CQC), Health Education England (North Central and East London), and Public Health England to inform decisions about where improvements are required.

The main items for improvement that we welcome in this Quality Statement have been:

- The full implementation of the Epic Electronic Patient Record (EPR) system.
- The MyGOSH patient portal where patients will now have access to records, documentation, blood results and be able to communicate with the clinicians managing their care.
- Support to remote working through on-line mediums and dealing with the COVID-19 pandemic.
- Implementing the Speak Up programme which recognises the requirement to respond to some long-standing improvements in culture within the organisation.
- Reducing the number of rejected samples for laboratory testing; this improves patient experience by reducing the number of clinical interventions and enabling quicker diagnosis and treatment plans to be made.
- The focus on the Specialised Services Quality Dashboard (SSQD); these are metrics agreed with the national Clinical Reference Groups which supports benchmarking across the portfolio of specialised services.

The Trust has some challenges to respond to over the coming year, these include:

- The recent CQC report published in January 2020; whilst we acknowledge the progress made for medicines management, mainly around medication risk assessments, and storage, administration and destruction of medicines including controlled drugs but there is more to do in pharmacy and other key areas. During the coming year we would like to see improvements in referral to treatment targets, the timeliness of incident investigations and production of discharge summaries which are clearly very important for General Practice and the other healthcare professionals involved in the care of children and young people. NHSEI will work with the Trust to oversee delivery of the Trust's "Always Improving" CQC action plan.
- Assessing waiting list back logs which have, in some cases, been compounded by the COVID-19 pandemic. The Trust will need to work with the North and South Thames Paediatric networks to ensure that patients are managed according to clinical priority, to reduce risk for patients and to assure that capacity for specialist care is factored into restoration plans so that patient safety can be maintained. This will also need to include improvements in critical care utilisation particularly over peak periods such as Winter.
- Optimising patient and staff safety through improvements around information governance, organisational culture and, to address questions about the transparency of some safety issues.
- A Medicines and Healthcare products Regulatory Agency (MHRA) inspection of the pharmacy aseptic dispensing unit identified a number of critical and major findings concerning quality monitoring and internal processes. As a result of the inspection, the MHRA recommended a temporary reduction of manufacturing capacity to allow for issues to be addressed, and resolved, in order to allow safe delivery of service. In response, the Trust performed an internal review and identified contributing factors; these included issues with quality management systems, leadership and staff culture. We note the progress that has been made so far in terms of changes to processes and staffing, and we will continue to support the Trust in upcoming inspections.
- The Trust has made progress in analysing annual staff survey results but there is a considerable amount of work to be completed with regards to culture and engagement to improve the Workforce Race Equality Standard (WRES).

NHSEI will work with the Trust and our strong leadership teams over the coming year to ensure that necessary improvements on these and other priority areas, as they are identified, are delivered.

Comments from the Chair of the LB Camden Health and Adult Social Care Scrutiny Committee

Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Councillor Alison Kelly, and they should not be understood as a response on behalf of the Committee.

Thank you for sending your 2019/20 quality report for comment. The report is comprehensive and easy to follow. The huge steps that GOSH has taken to make this year's report understandable are much appreciated.

I would like to start by putting on record our huge gratitude for the leadership shown by the top team at GOSH and the dedication of GOSH colleagues, both clinical and those in support roles. GOSH continues to deliver incredibly impressive services and for children and their families with compassion and total commitment. The dedication of colleagues has, once again, been highlighted during the COVID-19 crisis. Thank you also for rapidly taking on additional regional responsibilities during the crisis, including treating older patients and those detained under the Mental Health Act.

The Trust is to be congratulated on the overall progress made in 2019/20. The first section, on fulfilling achievements during the year, is a highly positive start to the report. The photographs of children are beautiful and remind us all what GOSH is all about.

The draft report does not include a contents page. Once included, the report will be easier to navigate. The statement from the Chief Executive is also not included in the draft. This is absolutely understandable in the current crisis, however this section is exceedingly important as it sets the tone for the whole report.

The following observations were made in accordance with a set of core governance principles which guide the scrutiny of health and social care in Camden.

1) Putting patients at the centre of all you do
Safety, clinical effectiveness and experience were the priorities for improvement in 2019/20. The report clearly outlines the impressive progress made in a range of areas, so much is moving in the right direction. The need for cultural change to achieve zero preventable harm is highlighted. The Speak UP Programme is a brave approach and is to be commended.

The way GOSH is now consistently listening and learning from patients and their families is to be commended. The development of feedback software with young people is a model of excellent practice. The priorities for 2020/21 are clear.

2) Focussing on a common purpose, setting objectives, planning
Part 2a of the report on priorities for improvement is clear, including what we said we'd do, what we did, what the data shows, what's going to happen next and how this benefits patients.

The description of the impact of the change in focus to support staff perception of emotional burden and resilience is interesting and hugely positive. The description of how the new approach benefits patients illustrates the importance of the focus on staff wellbeing.

3) Working collaboratively
The report is full of interesting examples of working positively with patients and their families and with staff, including about cultural change. Work with the National Institute for Health Research, with UCL and to benchmark with specialist paediatric healthcare peers are all good practice.

We know that GOSH takes seriously its collaborative working with Camden Council. In the next report, it might be appropriate to include details of the increasing amount of work with Camden Council and other local bodies, which is of mutual benefit to the Trust and to Camden residents.

4) Acting in an open, transparent and accountable way – using inclusive language, understandable to all – in everything it does
The report on the GOSH bereavement survey makes clear the progress the Trust has made and the remaining areas for improvement. This hugely challenging and sad aspect of the Trust's work has been a contentious issue. The report describes how it is now being managed far more consistently and appropriately. It is clear, and quite understandably, that there is still more work to do.

Many congratulations that the Trust's CQC rating for 'Well led' is now 'Good'. This report is a public example of progress made. The information and action on the CQC enforcement notices are clear. Other action areas are also explicit.

The Department of Health indicators show that there is still much work to do. However, the fact that staff are increasingly speaking out isn't necessarily a sign that things are getting worse, the figures might suggest that staff are feeling increasingly confident about speaking up.

I would like to finish by thanking GOSH for its huge commitment to putting the child, the patient, first and always. I would like to formally record my thanks for the huge number of positive changes brought about under your new leadership, they are hugely impressive.

Feedback from members of the Council of Governors

This report is a comprehensive summary of quality across GOSH in the year 2019/2020. It is intended to provide an overview of the key quality improvement information as well as updates on service improvements and priorities for the year. As governors who hold the NEDS to account it supports our observations of quality and safety issues reviewed within the QSEAC Committee.

This year we found the report to provide an important overview of key projects and initiatives, indicating good progress in key areas as well as helpfully highlighting programmes that require ongoing focus.

The format of the report is inviting and open and includes 'what is' boxes that explain technical information in straightforward language. We would encourage all patient and families at GOSH to read the report and hope that it is a reflection of the experience that they have of life at GOSH.

We particularly welcome the increased focus on research activity and key initiatives in experience including in the care of children and young people with learning disabilities and autism.

The report has good continuity with the same report last year which provides for insight into the progress from year to year. As Governors we welcome the increased emphasis on patient experience.

Annex 2:
Statements of assurance

Statement of directors' responsibilities for the *Quality Report*

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

In preparing the *Quality Report*, directors are required to take steps to satisfy themselves that:

- The content of the *Quality Report* meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2019/20* and supporting guidance *Detailed Requirements for Quality Reports 2019/20*.
- The content of the *Quality Report* is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2019 to May 2020
  - papers relating to Quality reported to the board over the period April 2019 to May 2020
  - feedback from commissioners dated 22 June
  - feedback from governors dated 21 May
  - feedback from Councillor Alison Kelly, Chair of Camden Health and Adult Social Care Scrutiny Committee dated 25 May 2020
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 6 July 2020
  - National Paediatric Outpatient Survey 2016
  - Children and Young People's Inpatient and Day Case Survey 2016
  - the national NHS Staff Survey 2018
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 26 May 2020
  - CQC inspection report dated 22 January 2020
- The *Quality Report* presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The *Quality Report* has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report*.

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

By order of the board

DATE

Chair

DATE

Chief Executive

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

The *Annual Report and Accounts* is available to view at www.gosh.nhs.uk.

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Attachment W

Summary of the Audit Committee
held on 26th May 2020

The Committee noted the minutes for the previous meetings of the Finance and Investment Committee, QSEAC and People and Education Assurance.

Chief Financial Officer's review of the Annual Financial Accounts 2019/20, including the Going Concern assessment

The annual report had been prepared on a going concern basis and the committee noted the assumptions underpinning the going concern statement which were felt to be prudent. Discussion took place around the impact of the COVID-19 pandemic on the valuation of land and buildings which would require a material uncertainty statement but would not lead to a qualification of the audit of the accounts. Discussion took place on non-IPP debtors and the committee requested further discussion at the Finance and Investment Committee.

Annual Financial Accounts 2019/20 and GOSH Draft Annual Report 2019/20 including Annual Governance Statement and Annual Audit Committee Report

The Committee discussed the substantial action that the Trust had taken in response to the pandemic and noted the report section adding that reference to the pandemic should also be reflected in the assurance committee report section. The Committee agreed to recommend the annual accounts, annual report, annual governance statement and representation letter to the Board for approval.

Quality Report 2019/20

The report was not yet complete and it was agreed that the final report would be presented to the July 2020 meeting of the QSEAC and be considered for approval by the Board in July 2020.

Internal Audit Progress Report and Annual Report

The workplan for the year had been completed and discussions took place about the review of access and activity data which had provided a rating of 'partial assurance with improvements required'. The Committee expressed concern about the errors detected and noted that auditors were not able to provide assurance about the Trust's reporting of RTT. It was confirmed that a Chief Data Officer was being recruited to support improvement work in this area. It was noted that although the Trust had received a number of reports with a rating of 'partial assurance with improvements required', this was in part due to the use of the Audit resource in areas that were likely benefit from the review and recommendations made. The Committee reviewed the pattern of recommendations arising from reviews in comparison to other Trusts and noted that the pattern was broadly positive. The Committee noted the Head of Internal Audit Opinion which was 'partial assurance with improvements required'.

Final Report on the financial statement audit for the 12 month period ended 31 March 2020

Audit work was substantially complete but was not yet finalised. Auditors were anticipating issuing an unqualified opinion subject to completion. No additional notes were anticipated related to going concern or value of money. No evidence of bias or other issues had been identified in the review of management override of controls. Further discussion took place around the going concern statement particularly related to COVID-19. It was noted that it was clear that NHS England were committed to funding these costs. Discussion took place around overall debtors and it was noted that once IPP debtors had been removed levels of debt were likely to be in line with other organisations.

The Committee expressed disappointment at a failure to complete recommendations related to IT and it was confirmed that this would to followed up as part of the work taking place with Microsoft.

Risk matters between meetings

- Cyber Security Update

It was noted that a robust review of GOSH's systems had taken place and the recommended actions would be reviewed.

The Committee discussed the importance of continuing to ensure that robust assurance was received in these key areas and requested risk based progress reports going forward.

Local Security Manager Work-plan 2020/21
The Committee noted the importance of focusing on being security conscious at GOSH. It was noted that consideration was being given to a security contract that was separate from the general facilities contract to enable greater supervision and oversite.

Report from the Risk Assurance and Compliance group on the Board Assurance Framework
The Risk Assurance and Compliance Group had reviewed the refreshed risk statements and the additional BAF risks. The RACG had proposed that the risks related to the achievement of the Better Value programme and delivery of the IPP strategy were subsumed into the financial sustainability risk. The Committee expressed some concern that focus on these risks could be lost and it was agreed that this would be reviewed again at the next meeting following further discussion at the RACG in the interim.

Local Counter Fraud Service Annual Report 2019/20
The Trust had been rated green against its NHS Counter Fraud Authority Self Review Tool. The Committee expressed concern about the proportion of respondents to the Counter Fraud staff survey who had said that they were not aware of the Trust's anti-fraud and anti-bribery policies and reporting procedures despite compliance with counter fraud mandatory training of 98%. It was confirmed that a communications plan was being developed to further raise awareness. The Committee noted that reporting rates for suspected fraud were broadly in line with that of other organisations.

Update on Freedom to Speak Up at GOSH
Current concerns being raised were around PPE, workload and junior doctor access to training whilst outside their usual areas during the pandemic period. It was confirmed that junior doctors would return to their usual rotas by mid-June. The Committee said that it was important to continue to highlight the availability of the service even if the FTSU ambassadors and guardian were not physically working in the Trust.

Audit Committee Annual Effectiveness Survey Results
The responses were broadly in line with previous years'. Some respondents had felt that there continued to be overlap in the work of the Finance and Investment Committee, Audit Committee and Board. It was agreed that where these arose, it would be flagged at the time.

Review of non-audit work conducted by the external auditors
The Committee noted the non-audit work conducted by Deloitte.

Assurance of compliance with the Bribery Act 2011
The Committee noted the report.

Update on raising Concerns at GOSH (Whistleblowing)
It was noted that no new cases had been raised.

Attachment X

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Quality, Safety and Experience Committee held on 2nd July 2020

The Committee approved an amendment to the minutes of the January meeting.

Update on MyGOSH

The Committee noted that 27% of patients with an appointment were signed up to MyGOSH with a good average number of logins per user. Video clinics had been embedded into MyGOSH in a short timeframe which was a significant achievement. Work was taking place to ensure that translators could also join these clinics. The Committee emphasised the importance of ensuring that patients and families were not disadvantaged if they did not have access to the internet or computers. They also encouraged more rapid sign up where possible noting the immediate benefits to patients and families as well as to the trust.

Integrated Quality and Performance Report

There had been an increase in the number of serious incidents and red complaints. Each area was being scrutinised and no themes had been found. The committee discussed the incident closure rate and time to closure which remained red. It was noted that there were now no actions outstanding from before 2019 however the committee emphasised the importance of improving this and requested that substantial improvements were made by the next meeting. It was reported that very positive feedback was being received through the Friends and Family Test.

Safeguarding Annual Report 2019/20

During the pandemic GOSH had been working with safeguarding teams from other North Central London Trusts from which GOSH had accepted paediatric patients. Regular meetings had taken place and a learning event was being planned to consolidate learning. An increase in abusive head trauma had been identified at GOSH and this was being discussed nationally and internationally for education purposes. It was noted that the Named Doctor had retired and an interim was in place. Recruitment was taking place for a substantive appointment. The child protection national information sharing system had been approved for use in scheduled care at GOSH which would be extremely helpful for flagging relevant patients. An honorary contracts policy had been completed including clear boundaries for staff which would support improvement in honorary contract safeguarding training. The Named Nurse would be retiring in the autumn and a replacement is being recruited.

Internal Audit Progress Report

The review of Discharge planning had provided a rating of partial assurance with improvements required. When the review had taken place GOSH had been at an early stage in implementing the national best practice recommendations which had been published. It was noted that the recommendations are tailored to district general hospitals which were not as specialist and could more easily predict length of stay but it was agreed that it was important for GOSH to develop local targets in line with the spirit of the guidance.

Attachment X

Internal and audit recommendations update
GOSH had only one outstanding internal audit recommendation and was now the auditors' best performing London Trust in this respect.

Overview and Emerging clinical and risk issues
An overview of the work to prioritise patients on the waiting lists was provided. It was noted that 2200 patients on the list had been categorised which comprised 24% of the waiting list and completing this work was challenging. 100 patients had now breached 52 week waits and 50% of these patients were in the dental service. A new paediatric dentist had joined the Trust however activity in this specialty was complex as it was aerosol generating. The Committee emphasised the substantial challenge that would be provided by a second wave of the pandemic coinciding with winter pressures.

MHRA update
A follow up inspection of the pharmacy had been extremely positive about the progress made in the time. Since this had happened there had been two critical deviations in one unit of the service. Mitigations had been put in place and a meeting would be taking place with the Inspection Action Group (IAG) on 6th July. It was emphasised that pharmacy was business critical and it was essential that there was resilience in the team to ensure work pressures were met and that annual leave was possible.

Patient and Family Experience: risks related to COVID 19
The PALS service had become virtual and was now operating a seven day service and although the Trust had been given permission to pause complaints handling, only one case had to be paused due to the substantial involvement of the infection control team and the impact the investigation would have had on their capacity. A family and patient information hub had been developed which was supporting a lower number of complaints and PALS contacts. The Committee discussed the impact on children and young people of being cared for by staff wearing PPE. It was noted that a recent research proposal in this area was not accepted by the charity and the committee emphasised the importance of continuing to seek funding.

Freedom to Speak Up Guardian Update Q1 – Quality related
A number of contacts to the service were being received around why some staff were allowed to work from home while others had to be on site, which was in line with questions received in the Chief Executive's Big Briefs. The Guardian for Safe Working had held meetings with Junior Doctors to listen to their concerns. The fixed term contract for the Freedom to Speak Up Guardian role had ended and a substantive post holder was being sought on a full time basis which would increase the accessibility of the service. In the meantime an interim Guardian has been appointed on a part time basis.

Annual Complaints Report 2019/20
The overall number of complaints and the number of red complaints had reduced in 2019/20 on the previous year. As the Trust received a low number of complaints it was challenging to identify themes however work would take place to look across several years. Discussion took place around the proportion of complaints received from patients or families with a learning disability. Work was taking place to clarify the data on patients and families with learning disabilities which was currently thought to be underreported. The significant improvement in clinic letter and discharge summary turnaround times as a result of Epic was welcomed by the Committee.

Update on Paediatric Intensive Care Audit Network (PICANET) Quarterly RSPRT plot
Discussion took place about the increase that the Trust had experienced in crude mortality data. The deaths had been reviewed and it was clear that in a number of cases there were a clear COVID-19 impact and further cases for which COVID-19 was highly likely to have had an impact but there had not yet been findings from the Coroner.

Health and Safety Update
The Committee discussed the recall of a particular mask and it was reported that the infection control team were confirming whether further action was required. Interviews for the Fire Officer post would be taking place shortly and it was confirmed that the Trust remained compliant with requirements in the interim.

Clinical Audit Update (January – June 2020) and Clinical Audit Workplan 2020/21
The programme of work was outlined with particular focus on medicines management. A number of COVID-19 related piece of NICE guidance had been published and a process had been developed to ensure they were in place along with an audit trail of decisions taken. It was confirmed that clinical audit had been involved in the development of both the quality strategy and safety strategy and audit would be a key part of monitoring both.

Great Ormond Street Hospital Paediatric Bioethics Centre (PBC) Report
The ethics team had been focusing on supporting members of staff who had been deployed to other Trusts. The team had been required to rapidly develop guidance for treating children with COVID-19 and the team's experience during the pandemic had highlighted the importance of working closely with clinical teams.

Quality Report
The Committee recommended the Quality Report the Board for approval.

Revised Incident Management Policy
The Committee noted the policy which had been approved by the Policy Approval Group.

Assurance of compliance with Risk Management Strategy
It was noted that 80% of high risks had been reviewed in line with the risk management strategy. Plans are in place to close the remaining 20%

Update from RACG
The operational performance risk score had been increased and the committee agreed to undertake a deep dive into this risk at the next meeting. A review of the mortuary and histopathology had taken place which confirmed accreditation would be retained with a small number of recommendations.

Freedom of Information Act Annual Report 2019/20
There had been 80% compliance with the required timeframes. The 20% that were not compliant were complex FOIs generating thousands of documents for review and redaction. The Committee discussed the type of FOIs received which were in large part commercial requests and expressed some concern about the NHS resources required to share information where it was not always clear the public interest but more the commercial interest. This was an unintended outcome of the FOI

legislation. It was noted that GOSH was part of an FOI network and could therefore collaboratively respond to a number of requests.

Revised Terms of Reference and Workplan
The Committee noted the changes to the terms of reference and workplan and agreed that further discussion was required about whether an additional meeting was required and the purpose of that meeting.

Update from Audit Committee (April and May 2020)
The Committee noted the update.

Attachment Y

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
15 July 2020

Board Assurance Committee reports: Finance and Investment Committee (July 2020)	**Paper No: Attachment Y**
Submitted by: Helen Jameson, Chief Finance Officer Paul Balson, Deputy Company Secretary **Item presented by:** James Hatchley, Chair of the Finance and Investment Committee	

Aims / summary

This report summarises the work of the Finance and Investment Committee (FIC) since its last report to the Trust Board on 26 May 2020.

Since the last report to the Trust Board, the Committee met on 1 July 2020. The highlights and points of discussion are reported below.

The Month 2 Finance and Performance reports are reported elsewhere in the July Trust Board papers.

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

Overview

The Chair noted the timing and importance of the meeting. During the first peak of COVID-19, the Trust's finances had been relatively protected by NHSE/I. In August the Trust will move to a new funding regime which could prove even more challenging for GOSH. It was important that the Committee focus on recovery and focus on revised plans to enable us to look forward and consider the appropriate next steps with major capital projects such as the Children's Cancer Centre.

Lady Amanda Ellingworth, Non-Executive Director observed the July meeting.

Corona Virus – Reformation plan

The Restoration and Strategy Delivery Group continued to work alongside the Operational Board to establish new ways of working required because of the pandemic.

The focus of the group has been to ensure the health and wellbeing of staff working at home and to ensure the hospital is COVID-19 secure.

Finance report Month 2

The CFO presented the item. The report is presented elsewhere in the Trust Board papers. Key discussion points in response to the report were:

- The revised format linked activity to finance and compared current and pre-COVID-19 spends and was well received by the Committee.
- Discussions with the STP and regional NHSE/I on how COVID top-up amounts were calculated were ongoing and presented significant uncertainties. Notwithstanding the Trust would forge ahead and ensure that all patients were treated as promptly as possible based on clinical priority. The Committee endorsed this approach recognising the importance of gaining clarity and fairness in commissioning as soon as possible.
- It was confirmed that the cash position of the Trust remained relatively strong and was in line with plan.

Performance update Month 2

The Clinical Director of Operations presented the item. The report is presented elsewhere in the Trust Board papers. Key discussion points in response to the report were:

- As of 22 June 2020, the Trust had started admitting elected patients and as of 1 July, outpatients utilisation was up to 50%. Only 24.28% of patients were currently taking up appointments which was adversely affecting the diagnostic waits metric.
- The Clinical Director of Operations presented the dashboards that helped the Trust manage bed spaces, capacity and theatre utilisation.
- The Committee encouraged all the performance statistics to be considered on a department by department basis and for the national picture to also be presented in the areas with the biggest waits so national factors impacting underperformance can be identified e.g. in the case of Dental services where there is a national shortage of consultants
- The Committee requested immediate focus on the improvement of the performance of discharge summaries metric as being 1) in our control and 2) based on a lower volume of patients.

Annual review of the capital program

The Chief Finance Officer presented the process that created the 2019/20 capital plan as well as the approach to managing it in year. The Committee noted the report and flagged the importance of ensuring backlog maintenance was considered as important as new capital projects.

It was recognised that the Trust was in a good relative position as it relates to maintenance relative to a significant number of other London Trusts

Update on the 2019/20 National Cost Collection

The CFO informed the Committee that in a change to previous arrangements, a national cost collection submission would be required from GOSH. The committee acknowledged that the conclusions of the report may be impacted by COVID in the period under review and make comparability against previous years and other Trusts difficult. The submission would be approved by the Trust Board in due course.

Procurement update

The Procurement team had continued making good progress on transactional procurement (PO processing and compliance as well as catalogue management) and work continued on improving contracted spend.

The main focus of the team during the pandemic has been the sourcing of Personal Protective Equipment (PPE) for staff.

Commercialisation

The Committee received two reports from the Commercial Director:

Update on Commercial activities

The paper provided an update on the Trust's commercial strategy. Although COVID-19 resulted in delays to several workstreams, there had been notable progress in the Education and training, DRIVE workstreams, clinical services and in progressing with high level discussions related to research topics. The success of all workstreams was dependent on the speed at which the organisation returned to the new 'normal state'.

The immediate focus for the Commercial Director was to ensure that any 'quick wins' were not missed at the same time as preparing for the medium to long-term opportunities.

International and Private Patients (IPP) recovery overview

During COVID-19, the IPP Directorate had in effect been closed to new admissions but it remained important to invest in supporting the value in the franchise and prepare the ground work for an appropriate re-opening of the IPP facilities at the Trust when appropriate and in a way consistent with the parameters set. This included improving the efficiency of in-house processes, appealing to existing and new and markets and improving its online presence.

The Committee noted that both NHS and IPP patients were subject to the same clinical prioritisation process. This ensured the fair treatment of patients, it is recognised that this could put the Trust at a financial disadvantage with other private healthcare providers, as it would turn down acceptance of private work in favour of NHS patients.

The Committee discussed developments in reclaiming IPP debt.

Electronic Patient Record

The Committee received a report benchmarking the implementation of EPIC at GOSH compared to other Hospitals and requested that management guide the committee on the core areas of focus across the significant number of metrics. The Committee noted the very positive summary of the assessment of the way EPIC had been implemented to date even if there was always more that could be done.

The Committee was informed that the Trust had invested in improving the data quality governance arrangements at the Trust, which will provide assurance to the Trust Board.

The Committee discussed the resource requirements for ongoing maintenance and development of EPIC and ensuring EPIC was optimised to enable the continuing evolution of the practice e.g. face to face video consultations.

Major Projects

The Chief Executive provided an update on the Trust's major projects:

ZCR	There are some remedial works that need to be prioritised before Winter. Once fully complete, a thorough post-implementation review would be undertaken. The GMP facility was noted as a major strategic asset
Children's Cancer Centre	Planning for next steps to be appropriately considered by the Trust Board and the Charity in parallel to ensure the Project is able to restart in the form agreed as required.
Sight and Sound Project	The contractor had made good progress during lockdown, however, prior to COVID, they were 24 weeks behind schedule and negotiations on the contract are ongoing. It was recognised that the end product of this would also be a world class facility for Children with sight and hearing issues.

End of report

Attachment Z

People and Education Assurance Committee
June 2020

Summary

Minutes of the meeting held on 18th February 2020

Ms Kathryn Ludlow, Chair explained that during these unprecedented times the Committee would like to focus on key COVID related issues and asked for any comments or amendments to the minutes to be emailed to herself or Ms Bella Summers, Executive Assistant. No comments were received.

Staff Stories

Dr Daljit Hothi, Consultant and Associate Medical Director, Dr Pinki Munot, Consultant Neurologist and Lead for International Medical Graduates (IMGs) and Dr Ashwin Pandey, Clinical fellow in Haem-oncology and Junior Doctor's Forum Representative for IMG joined the Committee to talk about the Health and Wellbeing offer during the acute COVID crisis. They highlighted that the IMGs were identified as being a particularly vulnerable group especially as they were away from home.

The wellbeing group has continued communication with staff members and utilised offers of support from the BAME forum Chair and peer leaders whilst surveying groups through to the recovery phase. The wellbeing work continues at pace, its profile is expanding, being refined and updated. Alongside the wellbeing offer, staff and managers have been supported to take leave to ensure they are rested and staff have been polled in the weekly briefings.

Workforce Response to COVID19

Ms Sarah Ottaway, Associate Director of HR & OD presented to the Committee a summary of the facts and figures related to COVID. The Built Environment team continue to work on space within the organisation, having noted a loss of around 60% non-clinical office desk space. The returning to work site safety project will run together with the working from home group to ensure those working from home are supported and only those who need to be on site are brought back. The organisation launched the Demographic Risk Assessment tool that was noted to cause some anxiety and has been supported by HR Business Partners and Occupational Health. It was confirmed there is an assessment process for testing staff prior to staff returning to site.

People Strategy Delivery Plan – Summary

The People Strategy Delivery plan was noted to have been presented at Trust Board and was welcomed by this Committee. The report is focused on how HR will support the organisation following the COVID crisis. The pulse survey will be used to sense check ongoing work and new issues including PPE and homeworking are being responded to in the weekly all staff briefings. It was reported that although morale was higher during the acute phase of the pandemic, staff are very tired and the next phase is likely to be more challenging while the organisation is reorganised into new ways of working and that decisions made will reflect on the Trust and the Board. Mr Shaw, Chief Executive assured the Committee that the organisation is committed to working with and supporting staff through the recovery phase of the crisis.

GOSH Learning Academy (GLA)

Ms Shields, Director of Education said the GLA was well positioned within the COVID pandemic to be flexible in its approach and was able to deliver at pace and respond to Trust and STP requirements. The Committee was provided with assurance regarding the six priority areas that had been either suspended or delayed during the COVID crisis and how the GLA refocused in line with the delivery plan. Leadership was refocused in line with the People Strategy and the GLA is supporting leadership within the Health and Wellbeing programme. The three year grant was noted to have been extended for at least a further six months.

Update on Board Assurance Framework (BAF)

Dr Anna Ferrant, Company Secretary stressed that the BAF has been through a review against the new strategy and has been updated in accordance with the risks the organisation is facing around COVID. The Committee agreed to focus on the culture risk at the meeting scheduled in September, in accordance with the staff survey preparation, Health and Wellbeing and COVID.

Safe Staffing Report

Recruitment was noted to have continued throughout the crisis with retention having also been improved. The importance of monthly monitoring was highlighted to ensure a stable set of figures for workforce reporting information. The Nursing Workforce Advisory Committee has been re-established and the retention plan has been rewritten and was reported at Trust Board. International Private Patients (IPP) nursing staff have been redeployed to general paediatrics and the team is regrouping in order to re-establish the directorate.

Update on Staff Focused Whistle Blowing Cases

There has been no whistleblowing cases, however the Committee was told that the channels for promoting whistleblowing had been actively communicated throughout the Trust. Dr Sanjiv Sharma, Medical Director has been reviewing the process of responding to FOI requests of which the organisation receives a substantial amount.

Summary report from the Quality Safety and Experience Assurance Committee
Summary update from Finance and Investment Committee

The Committee noted the summary reports from the Quality Safety Experience and Assurance Committee and the Finance Committee.

Attachment M

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 15 July 2020	
Revised Constitution: Annexes for new classes and constituencies, staggered elections and digital AGMs **Submitted by:** Paul Balson, Deputy Company Secretary	**Paper No: Attachment M**

Aims / summary

In July 2018 the Council agreed in principle to change the way the public and patient/carer members were allocated to classes. The changes ensured alignment with current electoral boundaries and ensured that the number of Governors voted for was proportionate to where GOSH's outpatients typically came from.

In November 2018, the Council also agreed for the new classes to be implemented from 1 March 2021 and to implement phasing of elections at the next election, which will run from 10 November 2020 to 3 February 2021.

To enact these changes, the relevant Constitution annexes need to be updated. The Constitution Working Group met on 1 July 2020 to discuss areas of change to the Trust Constitution. These changes are provided in **Attachment 1** Annex 1 – Public Constituency, **Attachment 2** Annex 3 Patient and Parent/Carer Constituency and **Attachment 3** Annex 4: Composition of Council of Governors.

These annexes are direct replacements for the existing annexes and cover the redrawn constituency boundaries and reallocation of governors. There is no change to Annex 2 – Staff Constituency.

Attachment 4 Annex 11 - Composition of the Council of Governors – transitional period allows for the phasing of elections and will apply between 10 November 2020 and 29 February 2024 (the end of phasing), after which time it will be removed as phasing will no longer continue.

Additionally, the Constitution Working Group agreed that the Constitution needed to provide for the flexibility to hold an AGM and AMM virtually (including any required virtual membership voting at a meeting) to ensure essential business can be maintained under social distancing rules etc. This change is included at the amendment to Annex 10 (**Attachment 5**).

The Trust Constitution states The Trust may make amendments of its constitution only if:

- More than half of the members of the Council of Governors of the Trust voting approve the amendments, and
- More than half of the members of the Trust Board of the Trust voting approve the amendments.

These changes are endorsed by the Constitution Working Group and recommended to the Council of Governors and Trust Board for approval in July 2020.

Attachment M

Action required from the meeting The Trust Board is asked to **approve** the changes to the Trust Constitution: • Attachment 1 Annex 1: Public Constituency • Attachment 2 Annex 3: Patient and Parent/Carer Constituency • Attachment 3 Annex 4: Composition of Council of Governors. • Attachment 5: Annex 11 - Composition of the Council of Governors – transitional period • Attachment 6: Amendment to Annex 10 to allow for virtual meetings and voting.
Contribution to the delivery of NHS Foundation Trust strategies and plans
Financial implications None
Who needs to be told about any decision? Once approved, the changes will be communicated to the membership at the Annual General Meeting and Annual Members Meeting (not vote is required on the changes) NHSE/I will be informed of the changes.
Who is responsible for implementing the proposals / project and anticipated timescales? Corporate Affairs Team
Who is accountable for the implementation of the proposal / project? Chief Executive

Annex 1
Public Constituency

From 10 November 2020 and going forward with each new election cycle thereafter, calls for nominations, nominations, and subsequently elected Governors for the Public Constituency shall be for the following classes:

The Public Constituency:

Class	**Area**	**Governors**	**Minimum number of members**
London	All London Boroughs (32) Barking and Dagenham, Barnet, Bexley, Brent, Bromley, Camden, City of Westminster, Croydon, Ealing, Enfield, Hackney, Hammersmith and Fulham, Haringey, Harrow, Havering, Hillingdon, Hounslow, Islington, Lambeth, Lewisham, Merton, Newham, Redbridge, Richmond upon Thames, Royal Borough of Greenwich, Royal Borough of Kensington and Chelsea, Royal Borough of Kingston upon Thames, Southwark, Sutton, Tower Hamlets, Waltham Forest, Wandsworth City of London	3	300
Home Counties	Bedfordshire Berkshire Buckinghamshire Essex Hertfordshire Kent Surrey Sussex (East and West)	2	300
Rest of England and Wales	Bristol, Cambridgeshire, Cheshire, , Cornwall, including the Isles of Scilly, Cumbria, Derbyshire, Devon, Dorset, Durham, East Riding of Yorkshire, Gloucestershire, Greater Manchester, Hampshire, Herefordshire, Isle of Wight, Lancashire, Leicestershire, Lincolnshire, Merseyside, Norfolk, North Yorkshire, Northamptonshire, Northumberland, Nottinghamshire, Oxfordshire, Rutland, Shropshire, Somerset, South Yorkshire, Staffordshire, Suffolk, Tyne and Wear, Warwickshire, West Midlands, West Yorkshire, Wiltshire, Worcestershire	1	300

Annex 3
Patient and Parent/Carer Constituency:

From 10 November 2020 and going forward with each new election cycle thereafter, calls for nominations, nominations, and subsequently elected Governors for the Patient and Parent/Carer Constituency shall be for the following classes:

Class	**Area**	**Governors**	**Minimum number of members**
Patient Class			
London	All London Boroughs (32) Barking and Dagenham, Barnet, Bexley, Brent, Bromley, Camden, City of Westminster, Croydon, Ealing, Enfield, Hackney, Hammersmith and Fulham, Haringey, Harrow, Havering, Hillingdon, Hounslow, Islington, Lambeth, Lewisham, Merton, Newham, Redbridge, Richmond upon Thames, Royal Borough of Greenwich, Royal Borough of Kensington and Chelsea, Royal Borough of Kingston upon Thames, Southwark, Sutton, Tower Hamlets, Waltham Forest, Wandsworth City of London	3	150
Home Counties	Bedfordshire Berkshire Buckinghamshire Essex Hertfordshire Kent Surrey Sussex (East and West)	2	150
Rest of England and Wales	Bristol, Cambridgeshire, Cheshire, , Cornwall, including the Isles of Scilly, Cumbria, Derbyshire, Devon, Dorset, Durham, East Riding of Yorkshire, Gloucestershire, Greater Manchester, Hampshire, Herefordshire, Isle of Wight, Lancashire, Leicestershire, Lincolnshire, Merseyside, Norfolk, North Yorkshire, Northamptonshire, Northumberland, Nottinghamshire, Oxfordshire, Rutland, Shropshire, Somerset, South Yorkshire, Staffordshire, Suffolk, Tyne and Wear, Warwickshire, West Midlands, West Yorkshire, Wiltshire, Worcestershire	1	150
Parent/Carer Class			
Class	**Area**	**Governors**	**Minimum number of members**
London	All London Boroughs (32)	3	300

	Barking and Dagenham, Barnet, Bexley, Brent, Bromley, Camden, City of Westminster, Croydon, Ealing, Enfield, Hackney, Hammersmith and Fulham, Haringey, Harrow, Havering, Hillingdon, Hounslow, Islington, Lambeth, Lewisham, Merton, Newham, Redbridge, Richmond upon Thames, Royal Borough of Greenwich, Royal Borough of Kensington and Chelsea, Royal Borough of Kingston upon Thames, Southwark, Sutton, Tower Hamlets, Waltham Forest, Wandsworth City of London		
Home Counties	Bedfordshire Berkshire Buckinghamshire Essex Hertfordshire Kent Surrey Sussex (East and West)	2	300
Rest of England and Wales	Bristol, Cambridgeshire, Cheshire, , Cornwall, including the Isles of Scilly, Cumbria, Derbyshire, Devon, Dorset, Durham, East Riding of Yorkshire, Gloucestershire, Greater Manchester, Hampshire, Herefordshire, Isle of Wight, Lancashire, Leicestershire, Lincolnshire, Merseyside, Norfolk, North Yorkshire, Northamptonshire, Northumberland, Nottinghamshire, Oxfordshire, Rutland, Shropshire, Somerset, South Yorkshire, Staffordshire, Suffolk, Tyne and Wear, Warwickshire, West Midlands, West Yorkshire, Wiltshire, Worcestershire	1	300

A “Parent” is defined as any person with a child who has been a patient at the Trust (as defined above) and who has attended the Trust with the patient within the 10 years immediately preceding the date of application of the parent to become a member of the Trust.

A “Carer” must be the parent or person acting in loco parentis for an inpatient or outpatient **of any age** and have attended the Trust with the patient within the 10 years immediately preceding the date of application of the carer to become a member of the Trust.

Attachment M
Attachment 3 Annex 4 Composition of Council of Governors.

Annex 4
Composition of Council of Governors

The composition of the Council of Governors shall, from 1 March 2021 onwards, be:

Constituency	**Number seats on the Council of Governors**
Elected Governors	
Public London	3
Public Home Counties	2
Public Rest of England and Wales	1
Patient London	3
Patient Home Counties	2
Patient Rest of England and Wales	1
Parent/Carer London	3
Parent/Carer Home Counties	2
Parent/Carer Rest of England and Wales	1
Staff	5
Total Elected Governors	**23**
Appointed Governors	
University College London, Institute of Child Health	1
London Borough of Camden	1
Young People's Forum	2
Total appointed Governors	**4**
Total Governors	**27**

Until 28 February 2021 the composition of the Council of Governors shall be:

Constituency	**Number of seats on the Council of Governors**
Elected governors	
Patient and carer constituency	
Patients from London	2
Patients from outside London	2
Parents and carers from London	3
Parents and Carers from outside London	3
Public constituency	
North London and Surrounding Area	4
South London and Surrounding Area	1
The rest of England and Wales	2

Attachment M
Attachment 3 Annex 4 Composition of Council of Governors.

Staff constituency	5
Appointed governors	
University College London, Institute of Child Health	1
London Borough of Camden	1
Young People's Forum	2
Total	**26**

Annex 11
Composition of the Council of Governors – transitional period

The Transitional Period is required to transition from the current election cycle, where all Governors are elected on the same day and have their terms expire on the same day, to a phased election model, where the Trust will hold elections every year, and in each election, approximately one third of elected governor positions will be available to be filled.

To achieve the transition to this phased election model a transitional period will apply between 10 November 2020 and 29 February 2024 ("**Transitional Period**").

On 10 November 2020 the Trust will call for nominations for Governors who will be elected on 1 February 2021 and subsequently take office from 1 March 2021. Calls for nominations, nominations, and the subsequently elected Governors in this period will be elected for varying term lengths between 1 and 3 years, described in this Annex. As these terms expire new elections will be held for 3 year appointments.

Thereafter all elections will be for three year terms as posts fall open.

In order to produce phased elections, the Governors shall be elected on 4 January 2021, to take up office on 1 March 2021, for the following term lengths:

Public Constituency Governors:

Constituency Name	Number of Governors	Term length
London	3	• The highest polling candidate will serve for 3 years[1] • The second highest polling candidate will serve for 2 years • The third highest polling candidate will serve for 1 year.
Home Counties	2	• The highest polling candidate will serve for 2 years • The second highest polling candidate will serve for 1 year
Rest of England and Wales	1	• The highest polling candidate will serve for 3 years

Patient Constituency Governors:

Class	Number of Governors	Term length
London	3	• The highest polling candidate will serve for 3 years • The second highest polling candidate will serve for 2 years • The third highest polling candidate will serve for 1 year.
Home Counties	2	• The highest polling

[1] If the highest polling candidate is [Teskeen Gilani], she will be appointed to serve for two years owing to her previous length of service, and the second highest polling candidate shall be appointed to serve for three years.

		candidate will serve for 2 years • The second highest polling candidate will serve for 1 year
Rest of England and Wales	1	• The highest polling candidate will serve for 3 years

Parent and Carer Constituency Governors:

Class	Number of Governors	Term length
London	3	• The highest polling candidate will serve for 3 years • The second highest polling candidate will serve for 2 years • The third highest polling candidate will serve for 1 year.
Home Counties	2	• The highest polling candidate will serve for 2 years • The second highest polling candidate will serve for 1 year
Rest of England and Wales	1	• The highest polling candidate will serve for 3 years

Staff Constituency Governors:

Class	Number of Governors	Term length
London	5	• The highest polling candidate will serve for 3 years • The second highest polling candidate will serve for 3 years • The third highest polling candidate will serve for 2 year • The fourth highest polling candidate will serve for 2 year • The fifth highest polling candidate will serve for 1 year

As the newly elected Governor term lengths expire, all subsequent elections shall be for three year terms.

5.5 The Council of Governors may:

5.5.1 arrange for a members' meeting to be held in different venues each year;

5.5.2 make provisions for a members' meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below;

5.5.3 make provision for a members' meeting to be held by virtual means. In making such provision the Council of Governors shall ensure that virtual means chosen are accessible to members and include alternative means of joining the meeting, such as by video and by telephone. Virtually convened members meetings will have the quorum requirements as set out in paragraph 5.10 of this Annex 10.

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
15 July 2020

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 1**

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 28th November 2019.

Date	Description	Signed by
26/06/2020	GOSH Chillers Project – Contract Documentation	MS, 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