GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
MEETING OF THE COUNCIL OF GOVERNORS
Wednesday 5 February 2020
3:00pm – 5:30pm
Charles West Room, Level 2, Barclay House

NO.	ITEM	ATTACHMENT	PRESENTER	TIME
1.	**Welcome and introductions**		Michael Rake, Chair	3:00pm
2.	**Apologies for absence**		Michael Rake, Chair	
3.	**Declarations of interest**		Michael Rake, Chair	
4.	**Minutes of the meeting held on 26 November 2019**	**A**	Michael Rake, Chair	
5.	**Matters Arising and action log** **Selection of indicator for audit (for Quality Report)**	**B** **C**	Anna Ferrant, Company Secretary Peter Hyland, Director of Performance and Information	
6.	**GOSH Strategy – final**	**D**	Mat Shaw, Chief Executive	3:10pm
7.	**GOSH CQC Inspection Report 2019**	**E - presentation**	Róisín Mulvaney, Head of Special Projects – Quality and Safety/ Anna Ferrant, Company Secretary	3:25pm
8.	**Operational Plan 2020/21 Update**	**F - presentation**	Phillip Walmsley, Interim Chief Operating Officer/ Peter Hyland, Director of Performance and Information	3:55pm
	PERFORMANCE and ASSURANCE			
9.	**Chief Executive Report including:** • **Integrated Quality Report December 2019 data (highlights)** • **Performance dashboard December 2019 data** • **Finance report December 2019 data (highlights)**	**G**	Mat Shaw, Chief Executive	4:15pm
10.	**Reports from Board Assurance Committees (and agendas):** • **Quality, Safety and Experience Assurance Committee (January 2020)**	**H**	Amanda Ellingworth, QSEAC Chair	4:30pm

	• **Finance and Investment Committee (December 2019)** • **People and Education Assurance Committee (December 2019)**	**I** **J**	James Hatchley, FIC Chair Kathryn Ludlow, PEAC Chair	
11.	**Update from the Young People's Forum (YPF)**	**K**	Josh Hardy and Emma Beeden, Members of YPF	4:45pm
	GOVERNANCE			
12.	**Process for appointment of a Lead Governor and Deputy Lead Governor at GOSH**	**L**	Paul Balson, Deputy Company Secretary	4:55pm
13.	**Governance Update** **Council effectiveness survey action plan update** **Refreshed NED appraisal process** **Refreshed Chair and NED terms and conditions**	**M** **Q** **N** **O**	Paul Balson, Deputy Company Secretary Paul Balson, Deputy Company Secretary Anna Ferrant, Company Secretary Anna Ferrant, Company Secretary	5:05pm
14.	**Any Other Business**	**Verbal**	Chair	5:25pm

ATTACHMENT A

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT MINUTES OF THE COUNCIL OF GOVERNORS MEETING
26th November 2019
Charles West Boardroom

Sir Michael Rake	Chair
Miss Alice Rath	Patient and Carer Governor: Patients outside London
Miss Faiza Yasin	
Mrs Stephanie Nash	Patient and Carer Governor: Parents and Carers from London
Mrs Mariam Ali	
Mrs Lisa Allera	Patient and Carer Governor: Parents and Carers from outside London
Dr Claire Cooper-Jones	
Mrs Carley Bowman	
Mr Simon Hawtrey-Woore	Public Governor: North London and surrounding area
Mr Simon Yu Tan**	
Mr Colin Sincock	Public Governors: The rest of England and Wales
Mr Julian Evans	
Ms Fran Stewart	Public Governors: South London and Surrounding Area
Ms Margaret Bugyei-Kyei	Staff Governor
Mr Nigel Mills	
Dr Quen Mok	
Mr Paul Gough	
Dr Sarah Aylett	
Mr Josh Hardy	Appointed Governor: Young People's Forum
Cllr Lazzaro Pietragnoli*	Appointed Governor: London Borough of Camden
Prof Jugnoo Rahi	Appointed Governor: UCL GOS Institute of Child Health

In attendance:

Mr Akhter Mateen	Non-Executive Director
Lady Amanda Ellingworth	Non-Executive Director
Ms Kathryn Ludlow	Non-Executive Director
Prof Rosalind Smyth	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Mr Matthew Shaw	Chief Executive
Ms Helen Jameson	Chief Finance Officer
Dr Anna Ferrant	Company Secretary
Mr Paul Balson	Deputy Company Secretary
Mr Peter Hyland*	Director of Operational Performance and Information
Ms Caroline Anderson*	Director of HR and OD
Ms Victoria Goddard	Trust Board Administrator (minutes)

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

31	**Apologies for absence**
31.1	Apologies for absence were received from: Miss Elena-May Reading, Patient and Carer Governor; Miss Zoe Bacon, Patient and Carer Governor; Dr Emily Shaw, Parent and Carer Governor; Mr Theo Kayode-Osiyemi, Public Governor; Miss Teskeen Gilani, Public Governor; Miss Emma Beeden, Appointed Governor.
32	**Declarations of Interest**
32.1	No declarations of interest were received.
33	**Minutes of the meeting held on 17 July 2019**
33.1	The Council of Governors **approved** the minutes of the previous meeting.
34	**Matters Arising and action log**
34.1	The actions taken since the previous meeting were noted.
35	**Chief Executive Report**
35.1	Mr Matthew Shaw, Chief Executive thanked Governors for their involvement in the recent CQC inspection and said that positive informal feedback had been received. It was anticipated that the formal report would be received in the coming months.
35.2	Work was taking place to improve the RTT position following the decision to reduce activity over the EPR go-live period. The trajectory set out an improvement plan that would ensure the Trust was compliant by the beginning of 2020/21. The key focus nationally was around 52 week waits and GOSH was focusing on the dental service in this regard.
35.3	An article had been published in the press about the Trust's Gastroenterology Service following the publication of the draft report of the external review which GOSH had been required to release in response to a Freedom of Information (FOI) request. Mr Shaw said that there must be space for staff to discuss draft reports and added that the Trust strongly refuted the allegation that any information had been withheld. All evidence to support changes made to the report had been provided to the journalist. He said that he and the Chair had written to the publication. Further FOI requests had been received related to emails, discussions and telephone calls.
35.4	The Children's Cancer Centre Outline Business Case had been approved by the Trust Board and work was beginning to engage with relevant clinical services (cancer), the GOSH school and the pharmacy all of whom would be located in the new building. The Full Business Case would be presented to the Trust Board at the end of 2020.
35.5	Mr Shaw welcomed the People Strategy which had been launched during Open House in the week of 19th November and was due to be formally signed off at

	the Trust Board meeting on 27th November.
35.6	Mrs Carley Bowman, Patient and Carer Governor said that previously the Council of Governors had raised concerns about the gastroenterology service and the transparency of the Board with the Council. She asked whether Non-Executive Directors were satisfied that the Trust was being as open as possible with patients and families. Mr Shaw said that there had been extremely complex issues in the service over a number of years which had been challenging to work through. He said that good engagement was taking place with the gastroenterology team which was feeding into responses and information had been provided on the GOSH website being clear about how people could seek advice if they had concerns. He said that it was disappointing that the matter continued to be raised as it was challenging for families. The majority of actions in the gastroenterology action plan were complete and work was continuing to work with other London centres to ascertain where paediatric care could best be provided.
35.7	In response to the question, Mr James Hatchley, Non-Executive Director said that he was confident that substantial progress had been made in terms of transparency and added that there was a focus in the People Strategy on relationships and communications.
35.8	Dr Sarah Aylett, Staff Governor highlighted the high profile inquest which was related to the provision of ECMO at GOSH. She said that following the change in the bank rate for some nurses, there had been an impact on the service. Mr Shaw said that the Trust had two permanent ECMO beds which he was fully satisfied that GOSH could staff. He said that this could be flexed to three beds on occasion as required. Benchmarking had shown that in terms of bank rates, only one Trust paid more than GOSH and Mr Shaw said that it was vital to be competitive.
35.9	Ms Margaret Bugyei-Kyei, Staff Governor queried the causes of surgical list cancellations if staffing levels were adequate and Mr Shaw said that the national vacancy rate for paediatrics was approximately 25% against a rate of approximately 8% at GOSH. He said that activity was not linear and there were points at which there were peaks when responding to emergencies. Dr Quen Mok, Staff Governor highlighted that the Trust which offered a higher bank rate than GOSH had been able to open a greater number of beds and it was also noted that there had been a recent new development external to GOSH at another Trust which offered an excellent environment for critical care nurses to work in. Mr Shaw said that the relevant Trust's contract allowed for payment for increased activity whilst GOSH's did not. Ms Bugyei-Kyei emphasised the importance of encouraging skilled nurses to remain at GOSH through continued development and noted that this was a key component of the People Strategy.
35.10	Mr Josh Hardy, Appointed Governor asked what action the Trust would be taking to address the shortfall in IPP income and Mr Shaw confirmed that GOSH had recently signed a preferred provider agreement with one territory which was extremely positive and had already led to an increase in referrals from that area. He said that activity had increased in quarter two 2019/20. Work was taking place around insurance schemes for doctors, nurses and allied health professionals to enable all types of clinicians to undertake private work on site. The IPP strategy group continued to meet monthly to review the various

	workstreams.
35.11	Dr Mok expressed concern about the continuing and increasing reliance on IPP activity to reduce the deficit from NHS activity. She highlighted the extremely complex nature of many patients who often had very significant co-morbidities which put significant pressure on critical care. Mr Shaw agreed that it was important to diversify the Trust's portfolio. Ms Helen Jameson, Chief Finance Officer said that it was vital to transform services and take advantage of digital solutions to improve efficiency as it would not be possible to increase NHS income without this.
35.12	<u>GOSH strategy</u>
35.13	Due to the current period of purdah it was not possible for the Board to approve and publish the Trust's strategy, however it would be reviewed during the confidential session of the Board for further comment and approved at the February 2020 Board in the public session.
35.14	Mrs Bowman asked whether the Trust's Always Values continued to be part of the strategy and Mr Shaw confirmed that it did however it was possible that one always value would be replaced by 'Always Kind' in response to feedback.
35.15	<u>Finance report (highlights)</u>
35.16	Ms Jameson said that at the end of October 2019 the Trust was £100,000 adverse to control total year to date which was primarily as a result of underperformance in IPP and had partially been offset by staff vacancies across the Trust. Cash remained strong. Depth of coding had reduced following the implementation of Epic which was contributing to NHS income being approximately £1million behind plan.
35.17	Mr Paul Gough, Staff Governor highlighted that the Finance and Investment Committee (FIC) had reviewed a list of high cost contracts which had included the cost of providing the staff bank. He asked if there had been an update on the substantial costs involved and Ms Jameson said that this would be reported to the next FIC meeting.
35.18	Ms Fran Stewart, Public Governor noted that IPP debtors were above plan and asked what action was being taken. Mr Akhter Mateen, Chair of the Audit Committee said that a discussion had previously taken place at Audit Committee about whether the target should be changed as it was extremely challenging to achieve however it had been agreed that it should remain the same in order to encourage sufficient focus. He said that following an improvement in debtor days this had begun to move adversely again in October. Ms Jameson said that the rate of pay had decreased in October and November leading to an increase in the levels of debt despite a reduction in provisioning as aged debt was paid. The Trust had changed its payment model and the way in which payment were incentivised which had led to improvements. Ms Jameson said that it had become clear that GOSH was being paid first of all Trusts nationally. Mr Mateen highlighted that some of the payments which were being received had been fully provided for which was positive in terms of GOSH's financial position.
35.19	Ms Stewart asked how the GOSH's level of cash compared to that of other

	Trusts and Ms Jameson said that it was significant compared to others' which was very positive.
36	**Annual Business Planning at GOSH**
36.1	Mr Peter Hyland, Director of Operational Performance and Information said that business planning guidance had not yet been issued by NHS England and Improvement however it had been anticipated that it would be in line with the previous year with a focus on efficiency and financial sustainability. The Trust had moved to a block contract due to the EPR go-live and it was likely that this would continue. It was confirmed that a discussion would take place at the Council of Governors' meeting in February 2020. Mr Shaw said that it was likely to be a very challenging financial environment for the remainder of 2019/20 and 2020/21.
37	**Selection by Governors of a Local Quality Indicator for external data testing and inclusion in the Quality Report 18/19**
37.1	**Action:** Mr Hyland said that as part of the Quality Report the Trust's external auditor would test the accuracy of data for three indicators two of which were mandated and one would be chosen locally by Governors. He presented five potential indicators for selection and asked Governors to send their first and second preference to Alissa.Angelova@gosh.nhs.uk by 13th December 2019.
38	**Reports from Board Assurance Committees**
38.1	Quality, Safety and Experience Assurance Committee (October 2019)
38.2	Lady Amanda Ellingworth, Chair of QSEAC said that she had been working with the Medical Director and Chief Nurse to develop an agenda for the Committee to be more focused on assurance and being clear about improvements being made and timelines for the improvement. She said it was important to ensure work was being prioritised effectively. Lady Ellingworth said there was a focus from the executive team on ensuring that all issues were highlighted to the Committee event when they were emerging issues.
38.3	Considerable time had been spent reviewing the MHRA report on pharmacy in order to ensure lessons were learnt throughout the Trust.
38.4	Focus would continue to be placed on the quality and safety impact of the Better Value programme.
38.5	Audit Committee (October 2019) including refreshed terms of reference
38.6	Mr Akhter Mateen, Chair of the Audit Committee said that the Committee had reviewed its Terms of Reference in response to the publication of the NHS Audit Committee handbook. The BAF was also reviewed at each meeting along with deep dives into particular risks along with an update on GDPR and data quality.
38.7	An external review had taken place on emergency planning and it was confirmed that GOSH was 100% compliant and was one of only two Trusts in London where this was the case.

38.8	Three internal audit reports had been reviewed, all of which had received assurance ratings of partial assurance with improvements required however no red rated recommendations had been made. Work had taken place to reduce the outstanding overdue audit recommendations and this had now been reduced to two.
38.9	The Committee had asked for a follow up discussion on cyber security at the next meeting as this continued to be a key issue for the Trust.
38.10	<u>People and Education Assurance Committee (July and September 2019)</u>
38.11	Ms Kathryn Ludlow, Chair of the PEAC said that two meetings of the new committee had taken place and it was important that there was a strong focus on culture. The workplan would be reviewed at the next meeting to ensure that the objectives of the committee were achievable and to review how success would be monitored. Staff stories would be presented at the Committee in the same way that the Trust Board received patient stories and the Committee would oversee three BAF risks.
38.12	Mr Colin Sincock, Public Governor asked about the work taking place around bullying and harassment. Ms Ludlow said that it was positive that staff were willing to speak up and progress would continue to be reviewed through the staff survey.
39	**Update from the Young People's Forum (YPF)**
39.1	Mr Josh Hardy, Member of the Young People's Forum said that three meetings of the YPF had taken place in the period and a new Chair and Vice Chair had been elected. The CQC had also visited the forum to speak to members and had discussed what went well and could be improved at the Trust and members had reported that care was outstanding however work was required to improve transition.
39.2	The YPF had taken part in a stakeholder panel for the patient experience lead and had formed part of the interview panel for the catering manager role. The forum had continued to work with PALS and complaints in response to the children's commissioner's report.
40	**GOSH People Strategy**
40.1	Ms Caroline Anderson, Director of HR and OD said that following concerns raised in the Trust's staff survey a programme of work had been established and the People Strategy was a key component of this. She said that in the introduction to the strategy was a commitment statement to staff which had historically not been present.
40.2	Dr Sarah Aylett, Staff Governor said that feedback received in clinical areas was that there had been a reduction in the number of administrative staff which put increased pressure on remaining staff. Ms Anderson said that there was a turnover rate of 25% amongst administrative staff which was a risk to the organisation. She said that this had become the first workstream. Dr Aylett said that it was important to encourage teamwork and a shared identity and Ms Anderson said that in general staff worked well within their teams but it was vital

	to share across teams to inspire a connection to the wider organisation.
40.3	Mr Sincock highlighted the importance of career development plans and suggested that this should be in place for all staff. Ms Anderson said that plans were well established for clinical staff however improvement was required in terms of other staff. Mr Sincock noted that the response rate for the staff survey was approximately 50% and asked for a steer on the barriers to staff responding. Ms Anderson said that the staff survey was not as embedded in the NHS as it was in other sectors and going forward pulse surveys would begin in order to receive feedback from staff on a more ongoing basis.
40.4	Miss Faiza Yasin, Patient and Carer Governor emphasised the importance of taking a holistic approach to the health and wellbeing of staff and Ms Anderson said that there were a lot of resources available to staff but they were often difficult to navigate and it was important to ensure services were integrated. Work would take place to carry out a baseline assessment of current resources. She added that it was important to support line managers to be clear about their responsibilities around staff wellbeing.
40.5	Mr Paul Gough, Staff Governor welcomed the work and said that he felt GOSH successfully promoted administrative staff however it was important to recognise that as a relatively small Trust there were not always pathways available. Ms Fran Stewart, Public Governor asked whether there would be a resourcing plan for the next five years and Ms Anderson said that it was vital to take two years to implement a solid foundation and then reassess priorities however she emphasised that the Board and Executive Team were committed to implementing the strategy. Sir Michael agreed and said that whilst the Board welcomed the strategy, it was vital to ensure it was well executed.
41	**Update from the Council Nominations and Remuneration Committee**
41.1	<u>Chair and Non-Executive Director Appraisals</u>
41.2	Dr Anna Ferrant, Company Secretary said that the appraisals of the Chair and three Non-Executive Directors had recently been undertaken which involved soundings being taken from the Council of Governors and Executive Team and feedback provided to the appraiser. She said that the appraisals had been discussed at the Council of Governors' Nominations and Remuneration Committee and all had been recommend to the Council for approval. *Sir Michael left the meeting and Mr Mateen took the Chair.*
41.3	• <u>Sir Michael Rake</u>
41.4	Mr James Hatchley, Senior Independent Director said that he had undertaken the appraisal of the Chair and feedback had been received from Executive Directors, the Council of Governors and other Non-Executive Directors
41.5	The Council **approved** the outcome of the appraisal of the Chair. *Mr Akhter Mateen, Ms Kathryn Ludlow and Professor Rosalind Smyth left the room. Sir Michael Rake re-joined the meeting and took the Chair.*

41.6	• Akhter Mateen, Kathryn Ludlow and Rosalind Smyth
41.7	Sir Michael said he felt that each Non-Executive Director brought significant benefits to the Board in different ways.
41.8	The Council **approved** the outcome of the appraisals of three Non-Executive Directors. *Mr Akhter Mateen, Ms Kathryn Ludlow and Professor Rosalind Smyth re-joined the meeting.*
41.9	Chair and NED Objectives 2020
41.10	NHS England and NHS Improvement had recently published guidance on a standard framework within which annual appraisals for provider chairs were applied and managed. This had been reviewed by the Council of Governors' Nominations and Remuneration Committee and it had been felt to be appropriate with some amendments which had been incorporated into the papers. Dr Ferrant said that the Committee had felt that it was appropriate to align the process for appraising the Chair with the process for appraising the Non-Executive Directors. This would be presented at the February 2020 Council meeting.
41.11	The Council **approved** the revised competency framework for appraising both the Chair and Non-Executive Directors.
41.12	Appointment of a Non-Executive Director on the GOSH Board
41.13	Dr Ferrant said that in 2018 it had been agreed to reappoint Professor Rosalind Smyth as a Non-Executive Director on the Board for an additional period of one year over and above the usual two three year terms of a Non-Executive Director. This had been agreed in order to provide stability to the Board after a period of churn for both Executive and Non-Executive Directors. The Council of Governors' Nomination and Remuneration Committee had felt that as the Board was now in a period of stability it was important to revert to the usual process. As the appointment was to be made by UCL, Sir Michael had contacted the Vice Provost (Health) at UCL and a process was being undertaken to identify a preferred candidate who would be subject to approval by the Council.
41.14	Due to the important nature of the relationship between GOSH and the UCL GOS Institute of Child Health, Sir Michael had agreed that Professor Smyth would be invited to the Board as a non-voting member for relevant discussions. Professor Smyth emphasised her commitment to the Trust and the relationship with the Institute of Child Health. The Council of Governors thanked Professor Smyth for her work as part of the Board.
41.15	Sir Michael said that he would sit on the selection committee to identify the preferred individual.
41.16	Chair and NED Remuneration
41.17	Dr Ferrant said that guidance had been published by NHS England and Improvement on the remuneration of Chairs and Non-Executive Directors in the

	NHS in order to address a longstanding issue of disparity between the remuneration of Chairs and Non-Executive Directors of NHS Trusts and NHS Foundation Trusts.
41.18	Previously GOSH had conducted a benchmarking exercise of similar sized Trusts and there had been no increases in remuneration, (including cost of living), in recent years. The recommendations provided a limit of £13,000 or £15,000 where they chaired meetings. Dr Ferrant proposed that the changes did not impact existing salaries but would be implemented as new Board members joined or were reappointed for second terms. It would also be applied to the newly appointed UCL nominated Non-Executive Director.
41.19	The Council **approved** the proposal and its application.
42	**Update from the Membership Engagement Recruitment and Representation Committee (MERRC)**
42.1	Mr Paul Balson, Deputy Company Secretary said that the committee had noted that workstreams on the use of social media were on-going and agreed that this was extremely positive. The Trust would be consulting with the Young People's Forum to garner their views and suggestions on the use of social media which would support the key aim to increase membership and engagement with young people.
42.2	**Action:** Mr Gough suggested that the MyGOSH patient portal was used to highlight membership to families and to encourage them to become members and it was agreed that this would be explored.
42.3	Discussion took place around the importance of engaging with members and Mr Balson said that this was a priority for MERRC to achieve a flow of information between the Trust and members. Dr Ferrant highlighted that as agreed previously by the Council of Governors changes would be made to constituencies in 2020 as well as elections and substantial engagement would take place on this.
42.4	Mrs Carley Bowman, Patient and Carer Governor asked whether Governors were able to undertake recruitment in the Lagoon alone and Mr Balson said that Governors were welcome to do so and he could provide membership materials to support recruitment.
42.5	The Council discussed the benefits, particularly for young people, which would encourage people to sign up as a member and Mr Balson said that feedback received from the Young People's Forum was that the benefits were not always clear. Discussion on this had taken place at MERRC and committee members had highlighted the importance of showing that members were contributing to the Trust.
43	**Update from the Constitution Working Group**
43.1	<u>Council of Governors' Effectiveness Review Survey Results</u>
43.2	Mr Balson said that a 73% response rate had been received in the Council of Governors' Effectiveness review and a number of recommendations had been

	made as a result of the feedback provided. Governors felt they had a good understanding of the role however a third of respondents felt that meetings were dominated by a few Governors and some felt that there was insufficient time in meetings.
43.3	**Action:** The Council discussed whether an additional meeting or longer meetings were required and it was noted that a consensus could not be reached during the Governor pre-meet. It was agreed that further discussion would take place at the next meeting. Sir Michael said that it was important to reflect on the impact of an additional meeting on the Trust as a whole to be respectful of the time of all involved.
43.4	Discussion had taken place at the Governor pre-meet around strategies to enable all Governors to contribute to discussions. Sir Michael said it was important to create a positive environment in which contributions were welcome from all. He said that he would be happy to discuss this further with the Lead Governor outside the meeting if required.
43.5	<u>Review of Buddying System</u>
43.6	At the July meeting, the Council agreed that the buddying programme would continue with some amendments. The Constitution Working Group had reviewed proposals for the structure and objectives of buddying and it was agreed that the first meeting of buddy groups would take place in advance of February 2020 with Mr Balson providing support to arrange the meetings.
44	**Governance Update**
44.1	Mr Balson said that the Trust Board had approved a revised Terms of Reference which had been provided to Governors for information. He also asked that Governors reviewed and signed their code of conduct.
44.2	An online system for making declaration of interests and gifts and hospitality, called 'Declare', had been launched on 11th November 2019. Governors' existing declarations had been uploaded to the system and Governors were asked to log in to review this information. From 2nd December 2019 Governors were asked to update their information to reflect any changes in information.
44.3	Mr Colin Sincock, Public Governor said that he and Mr Theo Kayode-Osiyemi had attended "GovernWell: Member and public engagement" which had highlighted the need to review the way in which members could interact with Governors and assess whether there were any barriers to this interaction as well as the time and financial resources involved in facilitating such engagement. He suggested that the Trust should become involved in the NHS youth forum and it was confirmed that some Governors were already engaged in this work.
44.4	Sir Michael highlighted that GOSH had won an award for its annual report and accounts.
45	**Any other business**
45.1	Sir Michael thanked Governors for their time and engagement throughout 2019.

ATTACHMENT B

Attachment B

COUNCIL OF GOVERNORS ACTION CHECKLIST
February 2020

Checklist of outstanding actions from previous meetings

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
37.1	26/11/19	Mr Hyland said that as part of the Quality Report the Trust's external auditor would test the accuracy of data for three indicators two of which were mandated and one would be chosen locally by Governors. He presented five potential indicators for selection and asked Governors to send their first and second preference to Alissa.Angelova@gosh.nhs.uk by 13th December 2019.	**Governors**	**December 2019**	Result on agenda under Matters Arising
42.2	26/11/19	Mr Gough suggested that the MyGOSH patient portal was used to highlight membership to families and to encourage them to become members and it was agreed that this would be explored.	**PB**	**February 2020**	On agenda under MERRC update
43.3	26/11/19	The Council discussed whether an additional meeting or longer meetings were required and it was noted that a consensus could not be reached during the Governor pre-meet. It was agreed that further discussion would take place at the next meeting. Sir Michael said that it was important to reflect on the impact of an additional meeting on the Trust as a whole to be respectful of the time of all involved.	**PB**	**February 2020**	On agenda under action plan for Council effectiveness survey

Council of Governors

5th February 2020

Selection by the Council of Governors Councillors of a Local Quality Indicator for external data testing and inclusion in the Quality Report 2019/20

Summary & reason for item:

Following the last Council of Governors meeting, thirteen of the Governors responded to make a selection of the local Quality Indicator to be audited. This paper details the output of this and provides time frames around the next steps.

Governor action required:

To note the selected indicator

Report prepared by: Peter Hyland, Director of Operational Performance and Information

Item presented by: Peter Hyland, Director of Operational Performance and Information

Selection by Governors of a Local Quality Indicator for external data testing and inclusion in the Quality Report 2019/20

Introduction

As part of the annual preparation for the Quality Report, Deloitte will test the accuracy of data for three indicators as set by NHS Improvement. One of the indicators is to be determined locally.

GOSH asks its Council of Governors to select a local indicator from a shortlist felt to be of most relevance to our organisation and its members. The selection was conducted by e-mail in November and December 2019 to enable every governor to participate. The list of five indicators provided for the selection are provided below complete with a description of each.

List of local indicators to select from for 2019/20:

Domain	Indicator	Description
Safety	CV Line related blood-stream infections (per 1000 line days)	A central venous line (CVL) is an indwelling tube with its tip lying in the central veins. Infections are significant because they harm the patient, disrupt treatment provided through the CVL, and cost money to treat. A large percentage of children at GOSH require CVLs and while the rate of infection is not high, the absolute number is significant. Surveillance of infections is used to drive the preventative intervention programme.
Responsiveness	Last Minute Non-Clinical Hospital Cancelled Operations	Last Minute Non-Clinical Hospital Cancelled Operations is a nationally reported standard on a quarterly standard with a tolerance of less than 0.8% of elective admissions. This indicator is directly related to the experience of the patient as cancellation of the patient on the day of surgery is not acceptable. This has been an area of delivery the Trust has struggled to achieve recently, although there is focused work being completed to reduce the volume.
Productivity	Number of PICU Delayed Discharges	Number of patients who are fit and ready for discharge from PICU but who are unable to be discharged due to capacity issues. This can be either a discharge internally within the organisation or to an external hospital.
People	% of compliance against the Trust mandatory training standard	As employees of GOSH, all staff are required to complete mandatory training which is adjusted based on the role of the individual. The indicator is inclusive of all substantive staff members (we do collect and monitor mandatory training for other staff as well) and the mandatory training

		they are required to complete which is role specific. Therefore the indicator is made up of each employee, multiplied by the number of courses they have completed, divided by the number they are required to complete.
Effective	Discharge Summary Turnaround rate within 24 hours	The Trust is required to provide a discharge summary for any inpatients (including daycases) within 24 hours of the patient being discharged, to the patient, GP and referrer as appropriate. Given the recent go-live of the Epic EPR system, there has been a considerable focus on this over previous months, with the data used to make up the indicator is taken directly from the Epic system.

For information, the last year (2018/19) the Council selected the Number of PICU Delayed Discharges and the previous year CV Line related blood-stream infections (per 1000 line days).

Which indicator was selected by the Council for 2019/20?

We had thirteen responses in total, each selecting a first and second choice indicator. As we had a tie with the first choice, we also included the second choice indicator into the selection process. A summary table of the selection is included below:

Domain	Indicator	1st	2nd	Total
Safety	CV Line related blood-stream infections (per 1000 line days)	4	1	5
Responsiveness	Last Minute Non-Clinical Hospital Cancelled Operations	4	4	8
Productivity	Number of PICU Delayed Discharges	0	3	3
People	% of compliance against the Trust mandatory training standard	2	2	4
Effective	Discharge Summary Turnaround rate within 24 hours	3	3	6

Therefore the selected indicator is our responsiveness indicator- '**last minute cancellations for non-clinical reasons**.'

Testing on the data will commence in February 2020 and the outcome of the audit will be shared at the next Council of Governors' meeting.

Attachment D

Great Ormond Street Hospital for Children
NHS Foundation Trust

Council of Governors
5th February 2020

Summary & reason for item:

Above and beyond is the new strategic framework for GOSH, developed during 2019 in consultation with patients, families, staff and partners. It builds on the work done to develop the 2017 strategic framework *Fulfilling Our Potential* and restates our purpose as an organisation focused on advancing care for children and young people with complex health needs.

The framework is submitted to the Council today for noting and is on the Board agenda at tomorrow's meeting for approval. It provides a statement of purpose that explains why our organisation is focused on specialist care, our role as a partner to the global child health community and our commitment to the staff who work here as well as the patients and families we serve. It also provides a set of 'due north' principles and an ambitious set of programmes to transform our skills and capacity to deliver a patient-centred, digital-first culture, driving better outcomes, more research discoveries and a better experience for patients, families, staff and partners.

We will be launching the strategy at an all-staff meeting in early March and are developing a strategy toolkit for GOSH leaders to support them in operationalising the strategy across directorates and departments.

The executive team will oversee progress on implementing the strategy at a new executive team strategy meeting, which will be held every six weeks. They will oversee the six programmes of work:

- Making GOSH a great place to work by investing in the wellbeing and development of our people.
- Delivering a Future Hospital Programme to transform outdated pathways and processes.
- Developing the GOSH Learning Academy as the first-choice provider of outstanding paediatric training.
- Improving and speeding up access to urgent care and virtual services.
- Accelerating translational research and innovation to save and improve lives.
- Creating a Children's Cancer Centre to offer holistic, personalised and co-ordinated care.

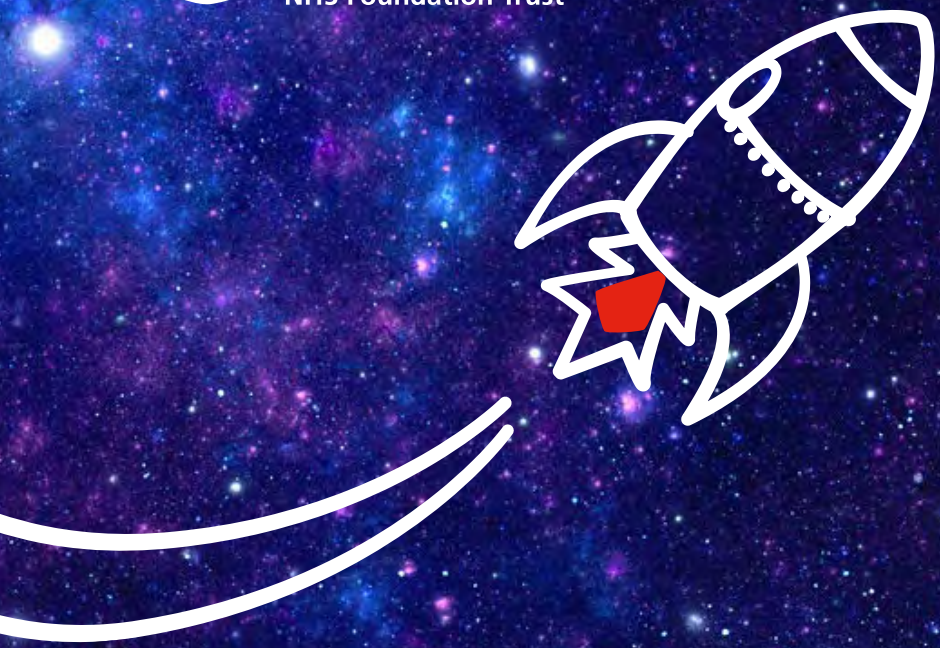
Each of these will be led by an executive team SRO and delivered through a programme board, which will report into the executive team strategy meeting. We propose to update the Council at each meeting (via the Chief Executive's report) on our progress in implementing the strategy through each of the priority programmes

Governor action required: Noting

Report prepared by: Louisa Desborough, Strategic Partnerships Adviser

Item presented by: Matthew Shaw, CEO

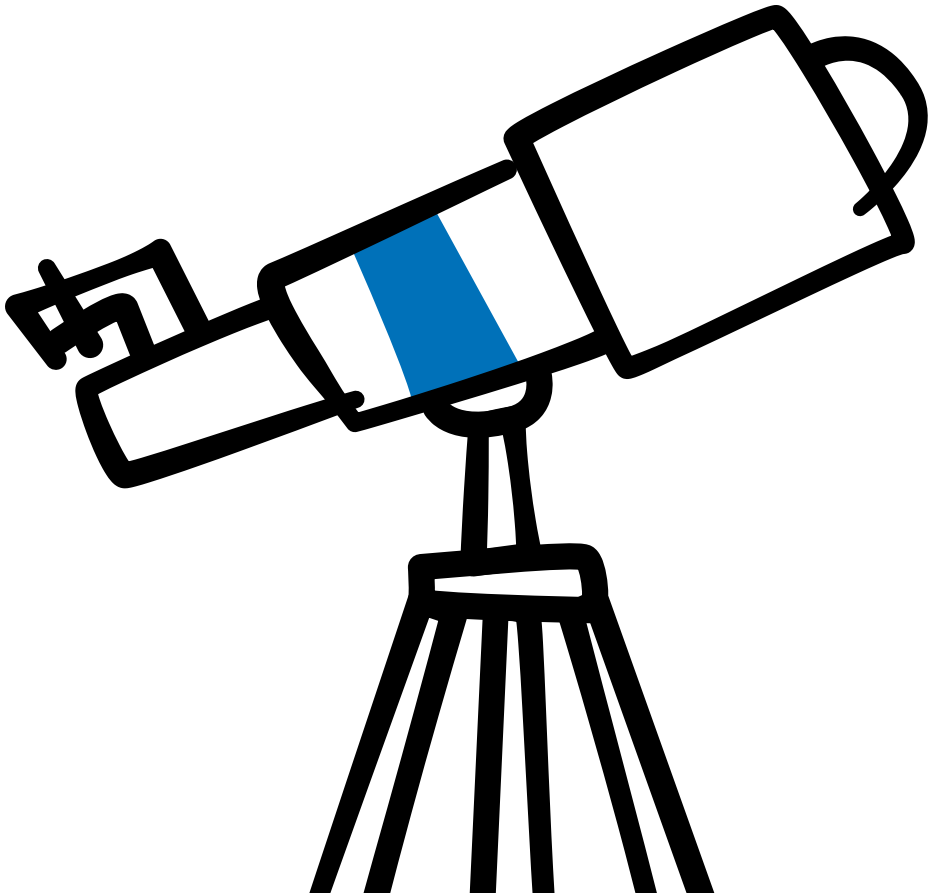
NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust



ABOVE and BEYOND

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

Our vision for 2025



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

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

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

By working with our partners and focusing our time and energy on a limited set of ambitious goals, we'll do right by our patients and right by our staff. More children will fulfil their potential, and the GOSH of 2025 will be truly out of this world.

Matthew Shaw, Chief Executive

Our Purpose

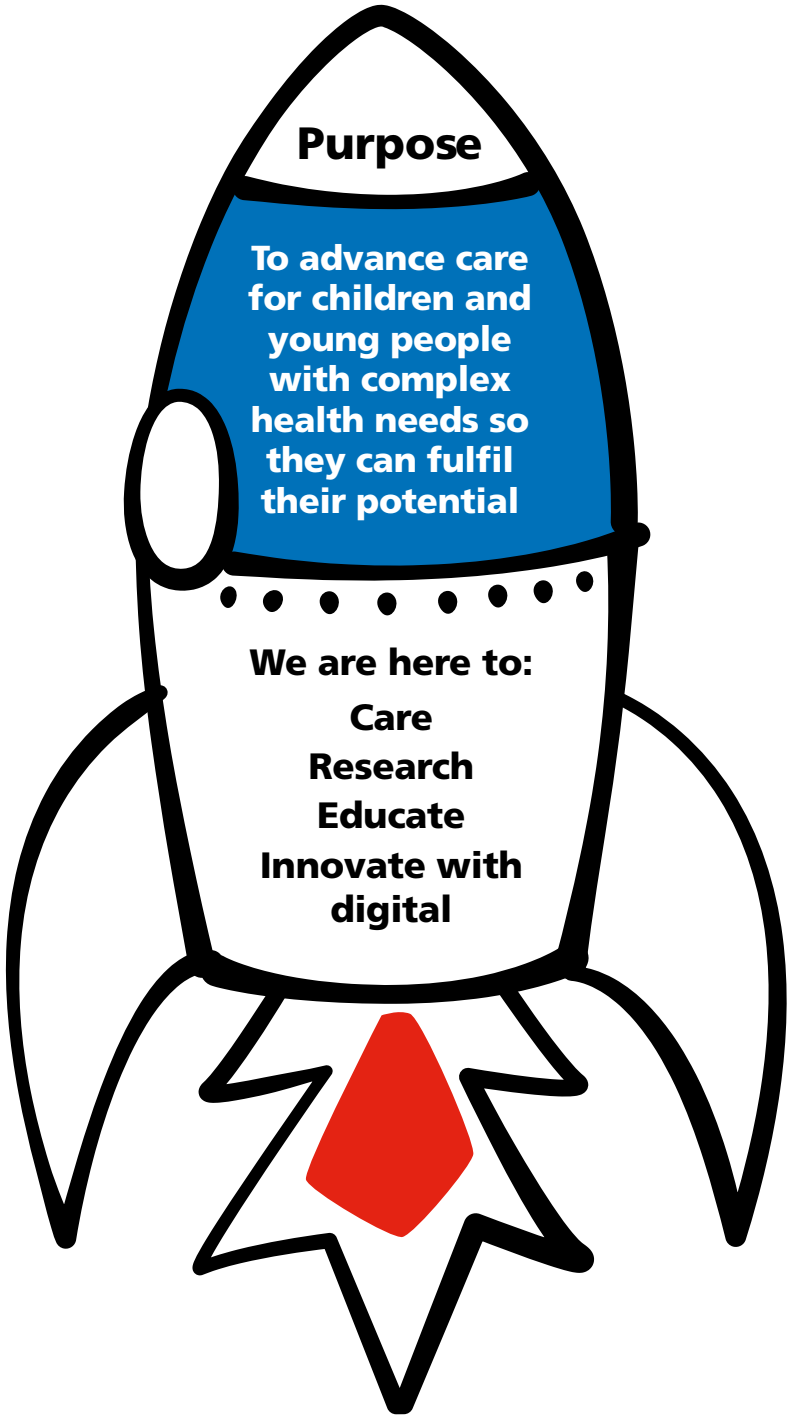
At Great Ormond Street Hospital we advance care for children and young people with complex health needs so they can fulfil their potential.

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

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

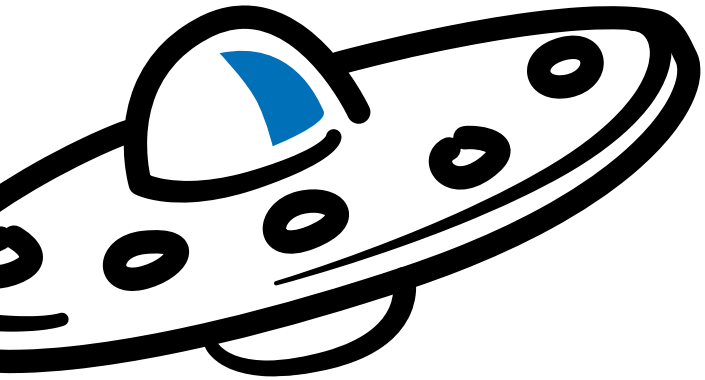
We are here to **EDUCATE**; to be a stimulating place for children and young people, to help colleagues build rewarding careers and to provide outstanding training to drive improvements in paediatric care.

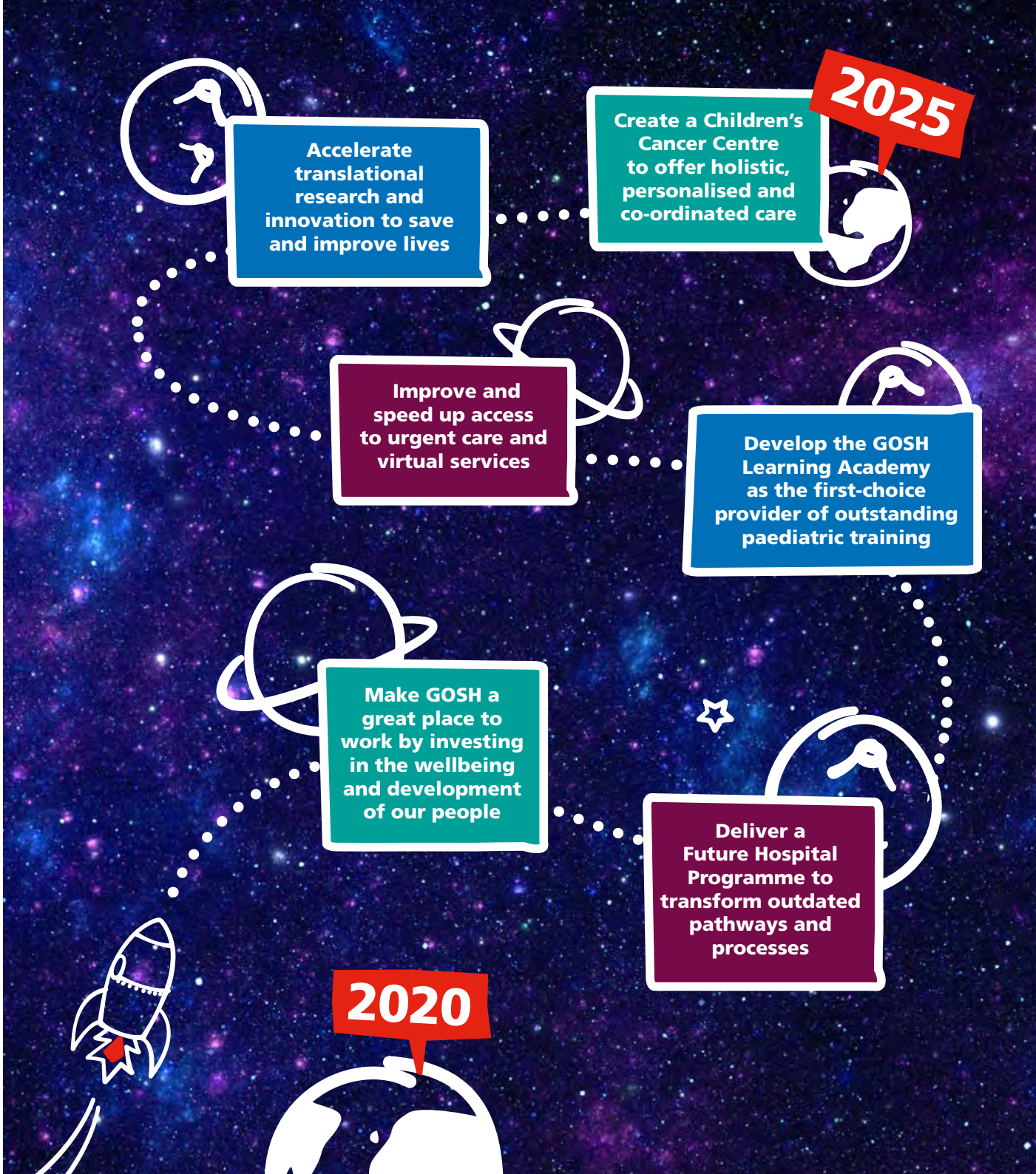
We are here to **INNOVATE WITH DIGITAL**; to embrace and master digital technologies that will help us save and improve lives and make support available to children and families around the clock.



Our Priorities

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





Our Principles

Six clear principles will guide our planning, our decision making and our day to day work. Sticking to our principles gives us the best chance of achieving our purpose and delivering our priorities while doing the things that matter most to the GOSH community. But that will sometimes be hard. We will have to say no to things in order to focus on what matters most.

Principle 1: Children and young people first, always

GOSH in 2025 will be very different to the hospital established in 1852. But while our founders would marvel at our progress and wonder at our technology, our ethos would be quite familiar. Fulfilling the potential of children and young people has always and will always drive us on to achieve great things.

Principle 2: A values-led culture

Always Welcoming, Helpful, Expert and One Team.

In 2025, GOSH will be a tolerant, inclusive, open and respectful place where staff are valued for who they are as well as what they do. Our people will enjoy coming to work and will live the GOSH Always Values – Always Kind and Welcoming, Always Helpful, Always Expert and Always One Team. We will form strong, supportive multi-disciplinary teams in which everyone has the freedom to learn and contribute and no one is afraid to speak up.

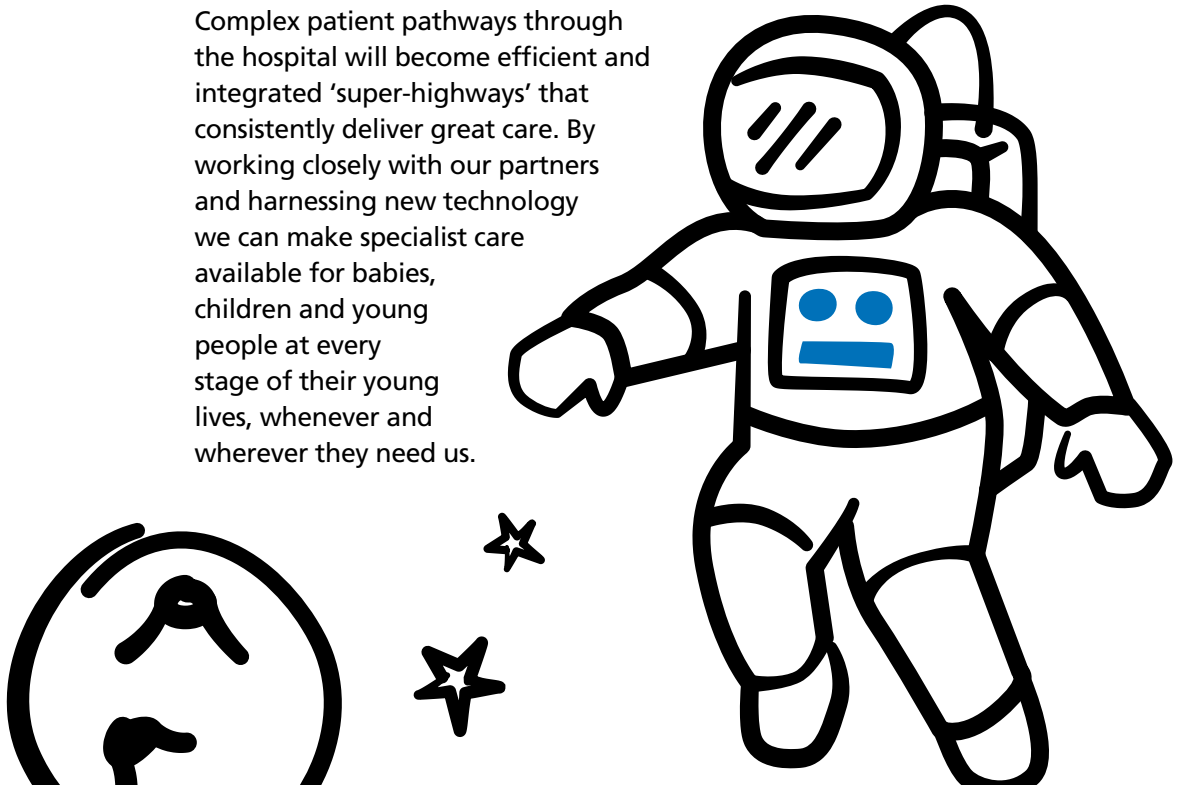
Principle 3: Quality

Safe, kind, effective care and an excellent patient experience.

In 2025 we will be world leading in clinical outcomes and service design that puts patients first. Patients and families will be confident in their care because clinical outcomes across all our services will be scrutinised and benchmarked against our international peers and made publicly available on our website.

Maintaining quality means maintaining our core focus on specialised services for rare and complex conditions, while supporting our partners in developing population health and prevention approaches to improve the health of children everywhere. We will develop our capabilities in cancer, cardiac, neurology and rare diseases and nurture the broad base of services that are essential to high quality, holistic care in the specialist children's hospital setting.

Complex patient pathways through the hospital will become efficient and integrated 'super-highways' that consistently deliver great care. By working closely with our partners and harnessing new technology we can make specialist care available for babies, children and young people at every stage of their young lives, whenever and wherever they need us.



Principle 4: Financial strength

Stronger finances support better outcomes for more children and young people.

In 2025 we will be a more efficient, resourceful and resilient organisation. We will take a proactive and enterprising approach to developing long term partnerships, seizing opportunities and creating diverse streams of income. The generosity of philanthropic donors will enable us to go over and above what is possible through the NHS so we can extend our reach to help more children and advance discovery. We will use our influence to champion a fairer funding deal for children who need complex care.

Principle 5: Protecting the environment

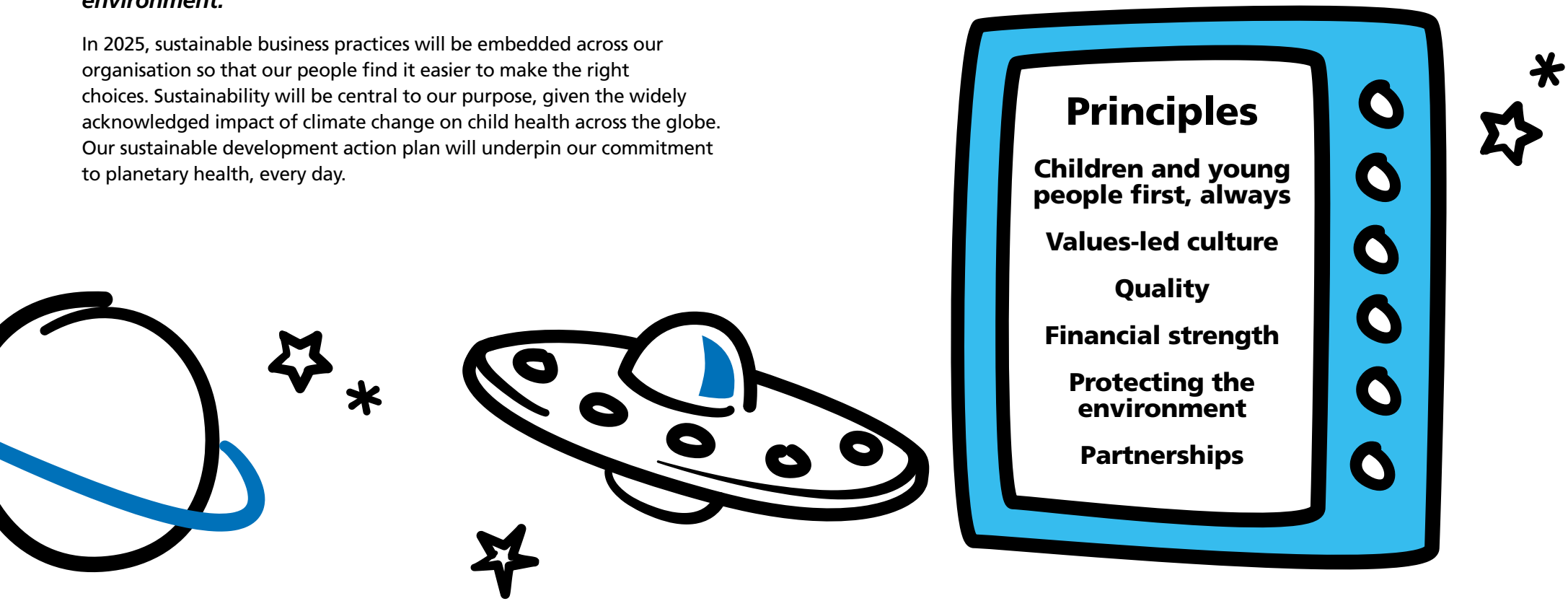
We aren't caring for children if we don't protect the environment.

In 2025, sustainable business practices will be embedded across our organisation so that our people find it easier to make the right choices. Sustainability will be central to our purpose, given the widely acknowledged impact of climate change on child health across the globe. Our sustainable development action plan will underpin our commitment to planetary health, every day.

Principle 6: Partnerships

Together we can do more.

In 2025, we will never work in isolation if we can better achieve our goals by working with others. Our NHS, charitable, academic and business partnerships allow us to make faster progress – connecting us to the global effort to advance care for children and young people, driving us to contribute where we are strongest and bring in expertise where we need it. We will be proactive in asking for help from policy makers and in making the case for the change to remove barriers to progress. We work with regional and national partners and our patients and families, to co-design pathways of care that work best for children and young people. By partnering with academia and industry, we will accelerate research and innovation into clinical practice to save and improve more children's lives.



You can find out more about *Above and beyond* by getting in touch with our strategy team:

strategyandplanning@gosh.nhs.uk

Attachment E

Council of Governors

5 February 2020

GOSH CQC Inspection Report 2019

Summary & reason for item: The attached presentation provides a high level overview of the results of the CQC inspection which was undertaken between October and November 2019 and was published on the 21st January 2020.

The key points are:

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

A copy pf the report is attached.

The CQC issued 2 enforcement notices:

<u>Regulation 12: Safe Care and Treatment</u>
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.

<u>Regulation 17: Good Governance</u>
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.

In total the hospital has been advised of 4 'Must Do' actions which are required to bring services in line with legal requirements. These link to the actions to address the enforcement actions. The Trust has also been advised of 18 'Should Do' actions (10 Trust wide, 2 Critical Care, 3 Surgery and 3 Mental Health) which are required to comply with minor breaches that did not justify regulatory

action and to prevent the service from failing to comply with legal requirements in future, or to improve services.
An action plan has been developed to address all Must Do and Should Do actions. The plan to address the enforcement notice must be submitted to the CQC by the 13th February 2020. We must inform the CQC in writing when these actions are complete. An executive led committee, Always Improving, has been established and will meet monthly to review progress against this action plan, whilst supporting the ongoing work on the journey towards Outstanding. This committee will report into the Risk, Assurance and Compliance meeting.

Governor action required: Note the report, the regulatory actions and acknowledge progress made since the last inspection and which is reflected in the report, including the many examples of outstanding practice.

Report prepared by: Róisín Mulvaney, Head of Special Projects – Quality and Safety

Item presented by: Róisín Mulvaney, Head of Special Projects – Quality and Safety

Great Ormond Street Hospital for Children NHS Foundation Trust

Inspection report

Great Ormond Street Hospital
Great Ormond Street
London
WC1N 3JH
Tel: 02074059200
www.gosh.nhs.uk

Date of inspection visit: 01 October to 7 November 2019
Date of publication: 22/01/2020

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall trust quality rating	Good
Are services safe?	**Requires improvement**
Are services effective?	**Outstanding**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) was established in 1852 in the London Borough of Camden and was the first hospital providing in-patient beds specifically for children in England. Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust achieved foundation trust status on 01 March 2012.

The hospital is the only specialist children's hospital in the UK that does not have an accident and emergency department. All children treated at the hospital are referred from other hospitals or their general practitioner, both within and outside the UK.

The trust operates from a single site in central London and has approximately 418 beds. It is registered with the Care Quality Commission (CQC) to care for children aged 0 to 18 year of age. Together with the UCL Institute of Child Health, it forms the UK's only academic biomedical research centre specialising in paediatrics.

The trust was last inspected in January 2018 (report published April 2018). The trust rating stayed the same since our last inspection, we rated the trust overall as good.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

What this trust does

Great Ormond Street Hospital for Children NHS Foundation Trust is a tertiary specialist children's hospital and has the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services. nephrology and renal transplants. Children are also treated from overseas in the International and Private Patients' (IPP) department.

There are more than 50 different clinical specialties at Great Ormond Street Hospital (GOSH). It provides surgery, medical care, critical care, end of life care, outpatients services, and child and adolescent mental health services. The hospital has 418 beds including there are 42 critical care beds, seven inpatient mental health beds and three-day case mental health beds.

The tier 4 child and adolescent mental health inpatient unit (Mildred Creak unit) provides care to young people aged seven to 14 years for a range of complex social and emotional mental health needs. The trust does not admit patients held under the Mental Health Act. The unit works in collaboration with the local community mental health trust so that if required, the Mental Health Act can be applied on site, before the child is transferred to an appropriate alternative location.

Between March 2018 to February 2019, the trust had 40,349 elective admissions of which 26,583 were day cases and 13,766 were elective and 3,038 non-elective admissions. On a weekly basis on average 4,673 patients were seen in the outpatient's department.

The trust provides surgical treatment for rare and complex conditions. It is the only centre nationally that provides tongue reduction surgery for macroglossia associated with Beckwith Wiedemann Syndrome. Data demonstrates a decreasing surgical complications and excellent functional outcomes for these children.

Summary of findings

The trust is the world leading centre for children requiring slide tracheoplasties and has the largest series of slide tracheoplasties to treat long segment tracheal stenosis. Data shows a significant improvement in survival over time, despite increasing patient complexity.

In 2018 GOSH collaborated with University College London Hospital and researchers from University College London to carry out the first two operations on the damaged spinal cords of babies in the womb in the UK.

In 2019 GOSH was officially recognised as a Centre of Clinical Excellence by Muscular Dystrophy UK. The hospital provides comprehensive services for children and young people with muscle wasting conditions and provides the highest number of dedicated neuromuscular clinics nationally.

The trust is the largest centre in the UK for children with heart or brain problems, and the largest children's cancer centre in Europe. In 2018 GOSH became the first hospital in the UK to offer a new pioneering cancer treatment to children. Patients with B-Cell acute lymphoblastic leukaemia (ALL) can now receive the new personalised treatment, known as CAR-T therapy. This is the first treatment of its kind to become available to UK patient's outside of clinical trials.

The neurosurgical team at GOSH is providing the first Laser Interstitial Thermal Therapy (LITT). This is a minimally invasive treatment which is designed to destroy abnormal brain tissue in an extremely targeted manner, whilst causing minimal damage to overlying or surrounding health brain tissue. It is particularly helpful in treatment of epilepsy-causing or malignant lesions in deep and difficult to access areas of the brain. It reduces the high risk of complications including endocrine disturbance, stroke, visual loss and memory disturbance.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. Our planning decisions took account of information provided by the trust, and information we had collected and reviewed during the past year. This included feedback from patients, the public, staff and other stakeholders.

We carried out the unannounced core service inspection on 01-03 October 2019. We inspected the core services of critical care, surgery and child and adolescent mental health services at Great Ormond Street Hospital (GOSH).

We also inspected the well-led key question for the trust overall. We summarise what we found in the section headed Is this organisation well-led? The announced well-led part of the inspection took place on 06-07 November 2019.

We held discussions with staff prior to inspection and attended the young people's forum and a trust board meeting.

During inspection we spoke to staff from a range of clinical areas and disciplines and at different grades. This included: healthcare assistants; housekeeping, nurses, doctors, consultants, and allied health professionals. We spoke with members of the leadership team, which included executives, non-executive directors, the chair and company secretary.

Summary of findings

We reviewed patient related information, including many electronic patient records and risk assessment tools. We looked at policies and procedures, safety checks and medicines records. In addition, we reviewed minutes of meetings, formal performance reports, risk registers and other governance information.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- Overall, we rated effective and caring as outstanding, responsive and well led as good, and safe as requires improvement. We rated two of the trust's eight services as outstanding and six as good. In rating the trust, we considered the current ratings of the five services not inspected this time.

Our full Inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website.

We rated well-led for the trust overall as good.

Are services safe?

Our rating of safe went down. We rated it as requires improvement because:

- Some services did not always control infection risk well. Staff used equipment and control measures inconsistently, they did not always use hand sanitisers when entering or leaving the wards, or when moving between patient bays
- In some clinical areas, systems to ensure equipment was maintained and safe to use were not effective and did not always follow national guidance.
- The service did not always use systems and processes to safely store, record or destroy medicines in line with legislation.
- Pharmacy provision on the critical care wards was below that recommended by the Society of Critical Care Medicine.

However

- The service provided mandatory training in key skills in line with trust targets.
- 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.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Managers regularly reviewed and adjusted nurse staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff knew how to assess, monitor and manage patient risk. Staff identified and quickly acted upon children and young people at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Summary of findings

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learnt with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results to improve safety. Staff collected safety information and shared it with staff, children, young people and parents.

Are services effective?

Our rating of effective stayed the same. We rated it as outstanding because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored children and young people regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools. Children and young people were given pain relief in a timely way.
- Staff actively monitored the effectiveness of care and treatment. Opportunities to participate in benchmarking, peer review and research were proactively pursued. They used the findings to make improvements and achieved good outcomes for patients.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide high quality, effective care.
- Key services were available 24 hours a day, seven days a week to support timely patient care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support those children, young people and or their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- Staff treated all children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff took time to interact with children, young people and their families in a respectful and considerate way.

Summary of findings

- Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. There was access to a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment.
- Staff understood the emotional and social impact that a patient's care, treatment or condition had on their wellbeing and the whole family.
- Staff supported and involved children, young people, families and carers to understand their condition and make decisions about their care and treatment. They communicated with the child about their care and treatment in a way they could understand, using toys or books to help explain.
- Children and their families were consistently positive about how staff treated them. They told us that staff went the extra mile and that the care their child received exceeded their expectations.

- Staff provided children, young people and their families with relevant information, both verbal and written, so they could make informed decisions about their care and treatment.

- Children and young people and parents were treated as important partners in the delivery of care.

- The palliative care team worked collaboratively with the clinical staff and family liaison team to manage end of life patients and ensure parents received the support and guidance that met their individual needs.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of children, young people and their families served. They pro-actively liaised with services and with others in the wider system and local/national organisations to manage the discharge care pathway and plan future care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Children and young people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge were mostly in line with national standards.
- Children, young people and their families could easily give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with all staff. The service included children and their families in the investigation of their complaint.

Are services well-led?

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Most were visible and approachable in the service for patients and staff. The majority of leaders supported staff to develop their skills and take on more senior roles

Summary of findings

- Most services had a vision and strategy for what they wanted to achieve, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and were aligned to trust's plans and developments within paediatrics.
- The culture of the services provided were centred on the needs and experiences of children, young people and their families who used services. The service had an open culture where children, young people, their families and staff could raise concerns without fear.
- Staff felt respected, supported and valued. The services promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders operated effective governance processes, throughout the service. However, the planning and implementation of the electronic patient record did not meet the individual needs of all services. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- There was a culture of collective responsibility between teams and services and positive relationships between staff and teams.
- Data or notifications were consistently submitted to external organisations as required.
- The service had plans to cope with unexpected events and staff were aware of actions they needed to take to achieve safe continuity of services.
- Leaders and staff actively and openly engaged with children, young people and their families, staff, equality groups, the public and local and national organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However;

- Although staff could access the data they needed, in easily accessible formats, to understand performance, make decisions and improvements, this data was not always accurate or reliable. Work was in progress to integrate information systems.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice at Great Ormond Street Hospital at trust wide level and in surgery and critical.

For more information, see the Outstanding practice section of this report.

Summary of findings

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found 19 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued two requirement notices to the trust. Our action related to breaches of one legal requirement at a trust-wide level and two were in the core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Trust well led

- The trust's young people's forum actively engaged with young people and their siblings to ensure their views and experiences influenced and informed service developments in the trust.
- The neuromuscular study of children living with spinal muscular atrophy lead by the trust resulted in a drug being licenced and approved by NICE. This will improve their quality of life and delay progression of the disease.
- The trust's Gene therapy programme, a new type of therapy where a working copy of the gene can be inserted into the patients' own cells using a modified, harmless virus, has resulted in patients with severe combined immunodeficiency being cured without a transplant.
- A GOSH consultant neurologist coordinated the EpiCARE European Reference Network for Rare and Complex Epilepsies. The network was recently awarded a Silver Dolphin Award at the 10th Cannes Corporate Media & TV Awards for a short film which demonstrated a Europe-wide collaboration that helped a four-year-old Finnish boy diagnosed with hypothalamic hamartoma. This support and advice improved the boy's quality of life.
- The trust had held two 'Play street' events in July and October 2019, as part of the local clean air campaign, which the local council was very supportive of. The road outside the hospital was closed to traffic and games and activities were provided. This event not only promoted clean air and the benefits to children but provided an opportunity to engage with the local schools who attended.
- The teen careers fair for the trust's patients, introduced these young people to a range of companies, assisted them to sign up to work experience opportunities while learning new skills and take part in workshops. The day was positively evaluated and demonstrated to young people what they could achieve despite having a health condition.
- There was a structured appraisal process for the NEDs, that included a view of their attendance and contribution at specific groups and committees. This along with feedback from the council of governors informed their appraisal which was co-ordinated by the company secretary.

Summary of findings

Critical care

- The senior leadership team had introduced weekly psychological support sessions. These weekly sessions were supported by the ad hoc provision that was available when staff were aware of a possible bereavement. This approach ensured emotional support was provided at a “pre-brief", which also allowed staff to be proactively supported and arrange a commemoration service for patients if they wished.

- Family liaison sisters provided support to families during a bereavement or to those families needing additional support. In the event of an expected bereavement, the family liaison team worked proactively in collaboration with the palliative care team to provide additional support, and access to psychology support for families and siblings. This facilitated individual timely support at the level the family and siblings required.

- The critical care research team were embedded in the critical care areas working in collaboration with clinical and academic teams. They were involved in numerous local, national, and international clinical and academic research projects that had resulted in improvements to patient treatment and outcomes.

- Critical care staff were lead authors on four of the eight multiple centre trials published globally in paediatric intensive care in 2018 and 2019. They were the largest global contributor from any the paediatric intensive care units.

Surgery

- To support complex cardiac surgery the service had recently started using pioneering 3D heart modelling and virtual reality. A virtual reality model of a patient’s heart can assist clinicians to virtually plan and practice complex procedures ahead of surgery, contributing to improved patient outcomes.

- In collaboration with a local acute NHS trust and local university, the service successfully performed specialist fetal surgery, the first surgery of its kind in the UK. In comparison to postnatal surgery, fetal surgery has been shown to improve short and medium-term outcomes, preventing damage to the baby’s spinal cord in the last trimester of pregnancy.

- To improve the child and their families experience several initiatives across the service had been introduced. For example, a poet visited the surgical wards and created bespoke poems for patients to reduce their anxiety. The trust had also recently employed its first full-time music therapist, providing patients with opportunities for creative expression.

- The service participated in the Harvey’s gang initiative, allowing children with complex needs and long-term conditions to become trainee biomedical scientists for the day. This helped children gain a better understanding of what happens to their blood samples.

Summary of findings

- The trust had a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment. Play staff held blood parties using disco lights and sensory equipment to distract patients while the child was having their blood taken.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations.

We told the trust that it must take action to bring services into line with three legal requirements.

Trust well led

The trust MUST:

- Ensure the board assurance framework reflects all known medicine risks, including the storing, administration and destroying of medicines in line with legislation and the trust medicines management policies.

Critical care

The trust MUST:

- Ensure medicines are stored safely, in line with legislation and the trust medicines management policies.

Surgery

The trust MUST:

- Ensure medicines are stored safely and destroyed in line with legislation and the trust medicines management policies.

Child and Adolescent Mental Health services

The trust MUST:

- Ensure that the electronic patient record system meets the needs of the service, so staff can record, update and find patient records promptly. This includes further development of, and staff adherence to, electronic patient record storage protocols.

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of findings

Trust wide

The trust SHOULD;

- Continue to develop and implement a formal board development programme.
- Take action to develop and assure itself about financial sustainability going forward.
- Continue to promote the role of the FTSUG, taking proactive action to identify and address themes from staff contacts with the FTSUG.
- Raise staff awareness of the safe and respectful behaviour policy and improve access to conflict resolution training.
- Continue to improve the quality of WRES data to enable this to be used to inform areas for development.
- Raise staff awareness of the role of the accredited safety champions.
- Clarify the role and expectations of governors in interview stakeholder groups, including for which roles they will be invited to participate in groups for.
- Improve the oversight of delivery of services by the pharmacy department, including identifying and reporting key performance indicators via the directorate performance process to the board.
- Take action to improve the number of incidents closed within the trust's 45 working day target.
- Improve the accuracy of the trust's information asset register.

Critical care

The trust SHOULD;

- Consider developing a directorate clinical strategy for critical care areas.
- Provide consistent checks in relation to all in use resuscitation equipment in the critical care areas, in line with guidance from the Resuscitation Council.

Surgery

The trust SHOULD;

- Improve the timeliness of discharge summaries sent to the patient's GP.
- Continue work to improve referral to treatment times.
- Review and improve systems for equipment maintenance in theatres so that staff are assured it is fit for use.

Child and Adolescent Mental Health services

The trust SHOULD;

- Continue to take action so that staff, patients, family members and carers are not negatively affected by the lack of disabled access to the roof terrace.
- Provide training and support to all relevant staff so that they are competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years.

Summary of findings

- Provide timely administrative support for the service, so audits and document scanning are not delayed.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services, in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust improved. We rated well-led as good because:

- Managers at all levels in the trust had the skills, knowledge and experience to run a service providing high-quality sustainable care. Leadership had been strengthened since the last inspection with several changes of both executives and non-executives. The executives were described as an inclusive, dynamic team who were open and transparent.
- Leaders were knowledgeable about the challenges to quality and sustainability the trust faced including those arising from the current NHS financing model for specialised services; and its dependence on continuing to be able to attract international private patients. Leaders were proactive in addressing these through a range of initiatives including exploring alternative international markets and research activity.
- The trust had a vision and strategy, that was currently being refreshed in consultation with staff, children, families and stakeholders. Staff understood the trust's vision, values and strategy and were supportive of these. Several strategies to support the trust strategy were either in place or currently being developed. These aligned and supported the trust's vision.
- The hospital had a culture in which staff could speak openly about safety concerns allowing these to be effectively managed and safe high-quality care delivered. Leaders at all levels across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Leaders did not tolerate behaviour that was not in line with the trust's values, regardless of seniority. In some directorates staff continued to report issues with bullying and harassment, low morale and lack of staff engagement. Several initiatives had been implemented to address these including a 'stand up for our values', program to tackle those behaviours that were not in line with the trust's values and promoting the Dignity at work policy. At the time of our inspection the impact of these initiatives had not yet been measured but will be measured through the next NHS staff survey and staff engagement.
- Staff, patients and relatives were actively encouraged to raise concerns and the systems and processes in place made this accessible to all. The trust did not tolerate violence and aggression towards its staff and had a range of initiatives in place to address this.
- All staff were provided with the opportunity to participate in appraisal. Many areas had succession planning in place for leadership roles and staff were provided with opportunities to develop the skills and knowledge to be successful in obtaining promotion.
- Staff considered that quality was always given the same priority as finances. The focus was always on safety and quality when decisions about service developments and financial restraints were being discussed. They felt confident that quality was not being compromised to manage financial balance and the medical director and chief nurse took the lead in ensuring all cost improvement programmes did not negatively impact on quality.

Summary of findings

- Since the last inspection the trust had reviewed its governance structure in consultation with staff looking at what was currently working well and what needed improvement. The trust had a strategic plan, operational plans and supporting strategies that clearly articulated the trust's objectives, requirements and performance standards.
- There were clear reporting lines from ward to board and from board to wards, to manage performance and identify potential issues or failure to meet local and national standards. These were informed by the integrated quality and performance report which included both safety and financial information and discussed at the monthly directorate performance review meetings, attended by the directorate management team and representatives from the trust executives.
- The trust had developed a long-term financial model that was subject to regular in-depth scrutiny by the board through its finance and investment committee. The trust had concluded that, under current NHS financial assumptions, it was likely to face significant financial challenge over the next two years.
- Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives.
- The board were sighted on information governance issues including some issues with data quality which could impact on its ability to accurately report performance internal and externally. While data quality was improving, and action was taken when specific data issues were identified, more work was required to ensure accurate data was available to inform discussions and provide assurance.
- There was a clear system for categorising, reporting, investigating and learning from serious incidents, supported by the incident reporting and learning policy and duty of candour policy. Themes from serious incidents were used to inform targeted improvement work or organisational learning, for example the changes to handover and provision of revised duty of candour training.
- Children, young people and their families were aware of how to raise a complaint. Complaints and concerns were taken seriously and responded to in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns being raised.
- The trust had systems and processes for identifying risks, planning to eliminate or reduce these, and coping with both the expected and unexpected. The risks recorded on the corporate risks register reflected those that leaders stated were the top risks and there was evidence that these were regularly reviewed.
- The trust had taken a range of approaches to actively engage with patients, staff and stakeholders to plan, develop and manage services and collaborated with partner organisations effectively. There was evidence the trust had changed its attitude and approach to stakeholder working with an increased emphasis on commitment to partnership working with others.
- The trust was leading and participating in numerous research projects and had systems and processes in place to achieve its aim of being a research hospital. Staff at all levels were encouraged and supported to participate and lead research projects, many of which had resulted in improvements in treatments and patient outcomes.
- The trust were committed to learning and continually improving services from internal and external reviews. There were systems and processes in place to manage quality improvement projects including an agreed trust wide improvement methodology.
- The hospital participated in networks with other trusts in the UK and internationally to improve children's health. Some of these networks were chaired by trust clinicians, while others the trust had representation on. We saw examples were the work of these networks had resulted in positive impacts for children and their families.

Summary of findings

However;

- The trust acknowledged that their WRES performance was poor and this was an area that had not been focused on for the last three years. They considered they were behind other trusts but had plans to address this. Action was being taken and the results had been used to draft an action plan .

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Jan 2020	Outstanding ➔➔ Jan 2020	Outstanding ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ↑ Jan 2020	Good ➔➔ Jan 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Great Ormond Street Hospital NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016
Surgery	Requires improvement ➔➔ Jan 2020	Outstanding ↑ Jan 2020	Outstanding ↑ Jan 2020	Good ➔➔ Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Critical care	Requires improvement ↓ Jan 2020	Good ➔➔ Jan 2020	Outstanding ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ↑ Jan 2020	Good ➔➔ Jan 2020
Neonatal services	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Transition services	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Requires improvement Jan 2016	Good Jan 2016
End of life care	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016
Outpatients	Good Apr 2018	N/A	Outstanding Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Child and adolescent mental health wards	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ↓ Jan 2020	Good ➔➔ Jan 2020	Requires improvement ↓ Jan 2020	Good ➔➔ Jan 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Acute health services

Background to acute health services

Great Ormond Street Hospital for Children NHS Foundation Trust is a tertiary specialist children's hospital and has the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services. nephrology and renal transplants. Children are also treated from overseas in the International and Private Patients' (IPP) wing.

There are more than 50 different clinical specialties at Great Ormond Street Hospital (GOSH). It provides surgery, medical care, critical care, end of life care, outpatients services, and child and adolescent mental health services. The hospital has 418 beds including there are 42 critical care beds, seven inpatient mental health beds and three-day case mental health beds.

Between March 2018 to February 2019, the trust had 40,349 elective admissions of which 26,583 were day cases and 13,766 were elective and 3,038 non-elective admissions. On a weekly basis on average 4,673 patients were seen in the outpatient's department.

We carried out the unannounced core service inspection on 01-03 October 2019. We inspected the core services of critical care, surgery and child and adolescent mental health services at Great Ormond Street Hospital (GOSH). During our inspection we spoke with 31 children and young people. 150 staff, 18 carers/relatives.

We observed care and looked at a wide range of documents including patient records, policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of acute services

Good ➔➔

Our rating of services stayed the same. We rated it them as good because:

- The service provided mandatory training in key skills in line with trust targets.
- 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.
- Staff knew how to assess, monitor and manage patient risk. Staff identified and quickly acted upon children and young people at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Summary of findings

- Staff assessed and monitored children and young people regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools. Children and young people were given pain relief in a timely way.
- Staff actively monitored the effectiveness of care and treatment. Opportunities to participate in benchmarking, peer review and research were proactively pursued. They used the findings to make improvements and achieved good outcomes for patients.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide high quality, effective care.
- Staff treated all children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff took time to interact with children, young people and their families in a respectful and considerate way.
- Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. There was access to a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment.
- Children and young people and parents were treated as important partners in the delivery of care.
- The service planned and provided care in a way that met the needs of children, young people and their families served. They pro-actively liaised with services and with others in the wider system and local/national organisations to manage the discharge care pathway and plan future care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The culture of the services provided were centred on the needs and experiences of children, young people and their families who used services. The service had an open culture where children, young people, their families and staff could raise concerns without fear.
- Staff felt respected, supported and valued. The services promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders operated effective governance processes, throughout the service. However, the planning and implementation of the electronic patient record did not meet the individual needs of all services. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with children, young people and their families, staff, equality groups, the public and local and national organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However;

- The service did not always use systems and processes to safely store, record or destroy medicines in line with legislation.

Great Ormond Street Hospital

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London
WC1N 3JH
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www.gosh.nhs.uk

Key facts and figures

Great Ormond Street Hospital for Children NHS Foundation Trust is a tertiary specialist children's hospital and has the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services. nephrology and renal transplants. Children are also treated from overseas in the International and Private Patients' (IPP) wing.

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We observed care and looked at a wide range of documents including patient records, policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of services at Great Ormond Street Hospital

Good ➔➔

Our rating of services stayed the same. We rated it them as good because:

- The service provided mandatory training in key skills in line with trust targets.
- 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.
- Staff knew how to assess, monitor and manage patient risk. Staff identified and quickly acted upon children and young people at risk of deterioration.

Summary of findings

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored children and young people regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools. Children and young people were given pain relief in a timely way.
- Staff actively monitored the effectiveness of care and treatment. Opportunities to participate in benchmarking, peer review and research were proactively pursued. They used the findings to make improvements and achieved good outcomes for patients.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide high quality, effective care.
- Staff treated all children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
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- Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. There was access to a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment.
- Children and young people and parents were treated as important partners in the delivery of care.
- The service planned and provided care in a way that met the needs of children, young people and their families served. They pro-actively liaised with services and with others in the wider system and local/national organisations to manage the discharge care pathway and plan future care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The culture of the services provided were centred on the needs and experiences of children, young people and their families who used services. The service had an open culture where children, young people, their families and staff could raise concerns without fear.
- Staff felt respected, supported and valued. The services promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders operated effective governance processes, throughout the service. However, the planning and implementation of the electronic patient record did not meet the individual needs of all services. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with children, young people and their families, staff, equality groups, the public and local and national organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However;

Summary of findings

- The service did not always use systems and processes to safely store, record or destroy medicines in line with legislation.

Surgery

Good ↑

Key facts and figures

Great Ormond Street Hospital for Children NHS Foundation Trust provides elective and emergency surgical services to children and young people. As a tertiary hospital, patients are referred from other healthcare providers throughout the UK and overseas.

Surgery services include: general surgery; orthopaedics; cardiac surgery; urology; transplant; neurosurgery; ear, nose and throat (ENT); and plastics.

From March 2018 to February 2019, the trust had 7,330-daycase admissions, 297 emergency admissions and 5,196 elective admissions.

(Source: Hospital Episode Statistics)

Surgery services at Great Ormond Street Hospital are provided within six of the eight directorates.

There were ten surgical in-patient wards, of which five wards are equipped to provide care for patients who need high dependency care. There was a designated day care ward and a pre-assessment unit. The hospital has 14 operating theatres and two recovery areas, one with an infectious patient bay. A 24-hour, seven day a week emergency theatre and anaesthetic room is available.

During this inspection, we visited 10 surgical wards, the main theatres and the interventional radiology theatres over three days during our unannounced inspection on 1 October to 3 October 2019.

We spoke with 26 children and young people and 10 parents, and 106 members of staff including medical and nursing staff, healthcare assistants, therapy and domestic staff. We observed care and looked at a wide range of documents including patient records, policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. Staff kept detailed, up to date records of children and young people's care and treatment. The service-controlled infection risk well. Staff knew how to assess, monitor and manage patient risk. The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and research were proactively pursued. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff worked well together for the benefit of patients. Staff advised patients on how to lead healthier lives and supported them to make decisions about their care. Key services were available seven days a week.

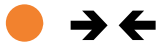
Surgery

- Staff respected patient's privacy and dignity. They provided emotional support to patients, families and carers and helped them understand their conditions. Patient and parent feedback was consistently positive. Children and young people told us staff treated them well and with kindness. Parents told us that staff went the extra mile and that the care their child received exceeded expectations.
- The service planned and delivered care, in collaboration with other organisations, to meet the needs of patients. Staff took account of children, young people and their parents' individual needs and preferences. The trust made it easy for children, young people and parents to give feedback and used this information to improve care and services provided.
- Leaders had the skills and knowledge to deliver effective services. They supported and encouraged staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued and were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- In theatres, systems to ensure equipment was maintained and safe to use were not effective.
- Not all medicines were stored safely or destroyed in line with legislation.
- Discharge summaries and clinic letters were not always sent to the patient's GP in a timely manner.
- Staff were unclear whether information leaflets were available in different languages and formats.
- The service was looking at ways to improve access, as referral to treatment times were below the England average.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- In theatres, systems to ensure equipment was maintained and safe to use were not effective.
- Discharge summaries and clinic letters were not always sent to the patient's GP in a timely manner.
- Not all medicines were stored safely or destroyed in line with legislation.
- Treatment rooms where medicines were stored were secured using swipe cards. On the wards without electronic cabinets to store medicines, we saw that medicines cupboards and fridges within the room were unlocked. We were told that access was controlled by the ward matron and the pharmacy department who authorised this access, in line with trust policy. However, we observed non-clinical staff also had access to the treatment room, and therefore the medicines.

However:

- The service provided mandatory training in key skills and ensured that all staff had completed this training.
- The service had effective processes in place to keep people safe and protected from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, their families and themselves from infection. They kept equipment and the premises visibly clean.
- In most areas the design, maintenance and use of facilities, premises and equipment kept people safe.

Surgery

- Staff knew how to assess, monitor and manage patient risk. Staff identified and quickly acted upon children and young people at risk of deterioration.
- Despite vacancies, nursing staffing levels and skill mix were planned and reviewed to keep patients safe. Managers gave bank and agency staff a full induction.
- The service had enough staff with the right skills, training and experience to keep patients safe.
- Staff kept detailed, up to date records of children and young people's care and treatment. Records were stored securely and easily available to all staff providing care.
- Staff safely prescribed, administered and recorded medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learnt with staff. When things went wrong, staff apologised and gave children, young people and their families honest information and support.
- The service used monitoring results to improve safety. Staff collected safety information and shared it with staff, children, young people and their families.

Is the service effective?

Outstanding ☆ ↑

Our rating of effective improved. We rated it as outstanding because:

- The service provided care and treatment based on national guidance and evidenced-based practice.
- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods of time.
- Staff assessed and monitored children and young people regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools. Children and young people were given pain relief in a timely way.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and research were proactively pursued.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide high quality, effective care.
- Key services were available 24 hours a day, seven days a week to support timely patient care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Surgery

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Staff took time to interact with children, young people and their families in a respectful and considerate way.
- Patient and parent feedback was consistently positive. Children and young people told us staff treated them well and with kindness. Parents stated that staff go the extra mile and that the care their child received exceeded their expectations.
- Staff gave patients and their families emotional support and advice when they needed it.
- The trust had a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment.
- Staff understood the emotional and social impact that a patient's care, treatment or condition had on their wellbeing. There were initiatives across the service to improve patient experience.
- Staff communicated with children and young people about their care and treatment in a way they could understand. For younger patients, staff used toys and story books to help explain their care and treatment.
- Staff provided parents with relevant information, both verbal and written, so they could make informed decisions about their child's care and treatment.
- Patients and parents were both treated as important partners in the delivery of care. Parents were encouraged and supported to deliver their child's own care on the ward, this prepared them to support their child after discharge.

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and delivered care, in collaboration with other organisations, to meet the needs of patients.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.
- It was easy for children and their families to give feedback and raise concerns about the care they had received. The service treated concerns and complaints seriously. They investigated them, including the child and their families in the investigation of their complaint. Lessons learnt were shared with all staff to improve care and services provided.

However:

- Staff were unclear whether information leaflets were available in different languages and formats.
- The service was looking at ways to improve access to services, as referral to treatment times were below the England average.

Surgery

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for children, young people, their families and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn this into action, developed with stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. The service promoted equality and diversity in daily work and provided opportunities for career development.
- Staff were focused on the needs of children and young people receiving care. The service had an open culture where children and young people, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks, taking action to reduce their impact.
- Leaders and staff actively and openly engaged with children, young people, their families, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations, locally and nationally, to help improve services for children and young people.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Outstanding practice

- The service had recently started using pioneering 3D heart modelling and virtual reality to support complex cardiac surgery. Use of a virtual reality model of a patient's heart has been shown to assist clinicians to virtually plan and practice complex procedures ahead of surgery, reducing the risk of complications and improving outcomes.
- In collaboration with a local acute NHS trust and university, the service successfully performed specialist fetal surgery, for a baby with spina bifida. This was the first time this surgery had been performed in the UK. In comparison to postnatal surgery for this condition, fetal surgery has been shown to improve short and medium-term outcomes, preventing damage to the baby's spinal cord in the last trimester of pregnancy.
- There were initiatives across the service to improve patient experience. These included a poet visited the surgical wards and created bespoke poems for patients. The trust had also recently employed its first full-time music therapist, providing patients comfort and opportunities for creative expression. These initiatives had been positively evaluated by children and their parents.

Surgery

- The service participated in the Harvey's gang initiative, allowing children with complex needs and long-term conditions to become trainee biomedical scientists for the day. This helped children gain a better understanding of what happens to their blood samples.
- The trust had a range of services to support children and young people who were frightened, confused or phobic about aspects of their care and treatment. Play staff held blood parties using disco lights and sensory equipment to distract patients while they were taking blood.

Areas for improvement

Actions the service MUST take to improve:

- The service must ensure medicines are stored safely and destroyed in line with legislation and the trust medicines management policies.

Actions the service SHOULD take to improve:

- Improve the timeliness of discharge summaries sent to the patient's GP.
- Continue work to improve referral to treatment times.
- Review and improve systems for equipment maintenance in theatres so that staff are assured all equipment is fit for use.

Critical care

Good

Key facts and figures

Great Ormond Street Hospital has 42 ICU beds located in three critical care areas; these are neonatal (NICU); cardiac (CICU) and paediatric (PICU), all on the fourth floor of the variety club building. The PICU provides general paediatric intensive care and had 19 beds (of which 13-15 were open at the time of inspection). CICU provides cardiac intensive care and now has 23 beds, split across Flamingo and Alligator ward (where 15-17 beds were open).

NICU provides neonatal intensive care and although is a critical care ward, it is part of the neonatal core service and so not part of this inspection.

(Source: Trust Routine Provider Request)

At the time of the inspection there were a number of critical care beds closed as the directorate did not have sufficient staff. This is reflected in the report.

Critical care services at Great Ormond Street Hospital provide care to children and young people under the age of 18 requiring high dependency (level two) and intensive care (level three). Level two care describes patients requiring more detailed observation or intervention. This includes support for a single failing organ system or post-operative care, and those 'stepping down' from level three care. Level three care refers to patients requiring advanced respiratory support alone or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multiple organ failure.

We visited all critical care wards (excluding NICU) over three days during our unannounced inspection on 01 October to 03 October 2019.

We reviewed 10 patient care records and observed care being provided across all critical care areas. We spoke with five parents, we were unable to speak to any children or young people, and 33 members of staff including nurses, consultants, junior doctors, physiotherapists, pharmacists, dietitians, and administrative staff. We also reviewed the trust's performance data and looked at trust policies for critical care.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- There were significant vacancies in the nursing workforce, but critical care wards were mitigating this risk to avoid any negative impact on patient care.
- Patient records for the critical care wards were entered on an electronic records system. All ten sets of patient records we reviewed were fully completed and stored securely.

Critical care

- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them using the trust's systems and processes. Managers investigated incidents and shared lessons learnt with the whole team and the wider service.
- During the inspection we saw staff treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they deliver to patients and family members, including being considerate to patients who were not conscious, during any interactions.
- Family members spoke very positively about the care their child received in critical care and how they were treated by the staff on the wards.
- Family liaison sisters provided keyworker support for families experiencing a bereavement or those needing additional support.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to assist patients access services.
- Families could access the family liaison service, a service staffed by senior nurses who worked across PICU and CICU. The family liaison service provided practical and emotional support to patients, parents, and other family members.
- It was easy for people to give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them, involving family members and shared lessons learnt with all staff.
- Staff we spoke with stated that the directorate leadership team were visible on the wards and approachable. We observed that critical care staff interacted well with the ward leadership team during the inspection and that they were approachable.
- At the time of our last inspection it was identified that there were tensions between nurses and doctors on the critical care wards. During this inspection we found an improved relationship between doctors, nursing, and allied health professionals (AHP). Staff were very positive about their colleagues and we observed a collaborative working culture in place between the various disciplines.
- Prior to the inspection we were informed that there had previously been some tensions within the nursing workforce. However, on inspection staff were positive about the nursing leadership. Staff stated that they felt there was now improved morale and that it felt like a different working atmosphere.
- There was an effective corporate governance framework in place which oversaw service delivery and quality of care. The service had systems and processes to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. The critical care research team was embedded within the running of the service and was involved in numerous local, national, and international clinical and academic research projects.

However:

- We observed inconsistent staff compliance with IPC best practice guidance in relation to hand hygiene.
- Resuscitation equipment on critical care wards was not consistently checked, which was not in line with guidance from the Resuscitation Council.
- Critical care wards had a significant turnover of its nursing workforce, which meant that since our last inspection many experienced staff had left the service.

Critical care

- The availability of pharmacy cover on critical care wards fell below the levels recommended by the Society of Critical Care Medicine. Staffing for pharmacy, a known risk, was on the directorate risk register.
- On PICU we saw medicines cupboards and fridges within the medicine's room were unlocked. We also found some expired medicines which had not been segregated from medicines still in use.
- We were told by staff that medicine related incidents had increased since the implementation of electronic prescribing, which was also on the board assurance framework (BAF).
- At the time of our inspection all critical care wards had beds closed which was impacting on their ability to admit children requiring intensive care. Staff on the critical care wards and the directorate leadership team stated that this was due to the wards not having sufficient staff to meet the critical care staffing level standards. Data provided by the trust demonstrated that between the 02 and 30 of September 2019, of the 19 PICU beds, 13 to 15 beds were open. Similarly, 15 to 17 of the 21 cardiac intensive care beds (split across Flamingo and Alligator), were open.
- Availability of beds was a significant factor in the number of refused admissions to critical care wards. Staff we spoke with stated that the number of refused admissions was higher than the national average.
- Delayed discharges for clinically fit patients from PICU to the wards was a recognised issue and on the directorate risk register. It was acknowledged that these delayed transfers were having a negative impact on flow and capacity. To mitigate this risk there were daily bed management reviews in critical care. In September 2019, the trust had commenced a project focusing on internal trust discharges which involved clinical leads. This continued to be an issue and update notes on the directorate risk register stated that step down capacity on the wards was limited due to the lack of available nursing staff.
- Although staff were positive about their colleagues across all disciplines and the change in morale, staff were frustrated about some of the decisions taken by the trust. Particularly in relation to a change in the specialist nurse bank rates. All members of the multi-disciplinary team were aware of the impact this had had on the morale of the nursing staff. Many staff felt that this could have been a contributing factor in staff turnover in the past 12 months.

Is the service safe?

Requires improvement

Our rating of safe went down. We rated it as requires improvement because:

- We observed inconsistent staff compliance with IPC best practice guidance in relation to hand hygiene. On occasion staff did not use hand sanitisers when entering or leaving the wards, or when moving between patient bays
- Resuscitation equipment on critical care wards was checked inconsistently, which was not in line with guidance from the Resuscitation Council. There were some days where resuscitation equipment was not checked.
- The available pharmacy cover on critical care wards fell below the levels recommended by the Society of Critical Care Medicine. Staffing for pharmacy was on the directorate risk register. Pharmacy cover on critical care wards varied between 1.6 and 1.8 WTE which was below the recommended level.
- Treatment rooms where medicines were stored were secured using swipe cards. On PICU we saw that medicines cupboards and fridges within the room were unlocked. We were told that access was controlled by the ward matron and the pharmacy department who authorised this access, in line with trust policy. However, we observed nonclinical staff also had access to the treatment room, and therefore the medicines.
- On PICU we found expired medicines including total parenteral nutrition in the fridge, which had not been segregated from medicines which were still in use.

Critical care

- We were told by staff that medicine related incidents had increased since the implementation of electronic prescribing, this known risk was on the BAF and included mitigating actions.

However:

- 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 this training.
- The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff effectively managed clinical waste.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- There were significant vacancies in the nursing workforce, on PICU this was 16%, while on CICU it was 12%. The critical care wards were mitigating this risk but it was having a negative impact on their ability to admit children and young people who required critical care.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Patient records for the critical care wards were entered on an electronic records system. All ten sets of patient records we reviewed were fully completed and stored securely.

•The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them using the trust's systems and processes. Managers investigated incidents and shared lessons learnt with the whole team and the wider service.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- The hospital had a paediatric dietetics team, which included specialised paediatric dietician for both the PICU and cardiology. Children's nutrition and hydration needs were assessed and met through a range of clinical guidelines including the infant feeding guideline.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease their pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- During our inspection we observed positive and collaborative working relationships across the multidisciplinary team. Staff stated they worked well together, and this was supported by effective and approachable clinical leadership.

Critical care

- Critical care staff provided advice to patients and families on managing their care after discharge. We observed staff from different disciplines advising patients on how to maintain their recovery after they had left the hospital, including clinical nurse specialists and family liaison workers.
- Staff understood the need to record consent, and the principles of ensuring that consent was informed when given. Staff clearly recorded consent to treatment in the patients' records as necessary.

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding because:

- During the inspection we saw staff treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they delivered to patients and family members, including being considerate to patients who were not conscious, during any interactions.
- Staff were understanding of the needs of working with children and young people, they were friendly and conscientious in their approach, putting the child at ease. We observed staff taking time to speak and play with children or soothe those who were anxious or distressed.
- Family members spoke very positively about the care their child received on the critical care wards and how they were treated by the staff.
- Following the inspection, the trust provided FTT data for critical care wards. Data showed that between September 2018 and September 2019, the average number of family members who were likely to recommend the service was 96%, which is above the trust's target.
- In the event of a patient death, the service followed up family members and invited them back to meet with staff. This offered an opportunity to discuss and identify any support they required and obtain feedback on the care they and their child received.
- Staff understood the impact that patients' care, treatment and condition had on their wellbeing and on the wellbeing of their families.
- Medical staffing on each of the critical care wards was two consultants on duty during the day shift: one lead consultant and a supporting consultant. The second consultant was available to provide additional advice and support to family members throughout the day. We observed the second consultant frequently took time to check in on families.
- The palliative care team worked collaboratively with the critical care staff and family liaison team to manage end of life patients to ensure the needs of the child, family and staff were met.
- Staff stated that psychologists and the directorate leadership team provided debriefs and emotional support for staff when they knew there would be a difficult or distressing bereavement. To support staff senior leaders had introduced weekly psychological support, this provided an opportunity to not only discuss those likely bereavements, but also emotional support for unexpected bereavements. Support could also be provided at a "pre-brief", for expected deaths, which allowed staff to be proactive in supporting children and their parents and arrange a commemoration if they wished.
- Family members were positive about the care their child received. They stated that staff were professional and welcoming and that they were kept well informed of treatment plans.

- The family liaison sisters provided keyworker support for families experiencing a bereavement or requiring additional support.
- Critical care wards held numerous events for families and children, as well as advertising the availability of trust wide family activities, supported by the play specialist, art therapists, and volunteers.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Critical care wards had space at the bedside for one parent to stay, parent accommodation locally was guaranteed for both parents if their child was on a critical care ward. We observed information leaflets relating to accommodation were available throughout critical care wards.
- There was clear signage throughout the main hospital building, which meant it was easy for visitors to locate the critical care wards. The trust website provided useful information about the critical care wards, including visiting times, key staff and what treatments were offered on these wards.
- Staff were aware of how to access translation services if the child or family were unable to communicate in English. Some staff stated they spoke other languages so could offer some translation but would use interpreters where appropriate.
- In communal areas and throughout the critical care wards there was a range of information for parents to access specialist support and advise. This included for emotional and spiritual support, specialist health and social care input, and signposting to supporting charities. Critical care wards had produced a range of public information leaflets, all parents were provided with a pack of this information when their child was admitted to the critical care wards.
- The hospital chaplaincy and spiritual care team was available to meet the religious needs of children and their families. A duty chaplain was available on site seven days a week including evenings, and the service also offered a 24-hour, seven day a week on-call service.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to assist patients and their families access services.
- Families could access the family liaison service, a service staffed by senior nurses who worked across PICU and CICU. The family liaison service provided practical and emotional support to patients, parents, and other family members.
- All children and young people were seen by a consultant within 14 hours of emergency admission and had a consultant review twice a day. This was in line with the NHS England standards for seven-day services.
- Staff were positive about the quality of referral from the Children's Acute Transport Service (CATS). CATS was a specialist multidisciplinary team, which could rapidly transport critically ill children in the North Thames and East Anglia Regions to access intensive care.
- The clinical site practitioners (CSP) provided the critical care outreach service to other wards, 24 hours a day, seven days a week.
- CSPs were supported in providing the outreach service for discharged critical care patients by the intensive care outreach network (ICON). ICON staff consisted of experienced doctors, either at senior fellow or consultant level, and there would be one member of this team on duty on every shift.

- It was easy for people to give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them, involving family members and shared lessons learnt with all staff.

However:

- At the time of our inspection all critical care wards had beds closed which was impacting on their ability to admit children requiring intensive care. Staff on the critical care wards and the directorate leadership team stated that this was due to the wards not having sufficient staff to meet the critical care staffing level standards. Data provided by the trust demonstrated that between the 02 and 30 September 2019, of the 24 PICU beds, 13 to 15 beds were open. Similarly, 11 to 13 of the 21 CICU beds, and four to eight of the nine Alligator Ward beds, were open.
- Availability of beds was a significant factor in the number of refused admissions to critical care wards. Staff we spoke with stated that the number of refused admissions was higher than the national average.
- Based on the paediatric intensive care audit network (PICANet) data the trust was an outlier in terms of refused emergency referrals. Data provided by the trust showed that between April and June 2018 critical care wards refused 24% of referrals, compared to 6% nationally, between July and September 2018 35% of referrals were refused compared to 8% nationally and between October and December 2018 34%, of referrals were refused compared to 17% nationally.
- Delayed discharges for clinically fit patients from PICU to the wards was a recognised issue and on the directorate risk register. It was acknowledged that these delayed transfers were having a negative impact on flow and capacity. To mitigate this risk there were daily bed management reviews in critical care. In September 2019, the trust had commenced a project focusing on internal trust discharges which involved clinical leads. This continued to be an issue and update notes on the directorate risk register stated that step down capacity on the wards was limited due to the lack of available nursing staff.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- Staff we spoke with stated that the directorate leadership team were visible on the wards and approachable. We observed that critical care staff interacted well with the ward leadership team during the inspection.
- Staff knew the management arrangements and their specific roles and responsibilities. Nursing and medical leadership provided clinical support to staff, as well as leadership for the delivery of care and bed management.
- At the time of our last inspection it was identified that there were tensions between nurses and doctors on the critical care wards. During this inspection we found an improved relationship between doctors, nursing, and allied health professionals (AHP). Staff were very positive about their colleagues and we observed a collaborative working culture in place between the various disciplines.
- Prior to our inspection we were informed that there had been some tensions within the nursing workforce and issues with the nursing leadership. However, during our inspection staff were positive about the new nursing leadership. Staff stated that they felt there was now improved morale and that it felt like a different working atmosphere.
- Staff demonstrated an awareness of the trust's values which were displayed on the critical care wards. Critical care staff stated that the trust values were embedded on their wards.
- There was an effective corporate governance framework in place which oversaw service delivery and quality of care.

Critical care

- The last four governance committee minutes included discussions about complaints, incidents, key performance indicators (KPIs), training, risk register, learning, issues from other health and safety committees, and other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the monthly critical care governance meetings. The meetings were minuted for dissemination to other staff who were not able to attend.
- The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- At the time of the last inspection, some risks had been on the risk register for over three years and minutes of the monthly critical care board did not demonstrate progress on resolving these. On this inspection we observed each risk on the risk register had an action plan to mitigate any potential risks to patients, and these were reviewed at least monthly in the risk action groups and reflected in an updated register.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. The critical care research team was embedded within the running of the service and was involved in numerous local, national, and international clinical and academic research projects.

However:

- The service had a business plan that identified aspirational targets and goals for the coming year but did not have a specific vision or strategy for the future of critical care wards. Senior staff recognised that there was not a long-term development plan for critical care, it was reported that this was for several reasons, including refurbishment of the space around PICU and NICU, as well as the lack of certainty around the number of beds that could be opened.
- Although staff were positive about their colleagues across all disciplines and the change in morale, staff were frustrated about some of the decisions taken by the trust. Particularly in relation to a change in the specialist nurse bank rates. All members of the multi-disciplinary team were aware of the impact this had had on the morale of the nursing staff. Many staff felt that this could have been a contributing factor in staff turnover in the past 12 months.

Outstanding practice

- The senior leadership team had introduced weekly psychological support sessions that supported the ad hoc provision available, when they were aware of a possible bereavement. This approach ensured emotional support was provided at a “pre-brief", which also allowed staff to be proactively supported and arrange a commemoration for patients if they wished.
- Family liaison sisters provided support to families during a bereavement or to those families needing additional support. In the event of an expected bereavement, the family liaison team worked proactively in collaboration with the palliative care team to provide additional support, and access to psychology support for families and siblings. This facilitated individual timely support at the level the family and siblings required.
- The critical care research team were embedded in the critical care areas working in collaboration with clinical and academic teams. They were involved in numerous local, national, and international clinical and academic research projects that had resulted in improvements to patient treatment and outcomes.
- Critical care staff were lead authors on four of the eight multiple centre trials published globally in paediatric intensive care in 2018 and 2019. They were the largest globally contributor from any the paediatric intensive care units.

Critical care

Areas for improvement

Actions the service MUST take to improve:

- Ensure medicines are stored safely, in line with legislation and the trust medicines management policies.

Actions the service SHOULD take to improve:

- Consider developing a directorate clinical strategy for critical care areas.
- Provide consistent checks in relation to all in use resuscitation equipment in the critical care areas, in line with guidance from the Resuscitation Council.

Mental health services

Background to mental health services

The Mildred Creak Unit is a ten-bedded inpatient service within the department of child and adolescent mental health at Great Ormond Street Hospital for Children. The service provides specialist care to male and female patients aged seven to 14 years with a range of complex social and emotional mental health needs, including somatising disorders (medically unexplained symptoms). Patients can access a range of psychological interventions and receive specialist support to manage their physical health.

Three beds are designated day beds. These beds are used to support an intensive home-based treatment package provided as an alternative to inpatient admission.

The trust is not registered to detain patients under the Mental Health Act. All patients staying on Mildred Creak Unit are there on an informal basis. Consent for care and treatment is given by patients and their parents. If patients require detention under the Mental Health Act, the service arranges their transfer to a specialist mental health hospital.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our inspection team for this core service comprised two CQC inspectors, a nurse specialist advisor and a CQC Mental Health Act reviewer. We inspected the service over two days.

During our inspection we:

- toured the ward area including the clinic room
- interviewed the ward manager and other members of the senior leadership team
- interviewed three registered nurses and one healthcare assistant
- interviewed the ward consultant psychiatrist and one junior doctor
- interviewed other members of the multi-disciplinary team including a social worker and child and adolescent psychologist
- interviewed five patients and three family members of patients
- reviewed the care records of six patients
- checked the prescription charts for every patient
- attended a community meeting and observed a staff meeting and handover

Summary of findings

- and reviewed records relating to the overall quality of the service.

Summary of mental health services

Good ➔➔

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The ward environment and all equipment used was clean and well maintained. The ward had enough nurses and doctors to provide support to patients. Staff assessed and managed risks well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff completed assessments of patients' individual needs. They provided specialist treatment to meet the needs of patients. Care was delivered in line with national guidance about best practice and the service had developed its own unique ways of working to meet the specific needs of patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward team had access to the full range of specialists required to meet the needs of patients. Staff received mandatory training, supervision and appraisal and regular reflective practice sessions to improve patient care. The ward staff worked well together as a multi-disciplinary team and with other services involved in each patient's care pathway.
- Staff treated patients with compassion, kindness, dignity and respected their privacy. Staff understood the individual needs of patients and put them and their families at the centre of care and treatment decisions.
- Staff planned and managed discharge well and liaised effectively with services that provided aftercare. As a result, discharge had not been delayed for anything other than a clinical reason.
- The service was delivered by leaders who worked effectively with staff to help create an open and supportive working culture.

However:

- Ineffective governance around the introduction of the new electronic patient record system impacted on the work of the unit. The new system did not meet the unit's needs. This had been recognised, but not promptly addressed. Staff could not record, update and find patient records promptly. Protocols and guidance for electronic patient record storage had not been implemented effectively.
- Two registered nurses were not competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years.
- Timely administrative support for the service was not in place; as resulting in completion of some audits had been delayed and some paper records were not available for staff to view.
- There was no disabled access to the roof garden terrace for staff, patients and family members, but staff arranged for all patients to have regular access to fresh air.
- At the time of our inspection patients did not have access to independent advocacy whilst the trust arranged a new provider.

Child and adolescent mental health wards

Good →←

Key facts and figures

The Mildred Creak Unit is a ten-bedded inpatient service within the department of child and adolescent mental health at Great Ormond Street Hospital for Children. The service provides specialist care to male and female patients aged seven to 14 years with a range of complex social and emotional mental health needs, including somatising disorders (medically unexplained symptoms). Patients can access a range of psychological interventions and receive specialist support to manage their physical health.

Three beds are designated day beds. These beds are used to support an intensive home-based treatment package provided as an alternative to inpatient admission.

The trust is not registered to detain patients under the Mental Health Act. All patients staying on Mildred Creak Unit are there on an informal basis. Consent for care and treatment is given by patients and their parents. If patients require detention under the Mental Health Act, the service arranges their transfer to a specialist mental health hospital.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our inspection team for this core service comprised two CQC inspectors, a nurse specialist advisor and a CQC Mental Health Act reviewer. We inspected the service over two days.

During our inspection we:

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- interviewed other members of the multi-disciplinary team including a social worker and child and adolescent psychologist
- interviewed five patients and three family members of patients
- reviewed the care records of six patients
- checked the prescription charts for every patient
- attended a community meeting and observed a staff meeting and handover
- and reviewed records relating to the overall quality of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The ward environment and all equipment used was clean and well maintained. The ward had enough nurses and doctors to provide support to patients. Staff assessed and managed risks well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.

Child and adolescent mental health wards

- Staff completed assessments of patients' individual needs. They provided specialist treatment to meet the needs of patients. Care was delivered in line with national guidance about best practice and the service had developed its own unique ways of working to meet the specific needs of patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward team had access to the full range of specialists required to meet the needs of patients. Staff received mandatory training, supervision and appraisal and regular reflective practice sessions to improve patient care. The ward staff worked well together as a multi-disciplinary team and with other services involved in each patient's care pathway.
- Staff treated patients with compassion, kindness, dignity and respected their privacy. Staff understood the individual needs of patients and put them and their families at the centre of care and treatment decisions.
- Staff planned and managed discharge well and liaised effectively with services that provided aftercare. As a result, discharge had not been delayed for anything other than a clinical reason.
- The service was delivered by leaders who worked effectively with staff to help create an open and supportive working culture.

However:

- Ineffective governance around the introduction of the new electronic patient record system impacted on the work of the unit. The new system did not meet the unit's needs. This had been recognised, but not promptly addressed. Staff could not record, update and find patient records promptly. Protocols and guidance for electronic patient record storage had not been implemented effectively.
- Two registered nurses were not competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years.
- Timely administrative support for the service was not in place; as resulting in completion of some audits had been delayed and some paper records were not available for staff to view.
- There was no disabled access to the roof garden terrace for staff, patients and family members, but staff arranged for all patients to have regular access to fresh air.
- At the time of our inspection patients did not have access to independent advocacy whilst the trust arranged a new provider.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- All ward areas were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves and followed best practice in anticipating, de-escalating and managing behaviour that challenged. Staff used restraint only after attempts at de-escalation had failed and minimised the use of restrictive interventions.

- 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. The provider had a named nurse and doctor for child safeguarding and the unit had a safeguarding lead.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The service had a good track record on safety and managed patient safety incidents well. Staff recognised incidents and reported them appropriately. There was a clear process in place to ensure serious incidents were investigated and any lessons learnt identified. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

Our rating of effective stayed the same . We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission and reviewed patient's individual needs and risks on a regular basis.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice where this existed. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised tools to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for all new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other teams within the trust and with relevant services outside the organisation.

However:

- Two registered nurses could not explain Gillick competence in relation to their role when treating patients aged under 16.
- At the time of our inspection an advocacy service was not available to patients staying on the ward. There were plans in place to reinstate the service using a new provider.

Child and adolescent mental health wards

Is the service caring?

Good 

Our rating of caring went down. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition, adapting their communication to make sure it was age-appropriate.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.
- Patients were also encouraged to support one another and engage in group activities as part of their recovery.
- Staff informed and involved families and carers in the decision-making progress. Parents gave positive feedback about the care and treatment patients received on the Mildred Creak Unit.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

Our rating of responsive stayed the same . We rated it as good because:

- Staff planned and managed discharge well. They pro-actively liaised with services that provided aftercare and were appropriately assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was not delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. Patients could access a quiet space away from the main ward when needed.
- Staff ensured patients had access to the hospital school and their education needs were met.
- The food was of a good quality and patients could make hot drinks and snacks at any time, under supervision from the staff.
- The ward met the needs of all patients who used the service, including those with protected characteristics. Staff helped patients with communication, cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, and shared these with the whole team and the wider service.

However:

- There was a lack of disabled access to the roof garden terrace for staff, patients, family members and carers to use, although staff worked to ensure all patients had access to fresh air.

Child and adolescent mental health wards

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- There was ineffective governance in respect of the introduction of the new electronic patient record system to this unit. It did not fully align to the needs of the unit. This was recognised, but it had not been rectified in a timely way. There was a lack of guidance and clear protocols for staff to follow to ensure the consistent storage and updating of records on the electronic patient record system.
- The service did not have access to timely administrative support and the completion of audits and document scanning was delayed.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the service they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in local and national quality improvement activities.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Child and Adolescent Mental Health services

The trust MUST:

- Ensure that the electronic patient record system meets the needs of the service, so staff can record, update and find patient records promptly. This includes further development of, and staff adherence to, electronic patient record storage protocols.

Child and Adolescent Mental Health services

The trust SHOULD;

- Continue to take action so that staff, patients, family members and carers are not negatively affected by the lack of disabled access to the roof terrace.
- Provide training and support to all relevant staff so that they are competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years.
- Provide timely administrative support for the service, so audits and document scanning are not delayed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Our inspection team

Fiona Wray, inspection manager led this inspection. Carolyn Jenkinson, Head of inspection and three executive reviewers, supported our inspection of well-led for the trust overall.

The team included five inspectors, two medicine inspectors, four specialist advisers, one mental health reviewer and an expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

CQC Report January 2020

Inspection Oct-Nov 2019

Great Ormond Street Hospital for Children NHS Trust

GOSH 2019 CQC Inspection

2018

Ratings for Great Ormond Street Hospital for Children NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015
Surgery	Requires improvement ↓ Jan 2018	Good →← Jan 2018	Good ↓ Jan 2018	Good ↑ Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018
Critical care	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Requires improvement Apr 2015	Good Apr 2015
Neonatal services	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Good Apr 2015
Transition services	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Requires improvement Apr 2015	Good Apr 2015
Services for children and young people	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Good Apr 2015
End of life care	Good Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015
Outpatients	Good →← Jan 2018	Not rated	Outstanding →← Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018

2019

Ratings for Great Ormond Street Hospital NHS Trust

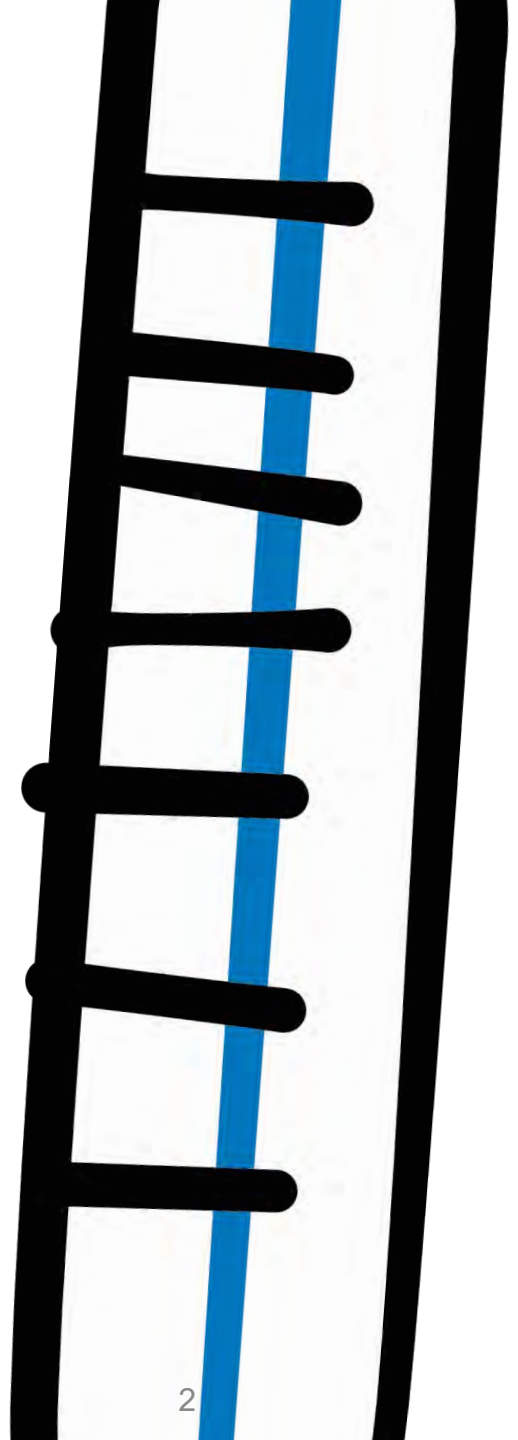
	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016
Surgery	Requires improvement →← Jan 2020	Outstanding ↑ Jan 2020	Outstanding ↑ Jan 2020	Good →← Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Critical care	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Outstanding →← Jan 2020	Good →← Jan 2020	Good ↑ Jan 2020	Good →← Jan 2020
Neonatal services	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Transition services	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Requires improvement Jan 2016	Good Jan 2016
End of life care	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016
Outpatients	Good Apr 2018	N/A	Outstanding Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Child and adolescent mental health wards	Good →← Jan 2020	Good →← Jan 2020	Good ↓ Jan 2020	Good →← Jan 2020	Requires improvement ↓ Jan 2020	Good →← Jan 2020

Headlines:

Overall Trust rating of **Well Led** – **GOOD**
All Hospital services are rated either **GOOD** or **OUTSTANDING**
Rating for Safe has deteriorated to **Requires Improvement**

Surgical Services (spanning 6 of our Directorates) – improved to **GOOD** overall with **Caring** and **Effective** now rated as **OUTSTANDING** and moving to **GOOD** in **Well Led**

Critical Care – improved to **GOOD** in **Well Led**
Mental health – rated **GOOD** overall



OUTSTANDING PRACTICE

YOUNG PEOPLE'S FORUM

Our YPF actively engages with young people and their siblings so their views and experiences influence and inform service developments

The support available from our Family Liaison Sisters for bereaved families is outstanding

We led the drug trial for a new Spinal Muscular Atrophy treatment which has now been approved by NICE.

Research is embedded in our critical care teams. They were lead authors on 4 of the 8 multiple centre trials in Paediatric Intensive Care published globally in 2018 and 2019

Our two Play street events promoted clean air and the benefits to patients, and were an opportunity to engage with the local community.

New Gene Therapy has treated patients with severe combined immunodeficiency without a transplant

GOSH is the first centre in the UK undertaking foetal surgery for Spina Bifida

Weekly psychological support sessions for critical care staff include pre-briefs ahead of possible bereavements

Pioneering 3D heart modelling and virtual reality helps clinicians plan and practice complex procedures

Participating in Harvey's Gang allows children to understand what happens to their blood samples

We have a well structured appraisal process for Non-Executive Directors

GOSH teens CAREERS FESTIVAL

We introduce patients to a range of companies and help them sign up for work experience opportunities and learn new skills

We got a silver dolphin award at Cannes for a short film showing a European collaboration, coordinated by our Consultant Neurologist

Our range of services to reduce anxiety, including:

- blood parties using disco lights and sensory equipment to distract patients while having their blood taken
- poets on the ward
- music therapist to provide opportunities for creative expression

Enforcement Notices

Regulation 12 Safe Care and Treatment

The service did not always use systems and processes to safely store, record or destroy medication in line with legislation

- PICU: access to rooms where medication is stored was not appropriately controlled.
- Theatre and 1 Surgical Ward: IV fluids not stored securely
- Surgery: not denaturing CDs in line with policy
- Surgery: Temperature in rooms used to store medicines were not stored and recorded.

Regulation 17 Treatment of disease, disorder or injury

The known medicines risks raised at the previous inspection relating to safe storage of medicines had not been mitigated. The Trust must ensure the BAF reflects all known medicine risks.

In CAMHS there was ineffective governance in respect of the introduction of the new EPR system. The new system did not meet the unit's needs. This had been recognised but not addressed promptly.

The Trust is progressing action plans to address both enforcement notices and is due to respond to CQC on 13th February 2020

Provision of Safe Care

We were rated **Requires Improvement** for **Safety**

This relates mainly to:

- Consistent management of medicines
- Consistently managing our infection control risk
- Consistency of systems to ensure that our equipment is maintained and safe to use
- Pharmacy provision on critical care wards was below recommended standards

We MUST do:

- Ensure that our Board Assurance Framework reflects all known medicines risks
- Ensure that our medicines are stored safety and destroyed in line with legislation in critical care and surgery
- Ensure that the EPR meets the needs for the CAMHS service so staff can record, update and find patient records promptly.

We have established a monthly executive led **Always Improving** meeting to focus on embedding change in light of the findings, and to establish ongoing monitoring of compliance with CQC regulations across our services.

The Should Do's

Trust Wide

- Continue to implement a formal board development programme
- Take action to develop and assure itself about financial sustainability going forward
- Continue to promote the role of the Freedom to Speak Up Guardian
- Raise staff awareness of the safe and respectful behaviour policy
- Continue to improve on our WRES data
- Raise awareness of the accredited safety champions
- Clarify role and expectations of governors in interview stakeholder groups
- Improve oversight of pharmacy department including development of KPIs via the directorate performance process
- Take action to improve the number of incidents closed within 45 working days
- Improve accuracy of Trust's information asset register.

Critical Care

- Consider developing a directorate clinical strategy for critical care areas
- Provide consistent check in relation to all in use resuscitation equipment in the critical care areas

Surgery

- Improve the timeliness of discharge summaries sent to the patient's GP
- Continue work to improve referral to treatment times
- Review and imped systems for equipment maintenance in theatres so that staff are assured it is fit for use.

CAMHS

- Continue to take action so that staff are not negatively affected by the lack of disabled access to the roof terrace
- Provide training to improve understanding of Gillick competency
- Provide timely admin support so audits and document scanning are not delayed

Benchmarking

Ratings for Great Ormond Street Hospital NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016
Surgery	Requires improvement → ← Jan 2020	Outstanding ↑ Jan 2020	Outstanding ↑ Jan 2020	Good → ← Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Critical care	Requires improvement ↓ Jan 2020	Good → ← Jan 2020	Outstanding → ← Jan 2020	Good → ← Jan 2020	Good ↑ Jan 2020	Good → ← Jan 2020
Neonatal services	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Transition services	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Requires improvement Jan 2016	Good Jan 2016
End of life care	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016
Outpatients	Good Apr 2018	N/A	Outstanding Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Child and adolescent mental health wards	Good → ← Jan 2020	Good → ← Jan 2020	Good ↓ Jan 2020	Good → ← Jan 2020	Requires improvement ↓ Jan 2020	Good → ← Jan 2020

Ratings for Sheffield Childrens Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019
Medical care (including older people's care)	Good Oct 2016	Good Aug 2014	Good Aug 2014	Good Oct 2016	Good Oct 2016	Good Oct 2016
Surgery	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019
Critical care	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Oct 2016	Good Aug 2014
Neonatal services	Good Aug 2014	Requires Improvement Oct 2016	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Transition services	Good ↑ Jul 2019	Good ↑ Jul 2019	Good → ← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019
End of life care	Good Aug 2014	Good Aug 2014	Good Aug 2014	Outstanding Aug 2014	Outstanding Aug 2014	Outstanding Aug 2014
Outpatients	Good → ← Jul 2019	N/A	Good → ← Jul 2019	Requires Improvement ↓ Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019

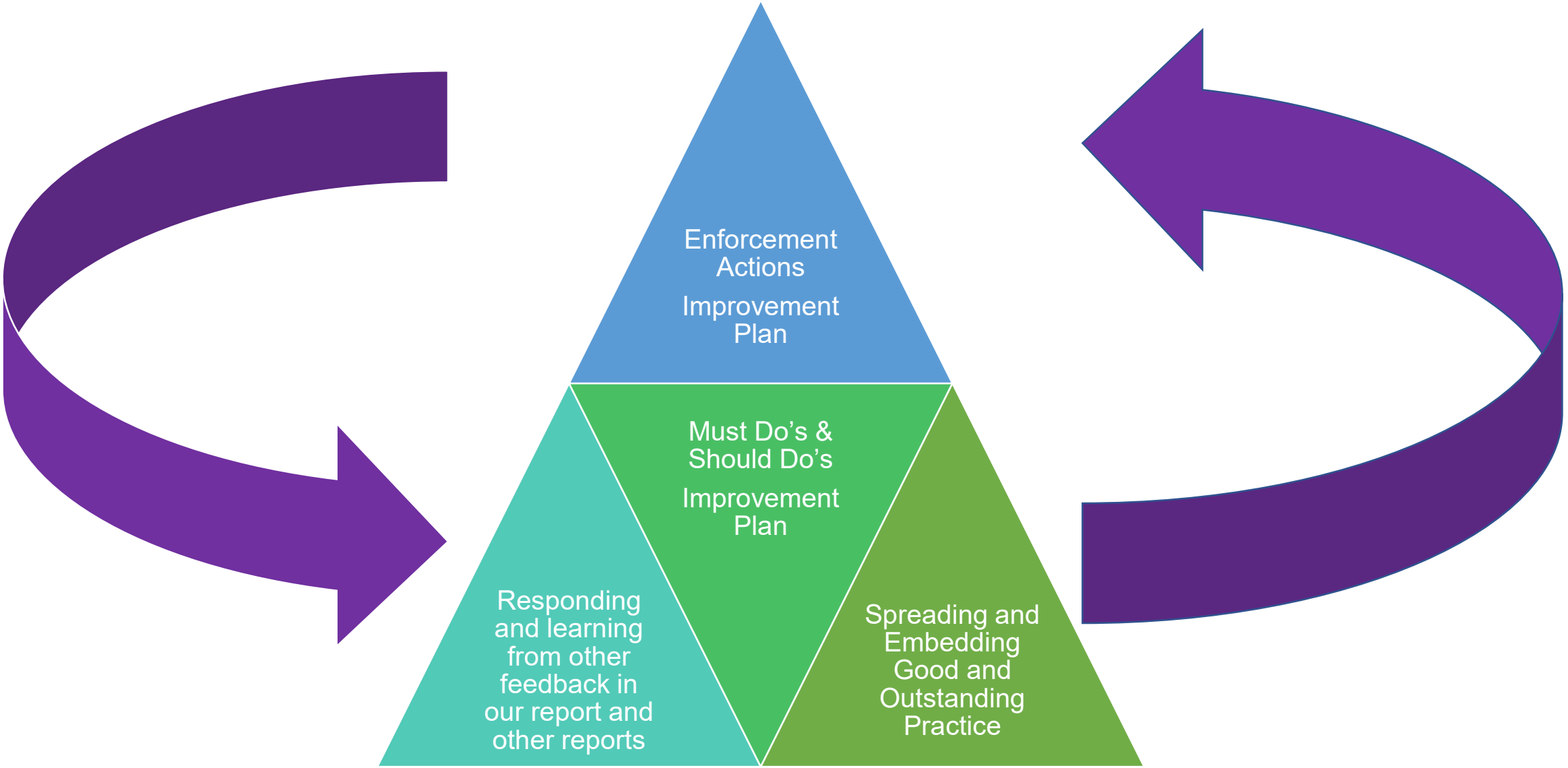
Ratings for Birmingham Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Medical care (including older people's care)	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Surgery	Good ↑ Oct 2019	Good ↓ Oct 2019	Outstanding ↑ Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019
Critical care	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Transition services	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	N/A	Outstanding Feb 2017	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017
Overall*	Good ↑ Oct 2019	Outstanding → ← Oct 2019	Outstanding → ← Oct 2019	Outstanding → ← Oct 2019	Good → ← Oct 2019	Outstanding → ← Oct 2019

Ratings for Alder Hey Children's Hospital

	Safe	Efective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Aug 2014	N/A	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Medical care (including older people's care)	Requires Improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Surgery	Requires Improvement Apr 2017	Good Apr 2017	Outstanding Apr 2017	Good Apr 2017	Requires Improvement Apr 2017	Requires Improvement Apr 2017
Critical care	Good → ← Jun 2018	Good → ← Jun 2018	Outstanding → ← Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018
Neonatal services	Good Aug 2014	N/A	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Transition services	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
End of life care	Good → ← Jun 2018	Good → ← Jun 2018	Outstanding → ← Jun 2018	Good → ← Jun 2018	Good ↓ Jun 2018	Good ↓ Jun 2018
Outpatients	Requires Improvement Jun 2018	N/A	Good Jun 2018	Requires Improvement Jun 2018	Good Jun 2018	Requires Improvement Jun 2018
Diagnostic imaging	Good Jun 2018	N/A	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Requires Improvement ↓ Jun 2018	Good → ← Jun 2018	Outstanding → ← Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018

Always Improving: 2020 Focus



Great Ormond Street Hospital for Children NHS Foundation Trust

Council of Governors

5 February 2020

Business Planning and Operational Planning Update 2020/21

Summary & reason for item:

- The Long Term Plan sets out a vision for the NHS and in response to its ambitions as well as our internal and external opportunities and challenges, the Trust must develop business plans and an operating plan.
- The Trust's internal planning process have been improved further for 2020 with stronger governance, review, and challenge across important areas – quality, activity, workforce, finance, and better value.
- Emerging themes and areas of focus include:
- Between now and the start of the 2020/21 financial year, our planning will continue to be reviewed, supported, and challenged through the Operations Board, Executive Management Team, Finance and Investment Committee and Trust Board.
- The reason for this item is to include members in a presentation of the business planning work that's been completed to date and the future work that needs to be completed to ensure our business plans and operational plans are in place for 2020/21.

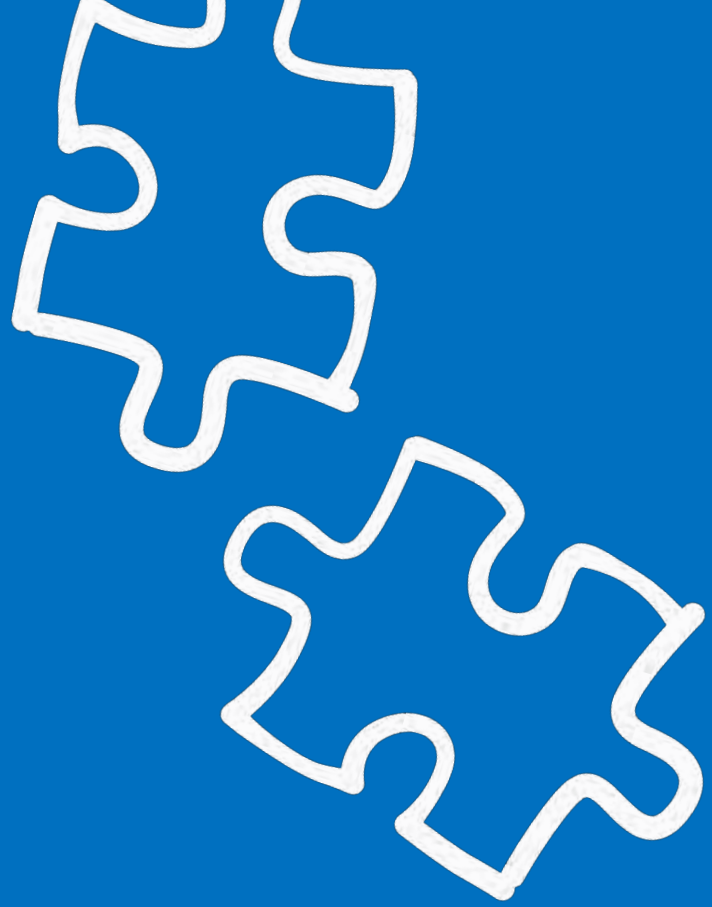
Governor action required:

- To acknowledge the business planning and operational planning work that's been completed to date as well as the remaining work that needs to be completed for 2020/21.
- To acknowledge the most pressing challenges that face the Trust and the plans that are being developed in response.
- To ask questions and offer feedback on the work that's been and is being undertaken.

Report prepared by: Peter Hyland, Director of Operational Performance and Information

Item presented by: Peter Hyland, Director of Operational Performance and Information

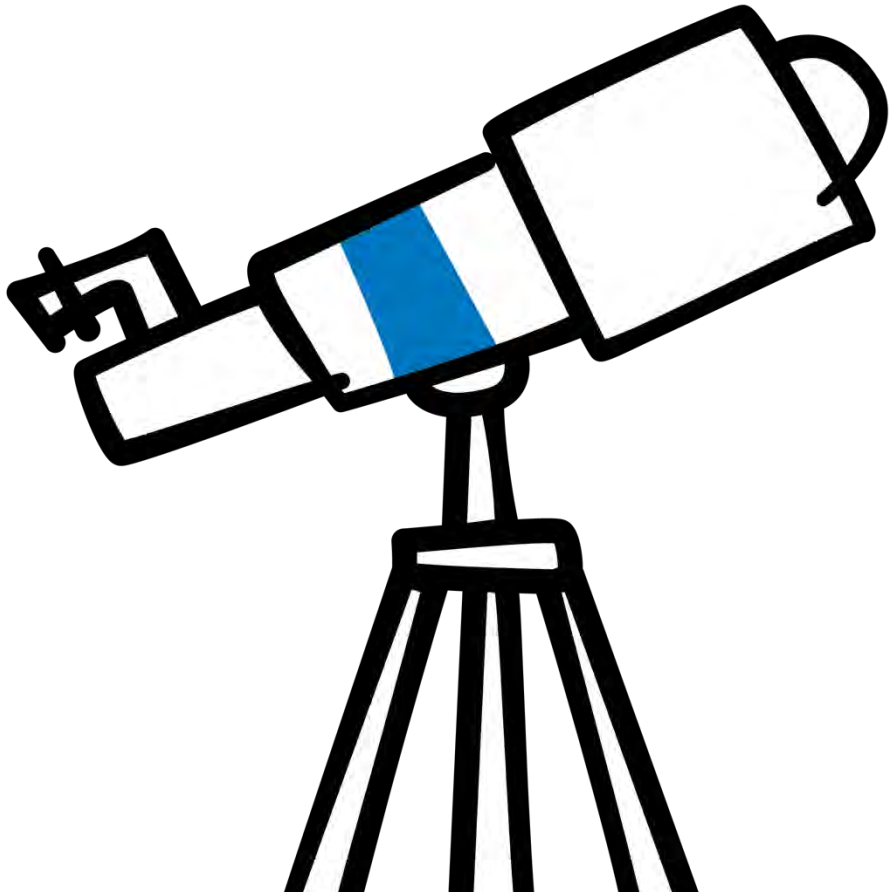
Business Planning and Operational Planning Update 2020/21



Council of Governors

Wednesday 5 February 2020

Context for GOSH



- Significant challenges across the country
  - Financial
  - Workforce
  - Operational
- The 10 year plan aims to improve things:
  - Integrating care
  - Harnessing technology
  - Workforce planning
- Other challenges for GOSH:
  - Our place in the system – locally, regionally, nationally, etc.
  - The scope and scale of specialised services and commissioning
  - Our workforce and culture
  - Epic's Electronic Patient Records system
  - New GOSH Strategy - Above and Beyond

Business Planning at GOSH

- Strengthened our internal 20/21 planning process:
  - Each clinical and corporate area has a business plan for 2020/21
  - Better governance, clearer guidance and timetable, earlier budget-setting rules and more consistent support
  - Three iterations of plans have been received with emerging themes and focus for 2020/21 – see the next slide.

What Our Plans Tell Us…

Clinical Directorates

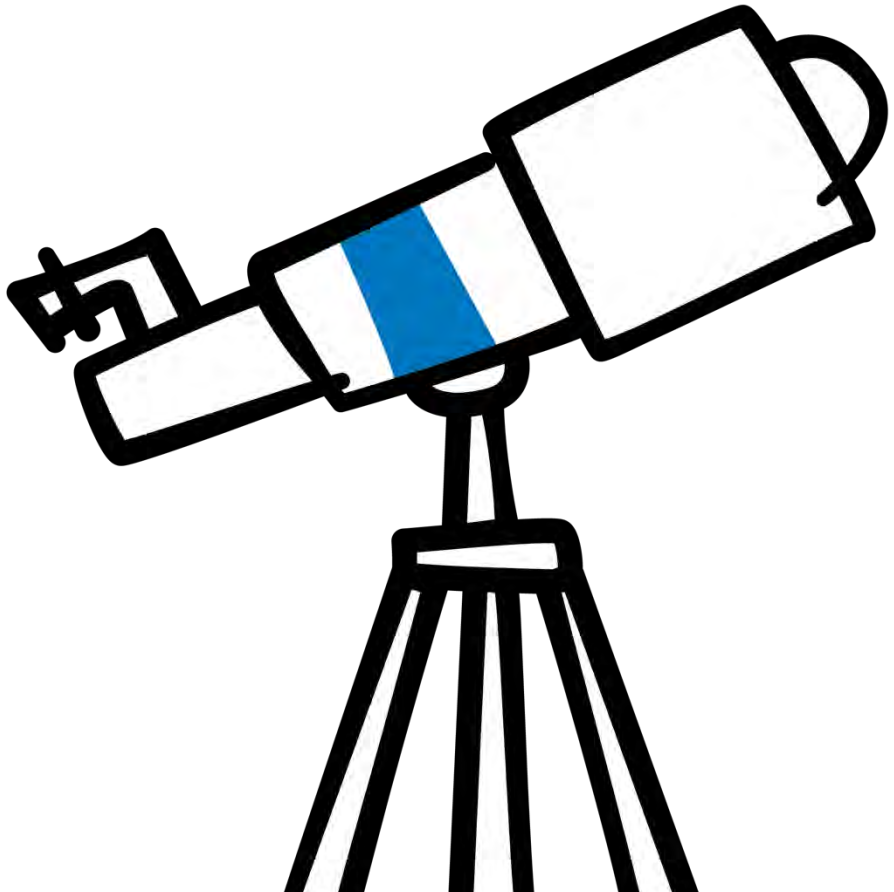
- **Activity and capacity:** we need enough space, staff and equipment to see the patients our contract directs us to
- **Staffing:** we need the right staff, in the right roles, with the right training
- **External collaboration:** we need to work with external partners and networks
- **Internal collaboration:** we need to ensure we work together within the organisation too
- **Funding:** we have to work efficiently to ensure we use money in the best way
- **Digital Transformation:** we need to use the latest technology tpo support our patients, especially to reduce travel to GOSH
- International and private patients: we need the capacity to support our IPP and we need to maximise commercial opportunities
- **Space and equipment:** we need to use the space we have effectively, efficiently and sustainably. We need to plan for the future too

What Our Plans Tell Us…

Corporate Directorates

- **Staffing:** we need to recruit and retain staff, especially nurses
- **Space:** we need to ensure patient and family accommodation is fit for purpose and prepare for the build of the Children's Cancer Centre
- **Quality and regulatory:** we need to ensure the organisation continues to maintain and drive standards up
- **Funding and commercialisation:** we need to work within a reduced funding envelope and maximise commercial opportunities
- **Digital solutions:** we need to explore new technologies
- **Learning:** we need to work on further developing the Learning Academy
- **Budget setting and activity planning:** we need to ensure that the money we have balances with the number of patients we need to care for
- **Contract:** we need to know what contract we will have with NHSEI and how they will fund us

Operational Plan



- At this time the NHS has not received planning guidance from NHS England or NHS Improvement, however operational plan drafted to ensure that:
  - Our **strategy** is set out to guide the organisation
  - **Activity** plans reflect latest information and targets
  - **Transformation** priorities and programmes are set
  - **Budgets** and financial information is up to date
  - **Quality and satefy** continues to be embedded
  - **Workforce** planning supports our future

Timetable and next steps

- 24 January – third submission of clinical and corporate plans
- 31 January – third PMO ‘open surgery’ to support better value plans
- 6 February – submission of plans to Public Trust Board
- 12 and 13 February – updates to Operational Board and EMT
- 21 February – update to Finance and Investment Committee
- 24 and 26 February – updates to Operational Board and EMT
- 28 February – fourth submission of clinical and corporate plans
- 5 March – draft 2020/21 Operational Plan to NHS Improvement
- 20 March – submission of final plans for sign off
- End of March – budget sign off and Trust Board final sign off

Key challenges and risks

- RTT delivery and other key standards
- Workforce – recruitment and retention
- The costs and affordability of specialist work
- Requirement to deliver savings
- Mismatch between activity and financial modelling

Attachment G

Council of Governors

5 February 2020

Chief Executive Report – February 2020

Purpose

The purpose of this paper is to provide a summary of key work priorities and achievements since the 26 November 2019 report to the Council of Governors. The report includes:

- Our CQC report has now been published
- Review of urology surgical services
- Update on complex case
- Launch of new 5-year strategy
- Executive summaries of:
    - Integrated Quality Report December (November data) 2019
    - Month 8 Finance report
    - Trust Board Dashboard – December 2019
- Trust Board update
- GOSH news
- Appendices

Governor action required:

Governors are asked to note the report and pursue any points of clarification or interest.

Report prepared by:

Paul Balson, Deputy Company Secretary, paul.balson@gosh.nhs.uk

Report presented by:

Matthew Shaw, Chief Executive

Attachment G

1 Our CQC report has now been published

On 22nd Jan 2021, the CQC summary report for GOSH 2019 was published. The report was based on a prior inspection of all core services and recent inspections of surgery, critical care and child and adolescent mental health wards. This was in addition to an assessment against the 'Well-Led' dimension.

In summary, that the organisation remains rated as 'Good' overall.

Across the five CQC domains, we were rated outstanding for the effectiveness of our services and the caring way in which they are delivered. We were also rated good for Well-Led and for being responsive to the needs of our patients.

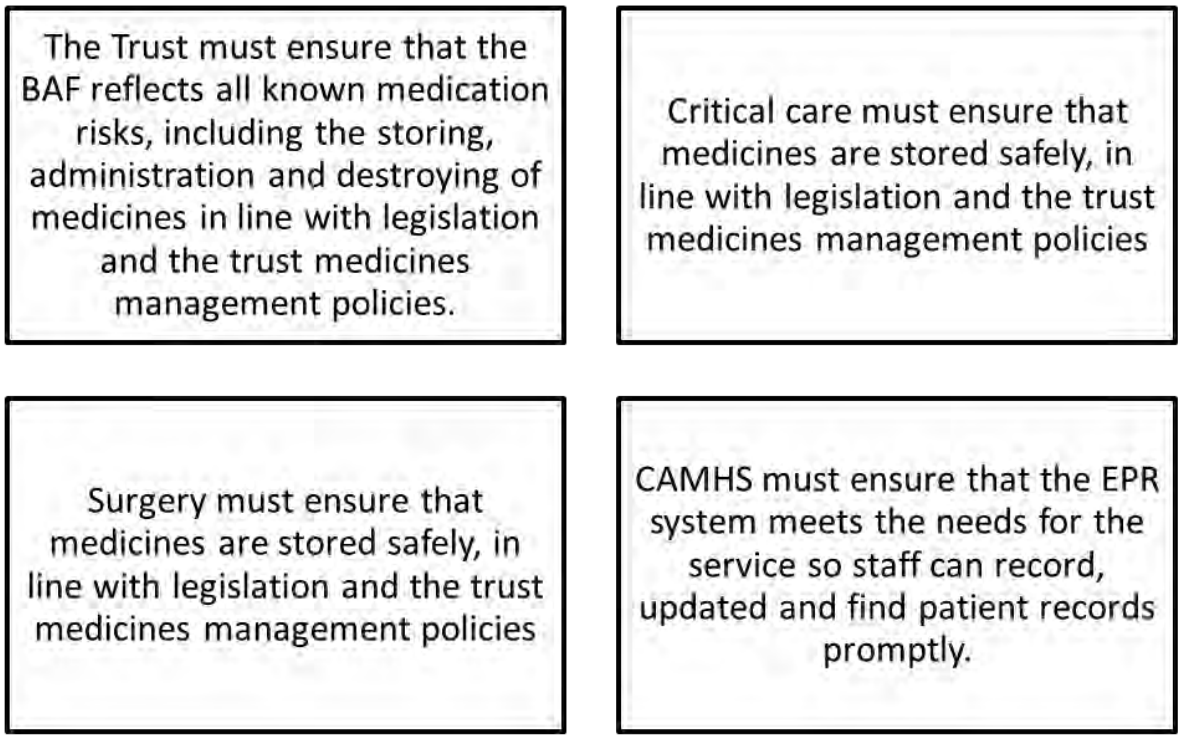
Areas of outstanding practice seen on the most recent visit included:

Collaborative work of teams to support families during a bereavement
Work by staff to create initiatives to improve a child or family's experience through increasing their understanding of a treatment or helping children or young people who are frightened or phobic about aspects of their care and treatment
Ensuring young people's views and experiences influence and inform service development
Contribution to global research into paediatric intensive care
The Gene Therapy Programme which has resulted in patients with severe combined immunodeficiency being cured without a transplant
Neuromuscular study of children with spinal muscular atrophy, which now licenced and approved by NICE, will improve the quality of life for patients with SMA and delay progression of the disease
The use of pioneering 3D modelling and virtual reality to plan and practice surgical procedures and collaboration with local acute trust to successfully perform specialist foetal surgery, the first of its kind.

While inspectors highlighted some good safety practices, our rating for safety was reduced to 'Requires Improvement'. This was largely due to inconsistent processes in some clinical areas in relation to equipment use, maintenance and medicines storage.

The inspectors did highlight clear good practice in managing patient safety such managing patients at risk, detailed record keeping, collating safety information, and ensuring the right provision of staff are in place to keep patients safe.

Attachment G
The report includes four 'Must Do's:



In addition, two enforcement notices were issued to the Trust. These related to breaches of one legal requirement at Trust level and one in the core services:

- Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment (Trust Level)
- Regulation 17 HSCA (RA) Regulations 2014 Good Governance (Mental Health)

The breach of regulation 12 at Trust level meant that the Trust could not score any more than 'Requires Improvement' for Safe Care. Similarly, the breach of regulation 17 for the roll out of Epic for our CAMHS service limited their rating of Well Led to 'Requires Improvement'.

The Trust is required to provide an update to the CQC in February on progress against the actions to address these breaches.

There has been a huge amount of change over the last 12 months and the feedback from the CQC inspection gives us confidence that we are on the right track. It has been a real team effort to get where we are now.

This really is a time to celebrate all the amazing work staff do for patients and their families every day. Next stop, Outstanding!

I will also provide an update at the Council meeting, including an overview of the actions being taken to respond to the recommendations.

2 Review of urology surgical services

As you may be aware, last year, the Trust asked the Royal College of Surgeons to review our urology surgical service. This was because staff and families told us that things were not working as well as they could be.

The review raised some concerns around team working which could have the potential to impact on patient care and safety. It is important to note, that it did not say there were any current patient safety concerns.

The review was published on our website as part of our public board papers in November 2019. This was an important step in us being more open and transparent about our services.

The review has been picked up in the press and you may have seen this in the *Times* or *Telegraph*.

The Urology team are engaged in moving the department forward and are making good progress against the issues raised. I will provide a verbal update on this item at the Council meeting.

3 Update on complex case

As you may remember at the November 2019 Council meeting, I informed you about an inquest into the death of our former patient Amy Allan.

Amy had a complex cardiac condition and came to GOSH in September 2018, aged 14, for spinal surgery. After surgery, she was admitted to intensive care, but sadly Amy's condition deteriorated and she died later that month.

As I have said before, we did not get it right for Amy or her family, something I am very sorry about. It is important we learn from what did not go well.

At the time of the inquest, we were already making changes to practice. After the inquest, we were given a 'Preventing Future Deaths' report by the Coroner. This was because the Coroner did not feel we were doing enough to learn from the incident and wanted to encourage us to reflect more widely on actions we needed to take.

We re-examined the care provided to Amy and identified additional learnings, some of which will improve care right across the hospital and not just in the services which cared for Amy.

I wanted to share these with you and am happy to take any questions at the Council meeting:

Area	Improvement
Team working	We always need to work as one team and do things collaboratively so we can do the complex and difficult things we need to help children and their families.
Robust Multi-disciplinary team (MDT) working	We have put systems in place to ensure we have the right people present at the right times in our MDT meetings so we can share clinical information effectively between teams. We started with the Spinal MDT, but this is being rolled out to all MDTs in early 2020.
Better recording of clinical information	We are now recording MDTs on the Electronic Patient Record, which means the outcome of the discussion is accessible in the patient record for all staff looking after the patient.
Improved systems and safety nets in 2020.	Communication between teams in the days and weeks ahead of high-risk admissions have been improved as well as on the day of admission. This will include a phased expansion of our Anaesthetic Pre-Operative Assessment service.
Early discussions around Extracorporeal membrane oxygenation (ECMO).	If staff think that the use of ECMO might be a possibility following an elective intervention, it is crucial that this is discussed with the cardiac team as early as possible so we can assess whether this is the right thing for the patient. In the rare cases that this is appropriate we need to make sure that all the relevant preparation work, including consent, has been done in advance of admission.

4 Launch of new 5-year strategy

We are delighted to be able to share with the governors on this agenda our new 5-year strategy framework:

Above and Beyond

This was created following last year's consultation with GOSH staff, governors, patients and families, members and partner organisations. The framework sets out a statement of purpose, a set of 'due north' principles and a series of priorities to advance care for children and young people with complex health needs.

'Above and Beyond' is underpinned by an ambitious set of programmes that aims to transform our skills and capacity, deliver patient-centred care and digital-first culture, drive better outcomes, more research discoveries and a better experience for patients, families, staff and partners.

We will be launching the strategy at an all-staff meeting in late February and are preparing a strategy toolkit for GOSH leaders, which will support them in operationalising the strategy across directorates and departments.

We propose to update the Council at each meeting (via the Chief Executive's report) on our progress in implementing the strategy through each of the priority programmes:

- Making GOSH a great place to work by investing in the wellbeing and development of our people.
- Delivering a Future Hospital Programme to transform outdated pathways and processes.
- Developing the GOSH Learning Academy as the first-choice provider of outstanding paediatric training.
- Improving and speeding up access to urgent care and virtual services.
- Accelerating translational research and innovation to save and improve lives.
- Creating a Children's Cancer Centre to offer holistic, personalised and co-ordinated care.

5 Integrated Quality Report December (November data) 2019

Each month the hospital publishes an integrated quality report. This includes a range of key performance indicators (KPIs) relating to:

- Delivery of safe, harm-free care
- Whether patients have had a good experience of care
- The effectiveness of our care
- How responsive we are to the need to change and improve
- How we lead and support our people in delivery of care

The KPI dashboard, as included in the Integrated Quality Report, is available at Appendix 1. The December 2019 IQPR report which looks at November data will be presented at the Trust Board on 6 February 2020.

The key highlights from this report (November 2019 data) are below:

5.1 Safety Incident Closures

The number of incidents closed significantly improved in November 2019. While work continues to tackle the backlog of incident (i.e. those taking longer than 45 working days to investigate) our incident closure rate is anticipated to be under target.

A breakdown of open incidents is regularly shared with relevant teams and progress monitored via the Patient Safety and Outcomes Committee (PSOC) and Senior Leadership Team (SLT).

5.2 Duty of Candour compliance

There were eight overdue stage 3 duty of candour investigations (i.e. delay in sharing with the family). Further training in Root Cause Analysis (RCA) methodology is required at a local level to support the increased numbers of investigations. An external provider is being sourced and training is expected to begin in March 2020. Monthly monitoring continues with opportunity for escalation at weekly safety meeting.

5.3 Patient Experience

The Trust met the target response rate for Friends and Family Test feedback and 98% of patients recommended our in-patient care in November 2019. The outpatient recommendation rate fell to 91%, which was the lowest since April/May 2019.

Inpatient FFT Response Rate deteriorated for the month of December 2019 at 21.45%, however, it should be noted that significant improvements were made since the start of the financial year with the September to November 2019 averaging 27%, meeting the Trust internal target of 25%. It is fully expected that January 2020 will return to above 25%.

Out of 2,993 patients eligible to respond, 642 patients completed the survey with 97.35% providing a positive recommendation response.

Comments were predominantly related to waiting times, signage, appointment changes, temperature and the availability of toys and play rooms. All comments, both positive and negative are reviewed by the directorate and appropriate actions taken where required.

5.4 Re-opened complaints

The reasons for reopening complaints include, but are not limited to: requests for meetings (offered to all complainants), disputed investigation findings, further questions prompted by the investigation and disputed invoices for care (IPP). A revised categorisation for re-opened reports will be reviewed at Patient Family Experience and Engagement Committee (PFEEC) in February 2020.

5.5 Serious Incident Actions

See 7.2 Safe.

5.6 Performance

The Trust continues to underachieve against the 99% national Referral to Treatment (RTT) standard, reporting 96.79% of patients waiting within 6 weeks for the 15 diagnostic modalities.

There was a slight decrease in the number of breaches reported in November (43) compared to the number of breaches reported in October (49). The Trust did not achieve the RTT 92% standard, submitting performance of 85.71%, with 806 patients waiting longer than 18 weeks, however a slight improvement of 0.72% from the previous month.

There has been a significant rise in our 52-week breaches during the course of Q3. In November 2019, we reported 25 breaches, and early indications show that we will report a similar number for December 2019.

6 Month 8 (November 2019) Finance report

Key points for Governors to note:

1. The Trust is required to achieve an overall control total agreed with NHSI annually. The Trust was £0.5m favourable to the control total year to date (YTD) at Month 8. This was principally due to vacancies across the organisation partially offset by underperformance in private patient income.

2. The Trust was behind its income target by £4.5m (excluding pass through) at Month 8. Private patient income has improved since the start of the year but at Month 8, it was £3.6m behind plan. NHS Clinical Income that is not on block contract has improved in month and is now ahead of plan by £0.2m.
3. Pay was underspent YTD by £6.1m due to the high number of vacancies across the Trust that are not being covered by equivalent Bank or Agency and reduced research costs (offset by income).
4. Non-pay was £1.5m above plan YTD (excluding pass through). This was due to increased expenditure on computer software costs and premises costs associated with the new buildings. These costs have been being partly offset by reduced private patient debt releasing impairment to receivables.

Cash held by the Trust was higher than plan by £19.3m which included £8.2m received earlier in the year which related to Provider Sustainability Fund (PSF) for 2018/19.The full Month 8 finance report is available at Appendix 2.

7 Trust Board Dashboard – December (December data) 2019

The Trust Board Dashboard provides a summary of Trust performance in key areas and domains. The key messages are:

7.1 Caring

See 5.3. Patient Experience.

7.2 Safe

At the end of December 2019 there were 1,258 Incidents open on Datix, with 964 overdue. This was a reduction of 195 from October 2019. Each directorate has an action plan to review and close where actions have been completed.

The Trust reported no incidents of MRSA in December 2019 with a year to date position of zero. There was one incident of C-Diff reported in December 2019. The year to date position is seven.

For the last two reporting months, there has been an decrease in Central Venous (CV) Line Infection Rates. Root Cause Analyses continue for all infections and the outcomes will be closely reviewed.

The 574 open actions that were related to incidents on DATIX have been significantly reduced down to 159 in November 2019. This is supported by regular reporting to directorate teams and support from the patient safety team. Actions related to recent Serious Incidents are managed through 'Closing the Loop'.

7.3 Responsive

91.02% of patients were waiting within 6 weeks for a diagnostic test (DM01) for December, 104 patients breached the standard with 89 attributable to Imaging including Cardiac MRI. This is a significant deterioration from November 2019 where 43 breaches were reported. An updated recovery action plan and trajectory is in development and processed for sign-off by both the Trust and NHSE.

The Trust reported 84.98% patients waiting below 18 weeks against the Referral to Treatment (RTT) Incomplete Pathway national standard of 92%. Since EPR go-live the Trust has not met this standard for variety of reasons including, but exclusive to: reduction in activity over the four week go-live period, loss of key clinical staff in Dental, Plastic Surgery and Orthopaedics, bed capacity issues, capacity constraints in highly specialised services e.g. Selective Dorsal Rhizotomy (SDR), and increases in volume of complex non-elective patients particularly in Cardiac Surgery. Individual services are in the process of developing updated recovery action plans and trajectories for sign off and will be circulated in due course.

For December 2019, 27 patients were reported waiting 52 weeks and over. Of these fourteen were Dental, seven Neurosurgery, three Plastic Surgery, two Ear, Nose and Throat, and one Endocrinology. A separate 52 week trajectory is being produced with sign-off expected early February 2020.

7.4 Well Led

Appraisal rates increased in December for both Consultant and Non-Consultant moved to 94% and 90% respectively. Mandatory Training was 95%, however, there a number of competencies that are below 90%, which the directorates are addressing.

7.5 Effective

Discharge Summaries within 24hrs have been a significant challenge since April 2019 following the introduction of new workflows within EPR. Directorates have focused on improving this metric in terms of the turnaround and number outstanding. For December 2019 the Trust reported 68.20% of patients receiving a Discharge Summary within 24 hours with 51 discharge summaries outstanding in month and 149 year to date (compared to 57.38% and 687 outstanding in July 2019). The slight deterioration in December 2019 performance is attributed to the Christmas period and is expected to improve in January 2020.

The same level of focus and scrutiny is now being applied to Clinic Letter Turnaround, which currently stands at 53.84% within 7 days and 7,725 clinic letters outstanding for December. Focused work is also looking at those areas by speciality where patients have multiple letters within the same service which have not been sent, to understand if some of the earlier letters can be closed off. This has the potential to reduce the backlog by up to 25%. It should be noted that some appointments do not require a letter and the Trust's EPR is being optimised to capture this.

The full dashboard is available at Appendix 3.

8 Trust Board update

The most recent meeting of the Trust Board was held on 27 November 2019. Highlights from this meeting that are not reported elsewhere within the Council of Governors' papers are summarised below.

8.1 Chief Executive Update

At her last Trust Board meeting, Professor Rosalind Smyth was thanked her for her contribution to the Board over the past 7 years.

Mr Matthew Tulley, Director of Development was thanked for his work at GOSH and was wished well in his new role. Stephanie Williamson has taken on the role of Acting Director of Development pending the recruitment of a substantive candidate.

GOSH hosted a positive European Children's Hospital Organisation (ECHO) meeting and agreed to work collaboratively on several workstreams.

The Children's Alliance met and discussed the tariff challenges. The changes to tariffs mutually affect paediatric organisations.

8.2 Transparency in Healthcare

Dr Sanjiv Sharma, Medical Director presented a paper that highlighted the Board's commitment to being open and transparent. I informed the Board that GOSH was committed to putting issues into the public domain and being open internally.

8.3 Emergency Preparedness, Resilience and Response Assurance 2019 Compliance

Mr Phillip Walmsley, Interim Chief Operating Officer informed the Board that GOSH was 100% compliant with all business continuity standards. The Trust was one of only two in London to achieve this score.

8.4 Brexit Update

Mr Phillip Walmsley, Interim Chief Operating Officer confirmed that GOSH's position in relation to Brexit continued was green against assurance questions set out by NHS England and NHS Improvement.

8.5 Patient Experience and Engagement Framework

Ms Alison Robertson, Chief Nurse presented the Patient Experience and Engagement Framework that had been developed to set out the ambition, vision and priorities to enable GOSH to understand and improve the experiences of patients and families in partnership with the GOSH Children's Charity. This was partially in response to a Patient Story from a patient's sibling at Trust Board

8.6 Electronic Patient Record (EPR) Update

Mr Richard Collins, Director of Transformation reported that the EPR programme was in the optimisation phase and would continue until October 2020. The Trust had been the first UK site to undertake an upgrade that has increased the functionality of the system.

8.7 Directorate presentation: Blood, Cells and Cancer Directorate

The Board received a presentation from Dr Clarissa Pilkington, Chief of Service for Blood, Cells and Cancer on the achievements, challenges risks and opportunities within the Directorate.

8.8 Approach to business planning and budget setting 2020/21

Ms Helen Jameson, Chief Finance Officer reported that a business planning process for 2020/21 financial year had been developed and would be updated as NHS England and NHS Improvement released further planning guidance.

8.9 Infection Control Update

The Trust had successfully implemented the second phase of the 'gloves off' campaign. A key area of risk was around the maintenance of the estate to support infection control. The Trust's internal auditors had been asked to undertake an audit on ventilation in order to receive recommendations on potential improvement actions.

8.10 Feedback from Non-Executive Directors (NED) walkrounds

The NEDs provided feedback on their walkrounds of the Trust:

NED and area visited	Summary of feedback
Akhter Mateen and Chris Kennedy at Camelia Botnar laboratories	Staff welcomed the visit. They reported that they felt that they were located a long way from the rest of the hospital and were under-valued. NEDs noted it was important to identify other areas of the Trust that felt the same way. It was confirmed that that action was being taken to reduce the risks associated with the storage facility for liquid gas.
Sir Mike Rake and Kathryn Ludlow at Cardiac Intensive Care Unit	This was a follow up visit and the unit fed back on their adoption of EPR.
Lady Amanda Ellingworth, Professor Rosalind Smyth and	The team discussed the recent merger to become the North Thames Genomic Medicine Centre and were appreciative of staff being able to work on one site.

James Hatchley at Genetics	The service was a world-class facility, supported by the recent excellent outcome in the team's regulatory inspection.

8.11 Accessing Board papers

The full sets of papers, including those for the Trust Board meeting in November 2019 are uploaded here: https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board/trust-board-meetings. The February 2020 agenda and papers will also be on the website prior to the meeting.

If you would like to observe the Trust Board or have any queries please contact: Victoria Goddard, Trust Board Administrator Victoria.Goddard@gosh.nhs.uk.

9 GOSH news

9.1 Building our new Children's Cancer Centre (CCC)

On Wednesday 4 December 2019, the Trust launched Phase 4 of GOSH's Redevelopment Programme. The objective of the launch was to ask more than 80 clinicians, allied health professionals and representatives from the GOSH charity: *What makes a great clinical building and how do clinicians make sure their voices are heard in the design process?*

Attendees were given the call to action to tell colleagues to get involved in this exciting process to shape the way this building will be designed, to ensure it offers the best possible clinical, patient and research experience.

9.2 Zayed Centre for Research welcomes GOSH staff to new workspaces

On Monday, 2 December, 245 GOSH staff from Cardiology, Immunology, Infectious Diseases and BMT functions kicked off the working week in their new workspaces in the Zayed Centre for Research into Rare Disease in Children.

The move was another milestone for this inspirational building and followed the opening of dedicated new Outpatient facilities (Falcon) in October. It means that the move of GOSH staff into the workspaces is now complete. Further moves of researchers from UCL will take place in coming weeks, with the building reaching full occupancy in 2020.

9.3 2019 Staff Awards

We had a great evening cheering on our finalists and award winners on Wednesday 20 November 2019 at our GOSH Staff Awards.

I was joined by special guest Lisa Faulkner and we were serenaded by our singing sensation staff nurse Beth Porch on the ukulele.

Attachment G
In addition to the long services awards for 10, 20, 25, 30, 35, 40, 45 and 50 years' at GOSH, the following awards were deservedly awarded:

- Always Welcoming
- Always Expert
- Always One Team – Team of the Year
- Always Helpful
- Gwendoline Kirby Award for Nurse Leadership
- Changemaker of the Year
- Volunteer of the Year
- Apprentice / Student of the year
- Child, Young Person and Family Award
- Chief Executive's Award

9.4 New Commercial Director

Chris Rockenbach – General Manager in International and Private Patients has been appointed as the Trust's commercial director. The main aim of the role will be to maximise our commercial income to support the delivery of NHS care and enable us to transform our services.

9.5 Six new appointees to the Medical Directorate

In December 2019, six familiar faces to the Trust were appointed to positions in the Medical Director's Team to lead and support on several workstreams.

Sophie Varadkar - Deputy Medical Director (starts in post from 6 January 2020).

Sophie will support the work of our medical staff in delivering safe and quality care for the children and young people we look after as well as being the medical lead for the Trust's Legal team.

Simon Blackburn - Director of Medical Education and Deputy Director of the GOSH Learning Academy (starts in post from 1 December 2019).

Simon will be work to make GOSH the standard for innovative and open learning.

Dr Philip Cunnington - Associate Medical Director for Regulatory Affairs and Culture (starts in post from 1 January 2021).

Phil will be responsible for our doctors' annual appraisals to support their professional development. He will also be key to the success of the Speak Up programme and lead on other culture improvement planning in line with our People Strategy.

Dr David de Beer - Associate Medical Director for Safety, (starts in post from 1 February 2020).

David will play a central role in setting the Trust's safety agenda, working closely with the Safety team and Deputy Chiefs of Service to support GOSH deliver safe clinical environments. David will also become the medical lead for our resuscitation services – where simulation services will be key to delivering the objectives set out for the GOSH Learning Academy.

Dr Daljit K Hothi - Associate Medical Director for Wellbeing, Leadership and Improvement (starts in post from 1 December 2019).

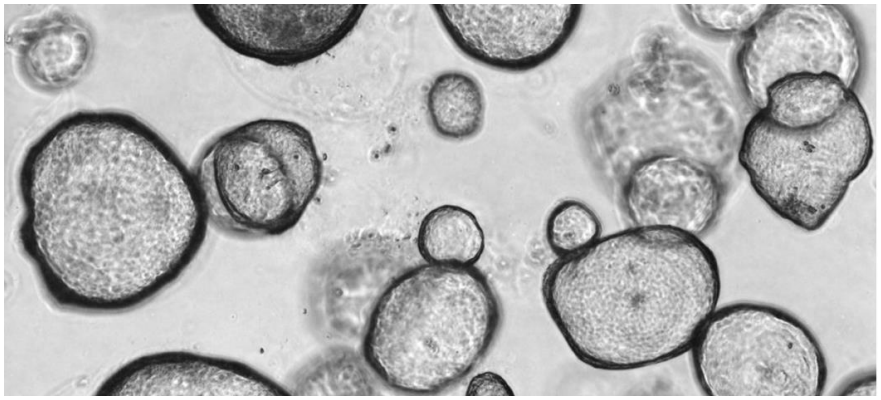
Dal will work alongside teams to design and implement medical leadership development programmes to recognise and retain our talented workforce, as well as ways we can improve clinical teams' wellbeing. She wll also provide medical leadership to support the development of a quality strategy, and help build the quality improvement capability at GOSH.

Renee McCulloch - Associate Medical Director for Workforce (starts in post from 1 December 2019).

Renee will oversee the working patterns of our clinical colleagues so that we have safe staffing levels and are fit for future demands. Renee will also continue as the Trust's Guardian of Safe Working.

10 Other GOSH news

10.1 Patients closer to receiving regenerated tissue major study reveals



Doctors are closer than ever to using regenerated tissue in treating patients following new breakthroughs in stem cell research published today in Nature Communications.

An international group of researchers led by National Institute for Health Research Professor Paolo De Coppi and Professor Nicola Elvassore at University College London Great Ormond Street Institute of Child Health (UCL GOS ICH) have developed a new gel to grow tissue in the form of organoids (laboratory grown structures of human stem cells that model the shape and function of tissue such as muscle) so they can be used in human treatment.

While organoids hold significant potential for use in the replacement and repair of damaged or diseased tissue, the gels currently used to culture human organoids have been unsuitable for use in patients.

However, the researchers led by Professor De Coppi, who is a Consultant Paediatric Surgeon at Great Ormond Street Hospital, have developed an extracellular-matrix (ECM) hydrogel from decellularised piglet intestinal tissue that means organoids could be suitable for use in human treatment.

10.2 Open House 2019

Between Monday 18 – Friday 22 November 2019 GOSH held Open House. This year was our biggest and best year yet. Over five days, we:

- Had over 80 stalls in our Lagoon marketplace as well as on Panther, Bear and Squirrel wards.
- Joined tours visiting DRIVE, the Hospital School, GOSH Arts Collection, hospital history (with our Archivist Nick Baldwin) and the Zayed Centre for Research into Rare Disease in Children.
- Launched the new Trust Brand, People Strategy and the GOSH Learning Academy (pictured).
- Celebrated our Staff Awards.
- Held our third GOSH Conference.
- Hosted a Quiz Night in the Lagoon

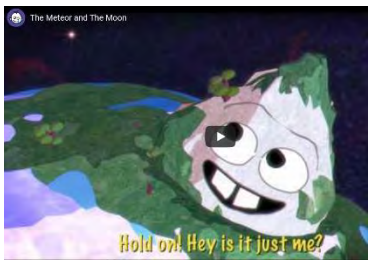
10.3 Launch of the 'Let's talk communication pack

The Trust circulated its new 'Let's Talk Communication' pack for staff who work with children and young people with communication difficulties

The pack includes resources for use on the wards with patients such as: Makaton signs, symbols, photos from around the hospital (e.g. X-Ray, CT, Lagoon), choosing boards and now and next boards.

10.4 Bringing stories imagined by GOSH School pupils to screen

Fantasy stories written by patients at Great Ormond Street Hospital have been brought to life in a series of animations by a team of professional animators, composers, song writers and celebrities.



The animation shorts based on the stories of four GOSH pupils can be watched on these links:

- The Meteor and the Moon
- The King and the Master Builder
- A Picnic in the Park
- Skinny and Fluffy

10.5 GOSH website revamp

Our Digital team have revamped the GOSH website (gosh.nhs.uk) in terms of a new:

- Colour palette
- Larger and more readable font
- Engaging icons which illustrate our key content areas

We are keen to gauge Governor views on the website, so do please drop us a line at social.media@gosh.org to let us know what you think.

11 Appendices

- Integrated Quality Report – December 2019 (November data) - Appendix 1
- Finance report Month 8 (November 2019 data) – Appendix 2
- Trust Dashboard January 2020 (December 2019 data) – Appendix 3

Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality &Performance Report December 2019 (November data)

Sanjiv Sharma
Medical Director

Alison Robertson
Chief Nurse

Phil Walmsley
Interim Chief Operating Officer

Hospital Quality Performance – December 2019 (November data)

Are our patients receiving safe, harm-free care?

	Parameters	September 2019	October 2019	November 2019
Patient Safety Reporting	R<60 A 61-70 G>70	505	588	552
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	76%	23%	36%
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	423	408	720
Average days to close (2018 -2019 incidents)	R ->50, A - <50 G - <45	40	93	80
Medication Incidents (% of total PSI)	TBC	23.2%	18.5%	17.7%
WHO Checklist (overall)	R<98% G>98-100%	99.0%	99.1%	98.7%
WHO Checklist (Theatres)	R<98% G>98-100%	99.4%	99.5%	99.3%
WHO Checklist (non-theatres)	R<98% G>98-100%	98.1%	98.1%	97.4%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	7.1%	5.8%	5.1%
New Serious Incidents	R >1, A -1 G – 0	1	2	3
Overdue Serious incidents	R >1, A -1, G – 0	0	0	0
Safety Alerts overdue	R- >1 G - 0	2	2	1
Serious Children's Reviews Safeguarding children learning reviews (local)	New	1	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	Sept 19	Oct 2019	Nov 2019
Specialty Led Clinical Audits on Track	R 0- 60%, A>60-75% G>75-100%	87%	81%	81%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	77	89	97
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	Sept 2019	Oct 2019	Nov 2019
Friends and Family Test Recommend rate (Inpatient)	G – 95+, A- 90-94, R<90	97%	98%	98%
Friends and Family Test Recommend rate (Outpatient)	G – 95+, A-90-94,R<90	94%	93%	91%
Friends and Family Test - response rate (Inpatient)	25%	29%	29%	26%
PALS (per 1000 combined pt episodes)	N/A	6.48	7.76	7.41
Complaints (per 1000 combined pt episodes)	N/A	0.52	0.42	0.08
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	7%	7%	7%
Re-opened complaints (% of total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	13%	14%	15%

Are our People Ready to Deliver High Quality Care?

	Parameters	Sept 19	Oct 2019	Nov 2019
Mandatory Training Compliance	R<80%,A-80-90% G>90%	94%	95%	95%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	87%	89%	90%
PDR	R<80%,A-80-89% G>90%	89%	89%	90%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	89%	88%	92%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	89%	94%	91%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	95%	95%	95%
Resuscitation Training	R<80%,A-80-90% G>90%	89%	93%	92%
Sickness Rate	R -3+% G= <3%	2.6%	2.7%	2.8%
Turnover - Voluntary	R>14% G-<14%	15.5%	15.7%	16%
Vacancy Rate – Contractual	R- >10% G- <10%	10%	8.3%	7.3%
Vacancy rate - Nursing		8.3%	8.3%	5.4%
Bank Spend		4.5%	5%	4.9%
Agency Spend	R>2% G<2%	0.7%	0.7%	0.7%

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

Responsive Hospital Metrics		Sep-19	Oct-19	Nov-19
Diagnostics: patient waiting <6 weeks	R<99% G -99-100%	96.92%	95.19%	96.79%
Cancer 31 day: referral to first treatment	R<85% G 85%-100%	100%	100%	100%
Cancer 31 day: Decision to treat to First Treatment	R<96% G 96-100%	100%	100%	100%
Cancer 31 day: Decision to treat to subsequent treatment - surgery	R<94% G94-100%	100%	100%	100%
Cancer 31 day: decision to treat to subsequent treatment - drugs	R<98% G 98-100%	100%	100%	100%
Cancer 62 day: Consultant upgrade of urgency of a referral to first treatment	-	100%	92%	100%
Theatre Cancellation for non-clinical reason	-	46	31	TBC
Last minute non-clinical hospital cancelled operations - breach of 28 day standard		4	4	TBC
Urgent operations cancelled for a second time.	R 1+ G=0	0	0	0
Same day/day before hospital cancelled outpatients appointments	-	1.66%	1.87%	1.81%
RTT Incomplete pathways (national reporting)	92%	83.71%	84.99%	85.71%
RTT: Average Wait of All RTT Pathways		9.75	9.42	9.60
RTT number of incomplete pathways <18 weeks	-	4810	4778	4834
RTT number of incomplete pathways >18 weeks	-	935	842	806
RTT Incomplete pathways >52 weeks Validated	R - >0, G=0	13	16	25
RTT incomplete pathways >40 weeks validated	R - >0, G=0	76	84	93
Number of unknown RTT clock starts – Internal Ref	-	8	4	5
Number of unknown RTT clock starts – External Ref	-	314	310	356
RTT: Total number of incomplete pathways known/unknown - <18 weeks	-	5151	5110	5201
RTT: Total number of incomplete pathways known/unknown - >18 weeks	-	948	857	825

Effective & Productivity Hospital Metrics		Sep-19	Oct-19	Nov-19
Discharge summary 24 hours	R=<100% G=100%	66.34%	72.36%	69.37%
Clinic Letter– 7 working days	R=<100% G=100%	61.64%	75.86%	65.49%
Was Not Brought (DNA) rate		7.03%	6.10%	6.14%
Theatre Utilisation – Main Theatres	R<77% G>77%	Data under review		
Theatre Utilisation – Outside Theatres	R<77% G>77%			
Trust Beds	Bed Occupancy	Data under review		
	Beds available	396	396	396
	Avg. Ward beds closed	47	62	47
	ICU Beds Closed	6	7	5
Refused Admissions	Cardiac	1	0	3
	PICU/NICU	18	12	32
PICU Delayed Discharge	Internal 8-24 hours	1	0	3
	Internal 24h +	3	0	0
	External 8-24 hr	0	1	2
	External 24h+	1	0	3
	Total 8-24h	1	1	5
	Total 24h +	4	0	3
PICU Emergency Readmission <48h	-	1	0	2
Daycase Discharges	In Month	2,074	2,399	2,451
	YTD	12,689	15,088	17,539
Overnight Discharges	In Month	1,393	1,558	1,664
	YTD	8,572	10,130	11.794
Critical Care Beddays	In Month	1,296	1,163	999
	YTD	7,776	8,939	9.938
Bed Days >100 days	No of Patients	2	8	9
	No of Beddays	257	1,479	1,874
Outpatient attendances (All)	In Month	16,837	18,560	19,713
	YTD	105,005	123,565	143.278

Well Led Dashboard

Is our culture right for delivering high quality care?

	Target	September 2019	October 2019	November 2019
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	87%	76.1%	84.6%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G- 0	469*	457	159
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G- 0	3	8	7
Duty of Candour Cases	N/A	6	11	4
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%	66.6%	50%	100%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	66.6%	50%	100%
Duty of Candour - Stage 3 Total sent out in month	Volume	2	5	3
Duty of Candour – Stage 3 Total (%) sent out in month on time	R<50%, A 50-70%, G>70%	0%	60%	0%
Duty of Candour – Stage 3 Total overdue (cumulative)	G=0 R=1+	8	6	8
Policies (% in date)	R 0- 79%, A>80% G>90%	81%	83%	80%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	88%	90%	89%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	100%	100%	100%
Inquests currently open	Volume monitoring	5	5	6
Freedom to speak up cases	Volume monitoring	6	10	12
HR Whistleblowing - New	Volume monitoring	0	0	0
HR whistleblowing - Ongoing	12 month rolling	1	0	0
New Bullying and Harassment Cases (reported to HR)	Volume	0	0	0
	12 month rolling	2	2	2

Are we managing our data?

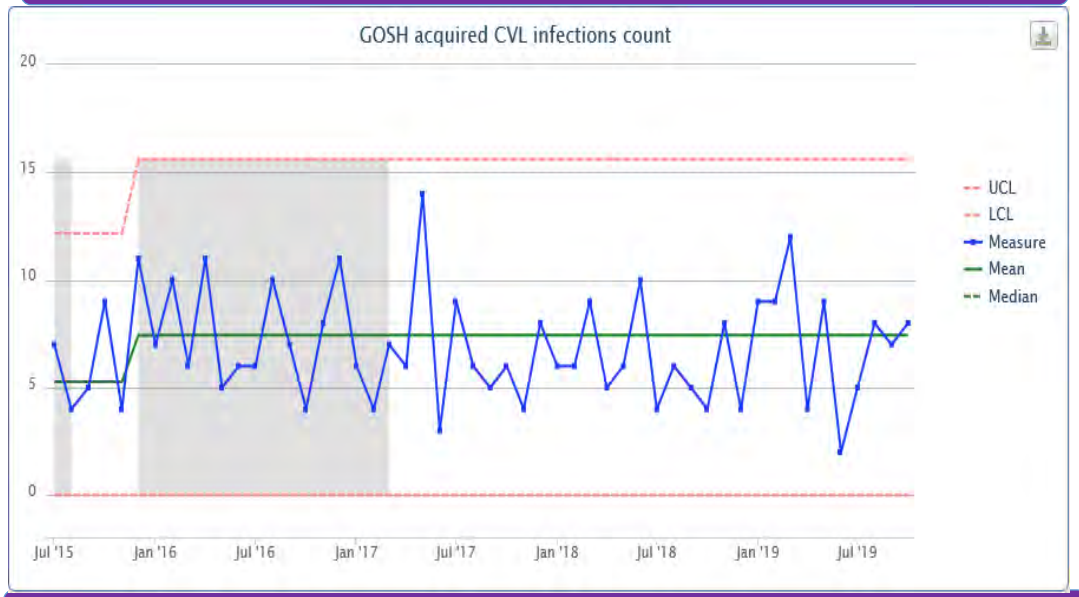
	Target	Sept 2019	Oct 2019	Nov 2019
FOI requests	Volume	54	52	52
FOI % responded to within timescale	R- <65% A – 65-80% G- >80%	100%	95%	100%*
FOI - Number requiring internal review	R>1 A=1 G=0	1	0	0
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	20	13	8
IG incidents reported to ICO	volume	0	1	1
SARS (Medical Record) Requests		141	141	132
SARS (Medical Record) processed within 30 days	R- <65% A – 65-80% G- >80%	100%	99.2%	97.7%
New e-SARS received	volume	0	3	1
No. e-SARS in progress		0	3	4
E-SARS released	volume	3	0	0
E-SARS released past 90 days	volume	0	0	0

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

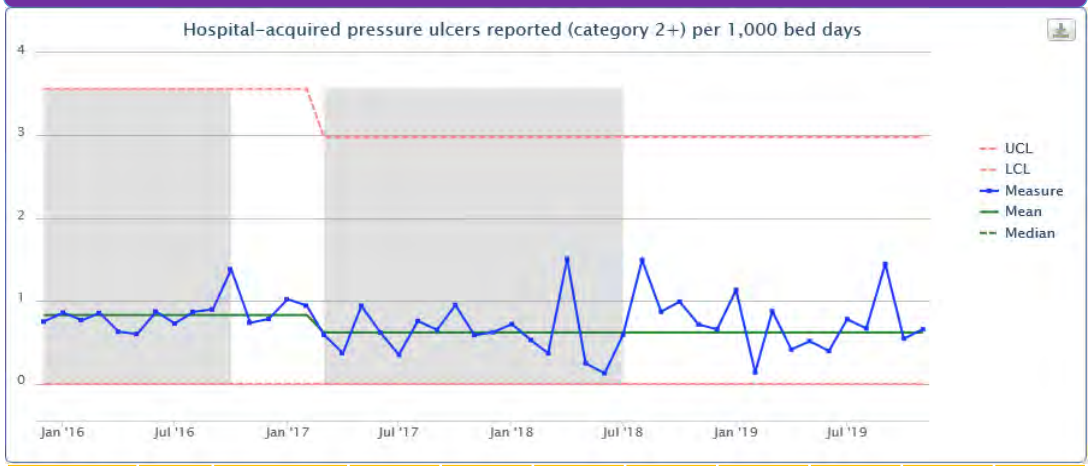
* FOI compliance: 26 were required to be completed within the month of November 2019. The remaining 26 status is as follows: 14 are currently being responded to and remain within the 20 day timeframe; 1 request has been sent requesting clarification; 4 responses are currently in draft and awaiting approval and 7 requests are pending by the FOI applicant (as per section 45)

Do we deliver harm free care to our patients?

CVL Infections



Pressure Ulcers

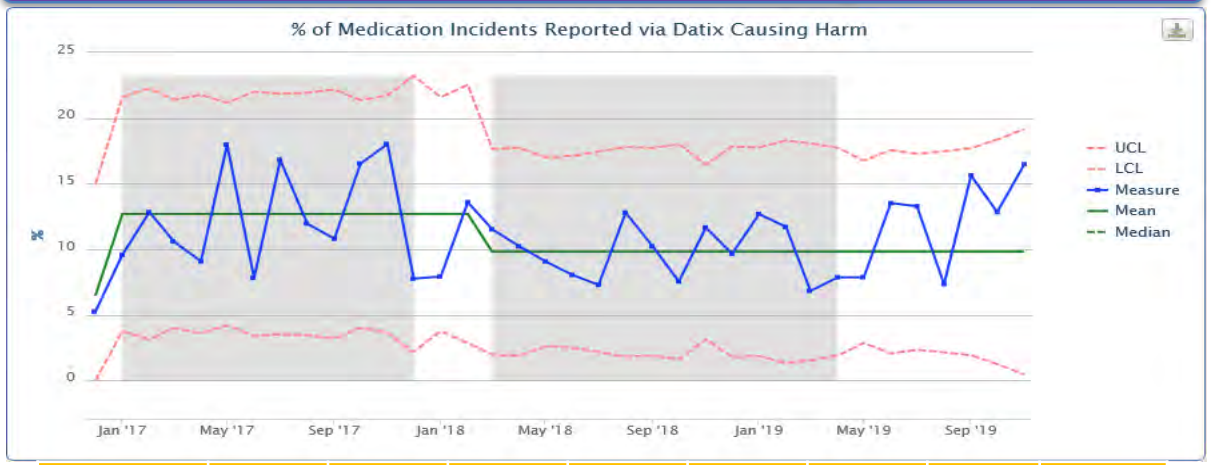


			April 19	May 19	Jun 19	July 19	August	Sept 19	Oct 19	Nov 19
Hospital Acquired Pressure Ulcer (2+)	Volume	R – 12+, A 6-11 G =0-5	3	4	3	6	5	11	4	5
	Rate	R=>3 G=<3	0.41	0.52	0.4	0.78	0.67	1.45	0.54	0.66

Infection Control Metrics

				2019
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	8	7	7
	YTD	43	50	57
C Difficile cases - Total	In month	0	0	2
	YTD	4	4	6
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	0	0	1
	YTD	2	2	3

Medication incidents causing harm

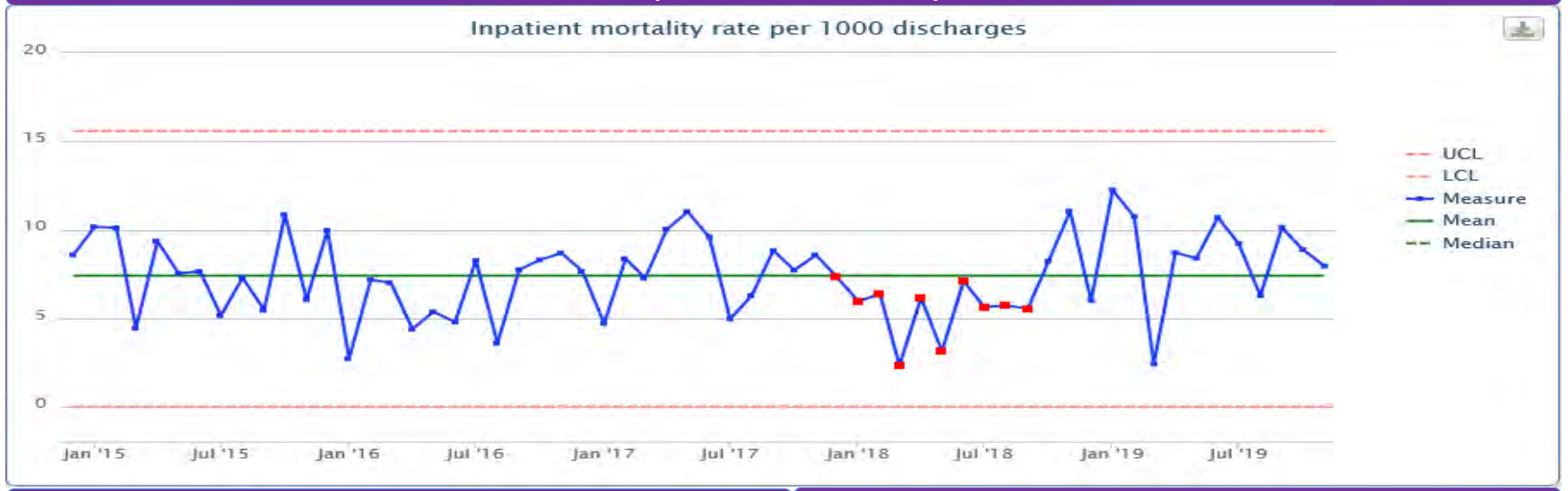


	April 19	May 19	Jun 19	July 19	August	Sept 19	Oct 19	Nov 19
% medication incidents causing harm	8%	8%	14%	13%	7%	16%	13%	16%

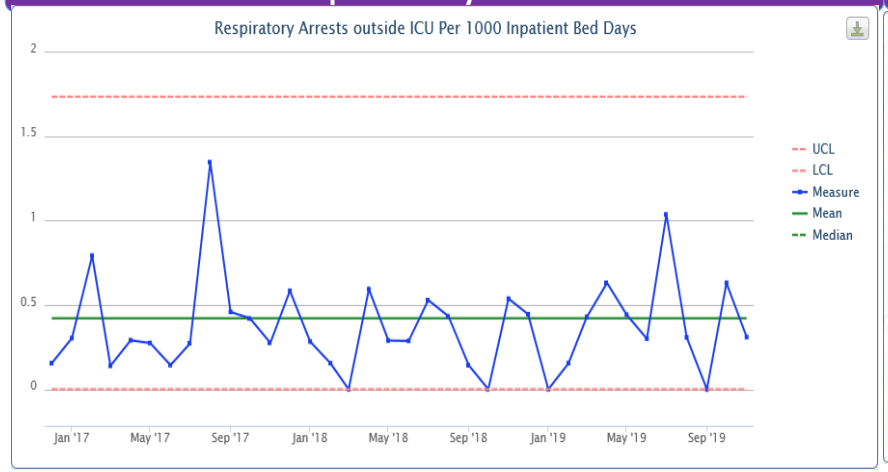
**The dashboard data continues to report on open and closed incidents. As stated in last month's report, the level of harm may not have been amended, pending the investigation. It should be noted that the definition of low harm includes events whereby an additional procedure, eg a blood test, is required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

Does our care provide the best possible outcomes for patients?

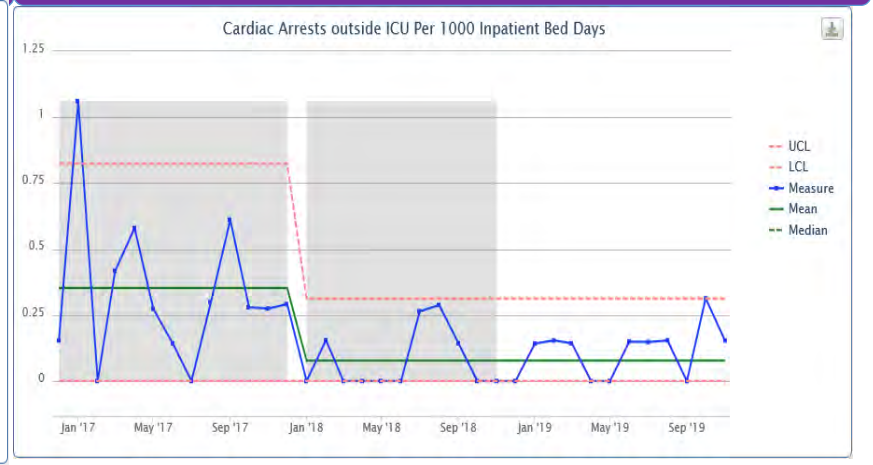
Inpatient mortality



Respiratory Arrests



Cardiac Arrests



No concerns noted in rates of respiratory and cardiac arrest based on current data.

In October 2019 PICANET advised that risk-adjusted resetting probability ratio test (RSPRT) reset points had occurred that suggested a higher PICU/NICU mortality rate than expected between the period 01/07/2018 to 30/06/2019. A full report outlining the response and actions taken was reviewed at PSOC on the 11th December 2019. The report concluded that the reason appears to be the death of patients with considerable comorbidities which are not reflected in the methodology used to measure how sick patients are on arrival to PICU/NICU. This has been fed back to PICANET to review and will be raised at the next PICANET Clinical Advisory Group in March 2020.

Well Led Overview

There were 4 cases identified within the month of November 2019, all of which achieved 100% compliance in terms of stage 1 and 2 of **duty of candour** (DoC). With regard to stage 3 compliance, with all incidents since April 2019 (n=45), 8 cases are overdue completion of the RCA reports in order to be shared with the patient/parent/carer. 3 local RCA reports were completed, approved and shared with the patient/parents/carers. A review of the 45 cases is underway in terms of sharing of the reports with the family, as compliance appears to have been miscalculated between the investigation report being completed (45 working days) and the requirement to share with the family at the very latest timeframe of 90 days. Updated/validated data will be included within the next report. In terms of RCA training, an external company is currently being sought to provide systems investigation training for all senior investigators within the Trust. This will enable us to undertake investigations as proposed in the recent National Patient Safety Strategy. This will focus on systems analysis and well the human factors elements.

High risk monthly review performance has increased with compliance at 84.6%. With the patient safety team now at full capacity, training and support of the non-clinical teams in terms of their risk upload and review compliance has commenced. There are 10 risks that were not reviewed within the timescale set as per Risk Strategy: 7 of which sit within the non=clinical areas. All bar 3 were only recently expired (<1-4 weeks). The four overdue (>3months) have been escalated for review (these relate to non-clinical issues). This continues to be monitored monthly.

A similar number of **FOI** requests for the month of November 2019 (n=52) when compared to the previous 2 months (n=54 and n=52). Of these, 26 have been closed within the allocated timescale. Of the remaining 26, 14 x requests are being processed within 20 working days (compliant); 1 x request for clarification sent to the FOI applicants (compliant); 4 x responses drafted/or approval pending (compliant); and 7 x requests pending validation by the FOI applicants (before processing) to comply with Section 45 (code of practice) within different deadlines up to 23/12/2019.

Safety Overview

The number of incidents being quality checked and closed within November 2019 had increased significantly to 720. Directorates have completed their investigations and are awaiting central review and closure. Work is ongoing to prioritise closure of the incidents that have had their investigations completed. The percentage of incidents being closed within 45 working days has increased slightly this month to 36%. The central team are continuing their aim to close a minimum of 150 incidents per week.. A weekly report will continue to be circulated in order to monitor progress.

There was 1 open SI investigation from September 2019 with 2 new SI's declared in November, so 3 SI's are currently in progress and are within the timescale for completion.

With regard to overdue SI actions, there are currently 167 open SI actions, of which 159 are overdue (cf 457 on previous month) . Assurance has been provided stating at the majority of remaining actions have been completed but have not yet been formally closed as collation of evidence is ongoing. Once uploaded/signposted, these outstanding actions will be closed. Work is ongoing. This will continue to be monitored monthly via PSOC and the MD & DCOS meetings.

There are currently 4 open CAS alerts in November 2019, one of which is overdue and awaiting a response/confirmation of action underway. All other alerts are within timescale. Details of these are provided later in the report.

Patient Experience Overview

- The number of formal complaints (n=2) was significantly lower than usual (based on the average of 6.83 per month over the last 12 months). This comes after much higher complaint numbers in September and October 2019. There is no apparent reason for this reduction and it is noted that there was also no significant change in patient activity this month.

- There was a slight decrease in Pals cases and a marked reduction in complex cases and in escalation to formal complaints. This reflects continued effective collaboration between specialties and the Pals team to facilitate prompt and effective resolutions for patients and families.

- The predominant theme of complaints and Pals cases again related to communication particularly when trying to reach teams or obtain information by telephone. A staff education day in December promoting MyGOSH and sharing good practice was well attended. Staff continue to encourage patients and families to sign up and use the communication portal and there are now around 8,100 registered MyGOSH users. Other actions to improve communication include a 'mystery caller' scheme which will be monitored and reported through PFEEC.

- The volume of FFT feedback reduced from 2191 in October to 1611 in November but the Trust met the response target of 25%. The launch of the ZCR contributed to higher FFT numbers in October and numbers of ZCR feedback increased further this month.

- The Outpatient recommendation rate (91%) fell to its lowest since April/ May 2019 with comments made about waiting times, appointment changes, the temperature and availability of toys in some areas and confidential questions being asked in public areas. Negative comments about Falcon related to poor signage, a closed coffee shop and lack of a play room.

- IPP's complaint rate by patient activity reduced this month and the directorate achieved a 35% FFT response rate. Although the FFT inpatient recommendation rate increased slightly from 79% to 85% in November, it did not meet the Trust target of 95% and comments related to the hospital/ ward environment, nursing care and coordination of care.

- Overdue red complaint actions slightly decreased this month to 7 and are being monitored through PFEEC and Closing the Loop. Some actions have remained open pending additional assurance around the effectiveness of these changes, which includes audit and further monitoring.

- There were no new reopened complaints in November but the overall percentage in a 12 month rolling period increased. Revised criteria for reopened complaints will be reviewed at PFEEC in January 2020.

Emerging trends in Patient Safety

Radiopharmaceuticals

- There have been a large number of concerns raised by the Radiology & Interventional Radiology services around supply of radiopharmaceuticals to the Trust and this has been reflected in a number of incident reports (3 – but covering several linked incidents). Some key issues are mislabelling of products, delays in quality testing of products, products delivered off-schedule and poor communication. The service are addressing these issues directly with the supplier. Meetings have been arranged with key members of the Trust executive team. Alternative suppliers are being investigated. This has been raised via the Operations and Images RAG committee and a risk recorded via the risk register with a current risk rating of 9 (moderate). This continues to be monitored as per Risk Strategy.

Bed Bugs

- There was an outbreak of bed bugs reported at the end of October 2019 on Sky Ward and Ocean Theatres which caused severe disruption to staff, patients and families. Sky Ward was shut, temporarily reopened and then shut again. A plan has been made with a pest control company to ensure all bed bugs are removed. A serious incident was declared on 26 November 2019 to look into the incident and identify key learning. There have been a number of ramifications including financial, reduction of lists, cancelations, removal and destruction of medications and stock. An increase in informal complaints with the ward and via Pals. The planned re-opening of 8 planned beds have been delayed for 8 weeks. The increase in stress on the ward has contributed to a dip in morale.

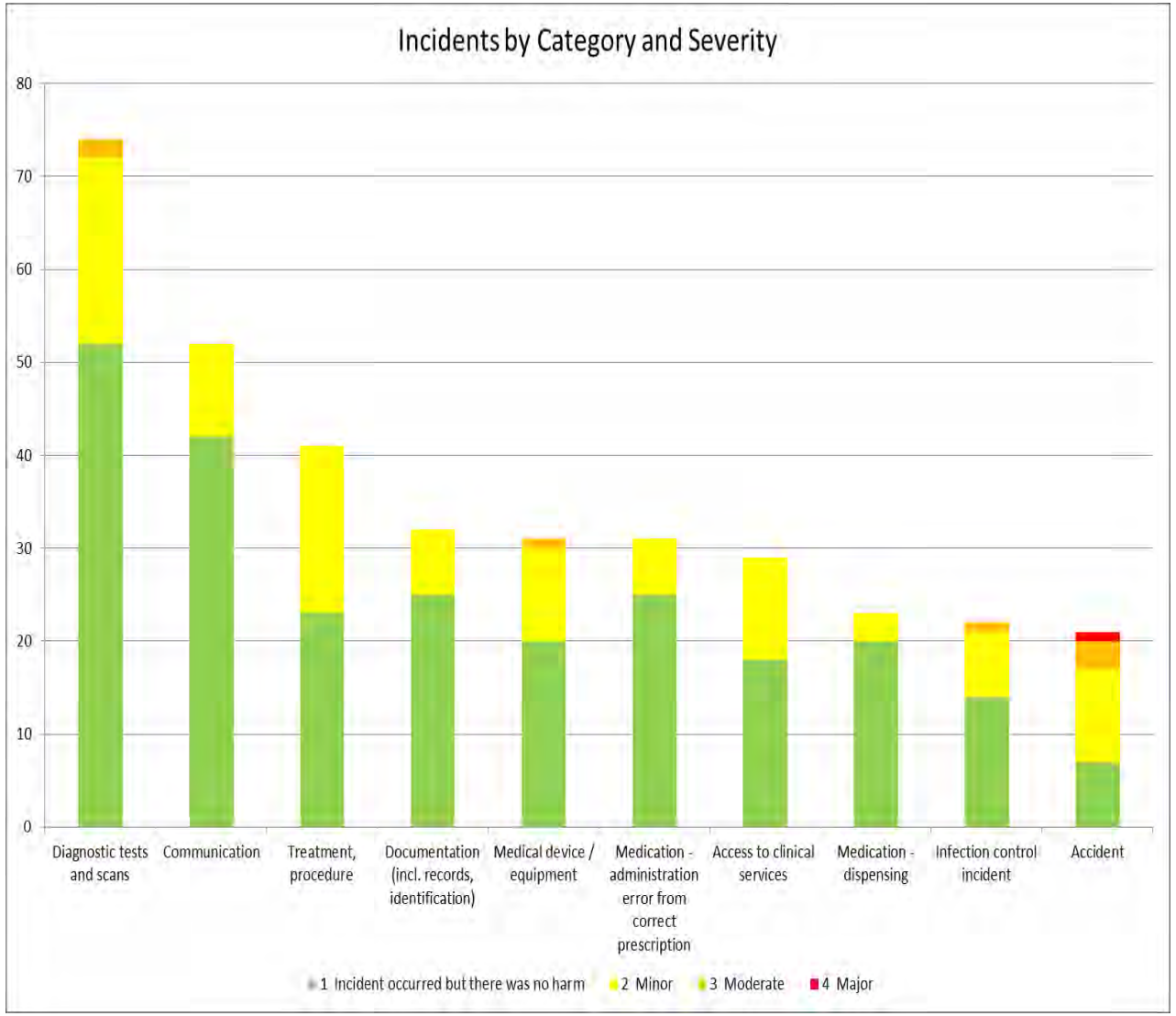
Patient Transport

- There were 6 incidents last month relating to differing issues related to patient transport within 50 miles. These included unsuitable vehicle to transfer neonates; delays in transporting patients from home in order to attend appointments as well as delays in picking up patients following discharge. This has been escalated to the external provider as such provision is under contract. A meeting was held with the COO and the Trust Head of Finance; Estates & Facilities as well as Security. The plan is provision of a dedicated night duty crew for the Trust to commence at 18.00hrs. The start date will be confirmed on Wednesday 18th December 2019 following which a further meeting with the COO and the regional manager of the external company is scheduled. In liaison with the PALS team, there were no increases in concerns around patient transport observed within the PALS team for this timeframe

Upcoming Inquests

Reference	Date of Inquest	Brief Description	Linked Complaint or Serious incident?	Potential Risks	Assessment of preparedness	GOSH witnesses called
13106/LK/FO	02/12/19	Born with complex cardiac issues; operated on at GOSH. Following a heart transplant at GOSH suffered neurological complications and renal dysfunction. Decision to move to palliative care.	No There are 4 incidents relating to admission but these are graded as No Harm.	None apparent at present.	On track.	1
00168-2019/NB	23/12/19	Child died while on clinical trial.	Yes – 2 incident forms relating to patients outpatient deterioration and admission to PICU. Clinical Trial SUSAR, but no GOSH investigation.	Clinical trial	Statements all submitted, on track.	1
01858-18/MD	31/03/20 and 01/04/20	Diagnosis of Rett syndrome. Previously a GOSH patient; transferred to Kings College Hospital. LA issued care proceedings in 2018 over concerns parents were not complying with care plans and were obstructing her care.	Multiple PALS contacts and several historic incidents graded minor/no harm.	Publicity likely, following family engagement with press during their child's lifetime. Parents instructed same solicitors in care proceedings as CG's parents used in High Court.	On track.	2
13438/2019/AS	18/02/20	Child was tracheostomy ventilated; trachy displaced at home and carer was unable to replace leading to hypoxic cardiac arrest. Parental concerns concerning the training of the carers supplied in the community and their ability to look after children with a tracheostomy. Police not investigating, we are advised that the Nurse was referred to NMC.	No	Low risk for GOSH – home care nurse not provided by nor trained by GOSH. Possible publicity – due to family's concerns about care company provision at home (not to do with GOSH care).	Tight time frame for statements. Three requested, due date extended to 19/12/19	Unknown - TBC.
Ref?/19/OG	TBA	Previously well 10 m/o old baby transferred to GOSH after out of hospital cardiac arrest. It was clear that baby suffered irreversible, catastrophic brain injury and intensive care was withdrawn after discussion with parents. Reason for Referral: the cause of death is unknown	No There are 3 incidents relating to admission, graded as low, or moderate (but did not contribute to death).	None apparent at present.	Tight time frame for statements – one in draft form, due date extended to 09/12/19.	Unknown - TBC.
1975/19/SA	13/03/2020	Baby girl transferred to GOSH from Malta at about a week old. She had very complex cardiac anatomy and other more minor congenital abnormalities. She had a very difficult intensive care course with three major cardiac operations, a long run on extra-corporeal life support, and she suffered two cardiac arrests. Intensive care was withdrawn after it was established that she had suffered a catastrophic and irrecoverable ischaemic brain injury.	Several incidents. One relates to extravasation injury due to the PICC line used for TPN, graded moderate harm and DoC started..	Clinical risk Low risk of publicity expected.	On track, two statements due on 10/01/20	Unknown - TBC.

Understanding incidents



This month the "**diagnostic tests and scans**" category remained the highest in the Trust reflecting the ongoing issues with delays/increased pressures in labs (discussed in last month's IQPR). It should be noted however that the numbers are slightly reduced when compared to the October data. Issues raised continue to be monitored weekly via the Executive Committee with the aim that the backlogs will be cleared by April 2020. There continues to be ongoing work with support from the QI team around duplication of test requests and unnecessary test requests which will impact on the workload currently experienced.

Communication remained our second highest incident category. Communication covers both intra and inter team communication, as well as communication with parents. As a Trust communication issues form a very large proportion of incidents relative to other specialist centres. A number of these reported incidents reflect issues with sight of internal referrals; sight of external referrals/comms from external care providers as well as communications from parents/carers. Currently work is ongoing within EPIC to increase visibility and improve functionality via EPIC messaging and providing an improved link for external providers.

With regard to the broad category of **"Accident"** the reported incidents cover slips, trips and falls, inappropriate positioning of patient, collision /contact with an object and contact with sharps. There is no trend identified related to any one particular area or person. For noting, work is commencing around a review of categorisation and sub-categorisation of incidents to ensure that incidents are reported correctly and more specifically which will allow for improved review of trends and themes.

Patient Safety Alerts

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

Date issued: 12/07/2019

Date due: 31/10/2019

Update: Awaiting update from estates

EFA 2019/005: Issues Concerning Doorstops/Door Buffers

Issued 31/10/2019

Date Due: 31/10/2021

Awaiting confirmation of action underway from Estates.

MDA 2019/040: Alaris Gateway Workstation and Alaris Gateway Workstation web browser interface software update

Date Issued: 27/11/2019

Date Due: **27/12/2019**

Update: currently in communication with BME with regard to this software update

NatPSA 2019/001/NHSPS: Depleted batteries in intraosseous injectors

Date Issued: 05/11/2019

Date Due: 05/05/2020

Update: action underway. Replacement batteries on order.

Patient Safety – Serious Incident Summary

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

2019/22539 ICO Breach Incident

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

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

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

Learning from Serious Incidents: 2019/3785

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

Recommendations:

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

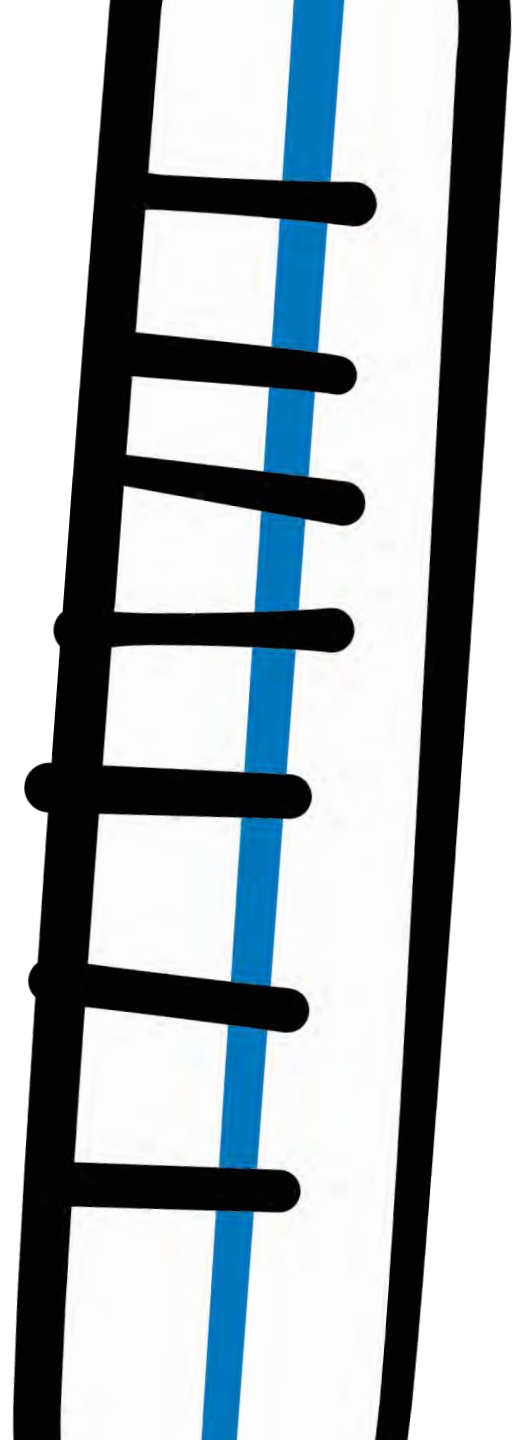
Clinical Audit – current work plan

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

Audit	Why are we doing this audit?	Status
Controlled Drugs documentation and storage (re-audit)	Audit completed in July 2019 highlighted areas for improvement. This audit will help us assess if the actions that have been implemented have resulted in an improvement.	Data collection is due to be completed in December, and will be reported in January 2020
Review of compliance with Mental Capacity Act for procedures (re-audit)	To review our progress with ensuring that mental capacity act assessments are taken where necessary as part of our consent process.	Data collection is underway. Planned date for report is February 2020
Learning from complaint (18/093)	To determine if we have changed our practice on PICU for documenting updates given to families, as recommended following a complaint.,	Completed in December 2019. The complaint action plan committed to a specific change of practice to document the update given to the patient's family in the evening PICU ward round. This change was evident in 35% of admission days reviewed in the audit. The limiting factor to meeting this was the availability of devices to document ward round. Actions have been agreed and a re-audit will take place in February 2020 to assess progress.

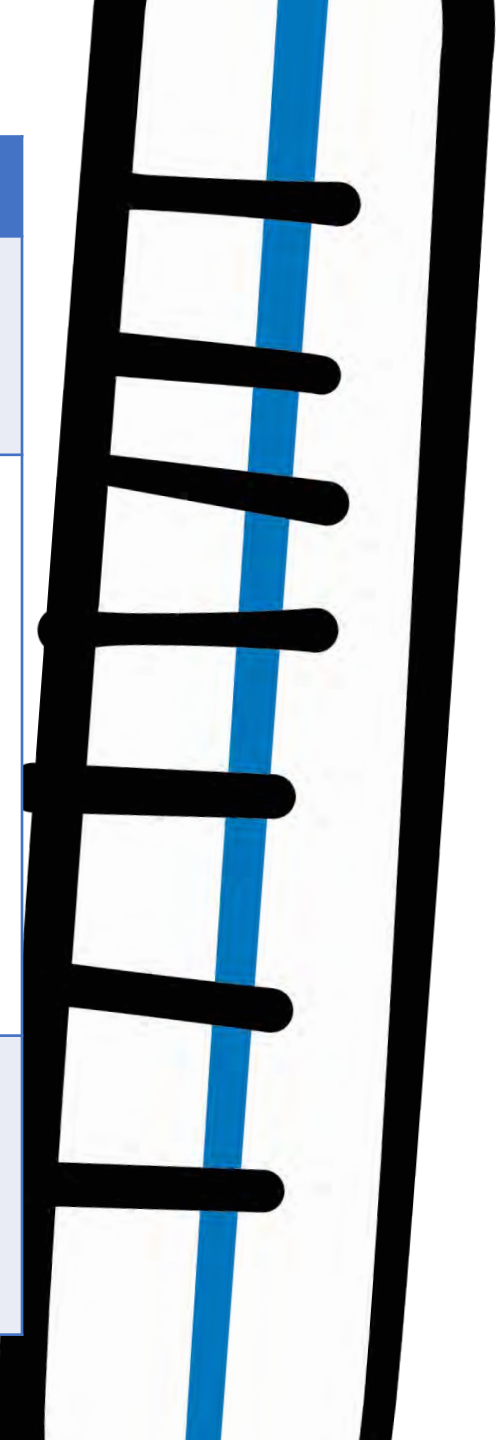
Clinical Audit – current work plan

Audit	Why are we doing this audit?	Status
Safeguarding –survey on learning from Serious Case Reviews	Review our awareness of some of the key learning from recent serious case reviews that GOSH have been involved with	Data analysis and report in progress.
Learning from incidents -CVL insertion in Interventional Radiology	7 MSSA infections following CVL insertions placed in Interventional Radiology have been reviewed as root cause analyses since June 2018. It has therefore been recommended by Infection Control that an audit of best practice to minimise the risk of infection pre, during, and post CVL insertion takes place	Data collection in progress.
Learning from incidents- ECHO machines audit	The audit determines whether key processes to minimise risk of infection associated with ECHO machine are being followed. This is following learning from a MRSA outbreak within cardiac services between Feb and June 2019.	The audit has been completed and reported to the Heart and Lung Infection Prevention and Control Committee. The learning from the MRSA outbreak around the adequacy of cleaning of ECHO machines has not been implemented. An action plan to improve this is being overseen by the Assistant Chief Nurse for Heart and Lung. This will be re-audited in January 2020.
Monitoring of Fridge temperatures	Learning from quality rounds highlighted that there could be clearer processes around the monitoring of fridges and freezers in clinical areas. This audit helps assess whether a new policy to support this has been implemented.	Reported to the November 2019 PSOC It was recommended in the audit and agreed at PSOC, that the policy would be updated to clarify what the processes is for documenting fridge and freezer temperature checks at weekends.
Actions from SI 2017/13562 Retained foreign object in theatres	To check if we have implemented changes to minimise the risk of an incident. The audit applies to the surgical count process for cases where metallic reduction heads attached to screws are used.	Audit plan agreed with Spinal Team Leader .Data collection to take place when relevant cases meeting the inclusion criteria occur.



Clinical Audit – current work plan

Audit	Why are we doing this audit?	Status
Bereavement Survey	To review and act on feedback received from families whose child died at GOSH in 2018. Clinical Audit are providing support to Bereavement Services to undertake this work.	This is planned to be reported to PFEEC in February 2020
Learning from an inquest- GOSH MDT meetings	Learning from an inquest has highlighted the need to ensure appropriate attendance and documentation at GOSH multidisciplinary team (MDT) meetings. Standard terms of reference are being introduced for MDTs to support best practice and ensure that appropriate attendance and clear decision making is recorded. This audit assesses current practice and provides a baseline assessment by which future improvements will be measured	This audit has provided a baseline measure of performance against key standards outlined in the new GOSH Multidisciplinary Team (MDT) Meetings Terms of Reference. It has shown areas for improvement, particularly around confirming who is attending meetings. This in advance of work that is planned to take place to ensure that all MDTs practice in aligned to the Trust Multidisciplinary Team (MDT) Meetings Terms of Reference. The audit and recommendations are to be presented to PSOC in December 2019
Lessons Learned audit plan–Potential missed diagnosis of bowel obstruction(SI2019/442	To check if a recommendation from an SI has been implemented. The audit looked at whether body maps are being reviewed at the Motility MDT meeting.	The audit has been completed and will be reported to Closing the Loop on the 11th December. The audit highlights that the actions required from the SI have been completed



Quality Improvement

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

1. Mentoring QI Projects

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

Project Commenced	Area of work	Project lead:	Expected completion date
Dec 2018	**Improve handover** quality and continuity of care for outlying patients in the cardiology service	Craig Laurence (Cardiac Fellow)	Nov 2019 (Delay due to Project Lead capacity – relaunch Dec 19)
Jun 2019	To reduce the number of **unnecessary blood tests**, when ordered in sets/ bundles, in Brain Division	Spyros Bastios (Metabolic Consultant)	April 2020
Aug 2019	To **improve patient satisfaction of the consenting process** in cardiac anaesthesia	Marc Cohen	Aug 2020
Sept 2019	To provide **daily debrief sessions** to staff on the renal unit to **improve moral and reduce stress**	Sarah Owens	Dec 2019 (Project complete- post project review in Jan 20)
Nov 2019	To **reduce unnecessary fasting** of patients re-procedure on Safari Ward	Elena Stanton (Trainee-Anaesthetics)	Feb 2020
Nov 2019	To ensure all **Haem/Onc TTO medication** is ready at time of planned discharge	Anupama Rao (Consultant, Haematology/Oncology)	April 2020
Oct 2019	To **reduce unnecessary blood sampling** post-operative neurosurgical HDU patients	Orla Hayes (Staff Nurse)	June 2020 (No longer requiring support)

2. Local / Directorate QI Projects

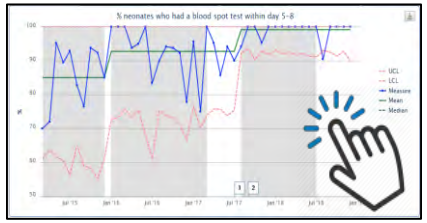
The QI Team also provides QI support and expertise to local or divisional improvement work. The following graphics, maps where registered QI activity is taking place across the Trust:

Project Commenced	Area of work	Project lead:	Expected completion date
Dec 2018	To improve IR theatre utilisation by implementing **ZAPPP** (zero acceptance of poor patient preparation) policy	Sam Chippington (IR Cons)	Currently paused due to IR Team capacity.
May 2019	Supporting the development of a joined up, pan-trust approach to the **management of acute gastro-intestinal haemorrhage** for inpatients	Sian Pincott (DCOS-BBM)	Aug 2019
Sept 2019	To reduce variation in the pre-op processes undertaken by **Orthopaedic CNS service**	Claire Waller (Matron)	Feb 2020 (project timeframe adjusted due to widened scope)
Oct 2019	To implement a **nursing PGD in Haem/Onc** to **reduce unnecessary delays in administering Pip/Taz** to patients developing sepsis	Vicki Villalobos- Lopez (Practice Educator)	Jan 2020
Oct 2019	To improve staff satisfaction through redesign of the **Palliative Care on-call service**	Julie Bayliss (Clinical Lead)	April 2020

Activity Commenced	QI Activity (Ad-hoc teaching/facilitation)	Project lead:	Expected completion date
Dec 2019	Facilitate process mapping of speech and language referral pathways	Chantelle Sculfor (Service Manager)	Dec 2019
Dec 2019	Facilitate study day for all Practice Educators to build QI capability	Cross- divisions: Practice Educator Team	Dec 2019

3. Trust wide QI Projects

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



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

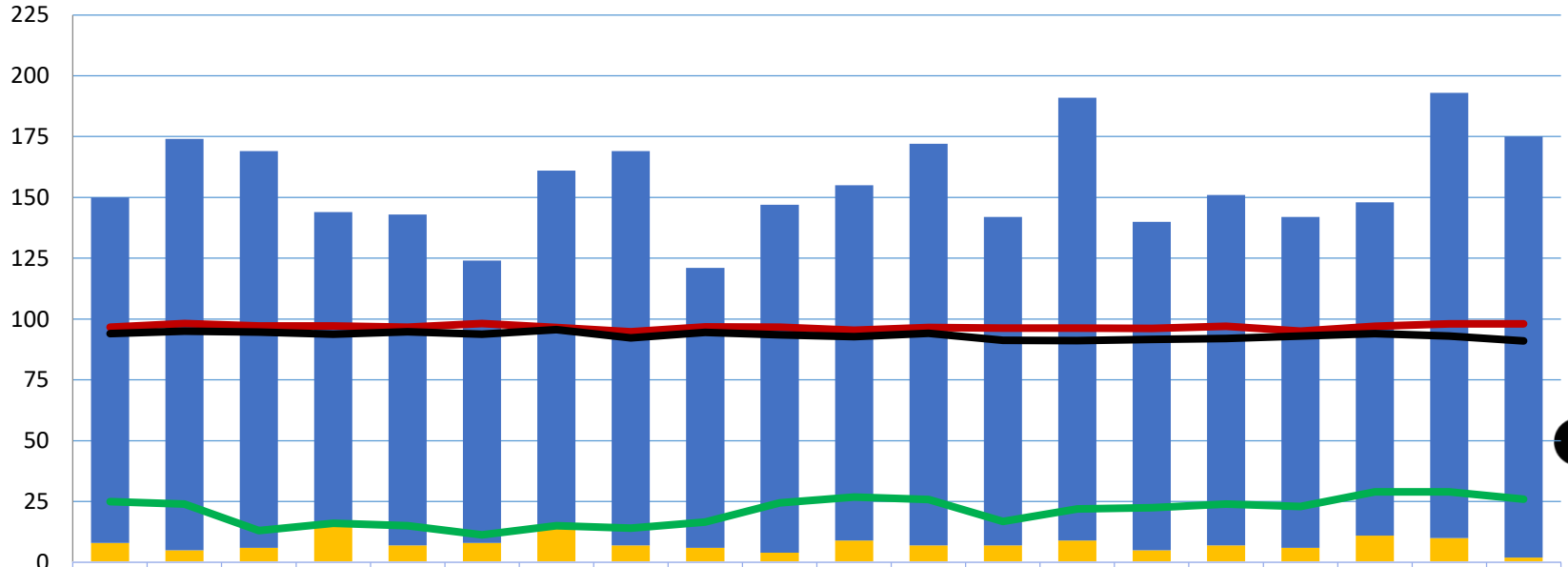
Project Commenced	Area of work	Project Lead (PL) Exec Sponsor (ES)	Expected completion date
Oct 2019	Supporting the **medication safety work stream** of the Hospital Pharmacy Transformation Programme Board (HPTPB): **Uncollected Medications**	PL: Stephen Tomlin ES: Andrew Taylor	April 2020
Jun 2019	Improving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

**Click links to open project dashboard*

Patient Experience Overview

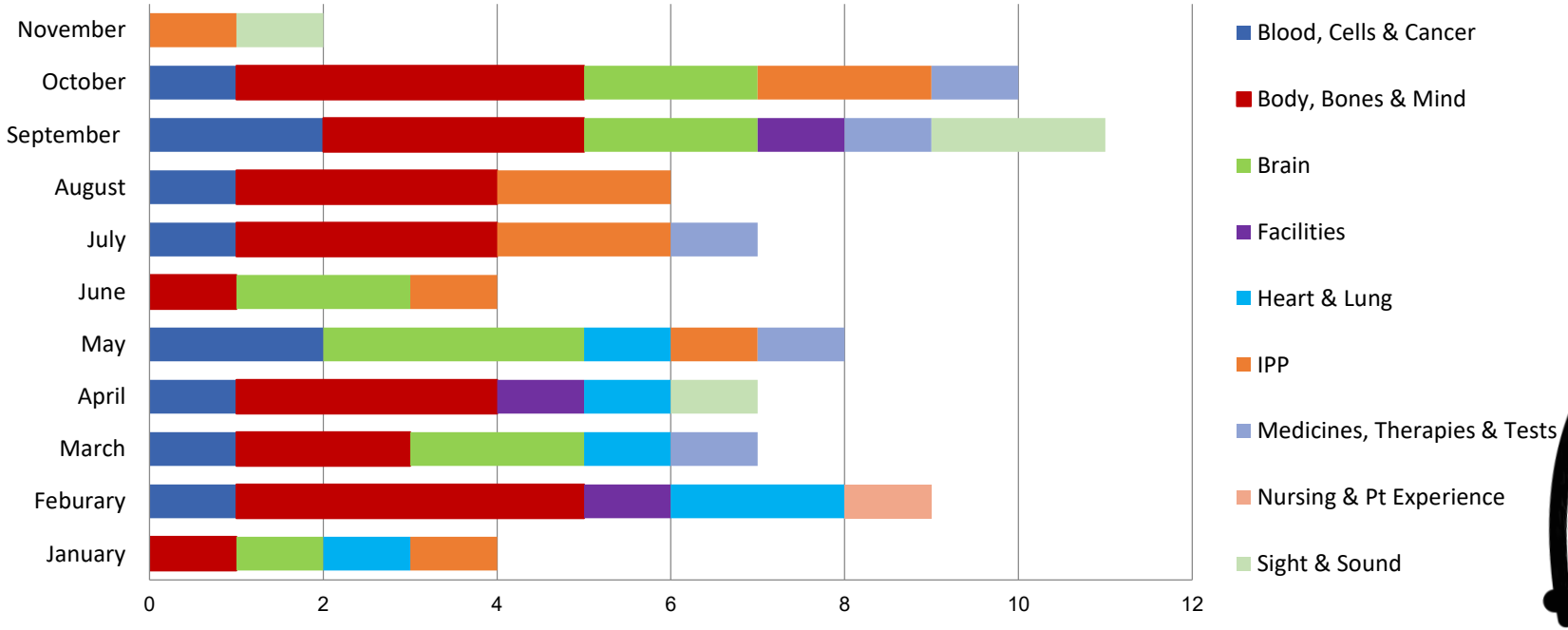
Are we responding and improving?

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



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
PALS	142	169	163	129	136	116	146	162	115	143	146	165	135	182	135	144	136	137	183	173
Formal Complaints	8	5	6	15	7	8	15	7	6	4	9	7	7	9	5	7	6	11	10	2
FFT recommendation rate - Inpatients %	97	98	97	97	97	98	97	95	97	97	95	97	96	96	96	97	95	97	98	98
FFT recommendation rate - Outpatients %	94	95	95	94	95	94	96	92	95	94	93	94	91	91	92	92	93	94	93	91
FFT % response rate	25	24	13	16	15	11	15	14	17	25	27	26	17	22	22	24	23	29	29	26

Complaints: Are we responding and improving?

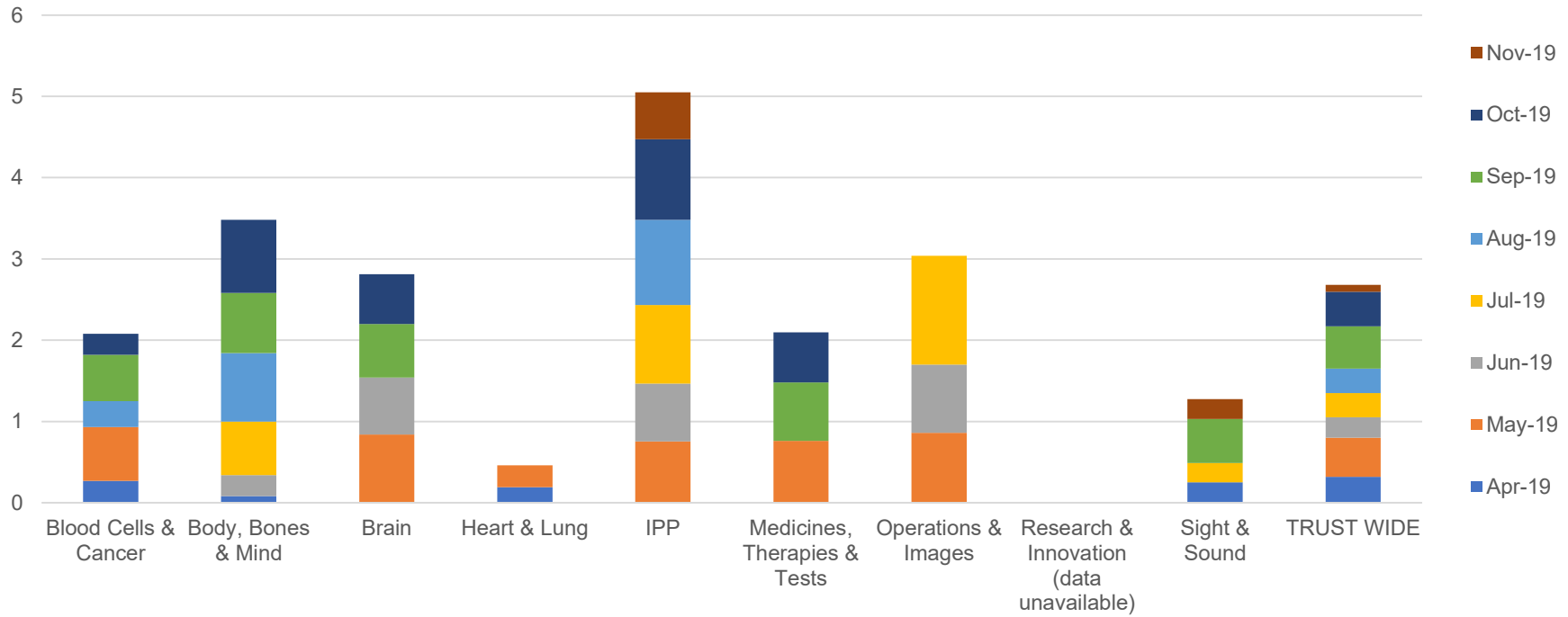


There were two new formal complaints received in November 2019 which is much lower than the average of 6.83 complaints (based on the last 12 months YTD) and complaints received in October (n=10). This was also reflected in complaint numbers for the same period in 2018, although the decrease (from 15 in October 2018 to 7 in November 2018) was not as significant. A reason for the decrease has not been identified but will continued to be monitored.

Within complaints this month families reported concerns regarding:

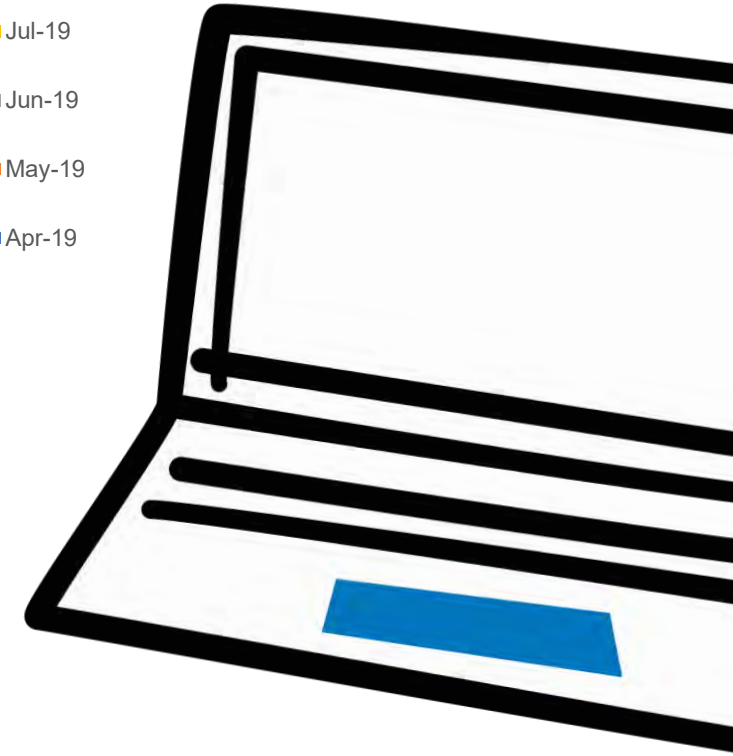
- A lack of communication from a medical secretary. This included concerns regarding emails and phone calls not being responded to.
- The behaviour and email communication from a consultant which the parents found 'rude' and 'insensitive'.

Complaints by patient activity*

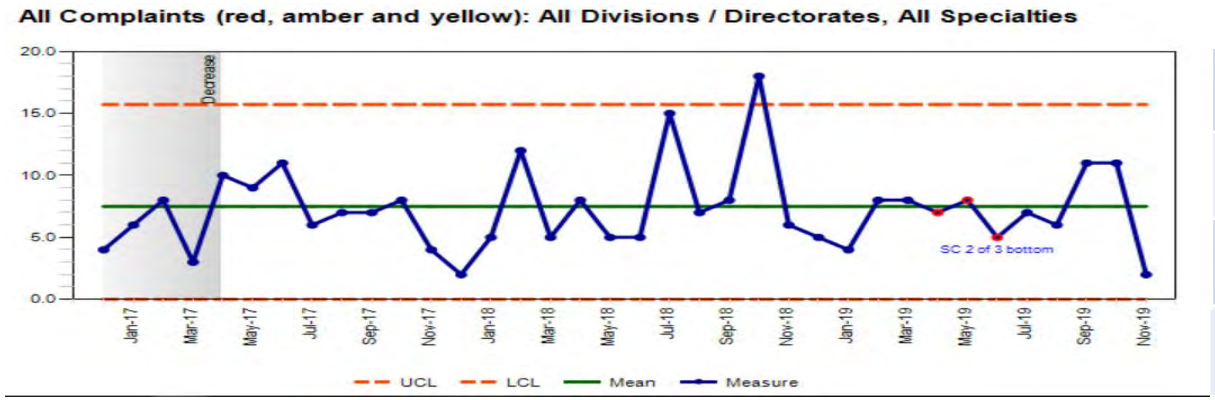


**Combined patient activity (CPE) = the number of inpatient episodes + the number of outpatient appointments attended*

In line with very low numbers of complaints in November, the complaint by patient activity rate across the Trust decreased significantly in November at 0.08 per 1,000 CPE (previously 0.42). With the exception of Sight and Sound at 0.24 complaints per 1,000 CPE, complaints by patient activity decreased across all directorates.



Red Complaints: Are we responding and improving?



No of new red complaints this financial year 2019/20:	3
New Red complaints opened in November 2019	0
No of re-opened red complaints this year 2019/20:	1
Open red complaints (new and reopened) as at 08/12/2019:	0

Recently closed red complaint

Ref	Due Date	Divisions Involved	Background	Next Steps:
19/046	20/11/19	CAMHS	Information governance breach- report containing highly sensitive information was sent to the wrong address. Investigated as a Serious Incident.	Investigation completed and response sent. The action plan will be followed up and reviewed at Closing the Loop Group.

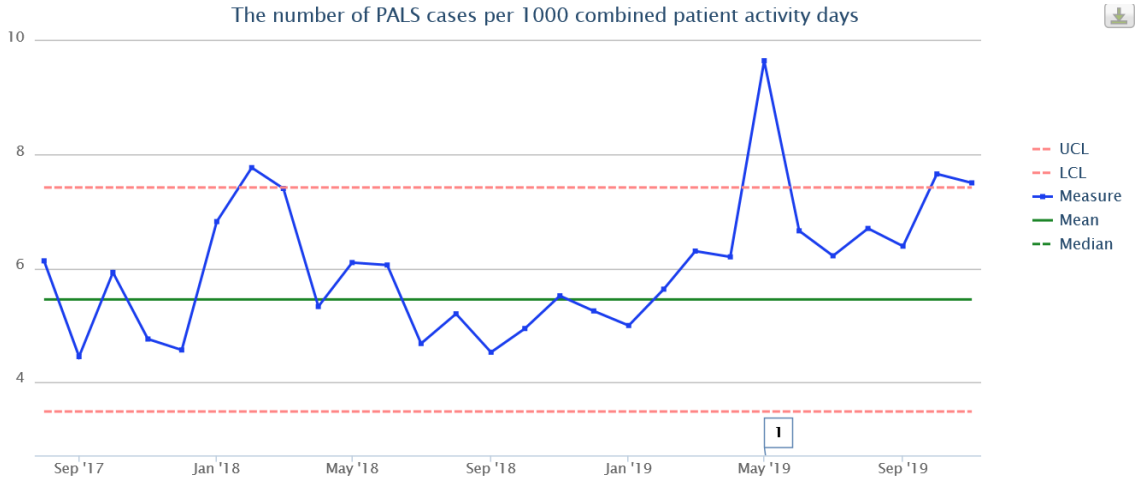
Recently closed reopened red complaint

Ref	Reopened Date	Divisions Involved	Background	Next Steps:
*18/081	17/06/19	IPP	Parents are concerned that there was a delay in identifying sepsis . Investigation concluded patient's presentation was complex/ unusual and sepsis protocol was followed appropriately.	A meeting with the parents and Sepsis Lead has now taken place. The complaint has been closed.

There are seven overdue Red Complaint actions. One outstanding action for 18/056 has been updated following inquest and is being monitored via QSEAC. Complaint 19/010 has four outstanding actions regarding processes for management of IPP patients and escalation and was discussed at Closing the Loop in December. 18/095 has one outstanding action with a third party provider. 19/003 is now overdue as a guideline for the use of pacifiers requires completion. This is being followed up at the next Closing the Loop meeting.

Pals – Are we responding and improving?

Cases – Month	11/18	10/19	11/19
Promptly resolved (24-48 hour resolution)	148	144	161
Complex cases (multiple questions, 48 hour+ resolution)	12	36	10
Escalated to formal complaints	0	1	0
Compliments about specialities	3	2	2
*Special cases (e.g. large volume of contact following media interest)	0	0	0
Total	**163**	**183**	**173**
Themes for the top six specialties			
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families, transport)	52	65	54
Admission / Discharge / Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation; waiting times to hear about admissions; lack of communication with families, Accommodation)	17	4	9
Staff attitude (Rude staff, poor communication with parents, not listening to parents, care advice)	10	15	5
Outpatient (Cancellation; Failure to arrange appointment; poor communication, franking of letters)	44	50	47
Transport (Eligibility, delay in providing transport, failure to provide transport)	11	9	10
Information (GOSH information, Health information, care advice, advice NHS, access to medical records, incorrect records, missing records, support/listening)	29	40	45

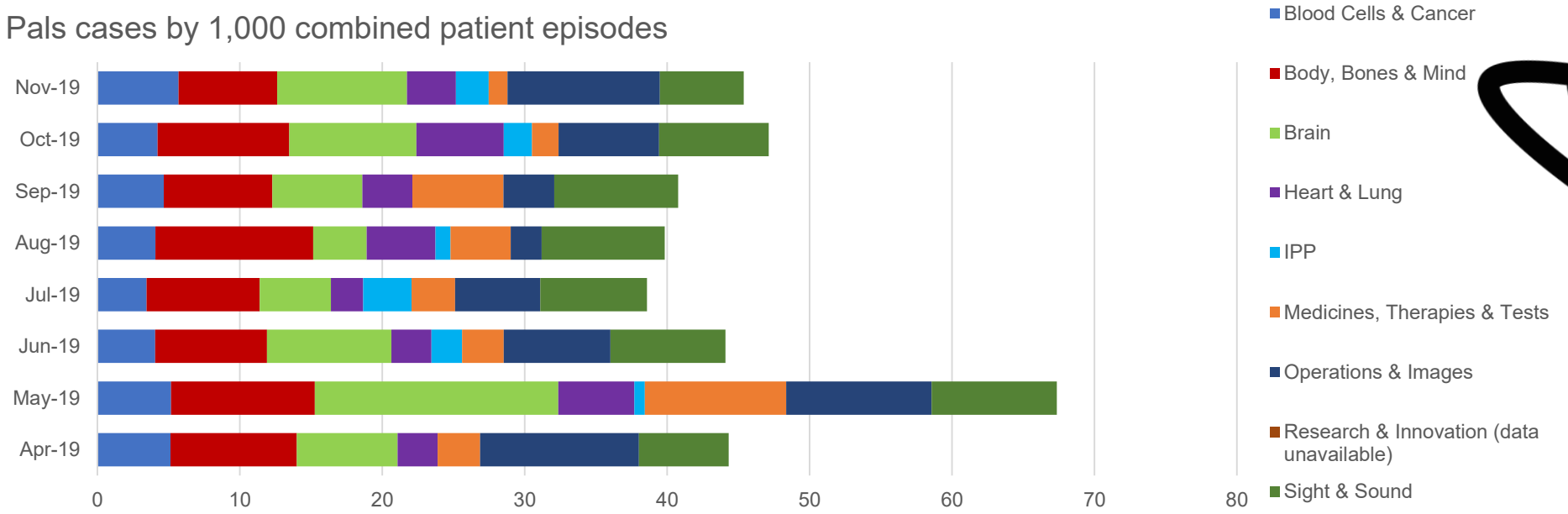


There has been a slight decrease in Pals cases for November 2019 (173) in comparison to the preceding month October (183).

The percentage of complex cases received has also reduced with approximately 19% of cases received in October being complex in comparison with 5% being classed as complex in November. This could be in response to increased productivity within the Pals team related to additional staff recruitment.

There is a notable drop in the volume of cases received regarding poor staff attitude. In October 8.1% of all Pals cases were related to negative staff behaviour but in November this figure has dropped to 2.9%.

Pals cases by directorate



Pals case numbers

	Blood Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	IPP	Medicines, Therapies & Tests	Operations & Images	Research & Innovation	Sight & Sound
Apr-19	19	33	20	15	0	4	8	0	25
May-19	16	36	41	20	1	13	12	1	30
Jun-19	13	30	25	11	3	4	9	0	30
Jul-19	13	36	17	10	7	5	9	0	31
Aug-19	13	34	10	18	2	6	3	0	34
Sep-19	16	31	19	15	0	9	5	0	32
Oct-19	16	41	29	25	4	3	11	2	36
Nov 19	21	32	30	15	4	2	17	0	24

With the exception of BCC, Brain and Operations and Images, all directorates received lower Pals cases.

Operations and Images received their highest number of cases since May 2019. The November cases by patient activity reached 10.69 per 1,000 CPE

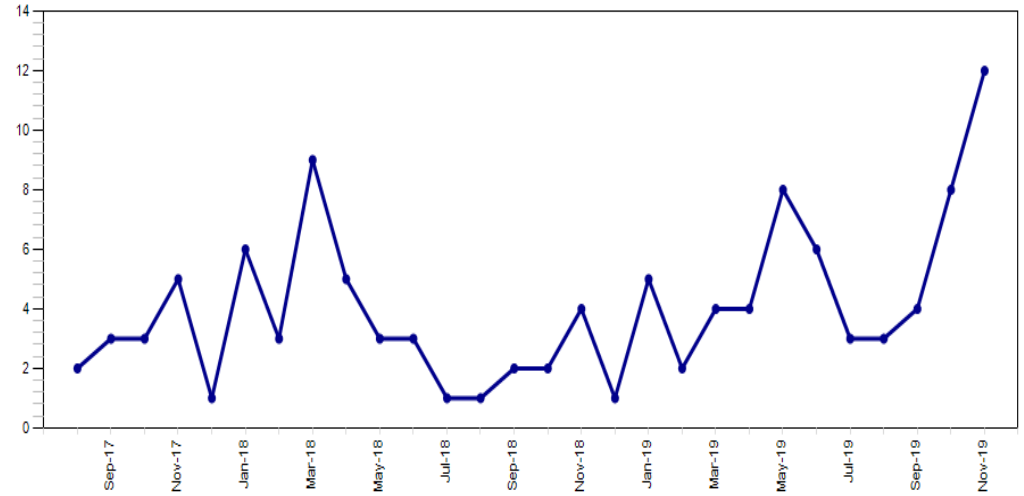
Pals – Are we responding and improving?

Top specialities - Month	11/18	10/19	11/19
Radiology	4	8	13
Gastroenterology	9	15	11
Neurology	5	12	10
Spinal	4	3	7
Facilities	2	2	7

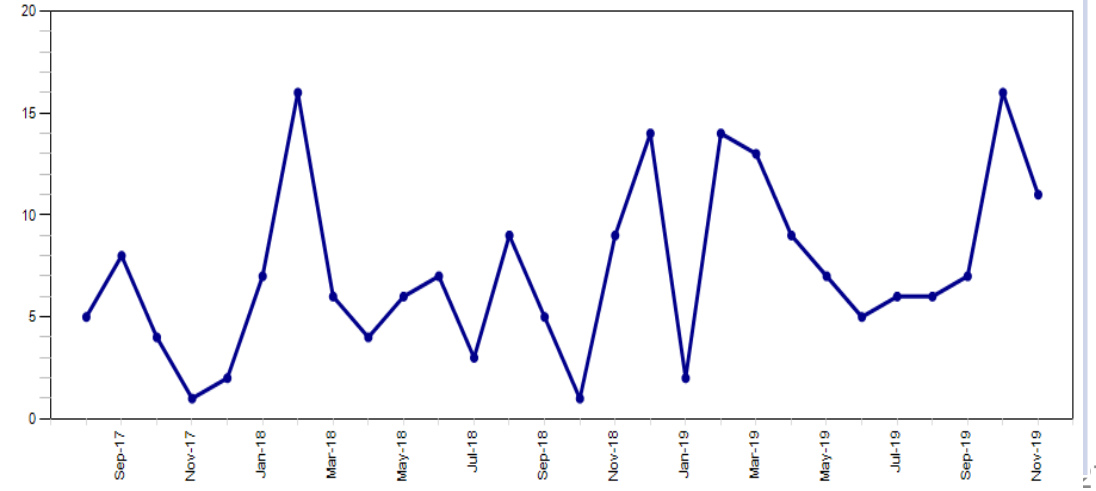
Radiology- Pals cases increased in November 2019 (13) in comparison to the preceding month October (8) and November 2018 (4). The two common themes for Radiology this month centred around lack of communication between parents/patients with a particular focus on the inability to contact the department by telephone This has been raised with the Service Managers who are working with the administrative teams to resolve these issues. A new permanent staff member has recently been recruited to the admin team which should help with answering incoming calls. The second theme relates to cancellation of appointments and admissions due to the malfunction of an MRI machine. Pals were made aware of this issue and where appropriate, assisted with reimbursing families.

Gastroenterology- There was a reduction in Pals cases (11) in comparison to the preceding month October (15). This included a lovely compliment regarding clinical care and a positive inpatient admission. Common themes for other Pals cases related to a lack of communication in particular difficulties contacting the team and voicemails not being returned. In recognition of this consistent theme, Pals will carry out a "mystery caller" exercise to test the service and try to better understand the issues experienced by families. Gastro Clinical Nurse Specialists are due to attend a MyGOSH training day in order to maximise usage and improve communication channels. The Head of Nursing and Specialist Lead are also regularly reviewing waiting lists in order to better manage the number of complex patients on the wards at one time.

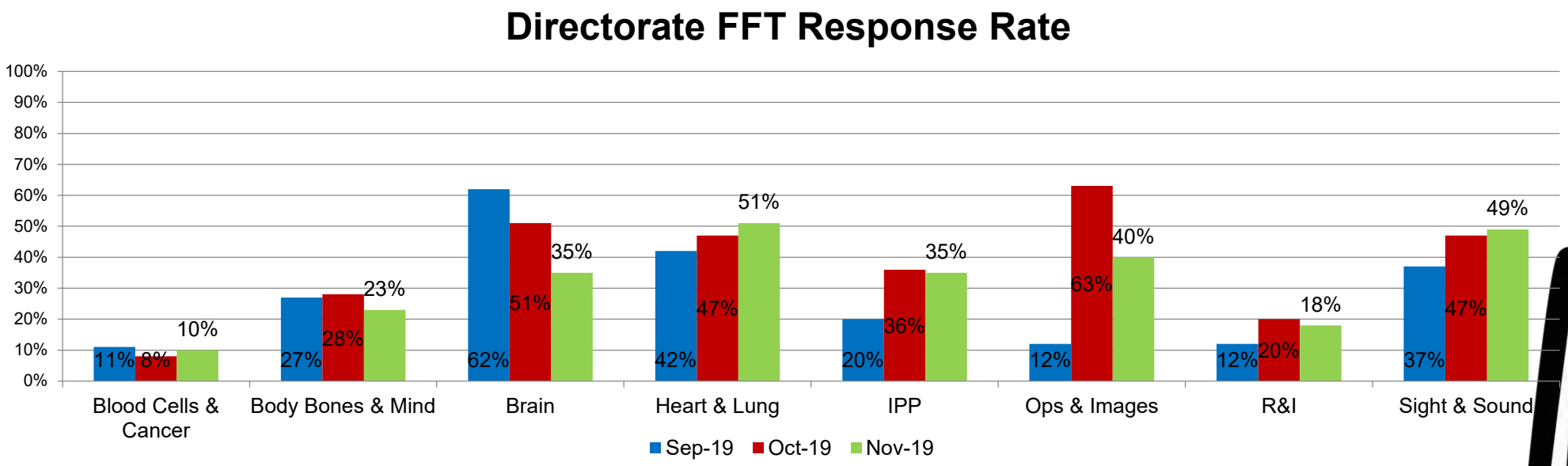
Radiology Cases



Gastroenterology Cases

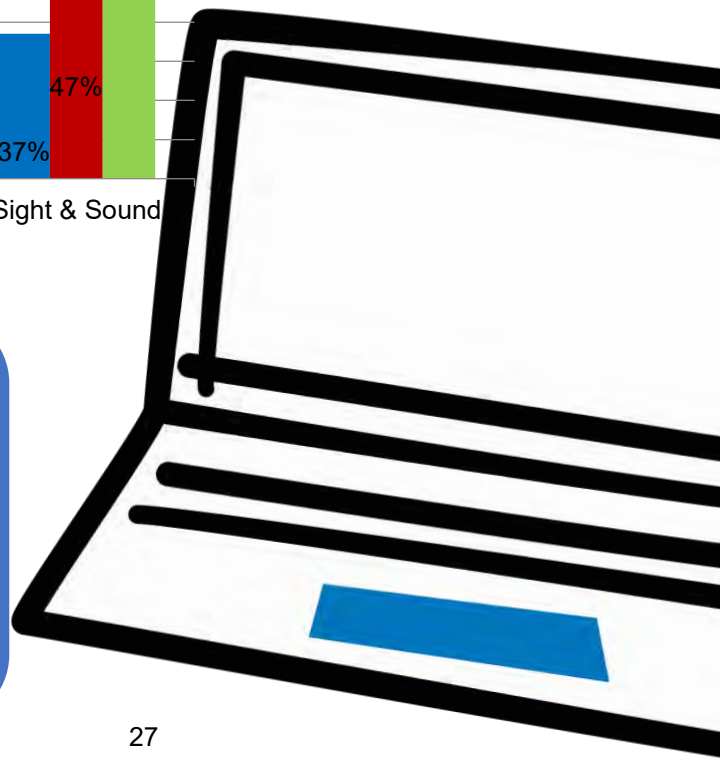


FFT: Are we responding and improving?

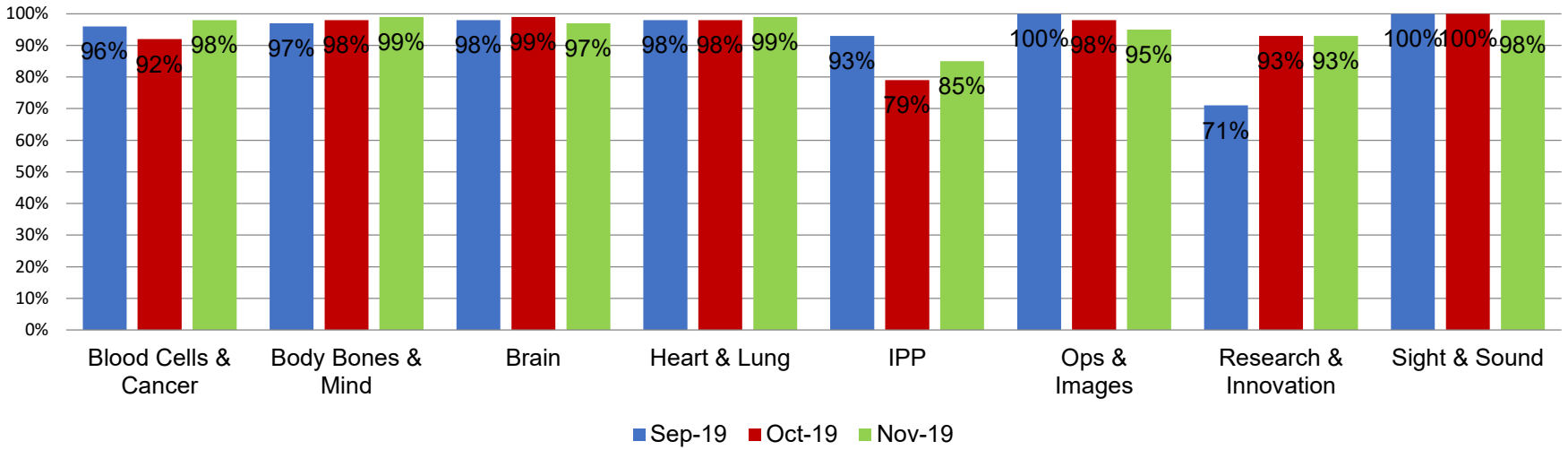


The overall FFT response rate reached above the Trust target of 25% for the third consecutive month. However, the amount of feedback overall reduced this month from 2191 to 1611 for both inpatient and outpatient areas.

Three directorates scored below the Trust Target of 25%- Blood Cells and Cancer, Body Bones and Mind and Research and Innovation. The Patient Experience team is working with the relevant directorates to consider possible approaches to address the difficulties in meeting the Trust's response rate where as a result of the frequency of patient appointments (for example in some areas patients attend three times a week), families may be reluctant to give feedback.



FFT: Are we responding and improving?



	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Apr 19	516	399	40	**955**	**85.3%**
May 19	667	701	51	**1419**	**79.4%**
June 19	714	836	40	**1590**	**80.4%**
July 19	922	865	77	**1864**	**79.1%**
Aug 19	732	945	42	**1719**	**81.4%**
Sep 19	874	761	30	**1665**	**84.1%**
Oct 19	1008	1116	67	**2191**	**81.7%**
Nov 19	897	659	55	**1611**	**83.5%**

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

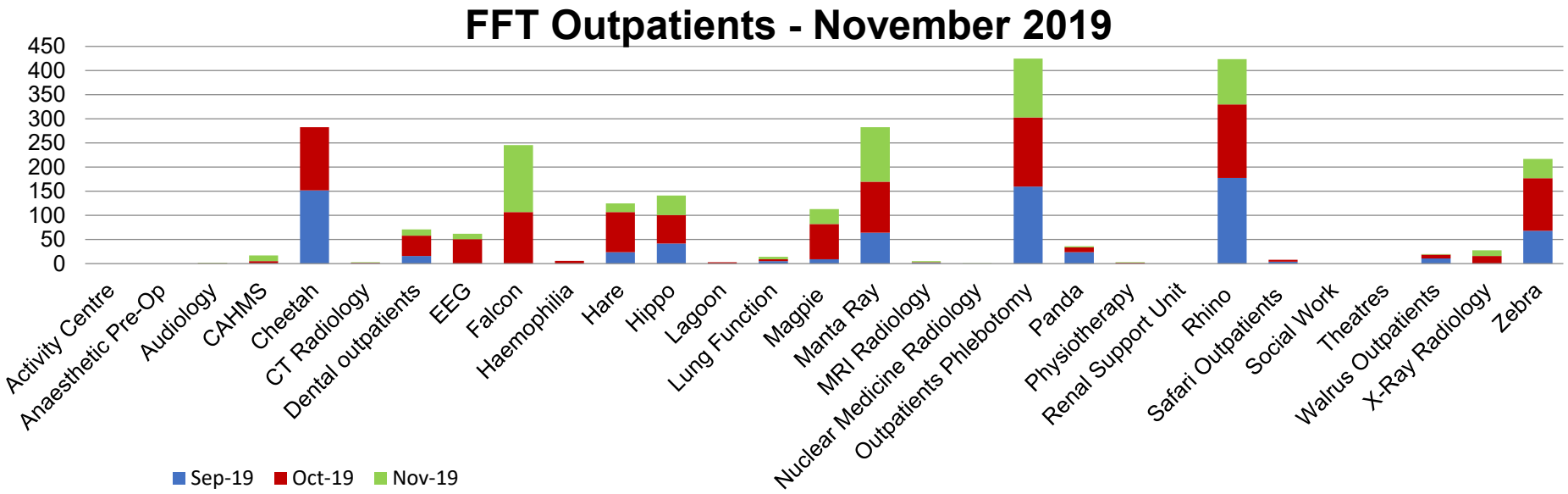
International Private Patients

The negative comments received related to the hospital environment, cleanliness and housekeeping, nursing care and poor co-ordination of appointments. However, there were also many positive comments about all staff groups.

Research & Innovation.

The preference for the Somers CRF and less clinical environment was reflected in the negative comments raised by families. There were numerous positive comments about the staff.

FFT: Are we responding and improving?



The above chart outlines the number of the FFT responses within Outpatients. The amount of feedback received in Outpatients has decreased significantly from 1116 in October to 659 this month. The Patient Experience team will liaise with the relevant teams to better understand the reasons for this.

Positively, three directorates scored 100% to recommend for their outpatient areas- Body Bones and Mind, Heart & Lung and Medicines, Therapies and Tests.

Falcon received the highest number of responses throughout November (139) with positive feedback about the new building and facilities. Negative comments about Falcon related to poor signage, a closed coffee shop and lack of a play room.

The overall Outpatient recommendation rate (91%) fell to its lowest since April/ May 2019 with comments made about waiting times, appointment changes, the temperature and availability of toys in some areas and confidential questions being asked in public areas.

FFT: Are we responding and improving?
Qualitative Comments

‘Our daughter was admitted for a major operation. It was a very scary time for us. The staff have gone above and beyond during our stay. We can’t thanks everyone enough for being amazingly outstanding at what they do’.

Koala Ward

‘Overall just lovely experience, I felt we were taken care of very well, I wish we were referred to this hospital before! Also doctors were extremely knowledgeable and professional with passion to help which is so important’.

Outpatient Phlebotomy

‘The quality of the care for our son was amazing. We felt that nurses took the time and care to get to know him and showed real concern and skill, not just ticking the boxes. It was excellent to have the same nurses repeatedly as that built a relationship and understanding. We felt the nurses work as a team together and also with the surgeon / doctors. We loved the visits from GOSH Arts and the Play Specialist,.

Chameleon Ward

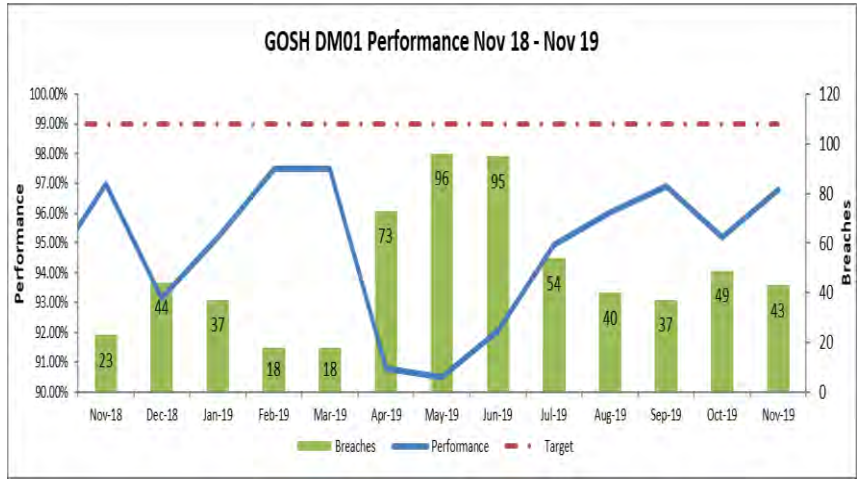
‘We really appreciate the calm friendly atmosphere in outpatients. It is lovely when people take the time to be friendly - to ask about our journey and chat to us. Appointments can be daunting but smiles and kind words go a long way to making it a more pleasant experience.’

Zebra Outpatients

Responsive – Diagnostic Waiting Times

November 2019 Summary

- The Trust continues to underachieve against the 99% national standard, reporting 96.79% of patients waiting within 6 weeks for the 15 diagnostic modalities
- There was a slight decrease in the number of breaches reported in November (43) compared to the number of breaches reported in October (49).
- Of the 43 breaches, 38 are attributable to modalities within Imaging (27 of which are MRI) and 5 in Gastroscopy.
- At the time of writing the report, the Trust is forecasting 120 breaches for December.



Breaches fall in four distinct themes: 19 due to booking process issues (Booked past breach date with no reasonable offers, issues and delays in contacting patient, patient DNAd appointment which wasn't confirmed), 8 due to lack of capacity (MR5, Crohn's capacity, Manometry capacity), 10 due to tolerance (Patient unwell) and 6 due to Trust process issue (Cancelled due to urgent patient, List overrun, no bed for complex patient, transport not booked for patient)

The Trust continues to monitor the diagnostic recovery plan which has been shared with NHSI, but is also currently working up a new recovery plan which will detail compliance against the standard towards the end of the year.

Cancer Wait Times

At the time of writing the report for the month of November 2019, no breaches against the cancer standards attributable to the Trust were reported, with performance being at 100%. Indicative performance for December projects compliance against all standards.

Responsive – Referral to Treatment

November 2019 Summary

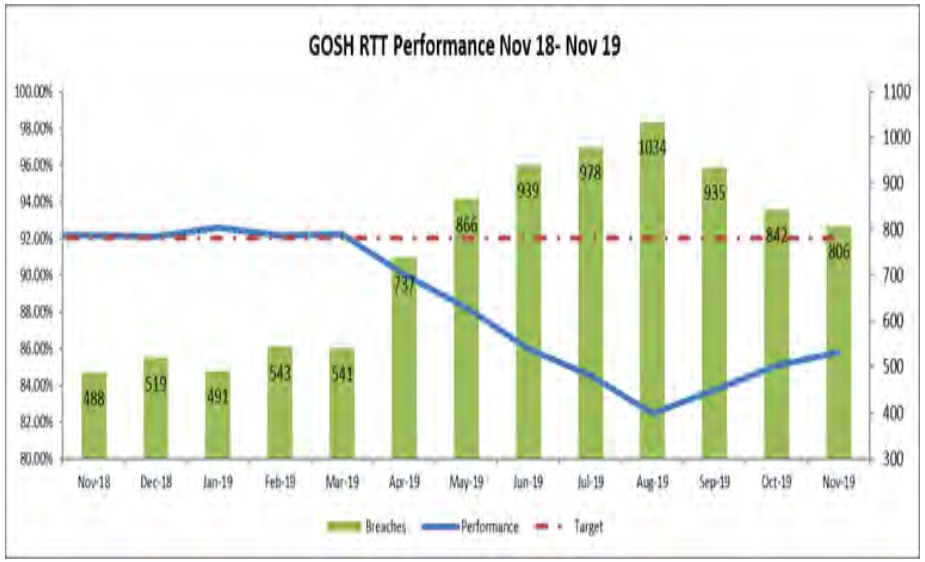
- The Trust did not achieve the RTT 92% standard, submitting performance of 85.71%, with 806 patients waiting longer than 18 weeks, however a slight improvement of 0.72% from the previous month.
- Dental/Maxfax relates to the loss of two consultants (retirement and maternity leave) leaving only one consultant within the service who can complete GA work. Plastic Surgery has also experienced a loss of consultant within a highly specialised service. Cardiac Surgery has experienced bed capacity issues due to the increase in volume of complex non-elective patients requiring 2:1 nursing. Orthopaedics is linked to utilisation, future loss of a consultant and specialisation as well as limited bed capacity on Sky ward due to infection control. Also, the SDR service within Neurosurgery, which became NHS commissioned in July 2018 has resulted in significantly more demand than we have capacity to provide and as such has impacted on our RTT position. We are meeting with NHSI/E at the end of January to discuss these issues.
- The Trust is currently reviewing all under achieving specialties and working with services to produce recovery plans and trajectories. The number of patients waiting 40 weeks+ has again increased to 93 patients in November (from 84 patients in October), primarily driven by the 52 week position.
- GOSH is participating in the national pilot for RTT reporting which is proposing a shift to an average based standard.
- In terms of this standard for the month of November, the Trust has an average wait for an incomplete pathway of 9.60 weeks against a GOSH average standard of 8.1 weeks. This is a slight deterioration from commencing the pilot in July, where the average wait for an incomplete pathway was 9.55 weeks

52+ Week Waits: Incomplete pathways

The Trust reported 25 patients waiting over 52 weeks in the following specialties:

- **Dental (11)-** 3 patients were treated in December resulting in a clock stop, 6 patients have a contact date in January 2020, and 2 complex patients requiring joint intervention with other specialties are still awaiting a TCI.
- **Neurosurgery (5)-** SDR patients – Provisional pre-op dates between Jan and March 2020
- **Plastic surgery (3)** – 2 patients to be seen in January 2020, one patient has been put on active monitoring as patient is not ready for surgery
- **Dermatology (2**)- One patient has been put on active monitoring and the other patient was treated in December
- **ENT (2)**- One patient is to have joint surgery with the dental team in January 2020, and the second patient has DNAd multiple times and is still awaiting a TCI.
- **Craniofacial (1)-** Patient was treated in December.
- **Endocrinology (1)-** Patient was seen in early January 2020.

Early indications show that we will also be reporting 25 patients waiting 52+ weeks as at the end of December 2019

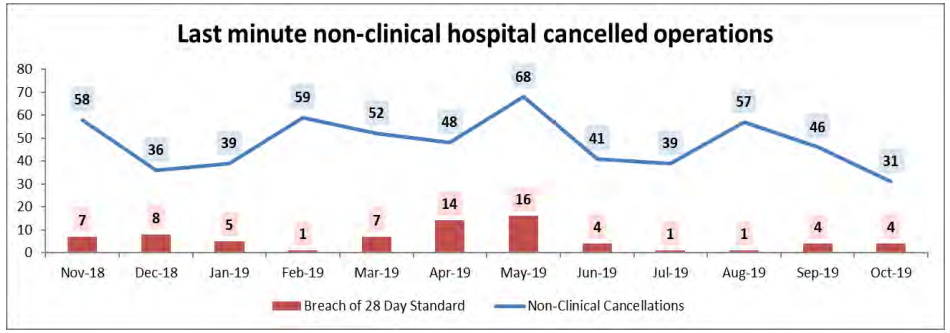


Responsive – Last minute non-clinical hospital cancelled operations (and associated 28 day breaches)

Last minute non-clinical hospital cancelled operation.

Reported in the dashboard are the monthly breakdowns for this quarterly reportable indicator, with the latest available position is for October 19, and we are currently working on the submission of the return for Q3.

For October, there were 31 patients cancelled compared to 46 in September. The areas contributing most to the monthly position are Cardiac Surgery (7), Orthopaedics (7), Dermatology (6), Spinal Surgery, ENT (3), Plastic Surgery (2), BMT (1) and Cardiology (1). The top three reasons recorded for the month are Clinician unavailability (7) and ICU bed unavailability (7).



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

The Trust reported 4 last minute cancelled operations not readmitted within 28 days in October, a similar position to what we reported in September. The areas contributing to the breaches are Orthopaedics (1), Spinal Surgery (1), Neurology (1) and Neurosurgery (1).

Urgent operations cancelled for a second time

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

Data Completeness – Mental Health Identifiers

Mental Health Identifiers: Data Completeness

The Trust is nationally required to monitor the proportion of patient accessing Mental Health Services that have a valid NHS number, date of birth, postcode, gender, GP practice and commissioner code. Within this area the Trust met the 97% standard with 98.19% of patients having valid data in November. This was a slight increase from October when the trust reported 97.84%.

Mental Health: Ethnicity Completion - %

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

The Trust has seen a significant improvement in collating ethnicity for patients accessing mental health services, with 70.88% in November having a valid ethnic code. This continues to be addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work. Capture of this data is now completed within the EPIC system.

Patients with a valid NHS Number

% of patients with a valid NHS Number Inpatients and Outpatients

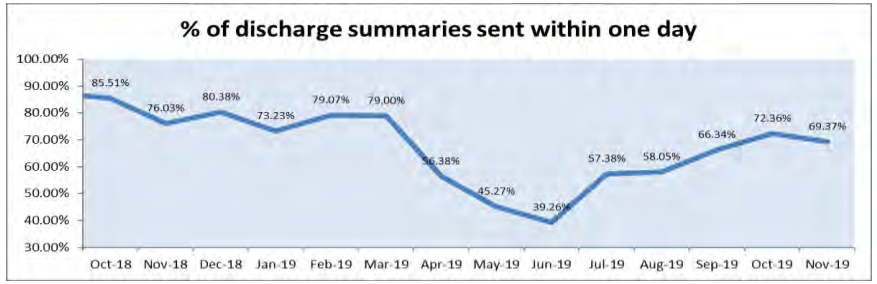
This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

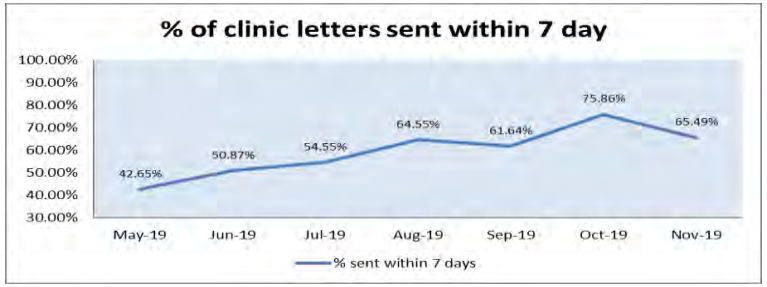
Nationally the Trust is monitored against achieving 99% of patients having a valid NHS Number across all services being accessed. As the report depicts for both Inpatients and Outpatients this is below the standard, nationally the average for both indicators is above 99%. Work is continues to improve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

Effective – Discharge Summaries

November 2019 Summary

- Although not at the required standard of 100% compliance, considerable focus has been placed on this indicator by both the operational and clinical teams to improve compliance. For the month of November, 69.37% of patients who were discharged from GOSH received a discharge summary within 24 hours, a deterioration from the October position of 72.36%.
- This focus includes backlog clearance of discharge summaries and the embedding the completion of discharge summaries in real time into clinical practice. Compliance against the standard continues to be reported on a weekly basis though SLT and the weekly General Managers meeting. Significant improvement has been made in reduction of the backlog also, with no discharge summaries pre-dating September.
- Working groups have been initiated to focus on specific challenges experienced by services and ensure resolutions are agreed and transacted. Training materials and courses have been reviewed and the workflow has been clearly communicated. Targeted support will be offered to individuals/services with poor metrics. The EPR team in conjunction with service managers will approach clinicians with additional training and guidance.





Clinic Letter Turnaround Times

For November 2019, performance has deteriorated in relation to 7 day turnaround; 65.49% compared to 75.86% in October.

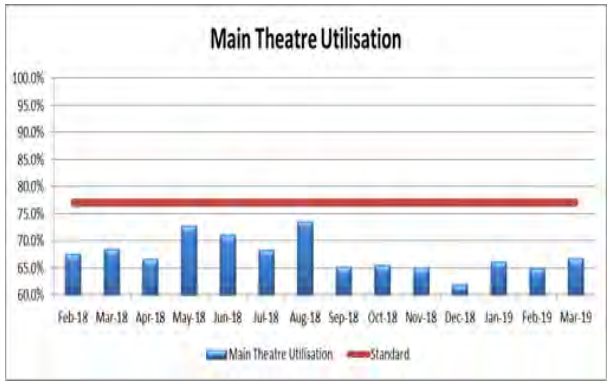
The EPR team have now rolled out the 'clinic letter not required' button within Epic, to specific services at a clinic level which can be used for specific patient appointments where a clinic letter will not be required for clinical reasons. In addition, additional training is being provided for Clinicians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

Productivity – Theatre Utilisation

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

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

A working group has been established to review theatre utilisation reports and % utilisation of main theatres should be available by end of January.



Bed Occupancy and Closures

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

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

Bed closures: The average number of beds closed in November (47) was lower than the number reported in October (62). This was mainly due to Butterfly and Kingfisher having an average of 6 beds closed over the month mainly due to staffing and NICU/PICU/CICU have experienced an average of 5 beds closed. Although Sky ward was closed due to infection control, the patients were decanted to another areas of the hospital.

Trust Activity

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

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For the month of November, there were nine patients whose stay in hospital at point of discharge was over 100 days, accumulating 1,874 bed days in total.

Productivity – PICU Metrics

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

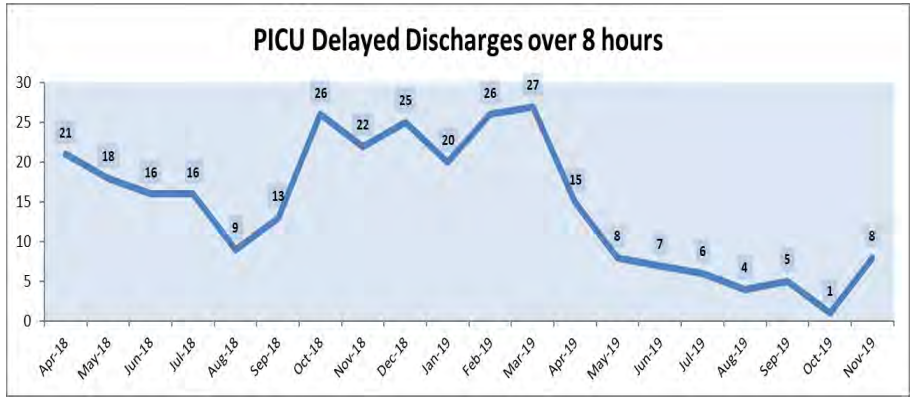
CATS referral refusals to PICU/NICU: The number of CATS referral refusals into PICU/NICU from other providers during November has increased to 31 from an October position of 12.

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

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

PICU Delayed Discharges:

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



PICU Emergency Readmissions:

There were two readmissions back into PICU within 48 hours for the month of November, compared to none in October.