Meeting of the Trust Board
Wednesday 7 July 2021

Dear Members

There will be a public meeting of the Trust Board on Wednesday 7th July 2021 at 2:30pm via Zoom.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**2:30pm**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2	**Minutes of Meeting held on 26 May 2021**	Chair	**L**	
3.	**Matters Arising/ Action Checklist**	Chair	**M**	
4.	**Chief Executive Update**	Chief Executive	**N**	**2:40pm**
5.	**Patient Story**	Chief Nurse	**O**	**2:50pm**
6.	**Directorate presentation: Brain Directorate**	Chief Operating Officer/ Senior Leadership Team for Directorate	**P**	**3:05pm**
	STRATEGY AND PLANNING			
7.	**Annual Sustainability Management Plan 2020/21**	Director of Estates, Facilities and Built Environment	**Q**	**3:20pm**
8.	**GOSH Quality Report 2020/21**	Medical Director	**R**	**3:30pm**
	PERFORMANCE			
9.	**Integrated Quality and Performance Report (Month 2 2021/22) May 2021 data**	Medical Director/ Chief Nurse/ Chief Operating Officer	**S**	**3:35pm**
10.	**Finance Report (Month 2 2021/22) May 2021 data**	Chief Finance Officer	**U**	**3:50pm**
11.	**Safe Nurse Staffing Report (April - May 2021)**	Chief Nurse	**V**	**4:00pm**
12.	**Annual Safeguarding Report 2020/21**	Head of Safeguarding	**W**	**4:10pm**
13.	**Completion of Royal College Review Actions**	Medical Director	**X**	**4:20pm**
	ASSURANCE			
14.	**Responsible Officer Annual Report 2020/21**	Responsible Officer/ Medical Director	**Y**	**4:30pm**
15.	**Board Assurance Committee reports** • **Quality, Safety and experience Assurance Committee – 1 July 2021**	Chair of QSEAC	**Verbal**	**4:40pm**

	• **Audit Committee Assurance Committee Update – May 2021 meeting** • **Finance and Investment Committee Update – May 2021 and June 2021** • **People and Education Assurance Committee Update – June 2021 meeting**	Chair of Audit Committee Chair of the Finance and Investment Committee Chair of the People and Education Assurance Committee	**1** **2** **3**	
16.	**Council of Governors' Update - July 2021 meeting**	Chair	**Verbal**	**4:55pm**
	GOVERNANCE			
17.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			**5:00pm**
18.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 29 September 2021.			

DRAFT Minutes of the meeting of Trust Board on 26th May 2021

Present

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

In attendance

Cymbeline Moore	Director of Communications
Zoe Asensio Sanchez	Director of Estates, Facilities and the Built Environment
Dr Shankar Sridharan	Chief Clinical Information Officer
Richard Collins	Director of Transformation
Mark Sartori	Trustee, GOSH Children's Charity
Claire Williams*	Head of Patient Experience
Nicola*	Mother of GOSH patient
Clare Gilbert*	Clinical Nurse Specialist, Endocrinology
Dr Antonia Dastamani	Consultant, Endocrinology
Darren Darby	Director of Nursing, Corporate
Paul Balson	Head of Corporate Governance
Dr Allan Goldman*	Group Director, Medicines, Therapies and Tests
Nick Towndrow*	General Manager, Medicines, Therapies and Tests
Kimberly Gilmour*	Chief of Laboratory Medicine
Stephen Tomlin*	Chief Pharmacist
Angela Barnicoat*	Chief of Clinical Genetics
Chris Ingram*	Fire, Health and Safety Manager
Renee McCulloch*	Associate Medical Director and Guardian of Safe Working
Dr Pascale du Pre*	Consultant in Paediatric Intensive Care and Medical Lead for Child Death Reviews
Helen Dunn*	Director of Infection Prevention and Control
Daniel Sumpton*	Freedom to Speak Up Guardian
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Alison Kelly	Governor (observer)
Beverly Bittner Grassby	Governor (observer)
Peace Joseph	Governor (observer)

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

10	**Apologies for absence**
10.1	Apologies for absence were received from Amanda Ellingworth, Non-Executive Director.
11	**Declarations of Interest**
11.1	No declarations of interest were received.
12	**Minutes of Meeting held on 30th March 2021**
12.1	The Board **approved** the minutes of the previous meeting.
13	**Matters Arising/ Action Checklist**
13.1	The actions taken since the last meeting were noted.
14	**Patient Story**
14.1	The Board received a patient story via video conference from Nicola, the parent of Felix, aged 17 months, who had been treated by the Hyperinsulinism Service at GOSH. Nicola said that she had had a good experience at the Trust prior to the onset of the pandemic and once the pandemic had begun the team had been supportive and she had been able to attend the Trust for appointments. Nicola said that it had been isolating as a new mum during the pandemic and she had not been able to do the activities with Felix that she had anticipated and the support from the GOSH team had been important.
14.2	Nicola said that when she and Felix had come to the hospital for an overnight stay she had not received a welcome or orientation and felt there was an overall lack of communication. Play areas had not been open which had been challenging and it had been extremely difficult to sleep as the chair which pulled into a bed had been very uncomfortable. There had also been a long wait for discharge and no communication as to the reason for this or potential timelines.
14.3	Matthew Shaw said that it was important to make a commitment to respond to feedback and highlighted the challenges for parents looking after their children when in a different environment particularly when there were difficulties with the overnight accommodation.
14.4	Shankar Sridharan, Chief Clinical Information Officer said consideration was being given to building a timeline for patients and families to ensure they were aware of what would take place in the day and knew when they would be able to leave the ward.
14.5	James Hatchley, Non-Executive Director asked about Nicola's experience of MyGOSH and Nicola said that the platform had worked well and she had attended an appointment with Felix via videoconference however as the team was very responsive by telephone she had used MyGOSH as a secondary form of communication.

14.6	Alison Robertson, Chief Nurse said that it was important to understand from feedback such as Nicola's that areas such as the provision of appropriate sleeping space for parents and carers was vital in terms of experience. Feedback on beds had been received from throughout the Trust and it was important to learn from this for the Children's Cancer Centre. Alison Robertson said that it was vital to have patient and family engagement in design and development of this new building.
14.7	Clare Gilbert, Clinical Nurse Specialist said that the team had been empowered by their ability to change their ways of working so quickly at the start of the pandemic and it was hoped that this drive would continue.
15	**Directorate presentation: Medicines, Therapies and Tests Directorate**
15.1	Allan Goldman, Group Director, Medicines, Therapies and Tests said that many of the teams in the directorate were not directly patient facing however the majority of patients at GOSH received care or support from the directorate. The laboratory service consisted of five large laboratories each with different highly specialist and nationally commissioned areas and staff from the directorate had volunteered for redeployment to the adult sector with equipment being loaned to key services.
15.2	Nick Towndrow, General Manager said that the directorate had been successful in reducing the number of overdue incidents and the laboratory services had been successful in maintaining all accreditations. The team was working towards being the first paediatric Trust to have point of care services accredited by UKAS. An initiative called Pill School had been developed to support patients to take tablets which many patients preferred and also led to efficiency savings and the directorate had delivered a surplus against its Control Total in 2020/21.
15.3	Sanjiv Sharma said that the laboratory service had been instrumental in achieving the Trust's good position in terms of testing for COVID19 and had ensured that capacity was in place to also provide testing for staff.
15.4	Akhter Mateen asked what impact the EPR had on the directorate since going live. He asked how effective the risk management processes were in the directorate. Allan Goldman said that a number of the services in the directorate were highly regulated and there were oversight of risks from this perspective. Kimberly Gilmour, Chief of Laboratory Services said that Epic had been transformative for the labs and had substantially reduced the time required per sample.
16	**Chief Executive Update**
16.1	Matthew Shaw noted that the sentencing had taken place of a former GOSH member of staff. He apologised for the crimes that had taken place on the GOSH site.
16.2	BBC Panorama had referred to a review of GOSH's Gastroenterology Service in 2015. Matthew Shaw said that the Trust had been transparent about the shortcomings of the service and commended the team for making considerable improvements. A follow up review was being commissioned and this would be made public once complete. Matthew Shaw said that it was vital to continue to create safe spaces for clinicians to highlight errors in order to identify learning.

16.3	GOSH had been selected as part of an accelerator programme to support the treatment of the backlog of patients following the pandemic which was extremely positive.
16.4	Matthew Shaw said that he had been appointed as the executive lead for specialist hospitals on the Provider Alliance Board. The Provider Alliance would be considering the proposed legislative changes in the NHS White Paper.
17	**GOSH Foundation Trust Annual Financial Accounts 2020/21 and Annual Report 2020/21**
17.1	Helen Jameson, Chief Finance Officer said that the Trust had delivered a £12.9million surplus against the Control Total and cash was strong at £126million. The increase in cash was a result of a reduction in debtors caused by the decrease in International and Private Care activity and also the change to the NHS framework and a move to payments in advance. The profile of the Trust's costs had changed considerably as a result of the pandemic resulting in increased pay costs as a result of sickness and the work required to support the STP. There had also been a reduction in the use of high cost drugs.
17.2	Akhter Mateen said that the GOSH team and the auditors had worked extremely well and the Trust was ahead others in their completion of the accounts and readiness to submit. The documents had been considered by the Audit Committee and no concerns were raised. The Trust's external auditors had substantially completed their work and did not anticipating raising any concerns which would prevent the sign off of the accounts and a clean opinion being given. A Value for Money self-assessment had been completed by the Trust and the auditors did not anticipate any concerns being raised in this area which would impact their opinion.
17.3	The Audit Committee had also reviewed the Annual Report and made some small editing suggestions. The Committee had also requested an update to the Head of Internal Audit report in order to highlight the beneficial impact of the EPR during the pandemic.
17.4	The Committee agreed to recommend the Annual Report and Accounts to the Board along with the Annual Governance Statement and Letter of Representation.
17.5	The Audit Committee **approved** the following documents and delegated sign off to the Chief Executive and Chief Finance Officer. • Annual Report 2020/21 • Annual Accounts 2020/21 • Annual Governance Statement • Head of Internal Audit Opinion • Letter of Representation.
18	**Compliance with the Code of Governance 2020/21**
18.1	Anna Ferrant, Company Secretary said that Trusts were required to report against the Code of Governance in the Annual Report on the basis of either compliance with the Code or an explanation where there was a gap in compliance. A review had been undertaken against all the Code's provisions and

	had found that the Board had met the requirements of the Code of Governance during 2020/21.
18.1	The Board noted the review and **approved** the statement to be included in the Annual Report.
19	**Compliance with the NHS provider licence – self assessment 2020/21**
19.1	Anna Ferrant said that Foundation Trust Board were required by NHS England/Improvement to annually declare compliance or otherwise with a small number of Foundation Trust licence conditions and one requirement under the Health and Social Care Act. Although no guidance had been released for 2020/21 the exercise was being carried out in line with good governance. In previous years there had been a requirement to take into account the views of the Council of Governors and therefore the evidence cited had been reviewed by the Council at its April 2021 meeting. Governors were satisfied with the evidence provided and had agreed the recommendations.
19.2	Chris Kennedy, Non-Executive Director highlighted that there was considerable reliance on the knowledge of the Company Secretary and asked if a succession plan in place. Matthew Shaw said discussion was taking place around recruiting a Deputy Company Secretary.
19.3	The Board **agreed** the Trust's responses to the conditions taking to account the views of the Governors.
20	**GOSH 2021/22 Budget**
20.1	Helen Jameson, Chief Finance Officer said that following approval of the budget at the previous Trust Board meeting there had been an update to the anticipated income for the first 6 months of 2021/22 as a result of additional COVID19 funding, elective recovery funding and a top of in lieu of non NHS income. The overall change would be an increase in income of £16.6m for the first 6 months of the year. Work was taking place to understand the impact of the accelerator programme, a potential third surge of the pandemic and a potential surge in Respiratory Syncytial Virus (RSV). Helen Jameson said that it was anticipated that the Trust would be paid for over performance and the accelerator programme would fund transformative change.
20.2	Russell Viner, Non-Executive Director asked whether there was a potential upside or downside to International and Private Care (I&PC) income and Helen Jameson said that there was a potential upside towards the end of the year. She added that as I&PC patients tended to be complex requiring longer stays therefore there had been a delay in the reduction to income. Recovery of income would be heavily reliant on the recovery of travel corridors.
20.3	Akhter Mateen highlighted the potential growth in I&PC income and noted that this would require approval by the Council of Governors if the total growth in non NHS income exceed more than 5% in year. Helen Jameson agreed that as a result of the significant reduction in this area there was likely to be growth at a level requiring discussion.
20.4	John Quinn, Chief Operating Officer emphasised the importance of focusing on the backlog of patients notwithstanding the requirements around Better Value

	and Richard Collins, Director of Transformation noted that as part of this focus it was possible that investment would also be required. Sir Michael Rake said that it had been clear from zoomarounds and discussions with staff Governors that considered communication about efficiency requirements was required.
21	**Trust Risk Appetite Statement**
21.1	Anna Ferrant presented the revised risk appetite statement. The Risk Assurance and Compliance Group (RACG) had led a review and update of the Trust Risk Appetite Statement taking an approach based on the risk appetite guidance note from the Governance Finance Function. Consideration had been given to the review of the Trust's strategy and the context of the risks on the BAF. The revised risk appetite statement had been reviewed by the Audit Committee and Executive risk leads. The document had been updated following discussion at the Audit Committee.
21.2	Discussion took place around the wording of the risk appetite for patient harm which was currently listed at 'averse'. It was agreed that this was appropriate given the definition of averse.
21.3	The Board **approved** the revised Trust Risk Appetite Statement.
22	**Board Assurance Framework Update**
22.1	Anna Ferrant said that two new risk statements had been drafted on the Board Assurance Framework around the Trust's strategic position and estates compliance. Akhter Mateen confirmed that this had been supported by the Audit Committee and the Board **approved** the wording of the two new risks.
22.2	The Audit Committee had recommended to the Board for approval revised risk scores for the Financial Sustainability risk and the research infrastructure risk. On the basis that the Trust had some mitigations in place to control the financial sustainability risk it was proposed that the net score was reduced from 25 to 20. As a result of external factors which were not within the Trust's control and had the potential to affect future research funding it was proposed that the gross risk score of the research infrastructure risk was increased from 12 to 16. The Board **approved** the proposed changes.
23	**Integrated Quality and Performance Report – Month 1 2021/22**
23.1	Sanjiv Sharma, Medical Director said that there had been a reduction in the number of incidents closed during the period however there had been improvements made in more recent data. Review of high level risks and compliance with Duty of Candour continued to be below expected levels. Sanjiv Sharma confirmed that whilst the requirements were completed this was not within the necessary timeframes.
23.2	Russell Viner highlighted the importance of working with families through Duty of Candour in the early stages where issues arose to prevent escalation of these issues as far as possible and promote a good working relationship as far as possible. Sanjiv Sharma agreed and said that the Trust was working with Action Against Medical Accidents (AvMA) around Duty of Candour and compassionate apologies and understanding the impact on patients and families.

23.3	Alison Robertson, Chief Nurse said the Friends and Family Test response rate continued to be positive and above the internal target and the team reviewed all feedback received, both positive and negative. Nine complaints had been received in the month two of which were complex red complaints involving a number of specialties. Both red complaints had been discussed at an Executive Incident Review Meeting (EIRM) and one had been declared a Serious Incident. A thematic review of red complaints was taking place due to the unusually high number received in the year and this report would be presented to the QSEAC in July 2021. The actions arising from red complaints were monitored and progress had been made with five overdue actions.
23.4	The PALS team continued to receive a large number of contacts however the number of COVID19 related had reduced. A large number of contacts had been around Dermatology and Cardiology and these teams had been invited to the Patient and Family Engagement Experience Committee to discuss this.
23.5	John Quinn said that diagnostic waits were not making the required progress and this was being investigated and RTT continued to improve on a monthly basis. Long waits over 52 weeks also continued to improve. Cancer performance remained strong and the Trust continued to meet targets in this area.
23.6	Akhter Mateen asked whether the work around data quality remained on target and emphasised its importance as data around recovery was reported. John Quinn confirmed that the Chief Data Officer remained focused on this and a data quality committee was being developed to ensure that all areas of definitions were being sampled.
24	**Annual Health and Safety and Fire Report 2020/21**
24.1	Chris Ingram, Fire, Health and Safety manager said that one matter currently rated amber was for fire risk assessment in some non-clinical areas. Extra resource had been requested to complete this work. Fire safety training had moved to 90% compliance since the report had been written. Sir Michael Rake said that this was a critical area and it was vital to ensure that improvements were made and Matthew Shaw said that a number of areas of learning had been identified and had been discussed at the Audit Committee.
25	**Month 1 2021/22 Finance Report**
25.1	Helen Jameson said that the financial position at month 1 was a deficit of £2.9million which was £1.4million below plan. This was driven by both NHS and private patient income which was adverse to plan. Non pay costs were below plan and pay costs were in line with plan. Cash remained strong at £132million and capital expenditure was in line with plan.
26	**Guardian of Safe Working Report Q4 2020/21 and Annual Report 2020/21**
26.1	Renee McCulloch, Associate Medical Director and Guardian of Safe Working said that the second surge of the pandemic had been well managed in terms of junior doctor response. A clear escalation strategy had been developed and a shadow rota was also in place. Fellows from I&PC had been moved to areas with greater activity and had adjusted their working patterns on a weekly basis. This flexibility had enabled the Trust to maintain its priority elective activity.

26.2	Sir Michael Rake welcomed the positive reactions from staff and the supportive environment which had been developed. Renee McCulloch added that the workforce lead role had now been formalised.
26.3	Wellbeing surveys had good response rates and had not identified a greater level of burnout after the second surge than had been the case following the initial onset of the pandemic. Although there were some individuals who did score highly in terms of burnout overall numbers were low.
26.4	One rota in Child and Adolescent Mental Health (CAMHS) remained under review to achieve compliance as it was a complex rota shared with five other Trusts. All critical care rotas were now compliant as a result of approved business cases.
27	**Learning from Deaths Mortality Review Group - Report of deaths in Q3 2020/2021**
27.1	Pascale du Pre, Consultant in Paediatric Intensive Care and Medical Lead for Child Death Reviews said that there had been 26 deaths in the reporting period and all cases had been subject to review. A child death review meeting had taken place in 24 cases with the remaining two cases going through the coronial process before the meeting could take place.
27.2	The Trust had been able to continue to review deaths and mortality in real time through PICANET and no outliers had been identified and no cases had met the criteria for Serious Incidents.
27.3	The reporting period had occurred during the second surge of the pandemic and two cases had been identified which had been impacted by this. The patient and family experience element of cases was also being considered given visiting restrictions and feedback was being received in this regard.
27.4	Sir Michael Rake highlighted the increase in mortality which had occurred in May 2020 and Pascale du Pre said that this had been investigated and found to be as a result of patients who died at GOSH due to the movement of services during the first surge of the pandemic. The deaths were not directly related to COVID19 or as a result of delayed presentation.
27.5	Russell Viner said that the findings were extremely positive given the context of the pandemic surge and congratulated the leadership across and the Trust and staff in all areas.
28	**Safe Nurse Staffing Report (February - March 2021)**
28.1	Alison Robertson said that the reporting period covered the period in which a number of nurses were redeployed to adult settings during the second surge of the pandemic. Debrief sessions had taken place with all these staff to consider their health and wellbeing and ensure that learning could be identified in case of a third surge. Bank utilisation remained high during the period in order to backfill including to support NCL deployments, staff vaccination clinic, high patient acuity, staff self-isolation, high maternity rates and staff sickness. Vacancies and turnover remained stable during the period.
28.2	

28.3 28.4 28.5 28.6	Two Datix reports had been raised in March both of which had been investigated and closed with no patient harm and appropriate mitigations put in place. The Trust had suspended reporting 'Care Hours Per Patient Day' until budgeted establishment templates had been updated to ensure that information was reliable. <u>Nursing Establishment Review</u> Guidance had been received from NHS England/Improvement that no changes should be made to reduce staffing establishments based on data from 2020/21 as it would not provide an accurate assessment of patient acuity. Alison Robertson confirmed that based on the data collected from the review current establishments were safe. James Hatchley asked if there were any indications within London that there would be an increase in people leaving nursing and Alison Robertson said that there was concern nationally about the impact of the pandemic on people's career goals. The Trust continued to maintain its recruitment pipeline in order to futureproof against an increase in turnover. As a consequence of the national profile of nursing throughout the pandemic there had been an increase in the number of people applying to train as a nurse.
29	**Gender Pay Gap Report 2020/21**
29.1 29.2	Caroline Anderson, Director of HR and OD said that in common with many NHS Foundation Trusts GOSH continued to have a gender pay gap however this gap was smaller than that of the previous year. The gap was primarily driven by the traditional demographics of the healthcare workforce with nursing and administrative and clerical professions being predominantly female and women comprising 77% of the overall Trust workforce. Akhter Mateen asked if similar assessments of the workforce were made in terms of race and disability equality and Caroline Anderson said that it was in terms of disability however the numbers of staff with a disability captured by HR was very small and therefore if was challenging to draw valuable conclusions.
30	**Infection Control Update**
30.1 30.2 30.3	Helen Dunn, Director of Infection Prevention and Control said that the team's key activity continued to be around the response to the COVID19 pandemic and the team had now moved to full establishment. The team was focused on a number of key risks including the work was taking place with estates and facilities on water and ventilation and the activity required to bring the domestic services in house. There had been an increase in the number of C. difficile infections from the previous year which was primarily in patients who had been transferred from other Trusts however some appeared to be hospital colonised and this was being reviewed. Chris Kennedy congratulated the team on their work throughout the pandemic and asked if there were any early observations about the capability of the cleaning team around infection control. Helen Dunn said that meetings had taken place with the Director of Estates, Facilities and the Built Environment

	following the completion of hand hygiene audits to consider how this training would be embedded.
30.4	Russell Viner asked if there was a greater awareness of infection control as a result of the pandemic. Helen Dunn said that some areas had seen reduced activity and had greater compliance with screening which was indicative of the impact of workload on infection control practices.
31	**Annual Freedom to Speak Up Report 2020/21**
31.1	Daniel Sumpton, Freedom to Speak Up Guardian said that there had been a number of changes to the guardians over the year which had at times impacted the on the continuity, provision and promotion of the service. As the service had stabilised there had been an increase in the cases reported. Issues raised were predominantly around bullying and harassment and the behaviours of colleagues and managers. Daniel Sumpton said that whilst improvements were being made staff from a BAME background were still less likely to speak up at GOSH than at other Trusts; he emphasised the importance of staff feeling able to speak up.
31.2	Kathryn Ludlow, Non-Executive Director highlighted that 8 cases had been raised anonymously in 2020/21 compared to zero in the previous year. Daniel Sumpton said in his experience cases were often raised anonymously as a result of staff not feeling safe to raise a concern publically however it was important that this option was available to maximise the opportunity for staff to raise concerns. Matthew Shaw said that this was a cultural issue which must continue to be addressed and added that a large proportion of concerns raised at the Virtual Big Brief were also submitted anonymously.
31.3	James Hatchley noted that two members of staff who raised concerns had highlighted that they had experienced detriment as a result of speaking up. He asked how this could be resolved. Daniel Sumpton said that this remained unresolved and added that work was taking place on the voices of staff members who had been through the speaking up process. He said that when a manager took a member of through formal HR processes this was likely to lead to a breakdown in the relationship and a feeling of being ostracised. Caroline Anderson said that this was key in a number of relationship issues and emphasised the importance of resolving issues informally where possible.
31.4	Daniel Sumpton said that word of mouth was extremely important in highlighting staff experience of the Freedom to Speak Up service and therefore it was importance to share this experience more widely.
32	**Board Assurance Committee reports**
32.1	<u>Audit Committee update – April 2021 meeting and May 2021 (verbal)</u>
32.2	Akhter Mateen, Chair of the Audit Committee said that two Audit Committee meetings had taken place in the reporting period. The year-end Audit Committee which had met directly prior to the Board had focused on the year-end documents. It had been confirmed that the Trust had received a green rating in relation to Counter Fraud work throughout the year and the internal auditors had confirmed that overdue recommendations had reduced to zero which was the best performance by their Trusts in London.

32.3	Enhanced monitoring of ICT continued and an interim meeting had taken place with members of the team and committee members.
32.4	<u>Quality, Safety and Experience Assurance Committee update – April 2021 meeting</u>
32.5	Anna Ferrant said that the Committee continued to focus on medicines management and had requested a route map towards closing the gaps including timeframes for monitoring.
32.6	<u>Finance and Investment Committee: Revised Terms of Reference</u>
32.7	The Board **approved** the Finance and Investment Committee Terms of Reference.
33	**Council of Governors' Update – April 2021**
33.1	Sir Michael Rake said that a good process had taken place for the election and induction of new Governors and the Council had discussed the importance of receiving papers in good time. It had been agreed that the Lead Governor would be involved in setting the agenda for meetings to ensure there was a balance between areas of Governors' interest and statutory requirements.
34	**Declaration of Interest Register (Directors and Staff)**
34.1	Anna Ferrant presented the annual update and said that the GOSH policy had been updated in line with NHS England's model policy. This required the Trust to identify decision makers, those staff who had influence in the spending of tax payers' money. The definition of decision makers had been updated and this had significantly increased the number of Decision Making Staff at GOSH. The Trust continued to monitor performance however it had been confirmed that 100% compliance was necessary to meet the NHS Counter Fraud Authority standard which was extremely challenging.
35	**Director and Governor Code of Conduct**
35.1	The Board **approved** the Director of Governor Code of Conduct.
36	**Any other business**
36.1	There were no items of other business.

Attachment M

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 2021

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
216.7	30/03/21	Kathryn Ludlow asked whether incidents were likely to be occurring as a result of staff fatigue or key staff having been redeployed. Alison Robertson said that it was challenging to identify themes as a result of the small overall numbers. It was agreed that this would be discussed with the network for complaints to ascertain whether other Trusts had experienced a similar increase in red complaints and whether there was a view that this was related to the pandemic.	AR	May 2021	Action closed: Anecdotally members of both a National NHS Complaints Forum and Patient Experience Network had referred to increased complaint numbers following an initial lull when the pandemic started. This has been difficult to quantify given very variable approaches to risk grading/ assessment of complaints and a reduction in organisations publishing detailed complaints data during the pandemic. Requests to other organisations regarding this issue received a low response although one care provider confirmed a marked increase in complex complaints which has continued to rise as restrictions ease. A thematic analysis of red/ high risk complaints and actions in response to this was presented at QSEAC and themes, trends and learning continue to be closely monitored.

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **7 July 2021**	
Chief Executive Report **Submitted by:** Matthew Shaw, CEO	**Paper No: Attachment N** ☐ **For information and noting**
Purpose of report Update on key operational and strategic issues.	
Summary of report An overview of key developments relating to: • Covid-19 response and operational pressures • Key people, finance and service issues • Strategy and partnerships	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust priorities ☐ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** ☐ **PRIORITY 4: Improve and speed up access to urgent care and virtual services** ☐ **Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** ☐ **Leadership, capacity and capability** ☐ **Vision and strategy** ☐ **Culture of high quality sustainable care** ☐ **Responsibilities, roles and accountability** ☐ **Effective processes, managing risk and performance** ☐ **Accurate data/ information** ☐ **Engagement of public, staff, external partners** ☐ **Robust systems for learning, continuous improvement and innovation**
Strategic risk implications BAF Risk 3: Operational Performance BAF Risk 12: Inconsistent delivery of safe care BAF Risk 14: Culture	**Financial implications** Not Applicable
Implications for legal/ regulatory compliance Not Applicable	**Consultation carried out with individuals/ groups/ committees** Not Applicable

Who is responsible for implementing the proposals / project and anticipated timescales? Executive team	**Who is accountable for the implementation of the proposal / project?** CEO
Which management committee will have oversight of the matters covered in this report? Executive team	

Part 1: A reflection on current operational pressures (including pandemic recovery)

The Trust is currently working through an extremely challenging period characterised by four main pressures:

1) Accelerating recovery of the backlog by working towards 120 per cent of our usual activity;
2) Planning and implementing a careful reset for clinical and corporate teams, embedding new ways of working with less on-site space, fatigue and staffing changes;
3) Accommodating a shift in gear within the system to get a range of big ticket programmes back up to speed – from new NHS services, to emerging ICS, regional and national partnership structures and our own portfolio of strategic change programmes;
4) Planning for known risks that will impact our capacity and productivity in the months ahead including winter pressures, a likely surge in Respiratory Syncytial Virus (RSV) and the next stage of the staff vaccination programme.

In spite of these pressures, our underpinning priorities for this year are unchanged – namely:

1. An unrelenting focus on 'fixing the basics' to ensure all our teams in all areas of the hospital are able to perform at a consistently high standard;
2. Vigilance on the safety and quality agenda, including through weekly performance meetings with the directorates to drive accountability and monitor key metrics on progress;
3. Continuing to roll out our People Strategy, building on good progress on our key workforce metrics (noting vacancy, turnover, agency spend, PDR and Statutory and Mandatory training all achieved or exceeded against targets in May and sickness was within 10 per cent of target). In particular, we need to progress our *Seen and Heard* Diversity and Inclusion strategy, developing better career opportunities for BAME colleagues, a more inclusive working culture and values-based people management practices.

Operationally, the hospital is currently extremely busy, with our hard-working teams finding efficiencies and driving various innovations to ensure we are now seeing more children and young people within the working week than ever before.

We are delivering two of NHSE's Accelerator Systems Programmes – one for Paediatrics and one for the NCL ICS. Accelerator pilot sites must deliver 120 per cent of last year's baseline activity during June and July and the programme was established by No.10 to rapidly trial innovations and interventions to boost activity, which can then be scaled and adopted by others.

We are working in partnership with Alder Hey to lead the paediatrics workstream as co-chairs of the UK Children's Hospitals Alliance (UKCHA). The accelerator is made up of five of the UK's leading specialist children's hospitals – Alder Hey, Birmingham Children's, Great Ormond Street, Manchester and Sheffield Children's hospitals. We have also been able to secure funding to involve five other CHA hospitals with big paediatric departments – Bristol Royal Hospital for Children, Evelina London Children's Hospital, Leeds Children's Hospital, Oxford University Hospital and University Hospital Southampton. This group is working together extremely well and we are excited about the potential to develop medium to long term innovations to benefit paediatric care across England.

Part 2: People

Our corporate teams are working on a transformational post-pandemic workplace strategy, which will initially deliver a set of evidence-based principles for us to share with our staff in September, so they know what to expect over the coming year. This is a complex and wide-ranging piece of work that will see the trust working in entirely new way and we are seeking support via the GOSH Charity to ensure our practices line up with the best in the sector, and that we are doing all we can to support our staff.

The workplace strategy will address the short term challenge of a significant reduction in usable desk space and the needs and preferences of staff in terms of on and off site working. It will also address issues including staff contracts to reflect hybrid working and support for managers and individuals to navigate the changes while maintaining productivity, connection and wellbeing.

We have committed six full time staff to support the Government's Vaccination Programme, including the potential need to administer Covid boosters in the Autumn. Covid vaccine uptake is being closely monitored by EMT and 75% of substantive staff are recorded as having had a vaccination. Recognising that we have a young workforce and that this figure will likely be increasing all the time we are working on data cleansing, after which we hope the figures will be upwards of 80 per cent. In the meantime, there has been a great deal of work put into signposting staff to information to support uptake, through internal communications channels (including a Q&A with David Goldblatt,) occupational health teams, peer support networks and line managers.

Part 3: Quality & Safety

Quality and safety continues to be a key area of focus as described above. The staff consultation within the quality and safety team has now concluded and recruitment is ongoing.

We are working to support directorates in driving improvements in their quality and safety metrics, covering duty of candour, surgical pre-assessment and universal implementation of the WHO checklists. Performance meetings are currently taking place weekly and we have held sessions with directorates to ensure there is clarity on expectations.

Ends

Attachment O

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7 July 2021

Patient Story- 'One Day of Hope' **Submitted by:** Alison Robertson, Chief Nurse **Prepared by** Claire Williams, Head of Patient Experience and Engagement	**Paper No: Attachment O** □ **For information and noting**

Purpose of report
The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories for the Trust Board. The purpose of the stories is to ensure that patient and family experiences are shared, and that this informs further action to share good practice and drive improvements.

Summary of report
Dorothy Moore Brooks, Senior Chaplain and Deputy Team Leader of the Chaplaincy and Spiritual Care team will attend the Trust Board meeting by zoom. She will talk about the multi team approach taken to respond to a family's request to get married in the hospital with their critically ill baby son present. Dorothy will describe the process of listening to and understanding the family's wishes, arranging the wedding, and the joy this brought in unimaginably difficult times.

Action required from the meeting
For information.

Contribution to the delivery of NHS Foundation Trust priorities □ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** □ **Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** □ **Culture of high quality sustainable care** □ **Engagement of public, staff, external partners** □ **Robust systems for learning, continuous improvement and innovation**

Strategic risk implications
BAF Risk 14: Culture

Financial implications
Not applicable

Implications for legal/ regulatory compliance

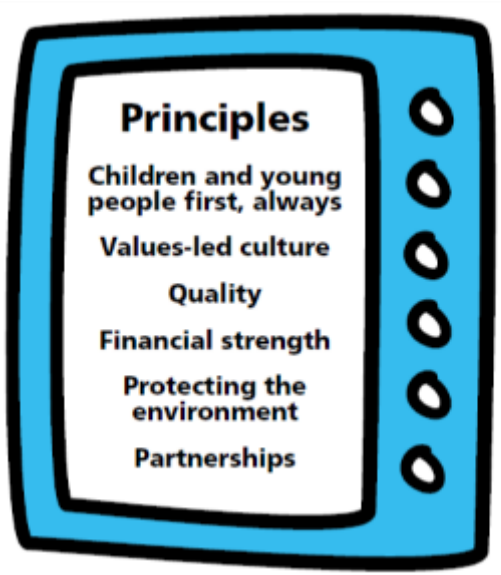
- The Health and Social Care Act 2010
- The NHS Constitution for England 2012 (last updated in October 2015)
- The NHS Operating Framework 2012/13
- The NHS Outcomes Framework 2012/13

Consultation carried out with individuals/ groups/ committees
N/a

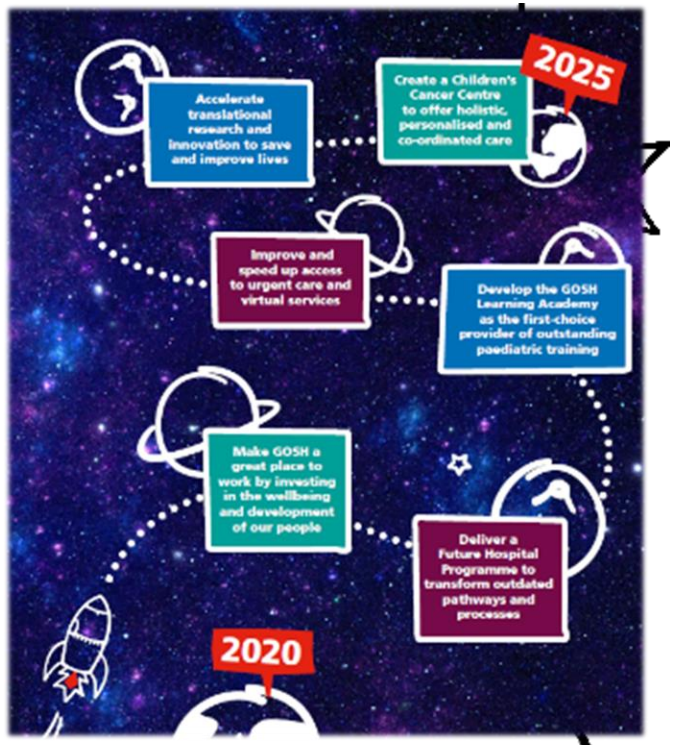
Attachment O

Who is responsible for implementing the proposals / project and anticipated timescales? Head of Patient Experience and Engagement
Who is accountable for the implementation of the proposal / project? Chief Nurse
Which management committee will have oversight of the matters covered in this report? Patient and Family Experience and Engagement Committee

Brain
DIRECTORATE REVIEW



Trust Board
Date of meeting



Martin Tisdall Chief of Service

Robert Robinson Deputy Chief of Service

Alison Taberner-Stokes Head of Nursing

Brain Leadership Team

Chief of Service

Martin Tisdall

Deputy Chief of Service

Robert Robinson

Head of Nursing and Patient Experience

Alison Taberner-Stokes

General Manager

Zoë Hallett

Epilepsy

Endocrine

Metabolic

Neurology

Neuromuscular

Neurodisability

Neurophysiology

Neurosurgery

Directorate Profile

Our Budget:

- Annual Budget 21/22: £23.41mil

Our Space

4 wards:

- **Koala** – Neuroscience Ward
- **Possum** – Neuroscience Ward
- **Squirrel Endo/Met** – a specialist endocrine and metabolic
- **Kingfisher** – Nurse lead short stay unit for endocrine, metabolic and gastro patients.
- **Alligator RANU** – day case neuroscience and metabolic patients.

Our Highly Specialised Services:

- Bardet-Biedl syndrome service
- Complex childhood osteogenesis imperfecta service
- Congenital hyperinsulinism service
- Diagnostic service for rare neuromuscular disorders
- Lysosomal storage disorders service
- Multiple sclerosis management service for children
- Vein of Galen malformation service

Our Staff

Staff Group	WTE
Additional Clinical Services	16.3
Administrative and Clerical	61.9
Estates and Ancillary	3.9
Healthcare Scientists	22.1
Medical and Dental	89.6
Nursing and Midwifery Registered	132.5
Grand Total	**326.3**

Our Specialties

- Bardet-Biedl syndrome service
- Endocrine
- Epilepsy
- Metabolic
- Neurodisability
- Neurology
- Neuromuscular
- Neurophysiology
- Neurosurgery

Top three success and challenges in the last year

Top three successes

- #1 Opening of intraoperative MRI suite and 6 Neuroscience beds on Possum Ward
- #2 Continued development of foetal medicine services in collaboration with UCH.
- #3 Continued recovery of activity and RTT position since first wave of pandemic.

Top three challenges

- #1 Backlog of inpatient and outpatient waiting lists as a result of COVID-19
- #2 Capacity: Surgical, inpatient beds and outpatient space
- #3 Succession planning for complex and specialist services

Top three priorities

- #1 Reduce waiting times and waiting list backlogs
- #2 Secure future workforce stability
- #3 Further develop research strategy

Successes

First Foetal Spina Bifida Case

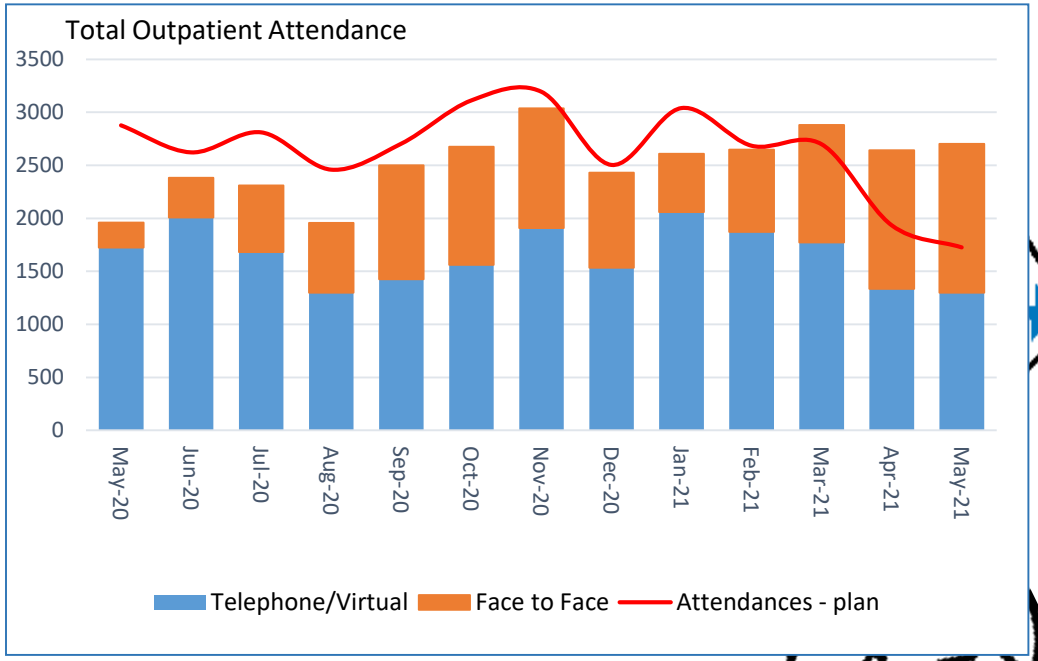
Foetal repair cohort

Intraoperative MRI Surgical Team

Principle 1: Children and young people first, always

Activity

- Delivered 91% of Inpatient and Outpatient activity plan in 20/21
- 70% of outpatient activity delivered remotely in 20/21
- Currently reporting 118% of elective Neurosurgical activity so far in 21/22
- Outpatients now over performing and delivering 50:50 split, face to face to virtual



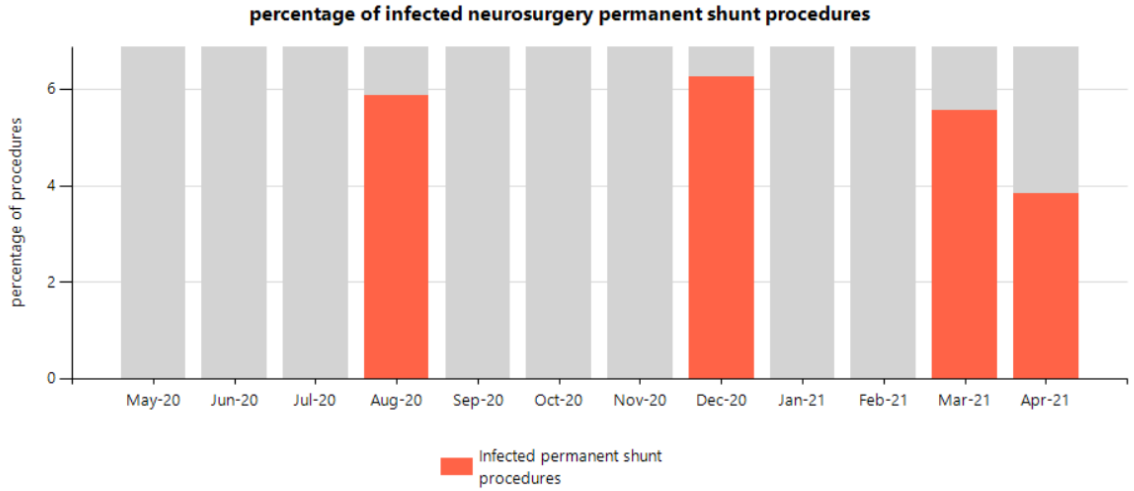
Research and Innovation

- Significant research portfolio in particular in Metabolic, Neuromuscular and Neurology
- Neuromuscular team delivered the STRIVE-EU trial at one of only two UK sites for the new Zolegnsma gene therapy for SMA
- Research income past 3 years:

2018-19	2019-20	2020-21
£222,846	£365,946	£233,102

Principle 1: Children and young people first, always

Clinical Outcomes



permanent shunt procedures

May-20 to Apr-21

infections

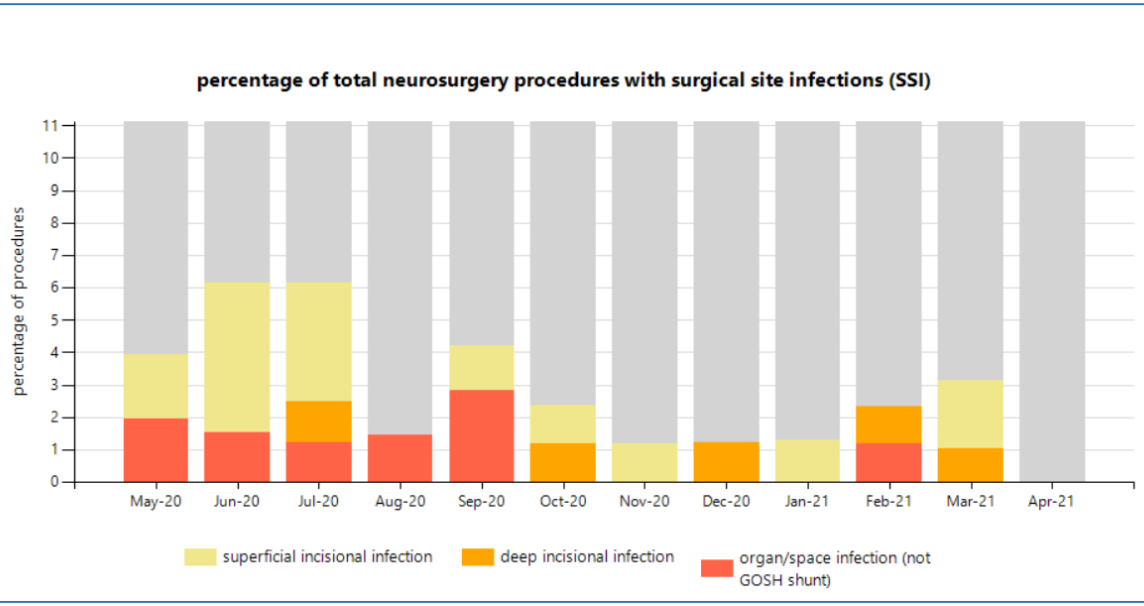
4

procedures

177

infection rate

2.3%



all procedures

May-20 to Apr-21

942

superficial incisional

13 (1.38%)

deep incisional

5 (0.53%)

organ/space

7 (0.74%)

Principle 1: Children and young people first, always

Restoring elective activity and clinical prioritisation

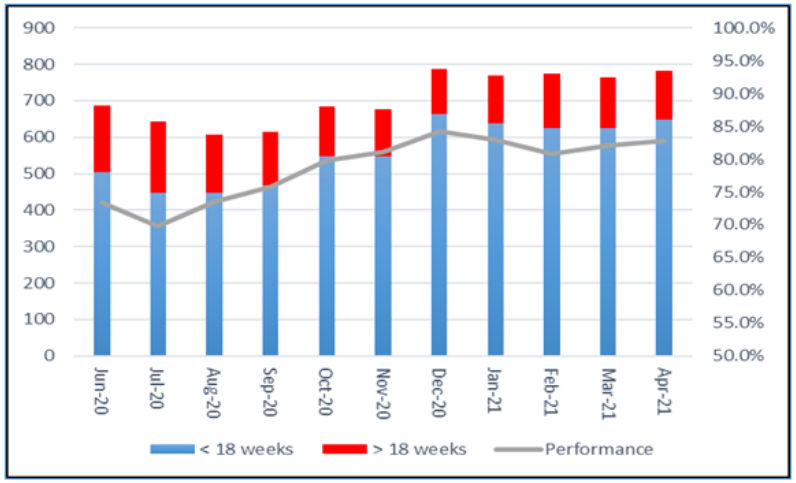
Situation:

- RTT recovering
- 52 week waits improving

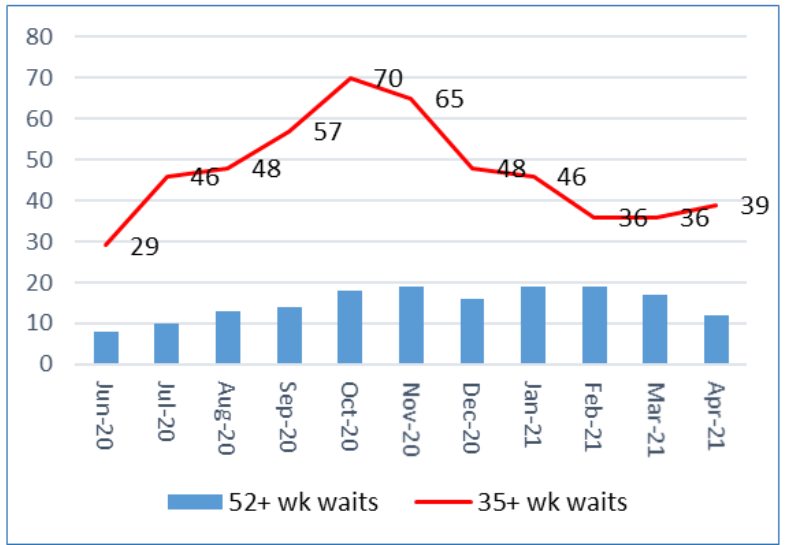
Challenges:

- Theatre capacity- impact of iMRI
- Social distancing in Kingfisher Ward has meant the closure of 6 beds.
- Late pathway referrals from local hospitals.

RTT incomplete pathways:
% of patients waiting < 18 weeks = 84.72% May 21



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



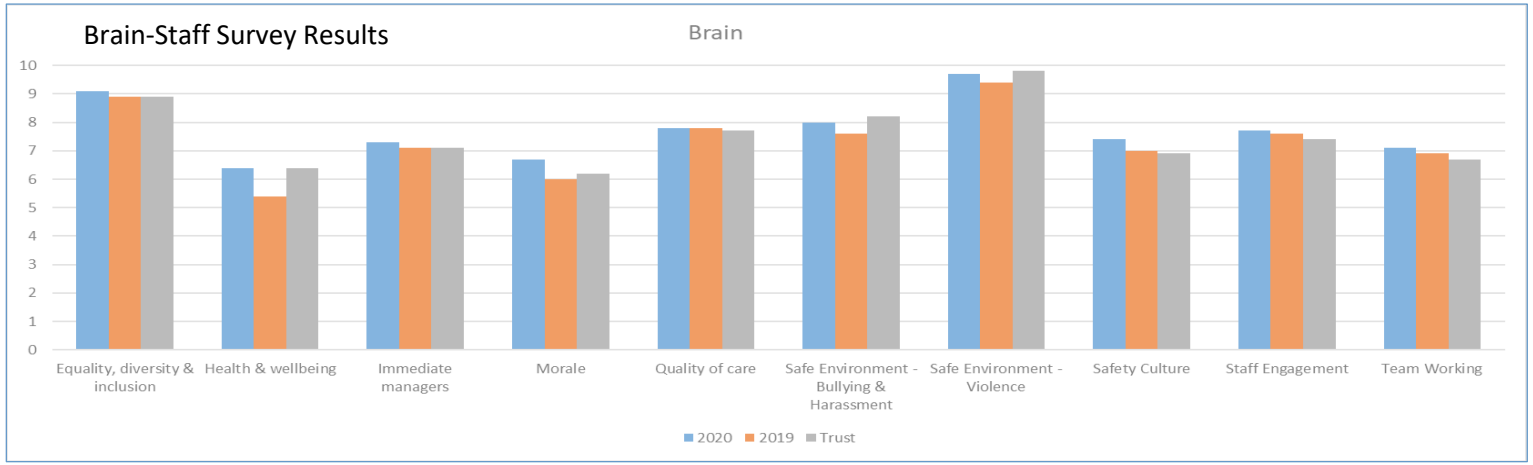
Actions:

- Focus on P2 and 52+ week waits
- Accelerator programmes to expand capacity.
- Deliver care virtually as appropriate
- Opening of 6 additional beds on Possum Ward.

Principle 2: A values-led culture

What are the top three issues for workforce?

- Succession planning for highly specialised consultant roles such as Calcium and OI.
- Nursing recruitment and retention has become increasingly challenging as a result of the COVID-19 Pandemic.
- Junior doctor workforce resilience-exploring diversification (ie ANP and Physician Associate roles)



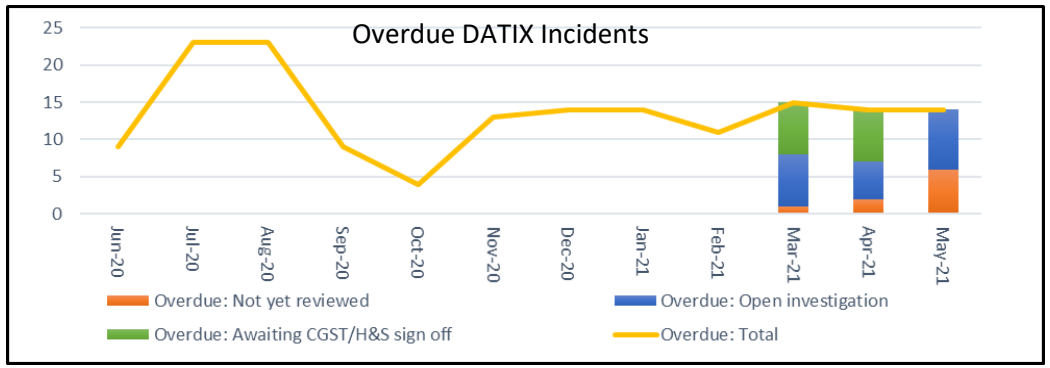
Key Actions

- Staff engagement program
- Directorate communication strategy.
- Leadership education Program
- New Starters

Principle 3: Quality

Quality & Safety Improvements:

- Significant improvement in backlog of clinic letters and average days to send letters
- Improvement to 24 hour turnaround time for discharge summaries.
- Reduction in number of overdue DATIX incident investigations.

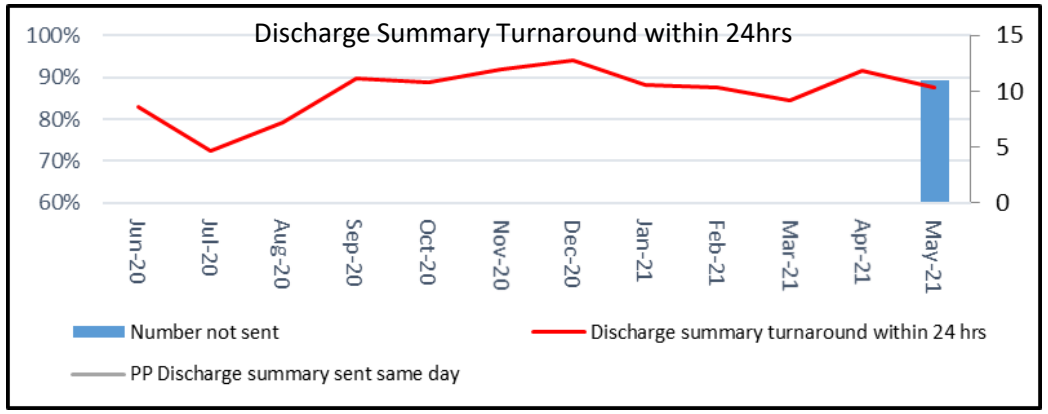


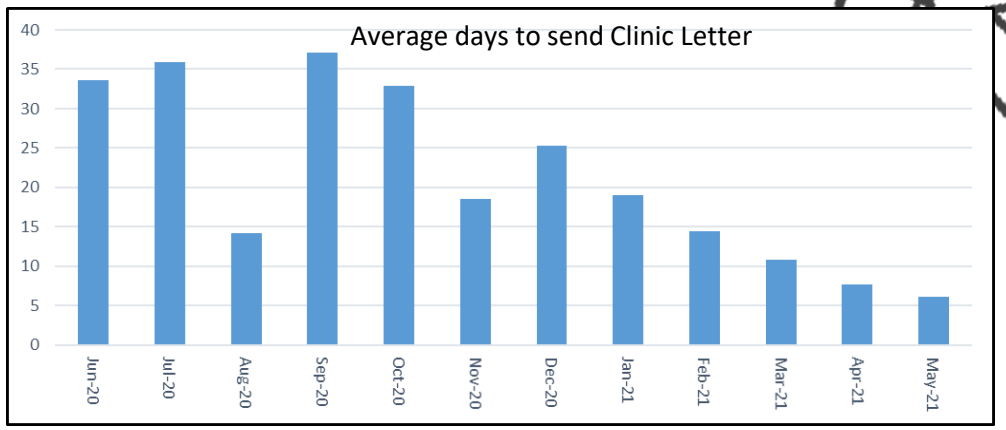
Complaints Annual Summary

12 reported formal complaints in last 12 months

9 Brain directorate / 3 joint with another directorate

Predominant themes: communication / information





Principle 4: Financial strength

	19/20 Actuals (£m)		Full Year NHSE Plan 20/21 (£m)	Full Year Actuals - 20/21 (£m)		M2 YTD Plan - 21/22 (£m)	M2 YTD Actuals - 21/22 (£m)		Full Year NHSE Plan 21/22 (£m)
Non Clinical Income	0.98		0.49	0.46		0.15	0.08		0.84
Non-Nhs Clinical Income	1.23		1.74	1.46		0.12	0.08		0.83
Pay	(20.37)		(21.81)	(22.17)		(3.80)	(3.75)		(23.13)
Non Pay Costs	(2.13)		(1.24)	(1.44)		(0.34)	(0.20)		(1.95)
Grand Total	**(20.30)**		**(20.82)**	**(21.68)**		**(3.87)**	**(3.80)**		**(23.41)**

Efficiency & Savings-Better Value 21/22

- **Better Value Target of £357K**
- **Target partially identified (£227K identified)**
- **Reduction in use of independent sector vEEG telemetry**
- **Admin vacancy factor**
- **Increase private vEEG telemetry**
- **Exploration of** reduction in blood products used
- **Overseas fellow income-**exploring expanding opportunities for overseas clinical fellows who come with income.

2020/21 Position

- **Reduced International and Private income**
- **Reduction of non-pay expenditure on 19/20**
- **Increased pay costs**

2021/22 Position

- **Currently positive against plan**
- **Private Income –** phased through year
- **Pay Budget-** Increase of previous years due to a number of approved business cases

Principle 5: Protecting the Environment

Commitment to Sustainability:

- Increase use of virtual clinics and telemedicine across the directorate, in particular harnessing technology such as Q Global neuropsychology assessments as part of epilepsy and MS assessment.
- Increased use of home video telemetry over last 12 months, reducing journeys to the hospital.
- Of 2 of 14 Cycle Champions at GOSH are Brain Directorate specialty leads.
- Directorate commitment to ‘gloves off campaign’

Current developments in environment

- Additional 6 beds on Possum Ward.
- RANU recently moved from Southwood Building to Alligator-better environment for patients.
- Challenges remain in relation to outpatient space, specifically for Neurodisability and physio gym space

Principle 6: Partnerships

System Working

- NCL Paediatric Neurology Network
- Ongoing collaboration with UCH for foetal surgery.
- Neuromuscular team leading SMA Reach Network
- Plan to bid for the new Highly Specialised Service-Inherited White Matter jointly with Guys and St Thomas's Hospital.
- Supporting the paediatric delivery of Channelopathies Service with UCLH.
- Partnership with GSTT to deliver care for patients receiving Zolgensma gene therapy.

Charity

- Funding from GOSH charity has enabled the directorate (jointly with O&I) to build and open the new intraoperative MRI suite.
- Partnership with the Ophthalmology team to deliver intraretinal Brineura
- Support from Duchenne Research Fund to fund a physiotherapy services

Attachment Q

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7th July 2021

Sustainability & Climate paper **Submitted by:** Zoe Asensio-Sanchez, Director of Estates, Facilities and the Built Environment and Nick Martin, Head of Sustainability and Environmental Management	**Paper No: Attachment Q** □ **For information and noting**

Purpose of report
There is no blue print on investment into this agenda within a Trust and this paper aims to begin the conversation and decision making process so that GOSH can lead the way through seeking discussion around the following 3 points:
- How can the KPIs, data quality and our ability to monitor the journey towards our Net Zero targets be improved going forward?
- How do we find investment to meet our targets internally or through external sources
- There is belief within GOSHCC fundraising teams that our strength on this agenda is attracting new GOSH core funding sources. How do we maximise this appetite and build new partnerships to fund our Climate & Health Emergency Response (info available on request)

The GOSH sustainability programme sits within the EF&BE team and has worked closely with EMT and the Trust board over the last few years to refine and develop the programme. This is a key strategic objective for the Trust.

Following the declaration of a Climate Health Emergency in April (as approved by the Trust board in March), the attached paper – already taken to the Finance & Investment Committee (FIC)- provides an update on progress and processes in place for this work.

The paper covers:
- What KPIs are/will we use to measure progress & performance?
- Is the data good quality?
- An estimate of investment required

Future work will include an assessment of what results from our KPIs will trigger action. This requires further development

<u>Climate Change Conference in Glasgow</u>
The GOSH team have mapped out the opportunities provided by the conference including:

- To form a coalition of child health organisations in the UK and internationally to advocate
- To share resources within the community
- To support others who have less resources to respond to the crisis.

The team are organising to cycle from London to Glasgow and arrive in time for COP26 as well as organising virtual events and webinars. The ride will take 7 days (from 24th October to 21st October) and whilst the initial plans included 75 riders that is now reduced to 25. The example routes are being reviewed but expect to cycle 66 miles per day but is flexible and will be adjusted as required. The team have been working with

logistics companies to support arrangements for the ride. Costs are currently under review but will include a registration fee for riders.

The original ride plan is currently being updated based on lack of sign up from other Trust's charities. The team here will no longer be partnering with the GOSH charity but instead will plan for 25 riders, with representatives from GOSH and 5 or 6 other trusts. The route will include stopping at key paediatric hospitals and will link with local virtual rides and other Climate Health Emergency activities. The team will produce a film and webinars to accompany the ride. Further information is provided as reading.

Action required from the meeting
Trust Board are asked to NOTE the contents of the report. Feedback or contribution to the KPI development is welcomed.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
□ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people **□ PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** **□ PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care** **□ Quality/ corporate/ financial governance**	**□ Leadership, capacity and capability** **□ Vision and strategy** **□ Culture of high quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance** **□ Accurate data/ information** **□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**

Strategic risk implications
BAF Risk 3: Operational Performance

Financial implications
The Climate & Health Emergency response and our net zero targets will need to be funded. As yet detailed figures don't exist on this

Implications for legal/ regulatory compliance
Not applicable

Consultation carried out with individuals/ groups/ committees
This paper was created in partnership with Sustainability Team members, Built Environment Chief of Staff, GOSH Director of Finance, EMT and FIC.

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

Who is accountable for the implementation of the proposal / project?
Zoe Asensio-Sanchez

Which management committee will have oversight of the matters covered in this report?

GOSH Sustainability Programme and Climate & Health Emergency response: KPIs, data quality and estimated investment

Background

There is currently no blue print we can follow to understand our Trust net zero investment needs and we are beginning a conversation internally and externally about our approach. However we are considered to be leading the way in many regards and therefore are closer to the market place and new technologies and innovations coming forward than many of our peers. We have built a strong external profile and contacts across sectors and we are regularly approached for advice and also offers of support from thought leaders, new tech and regarding emerging measuring and monitoring systems.

New methods for working on ROI are being devised by NHSE (Greener NHS) currently and we are keeping close to these as we are with refined KPIs. They have advised that these may increasingly be centralised as the agenda becomes further embedded in NHS functioning.

The paper therefore begins a conversation by outlining KPIs that allow for an assessment of our progress, an indication of data quality behind them and provides a very high level estimate of investment required to meet our targets.

Targets

As shown in the graphic (at the end of the paper) GOSH has set 2 high level targets for reaching net zero carbon emissions by 2030 (emissions we control) and 2040 (those we can influence but not directly control). However beneath this a series of sub targets will be necessary in order to ensure the correct – both small and big ticket - carbon reduction interventions are prioritised, planned for, measured and coordinated with our core business. Pathway planning & technical carbon foot print analysis is required to set these sub targets with confidence and therefore design the longer term intelligent KPIs that will drive progress towards them.

Beyond Carbon reduction alone, an effective CHE response also requires a series of wider activity - and therefore KPIs – covering a range of person centred objectives.

This table below summarises GOSH's current ability to measure progress against key programme areas of our sustainability programme and Climate & Health Emergency response.

Programme area	KPIs: What we are measuring.	Target we aim to reach (includes some current baseline for context)	Regularity of reporting	Data Quality
Energy	*Electricity & Gas use- kWh & £* - Barclay House - Weston House - ZCR - Italian Hospital - Great Ormond Street Hospital clinical block (Island site includes all other clinical buildings)	**Target: 10% reduction in 2 years** will be achieved through efficiencies due to both staff behaviour changes and technical interventions. We'll also increase the renewables content (reducing carbon) within the energy mix we purchase through changing our procurement practices and energy provider. Later carbon reduction standards will only be met due to wider 'Grid Decarbonisation' that reduces carbon in this mix still further.	**Monthly**	Energy use data drawn from bills downloaded from gas/elect supplier web portals. Limited data granularity through lack of sub metering and BMS (Building Management System) functionality. Therefore ability to target & measure energy efficiency interventions on a theatre/ward/floor/building/or even wider area isn't really possible. A programme of measurement using portable metering systems may be an option in some circumstances to gain this insight
Waste	*Waste Tonnage and cost (data broken down to total/ recycled/energy recovered) for following waste streams:* - Dry mixed recycling - General waste - Clinical waste - Offensive waste - Hazardous/WEEE - Confidential - Bulky - Food - Reported contamination cases & total penalties	**Target: Reach zero waste to landfill in 2 year** **5% increase in overall recycling rates** and reduction in other waste streams **30% reduction in reported contamination cases in 2 years**	**Monthly**	Information from sub-contractor received on a monthly basis provides consistent weight and cost data Combined with contamination data it allows for some ability to target interventions through localised hospital campaigns supported by a 3rd party partner.

Water	*Water use in litres and cost*	Not available **10% reduction in water use in 2 years**	**Monthly**	Currently poor quality and accessibility
Medical Gas	Anaesthetic Gases in litres & Co2 equivalent - Desflurane - Nitros Oxide - Suverflurane - Isoflurane - Inhaler gases	**20% reduction in 2 years** Last year of GOSH use: 169 Litres/ 625 tonnes CO2 345600 Litres/193 tonnes CO2 847 Litres/167 tonnes CO2 64 litres/49 tonnes CO2 Tbc	Monthly typically More frequently during campaigns	Good data but basic. Significant opportunity to link usage data to EPIC increasing quality and accessibility for use when running Greener Anaesthesia campaigns.
Staff engagement & activity	*Green Champions* - staff sign ups - working groups created *CHEER (staff behaviour change) mobile app data* - Staff registrations - Staff actions taken - Co2 avoided in KG	**Target: 10% of staff signed up (to all engagement activities) in year 1 (500) 30% in year 2 (1500)** **Target: 10 x working groups (one for each SDMP area) producing measurable outputs in year 1** Current baseline 60 8 133 3196 **(target of 50,000 in 2 years)**	**All weekly**	Easily recordable data with ability to tailor as with a new effort/impact metric created MS Office Forms allows for visualisation graphics etc

	Taking the Temperature survey results- *- Staff responses*	4774.8kg **(target of 75,000kg in 2 years)** 86 responses (target as top)		
Air quality	*Live monitoring station data in ug/m3 (micro grams per cubic meter):* - Nitrogen Dioxide (No2) - PM2.5 Particulates *Clean Air Hospital Framework (CAHF)* - GOSH delivery score CAHF downloads and peer usage	**Target: 50% reduction in no2 & PM2.5 breaches in 5 years** **5% reduction in daily average No2 & PM2.5 in 3 years** *Current baseline* Breaches WHO levels on 7 of 14 days (no2) Breaches WHO levels on 9 of 14 days (PM2.5) ***2023/4* target- 738.5 points/70% complete (Excellent rated)** Current baseline *2019*- 158.5 points/15% complete *2021*- 386.5 points/37.5% complete **Target: 50% (111) of Trusts to have downloaded and 25% (56) pledged to become Clean Air Hospitals** Current basline 48 NHS Trusts have currently downloaded framework of which 18 pledged to become clean air hospitals.	**Weekly** **6 monthly** **6 monthly**	The graphs in appendix 5a & b show No2 and Particulate levels for the last 2 weeks at main entrance. Half hourly data linked to the Imperial College monitoring network (Part of GLA's BreatheLondon programme). Strong data. Not scientific but covers wide range of interventions and allows for benchmarking between other Trusts.

	- Local public realm interventions Quantitative • Vehicle numbers on street - cars, deliveries & ambulance • parking on streets - permit, pay & display, doctor spaces, ambulance, etc • pedestrian numbers • pedestrian crossing • bicycle numbers • air quality • noise • ages of pedestrians • social interactions/groupings Qualitative • perception of safety study	**Target: GOS becomes 1-way within 1 year** **25% reduction in combustion engine traffic in 2 years** **Target: 5% Improvement in all positive metrics and decrease in negative in 18 months** LB Camden have modelled a one way GOS predicting a 30% reduction in traffic. **Target: 50% improvement in positive perception from staff and community**	**6 monthly** **Monthly** **3 monthly**	Measured through website data and accompanying survey. From this year uptake can also be measured through NHSE Premises Assurance Model (PAM) returns. A mixture of qualitative and quantitative data will be gained through tried and tested methods including vehicle counts, surveys and electronic sound/air monitoring.
CCC & wider estate links	*Carbon baselining process feeding into creation of a dedicated 'Sustainability Decision Making Framework'*	**Target: Estate baselining complete within 6 months**	6 monthly refresh	Although relies on some limited data sources it will draw on expertise of specialist M&E engineering partners

	- GOSH Estate carbon baseline assessment - Carbon links between CCC/wider estate/ongoing Master Planning			
Staff travel	Staff travel survey responses provide quantitative data on - Staff journey time/distance/modes - Active travel transition support needed	**Target: 10% of staff transitioned to active travel modes 3 days/week in 18 months** **Target: Bi monthly staff engagement/ support initiatives delivered**	6 monthly (launches in July) Bi monthly	
Procurement	- £ uplift required to replace products with more sustainable alternatives - £ saving identified through lifecycle analysis of using these (reusable products etc) - Specific focus area on single use plastics as per NHS Long Term Plan	**Target: Total cost of uplift required for all spend is identified. (18 months)** **Target: Using lifecycle assessment total savings over next 5-10 years is identified (18 months)** **Target: Single use plastic specific uplift & savings identified as per NHS LTP (1 year)**		- Strong financial comparison data will be available - Following lifecycle analysis processes allow for clear long term procurement decision making
Fundraising	GOSHCC partnership - Number of new funders attracted by sustainability offer - £ Value of above (restricted & unrestricted incom Pro Bono support	**Target: 10 existing funding partnerships contributing to sustainability response and 5 new to GOSH partnerships contributing due to sustainability offer** **Target: £500,000 unrestricted and £500,000 restricted income in 2 years** **Target: £300,000 Pro Bono support in 2 years**	Monthly	Good data if the right system is in place to capture it

	- £ equivalent of product and service provided due to sustainability offer			As above
	Grant Funding - £ secured for sustainability offer (restricted & unrestricted)	**Target: £500,000 grant funding in year 2 years**		
		Current basline 8 new charity funding leads in recent months. According to Charity colleagues all of these either 'must' have a strong environment/sustainability offer to apply or having that has, 'brought an angle increasing likelihood of deal being clinched' by the Trust.		Maybe hard to quantify
		2 small partnerships. Not monetised		Generally simple to quantify
		£103k provisional offer for restricted estates carbon efficiency measure		

Table: GOSH Sustainability & Climate & Health Emergency response KPIs. (In order to demonstrate the exact contribution of meeting each of these KPIs to the overall CHE net zero targets, further carbon analysis and baselining will be carried out).

Current spend

The Sustainability Team currently has 2.5 posts funded through the Built Environment revenue budget and £10-15k pa allocation of revenue to cover minor project costs. The only other spend includes the GOS Parklet (£10k Charity COVID fund) and Public Realm concept designs (£20k for short/long term pieces). Approx £1m pa invested via the capital programme to make the estate more sustainable.

We have been building a strong partnership with the GOSH CC across the last year where we have accumulated 8 strong funding leads in recent months with as many more opportunities on the backburner awaiting permission to engage.

Future investment estimate

Enabling the Trust Climate & Health Emergency Response targets to be met is estimated to require 0.75% (NHSI/Committee on Climate Change guidance) of annual operational expenditure, which equates to £4.25 million pa on GOSH 2020/21 expenditure.

An indicative apportionment (taken from best peer practice) of the £4.25m is reflected below and linked to KPI areas. The source of funds would ideally be from existing allocated invest to save capital or will form future invest to save business cases. This also presents a significant opportunity to work with the GOSHCC fundraising team on a potential sustainability fund.

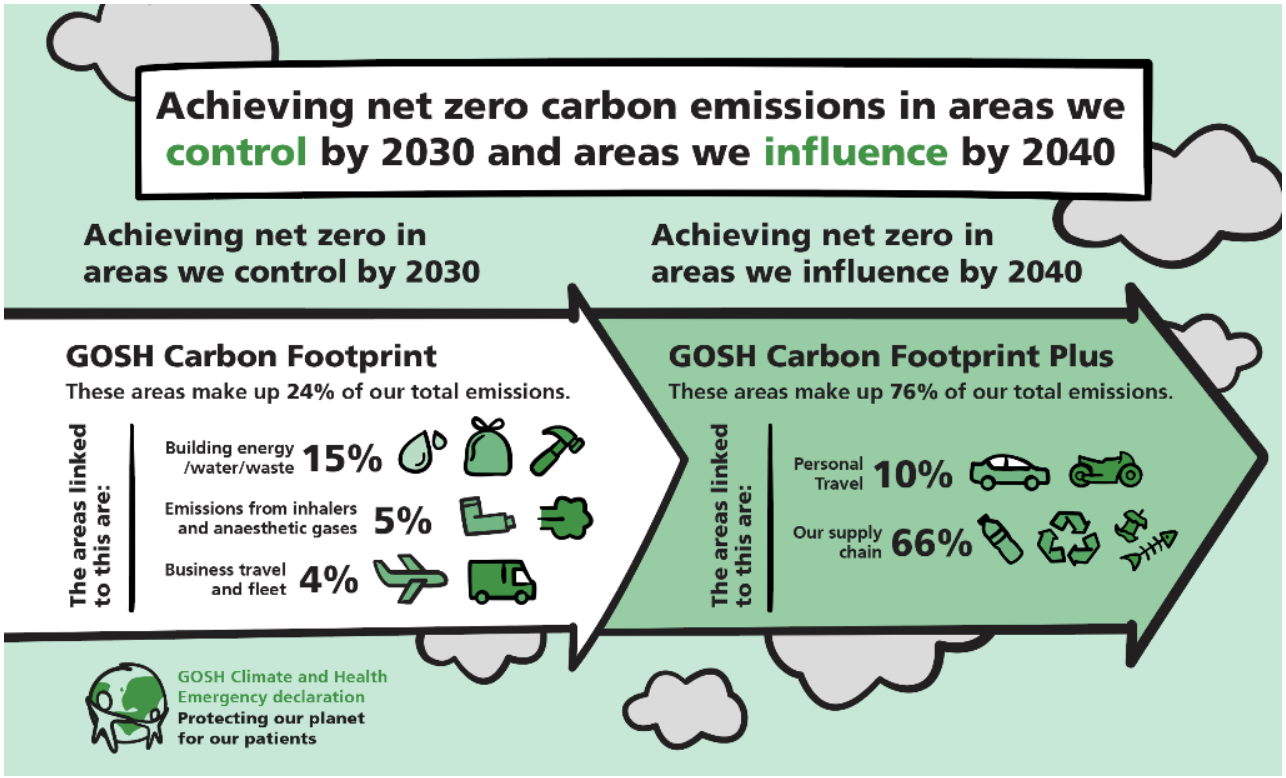
Spend apportioned for KPI areas contained in main table below:

- £2.8m on invest to save projects (estimated value of energy efficiency/transport projects including lighting to LED conversions, Mechanical & Electrical (M&E) Estate interventions, electric vehicles)
- £0.4m on transformation and culture change projects (estimated cost of transformation and engagement projects including clean air hospital framework, CHEER App, Green Champions, CHE responders etc)
- £0.25m on resources to support delivery (estimated cost of existing and new staff, communications and external project support, baselining & Sustainability Impact Assessment for all other KPI areas)
- £0.8m) on pilot schemes for sustainable procurement initiatives (estimated uplift on replacing products/services with more sustainable alternatives, including reduction in single use plastics)

- **A summary of fundraising options is also outlined below**

Governance

We'll submit a KPI report and score card on a 2 monthly basis into the BE/E&F performance management structure for review. This will be timed to report into the Audit Committee and EMT.


Achieving net zero carbon emissions in areas we control by 2030 and areas we influence by 2040
Achieving net zero in areas we control by 2030
Achieving net zero in areas we influence by 2040
GOSH Carbon Footprint
These areas make up 24% of our total emissions.
The areas linked to this are:
Building energy /water/waste 15%
Emissions from inhalers and anaesthetic gases 5%
Business travel and fleet 4%
GOSH Carbon Footprint Plus
These areas make up 76% of our total emissions.
The areas linked to this are:
Personal Travel 10%
Our supply chain 66%
GOSH Climate and Health Emergency declaration
Protecting our planet for our patients

Attachment R

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 7 July 2021	
Quality Report 2020-2021 **Submitted by: Sanjiv Sharma, Medical Director**	**Paper No: Attachment R**

Aims / summary

The Trust Annual Quality Report 2020-21 is attached for information and noting. In late May 2021 all Trusts were advised that the Quality Report would need to be submitted by 30 June 2021. The report will be published on the GOSH website.

Feedback on the Quality Report has been received from our NEDs, Governors and external stakeholders including the Chair of Camden Health and Adult Social Care Scrutiny Committee and the NHSEI, London Region, Specialised Commissioning.

The Quality, Safety and Experience Assurance Committee received a copy of the final report at its meeting on 1 July 2021.

Action required from the meeting
To note and receive the report

Contribution to the delivery of NHS / Trust strategies and plans
The Quality Report publicly sets out GOSH's commitment to improving quality. It also celebrates our achievements and identifies areas for growth for the forthcoming year.

Financial implications
None

Legal issues
None

Who is responsible for implementing the proposals / project and anticipated timescales
Sue Chapman for the 2020-2021 Quality Report publication

Who is accountable for the implementation of the proposal / project
Dr Sanjiv Sharma as Executive Director for Quality and Safety for the 2020-2021 Quality Report publication.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Quality Report

2020-2021

Table of contents

What is the Quality Report?

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

What does it include?

The content of the Quality Report includes:

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

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) was established in 1852 and was the first hospital providing in-patient beds specifically for children in England. Today, GOSH is a tertiary and quaternary care hospital that provides specialised and highly-specialised services to children and young people (CYP) with rare and complex conditions. GOSH is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. There are 63 different clinical specialties at GOSH and around half of patients come from outside London. GOSH is also renowned internationally. We work with governments and other sponsors to welcome 5,000 children annually from around 90 countries that lack the facilities and expertise to treat rare or complex paediatric conditions.

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

Our strategy: To go above and beyond

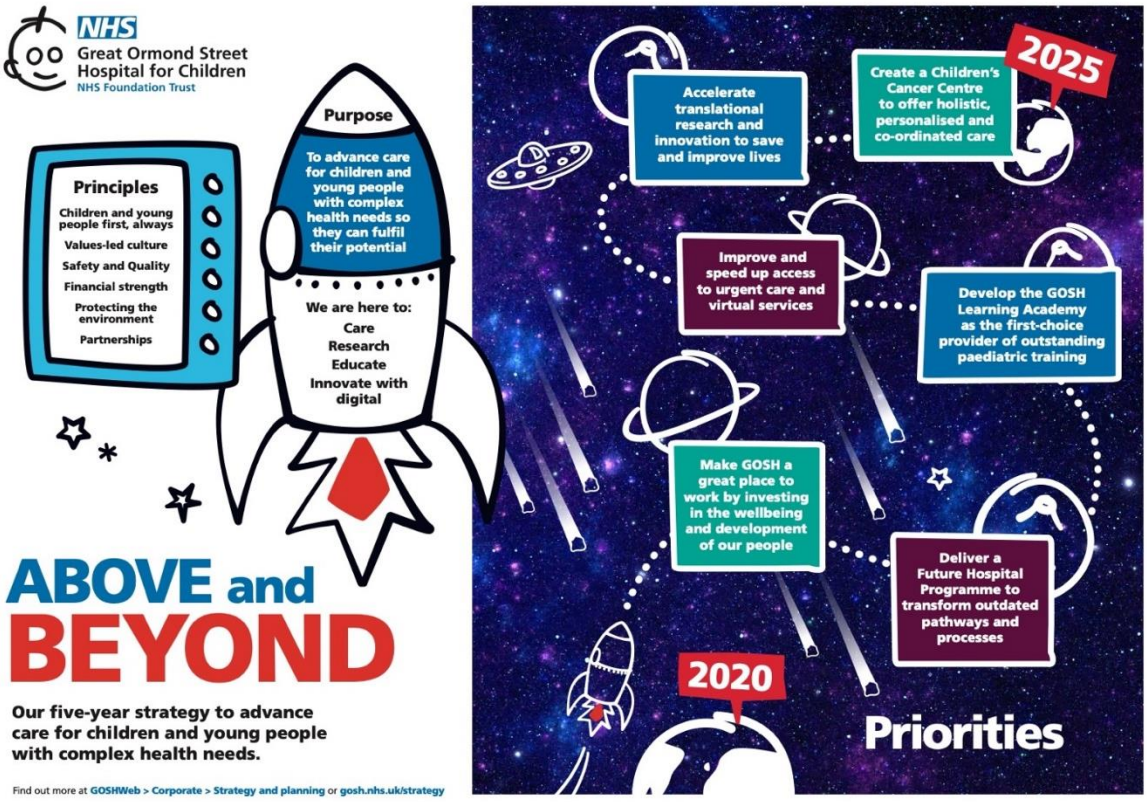
As a Trust we have a clear purpose which has endured since the Hospital first opened it's doors in 1852. We provide healthcare for children. How and what we deliver has always and will continue to be driven by the needs of our patients. With clarity about our purpose and the needs of our patients, we have developed a set of principles and priorities to guide us. We have a vast set of enablers that facilitate the work we do, from human support and capacity to expert medical knowledge, to the bricks and mortar premises that house us. Our enablers allow us to get on with the activity of providing care to our patients. Each one of our activities generates an outcome for our patients. Achieving the very best outcomes for our patients is our ultimate goal.

Our purpose is **to advance care for children and young people with complex health needs**.
We have six guiding principles:

1. Children and young people first, always
2. Always welcoming, helpful, expert and one team
3. Safe, kind, effective care and an excellent patient experience
4. Stronger finances support better outcomes for more children and young people
5. We aren't caring for children if we don't protect the environment
6. Together we can do more

Above and Beyond

Our Trust Strategy Above and Beyond, sets GOSH's vision for the next five years and lays out priorities that are strategically important.



Our big six priorities for the next four years are:

- Make GOSH a great place to work by investing in the wellbeing and development of our people
- Deliver a Future Hospital Programme to transform outdated pathways and processes

- Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training
- Improve and speed up access to urgent care and virtual services
- Accelerate translational research and innovation to save and improve lives
- Create a Children's Cancer Centre to offer holistic, personalise and co-ordinated care

To help move us from strategy to activity, the Trust has and is developing enabling strategies that cover the themes of:

- People
- Clinical business
- Research
- Education
- Transformation

Our Key achievements in 2020/21

- Recognition by the Children's Commissioner for good practice in opening a new paediatric ward specifically for children presenting to hospitals within North Central London with acute mental health support needs during the first wave of COVID-19-19-19
- Developed a Little Room of Horrors (escape room) for staff as part of Break-the-Chain week to raise awareness of infection prevention and control
- Supported the launch of electronic patient records at the Royal Devon and Exeter Hospital.
- Launched new app called CHEER (children, climate and health emergency response) to help motivate staff and track their sustainable travel, electrical device use and food choices
- Our Zayed Centre for Research won a European Healthcare Design Awards, American Institute of Architecture UK Design Award, Architecture Master prize, and 'caring' category at New London Architecture Awards
- Our Apprenticeship Team won a BAME Apprenticeship Award
- The Minimal Residual Disease Team in Haematology won an Innovations in Healthcare Science Award
- Lion Ward won a Solving Kids' Cancer NHS Hero Award
- UCL Great Ormond Street Institute for Child Health achieved gold award in the Athena SWAN Charter
- Medical Journalists' Association award won by the BBC for their coverage of Safa and Marwa, craniopagus conjoined twins' story
- Developed the COLLABORATE Leaders' Network to share exemplary and new practice in leadership and management
- Developed an acute, multi-layered, multi-dimensional Staff Wellbeing Service during COVID-19. This resulted in a 17% increase in our staff perception that the trust was taking positive action on health and wellbeing. This was the largest improvement across the staff survey.

Our key strategic objectives for 2021/22 are:

Make GOSH a great place to work by investing in the wellbeing and development of our people	• External recruitment, promoting GOSH as a creative, diverse and inclusive employer of choice • Create internal career paths and progression opportunities • Create a more inclusive work culture • Create channels and safe spaces which amplify the employee voice • Ensure that wellbeing is considered across the organisation • Provide occupational health and support services that meet the needs of our changing context • Ensure our staff feel safe and secure while working
Deliver a Future Hospital Programme to transform outdated pathways and processes	• Continue to optimise and integrate our electronic patient record • Improve inpatient flow • Transform our outpatient services • Redesign our clinical pathways • Transform our pharmacy services • Integrate technology into our everyday • Value and integrate our patient, family and partners contributions
Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training	• Build sustainability • Utilise our education voice • Broaden our education portfolio • Support educational research and innovation e.g. virtual reality • Ensure education is accessible for all • Launch our Virtual Learning Environment • Continue with patient safety simulation programmes • Ensure we have the skills and knowledge to support the Trust's six priorities • Partnership working through DRIVE, STP, HEE
Improve and speed up access to urgent care and virtual services	• Technology to support care • Always say yes, safely • To right size services • Optimise use of electronic patient records • Working in partnership • Increase use of MyGosh patient portal • Refine theatre scheduling • Open Operations Hub • Revised Bed meeting implementation
Accelerate translational research and innovation to save and improve lives	• Continue to transform GOSH into a Research Hospital • Maximise the use of the rich data sets and analytic capacity • Maximise the use of patient biological samples by building a fit for purpose Sample Bank • Harness digital innovation • Renew NIHR funding to support our world-class Biomedical Research Centre and Clinical Research Facility • Establish and embed a fit for purpose commercial strategy • Support and develop clinical academic careers
Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care	• Clinically lead project – this is not just about a building • Meaningful patient and family engagement to inform design • Clear transparent governance between the Hospital and Charity • Early consideration of future digital and research innovations • Robust and proactive cost, programme and risk management • Sustainable approach to design incorporating nature • Establishing the best long term solution for our Imaging and Intensive Care services

Our contribution during COVID-19

The COVID-19 pandemic has had a significant impact on the NHS. Although the disease primarily affected adults and the elderly in particular, we supported our partners and the wider NHS to respond to the pandemic whilst continuing to provide care for children with critical illness and rare and complex diseases.

We supported the North Central London (NCL) sustainability and transformation partnership in a number of ways. General paediatric patients were transferred from hospitals across NCL to GOSH to allow our NCL partners to use these wards to care for adults. We diverted staff from other duties, reconfigured rotas and collaborated with centres across NCL to admit 315 children and young people under our General Paediatric team. The youngest was 13 days, the oldest was 18 years.

The pandemic had a significant impact on children's mental health. Children were being held for longer periods in emergency departments whilst waiting for a suitable environment for ongoing care. Recognising the significant impact of this, we opened a new ward to provide a dedicated and safe environment to support this group of vulnerable children. GOSH requested and were granted a temporary amendment to our Care Quality Commission (CQC) registration to allow us to assess and/or treat patients detained under the Mental Health Act 1983. Clinical experts from our Child and Adolescent Mental Health team worked with our general paediatric team and the wider hospital to provide support. The effort was recognised in a report published by the Children's Commissioner which praised GOSH for its 'innovative response' in supporting this group of children and young adults.

Paediatric haematology and oncology service at University College London Hospitals (UCLH) were also transferred to GOSH with both teams collaborating to ensure continuity of treatment. Our long-standing partnership with UCLH smoothed this transition and children with life-threatening illness continued to receive high quality specialist care throughout the pandemic.

The pandemic brought a surge of adult patients requiring critical care. To allow other hospitals to convert their paediatric intensive care units to care for adults, GOSH increased paediatric intensive care capacity to ensure we 'never said no' to a child needing critical care. Staff were deployed from wards across GOSH to support the service and our education team stood up development programmes through the GOSH Learning Academy to rapidly upskill staff. The Children's Acute Transport Service (CATS) supported paediatric critical care transfers across London and beyond, and stood up 'Big CATS' to transfer adults critical care patients between hospitals to support the increased demand. We loaned critical care equipment including ventilators and life-saving ECMO machines to hospital across London. We also supported the Nightingale Hospital by deploying staff to lead education programmes and provide clinical and operational leadership.

In late Spring 2020 GOSH and other hospitals experienced a sudden increase in children admitted to the paediatric intensive care unit (PICU) with shock and fever. Children's hospitals and professional organisations came together and found that a small number of children experienced a significant systemic inflammatory response to COVID-19. This rare but serious complication was given the name PIMS-TS. GOSH saw high numbers of children with PIMS-TS, most of whom required admission to paediatric intensive care. Our infectious diseases ward, Pelican, was re-purposed to care for children with PIMS-TS and our clinicians and researchers collaborated to share understanding on how to identify and treat this new disease. Since December we have treated 107 children with actual or suspected PIMS-TS and you can read more about how we did this in the next section of the report.

GOSH responded to requests to support our NCL partners by deploying staff to areas of most need. During the second surge 126 nurses were deployed to external hospital across London. They supported a

range of services including General Paediatrics, Adult Intensive Care Units, mental health units and emergency departments at the Royal Free, Whittington, University College, North Middlesex and Barnet Hospitals. Many worked under extremely challenging conditions to ensure the NHS could continue to support all patients who needed care.

Our GOSH Learning Academy (GLA) led on upskilling and refresher sessions to support staff at GOSH and prepared others who were deployed to hospitals across NCL. At the height of the pandemic the Learning Academy delivered a 7-day a week service. Sessions in general paediatrics, adult vaccination, anaphylaxis, adult Basic Life Support (BLS) and adult ICU skills were delivered by the education team to support clinical competence. By May 2020 over 2,000 clinical and non-clinical staff had attended GLA COVID-19 up-skilling and update sessions, including many colleagues from external Trusts redeployed to GOSH. This included clinical staff who were 'out of current clinical practice' to clinical staff needing critical care skills to non-clinical staff who had not worked previously in clinical environments. GLA also worked with senior nursing staff and education teams to ensure skills and competencies developed during the first surge were maintained to support a rapid response during the second surge. The GLA also provided education for the Nightingale Hospital with several senior educators redeployed to up-skill the large volume of staff required.

Continuing to care for children remained our mission throughout the pandemic. During the first wave elective work was postponed and restrictions were in place which prevented many face-to-face consultations. Our ICT, Epic and Improvement teams worked with clinicians to develop virtual clinics so we could continue to support patients remotely. During the pandemic a large proportion (64%) of GOSH's outpatient work was conducted virtually, using telephone or video conferencing. You can read more about our virtual clinics later on in the Quality Report.

To support children and families information was made accessible through the Covid Information Hub on our website. Patients and families could access information about how the Trust was operating, and guidance on isolating and shielding, with specially developed resources to help children and young people cope with the changes related to COVID-19. The GOSH charity provided a large number of tablet devices to enable patients and their carers to stay in touch with family and friends who could not visit due to restrictions in the hospital. The charity also provided items for arts, craft, music and sensory activity packs for children as well as toiletries, toothbrushes and other items to support families at the hospital.

Following advice from NHS England we were able to re-start our elective work at the end of April 2020. To ensure we were treating children in most need first, we established a clinical prioritisation group, led by our Medical Director. The group developed clear criteria and processes to ensure each child was assessed and treated in priority order and delays to treatment were assessed, monitored and documented. Our EPR team worked with clinical and operational colleagues to rapidly develop a 'first of type' digital solution to support the clinically prioritisation of patients based on clinical assessments. This was designed and deployed to over 4,000 clinical and operational staff in just four weeks. This solution has been shortlisted for a Health Service Journal award in the Operations and Performance Initiative of the Year category.

Keeping children, families and staff safe and informed was a priority. At the peak of the pandemic, our senior leaders were meeting daily at the Silver and Gold operational meeting. Information was cascaded to the rest of the hospital via departmental bronze meetings, the daily coronavirus email and a weekly live blog with the CEO and executives. The blog was viewed by several hundred staff on site and working remotely each week. We set up an internal website as a single hub for all Covid-related documentation, research and policies for both internal staff and guests. Within a week there were hundreds of documents and links available in a single place and the site was continually updated so staff had access to the most current information.

GOSH laboratory service worked in partnership with the infection control team and UCL Great Ormond Street Institute of Child Health to establish a COVID-19 testing facility for patients and staff. This vital service enabled us to protect patients, families and staff by rapidly identify those who had COVID-19. During 2020-2021 we tested 2285 staff, 7617 patients and 639 parents at GOSH. We also supported external hospitals by delivering 8291 COVID-19 tests for patients receiving mental health services at Barnet, Enfield and Haringey Trusts' and 1713 tests for NHS staff outside of GOSH.

Personal Protective Equipment (PPE) was essential to protect staff caring for children with COVID-19. At the height of the pandemic supplies of vital equipment like masks was maintained by using different suppliers. At least 23 different types of masks were available. This presented challenges as staff needed to be tested against each type of mask to ensure a proper seal. Our infection prevention and control (IPC) team set up fit test "clinics" for staff and our improvement team developed a browser-based application with a central database to store their results. This allowed 3705 staff who had masks fit tested to see their results and allowed the IPC team to assess the impact if supplies masks were disrupted.

At the end of 2020 a vaccine to protect against COVID-19 was released. 300 GOSH staff undertook training to become vaccinators. Our improvement team developed an in-house booking system so staff could choose a date and time slot for their vaccinations, with calendar appointments sent automatically. To date we have delivered 8997 vaccines to our staff.

We were extremely sad to hear of the untimely death of three of our treasured GOSH colleagues as a result of COVID-19, and our sympathies are with their families and friends.

A new paediatric disease triggered by COVID-19: PIMS-TS

Most children with COVID-19 have either no symptoms or show only very mild symptoms. However, in late Spring 2020 GOSH and other hospitals experienced a sudden increase in children admitted to the paediatric intensive care unit (PICU) with shock and fever. Children's hospitals and organisations such as the Royal College of Paediatrics and Child Health (RCPCH) and NHS England came together and found that a small number of children experienced a significant systemic inflammatory response to COVID-19. This rare but serious complication was given the name PIMS-TS.

From around April 2020 we began to see relatively large numbers of children with PIMS-TS at GOSH, nearly all of whom required intensive care. As this was a new disease there were no recommended treatments or pathways for us to follow. We repurposed Pelican Ward so our multidisciplinary team (MDT) could work together to care for children with suspected PIMS-TS after transfer from intensive care. Large numbers of GOSH specialists, laboratory staff, therapists, the infection prevention and control team, specialist nurses and researchers worked intensively together to develop completely new treatment protocols and pathways. Our clinicians collaborated with experts from across the UK to develop a national consensus management pathway for PIMS-TS.

To support children who were ready to leave hospital we set up a new PIMS-TS MDT clinic. The clinic provided expert specialist input and the best possible follow-up experience, limiting hospital visit time, providing information and support from a defined group of specialists, with an easy contact point for concerns and queries. The clinic is co-ordinated by the infectious diseases team and provides a contact point for specialist nurses and other members of the MDT. The clinic has been running for just over a year, is a leader in the field and a model for similar clinics elsewhere in the world.

Research was essential so we could understand the cause of the disease and how best to treat it. GOSH staff helped to modify the 'RECOVERY' research trial protocol to allow children and young people with PIMS-TS (and COVID-19) to participate. To date, GOSH has recruited the largest number of UK paediatric patients. Our Clinical Research Facility ensured as many children as possible were included in observational studies and we have contributed to a large number of collaborative, high impact research papers to share our experience for benefit of patients across the globe.

All members of the MDT have gone above and beyond throughout the two waves of the pandemic so far, often working way beyond their contracted hours and with extreme dedication to ensure that children and young people suffering from this rare but severe response to Covid receive the highest quality of care.

Part 1: A statement on quality from the Chief Executive

This Quality Report covers an unprecedented period for Great Ormond Street Hospital for Children (GOSH). As part of the wider NHS response, our hospital and our hard working, committed team responded swiftly, flexibly and collaboratively to fast moving situations throughout the global pandemic. Our three quality priorities, of safety, clinical effectiveness and a positive experience for patients and families, helped us respond in a consistent fashion that aligns with our core principles. By launching our Trust Strategy, Above and Beyond, in the summer of 2020, we were able to enshrine the principle of quality in a document that will guide our work to 2025.

Of our three quality priorities, safety has most definitely been front of mind in the face of COVID-19. As we learned more about the virus, it became apparent that the disease posed a more significant danger to older people and vulnerable adults than to children and the young. Nonetheless, our responsibility to keep our patients, families and staff safe, and our commitment to support the wider healthcare system, required that we implemented change at pace. As a result of internal and external scrutiny of our patient safety processes and learning from our mistakes, errors and incidents, we have made a commitment to an extensive patient safety transformation programme over the next three years, partnering with external experts and patents.

Our laboratory service, working with the infection control team and UCL Great Ormond Street Institute of Child Health, worked quickly to establish a Covid testing facility for patients and staff. This testing facility rapidly identified those who had the virus so we could manage patient care and support our colleagues and families accordingly. We tested 2285 staff, 7617 patients and 639 parents at GOSH. We used the results to move children and young people onto appropriate care pathways to reduce the risk of cross infection. Reluctantly, we imposed visiting restrictions on our families, which we applied as compassionately as we could. Across the hospital site we developed and followed strict rules on hand hygiene, social distancing, mask wearing and home working to manage the risk of contagion.

As the wider NHS came under pressure, we increased the capacity of our paediatric intensive care units. This allowed us to take more patients from other Trusts so that they, in turn, could care for high numbers of adult patients as safely as possible. Later in the year, when a vaccine became available for COVID-19, 300 GOSH staff trained to become vaccinators and our improvement team set up an in house booking system to help staff access the vaccine as quickly as possible. To date we have delivered 8997 vaccines to our staff, supporting the most effective strategy available to keep colleagues, patients and families as safe as we can from the virus. We continue to advocate the vaccine programme to our staff and families to give them and the wider community the best protection against COVID-19.

We chose to launch our strategy, Above and Beyond, in the eye of the pandemic storm so we could reaffirm a clear, consistent direction for the Trust. While external challenges like COVID-19 might alter our day-to-day work, they don't change the core priorities that we are working towards, nor the principles that underpin everything we do. Safe, kind, effective care is what our committed colleagues strive so hard to provide and this has been enshrined as a core principle of Above and Beyond, where it will underpin multiple programmes. We committed to make GOSH a great place to work, where staff feel safe and secure, and to create a more inclusive working culture in which people feel psychologically safe to ask questions and challenge their colleagues. We also set out to develop further patient safety simulation programmes, to support constant improvement.

Our clinical effectiveness, the second of our quality principles, was particularly tested in the Spring of 2020. In mid-April, healthcare professionals in the UK observed a cluster of children with an unexplained inflammatory response following COVID-19 infection. Clinicians, researchers and clinical scientists from the UK and overseas came together to communicate, collaborate and work towards a common purpose:

the identification of a new emerging disease. This rare but serious complication became known as PIMS-TS and GOSH is proud to have contributed to this global collaboration.

Improved clinical effectiveness will be reinforced by our strategic priority to develop our GOSH Learning Academy (GLA). Our GLA will ensure education is accessible for all and that we have the skills and knowledge to operate effectively. It was our GLA that led the upskilling of our staff to support their deployment in new areas in response to the pandemic and prepare them to join with hospitals across North Central London. By May 2020 over 2,000 clinical and non-clinical staff had attended GLA COVID-19 up-skilling and update sessions, in general paediatrics, adult vaccination, anaphylaxis, adult Basic Life Support (BLS) and adult ICU skills.

We are also committing to accelerate translational research and innovation. Our determination to maximise the use of our rich data sets and patient biological samples will help us find improved treatments. During 2020/21, in the face of the pandemic and with research staff working flexibly to support other areas of the hospital, we managed to run 1,175 research projects at GOSH/ICH. As the COVID-19 situation becomes less acute, we will build on this to engage more research participants and staff.

The experience of our patients and staff, the third of our quality principles, has been widely affected by our response to the pandemic. Reduced visiting has been hard for our families, and social distancing presented major challenges for our outpatient services. Swift moves to take advantage of new technologies meant we were able to offer changed but still positive experiences for our patients. Our ICT, Epic and improvement teams worked closely with clinicians to develop virtual clinics so that 64% of our outpatient work could be conducted using telephone or video conferencing. In parallel, we improved MyGOSH, a safe online portal that gives children, young people and families access to parts of their electronic patient record. This meant families could keep in touch with their GOSH team, view test results, review and reschedule their appointments and communicate securely with their medical team.

Putting children and young people first, always, remains a core principle of our strategy, and that means designing services and systems that work for them and their families. Further increasing the use of MyGOSH will help us improve and speed up access to urgent care. In addition, our future hospital programme will lead to a transformation in outpatient and pharmacy services and a redesign of our clinical pathways. As we set out to create a world leading children's cancer centre, it is meaningful patient and family engagement that will shape our design and our services.

This Quality Report describes in detail the work I've highlighted here. It sets out the projects that we've completed in the year so far and describes how our strategy will provide a platform for quality improvements in the future. It sets out information that serves as reassurance from the Board as to the quality of our services and maps out how we are performing against core quality indicators and national targets.

Quality remains a watchword at GOSH. I would like to thank all our colleagues for their excellent contributions and for their determination to deliver on our quality priorities in a challenging environment.

Mat Shaw
Chief Executive

Part 2a: Priorities for improvement

This part of the report sets out how we have performed against our 2020/21 quality priorities. These are made up of a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his 2008 NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare.

Safety

We are committed to reducing avoidable harm and improving patient safety as rapidly as possible. Our aim is to ensure that each patient receives the correct treatment or action the first time, every time. However when this does not happen we are committed to learning from mistakes, errors and incident to ensure the safety of patients and their families, visitors to GOSH and our staff.

Clinical effectiveness

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

Experience

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

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

Reporting our quality priorities for 2020/21

In our previous Quality Report, we identified three priority areas for improvement in Safety (improving medicine's safety), Clinical effectiveness (Improving Psychological and Mental Health Services documentation) and Experience (Improving the experience of children and young people with learning disabilities). These are reported below. We have also chosen to report on three further quality improvement initiatives which are related to our response to COVID-19. The six quality priorities reported for 2020/21 are:

Safety

- Improving Medicine's safety
- Staff well-being through our Well-being Hub

Clinical effectiveness

- Improving Psychological and Mental Health Services documentation
- Virtual clinics

Experience

- Improving the experience of children and young people with learning disabilities
- Improving communication through MyGOSH

In this section, we report on our performance against each quality priority by outlining:

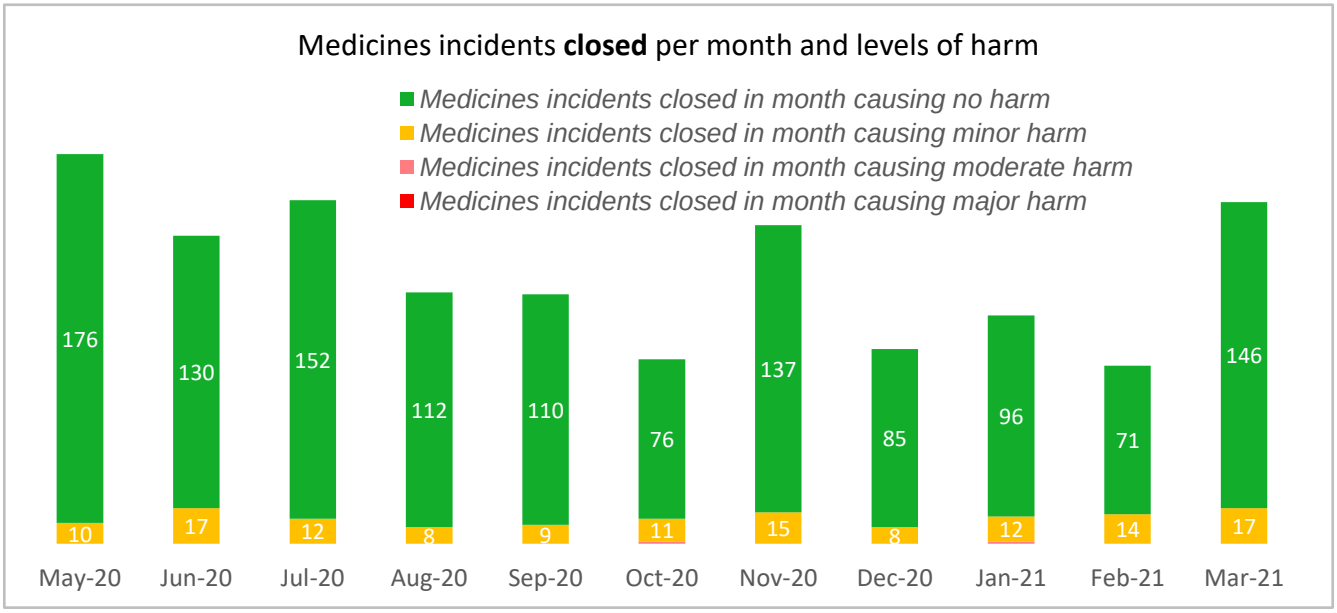
- What we said we'd do
- What we did
- What the data show
- What's going to happen next
- How this benefits patients

Safety: Improving Medicines Safety

What we said we'd do
There are around 4000 drug administrations a day at GOSH. Many of the medicines are highly specialist and being used in innovative ways so it is really important to have good over-sight and understanding of our medicines safety.

We have updated all our medicines policies and procedures on storage, administration and disposal of controlled drugs so everybody knows what to do. There is direct teaching, an updated medicines training package on the intranet and a monthly newsletter "*Medicines Matter*".

Medicines Incidents per month and reported levels of harm



What the data show
We benchmarked our error reporting rate and whilst it is difficult to compare our error reporting rate, it is in line with other centres. There was a worry that we were reporting a higher frequency of errors causing harm and thus we sought an external review of our errors over a one year period. The review concluded that, in general, we had a low threshold for "declaring harm" as opposed to a higher proportion of harm related events. The advice was not to change the culture of reporting, but to monitor against our own trends.

To keep medicines safe we reviewed our ward drug room and audited 10 wards. This looked 1069 "swipe-card" access entries into the drug rooms. Along with many aspects of the medicines policy these audits are repeated yearly.

Many medicines were left uncollected in pharmacy, giving rise to concerns about medicine waste, patient compliance and lack of space in pharmacy. A Quality Improvement project was initiated to improve understanding of the number and type of medications. Key findings included:

- 23% of uncollected medications had been 'discontinued' on EPIC after they had been dispensed.
- 13% of medications had 'expired'
- 50% of families interviewed were not aware there was a prescription waiting for collection.

- Long waits in pharmacy was reported by parents as the main reason why they did not collect medications
- 2/3 of families were not informed at their next appointment that uncollected medication was in the pharmacy.

The review showed that most issues were related to communication and shared understanding between i) prescribers and their patients; ii) prescribers and pharmacy through EPIC; and iii) pharmacy and patients. Covid has fundamentally changed many of our processes for supplying outpatients and the large number of uncollected medicines has been eliminated. However the issue of collective understanding of systems and good communication still remains relevant and important and is being addressed through the Medicines Optimisation Committee. A number of projects focusing on medicine supply outside of the Trust have been started supported by several focus groups partnering with parents and children and the multidisciplinary clinical teams to ensure we get this right moving forward.

What's going to happen next

We have a programme of work to improve work flows in pharmacy and to benefit from the safety features of the EPIC system. Progress has been slower than we would have hoped due to the impact of COVID-19 but we remain committed to improved medicines safety.

How this benefits patients

We are really encouraged by the enormous amount of work we have achieved in this area and with our plans for the future. Technology will be key to some aspects of medicine safety moving forward and we are already fully engaged with assessing these. Until then we feel as if we have created the right structures and culture to ensure we keep medicines practice as safe as possible for our children, their carers and our staff.

Safety: Staff well-being through our Well-being Hub

Our people are the head, the heart, the hands and the face of GOSH. They make us who we are and allow us to do extraordinary things.

GOSH People Strategy 2019-2022

What we said we'd do
Working with seriously ill children and their families, many of whom have complex conditions and uncertain futures, is physically and emotionally challenging. The COVID-19 pandemic exacerbated many of these pressures, whilst social distancing removed some of the normal support mechanisms used by our staff. Many staff were isolated from family and friends. Some found themselves unable to travel to family and friends due to international travel restrictions. Others were required to shield at home and were separated from work colleagues and on-site support. So supporting our people to ensure their well-being was a priority during the pandemic.

What we did
Experts from across GOSH came together with external partners in our Wellbeing Operational Group. The shared aim was to ensure support for all GOSH staff including those working within the hospital and those working from home. Many GOSH staff offered their time selflessly, over and above their normal work commitments.

We created a Well-being Hub, accessible to all staff. Our 'well-being' email were triaged by Consultant Psychologists and staff received a phone response within 24 hours. Camden Adult Mental Health Trust ensured we had seamless access to adult psychiatrists for advice and referrals for treatment. The Well-being Hub provided bereavement support, psychological first aid and helped staff experiencing anxiety, stress or experiencing an acute deterioration of their pre-existing mental health condition. Our Virtual Well-being Hub signposted staff to resources inside and outside of GOSH. This included both emotional and practical support such as ICT equipment and advice for home workers and accommodation and food for staff on-site.

Sadly, three colleagues died due to COVID, which deeply affected our staff. The wellbeing groups provided bespoke bereavement support which would not have been available in the community.

What the data show
In 2020, CareFirst, an external provider received 72 calls for emotional health. During Covid the GOSH wellbeing hub responded to more than 1100 requests for support. Feedback from staff was positive with an emphasis on the specific challenges faced at GOSH. Comments include "they know what it's like at GOSH' and 'they know what it's like to work here".

The evaluation of the wellbeing hub was really positive…."The 'wellbeing' email was quick to respond and kind - I have no suggestions on how to make it better as I thought it was excellent." And "so much has been created for us…. it helps me feel part of the GOSH family whilst remote working".

Feedback from the NHS Staff Survey 6 months after the start of the GOSH wellbeing services saw a 17% increase in positive responses the question: 'does your organization take positive action on health and wellbeing'.

As a result of the investment in our people's well-being we now have:

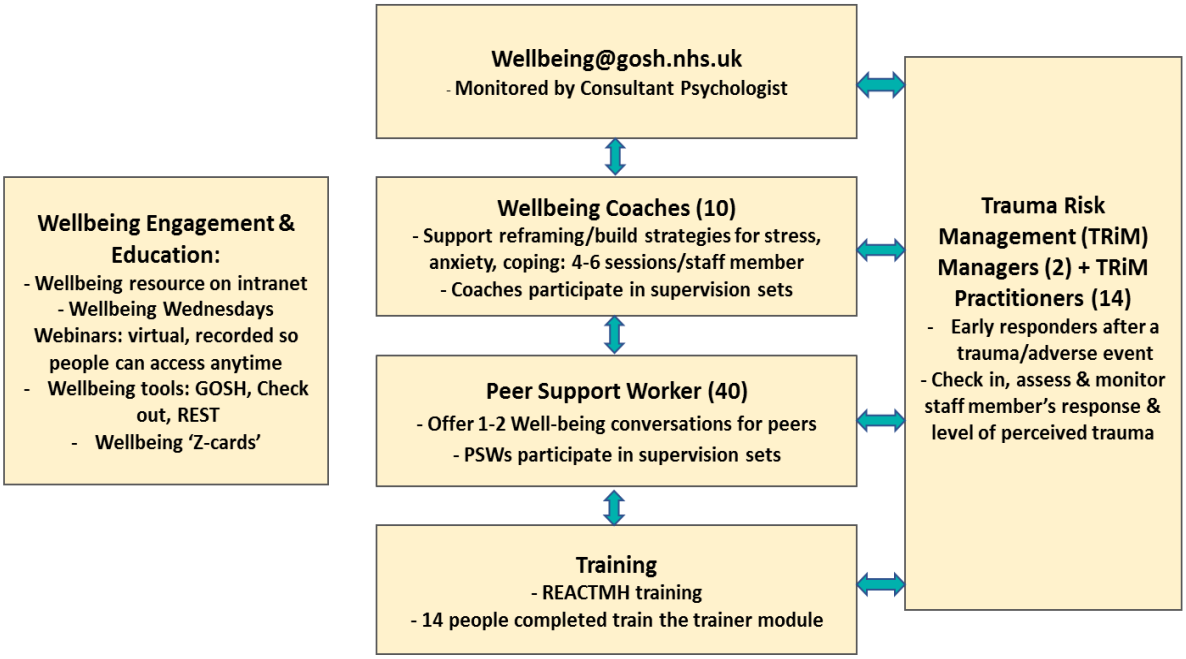
- 40 active Peer Support Workers that connect with their communities and listen, signpost and provide basic psychological first aid
- 11 Wellbeing Coaches that provide a series of coaching sessions to manage anxiety, stress or help staff to reframe and mentally adjust to their new lives

- 16 Trauma Risk management Practitioners (TRiM) practitioners that assess colleagues for trauma, a step in changing the culture where trauma is openly discussed and managed
- Well-being Wednesday - 20 minute webinar focused on wellbeing which is recorded and available to all staff.
- Dedicated, 20 minute drop-in sessions for communities of staff that may not access on-line resources

What's going to happen next

We have a four-part programme of work to build on the success of our well-being hub.

1. ***Staff Mental Health Surveillance Program*** run by GOSH psychologists supported by external Stakeholders such as NHSE, NHS Practitioners Health, Carefirst and Camden Mental Health Trust.
2. ***Leading Self*** - a series of interactive, open access, virtual webinars to encourage staff members to take personal responsibility and become better advocates for their own health and well-being. A staff well-being barometer, as a self-assessment tool, will assess progress.
3. ***Leading Teams***: a multi-modal team mental and emotional resilience training programme including webinars, facilitated team training sessions and team coaching, supported by a team resilience assessment tool.
4. ***Corporate/System Leadership***: a well-being specific development opportunity for leaders, combining training and coaching to explore values, behaviours and actions that will result in compassionate, inclusive leadership.



How this benefits patients

Our well-being work was very much developed 'by our staff, for our staff'. Making sure we have a resilient, healthy and compassionate workforce ensures we can continue to deliver high quality care to our children and their families and embodies our 'one team' values.

Clinical effectiveness: Improving Psychological and Mental Health Services documentation

Last year's Quality Report spoke of our plan to improve documentation in our Child and Adolescent Mental Health Service (CAMHS). Since the last Quality Report the CAMHS has merged with our psychological services as part of the strategic vision for mental health care and is now known as Psychological and Mental Health Services or PAMHS.

What we said we'd do
We identified that improvements were needed to healthcare record documentation through staff feedback. The CQC also remarked that the system did not allow easy filtering or vision of key governance issues to allow staff to find key documents easily.

We said we would:

- Improve recording of consent and competence and ensure that these are accessible on the electronic record.
- Improve the layout of the electronic record to make it easier to navigate e.g. a drop down tab for 'Core team minutes'
- Add suitable templates for core meetings such as ward rounds, clinical review meetings, and standardise discharge summaries
- Improve the recording of risk assessments with a suitable template, including adequate free-text space for documentation ad comments.

What we did
The Mildred Creek Unit (MCU) Nursing Team have worked collaboratively with the electronic patient record (EPR) team to design and implement a well-functioning and robust means of documenting care. Since the CQC visit significant advances have been made and this has improved staff confidence with the system.

The MCU navigator allows an easier movement through the patient records as staff can filter to find key documents such as ward round recommendations or risk assessment. We improved our Ward Round Template to make it clear which members of the multi-disciplinary team (MDT) attended and ensure all documents are clearly dated. There is now a section on Gillick Competence, with the date of assessment and considerations over reassessment clearly visible. The template also specifies parental consent dates and identifies who should provide consent. Parental and patient goals and ward recommendations including working discharge dates are outlined.

The risk assessment template, and past risk assessments can be reached through the navigator and have the expected clear measurable risks. This allows prompt action planning and mitigation by the MDT as required. Monitoring of reassessments can now be audited through the ward round entries which allows oversight from the consultant and ward manager. The core team minutes follow a similar structured template to ward rounds, allowing MDT attendance monitoring and a clear action log at the close of the meeting.

All new staff across PAMHS and all requiring updates are now having bespoke Epic training this has been made possible since the appointment of the Epic Training Lead

What the data show
A documentation audit is undertaken monthly to monitor the recommendations from the CQC inspection. These were reassessed during our 2021 QNIC inspection and the improvements were noted by the assessment team.

We surveyed staff to get feedback on our progress. Comments were positive:

"The improvements to the ward round template allow the long stay panel to clearly view the patient journey, goals, outcomes and working discharge dates. Action planning ensures potential delays are identified early"
"An ongoing rolling training sessions around competency assessment has been really useful for new staff to ensure as key workers the requirements and documentation required"

What will happen next
To understand the longer term impact, progress will be reviewed regularly over the coming 12 months through ongoing audits and staff feedback.

We are also working to improve the documentation of consent. Although it is included in the ward round templates, it is currently documented on paper and uploaded to the Epic records which can mean a delay in this being visible electronically. The MCU and EPR teams are working with the trust wide consent project to ensure for the specific needs of mental health patients are addressed.

How this benefits patients
Patient safety and care quality is improved, particularly around easier navigation and location of documents. The recommendations from ward rounds and the dates and outcomes of competence assessments, consent and risk assessments are visible and accessible to all the healthcare team. This facilitates clear communication to ensure treatment is timely, effective and inclusive of patient's preferences and wishes.

Clinical Effectiveness: Virtual Clinics

What we said we'd do
Virtual clinics were key to our Above and Beyond strategy to help speed up our response times, reduce the cost and inconvenience of travel and make healthcare more accessible, particularly for those who live far from GOSH. COVID-19 brought social distancing into our lives which presented GOSH with immediate challenges in seeing our patients and families. For some, Virtual Clinics became the only viable way to ensure our patients were seen quickly and safely.

What we did
During 2020, GOSH rolled out Virtual Clinics in almost all specialities. We integrated a video communication platform with our electronic patient record system to provide a secure, safe environment. Children and families were offered the choice of video or telephone appointments. Our enhanced functionality now allows third parties to join video visits, meaning patients and families can have joint appointments with another speciality or even with their GP or secondary care clinician. Joint appointments also allow us to invite interpreters, playworkers and others to support those with language difficulties and other needs.

What the data show
In 2019-2020, less than 1% of outpatient activity was delivered via video. That rose to 24% in 2020/21, meaning almost a quarter of outpatient consultations 'went virtual'.

Understanding our patients and families experience was very important. Overall 85% of families who responded said they were extremely/very satisfied with their experience during the virtual visit. Overall patent and families experience scores were lower when the focus was on treatment rather than assessment or follow-up. The majority of families said that they would prefer a mix of face-to-face and virtual appointments going forward.

What did children and families like?	What did children and families dislike?
• No commute to GOSH • Don't need to get on public transport during Covid. • Had time to ask all questions. • Didn't feel rushed. • Appointment started on time. • No travel costs • Child felt more comfortable in familiar surroundings	• Poor visibility made it difficult to be reviewed by a surgeon • Doctor did not attend! • English is not our first language so would prefer a mixture of appointment styles • Didn't feel as involved as I could have been. • Zoom was too long with too many people • Video clinics are tiring. • Zoom fatigue.

What's going to happen next
We listened to families and staff comments and have already made changes such as a zoom 'how to guide' and requesting any images to be sent beforehand and uploaded into the child's electronic health record. We continue to refine and improve our virtual clinics in response to feedback. A stakeholder event is planned to gather further improvement ideas and implement ideas. We continue to gather data on outcomes and experiences following virtual clinics

How this benefits patients
Virtual clinics cannot replace all appointment types, particularly if a physical examination or diagnostic tests are needed. They do allow us to see children and families who may not want or cannot travel or attend hospital. We are now able to provide care closer to home, which reduces transport time and costs. All these benefit children and families as well as helping to protect the environment.

During Covid, virtual clinics kept patients and families safe and allowed them to access care and support. Our outcome data and feedback demonstrates that virtual appointments can be an effective and valuable alternative when face-to-face meetings are not desirable or possible.

Experience: Improving the experience of children and young people with learning disabilities

What we said we'd do
We are committed to ensuring that children and young people (CYP) with learning disabilities, autism or additional needs and their families receive equal access to safe, high quality care and treatment that is individualised to meet their particular needs, across all of our services.

In 2019/20 we planned to deliver four interconnected workstreams:

1. Develop and implement a comprehensive and targeted programme of staff training on learning disabilities
2. Improve safety for CYP with learning disabilities
3. Increase involvement of CYP with learning disabilities in making decisions about their care and planning services
4. Improve the hospital experience for CYP with learning disabilities and their families through the use of an accessible patient reported experience measure (PREM) purposefully designed to meet their needs

What we did
We developed a Learning Disability Strategy which was approved at Trust Board. This provided a clear vision and programme of work to support our four interconnected workstreams. Unfortunately the COVID-19 pandemic, staff deployment and long-term staff sickness has slowed our work plan and led to a revision to the workstream priorities.

We have increased our Learning Disability Education resource in collaboration with the GOSH Learning Academy. Prior to the implementation of social distancing and other Covid restrictions we developed a multi-professional Learning Disability Simulation education and training co-delivered with actors with lived experience. The roll-out was delayed as our education and learning disabilities staff were deployed to support the COVID-19 effort through assuming clinical duties or focusing on training related to Covid. We were also restricted in our ability to have external visitors on site, which meant the actors with lived experience could not attend GOSH to participate.

We have, in collaboration with the Mental Capacity Act (MCA) Lead, developed and launched a new process for reviewing patients aged 16 and over who are inpatients to ensure that the Trust is meeting MCA and Deprivation of Liberties (DoLS) legislation. This is being delivered in tandem with a programme of supporting education.

The introduction of mandatory COVID-19 testing on admission and before procedures had an immediate impact for CYP with learning disabilities and their families. The Learning Disabilities team developed new pathways to identify and support CYP with learning disabilities who struggled with testing. The team provided clinical support for the most complex cases and maintained a list of CYP with learning disabilities who benefitted from their specialist input.

What's going to happen next
The pandemic has led to a revised programme of work. Our current priorities are to improve our process and guidance around consent for CYP with learning disabilities and their families. We are also developing training so staff better understand and are able to implement reasonable adjustments. We are also developing a library of sensory toys so staff can better support CYP with learning disabilities.

Experience: Improving communication through MyGOSH

What we said we'd do
MyGOSH is a safe and secure online portal that enables children, young people and families to have access to specific parts of their electronic patient record at GOSH. MyGOSH has played a vital role during the COVID-19 pandemic by keeping children and families in touch with their GOSH team, even when they weren't able to visit GOSH in person. We now have a dedicated team to support patients and carers and assist with requests to sign up to MyGOSH.

What we did
Over the past year we have improved and enable new features. With MyGOSH you can now:

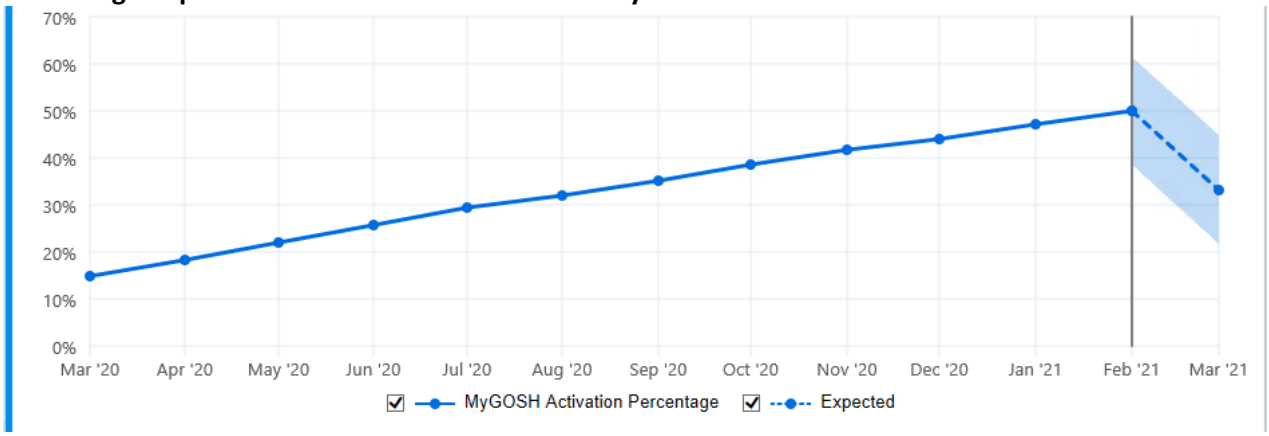
- Have a virtual outpatient video visit via the MyGOSH platform
- Review and reschedule certain appointments as well as accept earlier appointment offers
- See an up to date health summary, taken from the child's electronic patient record
- View test results
- Ask for repeat prescriptions for medicine that is only supplied by GOSH
- Communicate securely with the medical team
- Share the MyGOSH record with other health professionals.

At the start of the pandemic, some children and young people could not visit GOSH to have vital tests or assessments because of government travel and visiting restrictions. This was particularly problematic for our respiratory team, who could not perform vital tests to diagnose and monitor children with breathing problems. Through the collaboration of our clinical, biomedical and digital team we have enabled Video Visits by our Lung Function team, where spirometry assessments can now be performed remotely.

We also went live with a pilot of the MyGOSH Bedside application in Squirrel ward. Patients can download on the Bedside app either on their own personal tablet or one provided by GOSH. MyGOSH Bedside gives patients and their families access to their medical record and provides a platform to support education on their health condition, adherence to treatment, and increased communication. MyGOSH bedside also supports video consultations with clinicians and links carers who may not be able to travel to participate in discussions with their clinical team.

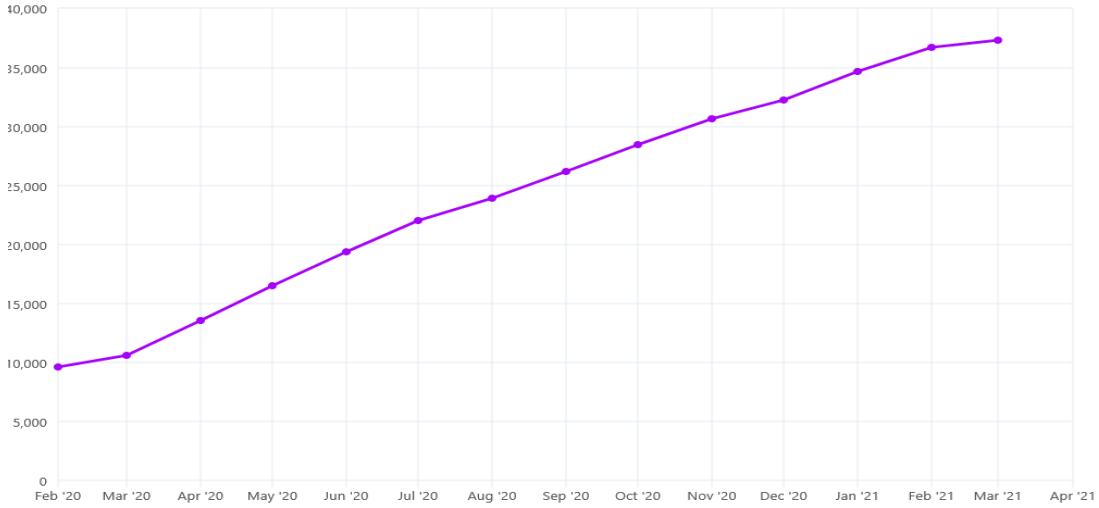
What the data shows
We have monitored the number of children and families who activated a MyGOSH account and this has increased by 35% overall in the last year.

Percentage of patients seen face to face who are MyGOSH active



The total number of MyGOSH Users has also increased from 10,619 to 37,311 by March 2021, which is a 251% increase over the last year.

Total MyGOSH users



At the end of 2020, we enhanced MyGOSH to allow patients and families to send 3 questions they might want answered at their next visit. We called this initiative 'Heads Up'. We released this at the end of January 2021 and within one month it was already being used by 55% of completed outpatient appointments.

What's going to happen next

During the last year, we looked at how MyGOSH can use data from wearable technology devices. Towards the end of 2020, we ran a pilot that successfully enabled MyGOSH users to submit their own data to their own electronic health record in Epic. Our next phase is to make the process automatic and to see how and where we can use this in clinical practice.

How this benefits patients

MyGOSH allows everyone to manage their health and care wherever they can get online. This helps patients and families to keep in touch with GOSH and to be more involved and in control of their own health and well-being.

Quality priorities for 2021/22

The following tables provide details of three of the quality improvement projects that GOSH will undertake in 2021/22. In common with previous quality reports these quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

The COVID-19 pandemic has meant we have not been able to consult widely on our quality improvement priorities. In previous years priorities have been selected with input from children, families and staff as well as our commissioners, Council of Governors, Young People's Forum, and the Patient and Family Engagement and Experience Committee. This was not possible in 2020-21 due to the late notification of the Quality Report, social distancing restrictions and the unprecedented workload of the pandemic. We have therefore selected three programmes of work that were planned prior to the pandemic but were delayed or suspended as a result.

Safety:

To eliminate avoidable harm

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improve identification and management of the deteriorating child	Thematic analysis of complaints, incidents, mortality review/ learning from deaths, identified the significant need to improve our identification and response to deteriorating patients. A Trust-wide Quality Improvement programme is being initiated by the Medical Director's Office which aims to improve: · Safety in the care provided · Effectiveness in the treatment · Timeliness in the response · Patient, family and staff experience Programme design will focus in the areas of: Identification of deterioration, Monitoring, Escalation and Review- re-escalation or de-escalation. The work done acknowledges the complexities which contributes to these areas in terms of the organisational, digital and human processes.	Number of mortality reviews identifying inadequate response to patient deterioration Learning from serious incidents, complaints and Root Cause Analysis – increase in appropriate management of deterioration Improved recording of parental and clinician concern Timeliness of observations sets (PEWS) Reports and updates of the Programme is submitted to Patient Safety and Outcomes Committee and Closing the Loop Committee

Experience:

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Managing uncertainty in healthcare	Uncertainty is a common experience in healthcare. Healthcare professionals have to communicate a wide range of facts and contextualise these facts to the individual circumstances of the patient. However, the public understanding of a number of factors such as statistical analysis result in challenges for the healthcare professional and the decision maker in evidencing informed consent. The healthcare professional may also need support in being open about the limitations of their knowledge while feeling a responsibility to assure the patient or family. This professional-cultural need to communicate assurance rather than open and informed consent can leave the healthcare professional vulnerable. Training is needed to better communicate how we know what we know, what we cannot know and how, given sometimes only partial information we can together make the most informed healthcare decisions we can.	Literature review: Identifying best practice guidelines in law, healthcare research and other research in communication and the public understanding of healthcare related information and risk. Co-production of training programmes with both healthcare professionals and families. Monitoring data sets such as Friends and Family Test responses, Pals and Complaints cases as well as Incident reports via Datix. This programme is supported by the Associate Medical Director, Dal Hothi.

Clinical effectiveness:

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Developing and implementing ward accreditation	Monitoring core standards of care helps identify areas for improvement and opportunities to share good practice. We have identified 7 quality pillars which support excellence in care: Patient Experience, Nursing Quality, Quality and Safety, Nursing Education, IPC, Nursing Workforce and Staff Experience.	Audits of the 7 quality pillars will be completed monthly by the ward teams supported by data from our electronic health record. Results will be available on an online dashboard in a easily visualised format, allowing ward teams to interpret data and assess what their priorities for improvement are.

Part 2b: Statements of assurance from the Board

This section comprises the following:

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

Review of our services

During 2020/21, GOSH provided and/or sub-contracted over 60 relevant health services. The income generated by these services reviewed in 2020/21 represents 100% of the total income generated from the provision of relevant services by GOSH for 2020/21. GOSH has reviewed all the data available to us on the quality of care in our services.

Participation in Clinical Audit

What is clinical audit?

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

Clinical Audit at GOSH supports the Quality framework outlined in the Trust Quality Strategy ("doing the right thing").

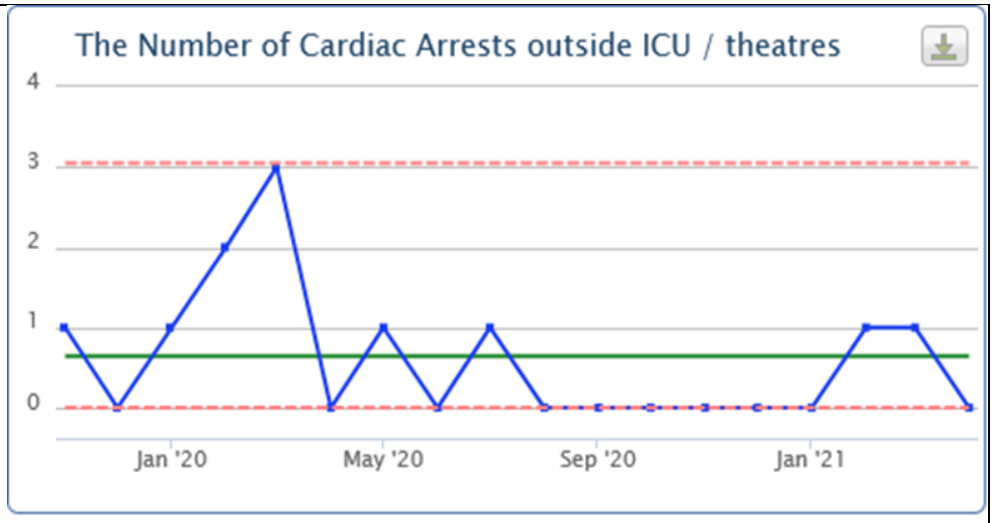
Participation in National Clinical Audit

During 2020/21 thirteen national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions have been outlined below.

Name of audit / clinical outcome review programme	**Cases submitted as a percentage of the number of registered cases required**
Cleft Registry and Audit Network (CRANE)	125/125 (100%)
Inflammatory Bowel Disease (IBD) IBD Registry	47/47 (100%)
Learning Disabilities Mortality Review Programme (LeDeR)	5/5 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)	31/31 (100%)
National Audit of Pulmonary Hypertension (NAPH)	663/663 (100%)
National Cardiac Arrest Audit (Intensive Care National Audit & Research Centre).	2/2 (100%)
National Audit of Cardiac Rhythm Management (National Institute for Cardiovascular Outcomes research)	254/254 (100%)
National Congenital Heart Disease ((National Institute for Cardiovascular Outcomes research)	965/965 (100%)
National Paediatric Diabetes Audit (National Paediatric Diabetes Association)	49/49 (100%)
Paediatric Intensive Care Audit Network (PICANet)	1753/1753 (100%)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	12 /12(100%)
UK Cystic Fibrosis Registry	200/203 (98.5%)
UK Renal Registry	At the time of writing the Nephrology service are reviewing administration support to ensure all 2020/21 cases are uploaded

The following national clinical audit reports and data were published from relevant mandatory national clinical audits in 2020/21.

Name of audit / clinical outcome review programme	Relevance to GOSH practice
Congenital heart disease including paediatric cardiac surgery	The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes. Predicted patient survival is determined for all centres using a calculation called PRAiS2, which adjusts for procedure, age, weight, diagnosis, and co-occurring conditions (co-morbidities). The 2020 National Congenital Heart Disease Audit report shows that in the last 3 years, all centres have performed such that 30-day survival was as predicted or better than predicted, given the alert and alarm control limits, for aggregated outcomes after all surgical procedures in children. "*Three centres performed 'better' than predicted (Alder Hey Children's Hospital, Liverpool (fifth year running); Bristol Royal Hospital for Children (second year running); and Great Ormond Street Hospital, London (following 4 years of performing 'much better' than predicted)), whilst this year one centre, Leeds General Infirmary, Leeds, was 'much better' than predicted. This is indicative of good performance and represents an opportunity for sharing more optimal practice across specialist centres." (*National Congenital Heart Disease Audit (NCHDA) 2020 Summary Report (2018/19 data), NICOR: National Institute for Cardiovascular Outcomes research) More information about this can be found on the NICOR website.
Inflammatory bowel disease Registry	The IBD registry report quarterly data. There is not significant paediatric data included in the report to allow measurement of GOSH practice against the national data. The Gastroenterology Service at GOSH participates in Improve Care Now, an international collaboration between Paediatric Gastroenterology centres .The collaboration benchmarks improvement in quality and monitors clinical outcomes for children with inflammatory bowel disease. As part of the Improve Care Now initiative, GOSH monitors specific IBD outcome measures and have routinely collected data since 2011. These data include outcomes relating to disease remission rates, nutrition and growth for the children we treat. More information about this can be found on the Gastroenterology clinical outcomes page on the Great Ormond Street Hospital Website.
National Cardiac Arrest Audit (NCAA) (ICNARC (Intensive Care National Audit & Research Centre).	The NCCA publish quarterly reports at organisational level to support benchmarking and to identify trends to inform practice and policy on both a local, and national level. GOSH has not had sufficient cardiac arrests in the 2020/21 to allow benchmarking in the reports. We place close attention internally with real time monitoring and oversight of cardiac arrests outside of ICU reported to the Patient Safety and Outcomes Committee. We have noted a trend in a reduction of cardiac arrests outside ICU/theatres this year.

	 Resuscitation Services developed and led the "Just in Case" support programme for the wards in March 2020 and the data suggests this programme has had impact.
Paediatric Intensive Care Audit Network (PICANet)	The Paediatric Intensive Care Audit Network Annual Report 2020 was published in February 2021. The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be 'adjusted' to consider the level of severity of the patients in respect of case mix. The 2020 PICANeT report compares Trusts Standardised Mortality Ratio[1] for the calendar years of 2017-19.The data in this report shows GOSH ICU mortality as within what would be expected based around the case mix. More information about this can be found on the Intensive Care Unit clinical outcomes page on the Great Ormond Street Hospital Website.
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	The 2019 UK Cystic Fibrosis Registry Annual Data Report was published in August 2020 and includes data about individual cystic fibrosis centres, to help the centres benchmark themselves against their peers. The data shows that GOSH clinical outcomes are within expected variation. The 2019 UK Cystic Fibrosis Registry Annual Data Report can be accessed here
UK Renal Registry	The UK Renal Registry report was published in 2020 and includes analyses of paediatric data to the end of 2018. Clinical Outcomes measures for the Nephrology service at GOSH can be found on the Nephrology Clinical Outcomes page on the Great Ormond Street Hospital Website and will be updated further in 2021/22.

The Health Care Quality Improvement Partnership (HQIP) have recently developed a public access website to display National Clinical Audit Benchmarking (NCAB). GOSH performance in key audit metrics

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

can be seen and compared with other Trusts for both the PICANET and NPDA audit programmes. This data can be seen for Great Ormond Street at https://ncab.hqip.org.uk/reports/card/trusts/RP4/

The NCAB highlight data from the 2020 PICANET report highlights "the crude number of qualified nurses per bed (WTE)" in 2019, and notes that only eight of the 26 PICUs nationally have been able to meet the standard. GOSH did not meet the standard for the calendar year of 2019 but note improvements since 2018. There have been challenges with the recruitment of ICU nurses nationally and in London. This issue is monitored by the PICU management team and is assessed as a low risk on the PICU risk register at the minute, due to progress made with recruitment and retention in the last two years. This had previously been a high risk.

Priority Clinical Audit plan

At GOSH we have a central clinical audit plan which prioritises audits to support learning from incidents, risk, patient complaints, and to investigate areas for improvement in both quality and safety. This important support to our learning culture is part of our Quality Strategy and explicitly planned for in our Quality Assurance Operational Delivery Plan.

Some of our key priority audits completed in 2020/21 are outlined in this section of the report. Despite the pressures of the COVID-19 pandemic we have been able to maintain resilience with both the quantity and quality of our priority clinical audits, and also been able to be agile and adaptive to the needs of the organisation, and taken on specific work to support with the COVID-19 response.

Quality of discharge summaries

This was an audit to allow us to proactively assess the quality of our discharge summaries in line with national standards. Our found significant improvement in compliance with standards for the content of a discharge summary, when compared to an audit of discharge summaries from 2016/17. This audit found 100% compliance with all mandatory national standards for the content of a discharge summary.

There were many clear examples of good practice enabled by our Epic patient record system including clear instructions on next steps for the patient and family, which were written directly to the family and in a clear and noticeable way.

Height and Weight in outpatients- action from a Serious Incident investigation (2020/3609)

Background

An audit was initiated as the outcome of a Serious Incident to help assess the position with some learning from the incident.

Aim of audit

To review adherence to best practice with height and weight recording for outpatient appointments.

Findings

There was a significant gap between GOSH and national standards and the practice for recording height and weight at outpatient appointments. The audit found approximately one in three children coming to GOSH had their height and weight recorded at a physical outpatient appointment.

An action plan was finalised with the Outpatient Matron and the Head of Nursing and Patient Experience for the Sight and Sound Directorate. This audit and the action plan were monitored by the Patient Safety and Outcomes Committee.

Changes made

As a result of the audit significant work has been undertaken to clarify and communicate the requirements for height and weighting patients in all outpatient clinic. A list of requirements is available

electronically to all staff in outpatients to support practice. We believe the opening of the new Sight and Sound building will further support the specialties moving there to height and weight patients.

Controlled Drugs audit

Why we did this audit

Learning from a Serious Incident in 2018 highlighted the importance of the documentation of controlled drugs. A detailed audit was conducted in July 2019. That audit found areas for improvement in documentation. An improvement action plan was agreed between the nursing education and pharmacy departments to support best practice. This included the development of digestible best practice guidance to be displayed in medicine storage rooms, revision of policy and an education roll out which took take place in September 2019

We did follow up audits to support our practice and to establish the effectiveness of our changes and have seen improvements in 2020/21.

These audits are part our Medicines Audit plan that are monitored and reviewed at our Medicines Safety Committee. Further audit was planned in 20/21 but postponed, with mitigations in place and an assessment or risk, due to pressures associated with the second wave of the COVID-19 pandemic. A repeat audit to assess sustained improvement is underway at the time of writing.

Audit of progress with implementation of core standards for GOSH MDTs

Background

A Learning from a Prevention of Future Deaths report in 2019 highlighted a general learning point at GOSH to ensure appropriate attendance and documentation at GOSH multidisciplinary team (MDT) meetings.

Work took place at GOSH throughout 2019/20 to introduce standardised terms of reference (and a structure for recording MDT attendance and decision making in EPIC. We completed a baseline a Trust wide audit to assess our performance against our key standards in November 2019. The audit was shared at our Patient Safety and Outcomes Committee (PSOC), and Operational Board. It showed some areas for improvement, particularly around confirming who is attending meetings, which informed work to enable and communicate. We re-audited this in 2020/21.

Highlights from this re-audit

- It is positive that that 98% of MDT encounters had clear actions documented in November 2020, this compares to 80% in November 2019
- There are challenges with evidencing appropriate quoracy. It was possible to demonstrate quoracy for 59% of MDT meetings reviewed in November 2020.

Next steps
The audit report was reviewed at PSOC. It was confirmed that the intended direction of travel should be for all MDTs meetings to have terms of reference in order to support demonstration of quoracy. The approach to do this will require clarification and be monitored via PSOC. This will be subject to audit in 2021/22.

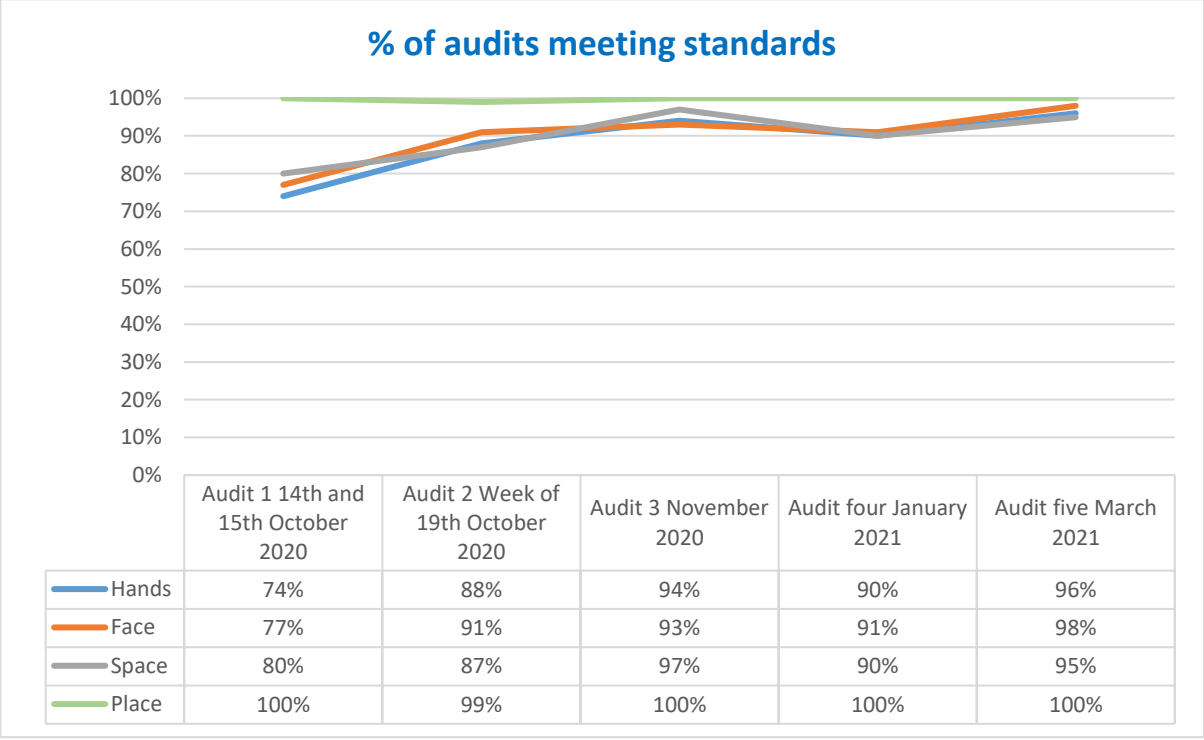
Hands, Face, Space, Place audits

At GOSH we have committed to a collective responsibility for keeping each other safe by meeting our Hands, Face, Space and Place guidance to support our staff and services to patients throughout the COVID-19 pandemic. We have used our clinical audit expertise and resource at GOSH to facilitate a series of audits to support maintenance and improvement in these standards. The aim of the audit was to encourage and empower staff to take responsibility for meeting standards at each part of the organisation, and to review, challenge, and change practice where necessary. This was supported by daily transparent feedback and learning during the weeks we ran the audits.

There have been a number of initiatives in place to support best practice across the Trust including:

- Guidance widely circulated through Coms, and messaging influenced by learning from audit
- High visibility of audit results and key messages profiled through the Senior Leadership Team, "Headlines "newsletter, and the Executive led all staff "Virtual Big Briefing"
- "Break the Chain" week in November 2020 led by Infection Prevention and Control,
- Emphasis on agency and a model of directorate and staff responsibility for meeting standards, owning audit results, and finding solutions.
- Engaging with junior doctors to understand what they need via the Associate Medical Director for Workforce and the Junior Doctors Forum

We have seen improvements, changes and widespread engagement since we started initial audits in October 2020.



	Audit 1 14th and 15th October 2020	Audit 2 Week of 19th October 2020	Audit 3 November 2020	Audit four January 2021	Audit five March 2021
Hands	74%	88%	94%	90%	96%
Face	77%	91%	93%	91%	98%
Space	80%	87%	97%	90%	95%
Place	100%	99%	100%	100%	100%

The latest Hands, Face, Space and Place audit results in March 2021 were very positive. We've exceeded 95% in all safety standards and have improved in all the areas we could have since January 2021. The

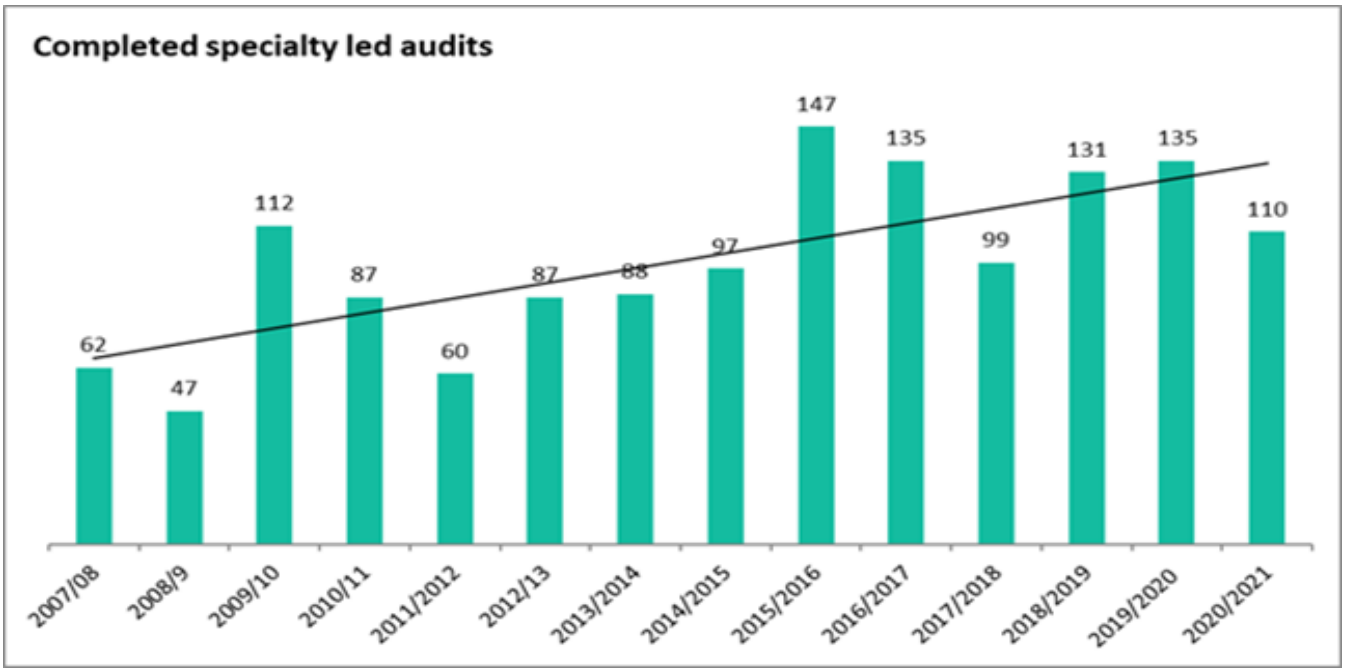
results show we're staying vigilant with hand washing and sanitising, as well as wearing our masks appropriately.

We are continuing to find innovative and supportive ways to monitor how well we are able to meet social distancing guidance at GOSH. We are planning further audit walk rounds in June 2021 to see how we are maintaining the standards we have set for ourselves and will review the frequency and approach we take with our audits in line with national guidance, and as the COVID-19 situation changes both locally and nationally.

Speciality led Clinical Audit

In addition to our priority clinical audit plan we support and enable clinical teams to engage in clinical audit as a way of reviewing and assessing the quality of care provided and to identify where improvements should be made. It is important to have timely oversight of the outcomes of specialty led clinical audit in order to be assured that teams are engaging in reviews of the quality of care provided, and that the outcomes of those can be monitored.

110 clinical audits led by clinical staff were completed at GOSH during 2020/21. We aim to have to have over 100 completed specialty led clinical audits per year. We were able to meet this target for 2020/21, which is testament to the commitment and resilience of teams to be able to engage in clinical audit and quality. We have seen a small reduction in the number of completed clinical audits this year due to the impact of the COVID-19 pandemic, which was anticipated. Our long-term data suggests we are encouraging a culture of sharing our specialty led clinical audit activity.



In this report it is not possible to list every clinical audit completed in 2020/21 that has had a positive impact on quality. A summary of completed clinical audits in 2020/21 can be obtained on request by contacting the Clinical Audit Manager at clinical.audit@gosh.nhs.uk

Some examples of excellent specialty led clinical audits completed in 2020/21 are described below.

Specialty	Audit Title	What difference will this audit make to the work of the team and patient care?
CATS	Cardiopulmonary resuscitation during inter hospital transport of paediatric patients	Transport of patients with ongoing resuscitation can be successful in groups of patients where additional lifesaving therapy (i.e ECMO) can be instigated. This will confirm some decision making around this process, particularly around the diversion of patients to ECMO centre.
ENT	Post-adenoidectomy VPI	Appropriate investigations and treatment took place for the vast majority of the patients. We have a better understanding of multidisciplinary clinic approach for post-adenoidectomy Velopharyngeal
Neurophysiology	Evaluation of collodion free electrode application	This audit enabled us to change our way of practice during the pandemic For our home video telemetry service parents were able to take the electrodes off at home themselves and did not have to come back to the hospital for removal of electrodes
Anaesthesia	Documentation of anaesthetic consent	Big improvement in documentation of consent process generally since the introduction of EPIC.We are improving in line with the GMC's Good Medical Practice guidelines for documentation of consent
Dietetics	A review of referral process of patients under haematology and oncology to dietetic service	The GOSH nutritional screening tool will be reviewed for accuracy and usability for children under care of haematology and oncology and compared to other nutritional screening tools available for this patient cohort

Learning from deaths

Death in childhood is a rare event. Whenever a child dies, it is important to learn if anything could be done differently in the future. We have systems and processes in place, to monitor mortality, highlight positive practice, and areas where improvements could be made in order to identity learning which could improve quality, the co-ordination of care, or patient and family experience. GOSH remains committed to a culture of learning, particularly from events which have a life-changing effect on families.

Implementation of the Child Death Review Statutory Guidance

The guidance outlines the statutory NHS requirements for child death reviews for all child deaths occurring after 29th September 2019. This requires a Child Death Review Meeting (CDRM) that is a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death. To support this process at GOSH a Medical Lead for Child Death Reviews in in post supported by a Child Death Review Coordinator. Assistance with data analysis and report writing is provided by the Clinical Audit Manager

Case record reviews take place through two processes at GOSH:
1. **Mortality Review Group (MRG).** This was established in 2012 to provide a Trust level overview of all deaths to identify learning points, themes and risks and take action as appropriate to address any risks. This process is linked with local case reviews (Morbidity and Mortality Meetings) undertaken by specialty teams and provides an additional oversight of inpatient deaths in the Trust. This group continues to review deaths to ensure a thorough level of review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as identifying learning points and making referrals to other safety investigation processes at the earliest opportunity.
2. **Child Death Review Meetings (CDRM)**. Child Death Review Meetings are "a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved

in the care of that child during life and their investigation after death." They include clinicians or professionals from external providers. CDRM meeting should be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews.

Deaths in 2020 and case record reviews

Between 1st January 2020 and 31 December 2020, ninety three children died at GOSH. All of those deaths have been subject to a case record review.

	Jan – Mar 2020	Apr –Jun 2020	July–Sep 2020	Oct –Dec 2020
Number of deaths	19	31	17	26
Deaths where modifiable factors [2]around GOSH care were identified	1	1	0	0
Cases where additional learning points for GOSH were identified[3]	6	6	6	9
Cases where excellent practice at GOSH was highlighted in the mortality review process[4]	8	21	7	18

Learning from reviews

The learning points from case record reviews and actions taken are shared via quarterly Learning from Deaths reports at the Patient Safety and Outcomes Committee, and at Trust Board. The Learning from Deaths reports highlight specific learning points and actions taken and are included in the public Trust board meeting papers that can be found at https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board/trust-board-meetings

Learning from deaths in	**Trust Board meeting discussed at**
Oct to December 2020	26th May 2021
July to Sep 2020	3rd February 2021
April to June 2020	26th November 2020
Jan to March 2020	15th July 2020

We highlighted in our 2019/20 Q4 Learning from Deaths report that there had been a theme for improvement in relation to learning points around the recognition of clinical deterioration/sepsis. There is now a Trust wide Quality Improvement priority project - "Identification and responsiveness to the deteriorating patient**".**

The review process highlighted particular positive aspects of care, the co-ordination of care, and communication at GOSH in fifty-four cases. The reviews highlighted the support and sensitivity offered from members of the child's clinical teams and those involved in wider holistic care including psychology, family liaison nurses, play team, chaplaincy, as well as multi-disciplinary working between different clinical teams involved in the child's care.

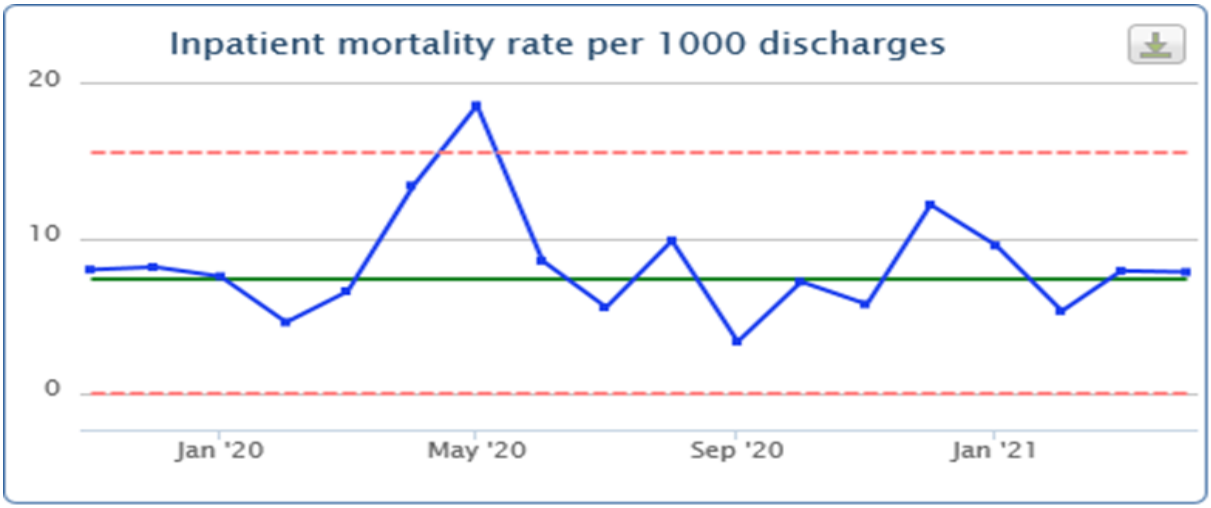
[2] Modifiable factors are defined as those, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child death

[3] These were not deaths where modifiable factors were identified, but where learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience. Learning points are not always indicative of suboptimal care, and reflecting through the mortality review process may highlight opportunities to share information to inform future case management.

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

Mortality rate

The crude mortality rate is within normal variation. Crude mortality reflects the number of deaths that occur, but does not consider how the sick the patient was on arrival in hospital. There have been no mortality outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths. This is important as the majority of patient deaths at GOSH are in intensive care areas. Risk adjusted mortality is monitored weekly at the PICU/NICU Morbidity and Mortality meeting. The gold standard for measuring paediatric mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANET).



The most recent PICANET report was published on the 11th February 2021 and covers the calendar years 2017-2019. The report shows GOSH PICU/NICU and CICU risk adjusted mortality as within expected range. The Health Care Quality Improvement Partnership (HQIP) have recently developed a public access website to display National Clinical Audit Benchmarking (NCAB) which draws upon that PICANET data. Our ICU risk adjusted mortality can be seen here .

Impact of COVID-19 pandemic on deaths at GOSH

We have been able to maintain resilience with our mortality reviews throughout the COVID-19 pandemic.

We amended our mortality review process at the start of the COVID 19 pandemic to ensure we understand where there has been impact of the pandemic on a death occurring at GOSH, and the experience of patients and families. Our mortality reviews have highlighted

1. The impact of the COVID 19 pandemic was noted explicitly on the experience for some families around managing visitation. It should be noted that GOSH has been following necessary national policy on COVID 19 visitation restrictions and paid close attention to them, as they changed, and their impact throughout the Covid 19 pandemic. GOSH guidelines on visiting have been frequently reviewed and amended when changes to national policy have allowed.
2. We noted in real time, an increase in our crude mortality rate in May 2020, above the upper control limit. The data is not risk adjusted to account for the sickness of the patient on admission, and it cannot be used in itself as a clinical outcome measure. The data represented an event that we internally decided we should review to understand the cause and identify if there were any factors that required further investigation. The increase was promptly noted and highlighted within our governance structure at GOSH. An expedited review of April and May 2020 deaths was led by the Medical Lead for Child Death Reviews. A report on the outcome of these reviews was shared at the July 2020 Patient Safety and Outcomes Committee, with the Quality, Safety and Experience Assurance Committee, and highlighted in the Learning from

Deaths reports shared at Trust Board. The conclusion of the report was that we saw an increase in deaths occurring at GOSH in May 2020 due to:

- Two deaths following admission to GOSH from another Trust who because of COVID 19 who would otherwise have died in a local hospital, and where death occurred at GOSH due to natural disease progression.
- One death where there was a COVID impact in terms of delayed presentation in the community.

The reviews did not indicate care or service delivery problems provided at GOSH which accounted for increased deaths.

Participation in clinical research

GOSH, together with the UCL Great Ormond Street Institute of Child Health (GOS ICH), is world-renowned for translational research and innovation. Our 'Research Hospital' vision is that research is fully integrated into every aspect of the hospital, to improve outcomes for our patients and the working lives of our staff. We are focused on delivering world-leading research for patient benefit. The importance of research at GOSH is demonstrated by its inclusion as a key priority of the Trust's Above and Beyond strategy. A broad portfolio of programmes and projects have been established, alongside a Research Planet Delivery Board, to ensure that we are successful in the delivery of our aim of accelerating translational research and innovation to save and improve lives.

Research activity

During 2020/21, we have run 1,175 research projects at GOSH/ICH. Of these, 284 were adopted onto the National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio, a prestigious network that facilitates research delivery across the NHS (Figure 1). Our already extensive research activity continues to grow year-on-year with the support of our NIHR Clinical Research Facility (CRF) and Biomedical Research Centre (BRC) awards, which began in April 2017, and, due to the COVID-19 pandemic, have been extended until September 2022 and November 2022 respectively. These underpin our entire research infrastructure at GOSH, in collaboration with GOSH ICH and we will apply for further funding under these schemes during 2021/22. Our BRC application will include a new research theme, Applied Child Health Informatics, utilising GOSH's status as the most digitally mature hospital in the UK (HIMSS level 7), and our advanced data science methodologies including artificial intelligence and machine-learning approaches to improve management of children with rare and/or complex disease.

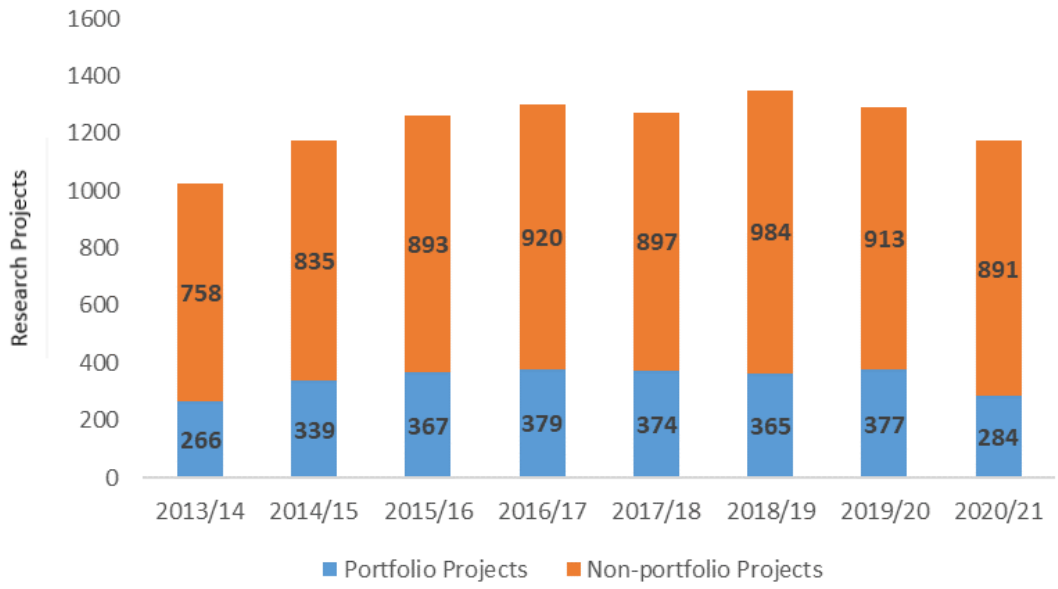


Figure 1: Number of research projects taking place at GOSH/ICH, highlighting the high-quality NIHR CRN Portfolio projects.

The overall trend for the CRF in 2020/21 is for fewer studies to be hosted, but these are of higher intensity with a higher proportion of trials being early-phase in line with our NIHR CRF strategy. Participant visits to the CRF over the course of the year of the pandemic were reduced by around 50%, though much of our research portfolio, particularly where essential treatment was being provided, was

maintained, with visits taking place remotely and medication couriered to patients' homes where possible.

In 2020/21, we had over 5,600 participants in research at GOSH (Figure 2), more than 3,000 of whom were recruited to a GOSH Staff COVID Serological Survey. All research undertaken is approved by the Health Research Authority (HRA), including Research Ethics Committee and Medicines and Healthcare products Regulatory Agency (MHRA) approval as appropriate.

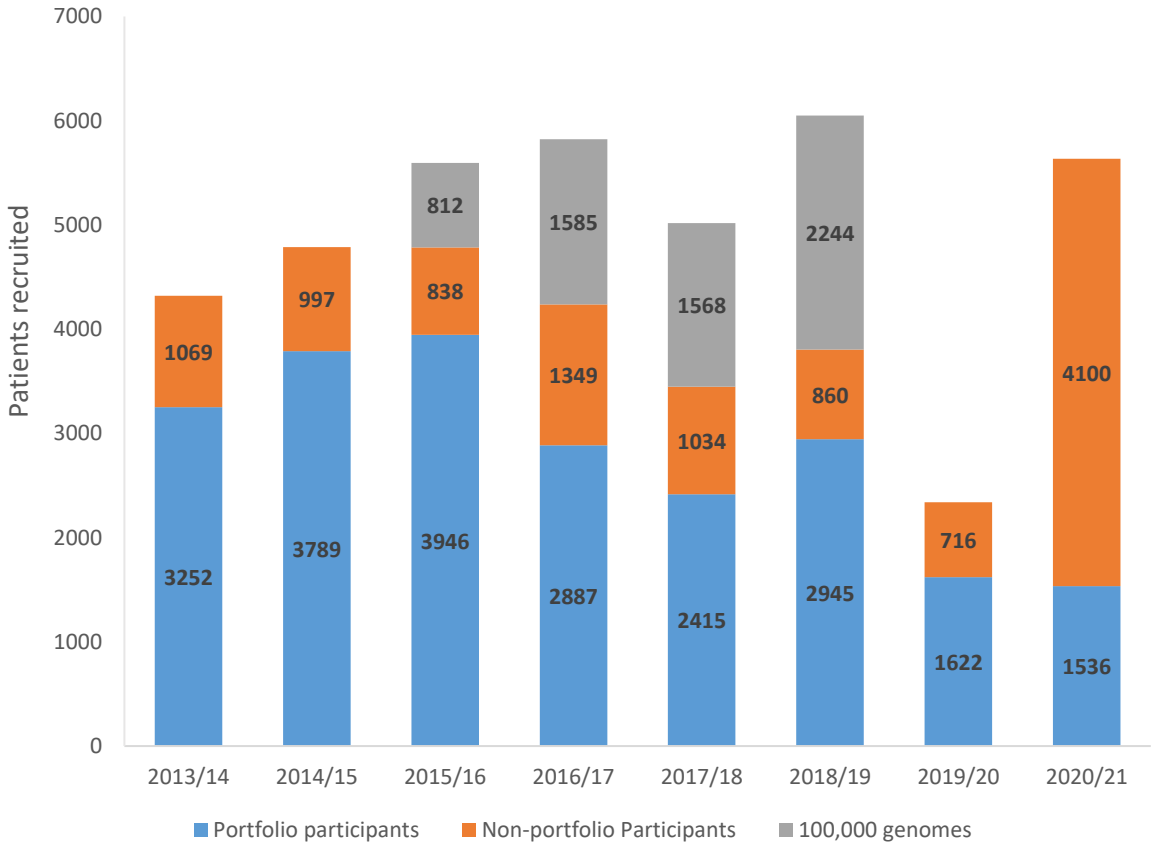


Figure 2: Number of research participants recruited at GOSH/ICH, highlighting the high-quality NIHR CRN Portfolio projects and those recruited to the 100,000 genomes project in previous years

Our extensive infrastructure and expertise have enabled us to maintain essential research activity during COVID-19 (research was completely stopped in many NHS organisations) and deliver a large portfolio of COVID research in parallel (we were able to register over 130 new COVID-19 research projects in total since the start of the pandemic; Figure 3). We have also adapted many of our studies due to COVID-19, for example offering remote visits and home dosing where appropriate. 35% of R&I staff (including 60% nursing workforce) were redeployed to provide frontline support for COVID-19 at the height of the pandemic, and many of our staff were involved in leading and supporting our first all-staff vaccine rollout at GOSH. Alongside this, we have delivered major breakthroughs in research from early stage science to clinical trials and virus manufacture. However, this has not been an easy year for research at GOSH – our staff have worked tirelessly to support the Hospital and the research effort but, as a result of added strains, we have not seen the growth in some areas that we had anticipated (active research studies and commercial research income).

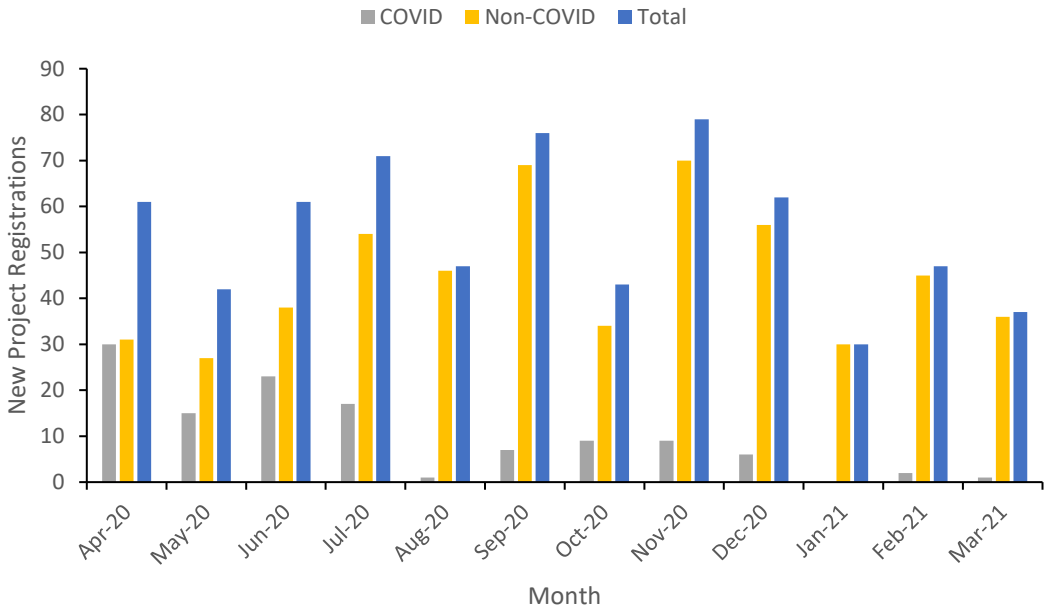


Figure 3: New Project Registrations in 2020/21

Launched in 2017 with a pilot phase, and formally launched in 2019, 2020-21 was the year that GOSH Sample Bank recruitment took off and exceeded its target of 500 recruitments in a single year, reaching a total of 662 patients. We expect recruitment to be healthy in 2021-2022, through more staff-wide communications and embedding taking consent for Sample Bank in the admissions process, to reach a target of 2000 patients by the end of March 2022 (Figure 4). Sample Bank is one of the key programmes of work being overseen by the Research Planet Delivery Board.

Through Sample Bank, the Pulmonary Hypertension team have been able to store explanted lung tissue from patients who received a transplant at GOSH. This tissue offers a unique opportunity for researchers to better understand a rare and complex disease, using tissue that would otherwise be discarded. We are also involved in a project looking at consenting across the Trust, with the aim of introducing e-consenting for Sample Bank as routine practice during clinical consenting.

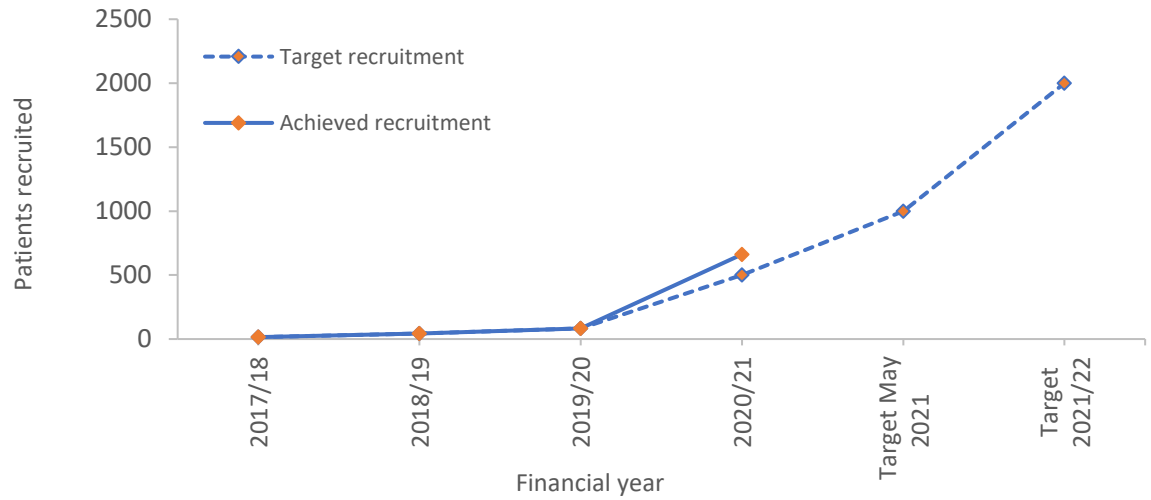


Figure 4: GOSH Sample Bank patient recruitment and targets

Research income

This year, we saw a significant drop in research income to £23 million (from £28 million last year) due to the impact of the COVID-19 pandemic where our research activity was reduced. R&I incurred £2.5m of COVID-19 related support costs indicating the contribution the team made to support other services and the activity, particularly on non-essential, commercial projects was reduced. Given the position we were in, R&I still ended the year in a strong position, contributing nearly £1m to the Trust over and above our core costs.

At the start of 2021/22 we will focus on recovering and exceeding our research activity, in order to meet ambitious targets for income, continuing to ensure that we provide sufficient infrastructure to support research delivery across the Trust. During 2021/22, we will also be bidding for the next round of NIHR BRC and CRF infrastructure funding, which will be critical to the success of our Research Hospital strategy.

Innovation

In December 2020, the Trust appointed a Director of Innovation, who is responsible for overseeing relevant workstreams as part of our Research Planet Delivery Board, for example digital innovation.

It has been essential to embed research within the Trust's electronic patient record system so that clinical care and research are fully integrated. This has proven especially important during the pandemic and can now be used to:

- Ensure priority research patients are seen, remotely where necessary, and staff can access e-patient records, collect data and flag adverse events wherever they are working.
- More rapidly and efficiently capture research activity.
- Provide specific and read-only access for Research Monitors, removing manual data processing.

In MyGOSH, we are testing the inclusion of patient-facing research information, capturing patients' expressions of interest and the potential to send information about research studies to eligible patients.

GOSH, and in particular the Zayed Centre for Research into Rare Disease in Children (ZCR), has played a key role in the world's first COVID-19 human challenge study. This study involves infection of healthy, young volunteers with coronavirus to test vaccines and treatments. The virus used has been manufactured at GOSH in the brand-new facilities in the ZCR, in collaboration with hVIVO and Imperial. ZCR is the largest single academic manufacturing unit for gene and cell therapies in the UK and one of the largest in the world.

There has been continued success for the gene and cell therapy research programme at GOSH and GOS ICH. Breakthroughs include a 'one size fits all' immune therapy, which could help to clear cancerous cells in children and adults who have exhausted all other treatment options for B-cell acute lymphoblastic leukaemia (B-ALL) and a clinical trial of Zolgensma, a new one-time gene therapy for some infants with SMA (spinal muscular atrophy) Type 1. In addition, an international collaboration with Harvard Medical School showed that the beneficial effects of gene therapy can be seen decades after the transplanted blood stem cells have been cleared by the body.

Journal publications

In 2020/21 we published 922 papers, 411 of these were with our academic partner. In the five year period between 2012 and 2016, GOSH and ICH research papers together had the second highest citation impact (1.997) of comparable international paediatric organisations.

Education and Training

We have a continued focus on education, with progress and achievements being monitored by our Research Planet Delivery Board with support from our BRC, Centre for Outcomes and Experience Research in Children's Health, Illness and Disability (ORCHID) and GOSH Learning Academy (GLA). Through these groups, we will continue to embed research and learning opportunities throughout careers at GOSH, to attract and retain research leaders. Development of research careers remains a priority.

Some of the highlights from 2020/21 include:

- Three Nursing/AHP internships awarded from NIHR GOSH BRC, in nursing and dietetics. These internships give clinical staff the opportunity to spend time developing research proposals.
- Funding was awarded by NIHR GOSH BRC for four clinical PhDs (three doctors, one clinician scientist).
- Successful funding from NIHR for one Advanced Fellowship, one Clinical Doctoral Fellowship and one Doctoral Fellowship.
- Three Pre-doctoral Clinical Academic Fellowships (PCAFs) awarded, in nursing and physiotherapy.
- One MRC Clinician Scientist Fellowship awarded.
- Two new NIHR Senior Investigators appointed.
- One NIHR Professorship awarded.
- Our first non-medical recipient of funding from NIHR for a Clinical Doctoral Research Fellowship was successfully awarded her PhD.
- First 'virtual' BRC Academic Training Day - 30 attendees developing their training in independent research.

Centre for Outcomes and Experience Research in Children's Health, Illness and Disability (ORCHID)

This research centre is unique; it brings together non-medical professionals to undertake their own research as well as collaborate on multidisciplinary studies, within the field of child health, within an NHS setting. Professor Faith Gibson, Director of Research – Nursing and Allied Health, leads this centre, and along with Dr Paula Kelly, Dr Polly Livermore, Dr Kate Oulton, Dr Debbie Sell and Associate Professor Jo Wray, provides leadership across our organization. This Research Centre, has two faculties - the Research and Clinical Academic Faculties - which provide the structure to address our objectives. One of our objectives is to contribute to the development of the future research workforce, particularly that of clinical academics, which falls under the remit of the Clinical Academic Faculty. As described above under 'Education and Training', we have achieved significant success. More specifically, three Doctorates were awarded in 2020/21 to researchers in ORCHID; two to AHP's (Speech & Language Therapy & Occupational Therapy) and one to a nurse. Our success in mentoring and academic supervision is clearly impacting on the workforce. We are achieving growth, and developing 'home grown' clinical academics. Building a community of clinical academics to deliver care in the NHS is a priority to which our work is closely aligned. We have shared our approach widely, contributing to a special edition of the Journal of Clinical Nursing dedicated to this subject.

A further objective is to provide research leadership across the professions of Nursing and Allied Health within and outside of GOSH. Research leadership, influencing a research culture, and building research capability and capacity are crucial. Importantly there is a need to evaluate progress and monitor change. We have reported our progress with the Allied Health workforce, and have also shared this widely.

The final objective we want to share in this year's report, is the generation of research evidence that underpins good outcomes for children and young people requiring complex care, this falls within the remit of our Research Faculty. We have a number of outputs that have been well-received, generating much interest nationally and internationally.

CQUIN payment framework

GOSH income in 2020-2021 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. As outlined in the Revised arrangements for *NHS contracting and payment during the COVID-19 pandemic* (NHS England and NHS Improvement 2020) the operation of CQUIN (both CCG and specialised) for Trusts was suspended for the period from April 2020 to July 2020.

CQC registration

GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2020/21 and the CQC has not taken enforcement action against GOSH during 2020/21.

As of March 2020, and in response to the NHSE/I request for the Trust to support the wider NHS during the COVID 19 pandemic, the Trust has expanded its registration to:

- Treat patients up to the age of 65.
- Treat patients who have been detained under the Mental Health Act.

There have been no inspections by the CQC during 2020 to 2021. The Trust will continue to conduct mock inspection framework (CQC Quality Rounds) in clinical directorates and review potential areas/sources of learning for example reviews of themes from other CQC reports and evaluation of CQC Insight reports.

Data quality

Good quality data is crucial to the delivery of effective and safe patient care. Data is vital to enable us to run our services efficiently as well as to identify any care quality issues and predict trends in order to take early action.

Highlights of the work completed in 2020/21 across Information Services, Data Assurance, Information Governance, and Clinical Coding include:

Information Services

- Statutory & Mandatory Returns datasets built in the EPR data warehouse with both internal (for validation) and external (for submission) reporting mechanisms.
- Statutory & Mandatory Returns datasets updated throughout the year as new versions and requirements released, including in-house XML translation to meet new requirements for submission in that format.
- Multiple datasets built in the EPR and HR data warehouses and QlikView to provide the Trust with oversight of various operational areas, from Theatre Utilisation to Patient Management, including any specific data quality issues.
- Standards for both data warehousing and reporting development consistently followed by the team and shared with other data teams across the Trust.
- Knowledge sharing with data teams across the Trust delivered via several means, including an Epic data warehouse user group established and run by the team.
- New processes developed for managing maintenance of data warehousing and reporting during system upgrades.
- Managed shutdown of warehouse data feeds from legacy systems and development of reporting on data from non-EPR systems, according to the requirements of diverse user groups.

Data Assurance

- Refreshed Data Quality Strategy and roll out of data quality Kitemark across Integrated Quality and Performance Reporting at Board level.
- GOSH achieved agreed data quality action plans from two internal KPMG audits – Referral To Treatment (RTT) and Data Quality Kitemark respectively.
- GOSH was part of the National Diagnostic PTL programme to help flag data quality issues affecting RTT reporting. The data quality metrics from this programme are now prioritised as part of the data assurance checks.
- Established data assurance workflows that covers daily, weekly and monthly data quality checks from integrated Epic data quality dashboards and Qlikview Patient Management reporting.
- Data assurance team works closely with the EPR team to develop training content, deliver training, standard operating procedures and data entry support for front-end users. During COVID, face-to face training was adapted to virtual learning.
- Data Assurance team continue to ensure all dimensions of data quality criteria is met which includes full validation of all unknown RTT clock starts, RTT clock stop audit, administrative pathway audit, clinical prioritisation and statutory reporting (RTT, DM01, DID and SUS).

Secondary Uses Service

As required by NHS Digital, GOSH submitted records during 2020/21 to the Secondary Uses Service (SUS) for inclusion in the National Hospital Episode Statistics. These are included in the latest published data. The table below shows key data quality performance indicators within the records submitted to SUS.

Indicator	Patient group	Trust Score	Average national score
Inclusion of patient's valid NHS Number	Inpatients	94.6%	99.5%
	Outpatients	95.8%	99.7%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.9%	99.8%
	Outpatients	99.8%	99.7%

Notes:

- The table reflects data from year to date 2020-2021 at month 12 SUS inclusion date.
- Nationally published figures include our international private and Non-English patients, who are not assigned an NHS number. Therefore the published figures are consequently lower at 94.6% for inpatients and 95.8% for outpatients.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

Information governance

The Trust is in the process of finalising its submission against the Data Security and Protection Toolkit (DSPT). This system allows us to demonstrate the controls we have in place to ensure the security and governance of the data we hold in the Trust. It also ensures we are meeting statutory data protection legislation such as the General Data Protection Regulations (GDPR). Meeting the DSPT requirements allows GOSH to maintain status as a `Trusted Organisation' with regards to sharing NHS data with NHS bodies and other trusted partners. Currently out GOSH meets 104 of the 110 requirements and has instigated action plans to complete the remaining 6 by October 2021.

Other activities of information governance are managing data sharing agreements with 3rd parties working with the Trust, managing data protection impact assessments for new systems and processes, managing the information asset register and overseeing policies related to the use of data and information in the Trust.

Clinical coding

GOSH has a dedicated and highly skilled clinical coding team, which continues to maintain high standards of inpatient coding. The depth of coding continues to sit above the national average due to the complexity of our patients.

GOSH continues to deliver a continuous individual internal audit programme to ensure that accuracy and quality are maintained, that national standards are adhered to, and any training needs are identified. As a result of the audit programme, key areas have been identified for further training sessions and these continue to be undertaken on a regular basis on either a team or individual basis, and we continue to standardise coding across the Trust. Independent training and study sessions have been implemented for each member of the clinical coding team.

Next steps for the clinical coding team is to introduce a robust validation programme working with clinical teams across all specialties. Work on this has already begun and hopefully the results will be evidenced in next year's audit.

The recent 2020 / 2021 audit for the Data Security and Protection Toolkit showed results of over 97.5% accuracy for primary diagnostic coding, and 90.45% for primary procedure coding.

200 FCEs were audited and the accuracy percentages were as noted below. The findings of the audit demonstrated a very good standard of diagnosis coding accuracy.

Area audited	Number of FCEs	Primary diagnosis accuracy	Secondary diagnosis accuracy	Primary procedure accuracy	Secondary procedure accuracy
Data security and protection toolkit	200	97.50%	98.02%	90.45%	82.34%

There were a number of areas of good practice noted – these included:

- Quality of diagnoses coding is very good
- The full electronic patient records were available at the time of audit
- The medical records were all accessible electronically and are available in a timely manner to the coders
- Histology results were checked and updated
- There are currently no vacant posts in the department
- Encoder is in use, which allows coding 5th characters and coders can select source documents and add any relevant notes to the episode coded.

There were also a few areas that could be improved, these included:

- Majority of errors were coder errors
- Errors identified from previous DSPT audits were noted to be repeated in this audit. E.g – adhesiolyis, missing codes for revisional operation
- Coders not reading through full op notes to extract all information and assign codes to fully reflect the procedures undertaken. This resulted in the high number of secondary procedure coding inaccuracy.

GOSH was subject to a national Payment by Results clinical coding audit during the 2020/2021 reporting period.

Priority clinical standards for seven-day hospital services

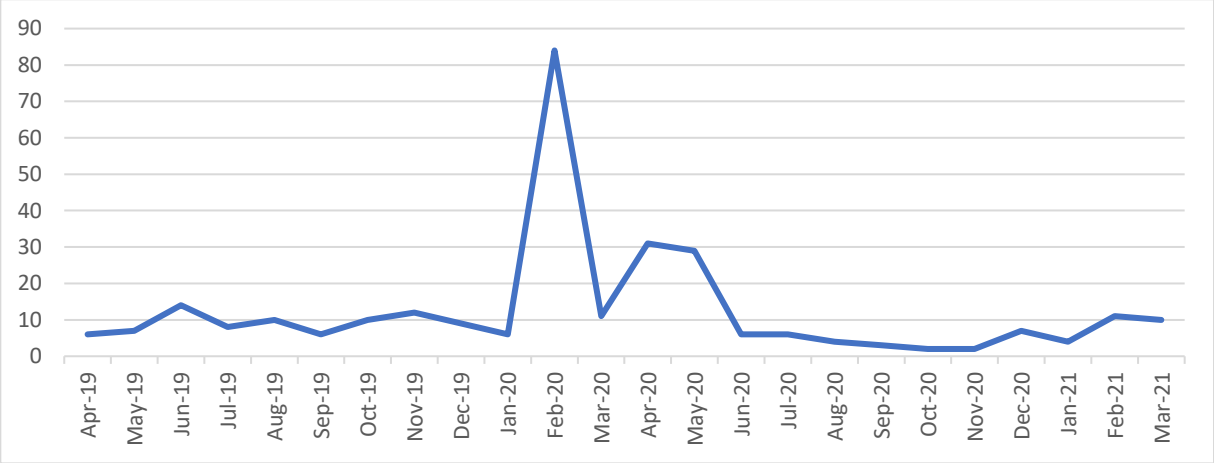
Participation in the NHS England seven-day service audit and self-assessment framework was suspended in March 2020 due to the unprecedented demand posed by the COVID-19 pandemic. We has not as yet been notified as to when it will resume.

Promoting safety by giving voice to concerns

Freedom to Speak Up Guardian

In 2020/21 the Freedom to Speak Up (FTSU) service dealt with 115 recorded cases. This compares to 183 recorded contacts in 2019/20 and 84 recorded cases in 2018/19. As was reported in last year's report, two special themes related to petitions brought by OCS staff accounted for 84 recorded cases in 2019/20 which accounts for the unusual increased number of concerns raised. This makes a year on year comparison difficult, but taking this number into account, it appears that there continues to be an increase in people accessing the service since 2018/19.

Freedom to speak up cases over the last 2 years



Staff highlighted bullying, harassment and difficult relationships with peers and managers as priority concerns. These tended to be complex and multi-faceted and on a number of occasions involved HR processes and investigations that were already in process. Patient safety and quality of care was the second highest concern raised and all matters have been, or are being, managed by the appropriate service leads. Some of the patient safety/quality of care issues were also related to the primary concern of bullying and harassment. The Guardian provides confidential and independent advice and support to our staff to raise concerns when they are unable to do so through other routes available to them or when they feel these have not been successful. Support and regular contact is provided throughout the process of speaking up. Feedback has highlighted the importance of this function for the wellbeing and empowerment of staff to speak up in future. The Guardian and Ambassadors promote awareness of FTSU pathways and promote a culture of speaking up. An important part of the Guardian role is also to support managers and leaders in the Trust to listen, act as required, and then feedback to those raising concerns.

The FTSU Guardian provides quarterly data and reporting to the National Guardians Office (NGO), Quality, Safety & Experience Assurance Committee and the People & Education Assurance Committee. In June, the Trust launched Praise as part of the Speak Up for Values programme. Praise continues to be well used in the Trust and is a positive way of acknowledging the good work of colleagues. The i-speak up platform was launched in October 2020 and allows people to provide feedback about a colleague's perceived unprofessional behaviour.

Due to COVID-19, the Speak Up for Safety training became an online only module via GOLD and continues to be part of induction for all new staff. The current compliance rate for people undertaking the Speak Up for Safety training is 85%.

In April 2021, the NGO national online training modules for workers and managers were embedded into the Trust training portfolio. This is an important step forward in meeting the national and local training needs of our staff.

Reducing rota gaps for NHS doctors and dentists in training

The importance of appropriate working hours and attendance at training and education opportunities for junior doctors has a direct effect on the quality and safety of patient care with increasing recognition on the negative effect of rota gaps on junior doctor training and wellbeing.

Supporting our staff during COVID-19
The pandemic exposed significant workforce risk of a nature not seen before – high levels of unexpected absence and a changing patient demographic, with the requirement to continue daily clinical activity and rapidly upscale required a flexible, responsive and clinically capable medical workforce. In response GOSH rapidly made changes to all rotas to ensure there was appropriate cover to support the organisation in the face of unknown demands. The entire clinical workforce was activated to ensure sharing of responsibilities.

Staff wellbeing during Covid was paramount to safety. All rotas were compliant, with contingency staffing factored in to provide 30-50% back up on both day and night shifts to manage unexpected absence (which reached 30% in the first surge). Rotas also had rest days that were fully respected.

In order to support the restoration of services and a continued adaptive response to COVID surges further innovative work has included the establishment of a team of consultants as medical workforce leads (MWLs) to lead on an out of hours management and improvement programme:

- We have maximised the efficiency of our workforce by increasing the numbers of doctors on duty in the hospital at night team.
- We have developed a Senior Medical Officer leadership role to support more effective and collaborative team working.
- Depending on clinical situational awareness, MWLs make real time decisions about whether this flexible hospital at night team are able to safely absorb unexpected rota gaps without the need to deplete day time staffing or request our doctors to work extra hours.
- We have established the minimum numbers of doctors required to safely run specialty areas whilst ensuring we have enough doctors on the establishment to make sure our doctors get rest days and take annual and study leave.
- An enhanced governance and risk infrastructure for out of hours working scrutinises rota gaps on a monthly basis and mitigates any risks identified
- Working closely with rota coordinators and specialty leads we have implemented a standard operational procedure for rota gap management.
- Continuous review and monitoring of the recruitment pipelines in anticipation of/ planning for rota gaps (as over 50% of our workforce are internal medical graduates) occurs regularly. We are developing a real time ‘medical pipeline dashboard’ to improve our workforce intelligence.

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

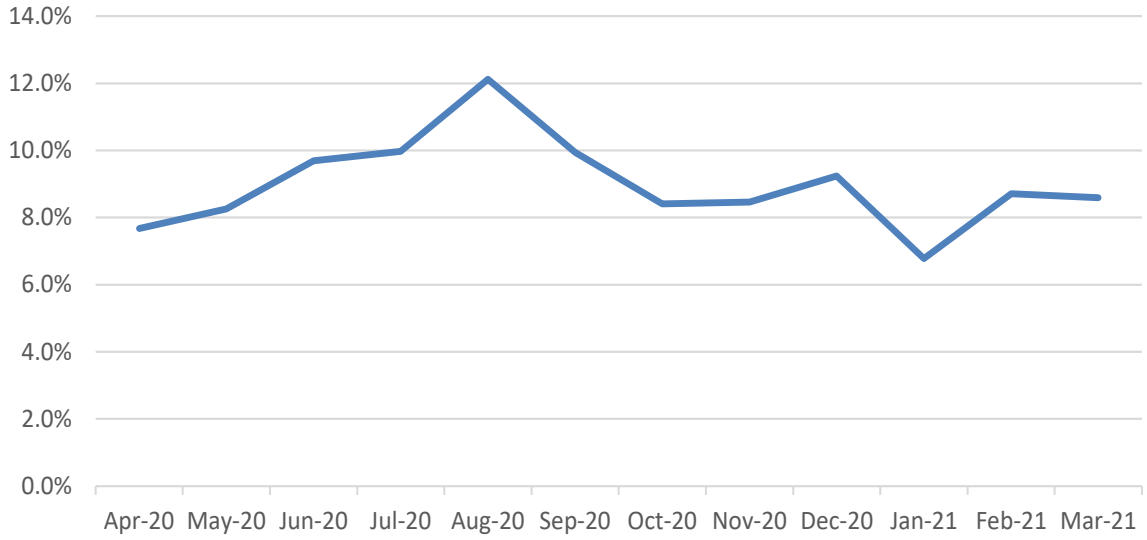
Exception Reporting System

Exception reporting (ER) is the mechanism by which doctors are able to report safety concerns in the workplace and as such GOSH enables both Health Education England (HEE) trainees and non-training (trust) grade doctors to exception report at GOSH, as we value all our doctor equally. In 2020/21 no immediate safety concerns were reported through this system. We do not find exception reporting an accurate reflection of rota gaps but it is a useful indicator for areas that may be under pressure.

Vacancy Rates

GOSH vacancy rate has varied between 6.8% and 12.1% over 2020/21 (broadly similar to the previous year; range 6.8-12.8%) and continues to sit below the national average. Our rota gaps were relatively low during the first and second COVID surge as we rapidly on boarded extra doctors; offering academics and regular bank staff short term contacts in order to minimise rota gaps.

Vacancy rates for junior doctors 2020-2021



Variations in numbers of trainees sent to the Trust by the London School of Paediatrics impact significantly on our ability to plan and mitigate rota gaps. Short notice leaves insufficient time to recruit to vacant posts and has had a major impact on several specialties as the availability of workforce alongside the extended lag time to recruitment has been impacted by the pandemic.

Part 2c: Reporting against core indicators

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2020	2019	2018	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
The percentage of staff who would be happy with the standard of care provided by the organisation if a friend or relative needed treatment.	91.5%	88.7%	88.2%	91.5%	95.5%	82.0%	91.5%	The survey is carried out under the auspices of the DHSC, using their analytical processes. GOSH is compared with other acute specialist trusts in England. Source: NHS Staff Survey. Time period: 2020 calendar year	The key actions associated with addressing staff survey findings have been incorporated into the GOSH People Strategy – with its four pillars: Capacity, Infrastructure, Skills and Culture & Engagement. The survey results indicate the need to prioritise the Culture & Engagement pillar. This workstreams purpose is to ensure all our people feel well led and managed, but also supported and empowered to do and be their best. The 2020 staff survey results show early evidence of positive change. The launch of the Trust *"Seen & Heard"* (Equality, Diversity & Inclusion) & *"Mind, Body & Spirit"* (Health & Wellbeing) Framework in September 2020 will embed further positive change towards our aim of Making GOSH a great place to work.
Percentage of staff who agreed that care of patients is the organisation's top priority.	89.1%	86.5%	84.2%	89.1%	91.8%	82.9%	89.1%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from managers in last 12 months.	13.8%	16.3%	17.2%	13.8%	7.2%	17.5%	11.3%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from other colleagues in last 12 months.	20.9%	24.4%	22.1%	20.9%	18.7%	23.6%	18.7%		
Percentage of staff who consider the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.	76.4%	75.9%	78.8%	76.4%	92.1%	74.9%	87.1%		

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2020-21	2019-20	2018-19	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Friends and Family Test (FFT) - % of responses (inpatient).	33%	24%	19%	33%	†	†	†	The rates are from NHS England Time period: 2020/21	FFT response rates at Great Ormond Street have been the highest in 2020/21 since FFT started at the Trust. GOSH maintained FFT throughout the COVID-19 pandemic as this is our main source of patient feedback, despite NHSE allowing the service to be suspended.
FFT - % of respondents who recommend the Trust (inpatient).	98%	97%	97%	98%	†	†	†		
Number of clostridium difficile (C.difficile) in patients aged two and over.	13	6	6	13	‡	‡	‡	The rates are from PHE Time period: 2020/21	Continuing to test stool samples for the presence of C.difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C.difficile in patients aged 2 and over (number of hospital acquired infections/ 100,000 bed days).	10.4	7.5	10.3	10.4	‡	‡	‡		

Note: C.difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. At GOSH, we test for C.difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported; where a request is made for enteric viruses; and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Healthcare Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report.

† Data is released by NHSE and was not available at the time of publishing this report.
‡ Data is released by PHE and was not available at the time of publishing this report.

Indicator	From local trust data			GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2020-21	2019-20	2018-19		
Patient safety incidents reported to the National Reporting and Learning System (NRLS):					
Number of patient safety incidents	5915	5069	6751	GOSH uses electronic incident reporting to promote robust reporting and analysis of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing.	Initiatives such as: Risk Action Groups, local training in root cause analysis, and "Learning from…" events and posters, improve the sharing of learning to reduce the risk of higher-graded incident recurrence. Initiatives are reported and monitored by the Patient Safety and Outcomes Committee.
Rate of patient safety incidents (number/100 admissions)	17.5	12.6	14.9		
Number and percentage of patient safety incidents resulting in severe harm or death	9* (0.2%)	4 (0.1%)	12 (0.2%)		
*At initial reporting of patient safety incidents zero were reported as resulting in severe harm or death. Nine incidents were initially reported under these levels of harm, however, after investigation they were found to be deaths or severe harm as a result of their underlying conditions and have subsequently been re-graded. Three of the nine incidents highlighted above are still open. Although the incidents occurred within 2020-2021, they did not come to our attention until after March 2021. These are currently being investigated to establish root cause and level of harm.					

E**xplanatory note on patient safety incidents resulting in severe harm or death**
It is mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC as part of the CQC registration process. GOSH also reports its patient safety incidents to the NRLS, which runs a national database designed to promote learning.

There is no nationally established and regulated approach to reporting and categorising patient safety incidents. Different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a lengthy investigation, which could result in the classification being changed. This complexity makes it difficult to do a formal comparison.

Part 3: Other information

NHS Improvement uses a limited set of national mandated performance measures, described in its Single Oversight Framework, to assess the quality of governance at NHS foundation trusts. Performance is measured on an aggregate (rather than specialty) basis and Trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

Performance against key healthcare targets 2020-2021

Domain	Indicator	National threshold	GOSH performance for 2020-21 by quarter				2020-21 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	100%	100%	100%	100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising: • surgery • anti-cancer drug treatments	 94% 98%	 100% 100%	 100% 100%	 100% 100%	 95.24% 100%	 98.31% 100%	 Yes Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	Apr-20: 76.17% May-20: 67.73% Jun-20: 59.55%	Jul-20: 55.64% Aug-20 57.48% Sep-20: 61.60%	Oct-20: 63.77% Nov-20: 67.01% Dec-20: 70.05%	Jan-21: 69.13% Feb-21: 69.46% Mar-21: 70.31%	†	No
Experience	Maximum 6-week wait for diagnostic procedures	99%	Apr-20: 40.34% May-20: 41.39% Jun-20: 53.65%	Jul-20: 66.33% Aug-20: 66.59% Sep-20: 66.00%	Oct-20: 68.44% Nov-20: 68.53% Dec-20: 61.92%	Jan-21: 53.29% Feb-21: 63.19% Mar-21: 72.32%	†	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

* Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)
† Data is not amenable to calculating mean value.

Additional Indicators – Performance against local improvement aims

The Trust has also implemented a range of local improvement programmes focusing on the quality priorities described in Part 2a. These are reviewed at each Trust board meeting. Statistical Process Control (SPC) charts are used to measure improvements over time and to identify areas that require further investigation. All measures remain within expected statistical tolerance.

Domain	Indicator	GOSH performance for 2020/21 by quarter				2020/21 mean
		Q1	Q2	Q3	Q4	
Effectiveness	Inpatient mortality rate (per 1,000 discharges)	13.54	6.31	8.32	7.65	8.73
Experience	Discharge summary completion time (within 24 hours)	71.96%	79.11%	84.36%	80.21%	79.50%
Effectiveness	PICU discharges delayed by 8-24 hours	3	1	10	4	4.5
Effectiveness	PICU discharges delayed by more than 24 hours	8	9	15	7	9.75
Experience	Formal complaints investigated in line with the NHS complaints regulations	17	17	27	17	78 total
Effectiveness	Last minute non-clinical hospital cancelled operations and breaches of 28-day standard* - Cancellations breaches	34 7	31 4	41 2	22 0	32 3.25
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge	4.2%	3.7%	2.2%	3.2%	3.2%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge	0.0%	0.0%	2.4%	1.9%	4.8%
Safety	GOS acquired Central Venous Line related bloodstream infections (per 1,000 line days)	1.5	1.1	1.3	0.8	1.2

+Does not include day cases
*'Last minute' is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery.

Performance against key healthcare targets 2019-2020

Domain	Indicator	National threshold	GOSH performance for 2019-20 by quarter				2019- 20 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	100%	100%	100%	Jan and Feb only: 100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising: • surgery • anti-cancer drug treatments	 94% 98%	 94% 98%	 100% 100%	 100% 100%	 89.47% 100%	 96.65% 100%	 Yes Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	Apr: 90.08% May: 88.26% Jun: 86.00%	Jul: 84.47% Aug: 82.45% Sep: 83.72%	Oct: 85.02% Nov: 85.71% Dec: 84.98%	Jan: 86.14% Feb: 85.95% Mar: 82.88%	†	No
Experience	Maximum 6-week wait for diagnostic procedures	99%	Apr: 90.79% May: 90.52% Jun: 92.08%	Jul: 94.93% Aug: 96.04% Sep: 96.92%	Oct: 95.19% Nov: 96.79% Dec: 91.02%	Jan: 87.94% Feb: 91.57% Mar: 74.77%	91.55%	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

* Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)
† Data is not amenable to calculating mean value

Additional Indicators – Performance against local improvement aims

In addition to the national mandated measures identified in the above tables, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in Part 2a. The table below sets out the range of quality and safety measures that are reviewed at each Trust board meeting. Statistical Process Control (SPC) charts are used to measure improvements in projects over time and to identify areas that require further investigation. All measures remain within expected statistical tolerance.

Domain	Indicator	GOSH performance for 2019/20 by quarter				2019/20 mean
		Q1	Q2	Q3	Q4	
Effectiveness	Inpatient mortality rate (per 1,000 discharges)	8.97	8.20	8.38	6.26	7.99
Experience	Discharge summary completion time (within 24 hours)	47.40%	60.36%	70.07%	74.25%	62.71%
Effectiveness	PICU discharges delayed by 8-24 hours	9	6	11	14	10
Effectiveness	PICU discharges delayed by more than 24 hours	21	9	3	9	10.5
Experience	Formal complaints investigated in line with the NHS complaints regulations	21	24	24	21	90 total
Effectiveness	Last minute non-clinical hospital cancelled operations and breaches of 28-day standard* - Cancellations breaches	157 34	142 6	104 9	83 9	122 15
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge	2.55%	2.32%	2.21%	2.34%	2.36%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge	0.00%	0.00%	3.87%	4.76%	3.02%
Safety	GOS acquired Central Venous Line (CVL) related bloodstream infections (per 1,000 line days)	1.7	1.2	1.3	2.6	1.7 per 1000 bed days

+Does not include day cases
*'Last minute' is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery.

Annex 1:

Comments from the Chair of Camden Health and Adult Social Care Scrutiny Committee

Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Cllr Larraine Revah, and they should not be understood as a response on behalf of the Committee.

Thank you for sending your 2020 - 2021 quality report for comment. The report is comprehensive and easy to follow.

GOSH continues to deliver incredibly impressive services and for children and their families with compassion and total commitment. The dedication of colleagues has, once again, been highlighted during the COVID-19 crisis.

The Trust is to be congratulated on the overall progress made in 2020/2021 in what has been an incredibly challenging year for everyone and particularly health services. The section on the Trusts key achievements for the year is a highly positive start to the report, and highlights some of the fantastic work the Trust has undertaken during COVID-19, for example opening a new paediatric ward specifically for children presenting to hospitals within North Central London with acute mental health support needs during the first wave.

The following observations were made in accordance with a set of core governance principles which guide the scrutiny of health and social care in Camden.

1) Putting patients at the centre of all you do.
Safety, clinical effectiveness and experience were the priorities for improvement in 2020/21. The report clearly outlines the impressive progress made in a range of areas.

Understandably, COVID-19 has slowed some of the progress in what the board aimed to achieve in relation to patient experience in the past year, and led to a revision of the priorities that emerged from the Trust's Learning Disability Strategy. The Learning Disability Education resource is a good initiative, I trust this will improve further once Covid restrictions are lifted, enabling actors with lived experience to attend GOSH to participate.

The way GOSH is now consistently listening and learning from patients and their families is to be commended. The MyGOSH communication tool and *Heads Up* effectively utilise technology to improve patients' ability to communicate with the Trust, the report demonstrates they have been hugely effective, with MyGOSH users increasing by 251% in the past year.

2) Focussing on a common purpose, setting objectives, planning.
The section of the report on prioritise for improvement is clear, including what we said we'd do, what we did, what the data shows, what's going to happen next and how this benefits patients.

The accounts demonstrate the Trust recognises the huge efforts of its staff and that their work can be physically and emotionally challenging. The work of the Wellbeing Operational Group and the Wellbeing Hub is very important in ensuring staff have access to appropriate resources to ensure they feel supported when they experience stress and anxiety.

The priorities for 2021/22 are clearly defined, it's very helpful that the report explains why they are important and how progress will be monitored, measured and reported. It is unfortunate that these

priorities were not widely consulted on, however these priorities provide an opportunity to pick up on work that was delayed due to COVID-19.

3) Working collaboratively.
The report is full of interesting examples of working positively with patients and their families and with staff.
For example, the report demonstrates the collaborative working during COVID-19, as the Trust worked with the NCL sustainability and transformation partnership, transferring patients from hospitals across NCL to GOSH to allow our NCL partners to use these wards to care for adults, and by deploying staff to NCL Hospital areas in most need.
The Trust's development of the COLLABORATE Leaders' Network to share exemplary and new practice in leadership and management is also commendable.

4) Acting in an open, transparent and accountable way - using inclusive language, understandable to all - in everything it does
The Freedom to Speak Up (FTSU) Service demonstrates the Trusts willingness to act in an open, transparent and accountable way to ensure staff feel confident to raise concerns and ultimately enhance patient safety and experience.

It is fantastic to read the Trust's Apprenticeship Team won a BAME Apprenticeship Award.

Cllr Larraine Revah
Chair of Camden Health and Adult Social Care Scrutiny Committee

Feedback from Members of the Council of Governors

The Quality Report confirms that we should hugely congratulated GOSH on the way it immediately stepped up and adapted its work across the whole organisation as a result of the Covid pandemic. The pandemic changed the requirements of patients, of families, of colleagues, of working with partners, of the use of the building – and so many processes and procedures.

The report provides an amazing story of the year and how life was transformed for so many – the many positive changes, but also the truly, truly difficult ones. The report begins with a moving introduction by Mat Shaw, the Chief Executive of GOSH. He succinctly describes the challenges, the successes during the year, focusing on the delivery of the Trust's three strategic priorities – safety, clinical effectiveness and improving the experience of patients and staff, putting children and young people first.

Turning to the main report, during the year, the Trust knew it had to change. And, regrettably, but inevitably, everyone was even more stretched than usual. For example, the Trust took on services for adults and for young people facing mental health issues – something it had never done before. The report is clear about the huge amount that went really well, the things that didn't go so well and the things that will be done far better in future. The Duty of Candor is one of the Chief Executive's key mantras. It is fully demonstrated throughout this report.

One disappointment is that there appears to be a lack of emphasis in the main report on colleagues, the amazing contribution they each make to GOSH and to each individual patient, and their families, and on the Trust's journey in relation to empowerment, speaking up, listening, safety, kindness, training, development, diversity, inclusion, equality, and encouraging health and wellbeing. For example, the GOSH Learning Academy is hardly mentioned. It is a beacon of excellence, as is the People Strategy.

It is positive that 91% of staff would be happy for a friend or relative to be treated at GOSH. However, only 76% consider that GOSH acts fairly regarding career progression regardless of ethnic background, gender, religion, sexual orientation, disability and age. There is so much to celebrate. GOSH is absolutely aware that there is also much more to do.

Cllr Alison Kelly
Appointed Governor (London Borough of Camden)
Great Ormond Street Hospital for Children NHS Foundation Trust

I agree with much of what has been said by my fellow Governor Cllr Alison Kelly and as always, the Quality Report is an excellent and through commentary of all the incredible work that happens in a year at GOSH, even more significant in the recent year.

As a parent Governor who has observed many of the Quality Safety and Patient Experience Assurance Committee meetings, I can confirm that the report covers much of the important ongoing priorities and activity of this group. I appreciate that the report has not been put into final format yet but I would be keen that as in previous years it is presented in a manner that ensures that it is an inviting and accessible read to patients and families of GOSH.

Despite the need to swiftly refocus efforts during the last year and the considerable toll that this has on staff it is reassuring to see the launch of and attention to wider strategic goals, including safely, education and experience. Also very encouraging to see that much of the learning from the COVID response will be put to good use, both from a clinical and operational perspective.

Mrs Lisa Allera
Parents and Carer from Home Counties Governor
Great Ormond Street Hospital for Children NHS Foundation Trust

Annex 2: Statements from NHSEI, London Region, Specialised Commissioning

NHS England and Improvement (NHSEI) would like to thank Great Ormond Street Hospital NHS Foundation Trust (GOSH) for the ongoing collaboration during the course of another very challenging 12 months for the NHS.

During this year, NHS England has continued with a 4 to 6 weekly Clinical Quality Review Meeting. This has enabled ongoing dialogue about the COVID pandemic plans, its impact and the Trust's response. Notable was the action taken by GOSH, working in collaboration with the paediatric networks and other tertiary centres, to identity and respond to a new group of sick children, now known as Paediatric Multi-System Inflammation Syndrome (PIMS-TS).

Great Ormond Street has continued to provide mutual aid for acute paediatric care across North Central London Integrated Care Systems (ICS) and over the course of the year the Trust has participated in regional-wide discussions about elective recovery of services for children and young people, as well as establishing internal processes to clinically prioritise children requiring medical and surgical care. There remains further opportunity for improvement to ensure equity for elective surgery recovery and to assist with a predicted increase in children presenting with respiratory infection.

The pandemic response included the development of virtual clinics which has helped to improve speed and ease of accessibility to healthcare. Other key notable achievements from the past year include:

- Ongoing implementation of the recommendations arising from an MHRA inspection.
- Developing a well-being hub which is accessible to all staff and the development of a "freedom to speak up" service.
- Developing a strategic vision for CYP requiring mental health care.
- Establishing a collaborative virtual Multi-Disciplinary Team (MDT) for children impacted by long Covid in partnership with University College London Hospitals NHS Foundation Trust and Evelina London Children's Hospital.

There are some challenges ahead this year with potential changes in ICS legislation; NHS England will continue to work with North Central London ICSs to determine GOSH's accountabilities at a local, regional and national perspective.

NHS England will continue to work with GOSH to take forward recommendations in relation to congenital heart disease, oncology, paediatric critical care and surgery in children, where the Trust will need to undertake a direct role, and, as host to the North Thames Paediatric Network, to navigate the successful delivery of these very important programmes of work.

Beyond these, the necessary focus on pandemic recovery and, the quality priorities identified by the Trust for 2021/22 there are some specific areas of improvement activities for GOSH to undertake which include:

- Implementing agreed recommendations from the recent external Veritas "Well Led" Assessment which is due to report in the Autumn.
- Working formally with external stakeholders to determine how to improve incident investigation processes, learning from deaths and how to undertake more successful engagement with families in coming to terms with the sad loss or deterioration of their children as a result of complex clinical scenarios.
- Providing demonstrable and sustained improvements in the staff survey feedback, particularly in relation to culture.
- Describing and demonstrating the implementation of the NHS Patient Safety Strategy.
- Improving performance in relation to Workforce Race Equality Standards.

NHS England looks forward to working with and supporting the leadership team at GOSH and the ICS to secure a successful outcome in these areas over coming months.

Annex 2: Statements of assurance

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance Detailed Requirements for Quality Reports 2019/20.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2020 to May 2021
    - papers relating to Quality reported to the board over the period April 2020 to May 2021
    - feedback from commissioners dated 30 June 2021
    - feedback from governors dated 28 June 2021
    - feedback from Non-Executive Directors dated 28 June 2021
    - feedback from Councillor Larraine Revah, Chair of Camden Health and Adult Social Care Scrutiny Committee dated 28 June 2021
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23 June 2020
    - Children and Young People's Inpatient and Day Case Survey 2018
    - the national NHS Staff Survey 2020
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 31 March 2021
    - CQC inspection report dated 22 January 2020
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report*.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

30th June 2021
Chief Executive

30th June 2021
Chair

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7th July 2021

Integrated Quality and Performance Report (IQPR) (May 2021 Data) **Submitted by:** Dr Sanjiv Sharma, MD Alison Robertson, Chief Nurse John Quinn, COO Caroline Anderson, Director of HR & OD	**Paper No: Attachment S** ☐ **For approval** √ **For discussion** ☐ **For information and noting**

Purpose of report

To present the IQPR data and narrative to the Board to show the monthly performance on the key indicators.

To provide the Board with assurance that the indicators on patient safety, patient experience and performance are monitored regularly.

Summary of report

- The report shows that the incident reporting rate remains stable; a decrease was observed in the number reported and it should be noted the Trust had increased activity. The percentage of incident closure rate has increased to 71% and average days to close decreased to 37.
- Two serious incident reports are overdue and the situation is monitored weekly.
- The position with high risk reviews and actions remain static and there is a focus on improving the performance in liaison with the directorates.
- The Friends and Family Test response rate in May was 43%, an improvement from last month when we reported 40% and remains above target. All directorates significantly exceeded the response rate (which ranged from 31 to 59%).
- There were four new formal complaints in May with concerns relating to communication and aspects of care. Overdue red complaint actions are unchanged this month (6) although progress has been made and updated completion dates are under review with the team concerned.
- Pals contacts (204) increased slightly this month. Contacts relating to Medical Records (families seeking information for the purposes of second opinions or to support requests for additional support) increased significantly. There was a decrease in concerns about communication but themes of contact received related to difficulties when contacting teams for confirmation and clarity on patient-specific care plans.
- We aim to have to have over 100 completed specialty led clinical audits per year. We are on track for meeting our target so far for 2021/22 (17 audits completed YTD).
- The In-Touch pulse survey for May shows static or improvements in 4 areas with 4 areas showing a decrease. Key movement is seen with how staff are coping with life at the moment with a 10% increase and communication between senior managers and staff is effective with a 12% decease
- RTT – Improvement in the position reported at the end May 2021 at 74.9%, 3.6% increase April and 2% above trajectory. 52 Week waits decrease of 96 patients (20%) to 369 at end of May.
- DM01 – Improvement in the reported position for May 2021 at 81.15, 4% increase and 9% above trajectory. 6 Week breaches decreased by 76 to 305.

Attachment S

Action required from the meeting The Board are asked to note the report	
Contribution to the delivery of NHS Foundation Trust priorities **□ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** **□ PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** **□ PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training** **□ PRIORITY 4: Improve and speed up access to urgent care and virtual services** **□ PRIORITY 5: Accelerate translational research and innovation to save and improve lives** **□ PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care** **□ Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** **□ Leadership, capacity and capability** **□ Vision and strategy** **□ Culture of high quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance** **□ Accurate data/ information** **□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**
Strategic risk implications BAF Risk 3: Operational Performance	
Financial implications Not Applicable	
Implications for legal/ regulatory compliance Not Applicable	
Consultation carried out with individuals/ groups/ committees Not Applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? Deputy Chief Operating Officer	
Who is accountable for the implementation of the proposal / project? Chief Operating Officer	
Which management committee will have oversight of the matters covered in this report? RACG, QSEAC, FIC, Closing the Loop and PFEEC.	

Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality & Performance Report June 2021 (May 2021 data)

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

Hospital Quality Performance – June 2021 (May data)

Are our patients receiving safe, harm-free care?

	Parameters	Mar 2021	Apr 2021	May 2021
Incidents reports (per 1000 bed days)	R<60 A 61-70 G>70	90 (n=782)	89 (n=628)	82 (n=587)
Incident investigations completed in month		345	755	528
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	633*	720	613
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	71.6%	61.5%	71%
Average days to close	R ->50, A - <50 G - <45	36	48	37
Medication Incidents (% of total PSI)	TBC	15%	26%	26%
WHO Checklist (Main Theatres)	R<98% G>98-100%	97%	97%	98%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	3.5%	3.7%	4.9%
New Serious Incidents		0	2	2
Overdue Serious incidents	R >1, A -1, G – 0	2	2	2
Safety Alerts overdue	R- >1 G - 0	0	0	0
Serious Children's Reviews Safeguarding children learning reviews (local)	New	0	0	0
	Open and ongoing	12	12	12
Safeguarding Adults Board Reviews	New	0	0	0
	Open and ongoing	2	2	2

Are we delivering effective, evidence based care?

	Target	Mar 2021	Apr 2021	May 2021
Specialty Led Clinical Audits on Track	R 0- 60%, A>60-75% G>75-100%	86%	84%	75%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	110	11	17
NICE guidance overdue for assessment of relevance	R=1+, G=0	0	0	0
Relevant NICE national guidance without a gap analysis	R=1+, G=0	0	0	0
Participation in mandatory relevant national audits	G=100%	100%	100%	100%

Are our patients having a good experience of care?

	Parameters	Mar 2021	Apr 2021	May 2021
Friends and Family Test Experience rating (Inpatient)	G – 95+, A- 90-94, R<90	98%	98%	98%
Friends and Family Test experience rating (Outpatient)	G – 95+, A-90-94,R<90	98%	97%	97%
Friends and Family Test - response rate (Inpatient)	25%	38%	40%	43%
PALS (per 1000 combined pt episodes)	N/A	9.78	8.70	9.30
Complaints (per 1000 combined pt episodes)	N/A	0.37	0.40	0.18
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	13%	12%	11%
Re-opened complaints (% of total complaints since April 2020)	R>12% A- 10-12% G- <10%	5%	5%	5%

	Parameters	Mar 2021	Apr 2021	May 2021
Mandatory Training Compliance	R<80%,A-80-90% G>90%	94%	94%	94%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	84%	85%	86%
PDR	R<80%,A-80-89% G>90%	91%	92%	91%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	91%	93%	94%
Honorary contract training compliance	R<80%,A-80-90% G>90%	90%	84%	87%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	90%	90%	89%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	96%	94%	91%
Resuscitation Training	R<80%,A-80-90% G>90%	89%	87%	88%
Sickness Rate	R -3+% G= <3%	2.3%	2.5%	3.1%
Turnover - Voluntary	R>14% G-<14%	10.7%	11%	11%
Vacancy Rate – Contractual	R- >10% G- <10%	6.0%	4.4%	4.9%
Vacancy Rate - Nursing		4.7%	1.1%	2.8%
Bank Spend		5.3%	5%	4.8%
Agency Spend	R>2% G<2%	1.1%	0.8%	0.8%

Hospital Quality Performance – June 2021 (May data)

Is our culture right for delivering high quality care?

	Target	Mar 2021	Apr 2021	May 2021
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	66%	62%	85%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G- 0	48	48	48
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G- 0	5	6	6
Duty of Candour Cases	N/A	7	7	5
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%	71.4%	57%	60%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	57%	57%	60%
Duty of Candour - Stage 3 Total sent out in month	Volume	3	6	1
Duty of Candour – Stage 3 Total (%) sent out in month on time	R<50%, A 50-70%, G>70%	33%	50%	0%
Duty of Candour – Stage 3 Total overdue (cumulative)	G=0 R=1+	5	3	5
Policies (% in date)	R 0- 79%, A>80% G>90%	91%	92%	92%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	90%	91%	90%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	83%	88%	88%
Inquests currently open	Volume monitoring	6	6	7
Freedom to speak up cases	Volume monitoring	10	15	12
HR Whistleblowing - New	Volume monitoring	0	0	0
HR whistleblowing - Ongoing	12 month rolling	1	1	0
New Bullying and Harassment Cases (reported to HR)	Volume	0	0	1
	12 month rolling	2	2	3

Are we managing our data?

	Target	Mar 2021	Apr 2021	May 2021
FOI requests	Volume	43	53	46
FOI Closures: % of FOIs closed within agreed timescale	R- <65% A – 65-80% G- >80%	96%	100%	95%
No. of FOI overdue (Cumulative)		0	1*	1*
FOI - Number requiring internal review	R>1 A=1 G=0	0	0	0
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	10	12	6
IG incidents reported to ICO	R=1+, G=0	0	2	0
SARS (Medical Record) Requests	volume	140	141	129
SARS (Medical Record) processed within 30 days	R- <65% A – 65-80% G- >80%	99%	99%	100%
New e-SARS received	volume	1	0	0
No. e-SARS in progress	volume	2	2	2
E-SARS released	volume	3	0	0
E-SARS partial releases		2	0	0
E-SARS released past 90 days	volume	0	0	0

Description	Target	Mar 2021	Apr 2021	May 2021
52 week + breaches reported (ticking at month end)	Volume	564	465	369
52 week + harm reviews to be completed (for treatment completed)		94	82	79
Clinical Harm Reviews Returned		17	13	TBC
Clinical Harm Identified		0	0	TBC

Do we deliver harm free care to our patients?

Central Venous Line Infections

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

Period	GOSACVCRB_No	DaysRecorded	Rate	Rate_YtD
Year 18/19	82	52959	1.5	1.5
Year 19/20	73	56045	1.3	1.3
Year 20/21	63	54015	1.2	1.2
Apr-21	4	5231	0.8	0.8
May-21	7	6546	1.1	0.9

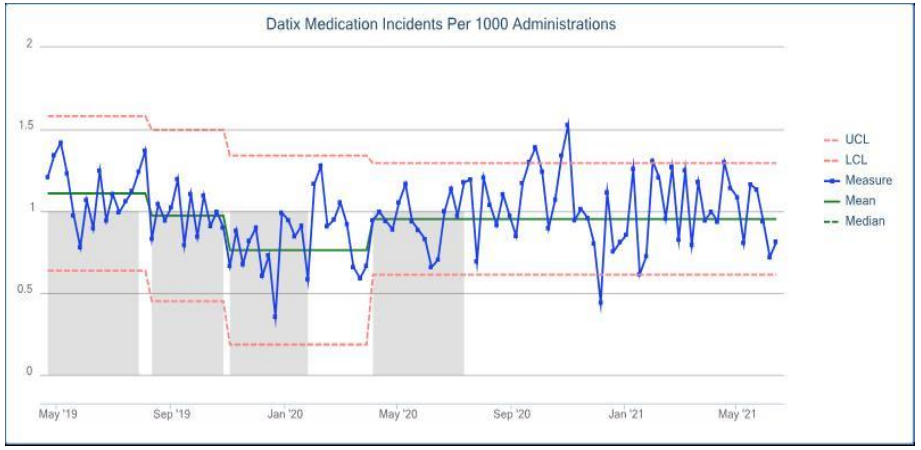
Infection Control Metrics

Care Outcome Metric	Parameters	Feb 2021	Mar 2021	Apr 2021	May 2021
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	6	5	4	7
	YTD (financial year)	66	71	4	11
C Difficile cases - Total	In month	1	0	0	0
	YTD (financial year)	11	11	0	0
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	1	0	0	0
	YTD	11	11	0	0

Pressure Ulcers

		Jan 21	Feb 21	Mar 21	Apr 21	May 21
Volume	R – 12+, A 6-11 G <5	7	4	2	3	6
Rate	R=>3 G=<3	0.59	0.6	0.59	0.59	0.59

Medication Incidents



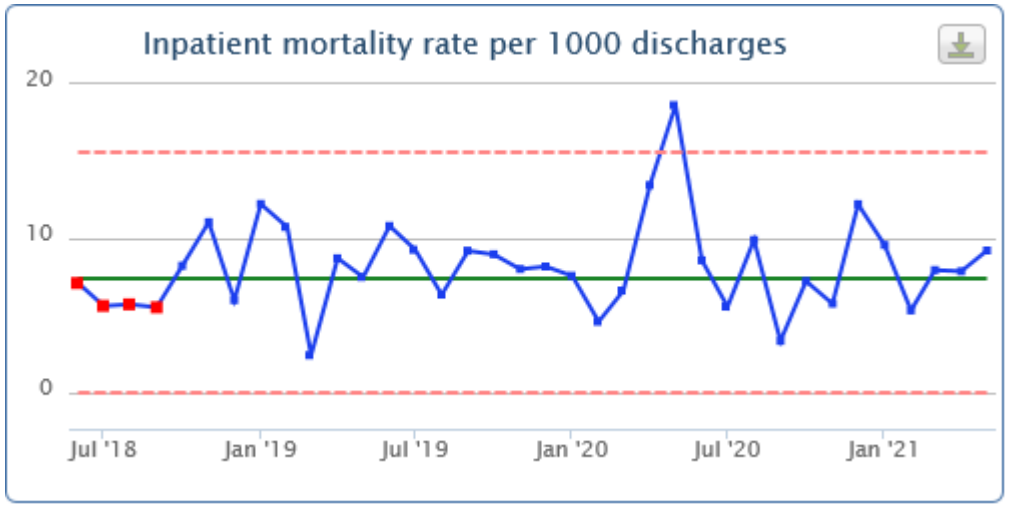
121 medication-related incidents were reported in May 2021. By category these were broken down as follows:

- Administration error-28%
- Dispensing error-16%
- Prescription error (incl admin from incorrect prescription)- 22%
- Storage/missing medication -27%
- Drug reaction- 2%

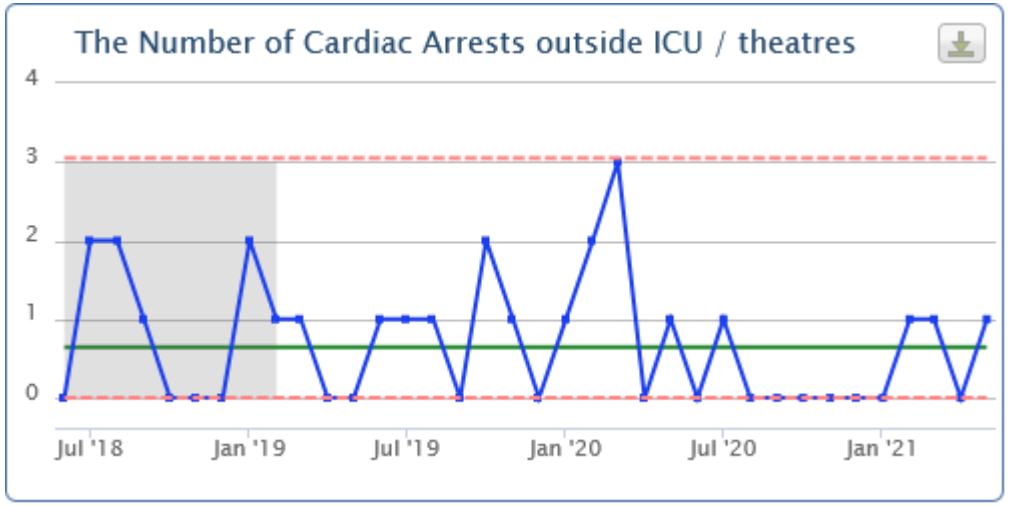
186 medication incident investigations were completed and closed in May. None of these incidents were reported as causing significant harm with only a small number (n=12) causing minor harm.

Does our care provide the best possible outcomes for patients?

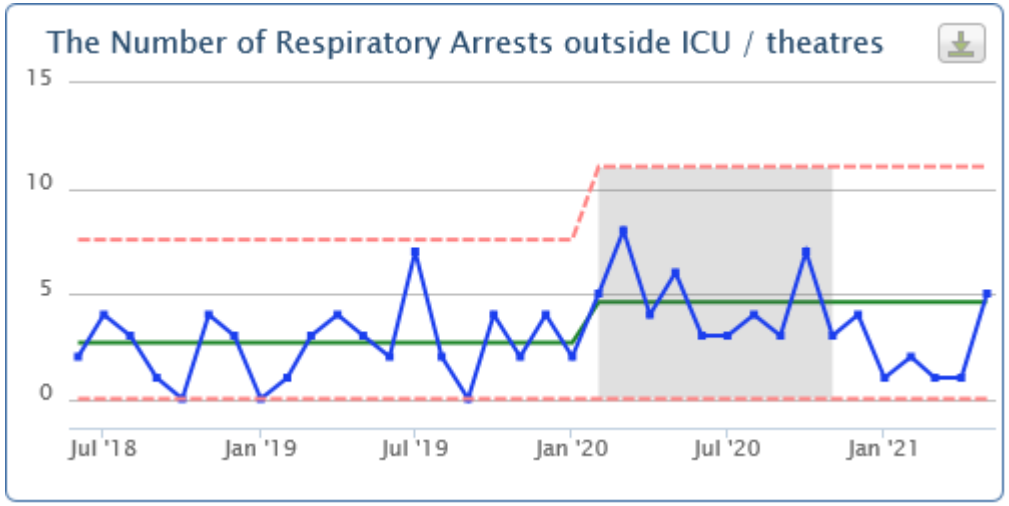
Inpatient mortality



Cardiac Arrests



Respiratory Arrests

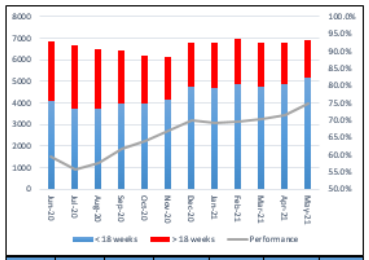


The crude mortality rate is within normal variation. There have been no outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths. This is important as the majority of patient deaths at GOSH are in intensive care areas. Risk adjusted mortality is monitored weekly at the PICU/NICU Morbidity and Mortality meeting. The gold standard for measuring paediatric mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANET) .The most recent PICANET report was published on the 11th February 2021 and covers the calendar years 2017-2019. The report shows GOSH PICU/NICU and CICU risk adjusted mortality as within expected range. The Health Care Quality Improvement Partnership (HQIP) have recently developed a public access website to display National Clinical Audit Benchmarking (NCAB) which draws upon that PICANET data. Our PICU and CICU risk adjusted mortality can be seen here

Do our processes and systems support patient access?

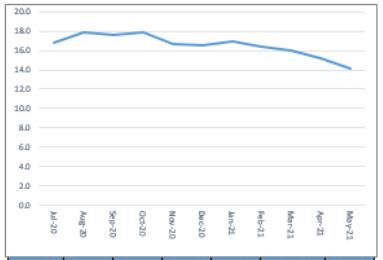
Patient Access

RTT incomplete pathways: % of patients waiting <18 weeks	Period	Target	Actual
	May-21	92.0%	74.92%



Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
67.01%	70.05%	69.13%	69.46%	70.31%	71.27%	74.92%

RTT: Average waits for open pathways	Period	Target	Actual
	May-21	8.1	14.1

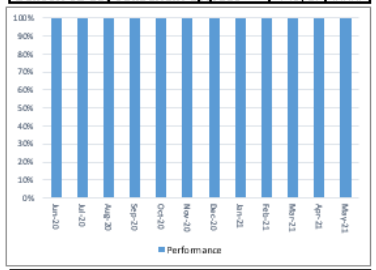


	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
3.65%	16.7	16.5	16.9	16.4	16.0	15.2	14.1

RTT: Incomplete pathways 52 weeks or more	Period	Target	Actual
	May-21	0	389

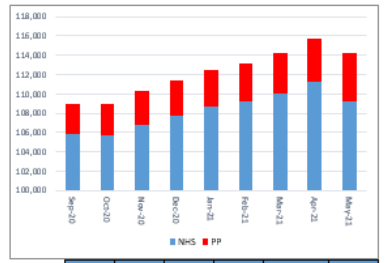
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
52 wks+	431	507	577	564	465	389
35 wks+	1165	1058	967	931	825	752

Cancer: 62 day consultant upgrade	Period	Actual
	May-21	####



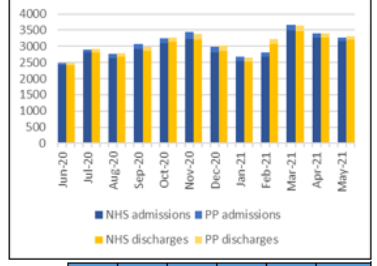
Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	####

Open referrals at month end (NHS & PP)	Period	Actual
	May-21	114,231



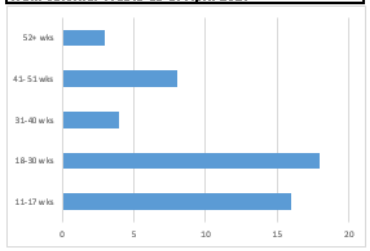
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
NHS	107,787	108,746	109,171	109,984	111,196	109,216
PP	3,649	3,719	3,920	4,254	4,587	5,015

Admissions (NHS & PP)	Period	Actual
	May-21	118
Discharges (NHS & PP)	May-21	3309



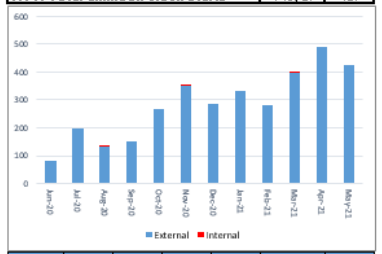
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Admissions	2966	2652	2783	3659	3381	118
Discharges	3019	2620	2775	3633	3392	3309

RTT: Weeks wait of 18 week RTT pathways received from external Trusts as at April 2021



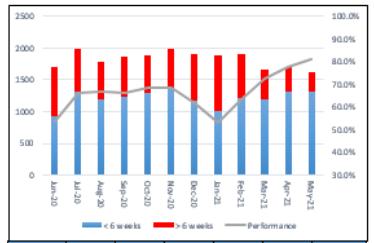
	0-10 wks	11-17 wks	18-30 wks	31-40 wks	41-51 wks	52+ wks
Total	4285	16	18	4	8	3

RTT: Total unknown clock starts	Period	Actual
	May-21	427



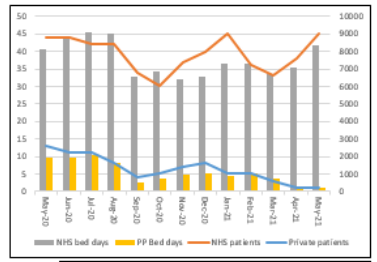
Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
350	285	334	281	399	489	427

Diagnostics: % of patients waiting less than 6 weeks for	Period	Target	Actual
	May-21	99.0%	81.15%



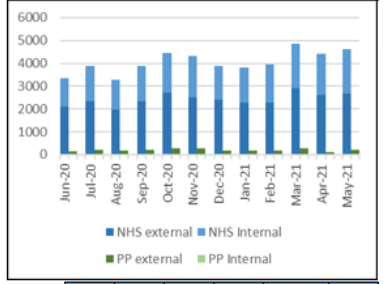
Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
68.53%	61.92%	53.29%	63.19%	72.32%	77.56%	81.15%

>50 days	Period	Actual
	May-21	46
Bed days	May-21	8,572



	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Patients	48	50	41	36	39	46
Bed days	7582	8180	8324	7402	7327	8572

External Referrals (NHS & PP)	Period	Actual
	May-21	2890
Internal Referrals (NHS & PP)	May-21	1975



	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
External	2597	2449	2428	3184	2735	2890
Internal	1463	1543	1690	1970	1802	1975

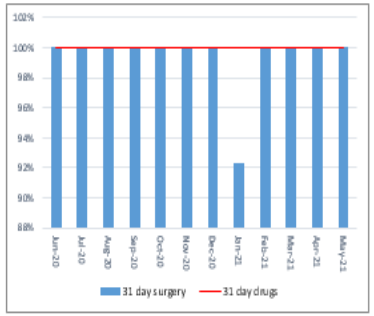
Diagnostics: National % patients waiting less than 6 weeks for a test	Period	Target	Actual
	Apr-21	99.0%	75.97%

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
70.78%	72.48%	70.83%	66.66%	71.54%	75.71%	75.97%

Cancer: 31 day referral to treatment	Period	Target	Actual
	May-21	85.0%	#####
Cancer: 31 day decision to treat	May-21	96.0%	#####

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
31 day RT	100%	100%	100%	100%	100%	#####
31 day DT	100%	100%	100%	100%	100%	#####

Cancer: 31 day subsequent treatment (Surgery)	Period	Target	Actual
	May-21	94.0%	#####
Cancer: 31 day subsequent treatment (Drugs)	May-21	98.0%	#####

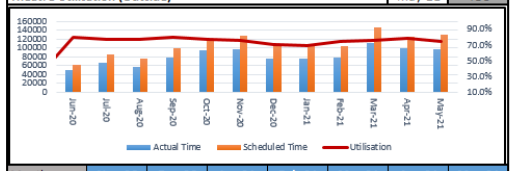


	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Surgery	100%	92%	100%	100%	100%	#####
Drugs	100%	100%	100%	100%	100%	#####

Are we productive and efficient?

Productivity & Efficiency

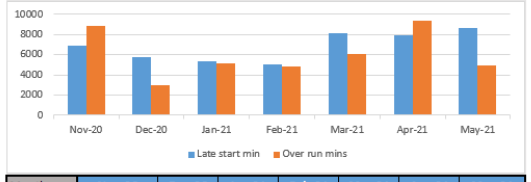
Theatre Utilisation (Main)	Period	Actual
	May-21	73.84%
Theatre Utilisation (Outside)	May-21	TBC



Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Main	76.20%	70.77%	69.85%	74.68%	75.18%	78.65%	73.84%
Outside	TBC	TBC	TBC	TBC	TBC	TBC	TBC

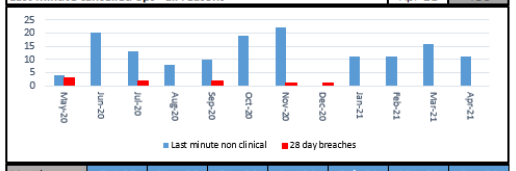
*Theatre session utilisation data is currently being investigated for March and April 2020

Late starts in Main theatres (minutes lost)	May-21	8656
Overruns in Main theatres (minutes lost)	May-21	4977



Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Late starts	6897	5708	5348	5055	8155	7885	8656
Overruns	8822	2990	5151	4794	6031	9342	4977

Last minute hospital cancelled ops for non clinical reasons	Apr-21	11
Last minute hospital cancelled ops - breaches of 28 day standard	Apr-21	0
Last minute cancelled ops - all reasons	Apr-21	TBC



Month	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Non clinical	19	22	0	11	11	16	11
Breaches	0	1	1	0	0	0	0

Average length of stay	Period	Actual
	May-21	TBC

Under construction

Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21

Bed Occupancy	Period	Actual
	May-21	77.60%

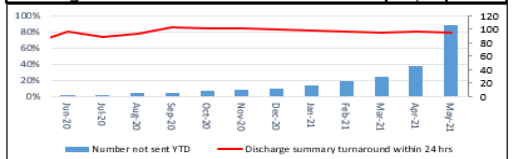
Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21

Average monthly ward bed closures (excluding weekends)	Period	Actual

Under Construction

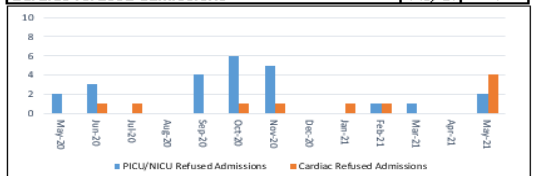
Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21

Discharge summary turnaround within 24 hours	May-21	79.41%
Discharge summaries - number not sent in	May-21	62
Discharge summaries - number not sent YTD	May-21	106



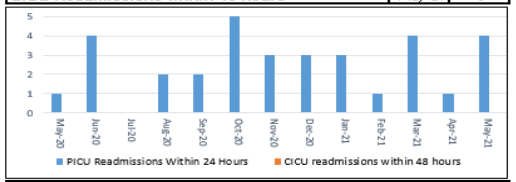
Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Performanc	84.88%	83.59%	81.77%	80.35%	79.03%	80.78%	79.41%
Not sent	3	1	4	7	6	17	62

PICU/NICU CATS refused admissions	May-21	2
Cardiac refused admissions	May-21	4



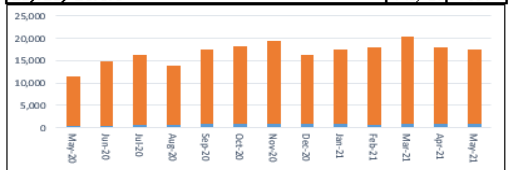
Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
PICU/NICU	5	0	0	1	1	0	2
Cardiac	1	0	1	1	2	0	4

PICU Readmissions within 24 hours	May-21	4
CICU Readmissions within 48 hours	May-21	0



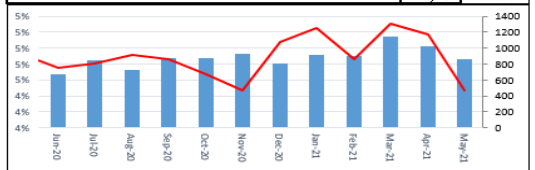
Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
PICU	3	3	3	1	4	1	4
CICU	0	0	0	0	0	0	0

Outpatient appointments cancelled on the day/day before	Period	Actual
	May-21	934



Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Cancellatio	906	867	921	765	877	839	934
Attendance	18501	15402	16537	17303	19609	17029	16674

DNA/Was Not Brought rate	Period	Actual
	May-21	4.46%



Month	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Rate	4.47%	5.08%	5.26%	4.86%	5.31%	5.18%	4.46%
DNAs	933	806	909	906	1148	1021	858

Clinic letter turnaround within 7 days	May-21	100%	75%
Clinic letter turnaround within 10 days	May-21		75%
Clinic letter turnaround within 14 days	May-21		82%

Month	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
7 days	66%	67%	63%	60%	63%	68%	63%	63%	65%	63%	67%	75%
10 days	73%	74%	69%	68%	69%	73%	67%	72%	75%	72%	76%	75%
14 days	80%	81%	79%	75%	76%	81%	75%	81%	82%	82%	83%	82%

Are we Safe?

There were 8 open **serious incident** investigations in May 2021. 2 were completed, approved and submitted to NHSE. The 2 SI listed as overdue have been due to the availability of key pieces of information/ staff but also due to the complexity of the investigations and requiring external input. These have been approved and submitted. 9 are awaiting NHSE review and final approval. As previously discussed, a review of the Serious investigation process had been commenced. The early draft has been completed and is currently being shared with stakeholders for review and comment. This includes the updated SI policy.

The incident reporting rate remains stable at 82 per 1000 bed days (n=587). A decrease was observed in the number reported but an increase in activity was also observed. The number of incidents being quality checked and closed is recorded as 613. The percentage of incident closure rate has increased to 71% and average days to close has decreased to 37. Compliance continues to be monitored weekly and summary reports and milestone documents are circulated to the Executive team, directorate/departmental leads as well as individual handlers.

WHO checklist: Performance for GA procedures (all departments) is at 96% and 98% in main theatres.
In the main theatres, this is a slight improvement since last month.
Completion rates across Oncology procedures is at 95%.

Row Labels	Incomplete	Complete	%
ANAESTHETICS	1	5	83%
CATH AND EP LAB		48	100%
CT	2	11	85%
GASTRO INVESTIGATIONS UNIT	4	60	94%
INTERVENTIONAL RADIOLOGY	13	303	96%
MAIN THEATRES	16	723	98%
MRI	20	163	89%
NUCLEAR MEDICINE		7	100%
Grand Total	**56**	**1320**	96%

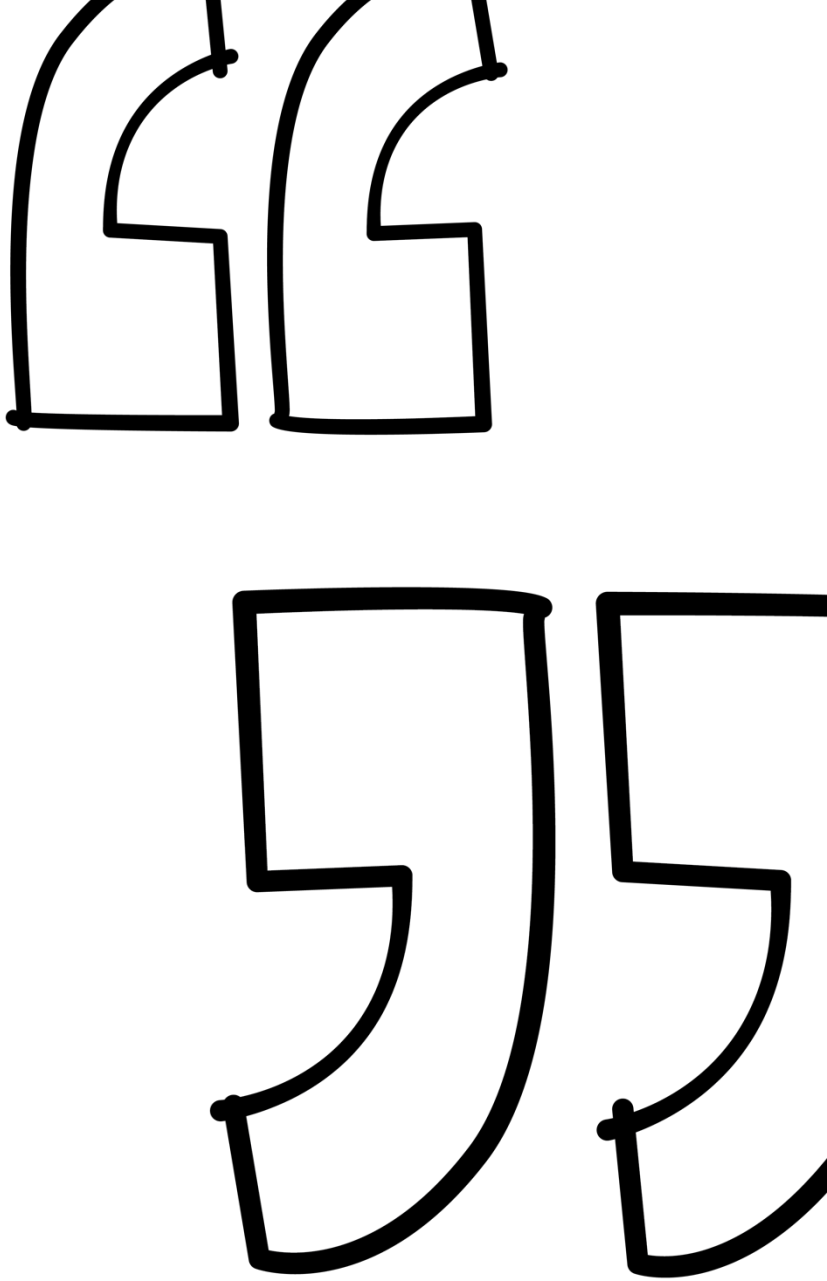
Are we Caring?

The **Friends and Family Test** response rate for May was 43%. This is an increase compared with April data. All directorates exceeded the response rate (which ranged from 31% – 59%). The experience measure for Inpatients remained high at 98% and 97% for Outpatients. Negative feedback primarily related to issues in Access, Admission, Discharge category. These related to long waits for medications, particularly within the BCC directorate. This has been escalated to the Pharmacy Team.

Outpatients response reduced this month to 432 submissions. Negative feedback within Outpatients related to cancelled or rescheduled appointments. There were comments about the lack of communication regarding the option of virtual clinics, families only discovered that this was an option after long journeys to GOSH. There were also comments from families that they found it distressing when they did not see the clinician they were expecting to see.

There was a marked reduction in new complaints received in May 2021 (n=4). Complaints related to concerns about aspects of care and communication. One complaint regarding a rejected kidney transplant due to inadequate and delays in follow up care and monitoring was graded red/ high risk and has been declared a Serious Incident. The measure for red/ high risk complaints remains amber and is under close review- two red complaints have been raised this financial year. Overdue red complaint actions are unchanged this month (n=6) although progress has been made and updated completion dates are under review with the team concerned.

Pals contacts increased slightly this month. Resolution timeframes remained high with 80% of contacts responded to within 48 hours or less. Contacts relating to Medical Records (families seeking information for the purposes of second opinions or to support requests for additional support) increased significantly. There was a decrease in concerns about communication but themes of contact received related to difficulties when contacting teams for confirmation and clarity on patient-specific care plans. Cardiology, Dermatology and Gastroenterology all saw decreases in Pals cases.



Are we Effective?

Clinical Audit

We have a priority clinical audit plan to support learning from incidents, areas risk, patient complaints, and to investigate areas for improvement in quality and safety. Key priority audits in progress are highlighted in the Clinical Audit section of the report.
We have completed priority two Trust wide audits in May 2021 and these are highlighted in the Clinical Audit section of the report

1. Enabling Optiflow outside of ICU
2. Control of access to medicine storage rooms

We are on track for meeting our target for completed specialty led audit so far for 2021/22 (17 audits completed YTD) This measure is useful as it gives an indication of the capacity of teams to engage in reviews of the quality of care provided, and of our oversight of that .

Quality Improvement

QI support the delivery of Ward Accreditation and this has made extensive progress. Data collection and visibility is being trialled in two wards with plans to roll out to spread further in May 2021. The trial includes a data collection application developed in-house. Key metrics determining ward status has been formulated and now being prioritised. The continuous improvement structure proposed to support Ward Accreditation has been presented to the senior nursing leads with favourable reception and is ready to be rolled out in the Trust following a PDSA approach. This support structure is expected to enable change in a meaningful way at all levels, with a basic level of training to all.
Trust wide QI work supported by the QI team is also now fully established in two key projects
Identification and responsiveness to the deteriorating patient
Increasing safety and reliability of TPN prescription and delivery
Significant diagnostic work has been done and working groups to roll out interventions are being considered
The QI team has successfully completed QI training to increase QI capability in the organisation for a 3rd cohort of staff. Preparations are being made for the 4th cohort with an intended start date of September.

Are we Responsive?

We are currently at 81.51% of patients waiting less than 6 weeks for the **15 diagnostic modalities (DM01).** This is a further increase from last month's position when we reported 77.56%. The number of breaches reported in May (305) compared to the number of breaches reported in April (381) has also decreased. The Trust is currently 9% above trajectory for returning to meeting the 99% standard. Routine requests are being categorised to an additional level to ensure patients are not adversely waiting longer than clinically safe, with patients waiting beyond the must be seen by date clinically reviewed.

The national diagnostic position for April performance stood at 75.97%, GOSH was tracking 2% above this. Nationally 310,802 patients were waiting 6 weeks and over for a diagnostic test at the end of April.

Comparative children's providers have seen similar movements. GOSH, Sheffield Children and Birmingham Women's and Children's reported performance of around 66-77% for April 2021 whilst Alder Hey was higher at 95.8%.

April 2021 **Cancer Waiting Times** data has now been submitted nationally and the Trust achieved 100% across all five standards. For May, the Trust is forecasting reporting 100% achievement across all standards too.

The Trust did not achieve the **RTT** 92% standard, submitting a performance of 74.92%, with 1738 patients waiting longer than 18 weeks, this is an increase in performance from the previous month's 71.27%. The Trust is currently 2% above predicted trajectory for the month of May. The current PTL consists of 10% of patients being categorised as P2 patients and 68% P3/P4 patients. As at the end of May, the Trust reported a total of 369 patients waiting 52 weeks or more; this is a decrease of 96 patients (20%) from the previous month. 69% of patients waiting over 52 weeks have a future contact booked.

Nationally, at the end of April, 58.89% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks, thus not meeting the 92% standard. The national position for April 2021 indicates a significant increase of patients waiting over 52 weeks with 367,142 patients compared to 10,864 in April.

RTT Performance for comparative children's providers is Sheffield Children (68.8%) and Birmingham Women's and Children's (78.9%) and Alder Hey (67.5%). On average 656 52-week breaches were reported in April for these providers.

Are we Well Led?

There were 5 incidents confirmed as requiring **duty of candour** in May 2021. Being Open/Duty of Candour conversations took place in 100% of incidents. 60% of stage 2 letters completed within the timescale of 10 days. 1 investigation reports was shared with families in May 2021. Unfortunately due to the length of time in completing these investigation, 0% were shared within the expected timeframe. A weekly candour catch up continues up with the directorates to help pre-empt and manage delays.

Risk Register: High risk monthly review performance increased in May 2021 when compared to the previous month. Compliance by May end was recorded as 86%. Risk compliance is now also discussed and reviewed at the monthly Performance reviews with all high risks and Trust-wide risks discussed monthly at the Operational Board meeting..

The Trust received 46 **FOI** requests in May 2021, a small number of which were deemed as non-valid and further requests were returned requesting clarification of which only 2 applicants responded (section 45). The remaining FOI requests that were due in May 2021, 95% were responded to within the legislated timescale. The 1 overdue FOI request was made in March 2021 is complex with extended time required to review all data requested. This was completed and the applicant responded to by the first week of June. The applicant has been kept informed regularly.

There are currently 62 open **Serious Incident actions** in May 2021 of which 48 are over their agreed date for completion. A number of actions have been completed in May 2021, however a number of new SI actions that were due for closure in May are reported now as overdue and are awaiting evidence before closure can be completed. The Patient Safety Team continue to work with the directorates to ensure completion and closure of the overdue actions . Closing the Loop meetings occur monthly which review the overdue actions to understand and address any barriers to completion of the action and embedding of the learning. Also actions owners are contacted directly to ensure actions are completed and evidence provided. Where there are delays in completing the action but there is a defined later date for completion/approval/closure, the action deadlines are extended to reflect the reasons for delay. SI actions by directorate/department are also reviewed at the monthly Performance meetings

Covid–19 at GOSH

We have changed the way that we work at GOSH in March in order to ensure that we play our part in supporting the NHS to respond effectively to Covid-19. This slide brings together a number of key metrics to help understand the overall picture.

There were 2 (cf 108 in Mar; 56 in Feb 2021)) COVID-19 related **incident** reported in May 2021, both rated as minor harm.

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

The Operations Board reviews all high risks (12+) monthly There were 11 risks rated at 12 and above. The top themes are: reduction in activities (and the risks to children and income), staffing and non-compliance to data protection (staff working differently, data stored on unencrypted devices and loss of data). There are no changes to the risks themes.

Workforce Headlines: May 2021

Contractual staff in post: Substantive staff in post numbers in May were 4962.7 FTE, an decrease of 9.3 FTE since April 2021.

Unfilled vacancy rate: Vacancy rates for the Trust increased to 4.9% in May from 4.4% the previous month and is lower than the same month last year (5.6%). The vacancy rate remains below the 10% target and it is lower than the 12 month average of 6.6%. Vacancy rates in the clinical directorates were all below target in May.

Turnover: is reported as voluntary turnover. Voluntary turnover was static in May at 11.0%, and it remains below the Trust target (14%). Total turnover (including Fixed Term Contracts) increased to 14.0% in April. The low rates seen over the last year are likely at least in part attributable to the impact of COVID and while turnover is expected to remain below target for much of 2021, it is expected to continue to increase in Quarter 1 2021/2022 as the impact of COVID recedes.

Agency usage: Agency staff as a percentage of paybill in May remained at 0.8% well below the local stretch target (2%) and a reduction from the 20/21 closing figure of 1.1%. Agency use is almost exclusively taking place within Corporate Non-Clinical Directorates and amongst some Allied Health Professional disciplines. Bank % of paybill reduced to 4.8% in May.

Statutory & Mandatory training compliance: In May the compliance rate across the Trust remained at 90% for the 10th month in a row, which remains above the target with all directorates achieving target. The medical and dental staffgroup are the only staffgroup below the 90% target (86%) Across the Trust there are 7 topics below target including Information Governance where the target is 95%. Safeguarding Children Level 3 compliance for substantive staff has fallen to 89% (slightly below the 90% target), while Honorary contract holders compliance has increased to 87% in May. Directorates and non compliant individuals receive reminders about required training modules.

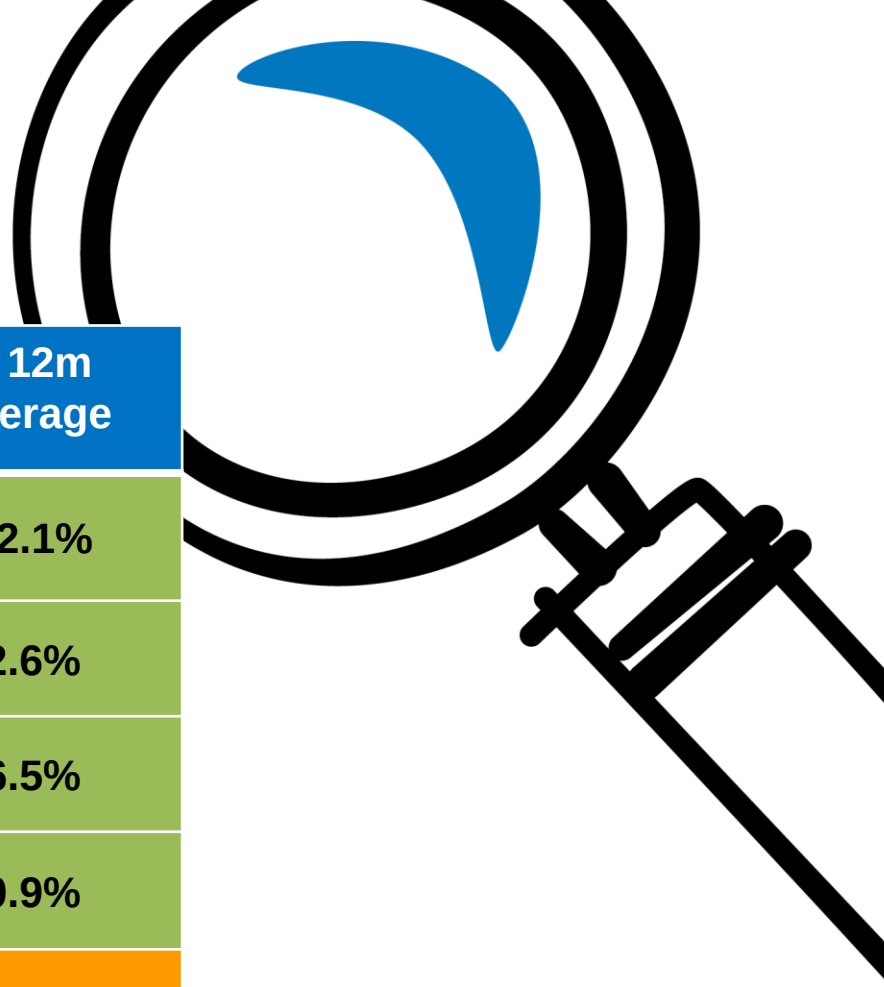
Appraisal/PDR completion: The non-medical appraisal rate decreased slightly to 91% in may, but remains above target with 12 Directorates achieving the 90% target. Consultant appraisal rates increased to 94% in May.

Sickness absence: Sickness rates in May increased to 3.1% which is above the Trust target (3%) and higher than the same month last year. Both long (more than 28 days absence) and short term sickness increased from April. Although COVID absences (both sickness and self isolation) increased in May, the most common reason for absence was Anxiety/Stress or Depression. The Trust continues to benchmark well against wider NHS absence rates and it is possible the increased absence rates at GOSH reflect better reporting following the rollout of the HealthRoster system trustwide.

Trust Workforce KPIs: May 2021

Great Ormond Street Hospital for Children
NHS Foundation Trust

Metric	Plan	May 2021	3m average	12m average
Voluntary Turnover	14%	11.0%	10.9%	12.1%
Sickness (1m)	3%	3.1%	2.6%	2.6%
Vacancy	10%	4.9%	5.1%	6.5%
Agency spend	2%	0.8%	0.9%	0.9%
PDR %	90%	91%	91%	88%
Consultant Appraisal %	90%	93%	93%	84%
Statutory & Mandatory training	90%	94%	94%	94%

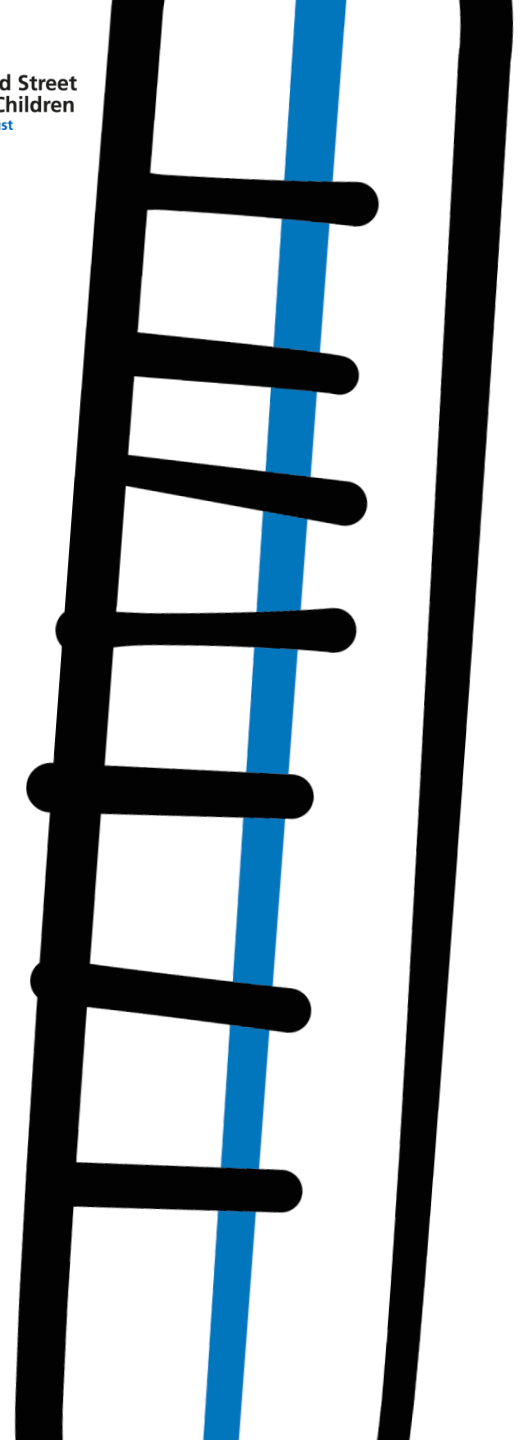


Key:
Achieving Plan | Within 10% of Plan | Not achieving Plan

Directorate (Clinical) KPI performance May 2021

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP	Genetics
Voluntary Turnover	14%	11.0%	7.8%	15.4%	7.8%	12.7%	12.9%	12.8%	7.8%	8.9%	12.2%
Sickness (1m)	3%	3.1%	**3.4%**	**3.8%**	2.4%	3.1%	3.2%	**3.9%**	2.7%	**3.6%**	1.0%
Vacancy	10%	4.4%	-2.4%	-6.4%	0.3%	3.0%	-4.1%	2.3%	2.2%	-1.1%	-3.3%
Agency spend	2%	0.8%	-0.4%	0.0%	0.0%	0.0%	1.1%	0.7%	0.0%	0.9%	0.0%
PDR %	90%	91%	90%	90%	90%	92%	94%	87%	97%	92%	88%
Stat/Mand Training	90%	94%	93%	91%	93%	91%	95%	92%	98%	99%	98%



Key:

Achieving Plan Within 10% of Plan Not achieving Plan

Directorate (Corporate) KPI performance May 2021

Metric	Plan	Trust	Clinical Operations	Corporate Affairs	ICT	Property Services	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation	Transformation
Voluntary Turnover	14%	11.0%	15.3%	**16.3%**	11.5%	5.6%	3.8%	1.6%	10.3%	6.6%	11.6%	11.0%
Sickness (1m)	3%	3.1%	1.5%	2.2%	2.4%	**4.6%**	0.5%	**3.6%**	1.9%	**4.3%**	2.4%	0.1%
Vacancy	10%	4.9%	4.2%	**13.8%**	**10.2%**	5.3%	12.0%	1.8%	**17.1%**	3.0%	10.7%	11.3%
Agency spend	2%	0.8%	1.2%	**4.6%**	**18.2%**	0.8%	**4.7%**	**2.7%**	**5.9%**	1.9%	0.0%	0.0%
PDR %	90%	91%	91%	86%	**71%**	92%	92%	90%	**78%**	86%	94%	89%
Stat/Mand Training	90%	94%	91%	87%	88%	97%	96%	97%	97%	97%	97%	96%

Key:

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

Great Ormond Street Hospital for Children
NHS Foundation Trust

In Touch pulse survey – May 2021

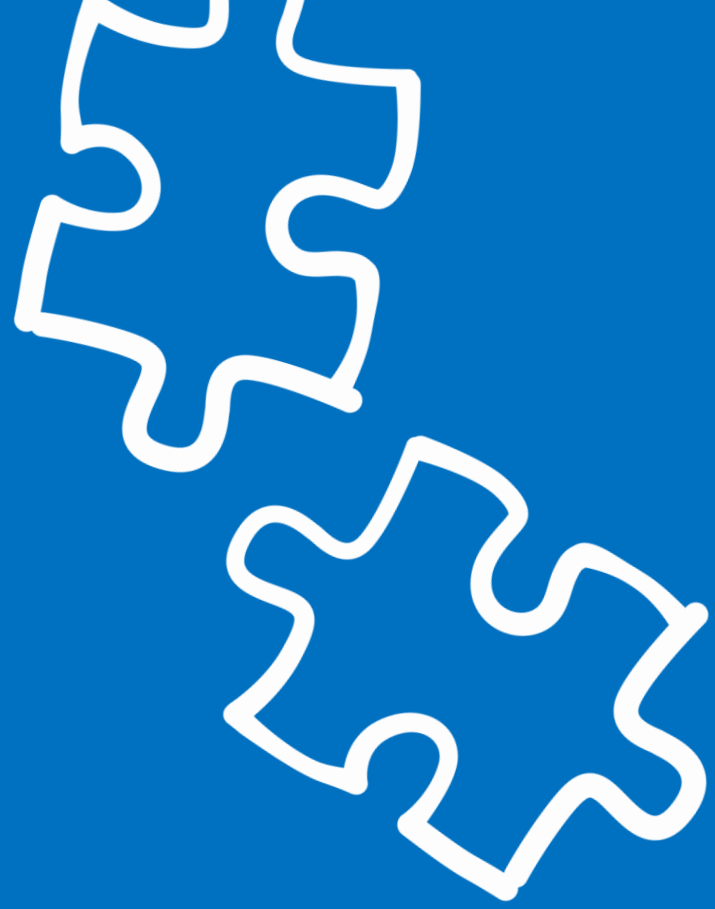
Question	Response	2019 NHS Staff Survey	2020 NHS Staff Survey	In Touch June 2020	In Touch Aug 2020	In Touch Feb 2021	In Touch May 2021
How do you feel you are coping with life at the minute?	Very Well/Pretty Well	-	-	66%	66%	53%	63%
Do you know where you would go for wellbeing help and advice, if you needed support?	Yes	-	-	80%	82%	85%	82%
If you are working on-site, how safe do you feel?	Very Safe/Safe	-	-	64%	73%	73%	82%
My immediate manager is taking a positive interest in my health and wellbeing	Strongly Agree/Agree	71%	73%	71%	72%	68%	68%
Communication between senior management and staff is effective at the moment	Strongly Agree/Agree	44%	50%	63%	69%	70%	58%
Senior managers are acting on feedback	Strongly Agree/Agree	37%	41%	51%	56%	52%	42%
I am involved in deciding on changes introduced that affect my work/team	Strongly Agree/Agree	55%	55%	43%	45%	45%	50%
I feel able to speak up about anything that concerns me in the organisation	Strongly Agree/Agree	-	68%		-	58%	57%
I feel I know how I can contribute to the climate health emergency	Strongly Agree/Agree	-	-		-	-	49%

Key
Improved
Declined
No change

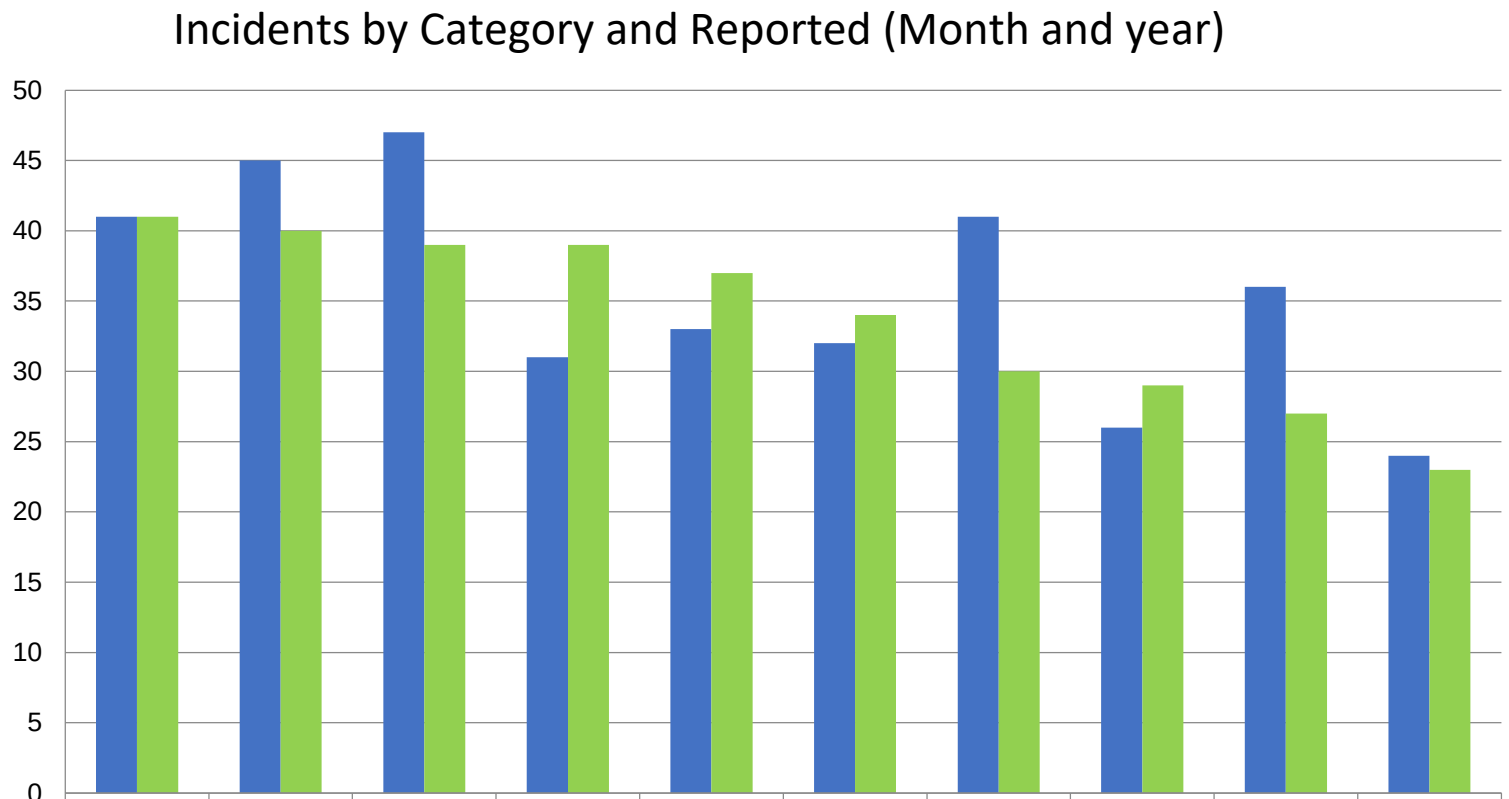
Quality and Safety

This section includes:

- Analysis of the month’s patient safety incidents
- Lessons learned from a recent serious incident
- Summary of Serious Incidents
- Overview of Safety Alerts
- Progress update on speciality led clinical audits
- Update on priority audits
- Summary of Hands, Face, Space & Place audit findings
- Overview of WHO Safer Surgery Checklist performance
- Overview of Quality Improvement work



Understanding our Patient Safety incidents



	Communication	Treatment, procedure	Diagnostic tests and scans	Medical device / equipment	Medication - storage / missing	Medication - administration error from correct prescription	Access to clinical services	Medication - prescription (including administration from incorrect prescription)	Documentation (incl. records, identification)	Skin integrity/Pressure issues
Apr 2021	41	45	47	31	33	32	41	26	36	24
May 2021	41	40	39	39	37	34	30	29	27	23

Access to Clinical Services incidents showed an increase in May 2021 with the booking of clinics in outpatients and extended clinic times being the main theme. There was also a number of incidents reported where the bed management policy wasn't followed when patients were being admitted into the Trust. Outpatients clinic booking is being followed up with individual teams in co-ordination with the central booking office. Clinic waiting times are partly related to covid-19 requirements and are being closely monitored

Medication storage incidents showed an increase in May 2021 of reported liquid controlled drug discrepancies identified when measured either during weekly checks or following the admission of a drug dose. Due to the viscosity (thickness) of some drugs, and the frequency that doses are drawn, a certain amount of disparity is expected. However it is important that wards report all drug discrepancies of more than 10% and the number of incidents in this category reflects the good reporting culture amongst clinical teams.

Patient Safety – Serious Incident Summary

New & Ongoing Serious Incidents

Directorate	Ref	Due	Headline	Update
H&L. O&I, BBM	2020/8287	12/02/21	Concerns regarding the treatment plan during thoracic surgery	07/06/21: to be resubmitted to MD for final review this week
BBM	2021/4284	24/05/2021	Surgical management and follow up of orthopaedic patient	01/06/2021: awaiting feedback from the Portland.
BBM, H&L, BCC, O & I	2021/7299	30/06/2021	Unexpected deterioration of patient following elective surgical procedure	07/06/2021: Report in draft
Nursing and Patient Experience	2021/7626	06/07/2021	IG breach – father had access to mother's secure address via MyGOSH	07/06/2021: Panel arranged for 17/06
BBM	2021/9428	28/07/2021	IG breach – oversharing of sensitive information in clinic letter to nursery	01/06/2021: investigation underway
BBM	2021/10360	10/08/2021	Failure to follow up orthopaedic patient with knee implant, resulting in overcorrection	01/06/2021: investigation underway
Brain/O&I	2021/11391	24/08/2021	Faulty batch of histoacryl glue impacting patient outcomes	07/06/2021: Investigation underway
BBM	2021/11542	25/08/2021	Delay in follow up of renal patient resulting in irreversible changes to transplant kidney	07/06/2021: investigation underway

20-22325 : Retained guidewire following central line insertion

What happened?

A central venous line was inserted to administer medications for a critically unwell patient. It was noted on x-ray imaging approximately ten hours later that the guidewire (used to help insert the catheter) was still inside the line- this should have been removed following confirmed placement of the central line.

Root cause analysis:
The guidewire was inadvertently not removed at the end of the central venous catheter insertion procedure. It has not been possible to identify a single root cause that led to this, although the investigation has found that there were multiple factors involved.
The central line insertion was for a critically unwell baby who required the access urgently for medication, and there had been previous unsuccessful attempts. This may have added pressure to the clinician in preparing for and inserting the line. In addition, due to activity on the unit the clinician did not have an assistant able to assist the procedure who may have been able to prompt use of the available checklists in real time and help obtain the equipment needed to secure the catheter.

Key learning and recommendations

- Ideally a second member of staff should assist this procedure, even where this is not possible there must still be a second check to confirm the wire removal. This must now be recorded on Epic
- Importance of the pre procedural checklist and recording on Epic, however It is recognised that the use of a checklist and observers will only minimise the likelihood of an error occurring if all staff involved understand the importance of the checks rather than it being just mandated. Education for medical and nursing staff is key including encouraging members of staff to speak up if they have concerns
- Some physical changes have been made since the incident such as changes to the procedural note on Epic, location of the pre procedural checklist on the central line trollies
- The Trust is not aware of paediatric appropriate insertion kits that may prevent further physical barriers (such as stickers or locked packs) but this will be explored with manufacturers

Trust-wide learning

Importance of local induction and ensuring any changes in practice are shared within teams

Patient Safety Alerts/ MHRA/ EFN Alerts

NatPSA/2021/001/NHSPS:
Supply disruption of sterile infusion sets and connectors manufactured by Becton Dickinson (BD)
Date issued: 11/03/2021
Date due: 21/06/2021

NatPSA/2021/002/NHSPS:
Urgent Assessment/treatment following ingestion of 'super strong' magnets
Date issued: 19/05/2021
Date due: 21/06/2021

NatPSA/2020/006/NHSPS:
Foreign body aspiration during intubation, advanced airway management or ventilation
Date issued: 01/09/2020
Date due: 01/06/2021

NatPSA/2020/008/NHSPS:
Deterioration due to rapid offload of pleural effusion fluid from chest drains
Date issued: 01/12/2020
Date due: 21/06/2021

FSN – FSN - MOD1329. GS777 Wall Transformer and ProBp 3400 Potential Fluid Ingress
Date issued: 30/04/2020
Date due: N/A

FSN – Fannin pre-filled N/Saline Syringe 10ml
Date issued: 27/07/2020
Date due: N/A

FSN – Rashkind – UK DCL HCP FA927 Rashkind Balloon Septostomy Catheter Recall
Date issued: 11/09/2020
Date due: N/A

FSN – Product recall – BD PosiFlushT XS 10mL syringe
Date issued: 20/07/2020
Date due: N/A

FSN/FA902: Medtronic Heartware HVAD System Battery Charger AC Adapter Controller Power Port Incompatibility
Date issued: 03/02/2020
Date due: N/A

CEM-CMO-2021-008
Fang Tian FT-045A FFP3 masks RECALL - Immediate Action Required
Date issued: 24/02/2021
Date Due: N/A

FSN - NR-FIT EVDs
NR-FIT EVDs - Product Recall
Date issued: 21/01/2021
Date Due: N/A

Clinical Audit –current priority plan

A central clinical audit plan prioritises audits to support learning from incidents, risk, patient complaints, and to investigate areas for improvement in quality and safety.

Those audit priorities have been identified via

- response to learning from incident
- to assess changes in practice,
- in response to emerging national or Trust guidance where clinical quality assurance is of value.

They have been identified where recommended by the Clinical Audit manager and where directed and consulted with directorates management teams , PSOC and Closing the Loop,

This is an iterative plan and items will be added as identified where there is organisational value.

GOSH/IPP response to Patterson Inquiry
Audit report drafted. Recommendations to be finalised with I+PC Management team

Learning from an incident Respiratory arrest following residual anaesthetic agent in patient cannula following a general anaesthetic (2020/20297)
Actions in response to the audit are being agreed with the team leading the audit

Learning from complaint (18/093) This audit has been completed and the report will be shared with June Closing the Loop meeting

Hands Face Space Plan Walk round
Clinical Audit manager is leading walk round reviews in June 2021 to provide ongoing assurance that COVID safe working standards are being maintained.

Review of frequency of I+PC Consultant ward round presence
Request from the Medical Director and IPP management team that we provide assurance as to whether the standards for IPP Consultant ward rounds are being met. Recommendations being agreed with I+PC Management team

Medicines Clinical Audit Plan
Key audits to focus on best practice with medicines management. Monitored and directed by the Medicines Safety Committee. Audit on controlled drugs storage is underway and to be reported in June 21

Learning from SI 2020/23369
Audit to be completed by October 2021 to establish whether consent forms are being appropriately uploaded into the electronic patient record

Quality of clinical documentation
This audit is being piloted in I+PC at the time of writing. The Clinical Audit Manager is engaging with the Deputy Chiefs of Service to establish plans ,viability, and capacity for competing across all directorates. We are prioritising this audit as we know that high quality clinical documentation supports patient care and communication . Quality of documentation, particularly around documentation of discussions with families , can be a themes raised in incident and complaints, and the audit was committed to support learning from a serious incident.

Clinical Audit –priority audit completed in last month

Enabling Optiflow outside of ICU
A GOSH learning from deaths report was reviewed at Closing the Loop in 2020

It highlighted good practice about management of a child transferred out of ICU on Optiflow."*The child was transferred to Elephant ward on Optiflow, where they had been cared for throughout treatment and parents felt supported by familiar staff. It is not normally easy to transfer children out of ICU on Optiflow as no nursing capability in place to nurse children on Optiflow at GOSH."*

This learning point was tracked through Closing the Loop and resulted in plans to develop a project to manage patients on Optiflow outside of ICU .

The process of discharging children from ICU on optiflow started on 16th November 2020. This supports ICU flow and the wards to safely manage children on optiflow.

Aim of audit
To review whether this is working and to ensure there are no adverse events or complications.

Key findings of this audit

Between December 2020 and Feb 2021 we noted 12 patients discharged from ICU to wards on Optilfow. The audit showed: .

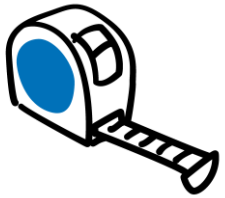
- There were no adverse events noted around management of Optiflow for those patients and since the roll out of Optiflow outside of ICU.
- Wards reported confidence in managing patients on Optiflow.
- No additional support was requested.
- No clinical incidents associated with management of Optiflow outside of ICU.

Clinical Audit - control of access to medicine storage rooms

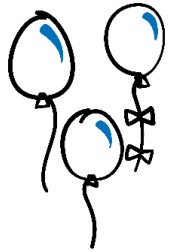
Background
A process for the control of access to medicine storage rooms was associated with a CQC "must do" action from the GOSH 2020 CQC report. This is a specific check of adherence to the policy for control of access to medicine storage rooms and is part of the Medicines audit plan.

Key findings
This audit provides evidence that the policy in place to restrict access of wards to registered staff is being followed, and there is control of that process. 1069 swipe access were reviewed on ten wards which highlighted access via security cards was in in line with Trust policy

Specialty led clinical audit



There are currently 285 clinical audits registered at GOSH.



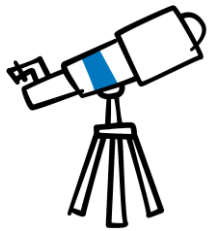
We aim to have to have over 100 completed specialty led clinical audits per year. We were able to meet this target for 2020/21 , which is testament to the commitment of teams to clinical audit .We have seen a small reduction in the number of completed clinical audits in 2020/21 due to the impact of the pandemic, which was anticipated.

Specialty audits on track
It is important to have timely oversight of the outcomes of specialty led clinical audit in order to be assured that teams are engaging in reviews of the quality of care provided, and that the outcomes of those can be monitored.

This is essentially about knowing what clinical audit we are doing in the Trust

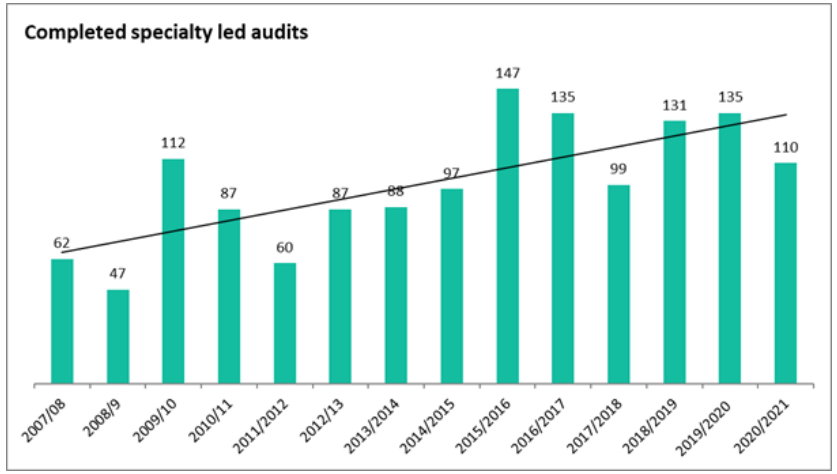
The Trust is expected to provide evidence to regulators, including the CQC, that specialty led clinical audit activity takes place.

We are on target for speciality audits on track



To find out more about clinical audit at GOSH and see what audits are taking place, and learning from completed work please see the link below

http://goshweb.pangosh.nhs.uk/clinical_and_research/CGST/clinical-audit/Pages/clinical-audit.aspx



We are on track for meeting our target so far for 2021/22 (17 audits completed YTD) This measure is useful as gives an indication of the capacity of teams to engage in reviews of the quality of care provided.

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

1. Priority improvement programmes (May 2021)

Programme of work	Priority projects	Executive Sponsor (ES)
Highly reliable clinical systems	➢ Identification and responsiveness to the deteriorating patient	Sanjiv Sharma
	➢ Increasing safety and reliability of TPN prescription and delivery	Polly Hodgson
	➢ Co-designing the SI framework	Sanjiv Sharma
	➢ Establishing a Tri-parallel process for SIs, Red Complaints and High Profile cases	Sanjiv Sharma
Wellness at Work	➢ Design, development and testing of wellbeing indicator ➢ Establishing 'team self care': local team-level wellbeing initiatives	Dal Hothi
Caring for the complex patient	➢ Safe management of patients with high BMI	Sanjiv Sharma
Continuously finding better ways to work	➢ Introduction of a Ward Accreditation Programme to increase clinical quality and oversight of quality metrics from Board to Ward	Alison Robertson
	➢ Reducing pre-analytical laboratory sample rejections/ building laboratory capability for improvement	Dal Hothi
Building capacity and capability for improvement	➢ QI Education Programmes ➢ Project Coaching	Dal Hothi
The QI team is also supporting the Clinical Pathway Redesign Programme, and associated projects in partnership with the Transformation team.		

2. Directorate-level/ Responsive QI Work-

Directorate projects

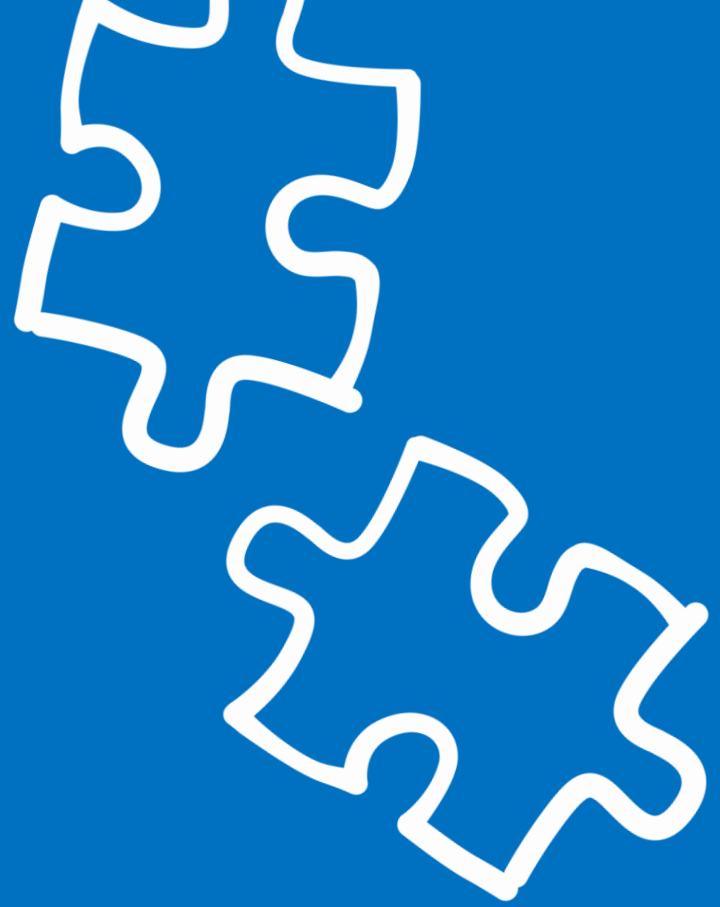
Project Commenced	Area of work	Project lead:	Expected completion date
May 2020	Increase opportunities to empower and enable children and young people to register their complaints	Claire Williams (Head of Patient Experience)	July 2021
Oct 2020	Increase communication skills training across all Allied Health Professionals placement pathways at GOSH	Ali Toft (AHP Information Officer) and Vicki Smith (AHPs Education Lead)	September 2021
Oct 2020	Improve holistic elements of care for cardiothoracic transplant patients	Helen Spencer (Consultant in Transplant and Respiratory Medicine)	August 2021
Oct 2020	Improve nursing staff morale in PICU	Kate Plant (Chief Nurse Junior Fellow)	August 2021
Jan 2021 (Restart)	Reduce waste in the process, standardise activities and enable a process driven pathway to the Orthopaedic CNS activity	Claire Waller (Matron)	January 2022
February 2021	Improve effectiveness of pre-chemotherapy/procedure bloods process on Safari Unit	Dave Burley (Assistant Service Manager)/ Safari Improvement Group	September 2021
March 2021 (Restart)	Reduce the number of unnecessary blood tests, when ordered in sets/ bundles, in Brain Division	Spyros Batzios (Metabolic Consultant)	December 2021
March 2021	Improve nurse satisfaction of the nursing handover process on Chameleon ward	Sarah Murphy	June 2021
March 2021	Improve communication experiences for hospitalised children and adolescents with learning disabilities and/or Autism.	Ruth Garcia-Rodriguez (Consultant Child and Adolescent Psychiatrist)	September 2021
April 2021	Improve the capability of leadership development trust wide	Emilia Piera-Adamczyk (L&D Partner - Organisation and Employee Development)	September 2021 (paused)

The QI team has held 4 QI project surgeries during the month of May

Patient Experience

This section includes:

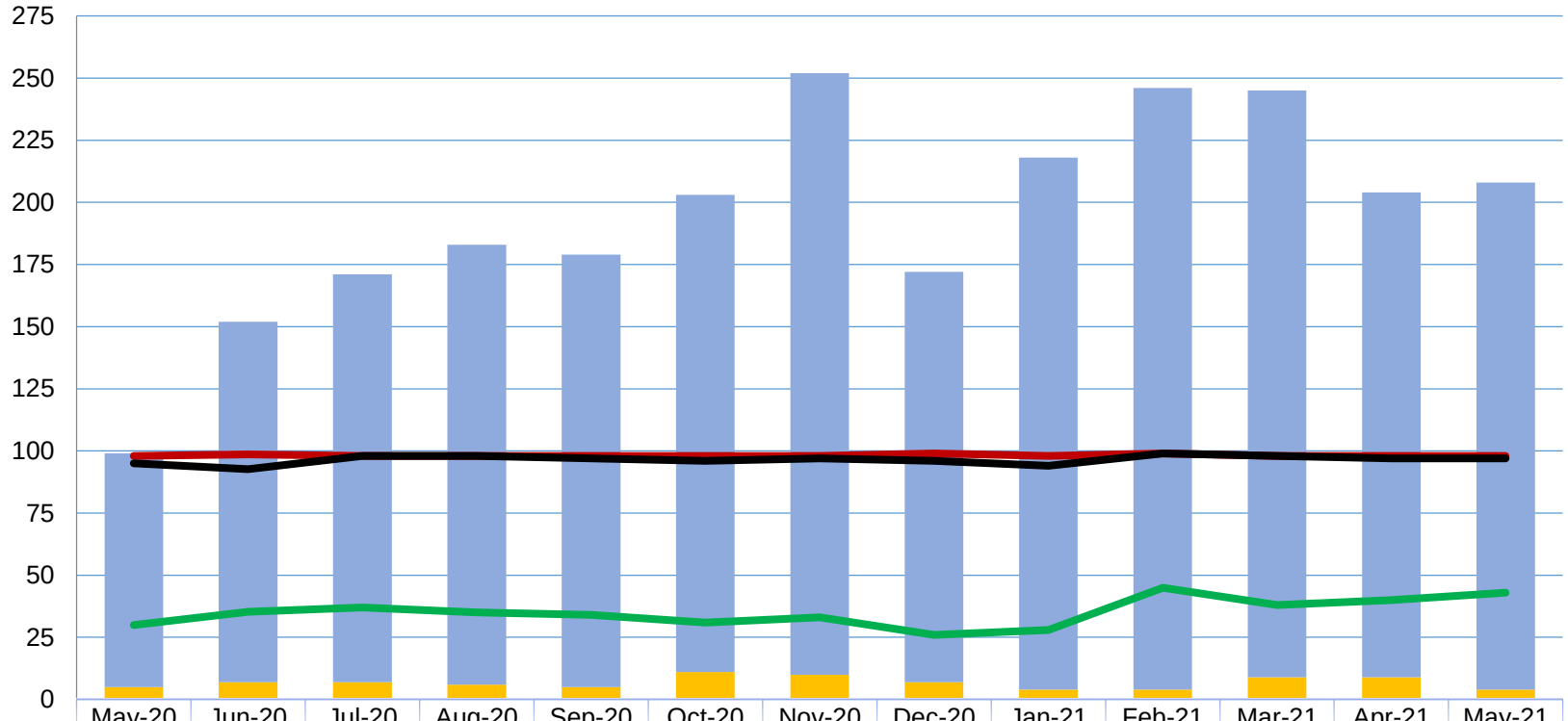
- Integrated overview of patient feedback
- Monthly assessment of trends and themes in complaints
- Overview of Red Complaints
- Pals themes and trends
- Learning and improvements from Pals contacts
- Friends and Family Test feedback trends and themes



Patient Experience Overview

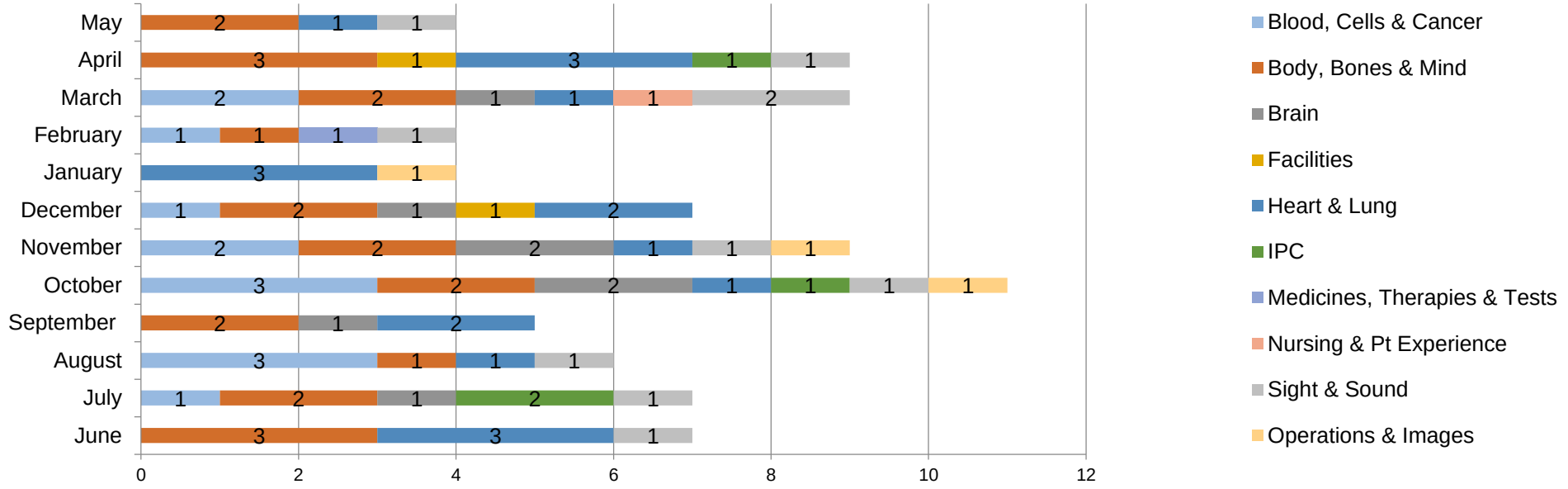
Are we responding and improving?

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



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Pals contacts	94	145	164	177	174	192	242	165	214	242	236	195	204
Formal Complaints	5	7	7	6	5	11	10	7	4	4	9	9	4
FFT rating of experience - Inpatients %	98	99	98	98	98	98	98	99	98	99	98	98	98
FFT rating of experience - Outpatients %	95	93	98	98	97	96	97	96	94	99	98	97	97
FFT % response rate	30	35	37	35	34	31	33	26	28	45	38	40	43

Complaints: Are we responding and improving?



In May 2021 we received 4 formal complaints. This was a significant reduction in the 9 complaints received in March and April respectively. It was also lower than the average number of complaints (6.9 complaints per month based on the last 12 months). One of the complaints received was graded red/high risk.

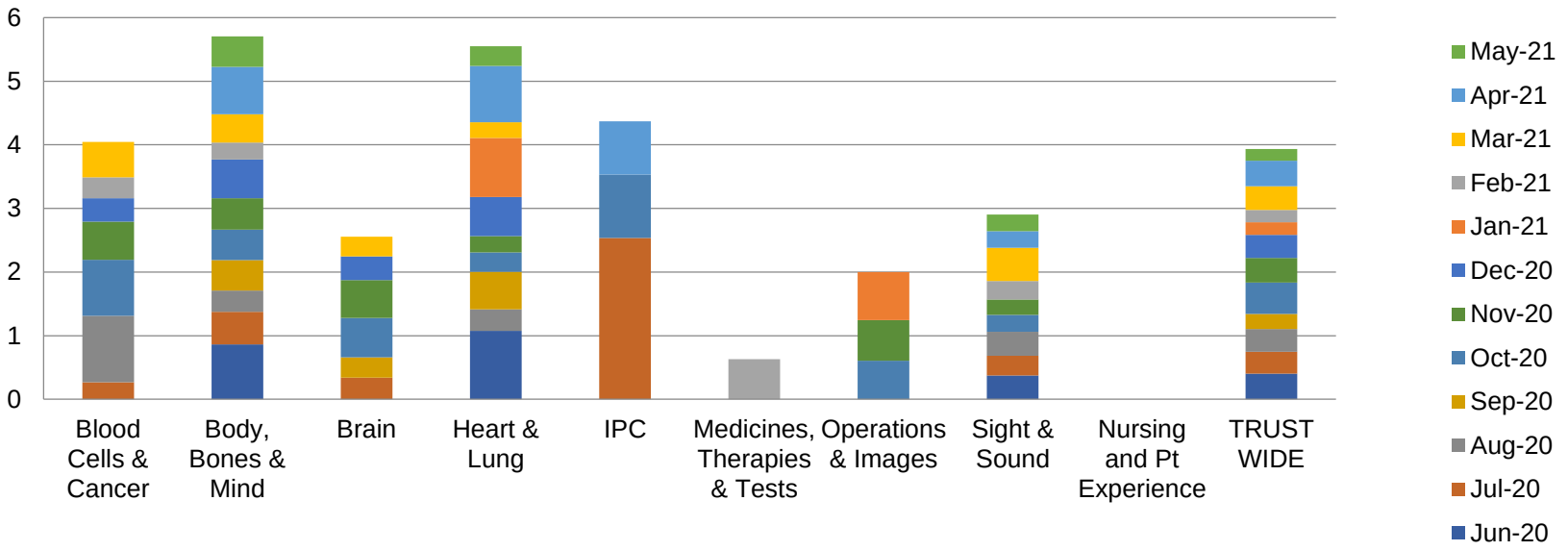
This month families reported concerns about:

- An extended admission and query if this was related to a potential retained needle during surgery. Concerns were also raised around aspects of care received on the ward
- the accuracy of information within a clinical report from 2018
- A lack of communication from the clinical and administrative teams and poor co-ordination of care when under multiple specialities. Concerns were also raised about delays in treatment following a missed internal referral
- rejection of a patients kidney transplant due to infrequent and delayed follow up care/monitoring

At the time of writing (15/06/21), there are 15 open/ active complaints.

Complaints by patient activity*

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



Following a slight decrease in patient activity and reduced numbers of complaints, the complaint rate per 1,000 CPE was the lowest in the last 12 months.

The complaint rate for Body Bones & Mind (complaints related to CAMHS and Nephrology) fell this month to 0.475 per 1,000 CPE.

Sight and Sound's complaints rate (0.259 per 1,000 CPE) was the lowest since November 2020.

Heart and Lung's complaint rate fell from 0.885 per CPE in April to 0.307 in May with one complaint relating to Cardiac Surgery.

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

NEW red complaints opened in **May 2021**	**NEW** red complaints **since APRIL 2021***	**REOPENED** red complaints **since APRIL 2020**	**ACTIVE** red complaints (new & reopened) as of 31/05/21	**OVERDUE** red complaint actions
1	2	0	4	6

New Red Complaint

Ref	Directorate	Description of Complaint	EIRM Outcome:	Update:
21-013	Body Bones & Mind	Parents raise concerns around monitoring and care after transplant surgery. They query if this took place frequently enough and if this contributed to the organ rejection.	Serious Incident was declared on 02/06/2021	An EIRM took place on 02/06/2021 and concluded that the SI criteria was met. The family have been updated and their specific questions will also be investigated and responded to. The SI investigation is underway and will be finalised in August 21.

Active Red Complaints (including reopened complaints)

Ref	Directorate	Description of Complaint	EIRM Outcome:	Update:
19-085	IPC (Orthopaedics - led by BBM)	Parents raise concerns and questions about their child's surgery which took place at GOSH privately.	Further EIRM took place on 24/2/21 and declared an SI. Complaint also regraded from Amber to Red at this time.	An external review of the surgery/care took place. Following this, the EIRM concluded the SI criteria was met and an SI investigation needed to take place with the input of the Portland Hospital. The SI report has been drafted but we are awaiting information from the Portland. The family have been kept updated.
20-076	Body Bones & Mind (plus input from Heart & Lung, Blood Cells & Cancer)	Parents are concerned about the management of their child's Sickle Cell Disease and her deterioration following surgery.	EIRM took place on 31/03/21 and declared an SI.	SI investigation underway and is due to be completed by the end of June 2021. Concerns also raised by the parents to their MP.
20-070	Body Bones & Mind	Information governance breach (inappropriate sharing of personal and sensitive information).	Serious Incident was declared on 10/05/21.	Response to three complaint queries (outside of the scope of the SI) was sent in May 21. SI investigation is underway and will be finalised in August 21. The incident was also reported to Information Commissioner's Office.

** Includes one historic complaint regraded in April 2021*

Pals – Are we responding and improving?

Cases – Month	05/20	04/21	05/21
Promptly resolved (24-48 hour resolution)	74	138	164
Complex cases (multiple questions, 48 hour+ resolution)	18	52	38
Escalated to formal complaints	2	4	1
Compliments about specialities	0	1	1
Total:	**94**	**195**	**204**
Top Six Themes			
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families).	49	104	84
Admission/Discharge /Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation).	2	4	5
Staff attitude (Rude staff, poor communication with parents, not listening to parents, care advice)	0	0	0
Outpatient (Cancellation; Failure to arrange appointment).	3	11	20
Transport Bookings (Eligibility, delay in providing transport, failure to provide transport)	2	16	5
Information (Access to medical records, incorrect records, missing records, GOSH information, Health information, care advice, advice, support/listening)	38	60	90

The 204 contacts recorded in May not only represents a 4% increase on the preceding month but is also the highest number recorded in the month of May to date. Additionally the number of promptly resolved contacts remains high with 80% of May's contacts being responded to and resolved within 48 hours or less.

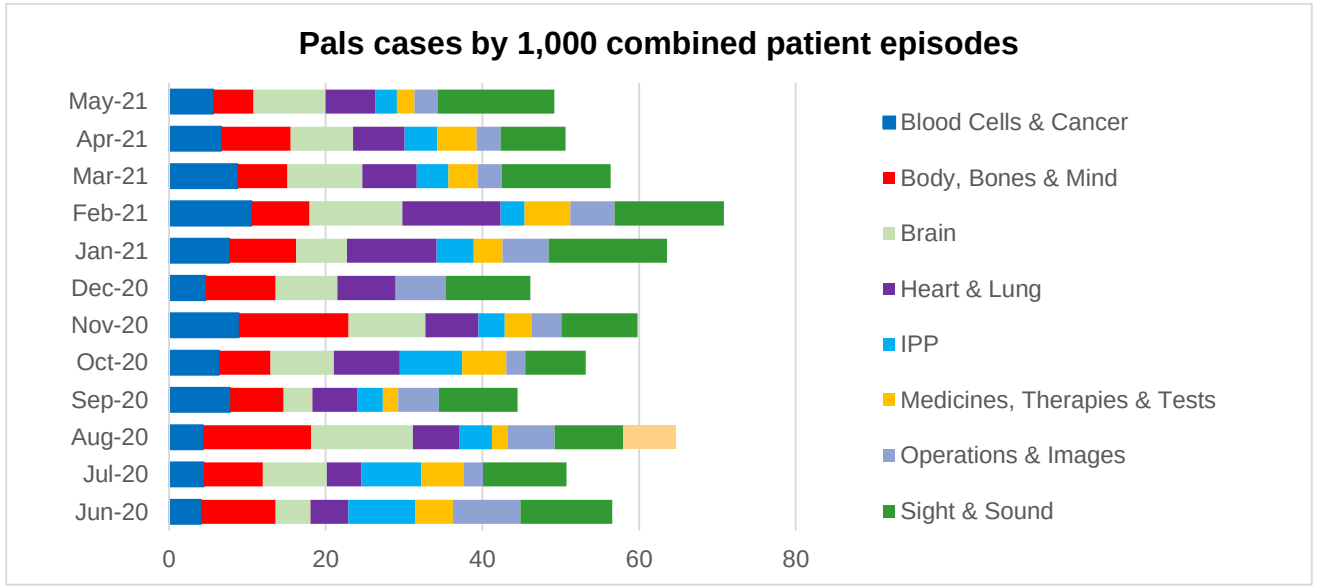
Pals have noted a spike in the volume of requests for Medical Records with the 10 contacts received in May representing the largest number since July 2020. Requests in May largely consist of parents/carers wishing to share clinical information with external organisations, typically for second opinions or to support requests for additional assistance (e.g. from SEN teams in educational settings). Pals continue to work alongside the Medical Records team in sharing and monitoring requests in order to determine whether May's figures represent an isolated spike or whether further initiatives are required to increase awareness and accessibility of the records requesting process.

The decline in communication specific contacts noted in the previous reports continues into May with the 84 contacts received representing a further 20% decrease compared to the previous month. However, despite this, the themes of contacts remain constant with a particular emphasis being placed on Parents/Carers experiencing difficulties when contacting teams for confirmation and clarity on patient-specific care plans.

Pals received a glowing compliment from a former patient who wished to reach out to the Epilepsy team and provide an update on her life after GOSH and the 'huge' impact that her treatment has had on her ability to live a *'positive, happy and fulfilling life.'*

Pals cases by directorate

The Sight and Sound directorate recorded its highest volume of Pals contacts in 2021 (14.89 per 1,000 CPE). A contributory factor for this involves increases in requests for copies of Medical Records and other general queries regarding outpatient appointments.



	BC&C	BB&M	Brain	H&L	IPP	MT&T	O&I	R&I	S&S
June-20	14	33	13	14	4	8	8	0	31
July-20	17	30	24	15	6	9	3	0	35
Aug-20	14	43	33	18	3	3	8	0	24
Sep-20	27	30	12	20	3	5	8	0	35
Oct-20	24	29	27	29	8	9	4	0	30
Nov-20	34	60	34	27	4	6	6	0	41
Dec-20	15	31	22	25	0	0	9	0	38
Jan 21	26	33	20	38	4	6	8	0	52
Feb 21	36	29	37	44	3	10	9	0	50
Mar-21	36	30	32	30	5	7	9	1	55
Apr-21	24	38	25	23	5	6	6	0	33
May-21	19	23	29	21	3	4	5	0	60
YTD	**286**	**409**	**308**	**304**	**48**	**73**	**83**	**1**	**484**

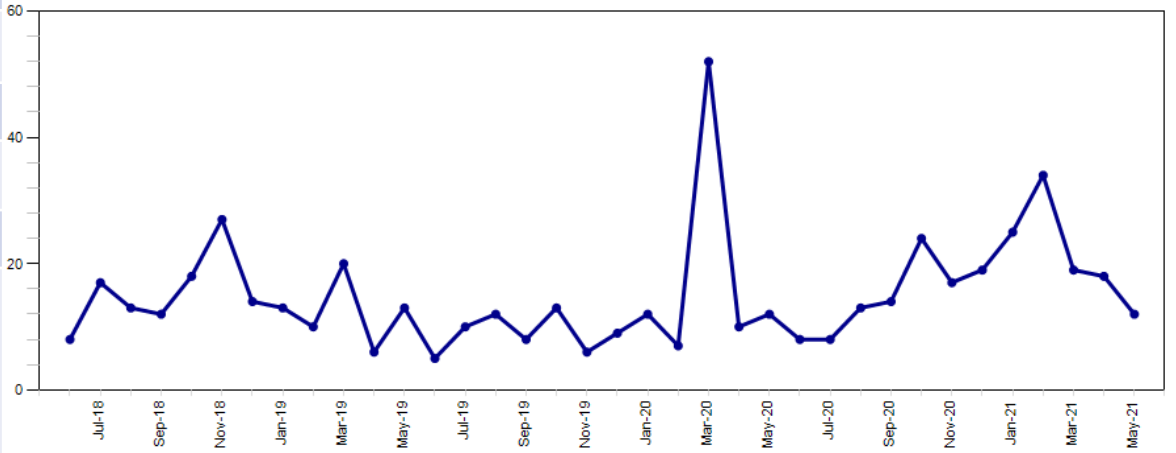
Pals – Are we responding and improving?

Top specialities - Month	05/20	04/21	05/21
Cardiology	12	18	12
Medical Records	4	3	10
Endocrinology	3	8	10
Ophthalmology	2	10	10
Respiratory	0	3	8

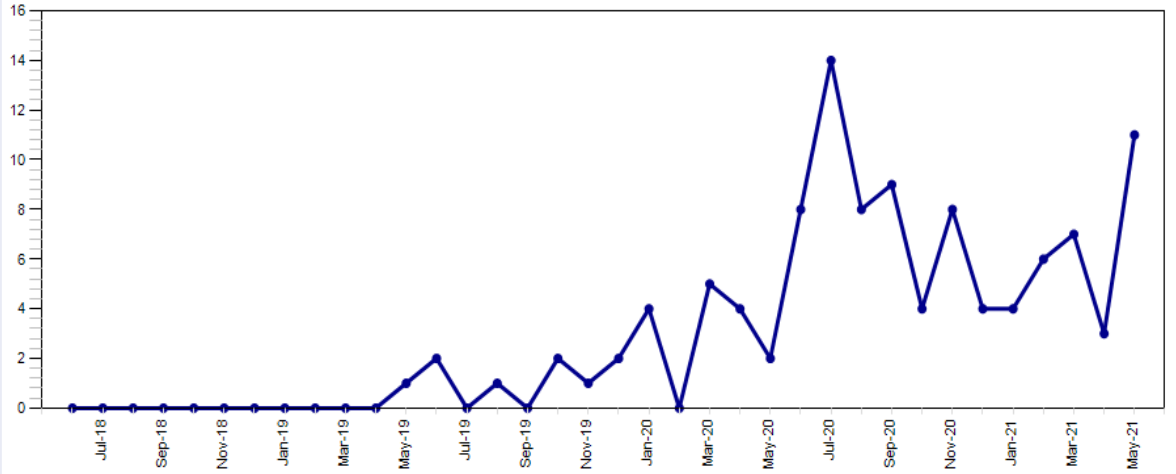
Cardiology- Pals would like to highlight the continued proactive and prompt approach employed by the Cardiology team when responding to and resolving Pals contacts. This can be illustrated by May's contacts not only representing a 20% decrease on the previous month, but also the third consecutive month where contacts have fallen. Prominent themes remain consistent for May with a large number of contacts centring around parents/carers seeking advice, guidance and reassurance on patient-specific care plans and queries. Pals continue to work closely with the Cardiology service, ensuring that contacts are promptly shared and that the team are made aware of newly emerging and recurring themes.

Dermatology/Gastroenterology- In addition to highlighting the above, Pals would also like to draw attention the positive work undertaken by the Dermatology and Gastroenterology services who have recorded a 46% and 58% decrease in contacts in comparison to the preceding month respectively. In addition to this May also represents the third consecutive month featuring a decrease in the number of Dermatology related contact. Pals continue to work alongside both specialities who remain positive and effective in their approaches.

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



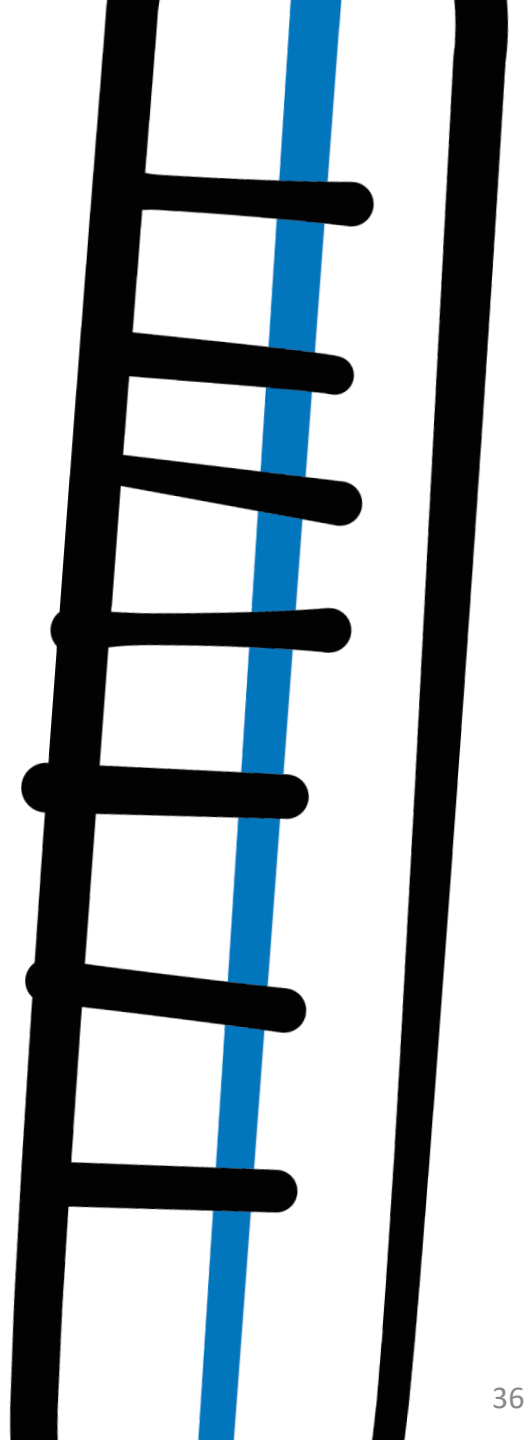
Medical Records contacts by patient activity- (total cases excluding formal complaints)



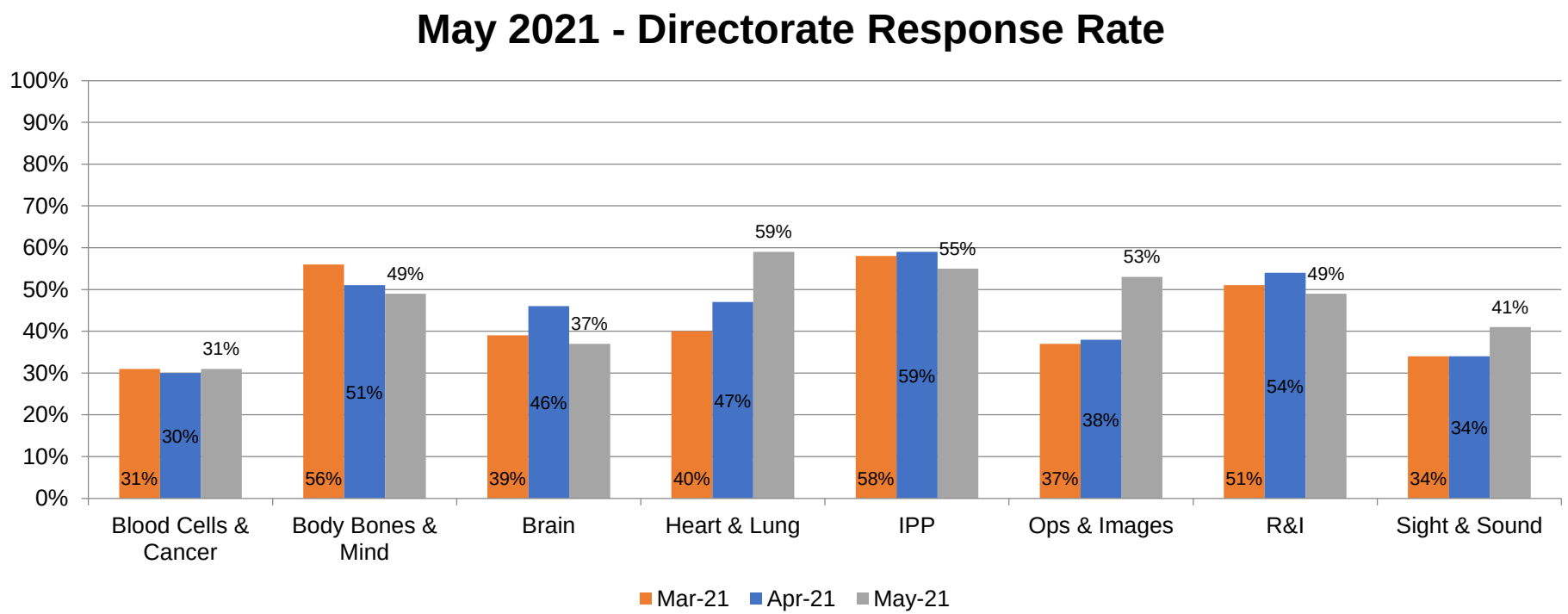
Learning from Pals

Pals were visited by a number of families who after travelling to GOSH, found that their appointments or admissions had previously been cancelled by the speciality team. Whilst these families had typically received notification of these cancellations either directly by the service or via the MyGOSH app, a large number had then received an automated text message confirming the visit, resulting in them believing that these had been reinstated.

Pals understand the frustrations and financial implications of a wasted journey. In addition to providing travel reimbursements, Pals are currently working alongside the EPR and Communications team in order to identify the reason for these automated messages and find a solution to prevent these from being incorrectly sent in the future.



FFT: Are we responding and improving?

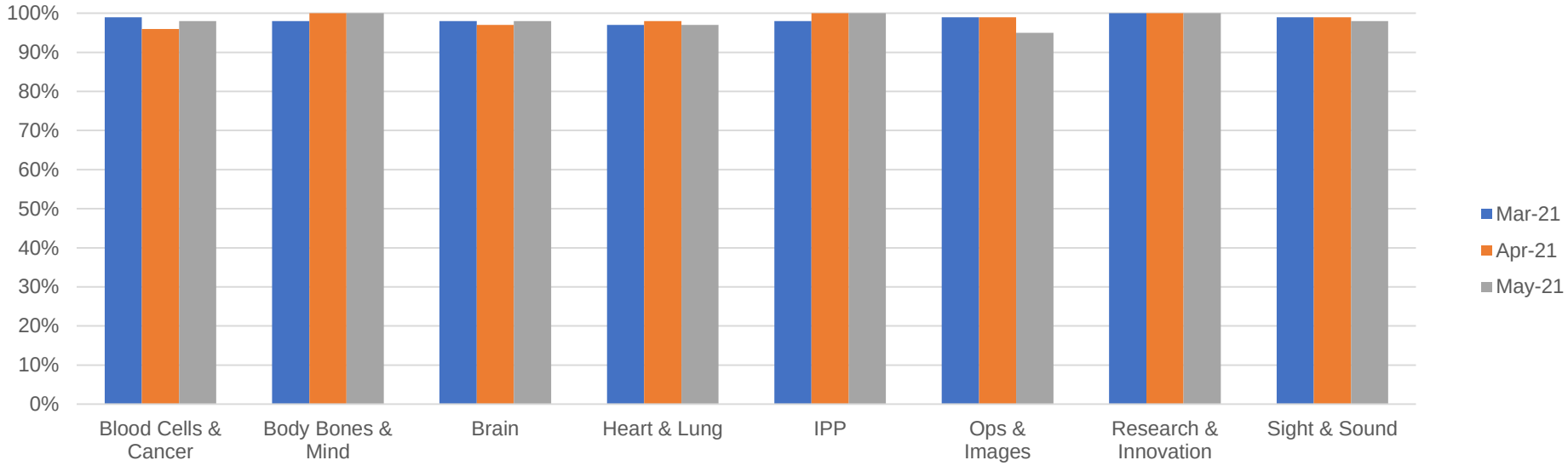


The Trust response rate increased slightly from April to March to 43% which significantly exceeded the Trust target of 25%. Once again, every directorate achieved above the Trust target for the response rate and the experience measure.

The highest number of negative comments related to access, admission and discharge. This was prevalent within the Blood Cells and Cancer Directorate and all the comments were related to the delays in discharge because of long waits for medications. This has been passed on to the Pharmacy Team for review and action.

Positive comments were predominantly about the staff and the care received. Comments related to family involvement in care and staff having a good bedside manner with patients. There were also positive comments about the facilities provided within the hospital. In addition there were comments about the cleanliness of the hospital and families feeling safe here during the pandemic.

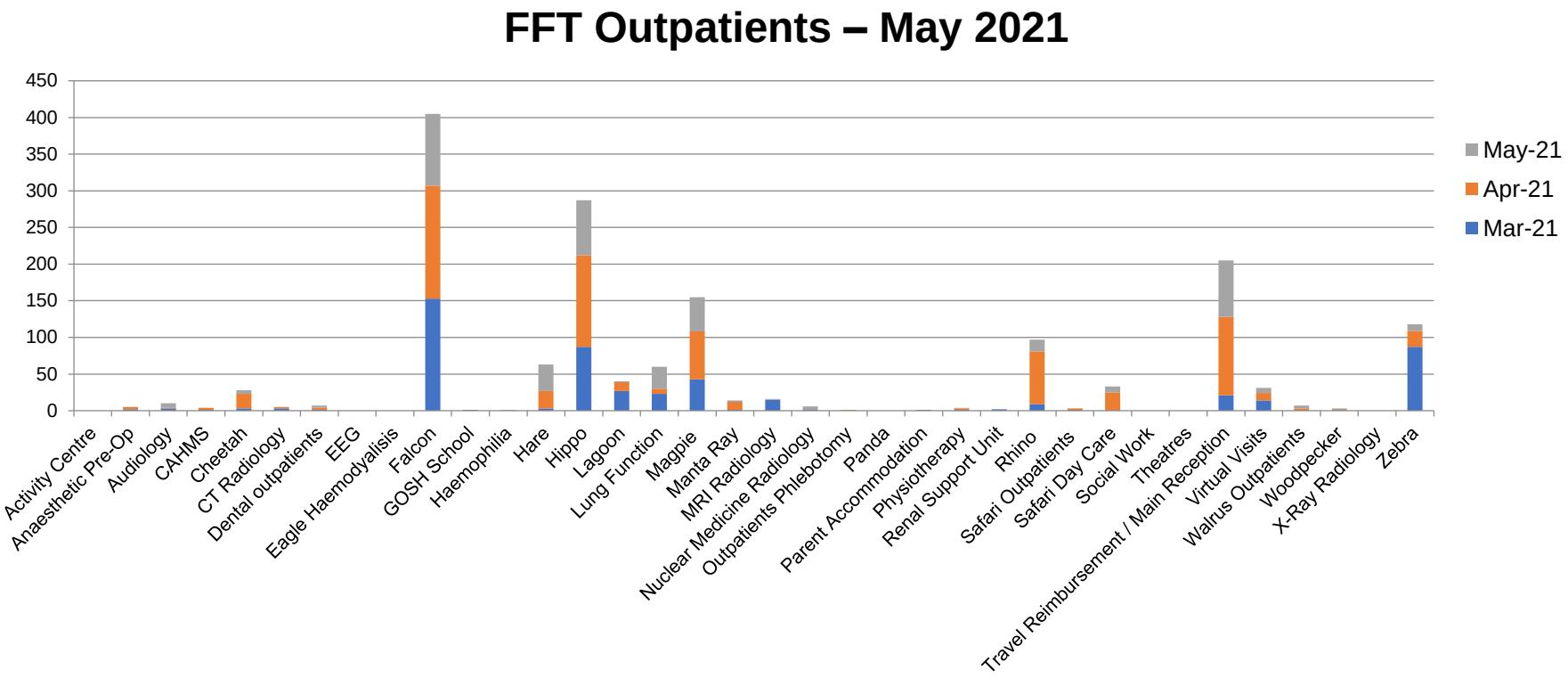
FFT: Are we responding and improving?



	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% of FFT comments from CYP	% with qualitative comments (All areas)
Nov 20	827	303	98	**1228**	**13.3%**	**90.1%**
Dec 20	559	185	46	**790**	**12.8%**	**88.7%**
Jan 21	539	87	37	**663**	**15.1%**	**95.9%**
Feb 21	887	504	100	**1491**	**21.6%**	**83.6%**
Mar 21	986	503	169	**1658**	**15.4%**	**87.3%**
Apr 21	989	675	125	**1789**	**15.9%**	**87.1%**
May 21	980	432	163	**1575**	**14.1%**	**90.1%**

- Inpatient response rate – **43%**
- Response rate has consistently been above Trust Target since May 2020.
- Experience measure for inpatients – **98%**
- Experience measure for outpatients – **97%**
- Very high percentage of responses with qualitative comments – **90%**
- **14%** of FFT comments are from patients.
- Highest percentage of negative comments were related to access, admission and discharge.
- Highest percentage of positive comments related to Always Helpful.

FFT: Are we responding and improving?



The volume of feedback received in outpatients throughout May has reduced compared with April. However, the number is still substantially higher than at the beginning of the year. The new Sight and Sound Centre opens next month and we anticipate that we will receive a high volume of feedback from the new areas. The feedback software and the online feedback page are being updated to reflect the new outpatient areas and new FFT boards have been ordered to reflect the design of the internal signage.

Positive comments related to the expertise of staff and the time taken to provide clear and concise explanations to families. Friendliness of staff and the clinic environments were also praised. Negative comments related to cancelled or amended appointments. Families also raised concerns about not seeing the doctor that they expected to see and not being told about the option of a virtual clinic until they had travelled to GOSH. A parent quoted that "***the emotions that parents and their children invest in these appointments should not be taken lightly".***

FFT Focus – May 2021
Discharge Delays - BCC

The waiting time to process TTOs and to get discharge medicine can be reviewed and process and delay minimised.

We had great care from the booking team all the way to the specialists. We really appreciate the care and support received, but we waited over 3 hours to get our baby's medicine.

Excellent, attentive and warm care throughout our visit here. Very impressed with the care we have received and fitting of the reputation we had of GOSH prior to our visit. It did take a number of hours to receive the medicine - over 4 hours, this did tarnish the otherwise excellent care we received.

All of the above comments have been shared with the relevant service areas.

FFT: Are we responding & improving? Qualitative Comments

'From tears to laughter we have been supported as parents throughout, and our little one has received the best possible care from the whole of GOSH Team with exceptional staff who have gone above and beyond where nothing has been too much trouble, we couldn't thank you enough!' – **Possum Ward**

'The hospital is kind, caring and fantastic and continues to be helpful at all times ensuring security and assurances to both child and parents' – **Walrus Day Ward**

'Very thorough and thoughtful appointment. Gave me the opportunity to ask all my questions. Felt listened to and that they really care and understand my child's issues. Wonderful Care' – **Virtual Visit**

'We were made to feel so welcome. Everyone is so helpful. My son felt like he was on holiday! Thank you' - **Squirrel Endo/Met Ward**

Great Ormond Street Hospital for Children
NHS Foundation Trust

IQPR Trust Performance Update June 2021

Reporting May 2021 data

John Quinn, Chief Operating Officer

Overview

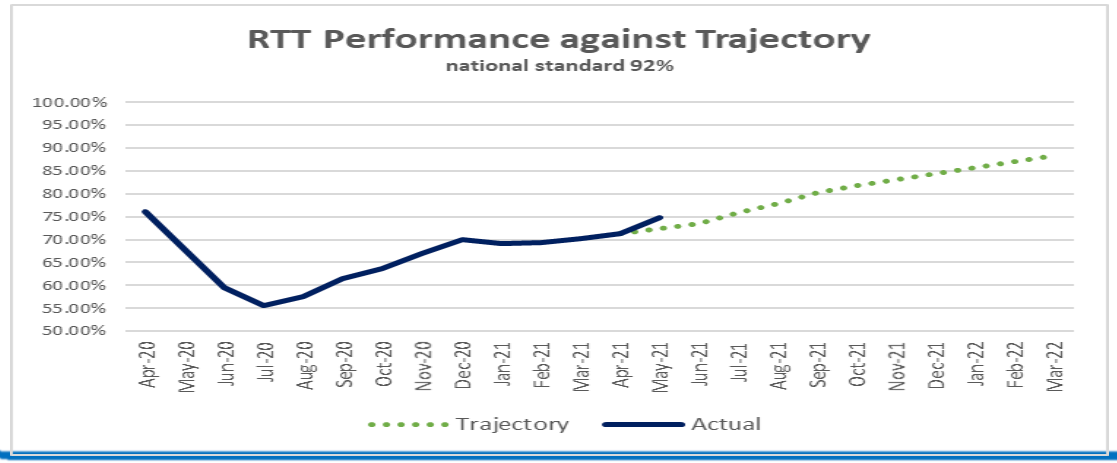
Standard	Target	Current Performance	Trend	Forecast Compliance
Referral to Treatment (RTT)	92% in 18 wks	74.9%	↑ 3.65%	September 2022
No. over 18 Week waits	-	1738	↓ 214	-
52 Week waits	0	369	↓ 96	June 2022
104 Week Waits	0	12	↓ 2	October 2021
Diagnostics	99% in 6 wks	81.1%	↑ 3.5%	March 2022
31 Day: Decision to treat to 1st Treatment	96%	*100%*	⟷	
31 Day: Subsequent treatment – surgery	94%	*100%*	⟷	
31 Day: Subsequent treatment - drugs	98%	*100%*	⟷	
62 Day: Consultant Upgrade	No national target	*100%*	⟷	

RTT

Performance

Forecast – 72.4%

Actual v Forecast



74.9%
People waiting less than 18 weeks for treatment from referral.

Target 92%

3.6%

369
Patient wait over 52 weeks

96

12
Patients waiting over 104 weeks

2

Challenged Directorates – below 80% performance

Body, Bones and Mind – 61.7%
Heart and Lung – 79.6%
Sight and Sound – 65.7%

Bottlenecks

- 68% of over 18 week patients prioritised as P3/P4
- Insufficient theatre capacity in Craniofacial, Plastic, SNAPs, Gastroenterology, Ophthalmology, Orthopaedics and Spinal to reduce long waits
- Specialist surgeon activity
- Bed availability due to social distancing and staffing
- Cardiology outpatient capacity
- Pre-op Assessment capacity
- Risk of available staff for the all Accelerator Programme sessions identified

Actions

- Additional theatre and clinic sessions identified by directorates for June, July and September
- Trialling 2 patients per list in Spinal for 6 weeks
- Bed closures being signed off by Senior Directorate Team
- Weekly meeting with service leads and theatre team to ensure capacity is used appropriately
- Intensive PTL validation as ‘missed’ stops identified

RTT - continued

Performance

Challenged Directorates

Directorates – below 80% performance May 2021

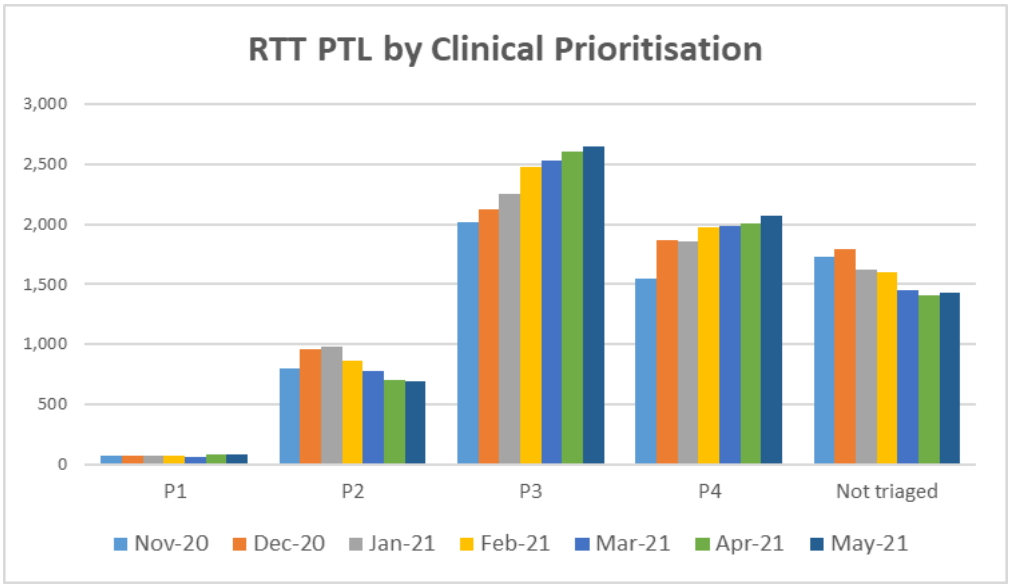
Body, Bones and Mind – 61.7%
Heart and Lung – 79.6%
Sight and Sound – 65.7%

Key Specialties

- Orthopaedic breaches increased by 64 breaches from June 2020 (180) to 244 for May 2021
- SNAPS peaked in January 2021 at 172 breaches but has decreased by 40 to 108 at May month end
- Spinal Surgery peaked at 118 breached February 2021 and has now decreased by 21 to 97 breaches for May 2021
- Cardiology has reduced by 287 breaches from May 2020 (428) to 141 for May 2021
- Plastic Surgery increased by 28 breaches from 178 in May 2020 to 206 for May 2021
- Dental breaches have reduced by 118 from a starting point of 185 in May 2020 to 67 for May 2021

	Projected Date (not signed off/validated)	Feb-21	Mar-21	Apr-21	May-21	% change	May 2021 No. of >18 Weeks	Breaches
Body, Bones & Mind								
CAMHS	N/A - continue to meet	92.94%	97.45%	90.07%	92.50%	2.43%	12	
Gastroenterology	Mar-22	73.08%	72.06%	73.58%	74.07%	0.49%	49	
General Paediatrics	Feb-22	54.17%	65.00%	58.82%	66.67%	7.84%	8	
Nephrology	N/A - continue to meet	89.02%	93.94%	96.05%	93.15%	-2.90%	5	
Orthopaedics	Does not meet 92%	43.85%	41.55%	43.02%	43.39%	0.37%	244	
SNAPS	Jan-23	50.61%	51.91%	56.44%	61.43%	4.99%	108	
Spinal Surgery	Does not meet 92%	45.62%	49.01%	49.25%	49.74%	0.49%	97	
Directorate Total	Nov-22	**57.36%**	**57.89%**	**59.16%**	**61.76%**	**2.60%**	**535**	
Heart & Lung								
Cardiac Surgery	Feb-22	76.9%	62.7%	63.8%	72.2%	8.39%	15	
Cardiology	Mar-22	64.3%	67.4%	72.2%	79.7%	7.53%	141	
Pulmonary Hypertensio	Sep-21	33.3%	66.7%	60.0%	50.0%	-10.00%	1	
Respiratory Medicine	Dec-21	92.1%	81.8%	89.8%	90.9%	1.11%	3	
Directorate Total	Mar-22	**66.1%**	**67.9%**	**72.7%**	**79.6%**	**6.88%**	**160**	
Sight & Sound								
Audiological Medicine	Mar-22	80.4%	75.9%	68.5%	60.6%	-7.81%	61	
Cleft	Mar-22	65.1%	62.1%	65.5%	77.0%	11.53%	14	
Cochlear Implant	Mar-22	77.3%	68.2%	26.7%	53.3%	26.67%	7	
Craniofacial	Does not meet 92%	50.8%	49.0%	47.5%	51.1%	3.66%	85	
Dental	Does not meet 92%	43.0%	38.2%	38.8%	57.6%	18.77%	67	
Ear Nose and Throat	Dec-21	61.0%	62.1%	65.7%	70.8%	5.12%	121	
Maxillofacial	Mar-22	63.0%	57.7%	51.2%	59.6%	8.47%	46	
Ophthalmology	Oct-22	68.4%	70.3%	71.7%	75.7%	3.99%	100	
Orthodontics	Dec-22	53.8%	44.4%	34.8%	42.1%	7.32%	22	
Plastic Surgery	Does not meet 92%	49.5%	48.3%	47.9%	54.1%	6.25%	206	
Urology	Dec-22	67.57%	72.75%	78.99%	80.44%	1.45%	62	
Directorate Total	Mar-23	**60.3%**	**60.1%**	**60.6%**	**65.7%**	**5.11%**	**791**	

RTT PTL - Clinical Prioritisation



P2	P3	P4	Not Prioritised
693 ↓ 4	2644	2073	1433

Clinical Prioritisation – past must be seen by date

P2	P3	P4
168 ↓ 30	389 ↓ 8	219 ↓ 12

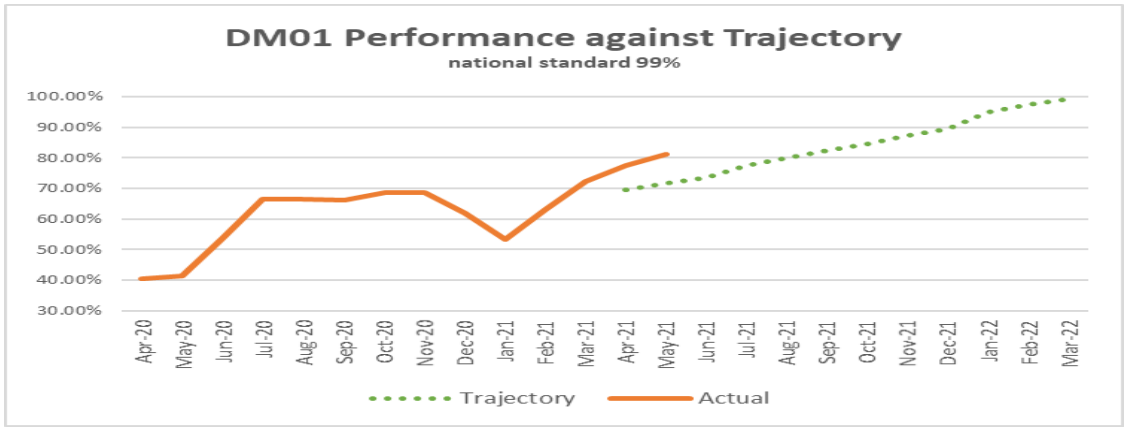
- The current RTT PTL is 6929 patients, 1433 require clinically prioritising with 1094 being under 18 week waits. The remaining patients on the PTL are cohorted as follows:, P1a/P1b – 86 patients (0.58%), P2 – 693 (10%), P3 – 2644 (38%) and P4 – 2073 (30%).
- It is recognised some sub-speciality areas including Dental/Maxfax, Plastic Surgery, Orthopaedics, Spinal and SDR have significant backlogs with many of these patients being within the clinical priority groups of 3 and 4.
- Since the second Covid-19 wave P2 patients have reduced from 983 at January 21 submission to 693 at May 21, reduction of 290 patients.
- The number of P2 patients waiting beyond their must be seen by date has seen a reduction of 30. The largest volume of breaching patients are within SNAPs (30), Dental (17), Orthopaedics (14), Plastic Surgery (11) and Gastroenterology (10). All these areas have requested additional theatre lists and/or clinics as part of the accelerator programme.
- The Trust receives a high volume of patients on inherited RTT pathways. As at the end of May, 62% of patients on the Trust's RTT ticking waiting list were referred from other Trusts, and 0.76% (33) of these patients had been waiting more than 18 weeks at their referring Trust. Three of these patients were waiting 52 weeks or more when they were referred to us, with one of them at 85 weeks wait.

Diagnostics - DM01

Performance

Forecast – 71.6%

Actual v Forecast



81.15%
People waiting less than 6 weeks
Target 99% ↑ 4%

305
Number of Breaches
↓ 76

Challenged Directorates

Of the 305 breaches, 200 are attributable to modalities within Imaging (93 of which are Non obstetric US and 89 of which are MRI), 40 in ECHO, 7 in Sleep Studies, 28 in Gastroscopy, 4 in Audiology, 18 in Colonoscopy and 8 in Cystoscopy

Over the last 4 months the number of breaches have reduced by 65% from the 881 reported January. With MRI, Non-obstetric Ultrasound and Echo's all see circa 57% reduction.

Bottlenecks

- MRI and Ultrasound Capacity.
- Some of the challenges faced by the Trust include some patients who are still choosing not to come in, cancelling at the last minute and requesting future dates mainly due to schools reopening and wanting future appointments during school holidays, and patients being prioritised as P4
- Booking processes within teams

Actions

- 60 additional Ultrasound slots in place.
- Additional lists requested via the Accelerator Programme
- Improved patient engagement
- Introduction of weekly performance meeting with clinical lead, lead radiographer and booking team to ensure capacity is used appropriately

Diagnostic Prioritisation

- National guidance released on clinically prioritising patients waiting for a diagnostic test covering elective wait and planned patients into D1 to D6 groups.
- Timeline for work has been set to run June – August and is included in the weekly NHSE waiting list submissions.
- Working group is established which includes Deputy Chiefs of Service, Operational Teams, Medical Directors Office and Performance to establish patient cohorts through clinical risk stratification.
- Any potential risks will be raised through Trust reporting streams

Cancer Waiting Times

Performance

Forecast – 100%

April Actual

100%
31 Day Referral to First Treatment
Target 96%

100%
31 Day: Subsequent Treatment – Surgery
Target: 94%

100%
31 Day: Subsequent Treatment – Drugs
Target:98%

100%
62 Day Consultant Upgrade.
No Target

May Forecast

100%
31 Day Referral to First Treatment
Target 96%

100%
31 Day: Subsequent Treatment – Surgery
Target: 94%

100%
31 Day: Subsequent Treatment – Drugs
Target:98%

100%
62 Day Consultant Upgrade.
No Target

Bottlenecks

- No significant issues identified with regards to achieving standards
- Late pathway referrals from other providers are being closely monitored

Activity Monitoring

The Trust submits weekly information for NHS Acute Specialties only as part of monitoring 2021/2022 activity against 2019/20. The information below depicts current performance covering the period calendar weeks 14 – 24, 30/03/2021 – 13/06/2021.

	Daycase			Elective			Emergency			First outpatient			Follow-up outpatient		
Calendar Weeks	2019	2021	%	2019	2021	%	2019	2021	%	2019	2021	%	2019	2021	%
14	502	346	68.9%	226	248	109.7%	59	59	100.0%	693	423	61.0%	3637	2248	61.8%
15	503	409	81.3%	250	217	86.8%	65	49	75.4%	694	421	60.7%	3575	2715	75.9%
16	414	479	115.7%	212	219	103.3%	59	53	89.8%	511	597	116.8%	2732	3267	119.6%
17	306	456	149.0%	137	268	195.6%	56	59	105.4%	274	671	244.9%	1701	3342	196.5%
18	344	468	136.0%	218	289	132.6%	57	51	89.5%	339	620	182.9%	2200	3380	153.6%
19	368	405	110.1%	208	206	99.0%	61	40	65.6%	366	494	135.0%	1859	2906	156.3%
20	405	439	108.4%	270	254	94.1%	59	62	105.1%	497	658	132.4%	2697	3425	127.0%
21	431	478	110.9%	269	282	104.8%	51	52	102.0%	597	675	113.1%	2945	3143	106.7%
22	403	465	115.4%	251	271	108.0%	48	60	125.0%	406	651	160.3%	2218	3007	135.6%
23	406	409	100.7%	285	222	77.9%	59	57	96.6%	601	404	67.2%	2775	2188	78.8%
24	443	518	116.9%	298	254	85.2%	48	51	106.3%	643	725	112.8%	2974	3344	112.4%

NHS Acute Specialty Daycase discharges over the last 11 weeks is 107% of 2019/2020 and Elective discharges 104%.

NHS Outpatient First Outpatient attendances over the last 11 weeks is 112% of 2019/2020 and Follow-up attendance 126%.

From 1st June 2021 Accelerator sessions have commenced in theatres and outpatients.

Children's Alliance Accelerator Bid

As part of the Accelerator Programme the operational teams have proposed the additional activity below, the areas included are based on the following considerations:

- Volume of P2 patients
- Number of Long Waits (52 weeks and over)
- Follow-up patient backlogs

The additional activity is planned from 1st June 2021 – 30th September 2021

			Patients per week		
Directorate	**Specialty Name**	**TFC**	**Elective**	**Daycase**	**Outpatients**
BBM	Gastroenterology	251	10		9
	Orthopaedics	214	3		
	SNAPS	171	11		
	Spinal Surgery	214	2		3
Heart and Lung	Cardiology	321		7	
Brain	Epilepsy	223	1		
	Clinical Neurophysiology	401			2.25
	Endocrinology	252		3	2
Sight and Sound	Plastic Surgery	219	3	3	8
	Craniofacial	219	1		2
	Ophthalmology	216		1	4
	Ear Nose and Throat	215		2	
	Urology	211	3	6	16
	Urology	211	1	4	
	Maxillofacial	217			2
	Dental			8	
	Cochlear Implant	254	1		2
	Cleft	219			2
MTT	Neuromuscular	421			6
	Physiotherapy	650			10
	Weekly Total:		**36**	**34**	**68**
	Monthly total:		**144**	**136**	**273**

Appendix

Productivity and Efficiency

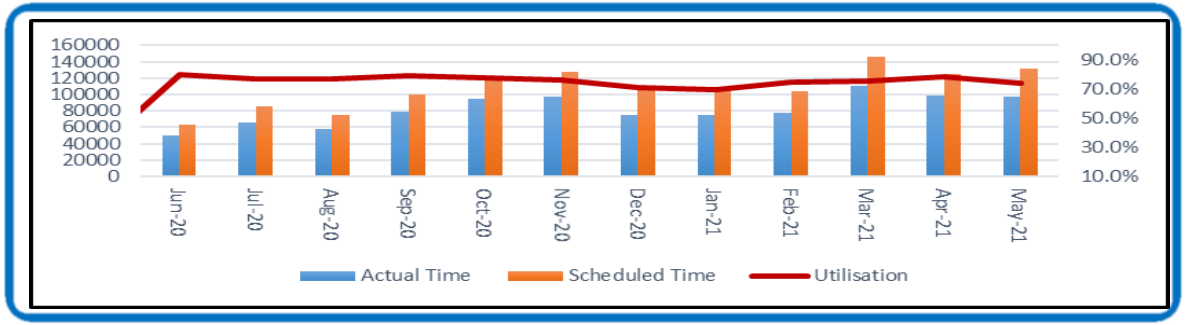
Theatre Utilisation

Performance

73.8%
of scheduled sessions in main theatres were utilised
4.8%

8656
Late start minutes
771 minutes

4977
Overrun minutes
4365 minutes



Bottlenecks

- Increase in late starts / overruns
- Reduced throughput in iMRI theatre
- Lists not always being fully utilised
- Potential reduction in throughput from June 2021 with no longer having a dedicated Covid-19 theatre due to cleaning turnaround times

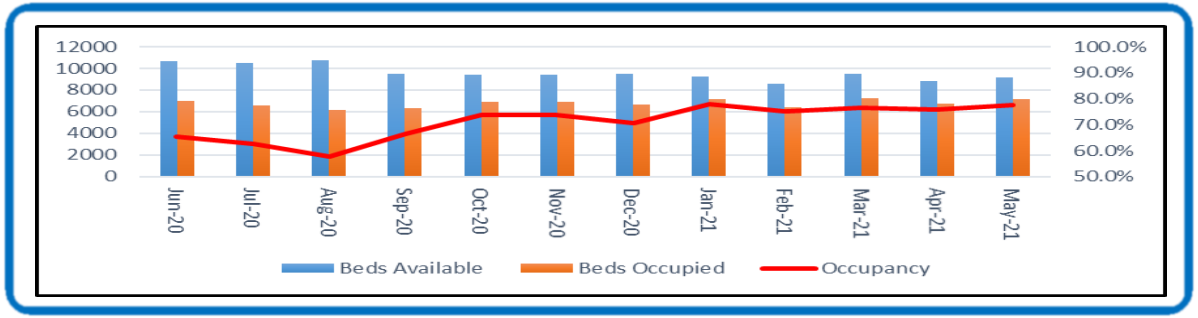
Bed Occupancy

Performance

77.6%
of inpatient beds (including ICU and I&PC) were occupied
1.1%

80.5%
Of NHS inpatient beds (including ICU were occupied)

Bed Closures



Bottlenecks

- Bed closures due to social distancing requirements
- Increased patient acuity on Cardiac wards impacting cancelled operations
- Potential additional demand pressure through anticipated RSV surge

Productivity and Efficiency

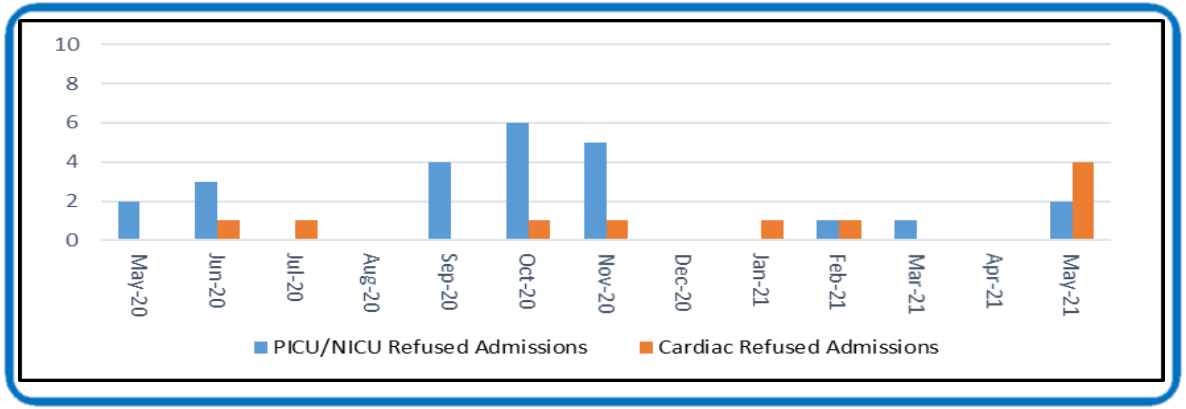
PICU/CICU

Performance

2
PICU/NICU CATS refused admissions
2

4
Cardiac CATS refused admissions
4

4
PICU readmissions within 24 hours
2



Bottlenecks

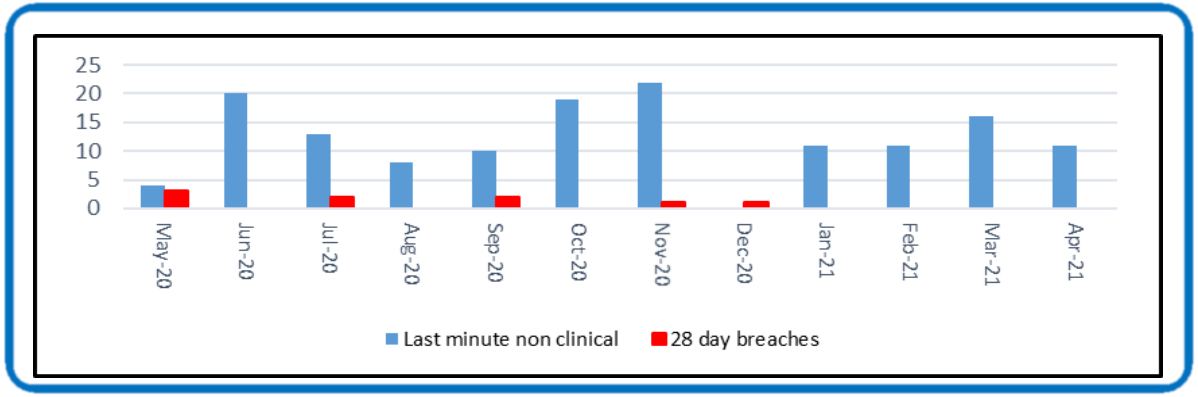
- No beds available for CATS admissions
- One of the cardiac refusals was an ECMO refusal.

Cancelled Operations

Performance

11
Last minute cancelled operations for non clinical reasons
5

0
28 day breaches- last minute cancelled operations



Bottlenecks

- List overrun
- Urgent patients taking priority

Patient Communication

Discharge Summaries

Performance | Forecast

79.41%
of patients who were discharged from GOSH had a letter sent to their referrer or received within 24 hours

Contractual target: 100%

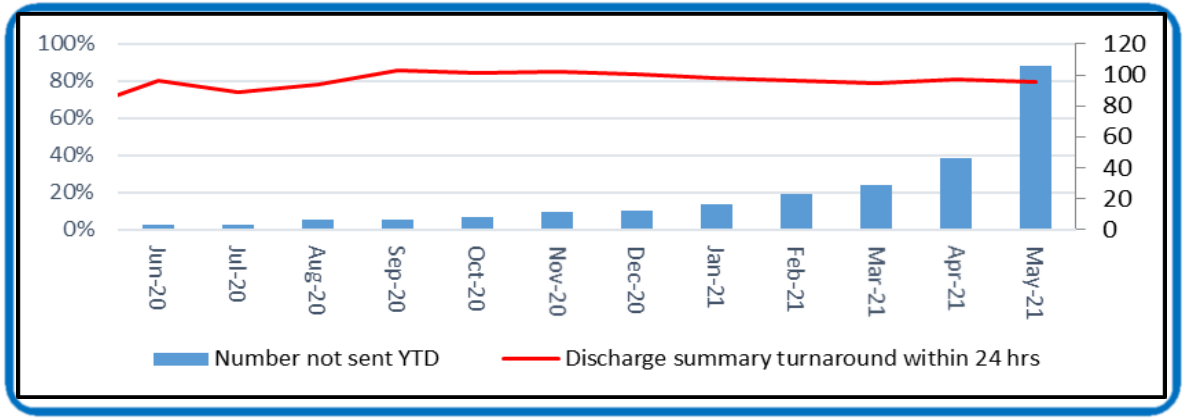
1.3%

88.2%
of letters were sent within 2 days of discharge

0%

106
Number of letter not sent ytd

60



Actions

- Focus at consultant meetings
- Directorates working with clinical teams on real time completion including weekends

Clinic letters

Performance | Forecast

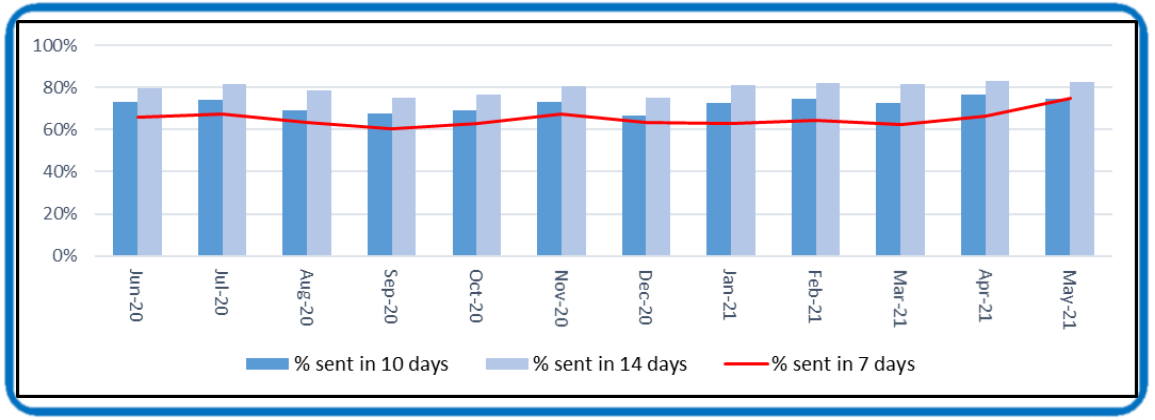
74.8%
of outpatient clinic letters were sent within 7 days

Contractual target: 100%

8%

2,159
Number of letters not sent (rolling 12 months)

1,318



Actions

- Focus at consultant meetings and directorate board
- Bespoke training provided to refresh teams of Epic workflow
- Action plans in place to initially meet 10 day turnaround and then reduce to 7 day

Great Ormond Street Hospital for Children
NHS Foundation Trust

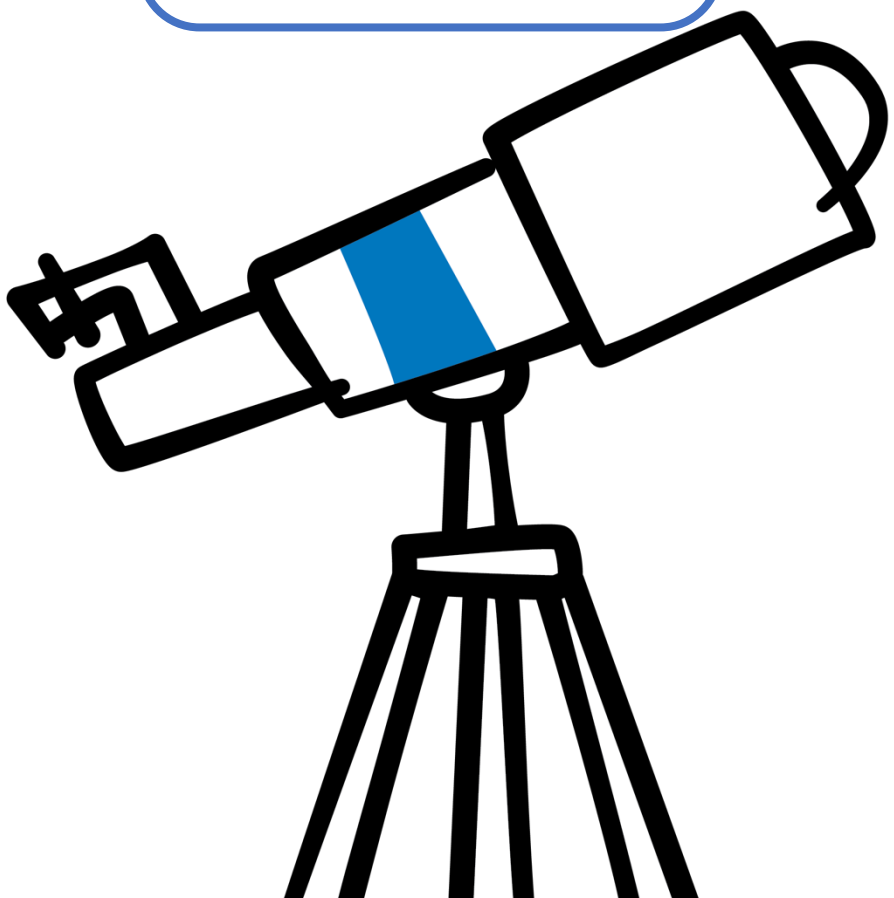
Clinical Outcomes Programme at GOSH

The Clinical Outcomes Programme supports clinical teams to establish their outcome measures, and collect, analyse and publish their outcomes data to the Clinical Outcomes Hub and the Trust website.

We seek to benchmark with other paediatric centres of excellence.

Outcomes published to Trust website

Clinical outcomes are measurable changes in health, function or quality of life that result from our care.



Published for first time

- Bardet-Biedl
- Perfusion Service
- Music Therapy

In development

- Gastrointestinal Allergy Nutrition Therapy Service
- Pilot project to integrate outcomes into EPIC for Beckwith-Wiedemann syndrome service

Updated since Nov 2020

- Cystic Fibrosis
- Dietetics
- Intensive Care
- Haemophilia
- Selective Dorsal Rhizotomy

Benchmarked clinical outcomes

Cystic Fibrosis

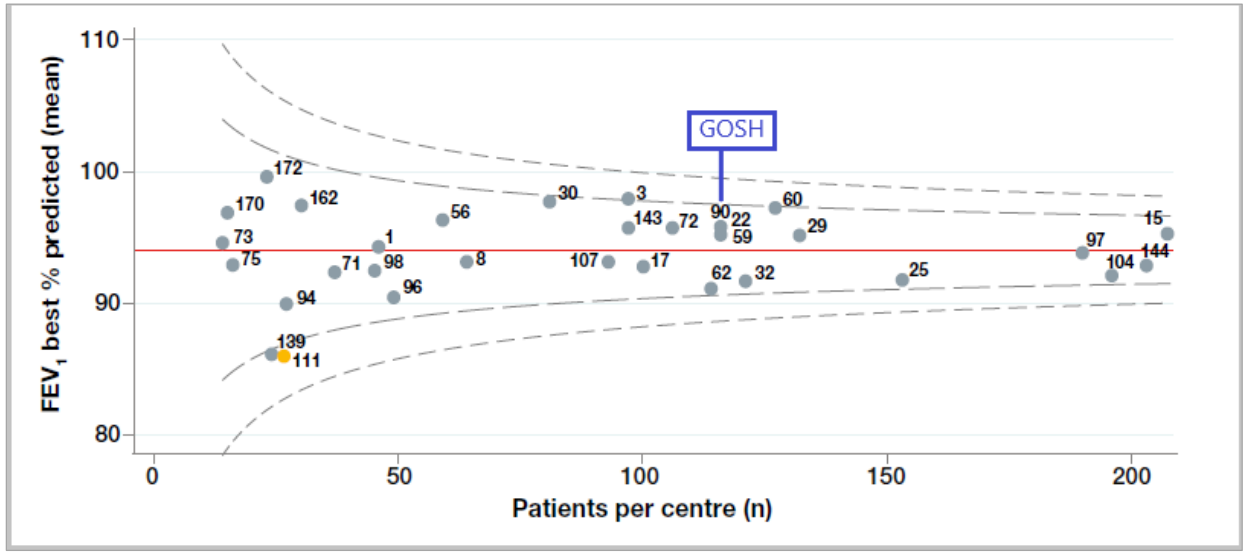
- There is natural variation between centres because of differences between the patients receiving care. Using only the national average as a standard makes it difficult to tell if a centres' outcome are within 'expected' variation. For this reason, the funnel plots also show 'control limits': the dashed curved lines on the graphs that give them the 'funnel' shape. Each graph shows the national average result for all paediatric CF centres in the UK as a horizontal red line in the middle of the funnel.
- If the result for a CF centre is between the two control limits its results are expected. If a result is below the bottom control it is lower than expected, if it is above the upper control limit it is higher than expected.

In 2019 the national average FEV_1 % predicted for all those with CF aged 6 and over was 94.1%. The result for our clinic at GOSH in 2019 was 95.8%, just above the national average value and within the control limits.

Lung function, measured by: Forced Expiratory Volume in 1 second (FEV_1)

One of the key measures undertaken to monitor CF lung function is the Forced Expiratory Volume in 1 second (FEV_1). This measures the volume of expired air blown out in the first second during a hard and fast breath out. This measure is then compared to that of an average child of the same age, sex, height and ethnicity, who does not have CF. This comparison is against 'population norms' to provide a benchmark for a normal range.

Figure: Age-adjusted Best FEV_1% predicted in patients aged six and over without a history of lung transplant, by paediatric centre/clinic

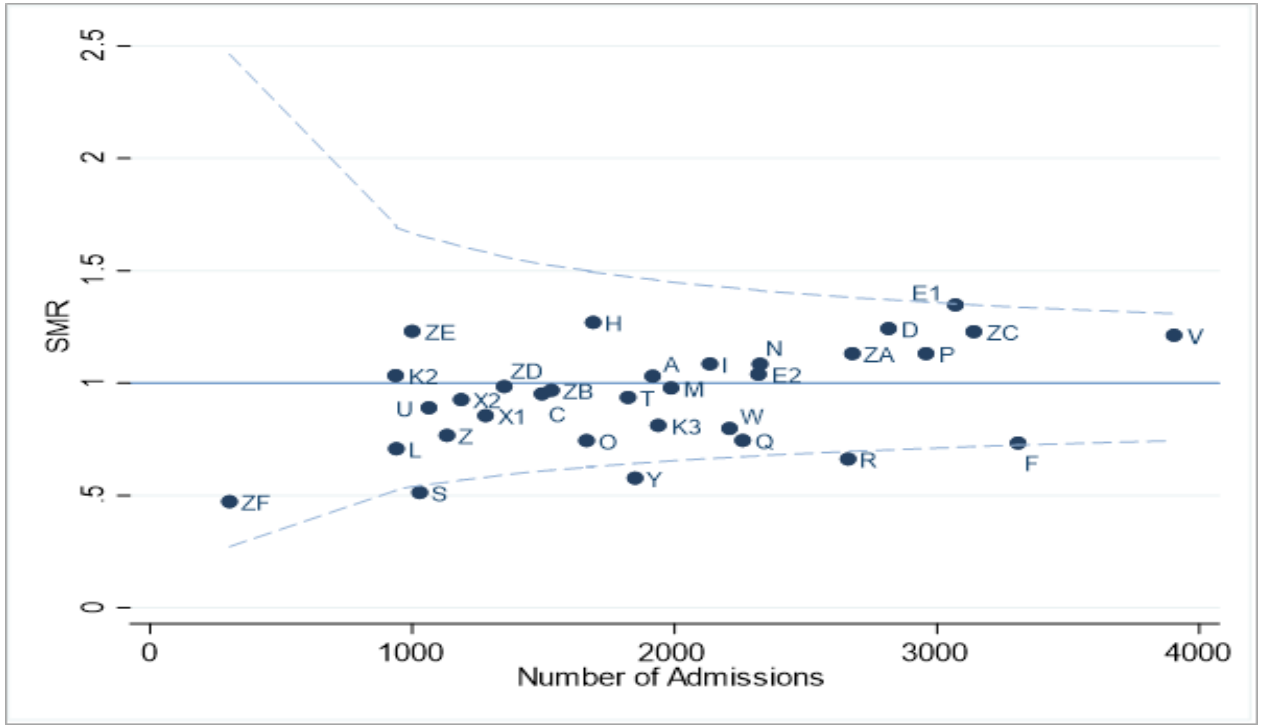


Published with the permission of the UK Cystic Fibrosis Registry

Intensive Care

- The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be 'adjusted' to consider the level of severity of the patients in respect of case mix.
- The PIM3 (Paediatric Index of Mortality version 3) score is calculated for every child admitted to ICU and assesses severity of illness and risk of death on admission and is based on medical history, interventions and physiological measurements taken from time of first contact with an ICU doctor up to the first hour after admission. The standardised mortality ratio (SMR) is the ratio of the percentage of actual deaths compared to the percentage of expected deaths based on the PIM3 score: this is a method of benchmarking the outcomes between ICUs nationally.

Figure: Standardised Mortality Ratio (SMR) funnel plot for PICU/NICU and CICU, Jan 2017 to Dec 2019, PIM3 Risk Adjusted (PIM3 Recalibrated 2020)



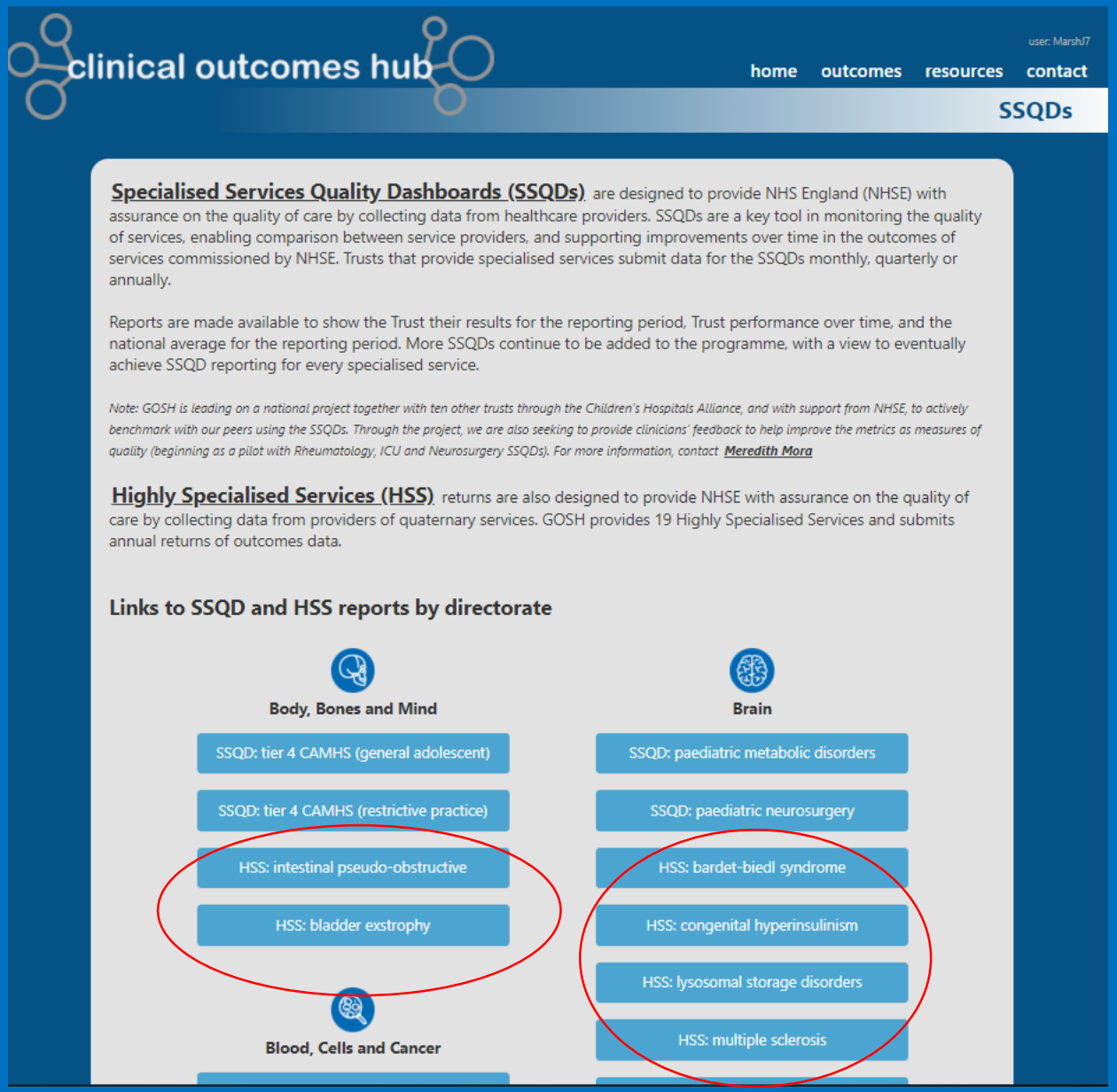
Funnel plot provided by the Pediatric Intensive Care Audit Network body (PICANet) for admissions to the GOSH ICUs between Jan 2017 and Dec 2019.

Centre E1 is the combined GOSH Paediatric and Neonatal ICUs (PICU/NICU) and Centre E2 is GOSH Cardiac ICU (CICU). The adjusted SMR indicates that the mortality rate for PICU/NICU and CICU are both slightly above 1. The mortality rates for both units however, fall within the expected range, as determined by the displayed confidence limits.

Clinical Outcomes Hub

- 2019/20 Highly Specialised Services (HSS) returns for 19 services across GOSH
- Specialised Services Quality Dashboards (SSQDs) available for 14 services across GOSH

http://qst/ClinicalOutcomes/



Attachment U

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7th July 2021

Month 2 2021/22 Finance Report **Submitted by: Helen Jameson, Chief Finance Officer**	**Paper No: Attachment U**

Aims / summary

The month 2 financial position is a surplus of £6.6m which is £7.6m favourable to plan in-month. Year to date (YTD) the Trust position is £3.6m favourable to plan. This has been achieved mainly through Elective Recovery Funding of £7.8m for additional day case, elective and outpatient activity in order to reduce patient backlogs and wait times, which was not included in the plan. However there is a potential that once the ERF is aggregated across the wider system and STP that this will amount to an unaffordable level for NHSE. Therefore it is possible that the income recognised by the Trust may not be received in full and that the rules around recognition of this may change in the coming months, presenting a further risk for H2 where there is likely to be more efficiency assumed within the block payment i.e. the Trust is likely to receive less than H1.

The benefit currently recognised from ERF is partially offset by lower than plan Covid-19 income (£1.5m adverse to plan) due to lower than expected costs incurred. The Trust is continuing to review its cost base to ensure that all Covid-19 costs are captured and reported YTD.

1. Income overall is £5.0m favourable to plan for the Trust in-month. The ERF income that was not included within the plan is £7.8m, but this benefit is offset by lower than plan Covid cost funding (£1.5m in-month) and lower than plan private patient income. Private Patient income is currently £2.0m below plan due to continued travel restrictions related to Covid-19. This lower private patient income impact is partially offset by impairment of receivables relating to private patient debt being favourable to plan (£0.7m) given payments continue to be received and new activity is low, reducing the aged debt profile.
2. Pay is £0.2m adverse to plan in-month; this is lower than expected given the additional ERF activity completed through reallocation of staff from private patient areas with low activity and charitable projects. Non-nursing bank spend this month is lower than in M1 due to lower backfill required for sickness coverage, the closure of Dolphin and the closure of the vaccine clinic. Staff turnover levels have remained low as a result of the pandemic and high staff levels have been retained across the board. The Trust continues to look to reduce the impact on staffing numbers of Covid-19 with appropriate challenge around proposed new posts and reviews of temporary staffing spend.
3. Non-Pay is £3.0m favourable to plan in-month. Key drivers of this are impairment of receivables relating to IPP (£0.7m favourable to plan), lower than plan usage of high cost drugs (including CAR-T) and pass-through expenditure (£0.8m), lower than plan utility and maintenance payments (£0.4m) and reduced clinical supplies relating to lab consumables and reagents. Further work is been undertaken in this area to ensure no costs are missing in relation to Covid.

4. Cash held by the Trust is £134.9m which is £3.4m higher than M1, largely driven by payments and reduction of IPP debt.

5. Capital expenditure as at M2 is £1.9m which is less than plan by £0.4m, £0.3m on the Trust-funded programme and £0.1m on the donated programme.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust increased in month by £3.4m, from £131.5m to £134.9m.
NHS Debtor Days	NHS debtor days remained the same as last month at 3 days, falling within the target of 30 days for the Trust.
IPP Debtor Days	IPP debtor days decreased in month from 281 days to 271 days.
Creditor Days	Creditor days decreased in month from 34 days to 31 days.

Action required by the meeting
To **note** the Month 2 Financial Position

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

Financial implications
Changes to payment methods and expenditure trends

Legal issues
N/A

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

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

Finance and Workforce Performance Report Month 2 2021/22

Contents

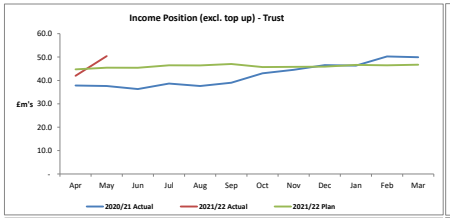
Trust Performance Summary for the 2 months ending 31 May 2021

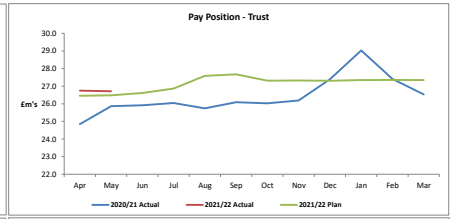
KEY PERFORMANCE DASHBOARD

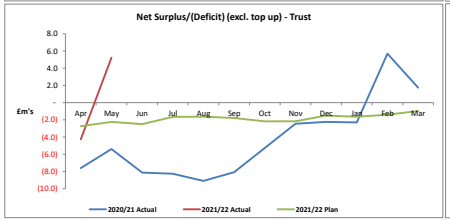
ACTUAL FINANCIAL PERFORMANCE

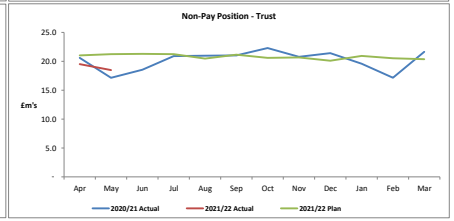
	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	£45.5m	£50.4m		£90.2m	£92.4m	
PAY	(£26.5m)	(£26.7m)		(£52.9m)	(£53.5m)	
NON-PAY inc. owned depreciation and PDC	(£20.1m)	(£17.1m)		(£39.9m)	(£35.3m)	
Surplus/Deficit excl. donated depreciation	(£1.1m)	£6.6m		(£2.6m)	£3.6m	
Top up	£0.0m	£0.0m		£0.0m	£0.0m	
Surplus/Deficit excl. donated depreciation	(£1.1m)	£6.6m		(£2.6m)	£3.6m	

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









AREAS OF NOTE:

In month 2, the Trust has generated a surplus of £6.6m in-month (£7.6m favourable to plan in-month), leading to a £3.6m surplus year to date. This has predominantly been achieved through Elective Recovery Funding (not included in the plan and therefore £7.8m favourable) for the volume of additional outpatient activity, day case and elective work completed by the Trust to reduce patient backlogs and waiting times. Offset against this, the Trust is below plan in relation to Covid-19 income due to lower than planned costs being incurred (£1.9m lower YTD); however the Trust is completing detailed reviews of the cost base in order to ensure all costs are captured in order to ensure that the correct claim against the 6 month Covid cost funding plan (£8.8m) is made. It should be noted that as the ERF scheme rules have not been completely confirmed the current assessment of income may change/reduce.

Private patient income continues to perform below planned levels, now at £2.0m adverse to YTD plan. Recovery and delivery of plan relating to this activity is a key risk to the delivery of Trust bottom line, particularly in H2 where the planned income delivery is higher than in H1. Private patient sponsors continue only to send their most complex patients abroad due to continued travel restrictions due to Covid-19. Given the lower levels of new activity, impairment of receivables relating to IPP are significantly favourable with the Trust total showing as £0.7m favourable to plan in-month due to continued debt payments and reduced new activity coming into the hospital; this in turn has reduced the aged debt profile.

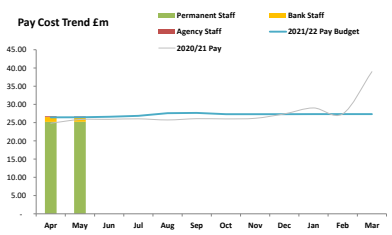
Pay is £0.2m adverse to plan; staff turnover levels have reduced as a result of the pandemic and high staff levels have been retained across the board. The Trust continues to look to reduce the impact on staffing numbers of Covid-19 with appropriate challenge around proposed new posts and reviews of temporary staffing spend. Non-Pay is £3.0m favourable to plan in-month due to the aforementioned impairment of receivables (£0.7m), lower than plan spend on high cost drugs (£0.8m) and lower than plan clinical supplies spend particularly in relation to lab

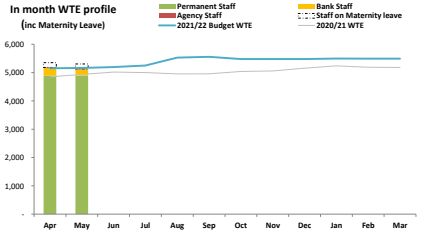
PEOPLE

	M2 Plan WTE	M2 Actual WTE	Variance
Permanent Staff	5,116.4	4,889.6	226.8
Bank Staff	43.7	221.4	(177.7)
Agency Staff	-	22.6	(22.6)
TOTAL	**5,160.1**	**5,133.5**	**26.6**

AREAS OF NOTE:

Month 2 WTE's have reduced from Month 1; this is driven through lower non-nursing bank usage given reduced requirments for sickness backfill. In addition, the closure of Dolphin and the ceasing of the vaccine clinic has also reduced the need for temporary staffing for coverage. The comparison of volume/price mix for the Trust staffing base when comparing to last year is significantly higher within administrative staff given the ceasing of capitalising EPR staff costs, now having to be recognised within the revenue position (happened in M10 last year, so 2020/21 only saw a partial effect). However, as can be seen by actual WTE v Plan WTE comparison (this month being 26.6 WTEs below plan), these posts have been included in the 2021/22 budget. THigh levels of admin agency staff continues due to additional senior assistance for the ICT directorate; the process of looking to recruit permanently and negate these costs is ongoing.



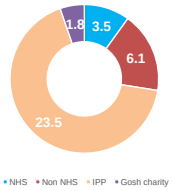


CASH, CAPITAL AND OTHER KPIs

Key metrics	*Apr-21*	*May-21*
Cash	**£131.5m**	**£134.9m**
IPP debtor days	**281**	**271**
Creditor days	**34**	**31**
NHS Debtor days	**3**	**3**

Capital Programme	*YTD Plan M2*	*YTD Actual M2*	*Full Year F'cst*
Total Trust-funded	**£1.2m**	**£0.9m**	**£18.0m**
Total Donated	**£1.1m**	**£1.0m**	**£17.9m**
Total Grant-funded	**£0.0m**	**£0.0m**	**£0.5m**
Grand Total	**£2.3m**	**£1.9m**	**£36.4m**

Net receivables breakdown (£m)

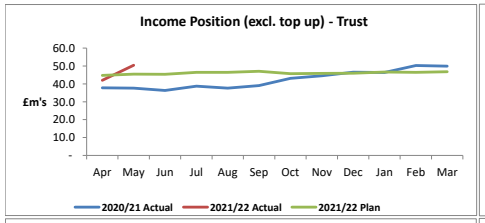


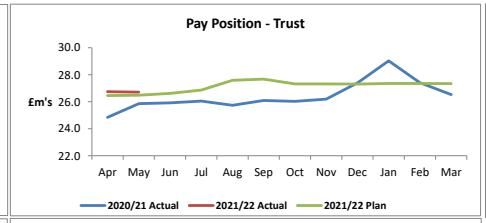
AREAS OF NOTE:

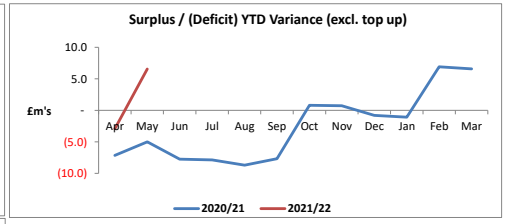
1. Cash held by the Trust increased in month by £3.5m.
2. Capital expenditure for the year to date is less than plan by £0.4m of which £0.3m is on the Trust-funded programme and £0.1m on donated.
3. IPP debtors days decreased in month from 281 days to 271 days. Total IPP debt decreased in month to £23.5m (£26.3m in M01). Overdue debt decreased in month to £25.1m (£26.1m in M01).
4. Creditor days decreased in month from 34 days to 31 days.
5. NHS debtor days remained the same as the previous month at 3 days.

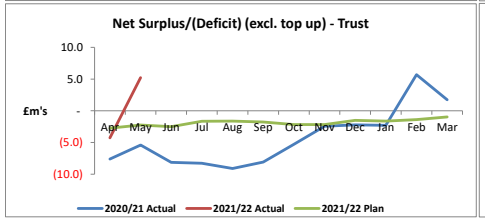
Trust Income and Expenditure Performance Summary for the 2 months ending 31 May 2021

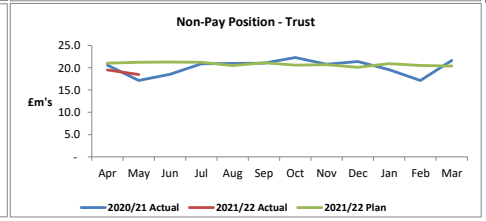
2021/22 Full year plan (£m)	Income & Expenditure	Month 2 Plan (£m)	Month 2 Actual (£m)	Month 2 Variance (£m)	Month 2 Variance %	Year to Date Plan (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	Rating YTD Variance	Notes	2020/21 Actual M2 (£m)	2021/22 Plan YTD (£m)	2021/22 Plan In-month M2 (£m)
436.56	NHS & Other Clinical Revenue	37.76	43.82	6.06	16.05%	74.86	80.17	5.32	7.10%	G	1	31.81	74.86	37.76
54.52	Private Patient Revenue	2.69	1.83	(0.86)	(32.08%)	5.31	3.35	(1.96)	(36.97%)	R	2	3.01	5.31	2.69
61.75	Non-Clinical Revenue	5.02	4.76	(0.25)	(5.04%)	10.04	8.88	(1.16)	(11.53%)	R	3	2.79	10.04	5.02
552.83	**Total Operating Revenue**	**45.47**	**50.41**	**4.95**	**10.88%**	**90.21**	**92.40**	**2.20**	**2.43%**	G		**37.61**	**90.21**	**45.47**
(322.87)	Permanent Staff	(26.23)	(25.24)	0.99	3.78%	(52.43)	(50.44)	1.99	3.79%	G		(24.49)	(52.43)	(26.23)
0.00	Agency Staff	0.00	(0.23)	(0.23)		0.00	(0.43)	(0.43)				(0.12)	0.00	0.00
(2.79)	Bank Staff	(0.25)	(1.25)	(1.00)	(395.96%)	(0.50)	(2.58)	(2.08)	(413.29%)	R		(1.25)	(0.50)	(0.25)
(325.66)	**Total Employee Expenses**	**(26.48)**	**(26.71)**	**(0.23)**	**(0.87%)**	**(52.94)**	**(53.46)**	**(0.52)**	**(0.98%)**	R	4	**(25.86)**	**(52.94)**	**(26.48)**
(104.16)	Drugs and Blood	(8.68)	(7.72)	0.96	11.06%	(17.35)	(15.52)	1.83	10.54%	G		(6.40)	(17.35)	(8.68)
(34.65)	Supplies and services - clinical	(2.88)	(2.46)	0.42	14.62%	(5.61)	(5.74)	(0.13)	(2.28%)	A		(2.05)	(5.61)	(2.88)
(77.87)	Other Expenses	(6.94)	(5.41)	1.53	22.09%	(13.81)	(10.91)	2.90	20.99%	G		(5.98)	(13.81)	(6.94)
(216.68)	**Total Non-Pay Expenses**	**(18.50)**	**(15.59)**	**2.91**	**15.75%**	**(36.76)**	**(32.17)**	**4.60**	**12.51%**	G	5	**(14.44)**	**(36.76)**	**(18.50)**
(542.34)	**Total Expenses**	**(44.98)**	**(42.30)**	**2.68**	**5.97%**	**(89.70)**	**(85.62)**	**4.08**	**4.55%**	G		**(40.30)**	**(89.70)**	**(44.98)**
10.49	**EBITDA (exc Capital Donations)**	**0.49**	**8.12**	**7.63**	**1,569.70%**	**0.51**	**6.78**	**6.27**	**1,237.72%**	G		**(2.68)**	**0.51**	**0.49**
(18.70)	Owned depreciation, Interest and PDC	(1.55)	(1.56)	(0.01)	(0.71%)	(3.13)	(3.16)	(0.03)	(0.92%)		7	(1.51)	(3.13)	(1.55)
(8.21)	**Surplus/Deficit (exc. PSF/Top up)**	**(1.06)**	**6.55**	**7.62**	**716%**	**(2.62)**	**3.62**	**6.24**	**238%**			**(4.19)**	**(2.62)**	**(1.06)**
0.00	PSF/Top up	0.00	0.00	0.00		0.00	0.00	0.00				4.19	0.00	0.00
(8.21)	**Surplus/Deficit (incl. PSF/Top up)**	**(1.06)**	**6.55**	**7.62**	**715.66%**	**(2.62)**	**3.62**	**6.24**	**238.29%**	G		**(0.00)**	**(2.62)**	**(1.06)**
0.00	PY PSF post accounts reallocation	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
(14.20)	Donated depreciation	(1.18)	(1.33)	(0.16)		(2.36)	(2.67)	(0.31)				(1.20)	(2.36)	(1.18)
(22.41)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(2.24)**	**5.22**	**7.46**	**333.02%**	**(4.98)**	**0.96**	**5.94**	**119.22%**			**(1.20)**	**(4.98)**	**(2.24)**
0.00	Impairments & Unwinding Of Discount	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
15.98	Capital Donations	0.55	0.47	(0.08)		1.10	0.97	(0.13)			6	0.22	1.10	0.55
(6.43)	**Adjusted Net Result**	**(1.69)**	**5.69**	**7.38**	**436.66%**	**(3.88)**	**1.93**	**5.81**	**149.77%**			**(0.97)**	**(3.88)**	**(1.69)**











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

Summary

- The month 2 financial position is a surplus of £6.6m which is £7.6m favourable to plan. This has been achieved mainly through Elective Recovery Funding of £7.8m for additional day case, elective and outpatient activity in order to reduce patient backlogs and wait times, which was not included in the plan.
- The latest Trust plan agrees with NHSE for the year totals to a target deficit for the end of the year of £8.2m.

Notes

1. NHS Clinical income is £6.1m favourable to plan. This is driven largely by Elective Recovery Fund income being significantly higher than plan (£7.8m) due to additional outpatient, elective and day case activity. This is partially offset by lower than plan Covid-19 income (£1.5m adverse to plan) due to lower than expected costs incurred. The Trust is continuing to review its cost base to ensure that all Covid-19 costs are captured and reported YTD.
2. Private Patient income is £0.9m adverse to plan in-month due to travel remaining suppressed due to Covid-19 and this remains a key risk for delivery of the current Trust bottom line position. International sponsors are still only sending their most complex patients overseas and with continuing travel restrictions, it is likely this income stream will continue to be affected until such time as travelling is deemed to be safer for patients. The private patient income target for the Trust grows throughout the year given expectation of an uplift in activity as the year progresses.
3. Non-clinical income is £0.3m adverse to plan in-month. This is largely driven by lower than plan charity income relating to timing of spend.
4. Pay is adverse in-month to the plan by £0.2m. Turnover levels within the staffing groups has reduced as a result of the pandemic and high staff levels have been retained across the board. The Trust continues to look at managing down the impact of Covid-19 on staffing and proposed new posts are carefully reviewed. Non-nursing bank staffing has reduced £0.1m compared to M1 whilst permanent staffing has remained broadly static.
5. Non pay is £3.0m favourable to the plan in-month. This is driven by impairment of receivables being £0.7m favourable to plan in-month given continued payments of debt coupled with reduced drugs expenditure due to lower usage of high cost drugs (including CAR-T). Covid costs are lower than planned for which there is a corresponding lower than plan income for Covid cost funding.

Trust Income and Expenditure Forecast Outturn Summary for the 2 months ending 31 May 2021

2021/22					
Income & Expenditure					Rating
	6 months NHSI Plan (£m)	6 months Forecast (£m)	Variance (£m)	Variance %	YTD Variance
NHS & Other Clinical Revenue	225.99	237.12	11.13	4.93%	G
Private Patient Revenue	18.39	11.58	(6.81)	(37.03%)	R
Non-Clinical Revenue	30.61	26.35	(4.26)	(13.93%)	R
Total Operating Revenue	**274.99**	**275.05**	**0.06**	**0.02%**	G
Permanent Staff	(150.79)	(153.56)	(2.77)	(1.84%)	R
Agency Staff	(1.71)	(1.30)	0.42	24.39%	G
Bank Staff	(9.10)	(8.97)	0.13	1.43%	G
Total Employee Expenses	**(161.60)**	**(163.82)**	**(2.22)**	**(1.37%)**	R
Drugs and Blood	(50.90)	(47.12)	3.78	7.42%	G
Supplies and services - clinical	(17.18)	(18.94)	(1.76)	(10.26%)	R
Other Expenses	(42.00)	(35.30)	6.71	15.97%	G
Total Non-Pay Expenses	**(110.08)**	**(101.36)**	**8.72**	**7.92%**	G
Total Expenses	**(271.68)**	**(265.18)**	**6.50**	**2.39%**	G
EBITDA (exc Capital Donations)	**3.31**	**9.87**	**6.56**	**198.43%**	G
Owned depreciation, Interest and PDC	(9.34)	(9.46)	(0.13)	(1.36%)	
Surplus/Deficit (exc. PSF/Top up)	**(6.03)**	**0.41**	**6.44**	**107%**	
PSF/Top up	0.00	0.00	0.00		
Surplus/Deficit (incl. PSF/Top up)	**(6.03)**	**0.41**	**6.44**	**106.72%**	G
Donated depreciation	(7.04)	(8.00)	(0.96)	(13.64%)	
Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	**(13.07)**	**(7.59)**	**5.48**	**41.90%**	
Impairments	0.00	0.00	0.00		
Capital Donations	3.45	3.45	0.00	0.00%	
Adjusted Net Result	**(9.62)**	**(4.14)**	**5.48**	**56.92%**	

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

Summary

- The 6 month forecast for GOSH shows a forecast outturn surplus of £0.4m. The key driver of this is the NHS income largely relating to ERF and reduced non-pay costs forecast. This will be updated on a monthly basis and in line with any changes to teh NHS financial framework.

Notes

1. The 6 month forecast for NHS & other clinical revenue is favourable to plan (£11.1m) driven by ERF income that wasn't included in the original plan.

2. Non-clinical income is forecast to be £4.3m adverse to the 6 month NHSI plan mainly due to lower levels of income from diagnostic testing and other commercial income.

3. Private Patient income is forecast to be £6.8m adverse to the 6 month NHSI plan, mainly due to the continuation of travel restrictions linked to Covid-19. International sponsors are still only sending their most complex patients overseas and this is forecast to continue with the continued international travel restrictions.

4. Pay is £2.2m adverse to 6 month NHSI plan is mainly due to the staffing costs to deliver additional ERF activity. This cost is lower than expected due to reallocation of staff associated with low levels of private patient activity and charitable projects. The pandemic has driven staff turnover to low levels which in turn has led to increased substantive staffing levels.

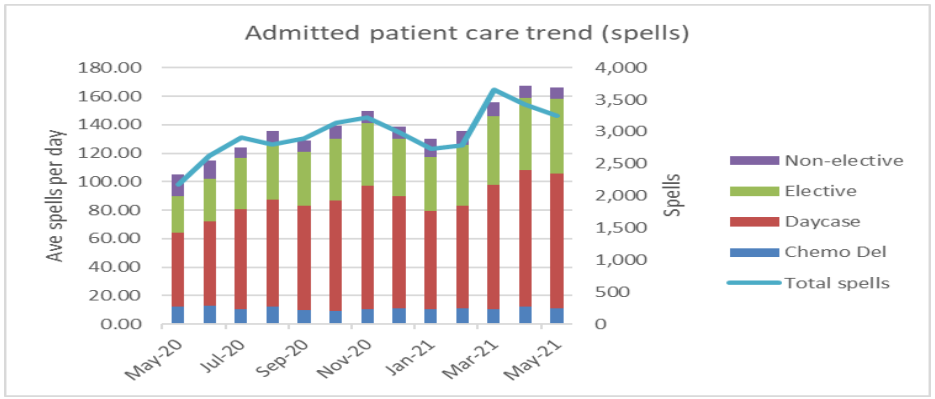
5. Non-pay forecast is £8.7m favourable against the 6 month NHSI plan due to reduced usage of high cost drugs associated with reduced private patients and patients requiring cost and volume high cost drug treatments (including CAR-T).

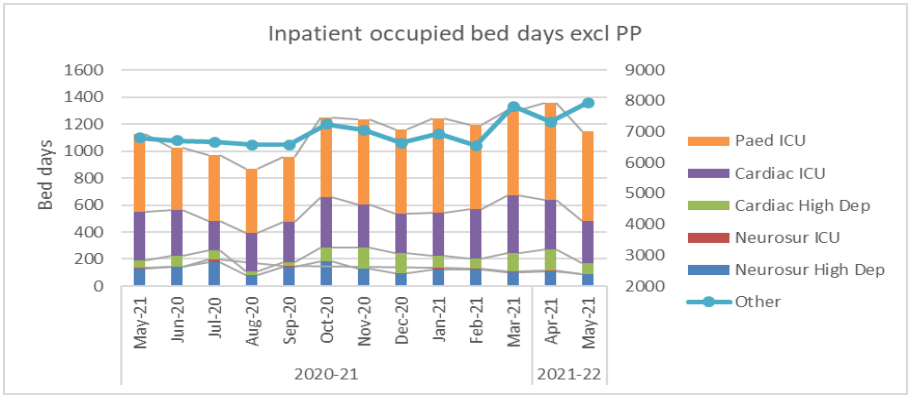
6. Premises costs are expceted to be lower then plan due to reduced utility bills and reduction in maintenance costs. Further work has been undertaken in this area to ensure no costs are currently omitted.

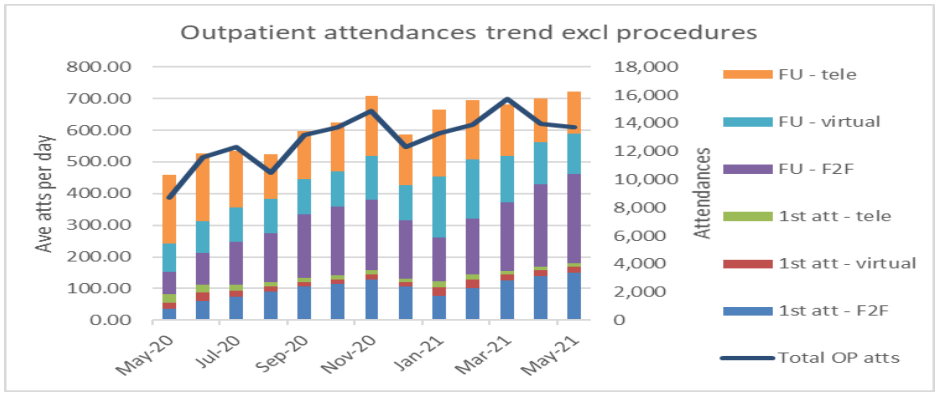
7. Purchase of Healthcare from NHS and Non-NHS costs and general supplies and services are also expected to be lower than plan linked to activity.

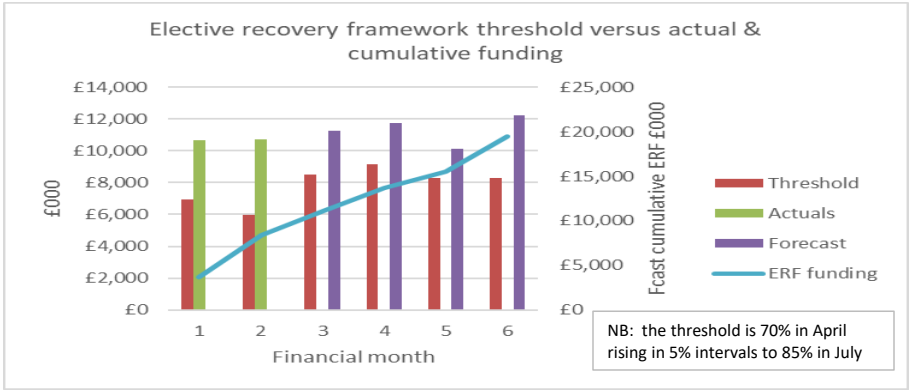
2021/22 Overview of activity trends for month ending 31 May 2021

Great Ormond Street Hospital for Children NHS Foundation Trust







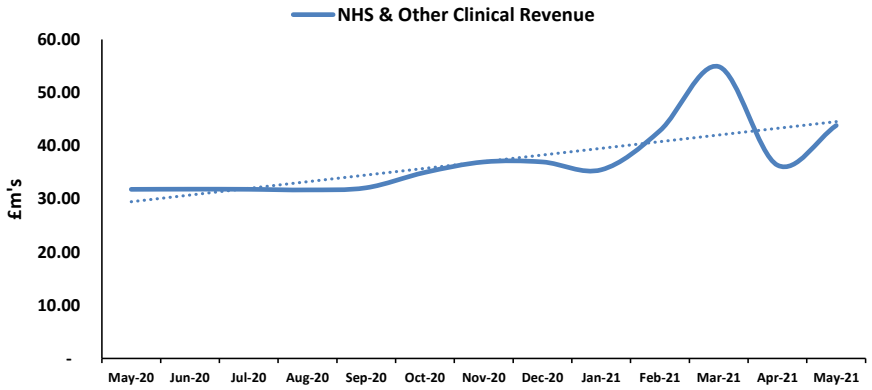


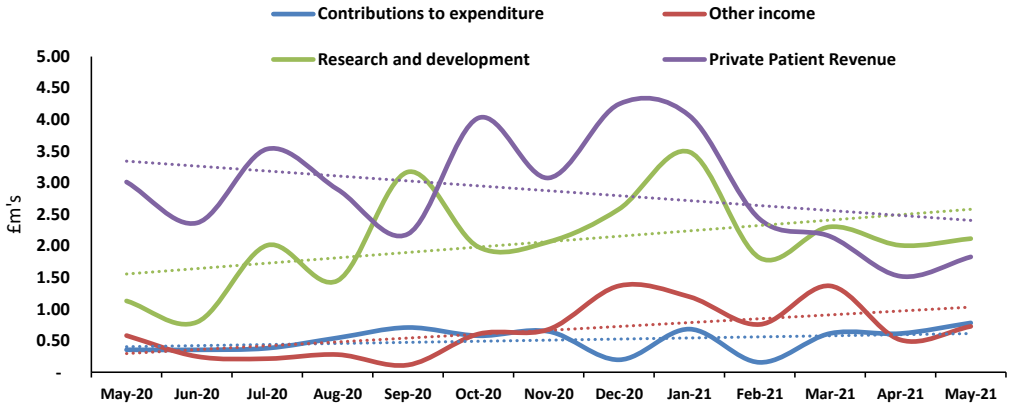
Summary

- Daycase spells have decreased 1.6% and elective spells have increased 4.5% per working day versus April. Non -elective activity continues to decrease with it being 10% below April levels.
- Overall occupied bed days have increased versus April however critical care bed days are lower across all locations with the biggest decrease in % terms being seen on Cardiac High Dependency
- Outpatient attendances per working day are at their highest since May -20 and are showing a sustained increase over the last 3 months versus the second lockdown period. Non-face to face attendances as a % of the total have dropped further to 40% when compared to April (43%) owing to the decline in COVID cases allowing more face -to-face activity.
- Clinical supplies and services costs are lower than April (£2.2m v £2.9m) despite activity trends being higher. This is driv en by some one off credits and reduced spend in cardiology which reflects the reduction in cardiac HDU bed days.
- A new graph has been added summarising the performance and forecast to the end of September for the elective recovery framewo rk (ERF). This shows the 2019/20 threshold we are being measured against (red bar), actual value of activity (green bar) and the forecast actual (purple bar). The blue line shows the forecast cumulative ERF funding that could be payble to GOSH by the end of September with £8.5m year to date May. The ERF has not reduced in May as a result of the decrease in daycase spells as this has been offset by the higher average va lue per spell for the increased elective activity and increased outpatient attendances. Nationally £1bn has been allocated for ERF and there is concern that funding received may be reduced as this may be insuffic ient under the current rules of the scheme.

NB: activity counts for spells and attendances are based on those used for income reporting

2020/21 Income for the 2 months ending 31 May 2021





Summary

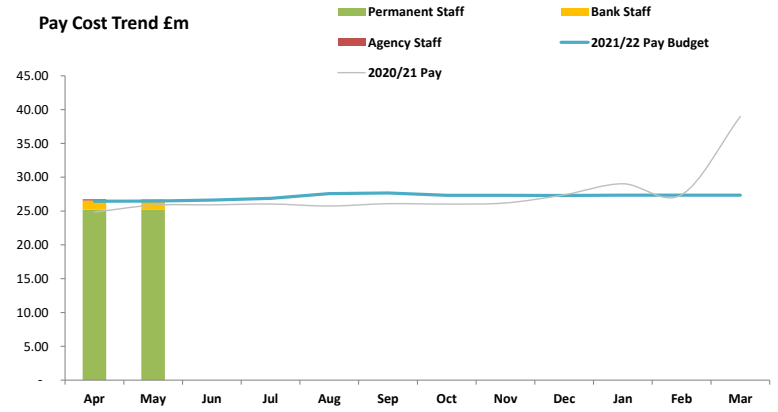
- NHS Clinical income is £6.1m favourable to plan. This is driven largely by Elective Recovery Fund income being £7.8m higher than plan due to additional outpatient, elective and day case activity. This is partially offset by lower than plan Covid-19 income (£1.5m adverse to plan) due to lower than plan costs incurred. The Trust is continuing to review its cost base to ensure that all Covid-19 costs are captured and reported YTD.
- Private Patient income is £0.9m adverse to plan in month and this is a key risk to the Trust's plan delivery. Given the continued travel restrictions both domestically and globally, sponsors are only sending their most complex patients abroad, resulting in significantly lower income levels for the Trust. The reduced level of referrals is expected to continue until after restrictions are lifted. The private patient income target grows throughout this year with the expectation that activity will begin to return as the year goes on; this is all dependent upon these restrictions lifting and continued success in limiting further waves of variants of Covid-19.
- Charitable income is £0.4m adverse to plan in month due to timing of spend
- Research and development income is broadly on plan YTD (total £4.0m).

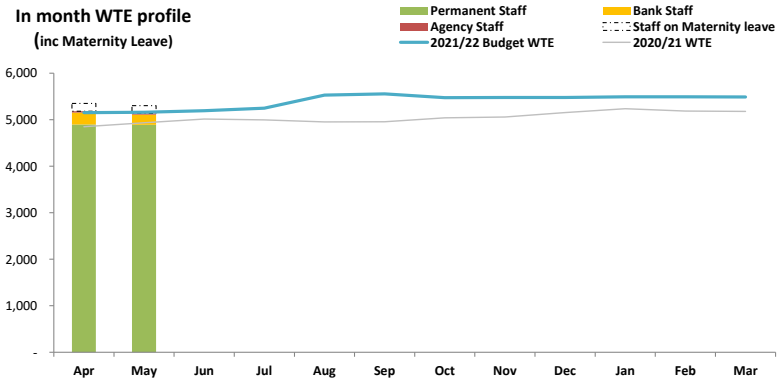
Workforce Summary for the 2 months ending 31 May 2021

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

£m including Perm, Bank and Agency	2020/21 actual full year			2021/22 actual			Variance			RAG
Staff Group	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	56.5	1,193.8	47.4	10.0	1,253.9	47.7	(0.6)	(0.5)	(0.1)	R
Consultants	60.3	387.7	155.5	10.2	405.0	151.1	(0.2)	(0.4)	0.3	A
Estates & Ancillary Staff	4.7	138.7	33.7	0.8	133.0	34.2	0.0	0.0	(0.0)	G
Healthcare Assist & Supp	11.3	325.9	34.7	1.8	317.2	34.4	0.1	0.1	0.0	G
Junior Doctors	31.4	377.0	83.2	5.3	389.8	81.9	(0.1)	(0.2)	0.1	A
Nursing Staff	89.8	1,600.9	56.1	15.1	1,611.2	56.3	(0.1)	(0.1)	(0.0)	A
Other Staff	0.7	12.3	53.8	0.1	15.6	52.1	(0.0)	(0.0)	0.0	G
Scientific Therap Tech	56.9	981.8	58.0	9.5	1,006.4	56.8	(0.0)	(0.2)	0.2	G
Total substantive and bank staff costs	**311.6**	**5,018.1**	**62.1**	**52.9**	**5,132.2**	**61.8**	**(0.9)**	**(1.2)**	**0.3**	R
Agency	3.7	28.3	129.4	0.4	25.4	101.8	0.2	0.1	0.1	G
Total substantive, bank and agency cost	**315.2**	**5,046.4**	**62.5**	**53.3**	**5,157.6**	**62.0**	**(0.7)**	**(1.1)**	**0.4**	R
Reserve*	1.9	0.3		0.2	0.0		0.2	0.2	0.0	G
Additional employer pension contribution by NHSE	12.4	0.0		0.0	0.0		2.1	0.0	2.1	G
Total pay cost	**329.6**	**5,046.6**	**65.3**	**53.5**	**5,157.6**	**62.2**	**1.5**	**(1.0)**	**2.4**	G
Remove maternity leave cost	(3.1)			(0.6)			0.1	0.0	0.1	G
Total excluding Maternity Costs	**326.4**	**5,046.6**	**64.7**	**52.9**	**5,157.6**	**61.5**	**1.5**	**(1.0)**	**2.5**	G

*Plan reserve includes WTEs relating to the better value programme

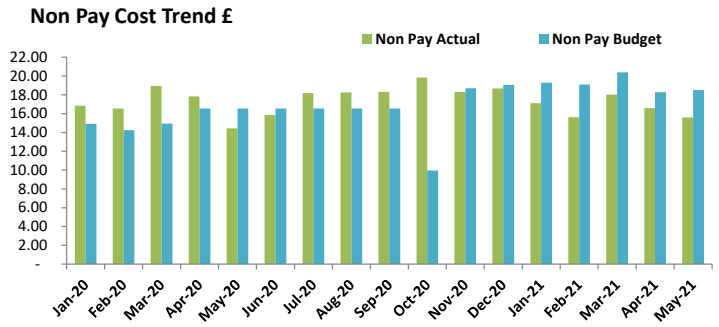


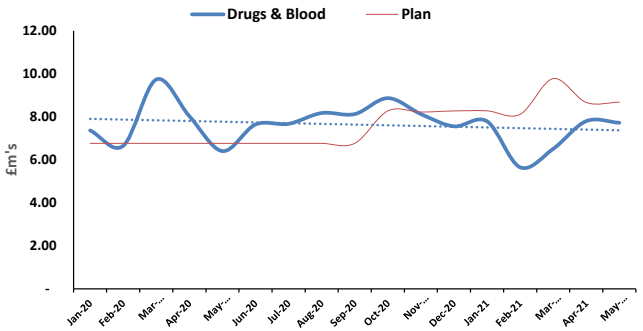


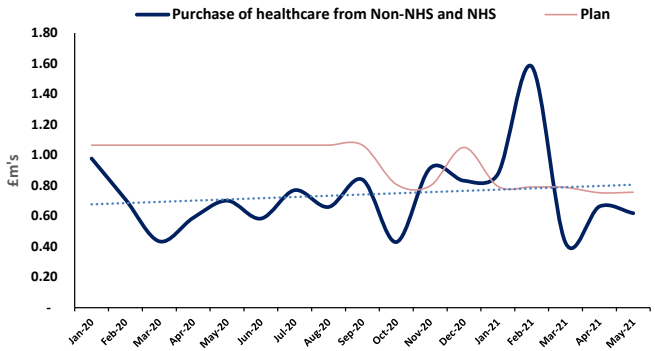
Summary

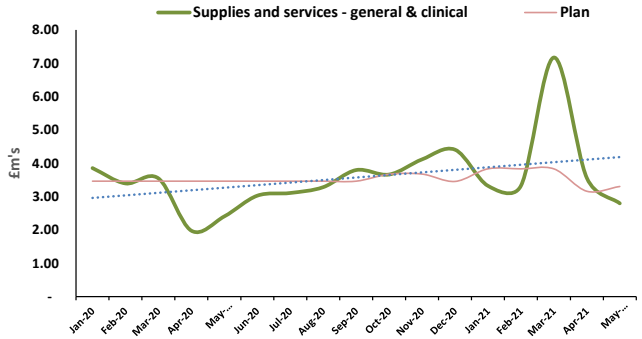
- Pay costs are slightly above plan in-month (£0.2m) due to continued high levels of staffing as a result of Covid which has resulted in low levels of staff turnover. The Trust is receiving reimbursement for costs relating to Covid and as a result there will be corresponding income for those pay costs identified.
- The largest change in volume and price mix comparing prior year to current year is in the Trust administrative staffing line; this is driven from EPR staff costs that were no longer able to be capitalised due to completion of works now having to be recognised within the revenue position of the Trust. This happened in M10 in the prior year and therefore the average WTEs last year only had a partial effect included for this change.
- Month 2 has seen lower non-nursing bank usage across the Trust; reduction in admin bank has been driven by a reduction in sickness backfill and staff no longer being required to support the vaccine clinic. Furthermore, the closure of Dolphin in April has resulted in lower consultant bank usage this month.
- Nursing bank has remained lower this year than last given less sickness backfill and with the closure of Dolphin. Further controls have been implemented by the operational teams to monitor bank usage requests and changes by each ward in order to keep this spend controlled.
- High levels of admin agency staff continues due to additional senior assistance for the ICT directorate. Agency spend in the Trust is monitored and consideration is given as to whether resources can be secured through the bank or fixed term contracts in order to reduce this cost.
- Pay costs may continue to rise in the year given plans in development to begin accelerating activity in order to reduce patient waiting times as a result of delays due to Covid-19.

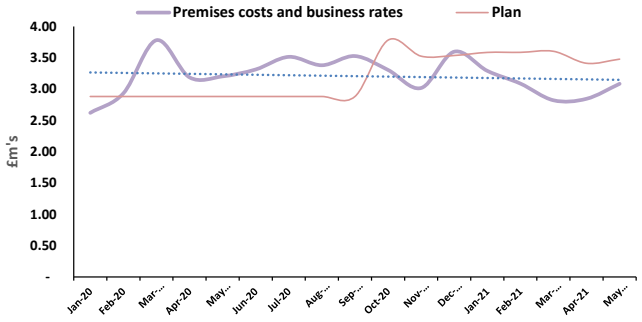
Non-Pay Summary for the 2 months ending 31 May 2021











Summary

- Non pay is £3.0m favourable to the plan in-month. This is driven by a number of element across the Trust as follows:
    - Impairment of receivables being £0.7m favourable to plan in-month given continued payments and reduced new activity, meaning overall aged debt is decreasing. This has been calculated in line with IFRS9 and the Trust's policy.
    - Drugs expenditure being £0.8m favourable to plan due to lower than plan usage (including CAR-T)
    - Clinical supplies and services is £0.7m lower than plan due to reduced spend on lab consumables, reagents and a plastic consumable shortage which is restricting activity
    - Premises costs being £0.4m favourable to plan due to reduced utility and maintenance costs, partially driven by lower than anticipated Covid costs which is offset by a corresponding reduction in income for covid cost funding.
- Covid costs are lower than planned in-month (£1.5m) for which there is a corresponding lower than plan income for Covid cost funding (£1.9m YTD). It is expected that non-pay costs will rise with additional elective, day case and outpatient activity as this continues, the opening of the Sight & Sound building and when further EPR optimisation work increases later in the year.
- Purchase of Healthcare from NHS and non-NHS & supplies and services in M2 has remained broadly on trend comparable to prior year. Additional activity is likely to be completed in order to reduce patient backlogs and therefore it is expected that these costs will rise in the coming months (including for higher IPP activity levels).

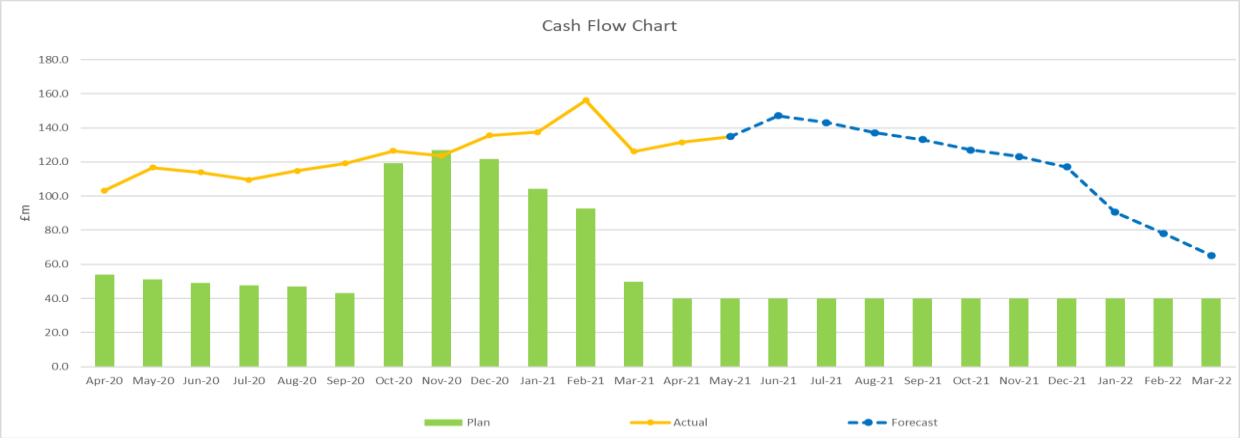
Cash, Capital and Statement of Financial Position Summary for the 2 months ending 31 May 2021

31 Mar 2021 Audited Accounts £m	Statement of Financial Position	YTD Actual 30 Apr 21 £m	*YTD Actual 31 May 21 £m*	In month Movement £m
532.75	Non-Current Assets	531.13	529.94	(1.19)
64.56	Current Assets (exc Cash)	62.60	72.73	10.13
126.19	Cash & Cash Equivalents	131.46	134.93	3.47
(102.80)	Current Liabilities	(108.42)	(115.18)	(6.76)
(6.45)	Non-Current Liabilities	(6.28)	(6.24)	0.04
614.25	**Total Assets Employed**	**610.49**	**616.18**	**5.69**

31 Mar 2021 Audited Accounts £m	Capital Expenditure	YTD plan 31 May 21 £m	YTD Actual 30 May 2021 £m	YTD Variance £m	Forecast Outturn 31 Mar 2022 £m	RAG YTD variance
6.50	Redevelopment - Donated	1.10	0.90	0.20	15.20	A
2.56	Medical Equipment - Donated	0.00	0.08	(0.08)	2.72	R
0.00	ICT - Donated	0.00	0.00	0.00	0.00	G
9.06	**Total Donated**	**1.10**	**0.98**	**0.12**	**17.92**	A
0.00	Total Grant funded	0.00	0.00	0.00	0.46	G
5.09	Redevelopment & equipment - Trust Funde	0.78	0.77	0.01	7.22	G
1.10	Estates & Facilities - Trust Funded	0.31	0.05	0.26	6.53	R
2.67	ICT - Trust Funded	0.13	0.12	0.01	3.86	G
0.00	Contingency	0.00	0.00	0.00	0.39	G
8.86	**Total Trust Funded**	**1.22**	**0.94**	**0.28**	**18.00**	A
2.56	**PDC**	**0.00**	**0.00**	**0.00**	**0.00**	G
20.48	**Total Expenditure**	**2.32**	**1.92**	**0.40**	**36.38**	A

31-Mar-21	Working Capital	30-Apr-21	31-May-21	RAG	KPI
5.0	NHS Debtor Days (YTD)	3.0	3.0	G	< 30.0
288.0	IPP Debtor Days	281.0	271.0	R	< 120.0
27.1	IPP Overdue Debt (£m)	26.1	25.1	R	0.0
95.0	Inventory Days - Non Drugs	82.0	119.0	R	30.0
31.0	Creditor Days	34.0	31.0	A	< 30.0
41.6%	BPPC - NHS (YTD) (number)	67.4%	53.8%	R	> 90.0%
70.6%	BPPC - NHS (YTD) (£)	75.7%	84.0%	R	> 90.0%
83.4%	BPPC - Non-NHS (YTD) (number)	66.4%	75.2%	R	> 90.0%
88.9%	BPPC - Non-NHS (YTD) (£)	93.1%	91.0%	G	> 90.0%

RAG Criteria:
NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 90%); Amber (90-85%); Red (under 90%)
IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (over 150 days)
Inventory days: Green (under 21 days); Amber (22-30 days); Red (over 30 days)



Comments:

1. Capital expenditure for the year to 31 May was less than plan by £0.4m: Trust-funded expenditure was less than plan by £0.3m; donated was on less than plan by £0.1m.
2. Cash held by the Trust increased in month by £3.5m.
3. Total Assets employed at M02 increased by £5.7m in month as a result of the following:
   - Non current assets totalled £529.9m, a decrease of £1.2m in month
   - Current assets excluding cash totalled £72.7m, an increase of £10.1m in month. This largely relates to the following: Contract receivables including IPP which have been invoiced (£3.2m lower in month); accrued income (£10.3m higher in month); capital receivables (£0.2m higher in month) and Other non NHS receivables (£2.2m higher in month).
   - Other non NHS receivables includes prepayments (£1.5m higher in month)
4. IPP debtors days decreased in month from 281 days to 271 days. Total IPP debt decreased in month to £23.5m (£26.3m in M01). Overdue debt decreased in month to £25.1m (£26.1m in M01).
5. The cumulative BPPC for NHS invoices (by value) increased in month to 84% (76% in M01). This represented 54% of the number of invoices settled within 30 days (67% in M01)
6. The cumulative BPPC for Non NHS invoices (by value) decreased in month to 91% (93% in M01). This represented 75% of invoices settled within 30 days (66% in M01)
7. Creditor days decreased in month from 34 days to 31 days.

Attachment V

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7 July 2021

Safe Nurse Staffing Report for reporting period April 21 **Submitted by: Alison Robertson, Chief Nurse.** **Prepared by: Marie Boxall, Head of Nursing - Nursing Workforce**	**Paper No: Attachment V** **□ For information and noting**

Purpose of report

To provide the Board with an overview of the nursing workforce during the month of April and May 2021 and in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing (2016) and further supplemented in 2018. It provides assurance that arrangements are in place to safely staff the inpatient wards with the right number of nurses with the right skills and at the right time.

Summary of report

- 31 international nurse have joined the trust to date, with 8 more in the pipeline. The Philippines remains on the 'Red List' countries which has led to additional challenges and unplanned costs.
- 111 Newly Qualified Nurses have been offered positions for Sept 2021, we expect a 30% attrition rate.
- The Trust nursing vacancy rate showed a decrease in April 2021 to 1.1% and 2.76% in May 2021, which is a significant decrease on the previous month and long term average. The decrease is driven predominantly by a reduction in the budget lines (-65 WTE on March 2021) rather than increased staff in post, and has been disputed by the Heads of Nursing and escalated appropriately. This is currently under review by the AD for HR & OD.
- There has been a significant drop in temporary staff usage compared to previous months, this has been attributed to the end of external deployments and staff vaccination clinics.
- There were a total of four Datix incidents during the reporting period. No patient harm occurred.
- The reported Care Hours Per Patient Day (CHPPD) was 16.51 in April and 16.24 in May, and recently published CHPPD was benchmarked against other Children's Trusts.

Action required from the meeting

To note the information in this report on safe nurse staffing which reflects actions as the trust experiences the second surge in the pandemic while maintaining care for priority patients and supporting general paediatric activity.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
□ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people **□ Quality/ corporate/ financial governance**	**□ Leadership, capacity and capability** **□ Vision and strategy** **□ Culture of high quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance** **□ Accurate data/ information**

Attachment V

Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.	**□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**
Strategic risk implications BAF Risk 2: Recruitment and Retention	
Financial implications Already incorporated into 21/22 Directorate budgets.	
Implications for legal/ regulatory compliance Safe Staffing	
Consultation carried out with individuals/ groups/ committees Nursing Board, Nursing Workforce Assurance Group	
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Nurse, Director of Nursing and Heads of Nursing	
Who is accountable for the implementation of the proposal / project? Chief Nurse; Directorate Management Teams	
Which management committee will have oversight of the matters covered in this report? People and Education Assurance Committee	

Attachment V
Safe Staffing Trust Report July 2021

Great Ormond Street Hospital for Children NHS Foundation Trust

1. Purpose

This paper provides the required assurance that GOSH had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage patient demand and capacity. This report covers the reporting period for April and May 2021.

2. Recruitment

We continue to maintain a number of recruitment pipelines to ensure the resilience and sustainability of our nursing workforce, especially as restrictions lift. The Philippines continues to remain on the 'Red List' countries which has posed additional challenges and costs, however we are working to support the arrival of those nurses who are ready and in a position to safely be deployed to the UK.

2.1 International Nurses (GOSH 50) –

31 international nurse have joined the trust to date:

- Cohort 1: (11 Candidates) 11 nurses now fully registered with the Nursing and Midwifery Council (NMC) and working in their clinical areas as Band 5 Registered Nurses.
- Cohort 2: (12 candidates) Currently studying and towards their Objective Structured Clinical Examination (OSCE) exams scheduled for the 22nd June 2021, working in a Band 3 unregistered capacity in their clinical settings.
- Cohort 3: (8 candidates) Arrived on 21st May 2021 and are currently studying towards their OCSE exam scheduled for 1st July.
- Cohort 4: (8 candidates) Preliminary Arrival Date: Friday 30th July 2021
- Cohort 5: (number TBC) Preliminary Arrival : September 2021 TBC

2.2 Newly Qualified Nurses (NQNs) –

The recruitment of our next cohort of NQNs for September has been completed with 111 offers made. We usually expect to see an average attrition rate of approx. 30% on this number (pre Covid pattern) and have also been advised by the education team that there may be a delay in some nurses completing on time due to disrupted studies as a result of the pandemic.

2.3 Healthcare Support Workers (HCSWs) – Band 2

7 Band 2 HCSW were appointed to join the May 2021 cohort.

2.4 Experienced Nurses

Following on from the NQN virtual open day we are planning a targeted virtual recruitment open day for experienced nurses on the 14th July to sustain this pipeline and support areas with high vacancy and/or those with a junior skill mix. We have also launched a focused recruitment drive for the Heart & Lung Directorate and in particular CICU.

3. Vacancy and Turnover Rates

The Trust Nursing Vacancy rate provided by the Workforce Information Team showed a decrease in April 2021 to 1.1% which is a significant decrease on the previous month and the long term average. The rate started to rise again in May moving to 2.76% overall, however this is still the 2nd lowest rate in the last 12 months. The decrease is driven predominantly by a reduction in the budget lines (minus 65 WTE on March 2021) rather than increased staff in post, and the Trust Human Resource (HR) team & Finance team are working together to urgently review and

validate the source numbers. This has been discussed at Nursing Workforce Assurance Group (NWAG) and escalated to the Director of Nursing, Deputy Director of HR and OD and the Deputy Head of Financial Management, as the 21/22 budgeted establishments have not been determined using the recommended process as outlined in the Staffing Establishment Review Report and Safe Staffing Policy, which follows NHSEI and National Quality Board (NQB) guidance. This reduction in budgeted lines impacts on data which informs safe staffing intelligence such as Safe Care, Rostering and Planned Care Hours per Patient Day (CHPPD) and therefore our ability to monitor and provide assurance.

Meanwhile the Nursing Workforce Team has linked in with directorate nursing teams to manually gather local intelligence on vacancies, and can confirm that the actual RN vacancy rate has remained stable at approx. 4% with 62 WTE vacancies across the trust (June 2021). The top two areas contributing to this rate are Heart & Lung (H&L), with a focused recruitment campaign underway and International & Private Care (I&PC). However with the closure of Hedgehog Ward, staff have been deployed to Bumblebee Ward therefore maintaining high nursing/patient ratios within this directorate.

In terms of recruitment there were 29 (27.8 WTE) new starters in April, offset by 20 (18.2 WTE) leavers. In May there were 8 starters (6.13 FTE) offset by 17 Leavers (15.30 FTE).

Voluntary turnover has increased slightly in April to 13% and reduced in May to 12.63% and remains below the Trust target of 14%.

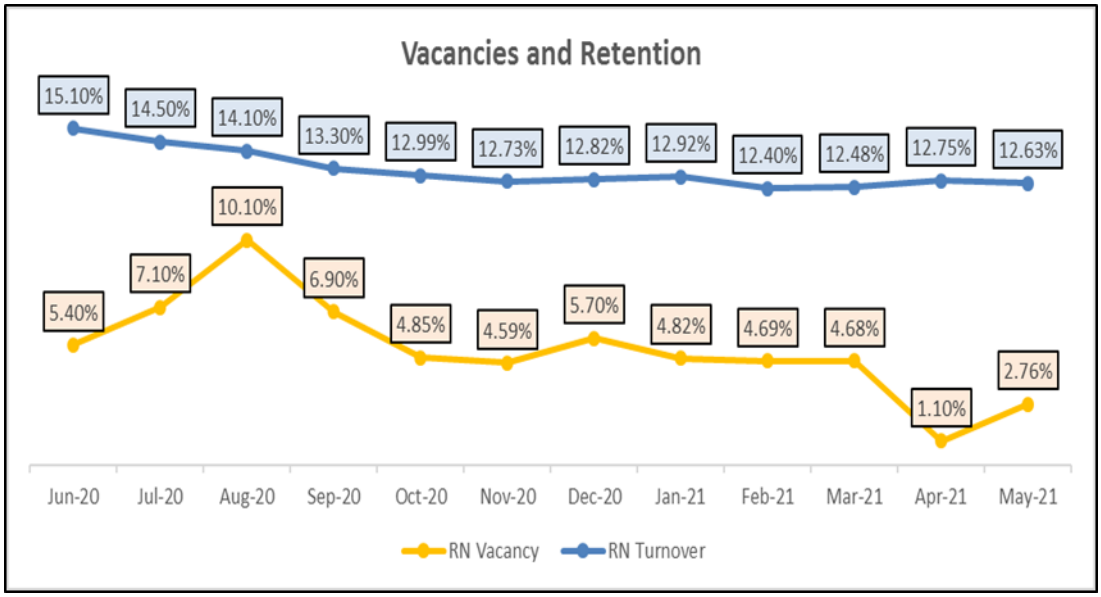


Fig.1 *Registered Nurse vacancy and voluntary turnover rate (12 month view)*

4. Temporary Staffing

The total shifts requested (excluding shifts requested then subsequently cancelled) reduced significantly in April to 1935 and May to 2155 from 3089 in previous months. Of these 80% were filled which is a decrease of 4% on the previous month. Agency usage (4 shifts) remained very low at 0.2%. The reduction in requests for temporary staffing during this period has been driven by the end of external deployments and cessation of the vaccination clinics. However we anticipate an increase in requests as

a result of the 'Accelerator' programme, and the impact of additional annual leave carried over into the new financial year.

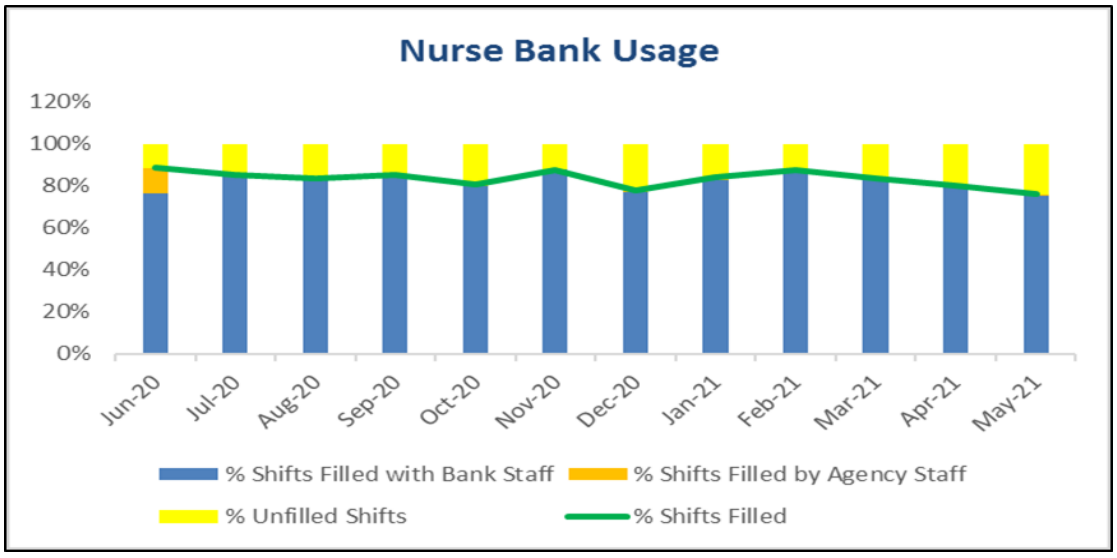


Fig.2 *Nurse Bank Usage (12 month view)*

5. Care Hours Per Patient Day (CHPPD)

CHPPD is calculated by adding the hours of Registered Nurses (RNs) and Healthcare Assistants (HCAs) available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported to provide a complete picture of care and skill mix. CHPPD data is uploaded onto the national Strategic Data Collection Service (SDCS) and published on NHS Model Hospital on a monthly basis.

CHPPD includes total staff time spent on direct patient care but also on activities such as preparing medicines, updating patient records and sharing care information with other staff and departments. It covers both temporary and permanent care staff but excludes nursing students and staff working across more than one ward. CHPPD relates only to hospital wards where patients stay overnight. From April 2021 Trust level CHPPD will include the ICUs.

The reported CHPPD for April 2021 was 16.51 made up of 14.40 Registered Nurses and 2.11 HCA Hours and in May 2021 was 16.24 made up of 14.14 Registered Nurses and 2.10 HCA Hours.

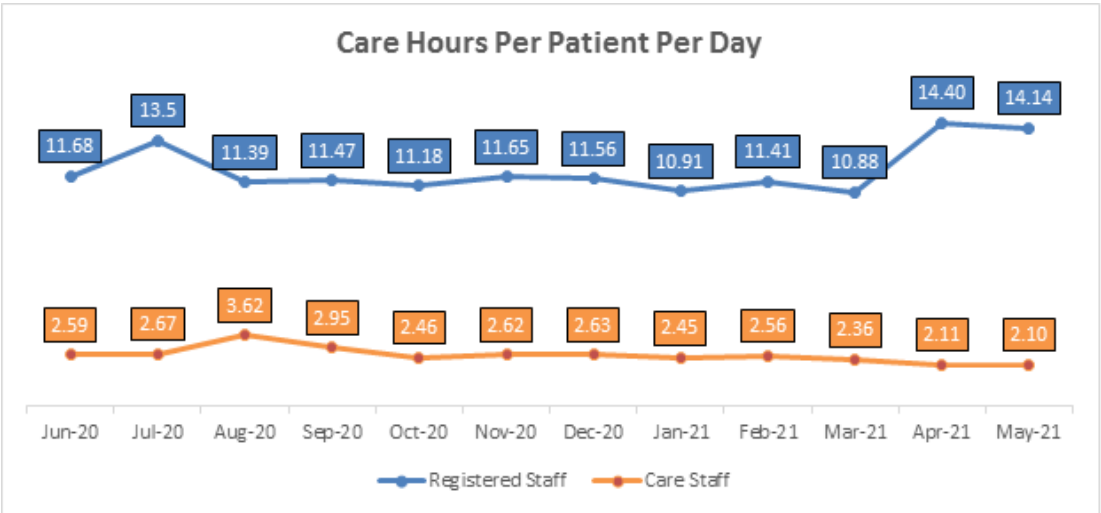


Fig. 3 *Care Hours per Day – Breakdown (12 month view)*

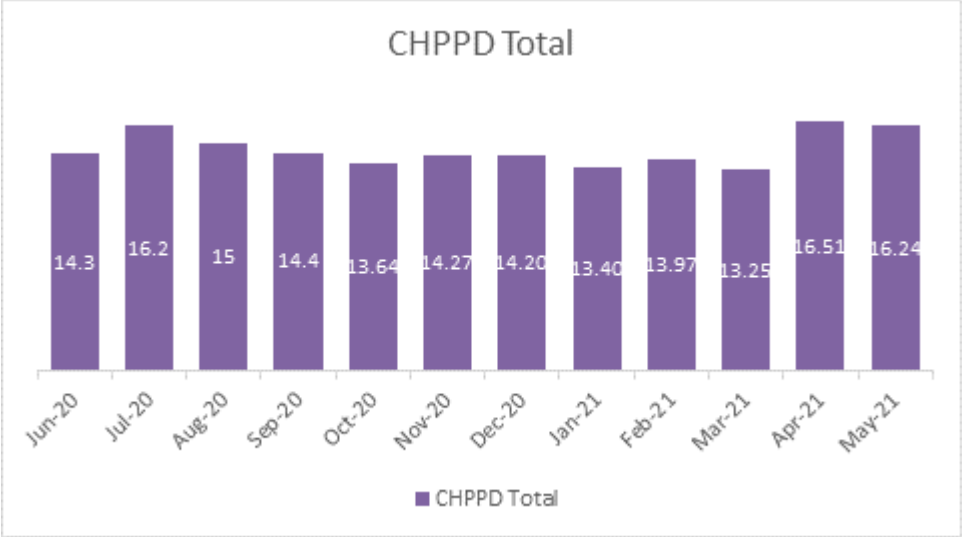


Fig. 4 *Care Hours per Day - Total (12 month view)*
N.B. As of April 2021 the reported Trust level CHPPD will include the ICUs in line with other trusts

To benchmark against some of our peers, the table below (Fig. 5) compares the most recent nationally published figures which include the ICUs (March 2021).

Organisation	Code	Total CHPPD	Total RN CHPPD	Total HCA CHPPD
Great Ormond Street Hospital For Children NHS Foundation Trust	RP4	15.97	13.98	2
Alder Hey Children's NHS Foundation Trust	RBS	19	16.54	2.47
Sheffield Children's NHS Foundation Trust	RCU	12.75	9.31	3.37
Birmingham Women's And Children's NHS Foundation Trust	RQ3	12.43	9.88	2.4

Fig. 5 *CHPPD Peer Comparison*

Reporting of accurate Actual vs Planned CHPPD on a monthly basis is a regulatory requirement. The Workforce Information Team are currently trialling a new process for extracting Actual vs Planned CHPPD based on the new budgets and demand templates on 3 wards/units (PICU, Squirrel, Koala) whilst parallel running of the original data. Once the budgets have been reviewed and the data has been validated the process will be replicated across the Trust.
The Clinical Operations team, Electronic Patient Records (EPR) team and the Workforce Information team have developed a 'beds staffed' functionality within EPIC which will also allow for more accurate reporting and refinement of the methodology.

6. Incident Reporting

Attachment V
Safe Nurse Staffing Report for reporting period April & May 2021

In April and May there were two reported safe staffing incidents in the Operations & Imaging (O&I) directorate. Both incidents have been investigated by the Head of Nursing (HoN) and assurance provided that appropriate action has been taken to prevent reoccurrence and confirmation that no patient harm occurred.
In May there were an additional two safe staffing incidents for nursing - one for Brain and one for H&L. Assurance has been provided by the HoN & Matron respectively that no patient harm occurred and recruitment plans are in place to reduce the likelihood of reoccurrence.

7. Safe Staffing for Nursing Policy

The new Safe Staffing Policy for Nursing which fully aligns with NHSEI Developing Workforce Safeguards Guidance (NHSEI 2018) was approved by the Policy Advisory Group (PAG) on the 9th June, and is now live.

Attachment W

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board **7 July 2021**	
Safeguarding Children, Young People & Adults Annual Report 2020/21 **Submitted by:** Alison Robertson, Chief Nurse and Executive Lead for Safeguarding	**Paper No: Attachment W** □ **For approval** □ **For discussion** ✓ **For information and noting**
Purpose of report To present an annual review of the safeguarding children, young people and adults activities and arrangements during 2020/21.	
Summary of report The purpose of this report is to provide assurance to the Board that the safeguarding arrangements to protect our patients and staff, are safe, robust and fit for purpose. In reviewing these activities during the very challenging period of a global pandemic, the report provides good evidence that the Safeguarding Service was able to meet the demands of an evolving health economy, a reduction in staffing due to re-deployment and illness and adaptions to new ways of working. During the year, two new essential services were launched, the Deprivation of Liberty Safeguards and the Perplexing Presentation Support Service. The Safeguarding Service acted swiftly to review policies and processes, following the arrest and conviction of the hospital porter for abuses against children, to ensure any risks were minimised and gaps closed. They worked closely with an extensive number of teams internally and external regulators, to provide assurance of the safeguarding arrangements. Highlights of Key Priorities for 2021/22 • Development of Safeguarding Strategy (including review of mandatory training and supervision policy). • Development of a Domestic Abuse Strategy, in-conjunction with Camden's Violence against Women & Girls (VAWG) Services. • Preparation for the Implementation of Liberty Protection Safeguards • External Independent Review of GOSH safeguarding arrangements during Q4 2021/22.	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust priorities:	**Contribution to compliance with the Well Led criteria:** ✓ **Leadership, capacity and capability**

✓ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** ✓ **PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** ✓ **PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training** ✓ **Quality/ corporate/ financial governance**	✓ **Vision and strategy** ✓ **Culture of high quality sustainable care** ✓ **Responsibilities, roles and accountability** ✓ **Effective processes, managing risk and performance** ✓ **Accurate data/ information** ✓ **Engagement of public, staff, external partners** ✓ **Robust systems for learning, continuous improvement and innovation**
Strategic risk implications BAF Risk 12: Inconsistent delivery of safe care	
Financial implications Not Applicable	
Implications for legal/ regulatory compliance <u>For noting:</u> The Trust has arrangements and adherence to The Mental Capacity Act (MCA) and its practical application, which includes the completion of the Deprivation Of Liberty Safeguards (DoLs) applications within the 72 hour legal timeframes to the Court of Protection, to patients over the age of 16 and their families at GOSH. The adherence to DOLS is an interim measure prior to the commencement of LPS expected in April 2022. In order to safeguard patients aged 16 and 17 and those over the age of 18 years effectively, the trust is required by Law to comply with the MCA and DoLs.	
Consultation carried out with individuals/ groups/ committees Operational Safeguarding Group Strategic Safeguarding Committee	
Who is responsible for implementing the proposals / project and anticipated timescales? Nurse Consultant Safeguarding/Named Nurse	
Who is accountable for the implementation of the proposal / project? Chief Nurse and Executive Lead for Safeguarding	
Which management committee will have oversight of the matters covered in this report? Strategic Safeguarding Committee	

Attachment W

ANNUAL REPORT 2020 - 2021

SAFEGUARDING CHILDREN, YOUNG PEOPLE & ADULTS

Michelle Nightingale
Nurse Consultant
Safeguarding/Named Nurse

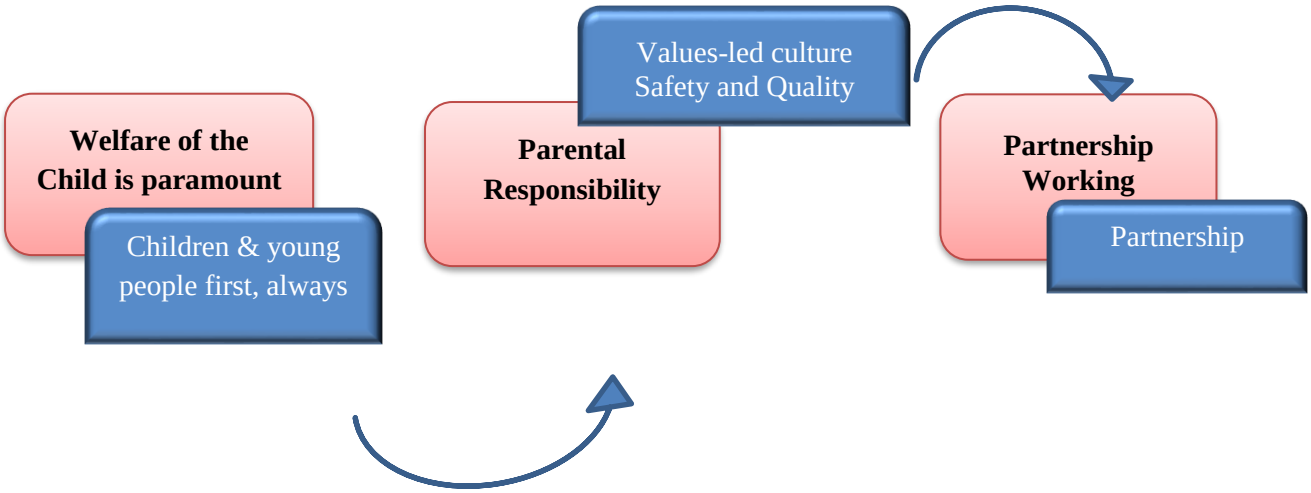
Lauren Whyte
Safeguarding Adults Lead
Senior Safeguarding Nurse Advisor
Children & Adults

Contents

1. Introduction

This report provides an overview of the safeguarding service activity across the Trust. It provides the Board with assurance that the service meets the Trust's vision and values, in protecting children, young people and adults from harm. The remit is for children (0 – 18 years), registered with organisation, visiting children and the children of adult patients, within a holistic approach of 'Think Family' [1]

A number of the Trust's Principles is in line with the key legislative framework of the Children Act 1989 and 2004:



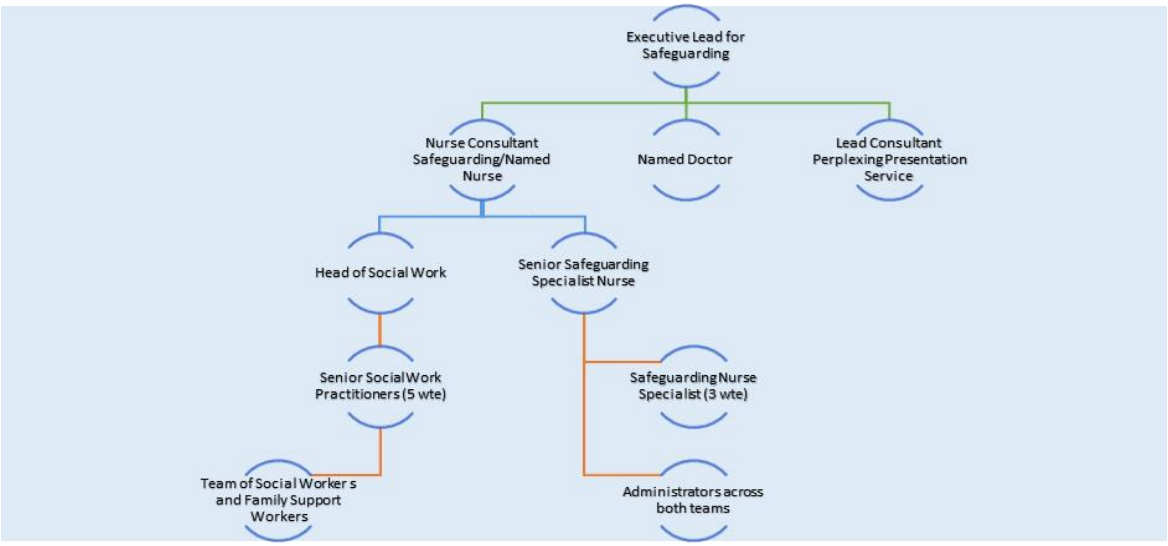
Children & young people first, always
The focus of care must be in the child's best interest, including consideration for their views, wishes and feelings, where appropriate. Recommendations from national and local Child Safeguarding Practice Reviews highlight the need to listen to children and involve them in decision making of their own care. Section 11 of the Children Act 2004, states there should be 'a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services.'

Values-led culture/Safety and Quality
All parents and carers who hold parental responsibility (PR) need to have their views and wishes for their child respected. It is important that consideration is always given to cultural or religious beliefs, language barriers, parental disabilities or other illnesses, as well differing parenting approaches with regards to the best outcomes for the child. The team work collaboratively with multi-disciplinary teams across the Trust to support families and always ensure that any engagement with families is supportive, offering signposting for those in need to appropriate services.

Partnership
The Safeguarding Service work closely across the UK and internationally with partner agencies from the child's or adult's locality, including police, children's social care, education, adult services and health organisations. Section 11 of the Children Act 2004, 'places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.'

[1] Think Family is the approach used by the Troubled Families programme to encourage services to deal with families, rather than responding to each problem, or person, separately.

2. Safeguarding Service Structure



Safeguarding Service Structure 2021

Safeguarding Service Leadership

The past year for Safeguarding has been a time when long-term projects have come to fruition, but also where we have adapted our traditional ways of working to meet the challenges that have presented over the course of the Covid 19 pandemic, there has been huge amount of change and transition within the safeguarding service with the retirement of the named professionals within the organisation and the recruitment of a new safeguarding senior team.

- Nurse Consultant Safeguarding/Named Nurse, Michelle Nightingale commenced in post on 16 November 2020
- Named Doctor, Deborah Zeitlin commenced in post on 1 September 2020
- Head of Social Work, Elleni Ross commenced in post on 5 October 2020
- Perplexing Lead Consultant, Alison Steele commenced in September 2020, leading on the Perplexing Presentation Support Service.
- Lauren Whyte, Senior Safeguarding Nurse Advisor (Children & Adults) commenced substantive post in June 2021

Governance Structure

The Strategic Safeguarding Committee meeting is attended by the Designated Nurse and Doctor from Camden Clinical Commissioning Group, to provide assurance to the CCG and NHS England & Improvement.

3. Performance and achievements

During 2020/21 we:

- Received and triaged 2,337 referrals via EPR. This is a 27% increase on the previous year with GOSH social work now responding to over 600 referrals per quarter since Epic was fully embedded in 2020. CP-IS notifications account for a large proportion of this increase as we are now notified of every single patient who is in care of the Local Authority or is subject to a Child Protection plan via this automated system.

- GOSH social workers have referred 163 patients to Local Authority social services this is a 44% increase on the number of referrals made in 2019/20.

- Co-ordinated the social and safeguarding needs of 308 children subject to Child Protection Plans (CPP)

- Ensured that Looked After Children's (LAC) needs were met, including coordinating the complexity of obtaining appropriate consent for procedures.

- The Team attended 286 virtual external child protection related meetings to represent or support staff.

- The Legal Team provided approximately 40 reports to Local Authorities where the Safeguarding Team was also involved.

- The Legal Team received approximately 550 requests for medical records and of approximately half of these, Safeguarding were asked to confirm whether or not they had relevant involvement and, if they did, to review and advise on disclosure due to safeguarding concerns.

- Covid 19 North Central London Response: Co-ordinated multi-disciplinary and multi-agency weekly meetings for patients from NCL partner hospitals – Chaired by the Nurse Consultant Safeguarding or Head of Nursing for Body, Bone & Mind.

4. Service Delivery

Despite the challenges of the global Covid-19 pandemic, the Safeguarding Service adapted its provision to meet the varying increasing demands emerging from an unprecedented situation.

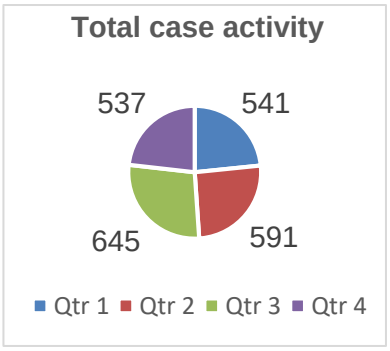
This is reflected in the increase in complex cases and therefore demand to the safeguarding teams within GOSH due to the national and international tertiary nature of the organisation. The majority of the under 18 year old patients remain registered with the Trust for much of their young lives, resulting in many safeguarding cases remaining open until formal discharge.

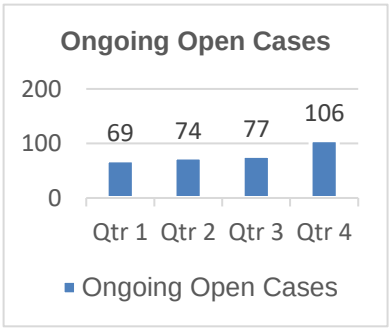
The Social Work and Safeguarding Teams continue to work closely together. All internal referrals are now sent via EPR to Social Work and Safeguarding. There is a daily Social Work and Safeguarding Hub Meeting (SWASH) to discuss any child protection level referrals. The duty social work manager and duty social worker along with the duty safeguarding nurse make an initial decision to agree tasks required.

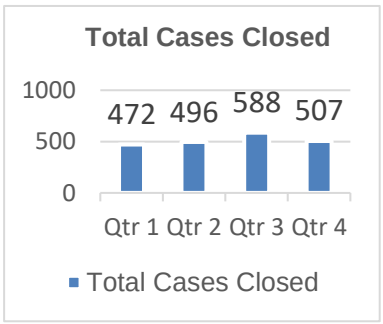
1. Partnership Working

The tables below provide an overview of the patient activities and nature of the referrals received into the team.

I. Safeguarding Interventions

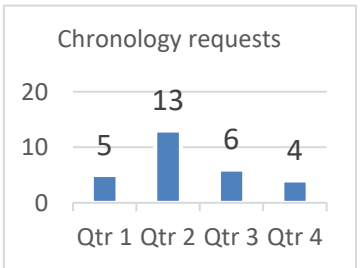


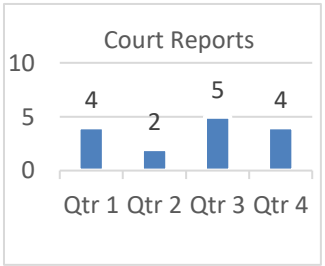




Over the year 2020/2021 referrals to the safeguarding team have significantly increased in comparison to the previous year. This can be attributed to a number of factors, including:

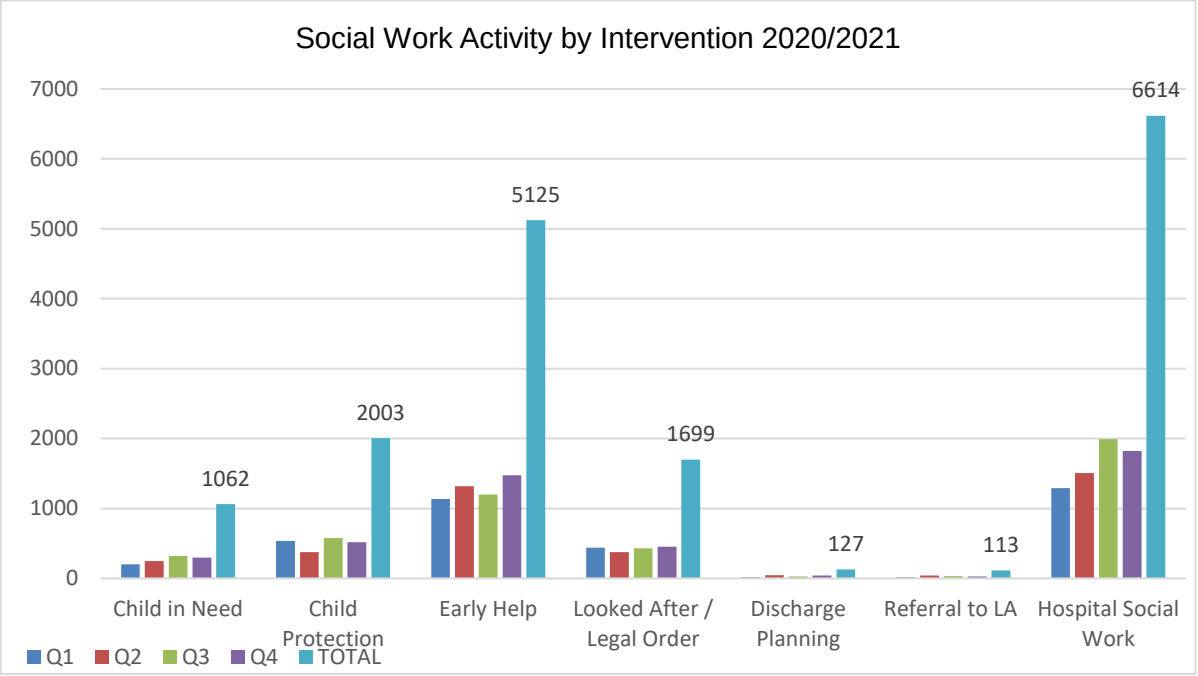
- The introduction of the pilot Child Protection Information System (CP-IS) into the EPR platform, leading to increase information gathering and sharing with Local Authorities.
- Increase in in-patient referrals during two Covid-19 lockdowns; in particular the increase of patients transferred to GOSH from the North Central London Hospitals network.





The Safeguarding Service provides safeguarding chronologies for case reviews, as well as court reports when requested by the Local Authority or Courts in-conjunction with the Legal team.

II. GOSH Social Work Activity



In 2019 the GOSH social work team created a new category of Hospital Social Work for work that has safeguarding elements or high social needs but does not meet threshold for Local Authority Safeguarding input whether that be Child in Need plans or Child Protection plans.

Child protection includes work carried out for children who are subject to a Child Protection plan or have current concerns that meet the threshold for a Section 47 Child Protection investigation.
Early Help refers to work undertaken primarily by Family Support Officers to assist families with practical matters such as debt, housing matters, welfare advice and making charity applications.
The total number of interventions for social work is 16,743 which shows an increase of 31% on the previous year's activity.

- **The main GOSH Social Work service**

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

- **Young Lives vs Cancer Team (Formerly CLIC Sargent**

In 2020 / 2021, the CLIC Sargent team structure has remained stable although there have been individual staff changes, meaning that the team has not been fully staffed more than 2 months at any one time.

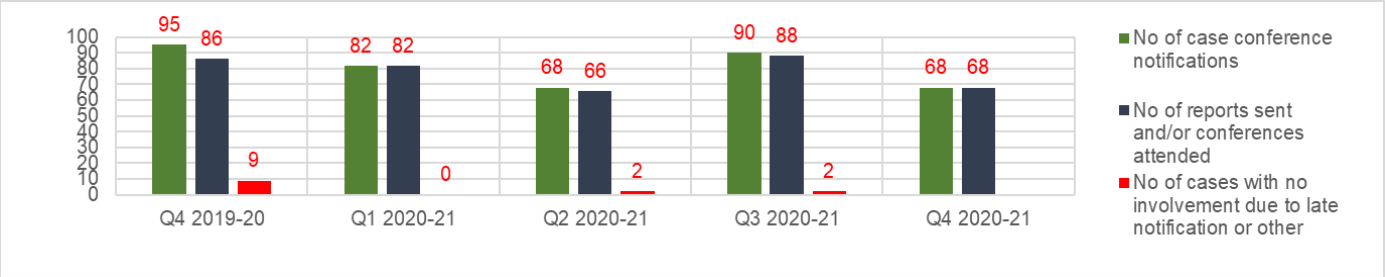
CLIC Sargent's fundraising has been affected by COVID-19. In an effort to ensure longer-term continuity of service, Social Work teams across CLIC Sargent have reduced their hours by 20% from mid-April 2020. Additionally, COVID-19 has led to all CLIC Sargent staff having to work from home from mid-March 2020. Despite these significant pressures, the CLIC Sargent team at GOSH has continued to

provide a service for all families of cancer patients treated at GOSH. They have also continued to facilitate our weekly parent/carer support group - previously held on the ward but now via virtual meeting.

III. Children subject to a Child Protection Plan (CPP)

GOSH is the first scheduled Tertiary Centre in the UK to pilot the Child Protection Information Sharing (CP-IS) digital platform via NHS Digital. CP-IS enhances information sharing between health and social care of vulnerable children subject to a Child Protection Plan or is a Looked After Child (LAC), from any Local Authority across the country, who attend non-scheduled health care such as Accident & Emergency or Urgent Care. The pilot will be audited during 2021/22 for effectiveness.

Figures below provide data of CP Conference notifications and attendance.



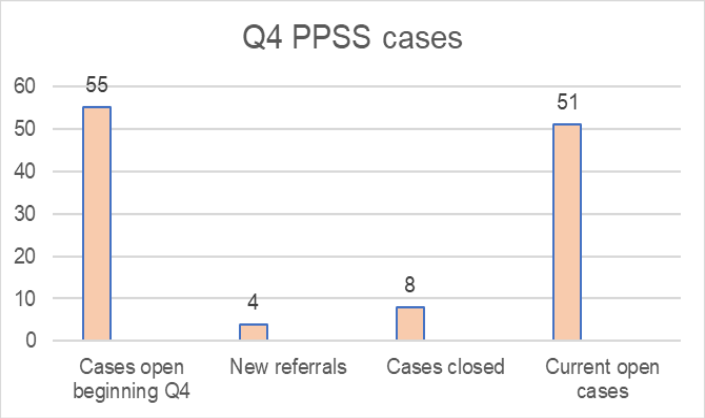
IV. Perplexing Presentation Support Service (PPSS) – 1 year Pilot to September 2021

This is a 1 year pilot service to address the increasing numbers of complex, possible Fabricated or Induced Illness cases. The core team includes; the Trust Lead for Perplexing Presentations, Lead General Paediatrician, Head of Social Work, Safeguarding Nurse Specialists and the team Co-ordinator, the meetings have continued running bi-weekly as indicated by the needs of the service. During this quarter the core team has also been supported by supervision with PAMHS Consultant Psychiatrist.

PPSS Core Multi-Disciplinary Team (MDT) occurs once every other week to discuss ongoing cases, within these core group meetings there have been 43 case discussions. In addition to these meetings there have been a further 17 MDT meetings facilitated to gain further clarity, discussions to agree a health consensus or planning next steps and sharing relevant health information amongst internal/external professionals.

In addition to MDT meetings there has been liaison with internal and external health professionals, with 193 interventions including telephone calls and email correspondence.

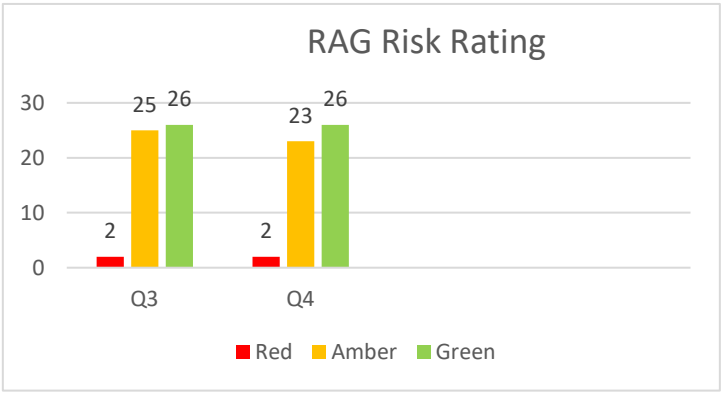
The PPSS pilot is currently being evaluated for effectiveness, with a view to being rolled out across the Trust. It is recognised that once the service is formally shared across the Trust the team may see a rise in activity as professionals are more aware of the service available.



This is the third quarter for the PPSS service. There have been 4 new cases referred into the service during Q4.

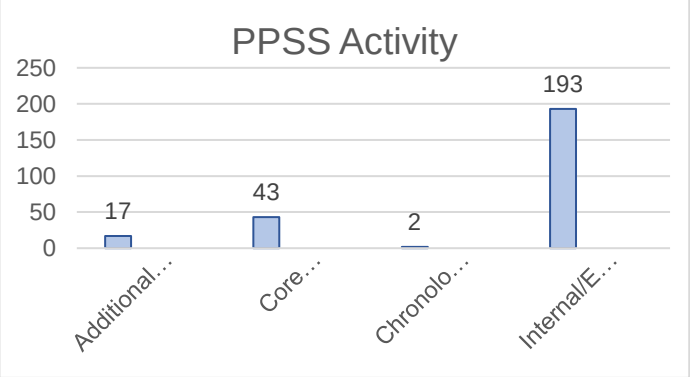
Within this quarter the team have been able to close 8 cases where clarity was gained and concerns were resolved, or the case was discharged and information appropriately handed over to local health teams.

This brings the current total number of cases open to PPSS at the end of Q4 to 51 cases.



Cases are risk rated (RAG) –

Green - cases where concerns are at a low level but ongoing requiring monitoring and communication with the MDT.
Amber – cases rated as medium risk but ongoing requiring input and communication with the MDT
Red – Cases agreed to be at high risk either there is an active section 47 enquiry ongoing, are on a CP plan.



Data was collected using the F2 function on EPIC. It should be noted that while this data collection tool is in its infancy some of this liaison may have been lost into the main safeguarding internal/external liaison.

There is ongoing development within the categories used within this to help in the accuracy of data collection.

V. Joint Working: Psychological and Mental Health Services (PAMHS) and Safeguarding Service

There is extensive joint working with PAMHS, within the Body, Bones and Mind Directive. GOSH Social Workers and the Safeguarding Nurse Specialist attend MDT and multi-agency meetings, as well as attendance at psycho-social meetings.

As a result of the winter Covid-19 2020/21 pressures, there was a significant increase in admissions of complex acute cases from the Child and Adolescent Mental Health Services (CAMHS) and patients detained under the mental health act, as a result of the North Central London Covid arrangements, monitoring of planned and unplanned therapeutic restraints was added to the quarterly safeguarding report in Q4 2020/21.

- **Recorded therapeutic restraints in Mental Health Services**

	Q1 (2020-21)	Q2 (2020-21)	Q3 (2020-21)	Q4 (2020-21)
No of Unplanned Restraints	19	5	2	0
No of Planned Restraint	0	0	0	94

Q1-Q3 context

In total there were 32 unplanned restraints throughout 2020, across 3 areas of the hospital that were at those points staffed with/or supervised by the Bones Body and Mind team.

Q4 context

In total there were 94 planned restraints through Quarter 4, and 0 episodes needing unplanned intervention.

Currently there are operational IT challenges with data collection on EPR of all planned restraints, therefore, whilst this is being rectified all will be recorded in the local restraint register.

All reporting via Mental Health Services Data Set Restrictive Interventions Reporting continues as per requirements.

A working group has been established to look more generally at restraint practice across the Trust, to ensure staff are aware of the newly revised policy, in line with the national guidance '*Reducing the Need for Restraint and Restrictive Intervention' (HM 2019)* and are trained in ways in which restraint can be avoided. This work will take place during 2021/22.

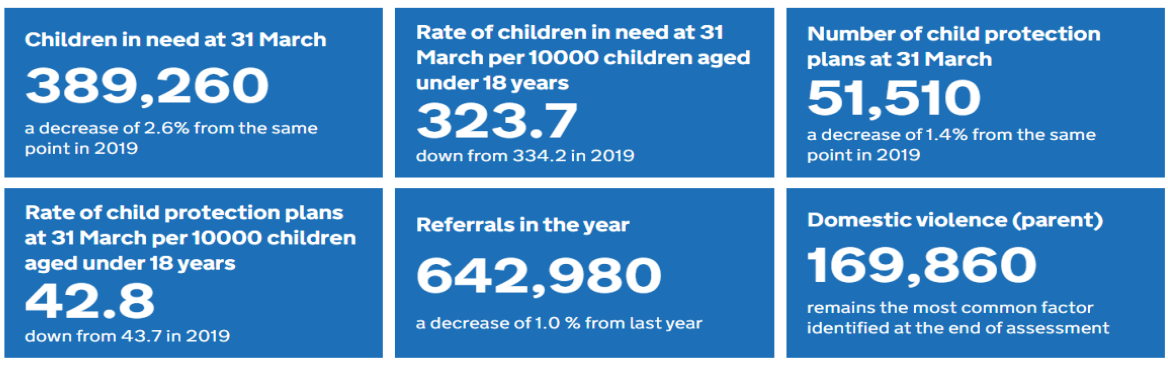
VI. National Picture and impact of the Covid-19 pandemic

Parental Characteristics

The impact of adverse childhood experiences (ACE) can continue into adulthood, influencing health, education and future relationships and life choices.

The parental characteristics which may contribute significantly to ACE are *Mental Health problems*, *Substance Misuse* and *Domestic Violence* which forms the Toxic Trio. The subject is included in Level 2 and Level 3 mandatory training.

National data to March 2020



The above table provides figures from referrals into Children's Social Care (CSC) across England and resulting factors affecting children and young people following assessment by CSC.

It was reported here were 642,980 referrals during the year ending 31 March 2020, a decrease of almost 8,000 (1%) from 2019.

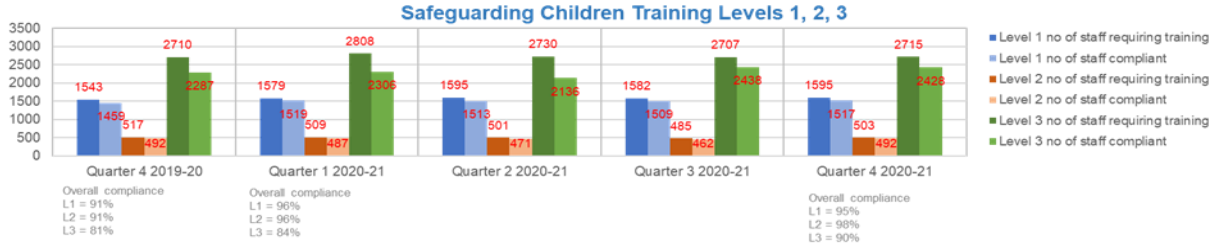
This decrease is largely accounted for by a drop in referrals in March 2020, which were just over 8,500 lower than 2018 and almost 10,000 lower than 2019. For the preceding eleven months the number of referrals showed a similar pattern to 2019 and were at a similar level.

The decrease in referrals in March 2020 is therefore likely to be explained by the nationwide lockdown which began during the month, in response to the COVID-19 pandemic.

Ref: (Gov.uk: https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need/2020#releaseHeadlines-summary v.UK 2020)

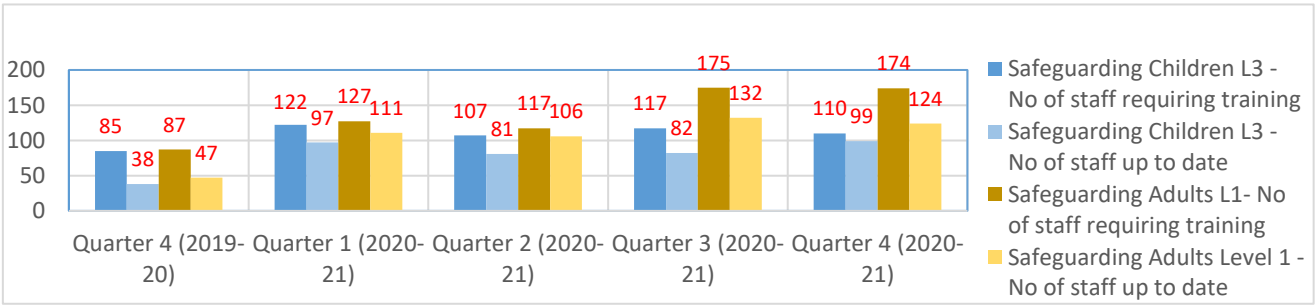
5. Training

Staff access statutory and mandatory training via the Gold Learning Site, with all training in line with the Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019). Safeguarding training continued to be delivered during the pandemic, adapting to the Zoom digital platform. Despite the challenges all staff were facing, compliance remained high with an over 90% rate during Q3 and Q4.



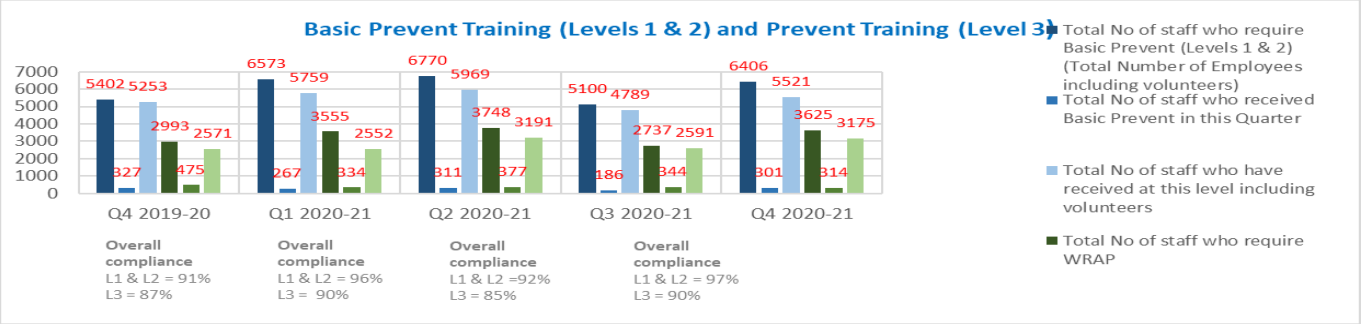
Honorary Contracts

A project was commenced in conjunction with HR to review the honorary contract holders, who were identified as a staff group with the lowest mandatory safeguarding training compliance. Compliance continues to be monitored ensuring evidence is either provided from their host trusts, or relevant training is completed through GOSH. In March 2021 a renewed focus on compliance in this cohort led to a year end compliance rate of 90% for Safeguarding Children Level 3.



Prevent training

This training programme is line with the Prevent Training and Competencies-Framework (NHS 2017) to meet the Prevent Duty (2015). The Framework is used in conjunction with the Intercollegiate Document (2019) to ensure consistency in training and competency development, identifying staff groups that require Basic Prevent Awareness (BPA) and those who are required to attend the Workshop Raising Awareness of Prevent (WRAP) or equivalent approved e-learning package (NHS 2017). Overall compliance has been at 90% or over.



6. Safeguarding Supervision

Effective practitioner supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect critically on the impact of their decisions on the child and their family. (Working together to Safeguard Children 2019)

The total number of staff who have accessed safeguarding supervision in Q4 is 943.

If measured this against the total number of 2,770 clinical staff required to do L3 safeguarding children training, the uptake for Q4 would be 26%.

In Q4 the planned sessions have increased. This can be attributed to an increase in case supervision and review by the nurse consultant for safeguarding and additional supervision within the General Paediatric team as well as case supervision in the new PPSS service.

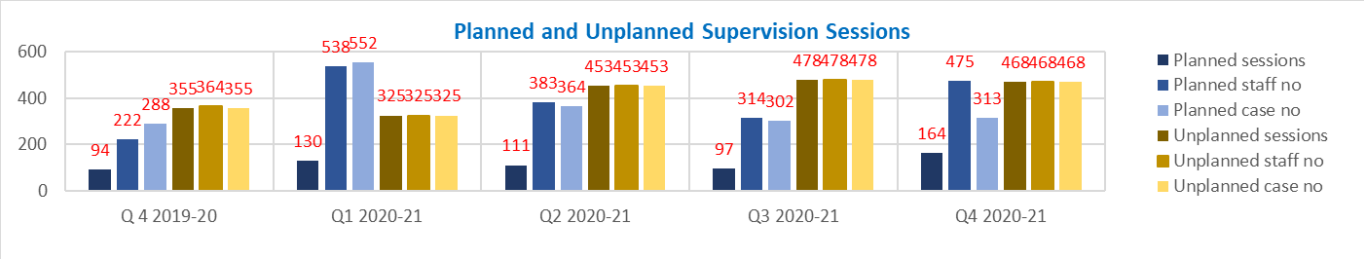
The number of staff who have attended those planned supervision sessions has also increased since Q3, this can be interpreted as a reduction in staffing pressure with the relaxing of restrictions. Unplanned supervision has remained stable and is relative to the safeguarding activity data in Q4 and a sign that systems to access supervision are in place.

It is important to note that the number of staff who have accessed supervision is significantly higher than in Q3 2019.

<u>Planned supervision data includes the following sessions where case supervision is provided by the safeguarding team.</u>

- Planned safeguarding individual and group sessions
- Social Work case management supervision
- Complex gastro MDT, Allergy, IBD, Complex endocrine and Fetal Cardiac CNS team
- Perplexing presentation support service MDT's
- General pediatrician peer review and supervision
- Case review and supervision led by the nurse consultant for safeguarding

I. A review of the Safeguarding Supervision process and policy, including a mapping of teams is underway during 2021/22, to enhance practice and confidence with safeguarding cases. Ideally it should be offered approximately every 3 – 4 months, with 2 hours protected time dependent on team.



7. Serious Incidents

1. Child Safeguarding Practice Reviews (CSPR), Serious Case Reviews (SCRs)

- The Trust currently has 6 open Serious Case Reviews (SCRs). Of these, 1 was published in Q1 with 26 multi-agency recommendations. Notification was also received in Q1 that a further 2 SCR's had been published in September 2020. These will be reviewed to consider any internal learning for GOSH.
- The remaining 3 SCR's are yet to be published. The delay continues due to on-going police investigations or criminal proceedings.
- The Trust currently has 2 open Child Safeguarding Practice Reviews (CSPR). There has also been 1 new CSPR received in Q1.

Local Learning Reviews

- There are currently:
- 2 open Child or Young person local reviews. There has also been 1 new Local Learning Review received in Q4.
- 2 open Adult Safeguarding Partnership reviews.

A number of learning events will be organised, following sign off by the local Safeguarding Children Partnerships or Adult Safeguarding Partnership.

2. People in a Position of Trust

The Trust is compliant with the guidance in Working Together to Safeguard Children (2020 update), which states that an allegation may relate to a person who works with children who has:

- behaved in a way that has harmed a child, or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children
- behaved or may have behaved in a way that indicates they may not be suitable to work with children

a) Internal Allegations against Staff or Volunteers (ASV).

The ASV process is led by a small group of senior leads, which investigates allegations whether internal or external, that may have an impact on their suitability to practice in whichever department they are based.

All investigations remain strictly confidential and are filed electronically in a restricted access file within safeguarding. Where it is necessary to liaise with the statutory agencies (i.e. children's social care or the police), this is completed in confidence via the Local Authority Designated Officer (LADO).

In Q4 there have been 3 such allegations. There were 9 meetings held in Q4 relating to open cases.

Total cases for 2020/21 to end of Q4 = 8 (Total cases for 2019/20 to end of Q4 = 18)

b) The Disclosure and Barring Service (DBS)

The Trust DBS policy was updated in December 2020, in line with national guidance and includes the Adult Barred List.

To review the effectiveness of the policy and process changes introduced in the last 12 months an audit will commence in Q2 2021/22, this will look at the operation of the Trust policy and review the DBS checking processes of selected contractors as per the policy monitoring guidance.

c) Persons Who Pose a Risk

The Safeguarding Team works closely with the Risk, Social Work, Security and Directorate Nursing Teams to ensure a safeguarding perspective is included in the risk assessment where there are concerns about a parent, carer or someone known to the family, under the person who may pose a risk process. This includes participation in meetings of cases of those who pose a risk, safeguarding and safe and respectful behaviour.

d) Specific high profile case – Operation Sheppey

A GOSH porter was suspended and then dismissed during 2020 following allegations of sexual abuse against children. He did not target patients at GOSH, but did exploit his position and use the site to commit some of his historical offences. He was subsequently sentenced to life imprisonment in May 2021.

The Trust response to this case was robust with the following actions:

- Safeguarding Governance Review Action Plan
- Assurance of current policies and procedures are contemporaneous and robust.
- Enhanced Local Authority Designated Officer (LADO) reporting, in-conjunction with the internal Allegations against Staff & Volunteers (ASV) process.
- Support for staff involved and stakeholder briefings.
- NSPCC Helpline
- Specialist training to be commissioned for those involved in Allegations against Staff & Volunteers (ASV), including working with perpetrators and MAPPA cases.
- CQC – review of ASV process
- Consideration given to a commissioned independent review of safeguarding by end of Q4 2021/22

8. Safeguarding Adults

GOSH treat a growing number of adult patients aged 18 years and over, who present with additional needs and safeguarding concerns. The Senior Nurse Specialist is the Trust MCA Lead and works closely with the Learning Disabilities Team This section provides an overview of the safeguarding adults (SGA) service and activity across the Trust.

Training

Level 2 Safeguarding Adults training is mandatory for all qualified staff at GOSH. This is currently a 30 minute assessed e-learning module.

Compliance with Safeguarding Adults Training: Level 1 = 95% Level 2 = 93%

Additional Safeguarding Briefings have been delivered to the specialties with the most adult patients.

Supporting the local safeguarding system

There is over 90% attendance at the Camden Safeguarding Adults Partnership Board meetings and the Quality and Performance Sub-group.

Quarterly reports are provided to Camden Clinical Commissioning Group to provide assurance of compliance with the North Central London Sustainability and Transformation Partnership's Safeguarding Adults Quality Assurance Framework.

The Senior Nurse Specialist for Safeguarding Adults and Children/MCA Lead, represents GOSH at the London Safeguarding Adults Provider Forum and MCA/DoLS Network.

Safeguarding Adult Reviews (SARs)

GOSH have not had any patients that require a contribution to any new Safeguarding Adult Reviews during 2020/21.

Adult patients seen at GOSH during 2020/21

Type of contact	Numbers		
	2020/2021	2019/2020	2018/2019
Admitted as an inpatient.(this includes cardiac MRI) *	582	582	671
Outpatients	5600	5600	6392
TOTAL	**3397**	**6182**	**7063**
Top 5 admitting specialties: Cardiology Urology Dental & Maxillary Facial Neurology Plastic Surgery Spinal Rheumatology Immunology Neuromuscular Gastroenterology Oncology	384 14 128 48 13 17 24 21 4	332 6 13 33 6 13 19 19 6	553 32 25 9 7 7

*Current data available does not distinguish between day cases and overnight inpatient stays. The reduction in the overall number of adult patients seen at GOSH is partly explained by the COVID-19 pandemic which resulted in a reduction in non-urgent cases at the end of the year.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs)

A trust wide MCA Audit identified a number of issues with MCA and DoLs at GOSH. The following measures are to mitigate the risk of non-compliance:

a) Implementation of e-consent is pending in EPIC optimisation which is part of the Trust's transformation strategy.

b) Increased training on MCA/DoLs and adult safeguarding will be incorporated into the forthcoming Safeguarding Training Strategy.

c) In addition, targeted updates/information sessions for relevant clinical teams have been provided by the safeguarding, LD and legal team as the need has arose.

d) There has been a Grand Round and presentation at SLT (Senior Leadership Team) and the Consultants Forum.

e) There is now a daily duty system reviewing all inpatients over 16 years to assess whether a DoLs is required, managed by both safeguarding and learning disability teams. This includes collaborative work with the legal team for joint targeted work with clinical teams where this is required.

f) A Growing up and Gaining Independence advice and support document has been created for families to support transition.

g) Documents to support MCA, Best Interests and DoLs assessments are now embedded in to the Trust's EPR system.

h) The Trust is now accurately reporting safeguarding adult data quarterly as part of the new safeguarding metrics for Camden.

i) The MCA Policy has been updated to reflect a Supreme Court ruling relating to the deprivation of liberty of young people aged 16 & 17 years.

Policy and procedures

II. The Safeguarding Adults Policy was updated in June 2021

*GOSH began to collate the number of MCA and DoLs reviews, assessments and application from the beginning of Quarter 3 2020/21, which is documented below:

***Quarter 3 to Quarter 4 MCA and DoLs Activity 2020/21**			
Number of duty reviews f impatient aged 16+	Number of Duty reviews patients requiring MCA assessment	Number of duty reviews patients requiring DoLs assessment	Number of Dols Applications made
284	**143**	**19**	**6**

Service Improvement:

Since the introduction of an MCA and DoLs daily duty system we have been able to ensure that capacity has been assessed on a number of patients which may have previously been sought directly from their parent or carer. This helps to promote independence and support transition which assists in supporting the patient experience.

Liberty Protection Safeguards (LPS)

The implementation of Liberty Protection Safeguards (LPS) has been deferred to April 2022. Preparatory work has been done and further work will be required once the Code of Practice and Statutory Guidance are published, to ensure that GOSH is able to take on the new roles and responsibilities that are required of hospitals under the Mental Capacity (Amendment) Act 2019.

In the interim it is now understood that deprivation of liberty applications are now required for young people aged 16+17 who lack capacity following the case of D (a child) 2019. This means that work has commenced embedding processes in to practice.

9. Audits

1. Learning from Serious Case Reviews and Experiences of Supervision

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

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

2. Voice of the Child

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

3. Mental Capacity Act (MCA)

The compliance with the MCA was re-audited in Q4 2020/21. This demonstrated that there continues to be scope for improvement in understanding the MCA.

This has been addressed throughout 2021 by implementation of the electronic consent form; Increased training on the MCA including a trust wide and external webinar.

10. Key Priorities 2021/22

- Development of Safeguarding Strategy (including review of mandatory training and supervision policy).
- Enhanced Female Genital Mutilation (FGM) awareness and training, to address the nil return reported throughout 2020/21.
- Development of a Domestic Abuse Strategy, in-conjunction with Camden's Violence Against Women & Girls (VAVG) Lead.
- Further work on parental characteristics which may affect the Trust's registered patients.
- CP-IS audit, led by NHS Digital to evaluate the effectiveness of the pilot, and which other Trusts can benchmark against.
- Preparation for the Implementation of Liberty Protection Safeguards.
- External Independent Review of GOSH safeguarding arrangements.

References

- Think child, think parent, think family: Introduction - Think Family as a concept, and its implications for practice (scie.org.uk)
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing (rcn.org.uk)
- prevent-training-competencies-framework-v3.pdf (england.nhs.uk)
- Mental Health Services Data Set - NHS Digital
- Reducing the need for restraint and restrictive intervention (publishing.service.gov.uk)

Attachment X

Trust Board **7 July 2021**	
Completion of Royal College Review Actions **Submitted by:** Sanjiv Sharma, Medical Director	**Paper No: Attachment X** **For information and noting**
Purpose of report This is paper gives formal notification of closure of the action plans resulting from Royal College invited reviews of Gastroenterology and Urology Services.	
Summary of report In the past five years, GOSH has commissioned service reviews from two Medical Royal Colleges: • Royal College of Paediatrics and Child Health (2015, 2017): Gastroenterology • Royal College of Surgeons (2019): Urology Three actions remain from the gastroenterology review, two of which relate to network working, and the remaining one relates to a follow up review. The Trust has taken steps to support closure of these actions and will now look to have these action plans agreed as complete.	
Action required from the meeting • Note and agree with the approach	
Contribution to the delivery of NHS Foundation Trust priorities Safety and Quality governance	**Contribution to compliance with the Well Led criteria** Driving improvements in delivery of clinical services Contributing to improved organisational culture Supporting systems working Open and transparent scrutiny of clinical services
Strategic risk implications BAF Risk 11: Inconsistent delivery of safe care	
Financial implications Not applicable	
Implications for legal/ regulatory compliance Not applicable	
Consultation carried out with individuals/ groups/ committees Previous updates provided to QSEAC	
Who is responsible for implementing the proposals / project and anticipated timescales? Body Bones and Mind Directorate	
Who is accountable for the implementation of the proposal / project? Medical Director	
Which management committee will have oversight of the matters covered in this report? Patient Safety and Outcomes Committee (PSOC)	

Attachment X

Completion of Open Royal College Review Actions

Context

In the past five years, GOSH has commissioned service reviews from two Medical Royal Colleges:

- Royal College of Paediatrics and Child Health (2015, 2017)
- Royal College of Surgeons (2019)

From these reviews, action plans have been developed, and led by operational leadership teams with oversight from the GOSH Executive Management Team. This summary paper outlines the Trust position in taking these action plans to completion.

Gastroenterology

Royal College of Paediatrics and Child Health (RCPCH) service reviews were conducted on the GOSH Paediatric Gastroenterology Service in 2015 and 2017. The results from these have been presented to Trust Board and have been shared publically. Action plans were developed by the specialty and have been tracked through internal processes (Executive Management Team, Patient Safety and Outcomes Committee, Risk Assurance and Compliance Group). The Trust believes that all actions which relate directly to organisational changes have now been met.

Most recently, a presentation to January 2021 Quality, Safety and Experience Assurance Committee (QSEAC – an assurance committee of the Board) outlined the position with regards to the gastroenterology action plan and subsequent to this a further discussion has been held at Trust Board. The action plan completion has progressed well with the exception of network working, the pace for which has been adversely affected by the Covid-19 pandemic.

Three actions remain from the gastroenterology review, two of which relate to network working, and the remaining one relates to a follow up review. Those actions which relate to system transformation will need to be led by the North Thames Paediatric Network and North Central London -Integrated Care System (NCL-ICS), although it is understood and accepted that GOSH must be an active contributor to this.

The Trust will seek to confirm completion of the gastroenterology action plan with NHS England and NCL-ICS at the Care Quality Review Group in July 2021. We will encourage these external stakeholders to continue to lead the development of NCL/North Thames paediatric gastroenterology services.

We will additionally organise for the next external review to start (a recommendation from the last report). This cannot be conducted through the RCPCH Invited Review Service as it is currently suspended. The panel to lead the review is comprised of two independent reviewers from the UK and two independent international reviewers and this has been discussed and agreed by the British Association of Paediatric Hepatology, Gastroenterology and Nutrition. Terms of reference have been drafted and will need to be agreed with the review panel. It is anticipated that this will commence in October 2021.

Urology

The Royal College of Surgeons (RCoS) were invited to undertake a review of the Urology Services at Great Ormond Street Hospital. This took place in two parts in the Spring of 2019: a case review of highlighted cases and a service review of the urology department. The reports were shared with the Trust in October 2019 and an action plan was submitted to Trust Board in November 2019. The deliberate inclusion of the report in the Trust Board papers as part of an ongoing commitment to improving transparency was identified by the HSJ and then subsequently by a range of other press in January 2020.

The RCoS action plan implementation was initially overseen by the Chief of Service for Body, Bones and Mind (BBM) Directorate and the Clinical Lead for Urology. The Executive and senior leadership team have been actively providing support, and six monthly updates were provided to the RCoS.

In December 2020, the Trust provided a third update to the RCoS on progress against the action plan to respond to the recommendations in the report. At the same time, the Urology department transferred to the GOSH Sight and Sound Directorate in order to help even-up the workloads of the directorate management teams and ensure sufficient support to take the Urology development program forward.

In January 2021, the RCoS wrote to the Trust to confirm that they were satisfied with progress and the review was now closed from their perspective, although they still wished to receive an update on the outcome of serious incident (SI) investigations being conducted in the department; these SIs were alerted to the RCoS by the Trust in October 2020. The urology team, with support from the

BBM Chief of Service and the Associate Medical Director for Safety, undertook an aggregated analysis of these incidents in order to identify and act upon any emerging safety threats. The analysis did not reveal any significant commonalities, the serious incident investigations have been completed and in March 2021 the RCoS were contacted to confirm this.

In response to a further Trust update relating to findings of these 3 SIs, the RCoS responded on 13th April 2021 that the investigations and learning points documented demonstrated that the *'Trust appears to be actively working to improve things'*. The RCoS reiterated their position of no further active involvement in respect of the review. All actions are now closed and the service remains subject to routine monitoring.

Attachment Y

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 7th July 2021	
Responsible Officer's Report **Submitted by:** Dr Philip Cunnington, Associate Medical Director and Responsible Officer	**Paper No: Attachment Y** □ **For information and noting**
Purpose of report To provide the Board with assurance that the statutory functions of the Designated Body and Responsible Officer are being appropriately discharged.	
Summary of report • The purpose of medical appraisal and revalidation is to support and develop our medical workforce through reflection on clinical practice, whilst complying with GMC and NHSE&I guidelines and frameworks. • Appraisal compliance 90.4% despite the pandemic, although a number were approved to defer their appraisal during the year.	
Action required from the meeting The Board is asked to note the contents of the update, and agree that the Chief Executive is able to sign the Statement of Compliance (attached)	
Contribution to the delivery of NHS Foundation Trust priorities □ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** □ **Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** □ **Leadership, capacity and capability** □ **Responsibilities, roles and accountability** □ **Effective processes, managing risk and performance** □ **Accurate data/ information** □ **Engagement of public, staff, external partners** □ **Robust systems for learning, continuous improvement and innovation**
Strategic risk implications BAF Risk 2: Recruitment and Retention BAF Risk 14: Culture	
Financial implications Not Applicable	
Implications for legal/ regulatory compliance The Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013) &	

NHS England Framework of Quality Assurance for Responsible Officers and Revalidation are the relevant pieces of legislation and guidance.

- Implications of non-compliance are that we fail to ensure that every doctor connected to GOSH:
  1. Receives an annual medical appraisal meeting nationally agreed standards;
  2. Undergoes the appropriate pre-engagement/employment background checks to ensure that they have qualifications and experience appropriate to the work performed;
  3. Works within a managed system in which their conduct and performance are monitored, with any emerging concerns being acted upon appropriately and to nationally agreed standards;
  4. Has a recommendation made to the GMC regarding their fitness to practise every five years, on which their continuing licence to practise is renewed.

- Risk of non-compliance:
  1. We fail to support and develop our medical staff to enable them to continue to deliver the highest quality care;
  2. For those who do not engage in the appraisal process the personal risk is that they will lose their licence to practise;
  3. We expose our patients and ourselves to risks concerning safety, if our pre-employment checks are not up to standard;
  4. We fail to address poor performance and behaviour promptly and in a manner that is consistent and following nationally agreed standards;
  5. We fail to support the wellbeing of our colleagues.

Consultation carried out with individuals/ groups/ committees
Not Applicable

Who is responsible for implementing the proposals / project and anticipated timescales?
Dr Phillip Cunnington, Associate Medical Director and Responsible Officer

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

Which management committee will have oversight of the matters covered in this report?
Medical Appraisal and Revalidation Committee

Annual Responsible Officers' Board Report

2021

1. Purpose of the Paper

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

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

2. Summary

All doctors are required to participate in an annual appraisal process, which reflects their complete scope of work. For those doctors in training posts this happens through the Annual Review of Competency Progression (ARCP) process. These annual processes help doctors satisfy the requirements for revalidation, which occurs every five years. For doctors arriving into our organisation who may be new to the National Health Service, this is a new process to get to grips with, as is the role of the GMC as the health regulator.

A nationwide decision was made in March 2020 to suspend appraisals due to the pandemic. Appraisals were due to restart from 1 October 2020 at the latest. The situation at GOSH was less pressured than other Trusts, therefore we took the decision to restart our appraisals from 1 August 2020. Appraisals due in the period mentioned above were classed as "Approved Missed" and a catch up appraisal was not required, in line with national guidance. Appraisals from 1 August 2020 took on a lighter touch than previous years, and supported reflective conversations including Health and Wellbeing, with less emphasis on documented evidence.

In addition to the suspension of appraisals, the decision was taken by the GMC to defer all doctors due for revalidation between March 2020 and March 2021 for 12 months. A further decision to defer doctors due for revalidation between April 2021 and July 2021 for four months in response to the pandemic was subsequently taken. These doctors would remain "Under Notice" for revalidation, allowing recommendations to be made where the requirements for revalidation have been met. This was designed to ease any pressure within the system.

The Annual Organisational Audit (AOA) for 2019/2020 was cancelled as is the AOA for 2020/21. A revised Board Report Template is due to be issued, but was not available at the time of writing this report.

NHSE&I Quarterly Reporting for 2020/21 was suspended except for Q3 – this was requested where designated bodies felt able to complete. At GOSH we were in a position to submit our Q3 report. A decision has now been taken nationally to cease quarterly reporting after the Q3 (2020/21) for established designated bodies.

Dr Philip Cunnington took over as Responsible Officer in January 2021 following a six month handover period with the previous RO.

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) had 644 doctors connected to it as a Designated Body at 31 March 2021.

2.1 Medical Appraisal

Category	2020/21 Appraisal Status	No.	%
1	Completed Appraisal	456	70.8%
2	Approved Incomplete or Missed Appraisal	126	19.6%
3	Unapproved Incomplete or Missed Appraisal	62	9.6%

Category 1 and 2 give a compliance of 90.4% overall.

There were 126 doctors classed as having an Approved Incomplete or Missed Appraisal (AOA Category 2) and the reasons are shown below:

- 46 joined the Trust from abroad and had been employed for less than 12 months on 31/03/21, and were therefore not yet due an appraisal;
- 3 had an agreed postponement due to long term sick leave or compassionate leave;
- 9 had an agreed postponement due to maternity leave;
- 2 had an agreed postponement due to sabbatical leave;
- 66 appraisals were cancelled or postponed due to COVID.

Of the 62 listed in Category 3:

- 26 appraisals have since been completed with a meeting date after 31 March 2021;
- 11 appraisals are in progress;
- 6 doctors have since left the Trust;
- 19 remain overdue and will be addressed through local processes.

NHS England released guidance for restarting appraisals advising that the focus for appraisal should be supportive and reflective conversations, with less emphasis on written documentation. The appraisal input form on the PReP (Premier IT e-Portfolio Revalidation Management Software) was amended to incorporate the new guidance including a “Health and Wellbeing” section. This more supportive approach has been well received according to feedback given to the appraisal office.

The system used for multi-source feedback exercises (Edgecumbe Doctor 360) moved to a new website October 2020. The new site allows for parent/patient feedback to be collected electronically via an email/text link enabling collection of feedback for revalidation following virtual appointments. However, electronic feedback is proving difficult to collect – face to face appointments followed by a form for completion had higher engagement from the parents.

Directorate Breakdown of Appraisals due 1 April 2020 – 31 March 2021

	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	IPC	Medicine, Therapies & Tests	Ops & Images	Sight & Sound	Corp	Total
Cat 1	**71**	**71**	**80**	**101**	**9**	**26**	**47**	**46**	**5**	**456**
Cat 2	**17**	**17**	**12**	**31**	**4**	**6**	**33**	**4**	**2**	**126**

Cat 3	**10**	**5**	**11**	**23**	**2**	**1**	**4**	**3**	**3**	**62**
Total	**98**	**93**	**103**	**155**	**15**	**33**	**84**	**53**	**10**	**644**
Compliance % (Cat 1&2)	**89.8%**	**94.6%**	**89.3%**	**85.2%**	**86.7%**	**97.0%**	**95.2%**	**94.3%**	**70.0%**	**90.4%**

The appraisal rate for each directorate is monitored at Directorate Performance Reviews.

2.2 Appraisers

The Trust had 163 trained appraisers at 31 March 2021.

The Appraiser Forum meetings remained on hold during most of 2020/21, the first being held on 25 March 2021 via zoom.

There are a number of appraisers due to leave or retire, and so New Appraiser Training has been booked for the year ahead. In addition, Appraiser Refresher Training is also in progress with particular attention to the new style of appraisal.

2.3 Revalidation

All doctors due to be revalidated between 17 March 2020 – 31 March 2021 were automatically deferred by 12 months by the GMC to ease the burden on those doctors during COVID. This was extended to include all doctors due revalidation up to 31 July 2021 who were deferred by four months. All of the affected doctors have been placed "Under Notice" which does allow for positive revalidation recommendations to be made if appropriate. However, it has been advised that deferral recommendations are not made until closer to their revised submission date.

Between 1 April 2020 and 31 March 2021, 12 doctors for whom GOSH is the Designated Body were due to have Revalidation Recommendations made to the GMC, of which ten were revalidated, and two were deferred until 2021/22 due to insufficient evidence.

A further 54, who had revalidation submission dates deferred, have had positive Revalidation Recommendations made during the period as a result of having sufficiently complete portfolios.

2.4 Quality Assurance

The Medical Appraisal and Revalidation Committee (MARC) was suspended from April 2020 and recommenced in August 2020. Those doctors due for revalidation have a complete review of all appraisal input forms, output forms and related supporting evidence. This is fed back to the MARC, and both the RO and the Revalidation Manager provide constructive feedback to appraisees and appraisers where the requisite standard has not been reached, even if this does not result in deferral.

Appraisers are scored by their appraisees, this is done anonymously at the end of their appraisal following acceptance of their Appraisal Output Form. To maintain anonymity a report is produced for the appraiser once they have completed a minimum of three appraisals. The report is attached to their portfolio for reflection in their own appraisal.

The report covers nine different aspects of appraisal and also includes areas for free typed comments.

2.5 Responding to Concerns and Remediation

In the past year there have been no completed Maintaining High Professional Standards (MHPS) investigation reports, and there are no ongoing MHPS investigations. There has been one case where successful remediation has taken place locally, and work is on-going in offering those involved further support.

In the past year we have had eight doctors either currently working, or who have worked at the Trust, undergoing investigation by the GMC. Of those currently still working in the Trust, two have had their referrals triaged and no further action was deemed necessary and their cases are closed; one doctor was subject to a professional conduct and wellbeing investigation which was closed following a local investigation, and with no sanctions imposed; one doctor is undergoing an investigation into their professional conduct but has no current restrictions on their practice; one doctor is undergoing a capability investigation and has supervisory restrictions imposed on their practice.

The remaining three doctors no longer work in the Trust. One is subject to a professional conduct investigation, unrelated to their time whilst undergoing a training rotation at the Trust, and has no restrictions on their practise; one is subject to a professional conduct and capability investigation related to events that occurred whilst employed by the Trust; one is a retired former employee who is undergoing a professional conduct investigation and who has had their application for voluntary erasure from the medical register rejected whilst the investigation takes place.

Annex A

Designated Body Annual Board Report 2021

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

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

Action from last year: Look into the possibility of holding a virtual Appraiser Forum with PReP attending once appraisers are able to resume normal activity
Comments: Appraiser Forums were stopped during the pandemic, the first Appraiser Forum was held virtually in March 2021 and worked well – a higher attendance level was noted, possibly due to better accessibility using zoom rather than face to face.
Action for next year: Continue with virtual Appraiser Forums, monitoring attendance.

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

Action from last year: Support the new Responsible Officer in maintaining expertise. Comments: The Responsible Officer, Philip Cunnington was appointed to the role which commenced in January 2021, having had a six month handover period with the previous RO. He completed his RO training in September 2019. Action for next year: Continue supporting the new Responsible Officer.

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

Yes it does. Action from last year: None Comments: None Action for next year: None

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

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

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

Action from last year: Continue with policy update and publish Comments: The Medical Appraisal Policy was updated, forwarded to Chiefs of Service for their comment, passed through MARC/PAG and LNC and is now live. Action for next year: Review policy when new appraisal requirements are confirmed nationally.

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

Action from last year: None. Comments: The GMC and local revalidation network have stated that peer review visits will re-start. Action for next year: None.

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

Action from last year: To continue to update the information as needed on GOSHWEB to assist short-term placements/locums, and to continue to provide support. Comments: Work is currently in progress on providing bank doctors & IMG doctors with targeted support (outside of the appraisal office). Action for next year: To continue to support the ongoing work as needed.

Section 2 – Effective Appraisal

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

Action from last year: Continue with investigating possibility of centrally uploading SI/Complaint information to PReP Comments: This was not possible during 2020/21, however when a doctor is due revalidation transfer of information is sought from their other areas of work outside of GOSH. Action for next year: The electronic system used for appraisal is due for renewal, and during tender process we will review what capability any potential new system may have for incorporating such information.

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

Action from last year: The Trust have developed a local process which identifies doctors that have failed to complete their appraisal without reason. These doctors are discussed at the Medical Appraisal and Revalidation Committee, and recent GMC guidance advises that all those more than three months overdue are discussed with the GMC ELA to decide what next steps should be taken. Doctors are made aware of this before they reach this milestone. We will continue with this process and review its success, with the aim of reducing the number overdue. Once appraisals and MARC restart the process will be required to restart with understanding of delays from 2019/2020. Comments: Process has restarted with an understanding of the impact of the previous 12 months, and discussions at MARC or with the RO continue to take place. Action for next year: To reduce the number that exceed three months overdue with education and the processes in place within the Trust.

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

Action from last year: Finalise policy, submit to PAG/LNC and publish on GOSH Web. Comments: The Appraisal Policy was approved 23 November 2020 and GOSH Web updated. Action for next year: Review policy in the event of substantial requirement changes.

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

Action from last year: Continue reviewing appraiser allocation numbers. Comments: Due to appraisals being suspended for half of the year it was not resource effective to monitor appraisees allocated to an appraiser unless it was highlighted as problematic and intervention needed. New appraisal software may support appraiser allocation, and this will be reviewed during the tender process. Action for next year: New Appraiser Training session to be held to bolster the number of trained appraisers, replace those leaving/retiring in the near future and to ease the burden in those departments with insufficient appraisers.

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

Action from last year: Continue with the in-house Appraiser Training course preparation with input from MARC and look into delivering this online. Comments: Changes to the requirements of appraisal impacted upon this work. Appraiser Forums have restarted and refresher training is planned. Action for next year: Appraiser Refresher training to be held for all appraisers.

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

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

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

Section 3 – Recommendations to the GMC

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

Action from last year: Review all those Under Notice with a view to submitting recommendations as soon as possible, paying particular attention to those who were revalidation ready and their original submission date has passed (prior to the GMC deferring submission dates). Comments: This work has been ongoing, with reviews taking place many months ahead of submission dates. Action for next year: Continue bringing revalidations up to date.

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

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

Section 4 – Medical governance

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

Action from last year: Continue to develop robust medical governance within the organisation. Comments: The Medical Directorate team have continued to work closely with doctors, the LNC and HR OD to ensure governance is robust and fair. Further work will focus on supporting those in leadership roles to address concerns early, with at elbow support and training offered to allow personal professional development as leaders, as well as enhancing the capability of the organisation. Action for next year: Continue to develop robust medical governance within the organisation.

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

Action from last year: Work with Medical Employee Relations team to develop senior management and offer peer support. Comments: Further work is required with the HR&OD Directorate to improve the capability of senior management in addressing and managing concerns. Training from the Trust's solicitors for senior managers was well received.

Action for next year: Continue to work with Medical Employee Relations team to develop peer support for both managers and those involved in cases.

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

Action from last year: Continue to develop good working relations. Comments: We have maintained good, close working relations with the GMC ELA and the Practitioners Performance Advisory Service (NHS Resolution) when our local Medical Employee Relations meetings highlight concerns. Action for next year: Continued peer support to reinforce the Trust's consistent approach to collective leadership when addressing concerns.

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

Action from last year: Run regular workshops for medical staff around Professional Behaviour. Comments: Plans to develop training with the GMC for all consultants within the organisation were put on hold as a result of a deep dive into culture and the Speak Up Programme. The Speak Up Programme now resides in the HR OD portfolio. Action for next year: Liaise with HR OD to ensure quality assurance and detailed demographic data analysis.

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

Action from last year: To continue to develop this work. Comments: Accurate records and close links with HR OD are essential. Action for next year: Ensure robust SOPs for on-boarding staff, especially to our Bank and when granting practice privileges.

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

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: To continue to develop this approach, coupled with the implementation of a senior management programme to increase the levels of competency in managing doctors in difficulty.

Comments: We are working closely with Medical ER and the LNC to ensure that our internal processes are transparent and fair.

Action for next year: Continue to develop this work and review demographic data.

Section 5 – Employment Checks

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

Action from last year: None.

Comments: Following a clinical incident weaknesses in our on-boarding of Bank staff have been highlighted and a SOP has been developed to make the process more robust.

Action for next year: Monitor the implementation of the new SOP.

Section 6 – Summary of comments, and overall conclusion

The majority of the action plan from the 2020/21 is complete, ongoing or looking to be adapted in line with new working practices.

Overall conclusion:

The Trust has recovered well from the impact on appraisal of the Covid pandemic, and appraisal rates stand at 90.4%. The revised format has been well received with feedback from appraisees confirming that it feels more personal and less institutional. The GMC have recognised this and are conducting a review of the appraisal process, recognising that after 17 years it needs to reflect the needs of the workforce. We have plans to augment the wellbeing aspect of appraisal, and offer training and support to appraisers in how best to approach wellbeing issues that are highlighted during the appraisal. It is hoped that this will enable appraisers to 'be there' for appraisees throughout the year, rather than at just one focal point. We are improving our ability to communicate appraisal rates to the Chiefs of Service, which will allow them to be better able to monitor those who are having difficulty, or who are late in completing, and enable them to factor the SPA time required for appraisers into the job planning process. This will also allow us to ensure that a minimum number of appraisals each year is met by appraisers, and to maintain our quality assurance. Our current licence agreement with Premier IT ends in April 2021, and we will seek tenders to ensure that we have a system that supports the Trust's commitment to appraisal.

Section 7 – Statement of Compliance:

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: Great Ormond Street Hospital for Children NHS Foundation Trust

Name: Mr Matthew Shaw Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

Attachment 1

Summary of the Audit Committee meeting

held on 26th May 2021

Matters arising

The Committee had requested a list of the Trust's top ICT 10 suppliers to ensure that the correct checks had been undertaken for the companies. This was ongoing and a list would be provided by cost and also in terms of priority such as where items were provided by a single supplier.

Internal audit: Head of Internal Audit Opinion and Internal Audit Charter

The Head of Internal Audit Opinion provided a rating of significant assurance with minor improvement potential which was an improvement on the previous year. The Committee noted that there were no overdue recommendations and requested that this trend is continued. Discussion took place about the importance of the Trust's EPR system throughout the pandemic and it was agreed that this would be noted as part of the review of EPR benefits realisation.

Risk management presentation

Due to connection issues, the presentation was unable to go ahead. The Committee requested a joint session with members of QSEAC to discuss the risk management framework given its importance and it was agreed that this would take place at an informal Board meeting. It was noted that a restructure of the Quality and Safety team was in progress to ensure that there was sufficient resource in this key area.

Chief Financial Officer's review of the Annual Financial Accounts 2020/21, including the Going Concern assessment

A £12.9million surplus against the Control Total had been reported and cash was very strong at £126million. The cost and income profile had changed considerably in comparison as a result of the pandemic. Discussion took place around the assurance of value and usability of stock provided by NHS England which was being stored at another Trust and it was confirmed that the value of this stock was not material. A decision had been taken nationally that resources transferred between Trusts during surges of the pandemic would be considered mutual aid and accounted for based on the activity in each respective Trust. The committee requested that consideration was given to whether sufficient explanation had been included in the accounts around the areas in which it was not possible to compare accounts to previous years such as high cost drugs. A detailed Value for Money assessment was being concluded by the Auditors. The Committee recommended the Annual Accounts to the Board for approval.

GOSH Draft Annual Report 2020/21

The Committee discussed some amendments to the annual report and agreed to recommend the following documents to the Board for approval:

- Draft Annual Report 2020/21
- Annual Governance Statement
- Annual Audit Committee Report

Final Report on the financial statement audit for the 12 month period ended 31 March 2021

The audit work was substantially complete and no material issues had been identified which would impact the accounts. A separate report from the auditors was required on Value for Money and this was also substantially complete with no concerns raised thus far. It was anticipated that a clean opinion would be provided in all areas and confirmation that nothing material had been identified in the VFM assessment. No evidence of management bias had been identified and no concerns had been identified around management override of

controls. It was noted that there was now a deadline of 30th June for the Quality Report and the committee requested review of a draft to provide comments. The Committee approved the Letter of Representation.

Risk matters between meetings

- Cyber Security Update

The ICT Improvement Board structure had been developed and would be considered by the Executive Management Team for approval. It had been agreed that the Board would be chaired by the Chief Operating Officer and that the COO and the Chief Executive would seek independent advice in parallel to this. Discussion took place around how the Trust would respond to a cyber crisis.

- Estates Compliance Issues

A Premises Assurance Model (PAMs) self-assessment had identified gaps in assurance around fire safety and ventilation. In terms of fire safety mitigations had been put in place and a constructor had been appointed to carry out the certification work required. A Root Cause Analysis was taking place for the ventilation issues which were related to commissioning decisions. An audit had been commissioned from a respected company and it was anticipated that both areas would be compliant by the end of July 2021.

Matters arising: Action 61.11: On call rota update (Risk 9: Business Continuity)
A good process had been in place during the pandemic to escalate issues as they arose and a set of processes were in place with key suppliers. Plans had been tested live when an issue arose with waste plants and had worked well. Work would be taking place to review shift patterns and allocations of maintenance on site to ensure the Trust had resilience in critical functions.

Report from the Risk Assurance and Compliance group on the Board Assurance Framework
The Committee recommended to the Board the proposal from the RACG to reduce the likelihood score of the financial sustainability risk from 5 to 4 given the robust mitigations in place, and increase the gross risk score of the research hospital risk to 4x4 with the net score remaining at 3x4.

Discussion took place around the comparative risk ratings of the BAF as a whole. The Committee asked the RACG to review the financial sustainability risk rating in the context of the BAF given the significant concerns around medicines management and cyber security.

Local Counter Fraud Specialist (LCFS) Progress Report
Four referrals had been received in the reporting period and five ongoing investigations were being led by third party organisations.

Counter fraud Annual Report
The Trust had achieved a green overall rating against the Counter Fraud Functional Standard Return which was positive given the change to some standards which had been applied retrospectively. Discussion took place around the amber ratings in some areas and it was noted that in many cases the correct processes were in the place such as Declarations of Interest but that the NHS Counter Fraud Authority required 100% compliance which was extremely challenging to achieve. The Committee approved the annual report.

Local Security Manager Work-plan 2021/22
The Committee noted the work plan for 2021/22.

Review of non-audit work conducted by the external auditors
It was noted that the external auditors had not undertaken any non-audit work for GOSH but had been contracted by NHS Digital to support the investigation into a cyber incident which had taken place.

Assurance of compliance with the Bribery Act 2011
The Committee noted the update.

Attachment 1

Update on raising Concerns at GOSH (Whistleblowing)

It was noted that no new cases had been raised and the committee requested a discussion at the next meeting around the visibility of all speaking up arrangements in the Trust.

Matters to be raised at Trust Board

- Annual Report and Accounts
- Cyber Security
- Estates
- Fire Compliance

Attachment 2

Finance and Investment Committee Update

The Finance and Investment Committee (FIC) met on:

- May 2021 to consider the security services tender evaluation,
- 23 June 2021 for a regular scheduled meeting.

GOSH security services tender evaluation (May extraordinary meeting)

At the May 2021 meeting the Committee endorsed the award of a three-year fixed cost contract with Carlisle Security Services Limited for the provision of security services at GOSH.

The Committee recommended a performance review after three months of both the in house cleaning and security contracts.

Highlights from the June 2021 meeting

Finance Month 2 report

Year to date (YTD) the Trust position was £3.6m favourable to plan. This was achieved mainly through Elective Recovery Funding (ERF) of £7.8m for additional day case, elective and outpatient activity in order to reduce patient backlogs and wait times, which was not included in the plan.

It was noted that as the ERF scheme rules have not been completely confirmed and the current assessment of income may change/reduce.

Integrated Quality and Performance Report (IQPR) Month 1 report

The Committee noted the IQPR report. The key highlights from this report are included in the Chief Executives report.

The Non-Executive Directors welcomed the new look report that contained:

- Recovery trajectories for key performance measures
- Details on the areas of the Trust with challenged performance and associated action plans
- Estimates of when backlogs for treatment were likely to be reduced to pre-COVID levels.

The Committee also noted that recovery of performance at the Trust was progressing well.

Sustainability at GOSH and Climate Emergency

The Committee received a report from Nick Martin - Head of Sustainability and Environmental Management on the key performance indicators that would be used to determine the effectiveness of GOSH's sustainability and Climate Emergency programmes.

The Non-Executive Directors discussed the balance between setting ambitious yet deliverable targets for carbon emission reductions, recycling and other indicators.

Procurement update

The annual review of the procurement service was presented. During 2020/21 the service continued to develop and deliver savings despite the impact of the COIVD-19 pandemic.

The Chair requested a review of single suppliers of equipment at the Trust, the clinical risk associated with substitutes and any mitigations via the Risk Assurance and Compliance Group.

Cyber Security update

The first ICT improvement Board chaired by John Quinn, Chief Operating Officer had taken place.

The Non-Executive Directors requested assurance in the next report that sufficient cyber due diligence was considered in all future information technology ventures such as app development.

Children's Cancer Centre

An update on the programme was presented that included information on the key risks regarding contingency, VAT rules and asset swap. It was agreed that a further workshop be held on these items to enable a deep dive.

Sight and Sound Centre

The Committee noted that the centre had opened and the patient numbers were on the increase.

Feedback from Governors

The Chair invited feedback from the Governors who observed the Committee meeting:

- Alison Kelly
- Beverly Bittner-Grassby
- Mark Hayden
- Olivia Burlacu
- Peace Joseph

A summary of the feedback included:

- The meeting was well chaired and the papers were interesting and helpful.
- It was good to see patients considered as individuals and not 'numbers' in several discussions.
- It was good to see the NEDs have differing views on certain items and discuss next steps.
- The amount of time allocated to agenda items and the number of items on the agenda should be reviewed.

The Chair, Chief Finance Officer and Head of Corporate Governance would consider these comments ahead of the next Finance and Investment Committee meeting on 28 July 2021.

End of report

Attachment 3

People and Education Assurance Committee
Wednesday 23 June 2021
Summary Points from Meeting

PEAC Survey Results 2020 / 2021

The first PEAC effectiveness survey received a good level of response from NEDs, Executives, Presenters and Governors and will continue annually. The Committee agreed the following recommendations:
Recommendation one: Further support to be provided to support authors on the purpose and role of the committee and the format of assurance reports with a tighter executive summary and reflections on benchmarking with other organisations and a focus on outcomes.
Recommendation two: Earlier identification of actions following a meeting and circulation to persons responsible will allow more time for authors to respond to the committee at the expected meeting.
Recommendation three: The agenda should make it clear when external investigation reports are presented and ensure that the necessary assurances are provided on how the Trust has or intends to respond with relevant action plans.

The NEDs agreed to read through and respond to the Company Secretary with comments and suggestions and/or to discuss at the Board Assurance Chairs meeting. The Committee agreed that as suggested by the Well Led review, operation of the assurance committees should be consistent.

People Strategy Update

The Committee discussed whether the Trust is succeeding in changing the culture and it was highlighted the work needs to be sustainable with a strong foundation and infrastructure including policies and procedures and would take time to create, develop, roll out and embed. The Committee discussed the strategy workplan and challenges to its implementation during the Pandemic.

Update from GLA including: Review of management development programme framework at GOSH and outputs

The Committee noted the GLA achieved all the year one milestones and the Charity have agreed an extension. The five year plan is on target to be achieved. The academic portfolio is accredited and on course to achieve and open up apprenticeship qualifications to external candidates nationally and internationally. It was highlighted that the greatest risks for the GLA currently include lack of international travel, face to face delivery and personal contact and the external review of the charity grant. Commercial sustainability was noted to be a difficult balance between direct competition and partnership working. The committee agreed that the GLA reports should focus on risks associated with sustainability and the NEDs agreed to discuss what reporting they would like between the committees.

Update on the management development programme

The first programme has completed and ran throughout the pandemic with the uptake broadly representing the staff demographics. The new programme will be called The Inclusive manager and new managers to the Trust will be required to complete the programme. JH noted the low numbers of completed evaluations from delegates and encouraged a technique be sought to elicit feedback.

OCS On-boarding Update and Workforce impact (including a view from the TU)

An update pf the TUPE transfer of OCS workforce was provided. The Committee was informed that the mobilisation team have worked closely with recognised TU and BAME colleagues throughout the process and permission has been granted from OCS to talk to the employees and feedback from communication has been positive. Collaboration with ICT and the Learning teams continues regarding methods of statutory and mandatory training and an apprenticeship provider has been confirmed.

Update on return to site work programme

The complexity of staff working off site and staff hybrid working was noted to have been managed well and had been largely successful during the pandemic. Decisions regarding return to site are being driven by space constraints and it was noted restrictions are expected to remain in place for the remainder of the year and possibly beyond. The programme requires a sustainable model with a focus on maintaining connection to the hospital and teams. It was agreed that off-site working was not ideal for new starters and the younger workforce and a decision tree has been developed to support managers to make decisions on returning staff to site.

Workforce Metrics Report

Turnover was noted as being suppressed during the pandemic and that the data is shifting and will require close attention. Sickness was noted to be increasing and Chair raised concern anxiety and depression are key causes. The Committee discussed why sick leave was difficult to capture and it was suggested to be down to the education of managers recording on HealthRoster. The Committee agreed that under reporting was unacceptable and was assured that this was an ongoing piece of work and education and that the HR Business partners were supporting the Directorates. The Committee agreed to bring back sickness absence for discussion and update in September as reporting was noted to be fundamental to managing people well. A discussion regarding reconciling information between HR and finance took place and it was noted to be causing difficulties for the nursing workforce.

Update on Staff Focused Freedom to Speak up Cases

The Committee were informed numbers of staff accessing the service had been increasing consistently over five months. Bullying and harassment remain the highest concern. Following the review of Speak Up, the programme will be integrated in the Seen and Heard framework and the FTSU role will be separate and will continue to report to the Medical Director. A discussion took place regarding improved support for line managers. The importance of creating psychological safety and inclusivity within the organisation was highlighted. The Committee agreed to focus on speaking up and safety and agreed the conversation was important to continue.

Volunteer Governance

The Committee agreed excellent progress had been made following the review and audit.

Allied Health Professionals Update

The Committee discussed the BAME AHP minority survey results and agreed that GOSH have some of the lowest rates which are recognised and the team are giving focus. Comments within the survey include discrimination and racism and Chair said they made very unhappy reading. Discussion focused on the importance of the Trust acting upon information received and organisation wide listening events.

Diversity and Inclusion Report - Including – focus on updates to Disciplinary process

It was noted that this was the first GOSH D&I report to be published and the programme of work would embed training and development with a focus on line management development, policy processes and supporting internal candidates to prepare for job applications. The Committee discussed diverse interview panels and agreed that the process must be practical with the right support and training in place to support.

Safe Staffing Report / Nursing Workforce

Discrepancies between HR and finance were noted as an issue for the nursing workforce and the Committee were informed the problems should be corrected from June. The committee agreed to bring back vacancy turnover to the September meeting.