Meeting of the Trust Board
Wednesday 29 September 2021

Dear Members

There will be a public meeting of the Trust Board on Wednesday 29 September 2021 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH at 2:00pm.

Company Secretary Direct Line: 020 7813 8330

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment	Page number	Timing
1.	**Apologies for absence**	Chair	**Verbal**		**2:00pm**
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 7 July 2021**	Chair	**L**	**3**	
3.	**Matters Arising/ Action Checklist**	Chair	**M**	**11**	
4.	**Chief Executive Update**	Chief Executive	**N**	**12**	**2:10pm**
5.	**Patient Story**	Acting Chief Nurse	**O**	**19**	**2:20pm**
6.	**Directorate presentation: Operations and Images Directorate**	Chief Operating Officer/ Senior Leadership Team for Directorate	**P**	**21**	**2:30pm**
	STRATEGY AND PLANNING				
7.	**Non-Emergency Patient Transport (NEPT) Contract**	Director of Estates, Facilities and Built Environment	**Q**	**29**	**2:45pm**
	PERFORMANCE				
8.	**Integrated Quality and Performance Report (Month 5 2021/22) August 2021 data (including proposed changes to the IQPR)**	Medical Director/ Acting Chief Nurse/ Chief Operating Officer	**S**	**56**	**2:50pm**
9.	**Finance Report (Month 5 2021/22) August 2021 data**	Chief Finance Officer	**T**	**117**	**3:00pm**
10.	**Safe Nurse Staffing Report for reporting period June & July 21** **Safe Nursing Establishment**	Acting Chief Nurse	**U** **4**	**129** **135**	**3:10pm**
	ASSURANCE				

11.	**Learning from Deaths Mortality Review Group - Report of deaths in Q4 2020/2021**	Medical Director	**V**	**143**	**3:20pm**
12.	**Director of Infection, Prevention and Control Annual Report 2020/21** **Infection Control Board Assurance Framework**	Director of Infection, Prevention and Control	**W** **X**	**157** **163**	**3:30pm**
13.	**Emergency Planning Annual Report 2020/21**	Chief Operating Officer	**Y**	**174**	**3:40pm**
14.	**Board Assurance Committee reports** • **Quality, Safety and Experience Assurance Committee – July 2021** • **Finance and Investment Committee Update – July 2021** • **People and Education Assurance Committee Update – September 2021 meeting** *The Audit Committee has not met since the last Trust Board meeting in July 2021*	Chair of QSEAC Chair of the Finance and Investment Committee Chair of the People and Education Assurance Committee	**Z** **1** **2**	**180** **183** **185**	**3:50pm**
	GOVERNANCE				
15.	**Register of Seals**	Company Secretary	**3**	**187**	**4:00pm**
16.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)				**4:10pm**
17.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 24 November 2021.				

Attachment L

Great Ormond Street Hospital for Children
NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 7th July 2021

Present

Sir Michael Rake	Chair
James Hatchley	Non-Executive Director
Chris Kennedy	Non-Executive Director
Amanda Ellingworth	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
Mark Sartori	Trustee, GOSH Children's Charity
Claire Williams*	Head of Patient Experience
Dorothy Moore Brooks*	Senior Chaplain and Deputy Team Leader of the Chaplaincy and Spiritual Care team
Martin Tisdall*	Chief of Service, Brain Directorate
Robert Robinson*	Deputy Chief of Service, Brain Directorate
Alison Taberner Stokes*	Head of Nursing and Patient Experience, Brain Directorate
Dr Philip Cunnington*	Responsible Officer
Michelle Nightingale*	Named Nurse for Safeguarding
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Peace Joseph	Governor (observer)

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

52	**Apologies for absence**
52.1	No apologies for absence were received.
53	**Declarations of Interest**
53.1	No declarations of interest were received.
54	**Minutes of Meeting held on**
54.1	The Board **approved** the minutes of the previous meeting.

55	**Matters Arising/ Action Checklist**
55.1	The actions taken since the last meeting were noted.
56	**Chair's Update**
56.1	Sir Michael Rake, Chair said that it was Alison Robertson's last Trust Board meeting as she would be retiring from the Trust in September. He thanked her for her work as Chief Nurse and Deputy Chief Executive.
57	**Chief Executive Update**
57.1	Matthew Shaw, Chief Executive thanked staff throughout the hospital for their hard work to sustain a high level of activity in order to reduce the backlog of appointments. He emphasised the importance of finding a balance between treating the maximum number of patients and ensuring there was appropriate rest time for staff.
57.2	Short term priorities continued to be around quality and safety, people, and the fundamental areas of operation. Additional focus was being placed on diversity and inclusion to ensure that real progress was being made in this area. New guidance around infection control was anticipated and clear communications would be required with staff at a time of considerable change.
58	**GOSH Quality Report 2020/21**
58.1	Sanjiv Sharma, Medical Director presented the report. He thanked the team for their work to adhere to the deadline which had been substantially shortened at short notice. The report had been presented to the QSEAC for approval on 1st July 2021 and would form part of the Annual Report.
58.2	The Board **noted** the report.
59	**Integrated Quality and Performance Report (Month 2 2021/22) May 2021 data**
59.1	Sanjiv Sharma reported that there had been improved performance around incident closure and compliance with the WHO checklist following focused work in those areas. Meetings had taken place with Directorate leads to emphasise the importance of improving Duty of Candour compliance. Training on conducting Root Cause Analysis would be taking place within the next two months after it had been delayed by the pandemic.
59.2	Alison Robertson, Chief Nurse said that there continued to be a strong performance in the Friends and Family Test response rate and patient and family satisfaction scores. The Patient and Family Engagement and Experience Committee had discussed the deep dive into red complaints received by the Trust in recent years and had identified some key themes. Actions had been presented against those themes and good progress was being made to improve the complaints process for families. Presentations were received from two Directorates in response to their high levels of PALS contacts. They had taken practical steps and the other Directorates would be encouraged to take similar actions.

59.3	Russell Viner, Non-Executive Director said that many of the matters discussed in the IQPR and by the Board in general had structures in place for improvement but it was key to ensure that these were embedded in the Trust's day to day activities.
59.4	James Hatchley, Non-Executive Director noted the potential for a surge in RSV cases in children and asked what planning had been done around this. Sanjiv Sharma said that the rise in RSV was a common occurrence each winter but it was anticipated that this would occur earlier in the year in 2021. The data and modelling from Australia showed that cases were primarily treated in the community or in secondary care settings leading to little increase in paediatric ICU activity. Sanjiv Sharma added that it was important to engage in conversations around this to ensure that GOSH was able to provide support to other organisations if necessary.
59.5	Alison Robertson said that the Trust would continue to adhere to the national COVID19 guidelines which had not yet changed. Caroline Anderson, Director of HR and OD said that the number of self-isolating staff had increased sharply in the previous week to over 70. Discussion was taking place nationally as to whether different arrangements for close contacts of COVID positive cases would be implemented for individuals who had received two vaccinations which was currently the case for 80% of GOSH staff. Sir Michael Rake asked if more could be done to increase the vaccine uptake rate amongst staff and Caroline Anderson said that weekly meetings took place to review the status of staff vaccinations and discussions were taking place with individuals who had not been vaccinated. She said that it was also important to capture data around staff who had been vaccinated outside the Trust.
59.6	Russell Viner noted that once a high proportion of adults had been vaccinated nationally, transmission would be primarily within the younger population and this could have an impact on the number of COVID positive patients treated by hospitals such as GOSH. He asked about the Trust's plans for flu vaccinations. Alison Robertson said that a letter had been received asking Trusts to prepare for COVID booster vaccinations in the autumn and health and social care staff would be included in the first wave of these vaccinations. It was anticipated that one vaccination clinic would be established to give both the flu and COVID19 vaccinations. She said that during the surges of the pandemic, hospital acquired infection had become a key issue in many Trusts and therefore it was vital that GOSH had robust infection control processes in place if the matter were to become more focused on children and young people.
59.7	John Quinn, Chief Operating Officer said that the RTT position continued to improve and a trajectory was in place to return to target. A number of patients continued to wait over 52 weeks and this metric continued to improve along with that of diagnostic waits. The Trust continued to achieve 100% against cancer waiting times standards. John Quinn said that activity in many areas of the hospital was at more than 100% of the previous year and reiterated that it was vital to consider staff wellbeing in this context.
60	**Patient Story**
60.1	Dorothy Moore Brookes, Senior Chaplain and Deputy Team Leader of the Chaplaincy and Spiritual Care team said that the parents of a patient in critical care had requested to get married on the unit with their baby son, Leo present.. Significant team work enabled the patient's parents to get married and have

	photos taken at the event,. Baby Leo has sadly died and we thank his parents for giving their permission to share this story.
60.2	The Board thanked the family and the Chaplaincy Team for the presentation.
61	**Directorate presentation: Brain Directorate**
61.1	Martin Tisdall, Chief of Service for Brain Directorate said that a key success of the Directorate had been opening the Intraoperative MRI suite in partnership with the GOSH Children's Charity which had significantly improved the standard of technology in the service. The directorate had been able to increase capacity however constraints remained and there was a considerable backlog of patients. There were a number of complex services in the directorate with a smaller number of patients and it was important to ensure that good succession planning was in place to maintain the stability of these services. Support was being sought from the GOSH Children's Charity for proleptic appointments in these areas.
61.2	The Directorate had been able to deliver 91% of inpatient and outpatient activity during the first year of the pandemic and was currently working at 120% of the previous year's activity under the accelerator programme. Martin Tisdall said that it was important to be transparent about outcomes and the directorate was working towards increased visibility of outcomes.
61.3	Robert Robinson, Deputy Chief of Service said that RTT had recovered significantly and was currently at 82%. A key long waiting service was Selective Dorsal Rhizotomy as this required physiotherapy from an external service which involved a significant waiting time. Social distancing requirements had led to the loss of 6 beds on Kingfisher Ward.
61.4	Alison Taberner Stokes, Head of Nursing and Patient Experience said that succession planning was key, particularly in two specialties. A pipeline was in place to reach full establishment by the end of September 2021 however this was currently having an impact on the team. Alternative workforce strategies were being considered including additional SHO or physician associate roles.
61.5	The directorate had improved scores in 9 out of 10 areas of the staff survey and a good communications strategy was in place with a newsletter to the directorate. A leadership education programme was in place with HR and Finance.
61.6	Robert Robinson said that focus had been placed on written communication with families such as clinical letters and discharge summaries and a substantial improvement had been made in this area. A number of overdue incidents remained outstanding and focus was being placed on appropriately closing these. Twelve formal complaints had been received for the directorate and a common theme had been around communication particularly with families. The use of MyGOSH had been extremely beneficial in this regard.
61.7	The Directorate had ended 2020/21 in a financial position that was adverse to plan primarily as a result of the significant reduction in International and Private Care (I&PC) and research income during the pandemic. This had been partly offset by the specialist services and high cost drugs offered by the Directorate including Nusinersen and Batten Disease. For 2021/22 the budget had been set at a deficit of £23million and the Directorate was currently surplus to plan. An

	assumption had been made that International and Private Care activity would recover and Martin Tisdall said that underperformance in this regard would impact the Directorate's year end outturn.
61.8	Sir Michael Rake said that Brain's innovative and creative work within networks epitomised the work of GOSH. He highlighted the importance of recruiting specialist staff internationally and asked whether there had been delays to this process as a result of Brexit. Caroline Anderson, Director of HR and OD said that it was not yet clear whether delays would be experienced but agreed that it was important to consider pipelines of staff and succession planning at an earlier stage.
61.9	Akhter Mateen, Non-Executive Director asked how the leadership team ensured that new members of staff were aware of the various ways in which they were able to speak up in the Trust. Martin Tisdall said that this was part of a wider question of communicating and engaging with the directorate. He added that the major incident command structure had been helpful in ensuring that information was disseminated and therefore the Directorate had continued to communicate in the way that they had when bronze meetings had been in place which had been helpful. An 'all Brain' email group had been developed and consideration was being given to reaching groups that wouldn't usually be included in the communications and the need to be visible.
61.10	James Hatchley highlighted the challenge of the staffing issues in the directorate in combination with the complex work and over performance of activity taking place. He said that given the good work on staff engagement taking place the staff survey results did not appear to be fully reflective of this work. Martin Tisdall said that traditionally there had been a motivated group of clinicians who were keen to deliver activity and take ownership of their patients and whilst this was positive, it had also led to ongoing under resourcing over time. He said that it was important to keep this under review to ensure the stability of the service going forward. A positive Getting It Right First Time (GIRFT) report had been received however this had also highlighted under resourcing and Martin Tisdall said that in this context it was vital to balance increased activity with the wellbeing of staff. He agreed that there were metrics in the staff survey which remained lower than anticipated given the work taking place and said that a deep dive into results had shown that diversity and inclusion was a key area for improvement.
61.11	Amanda Ellingworth, Non-Executive Director asked if the team had any reflections for the Board and Martin Tisdall reiterated the importance of staff wellbeing particularly during a time in which increased activity was vital to clear the backlog and in the context of an extremely challenging 18 months for staff both personally and profesionally. He added that Board support was important in the team's work with the Charity to bring forward proleptic appointments.
61.12	Russell Viner, Non-Executive Director noted the diversity of the specialties within the directorate and said that it was important to identify talented individuals early in their careers and at PhD level. He asked how costs and income flowed for mental health services. Alison Taberner Stokes said that Kingfisher Ward had been converted to support an increase in CAMHS patients which led to the service becoming part of the directorate during wave one of the pandemic..

61.13	John Quinn said that the team was high performing as a leadership team and a directorate and thanked them for their hard work. The Board thanked the directorate as whole for their work.
62	**Responsible Officer Annual Report 2020/21**
62.1	Philip Cunnington, Responsible Officer said that 2020/21 had been a challenging year and had demonstrated the importance of appraisal both for doctors personally and for the organisation. Despite the pressures of the pandemic over 90% of appraisals had been completed. During the year the medical appraisal process had been suspended and GOSH had resumed the process earlier than many other organisations with a focus being placed on the discussion of the appraisal itself. Feedback had been received that appraisal had felt like a personalised event.
62.2	Going forward the challenge was around wellbeing and additional tools would be launched to support this. Training would be introduced for appraisers to ensure they were comfortable in asking questions about wellbeing. A tender process was taking place to procure a system to support appraisal and an external review of a random sample of 10% of appraisal forms would take place to ensure that quality appraisals were being carried out.
62.3	Russell Viner said that it was challenging to carry out high quality appraisals at a time of significant pressure for many staff and asked if there were processes in place to ensure that all relevant staff were engaging. Philip Cunnington said that it was important to identify individuals who were late going through the appraisal process and explore why this was the case. Russell Viner asked whether there was a mechanism by which inappropriate behaviours could be challenged and Philip Cunnington said that whilst there was an appetite in the Trust to do this he felt there was more work to do. He emphasised the importance of creating an environment in which colleagues felt able to speak up. He added that it would be helpful to ask patients and colleagues to provide feedback throughout the year and to have access to a real time dashboard in order to maintain consistent standards.
63	**Finance Report (Month 2 2021/22) May 2021 data**
63.1	Helen Jameson, Chief Finance Officer said that the month 2 position was £7.6million above plan in month with a year to date position of £3.6million above plan. This was as a result of Elective Recovery Funding (ERF) of £7.8million being received in order to reduce the backlog of patients which had not been included in the plan. Cash remained strong and the capital programme remained in line with plan.
64	**Safe Nurse Staffing Report (April - May 2021)**
64.1	Alison Robertson said that maintaining a good pipeline of recruitment was fundamental to maintaining safe staffing levels. It was likely that there would be an increase in staff turnover once restrictions related to the pandemic were removed and as a result focus had been placed on recruitment.
64.2	Four Datix incidents had been raised as a result of staffing levels in the reporting period all of which had been investigated. It was confirmed that no patient harm had occurred.

64.3	Work was taking place to ensure that data held by HR, finance and nursing workforce was aligned and Kathryn Ludlow asked whether this was likely to have a retrospective impact on staff planning. Alison Robertson said that despite this issue which was in the process of being corrected, she was confident that establishments were appropriate and wards were staffed to this level.
65	**Annual Safeguarding Report 2020/21**
65.1	Alison Robertson said that it had been a challenging year for the safeguarding team with the retirement of key post holders as well as additional pressures as a result of the pandemic. The team had responded well and had been able to develop the Perplexing Presentations Service. Work was taking place to further integrate the social work and safeguarding teams and it had been agreed that an external review of safeguarding arrangements would be helpful and would take place towards the end of 2021/22.
65.2	Amanda Ellingworth asked about the culture around safeguarding at GOSH and Michelle Nightingale, Named Nurse for Safeguarding said that she had been holding meet and greets with staff to reflect on the ways in which safeguarding issues could be raised. She said that the aim was to build confidence in clinical teams in order to move the focus away from the safeguarding team and support staff to engage with local services themselves.
65.3	James Hatchley asked how the Trust ensured that external organisations working with GOSH had sufficient safeguarding processes in place. Alison Robertson confirmed that employment checks were undertaken before contracts with external organisations were signed and HR would undertake regular audits.
66	**Completion of Royal College Review Actions**
66.1	Sanjiv Sharma said that over the past five years the Trust had commissioned service reviews from two Medical Royal Colleges: reviews of the gastroenterology service in 2015 and 2017 by the Royal College of Paediatrics and Child Health (RCPCH) and a review of the urology service in 2019 by the Royal College of Surgeons.
66.2	Three actions remained open from the gastroenterology review, two of which related to network working and one relating to a follow up review. Steps had been taken to support the closure of those actions and work would take place to confirm that the action plans were complete.
67	**Annual Sustainability Management Plan 2020/21**
67.1	Zoe Asensio Sanchez, Director of Estates, Facilities and Built Environment said that substantial work had taken place around public engagement; there had been a relaunch of the Trust's Green Champions and a play street was scheduled.
67.2	**Action:** Chris Kennedy, Non-Executive Director highlighted that staff travel was being reviewed but not patient travel. He suggested surveys should also be undertaken around patient travel and it was agreed that this would be considered.
68	**Board Assurance Committee reports**

68.1	Quality, Safety and experience Assurance Committee – 1 July 2021
68.2	Amanda Ellingworth, Chair of the QSEAC said that the majority of the matters which had been discussed by the committee had also been discussed by the Board.
68.3	Audit Committee Assurance Committee Update – May 2021 meeting
68.4	Akhter Mateen, Chair of the Audit Committee reported that the update had been given at the July Council of Governors' meeting.
68.5	Finance and Investment Committee Update – May 2021 and June 2021
68.6	James Hatchley, Chair of the Finance and Investment Committee said that a discussion had taken place around the Patient Level Information and Costing Systems (PLICS) return which required sign off. The Board **agreed** that this approval should be given by the Finance and Investment Committee.
68.7	People and Education Assurance Committee Update – June 2021 meeting
68.8	**Action:** Kathryn Ludlow, Non-Executive Director said that an update had been provided at the July Council of Governors' meeting. Amanda Ellingworth said that appraisal was a key tool for all staff in the Trust and suggested that the PEAC had an overview of the way in which this was utilised for all staff across the organisation. This was agreed.
69	**Council of Governors' Update - July 2021 meeting**
69.1	Sir Michael Rake said that Governors had given feedback that they were receiving large amounts of information and had requested input into the agenda for Council of Governors' meetings. They had been pleased with the progress made in this area and were keen to understand the priorities of the Board. The Non-Executive Directors had encouraged Governors observe assurance committee meetings.
70	**Any other business**
70.1	There were no items of other business.

Attachment M

TRUST BOARD – PUBLIC ACTION CHECKLIST
September 2021

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
67.2	07/07/21	Chris Kennedy, Non-Executive Director highlighted that staff travel was being reviewed but not patient travel as part of the annual sustainability management plan. He suggested surveys should also be undertaken around patient travel and it was agreed that this would be considered.	ZAS	September 2021	The Facilities Team are in the process of recruiting a newly created Transport Manager role to oversee all aspects of patient travel. One of the specific duties of this role will be reviewing patient travel.
68.8	07/07/21	Amanda Ellingworth said that appraisal was a key tool for all staff in the Trust and suggested that the PEAC had an overview of the way in which this was utilised for all staff across the organisation. This was agreed.	CA	September 2021	Passed to the PEAC for ongoing assurance

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 29 September 2021	
Chief Executive's Report **Submitted by:** Matthew Shaw, Chief Executive	**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 • Key people, finance and service issues • Trust strategy and partnerships	
Action required from the meeting To review and 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 All BAF risks	**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: Current operational pressures

As previously reported, 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 weeks and months ahead including Covid (already putting pressure on local ICU capacity), the forthcoming surge of Respiratory Syncytial Virus (RSV), the Autumn phase of the vaccination programme and winter pressures.

The hospital continues to deliver well on throughput of activity, consistently topping the elective recovery table for North Central London, which is itself a high performing ICS.

We are delivering on NHSE's Accelerator Systems Programme, working with our colleagues across the Children's Hospitals' Alliance (CHA) to drive recovery and longer term transformation. As well as delivering on the ambitious recovery targets we have been working on an exciting range of innovations, including the development of predictive AI technologies and targeted health outreach interventions to reduce the number of children who miss their appointments each year.

We will be running 'Super Saturday' events in October and again in the New Year and our teams are currently exploring options for additional lists and/or clinics as well as other important activities that will support our patients and families that may not be possible for us to offer during the working week.

We recognise this will be a challenge for our busy staff, but as ever we have been hugely impressed by the thoughtful and sensitive response from our clinical leaders and their suggestions for ways in which we can make this a positive celebration of GOSH's critical role in recovering services for children.

There remains a great deal of concern within the NHS about the scale of Respiratory Syncytial Virus (RSV), after high levels of cases in parts of the country had a tremendously destabilising effect on the recovery of children's services. At GOSH we have only seen a very slight increase in patients with RSV post school return but we continue to monitor this closely and work with our system partners to offer support where it is needed.

Vaccines update

Following the Government's decision to offer booster vaccinations to health and social care workers, we are now running a joint COVID-19 booster and flu vaccination clinic at GOSH on Rhino Outpatients. The Department of Health and Social Care recommends a booster vaccine ahead of the winter months to maximise protection in those who are most vulnerable to COVID-19. It will be available to those working in health and social care who had their second dose of vaccine at least six months ago.

The Board will be aware that the NHS Chief Medical Officers have recommended that over 12s should be able to receive a single dose of the Pfizer-BioNTech Covid vaccination to prevent disruptions to education and benefit those growing up in the poorest areas. This came following the JCVI advice that there was likely to be only a marginal benefit to vaccinating adolescents on health grounds alone, and their recommendation to vaccinate children over 12 with specific underlying health conditions who are at greater risk.

Looking back at our Annual General Meeting

With all of these live operational pressures, it can be easy to lose sight of just how much our hospital community has achieved during a relatively short space of time. This is probably one of the reasons why taking part in our **Annual General Meeting** earlier this month was a really cathartic experience for many of us! It was a pleasure to look back on the fantastic achievements of 2020/21, including:

- **Responding to COVID-19 and restoring clinical services**, changing the way we engaged with and supported our patients, families and partners and responding comprehensively and collaboratively to the crisis through the sheer determination and will of our staff.
- **Investing in our staff so we can make GOSH a great place to work,** developing the way we take care of staff and ensure their voices were heard.
- **Making a difference now to impact the future for our young people,** becoming the first UK standalone children's hospital and first London NHS Trust to declare a Climate and Health Emergency.
- **Transforming outdated pathways and embracing the virtual world,** reconfiguring our Electronic Patient Record (EPR) to support admission of general paediatric patients from across NCL and oncology patients from other sites; providing access to NHS staff from other Trusts who were caring for patients admitted to GOSH; improving the functionality MyGOSH and transitioning to virtual visits and outpatients appointments.
- **Launching our Above and Beyond strategy** – securing our future beyond the pandemic and set out the priorities and principles that would help us achieve our goals.
- **Delivering essential research activity –** leveraging our extensive infrastructure and expertise to adapt to the changing needs arising from the pandemic and maintaining essential research activity.

Part 2: People

Staff health and wellbeing

We remain concerned about the wellbeing of all our staff, and particularly those working at the frontline for care, who have come an extremely challenging period into one that is more stable, but with ongoing pressures to reduce our waiting lists and uncertainties ahead over the pandemic trajectory and the impact of winter pressures. We experienced some staffing issues over the summer months, but these were mainly related to staff taking much-needed annual leave rather than Covid infections.

New Chief Nurse

I'm delighted to announce that we have appointed Tracy Luckett as our new chief nurse to take up the reins from Alison Robertson who stepped down on Tuesday 14 September.

Tracy is currently director of nursing and allied healthcare professions at Moorfields Eye Hospital. She began her nursing career in North Wales at Wrexham Maelor Hospital and worked in several trusts including Homerton University Hospital before joining Moorfields. Her commitment to nursing was recognised recently when she was presented with a prestigious Gold Award from the NHS chief nursing officer, Ruth May.

Tracy will be joining us on 1 February 2022 and will play a critical role in helping us deliver on our strategy, Above and Beyond. Tracy will sit on the Executive Team and Trust Board, where she will help set direction for the Trust. She will also be the leader and figurehead for our nursing and allied healthcare professional teams.

Darren Darby, our director of nursing, is now acting chief nurse at GOSH and will hold the position until Tracy joins the team. Huge thanks to Darren, whose skilled direction and leadership will help us through the winter and ensure a smooth transition next year.

Alison, who has been our chief nurse since spring 2018, has made a huge contribution to GOSH over the years. Having started her nursing career here at GOSH as a student in the late 1980s, she went on to build a fabulous career in clinical, operational and strategic roles at a number of prestigious teaching hospitals, before returning as our chief nurse. She is renowned for her calm approach, determination and experience, which have been so important in the last 18 months. We have all admired her ability to impose order and process in fast-moving situations, her heartfelt concern for our patients and staff, and her tireless representation on behalf of our nurses and allied healthcare professionals.

Other team changes

We will soon be welcoming a new Cancer Centre Programme Director, Cancer Planet Director and Director of Transformation. With the cancer centre staff members joining in October, these roles will bolster the skills and capacity of these two critical teams, enhancing our ability to deliver our transformation and cancer strategies.

In another major change to our workforce, we have now on-boarded our OCS staff after taking the decision to take our cleaning contract in house. This is an important step forwards for improving the terms and conditions these essential members of our extended GOSH family and improving their sense of belonging.

In other exciting news, our medical workforce teams were excited that GOSH recently made it to the top five in the GMC Junior Doctors survey and we were delighted to hear that our very own Paolo di Coppi has been elected the next President of the European Paediatric Surgeon's Association.

Diversity and inclusion

The Board is aware that our work on Diversity and Inclusion is a key priority for this year. We were delighted that on Thursday, 23 September our Medical Director Sanjiv Sharma was joined by renowned global allyship expert Karen Catlin for a one-hour special edition of the all-staff Virtual Big Brief. During the session colleagues discussed some of the actions we can all take to create a more diverse and inclusive workplace by being a better ally including

diversifying our networks; amplifying and advocate for others in meetings; use of inclusive language and opening career doors for people from under-represented groups.

On Friday, 24 September we are holding an a Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) event to support colleagues in sharing their views and expectations on how we will drive change at GOSH for our Black, Asian and minority ethnic (BAME) colleagues, colleagues with a disability and those with long-term health conditions. We are grateful to our HR team, the GOSH networks and a wide network of staff leaders and allies for their support to deliver these important events.

Part 3: Quality & Safety

Quality and safety continues to be a key area of focus as one of our 4 operational priorities for the year. The GOSH safety strategy 2020-25 set out to cultivate and nurture a just, kind and civil safety culture; one that supports the reduction of avoidable harm to children and young people and frees our staff to continuously and consistently learn and improve our care processes. We are developing a set of initiatives to support culture change including a communication and engagement programme to deliver a shift in beliefs, behaviours and ways of working so that safety improvements can be delivered better and faster.

Part 4: Partnerships

VIPs welcomed at the Zayed Centre for Research into Rare Disease in Children

We were delighted to host His Highness Sheikh Mohamed bin Zayed Al Nahyan, Crown Prince of Abu Dhabi, the Secretary of State for Health and Social Care Sajid Javid MP, and the Secretary of State for Education Minister Nadhim Zahawi MP at a visit to the Zayed Centre for Research into Rare Disease in Children last week.

We were able to introduce our guests to researchers working in immunology and COVID-19 research to understand how the facilities have enabled them to bring new treatment breakthroughs to patients and improve lives. They chatted to Mahboubian Professor in Gene Therapy, Claire Booth, who described her work using gene therapy as a potential cure for ACA SCID.

Our tour included the state-of-the-art specialist clean rooms and the largest single academic manufacturing unit for gene and cell therapies in the UK, where we were able to support the manufacture of the COVID-19 virus to supply to the world's first human challenge trial earlier this year.

During the visit I had a useful conversation with the minister regarding children's cancer and a number of other issues.

COP Ride for Their Lives

GOSH's Climate & Health Emergency response strategy involves long term health sector leadership and collaboration as well as forging links nationally and internationally. The COP 'Ride for Their Lives' will raise awareness (and in some cases funding) to galvanise

paediatric institutions and support them in taking the actions they need to take post COP. The cycle ride will culminate in the delivery of key messages to global Governments at the Summit – for example we'll be taking a 'Healthy Climate Prescription Letter' along with us and this will be accompanied by a coordinated editorial featuring in over 200 journals. An immersive installation by artist Michael Pinsky made up of five geodesic domes, emulating polluted environments in cities globally, will accompany the cycle ride.

Our cyclists will leave GOSH on 24 October 2021. We have 30 paediatric healthcare professionals signed up from GOSH, Evelina, Bristol Royal, Sheffield Children's, Great North Children's and the Royal Children's in Glasgow. They will be riding the 540 miles over 7 days with members of the GOSH YPF, who will deliver our messages to the event stage. The Ride for their Lives also includes virtual riders, who can't join the group in person, but whose mileage will be recorded towards our overarching goal. The combined aim is that paediatric health professionals will have cycled 1 million miles during October to amplify the climate message on behalf of the children they care for.

Ends

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
29 September 2021

Patient Story- care and support and longer-term admissions **Submitted by:** Darren Darby, Acting 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 the voice of patients and their families is heard, that their experiences are shared, and that this informs further action to share good practice and drive improvements.

Summary of report
Bertie (now aged 18 months old) was transferred to GOSH a few hours after birth following previously undetected issues with a rare tracheo-oesophageal fistula (an abnormal connection between the oesophagus and trachea). He has since been under the care of multiple specialties including Paediatric Surgery, Neurosurgery, Cardiology, Gastroenterology and others at GOSH.

Emma, Bertie's mum, will attend the Trust Board meeting by zoom to talk about her experiences at GOSH in relation to:

- The exceptional care provided to Bertie
- Support for Emma including regular communication, responsiveness and understanding from staff regarding any concerns and worries
- The open and transparent approach from staff in the context of a potential issue relating to a previous procedure which led Bertie to become unwell
- How it feels to be in the hospital for longer admissions in particular accommodation, breastfeeding at GOSH including vouchers and facilities, food in the Lagoon, 'beds' on the wards, and her insight into how some aspects could be improved for families
- Bertie's brother's positive experiences of facilities and activities when he was able to come on site.

Action required from the meeting
For information

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**	**□ Culture of high quality sustainable care** **□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**

Strategic risk implications Risk 12: Inconsistent delivery of safe care
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
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? Acting Chief Nurse
Which management committee will have oversight of the matters covered in this report? Patient and Family Experience and Engagement Committee

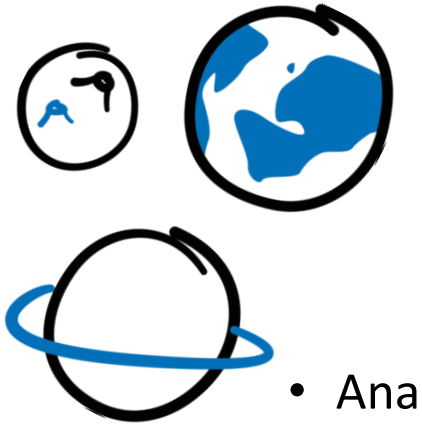
Operations and Imaging

Directorate Trust Board Update

2020-21

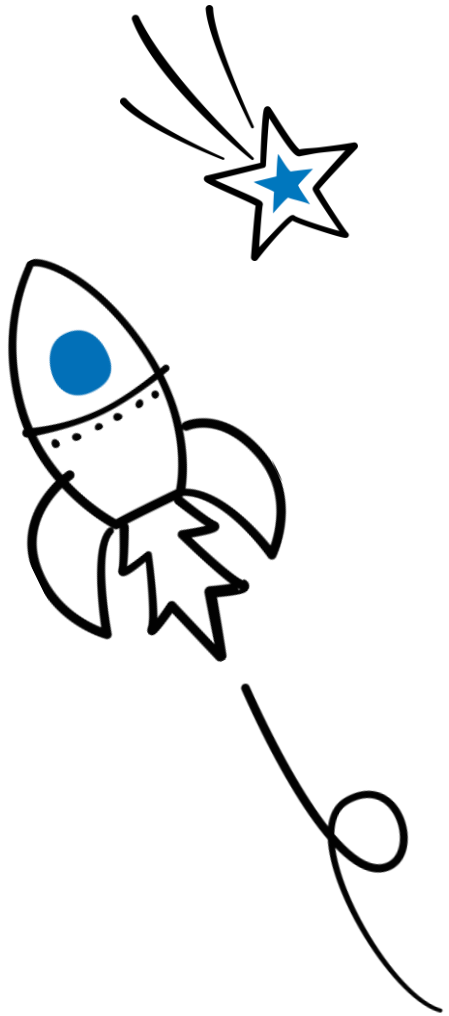
NHS Great Ormond Street Hospital for Children NHS Foundation Trust

OPERATIONS AND IMAGES



Who we are….

- Anaesthetic Pre-operative Assessment Service
- Admissions
- Theatres
- Anaesthesia
- Pain Service
- Radiology
- Nurse led Sedation Service
- Interventional Radiology
- Cardiac Catheter Lab
- Woodpecker and Nightingale



Since we last saw you……

- Managing the Directorate through a Pandemic
- Opening of intraoperative MRI
- Quality standards for Imaging accreditation 10th year
- Successful extensive Nurse recruitment (in a pandemic!)

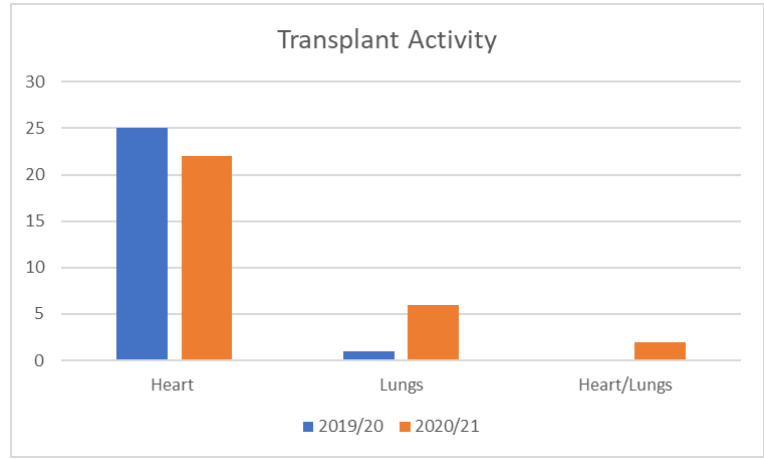
COVID and O&I

- General Paediatrics from across the NCL sector temporarily housed at GOSH.
- Uplift to emergency capacity
- Support for our staff
- Patient experience
- Preparation for supporting other services
- Deployment of staff
- PPE Challenges a high risk service with significant AGP interventions (intubation).
- Working closely with IPC

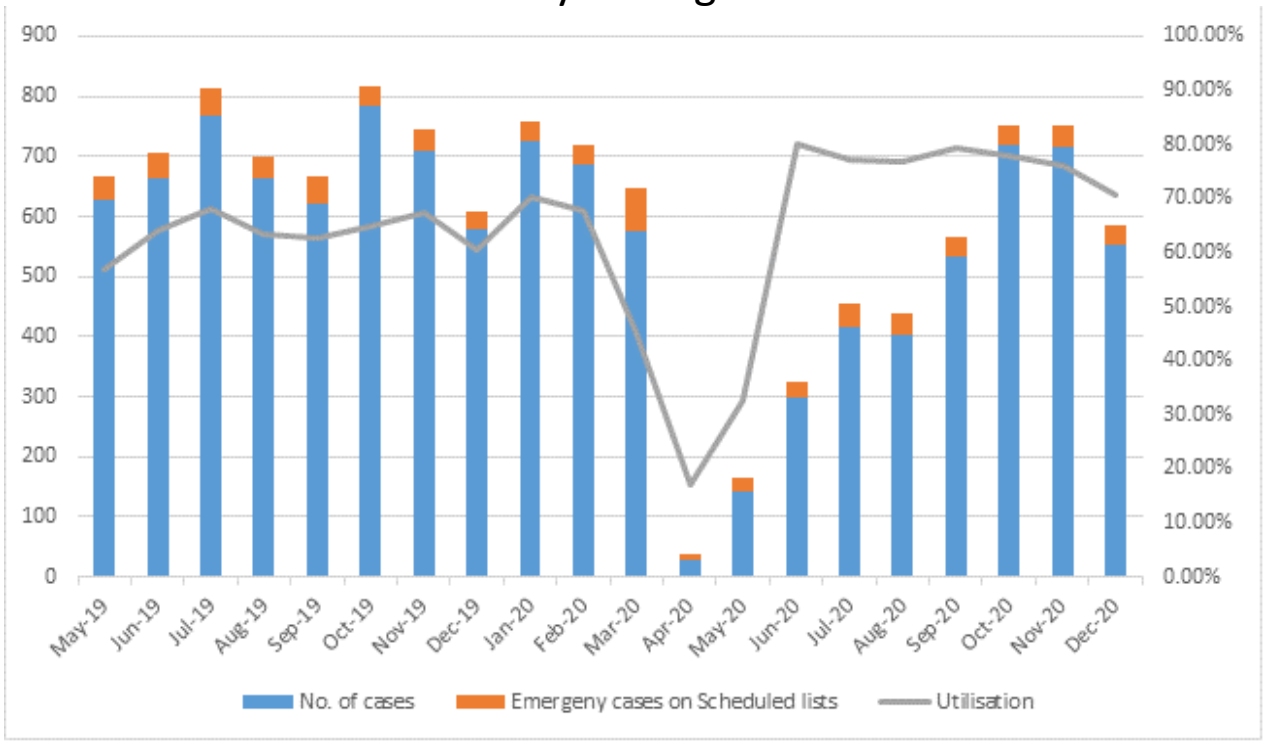
Restoration & Recovery

- Staff Wellbeing
  - New Normal
  - Stepped approach
- New ways of working
  - Impact on activity
  - Overruns
  - +10%

Restoration

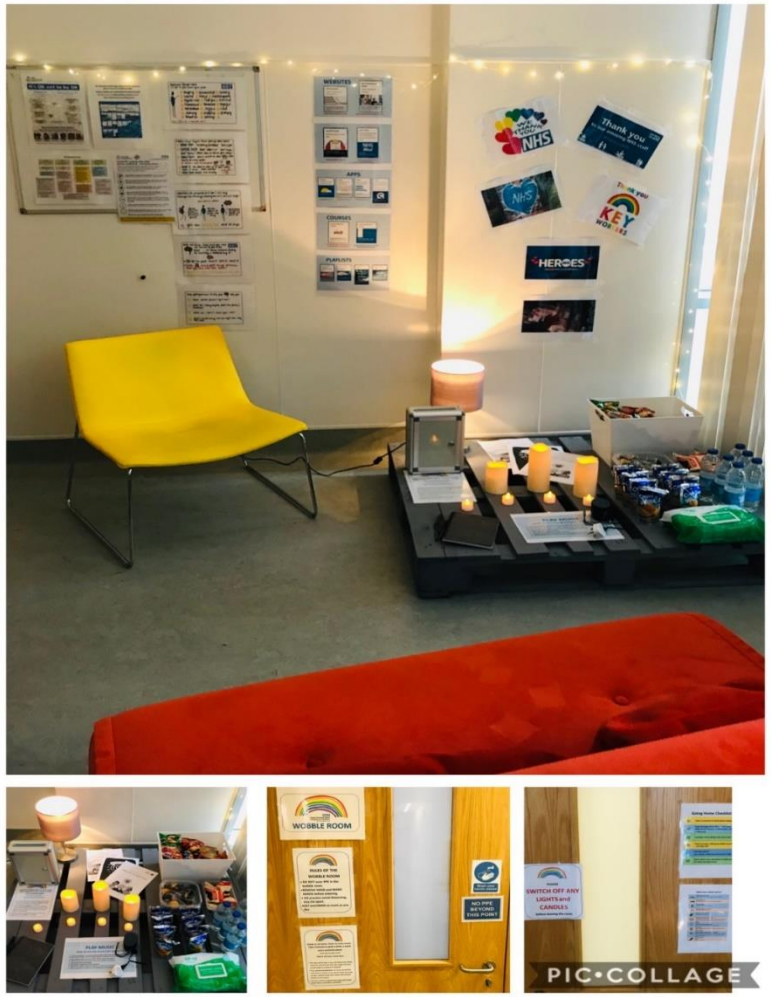


Theatre activity through the 1st wave



Looking to the future

- Staff wellbeing
- Efficient resource use
  - Embedding 6-4-2
  - Surgical Huddle
  - +10%
  - APOA
- Culture
- Retention
- CCC planning and futureproofing



Thank you!

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
29 September 2021

September 2021 Integrated Quality and Performance Report (IQPR) (August 2021 Data) and **Proposal for IQPR revisions** **Submitted by:** Dr Sanjiv Sharma MD Darren Darby, Acting Chief Nurse John Quinn Chief Operating Officer Caroline Anderson Director of HR & OD	**Paper No: Attachment S** ☐ **For approval** √ **For discussion** ☐ **For information and noting**

Purpose of report

Sept IQPR

To present the IQPR data and narrative to the Board to show the monthly performance on the key indicators and to provide the Board with assurance that the indicators on patient safety, patient experience and performance are monitored regularly.

Proposal for IQPR revisions

To set out for discussion a proposal for revision of the IQPR to provide improved assurance for the Board.

Summary of IQPR report

- The report shows that the incident reporting rate has decreased this month. It should be noted that this is set against decreased activity in the Trust. The percentage of incident closure rate has decreased to 72% and average days to close decreased from 34 to 32.
- The Trust did not have any overdue serious incident reports in August.
- 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 August was 28%, a decrease of 6% from the previous month, but still remains above target of 25%. Targets for ratings of experience for both inpatients (98%) and outpatients (97% rising from 94% in July) were all met. At directorate level, three directorates (BBC, BBM and S&S) did not achieve the target response rates.
- There were 8 formal complaints received in August 2021, which is an increase from the previous months (May, June and July) and in comparison to August 2020 (6). Overdue red complaint actions are unchanged this month (11) although progress has been made and updated completion dates are under review with the team concerned.
- PALS contacts (174) decreased significantly this month. This aligns with reduced patient activity in August and was consistent with contacts received in August 20 (177). Contacts relating to communication fell to their lowest recorded (14).
- We aim to have to have over 100 completed specialty led clinical audits per year. We are on track for meeting this target. (47 audits completed YTD).
- RTT – Slight decrease in the position reported at the end of August 2021 at 77.8%, 0.5% decrease from July and -0.2% below trajectory. 52 Week waits decrease of 25 patients (9%) to 247 at end of August.
- DM01 – Decrease in the reported position for August 2021 at 81.06%, 4.3% decrease from July and 1% above trajectory. 6 Week breaches increased by 42 to 243.

Summary of Proposal for IQPR Revisions

- Setting out rationale for the changes which are focused on improved assurance provision.
- Key elements: selection of important KPIs, consistency of format and integration to the reporting suite used within the Trust.

Action required from the meeting
The Board are asked to note the report.

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 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**	**□ 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
All BAF risks

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?
The MD supported by the AMDs

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

Which management committee will have oversight of the matters covered in this report?
RACG, Closing the Loop and PFEEC.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality & Performance Report September 2021 (August 2021 data)

Sanjiv Sharma	Darren Darby	John Quinn	Caroline Anderson
Medical Director	Acting Chief Nurse	Chief Operating Officer	Director of HR & OD

Hospital Quality Performance – September 2021 (August data)

Are our patients receiving safe, harm-free care?

	Parameters	June 2021	July 2021	August 2021
Incidents reports (per 1000 bed days)	R<60 A 61-70 G>70	90 (n=662)	91 (n=661)	82 N=587
Incident investigations completed in month		722	506	458
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	793	571	412
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	72%	76%	72%
Average days to close	R ->50, A - <50 G - <45	35	34	32
Medication Incidents (% of total PSI)	TBC	20.7%	22%	19.4%
WHO Checklist (Main Theatres GA only)	R<98% G>98-100%	98%	97%	97%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	4.9%	3.4%	3.7%
New Serious Incidents		2	1	1
Overdue Serious incidents	R >1, A -1, G – 0	1	1	0
Safety Alerts overdue	R- >1 G - 0	2	4	3
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	Jun 21	Jul 21	Aug 21
Specialty Led Clinical Audits on Track	R 0- 60%, A>60-75% G>75-100%	81%	76%	79%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	25	33	47
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	1	0	0
Participation in mandatory relevant national audits	G=100%	100%	100%	100%

Are our patients having a good experience of care?

	Parameters	June 2021	July 2021	August 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	96%	94%	97%
Friends and Family Test - response rate (Inpatient)	25%	35%	34%	28%
PALS (per 1000 combined pt episodes)	N/A	10.33	9.96	8.44
Complaints (per 1000 combined pt episodes)	N/A	0.28	0.29	0.38
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	11%	11%	11%
Re-opened complaints (% of total complaints since April 2020)	R>12% A- 10-12% G- <10%	5%	5%	4%

Are our People Ready to Deliver High Quality Care?

	Parameters	June 2021	July 2021	August 2021
Mandatory Training Compliance	R<80%,A-80-90% G>90%	94%	94%	91%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	86%	85%	86%
PDR	R<80%,A-80-89% G>90%	88%	88%	88%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	93%	92%	94%
Honorary contract training compliance	R<80%,A-80-90% G>90%	78%	74%	76%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	90%	89%	86%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	90%	89%	90%
Resuscitation Training	R<80%,A-80-90% G>90%	88%	86%	86%
Sickness Rate	R -3+% G= <3%	2.9%	3.6%	3.5%
Turnover - Voluntary	R>14% G-<14%	11.3%	11.4%	11.5%
Vacancy Rate – Contractual	R- >10% G- <10%	5.8%	6.5%	6.9%
Vacancy Rate - Nursing		3.6%	4.9%	5.8%
Bank Spend		4.9%	5.0%	5.1%
Agency Spend	R>2% G<2%	1.1%	1.1%	1.2$

Hospital Quality Performance – September 2021 (August data)

Is our culture right for delivering high quality care?

	Target	June 2021	July 2021	August 2021
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	89%	70.1%	75.9%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G- 0	37	25	51
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G- 0	6	11	11
Duty of Candour Cases	N/A	9	5	7
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%	88%	88%	100%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	82%	75%	66%
Duty of Candour - Stage 3 Total sent out in month	Volume	4	5	7
Duty of Candour – Stage 3 Total (%) sent out in month on time	R<50%, A 50-70%, G>70%	25%	0%	43%
Duty of Candour – Stage 3 Total overdue (cumulative)	G=0 R=1+	6	2	5
Policies (% in date)	R 0- 79%, A>80% G>90%	91%	88%	88%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	92%	88%	88%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	100%	100%	100%
Inquests currently open	Volume monitoring	8	12	14
Freedom to speak up cases	Volume monitoring	14	25	12
HR Whistleblowing - New	Volume monitoring	0	0	0
HR whistleblowing - Ongoing	12 month rolling	0	0	0
New Bullying and Harassment Cases (reported to HR)	Volume	0	0	0
	12 month rolling	3	3	3

Are we managing our data?

	Target	June 2021	July 2021	August 2021
FOI requests	Volume	54	40	
FOI Closures: % of FOIs closed within agreed timescale	R- <65% A – 65-80% G- >80%	82%	68%	85%
No. of FOI overdue (Cumulative)		1*	0	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	7	8	6
IG incidents reported to ICO	R=1+, G=0	0	0	0
SARS (Medical Record) Requests	volume	166	165	164
SARS (Medical Record) processed within 30 days	R- <65% A – 65-80% G- >80%	100%	100%	100%
New e-SARS received	volume	1	0	1
No. e-SARS in progress	volume	3	3	4
E-SARS released	volume	0	0	0
E-SARS partial releases		0	0	0
E-SARS released past 90 days	volume	0	0	1

Description	Target	June 2021	July 2021	Aug 2021
52 week + breaches reported (ticking at month end)	Volume	291	272	247
52 week + harm reviews to be completed (for treatment completed or seen in month)		62	123	98
Clinical Harm Reviews Returned at point of reporting		1	17	16
Clinical Harm Identified at point of		0	0	0

Do we deliver harm free care to our patients?

Central Venous Line Infections

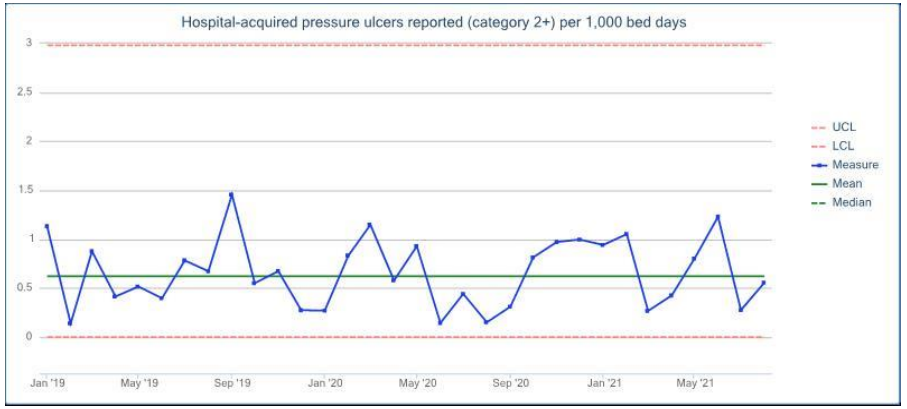
**GOSACVCRB (GOS acquired CVC related bacteraemias ('Line infections')*

Period	GOSACVCRB_No	DaysRecorded	Rate	Rate_YtD
Year 15/16	75	51976	1.4	1.4
Year 16/17	87	52679	1.7	1.7
Year 17/18	82	50843	1.6	1.6
Year 18/19	82	52965	1.5	1.5
Year 19/20	73	56214	1.3	1.3
Year 20/21	63	54124	1.2	1.2
Apr-21	4	5133	0.8	0.8
May-21	7	6382	1.1	1
Jun-21	3	7147	0.4	0.8
Jul-21	6	8275	0.7	0.7

Infection Control Metrics

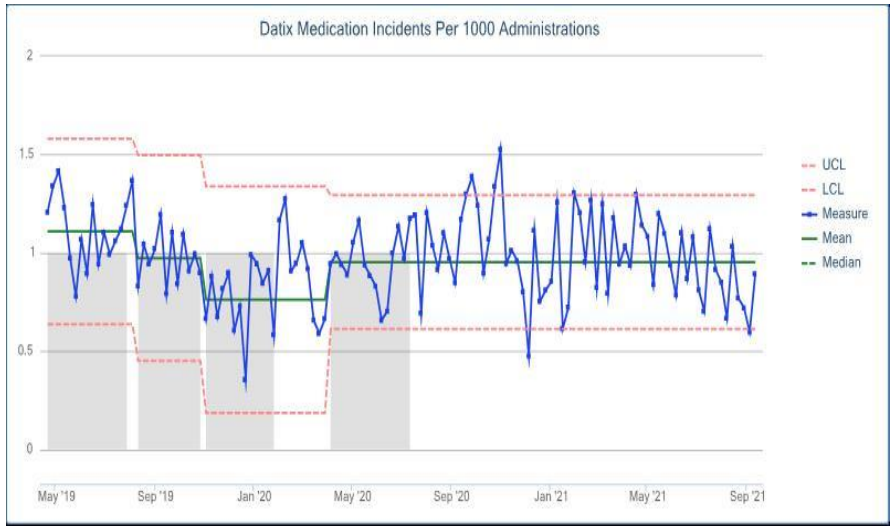
Care Outcome Metric	Parameters	May 2021	June 2021	July 2021	Aug 2021
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	7	5	2	2
	YTD (financial year)	11	16	18	20
C Difficile cases - Total	In month	0	1	2	2
	YTD (financial year)	0	1	3	5
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	0	0	0	0
	YTD	0	0	0	0

Pressure Ulcers



		June 21	July 21	August 21
Volume	R – 12+, A 6-11 G <5	9	2	4
Rate	R=>3 G=<3	0.59	0.59	0.56

Medication Incidents



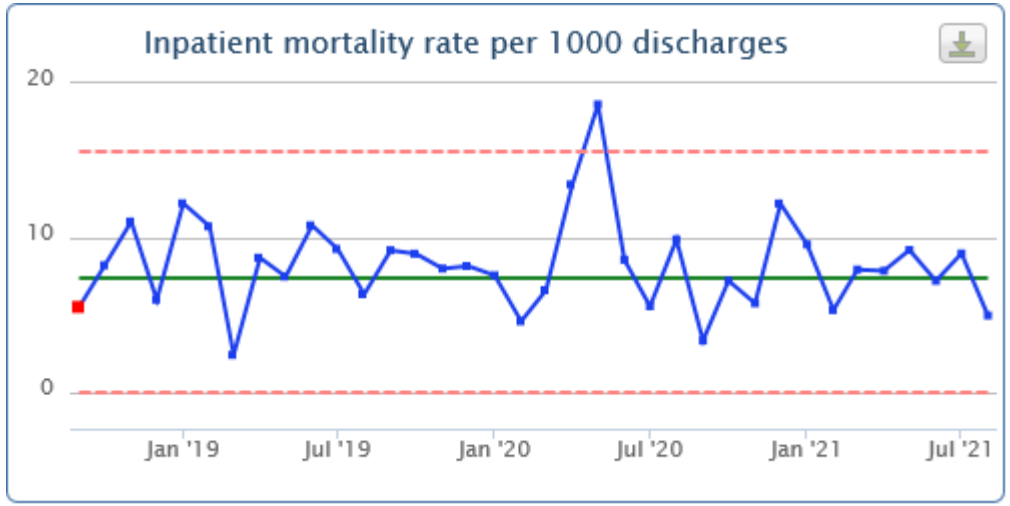
98 medication-related incidents were reported in August 2021.

34% of these reported incidents were related to drug administration errors from correct prescriptions and 23% were related to storage or missing medication.

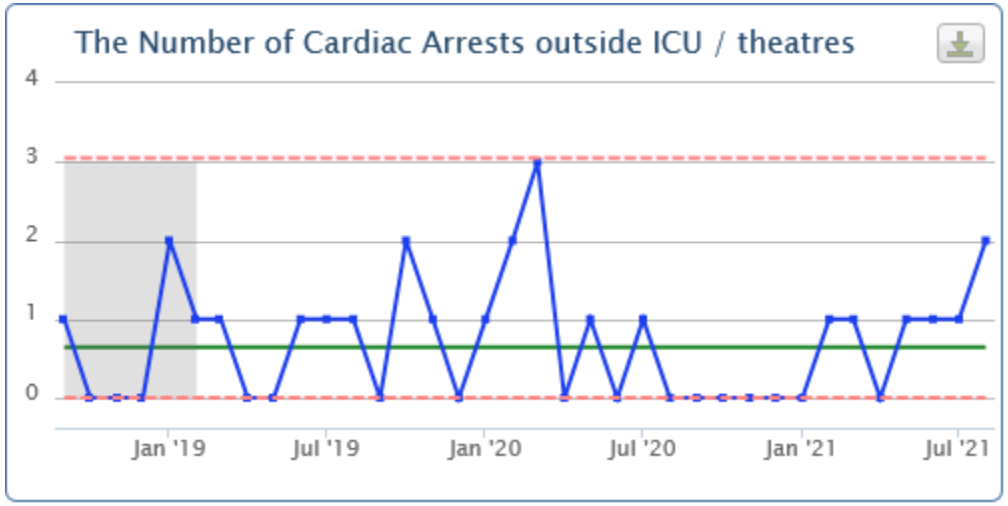
80 medication incident investigations were completed and closed in August. There were no incidents reported as moderate harm with only a small number (n=8) causing minor harm.

Does our care provide the best possible outcomes for patients?

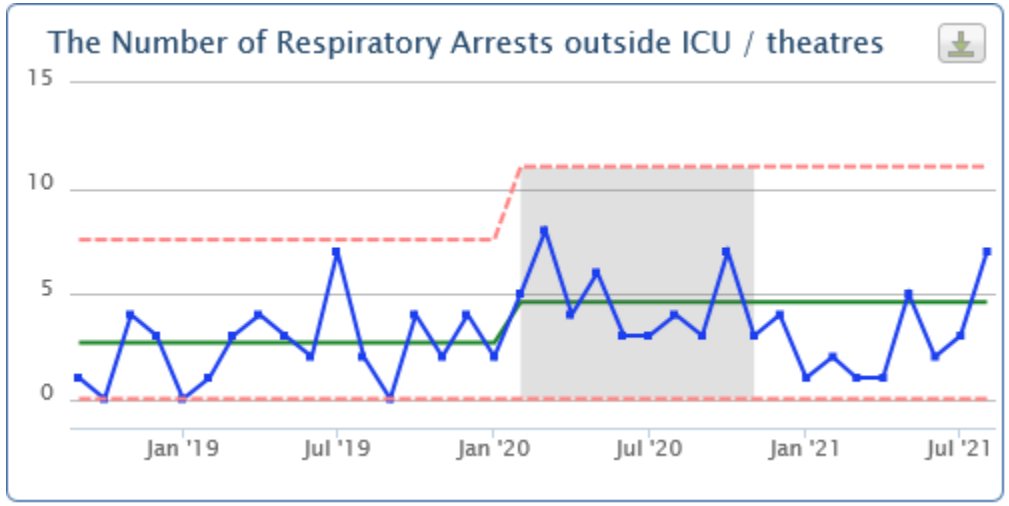
Inpatient mortality



Cardiac Arrests



Respiratory Arrests

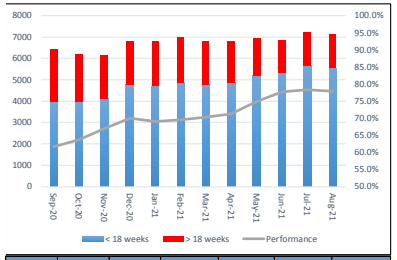


The crude mortality rate is within normal variation. There have been no outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths. This is important as the majority of patient deaths at GOSH are in intensive care areas. Risk adjusted mortality is monitored weekly at the PICU/NICU 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.

Do our processes and systems support patient access?

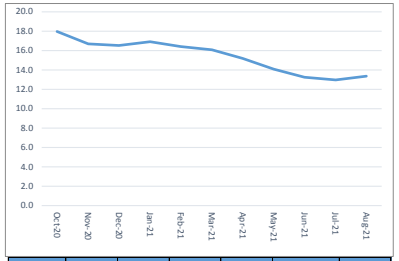
Patient Access

RTT incomplete pathways: % of patients waiting <18 weeks	Period	Target	Actual
	Aug-21	92.0%	77.82%



Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
69.46%	70.31%	71.27%	74.92%	77.67%	78.31%	77.82%

RTT: Average waits for open pathways	Period	Target	Actual
	Aug-21	8.1	13.4

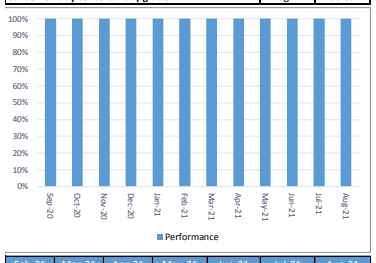


	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
-0.48%	16.4	16.0	15.2	14.1	13.3	13.0	13.4

RTT: Incomplete pathways 52 weeks or more	Period	Target	Actual
	Aug-21	0	247

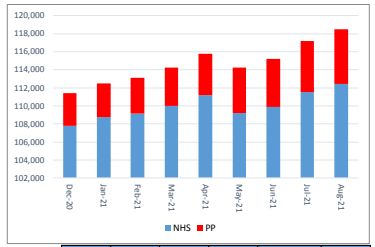
	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
52 wks+	564	465	369	291	272	247
35 wks+	931	825	752	654	647	609

Cancer: 62 day consultant upgrade	Period	Actual
	Aug-21	*100.0%*



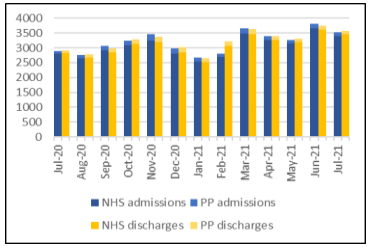
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	*100.0%*

Open referrals at month end (NHS & PP)	Period	Actual
	Aug-21	118,515



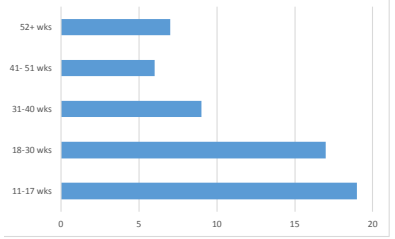
	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
NHS	109,984	111,196	109,216	109,904	111,516	112,426
PP	4,254	4,587	5,015	5,320	5,662	6,089

	Period	Actual
Admissions (NHS & PP)	Aug-21	3424
Discharges (NHS & PP)	Aug-21	3385



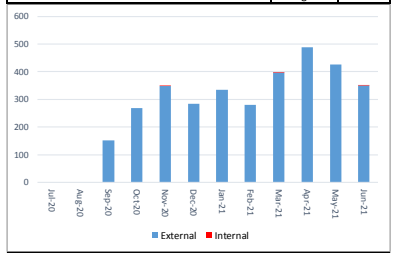
	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Admissions	3659	3382	3273	3805	3524	3424
Discharges	3633	3393	3313	3750	3581	3385

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



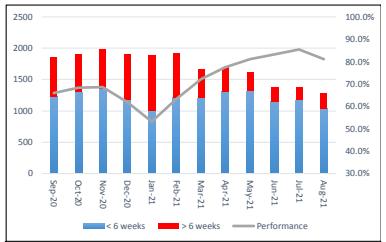
	0-10 wks	11-17 wks	18-30 wks	31-40 wks	41- 51 wks	52+ wks
Total	4473	19	17	9	6	7

RTT: Total unknown clock starts	Period	Actual
	Aug-21	357



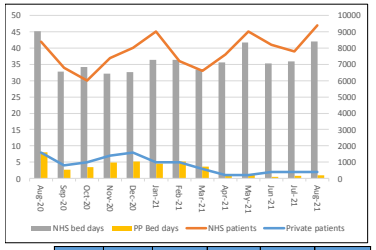
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
281	399	489	427	351	287	357

Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Period	Target	Actual
	Aug-21	99.0%	81.06%



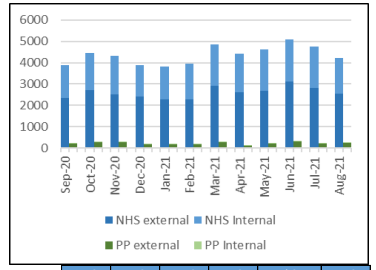
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
63.19%	72.32%	77.56%	81.15%	83.28%	85.36%	81.06%

Patients not yet discharged with LOS >50 days	Period	Actual
Bed days	Aug-21	8,619
	Aug-21	49



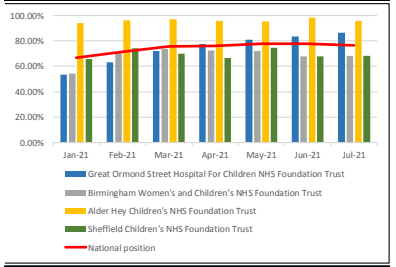
	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Patients	36	39	46	43	41	49
Bed days	7402	7327	8572	7178	7345	8619

	Period	Actual
External Referrals (NHS & PP)	Aug-21	2769
Internal Referrals (NHS & PP)	Aug-21	1701



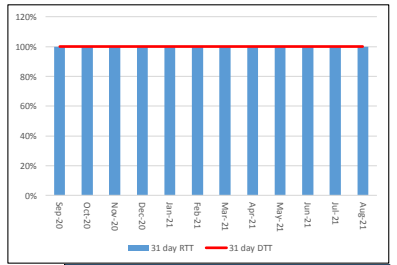
	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
External	3184	2735	2890	3415	3032	2769
Internal	1970	1802	1975	1996	1952	1701

Diagnostics: National % patients waiting less than 6 weeks for a test	Period	Target	Actual
	Jul-21	99.0%	76.49%



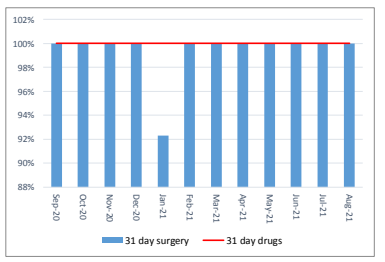
Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
66.66%	71.54%	75.71%	75.97%	77.70%	77.62%	76.49%

	Period	Target	Actual
Cancer: 31 day referral to treatment	Aug-21	85.0%	*100%*
Cancer: 31 day decision to treat	Aug-21	96.0%	*100%*



	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
31 day RTT	100%	100%	100%	100%	100%	*100%*
31 day DTT	100%	100%	100%	100%	100%	*100%*

	Period	Target	Actual
Cancer: 31 day subsequent treatment (Surgery)	Aug-21	94.0%	*100%*
Cancer: 31 day subsequent treatment (Drugs)	Aug-21	98.0%	*100%*

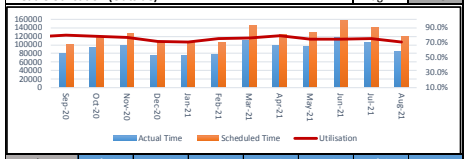


	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Surgery	100%	100%	100%	100%	100%	*100%*
Drugs	100%	100%	100%	100%	100%	*100%*

Are we productive and efficient?

Productivity & Efficiency

	Period	Actual
Theatre Utilisation (Main)	Aug-21	70.42%
Theatre Utilisation (Outside)	Aug-21	TBC

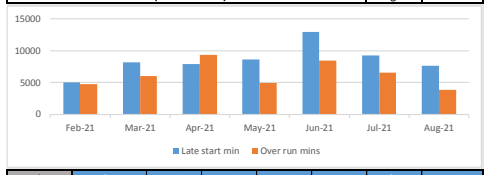


Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Main	74.68%	75.18%	78.65%	73.84%	74.17%	74.26%	70.42%
Outside	TBC	TBC	TBC	TBC	TBC	TBC	TBC

-3.84%

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

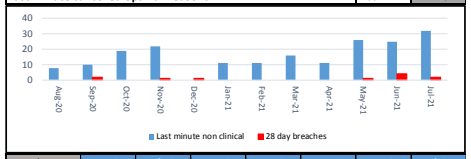
	Period	Actual
Late starts in Main theatres (minutes lost)	Aug-21	7679
Overruns in Main theatres (minutes lost)	Aug-21	3858



Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Late starts	5055	8155	7885	8656	12941	9298	7679
Overruns	4794	6031	9342	4977	8446	6539	3858

-1619
-2681

	Period	Actual
Last minute hospital cancelled ops for non clinical reasons	Jul-21	32
Last minute hospital cancelled ops - breaches of 28 day standard	Jul-21	2
Last minute cancelled ops - all reasons	Jul-21	TBC



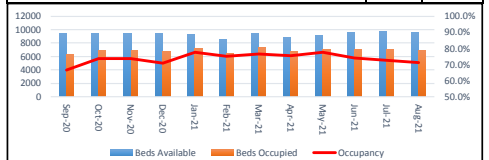
Month	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Non clinical	11	11	16	11	26	25	32
Breaches	0	0	0	0	1	4	2

Average length of stay	Period	Actual
	Aug-21	TBC

Under construction

Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Main	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Bed Occupancy	Period	Actual
	Aug-21	71.32%



Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Main	75.13%	76.48%	75.67%	77.60%	74.11%	72.50%	71.32%

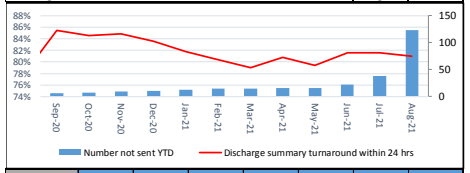
Average monthly ward bed closures (excluding weekends)	Period	Actual

Under Construction

Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Rate							

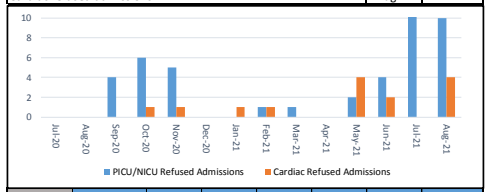
1.18%

	Period	Actual
Discharge summary turnaround within 24 hours	Aug-21	80.94%
Discharge summaries - number not sent in month	Aug-21	88
Discharge summaries - number not sent YTD	Aug-21	123



Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Performance	80.35%	79.03%	80.78%	79.36%	81.53%	81.56%	80.94%
Not sent	2	0	1	2	6	17	88

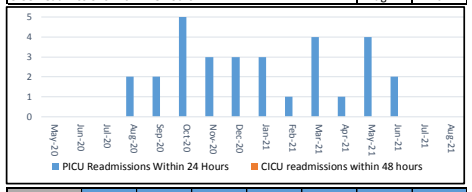
	Period	Actual
PICU/NICU CATS refused admissions	Aug-21	10
Cardiac refused admissions	Aug-21	4



Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
PICU/NICU	1	1	0	2	4	12	10
Cardiac	1	0	0	4	6	0	4

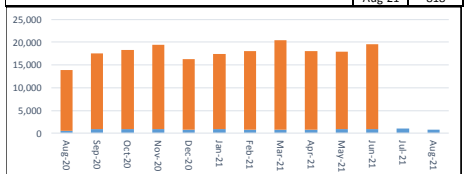
-0.62%

	Period	Actual
PICU Readmissions within 24 hours	Aug-21	0
CICU Readmissions within 48 hours	Aug-21	0



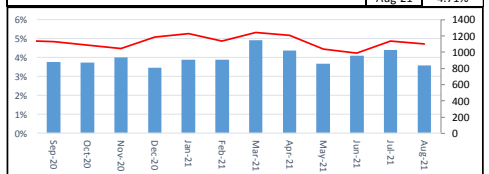
Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
PICU	1	4	1	4	2	0	0
CICU	0	0	0	0	0	0	0

Outpatient appointments cancelled on the day/day before	Period	Actual
	Aug-21	818



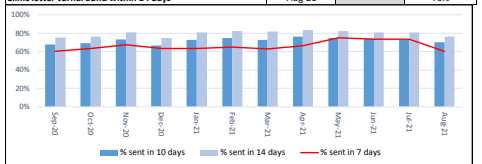
Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Cancellations	765	877	839	934	955	1014	818
Attendances	17303	19609	17159	17001	18646	0	0

DNA/Was Not Brought rate	Period	Actual
	Aug-21	4.71%



Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Rate	4.86%	5.31%	5.18%	4.46%	4.25%	4.87%	4.71%
DNAs	906	1148	1021	858	958	1024	840

	Period	Target	Actual
Clinic letter turnaround within 7 days	Aug-21	100%	60%
Clinic letter turnaround within 10 days	Aug-21		70%
Clinic letter turnaround within 14 days	Aug-21		76%



Month	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
7 days	60%	63%	68%	63%	63%	65%	63%	67%	75%	73%	73%	60%
10 days	68%	69%	73%	67%	72%	75%	72%	76%	75%	74%	73%	70%
14 days	75%	76%	81%	75%	81%	82%	82%	83%	82%	81%	81%	76%

Are we Safe?

There were 2 open **serious incident** investigations in August 2021. 2 ongoing SIs were completed, approved and submitted to NHSE. A number of reports have been reviewed by NHSE and queries have been forward to the Trust for response. A number of these are overdue our further response as awaiting information from both the patient safety team and the lead directorates. The aim will be to close these by the end of September 2021. The final draft of the revised SI processes/Policy has been delayed and will be presented for the Operational Board and other relevant committees in October with the aim that this will be approved by PAG in Quarter 3 2021-22.

The incident reporting rate has decreased at 82 per 1000 bed days (n=587). There was a decrease in the numbers of incident investigations completed by the appropriate teams and although 458 were reviewed and closed, the overall number of completed investigations and subsequent closures were lower than the number of reported incidents for the same month. However, the percentage of incident closure rate has decreased to 72% and average days to close has decreased slightly to 32 which remains well below the policy timeframe of 45 working days. 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.

There were **4 CAS alerts** that were noted to be overdue their respective closure deadlines in August. All 4 were escalated to a senior level with one subsequently reviewed and closed. Of the remaining 3 alerts, 2 are awaiting confirmation from clinical teams in terms of some of the actions related to each of the alerts and 1 is awaiting confirmation from an executive level prior to closure, this dialogue is ongoing with the aim that these will be completed by early October. There is an ongoing piece of work to refine the alert management process and all open patient safety alerts are now being presented to the Patient Safety Outcomes Committee.

WHO checklist: Performance for GA procedures (all departments) is at 95% and 97% in main theatres.

In Main theatres performance has decreased to 97% from last month when we reported 98%

Row Labels	Incomplete	Complete	%
ANAESTHETICS	1	1	50%
CATH AND EP LAB		30	100%
CT	7	10	59%
GASTRO INVESTIGATIONS UNIT	2	63	97%
INTERVENTIONAL RADIOLOGY	23	300	93%
MAIN THEATRES	11	684	98%
MRI	16	142	90%
NUCLEAR MEDICINE	1	7	88%
Grand Total	**61**	**1237**	95%

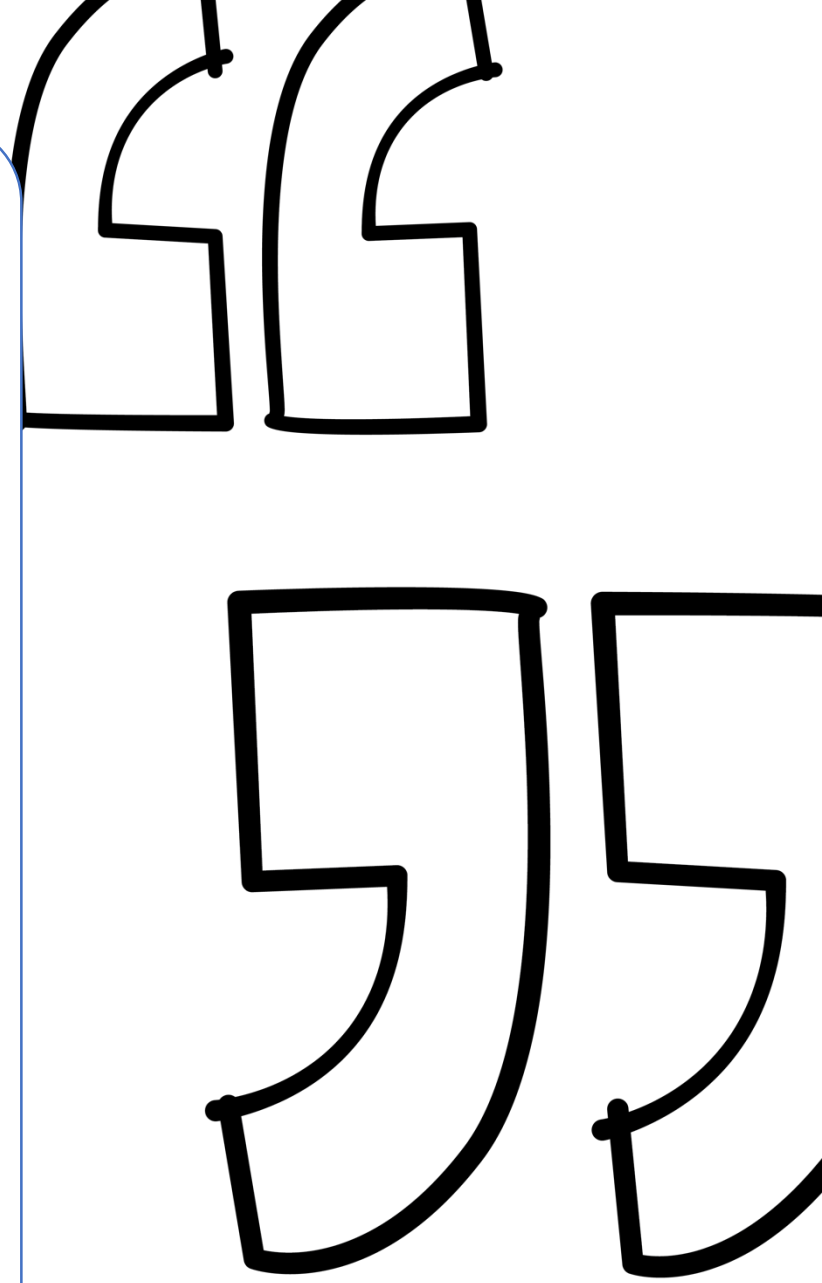
Are we Caring?

There was a significant reduction in **PALS contacts** from 235 in July 21 to 178 in August 21. This aligns with reduced patient activity in August and was consistent with contacts received in August 20 (n=177). Contacts relating to communication fell to their lowest recorded (n=14). Cardiology contacts reduced slightly but remain the highest for any individual specialty. Dermatology contacts were at their lowest since June 2019 following implementation of a comprehensive action plan presented at PFEEC in June 2021.

There were 8 new **formal complaints** in August which is an increase on recent months and in comparison to August last year (n=6). Complaints relate to a variety of issues around staff behaviour, delays in follow up appointments, sharing of information and discharge management. Three directorates saw an increase in their complaint rate, International and Private Care saw a significant increase (1.90 complaints per 1,000 CPE) from when it last received a formal complaint in April 2021 (0.84). Overdue red complaint actions remain at 11 but progress has been made on all of the actions and extended timescales have been agreed.

The **Friends and Family Test** response rate for August was 28% (a decrease from July). At Trust level, targets for FFT response rates and ratings of experience for both inpatients (98%) and outpatients (97% rising from 94% in July) were all met. At directorate level, three directorates (BBC, BBM and S&S) did not achieve the response rates. Feedback highlighted issues with delays in discharge whilst waiting for medication and surgery, communication regarding cancelled appointments and noise in the hospital at night time. Positively patients and families praised the care and support received from staff and clear communication regarding procedures enabling them to understand what will happen.

Blood Cells and Cancer did not achieve the trust target for rating of experience having received 8 negative comments (no particular theme has been identified). However, of note, the directorate have achieved their lowest rates (in the context of patient activity) for complaints and Pals contacts over the last 12 months.



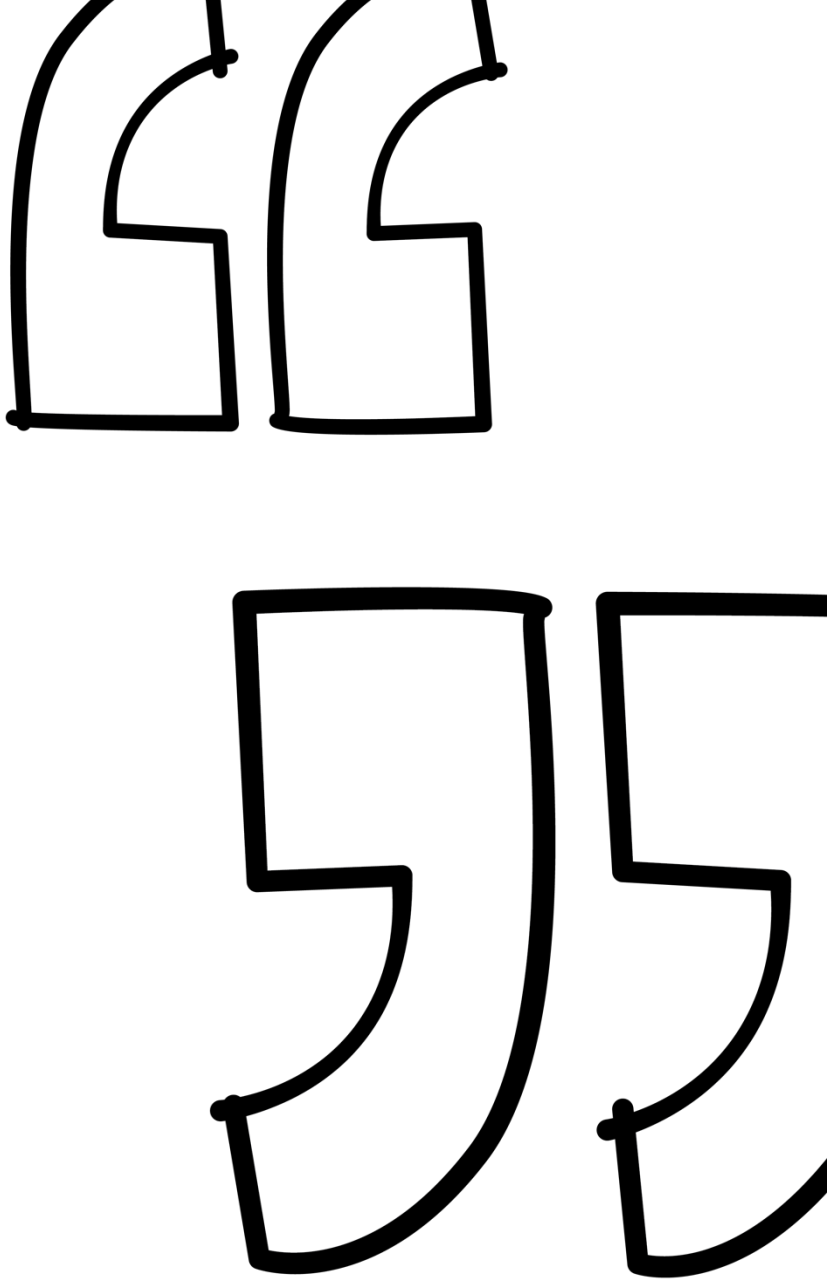
Are we Effective?

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

Three priority audits were concluded in the last month
1. PICU ward round and medical plans documentation, and documentation of PICU nursing observations.
2. GOSH/IPP response to Patterson Inquiry
3. Hands, Face, Space, Place Walkround

We are on track for meeting our target for completed specialty led audit so far for 2021/22 (47 audits completed YTD) .This measure is useful as it gives an indication of engagement in clinical audit.

We continue to monitor NICE guidance published each month and note that there is no NICE guidance overdue for review.



Are we Responsive?

We are currently at 81.06% of patients waiting less than 6 weeks for the **15 diagnostic modalities (DM01).** This is a decline from last month's position when we reported 85.36%. The number of breaches reported in August (243) compared to the number of breaches reported in July (201) has increased. The Trust is currently 1% 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 July performance stood at 76.4%, GOSH was tracking 9% above this. Nationally 325,229 patients were waiting 6 weeks and over for a diagnostic test at the end of July.

Comparative children's providers have seen similar movements. GOSH, Sheffield Children and Birmingham Women's and Children's reported performance of around 68-86% for July 2021 whilst Alder Hey was higher at 98.6%.

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

The Trust did not achieve the **RTT** 92% standard, submitting a performance of 77.8%, with 1576 patients waiting longer than 18 weeks, this is a slight decrease in performance from the previous month's 78.3%. The Trust is slightly below the predicted trajectory at -0.2% for the month of August. The current PTL consists of 9% of patients being categorised as P2 patients and 67.6% as P3/P4 patients. As at the end of August, the Trust reported a total of 247 patients waiting 52 weeks or more; this is a decrease of 25 patients (9%) from the previous month. 64% of patients waiting over 52 weeks have a future contact booked.

Nationally, at the end of July, 62.4% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks, thus not meeting the 92% standard. The national position for July 2021 indicates a decrease of patients waiting over 52 weeks with 278, 972 patients compared to 367,142 in April 2021.

RTT Performance for comparative children's providers is Sheffield Children (74%) and Birmingham Women's and Children's (80%) and Alder Hey (72.9%). On average 507 52-week breaches were reported in July for these providers.

Are we Well Led?

There were 7 incidents confirmed as requiring **duty of candour** in August 2021. Being Open/Duty of Candour conversations took place in 100% of incidents and all stage 2 letters were completed although only 66% within the 10 day timeframe. 7 investigation reports was shared with families in August 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 August 2021 when compared to the previous month. Compliance by August end was recorded as 75.9%. 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. A deeper dive review is due to be undertaken and presented at RACG to under the areas and barriers for timely review of these risks.

The Trust received 42 **FOI** requests in August 2021, with a small number of which were deemed as non-valid and further requests were returned requesting clarification (section 45). The remaining FOI requests that were due in August 2021 (n=27), 85% were responded to within the legislated timescale. This is an increase in compliance for this month. There were 2 FOI requests that narrowly missed their legislated deadline. One further request had its deadline extended and one is currently overdue. This was due to the amount of data requested from a number of departments and the level of quality checking of documents required. All applicants were kept informed regularly.

There are currently 51 open **Serious Incident actions** which is significantly higher than the position in July. A number of actions have been completed with evidence uploaded in August 2021. The Patient Safety Team continue to work with the directorates to ensure completion and closure of SI 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, there is a plan to highlight the total number of actions in this forum too. 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 29 COVID-19 related **incidents** reported in August 2021, two of which were graded as moderate harm. One of these incidents related to a patient who was infected with Covid 19 whilst an in patient. Investigation has identified that the patient was infected by their mother who acquired the infection in the community. The second moderate harm incident was a heath and safety incident relating to verbal abuse suffered by a staff member when arranging transport for a covid positive patient. Many of the remaining incidents were related to covid pathways and swabbing protocols.

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 10 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 from the previous month.

No COVID-19 outbreaks were recorded in August 2021.

Workforce Headlines: August 2021

Contractual staff in post: Substantive staff in post numbers in August were 5191.8 FTE, an increase of 241.7 FTE since July 2021. Headcount was 5604 (an increase of 290 on the previous month. The increase is primarily driven by the insourcing of domestic staff which happened on August 1st.

Unfilled vacancy rate: Vacancy rates for the Trust increased to 6.9% in August from 6.5% the previous month and is higher than the same month last year (6.0%). The vacancy rate remains below the 10% target and it is lower than the 12 month average of 6.5%. Vacancy rates in the clinical directorates remained below target in August.

Turnover: is reported as voluntary turnover. Voluntary turnover increased slightly to 11.5%, but it remains below the Trust target (14%). Total turnover (including Fixed Term Contracts) decreased slightly in August to 14.3%. 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 3 2021/2022 as the impact of COVID recedes.

Agency usage: Agency staff as a percentage of paybill in August increased to 1.2%, however it remained well below the local stretch target (2%). Agency use is almost exclusively taking place within Corporate Non-Clinical Directorates and amongst some Allied Health Professional disciplines. Bank % of paybill also increased to 5.1% in August.

Statutory & Mandatory training compliance: In August the compliance rate across the Trust reduced to 91% after 12 months in a row at 94%, although the rate remains above the target with all bar 2 directorates achieving target. Since the domestic services insourcing, Property Services has reduced to 65%. The Directorate Management and Learning teams are working to address gaps in compliance. The medical and dental staffgroup are the only staffgroup below the 90% target (86%). Across the Trust there are now 10 topics below the 90% target (including Information Governance where the target is 95%). Safeguarding Children Level 3 compliance for substantive staff is just below the 90% target (86%).

Appraisal/PDR completion: The non-medical appraisal rate remained at 88% in August with only 5 Directorates achieving target. Individual Directorates are being liaised with to improve compliance. Consultant appraisal rates increased slightly to 94% in August.

Sickness absence: Sickness rates reduced slightly in August to 3.5% as COVID absences reduced. However this reduction was offset by increases for other absence reasons, and the rate is well above the 3% target and higher than the seasonal average we expect to see. Anxiety, Stress and depression was the most common reason for absences, accounting for 16.4% of all absences.

Trust Workforce KPIs: August 2021

Great Ormond Street Hospital for Children
NHS Foundation Trust

Metric	Plan	August 2021	3m average	12m average
Voluntary Turnover	14%	11.5%	11.4%	11.4%
Sickness (1m)	3%	3.5%	3.3%	2.9%
Vacancy	10%	6.9%	6.4%	6.5%
Agency spend	2%	1.2%	1.2%	1.1%
PDR %	90%	88%	88%	88%
Consultant Appraisal %	90%	94%	93%	88%
Statutory & Mandatory training	90%	91%	93%	94%

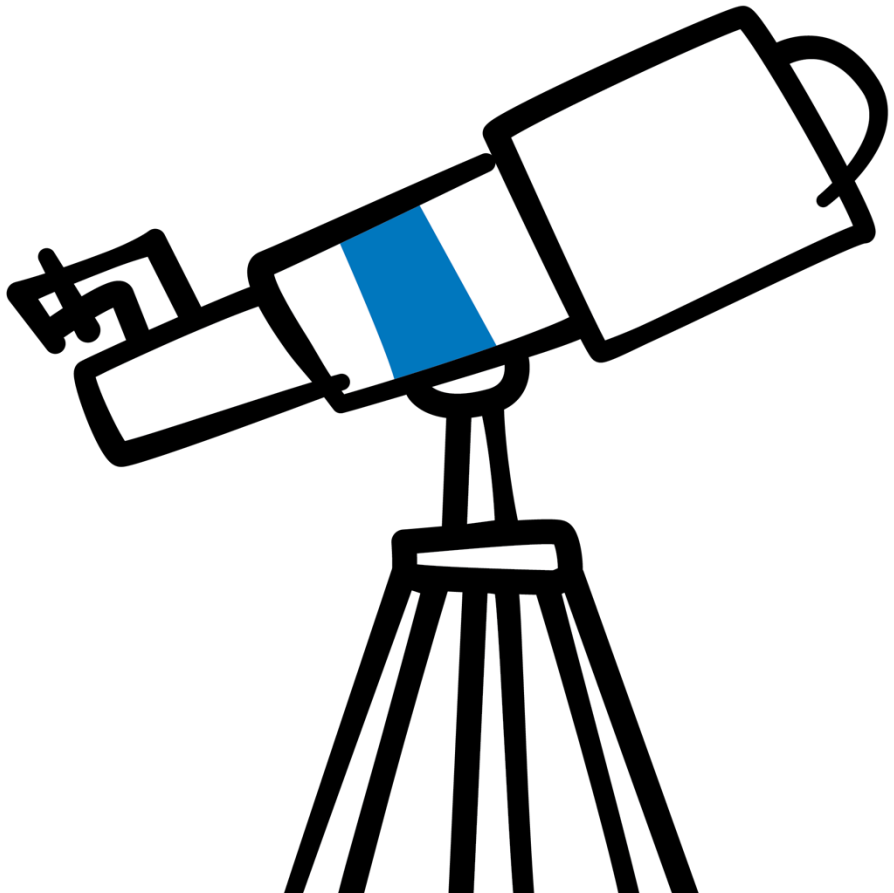
Key:
Achieving Plan | Within 10% of Plan | Not achieving Plan

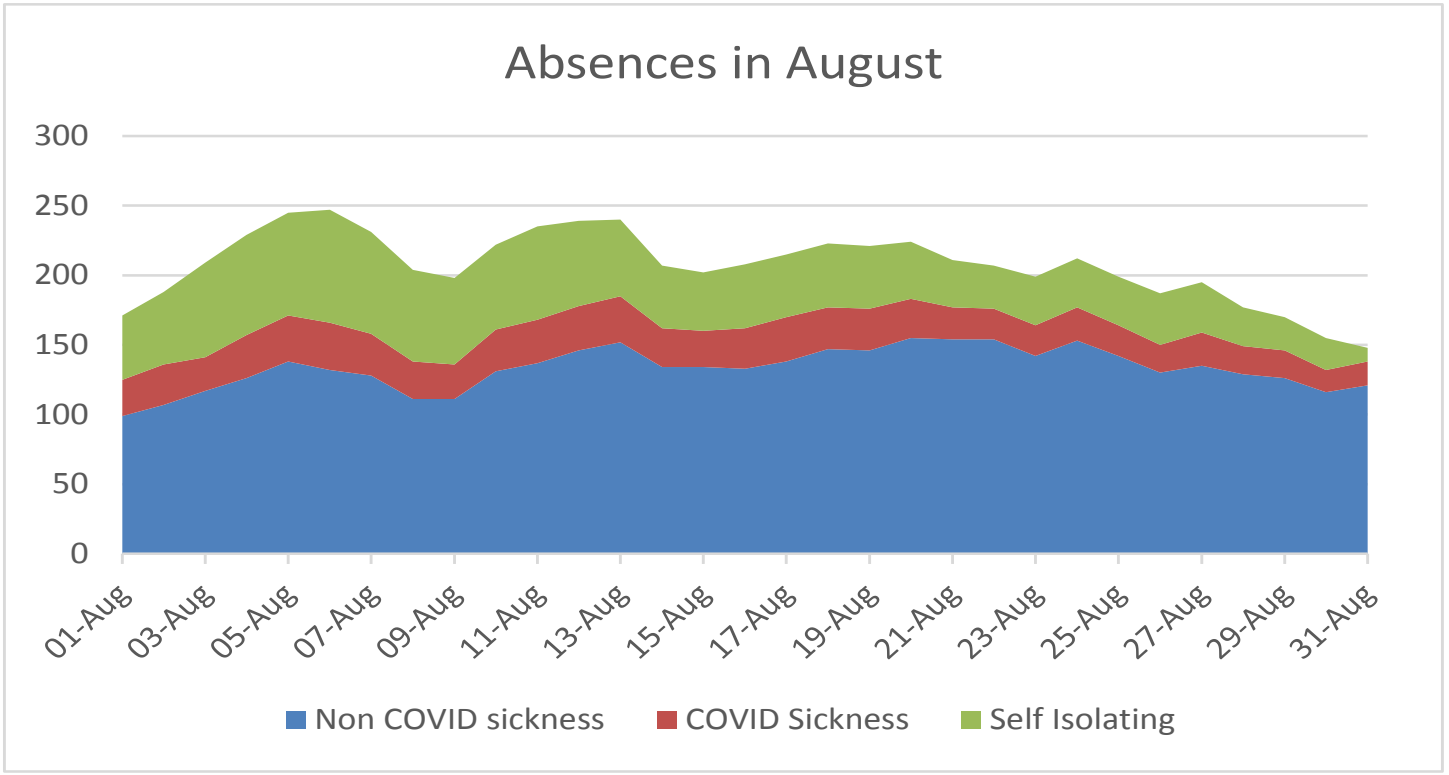
Directorate KPI performance August 2021

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP	Genetics	Clinical Operations	Corporate Affairs	ICT	Property Services	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation	Transformation
Voluntary Turnover	14%	11.5%	9.5%	14.6%	8.0%	12.6%	11.9%	13.1%	8.8%	12.1%	11.5%	14.4%	19.4%	11.5%	5.8%	7.5%	9.6%	12.9%	5.7%	12.0%	31.8%
Sickness (1m)	3%	3.5%	3.9%	2.8%	2.1%	3.7%	2.9%	4.9%	1.9%	4.7%	1.5%	2.9%	0.0%	3.3%	5.5%	2.3%	5.5%	0.8%	4.0%	1.6%	0.1%
Vacancy	10%	6.9%	2.0%	-3.0%	4.6%	4.2%	0.3%	3.2%	8.4%	5.4%	1.5%	7.5%	18.1%	17.7%	5.2%	16.5%	9.8%	27.8%	4.2%	13.4%	13.8%
Agency spend	2%	1.2%	-0.2%	0.2%	0.0%	0.2%	1.4%	1.7%	0.1%	1.5%	0.0%	0.5%	5.9%	22.2%	2.1%	7.9%	2.8%	7.4%	1.9%	0.0%	0.0%
PDR %	90%	88%	86%	85%	87%	89%	89%	84%	95%	93%	80%	88%	95%	71%	96%	76%	84%	55%	82%	91%	84%
Stat/Mand Training	90%	91%	92%	92%	93%	91%	95%	92%	96%	97%	98%	97%	86%	88%	65%	96%	97%	97%	97%	9%	98%

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

Absences in August



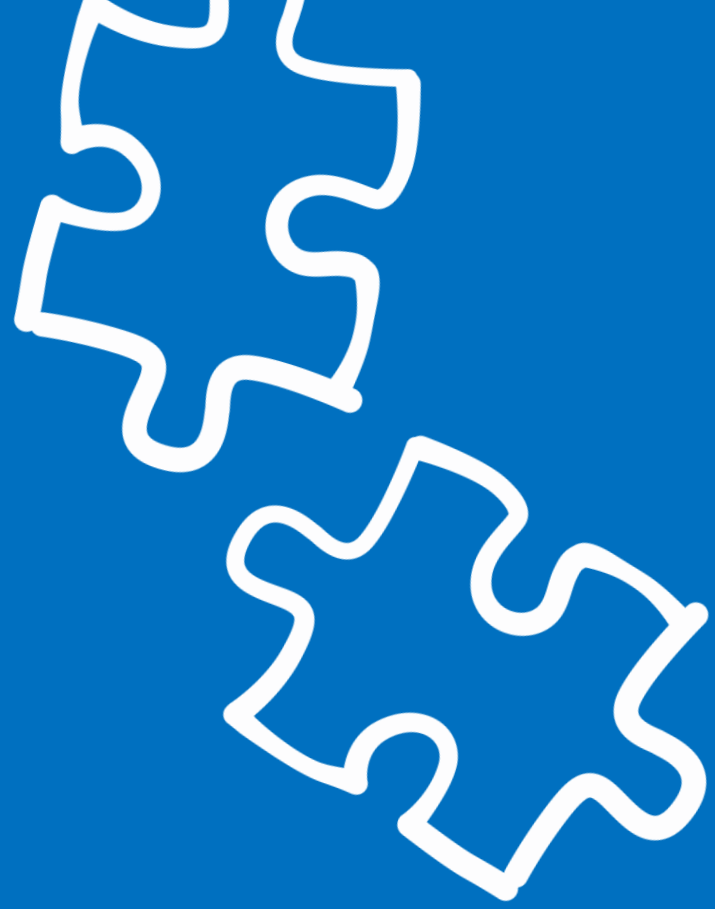


There were an average of 207 absences per day in August, down from 214 in July. The impact of COVID absence reduced from 102 to 74 per day in August.

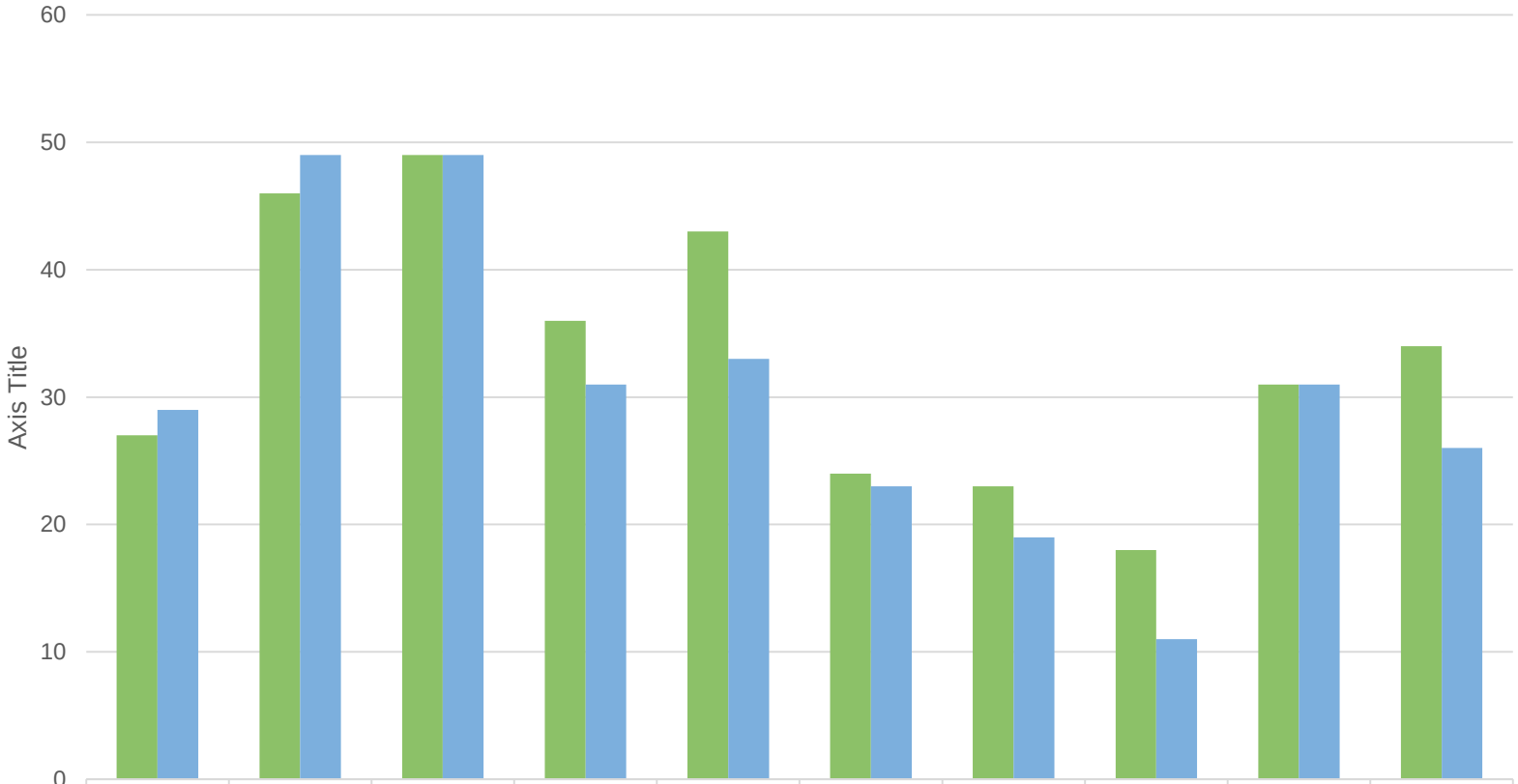
Quality and Safety

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



	Access to clinical services	Communication	Diagnostic tests and scans	Documentation (incl. records, identification)	Medication - administration error from correct prescription	Medication - storage / missing	Skin integrity/Pressure issues	Staffing	Treatment, procedure	Medical device / equipment
Jul	27	46	49	36	43	24	23	18	31	34
Aug	29	49	49	31	33	23	19	11	31	26

There was a slight increase in the number of communication incidences, rising from 46 to 49. The largest sub-category was communication between team (12), communication failure within a team (7). This month also saw 5 incidents reported where communication with families has been impacted due to the availability of interpreters via Big Word.

There was a significant reduction in the number of incidents where a medication administration error has occurred from a correct prescription. A recent trend analysis of a spike in these incidents in Blood, Cells and Cancer identified common factors and subsequent mitigations have been implemented to address this trend which will be monitored via RAG.

Patient Safety Serious Incident Summary

New & Ongoing Serious Incidents

Directorate	Ref	Due	Headline	Update
H&L	2021/15007	12/10/2021	Major haemorrhage during ECMO cannulation	01/09/2021: Panel meeting scheduled for September
BC&C	2021/16423	02/11/2021	Delays in administration of antibiotics in neutropenic patient.	01/09/2021: Panel meeting scheduled for the 06/09/2021

2021/11391: Faulty batch of Histoacryl glue potentially impacting patient treatment outcomes

What happened?

Histoacryl glue, a wound glue product that has been used for the endovascular treatment of brain arteriovenous malformations for over 30 years, is currently produced under licence by B.Braun, On 3 March 2021 the company published a partial recall for Histoacryl glue after batches of the product were identified as polymerising (hardening) less rapidly than expected. An email was received on 26 April which notified the procurement department that there was to be a total recall of the product. A second alert was published by B. Braun on 27 April 2021 detailing this information as well as further affected batches. A review of care within the Trust identified five patients as having been treated with the affected batches of Histoacryl glue.

Learning and recommendations

investigation found that there was no formal policy or process in place in the Trust for the management of Field Safety Notices (FSN) issued by companies. These are mostly managed on a local level, as companies communicate directly with their customers. FSNs can also be distributed by the MHRA via their CAS alert system, or on occasion by other bodies (such as NHS Supply Chain when the FSN relates to a nationwide shortage of a widely used product).

The lack of clear governance around FSNs poses a risk to patients and needs to be urgently addressed. A policy for the management of alerts is already in draft form and is expected to be finalised by mid-September 2021. This will give clear guidance to staff on how alerts should be distributed and what action should be taken once an alert is received.

investigation found that lot numbers of Histoacryl glue were not always recorded. In the theatres setting, Histoacryl glue counts as an implant and a lot number should always be recorded on the patient record.

- All-staff protected teaching time in theatre will be utilised to remind theatres staff (including scrub staff, anaesthetic staff, and surgeons) of the importance of recording log numbers. The findings of this Serious Incident investigation will be discussed for learning purposes.
- The EPR team will be asked to review how lot numbers are recorded on the patient record and to identify any enhancements to this system, in particular to identify whether a mechanical alert or notification can be added to remind staff when a lot number is not entered.
- A policy will be drafted and agreed to outline the management process and pathway for all safety alerts, including Field Safety Notices (FSNs).
- A communications package on what should be done on receipt of a FSN or safety alert will be developed and cascaded to all staff via a communications strategy.
- A list of major stakeholders/partners who supply the Trust with products will be compiled. These companies will be contacted and informed of our new policy for management of safety alerts. They will be asked to copy in the safety alerts email address for any FSN related communication.

Patient Safety Alerts/ MHRA/ EFN Alerts

NatPSA/2020/006/NHSPS

Foreign body aspiration during intubation, advanced airway management or ventilation

Issued:01/09/2020

Due: 01/06/2021

NatPSA/2020/008/NHSPS

Deterioration due to rapid offload of pleural effusion fluid from chest drains

Issued: 01/12/2020

Due: 01/06/2021

NatPSA/2021/006/MHRA

Inappropriate anticoagulation of patients with a mechanical heart valve

Issued: 14/07/2021

Due: 28/07/2021

NatPSA/2021/005/MHRA

Philips Ventilator, Cpap And Bipap Devices: Potential For Patient Harm Due To Inhalation Of Particles And Volatile Organic Compounds

Issued: 23/12/2021

Due: 17/12/2021

NatPSA/2021/003/NHSPS

Eliminating the risk of inadvertent connection to medical air via a flowmeter

Issued: 16/06/2021

Due: 16/11/2021

NatPSA/2021/009/NHSPS

Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures

Issued: 25/08/2021

Due: 25/11/2021

NatPSA/2021/008/NHSPS

Elimination of bottles of liquefied phenol 80%

Issued: 25/08/2021

Due: 25/11/2021

FSN /FA902

Medtronic Heartware HVAD System Battery Charger AC Adapter Controller Power Port Incompatibility

Issued: 03/02/2020

Due: N/A

FSN – Fannin

Fannin Pre-filled N/Saline syringe 10ml

Issued: 27/07/2021

Due: N/A

FSN - NR-FIT EVDs

NR-FIT EVDs - Product Recall

Issued: 21/01/2021

Due: N/A

Clinical Audit

Priorities

1. Monitoring involvement in required national clinical audits
2. A central clinical audit plan prioritises audits to support learning from incidents, risk, patient complaints, and to investigate areas for improvement in quality
3. Monitoring and supporting specialty led clinical audit

Clinical Audit –priority plan

Those audit priorities have been identified via responses 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.

Audit	Status
Learning from an incident Respiratory arrest following residual anaesthetic agent in patient cannula following a general anaesthetic (2020/20297)	First cycle of audit complete. Actions in response to the audit are being agreed with the team leading the audit
Learning from an incident 2020/23369 (audit of whether consent forms are being appropriately uploaded into the electronic patient record	Audit is to be completed in October 2021
Learning from an incident -Retained guidewire 2020/ 22325	Data collection and a draft report have been written , and next steps are to be agreed by the PICU team following presentation
Medicines Clinical Audit Plan	Key audits to focus on best practice with medicines management. Monitored and directed by the Medicines Safety Committee. Additional Clinical Audit resource is being directed to support a review of appropriate medicine storage safety (including CQC must dos) as part of the September Nursing Assurance Round
Quality of clinical documentation	An audit has been completed in I+PC and plan to make improvments has been identified in response to the learning from the audit. .A re-audit will take place in November 2021.

Highlights from completed priority audits in last month

Clinical Audit -PICU ward round and medical plans documentation, and documentation of PICU nursing observations.

Identified as a priority following a recommendation from an inquest and the Root Cause Analysis following the clinical deterioration of a PICU patient in February 2021 .

1. **Audit to assess the frequency with which ward rounds and plans are being documented in line with PICU policy.**

The audit criteria was met for all cases reviewed in the audit of documentation of ward rounds and plans. No improvements have been identified as being required

2. **Audit to assess the frequency of nursing observations taking place as described in the PICU standards for observations**.

The results of the nursing audit showed good standards of documentation against most parameters. However the measurement of blood pressure against the PICU standard operating policy showed 68% compliance. A meeting between the Specialty Lead for PICU and PICU Matron is planned for September 2021. A review of the findings of the audit around the frequency of blood pressure documentation against policy will be conducted and required next steps agreed.

Audit	Conclusion
GOSH/IPP response to Patterson Inquiry	Area of improvement highlighted 1. Documentation of lead consultant daily weekday review of I+PC inpatients as per the I+PC Practice Privilege Agreement 2. Documentation of scope of practice through the I&PC Practice Privileges Process Audit report and action plan presented to the August I+PC directorate board
Hands, Face, Space, Place Walkround – August 2021	Three hundred and fourteen observations were undertaken in the main thoroughfare of the hospital on five separate time points. 310/314 (99%) of staff were wearing a fluid repellent surgical mask Audit reported to the September Health and Safety Committee

Specialty led clinical audit

There are currently 282 clinical audits registered at GOSH.

We are on target for our measure for speciality audits being on track. This helps ensure 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. We are on track for meeting our target so far for 2021/22 completed audits (47 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.

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

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

1. Priority improvement programmes (Aug 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

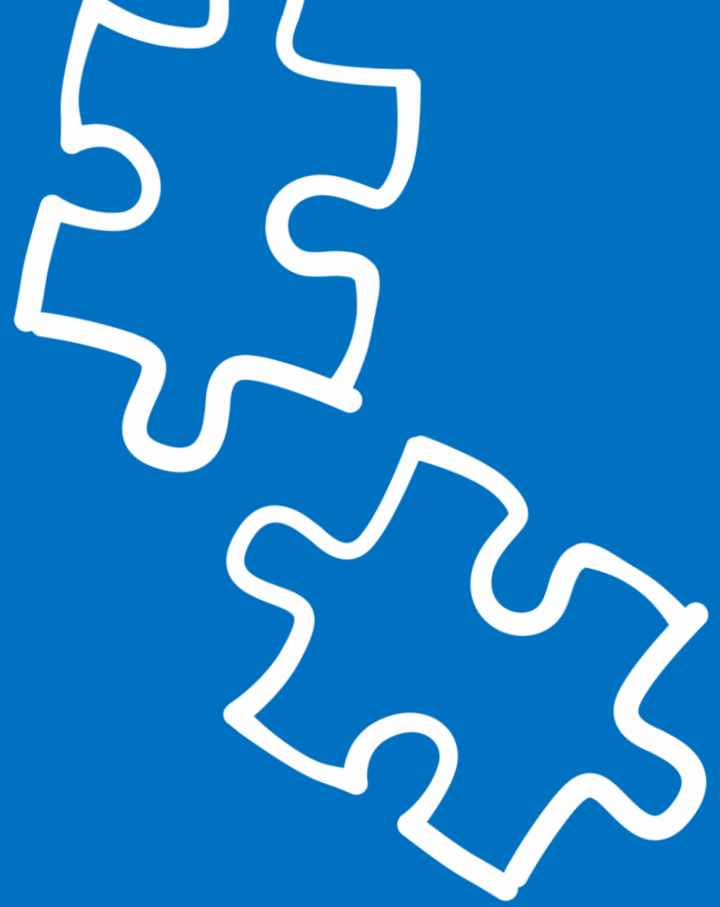
Project Commenced	Area of work	Project lead:	Expected completion date
May 2020	Increase opportunities to empower and enable children and young people to register their complaints	Claire Williams (Head of Patient Experience)	September 2021
Oct 2020	Increase communication skills training across all Allied 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
Oct 2020	Improve adherence with tracheostomy safety box equipment and bed space signage	Michaela Kenny (Chief Nurse Junior Fellow)	October 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	To produce an educational pathway aimed at transitioning undergraduate nurses to registered nurses, with 100% of host students meeting their core competencies and passing their six month probation	Hannah Fletcher, Clare Paul and Natalie Fitz-Costa (Practice Educators)	March 2024
March 2021	Improve nurse satisfaction of the nursing handover process on Chameleon ward	Sarah Murphy	June 2021 (Paused)
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

The QI team has held 3 QI project surgeries during the month of August

Patient Experience

This section includes:

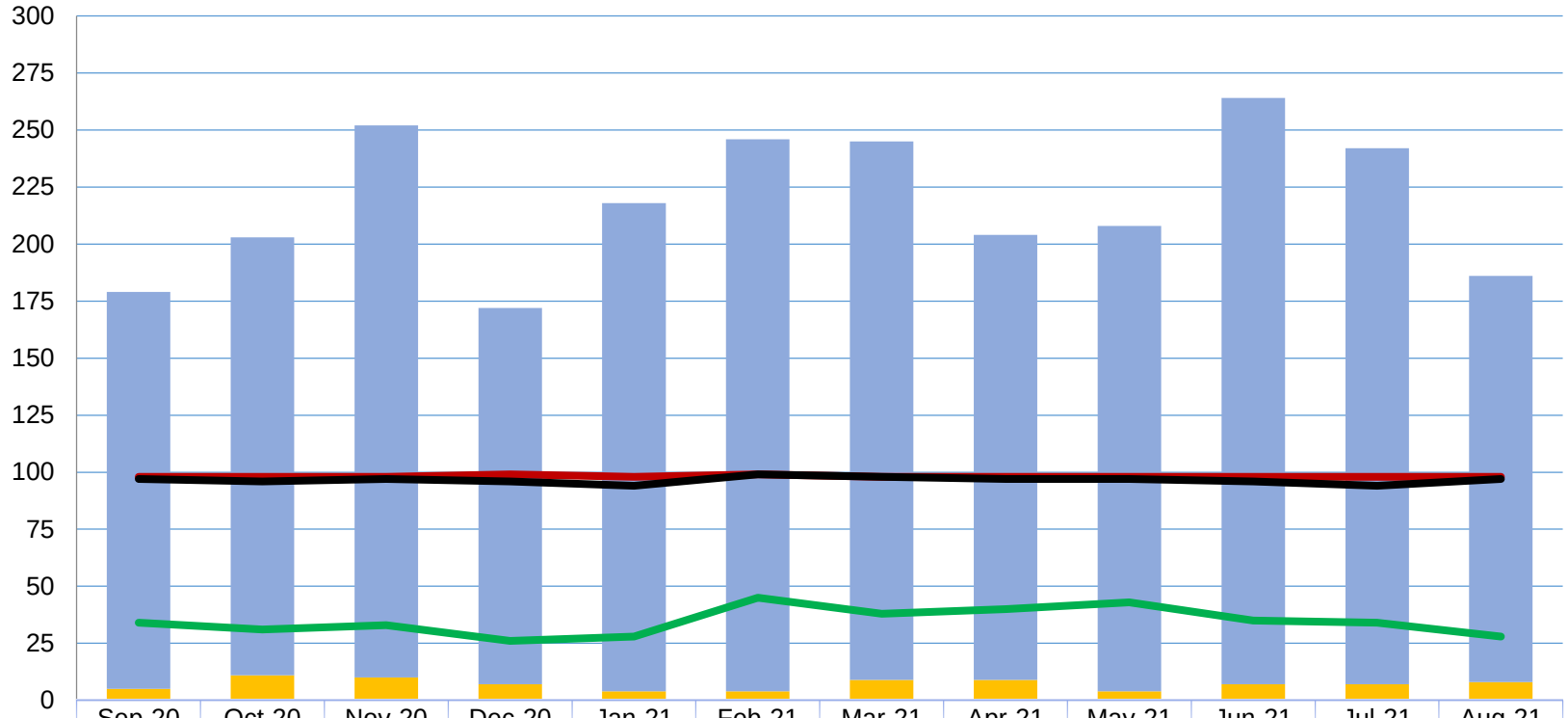
- Integrated overview of patient feedback
- Monthly assessment of trends and themes in complaints
- Overview of Red Complaints
- Pals themes and trends
- Learning and improvements from Pals contacts
- Friends and Family Test feedback trends and themes



Patient Experience Overview

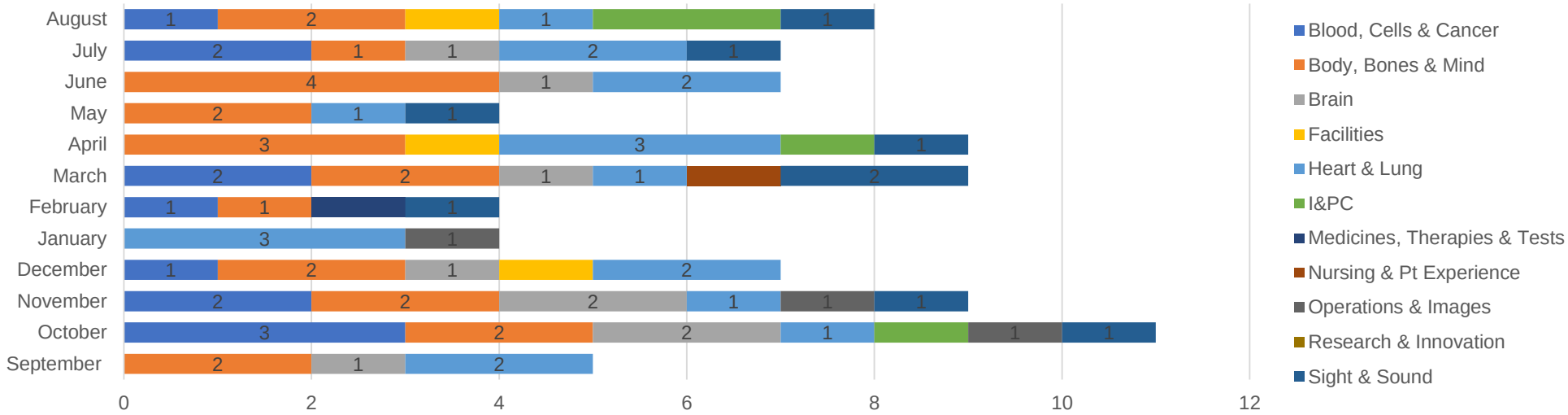
Are we responding and improving?

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



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Pals contacts	174	192	242	165	214	242	236	195	204	257	235	178
Formal Complaints	5	11	10	7	4	4	9	9	4	7	7	8
FFT rating of experience - Inpatients %	98	98	98	99	98	99	98	98	98	98	98	98
FFT rating of experience - Outpatients %	97	96	97	96	94	99	98	97	97	96	94	97
FFT % response rate	34	31	33	26	28	45	38	40	43	35	34	28

Complaints: Are we responding and improving?



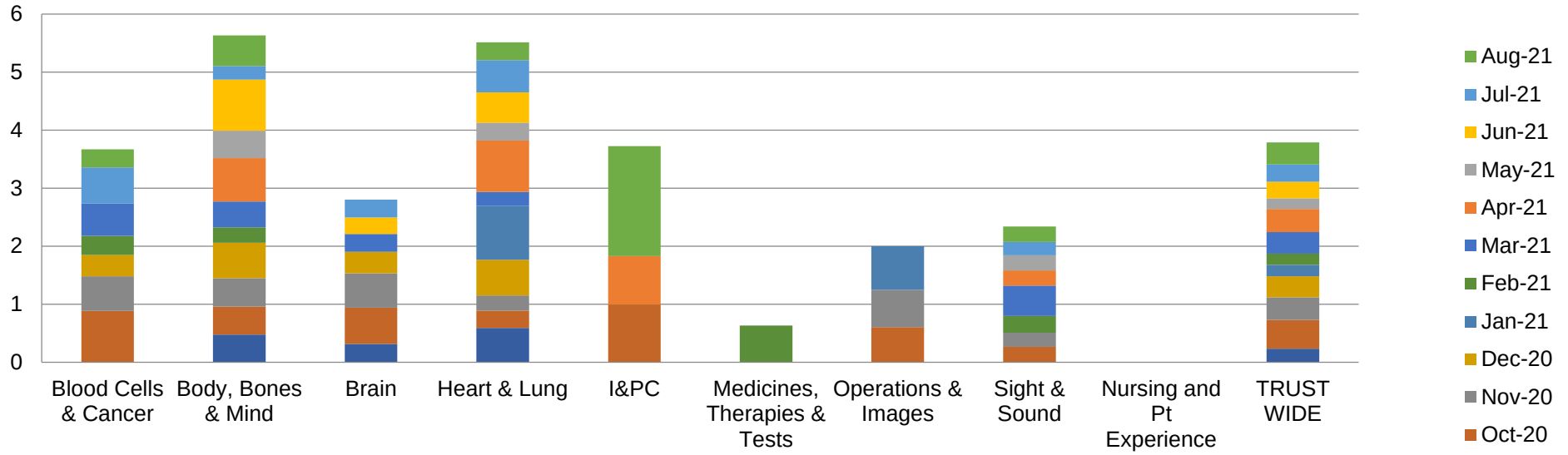
There were 8 formal complaints received in August 2021, which is an increase from the previous months (May, June and July) and in comparison to August 2020 (n=6). This month families reported concerns about:

- A lack of information both prior to traveling to the UK and admission to GOSH. The family report not being informed and describe a lack of support. Concerns were also raised regarding the COVID visitation rules, frozen food served and disposal of stored breastmilk.
- Care being followed up locally rather than at GOSH and a clinic letter relating to this.
- The process and management of their child's discharge, which the family describe as 'uncaring'. Concerns were also raised around the prescription of a trial drug when the ongoing and complex care needs of these group of patients can not be met in the community.
- A medication error which impacted on the ability to start treatment promptly. Concerns were also raised around the overprescribing of medication leading to the accumulation of unused medication.
- The manner of a member of staff and the way in which a patient's guardian and her mother were denied access to the hospital.
- Whether surgery that took place in 2019 was carried out correctly. Concerns were also raised around the lack of testing, clinical decision making and delays in follow up care.
- Father has raised concerns regarding the lack of communication/involvement in regards to his son's appointments at GOSH and his recent experience in the outpatients department.

At the time of writing (09/09/21), there are 9 open/ active complaints.
Of 35 new complaints received since 1 April 2021, 26 have been closed (17 within the original timeframe agreed and 9 with extended timeframes).

Complaints by patient activity*

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



The Trust rate of complaints by combined patient activity this month (0.38 complaints per 1,000 CPE) increased from last month (0.28).

Complaints were received under six directorates this month. Of these, three directorates saw an increase in their complaint rate:

- International and Private Care received two complaints and saw a significant increase in its complaint rate (1.90) from when it last received a formal complaint in April 2021 (0.84).
- Body, Bones and Mind also received two complaints and saw an increase in its complaint rate (0.53) from last month (0.24), which is their highest rate since June 2021.
- Sight and Sound received one complaint and saw a slight increase in their complaint rate this month (0.27) from last month (0.23).

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

NEW red complaints opened in **August 2021**	**NEW** red complaints **since APRIL 2021***	**REOPENED** red complaints **since APRIL 2020**	**ACTIVE** red complaints (new & reopened)	**OVERDUE** red complaint actions
0	2	0	1	11

New Red Complaint

Ref	Directorate	Description of Complaint	EIRM Outcome:	Update:
No new red complaints received				

Active Red Complaints (including reopened complaints)

Ref	Directorate	Description of Complaint	EIRM Outcome:	Update:
21-014	Body Bones & Mind (Spinal)	Mother raised concerns about incorrect placement of spinal screws instruments and the delayed identification of this.	EIRM took place on 24/06/21 and complaint was **not declared an SI.**	Root Cause Analysis and complaint investigation is underway. Extension granted as specialist input is required to draw conclusions and put together an action plan. The family have been informed and agree to the extension. The aim is to complete the responses by end of September.

** Includes one historic complaint regraded in April 2021*

PALS – Are we responding and improving?

Cases – Month	08/20	07/21	08/21
Promptly resolved (24-48 hour resolution)	141	188	131
Complex cases (multiple questions, 48 hour+ resolution)	32	39	43
Escalated to formal complaints	2	4	2
Compliments about specialities	2	4	2
Total:	**177**	**235**	**178**
Top Six Themes			
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families).	80	58	14
Admission/Discharge /Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation).	3	10	8
Staff attitude (Rude staff, poor communication with parents, not listening to parents, care advice)	0	6	17
Outpatient (Cancellation; Failure to arrange appointment).	19	39	48
Transport Bookings (Eligibility, delay in providing transport, failure to provide transport)	10	17	10
Information (Access to medical records, incorrect records, missing records, GOSH information, Health information, care advice, advice, support/listening)	65	105	81

There is a 24% decrease in the number of contacts recorded in August (n=178) compared to the preceding month (n=235). 74% of contacts were responded to and resolved by the relevant speciality teams within 48 hours or less.

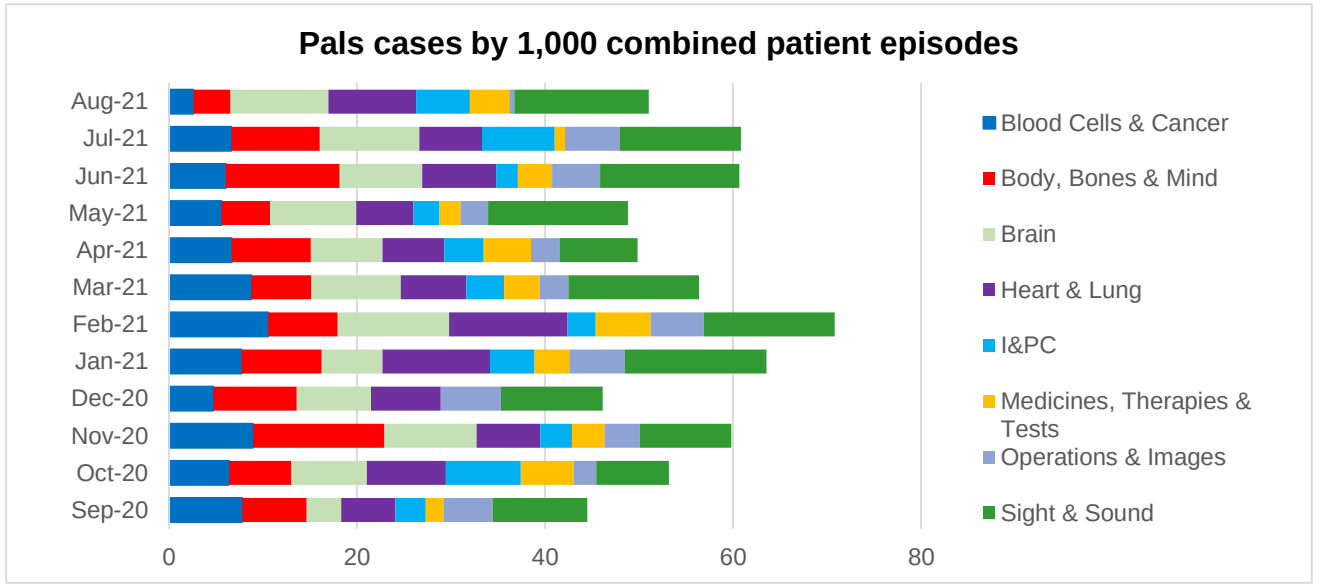
The 14 communication-specific contacts received in August represents a sustained reduction in communication concerns and the lowest total recorded to date. Pals consider this reflects the ongoing work undertaken by speciality teams to ensure that parents/carers are provided with clearly signposted and accessible avenues in which to share their concerns and queries. Additionally 85% of August's communication contacts were resolved by speciality teams in under 48 hours of being shared.

There has been an increase in contacts from the families of inpatients expressing dissatisfaction with the condition of equipment in the Patient Laundry. In addition to sharing these concerns with the Facilities team (who are in the process of arranging maintenance work) Pals continue to support families by providing a temporary reimbursement service for local laundry costs until this has been rectified.

Pals received two compliments from families regarding their experiences while attending admissions within the Trust. The first thanked the Endocrinology admissions coordinator for *his 'limitless kindness, patience and understanding'* while answering *'an endless stream of questions'* regarding an upcoming surgery. The second family praised the ICT team for the speed in which they reprogrammed a broken television in time for a long-term inpatient to watch a football match he had been looking forward to all week. For the latter the patient's dad described being left '*blown away'* by how the various teams came together to fix an issue that in *'other hospitals may have been considered trivial and unimportant'.*

PALS cases by directorate

In August the Blood Cells and Cancer directorate recorded its lowest volume of Pals contacts in 2021 (2.58 per 1,000 CPE). This can largely be attributed in declines in PALS contacts regarding Haematology, Rheumatology and Dermatology, the latter of which recording its lowest number since June 2019.



	BC&C	BB&M	Brain	H&L	IPC	MT&T	O&I	R&I	S&S
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
Jun-21	23	59	32	31	3	7	10	0	64
Jul-21	23	43	36	25	9	2	11	0	58
Aug-21	9	16	28	32	6	7	1	0	55
YTD	**296**	**421**	**334**	**345**	**53**	**69**	**86**	**1**	**571**

PALS – Are we responding and improving?

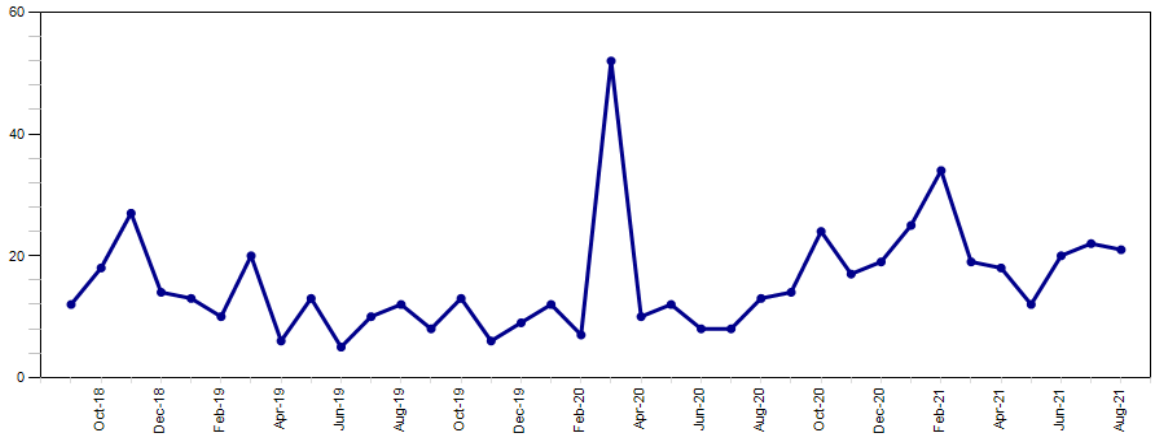
Top specialities - Month	08/20	07/21	08/21
Cardiology	13	23	21
Neurosurgery	20	8	12
Outpatients	3	7	12
Medical Records	7	11	11
Neurology	11	8	8

Cardiology- There has been a slight decrease in the volume of Cardiology contacts recorded in August (21) compared to July (23). Themes for Cardiology remain consistent with a large number of August's contacts centring around requests for clarity and guidance on clinical care plans. These include a mother querying the possibility of splitting care between GOSH and their local hospital and a father requesting further details on an upcoming admission. Pals continue to work alongside the Cardiology service who as ever remain proactive and positive in addressing what are often complex and challenging queries.

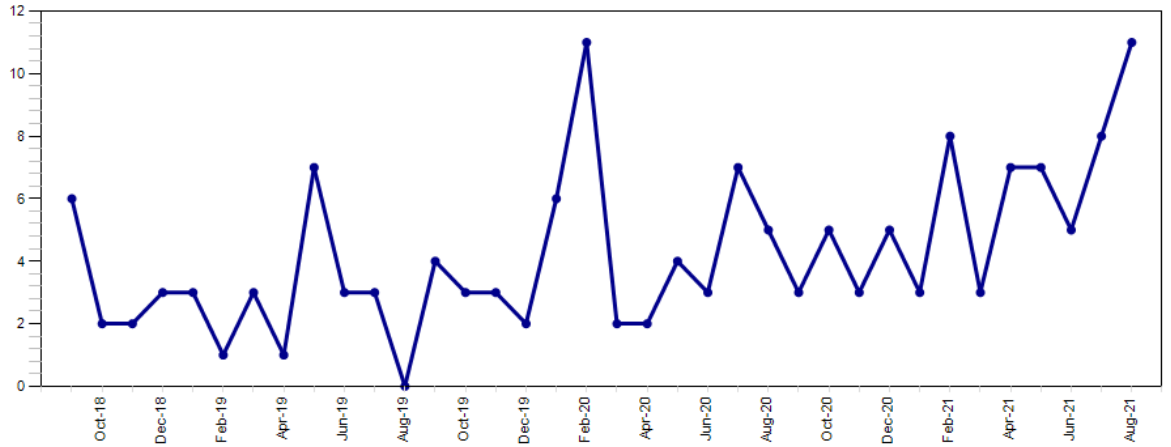
Neurosurgery- PALS received 12 Neurosurgery contacts in August. Similarly to Cardiology, a large number of these involve families requesting clinical advice and updates from the team. Examples include a mother requesting updates on approximate wait times following a recent referral and a parent requesting copies of clinical letters in order to share these in an upcoming appointment with his local team. Pals would like to thank the Neurology team, particularly the Head of Nursing for her ongoing support in providing prompt updates to patient queries. This support can be evidenced by approximately 70% of contacts being responded to and resolved by the service within 48 hours or less.

Dermatology- PALS would like to draw attention to the Dermatology team who in August recorded their lowest volume of contacts since June 2019 (n=2). This follows an action plan presented at PFEEC and sustained positive work being undertaken by both clinical and administrative teams within the speciality.

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



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

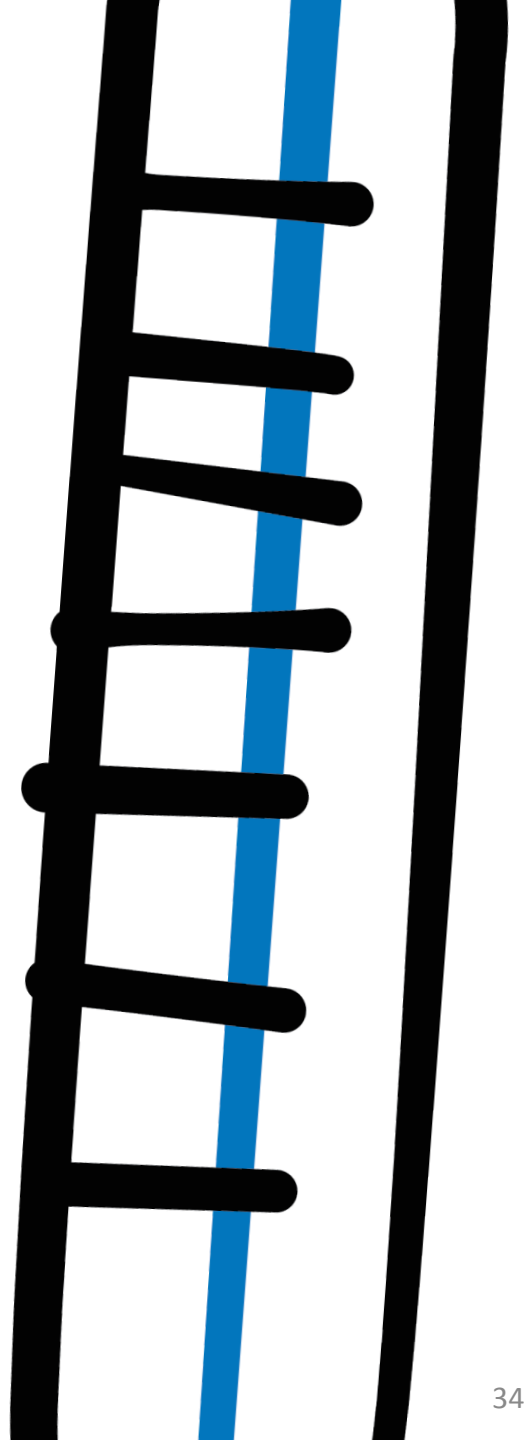


Learning from PALS

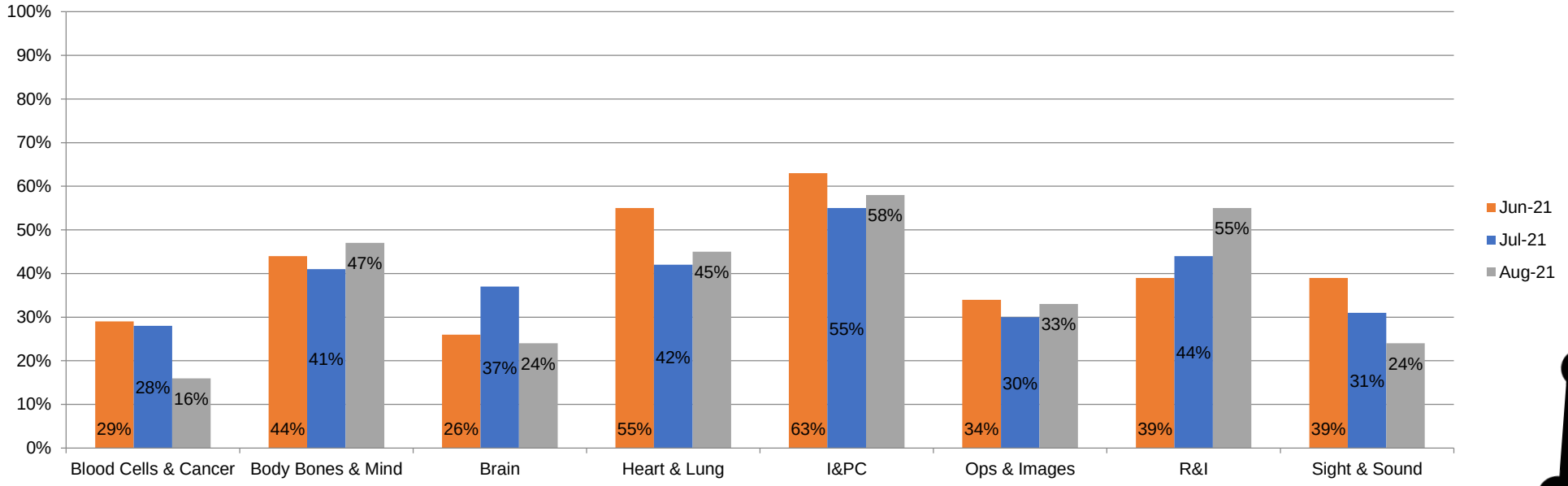
Pals were visited by a number of families with low incomes who described the financial challenges involved when travelling to GOSH. This was particularly difficult for visits arranged at short notice, with some families being left with little option other than to borrow money to afford the necessary travel costs.

While families were made aware of the Healthcare Travel Costs Scheme (funded by central government) after arrival at GOSH, they were often unable to provide the necessary eligibility documentation required to access the scheme. As a result there were increased delays in receiving reimbursements and in some cases this caused additional financial difficulties. Families often comment that had they known about this process beforehand, they would have been able to bring the required eligibility evidence with them, saving time for both themselves and the GOSH Travel Reimbursement team.

Pals understand the financial costs involved with travelling to GOSH and where possible have sought to support families with travel reimbursements. Pals have also shared feedback with the Outpatients and Travel Reimbursement team and are liaising with them to improve communication for families about access to this national support service.



FFT: Are we responding and improving?

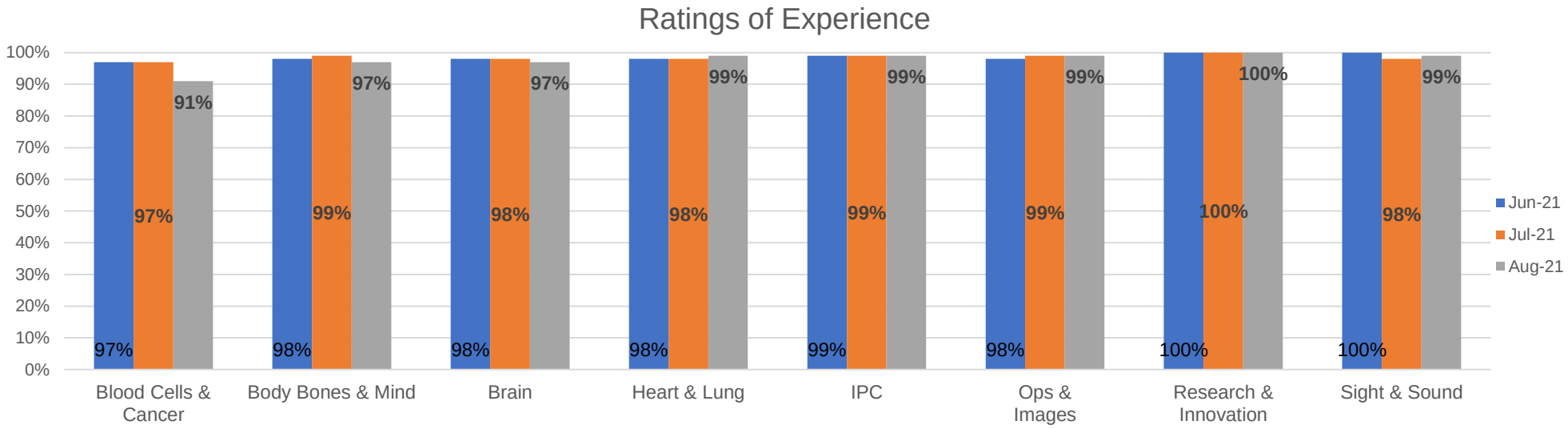


The Trust response rate decreased by 6% from the previous month to 28%. At directorate level, Blood Cells and Cancer, Brain and Sight and Sound did not achieve the Trust response rate target of 25%. As shown in the following slide, the experience rating target of 95% was exceeded at both Trust and directorate level with the exception of Blood Cells and Cancer who achieved 91%.

Consistent with previous months, the main theme of negative comments related to access, admission and discharge and the hospital environment. Comments highlighted issues with delays in discharge, surgery, suitability of equipment for older patients and noise on wards at night time.

Positive comments related to the standard of care and warm and helpful approach of staff. Families and patients praised the support from Play staff, clear explanations from clinical staff and excellent care. Feedback about I&PC highlighted two staff members who have great expertise in cannulisation and putting patients at ease.

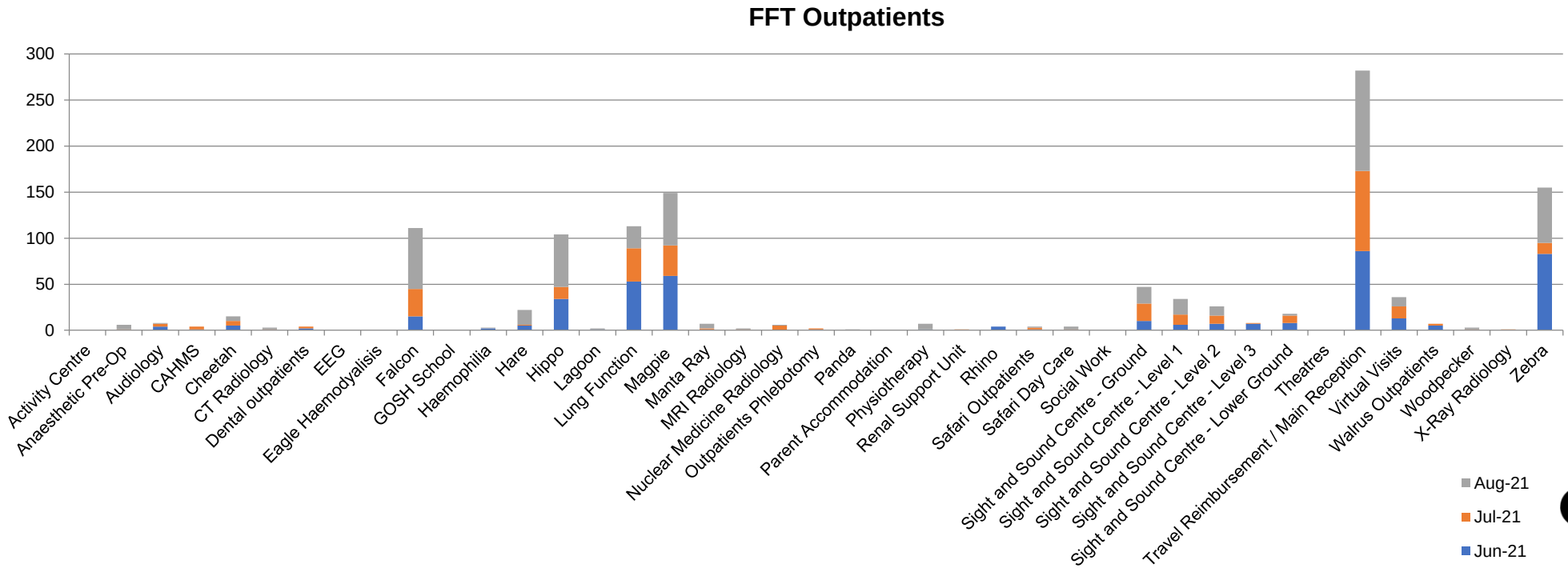
FFT: Are we responding and improving?



	Inpatient Comments	Outpatient Comments	IPC Comments	Total Feedback	% of FFT comments from CYP	% with qualitative comments (All areas)
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%**
Jun 21	951	409	190	**1550**	**16.6%**	**92.1%**
Jul 21	879	304	147	**1330**	**17.4%**	**91.7%**
Aug 21	691	481	145	**1317**	**13%**	*Not available*

- Inpatient response rate – **28%**
- Response rate has consistently been above Trust Target since May 2020.
- Experience measure for inpatients – **98%**
- Experience measure for outpatients – **97%**
- **13%** of FFT comments are from patients.
- Outpatient comments increased by 58%.

FFT: Are we responding and improving?



FFT feedback for outpatients increased by 58% in August and the response rate rose from 94% in July (below the Trust target) to 97%. Negative comments related to poor/ inadequate communication regarding delays (in some instances up to three hours), cancelled appointments and the one carer rule for outpatients. Specifically, families reported that having travelled long distances, the second parent/ carer had nowhere to go during the appointment.

The new Sight and Sound building continued to receive positive feedback with 44 comments about aspects of experience and care within the building. Overall the Sight and Sound outpatient rating of experience was 97%.

The Lung Function Unit in Heart and Lung received 24 compliments and achieved an experience rating of 100%.

FFT Comments

"*Always kept up to date, My son was made to feel very comfortable and we enjoyed the privacy of a private room. Very friendly nurses and we enjoyed talking to the surgeon before and after.*"

Walrus Day Ward

"All the staff on the ward and in surgery are just brilliant. Everyone had time to talk to us and explain what was going on. As a fairly new parent to GOSH a few more details on what is available e.g. the communal kitchen and how it works, where the canteen / garden is, nearby shopping centre is etc would be helpful if you in for more than a day. My child is 6ft 2 inches tall and both time he has been on Bear Ward the beds have not been big enough, it would be helpful if there was a better system for highlighting to the ward when the patient is taller. Also the door into the staff room at the end of the corridor needs a bit of TLC as it's very noisy when you are in a bay."

Bear Ward

"The experience has been wonderful, we were worried parents but each step of the way, we had support from various staff, when things changed during the operations we were updated. The post-op care was fantastic and so was the pre-op care. Communication via MyGOSH app was helpful. Thank you for the best hospital service"

Nightingale Ward

"We were welcomed onto the ward by very friendly staff who told us exactly what we should expect from our visit and what they are doing."

Magpie Ward

"The procedure was delayed and was not on the scheduled time as we were informed, my son was getting agitated and upset as he was hungry and had to NBM because of the procedure, this was very distressing for me as his mother.
Discharge took forever as we had to wait forever for my son's medication."

Lion Ward

"*Thanks to all the kind and lovely staff. My son was made really comfortable. He loves coming to the hospital*"

Otter Ward

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

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

IQPR Trust Performance Update September 2021

Reporting August 2021 data

John Quinn, Chief Operating Officer

Overview

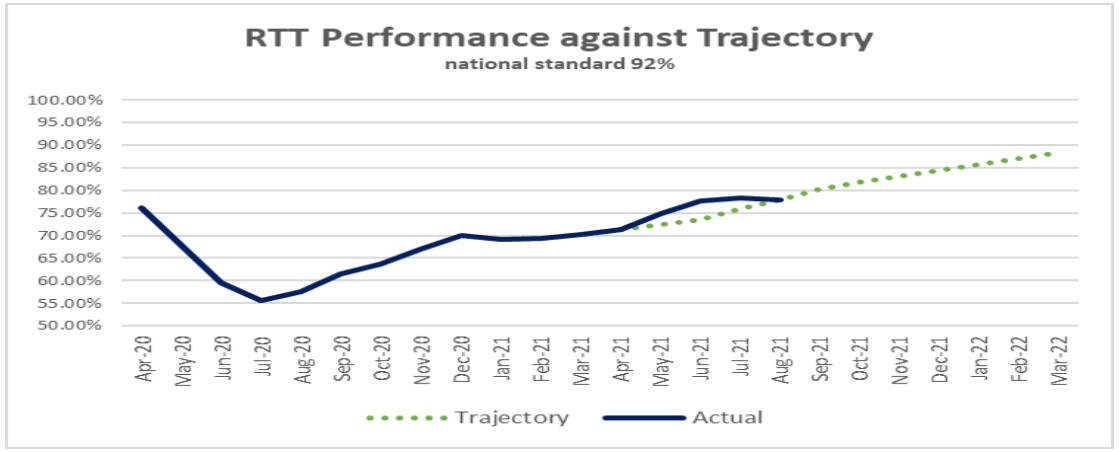
Standard	Target	Current Performance	Trend	Forecast Compliance
Referral to Treatment (RTT)	92% in 18 wks	77.8%	↓ 0.4%	September 2022
No. over 18 Week waits	-	1576	↑ 11	-
52 Week waits	0	247	↓ 25	June 2022
104 Week Waits	0	13	↑ 2	December 2021
Diagnostics	99% in 6 wks	81.06%	↓ 4.3%	March 2022
31 Day: Decision 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 – 78.0%

Actual v Trajectory



77.8%
People waiting less than 18 weeks for treatment from referral.

Target 92% ↓ -0.5%

247
Patient wait over 52 weeks

↓ 25

12
Patients waiting over 104 weeks

↑ 1

Directorate Performance

Blood, Cells and Cancer – 87.5%
Brain – 84.9%
Body, Bones and Mind – 66.3%
Heart and Lung – 82.0%
Medicines, Therapies & Tests – 97.7%
Operations & Images – 89.5%
Sight and Sound – 69.0%

Bottlenecks

- 72% of over 18 week patients prioritised as P3/P4
- Insufficient theatre capacity in SNAPs, Gastroenterology, Ophthalmology, Orthopaedics and Spinal to reduce long waits
- Specialist resource challenges particularly impacting Craniofacial and Plastic Surgery
- Bed availability and staffing pressures during July and continuing into August
- Covid-19 impact on patients and staff due to isolation and sickness
- Inherited long waits from other providers impacting ability to prevent 104 week waits
- Unexpected clinician absence in Orthopaedics and due to specialisation some patients cannot be treated by another member of the clinical team.
- Potential 3rd wave surge in September
- Increased annual leave in August 2021 reducing capacity across services

Actions

- Additional theatre and clinic sessions identified by directorates for June, July and September
- Bed closures being signed off by Senior Directorate Team
- Weekly meeting with service leads and theatre team to ensure capacity is used appropriately
- Relaunch and adherence to theatre 6-4-2 model
- Intensive PTL validation as ‘missed’ stops identified
- 52 week and 104 week wait trajectory submitted NCL for reduction in long waits
- Internal RTT trajectories in development by service and directorate

RTT - continued

Performance

Challenged Directorates

Directorates – below 80% performance August 2021

Body, Bones and Mind – 66.3%
Sight and Sound – 69.0%

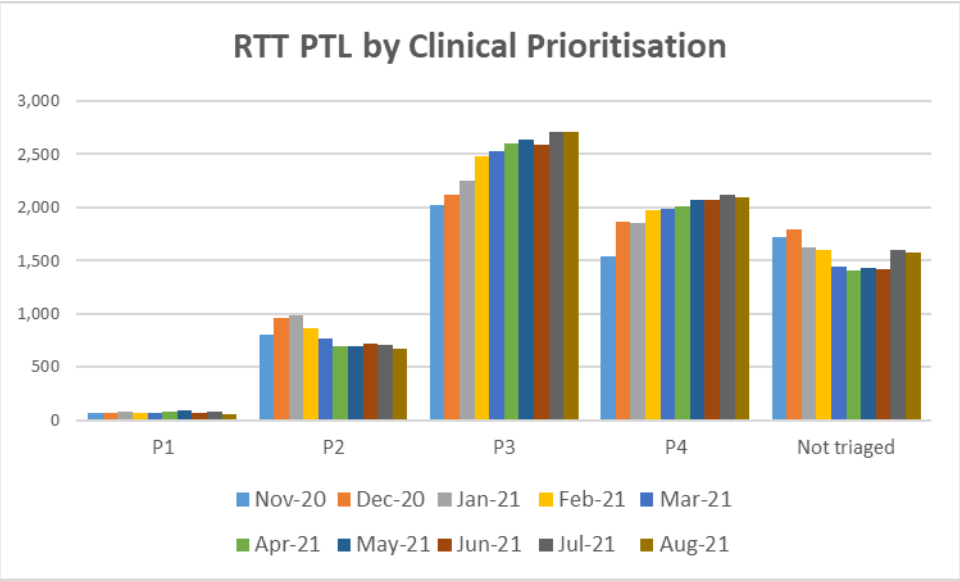
Body, Bones and Mind has improved RTT performance from previous month

Key Specialties

- Orthopaedic breaches have decreased by 21 as at end of August 2021 but still remain significant at 219. Further impact on long waits due to unexpected clinical absence
- SNAPS breaches peaked in January 2021 at 172 breaches, and have now decreased by 98 breaches as at end of August 2021.
- Spinal Surgery has decreased by 13 breaches to 80 in August 2021
- Cardiology breaches have decreased by 6 breaches to 116 in August 2021.
- Plastic Surgery breaches increased by 26 at the end of August 2021 and remains a significant challenge at 203.
- Dental breaches remain at 43 at end of August 2021, similar to July 2021.

	Projected Date (not signed off/validated)	May-21	Jun-21	Jul-21	Aug-21	% change	Aug 2021 No. of >18 Weeks	Breaches
Body, Bones & Mind								
CAMHS	N/A - continue to meet	92.5%	88.9%	88.7%	82.7%	-5.99%	22	
Gastroenterology	Mar-22	74.1%	73.5%	76.2%	78.3%	2.09%	49	
General Paediatrics	Feb-22	66.7%	75.9%	66.7%	51.9%	-14.81%	13	
Nephrology	N/A - continue to meet	93.2%	93.8%	98.8%	97.6%	-1.23%	2	
Orthopaedics	Does not meet 92%	43.4%	48.1%	44.4%	48.2%	3.80%	218	
SNAPS	Jan-23	61.4%	67.8%	72.0%	74.4%	2.42%	74	
Spinal Surgery	Does not meet 92%	49.7%	54.0%	51.3%	54.3%	2.98%	80	
Directorate Total	Nov-22	**61.8%**	**64.7%**	**65.3%**	**66.3%**	**1.00%**	**458**	
Heart & Lung								
Cardiac Surgery	Feb-22	72.2%	74.5%	80.4%	75.0%	-5.36%	12	
Cardiology	Mar-22	79.7%	80.5%	81.7%	81.6%	-0.15%	231	
Pulmonary Hypertensio	Sep-21	50.0%	66.7%	85.7%	100.0%	14.29%	2	
Respiratory Medicine	Dec-21	90.9%	90.6%	91.1%	92.1%	0.99%	5	
Directorate Total	Mar-22	**79.6%**	**80.5%**	**82.5%**	**82.0%**	**-0.51%**	**250**	
Sight & Sound								
Audiological Medicine	Mar-22	60.6%	63.9%	69.1%	68.8%	-0.35%	49	
Cleft	Mar-22	77.0%	61.5%	71.4%	83.9%	12.44%	5	
Cochlear Implant	Mar-22	53.3%	66.7%	68.8%	69.2%	0.48%	4	
Craniofacial	Does not meet 92%	51.1%	61.4%	65.4%	59.5%	-5.89%	77	
Dental	Does not meet 92%	57.6%	60.0%	73.5%	73.1%	-0.33%	43	
Ear Nose and Throat	Dec-21	70.8%	70.9%	74.7%	75.7%	0.99%	110	
Maxillofacial	Mar-22	59.6%	66.0%	66.9%	63.9%	-3.00%	44	
Ophthalmology	Oct-22	75.7%	80.7%	79.5%	75.7%	-3.76%	91	
Orthodontics	Dec-22	42.1%	57.1%	59.4%	60.6%	1.23%	13	
Plastic Surgery	Does not meet 92%	54.1%	60.3%	57.2%	52.1%	-5.12%	203	
Urology	Dec-22	80.44%	83.28%	75.4%	78.8%	3.40%	68	
Directorate Total	Mar-23	**65.7%**	**69.9%**	**70.5%**	**69.0%**	**-1.53%**	**707**	

RTT PTL - Clinical Prioritisation



P2	P3	P4	Not Prioritised
669 ↓ 34	2709 ↓ 1	2099 ↓ 20	1577 ↓ 25

Clinical Prioritisation – past must be seen by date

P2	P3	P4
191 ↓ 16	450 ↑ 48	225 ↑ 15

- The current RTT PTL is 7106 patients, 1577 require clinically prioritising with 1288 being under 18 week waits. The remaining patients on the PTL are cohorted as follows:, P1a/P1b – 52 patients (0.7%), P2 – 669 (9%), P3 – 2709 (38%) and P4 – 2099 (29%).
- It is recognised some sub-speciality areas including Plastic Surgery, Orthopaedics, Spinal and SDR have significant backlogs with many of these patients being within the clinical priority groups of 3 and 4.
- The number of P2 patients waiting beyond their must be seen by date has slightly decreased to 191, 133 (70%) are admitted and 58 (30% are non-admitted).
- The largest volume of P2 breaching patients are within SNAPs (26), Dermatology (20), Dental (16), Cardiac Surgery (13), Gastroenterology (12) and Orthopaedics (10). These make up 50% of the breached P2. 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 August, 78% of patients on the Trust's RTT ticking waiting list were referred from other Trusts, and 0.77% (43) of these patients had been waiting more than 18 weeks at their referring Trust. 12 of these patients were waiting 52 weeks or more when they were referred to us, with five of them at over 75 weeks wait.

Diagnostics - DM01

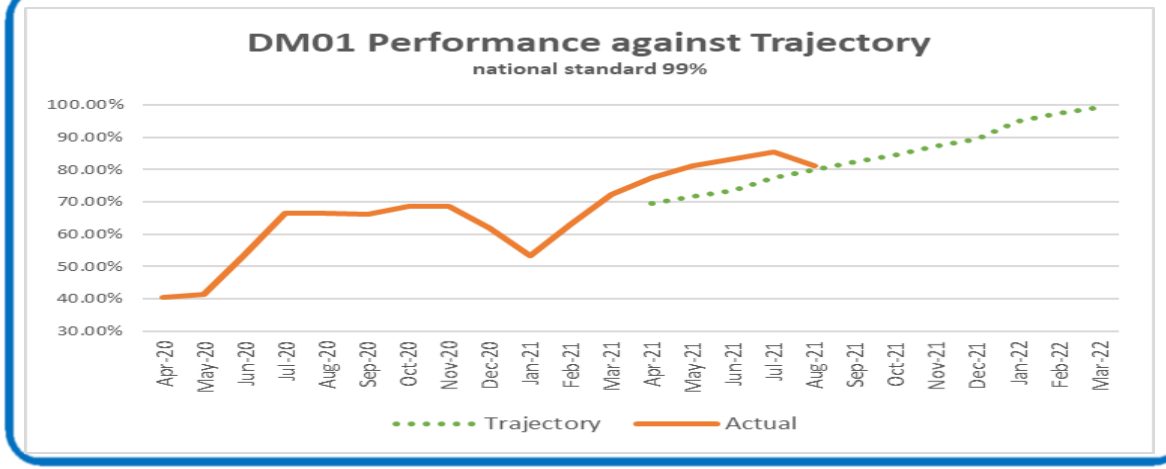
Performance

Forecast – 77.6%

81.06%
People waiting less than 6 weeks
Target 99% ↓ **4.3%**

243
Number of Breaches
↑ **42**

Actual v Forecast



Bottlenecks

- MRI GA capacity remains challenging and current demand exceeds available capacity, August saw an increase of 9 breaches
- Unexpected clinician leave in Respiratory impacting Sleep Studies
- Stress and sedated echo capacity is limited
- 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

- 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

Modality Focus

Of the 243 breaches, 122 are attributable to modalities within Imaging (109 of which are MRI), 42 in ECHO, 33 in Sleep Studies, 26 in Gastroscopy, 8 in Audiology, 5 in Colonoscopy ,5 in Cystoscopy and 2 in Urodynamics.

At the end of August 2021, 40 patients were reported to be waiting 13 weeks and over for their diagnostic test, a reduction of 3 from July. The majority are booked in September and October.

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. However, it is expected many organisations will require a longer time period.
- Review of patients waiting 13 weeks and over, ensure patients are clinically prioritised if not booked.
- Review planned patients 6 weeks past due to date
- NCL stated London Providers to only use codes D1 – D3
- Any potential risks will be raised through Trust reporting streams

Cancer Waiting Times

Performance

Forecast – 100%

July 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

August 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

Potential Sept breach for the 62 day consultant upgrade standard

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 – 35, 30/03/2021 – 29/08/2021.

	Daycase			Elective			Emergency			First outpatient			Follow-up outpatient		
Calendar Weeks	2019	2021	%	2019	2021	%	2019	2021	%	2019	2021	%	2019	2021	%
14	502	347	69.1%	226	248	109.7%	59	59	100.0%	693	423	61.0%	3637	2247	61.8%
15	503	410	81.5%	250	218	87.2%	65	49	75.4%	694	421	60.7%	3575	2718	76.0%
16	414	478	115.5%	212	219	103.3%	59	53	89.8%	511	598	117.0%	2732	3275	119.9%
17	306	457	149.3%	137	268	195.6%	56	59	105.4%	274	673	245.6%	1701	3392	199.4%
18	344	468	136.0%	218	289	132.6%	57	51	89.5%	339	626	184.7%	2200	3442	156.5%
19	368	405	110.1%	208	206	99.0%	61	40	65.6%	366	495	135.2%	1859	2941	158.2%
20	405	440	108.6%	270	254	94.1%	59	62	105.1%	497	663	133.4%	2697	3493	129.5%
21	431	480	111.4%	269	281	104.5%	51	52	102.0%	597	677	113.4%	2945	3206	108.9%
22	403	467	115.9%	251	270	107.6%	48	61	127.1%	406	654	161.1%	2218	3118	140.6%
23	406	405	99.8%	285	221	77.5%	59	55	93.2%	601	409	68.1%	2775	2259	81.4%
24	443	513	115.8%	298	255	85.6%	48	50	104.2%	643	737	114.6%	2974	3500	117.7%
25	485	462	95.3%	273	278	101.8%	54	61	113.0%	625	619	99.0%	2869	3321	115.8%
26	488	511	104.7%	275	251	91.3%	55	50	90.9%	615	618	100.5%	3085	3067	99.4%
27	438	472	107.8%	284	265	93.3%	53	51	96.2%	583	583	100.0%	2950	3182	107.9%
28	501	452	90.2%	274	245	89.4%	53	58	109.4%	631	691	109.5%	3012	3334	110.7%
29	465	477	102.6%	275	243	88.4%	52	50	96.2%	619	638	103.1%	2772	3150	113.6%
30	508	447	88.0%	279	233	83.5%	45	67	148.9%	536	650	121.3%	2738	2925	106.8%
31	433	468	108.1%	279	244	87.5%	47	68	144.7%	539	521	96.7%	2651	2681	101.1%
32	454	423	93.2%	288	231	80.2%	48	45	93.8%	570	526	92.3%	2573	2840	110.4%
33	418	462	110.5%	284	235	82.7%	39	53	135.9%	584	565	96.7%	2597	2660	102.4%
34	459	464	101.1%	238	254	106.7%	42	54	128.6%	538	557	103.5%	2555	2644	103.5%
35	394	440	111.7%	222	284	127.9%	34	55	161.8%	428	491	114.7%	2144	2656	123.9%

NHS Acute Specialty Day-case discharges over the last 22 weeks is 104% of 2019/2020 and Elective discharges 98%.
NHS Outpatient First Outpatient attendances over the last 22 weeks is 108% of 2019/2020 and Follow-up attendance 111%.

Children's Alliance Accelerator Activity

As part of the Accelerator Programme the operational teams proposed additional activity, 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 table below summarises actual activity done in August against what was planned with additional accelerator activity and 19/20 baseline.

		Elective Inpatient Admissions					Elective Daycase					Outpatients inc OPD procedures				
Specialty Name	**TFC**	**2019/20 Baseline**	**Planned activity with accelerator (2021/22)**	**Actual activity (2021/22)**	**% of 19/20 Baseline**	**% of plan achieved**	**2019/20 Baseline**	**Planned activity with accelerator (2021/22)**	**Actual activity (2021/22)**	**% of 19/20 Baseline**	**% of plan achieved**	**2019/20 Baseline**	**Planned activity with accelerator (2021/22)**	**Actual activity (2021/22)**	**% of 19/20 Baseline**	**% of plan achieved**
Dental	142	2	0	0	0%		5	2	3	60%	150.0%	110	127	134	122%	105.5%
SNAPS	171	48	50	54	113%	108.0%	32	26	34	106%	130.8%	252	252	320	127%	127.0%
Urology	211	49	82	103	210%	125.6%	159	198	176	111%	88.9%	238	238	447	188%	187.8%
Plastic surgery	219	70	69	63	90%	91.3%	54	52	30	56%	57.7%	710	715	632	89%	88.4%
Craniofacial	251	52	53	67	129%	126.4%	69	93	95	138%	102.2%	206	206	376	183%	182.5%
All Priority Specialties		221	254	287	130%	113.0%	319	371	338	106%	91.1%	1,516	1,538	1,909	126%	124.1%
All Paediatric Specialties		**1,156**	**1,000**	**1,070**	**93%**	**107.0%**	**1,898**	**1,818**	**1,892**	**100%**	**104.1%**	**14,557**	**16,856**	**16,073**	**110%**	**95.4%**

For the priority specialties the overall performance for Inpatients, Day-case and Outpatients is above the 19/20 baseline. However, all specialties again plan plus accelerator is below the agreed numbers. Impacts of the 'pingdemic' across patients and staff, increases in covid-19 positive and RSV patients can be attributed to the decreased activity

Appendix

Productivity and Efficiency

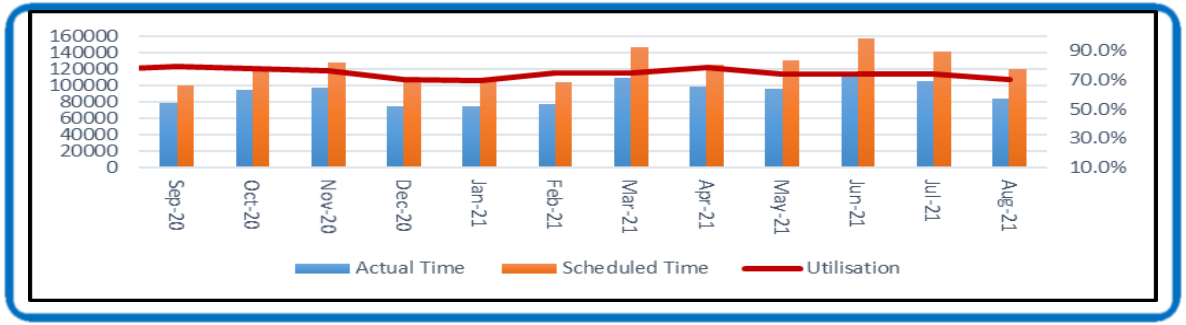
Theatre Utilisation

Performance

70.4%
of scheduled sessions in main theatres were utilised
3.84%

7679
Late start minutes
1619 minutes

3858
Overrun minutes
2681 minutes



Bottlenecks

- Lists not always being fully utilised. However, reinvigoration of 6-4-2 model is expected to improve throughput.
- Potential reduction in throughput from June 2021 with no longer having a dedicated Covid-19 theatre due to cleaning turnaround times. Level 2 cleans have significantly impacted theatres

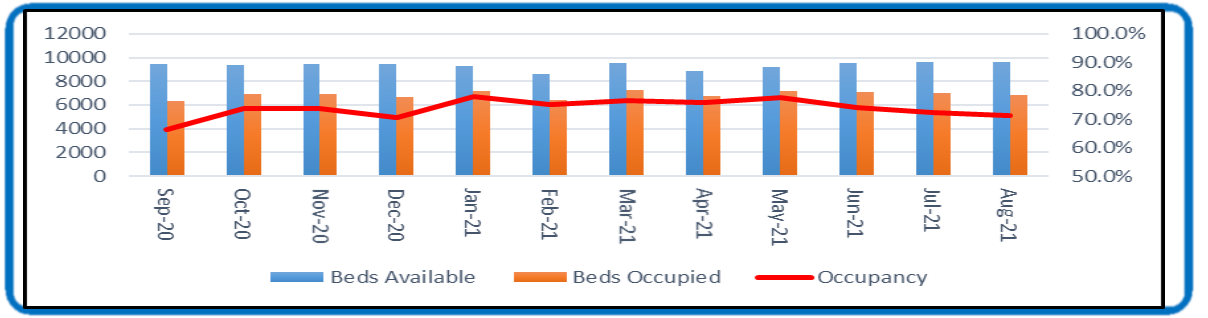
Bed Occupancy

Performance

71.3%
of inpatient beds (including ICU and I&PC) were occupied
1.18%

74.0%
Of NHS inpatient beds (including ICU were occupied)

Bed Closures



Bottlenecks

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

Productivity and Efficiency

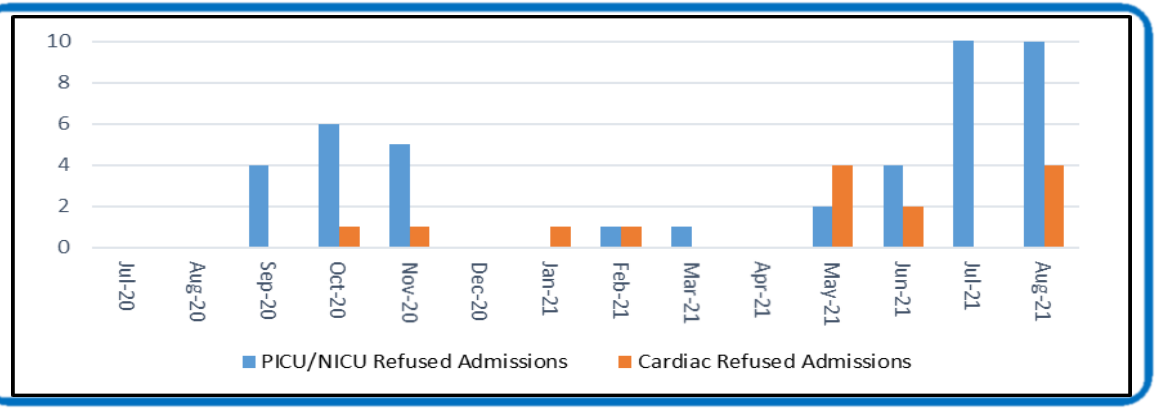
PICU/CICU

Performance

10
PICU/NICU CATS refused admissions
2

4
Cardiac CATS refused admissions
4

0
PICU readmissions within 24 hours



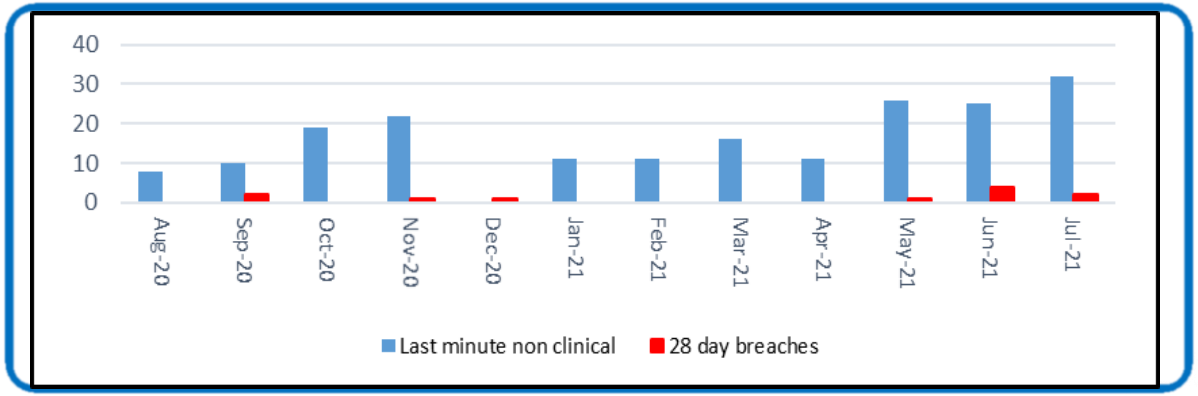
Bottlenecks:
- No PICU and CICU beds

Cancelled Operations

Performance

32
Last minute cancelled operations for non clinical reasons
7

2
28 day breaches- last minute cancelled operations
2



Bottlenecks
- 28% of the cancellations were due to List overrun
- Ward bed, CICU bed unavailability and urgent patients taking priority
- 28 day breaches due to list overrun and urgent patient taking priority. Patients were treated end of July.

Patient Communication

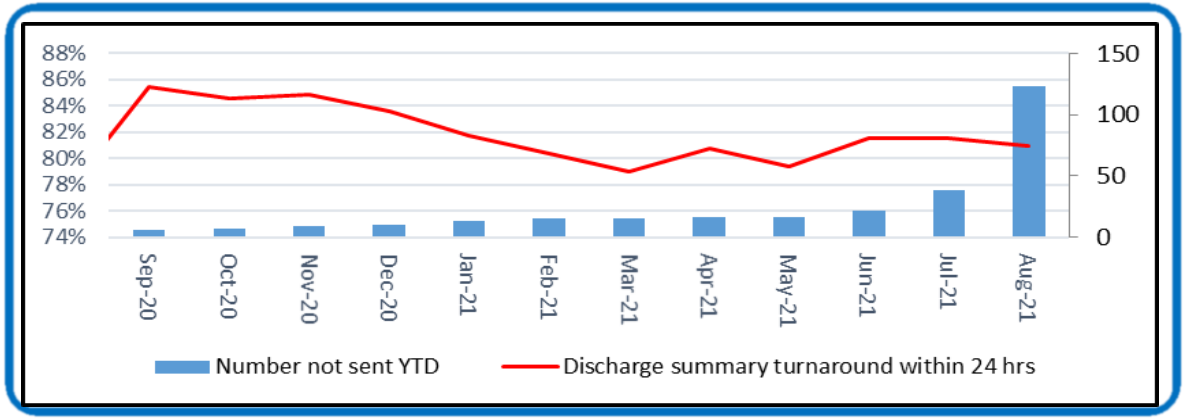
Discharge Summaries

Performance | Forecast

80.9%
of patients who were discharged from GOSH had a letter sent to their referrer or received within 24 hours
Contractual target: 100%
0.62%

93%
of letters were sent within 2 days of discharge
0%

123
Number of letters not sent ytd
61



Actions

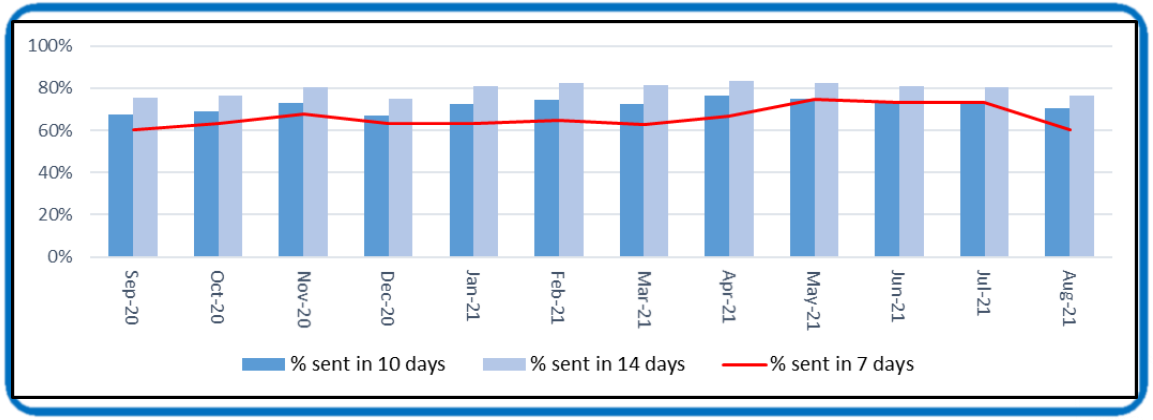
- Focus at consultant meetings
- Directorates working with clinical teams on real time completion including weekends

Clinic letters

Performance | Forecast

60%
of outpatient clinic letters were sent within 7 days
Contractual target: 100%
13.3%

2,476
Number of letters not sent (rolling 12 months)
159



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

Integrated Quality and Performance Report

Proposal for Revised Format

Sept 2021

Integrated Quality & Performance Report

Why are we changing it?

To improve and clarify the assurance we are providing to the Board

How are we intending to delivering this?

1. Providing a consistent structure and contents

   The report was originally put together amalgamating individual reports from each function. As a result it lacked coherence in style and content. By restructuring we aim to make it more accessible allowing easy access and clear information delivery.

2. Focusing on the important subjects

   There are too many metrics many of which are more operational than strategic. We have eliminated the many of these operational metrics and focus on the ones that we believe provide the information relevant for Board oversight of the quality and performance of the services the hospital provides.

3. Making it part of an integrated structure to manage the hospital

   Currently the IPQR includes many metrics which we do use to manage the hospital but we have not consistently aligned it to those management metrics. We want the IPQR to be part of an suite of metrics that are integrated and aligned.

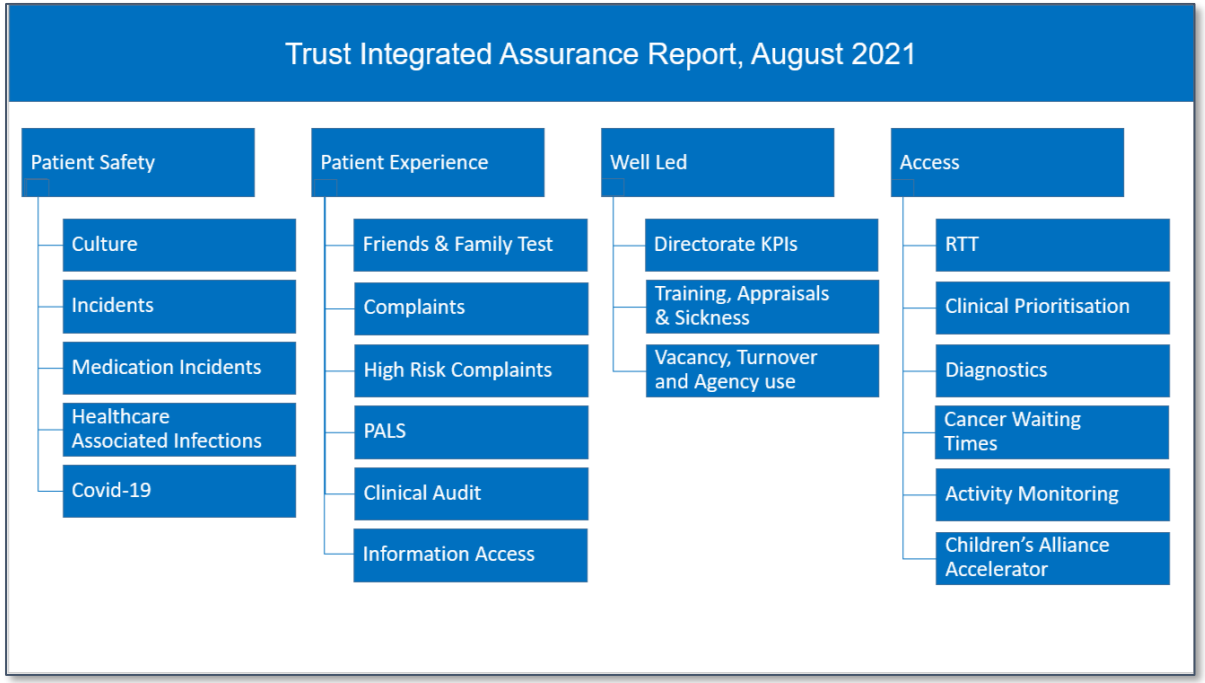
The process with have been through

1. Engaged with each of the key information providers across the Trust to explain the new structure and establish the key metrics that are important that indicate effective management.

2. Reviewed IQP reports from other Trust to look for best practice. Trusts packs reviewed were:
   - Alderhey
   - Barts
   - Guys and St Thomas
   - Newcastle
   - Portsmouth
   - East Suffolk & North Essex

3. Developed initial mock-up for internal review and feedback.

New report structure

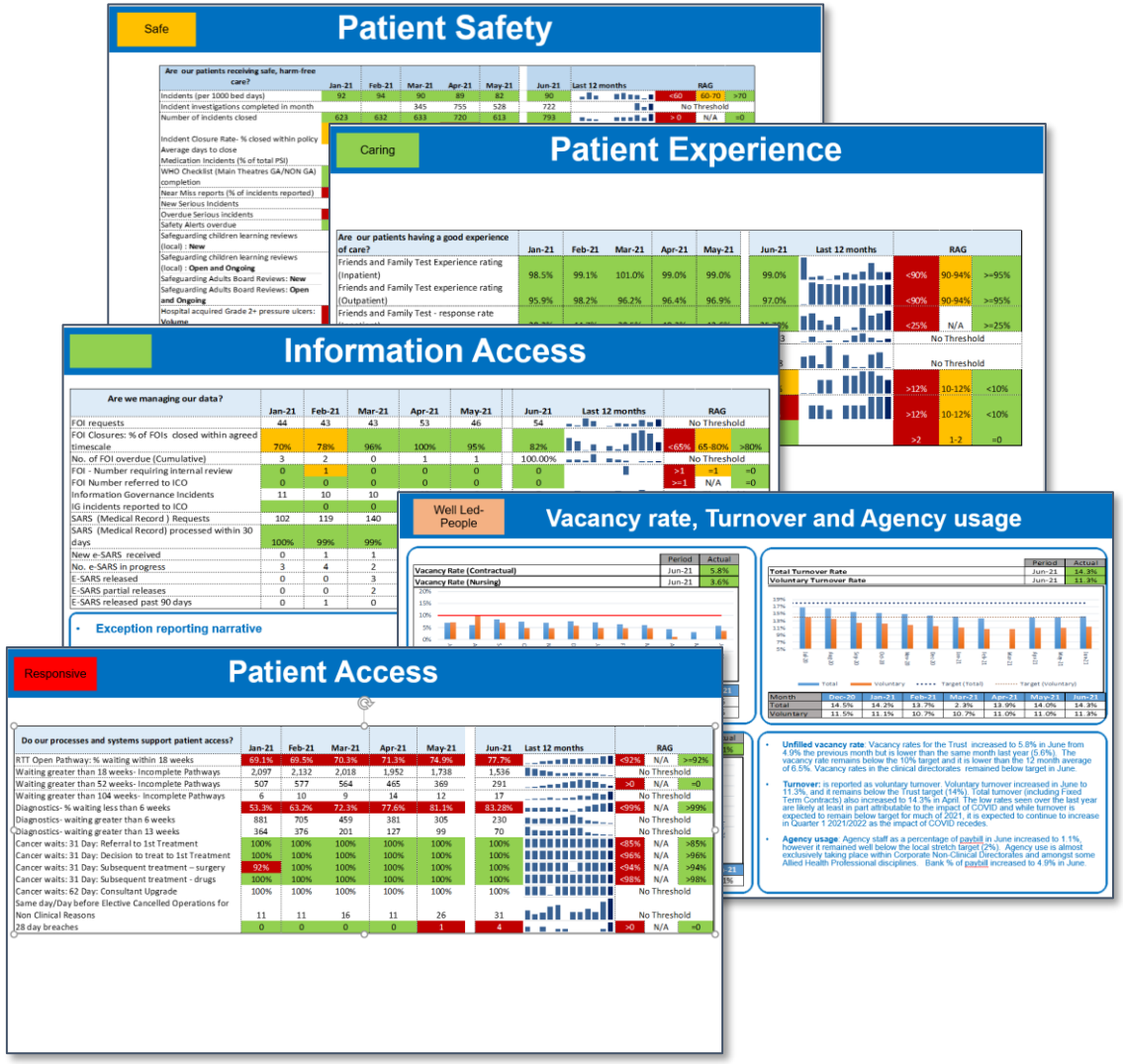


The report will be broken down into 4 main sections, covering:

- Patient Safety
- Patient Experience
- Well Led
- Access

This is the first stage in moving to a balanced scorecard approach.

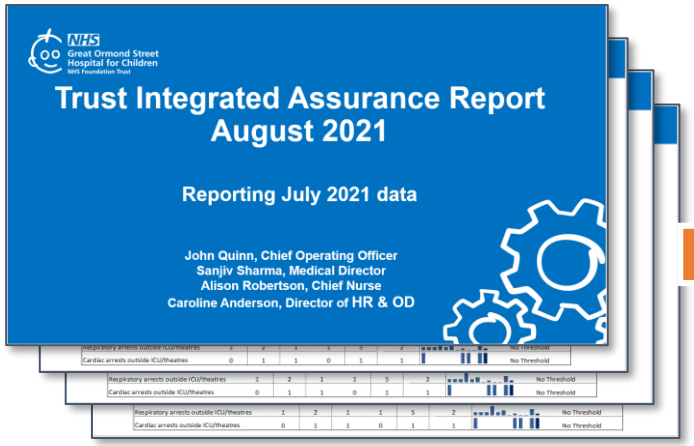
Look & Feel



The aim is to provide a consistent look and feel to the report. There will be a small number of standard page templates and these will be used throughout the documents. This will make it easier to navigate and find relevant KPIs.

Integrated and tiered reporting

The aim is to create an integrated suite of reporting tools that not only provide the assurance for the Board but also are used to manage the hospital.



FIC

Audit Committee

?

Timelines

Options:

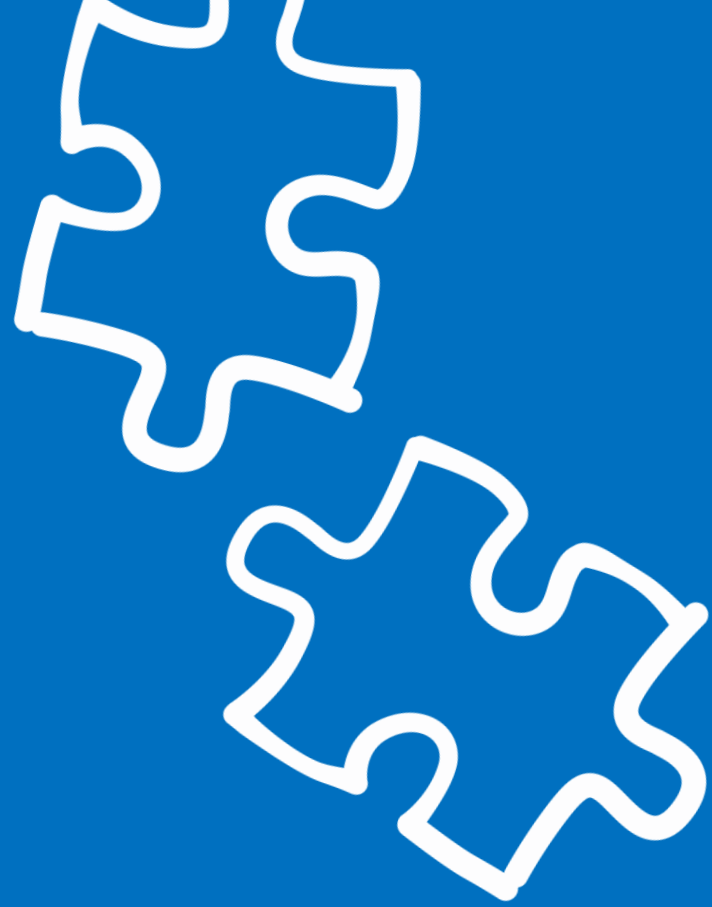
Option 1: Go for an early implementation with the expectation we will go through a number of iterations as we develop the final form:

- November 2021 - Prototype of revised format produced alongside existing IPQR
- February 2022 - Move to new format

Option 2: Start prototyping early but iterate the format off-line and start the new documents in FY 2021-22:

- February 2022 - Prototype of revised format produced alongside existing IPQR
- May 2022 - Move to new format

IQPR Revision Proposal



Attachment T

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
29 September 2021

Month 5 2021/22 Finance Report **Submitted by:** Helen Jameson, Chief Finance Officer **Presented by:** Helen Jameson, Chief Finance Officer	**Paper No: Attachment T**

Aims / summary

The month 5 financial position is a surplus of £0.8m in-month which is £1.3m favourable to plan. The Trust has a YTD surplus position of £1.4m which has been primarily achieved through Elective Recovery Funding (ERF) for additional day case, elective and outpatient activity in order to reduce patient backlogs and wait times, which was not included in the plan (£13.4m favourable YTD). ERF is being earned on activity levels above 95% of 2019/20 performance (in Months 1-4 it was 85%); currently given the continuing low private patient referral pipeline, the Trust are utilising this available bed space and capacity to earn ERF where possible. There does continue to be a risk that once the ERF is aggregated across the wider system and STP, that this will amount to an unaffordable level for NHSE. The income recognised by the Trust currently therefore may not be received in full, 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.

Key points to note within the financial position are as follows:

1. Income overall YTD is £2.2m favourable to plan for the Trust, largely driven by ERF activity. NHS and other clinical income is £10.5m favourable to plan YTD; ERF funding is currently £13.4m favourable to plan, partially offset by lower than plan Covid income given lower than plan spend (£4.6m adverse to plan). Private patient income is £5.0m adverse to plan YTD; this continues to be below plan due to continued travel restrictions related to Covid-19. Non-clinical income is also adverse to plan YTD (£3.4m) due to lower than plan charitable contributions and commercial income from research and development, both due to timing of projects.

2. Pay is £0.1m 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. In addition, this month saw the onboarding of OCS staff in relation to the in-housing of the cleaning contract. Further to guidance from NHSE/I, accruals relating to the 3% pay rise announced by government have not been made; however the backdated pay rise amounts will be paid in the September pay run and will be funded centrally by NHSE/I. Temporary staffing costs (bank and agency) remain high given continuing ERF/ accelerator activity and continuing Covid sickness/isolation. Staff turnover levels have remained low as a result of the pandemic and high staff levels have been retained across the board; however the Trust has seen some turnover within

permanent nursing within the last 2 months (NQN intake will arrive in late September).

3. Non-Pay is £2.0m favourable to plan in-month. Key drivers of this are lower than plan usage of high cost drugs and pass-through expenditure, and a one-off business rates rebate which in-month resulted in these costs being £0.8m favourable to plan. In addition, Covid-19 costs are lower than planned in-month and YTD, and the Trust continues to look for and monitor these costs where appropriate to ensure no costs are missing.

4. Cash held by the Trust is £129.8m which is £2.5m higher than Month 4. Capital expenditure is currently above plan by £0.4m, with the Trust funded programme below plan by £1.7m and the donated programme £2.1m above plan.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust is £129.8m which is £2.5m higher than M4.
NHS Debtor Days	NHS debtor days increased from 3 days in Month 4 to 4 days in Month 5, falling within the target of 30 days for the Trust.
IPP Debtor Days	IPP debtor days decreased from 191 days in Month 4 to 146 days in Month 5.
Creditor Days	Creditor days has decreased from 25 days to 24 days.

Action required by the meeting

To note the Month 5 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 5 2021/22

Contents

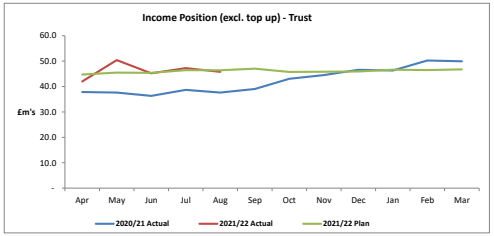
Trust Performance Summary for the 5 months ending 31 Aug 2021

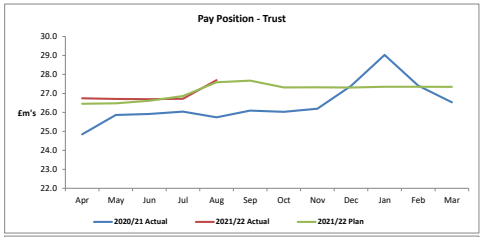
KEY PERFORMANCE DASHBOARD

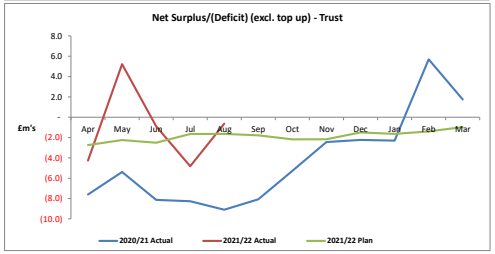
ACTUAL FINANCIAL PERFORMANCE

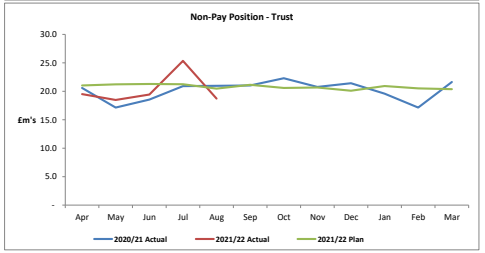
	In month			Year to date			Forecast
	Plan	Actual	RAG	Plan	Actual	RAG	6 months to M6
INCOME	£46.4m	£45.8m		£228.5m	£230.7m		£278.1m
PAY	(£27.6m)	(£27.7m)		(£134.0m)	(£134.6m)		(£163.3m)
NON-PAY inc. owned depreciation and PDC	(£19.3m)	(£17.3m)		(£99.4m)	(£94.7m)		(£113.8m)
Surplus/Deficit excl. donated depreciation	(£0.5m)	£0.8m		(£4.9m)	£1.4m		£1.0m

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









AREAS OF NOTE:

In Month 5, the Trust has generated a surplus of £0.8m in-month (£1.3m favourable to plan). The forecast last month (Month 4) for YTD Month 6 was for a £0.5m deficit; this month (Month 5) has seen this subsequently improve to a forecast of £1.0m surplus, largely driven by forecast improvements in ERF income to fund costs for additional activity. Given the continued suppression of the private patient referral pipeline, the Trust continue to utilise space and beds for NHS patients as far as possible, generating this additional income for the Trust through ERF and accelerator funding.

Trust performance YTD has been achieved through Elective Recovery Funding for activity levels above 95% of 2019/20 performance, enabling the reduction of patient backlogs and waiting times (£13.4m favourable to plan YTD). The Trust is however recognising less Covid-19 income than plan, which is in line with lower costs being incurred (£4.6m lower YTD). Key movements in-month relate to low high cost drugs and devices income (offset by expenditure) due to the summer seasonality resulting in fewer patients. Private patient income continues to perform below plan (£5.0m YTD) and remains a significant risk for the delivery of the financial position, especially as activity was expected to increase during the second half of the year and has remained low.

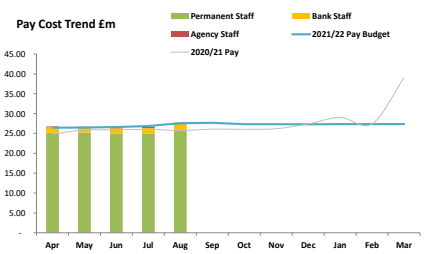
Pay is £0.1m adverse to plan in-month. Staff turnover levels have reduced as a result of the pandemic and high staff levels have been retained across the board. However this month also saw the TUPE transfer of OCS staff in relation to the in-housing of the Trust cleaning contracts, which has significantly increased the pay bill of the Trust. Despite the 3% pay rise announced by government last month, further to NHSE/I guidance no amounts have been included in relation to this rise; the payment will be funded centrally in September, and the pay rise will be backdated to the start of the financial year. Non-Pay is £2.0m favourable to plan in-month due to the aforementioned low levels of high cost drugs and devices expenditure, but also due to a one-off rebate in relation to business rates (£0.8m). Covid costs continue at lower than plan levels for which there is a corresponding lower than plan income.

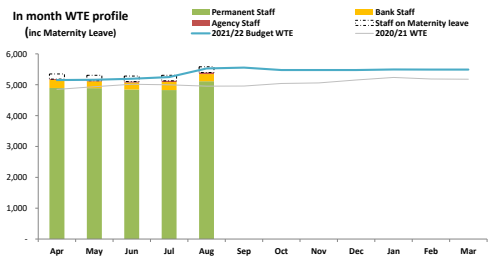
PEOPLE

	M5 Plan WTE	M5 Actual WTE	Variance
Permanent Staff	5,487.2	5,112.9	374.2
Bank Staff	40.7	233.7	(193.0)
Agency Staff	-	51.5	(51.5)
TOTAL	**5,527.8**	**5,398.1**	**129.7**

AREAS OF NOTE:

Month 5 WTE's are 271 higher than Month 4 due to the onboarding of OCS staff relating to in-housing of the cleaning contract; the majority of those being estates staff. Staff requirements remain high and temporary staff usage in relation to Covid sickness backfill and accelerator activity requirements across the Trust continue. The comparison of volume/price mix for the Trust staffing base when comparing to last year is significantly higher within estates staff due to the aforementioned TUPE transfer of OCS staff in Month 5, and also in 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). High levels of agency staff continues due to additional senior assistance for the ICT, IPP & Finance directorates; the process of looking to recruit permanently and negate these costs is ongoing.



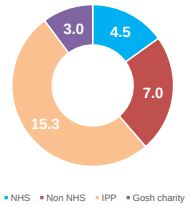


CASH, CAPITAL AND OTHER KPIs

Key metrics	Jul-21	Aug-21
Cash	£127.3m	£129.8m
IPP debtor days	191	146
Creditor days	25	24
NHS Debtor days	3	4

Capital Programme	YTD Plan M5	YTD Actual M5	Full Year F'cst
Total Trust-funded	£3.9m	£2.2m	£18.3m
Total Donated	£2.9m	£5.0m	£14.9m
Total Grant-funded	£0.0m	£0.0m	£0.5m
Grand Total	£6.8m	£7.2m	£33.7m

Net receivables breakdown (£m)

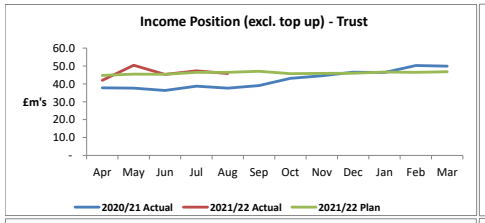


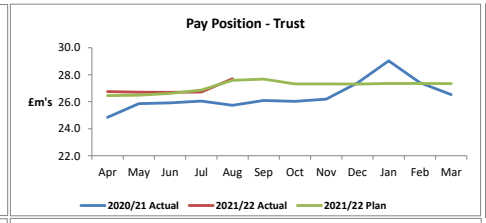
AREAS OF NOTE:

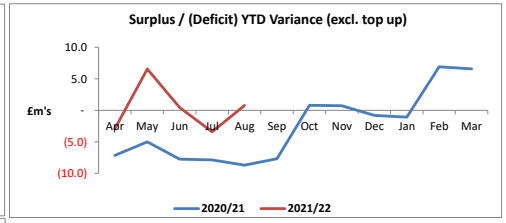
1. Cash held by the Trust increased in month by £2.5m to £129.8m
2. Capital expenditure for the year to date was £0.4m more than plan. The Trust-funded programme was £1.7m less than plan and donated was £2.1 more than plan.
3. IPP debtors days decreased further in month from 191 days to 146 days. Total IPP debt (net of cash deposits held) decreased in month to £15.2m (£18.7m in M04). Overdue debt decreased in month to £19.6m (£21.6m in M04).
4. Creditor days decreased in month from 25 days to 24 days.
5. NHS debtor days increased in month from 3 days to 4 days.

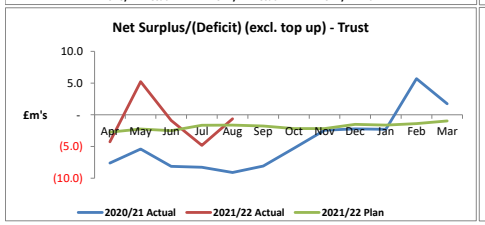
Trust Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2021

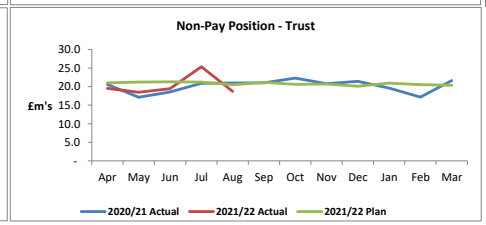
2021/22											Notes	2020/21	2021/22	2021/22
Full year	Income & Expenditure	Month 5				Year to Date (YTD)				Rating		Actual	Plan YTD	Plan In-month
plan		Plan	Actual	Variance		Plan	Actual	Variance		YTD Variance		M5		M5
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			(£m)	(£m)	(£m)
436.56	NHS & Other Clinical Revenue	37.76	39.12	1.36	3.61%	188.14	198.68	10.54	5.60%	G	1	31.70	188.14	37.76
54.52	Private Patient Revenue	3.51	2.31	(1.20)	(34.06%)	14.95	9.99	(4.96)	(33.19%)	R	2	2.90	14.95	3.51
61.75	Non-Clinical Revenue	5.15	4.35	(0.81)	(15.65%)	25.38	22.00	(3.39)	(13.34%)	R	3	3.02	25.38	5.15
552.83	**Total Operating Revenue**	**46.42**	**45.78**	**(0.64)**	**(1.38%)**	**228.47**	**230.67**	**2.19**	**0.96%**	G		**37.61**	**228.47**	**46.42**
(322.87)	Permanent Staff	(27.36)	(25.71)	1.65	6.01%	(132.79)	(126.03)	6.75	5.09%	G		(23.81)	(132.79)	(27.36)
0.00	Agency Staff	0.00	(0.41)	(0.41)		0.00	(1.64)	(1.64)		R		(0.44)	0.00	0.00
(2.79)	Bank Staff	(0.23)	(1.58)	(1.35)	(592.20%)	(1.21)	(6.90)	(5.69)	(470.55%)	R		(1.49)	(1.21)	(0.23)
(325.66)	**Total Employee Expenses**	**(27.59)**	**(27.70)**	**(0.11)**	**(0.42%)**	**(134.00)**	**(134.57)**	**(0.58)**	**(0.43%)**	R	4	**(25.74)**	**(134.00)**	**(27.59)**
(104.16)	Drugs and Blood	(8.67)	(7.31)	1.37	15.74%	(43.41)	(40.05)	3.36	7.73%	G		(8.18)	(43.41)	(8.67)
(34.65)	Supplies and services - clinical	(2.82)	(2.77)	0.05	1.77%	(14.06)	(16.43)	(2.37)	(16.87%)	R		(2.93)	(14.06)	(2.82)
(77.87)	Other Expenses	(6.26)	(5.66)	0.60	9.59%	(34.11)	(30.30)	3.81	11.16%	G		(7.15)	(34.11)	(6.26)
(216.68)	**Total Non-Pay Expenses**	**(17.76)**	**(15.74)**	**2.02**	**11.35%**	**(91.57)**	**(86.78)**	**4.79**	**5.23%**	G	5	**(18.26)**	**(91.57)**	**(17.76)**
(542.34)	**Total Expenses**	**(45.34)**	**(43.44)**	**1.90**	**4.19%**	**(225.57)**	**(221.35)**	**4.22**	**1.87%**	G		**(44.00)**	**(225.57)**	**(45.34)**
10.49	**EBITDA (exc Capital Donations)**	**1.08**	**2.34**	**1.26**	**116.66%**	**2.90**	**9.31**	**6.41**	**220.71%**	G		**(6.39)**	**2.90**	**1.08**
(18.70)	Owned depreciation, Interest and PDC	(1.55)	(1.56)	(0.01)	(0.91%)	(7.80)	(7.87)	(0.07)	(0.91%)			(1.50)	(7.80)	(1.55)
(8.21)	**Surplus/Deficit (exc. PSF/Top up)**	**(0.47)**	**0.78**	**1.25**	**266%**	**(4.90)**	**1.44**	**6.34**	**129%**			**(7.89)**	**(4.90)**	**(0.47)**
0.00	PSF/Top up	0.00	0.00	0.00		0.00	0.00	0.00				7.89	0.00	0.00
(8.21)	**Surplus/Deficit (incl. PSF/Top up)**	**(0.47)**	**0.78**	**1.25**	**266.51%**	**(4.90)**	**1.44**	**6.34**	**129.42%**	G		**0.00**	**(4.90)**	**(0.47)**
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	(1.17)	(1.42)	(0.25)		(5.87)	(6.83)	(0.96)				(1.21)	(5.87)	(1.17)
(22.41)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(1.64)**	**(0.64)**	**1.00**	**61.04%**	**(10.77)**	**(5.39)**	**5.38**	**49.95%**			**(1.21)**	**(10.77)**	**(1.64)**
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	0.60	0.93	0.33		2.85	4.96	2.11				0.50	2.85	0.60
(6.43)	**Adjusted Net Result**	**(1.04)**	**0.29**	**1.33**	**128.41%**	**(7.92)**	**(0.43)**	**7.49**	**94.63%**			**(0.71)**	**(7.92)**	**(1.04)**











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

Summary

- The month 5 financial position is a surplus of £0.8m which is £1.3m favourable to plan. The Trust has a YTD favourable position of £1.4m (£6.3m favourable to plan) which has been achieved mainly through Elective Recovery Funding for additional day case, elective and outpatient activity in order to reduce patient backlogs and wait times; a signifcant part of which was not included in the plan.

Notes

1. NHS Clinical income is £10.5m favourable to plan YTD driven largely by Elective Recovery Fund income being significantly higher than plan (£13.4m) through additional outpatient, elective and day case activity. This is partially offset by lower than plan Covid-19 income (£4.6m adverse to plan) due to lower than expected Covid costs incurred. This month has also seen £0.7m income relating to accelerator funding.

2. Private Patient income is £1.2m adverse to plan in-month and £5.0m YTD. Travel remains suppressed due to Covid-19 and this remains a key risk for delivery of the current Trust bottom line position. It is likely this income stream will continue to be affected until such time as travelling is deemed to be safer for patients and international sponsors resume normal patient travel volumes. 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 £0.8m adverse to plan in-month. This is largely driven by lower than plan charitable contributions and research and development income, both due to timing of projects.

4. Pay is adverse in-month to the plan by £0.1m. Further to guidance from NHSE/I, accruals relating to the 3% pay rise announced by government have not been made and this will be funded centrally by NHSE/I. Amounts relating to the pay rise will be made in September payments and will backdate to the start of the financial year. This month has seen the onboarding and TUPE of estates staff from OCS in relation to in-housing Trust cleaning contract. Estates staff alone have risen from 124 WTE's last month to 364 WTE's this month.

5. Non pay is £2.0 favourable to the plan in-month. This is driven by lower than plan usage of high cost drugs and devices in-month (£1.3m) and business rates rebates meaning these were £0.8m favourable to plan. Covid costs continue at lower than plan levels for which there is a corresponding lower than plan income for Covid cost funding.

Trust Income and Expenditure Forecast Outturn Summary for the 5 months ending 31 Aug 2021

2021/22					
Income & Expenditure					Rating
	6 months NHSI Plan (£m)	6 months Forecast (£m)	Variance (£m)	Variance %	YTD Variance
NHS & Other Clinical Revenue	226.56	239.88	13.32	5.88%	G
Private Patient Revenue	18.39	11.72	(6.67)	(36.25%)	R
Non-Clinical Revenue	30.56	26.47	(4.09)	(13.38%)	R
Total Operating Revenue	**275.51**	**278.07**	**2.56**	**0.93%**	G
Permanent Staff	(160.23)	(153.06)	7.17	4.48%	G
Agency Staff	0.00	(1.97)	(1.97)		R
Bank Staff	(1.44)	(8.24)	(6.81)	(473.61%)	R
Total Employee Expenses	**(161.67)**	**(163.28)**	**(1.61)**	**(0.99%)**	R
Drugs and Blood	(52.10)	(47.84)	4.26	8.18%	G
Supplies and services - clinical	(17.37)	(20.11)	(2.74)	(15.79%)	R
Other Expenses	(40.53)	(36.42)	4.11	10.14%	G
Total Non-Pay Expenses	**(110.00)**	**(104.37)**	**5.63**	**5.12%**	G
Total Expenses	**(271.67)**	**(267.64)**	**4.03**	**1.48%**	G
EBITDA (exc Capital Donations)	**3.84**	**10.43**	**6.59**	**171.81%**	G
Owned depreciation, Interest and PDC	(9.35)	(9.47)	(0.12)	(1.28%)	
Surplus/Deficit (exc. PSF/Top up)	**(5.51)**	**0.96**	**6.47**	**117%**	
PSF/Top up	0.00	0.00	0.00		
Surplus/Deficit (incl. PSF/Top up)	**(5.51)**	**0.96**	**6.47**	**117.35%**	G
Donated depreciation	(7.04)	(8.17)	(1.13)	(16.01%)	
Impairments)	**(12.55)**	**(7.21)**	**5.34**	**42.57%**	
Impairments	0.00	0.00	0.00		
Capital Donations	3.45	4.96	1.51	43.90%	
Adjusted Net Result	**(9.10)**	**(2.24)**	**6.86**	**75.35%**	

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

Summary

- The forecast to M6 for GOSH shows a forecast outturn surplus of £1.0m. This has improved from the forecast last month due to expected activity and funding relating to ERF. This forecast will continue to be updated on a monthly basis in line with any changes to the NHS financial framework.

Notes

1. The 6 month forecast for NHS & other clinical revenue is favourable to plan (£13.3m) driven by ERF income that wasn't included in the original plan.

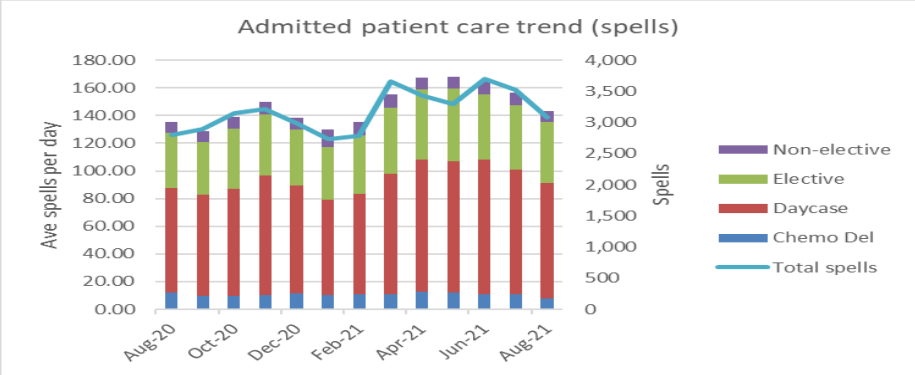
2. Non-clinical income is forecast to be £4.1m adverse to the 6 month NHSI plan mainly due to lower levels of income from diagnostic testing and other commercial income.

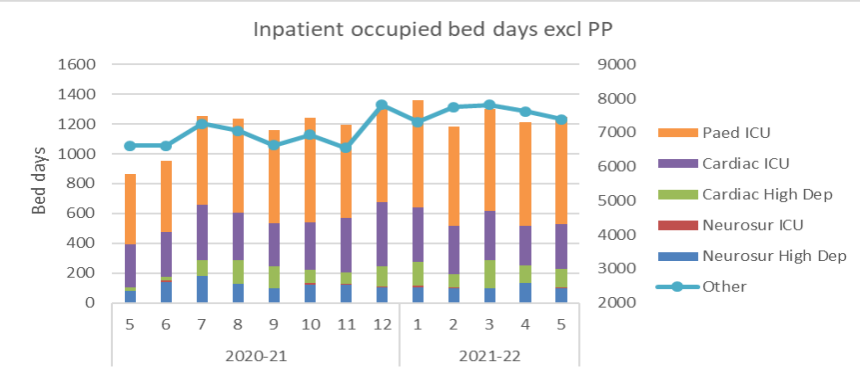
3. Private Patient income is forecast to be £6.7m adverse to the 6 month NHSI plan, mainly due to the continuation of travel restrictions linked to Covid-19. International sponsors are still only sending their most complex patients overseas and this is forecast to continue with the continued international travel restrictions.

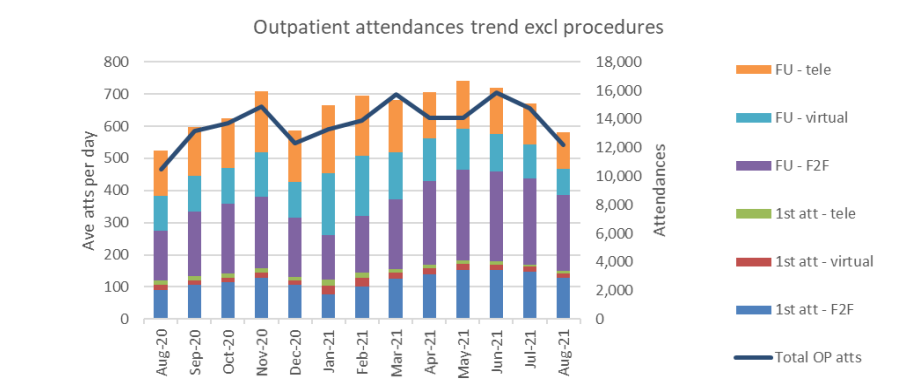
4. Pay is £1.6m adverse to 6 month NHSI plan is mainly due to the staffing costs to deliver additional ERF activity. This cost is lower than expected due to reallocation of staff associated with low levels of private patient activity. The pandemic has driven staff turnover to low levels which in turn has led to increased substantive staffing levels.

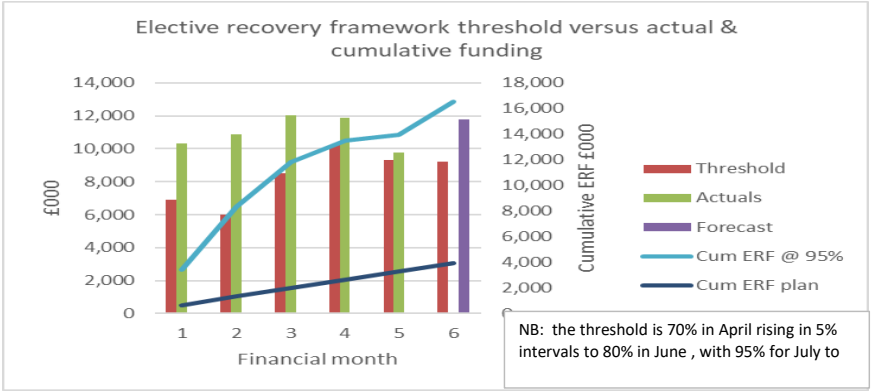
5. Non-pay forecast is £5.6m favourable against the 6 month NHSI plan due to lower usage of high cost drugs and devices and inclusive of the one-off benefit seen in Month 5 relating to business rates rebates.

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









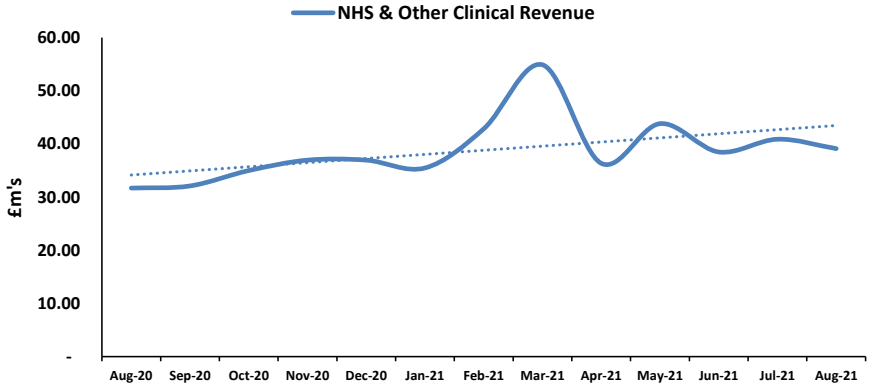
NB: the threshold is 70% in April rising in 5% intervals to 80% in June , with 95% for July to

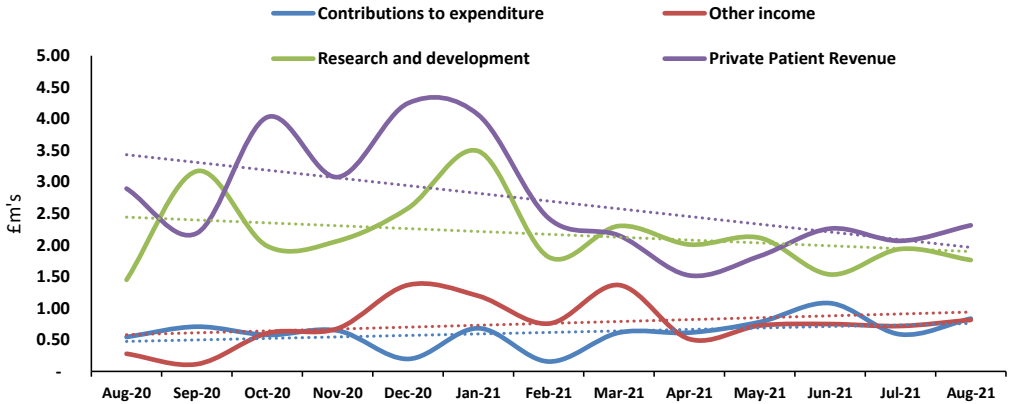
Summary

- Daycase and elective spells are at their lowest level since April however this is in line with expectations owing to the impact of seasonality. Daycase spells have decreased 7.8% and elective spells by 4.5% per working day versus July. Non-elective activity has shown a further decrease of 16.5% versus July (1.55 spells per day).
- Overall occupied bed days have decreased versus July by 2%. Cardiac and paediatric critical care locations bed days have increased slightly with this being offset by a reduction in non-critical care bed days.
- Outpatient attendances per working day have decreased 13.6% per working day versus July and are at a comparable level to November 2020. Non-face to face attendances as a % of the total have remained at a similar level of 37% when compared to July (38%) and are at their lowest level since August 2020.
- Clinical supplies and services costs are lower than July (£2.7m v £3.1m) reflecting the lower activity levels and return of pathology costs to previous levels.
- The current year to date performance versus plan is £16.0m (£13.3m favourable) whilst the forecast to the end of September is £15.6m favourable to plan. The current performance for August is £31k below the forecast at July however this may be recovered as activity is finalised. The forecast for September has been revised down by c5% (£455k) to reflect the current actiivity level expectations. The national calculation of ERF for April and May have been shared and the values are lower than the internal estimate due to an issue where episodes starting in a previous financial year have not been included for spells that have ended in 2021/22. This has been queried and it is hoped that the challenge is successful and this funding is recovered.

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

2020/21 Income for the 5 months ending 31 Aug 2021





Summary

- NHS Clinical income is £10.5m favourable to plan YTD. This is driven largely by Elective Recovery Fund income being £13.4m higher than plan due to additional outpatient, elective and day case activity. This is partially offset by lower than plan Covid-19 income (£4.6m 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.

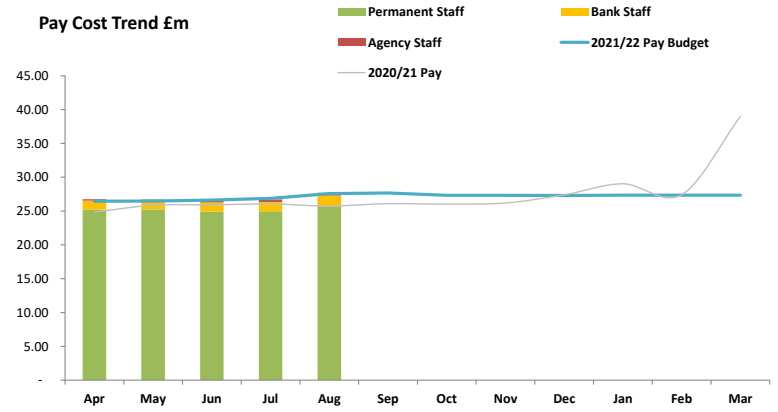
- Private Patient income is £1.2m adverse to plan in month and this is a key risk to the Trust's plan delivery. Given the continued travel restrictions both domestically and globally, sponsors are only sending their most complex patients abroad, resulting in significantly lower income levels for the 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.

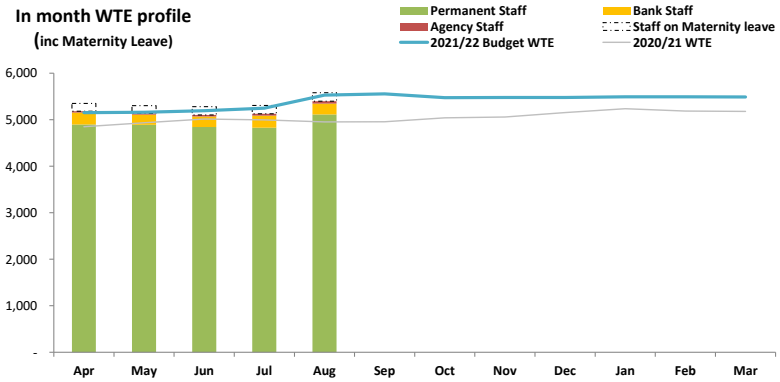
Workforce Summary for the 5 months ending 31 Aug 2021

*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	24.6	1,240.0	47.6	(1.0)	(0.9)	(0.1)	R
Consultants	60.3	387.7	155.5	25.7	395.6	155.8	(0.6)	(0.5)	(0.0)	R
Estates & Ancillary Staff	4.7	138.7	33.7	2.5	179.9	33.4	(0.6)	(0.6)	0.0	R
Healthcare Assist & Supp	11.3	325.9	34.7	4.6	321.9	34.3	0.1	0.1	0.0	G
Junior Doctors	31.4	377.0	83.2	13.2	384.6	82.2	(0.1)	(0.3)	0.2	A
Nursing Staff	89.8	1,600.9	56.1	37.7	1,602.1	56.5	(0.3)	(0.0)	(0.3)	A
Other Staff	0.7	12.3	53.8	0.3	15.3	52.9	(0.1)	(0.1)	0.0	A
Scientific Therap Tech	56.9	981.8	58.0	23.9	1,013.9	56.7	(0.2)	(0.8)	0.5	A
Total substantive and bank staff costs	**311.6**	**5,018.1**	**62.1**	**132.5**	**5,153.3**	**61.7**	**(2.7)**	**(3.5)**	**0.8**	R
Agency	3.7	28.3	129.4	1.6	35.3	111.6	(0.1)	(0.4)	0.3	A
Total substantive, bank and agency cost	**315.2**	**5,046.4**	**62.5**	**134.2**	**5,188.6**	**62.1**	**(2.8)**	**(3.9)**	**1.1**	R
Reserve*	1.9	0.3		0.4	0.0		0.4	0.4	0.0	G
Additional employer pension contribution by NHSE	12.4	0.0		0.0	0.0		5.2	0.0	5.2	G
Total pay cost	**329.6**	**5,046.6**	**65.3**	**134.6**	**5,188.6**	**62.2**	**2.7**	**(3.5)**	**6.2**	G
Remove maternity leave cost	(3.1)			(1.6)			0.3	0.0	0.3	G
Total excluding Maternity Costs	**326.4**	**5,046.6**	**64.7**	**132.9**	**5,188.6**	**61.5**	**3.1**	**(3.5)**	**6.6**	G

*Plan reserve includes WTEs relating to the better value programme

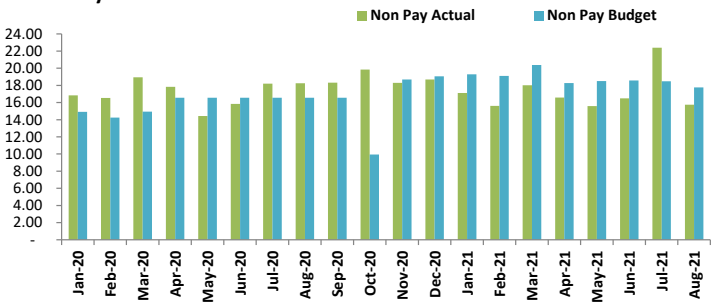


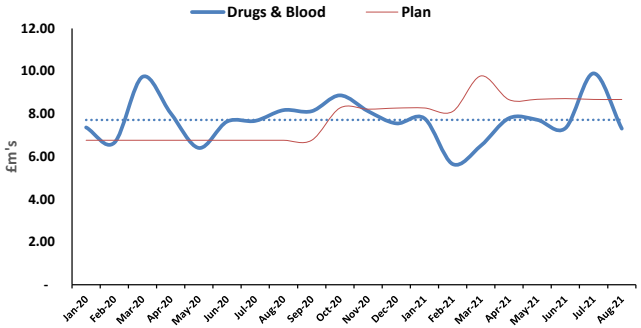


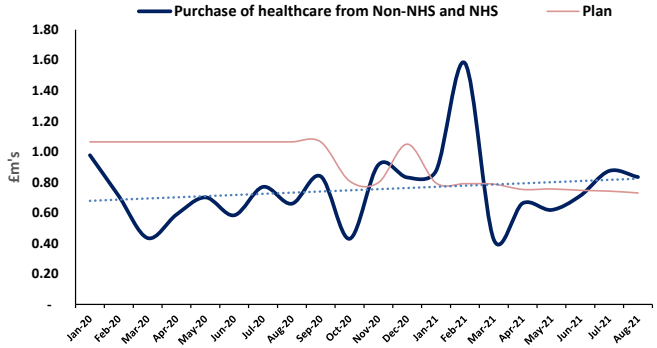
Summary

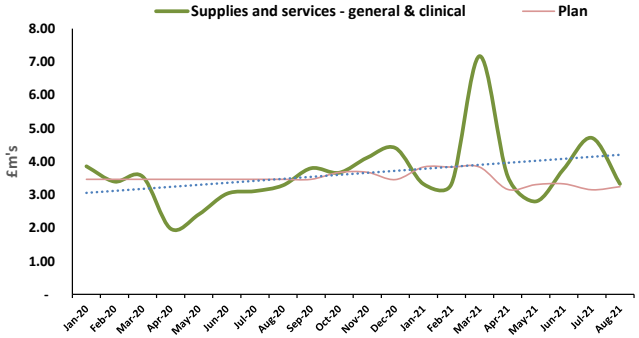
- Pay costs are adverse to plan in-month (£0.1m). Staffing levels overall remain high due to Covid driving down turnover and creating additional staffing needs, whilst the impact of the ERF and accelerator activity continues to require higher volumes of staff to work through the Trust patient backlogs.
- 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.
- The other significant movement relates to Estates and Ancilliary staff; the Trust cleaning contract with OCS has been brought in-house and the staff have been transferred via TUPE to the Trust. These staff now form part of the permanent staff base and in-month has seen the increase of 244 from Month 4 in the number of estates staff alone. These staff evidently were not here last year and therefore stand out as an immediate volume variance.
- Scientific, Therapeutic and Technical staff are showing as having an adverse volume rise this year in comparison to prior year with continued recruitment for activity in labs, pharmacy, radiology and the innovation directorate.
- Nursing has seen the start of some turnover month with lower permanent nursing WTEs for the second month in a row. Nursing bank costs YTD are still lower this year than last year given that last year saw the full impact of the first waves of Covid, associated sickness backfill and the staffing of Dolphin ward; however these remain high with some vacancies, sickness and additional activity requirements.
- Despite the imminent pay rise of 3% confirmed by government for the NHS, in line with NHSE/I guidance we have not accrued for these additional costs. This will in turn have an impact on the price variance when comparing to prior year once the pay rise is in place. The backdated pay rise has been confirmed to be paid in Month 6 and is to be funded centrally by NHSE/I.

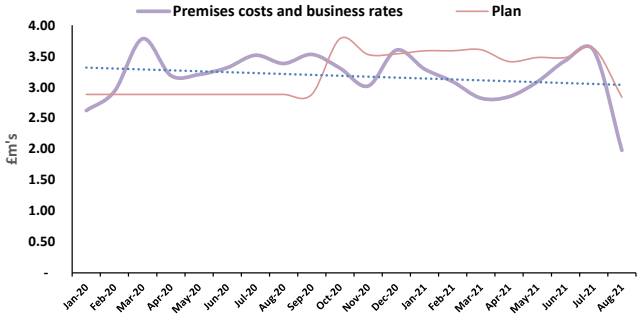
Non Pay Cost Trend £





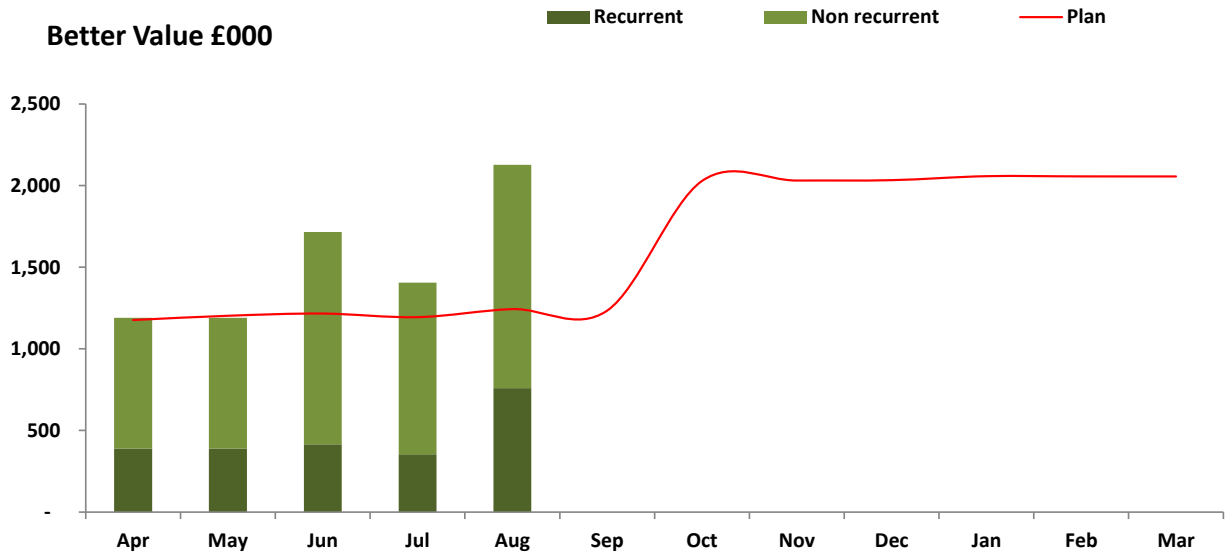


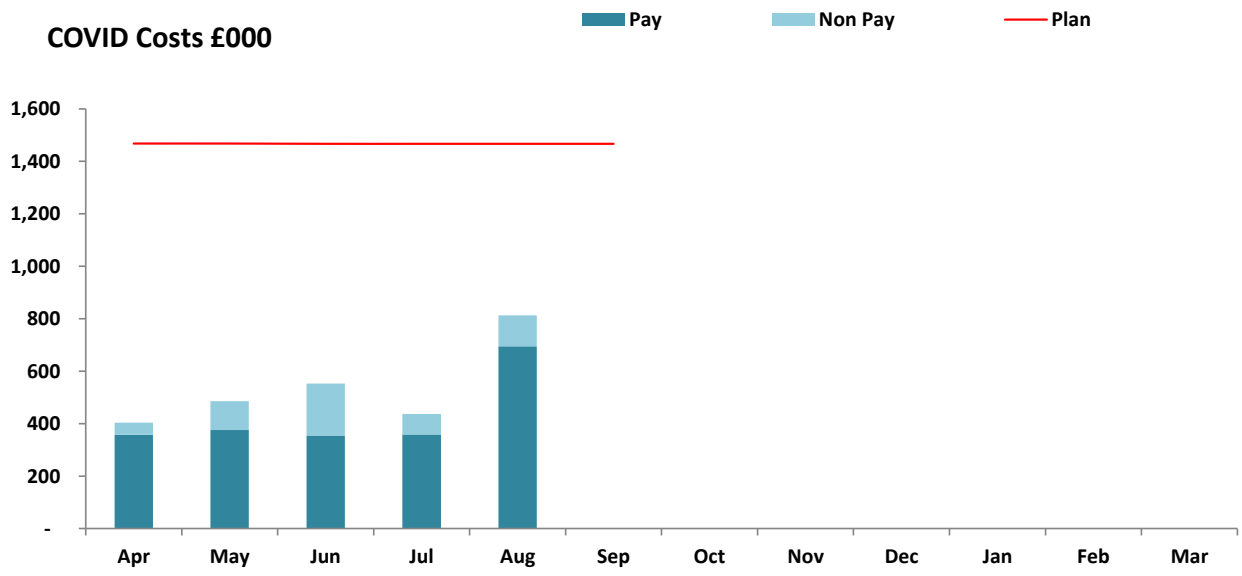




Summary

- Non pay is £2.0m favourable to the plan in-month. This is driven by two key elements as follows:
    - High cost drugs expenditure and devices are lower than plan (£1.3m) due to lower activity levels in the month.
    - The Trust has seen a rebate for business rates which means that in-month, these costs show as £0.8m favourable to plan.
- Impairment of receivables and supplies and services are broadly on plan this month.
- Covid costs are lower than planned in-month (£0.7m) for which there is a corresponding lower than plan income for Covid cost funding (£4.6m YTD). It is expected that non-pay costs will rise with continued additional elective, day case and outpatient activity.
- Purchase of Healthcare from NHS and non-NHS & supplies and services in M5 has remained 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).





Better Value and Covid-19 costs

- The Trust has a better value programme plan for H1 of £7.3m; however current forecast suggests that the Trust will deliver a savings programme of £9.3m in H1 largely through controlled spend, set to continue to Month 6. At Month 5 the Trust has delivered £7.6m of this programme through a combination of recurrent and non-recurrent measures.

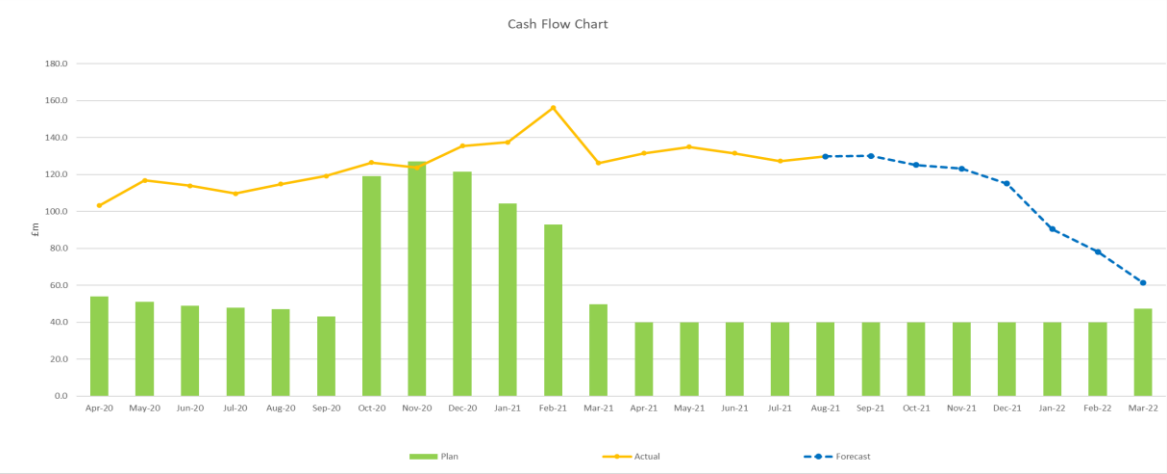
- Covid costs YTD have totalled £2.4m largely for additional staffing needs to meet the covid response and a variety of non-pay spends including decontamination, lab and consumables spend. Currently Covid income is £4.6m below plan YTD as costs are below allocated income.

31 Mar 2021 Audited Accounts £m	Statement of Financial Position	YTD Actual 31 Jul 21 £m	*YTD Actual 31 Aug 21 £m*	In month Movement £m
532.75	Non-Current Assets	529.39	528.10	(1.29)
64.56	Current Assets (exc Cash)	77.95	70.93	(7.02)
126.19	Cash & Cash Equivalents	127.26	129.78	2.52
(102.80)	Current Liabilities	(114.91)	(108.87)	6.04
(6.45)	Non-Current Liabilities	(6.16)	(6.11)	0.05
614.25	**Total Assets Employed**	**616.18**	**613.83**	**0.30**

31 Mar 2021 Audited Accounts £m	Capital Expenditure	YTD plan 31 Aug 21 £m	YTD Actual 31 Aug 2021 £m	YTD Variance £m	Forecast Outturn 31 Mar 2022 £m	RAG YTD variance
6.50	Redevelopment - Donated	2.75	4.36	(1.61)	12.00	R
2.56	Medical Equipment - Donated	0.10	0.60	(0.50)	2.90	R
0.00	ICT - Donated	0.00	0.00	0.00	0.00	G
9.06	**Total Donated**	**2.85**	**4.96**	**(2.11)**	**14.90**	R
0.00	Total Grant funded	0.00	0.00	0.00	0.46	G
5.09	Redevelopment & equipment - Trust Funde	2.62	1.48	1.14	6.90	R
1.10	Estates & Facilities - Trust Funded	0.79	0.12	0.67	6.22	R
2.67	ICT - Trust Funded	0.51	0.58	(0.07)	2.88	A
0.00	Accelerator programme	0.00	0.05	(0.05)	0.33	G
0.00	Sensyne	0.00	0.00	0.00	2.00	G
0.00	Contingency	0.00	0.00	0.00	0.00	G
8.86	**Total Trust Funded**	**3.92**	**2.23**	**1.69**	**18.33**	R
2.56	**PDC**	**0.00**	**0.00**	**0.00**	**0.00**	G
20.48	**Total Expenditure**	**6.77**	**7.19**	**(0.42)**	**33.69**	G

31-Mar-21	Working Capital	31-Jul-21	31-Aug-21	RAG	KPI
5.0	NHS Debtor Days (YTD)	3.0	4.0	G	< 30.0
288.0	IPP Debtor Days	191.0	146.0	R	< 120.0
27.1	IPP Overdue Debt (£m)	21.6	19.1	R	0.0
95.0	Inventory Days - Non Drugs	87.0	87.0	R	30.0
31.0	Creditor Days	25.0	24.0	G	< 30.0
41.6%	BPPC - NHS (YTD) (number)	42.8%	39.4%	R	> 90.0%
70.6%	BPPC - NHS (YTD) (£)	79.5%	76.1%	R	> 90.0%
83.4%	BPPC - Non-NHS (YTD) (number)	80.4%	82.4%	R	> 90.0%
88.9%	BPPC - Non-NHS (YTD) (£)	91.5%	91.9%	A	> 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 August was £0.4m more than plan; Trust -funded expenditure was £1.7m less than plan; donated was £2.1m more than plan. Forecast outturn includes the assumption that CDEL will be increased by £0.3m for the Accelerator Programme, but this has not formally been approved.
2. Cash held by the Trust increased in month by £2.5m to £129.8m.
3. Total Assets employed at M05 decreased by £0.3m in month as a result of the following:
• Non current assets totalled £528.1m, a decrease of £1.2m in month.
•Current assets excluding cash totalled £70.9m, decreasing by £7.0m in month. This largely relates to the following: Contract receivables including IPP which have been invoiced (£1.6m lower in month); accrued income (£4.3m lower in month); and other receivables (£1.9m lower in month). Other receivables include VAT receivable which decreased by £1.3m in month following receipt of the refund expected in relation to the June 21 return
In addition, capital receivables was £0.7m higher in month as well as Inventories (£0.1m higher in month).
•Cash held by the Trust totalled £129.8m, increasing in month by £2.5m.
•Current liabilities decreased in month by £6.0m to £108.9m. This includes Capital creditors (£0.2m lower in month) and NHS payables (£8.8m lower in month). The movement in NHS payables is largely as a result of the decrease in amounts due to NHSE (£9.2m of topup income paid to the Trust in the previous financial year was clawed back in month).
This is offset against the increase in expenditure accruals (£0.3m higher in month); other payables (£1.4m higher in month) and deferred income £1.3m higher in month.
4. IPP debtors days decreased further in month from 191 days to 146 days. Total IPP debt (net of cash deposits held) decreased in month to £15.2m (£18.7m in M04). Overdue debt decreased in month to £19.6m (£21.6m in M04).
5.The cumulative BPPC for NHS invoices (by value) decreased in month to 76% (79% in M04). This represented 39% of the number of invoices settled within 30 days (43% in M04).
6.The cumulative BPPC for Non NHS invoices (by value) increased in month to 92% (91% in M04). This represented 82% of invoices settled within 30 days (80% in M04).
7.Creditor days decreased in month from 25 days to 24 days.

Attachment U

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
29 September 2021

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

Purpose of report
To provide the Board with an overview of the nursing workforce during the months of June & July 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

- 39 international nurse have joined the trust to date. The Philippines remains on the 'Red List' countries which has led to additional challenges and unplanned costs. Funding has been approved by NHSEI for an additional 15 critical care nurses to support winter pressures and the anticipated RSV surge.
- The Trust nursing vacancy rate showed an increase in June & July 2021 to 3.63% and 4.88% respectively, with voluntary turnover rates remaining stable and below trust target at 12.75% in June and 12.79% in July respectively.
- There was a significant increase in reported Datix incidents (30) in June & July with no reported patient harm. This was predominantly driven by short term sickness and as a result of 'Track & Trace' self-isolation requirements.
- The reported Care Hours Per Patient Day (CHPPD) was 15.7 in June and 14.9 in July.
- The Biannual Safe Nursing Establishment Review was conducted in June & July and will be reported to Trust Board.

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** Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.	**□ 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 12: Inconsistent delivery of safe care
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? EMT

Attachment U
Safe Staffing Trust Report September 2021

Great Ormond Street Hospital for Children NHS Foundation Trust

1. Purpose

The purpose of this report is to provide 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 June and July 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) –

39 internationally recruited (IR) nurses 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) 12 nurses now fully registered with the Nursing and Midwifery Council (NMC) and working in their clinical areas as Band 5 Registered Nurses.
- Cohort 3: (8 candidates) Completed OCSE exam on 1st July, currently awaiting full registration with the NMC
- Cohort 4: (8 candidates) Arrived on the 30th July 2021 are currently studying towards their OCSE exam scheduled for 22nd September
- Cohort 5: (7 candidates) Preliminary Arrival : 15th October 2021 TBC

Additional funding has been approved to recruit 15 experienced IR critical care nurses to support winter pressures and the anticipated Respiratory Syncytial Virus (RSV) surge. We aim to work towards an arrival date in January 2022 pending visa and conditional requirements being processed within this timeframe.

2.2 Newly Registered Nurses (NRNs) –

The recruitment of our next cohort of NRNs for September has been completed with 82 nurses commencing this month. A further 6 NRNs have been deferred to a January 2022 start date due to incomplete hours and delayed exam boards.

2.4 Experienced Nurses

Following a successful local recruitment drive for the Heart & Lung Directorate, a total of 15 experienced nurses have been appointed, this is in addition to the above pipelines of IR and NRN nurses.

3. Vacancy and Turnover Rates

The Trust nursing vacancy rate increased in June 2021 to 3.63% and to 4.88% in July. This is attributable to staff movement as a result of lifting of restrictions and also phasing of posts.

In terms of recruitment there were 7 (6.5 WTE) new starters in June, offset by 19 (17.23 WTE) leavers. In July there were 8 starters (8 WTE) offset by 17 leavers (13.80 WTE).

Voluntary turnover has remained relatively stable and below trust target, at 12.75% in June and 12.79% in July.

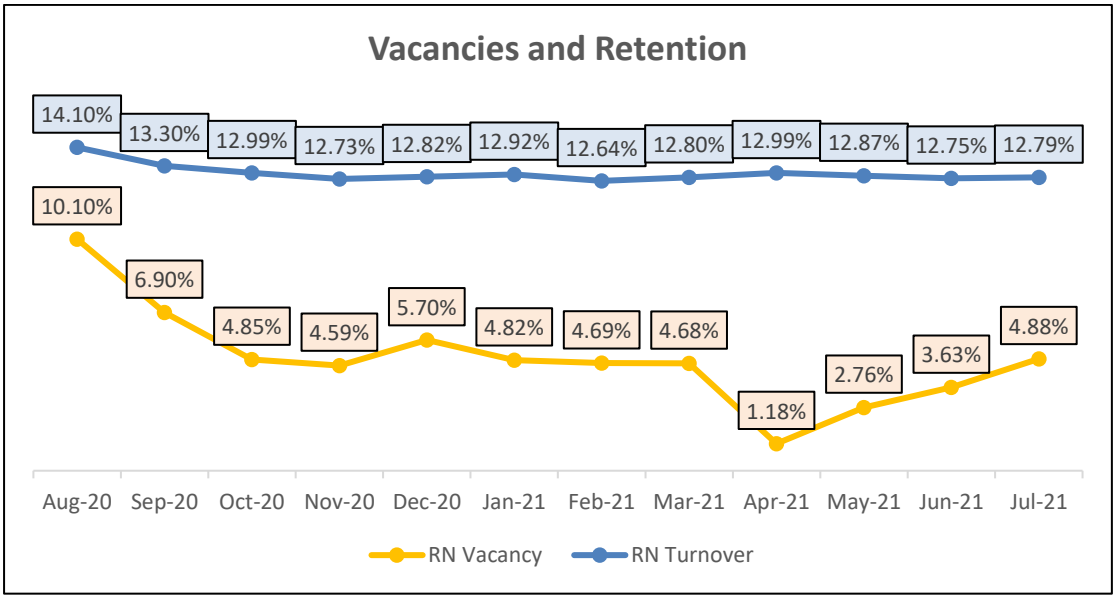


Fig.1 Registered Nurse vacancy and voluntary turnover rate (12 month view)

4. Temporary Staffing

The total shifts requested excluding shifts requested then subsequently cancelled increased in July 2021 from 2481 to 2810, a 13% increase on the previous month. Agency usage was only 5 shifts in June, with no shifts in July. Shifts filled by bank have reduced by 7% from 75% in June to 68% in July, increasing the percentage of unfilled shifts from 25% (June) to 32% (July). The majority of bank shifts are filled by our own substantive staff and we are observing a decrease in uptake as staff tire and demand increases due to staff sickness and the impact of 'Track and Trace' isolation during this period. Plans are in place to increase recruitment to the Nurse Bank and to reengage previous employees who may be interested in returning to temporary working.

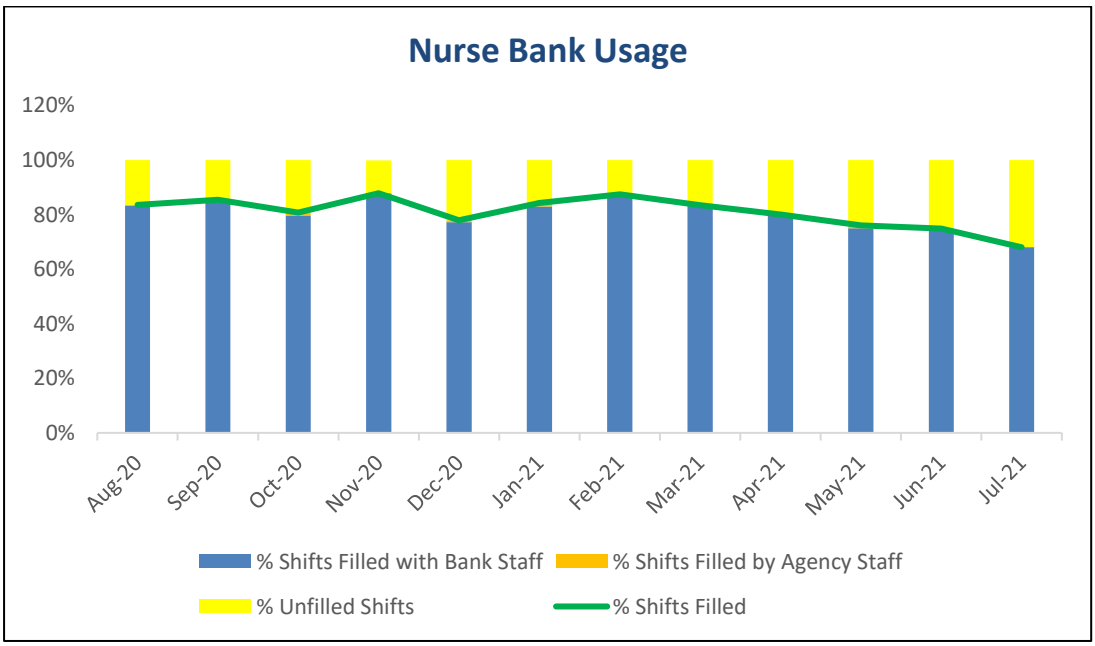


Fig.2 Nurse Bank Usage (12 month view)

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 Unify system 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/units including the ICUs, where patients stay overnight. The reported CHPPD for June 2021 was 15.7 made up of 13.6 Registered Nurses and 2.1 HCA Hours. In July 2021 the figure was 14.9 in total, 12.8 Registered Nurses and 2.1 HCA Hours.

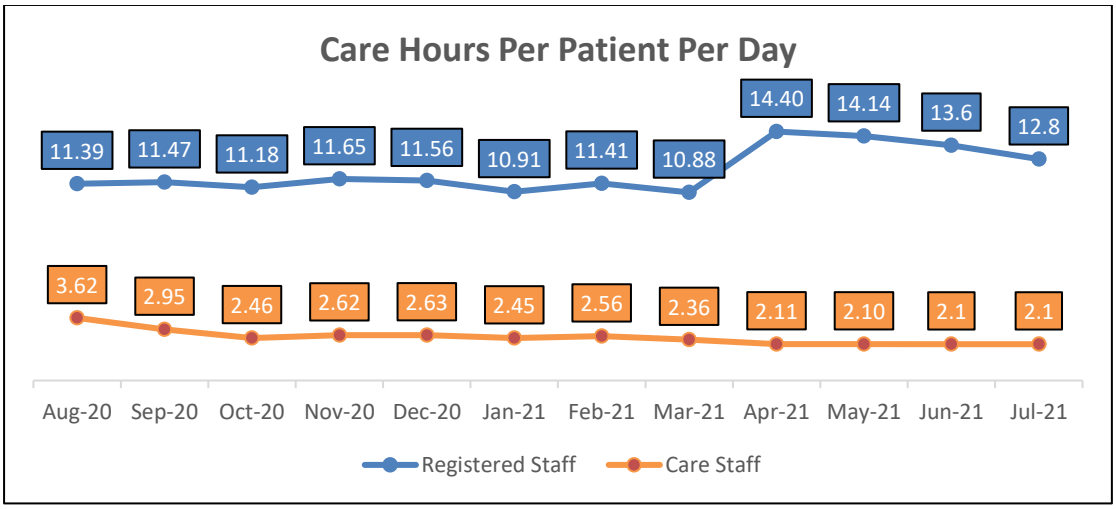


Fig. 3 Care Hours per Day – Breakdown (12 month view)

6. Incident Reporting

For the period of June and July, there was a significant increase in Datix incidents in relation to safe staffing levels predominantly driven by short term sickness and 'Track & Trace' isolation requirements. Incidents were reported in the following directorates.

- 8 incidents in Body, Bones & Mind (BBM)
- 7 incidents in Blood, Cells & Cancer (BCC)
- 6 incidents in Heart & Lung (H&L)
- 2 incidents in International &Private Care (I&PC)
- 5 incidents in Operations & Imaging (O&I)
- 2 incidents in Sight & Sound (S&S)

Assurance has been provided by the HoNs that no patient harm occurred and plans to mitigate the ever changing challenges as a result of the pandemic are under constant review.

7. Nursing Staffing Establishment Review

The biannual Nursing Establishment Review was undertaken in June and July, with the report going to Trust Board in September 2021.

Appendix 1 – June & July 2021 Workforce metrics by Directorate

June 2021						
Directorate	**CHPPD (Inc ICUs)**	**Actual vs Planned**	**RN Vacancies* (WTE)**	**RN Vacancies* (%)**	**Voluntary Turnover* %**	**Sickness (1 mo) %**
BCC	13.0	77.38%	-14.4	-6.6%	7.2%	4.1%
BBM	12.3	90.28%	1.1	0.6%	14.8%	6.3%
Brain	13.9	83.40%	0.6	0.4%	10.0%	1.6%
H&L	20.5	89.37%	28.1	5.2%	15.0%	4.0%
I&PC	15.2	82.29%	-1.2	-1.5%	11.6%	3.1%
O&I	N/A	N/A	0.0	0.0%	16.7%	4.5%
S&S	13.7	101.05%	4.2	5.5%	9.6%	4.1%

July 2021						
Directorate	**CHPPD (Inc ICUs)**	**Actual vs Planned**	**RN Vacancies* (WTE)**	**RN Vacancies* (%)**	**Voluntary Turnover* %**	**Sickness (1 mth) %**
BCC	10.79	71.15%	-10.9	-4.9%	8.0%	3.7%
BBM	12.36	81.19%	3.6	1.9%	13.3%	5.1%
Brain	13.29	79.70%	5.6	4.2%	10.9%	1.9%
H&L	19.95	81.90%	33.2	6.1%	15.5%	3.8%
I&PC	15.26	67.65%	-0.4	-0.6%	11.7%	2.7%
O&I	N/A	N/A	1.9	0.8%	14.2%	2.9%
S&S	11.13	89.73%	6.1	8.0%	11.9%	1.8%

*Relates to all RN grades. Trust totals within the narrative may include nursing posts from some other directorates not listed in the above tables. Vacancy rates in H&L have been addressed through a dedicated recruitment campaign.

Attachment 4

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
29 September 2021

Safe Nursing Establishment Sept 21 **Submitted by: Alison Robertson, Chief Nurse.** **Prepared by: Marie Boxall, Head of Nursing - Nursing Workforce**	**Paper No: Attachment 4** ☐ **For information and noting**

Purpose of report
To provide assurance to the Trust Board that arrangements are in place to review the establishments on a biannual basis, to determine if inpatient wards are safely staffed with the right number of nurses with the right skills and at the right time. This is in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018. It also incorporates NHSE/I's Developing Workforce Safeguards (2018).

Summary of report

- This report provides the Board with the findings from the Biannual Safe Nursing Establishment review which was conducted in June 2021.
- The review found that on the whole current staffing establishments are safe across the trust through mitigation, reduced bed base and limiting some activity, however if activity and acuity continues to rise or if new services are added then the establishments in those areas will need to be amended.
- A number of recommendations have been made for BBM and O&I directorates, Bear Ward (H&L) and Pelican Ward (BCC).
- The assurance process is compliant with the Developing Workforce Safeguards guidance (NHSE/I 2018)

Action required from the meeting
To note the information in this report on safe nurse staffing establishments

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** Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.	☐ **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
Risk 12: Inconsistent delivery of safe care

Financial implications
Already incorporated into 20/21 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? EMT and Nursing Board

Purpose

Since April 2019, Trusts are assessed annually for compliance with National Quality Board (NQB) guidance through the Single Oversight Framework (SOF) as described in Developing Workforce Safeguards (NHSI, 2018). Biannual nursing establishment reviews are undertaken every January/February and June/July, to provide assurance that the Trust is maintaining safe levels and also to review progress against the implementation of recommendations since the last report.

Introduction

Great Ormond Street Hospital (GOSH) has a responsibility to ensure a safe and sustainable workforce and all Trusts have to demonstrate compliance with the 'triangulated approach' to deciding staffing requirements described by the National Quality Board (NQB) guidance in the recent 'Developing Workforce Safeguards' by NHS Improvement (2018). This combines evidence based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time. The recently approved Safe Staffing for Nursing Policy (2021) also reflects these requirements to ensure the Trust is compliant.

The NQB guidance states that providers:

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

In line with NQB recommendations, a strategic biannual staffing review has been conducted, the key elements of which include:

Requirement	Compliance status
Using a systematic, evidence-based approach to determine the number and skill mix of staff required	
Using a valid and reliable acuity/dependency tool	
Exercising professional judgement to meet specific local needs	
Benchmarking with peers	
Taking account of national guidelines, bearing in mind they may be based on professional consensus.	
Obtaining feedback from children, young people and families on what is important to them and how well their needs are	

0

met. (Further refinement and detailed feedback to be included in future reviews)	

In addition to the above, the NQB's expert reference group's cross-check includes:

- Children and young people's ward managers should use at least two methods for calculating ward workload and staffing requirements.
- Boards should ensure there is no local manipulation of the identified nursing resource from the evidence-based figures in the tool being used, as this may adversely affect the recommended establishment figures and remove the evidence base. Children and young people's acuity/dependency tools should include a weighting for parents/carers, so their impact on the ward team is reflected in ward establishments.
- Most parents or carers will stay in the hospital, making a significant contribution to their child's care and wellbeing. However, they also require support, information and often education and training to enable them to care for their child in partnership with hospital staff. Their personal circumstances and responsibilities such as other siblings, work commitments and the travelling distance to the hospital may prevent them from visiting. The child or young person will then depend more on staff for fundamental care, stimulation and emotional support.
- Time-out percentages (uplift) should be explicit in all ward staffing calculations. Managers should articulate any reasons for deviation from the 21.6% to 25.3% range emerging from the evidence review. GOSH uplift is 22%.
- Staffing resource aligned to levels of patient acuity/dependency should be realistic and determined on quality assured services.
- Adjustments should be made to workforce plans to accommodate ward geography – for example, single-room design wards.
- Two registered children's nurses should be on duty at all times in an inpatient ward.
- Allocate time within the establishment for regular events such as patient inter-hospital transfers and escort duties for patients requiring procedures and investigations if this is not already factored into the validated acuity/dependency tool.
- Allow time for staff to respond effectively to changes in patient need and other demands for nursing time that occur often but are not necessarily predictable: for example, patient deterioration, admissions and end-of-life care. Capacity to deal with unplanned events should be built into the ward establishment using professional judgement. This is commonly referred to as 'responsiveness time'.

Methodology for Calculating Nursing Numbers

Since the last review, the Children's & Young People's Safer Nursing Care Tool (C&YP SNCT), has been fully implemented across all inpatient services within the trust with the most recent collection of data taken over a 4 week period in June. The C&YP SNCT is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013 which has been used successfully in many organisations. It has been developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing in Children's and Young People's in-patient wards. The tool, when used with Nurse Sensitive Indicators (NSIs), is a reliable method against which to deliver evidence-based workforce plans. Day case units and outpatient departments rely on professional judgement as no validated tool currently exists.

Decision support tools, such as those for measuring acuity/dependency, help managers determine safe, sustainable staffing levels and remove reliance on subjective judgements. Professional consensus suggests no single tool meets every area's needs, so NHSEI recommend combining methods.

In order to ensure a triangulated evidence based approach, comprehensive data packs were shared with the Directorate Heads of Nursing and Patient Experience (HoNs), and members of the review panel: Head of Nursing (Nursing Workforce), Director of Nursing, Clinical Site Director, Associate Director of Finance, and the Deputy Director of Human Resources and Organisational Development, ahead of the establishments' reviews. The packs contained:

- Data on the existing budgeted staffing establishment
- Data on previous budgeted staffing establishments
- Bed base including HDU bed numbers/Telemetry beds
- Safer Nursing Care Tool (SNCT) calculations for guidance based on patient acuity
- Royal College of Nursing (RCN) C&YP Workforce staffing ratios
- Calculations based on national guidance for that specialism i.e. Association for Perioperative Practice (AfPP), British Association for Paediatric Nephrology (BAPN), Paediatric Intensive Care Standards (PICS), RCN and Royal College of Radiologists (RCR) - Guidelines for nursing care in IR (2017), Association of Anaesthetists Great Britain and Ireland (AAGBI) - Immediate post-anaesthetic recovery, AAGBI - The Anaesthesia Team (2018)
- Registered/unregistered nursing workforce skill mix proportions
- Variance between data sets and recommended numbers
- Overview of datix incidents reported since the last review, to identify any themes, trends or areas for concern.
- Quality metrics
- Patient & family feedback including complaints
- Staff feedback
- Roster management
- Temporary Staff usage
- Professional Judgement (as determined by HoNs and teams)

Staffing Establishments

The staffing requirements for each ward was reviewed and cross referenced with directorate's own information. It is important to note that the establishments reviewed only reflect patient facing staff, to ensure that it is transparent and to determine what the nursing requirements are in place to provide direct nursing care based on the number of funded beds and patient acuity. Roles such as Advanced Nurse Practitioners and Clinical Nurse Specialists were not included.

The following information was shared with directorate teams and confirmed by Directorate HoNs, with challenge and assurance gained by the review panel members (as listed above). Each Directorate HoN was asked a number of questions which aligned with the NHSI Workforce Safeguards (2019) and Care Quality Commission (CQC) Key Lines of Enquiry.

The overarching assurance required is -

- That directorate nursing establishments are safe
- That directorate nursing establishment is correct

Review outcomes

The review found that overall the current establishments are safe through mitigation however due to increasing acuity and activity some areas will require an increase in their establishments to maintain patient safety and quality. Individual directorates are outlined as follows:

Sight and Sound (S&S) – Panther ENT The directorate HON confirmed that current staffing establishment was safe although it's lower than the recommended SNCT score. This has been influenced by high patient acuity in recent months and if this level persists then the establishment may need to be reviewed. **Panther Urology** staffing establishment was fully phased by Month 4 and is now deemed safe, however the junior skill was noted and additional approved Band 6 posts will assist in addressing the imbalance. No changes required.

Body, Bones and Mind (BBM) – The directorate HON confirmed that the current staffing establishments across the directorate are not correct and although it is safe based on existing activity and reduced bed base, would need to be increased to achieve optimal levels and to maintain patient safety. Mitigation is in place to address fluctuations in daily staffing levels as a result of vacancies, shielding and high levels of maternity leave, through use of bank staff and temporary closed beds. However in light of recent experience, this is not sustainable, as staff tire, and activity and acuity increases. SNCT scoring and professional judgement indicate that the current staffing establishment on **Squirrel Gastro** is adequate to safely staff 8 beds, however if this were to increase to 10 beds then the establishment would need to be reviewed. **Chameleon's** current staffing establishment is safe when mitigated by reduced activity at the weekends. However as levels of activity and acuity increases, the current establishment will need to be reviewed in order to maintain safety. It is currently managed through the use of temporary staffing/nurse bank which is not cost effective or sustainable in the longer term. **Eagle** staffing establishment is safe based on recent activity, however there is a discrepancy of 0.7 WTE in the agreed establishment, which is needed to align with the full SNCT recommended requirements. To provide a 'Green Pathway' it is also recommend an additional 2 WTE is added to the existing establishment, on a temporary basis until normal measures resume. **Sky ward** is experiencing increasing complexity and acuity of patients which has been clearly evidenced during the review. To deliver safe care the current establishment should be increased to 30 WTE, which would require an additional 1.8 WTE. **Mildred Creek Unit (MCU)** staffing establishment was deemed safe although the current establishment is missing 1.9 WTE and is being mitigated through changes to shift patterns, however this will revert in September and needs to be urgently addressed. The establishment will require a full review again ahead of planned relocation. The change in physical environment will need to be considered in maintaining patient safety and safe staffing levels. A specific mental health SNCT is under development which will be applied once available.

Brain - The Directorate HON confirmed that current staffing establishments across the directorate are safe. There were some minor discrepancies in the WTE figures due to be discussed with the finance Business Partner (BP). The current staffing establishment on **Koala** aligns with national staffing recommendations including telemetry, HDU and the SNCT score. Professional judgement supports the need for the current numbers due to the skill mix

requirement, ward environment and complexity of this patient group. **RANU (Alligator)** – no changes required. **Squirrel Endo-met** – A 0.5 WTE is currently missing from the existing establishment plus an additional 0.5 WTE is recommended based on professional judgment, to support education and development due to a junior skill mix. Therefore it is recommended 1 WTE is required to bring the establishment in line with the current patient activity, acuity and staff skill mix. **Kingfisher** – staffing establishment is deemed safe. **Possum** Ward was closed at the time of the review and scoring exercise.

International and Private Care (I&PC) – The directorate HoN confirmed that current staffing establishments across the directorate are safe and correct based on the SNCT scoring and professional judgement. It is worth noting that SNCT scoring and RCN ratios are applicable to NHS activity rather than private experience and expectations. Professional judgement is therefore added to reflect additional challenges such as cultural differences, language barriers and service user expectation, which impact on direct and indirect care provision in this area. **Butterfly** staffing establishments have been re-profiled to align to 18 beds **Bumblebee** staffing establishments have been re-profiled to align to 18 beds with the staff on from the Hedgehog establishment incorporated into the Bumblebee numbers. **Hedgehog** Ward is currently closed till January 2022, with no budgeted establishment at present.

Blood, Cells and Cancer (BCC) - The directorate HON confirmed that current staffing establishments across the directorate are safe, however there are still some minor discrepancies in the numbers which are currently under review with the local finance BP. **Lion, Giraffe and Elephant –** no changes required. Staffing establishments are safe and due to the small sizes of these wards nurses are deployed and patient acuity distributed to maintain safety. Professional judgement needs to be applied to the shared staffing establishment of **Pelican (inpatient)** and **Pelican (ambulatory - Badger)** due to working across two sites. As highlighted in the previous reviews conducted earlier this year, we are continuing to observe an upward trajectory in the patient acuity trend, with a gap in the current budgeted establishment and the SNCT recommended establishment. Once staff relocate to one site the establishment will be reviewed again to see if this trend persists or resolves. **Fox** and **Robin** establishments are safe and correct. **Safari** As a daycase unit the Directorate HoN confirmed that the current staffing levels were safe however once the ward is split across two sites this will require additional nursing resource and a repeat review of the establishment will need to be conducted.

Heart & Lung (H&L) – The directorate HON confirmed that current establishments are safe and correct based on regular planned activity. **Leopard** No changes required. **Kangaroo** No changes required. **Bear** As highlighted in the previous Staffing Establishment Review conducted earlier this year, we are continuing to observe an upward trajectory in the patient acuity trend, with a gap in the current budgeted establishment and the SNCT recommended establishment. Therefore a repeat exercise will be undertaken throughout September 2021 to confirm this trend, with an immediate recommendation for an additional 5 WTE to address the short fall ahead of winter pressures and the anticipated RSV surge. No changes required in relation to **NICU, Flamingo (CICU) or PICU**. Establishments align with national critical care guidance and are not determined by SNCT scoring, however if additional beds are opened then the establishments for these units will need to be reviewed.

Operations and Imaging (O&I) – Following a targeted recruitment campaign earlier this year, the shortfalls in the staffing establishment have been addressed and the directorate is deemed

safe. The recently appointed HON plans to conduct a full deep dive ahead of the next nursing establishment review to ensure the right people are in the right place, to ensure patient safety and effective use of the existing workforce. Based on professional judgement and RCR guidance, **Interventional Radiology**'s establishment falls short by 2 WTE. The current establishment in operating theatres is in line with national AfPP guidance and professional judgement. **Anaesthetics** – No changes required. **Scrub** –No changes required. **Recovery** – No changes required.

Recommendations from the previous report

1. To review and monitor nursing establishment requirements in H&L as triangulation indicates that it may be slightly under establishment on Bear Ward if activity and acuity levels remain high **– Completed as part of this review**
2. To review and monitor nursing establishment requirements in I&PC as triangulation indicates that it may be over establishment **– Completed**
3. To monitor and review skill mix in I&PC and reconsider proportions of registered to unregistered workforce based on need to ensure the right people with the right skills in the right place at the right time - **Completed**
4. Improve the way we capture feedback from children and their families and how we apply this to the establishment reviews – **In progress**
5. Improve the way we incorporate patient outcomes to improve triangulation and increased assurance into the review process - **Completed**
6. To follow the formal process outlined in the new Safe Staffing Policy ahead of the next biannual review to improve assurance and transparency - **Completed**
7. Gain confirmation of the number of commissioned High Dependency Beds (HDU) across the trust - **Completed**
8. To achieve improved the triangulation methodology of Nurse Sensitive Indicators with the implementation of the Ward Accreditation scheme – **Pending implementation of Ward Accreditation**

Recommendations prior to next review

1. Deep dive review in to the BBM directorate nursing establishment.
2. Focused review of patient acuity on Bear Ward, with an immediate recommendation for an additional 5 WTE.
3. Focused review of patient acuity and nursing establishment once Pelican relocates to single site.
4. O&I to conduct a review of current establishments with an emphasis on ensuring the right people with the right skills are in the right place.
5. For the additional recommended increase in establishments to be considered.

Conclusion

The review found that on the whole current nursing establishments are safe across the trust through mitigation, reduced bed base and limiting some activity. However if activity and acuity continues to rise or if new services are added then the establishments in those areas will need to be amended. The assurance process is compliant with Developing Workforce Safeguards guidance (NHSE/I 2018) however it will continue to evolve and improve. The next review is planned for January 2022, to be reported to board in March 2022.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
29th September 2021

Learning from Deaths Report – Learning from Deaths in Q4 2020/21 **Submitted by:** Dr Sanjiv Sharma , Medical Director Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews Andrew Pearson , Clinical Audit Manager	**Paper No: Attachment V** For information and noting

Purpose of report

To provide Trust Board with oversight of

1. Learning from deaths identified through mortality reviews, this includes positive practice, but also where there were modifiable factors.
2. Progress with the implementation of the Child Death Review Meetings (CDRM).

This scope of this report is GOSH inpatient deaths that occurred between 1st January 2021 and 31st March 2021.Twenty three children died at GOSH in this period.

Summary of report

This report was presented to the Patient Safety and Outcomes Committee (PSOC) in August 2021. This report has been updated since being reviewed by PSOC to reflect any changes that have occurred with progress with SI and RCA investigations, and includes he most recently available mortality data. It highlights learning points from mortality reviews and actions that are being taken in response to them.

23 GOSH inpatient deaths occurred between 1st January 2021 and March 2021. All have been reviewed by the Mortality Review Group or at a Child Death Review Meeting. Those reviews highlighted:

- One death is included in an SI investigation (2021/11391-Faulty batch of histoacryl glue impacting patient outcomes). An SI report has been drafted and is awaiting approval from NHS England. It is anticipated that this will take place by the 22nd September 2021. The learning, outcomes and actions identified will be reported to the Patient Safety and Outcomes committee once the SI report is approved.
- There was one death in this period investigated as a Root Cause Analysis (Clinical deterioration of a PICU patient) and where an inquest was concluded in June 2021. Learning points and actions have been identified via the conclusion of the GOSH Root Cause Analysis report in August 2021 and progress reported to the Coroner. The completed RCA report including actions undertaken, were reported to PSOC in September 2021.
- Particular excellent aspects of care the co-ordination of care, and communication in 15 deaths.
- Additional learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience in 10 cases. Those learning points and actions taken are described in the report.

- In 9 cases the impact of the COVID 19 pandemic was indicated as influencing the fact that the death occurred or GOSH, or as impacting on the experience of care. 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.

There are no outliers which require investigation noted in real time PICU/NICU risk adjusted mortality. Crude mortality is within normal variation.

Action required from the meeting
There are no recommendations or actions for the Board to consider
There are no overall themes highlighted in the report which require further Trust wide action and consideration by PSOC or Closing the Loop.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
Quality/ corporate/ financial governance	Culture of high quality sustainable care Effective processes, managing risk and performance Accurate data/ information 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
Meets the requirement of the National Quality Board to report learning from deaths to a public board meeting. Child Death Review Meetings (CDRM) are statutory following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019.

Consultation carried out with individuals/ groups/ committees
This report has been reviewed by the Patient Safety and Outcomes Committee

Who is responsible for implementing the proposals / project and anticipated timescales?
Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews

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

Learning from deaths –Q4 2020/21 report

Aim of this report

Highlight learning from deaths identified through mortality reviews at GOSH This scope of this report is GOSH inpatient deaths that occurred between 1st January 2021 and 31st March 2021

Summary

23 GOSH inpatient deaths occurred between 1st January 2021 and March 2021. All have been reviewed by the Mortality Review Group or at a Child Death Review Meeting. Those reviews highlighted :

1 death is included in an SI investigation (2021/11391-Faulty batch of histoacryl glue impacting patient outcomes).

0 deaths had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death. There was one death in this period investigated as a Root Cause Analysis (Clinical deterioration of a PICU patient) and where an inquest was concluded in June 2021. Learning points and actions have been identified via the conclusion of the GOSH Root Cause Analysis report in August 2021 and progress reported to the Coroner. The completed RCA report including actions undertaken, were reported to PSOC in September 2021.

Particular excellent aspects of ,care the co-ordination of care, and communication in **15** deaths.

Additional learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience in **10** cases. Those learning points and actions taken are described in the report.

In **9** cases the impact of the COVID 19 pandemic was indicated as influencing the fact that the death occurred or GOSH, or as impacting on the experience of care.

10th September 2021

Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews

Andrew Pearson, Clinical Audit Manager

The mortality review process at GOSH

Mortality reviews take place through two processes at GOSH:

1. Mortality Review Group (MRG). This was established in 2012 to provide a Trust level overview of all deaths to identify learning points, themes and risks and take action as appropriate to address any risks. This process is linked with local case reviews undertaken by specialty teams and provides an additional oversight of inpatient deaths in the Trust. This group continues to review deaths to ensure a thorough level of review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as identifying learning points and making referrals to other safety investigation processes at the earliest opportunity.

2. Child Death Review Meetings (CDRM)
These are now in place at GOSH following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019.Child Death Review Meetings are “a multi-professional meeting where all matters relating to a child’s death are discussed by the professionals directly involved in the care of that child during life and their investigation after death.” They include clinicians or professionals from external providers. CDRM meeting should be held within 12 weeks of the child’s death, following the completion of all necessary investigations and reviews.

Completion of mortality reviews

23 children died at GOSH between 1st January 2021 and 31st March 2021 Reviews (i.e. an MRG or a CDRM) have been completed for all cases.

Sixteen CDRMs have taken place, and seven have not been completed.

- 5 cannot take place until the completion of necessary coroner investigations reviews. 1 cannot take place until the conclusion of an SI investigation. This in line with the Child Death Review Statutory Guidance.
- 1 is not required as the patient was over 18
- 1 is planned to take place in September 2021 due to challenges in Consultant capacity to attend the meetings at an earlier stage.

This report highlights learning known at the time of writing, and it is important to note that additional learning could be identified at a later stage through the coroners /CDRM / SI processes.
The table below shows the summary of the deaths that occurred during the quarter using NHS England reporting guidance.

Total number of inpatient deaths at GOSH between 1st January 2021 and 31st March 2021	23
Number of those deaths subject to case record review (either by the MRG, or at a CDRM)	23
Number of those deaths declared as serious incidents	1
Number of deaths where a modifiable factor was identified at GOSH that may have contributed to vulnerability, ill health or death.	0
Number of deaths of people with learning disabilities	2
Number of deaths of people with learning disabilities that have been reviewed	2
Number of deaths of people with learning disabilities where a modifiable factor was identified at GOSH that may have contributed to vulnerability, ill health or death	0

Deaths that are subject to an SI investigation (1)

Incident (2021/11391) Faulty batch of histoacryl glue impacting patient outcomes	**Update**
BBraun conducted a recall of Histoacryl glue, a product marketed as a wound glue but used in neurovascular treatment of AVM and other venous malformations for over 30 years. They report delayed polymerization though further details have not been confirmed. Five patients were treated with the affected batches. Two patients subsequently died.	One patient who died in March 2021 is one of five patients treated with the affected batches. An SI report has been drafted and is awaiting approval from NHS England. It is anticipated that this will take place by the 22nd September 2021 The SI investigation focuses on the management of the safety alert process The learning , outcomes and actions identified will be reported to the Patient Safety and Outcomes committee once the SI report is approved.

Deaths that had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death. (0)

This report highlights learning at the time of writing from the mortality review process at GOSH , and it is important to note that additional learning could be identified at a later stage through the coroners /CDRM / SI processes. Modifiable factors are defined as factors, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths

There was one death in this period investigated as a Root Cause Analysis and where an inquest was concluded in June 2021.

Incident	**Update/Conclusion**
Clinical deterioration of a PICU patient.	An inquest was held in June 2021 and a Root Cause Analysis report finalised following the Inquest. The scope of the incident review is on the completion and visualisation of observations , and escalation of concerns on PICU . An update was given on the care of this patient and actions undertaken to the Coroner in August 2021. The following actions have been identified following the finalisation of the RCA report , which was reported to the Patient Safety and Outcomes Committee in September 2021 . The actions have been completed 1. Audit to assess the frequency with which ward rounds and plans are being documented in line with PICU policy. 2. Audit to assess the frequency of nursing observations taking place as described in the PICU standards for observations 3. Review the accessibility of computers in the intensive care unit to ensure timely documentation can be achieved. 4. Undertake an audit to understand if there are any barriers to the escalation of the deteriorating patient to the duty consultant 5. Improve the ability to see vital sign trends in context for an individual patient – for example by persistent realtime display of the T3 system at every ICU bed space. (business case and plan being developed for procurement and roll out)

Learning from excellence- positive practices , care , and communication highlighted through the reviews

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

Early suspicion of mitochondrial disorder, appropriate supportive treatment till diagnosis established, parents counselled from day one about possibility of death. Excellent coordination between lab, genetics and metabolic teams.
The team involved in the resuscitation attempts were commended for their efforts and good teamworking including the rapid debrief following the arrest.
All Available treatments were tried including multiple variations of chemotherapy locally and (cord) BMT at GOSH with ATG with conditioning regime to reduce the chance of GVHD. The local team were hugely grateful for the weekly emails during the GOSH admission updating them with the child's progress throughout the BMT - this should be highlighted more widely as an example of extremely good practice and credit to the BMT CNS team who are responsible for this. Fox Ward nursing team were commended for the time, resources and energy provided to this family in the midst of difficult social circumstances. The BMT team were extremely grateful for the support of the PICU team in discussions around redirection of care and in providing a peaceful and dignified death. The child was transferred to a hospice after death and the family and siblings are being supported weekly by the hospice who will continue to support the family for up to 3 years (or longer) if needed.
The team-working in A&E at the time of resuscitation between A&E/Paediatrics/NICU and anaesthetics at the local was highly commended. The family were updated appropriately during the resuscitation. The RCA identified that the baby was assessed in a timely manner and received good discharge advice with timely escalation at second presentation. Staff involved in the resuscitation were supported by the Paediatric Consultants. The local team (were commended for their open and transparent approach to undertaking an RCA when this was raised at the JAR. Two copies of the RCA will be provided one anonymised for governance and the parental copy to include child's name throughout (this is done routinely at this Trust but also in response to parents feedback that they wish for their child to be remembered by name and not as a case). The child deteriorated very rapidly and the results of investigations and timely reviews by the appropriate teams enabled the family to make timely decisions regarding redirection of care. The PICU nurse who was present at end of life was commended for the care provided to this family at end of life (and this was fed back to the staff member at the CDR meeting)
The *physiotherapy team worked extremely hard to prepare this child for extubation. The Neuromuscular team and PICU team worked really well together in order to provide the best care in line with the family's decision to withdraw ventilation and not to proceed to tracheostomy.*

Learning from excellence- positive practices , care , and communication highlighted through the reviews

Extent of CICU support offered was praised at M+M and CDR meeting. Very consistent palliative and symptom care support. Good communication with parents
Good teamworking in the run up to consideration of (TIPS) procedure between PICU/BMT/London hospital Liver teams.
The Childrens Community Nursing team were described as heroes who worked alongside Shooting Stars to enable care for this child who wanted to be at home. Funding was sought and obtained (unusually) very quickly from the CCG. This has been fed back to the individuals involved who were present at the meeting and their teams. The rapid decision around funding which enabled this child to get home quickly will be fed back to the CCG team in order to encourage this good practice (as this has been problematic in other cases)
GP identified need to refer to paediatric team. The referral was bounced back via a Referrals Review System and suggested that a more urgent assessment was necessary which was an example of expedited diagnosis as he was seen the following day as a consequence of this system. The rare diagnosis (of XXXXXX disease) was identified within 3 weeks of admission in part due to recognition of the unusual findings on imaging of calcification which was identified by a senior radiologist as indicative of (XXXXX) this rare disease. Good MDT approach, spiritual and psychological support for family, early involvement with palliative care, went to hospice after death. Family Support worker was credited for her help in obtaining British passport and practical support around funeral arrangements. XXXXX (PICU Consultant) and XXXXX (PICU Sister) were commended for their very sensitive response to the Complaint that the parents submitted.
There was good consistency throughout with consensus with all the numerous medical teams. A lead PICU Consultant and nursing team were allocated to the child early on which was helpful. The Psychology team provided weekly sessions offering an opportunity to support staff and the legal team joined these meetings which was helpful for staff in understanding the legal process and the teamworking was supportive and protective in enabling the team to best support the family during a challenging legal process
Good MDT working with BMT/Immunology/cardiology/PICU /team at UCLH good documentation of discussions with parents
Local team were commended for rapid postnatal identification of duct dependent lesion and commencement of Prostin and rapid transfer to tertiary centre for ongoing treatment. The Social work team were commended for their support for the mother who was supported to travel daily between her other children and GOSH.
Good MDT collaboration with cardiology, pulmonary hypertension team, genetics, respiratory and NICU
Mutlidisciplinary approach with multiple teams involved. Ongoing discussion with liver team at London hospital. Discussed at national HLH meeting.
good working between specialities, good recognition of bleed during/after IR procedure

Learning points identified

Where learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience.

Location of learning	Learning	Actions from learning
Community care	Antenatal testing (later in pregnancy and not for the purposes of termination) would have provided information that may have avoided unnecessary interventions (intubation etc) on the baby and earlier (antenatal) involvement of palliative care	
GOSH	1. The parents of this child went home and the child had a cardiac arrest shortly after admission, resuscitation attempts continued for >45 mins while awaiting parents arrival from home.. This case identified that consideration of offering accommodation and encouraging parents to stay nearby particularly during the initial hours following admission may prevent parents from having to travel long distances in the case of an emergency. 2. Despite referral to community nursing team on initial discharge from NICU, community nursing team were not alerted on discharge from subsequent admission to paediatric ward.	This did not affect the overall outcome however actions have been put in place to ensure communication occurs between hospital and community teams in future.
GOSH/national issue	1. The local team were hugely grateful for the weekly emails during the GOSH admission updating them with the child's progress throughout the BMT - this should be highlighted more widely as an example of extremely good practice and credit to the BMT CNS team who are responsible for this 2. This child received mismatched (cord) BMT due to national international lack of bone marrow donors from mixed race and non-white ethnic backgrounds This is a national issue that requires a wider national response to improve the numbers of bone marrow donors from mixed race and a variety of ethnic backgrounds to reflect the ethnicities of recipients needing bone marrow transplants. od practice	1.Shared via this report to PSOC as good practice

Learning points identified

Where learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience.

Location of learning	Learning	Actions from learning
Local hospital	The learning is clearly described in the RCA undertaken by the local hospital and the actions as follows:. 1. All children presenting to PAU/ED require 2 sets of observations- one on admission and one on discharge, regardless of time interval 2 All babies under 3 months presenting with a temperature of 37.5 and above with tachycardia should have a period of monitoring in the department 3 Refresher sessions to all staff on sepsis screening tool and PEWS 4 Audit and feedbacks on documentation to be given to staff to promote best practice Additionally it was identified at the CDRM that: 1. 1. Two copies of the RCA will be provided one anonymised for governance and the parental copy to include child's name throughout (this is already done routinely at the local but also in response to parents feedback that they wish for their child to be remembered by name and not as a case). This was an example of excellent practice and it was felt important to share this more widely.	Actions confirmed in local RCA report

Learning points identified

Where learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience.

Location of learning	Learning	Actions from learning
GOSH	1. The family identified that they found it difficult to recall information given at genetic counselling and would have valued more meetings/repetition. The family sought antenatal testing but were unable to achieve this for reasons which were not able to be elicited at CDRM. This may have changed the outcome of this pregnancy had the diagnosis been made antenatally (although this is speculation). 2. It was identified that written communication between GOSH and the local could be improved.	It was suggested that recording the meetings was a useful method for families to be able to listen back to information (and notably the option to re-listen to an audio recording was deemed more useful than written information) and this has already been shared with Genetics and has already been adopted in some areas it should be shared more widely to other teams. There is ongoing work at GOSH looking at how to improve communication between the PICU and the local hospitals for long term patients.
GOSH	Parents expressed ongoing distress regarding the volume and duration of the alarms at the time of withdrawal of life sustaining treatment .	This has been escalated to the ECMO lead nurses and practice educators to consider potential solutions in order to avoid this distress for other families.

Learning points identified

Where learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience.

Location of learning	Learning	Actions from learning
GOSH	1. Issues around acceptance of the MCCD by registrar (who referred to Coroner) suggest listing BMT in brackets beside the underlying disease in order that the MCCD does not read as though the procedure (BMT in this case) caused the death.	This learning has been fedback to individuals involved and will be shared more widely within the BMT team for whom these difficulties in registration of death most often arise.
GOSH/local	1. It was challenging to identify what the child wanted as both the parents and the child tried to shield one another from bad news (all protecting each other) and for this reason it was difficult to hear the child's side and to provide some services eg psychology. However child was was able to attend Art therapy sessions and was able to express that they wanted to go home which was facilitated. This scenario is seen in many families (especially associated with some cultures) and will be discussed more widely as an Ethics Grand Round at GOSH in order to develop strategies to manage this situation for other families. 2. It was identified that the debriefs being run locally could include the Children's Community Nursing teams and Dr XXXX plans to action this at XXXXXX going forward in order to reflect these excellent working relationships between teams.	1. Scenario to be discussed in Ethics Grand Round at GOSH 2. Local hospital to include Children's Community nursing teams in debriefs 3. The rapid decision around funding which enabled this child to get home quickly will be fed back to the CCG team in order to encourage this good practice (as this has been problematic in other cases)

Learning points identified

Where learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience.

Location of learning	Learning	Actions from learning
GP	1. GP identified need to refer to paediatric team. The referral was bounced back via a Referrals Review System and suggested that a more urgent assessment was necessary which was an example of expedited diagnosis as he was seen the following day as a consequence of this system. 2. The rare diagnosis (of a rare congenital Metabolic disease) was identified within 3 weeks of admission in part due to recognition of the unusual findings on imaging of calcification which was identified by a senior radiologist as indicative Identifiable please remove. The significance of any unusual findings and seeking the appropriate expert advice from the appropriate teams was identified as a learning point. The local team had already referred to Metabolic team and the correct investigations requested. This highlighted the need to establish clearly which investigations have been sent locally and to establish exactly which team has responsibility for chasing the results which could potentially delay diagnosis. In this case there was no delay in initiation of therapy. The diagnosis of this disease is challenging and the role of rapid exome sequencing as a diagnostic modality will be further explored as an action from this meeting.	1. The GPs at the practice have already reflected and reviewed this process at practice level.
GOSH	1. This case highlighted the potential need for signposting families for external provision of support particularly in cases where the legal route and families do not wish to engage with professionals associated with GOSH but still need support.	Psychologist will raise this at an upcoming meeting with the legal team to determine how best to provide this support not only to staff (which had previously been identified) but also to families following this case.

Impact of COVID 19 pandemic on deaths at GOSH in Q4

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

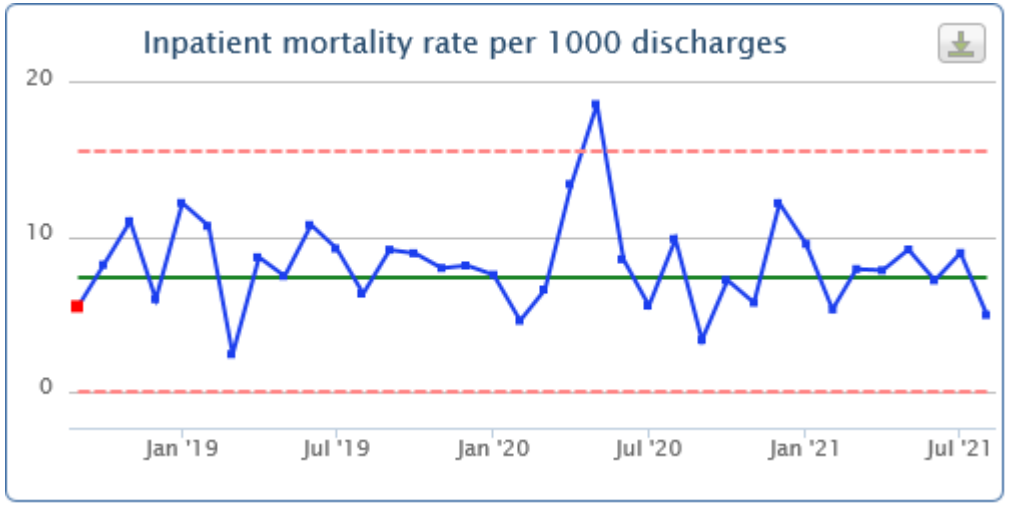
There were no deaths at GOSH in this period where it was possible to conclude that the COVID 19 pandemic had an impact on the death occurring at GOSH (e.g if the child had died at GOSH because of COVID 19 or received care at GOSH and died when that death may have taken place at GOSH due to relocation of services due to the pandemic)

In nine cases whilst it is not possible to definitively conclude, it was felt that there may have been an impact of the pandemic on the death occurring at GOSH or on the experience of the family and/or patient

1. Parent became positive for COVID-19 . A CTL infusion was postponed as parent was the donor. Additionally the nationally imposed visiting restrictions severely impacted the family experience.
2. There were some concerns about how the effect of Covid restrictions would impact on transfer to the hospice after death.
3. Family wanted to travel overseas for further treatment but were unable to do so due to Covid travel restrictions
4. A parent found visiting on their own very difficult and developed anxiety related to visiting difficulties
5. If not for the pandemic the patient would have been likely to have admitted to their local hospital where was well known .This probably would not have changed outcome but might have been better for the family
6. One parent was a healthcare worker and had been staying away from their child to reduce the risk of transmitting Covid .This meant the parent had not seen his child for several weeks prior to death
7. Challenges in arranging transplant due to Covid. Unfortunately there were delays accessing the donor because of COVID19 and during this time progressed to relapse, therefore treated with further chemotherapy and then 3 doses of the antibody-drug conjugate Inotuzumab to hold disease until transplant (veno-occlusive disease is a known complication)
8. Government imposed Covid visiting restrictions: Extended family not allowed to visit due to Covid restrictions. Family felt poor prognosis was evident from the time of admission yet were not able to have apply lifting of restrictions that apply to children at the end of life.
9. Parent in Europe and unable to travel because of COVID.

Mortality rate

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 approximately 80% of patient deaths at GOSH are in intensive care areas. Risk adjusted real time mortality is monitored weekly at the PICU/NICU Morbidity and Mortality meeting using the recognised RSPRT (Risk-adjusted resetting probability ratio test) method.

The gold standard for measuring variation in outcomes in paediatric mortality is through annual 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 for that period.

Attachment W

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 29th September 2021	
Infection, Prevention and Control Annual Report 2020 **Submitted by: Helen Dunn, Director of Infection Prevention & Control (DIPC)**	**Paper No: Attachment W** ☐ **For approval**

Purpose of report

The IPC annual report is a requirement stated within the Health & Social Care Act Code of Practice. It should contain detailed information on the activities of Infection Control Work streams and activities over the previous year. It is a public document that must be presented to the trust board and made available for members of the public.

Summary of report

- Change in DIPC occurred in the year of 2020 with a lead practice educator joining the team as well.
- Key Risks identified included the risk of acquisition of adenovirus on Robin and Fox. There are also risks within estates around water and ventilation associated with staffing and demonstration of compliance due to lack of authorised persons.
- Mandatory reporting remains stable although there was an increase in Cdiff reported in the year, a likely cause was the different patient mix with UCLH patients being on site resulting in being reported under our numbers. There were also 2 MRSA bacteraemia's which upon investigation where unavoidable.
- Screening for both MRSA and resistant gram negatives (stool screening) is below target and a key objective for this year is to improve both as numbers of hospital acquired resistant gram negatives have risen.
- Five COVID outbreaks were reported (all in staff).
- Central line surveillance continues to be stable and dropped slightly over the year from 1.3/1000 line days to 1.2/1000 line days.
- Work is underway to optimise sepsis bundle care and reporting with the deteriorating child group.
- 18 hospital acquired cases of COVID have been detected and investigated. In 11 of the cases parents were positive.
- Largest area of risk around COVID sits with ventilation and the identification that not all standard bedrooms were commissioned to 6 air changes. RCA underway by Built Environment Team and mitigations in place including increased fallow time on ward areas.

Action required from the meeting

The papers proposed are to be presented to Trust Board and made available for public reading.
Any key risks and activities are highlighted in the executive summary as well as the main body of the document.

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 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**	**□ 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 12: Inconsistent delivery of safe care	
Financial implications Not Applicable	
Implications for legal/ regulatory compliance The IPC annual report is a requirement under the Health & Social Care Act Code of Practice. The Board Assurance Framework reported on within the annual report is an assurance document required by NHSE/I and reviewed by the CQC. Any areas of risk are documented. Areas of non-compliance which do not have active action plans in place will	
Consultation carried out with individuals/ groups/ committees EMT Chief Nurse IPCC	
Who is responsible for implementing the proposals / project and anticipated timescales? DIPC	
Who is accountable for the implementation of the proposal / project? Not Applicable	
Which management committee will have oversight of the matters covered in this report? Infection Prevention Control Committee	

Executive Summary of Infection, Prevention and Control Report 2020

1. Purpose

Great Ormond Street Hospital for Children NHS Trust recognises the obligation placed upon it by the Health and Social Care Act Code of Practice of the prevention and control of infections and related guidance.

2. Infection Prevention and Control Staffing

Director of Infection Prevention and Control (DIPC)

Dr John Hartley, consultant Medical Microbiologist. DIPC since August 2009- May 2020

Helen Dunn, Consultant Nurse IPC since May 2020- present.

Executive Lead for IPC

Alison Robertson, Chief Nurse

Nursing and clinical scientist establishment:

- Lead Nurse for IP&C/Consultant Nurse IPC - Helen Dunn
- Deputy Lead Nurse in IP&C - Barbara Brekle
- Lead Practice Educator IP&C- Kate Harkus (started Aug 2020)
- IPC Nurse – Helen Saraqi
- IPC Nurse- Alyson Prince (0.4 WTE)
- Principal Clinical Scientist in IPC (0.6 NIHR fellowship until June 2019; currently with some backfill undertaking scientific IPC activity. Elaine is also the Trust Healthcare Clinical Scientist lead).

The Infection Prevention and Control Committee (IPCC)

Meets every month (except Aug & Dec). The committee reports to Patient Safety and Outcome Committee.

High risk identified by the IPCC include the increased risk of acquisition of adenovirus on Robin and Fox and the risks around ventilation and water due to lack of authorised persons.

3. Organisms Subject to Mandatory Reporting

No targets were provided for 20/21 except for MRSA which is no avoidable HAI infections and Cdiff, which was 5.

MRSA RCA's showed there both infections were unavoidable and Cdiff figures were higher than previous years due to a different case mix with UCLH cancer treatment onsite during the pandemic.

Organism	**Number reported 19/20 *(HAI)***	**Number reported 20/21 *(HAI)***
E-coli	10 (7)	19 (14)
Klebsiella Sp	26 (15)	14 (10)

Pseudomonas aeruginosa	19 (9)	15 (9)
MRSA	1 (0)	2 (2)
MSSA	23 (13)	20 (9)
Cdiff	7 (2)	13 (10)
VRE	2	7

4. Surveillance of MRSA and Multiple 'Resistant' Gram Negative Organism Including Screening

Screening compliance on admission for MRSA and resistant gram negatives organisms should be improved. Both are below the required standard and whilst MRSA transmission remains low there has been an increase in hospital acquired resistant gram negatives. This is a risk to organisation with the increased prevalence globally of carbapenamase producing entrobacteracciae.

Stool screening compliance remains at less than 20%. The target for MRSA screening is 80% but it averages between 50-60%. Changes to epic have been implemented to improve compliance as well as regular feedback to ward areas.

5. Investigation of Infection Prevention and Control Incidents and Outbreaks

Five outbreaks of COVID-19 have been reported all involving staff and no patients. Key themes included not wearing Fluid Resistant Surgical Masks (FRSM) at all times and staff eating and drinking together.

We are also part of the Public Health England (PHE) incident group looking at increased prevalence of Staph Capitis across the UK.

6. Management of Respiratory and Enteric Viruses

Whilst numbers of respiratory and enteric viruses have reduced as a result of lockdown and social distancing transmission still occurs. There has been huge improvement in the identification of respiratory symptoms and placing in correct isolation. Further work is needed with this for enteric viruses.

Respiratory viral infections detected:	**Total**	**Community onset**	**Hospital onset**
Total in 2018/19	616	417	199
Total in 2019/20	921	610	311
Total in 2020/21	472	384	88
Enteric viral infections detected:			
Total in 2018/19	600	311	289
Total in 2019/20	341	186	155
Total in 2020/21	131	71	60

7. Audit and Compliance to Policy

Hand hygiene and bare below the elbows compliance data has improved. Areas of improvement are still identified and included within local and trust wide action plans.

Care bundle compliance remains below the required standard and an IV working group led by IPC and the practice education team has formed to address the guidelines and any issues with education and adherence to these guidelines, including recording of information on Electronic Patient Record (EPR).

We remain an outlier for spinal surgical site surveillance but overall infection rates have dropped. Other surgical site surveillance including neurosurgery and cardiac continues.

8. Central Line Surveillance

1.2/1000 line days (63 episodes). (Rate 1.3 last year). Highest areas Panther, Kangaroo and Squirrel Gastro.

9. Wider Infection Prevention and Control Service

Estates & Facilities- there was a change in the decontamination contract. MEDU opened and the endoscopy unit and MEDU staff came in-house. Water testing did not take place for 6 months due to the pandemic. This has now re-established. Risk assessments are in place and regular reviews as legionella remains in 2 clinical buildings and 1 non-clinical building. The annual verification schedule for ventilation was not maintained.

Antimicrobial Stewardship- The team were heavily involved in the staff vaccine rollout. Changes were made to first line anti-fungal treatments in non-BMT patients. Work continues to automate point prevalence audits.

Sepsis- The sepsis programme in the trust was overseen by the Infectious Diseases Team for the time of this report. Issues remain with the reporting and management of sepsis within Epic, therefore a report was not able to be provided.

Occupational Health- Influenza uptake increased to 71.6% (59% in 19/20). There were 50 attendances for exposure to blood bourne viruses a decrease on the previous year. OH also provided skin surveillance for staff and saw an increase following the increased use of Personal Protective Equipment (PPE). The staff also provided return to work assessments for those who had been off with COVID-19.

10. COVID-19 Response and Board Assurance Framework (BAF)

The IPC team has maintained a responsive service as part of the pandemic, regularly reviewing guidance and ensuring that risks are identified and mitigated.

There were 18 hospital acquired COVID-19 cases since March 2020- 31 March 2021. All cases were investigated and 11 of the cases were also linked with parents being positive, highlighting the importance of parent testing at points in the pandemic. None of these cases were linked.

Lateral flow testing (LFT) was introduced in December 2020 and any staff who test positive either by LFT or PCR are risk assessed by the IPC team and any contacts identified. 5 outbreaks were reported as described earlier, related to staff only.

FIT testing has been provided and is now an established service with records of staff tested available. Both qualitative and quantitative testing is undertaken.

Audits have been conducted on IPC audit days, and with the clinical audit manager to ensure compliance with the BAF and identify any areas for improvement. A bespoke COVID-19 training module is available for all staff and compliance is monitored. A CQC visit was conducted in 2020 and no concerns were highlighted.

The largest area of risk currently identified for compliance with the BAF is the around the lack of assurance around ventilation within the organisation and the identification that not all standard bedrooms in the trust were commissioned to 6 air changes when they were opened despite them being designed to 6 air changes. An action plan and remediation plan is awaited from estates and an RCA is underway. Immediate risk mitigation was undertaken with COVID positive patients being looked after in Positive Pressure Ventilated Lobby's (PPVL) or other appropriate rooms and the fallow time being increased post aerosol generating procedures (AGPs).

Attachment X

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 29 September 2021	
BAF- Infection Prevention Control- COVID-19 **Submitted by: Helen Dunn, Director of Infection Prevention and Control**	**Paper No: Attachment X** **☐ For information and noting**

Purpose of report
The BAF serves to provide the executive team and board with assurance processes in place around COVID-19. The BAF is broken down into 10 sections which reflect the areas of compliance which must be demonstrated as part of the Health & Care Social Act (2015).

Summary of report
Through a number of incidents that have occurred regarding covid-19 it has been identified that not all contractors or agency staff on site are aware of our covid-19 guidance. Although this affects a small number of staff this could lead to increased risk so has been documented on the BAF whilst the mitigating actions are undertaken and a check is performed to ensure this is implemented.

The number of staff fit tested for masks (which we have in stock) has reduced. This is for two reasons; the first is that one mask which the majority of our staff were tested for has been removed from the push stock which we receive. The second reason is the updated CAS alert around the use of valved FFP masks in areas where sterile and invasive procedures are undertaken. Work is underway with support from senior clinical teams to address this reduction in fit testing compliance.

Action required from the meeting
Acknowledge the increased areas of risk identified in the BAF.

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**	**☐ Leadership, capacity and capability** **☐ 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**

Strategic risk implications
Company Secretary to complete

Financial implications
N/A

Implications for legal/ regulatory compliance
N/A

Consultation carried out with individuals/ groups/ committees
Who is responsible for implementing the proposals / project and anticipated timescales? DIPC
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?

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; the documented risk assessment includes: - a review of the effectiveness of the ventilation in the area - operational capacity - prevalence of infection/variants of concern in the local area	Hospital risk assessment completed and sent to silver/gold and trust board on how red, amber and green patients would be managed based on the layout of the hospital and ventilation standards. Plans in place for how to manage patients with AGP's across all parts of the hospital. PPE supplies monitored and avaliable on the ward. Prevelance rates and VOC/VOI monitored at operational covid meetings	Ventilation not at designed 6 a/c across all areas of the organisation. Action plan awaited from estates	Fallow times ammended in areas of the trust to ensure staff are not exposed to any remaining aerosols following AGP's.
triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways	Standard admission questions are available on the IPC intranet site. Questions asked on each admission/appointment to the hospital. In and outpatients to receive a screening call the day before attending. Processes have been put in place to support screening phonecalls prior to admission and on admission. Pathways in place for screening and alerting on patients with normal immunity, immunocompromised, and group 3.	Confirmation that these screening assessments have taken place in 100% of required cases and are documented appropriately on Epic. Audit to assess compliance with thistook place in Sep 2020 and showed good compliance. EPR have created reporting working benches to provide assurance around; screening compliance and telephone encounters for all work flows.	
when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given	During periods of high prevelance where risk is higher risk assessements are considered to move staff to FFP masks for all AGP's to reduce the risk of exposure. Fallow times have been published for the organisation so staff are aware how long they need to use FFP following an AGP	Not all standard bedrooms were built and commissioned to 6 a/c	
There are pathways in place which support minimal or avoid patient bed/ward transfer for duration of admission unless clinically imperative. That on occasion when it is necessary to cohort Covid or non-Covid patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	Red, Amber, Green Pathways in place and available on the GOSH Web Covid Hub. IPC team available advice on risks associated with patient movement. Patient pathways document contains information about how positive/suspected cases should be managed including decisions on movement-approved by Silver and Gold command. Incident reporting in place to highlight any issues with compliance, so that these can be investigated and learned from. Cleaning Guidelines in Place and regularly audited.	that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance;	
that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance	Cohorting was only taking play on COVID ICU this area was VHR so cleaned twice daily. Weekly & monthly cleaning reports avaliable to evidence this standard of cleaning. All COVID positive patients have level 2 clean on discharge- automatically requested through epic.	Any areas which pass below the standard of cleaning required have remedial actions carried out immediately.	
monitoring of IPC practices ensuring resources are in place to enable compliance with IPC practice: - Staff adherence to hand hygiene - Staff social distancing across the workplace & 2m social distancing unless staff are providing clinical or personal care and wearing appropriate PPE - Staff adherence to wearing fluid resistant surgical facemasks in a) clinical and b)non clinical settings	infection control hub on GOSH web with Guide FAQs etc. Hand, face, space, place audit undertaken at regular intervals which covers clinical and non-clinical areas. Quarterly IPC audits	Hands, Face, Place, Space audits have highlighted areas for improvement. Action plans are shared are SLT	Hands, face, space, place audits carried out regularly.
Monitoring of staff compliance with PPE, **with wearing appropriate PPE, within the clinical setting**. Consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Infection control links Break the chain champions Practice educators working alongside the IPC team Hands, Face, Space, Place Audits Incident reporting Freedom to speak up and Speak Up for Values process highlighted through Covid training programme to support staff in highlighting any issues with PPE compliance.	The Trust has given consideration to creation of the role of PPE guardians/safety champions but we currently feel that there is a robust level of local ownership of the importance of PPE. This is kept under review.	
Implementation of twice weekly lateral flow antigen treatment for NHS paitent facing staff, which include organisational systems to monitor results and staff test and trace.	Lateral flow testing has been available across the Trust for staff all patient facing staff since December 2020. There has been good uptake of lateral flow test collection.		
Additional targetted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional prevention and control/Public Health Team	The Trust has the capacity to provide additional staff testing if required, but the Trust does not have a high nosocomial rate currently. There have been 16 definitive/probable nosocomial infections in the last year, with 5 small staff outbreaks.	Additional targetted PCR testing for BMT staff had been agreed and implemented in line with national BMT guidance. However, following analysis of results over a 3 month period the risk was considered sufficiently low to move to lateral flow testing for BMT staff.	This has been added to the risk register to ensure it's kept under regular review. Capacity to offer this testing is available.
Training in IPC standard infection control and transmission based precautions are provided to all staff	Infection control is routinely included in Induction and mandatory update. 'Covid-ready' sessions were supported by practice educator teams. Covid mandatory training has been created.	Compliance for COVID mandatory training is not at the target 90%	Regular reporting of staff who need to do training through SLT and directorates.
IPC measures in relation to covid-19 should be included in all staff induction and mandatory training	Covid-ready. Training in place as of January 2021.	Compliance for COVID mandatory training is not at the target 90%, currently sitting at 80%	Regular reporting of staff who need to do training through SLT and directorates.

all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context: and have access to the PPE that protects them for the appropriate setting and context as per national guidance.	Videos are included in the mandatory training. Additional resources on the infection control hub on GOSHweb. Online covid training in place as of January 2021.		
There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygience and maintaining pysical distance both in and out of the workplace.	Posters and stands on display throughout the hospital including reception, lagoon, bathrooms. Posters are child friendly. There is a cartoon video (Otto the Octopus) which plays in main reception (and is available on the Trust website) which outlines the key safety precautions to take in a way that many of our patients can understand more clearly. The link to the video is included in texts to patients re: appointments. There are volunteers during working hours ensuring that face masks and hand hygiene precautions are following at the point of entering the building. There are physical distance markers (starfish) to help guide and support social distancing throughough the hospital.		
National IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way. Changes in guidance are board to the attention of the Board and any risks and mitigating actions are highlighted.	Dissemination pathway for CAS alerts via the patient safety team (with asscociated policy). Compliance with alerts is monitored monthly through IQPR. Dissemination pathway for emergency preparedness documents. Any guidance changes are disseminated and discussed at operational level prior to trust wide change. Changes in process and policy have been communicated to staff in all staff comms, snap comms and ward based teaching. Infection Control Committee meets regularly. This reports into Patient Safety and Outcomes Committee quarterly and to the Trust Board in line with the Board Assurance requirements. Annual IPC report.	There is no consistent national alerting system for new guidance from NHS E (not all guidance is issued via the CAS system)	Safety netting checks via Quality & Safety team.
Risks are reflected in risk registers and the Board Assurance Framework where appropriate	A Covid-19 RiskRegister has been developed and this is reviewed regularly at the Silver, and highlighted to the Trust Board as required through the BAF review process. Minutes and agenda avaliable for Ops Board/Silver.		
Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC normal practice and procedures in place as set out in the IPC policies. IPC committee, RCA investigation into HCAI alert based organisms from incident list. Weekly review of infection control issues through Exec led weekly safety meeting. Peer audit undertaken with Moorfields as part of NCL STP work (24.8.20)		
That Trust CEO, Medical Director or Chief Nurse approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	Process is in place with DIPC and Chief Nurse involved in SitRep sign off to ensure data quality.		
This Board Assurance Framework is reviewed and evidence of asssessments are made available and discussed at Trust Board	IPC BAF will be reviewed as part of the agreed reporting to Trust Board. Specific updates on outbreaks and safety relatied issues are also included in the monthly Integrated Quality and Performance Report.		
Ensure Trust Board has oversight of ongoing outbreaks and action plans	Regular updates from DIPC. Overview of outbreaks and their management included in Trust Board updates as part of the integrated quality and performance report.		
There are check and challenge opportunities by the executive/senior leadership teams in both clincial and non-clinical areas.	Senior leaders taking part in the Hands, Face, Space, Place Audits. Ad Hoc Visible leadership walkrounds by the Executive team Discussion of results of audits through the SLT meeting and Big Brief.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			

Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Standard infection control training for all staff which including information on AGPs and non-AGPS. Local Covid Training dissemination through the practice educator team. Decontamination of medical equipment policy. Covid Secure and Covid Risk Managed areas identified. Trust guidance in place for isolation and cohort areas with support from the infection control team as required.		
Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas	Our Clearning Teams are trained with standard infection control prevention. Using level 2 clean which is inline with national guidance. Q&A sessions provided with the infection, prevention and control team provided. Assurance received from cleaning tem that training has provided to staff on PPE for covid and any changes to cleaning	Incident reporting in January 2021 highlighted some issues with rostering of appropriately trained staff in some covid-19 isolation areas, but this was acted upon promptly and resolved.	
Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Staff in these areas are trained with standard infection control prevention. They are using level 2 clean which is inline with national guidance. Q&A sessions with the Trust IPC team have been run with cleaning staff. Infection cleans are audited by supervisors within OCS and trust team- mins avaliable from facilities meeting where this is presented		
Increased frequency, at least twice a day, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	The majority of our clinical areas are specified to very high risk and therefore we provide over and above usual expectations and in line with national expectations. SLA's and KPI presented at soft facilities peformance meeting Confirmation recieved of change of cleaning frequencies in trust to reflect covid advice		
Cleaning is carried out with neurtal detergent, a chlorine based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local IPCT whould be consulted on this to ensure it is effective against enveloped viruses	All areas of the hospital are cleaned with chlorclean or an approved alternative if it is unavaliable. This is specified within the contract, and audited. Chlorine is used in all cleans.		
Manufacturers guidance and recommended 'contact time' must be followed for all cleaning/disinfectat solutions/products	They are trained with standard infection control prevention. Using level 2 clean which is inline with national guidance. Q&A sessions provided. Evidence provided by cleaning team on training given to staff		
- frequently touched surface e.g door/toilet handles, patient call bells, overbed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids - electronic equipment e.g. mobile phones, desk phones, tablets, desktops and key boards should be cleaned a minimum of twice daily - Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Work has been undertaken with the facilities team to ensure that high touch areas in communal areas are cleaned as specified. Cleaning guidance for office areas has been developed. Safe working hub- video and documentation for staff to inform them Risk assessment for hand dryers completed- taken to Ops board Aug 2020 evidence recieved from OCS that cleaning is enhanced in areas as requested (e.g uplift of OPD etc) Covid mandatory training in place.	Review info on safe working hub re desk cleaning etc in offices. To be included with audit and regular submissions for areas designated covid secure.	
reusable non-invasive care equipment is decontaminated: between each use, after blood and/or body fluid contamination at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing or repair equipment	All reusable equipment is cleaned in line with the patient associated ward equipment cleaning matrix http://goshweb/clinical_and_research/clinical-ops/Laboratory%20Medicine/Infectioncontrol/Documents/Patient%20Associated%20Ward%20Equipment%20Cleaning%20Matrix%202019.pdf This is also monitored as part of the cleaning audits and fed back locally and through the IPCC		
Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen is treated as contaminated. Assurance reports from supplier of services FMs observe handling of linen when they are in the clinical areas and linen is being changed, any incorrect practice is brought to the attention of the NIC and/ or sister.		
Single use items are used where possible and according to Single Use Policy	single use policy- Contained within the decontamination policy		
Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	single use policy- Contained within the decontamination policy		
Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	This is monitored through the cleaning contract with spot check audits by the OCS supervisors. We currently exceed the national specifications for frequency of these checks.		

Ensure the dilution of air with good ventilation e.g. open window, in admission and waiting areas to assist the dilution of the air.	Most of our areas are mechanically ventilated. There was a trust wide audit. Ventilation committee and monitoring group meets to ensure that ventilation for AGP's is in line with national guidance. Trust wide assessment of ventilation currently being undertaken- reported to ventilation performance meeting (mins) Social distancing in place in waiting areas	The results of the Trust wide audit on ventilation are being compiled by estates.	Behind schedule on the ventilation. Needs to be escalated.
Monitor adherence environmental decontamination with actions in place to mitigate any identified risk	Audit process in place and managed closely by cleaning team and infection control.		
Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk.	monitored through the cleaning contract with spot check audits by the cleaning team supervisors		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Arrangements around antimicrobial stewardship are maintained	Antimicrobial rounds are taking place virtually to maintain social distancing and minimise contact whilst preserving arrangements for antimicrobial stewardship.		
Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Mandatory reporting up to date and maintained. Quarterly report to Board from Infection Control, with monthly IPC monitoring data through the IQPR		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			
Implementation of national guidance on visiting patients in a care setting	COVID clinical guideline which incorporates national guidance on intranet GOSH website covid FAQs are updated regularly in line with changes to advice. Hospital switchboard message is also updated in line with this guidance. Additional security presence at entrances to buildings to help communicate this message, with escalation to PALS in event of disagreement. There are arrangements in place to enable patient/family specific exemptions in exceptional circumstances with authorisation from the relevant Head of Nursing. The visiting guidance is kept under close review in light of feedback from families and is regularly considered through Silver.		
Areas in which suspected or confirmed COVID-19 patients being treated are clearly marked with appropriate signage with restricted access	Dolphin (designated covid ICU) signage for ingress and egress is clear. Infection alerts would be placed on epic with specifics about the viral resp illness the child was isolated for. Isolation door signs would be in place stating PPE required We are implementing a traffic light system for the patient's bed head to indicate what pathway they are on.	Audit found that signage could be improved with 61% compliance identified- plan with roll out of new PPE guidance to include training for staff	Follow up audit completed in May showed a hige improvement with signage and bedside posters of the green, amber and red pathways. Will continue to audit regularly
Information and guidance on COVID-19 is available on all Trust websites with easy read versions	All internal guidance is available on GOSH internal and external website. Easy read versions and translated versions available. August 2020 audit confirmed good quality up to date information was available on the external website including translations and easy read versions. A video for children on hygiene and visiting the hospital have also been developed.		
Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Discharge summary reflects infection control status. Timeliness of completion of discharge summaries is monitored monthly. Audit of quality of discharge summaries in July 2020 confirmed 100% compliance with inclusion of infection control status at time of discharge.	Continued work to improve timeliness of discharge summaries being shared outside the organisation.	
There is clearly displayed and written information available to prompt patients, visitors and staff to comply with hands, face and space advice.	Otto the octupus campaign includes posters on hands, face and space. Video running at outpatients. Video for children and written information on the website. Video is also running in main reception. Regularly updated FAQ on the website - which are signposted through in text reminders when attending for admissions or outpatients. Information is translated into top languages.		
Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	This has been considered for implemenation but GOSH already has its own behaviours which covers all points within the 'hands, face, space and place' guidance		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities must be undertaken to enable early recognition of Covid-19 cases	Admission screening questions in place on Epic. Parent Testing.		KPI on screening in the sitrep. Reviewed at silver on a daily basis.

Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non-COVID-19 cases to minimise the risk of cross-infection as per national guidance	This standard is not applicable to the GOSH main site in the absence of an emergency department. However, we do have a CATS triage pathway in place		
Staff are aware of the agreed template for triage questions to ask	Defined template for questions on Epic to support staff.		
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Triage is not always undertaken by clinical staff. However the process requires escalation of all 'no' answers to a clinical member of staff.	Not always undertaken by clinical staff, but any 'no' responses are escalated to clinical staff.	
Face coverings are used by all outpatients and visitors	The Trust policy is that Fluid Resistant Face Masks (FRSM) are recommended and provided for all outpatients and inpatient carers		
individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation	All children who suffer from severe immune defiencies or require protective isolation are managed in appropriate rooms. COVID is only known to currently cause disease and complications in a very small sub-set of children. Children with COVID are not looked after on Leopard (where children with CF and other long term respiratory conditions are managed)		
Provide clear advice to patients on the use of face masks to encourage use of surgical facemasks by all inpatients (particularly if moving around the ward) if this can be tolerated and does not compromise their clinical care	There is an individual risk assessment based on the child's age. Masks are offered to children from 11+		
Monitoring of inpatients compliance with wearing face masks particularly when moving aroudn the ward (if clinical ok to do so)	There is an individual risk assessment based on the child's age. Masks are offered to children from 11+.	This is not monitored specifically in the paediatric population.	
Ideally segregation should be with separate spaces but there is potential to use screens e.g. to protect reception staff	Reception areas have screens in place as part of safe working group work. See Safe working group minutes, action plans and hub. Audit of compliance with Covid-Secure arrangements completed. Hands, Face, Space, Place		
Ensure 2 metre social and physical distancing in all patient care areas	Use of floor markings and bed spaces have been assessed in all clinical areas.		
For patients with new onset symptoms isolation, testing and instigation of contact tracing is achieved until proven negative	All children who develop new symptoms after admission are placed in droplet precautions until two neagtive tests which is tested for the full panel of respiratory viruses or until symptoms resolve. For contact tracing see infection control incidents as evidence Covid outbreak protocol.		
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	Patients who test negative and develop symptoms would be placed back into droplet precautions and another sample taken- COVID 19 policy. Haem/onc flow Patients are asked if symptomatic on arrival. If they are unwell but their appointment is essential they would be isolated and seen Incident reporting process. Daily email with patients that have been put in droplet precautions to enable oversight.		
There is evidence of compliance with routine patient testing protocols in line with [Key Actions: infection prevention and control and testing document]	Trust guidance on covid testing. Audit of compliance in high risk areas (ICU) carried out in 2021.		
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Pre-Screening Calls prior to appointment. Screening on arrival. If non urgent- asked to go home as per PHE guidance and rearrange when well. COVID 19 guideline sets out the process for dealing with clinically unwell patients who need to be seen. IPC would be called and able to provide advice. If risk identifed would be recorded as an incident.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to communal areas.	Safe working group plans. One way systems where possible Reduced passengers in lifts		

All staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	In addition to standard IPC training on induction and update training, there has been additional Ad hoc education through the practice education team during the pandemic.This includes videos showing best practice for donning and doffing. Addidional guidance and support has been delivered via the Big Briefings and All Staff Comms. An infection control covid-19 hub was quickly established on the GOSH web.	There is evidence that not all contractors/agency on site are familiar with the COVID-19 guidance on-site.	work to be completed to have a quick guide for contractors on-site or agency staff attending with key covid-19 mitigations they need to undertake whilst here at GOSH
All staff providing patient care and working in the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	COVID clinical guideline on GOSHWeb. Videos to support donning and doffing have been produced and are available on the Infection Control Hub on GOSHweb. Fit testing SOP in place May 2020 audit showed high levels of compliance with donning and doffing practice.		
A record of staff training is maintained	Staff training records are maintained on GOLD. Fit testing training database was additionally set up during the pandemic. Fit testing SOP in place.		
Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Infection Control Audit schedule		
Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise covid-19 transmission such as: - hand hygiene facilities including instructional posters - good respiratory hygiene measures - maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care - staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside the workplace - frequent decontamination of equipment and environment in both clinical and non-clinical areas - clear visually displayed advice on the use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Hands, Face, Place Space audits. Infection Control Audit Schedule includes quarterly hand hygience audits. Posters, including instructional posters, floor marking in place. One way systems in place - with a Covid Secure assessment process in place. Communications to staff regarding travelling to work via daily Covid-comms. Support from volunteers services in addition to posters and visual advice on the reception screens regarding masks in main reception.		
Staff regularly undertake hand hygiene and observe standard infection control precautions	HH clinical guideline Quarterly Audits QI dashboards at ward level Infection control link nurse		
. The use of hand dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	Within clinical areas there are no hand towels in use. Risk assessmentfor hand dryers in public and staff areas has been undertaken and is being reviewed for approval at Operational Board in August 2020.	Monitoring for any staff or patient transmissions. Will review policy if there is an increase in these transmissions.	
Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas.	Starfish/octopus hand hygiene stickers/posters are up. Drying risk assessment has been completed, and is being reviewed for approval at Operational Board in August 2020.		
Staff understand the requirements for uniform laundering where this is not provided for on site	Staff Uniform Policy All staff comms Staff awareness of uniform policy and laundering requirements included in audit and as part of IPC audit day		
All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household displays any symptoms	All staff comms Referral Forms Covid-19 Clinical Guideline Mat's Big Briefing HR support and OH Covid outbreak protocol		
a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Outbreak policy.		
positive cases identified after admissions who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Infection control management, and weekly updates are included in the weekly safety report. Silver meeting receives updates. All User comms identiy the number of patients and staff who have symptoms. Outbreak protocol in place. Risk assessments undertaken by IPC (rather than OH). There have been 5 staff outbreaks since March 2020, including 1 in 2021.		

robust policies and procedures are in place for the identification of and management of outbreaks of infection	*Outbreak policy in place.*		
7. Provide or secure adequate isolation facilities			
restricted access between pathways if possible (depending on size of the facility, prevalence/incidence rate low/high) by patients/individuals, visitors or staff	Pathway document for Red, Amber Green Pathways in place. Audit undertaken of compliance with pathways in March 2021.		
areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Traffic light system at bed space. Visual prompts regarding infectious status are now included on all patient views within Epic.		
Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate	All patients are screened on admission. Patients with high probability are placed in screening cubicles within the COVID ICU Ops hub to advice on patients movement. IPC team to advice on risks associated with patient movement Covid Secure and Covid Risk Managed Pathways identified. Covid outbreak protocol		
Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Air validation of ICU, theatres and Hedgehog ward and all other PPVL rooms available in the organsiation, and the SIR on Pelican.		
Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Alert on Epic with an alert mismatch flag so that staff at the bedside and in the operational hub can see and manage patient care and patient placement accordingly. Standard isolation policy in place. Incident reporting policy. These patients are highlighted in the weekly safety report, with a monthly review as part of the IQPR.		
8. Secure adequate access to laboratory support as appropriate			
Testing is undertaken by competent and trained individuals	Specimen collection guideline updated in May 2020. UKAS accreditation up to date for the labs- SOPs for sampling procedures in lab held on Qpulse with appropriate training record		
Patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance	Patients are tested promptly with a rapid test available if clinically required. Realtime audit avaliable on Epic dashboard. Bronze microbiology meeting monitors overall TAT and escalates concerns accordingly Dasboard showing screening rates withn 24 hours of admission.	The TAT aren't always within 24 hours.	However there is a business plan being progressed to make lab 24 hours.
Regular monitoring and reporting of testing turnaround times with focus on time taken from the patient to time result is available.	live data on epic.		
Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Microbiology Bronze meeting.		
Screening for other potential infections takes place	Full standard infecton control service running		
That all emergency patients are tested for Covid-19 on admission	Covid guidance set out on GOSHweb.		
That all those inpatients who go on to develop symptoms of covid-19 after admission are retested at the point symptoms arise.	Covid guidance set out on GOSHweb. We have a specific flow chart for respiratory illnesses in children regarding retesting for covid if other respiratory viruses are not found during screening.		
That those emergency admissions who test negative on admission are retested on day 3 of admission and again between 5-7 days post admission	Covid guidance set out on GOSHweb.	GOSH does retest at day 3, but not at day 5 and 7. this is in line with good practice for paediatrics, wherease the identified standard in this document applies to the adult population.	
that sites with high nosocomial rates should consider testing covid negative patients daily	GOSH has had 20 incidence (probable + definitive) of nosocomial infection since the beginning of the pandemic, so this would not be considered a sufficiently high nosocomial rate. All instances have been risk-assessed and investigated/actioned appropriately, including external notification as required.		

That those being discharged to a care home are being tested for covid-19 48 hour prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	GOSH patients are not typically transferred to care homes, but may be transferred to hospice or nursing home. Testing takes place as necessary and infection control results are communicated in discharge summaries.		
that those being discharged to a care facility within their 14 day isolation period should only be discharged to a designated care setting, where they should complete their remaining isolation.	GOSH patients are not typically transferred to care homes, but may be transferred to hospice or nursing home. Testing takes place as necessary and infection control results are communicated in discharge summaries.		
That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	GOSH follows the RCPCH guidance on elective testing of paediatric patients.	Following RCPCH guidance rather than NHS E guidance which is primarily directed at the adult population.	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Staff are supported in adhering to all IPC policies, including those for other alert organisms	Policy in place and available on the infection control webpage on GOSH. Udpates are included regularly as guidance changes.		
Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Agreed dissemination pathway for all PHE national advice within organisation. Changes and updates are made by infection control team. Discussions and approval of changes to guidance at Silver/Operational Board (currently happening twice a week) for dissemination via Local Bronze Meetings. GOSH web - all guidance is updated in the infection control hub, staff comms via email (initially daily, but now scaling back), practice education on the ward.		
All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with PHE National Guidance.	Category B waste guidance is followed for all suspected infections. And Categaory 3 in the Lab. Waste Audit.		
PPE stock is appropriately stored and accessible to staff who require it	Stock levels are reviewed and circulated daily. Incident reporting and escalation pathways for staff who cannot access when they need it.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Managerial discussions. Facilitation of staff to work from home. Occupational Health support. Risk Assessment for vulnerable staff. Well being hub. Demographic Risk Assessments. Safe Working Risk Assessments. Cerfification of Covid Secure areas. The position at the end of July was 94% of all staff had completed the risk assessment, with 95% of BAME staff risk assessments completed. Amazon business account set up for Staff to order homeworking equipment directly.	Updated submission on risk assessments due to NHS E/I due at End of August.	
that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including BAME and pregnant staff	Completed for all staff.		
Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Fit testing service with up to date training records held on a central dashboards. Fit testing is now a funded service within IPC with permenant staff		
staff who carry out fit test training are trained and competent to do so	Competency checklist in place.		
all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Fit tesing database. SOP/guideline for fit testing.	With masks being removed from push stock and the increased use of FRSM for green pathway patients and AGPs there are a number of staff who are not fit tested for masks we have in stock. In addition the CAS alert for the removal of valved masks has meant that staff working in areas with invasive or surgical procedures should not wear a valved FFP mask so additional fit testing is required there.	Communications to clinical teams about the requirement for fit testing with support from senior teams. Options apprasial being considered regarding FFP masks used in clinical areas- due to presented at Ops Board at the end of Sep 2021.
a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Fit testing database.		

for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	Fit testing database.		
for members of staff who fail to be adequately fit tested a discussion should be had, regarding redeployment opportunities and options commensurate with the staff members skills and experience and in line with the nationally agreed algorithm	Fit testing database. Health Roster HR Redeployment plan OH Hoods.		
a documented record of this discussion should be available for the staff member and centrally within the organisation as part of the employment record including occupational health	Fit testing database.		
following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP3 respirator are re-deployed using the nationally agreed algorithm and a record kept in staff members personal record and occupational health service record.	Redeployment plan in place with HR. Hoods are available. OH support in place.	Follow up with HR for redployment plan.	Add sarah's update.
boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the Board	Fit testing database. Incident reporting.	Include in paper to November Board.	
consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	Health Roster.. Operational Hub. Daily Heod of Nursing Huddle.		
all staff should adhere to national guidance on social distancing if not wearing a face mask and in non-clinical areas.	Staying Safe @ GOSH guidance Safe working hub Hands, Face, Place Space.		
health and care settings are covid-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	Staying Safe @ GOSH guidance Safe working hub Hands, Face, Place Space.		
staff are aware of the need to wear facemask when moving through covid-19 secure areas	Staying Safe @ GOSH guidance Safe working hub Hands, Face, Place Space.		
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Daily monitoring of staff sickness and those who are self isolating/quarantining. The number and % of the workforce affected is included in the daily comms email to ensure good levels of visibility. Phone call service for staff who are self-isolating including peer support for medical staff who are unwell. Onsite testing is available including serology testing for all staff who want it. Access to national hubs for staff who live significant distances from the hospital.		
Staff that test positive have adequate information and support to aid their recovery and return to work	Opccupational Health Service screening prior to return to work. Safe return to site working group. Safe working checklists and risk assessments. Covid-secure areas certification. Managerial support. Well Being Hub which includes access to pyschological support.		

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 29th September 2021	
Emergency Preparedness Resilience and Response Annual Report 2021/22 **Submitted by:** Rachel Millen, Emergency Planning Officer John Quinn, Chief Operating Officer (Accountable Emergency Officer)	**Paper No: Attachment Y** ☐ **For Approval**
Purpose of report To present an annual review of this year's emergency planning work programme, and the current compliance of the national NHS England and Improvement core standards.	
Summary of report This report summarises the work of the emergency planning team, key aspects of the organisations emergency preparedness over the past year and how the trust maintains its readiness to prepare, respond and recover from both emergencies and disruptive challenges. Throughout the year a continuous process of exercising, testing, training and assurance has taken place. The Trust continues to work with external agencies such as NHS E&I and other trusts to ensure maximum preparedness and business continuity following any adverse major incidents.	
Action required from the meeting Approval of the report	
Contribution to the delivery of NHS Foundation Trust priorities ☐ **Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** ☐ **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 8: Business Continuity	
Financial implications Not Applicable	

Great Ormond Street Hospital for Children
NHS Foundation Trust

Implications for legal/ regulatory compliance NHSE&I Emergency Preparedness Resilience & Response National Core Standards. The Civil Contingencies Act (2004)
Consultation carried out with individuals/ groups/ committees Emergency Planning Group Operational Board
Who is responsible for implementing the proposals / project and anticipated timescales? Emergency Planning Officer 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? Emergency Planning Group / Operational Board

Great Ormond Street Hospital for Children
NHS Foundation Trust

Great Ormond Street Hospital NHS Foundation Trust

Emergency Preparedness, Resilience & Response Annual Report 2021/22

1. Executive Summary

The Trust is committed to developing and maintaining policies and procedures by taking a proactive approach to emergency preparedness, resilience and response (EPRR). The purpose of this report is to provide information relating to Business Continuity and Emergency Preparedness, Resilience and Response across the Trust in 2021/22. It explains incidents, compliance with NHS England & NHS Improvement (NHS E&I) core standards, Training and Exercises, and continuing plans to take forward and improve the management of emergency planning and business continuity in the Trust.

2. Introduction

This report summarises the work of the emergency planning team, key aspects of the organisations emergency preparedness over the past year and how the trust maintains its readiness to prepare, respond and recover from both emergencies and disruptive challenges. Throughout the year a continuous process of exercising, testing, training and assurance has taken place. The Trust continues to work with external agencies such as NHS E&I and other trusts to ensure maximum preparedness and business continuity following any adverse major incidents.

3. EPRR Assurance

The Emergency Planning Officer (EPO) will complete a RAG rated self-assessment against the NHS Core standards for EPRR on 17th September 2021.
Due to the impacts of COVID-19 last year's assurance was a breakdown of COVID-19 pressures and Winter Planning Preparedness. The organisation remained 'Fully Compliant'
This year's assurance meeting will take place on Monday 20th September. NHSE&I, the Trust's Accountable Executive Officer (Chief Operating Officer), The Trust's Alternative Accountable Executive Officer (Deputy Chief Operating Officer) and EPO will take part in the meeting, where we will review and confirm core standards have been achieved and therefore, we will then be issued a final compliance result. We are continuing to rate this as 'Fully Compliant'.

This year's deep dive will focus around oxygen supply, due to the shortages in 2020 due to COVID-19 pressures. We are confident that the Medical Gas Committee continues to maintain and prepare for possible oxygen issues.

At Trust level, The Emergency Planning Group continues to meet on a quarterly basis to review the progress of the yearly work plan and the training & exercise programme. Plans and policies are reviewed and discussed here before being taken to Policy Approval Group or Operational Board for agreement and sign off.

Great Ormond Street Hospital for Children NHS Foundation Trust

4. Business Continuity Plans and Polices

The Trust Business Continuity Plan had been reviewed ahead of this year's assurance meeting, confirming a yearly review of the policy has taken place. This continues to support the Business Impact Assess and RAG (red/amber/green) service criticality ratings.

Using a new 'Business Continuity Plan Tracker', there is now a fully functioning non-compliance system to track out of date service plans.

We also work closely in partnership with Moorfields eye hospital to ensure we share learning from a specialist hospital perspective. As well as arranged for a collaborative business continuity audit of each other's organisational plans.

5. Training and Exercises 2021/22

Training type	Audience/role	Content
Duty Manager refreshers *Bi-Monthly*	General Managers and Heads of Nursing on the Duty Manager rota with on call function	• Incident response • Setting up incident control centre • Scenario training • Lessons identified through minor incidents • Debrief
Exec on Call Training *Bi-Yearly*	Training for all Exec on call to confirm competence in understanding and how this will be implemented	• Incident Control Room • Key Stakeholders • Press / Media training • Recovery • Mutual Aid • Debrief
Strategic Leadership in Crisis training *3 Yearly*	Executive Management team and Directors fulfilling the Gold rota with on call function	• Civil Contingencies Act responsibilities • Defensive decision making • Legal considerations and logging
Incident Loggists Training *Monthly*	Volunteers from across the Trust fulfil the loggist role (16 in total)	• Emergency management overview • Methods of logging • Legal background and reasoning • Practical assessment

The ***Duty Managers*** who carry out the Trusts tactical on-call function (Silver rota) will ***receive refresher training on a bi-monthly basis*** in managing the response to emergencies, with an expectation that they attend at least one session per year. This regular training incorporates learning from real incidents which have occurred both in the Trust and across the London region, and includes setting up the incident control room and running through their roles. This will support the assurance process for on call training arrangements.

Exec on Call Training these sessions are in place twice yearly to support new members of staff who have joined the exec on call rota. Those on Exec on call are expected to compete this training once a year

minimum. As like the Duty Manager training this will also support the assurance process for on call training arrangements.

Strategic Leadership in Crisis training to the Executive team virtual dates are currently being shared with the Executive team. These sessions are ran by NHSE&I and are focussed on EPRR Planning and response arrangements, Awareness of the requirements of the CCA 2004 and associated guidance, roles and responsibilities of other emergency partners, planning and response arrangements within the organisation, concept of "Defensive decision making" and Overall performance of the response team. Exec on call staff are only expected to complete these sessions 3 yearly.

Sight and Sound Fire test – Ahead of the new Sight and Sound Building opening in the Old Italian Hospital. Staff completed a simulation exercise using smoke machines and alarms to assess emergency preparedness of the Sight and Sound OPD in the event of a fire. Taking into consideration evacuation routes, safe patient handling and transfer techniques and team familiarity with local fire plan. This exercise demonstrated the staff's existing knowledge of evacuation planning as on all exercises the outcome resulted in safe evacuations for all.

Exercise Flambé is an interactive table-top exercise which explores staff roles during a full ward evacuation as a result of a fire. The session identifies 'best practice' for their specific area and learning from the 'Live' evacuation exercises. These sessions are done on a rolling basis and the EPO has had input into the content of the training and has attended 8 of these in the current year.

14 ***Incident Loggists*** are currently trained and ready to log if required. These loggists are now being offered the opportunity to attend exercises to get an opportunity to test their logging skills ahead of a major incident.
Loggist refresher dates have become available and all staff have the opportunity to attend to refresh existing skills.

The learning from all training and exercises is shared with the Emergency Planning Group and supports the review process of the relevant emergency plans and training programmes. This is also taken to the Patch Emergency Planning Groups to discuss best practice.

6. Incidents

Beckton and Dickinson IV Line disruption – March 2021.

At the start of March we received notification from BD of supply disruption with consumable giving sets. This affects giving sets in relation to VP pumps and CC syringe drivers. BD were unable to provide any length of time as to when this situation would be resolved or any detailed explanation.

There was concern around the TPN sets, and so a plan was required to ensure safety and continued treatment.

The incident command for Gold, Silver and Bronze was stood up, and the agenda focussed solely around products of concerns, identification of where these products are being used and alternative solutions that could be used.
This was managed daily until we was at a safe position to stand this down to bi-weekly to monitor.
The lessons learned from this disruption noted:

- Review of organisational stock and identification of areas that rely solely on one stock need to be evaluated to identify what our contingency is.
- Acknowledgement of how well those involved stepped in and engaged with the incident and supported the management of the incident made this effective and helpful.
- A requirement to have a clear out of hour's escalation of safety alerts and other alerts which don't always come through via appropriate routes.

COVID-19 January 2019 – present

Since mid-January 2019, the Trust has been involved an unprecedented situation, with levels of incident management response never seen before in the history of the NHS due to the worldwide pandemic of COVID-19.
Although in March the incident command structure was stood down as the requirements fell into business as usual.
Due to an expected increased pressures due to COVID 19 the Silver Incident Command Structure stood back up, this currently remains at twice weekly meetings.

Respiratory Syncytial Virus (RSV) – Surge Planning

The organisations RSV surge plan was created in June 2021 and is currently being reviewed in line with new national guidance and additional impacts such as COVID and usual winter pressures to support this year's winter plan. As it stands RSV is currently being managed under the COVID 19 incident command structure to ensure appropriate escalation measures are available if required.

The EPO has ran a lessons learned from the 1st and 2nd wave of COVID table top, this supported the work ongoing with the trust COVID-19 Surge plan.
The lessons learned identified the incredible changes and adaptation to 'the new normal' that GOSH has incorporated and supported the running of the incident as well as filtering business as usual consequences.
In the event the 3rd wave has impacts, we will have best practise from previous waves to refer to and help manage this.

7. Next steps

The EPO supported by the Emergency Planning Group will continue to progress with emergency preparedness across the Trust with emphasis on training and exercises for all senior managers and decision makers. There continues to be a focus on business continuity across the Trust, which has only been further highlighted due to the COVID-19 response, and the lessons learned from this will be reviewed, debriefed and used to shape ongoing policy management.

Summary of the Quality, Safety and Experience Assurance Committee held on 1st July 2021

Chief Executive Update

The Committee noted the pressure under which staff continued to work due to the increase in activity, the significant backlog of patients and the ongoing uncertain external environment. The importance of staff speaking up in cases where the balance of activity and staff wellbeing was not correct was emphasised. Bed occupancy data was being closely monitored.

QSEAC Terms of Reference

One small change had been made to the Committee's Terms of Reference in response to the outcome of the committee effectiveness survey. All committee Terms of Reference would be further reviewed following the completion of the Well Led review.

Driver Diagram: A Road Map to Safer Care

The Quality and Safety Strategies had been developed into operational delivery plans with a number of strands. In order to ensure a coordinated approach and demonstrate the link to the strategy a driver diagram had been developed which described how various areas of the Trust could work together to achieve improved structures and processes. The work would be grouped by year based on priorities and interdependencies.

Research Hospital Update (from a quality/ patient experience perspective)

Funding for the Biomedical Research Centre and Clinical Research Facility was a key risk to the directorate and the team was working to ensure that the current bid was successful. A number of outcome metrics were monitored and reported to funders. Good progress had been made around governance structures for nurse and AHP research, much of which was related to patient experience.

Quality and Performance in the IQPR

WHO checklist compliance had improved along with the number of incidents closed. Focus was being place on serious incident and red complaint actions and Duty of Candour which remained red rated. Meetings had taken place with directorates to highlight the importance of these areas and the introduction of the balanced scorecard approach was likely to lead to more assurance based reporting. It was agreed that improvements in red performance metrics must be made by the next meeting.

Update on issues arising from patient stories at Board

Recent patient stories had a key theme of communication and MyGOSH was a positive development in this regard. Service and directorate specific action plans had been developed to address communication and positive work was taking place around welcoming patients and families to the ward.

Ward Accreditation Scheme

Good work had taken place to implement the scheme which would set a benchmark of recognisable standards for care and quality at ward level. There had been good engagement from staff.

Thematic analysis of red complaints

An analysis of 25 red complaints had identified a key theme around the deteriorating patient as well as a broad theme of communication. One Directorate was an outlier in the number of red complaints in the previous three years and additional work was taking places on the learning identified from these complaints.

Safeguarding Governance Review – Action Plan Update Report 2021

The report arising from the safeguarding governance review had been developed into an action plan. It was confirmed that there was sufficient resource and capacity to complete the actions.

Overview and Emerging clinical and risk issues covering (BAF Risk 13: Inconsistent delivery of safe care)
A number of complex issues were currently being managed by the Executive Team including two recent coronial inquests with narrative conclusions to which GOSH was required to respond. The Trust was approaching organisations to undertake the follow up review of the gastroenterology service as the Royal College of Paediatrics and Child Health has suspended its invited review service. A serious incident investigation was ongoing related to a faulty medical consumable.

Update on medicines management at GOSH (BAF Risk 11: Medicines Safety)
Focused work on an inventory had substantially decreased the amount of waste. Confirmation had been received that the MHRA would undertake a follow up review in early August 2021. Mock readiness inspections had taken place with positive outcomes. A large piece of work was taking place with the EPR team and constraints were being experienced due to a lack of capacity in the EPR team.

Great Ormond Street Hospital Paediatric Bioethics Centre (PBC) Report
An external review of the service would be taking place in the coming months and a five year plan would be developed to ensure that a more strategic approach was taken. The committee requested feedback on the experience of parents who had attended the committee.

Clinical audit update including the Clinical audit annual work-plan 2021/22
The clinical audit plan was based on learning which arose from incidents and was used to ensure that changes had been embedded. Proactive areas were also built in to the plan. The Trust had been highlighted by PICANET as being one of only eight paediatric ICUs nationally which were able to meet the standards for qualified nurses per patient.

The Life and Death of Elizabeth Dixon: review and lessons for GOSH
The recommendations of the review had been developed into action plan which would be overseen by the Patient Safety and Outcomes Committee (PSOC). The Committee emphasised the importance of supporting the staff who had been involved in the care of the patient whilst ensuring that the learning from the review was embedded.

Freedom to Speak Up Guardian Update (FTSU) (April - May 2021) – Quality related
The number of cases were rising to previous levels following a period of stability in the service which was positive and GOSH benchmarked midway in the group based on its FTSU index. The Committee noted the importance of ensuring that consistent communication was provided to staff and of understanding the outcome of the pulse survey which said that only 55% of staff felt safe to raise a concern. Work was taking place with staff forums to support all groups of staff to feel comfortable in speaking up.

Update from the Risk Assurance and Compliance Group (RACG) on the Board Assurance Framework
The RACG continued to monitor the BAF and particularly the medicines management risk in light of the follow up inspection of the pharmacy service by the MHRA. Consideration would be given on the implications of the outcome of the review on the controls in place.

Compliance Update with Always Improving Plan (BAF Risk 13: Inconsistent delivery of safe care)
'Must do' actions arising from the CQC inspection had been completed and good progress had been made against the 'should do' actions which were scheduled for completion by the end of July 2021. Work would now take place to consider the actions that would be required to achieve a rating of outstanding.

Overview of engagement with external safety organisations (BAF Risk 13: Inconsistent delivery of safe care)
An update would be provided at the next meeting on the work that was taking place.

GOSH Quality Report 2020/21

Committee members had reviewed the document and provided comments as had Governors. The Committee approved the report and congratulated the team on their work given the deadline which had been considerable shortened at late notice.

The Committee noted summary reports from the June 2021 meeting of the People and Education Assurance Committee and the April and May 2021 meetings of the Audit Committee.

Feedback from Governors

Discussion took place around the time available for each agenda item. Some Governors expressed some concern about the ability of committee members to thoroughly discuss each item, highlight concerns as required and the wider hospital implications for speaking up. The Committee said that although the agenda was busy many items had previously been discussed and committee members were familiar with the issues. Governors in their second term highlighted that they had become familiar with the pace of meetings and were assured that issues were appropriately discussed.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 29 September 2021	
Finance and Investment Committee Update – July 2021 **Submitted by:** Helen Jameson – Chief Finance Officer	**Paper No: Attachment 1**

Purpose of report

To provide the Board with an update on the key discussions at the July meeting of the Finance and Investment Committee. The Chair will provide the Trust Board with a verbal update on the 24 September meeting of the Finance and Investment Committee.

Summary of report

Finance Month 3 report (June 2021 data)

The Committee noted the Finance Month 3 report.

- The Trust had generated an in-month surplus of £0.4m. This was achieved through contributions from the Elective Recovery Funding (ERF). From July, the threshold above which ERF is earned was increased from 85% to 95%. In response, the Trust updated its forecast outturn to a £5m deficit for the first half of 2021/22.
- The Committee noted it would receive a paper on I&PC recovery at the September 2021 meeting of FIC.
- The Chief Finance Officer outlined the Integrated Care System's (ICS) decisions making arrangements.
- Further clarity was required on how the 3% pay raise for NHS staff would be funded.

Integrated performance update Month 3 (June data)

It was also noted that the Trust was above forecast trajectory on several targets.

Update on financial framework

The Committee noted the update to the NHS financial framework, most notably that the current nationally set block funding system would be replaced by an aligned payment and incentive (API) approach in 2021/22 (a mix of block variable and rates). This is perceived as a positive development as any move away from pure block gives scope that the Trust would be rewarded for potential outperformance.

Trust insurance update

The Committee noted the premium of £271,574 for 2021/22 and scheduled a thorough review of insurance arrangements ahead of the 2022/23 negotiations.

Cyber Security update

The Committee noted progress had been made across all the cyber security work streams and agreed to receive a broader ICT update rather than just a cyber-update from the 13 October Audit Committee and 22 November Finance and Investment Committee meetings onwards.

Major Projects update

The Committee held an extra session of the Finance and Investment Committee to focus on the Children's Cancer Centre to cover:

- Risk management processes of the project
- Risk management as it relates to cost estimates and potential response plans
- An appraisal of two options for the CCC:
    - Option 1: Charity to own the building and the Trust would lease it from the Charity
    - Option 2: Trust to own the building and keep them on its balance sheet as donated assets.
- The Committee endorsed option 2 due to its benefits and reduced risk to the Trust.

The Committee noted a £1.3m gap between the contractor and GOSH's valuations of the Sight and Sound final commercial settlement works. The Trust received 3rd party advice that it was in a good position to receive its estimate.

The Chair and Non-Executive Directors requested a review of pharmacy estate provision at the Trust.

Feedback from Governors

The Chair invited feedback from the Governors who observed the Committee meeting.

Action required from the meeting

None.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
□ Financial governance	**□ Leadership, capacity and capability** **□ Effective processes, managing risk and performance**

Strategic risk implications

BAF Risk #1: Financial Sustainability

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?

Not Applicable.

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

Not Applicable.

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

Executive Management Team

Attachment 2

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the People and Education Assurance Committee meeting held on 14th September 2021

Update on Delivery of People Strategy

Work had started on updating the branding around the people strategy prior to the pandemic and had been centred on 'change you can believe in'. Further consideration was required a result of the change that had taken place in the organisation during the pandemic. The strategy was moving into year two and the Committee discussed the prioritisation of the implementation of the People Strategy emphasising its importance. Discussion took place around staff engagement and the committee noted that although there was staff awareness on many elements of the strategy, communications with different groups of staff was complex and required different approaches.

Update from GLA

The Trust had achieved the 5th best score for Junior Doctor experience based on a General Medical Council survey of Health Education England sponsored training posts which was positive noting it was a subset of GOSH's overall Junior Doctor cohort. Discussion took place around the income that was being generated by the GLA and it was agreed that this would be the focus of future papers to the Committee. The Trust was the market leader in this area and all courses offered were fully accessible to GOSH staff.

Changes to the Staff Survey

The survey had been amended in response to the NHS People Plan and the Trust had developed a programme to maximise uptake including ensuring that paper based questionnaires were provided to groups of staff who did not routinely sit at a desk such as band 5 and 6 nurses. A new section of questions on health and wellbeing had been introduced covering staff fatigue. Discussion took place as to the Trust's target for achievement and agreed that it was important to ensure that results did not decrease on the previous year and were tracked over a number of years in order to identify the cumulative effect of incremental change.

Update on Board Assurance Framework

Deep Dive: Risk 13: Service Innovation

There were external risks to GOSH around the future configuration of NHS services along with the expansion of other Trusts. A transformation programme had been developed which included a theme on inpatient flow and administration in order to focus on the issues such as communication and transport which featured highly in PALS contacts. Themes would be structured both in terms of innovative thinking for the future and about work on the fundamentals of current practice. Focus was being placed on the specific responsibilities of the various roles within a project team.

OCS On-boarding Update and workforce impact

Work was beginning to review the T&Cs of the staff who had been transferred to GOSH. This was complex as T&Cs were mixed and work was taking place to ensure that changes were not detrimental to any group. Communication was vital and an additional member of bank staff had been engaged to support this. It was confirmed that the KPIs for the cleaning service had not changed and work was taking place to ensure that reporting was robust.

Quarterly workforce report

There had been an increase in voluntary turnover and vacancies and also in sickness rates. Sickness at GOSH had traditionally been low and a deep dive would take place into the data. The primary cause of

sickness was related to anxiety, stress and depression. Statutory and mandatory training was currently at 94%. It was confirmed that turnover was rising in corporate but not clinical areas.

Safe staffing report and nursing workforce update

Work had been taking place between nursing, HR and workforce to gain assurance about the data was being reported and there was now confidence that the correct vacancy rate of 4.88% was being reported and this triangulated with other data. Recruitment activity had been sustained throughout the pandemic and 82 newly qualified nurses would be joining the Trust in September 2021. All international cohorts would have joined to the Trust by the end of October 2021.

Test and Trace contacts had impacted some clinical areas and a number of Datix reports had been made related to staffing. Reviews of each report had shown that although staff were likely to have felt under pressure their shifts were not deemed to be unsafe and no patient harm occurred.

Appointment of trust Well Being Guardian and Diversity & Inclusion Guardian

It was agreed that discussion would take place amongst NEDs as to who would take on the roles.

Update on Staff focused Freedom to Speak Up cases

There had been an increase in the number of staff raising concerns which was positive and positive responses had been received from senior members of staff who were managing the issues. Specific work was taking place with groups of staff who were raising a number of concerns. Discussion took place around staff engagement with speaking up and whether they felt able to do so and the importance of ensuring that staff were assured that concerns would be acted upon was emphasised.

The Committee noted updates from the following committees:

- Summary Report from Quality Safety and Experience Committee
- Summary report from Audit Committee
- Summary Report from Finance and Investment Committee

GLA Pricing Plan

The committee noted the report.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
29th September 2021

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 3**

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

Date	Description	Signed by
21/09/2021	Deed - GOSHFT and Virocell Biologics Ltd: Lease of the Clean Rooms at the Zayed Centre for Research in Rare Disease in Children	MS, JQ
21/09/2021	Deed - GOSH Children's Charity and GOSHFT: Licence to underlet Clean Rooms at the Zayed Centre for Research in Rare Disease in Children	MS, JQ

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

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

Financial implications
N/A

Legal issues
Compliance with Standing Orders and the Constitution

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

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