Oversight of Patient Safety at Great Ormond Street Hospital

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Section 1: Executive Summary

Patient safety is a core purpose of everything we do at GOSH. Prior to the pandemic it was recognised at the Trust that there was a need to improve our approach to patient safety and be ambitious in the delivery of safe, holistic, high-quality care to our patients. This was the genesis of the Safety Strategy and Quality Strategy, both of which were produced with our staff and our patients and described where we want to be as an organisation. From this, a delivery plan was developed, and significant service reorganisation was undertaken to ensure we are organised to succeed. All of this has been done in collaboration with system partners and safety advocacy organisations who have sense checked and challenged throughout our improvement endeavours.

In our external landscape, several failures in healthcare safety and delivery have prompted investigations and recommendations which have and are changing the healthcare safety environment for the better. Most recently, the tragic neonatal deaths at the Countess of Chester Hospital have prompted a public enquiry, which will inevitably result in recommendation for healthcare organisations to incorporate into practice. This will take time, and there is a more pressing need for organisations to ask what systems, process, practice, and culture they have in place, that minimises the possibilities for any practitioner to work outside of expected norms, and where they do, what is in place for early recognition and correction? We must think about his across all healthcare error, and not just the terrible events at the Countess of Chester Hospital.

This paper seeks to provide an overview of the safety systems and processes GOSH has in place to keep our patients, staff, and healthcare environments safe. It is a descriptive paper and does not seek to provide data towards assurance; that is covered in other regular reports to Trust Board and its Assurance Committees. The significant continued improvements in safety at GOSH are managed through the Safety Transformation Board, with regular assurance reports provided to QSEAC; this paper does not detail that work but does acknowledge the areas in which further improvements are needed.

There is a significant number of safety processes to cover, and this paper covers these through descriptions of domains that relate to our people and culture, systems and processes, data, and governance.

Section 2: Introduction

Safety is always dynamic in highly complex, high risk, industries such as healthcare. As such, we must continue to review and assess our systems and processes to ensure they are both sensitive enough to detect error, deviations from the norm; and responsive enough to enable early interrogation and identification of learning.

Health is one of the most heavily scrutinised industries in the UK, and this is entirely appropriate. This scrutiny is applied through our leadership structures, commissioners, regulators, arm's length bodies, local authorities, local and national networks, the media, the general public, patients and their families.

Recently, GOSH has transformed the ways in which safety is viewed, actively aiming for sustained improvements in approach, systems, and culture of safety. Two years into this multi-year programme, it is timely for us to review the systems and processes in place which help to support the delivery of safe, high-quality care to our patients and their families or carers.

This review also provides the opportunity to learn from the failings identified in a number of recent high-profile cases or enquiries at Trusts such as East Kent, Birmingham, North West Ambulance Service and more recently Countess of Chester and Nottingham. With this knowledge, we are able to test our

organisational approaches to quality and patient safety, and importantly, facilitates the identification of any potential gaps, or deficiencies in our approach, for which we will adapt our existing plans for improvement. This is the purpose of this paper.

To achieve this, this paper provides an oversight of the mechanisms in place to listen and learn from safety concerns that have been identified through incidents, staff speaking up or patient feedback (Safety I approach), and those mechanisms which allow us to be proactive in the identification of safety concerns prior to their occurrence (Safety II approach).

The paper focuses on three key areas relating to people and culture; systems and processes; and governance incorporating both internal and external systems and processes in place, whilst providing case studies to demonstrate these operating as anticipated and highlighting potential areas of improvement.

Section 3: Background

In February 2023, the Trust Board made a collective statement that safety is our purpose, and that we will *Listen, Learn and Lead*.

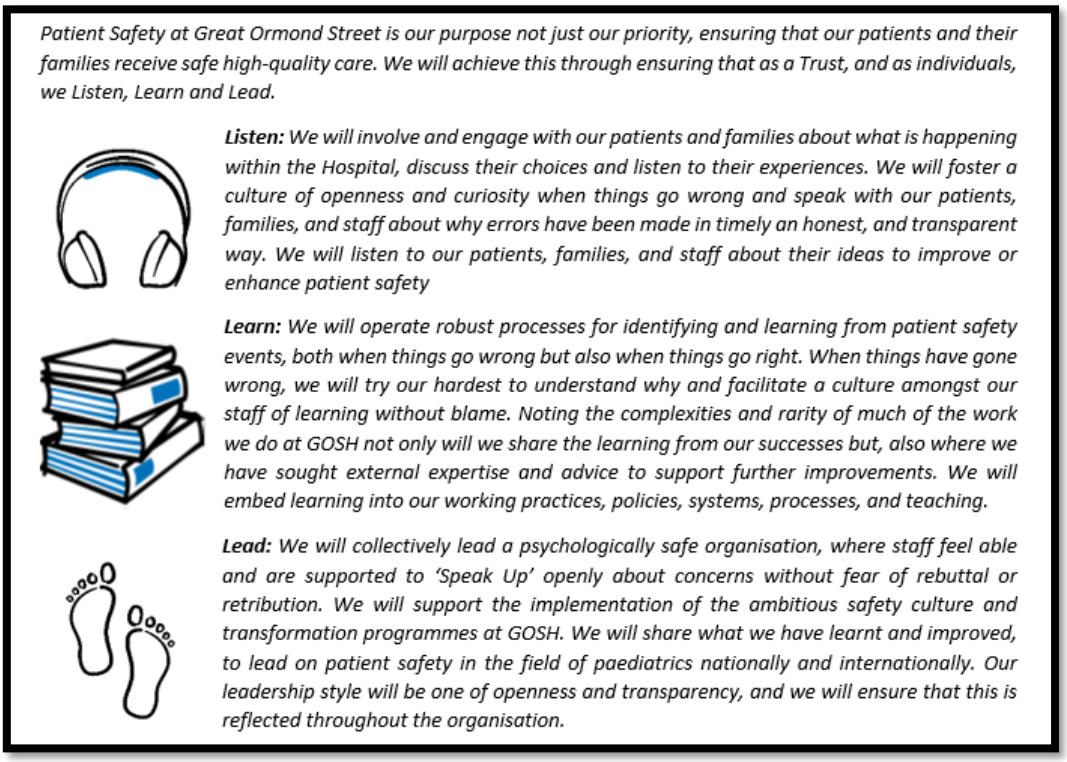


Figure 1: Great Ormond Street Hospital Safety Statement

The Trust has in place a Safety Strategy (2021 - 2026) and a Quality Strategy (2021 - 2026) (both submitted with this paper for information) which describe a multi-year approach to the development of safety and quality at GOSH. Both strategies are ambitious and describe the enhancement of world-class clinical services by improving the safety of care for children and young people with complex health needs.

In order to operationalise these strategies, delivery plans have been developed and incorporated into an overarching Safety Transformation Plan, with delivery overseen by the Safety Transformation Board, which includes colleagues from the healthcare system (North Central London Integrated Care

System (NCL ICS) and Specialised Commissioning) and the patient safety charitable sector, who attend as 'critical friends'. Assurance on progress of the Safety Transformation Plan is provided to the Board Quality Safety Experience Assurance Committee on a six-monthly basis. Oversight and risks in delivery of the projects are escalated to the Executive led Risk, Assurance and Compliance Group (RACG) monthly.

GOSH has in place a number of systems and processes to support an organised approach to managing safety; this is known as the hospital *Safety Management System (SMS)*. These are fully integrated across the Trust and include the activities listed below, which will be explained in more detail through this paper.

- Identification of safety hazards
- Improving the management of known safety risks
- Monitoring safety performance
- Evaluation of safety interventions
- Training and education for safety
- Promotion of safety surveillance and intelligence-gathering

The principles we maintain in order to provide assurance across the Trust of those activities, systems and process in relation to safety, quality and experience are listed below.

- Equal focus needs to be on the narrative and the numbers; there is more than just metrics
- No single figure / comment should be viewed in isolation; everything works as part of a system
- Every person in the organisation has a role to play in delivering safe systems; there must be ownership, accountability and escalation routes in place
- Data is critically important; information needs to be precise, valid, reliable, timely and relevant

Section 4: People and Culture

Our people are at the centre of our work around quality and safety, through the specific leadership roles we have in place, but also through their professional curiosity, their expertise, and their ability to intervene or problem solve. We actively encourage our staff to raise concerns, to constructively challenge when situations appear to not be safe, or when they witness deviations from best practice or from what is normally expected.

The culture at GOSH has been identified as needed to change and this has been described on our BAF. We will be launching our new People Strategy this year which has a focus on the culture of the Trust, safety culture, and one of creating a restorative culture as we further cement our commitment to a 'no blame' culture across our Trust. The safety culture programme will build on the foundations already in place and will utilise best practice from both nationally and internationally peers.

Our Leaders

The Chief Medical Officer (CMO) has Board level responsibility for safety and delivery of high-quality clinical services at the Trust, supported by the Executive Management Team. The Chief Nurse (CNO) has board level responsibility for Patient Experience, Infection Prevention and Control, Health Inequalities, Learning Disabilities and Safeguarding, and has recently been appointed the Executive Lead for Mental Health in recognition of the importance of this for our patients.

As a Unitary Board, the Chair, Non-Executives (NEDs) and the Executive Team all have collective, and individual, accountability for safety and are able to raise concerns directly and apply challenge where needed. Three NEDs sit on our subcommittee responsible for the oversight of safety, quality and

experience, a Senior Independent Director (SID) is also in post providing a sounding board for the Chair, and acts as the intermediary between the Directors and Chair when necessary. A skills assessment is completed with the NEDs on an annual basis, led by the Chair and Company Secretary, to understand whether additional skills or expertise is required in-line with the Trust's strategic objectives and forms the basis for any additional recruitment as required.

Supporting the CMO, the nominated lead for Safety is the Associate Medical Director (AMD) for Safety and Resuscitation who works with the five Deputy Chiefs of Service, each of whom is the nominated Directorate lead for safety and quality. The AMD also has operational responsibility for patient safety across the Trust, and line manages the Head of Patient Safety and the Director of Safety Surveillance. The Safety Surveillance Team is a novel team, not seen in other Trusts, and is responsible for the oversight of all regulatory compliance and safety horizon scanning in a way that allows the Trust to learn from others.

The Trust has additional senior roles supporting patient safety which include leads for Child Death Reviews, Organ Donation and the Human Tissue Authority. In addition are the Medicines Safety Officer, Director of Infection Prevention and Control, and the Named Nurse for Safeguarding. These roles are critical in supporting the delivery of safety systems, but also ensure that we comply with our statutory and legislative obligations in these areas.

Expertise

We recognise that we cannot improve patient safety and quality on our own, and *Patient Safety Learning*, *Civility Saves Lives* and *Action against Medical Accidents* have all supported the Trust over the past year in providing additional challenge and advocacy on behalf of our patients. Patient Safety Learning have been able to provide peer review as part of our Safety Transformation Board and have undertaken an assessment of GOSH against their national standards. We will aim to revisit this in November 2023 to assess our progress against their maturity matrix.

We have representation on the World Health Organisation's (WHO) Global Patient Safety Network, the only paediatric hospital member, which has helped elevate the voice of paediatrics on an international platform. Through this group we are able to share best practice, and learn from, a number of international countries. In light of the focus for World Patient Safety Day this year, our discussions to date have primarily been around elevating the voice of patients.

We are also developing our own knowledge and safety expertise, this year have presented at the International Society for Quality in Healthcare (ISQuA) Conference and at the International Forum on Quality and Safety in Healthcare.

The Clinical Audit Manager at GOSH provides expert support and advice to teams undertaking clinical audit, with approximately 40 projects supported directly in the last three months. Support ranges from a coaching conversation, governance advice and queries, to extensive involvement in planning and delivering projects. Examples in the last month of this support include:

1. Design guidance, and data support to help Walrus ward audit post catheter mobilisation time to improve patient experience and support a timely discharge (and to therefore increase flow).
2. Working with the hyperinsulinism team at GOSH, and with Alder Hey and Manchester Children's Hospitals to evaluate the effectiveness and experience of using a continuous glucose monitor.
3. Supporting a Children's Acute Transfer fellow with complex data analysis and audit structure to review antibiotic choice for respiratory referrals.

4. Data visualisation and guidance for STP Trainee in Genetic Counselling to review and understand best practice to present to Pan Thames Group.
5. Supporting Metabolic CNS to design audit to understand reasons for DNAs in PKU clinics.

Case Study #1 - Patient Safety Partners

We have recently recruited to four Patient Safety Partners (PSPs), two of which are young people who have lived experiences of being a patient at GOSH, and the remaining two being parents of patients at the hospital.

These roles have been newly developed and will see greater involvement of patients in the Trust's safety processes through membership at relevant committees and involvement in investigations and quality support visits across the Trust.

Two PSPs were able to join us for our World Patient Safety Day celebrations on the 15th September, and will be fully onboarded in the coming weeks, whereby we will formally announce their appointments. Due to time commitments, we anticipate that all four will be onboarded by January 2024.

Case Study #2 - Patient Safety Specialists

The Trust has eight Patient Safety Specialists (PSS) who are registered nationally. This role is described in the National Patient Safety Strategy and provides a conduit between NHS England's National Patient Team and the Trust.

The PSS team are all in senior positions across the Trust and have direct access to the Executive Team. This allows them to share learning and knowledge from external safety networks into the Trust; the result has been to integrate GOSH into the broader safety community in a much better way.

Case Study #3 - Young People's Forum

The Young People's Forum (YPF) is an integral part of the governance of the Trust, actively involved in co-production.

Recently the team have supported the development of the role of the Patient Safety Partners, and two young people have been successfully recruited to the role ensuring that the patient voice is heard at every level of the Trust.

The image below depicts the level of their involvement across the Trust over the past twelve months.

Figure 2: Young People's Forum contribution to Trust improvement

Education and Development

The Trust has in a place a Head of Education for Patient Safety (HoEPS), which is funded by the GOSH Learning Academy (GLA). Part of their remit is to support the continuous professional development of both knowledge and skills within the patient safety team and the Deputy Chiefs of Service group, and as part of this the Trust has welcomed subject matter experts such as Dr Mark Sujan, Associate Professor of Patient Safety at Warwick University and Professor Paul Bowie, Chartered Ergonomist and Human Factors specialist, safety scientist and medical educator with NHS Education for Scotland, to present around Human Factors and Patient Safety.

We have expanded the role of the 'Grand Rounds' to have a monthly specific focus on patient safety. These traditionally are used in medical education to help facilitate shared learning and understanding in healthcare settings. The Trust has delivered 13 *Safety Grand Rounds* to date which have focused on areas of learning including the East Kent Investigation Report, evacuation of the Trust's nursery, acting on a latent safety threats, and medicines safety to name a few. These topics have been identified either through external horizon scanning, or as a result of investigations or incidents internally.

Utilising our digital capability, the Trust has a suite of webinars and podcasts which are freely available to all staff which focus on areas pertaining to patient safety, and access to the national Patient Safety Syllabus Levels 1 and 2 within our eLearning platform. Some of these education materials have been developed specifically to increase knowledge and awareness across our workforce, and some are due to requirements for up-skilling in relation to the new patient safety incident response framework (PSIRF). We are working closely with the education arm of the Healthcare Safety Investigation Body (HSIB), who are due to facilitate a session in relation to strategic decision makers in October 2023.

The Trust now has circa 30 people trained in how to facilitate an After Action Review (AAR) and we are in the process of developing an AAR faculty to enable a cohort of staff to be utilised across the Trust as part of our learning responses, and to support the continued development of an open and learning culture.

We have in place an annual development programme for our Board and Executive team to support their continued professional development. These sessions are overseen by the Company Secretary and Chief Executive/Director of Human Resources and Organisational Development.

Case Study #4 - Patient Safety and Human Factors Conference
GOSH hosted its inaugural Patient Safety Conference in March 2023. This was opened with a discussion between Amanda Ellingworth and Melissa Mead, OBE who sadly lost her son to sepsis which was under recognised and insufficiently treated. She spoke about the importance of sepsis recognition, but also about medical error, candour and bravery in recognition of where to learn and improve. This set the tome for the day and a number of external expert speakers contributed, as well as staff who shared their experiences of patient safety and culture. The YPF also spoke about what patient safety means to them in a powerful video clip. The day was attended by over 300 attendees and was very positively received. We will repeat this in March 2024.

Section 5: Systems and Processes

This section explores those systems and processes we have in place to ensure our people have the right level of knowledge, skills and information to monitor safety and support the development of the culture within the Trust.

Integral to this is Speaking Up, and we provide an overview of the processes we have in place to enable our staff, contractors and patients to speak up.

Speaking Up

Within the Trust, there are a number of methods by which staff can speak up if they identify unsafe practice or near misses in relation to safety or quality. We have a dedicated Freedom to Speak Up Guardian (FtSUG) who works independently to the clinical or corporate directorates, and has unrestricted access to the CMO, Chief Executive and Non-Executive Director responsible for Whistleblowing. Following feedback from our staff, the FtSUG has dedicated, confidential, space away from the Trust's Executive Offices either located in the 'Hive' with the other staff support functions, or in a private office in one of the separate buildings around the Hospital site.

The 'iSpeakUp' platform exists to support staff who felt unable to speak up in the moment, or through other channels, and provides an anonymous route in which to do so. These are triaged to identify the most suitable person to address the concerns which is then shared with one of the members of the peer messenger network. This platform was initially launched during the pandemic, but currently is not well utilised across the Trust. We have recently met with the Peer Messenger Network to understand their thoughts and experiences of the process, and will be working with them to review how this can be re-invigorated to provider a greater number of resources and resilience for our FtSUG.

There are more informal networks in place across the Trust, with Virtual Big Brief (VBB) and a #AskTheExec segment whereby questions are submitted in advance, and can be raised anonymously by staff. This allows staff to ask questions directly of the Executive Management Team, and the recording is shared on 'OurGOSH' and through the weekly 'Headlines' email to all staff. This forum receives between 10 and 30 questions each fortnight and has resulted in changes taking place across the Trust. We are committed to ensuring that the anonymity function remains in place for this, but have noticed that the past forums have featured comments and behaviours which are not aligned to our values and have called on staff to be mindful of their comments. We will continue to monitor this

as we recognise the importance of staff being able to raise questions directly to the Executive Team, but also recognise the impact that some of the questions, comments and tone have on our staff.

We know that being in a minority ca be a barrier to people feeling that they have a voice and are able to speak up. At GOSH we have 4 D&I Networks across the Trust: Women's, Reach, Pride and Enabled and these networks have been relaunched over the past twelve months with renewed leadership teams in place. They have supported a number of events over the past months which have focused on that of inclusion, and how to support staff to feel safe in work irrespective of their particular characteristics. We recognise there is much more for us to do here and this will continue to feature in our culture work.

Case Study #5 - Internal Review triggered by concerns raised by staff
Following concerns raised through the speak up process by a member of clinical staff in relation to the individual practice of another member of staff, this was initially addressed through an informal process as part of the Trust's Maintaining Higher Professional Standards (MHPS) process. The informal processes were reviewed, and further concerns were raised regarding their clinical practice. These escalations triggered the threshold for a formal, internal investigation commissioned into the individual's practice which was overseen by the Directorate Senior Leadership Team. As part of this review, the findings corroborated the initial concerns raised and remedial action was taken across the relevant speciality.

Incident Reporting and the Events Review Group (ERG)

Incident reporting is also a key method for staff recording concerns, with approximately 500 incidents raised per month. These incidents range from near misses to those where harm has occurred. The below table provides a snapshot of the number raised since March 2023:

Level of Harm / Date	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Total
Near miss	86	68	65	97	69	84	469
1 Incident occurred but there was no harm	369	282	340	377	378	365	2111
2 Minor	50	40	40	50	41	45	266
3 Moderate	3	5	2	4	4	7	25
4 Major	1	0	1	0	0	3	5
5 Catastrophic / Death	1	0	0	0	0	1	2
Total	510	395	448	528	492	505	2878

We review all incidents on a daily basis for those which have been classed as moderate or above, and initial fact finding takes place to understand any potential factors, or remedial actions which need to be taken immediately.

Established from August 2023, the Events Review Group (ERG) focuses on reviewing all events rated moderate and above, to identify immediate opportunities for learning, and any immediate changes

needed at the Trust to maintain safe clinical environments. For incidents reported in the previous week, this meeting allows for prompt discussion supported informed by initial fact finding, and by the safety team. Incidents are presented by Directorates which drives a sense of ownership of safety by all, and not held by a corporate team.

During the ERG, the incident is presented and consensus is sought on Duty of Candour requirements, whether the incident meets the current Serious Incident Framework definitions, if a local investigation is warranted, if this should take the form of an After Action Review, or Root Cause Analysis. Whilst this meeting is new to the organisation, early feedback has been good, and its effectiveness will be more formally assessed at 6 months.

Policies

Policies provide a consistency of approach across the organisation, are important in maintaining safety standards and form an integral part of a Safety Management System.

The Trust has 177 policies in place, and these relate to all areas of the Trust including those which are of a contractual basis. A Policy Approval Group (PAG) is an established process in place to review all new or amended policies for consistency. The Corporate Affairs team have in place a live policy tracker and notifies individuals up to three months prior to the expiry of their policy to ensure a review is finalised before expiry.

Each of the policies have monitoring tables which detail the processes in place to understand whether they are being followed, with oversight at the Risk, Assurance and Compliance Group (RACG), an Executive Team sub-committee and chaired by the Chief Executive. We recognise that more needs to be done to ensure compliance with all policies in place, and also to review the number of policies the Trust holds.

Case Study #6 - Access Policy for those over 16 and 18 years
As GOSH is a specialist paediatric hospital certain permissions and considerations need to be in place for the treatment of those patients who are aged over 16 and 18 years with differing considerations. In the UK, adulthood is legally defined as being over the age of 18 years and therefore for the admission of this patients we need to consider safeguarding for both them and our patients and also the logistics of the treatment and/or intervention required. Lead by the Deputy Medical Director, the existing Access Policy and the process for implementation has been clarified across the clinical directorates with accountability sitting with the Chiefs of Service. The image below depicts the process now in place for those who are over 18 years old, and this is monitored through the Medical Director's Office and through the Performance Review Meetings.

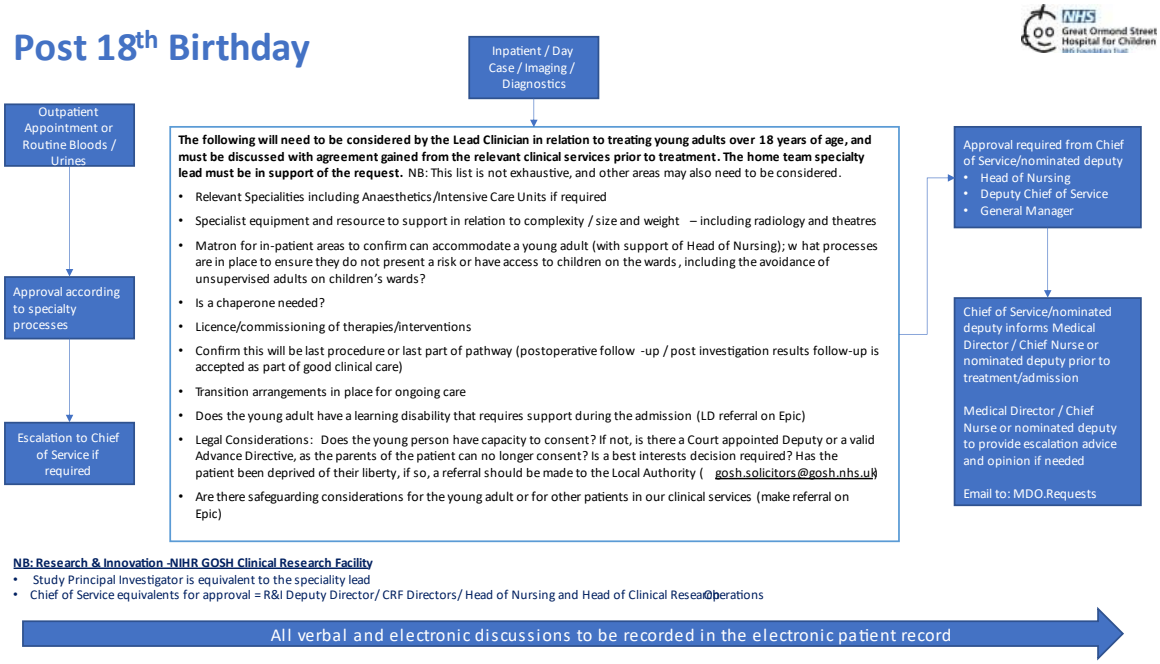


Figure 3: Access to clinical services at GOSH post 18th birthday

Clinical Guidelines

The Trust has 350 clinical guidelines. Created by specialities or departments, they focus on providing guidance to healthcare workers to support clinical decision making in real time and can be in relation to a specific procedure or presentation of symptoms.

Clinical Guidelines are stored on the Trust's intranet, and we have recently invested in a new reference storage system 'MindPalace' which will provide digital support. A Clinical Guidelines Committee is well established and reviews all guidelines in relation to format and structure, and that appropriate peer review and subject matter expertise has endorsed the clinical content – recognising the specialist elements of a number of the GOSH guidelines. No clinical guideline is published on 'OurGOSH' without receiving formal approval from this committee.

This is an area where we recognise there is need for improvement. The management of Clinical Guidelines is a risk on our risk register and is subject to greater scrutiny through the Quality, Safety, Outcomes and Compliance Committee.

Medical Examiners

In April 2023, the Trust became compliant with the national Medical Examiner system. As part of this, senior physicians provide independent scrutiny of the causes of death, outside their usual clinical duties. UCLH provide the Medical Examiner service at GOSH as part of a Service Level Agreement (SLA) which also allows for GOSH to provide expert paediatric scrutiny for those childhood deaths that occur at UCLH. The Medical Examiner scheme will become a statutory requirement from April 2024 following changes to the Health and Care Act 2022 expected in the Autumn of 2023.

All deaths which occur at GOSH are discussed with the UCLH Medical Examiner team which has resulted in a reduction of referrals to the Coroner's office in some cases and allows grieving families the opportunities to speak to someone independently in relation to the care provided.

Section 6: Data and Metrics

GOSH is a very data rich organisation, and we collate and review data from across patient safety, patient experience, research, clinical outcomes. The newly created *Clinical Information Unit* will be able to undertake greater analysis of our data to drive improvement in safety.

Our regulators have a greater reliance on data, and data submission and assessment will feature more prominently as part of the new single assessment framework (SAF) for the Care Quality Commission (CQC).

We recognise that in order to identify trends or deviations early and instigate prompt intervention where required that we need to ensure that we have the right metrics in place, and following discussions at the Trust's Quality, Safety, Outcomes and Compliance Committee (QSOCC) we are undertaking a review of all metrics used in relation to patient safety, quality and experience to ensure that as a Trust we are confident we are focusing on the right metrics and are able to identify hot spots throughout the Trust. This will be important ward to Board.

The data we have is presented to a number of different forums with some listed in the table below, and a greater summary of two specific reports – the weekly safety report and integrated quality performance report detailed below.

Report	Data	Audience
Performance Review Report	Friends and Family Test Scores; % positive response rate; Incidents, Risks; Infection Prevention Control Statistics; WHO Checklist Compliance; Cardiac Arrests outside of Intensive Care; Clinical Letter turnaround times; Discharge Summary turnaround time	Executive Management Team
Quality Report	Clinical Audit, Quality Improvement Projects; Clinical Outcomes; Analytic Requests	Quality, Safety, Outcomes and Compliance Committee (QSOCC)
Thematic Analysis	Review of all reported incidents within the previous quarter	Patient Safety Team, Deputy Chiefs of Service,
Focus on Safety	Review of complaints; red complaints; serious incidents; claims; inquests; incident reporting analysis	Quality, Safety and Experience Assurance Committee (QSEAC) and Trust Board

- **Weekly Safety Report**

This report is collated by the Patient Safety Team with input from the respective Directorate areas and shared with the Executive Management Team (EMT) / Directorate Senior Leadership Teams on a weekly basis to provide a snapshot of patient safety/experience for the previous week.

This report is due to be redesigned in light of the changes to the way in which we report and investigate incidents and will include a narrative of the data along with an overview from the Head of Patient Safety regarding any potential weak signals which have been identified through the week. This new report will be in place by December 2023 and forms part of a larger project looking at safety metrics across the Trust.

Headline data

Metric	5 - 11 September	30 August – 4th September	22- 29 August	15 – 21 August
Number of SIs declared / Number reviewed at ERG	1/3	0/2	1/3	2/4
Number of SI investigations underway	7	5	6	5
Stage 2 DoC (letter within 10 days) overdue	0	0	0	0
Stage 3 DoC (report within 60 days) overdue	0	0	0	0
Red complaints overdue / Total open red complaints	0/0	1/1	0/1	0/1
Infection prevention and control – ongoing outbreaks	0	0	0	0
IP&C events – points of note	0	0	0	0
Legal – points of note	0	0	0	0
Resuscitation – points of note	2	0	1	0
Safety Alerts & Compliance Visits (within next 10 working days)	0	1	2	2
Health and Safety– points of note	0	0	0	0
Safety Intelligence Briefings– reports, themes and plans	1	1	0	1

Figure 4: Headline data included in Weekly Safety Report

- **Integrated Quality Performance Report (IQPR)**

The IQPR is a monthly report, bringing together data from across patient safety, patient experience, safeguarding, infection prevention and control, patient access, and then two of the CQC domains of effective and well led. As you can see from the image below, the report is published with arrows which highlight the trends of the specific data sets and supported by red, amber, green (RAG) ratings where appropriate which are clearly defined as part of the glossary of the report.

The report is discussed at the Executive Management Team meeting and is reported to the Public Trust Board and our Commissioners from NHS England and North Central London Integrated Care Board.

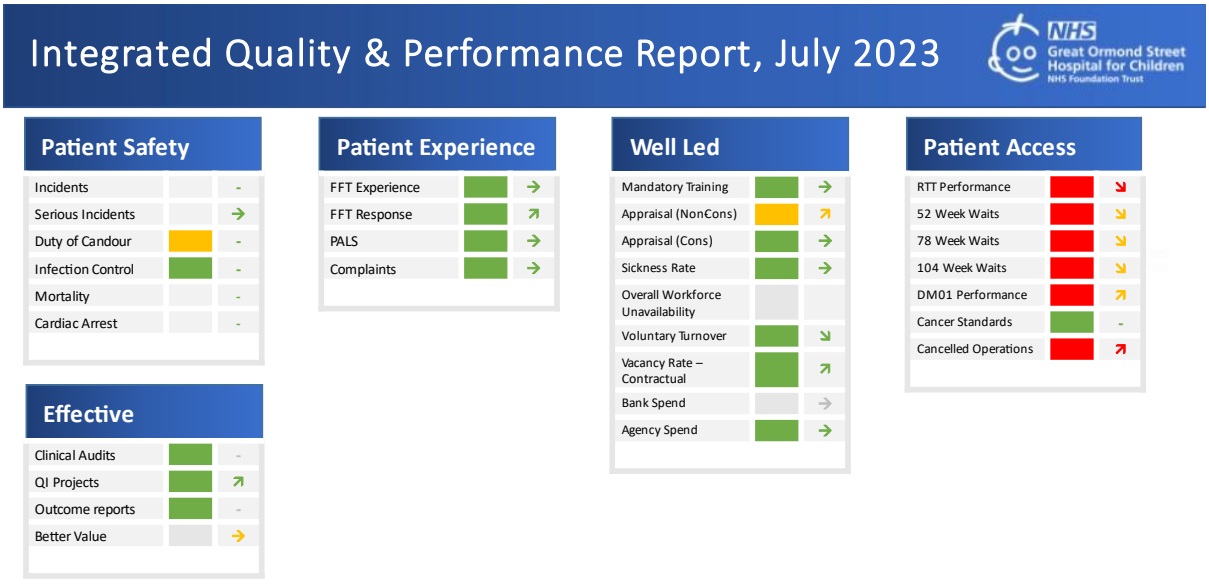


Figure 5: Headline metrics in Integrated Quality Performance Report

Horizon Scanning

Horizon scanning involves the systematic review of publicly available information, allows the Trust to learn from other organisations, identifying any potential threats, risks or emerging issues. Learning from others provides considerable opportunities for improvements in the delivery of safe high quality services for children and young people.

The sources GOSH has accessed to support learning have included regulatory reports, Prevention of Future Death (PFDs) notices issued to other healthcare organisations, and reports from other arm's length bodies including Healthcare Safety Investigation Branch (HSIB) and the Parliamentary Health Service Ombudsman (PHSO) as well as NHS England and other NHS Trusts.

Most recently, understanding the reports in relation to Shrewsbury and Telford, East Kent and Birmingham, and the collation of themes focusing on monitoring safe performance, values and behaviours, teamwork and culture, and organisational behaviours. These themes have been incorporated into the Safety Transformation Plan and have formed part of the business plan for the Medical Director's Office over the upcoming 12 months. Outside of the healthcare sector, the Baroness Casey report into the culture and leadership of the Metropolitan Police Service, have provided insights into organisational elitism, and defensiveness has been a barrier for a healthy organisational culture. GOSH has been criticised in the past for being defensive in its approach, and the Verita review in 2022 highlighted the 'Always Expert' as a weakness for the Trust which stifled the ability to look past hierarchies in relation to safety.

All of this intelligence is gathered, reviewed and embedded into programmes of work and used to help critically review those which are already on-going or to understand whether additional workstreams are required. We published Safety Intelligence Briefings (SIBs) which are issued in response to external publications and incorporate views from both the Safety Surveillance Team but also the clinical teams which the reports relate to and are incorporated into the work of the clinical directorates. In addition to this is the quarterly horizon scanning report which provides greater level of analysis and details of significant reports, and greater scrutiny of what this could mean for us.

Benchmarking

The Trust has access to a number of external data sources which include *Model Hospital* and the Gett*ing it Right First Time* (GIRFT) programme. GIRFT is a national programme, aimed at improving through standardisation, both treatment and care; this is achieved through clinically led reviews of particular specialities to review current practice and identify any potential areas of improvement using a data-driven evidence base. At GOSH, GIRFT reports are overseen by the Safety Surveillance Team, with progress on actions reported on a quarterly basis through to QSOCC.

Clinical Outcomes and submissions to National Datasets such as PICANet are all actively managed through the Trust, with benchmarking undertaken at both a national and international level.

Section 7: Governance

The final section provides an oversight of the governance processes we have in place to ensure that the systems and process are functioning as anticipated. We have focused on three layers of oversight which exist here at GOSH, with each layer having equal importance but creating concentric circles and can be found in Appendix One.

The Trust has in place governance processes and committee structures which support the two-way flow of information from Board to Ward and Ward to Board. These structures are reviewed on an annual basis and all meetings are subject to a meeting effectiveness review in line with their terms of reference.

All formal meetings within the Trust have clear terms of reference in place and appropriate escalation routes clearly document, there is no meeting which doesn't feed into a more strategic committees or groups, with escalations undertaken through exception reporting.

In relation to quality and safety, the governance and information flows have been redesigned over the past twelve months to ensure the correct structures are in place, and there is a clear escalation route between those on the front line and the Executive Team / Trust Board and the relevant sub committees. This is seen through the new quality governance management framework, and through the Chief Medical Officer and Chief Nurse reports which are presented to the Quality, Safety and Experience Assurance Committee (QSEAC) where a number of appendices from the operational / management committees are triangulated to provide a rounded 'picture' of safety, quality and experience.

As demonstrated below this piece of work ensures there is a clear route between a hospital ward and the Trust's governance structures.

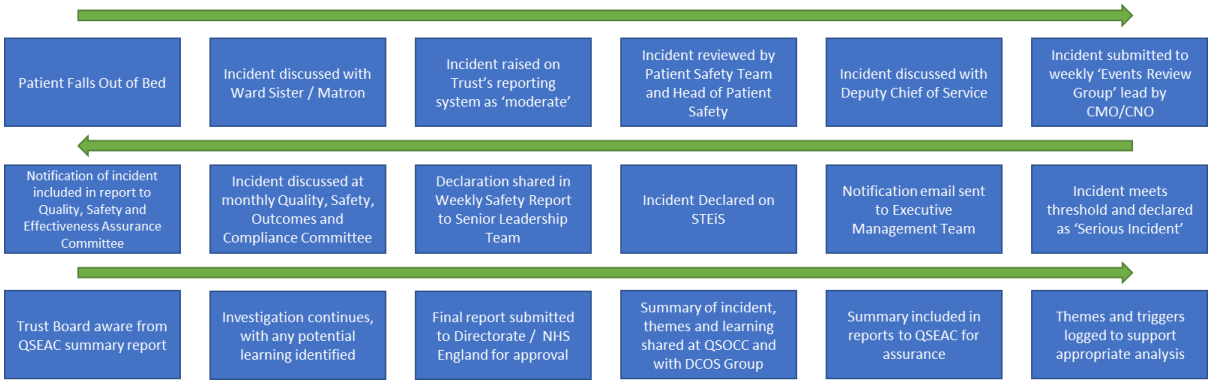


Figure 6: Flow of information from incident to Trust Board

Directorate, *Trust-wide* and *Executive*, *Trust Board* and *External* levels of safety oversight are set out as Appendix 1.

The Trust's governance and the new Quality Governance Management structures and their reporting lines is attached as Appendix 2. Within this structure are those meetings which have oversight and accountability of the use of medicines, medical devices and novel treatments which include the Drugs and Therapeutic Committee (DTC) and the Medical Equipment and Supplies Group (MESG). Both committees have delegated authority to make decisions in line with their terms of reference on behalf of the CMO; membership consists of a multidisciplinary team of professions, with support provided from senior members of the Pharmacy Team including the Chief Pharmacist, Medicines Safety Officer and Lead Pharmacist.

Safety Transformation Board

The Safety Transformation Plan ('the plan') has been designed to bring together *Safety* and *Quality* actions under one umbrella programme and incorporates the requirements set out in the National Patient Safety Strategy by NHS England. In addition to this, the plan incorporates the recommendations from independent internal and external reviews including:

1. Review of the effectiveness of the Trust's safety procedures ('the Verita Report'),
2. Review into Maternity Services at Shrewsbury and Telford Hospital NHS Trust ('the Ockendon Report')
3. Investigation into East Kent Maternity Services ('the East Kent Report').

SAFETY TRANSFORMATION PLAN

Theme	Safety Culture	Data and Insight	Patient Safety Frameworks	Professionalism	Patient Safe Services	Shared Learning	Leadership and Governance
Individual Projects	Psychological Safety Programme	Development of Safety Metrics	Implementation of PSIRF	Developing the Patient Safety Team	Medical, AHP and ACP Job Planning	Translating learning to a change in practice	Embed Patient Safety Accountability
	Freedom to Speak Up	CQC Readiness Programme	Deliver the NHS Patient Safety Priorities	Development of the Clinical Guidelines Process	Modernising Clinical Workforce	Collaboration with Patient Safety Learning	Developing the role of the Deputy Chiefs of Service
	Setting the tone for Patient Safety	Clinical Harm / Internal and External Reviews	Implementation of the Patient Safety Syllabus	Develop Educational Resources	Transforming Care	Horizon Scanning	Clinical Leadership
	MDT Standardisation	Quality Management System	Implementation of Patient Safety Partners	How the Medical Workforce E.A.Ts	Developing Second Opinions		Quality Governance Management Review
	Implementation of Quality Improvement Methodologies	Medical Workforce Planning	Migrate to LFPSE	Development with PGME	Quality Assurance and doing the right thing		Governance Arrangements within Medicines Management
	Incident Investigation and Report Process	Implement a new Risk and Incident Management System		Building capacity and capability within Quality Improvement	Quality Improvement and doing things better		Improve Communications from the MDO
	Medical Wellbeing				Patient Safety Maturity Matrix		Getting the Basics Right with Regulatory requirements

Figure 7: Safety Transformation Plan Workstreams

This singular action plan has been developed to ensure that the Trust has oversight of all relevant actions which are pertinent to patient safety. The plan incorporates 155 separate, high-level actions which span over three years and is based on the standards developed by Patient Safety Learning and covers the seven areas identified in the diagram to the left.

The reports listed above have a number of common themes, some of which have been the subject to further independent and high-profile investigations since the Francis Report was published in 2013. These include lack of teamwork, ineffective leadership, lack of oversight and staff fearful of speaking up in the NHS.

The Safety Transformation Board is chaired by the Chief Medical Officer, or the Chief Nurse and has broad representation from across the Trust, as well as colleagues from NHS England, North Central London Integrated Care Board and *Patient Safety Learning* who act as 'critical friends' providing constructive challenge and ensure that the patient and system voice is integral to the programme.

At the end of March 2022, 51% have either been completed or are on track with only 15% are being recorded as being delayed – 2% of which are 'Critically Delayed' and require intervention to rectify. Some of the actions that have been completed include:

- Delivered Incident Investigation training to the Patient Safety Team and Deputy Chiefs of Service, improved the accuracy and terminology used in investigation reports and implemented a standardised report design and sign off process

- Designed and published a new eLearning package in relation to Duty of Candour, and partnered with AvMA (Action Against Medical Accidents) to deliver bespoke training around the application of Duty of Candour with Empathy
- Issued new guidance on Medical Consultant Job Planning and procured a new electronic system to support
- Evaluated and redesigned the Quality Governance Management Framework for the Trust and implemented new meeting structures to improve the flow of information from Ward to Board and to ensure the correct level of accountability and oversight is in place.

The 2% 'Critically Delayed' is in relation to two specific actions regarding Clinical Guidelines and will be overseen by the new Associate Medical Director for Clinical Governance with intensive support to ensure the action is recovered at pace.

Clinical Audit

At GOSH we undertake audits to understand compliance with our safety systems and we have a very active audit programme in place.

Our approach is to ensure that clinical audit provides assurance of the integration of learning from sentinel events, safety notices and learning identified from horizon scanning (safety 1 and 2).It is pleasing to see the approach at GOSH recognised in the NCL ICB response to the GOSH 2023/23 Quality Account

"GOSH have illustrated how they utilise clinical audit to monitor the effectiveness of actions identified through investigations into Serious Incidents (SIs). An audit of medical documentation across fourteen specialities conducted during December 2022 and January 2023 involving 151 sets of case notes indicated that there was a clear management plans for these patients, more work was needed to ensure that management plans were communicated to parents.

The team who conducted the audit have developed an action plan in response to the findings and presented to and approved by the Medical Advisory Group in April 2023, and the Quality Safety Outcomes and Compliance Committee (QSOCC)."

Current priority plan of clinical audit:

Audit	The value of this audit	Status of audit
Mental Capacity Act audit	To evaluate progress with documentation and practice to ensure delivery of effective practice to reduce delays and maintain experience for young people	Audit underway and lead to review progress in September 2023 with MCA documentation
Quality of medical documentation re-audit	To build on work completed and respond to findings and changes planned this year	Audit completed- and intervention planned with Medical Advisory Group to implement guidance for junior doctors to set expectations and improve accessibility of information across specialties
MDT Terms of Reference -re -audit	Evaluate further progress with effective MDT documentation and practice following learning from a prevention of future deaths report in 2019	Currently further implementing TOR and re-auditing to evaluate progress. To be reported to October 2023 QSOCC

Flowmeter CAS alert re-audit-	Evaluate and support progress to reduce risk of inadvertent harm associated with non-delivery of a patient safety alert.	Audit completed in July 2023 and improvement in process and reduced risk associated with the alert
Looked after children NICE guidance	Act on NICE guidance to understand the frequency and delivering of key processes for looked after children at GOSH, and to consider health inequalities in this population.	Phase 1 of the audit completed- and to review next stage of the audit in October 2023 with the Safeguarding leads for this work
Palliative Care Referrals-	To review whether patients who died at Great Ormond Street and required palliative care referral were referred	Phase 1 of the audit completed, and next steps to be clarified with Palliative Care team
Complaint - Documentation of surgical /IR CVL (	Review implementation of learning from a complaint to reduce risk of miscommunication at discharge around the type of CVL inserted at GOSH	Audit timeframes to be agreed with Directorate leads, pending implementation of the action from the complaint
Medicine Safety Plan	Support the Medicine Safety Committee with a plan of audits to maintain and understand practice around • CD documentation • Storage of medicine	Controlled Drug audits concluded in July 2023 and outlined below. Planned additional audits in theatres in September 2023. Planned annual storage audit for October 2023
External learning review -child death review process	To review the recommendations made following an external learning review undertaken at GOSH in 2022/2023 which apply to the child death review process at GOSH	Feedback has been received from CDRM attendees – and further audit to evaluate the views of all CDRM attendees will commence in September 2023 and be embedded into the CDRM process
Clinical Harm Review Process	To ensure that reviews are taking place to ensure patients are not coming to harm as a result of delays in their pathways.	To be audited three months following implementation and finalisation of the process at GOSH (planned for September 2023)

Case Study #7 - Recently Concluded Priority Audit - Controlled Drugs; July 2023

The results continue to show progress – the average performance with all the criteria measured in the audit is 91%. This compares with 91% in the last audit in September 2022. Baseline performance following recommencement of standard CD audits in May 2019 was 80%.

A report with themes was reviewed at the July 2023 Medicine Safety Committee (MSC). Ward level improvement actions had been shared with Matrons and Heads of Nursing for oversight – and are being monitored by the Clinical Audit Manager and the MSC.

Support for Speciality and team led audit

In addition to our priority clinical audit plan, we support clinical teams to engage in clinical audit to review the quality of care provided and to identify where improvements could be made. 126 clinical audits led by clinical staff were completed at GOSH during 2022/23. We aim to have over 100

completed specialty led clinical audits per year. We were able to meet this aim for 2022/23, which is reflects an ability to engage in clinical audit and quality.

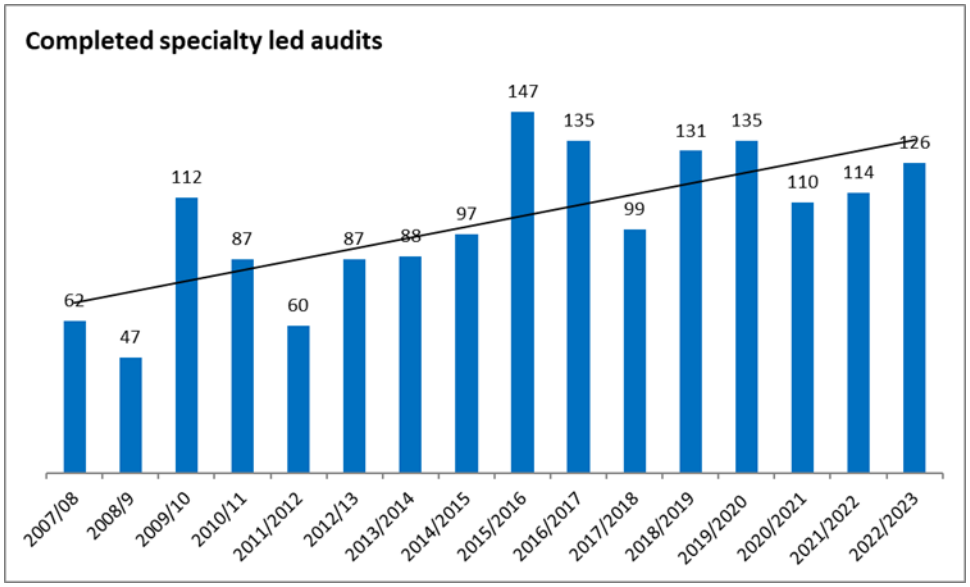


Figure 9: Yearly completion of clinical audits at GOSH

Audit in focus

Case Study #8 - Ambulation and discharge time for paediatric patients undergoing cardiac catheterisation as a day case – Walrus Ward
The team have worked to ambulate patients at two hours and discharge patients at four hours following post sheath removal. This benefits patients by allows them to be fit for discharge earlier and reduces the need for overnight beds. The team have audited the implementation of the change which has shown both the effectiveness and safety of ambulating patients at two hours. This work was presented at the 2023 World Congress of Cardiology in Washington *"This work has highlighted our achievement, and presenting here has shared our success with some American children's hospital who are interested in learning from our work here at GOSH" Vicky Gander, Ward Manager Walrus Ward*

Internal or Invited Reviews

Service level reviews are routinely commissioned across the Trust if safety or quality concerns have been identified. If impartial expert peer review is possible in house, a review is carried out internally. However, if there is any concern regarding this then the Trust has the ability to commission an invited review with the respective Royal College, or through coordination of an expert panel.

In relation to safety concerns, the normal process is for these to be commissioned by the Chief Medical Officer, terms of reference agreed with the reviewing panel, and the commission managed operationally by the Directorate leadership team. The findings and any resulting action plan are then reported through the existing committee structures. For reviews in relation to patient experience, safeguarding or IPC these are commissioned by the Chief Nurse.

The Trust has recently commissioned a number of external reviews through Royal Colleges, subject matter experts, or consultancy firms with expertise in specific fields. These include reviews into:

- Gastroenterology

- Lower Limb Orthopaedics
- Ethics
- Safeguarding

The review team are clearly briefed prior to the review taking place that all safety and quality concerns must be raised in real time to the CMO or commissioning Chief of Service so that the Trust is able to take immediate action. From these reviews, areas of improvement that have been identified are included within specific action plans, managed in Directorate areas and overseen through the Trust's existing governance structures.

Risk Management

The Trust has a comprehensive Board Assurance Framework (BAF) which currently has 20 risks included and has been rated as 'fully assured' by the internal auditors. This is reviewed on a monthly basis by the Executive Management Team through RACG and is scrutinised by the relevant assurance committees with oversight from the Audit Committee.

The Audit Committee has delegated authority from the Trust Board in relation to the addition, removal or downgrading of any of the items documented on the BAF. A summary of the BAF is presented to the Trust Board meeting at every public meeting, and each agenda item needs to clearly state how it aligns to the strategic risks of the Trust.

Risk registers are in place across all clinical specialities and corporate functions, and monthly Risk and Assurance Groups (RAGs) take place to oversee these at a local level. Risks which are rated as 15 and above, or have an impact on multiple specialities/areas are considered at the Operational Board monthly, and are reviewed in line with Trust Policy.

The Safety Surveillance Team have a role in overseeing the application of the Risk Management Policy, and adherence to the respective time frames listed within. Particular scrutiny is paid to those risks which are long standing, have had no change in scoring, and those which are rated as high impact or consequence with very low probability/likelihood to ensure that appropriate mitigations are in place.

Case Study #9 – Mental Health BAF Risk
In response to a gap analysis internally, and in light of the horizon scanning undertaken around Mental Health in Children and Young People, the Executive Team development a strategic risk in relation to Mental Health which details the following: A lack of strategic focus on the delivery of mental health services at GOSH contributes to inequitable access to safe, effective care for children and young people with psychological needs. As a result of this, a review has been undertaken of the mental health services provided by the Trust, and a request to the Care Quality Commission to add an additional regulated activity to our existing registration in relation to the ability to detain patients under the Mental Health Act. This change will enable us to provide the same level of care to our complex patients with both physical and psychological needs.

The Mortality Review Process at GOSH

Mortality reviews take place through three processes at GOSH which include a local M&M, a Mortality Review Group (MRG), and the Child Death Review Meetings (CDRM).

- **Mortality Review Group**

Established in 2012 to review inpatient deaths, and is linked in 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 level of review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as making referrals to other safety investigation processes at the earliest opportunity.

- **Child Death Review Meetings**

These are in place at GOSH following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019 and should be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews. The responsibility of coordinating these meetings is held by the organisation in which the child died. For GOSH this means coordinating with teams across the UK, given the geographical spread of our patients.

CDRMs a multi-professional meeting, including those from external providers, 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. The value of these meetings is enhanced by contributions from colleagues who have contributed to a child's care along all parts of the health and social care pathway.

We monitor our hospital mortality rate and check for any trends and changes in real time, which is reported in our Integrated Quality and Performance Report (IQPR). Importantly we also look at risk adjusted data, which considers how unwell the patient was on admission and the likelihood of death as a potential outcome. A proactive and close attention to our ICU mortality has allowed us to identify and quickly respond to any changes in our mortality, recent examples are described below.

Case Study #10 – Increase in mortality rate in May 2020
An increase in the mortality rate in May 2020 prompted a proactive internal review of deaths which was concluded in July 2020 by the Mortality Review Lead and Associate Medical Director for Safety to identify trends and understand the reasons for this. The review concluded: • Two deaths following admission to GOSH from another Trust because of COVID 19 who would otherwise have died in a local hospital, and where death occurred at GOSH due to natural disease progression. • One death where there was a COVID impact in terms of delayed presentation in the community. • The reviews did not indicate care or service delivery problems provided at GOSH which account for increased deaths. There were no triggers noted in risk adjusted data for this period.

Case Study #11 – Paediatric Intensive Care Audit Network (PICANet) Quarterly RSPRT plot - Cause for concern requiring further investigation (2019)
Three risk-adjusted resetting probability ratio test (RSPRT) reset points occurred that suggested a higher PICU/NICU mortality rate than expected between the period 01/07/2018 to 30/06/2019. A review was concluded in November 2019, which identified the deaths were associated with significant comorbidities which were not then reflected in the PIM3 scoring methodology used to risk adjust and assess ICU mortality outcomes.

As an outcome the GOSH report led to changes in the national risk adjustment scoring system to account for BMT patients. Following the GOSH review, the Clinical Audit Manager and the Medical Lead for Child Death Reviews were asked by PICANet to make a significant contribution to national guidance with PICANet on how Trusts should respond to trends in RSPRT data which was published in October 2022.

KPMG Internal Audit

The Trust has in place an annual Internal Audit programme, conducted by the Trust's Internal Auditors, and overseen through RACG and the Audit Committee on behalf of the Trust Board. The Internal Audit plan is created in partnership with KPMG and the Executive Management Team through understanding the strategy and objectives of the Trust, the risk profile or through consideration of the other forms of management and independent assurance in place.

The schedules as part of the internal audit plan are listed below:

2022-23 Schedule	2023-24 Schedule
• Managing Partnerships • Data Quality – Patient Safety and Clinical Prioritisation • Above and Beyond – People Planet • Risk – Patient Safety Alerts • Diagnostics • Core Financial Systems • Governance - Directorates	• Core Financial Controls • Complaints Management • Governance – Serious Incidents • Risk Management – Management of Ventilation and Infection Control • Business Continuity and Disaster Recovery • DSP Toolkit • Data Quality – Workforce Data

Case Study #12 – Clinical Harm Reviews

Following an internal audit review, and a rating of 'Partially Assured' the Trust has redesigned the clinical harm processes it has in place for the review of those on our waiting list.

This process has been designed utilising best practice and existing guidance from North Central London and other NHS Providers. Reporting will take place at the monthly Performance Review Meetings and reported to the Trust Board through the IQPR for oversight and an audit of the process is scheduled to take place in January 2024.

Section 8: Conclusion

In complex environments such as healthcare, in ensuring that we maintain safe environments and care, the Trust must ensure that it remains open, agile and responsive. The external landscape over the next 12 to 18 months will likely see changes in scrutiny and oversight, partly driven by interrogation of sentinel events in healthcare environments.

The Care Quality Commission were due to launch their new single assessment framework in July of this year, which has now been deferred to November 2023 with the potential roll our starting in the South of England, prior to moving to London and East of England. The Healthcare Safety Investigation Branch (HSIB) becomes the Health Services Safety Investigation Body (HSSIB), an Arm's Length Body of the Department of Health and Care with statutory rights from 1st October and ICBs/Specialised Commissioning is still being worked through in relation to oversight and accountability for safety and quality.

There is significant transformation internally in GOSH over the next 12 months, with the introduction of the new Patient Safety Incident Response Framework (PSIRF). This overhauls the management of incidents and serious incidents (go live January 2024), Learning from Patient Safety Events (LfPSE) the new reporting framework to replace the National Reporting and Learning System (go live in Autumn 2023) and there are plans to be one of the first NHS Trusts to roll out a Quality Management System to support a culture of continuous improvement in the next 6-12 months. This will continue to be monitored through QSEAC.

We are strengthening our leadership in relation to compliance and surveillance with a new Medical Lead role and a Faculty of After Action Review facilitators has been created to support a culture of systems based learning and to move away from that of identifying a singular root cause for incidents. Further to this, we will be the embedding of human factors tools and techniques, allowing the Trust to better understand work as imagined (WAI) versus work as done (WAD).

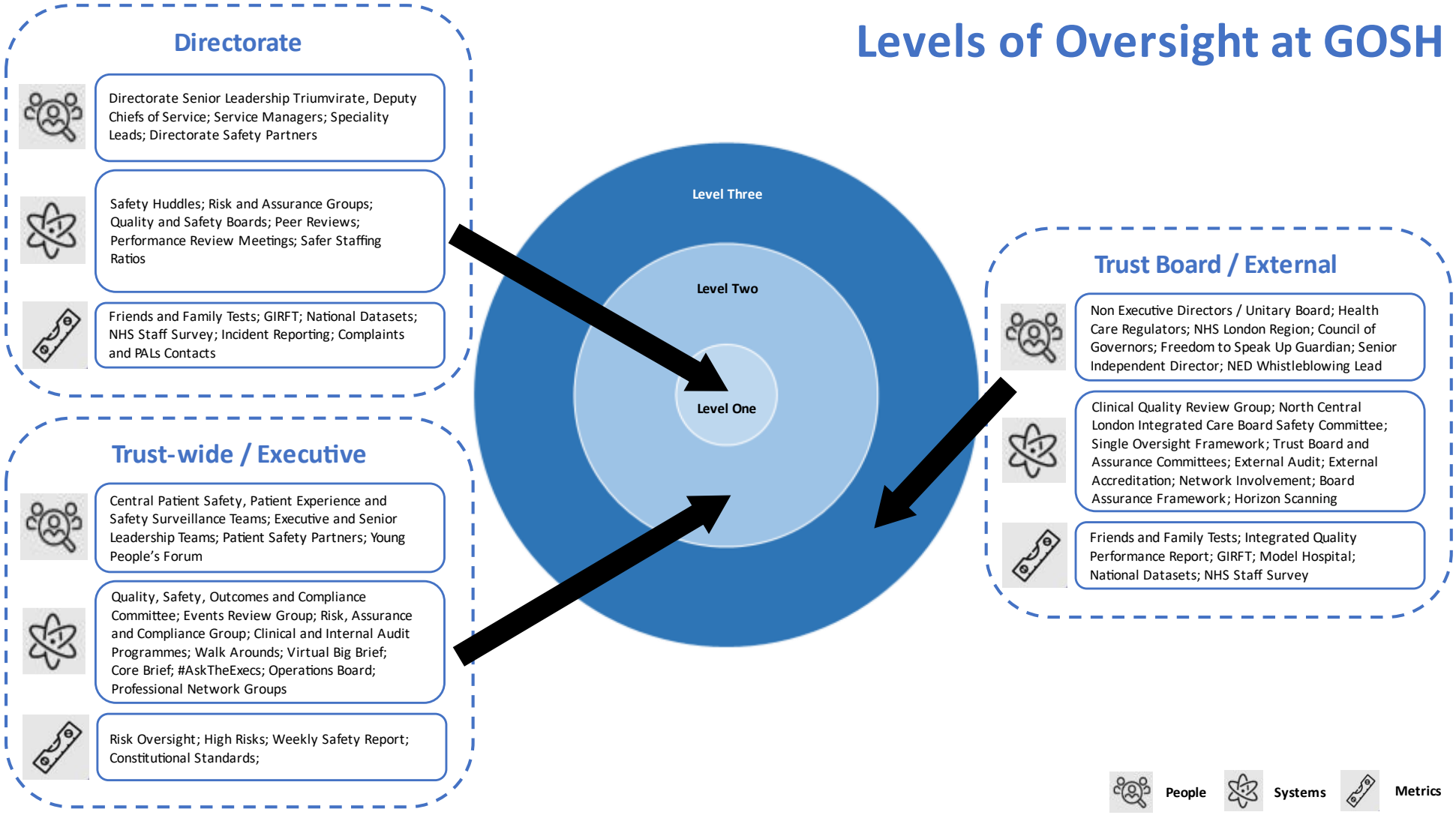
Safety metric reporting is currently under review to ensure that the narrative and context is provided, so that we are confident we are looking at the right metrics in the right environment to give a true picture of safety on site. Plans are also under way to develop a Paediatric Patient Safety Academic Unit to help improve understanding of patient safety at both GOSH and within the wider Health Service.

One of the areas the Trust is keen to develop, is that of understanding the 'weak signals' and to support a culture of professional curiosity whereby staff are empowered to raise concerns when something does not feel safe, where interactions and behaviours deviate from the expected norm. This 'soft intelligence' has been demonstrated to be incredibly valuable in gathering organisational safety information and must be supported.

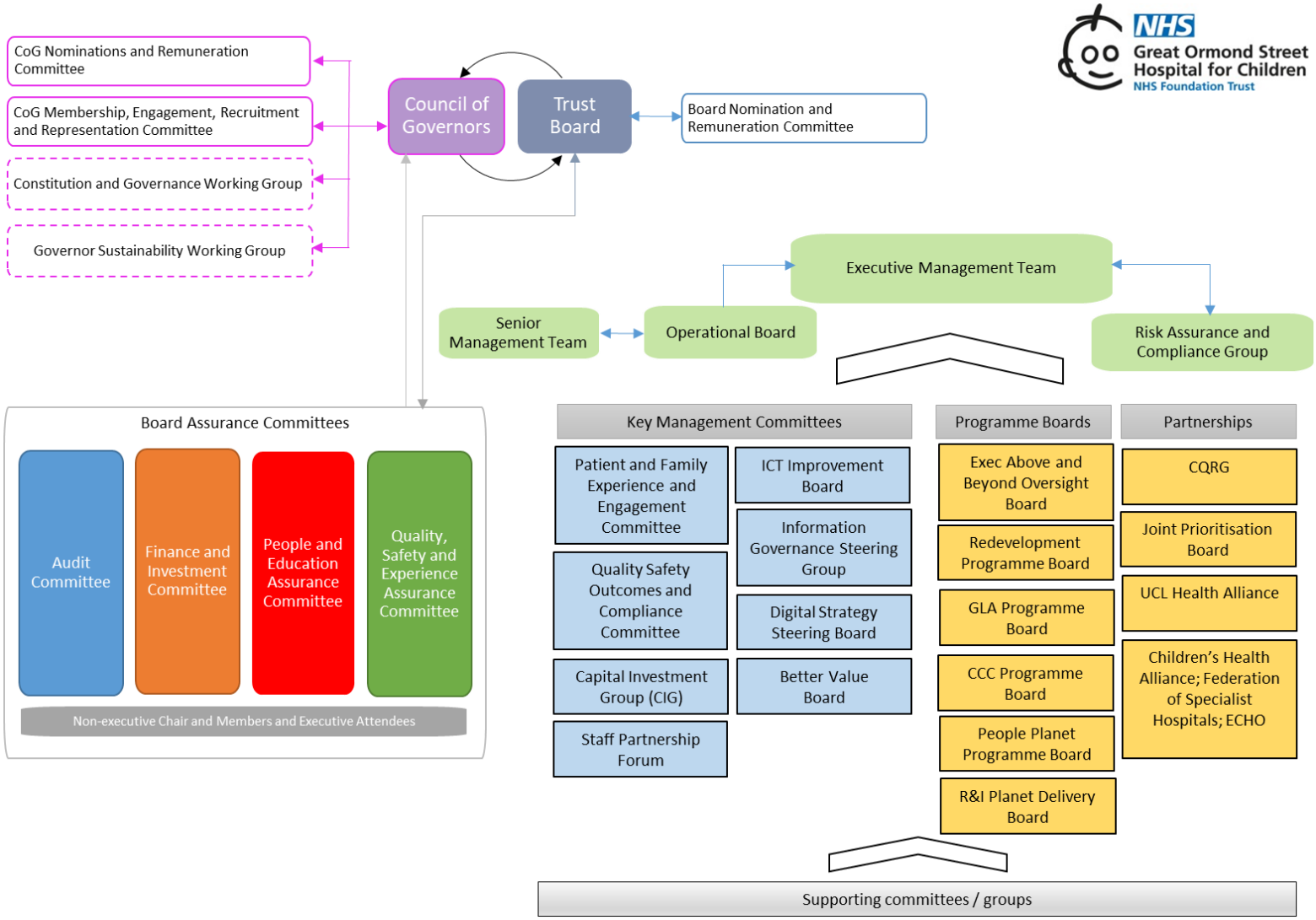
Although it is extremely rare, it is important to note, that despite having robust and failsafe processes and systems in place, as a Trust we need to be cognisant to the fact that the unthinkable could still happen.

As demonstrated through this paper, we have in place the systems and processes to monitor and to prompt action when needed. However, we need to continue to be vigilant and interrogate our data and the intelligence gathered, open to the need for change where appropriate, we allow and support staff to act on their concerns, that we listen, and most importantly we continue to learn.

Appendix One: Trust Oversight Structures



Appendix Two: Trust Governance Structure



Appendix Three: Quality Governance Management Framework