Great Ormond Street Hospital for Children NHS Foundation Trust

Quality Report

Great Ormond Street
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Outstanding
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust operates from a single site in central London. It is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. Children are also treated from overseas in their International and Private Patients' (IPP) wing. There are more than 50 different clinical specialties at Great Ormond Street Hospital (GOSH). Together with the UCL Institute of Child Health, it forms the UK's only academic biomedical research centre specialising in paediatrics. Its status as a Specialist Children's Hospital means that most of the children treated are referred from other hospitals or overseas.

We carried out this inspection as part of our comprehensive acute hospital inspection programme adapted for dedicated children's hospitals. The trust was rated as low risk in the CQC intelligent monitoring system. The inspection took place between 14 and 17 April and unannounced inspections took place between 1 and 3 May 2015. We also inspected the Children and Adolescent Mental Health Services (CAMHS) provided by this trust as part of our inspection.

Overall this trust was rated as Good. We rated it outstanding for being caring and being effective. We rated it good in providing safe care. We rated it as requires improvement in being responsive to patients' needs and being well-led.

We rated medical care and end of life care as outstanding. We rated critical care, child and adolescent mental health services and transitional services as good.We rated surgery and outpatients and diagnostic imaging as requires improvement.

Since our inspection, the trust alerted us to long-standing problems with the reliability of their patient information systems, which affected the validity of the trust's reporting of referral to treatment (RTT) times. This had the potential to delay admission of patients waiting for non-emergency treatment. We have reflected these problems in our assessment of services in this report.

Our key findings were as follows:

- All staff working at the hospital were extremely dedicated, caring and proud to work for the hospital.
- We saw high levels of care, professionalism and innovative treatment of patients who had been referred for care by other hospitals.
- The culture was very open and transparent. Parents and children were kept fully involved in their treatment. There was an evident commitment to continually improve the quality of care provided. Children and young people were involved in decision making as far as possible.
- We saw good examples of duty of candour in practice.Staff were very open when things had gone wrong, expressed full apology and offered full support to parents, children and carers.
- The new Chief Executive was very visible, had shared his vision for the trust and had gained the early respect of staff members.
- The executive team were well known to members of staff and patients and did regular walkabouts on the wards.
- There was outstanding care demonstrated in all departments where there was a tangible level of staff working together in pursuit of excellence of care. All supported the mission statement of the trust which was " the child first and always".
- When decisions were made to stop treatment, this was done thoroughly and with good governance via the ethics committee and always with maximum consultation with parents or carers.
- The reporting of incidents was fully embraced by all members of staff we spoke with. Incidents were thoroughly investigated and learning obtained and shared with all staff across the hospital.
- End of life care was embedded in all clinical areas of the hospital and not seen as the sole responsibility of the palliative care team.
- Where the trust had completed a refurbishment or rebuild, the facilities were modern, extremely child friendly and conducive to excellent patient care and dignity. There remained some wards, not yet refurbished, rebuilt or relocated where the environment was less good. The hospital recognised this and was in the middle of a total refurbishment/ rebuild project.

Summary of findings

We saw several areas of outstanding practice including:

- Clinicians from other hospital services delivered specialist training on physical health issues for CAMHS staff. In return CAMHS staff provided training and expertise to other departments across the hospital, for example on learning disabilities and autism.
- Because the hospital is treating many patients that could be treated at very few hospitals in the UK it is developing ground breaking clinical guidance which it is sharing with clinical colleagues in the wider medical community.
- The hospital has developed a pocket-sized guide to help staff working with children with learning disabilities.
- The Feeding and Eating Disorders Service (FEDS) received 100 % approval in the latest Friends and Family test with 93% saying they were extremely likely and 7% saying they were likely to recommend the service.
- The Psychological Medicine team provided an outreach service across the country where necessary.
- Staff in CAMHS were actively involved in research in their specialist areas including Autism and Feeding and Eating disorders.
- CAMHS introduced a screening tool for mental health problems and the psychological medicine team conducted a study to improve the understanding of the patient experience, diagnosis, treatment and outcomes regarding non-epileptic seizures in children.
- The FEDS and MCU (Mildred Creek Unit) teams developed a policy around re-feeding syndrome to increase understanding of the issue.
- In critical care there were excellent mortality and morbidity meetings, and robust safety monitoring of all patients.
- The Intensive Care Outreach Network (ICON), and Clinical Site Practitioners (CSP) team are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours per day, 7 days per week.
- In pharmacy services the chief executive receives monthly reports of prescribing errors; a daily check ensures all electronic prescriptions are screened before the end of each weekday (Monday to Friday) and patients are informed by text message when prescriptions are ready.
- In transitional care young people feel empowered by the Young Persons' Forum.
- Joint transitional care clinics are held with ongoing hospital providers.
- In outpatients weekly education sessions were protected to ensure staff maintained currency in mandatory areas and had the opportunity to take part in further specialist training from a clinical educator

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly the trust must:

- Resume WHO checklist audits in surgery
- Ensure that there are clear arrangements for reporting transitional care service performance to the board.
- Ensure that its referral to treatment (RTT) data and processes are robust and ensure that staff comply with the trust's patient access policy in all cases.
- Ensure greater uptake of mandatory training relevant to each division to reach the trust's own target of 95% of staff completing their mandatory training.
- Ensure that, particularly in critical care, communication between senior nurses and senior medical staff is enhanced and that the contribution of nursing is fully reflected in the hospital's vision.

In addition the trust should:

- Ensure early improvements in the environments of wards which have not been refurbished, rebuilt or relocated.
- Standardise radiation protection training for junior radiologists to overcome inconsistencies caused by short rotations.
- Develop a dedicated advocacy service for its Child and Adolescent Mental Health service (CAMHS).

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust operates from a single site in central London. It is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services. nephrology and renal transplants. Children are also treated from overseas in their International and Private Patients' (IPP) wing. There are more than 50 different clinical specialties at Great Ormond Street Hospital (GOSH). Together with the UCL Institute of Child Health, it forms the UK's only academic biomedical research centre specialising in paediatrics. Its status as a Specialist Children's Hospital means that most of the children treated are referred from other hospitals or overseas.

The trust is located in the London Borough of Camden, which is ranked 74th of 326 local authorities in the English Indices of Deprivation 2010 (where 1st is most deprived and 326th least deprived). The majority of the trust's services are commissioned by specialist commissioners at NHS England. The trust also has services commissioned by Clinical Commissioning Groups (CCGs) located in Barnet, Newham, Enfield, Haringey and Ealing in addition to referrals from further afield and abroad.

Great Ormond Street Hospital has been a foundation trust since 1 March 2012. The trust employs around 3975 staff, including 568 medical staff and 1445 nursing staff.

The trust is currently half way through a five phase redevelopment programme to rebuild two thirds of the hospital site over a twenty year period. One new clinical building in this phase opened in 2012 and another will open in 2017.

We carried out this inspection as part of our comprehensive acute hospital inspection programme adapted for dedicated children's hospitals. The trust was rated as low risk in the CQC intelligent monitoring system. The inspection took place between 14 and 17 April and unannounced inspections took place between 1 and 3 May 2015. We also inspected the Children and Adolescent Mental Health Services (CAMHS) provided by this trust as part of our inspection.

Our inspection team

Our inspection was led by:

Chair: Peter Blythin, director of nursing NHS TDA

Head of Hospital Inspection, Robert Throw, Care Quality Commission

The team included CQC inspection managers, inspection managers and inspectors, and a variety of specialists:consultant cardiologist, paediatric pharmacist, consultant renal medicine, consultant nurse children's medicine, oncology nurse, general paediatric surgeon, paediatric anaesthetist, cardiac nurse, theatre nurse chidren's surgery, paediatric intensivist, paediatric critical care nurse, neo-natal nurse,general manager outpatients, specialist rehabilitation nurse, physiotherapist, dietitian, medical records specialist, palliative care consultant, consultant nurse specialist, palliative care nurse, adolescent nurse specialist, consultant psychiatrist (CAMHS), consultant paediatrician, play specialist, student nurse paediatrics, NHS chief executive/chief operating officer.

Summary of findings

How we carried out this inspection

To get to the heart of children and young people's experience of care, we always ask the following five questions of every service and provider:

- Is it safe?

- Is it effective

- Is it caring

- Is it responsive to people's needs

- is it well led?

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hosptal. These included local Clinical Commissioning groups, NHS England, Monitor, Health Education England,the General Medical Council, the Nursing and Midwifery Council, Royal Colleges and local Healthwatch.

We held one listening event on 25 March 2015 with the intention of listening to the views of children and young people and their families and carers about the services they received.

We talked with children and young people, their parents and carers and members of staff from all the ward areas and diagnostic and outpatient services. We reviewed their records of personal care and treatment.

We carried out unannounced inspection visits between 1 and 3 May 2015 when we followed up in areas where we required further evidence.

What people who use the trust's services say

At the time of the inspection, latest Friends and Family Tests showed the following results:

- In the Friends and Family test survey, 98% of patients either recommended or highly recommended care and treatment at the trust (294 responses)
- In the staff Friends and Family test survey, 94 % of trust staff recommended or highly recommended care and treatment at the trust (609 responses)
- 73% of trust staff recommended Great Ormond Street Hospital for Children NHS Foundation Trust as a good place to work (609 responses).
- The latest (2014) inpatient experience research conducted on behalf of the trust by Ipsos MORI showed 94% overall inpatient satisfaction. The most recent research published by the same organisation for outpatients in 2012 showed 95% overall satisfaction.
- From November 2014 the trust had 35 reviews on the NHS Choices website. It scored 4 out of 5 stars overall with (out of 5) 4 stars for cleanliness;4 stars for treating patients with dignity and respect; 4 stars for same sex accommodation; 3.5 stars for staff cooperation and 3.3 stars for patient invovement in decisions.
- Healthwatch Camden conducted a survey on food provision at the trust in July 2014. While the findings were "generally positive" considering the wide cultural requirements of the patient population, they made recomendations for improvement in handover from kitchen to ward and in cases of staff absence; still wider cultural choice and greater consistency in quality.

Facts and data about this trust

Activity

- Inpatient admissions: 42,732 (2013-2014)
- Outpatient attendances: 213,671 (2013-2014)
- Deaths in hospital: 78 (Apr/14-Dec/14)

Bed numbers and bed occupancy

Summary of findings

- 400 beds
- Average (mean) bed occupancy: 94.5% (Q3 13/14-Q2 14 /15)

Incidents

Number of never events reported: Two

- Time period this relates to Feb 2014 - Apr 2015
- Details of the never events: one surgical error, one retained swab.
- Number of serious incidents requiring investigation: 26 - time period this relates to Feb 2014 - Jan 2015
    - Details of the type and location of serious incident: Other 14, grade 3 pressure ulcer 2, Medical equipment failure 2, Hospital equipment failure 1, surgical error 1, remaining 6.

CQC Inspection History

- Number of recent inspections: Four (two of the four inspections were joint inspection of Safeguarding and looked after children services with Ofsted at local London boroughs).
- Date of most recent inspection and results: 25 September 2012 – Published 4 January 2013 - Compliant.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? The hospital had systems and processes in place to protect children from harm. These included extensive reporting and learning from incidents including access to the Clinical Governance and Safety team website. Staff understood their roles and responsibilities in relation to safeguarding children and how they worked with other agencies to promote the child's best interest. Nursing and medical staffing levels were in line with national guidance and staff had access to a range of training both internal and externally. Ward areas throughout the hospital were clean and regular hygiene checks were taking place. Equipment was also clean and regularly serviced. Patient risks were appropriately identified and acted upon. We found that medical records were completed appropriately and the views of children and their family were fully taken into account. There were effective systems in place for prescribing and administering medicines to patients. We found examples of excellent care pathways for young people with specific long-term health needs transitioning to adult services. We found there were systems in place to manage a baby, child or young person's deteriorating medical conditions. Safer surgery checklists were being completed using a laminated wipe clean sheet but observational audits had not occurred since March 2014. **Incidents** There was a strong culture of encouraging staff to report incidents as well as robust investigation and learning from them. Where we reviewed serious incident investigations they were of a good standard utilising root cause analysis The trust learning, implementation and monitoring board (LIMB) reviewed all serious incidents and learning. Incidents were discussed at regular ward and theatre meetings. Changes to practice following incidents were cascaded to staff members by the trust governance team via emailed safety reports. We were able to inspect a range of these emailed safety reports which gave significant details of the incident and the subsequent learning.	Good 

Summary of findings

There had been two never events reported in the period February 2014 to March 2015. These were both in surgery and involved, firstly, a surgical error and, secondly, a retained swab.

Cleanliness, infection control and hygiene

All wards and theatres were visibly clean with cleaning schedules clearly displayed. All staff worked bare below the elbow and we observed all staff handwashing between patients.

The trust-wide infection control policy was up to date and included guidance on which children and young people should be isolated in a cubicle and included guidance on caring for children in incubators.

There was an annual infection control audit programme that included monthly hand hygiene and care bundle audits as well as central venous line, surgical site infection audits. All audit results were submitted using the electronic audit data collection tool via the trust's transformation website by the last day of each month. The findings of these audits were reported in the annual infection prevention and control report.

Environment and Equipment

The trust is currently half way through a four phase redevelopment programme to rebuild two thirds of the hospital site over a twenty year period. One new clinical building in this phase opened in 2012 and another will open in 2017.

Refurbished or new build wards were bright, airy and child friendly. Some older wards yet to be refurbished were cramped but the trust was taking steps to improve the environment in the meantime.

There were no shortages of equipment which was cleaned and maintained regularly, where necessary by the electro bio-medical engineering department [EBME]. There was an electronic tracking system for equipment out on loan to individual wards. Resuscitation trolleys were checked daily with checks documented.

Medicines

There was a trust medication policy and staff we spoke with were aware of polices pertinent to the administration of medicines to babies, children and young people. The trust had 24 hour/7 day per week access to specialist pharmacy advice.

Medication storage was safe and where we inspected the dispensing cabinets we noted that storage was safe in terms of access. We noted that drug fridges were locked and daily temperature checks were completed and records kept of these checks.

Summary of findings

As part of transitional pathway care pathways, young people and their family members were being taught how to administer their own medications. This was done in line with the trust's medication policy. We saw innovative practice in finding palatable ways of administering medicines to children.

However, we found that the interventional radiology department did not have an appropriate recording procedure in place for the disposal of controlled drugs. We found two open and unattended drug cabinets on a medical ward during our inspection. We found no assessment of risk of medicines purchased outside the trust and being used for international and private patients.

Records

Patient records were a mixture of paper and electronic. We found notes were completed, legible and were up to date. This included care plans, fluid charts, pain assessment, skin intact forms, pre-op checklists (in surgery) and consent. They included summaries of the care delivered and a record of the child's observations. Risk assessments were reviewed reflecting changing levels of risk.

In the records we reviewed, do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed appropriately and located at the front of patient records for easy access.

At the time of inspection we saw patient personal information and medical records were managed and stored securely.

Records of transition planning were variable within the trust. All young people were on a transition pathway in specialty wards such as cardiology, transplant and cystic fibrosis. We saw that most young people over the age of 11 on general wards did not have transitional care pathways.

Safeguarding

The trust had a safeguarding policy and procedure in place, and followed a local (CAMHS) guideline for the management of an absconding child. The safeguarding policy reflected national guidance and had been regularly reviewed.

Volunteers we spoke with described how robust their vetting process had been with personal information being checked and references verified in all cases. This included disclosure and barring service (DBS) checks on all staff.

All staff we spoke with told us that they had attended the appropriate level of safeguarding children training. Over 95% had

attended level 3 Safeguarding training. Staff were provided with safeguarding children update training annually. Staff were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns.

The trust receives a large number of visits from high profile celebrities. Visitors are always supervised.

Mandatory Training

The trust identified 28 mandatory training modules that staff were expected to complete including safeguarding and resuscitation. The level of training was dependent on the individual staff member's role but there was a 95% completion target set for all modules.

Whilst many staff had completed the mandatory training pertinent to their role the trust records showed that there was a variation of level of compliance with some areas not reaching the required trust target.

Nursing and Medical Staffing

Nursing staffing levels had been reviewed and assessed using the Paediatric Acuity Nurse Dependency Assessment (Panda) tool. Managers told us that generally the medical wards worked to a ratio of two patients for each nurse.

Nursing staff we spoke with told us that they felt there were enough nurses to keep patients safe. The trust was able to provide 1:1 and 2:1 nurse to child care where required.

The trust had its own nursing staff bank called Bank Partners. It was able to adequately manage any staffing shortfall through the use of bank staff which was mostly staff employed by the trust.

The trust had a low sickness absence rate of about 2.6%.

The trust had a total of 570 doctors (consultants, middle and junior grades) to cover 400 in-patient beds. 43.7% of doctors were consultants compared to an NHS average for England of 32.6%. The hospital had a large registrar group making up 53.9% of doctors compared to an NHS average of 39.5%. There were fewer junior doctors which meant that patients were looked after by more experienced doctors than in most NHS hospitals.

Doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and out of hours to provide safe care and that consultants were contactable by phone if they needed any support. We found examples of surgical consultants coming in at weekends and doing ward rounds at weekends.

Summary of findings

Care at night was provided by the hospital at night team which included site practitioners and rotational medical staff including the Intensive Care Outreach Network (ICON) and anaesthetists. The ICON was established in 2012 and consisted of a dedicated consultant and six ICON/ICU fellows to provide a seamless link between the intensive care units, high dependency units and wards throughout the hospital. This service was fully integrated into the hospital at night service.

Assessing and responding to patient risk

The trust used a children's early warning score (CEWS) system to monitor patients' conditions and monitor vital signs such as respiration, temperature and blood pressure for each patient at regular periods.

There was a trust clinical site team which consisted of senior nurses who were able to provide support to nursing staff caring for very sick children. The clinical site practitioners (CSP) provided the outreach service to the wards, 24 hours a day, seven days a week, assessing and responding to deteriorating patients outside the critical care units. They also led the resuscitation team in the event of a patient collapse. The CSP team also provided ward staff with telephone advice.

Referrals to the CAMHS service were considered carefully. The CAMHS team considered whether a child could be managed safely within the unit or whether there was a more appropriate service for them. If the needs or risks of a current patient exceeded current service provision they would be transferred to a more suitable unit.

Staff told us that they received referrals from a range of NHS trusts and embassies but often these did not include enough medical or clinical information. Staff managed this risk by proactively contacting the referring organisation to obtain the necessary information about the patient prior to treatment and in many cases going to the referring hospital to collect the patient and their medical records.

All referred children known or considered to be at risk of being MRSA positive were taken directly into isolation rooms, or managed on open ward with contact precautions if clinically necessary and risk assessed, in order to minimise the risk of cross infection.

Major incident awareness and training

Summary of findings

The trust had a major incident plan including local emergency resilience actions to be taken in the event of such an incident. The CATS children's ambulance service had their own plan that included their responsibilities in the event of a major incident including a vehicle accident.

Staff we spoke with were aware of major incidents plans and how patients would be evacuated from the hospital in an emergency. We found that emergency procedures, including the hospital major incident plan, had been tested in relation to patients, visitors and staff.

Plans were in place for a wide range of issues such as the loss of utilities, loss of staff, communications, IT and the emergency call system. In the event a unit needed to be evacuated alternative locations had been identified as suitable to accommodate level 2/3 patients.

Are services at this trust effective?

Outstanding ☆

Patients were being effectively treated that could only be treated at very few other hospitals in the UK. Because of this, the trust often developed its own clinical guidance which it shared with clinical colleagues in the wider medical community. Robust and regular clinical audit was firmly established.

Where there were NICE and other relevant guidelines treatments followed these guidelines. These were regularly reviewed and updated to ensure they reflected any changes in practice.

Pain was being effectively managed and regularly monitored. Nutrition and hydration was being effectively managed. There was good multidisciplinary team working throughout the hospital. Staff were fully experienced and competent dealing with issues of capacity and consent.

In CAMHS, each child had a core team who worked together to formulate detailed, person centred care plans. There were parenting, psycho-educational groups and weekly family therapy sessions available.

In End of Life care we found the trust was actively engaged in monitoring and improving quality and outcomes locally, even where there is a lack of nationally agreed audits and outcome measures for paediatric palliative care. Staff participated in national benchmarking, teaching and research opportunities.

Evidence-based care and treatment

Treatment adhered to National Institute for Health and Clinical Excellence (NICE), Royal College guidelines and professional

guidelines such as the intensive care society standards. The trust had an effective process of monitoring the implementation of NICE guidance by regular review. We found that all of the guidelines had been reviewed in 2014.

Because of the nature of patients at the trust there were many examples where there was no existing clinical guidance. The trust had often written its own guidance which it made available to other hospitals and clinical colleagues on its intranet site.

We found several examples of clinicians conducting their own research in their specialist area of treatment and publishing research papers and guides which were being used nationally and internationally.

Patient Outcomes

Many of the trust's clinical services provided outcome data to national or international registries. These registries monitor incidence of disease, clinical management of conditions and treatment outcomes. The trust had used this information to compare and challenge performance for example in in areas such as HIV, Nephrology and the treatment of Cystic Fibrosis. Due to the complex nature and acuity of patient conditions it was not always possible to produce like for like comparisons with other providers.

The trust had completed a large number of audits in all of its core services. We found that the trust had reviewed all potential national audits and had documented valid reasons why they were participating and how much progress had been made. The hospital provided us with documentary evidence showing action taken to improve patient care as a result of these audits.

The trust was now increasingly producing data and comparisons to other centres, both nationally and internationally. Audit results were either better than national average as in the National Paediatric Diabetes audit or in line as in PICANET information showing the trust's child intensive care mortality rate of 4.6%, which was line with other trusts who submitted data.

Planned re-admission within 30 days was 3.2% although the procedures carried out were of a complex nature, meaning these were often referred by other centres following unsuccessful surgery, or to carry out a procedure that was complex. The emergency re-admission rate within two days of surgery was 2.5% compared with 1.4% for other specialist children's trusts. Overall mortality rates had reduced to 1.6% from 3.8% three years ago.

Pain Relief

Summary of findings

The trust had a dedicated pain team available for patients 24 hours per day 7 days per week in addition to pain assessment and management being carried out by ward staff. The pain team were proactive in visiting all children in the hospital who may be at risk of suffering pain. They offered advice and support to staff and families for children who were in acute chronic pain and/or required anticipatory pain management plans. This included liaising with the local hospitals and hospices to children being cared for at home. We saw the pain team working on a number of wards during our inspection.

The trust used a number of age-appropriate tools to assess pain. Medical notes showed good records and appropriate actions taken in response to pain triggers.

Children's pain management plans were discussed with the pain team each morning. We observed a meeting and found the conversations were child focussed and sensitive. Staff were very aware of how distraction, including massage therapy, could help with pain relief.

Competent Staff

The trust's initial staff induction programme was detailed and comprehensive. Newly qualified nurses underwent a 6 - 12 months preceptorship where they were in a protected environment which supported their training and development.

All staff we spoke with were positive about the training and development opportunities given to them and the quality of this training, including the opportunity to gain further external qualifications.

Trainee doctors and nursing staff said they felt well supported.. Staff received regular appraisals and support from practice educators.

Multidisciplinary Working

Throughout our inspection, we saw evidence of effective multidisciplinary team working in all departments of the trust. This included weekly MDT meetings, handovers in the morning or evening, morbidity and mortality meetings, and patient assessments.

Staff from all disciplines we spoke with said they felt equally involved and included and said that MDT meetings were effective. We noted that multi-disciplinary working was embedded in the processes of the trust.

Seven Day Working

The trust provided more than average 7 day services.

Summary of findings

There was a consultant presence on all wards seven days a week. The Intensive Care Outreach Network (ICON), and Clinical Site Practitioners (CSP) team are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours per day, 7 days per week.

Surgery operated 7 days per week with elective lists at the weekends, predominantly for private patients and emergencies.

The end of life team provided a 24 hours a day, seven days a week service with a telephone service out of hours and at weekends.

Dietitians, pharmacists and radiographers operated a 7 day per week service with restricted hours at weekends. Specialist pharmacy, radiographer and physiotherapy services were available through a resident on-call service.

Consent

The trust had an up to date and comprehensive consent policy issued in October 2014. This included comprehensive consent forms for patients under 16 and a separate form for those 16 or older.

All staff we spoke with were aware of the trust's consent procedures and all understood their role and responsibilities when obtaining consent.

We found that staff had a good understanding of Gillick and Fraser guidelines and that these guidelines were being appropriately followed.

Where there was an issue of disagreement over consent, the trust ethics committee was involved to discuss and help teams to agree an appropriate course of action.

Are services at this trust caring?

Outstanding ☆

We found many examples to demonstrate that the hospital was delivering compassionate care. Parent feedback unanimously supported this. Emotional support was offered to patients, parents and staff. Parents told us they had a good understanding of the care their child was receiving and felt the hospital involved them in the care their children received. The trust scored highly in the Friends and Family test with well over 90% of patients complimentary or highly complimentary.

Patients and families received a high level of emotional support from nursing staff at ward level. In addition, the hospital social work team and chaplaincy service were proactive in finding people in need of additional support.

Summary of findings

Caring was fully embedded into clinical practice. Children and their families were treated with compassion, dignity and respect. Parents were positive about the care their children received. They felt informed, involved and able to ask questions when they were unsure of what was happening to their child. Families and children were provided with emotional support from a range of professionals.

Feedback was proactively sought to improve the service and staff adopted a can do attitude to meeting children's needs.

Staff were motivated and developed relationships with children and their families that were supportive, identifying and providing emotional support as necessary. Children and families were actively involved in their care and treatment, making informed decisions based on the information and explanations provided by staff.

Compassionate Care

Throughout our inspection, we observed patients being treated with the highest levels of compassion, dignity and respect. We saw nurses and doctors going the extra mile in this respect with the children in their care and their parents.

We observed a large number of interactions between staff and patients and their families. We observed that staff were open, friendly and approachable but always remained professional. We observed that patients and families were often delighted when they saw staff they knew and greeted them as if they were old family friends.

The Friends and Family test results for all departments was overwhelmingly positive with in many cases 100% of respondents recommending or highly recommending care at the trust.

In all the clinician patient interactions that we saw there was a deeply embedded emphasis on privacy dignity and compassion .We witnessed both doctors and nurses practising this at the bedside.

We noted post boxes and 'we value your opinion 'posters to gain patient feedback throughout the trust.

Patient understanding and involvement

Patients and families we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant and to ask as many questions as they wanted they were aware of what was happening with their care.

We observed excellent communication between nurses, doctors, parents and children, where children and parents were given good amounts of information regarding their care.

Summary of findings

A young people's forum engaged with young people to look at what improvements could make to enhance their patient experience. Parents and families we spoke with said they felt involved in decision making and the planning of care.

Play specialists supported siblings and other children through understanding what their brother/sister/ friend was experiencing.

Emotional Support

The trust had a comprehensive network of support for patients and families through hospital social workers and a proactive multi-faith chaplaincy service. Emotional support for staff was also available.

We observed that staff demonstrated an understanding of parents' and children's situations and worked well to lower people's anxiety. Families' needs were discussed at regular MDT meetings attended by clinical psychologists, chaplaincy and social workers. Active help was given to families to apply for assistance such as equipment and other grants.

Are services at this trust responsive?

Requires improvement 

We found many examples where the hospital and its staff had make a special effort to meet the needs of patients.

The trust performed in line with the England average in the Patient-led Assessments of the Care Environment (PLACE). The trust showed improvements between the 2013 and 2014 assessments in all four categories of: cleanliness, food, privacy dignity and well-being and facilities.

Systems and initiatives were in place that ensured patients' individual needs were being met. This included a nil by mouth reduction initiative, providing snack boxes post-surgery and organising staff to specific assessment duties. Meeting the needs of children with a learning disability had been a specific focus of the service and other special needs were also being met.

Parents were supported during and after discharge from the hospital. They had access to parent accommodation in an adjacent building to be close to their child.

Complaints and concerns were taken seriously, responded to in a timely way and improvements were made to the quality of care as a result of complaints or concerns.

Clinics and events were organised so that young people could meet their on-going care team before leaving GOSH to help ease the path of transition to adult services.

Summary of findings

We found end of life and palliative care was embedded in all clinical areas of the hospital and not seen as the sole responsibility of the palliative care team. It was tailored to meet the needs of individual children, young people and their families. It was delivered in a way that ensured flexibility, choice and continuity of care.

Outpatients and diagnostic imaging services were planned to meet the needs of children and young people using the service with evidence of flexibility in many areas. Systems were in place to coordinate care with other departments in the trust, these systems were monitored and action taken to improve responsiveness.

However, a review of the trust's referral to treatment (RTT) systems and processes prompted by concerns about the quantity of unknown clock starts and an audit of 18 week RTT incomplete pathway indicators identified issues with both the management and processing of RTT data. The review indicated both unreliability of trust data and inconsistent application of the trust's patient access policy.

Service planning and delivery to meet the needs of people

The trust as a specialist children's trust taking children from all areas of the UK and overseas did not serve a specific local population. However, there was a service user strategy that commenced in 2014 with an engagement exercise involving 2500 patients, families and staff members. This strategy also involved service users in the GOSH research programme.

We ascertained from the GOSH operational plan for 2014-16 that the plan was developed through wide consultation with local and national stakeholders to ensure that GOSH has a responsive, relevant and robust approach to development which is consistent with its vison for specialist children's health care

Commissioned services were national and international. There were links with local providers and community nurses for discharge planning. The children were discharged back to where they were commissioned from and the team liaised with the local community team or acute trust prior to discharge. Discharge planning took place with international hospitals. On the private unit there was a specific discharge liaison team.

Throughout our inspection we came across many examples of services tailored and modified to meet the needs of patients as those needs arose or changed.

We were concerned at the pace at which the trust was able to assess numbers affected and actual harm to patients. An early assessment of harm sampled 78 patients. Of those, the trust had been unable to

assess harm in 31 patients; six patients had suffered low harm, and one patient had suffered moderate harm (needing two procedures instead of one). The trust subsequently advised us that, based on its assessment of the number of patients waiting over 18 weeks, the risk of finding patients who had suffered moderate or severe harm was estimated at less than 0.1%.

Access and Flow

The trust does not have an Accident and Emergency Department. Most patients were transferred from district general hospitals (DGHs) following discussions between the consultant at the DGH and the appropriate consultant at the hospital. The hospital had clear guidelines for which patients are appropriate to be admitted.

There was a trust wide operational group who were responsible for the co-ordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new patients to be admitted into. Bed meetings were held at 9.30am and 3pm each day. They also discussed any action that was required when wards were at full capacity.

There was a bed management system that ensured managers had a clear picture of where the demands and spare beds were in the hospital at any given time. This meant that in the case of space being needed in an emergency the hospital was able to respond quickly and effectively.

During our inspection we observed that there was flow into, out of the hospital and within all the wards and every ward had some capacity to take new patients. Patients were admitted based on individual admission criteria relevant to the clinical and divisional specialty.

Between October and December 2014, the trust had worked with the NHS England Commissioners to reduce the backlog of patients who had been waiting over 18 weeks for treatment, during a period of amnesty against the Admitted Target. Statistics presented showed theatre utilisation for the last three months of 2014 running at between 50 and 70%.

Problems with RTT data found at the trust affected patients mainly coming to the trust for surgery and to outpatients and diagnostic imaging. Because the data reporting was not valid individual patients may have waited longer for treatment.

Discharge meetings were held prior to discharge. Discharge plans and summaries were produced in advance.

Summary of findings

The trust used a tracking system in outpatients when clinics were cancelled so that the causes could be understood and avoided in future.

Learning from complaints and concerns

There was a comprehensive policy and process for dealing with complaints monitored by the trust central complaints team. Complaints were logged by description, outcome, action and department. Complaints were also monitored by the LIMB group.

There was an emphasis on trying to resolve concerns locally by staff before they became formal complaints. Parents were invited to be on ward meetings where complaints and concerns were discussed. The Patient Advisory and Liaison Service (PALS) was proactive in dealing with patients' concerns. PALS staff would attend wards to see if any patients or their families had any concerns about the service they had received.

Staff we spoke with confirmed that lessons from complaints were cascaded and discussed at ward meetings and provided examples of how the service had learnt from complaints.

Are services at this trust well-led?

Requires improvement

The trust's core vision of "The child first and always" was well recognised and owned by staff throughout the trust. The newer version of "always welcoming, always helpful, always expert and always one team" was less well recognised. However this version of values had only been launched in the previous month. Staff were focused on delivering high levels of care to the patients they cared for.

The hospital had systems in place for ensuring effective clinical governance. We observed that there was a clear focus on reducing clinical risk and improving patient outcomes. Information was effectively shared within the trust and from the top to the bottom of clinical divisions.

There was clear leadership at a local, service and trust wide level. There were numerous examples of innovative practice and research. The chief executive and his executive team were very visible and shared their vision of the trust.

There were strong governance arrangements in place to monitor quality of service. There were clear channels for reporting incidents and learning from them. There were clear lines of escalating risk information, disseminating information, monitoring standards and meeting key performance Indicators.

Summary of findings

Staff worked in a culture of openness and flexibility, which many staff considered contributed to high levels of satisfaction and pride they felt working at the hospital. Staff were keen to explain that one of the reasons they liked working at the trust was because they felt valued; were included and liked how they were treated by leadership teams.

Staff were skilled in engaging with children, young people and their families. They listened to their views and concerns, when discussing treatment options with them.

However, with respect to the issues found with RTT reporting and inconsistent application of the patient access policy our concern was that the trust had been managing waiting lists in an inconsistent way. Some lists were managed locally by individual departments with insufficient oversight and control at trust level. Rules about validating RTT data are complex but they had not been undertaking this as well as they could.

Vision and strategy

The visions for the trust for 2014-19 were: to have the best patient outcomes and experience; to be an exemplar employee and excellent educator; to be a world-leading paediatric research institution; to be partner of choice for referrers, and to be a financially and environmentally sustainable organisation.

Consultants we spoke with stated that the new CEO had a clear vision for the future direction of the trust. This did not necessarily involve a radical structural change but emphasis on making structures work effectively and efficiently.

Some nurses were of the opinion that the trust vision and strategy needed to reflect more effectively the contribution of nursing to this vision.

Governance, risk management and quality measurement

There was a clear governance structure with a trust wide governance committee underpinned by divisional governance and performance meetings and governance meetings for individual specialties plus risk action groups attended by ward staff. Risk action groups fed in to the quality and safety structure. Key managers and staff were in attendance at all levels and action and follow up was taking place. We were however concerned that the trust had not picked up on issues with its referral to treatment data and recording earlier.

Risk management was embedded in the culture of the trust and staff demonstrated that they understood the principles of risk

management. In most departments risks were regularly reviewed and regularly removed as the issues were resolved. The trust risk department was proactive in progressing the investigation of incidents and the dissemination of learning from them.

The divisional monthly governance and performance review meetings covered a range of areas such as operational issues and included front-line staff. This approach assisted senior managers and data analysts understand the delivery of the service from the point of view of those delivering care and treatment.

30 minutes at the end of the divisional meetings and risk action groups was devoted to sharing learning from other divisions. Staff reported that this was effective for sharing learning across specialties. Changes to practice following incidents were cascaded to staff members by the trust governance team via emailed safety reports. We were able to inspect a range of these emailed safety reports which gave significant details of the incident and the subsequent learning.

The ethics committee was regularly available and played a key role in considering and ruling on difficult treatment decisions.

Leadership

The trust had had a succession of chief executives in recent years which had posed a challenge to leadership. However the new chief executive had quickly won the confidence of medical staff and was visible and readily available to all staff groups. He had run a series of open forum meetings to which staff at all levels had been invited. The executive team held regular walkabouts on wards. The trust chair, non-executive directors and governors performed specific and active roles in the leadership of the trust.

Divisional managers were regularly seen on wards and had a good understanding of the issues in their clinical areas. We were particularly impressed by the consistently high level of leadership we found in the ward managers we observed during our inspection.

Senior managers and senior clinicians were approachable and visible and staff felt well supported. However, some nursing and medical staff we spoke with reported difficulties in communication between some senior nurses and some senior medical staff and this relationship was strained, particularly in critical care.

The trust had been managing its RTT data and processes in a disorganised way with little oversight as to how individual departments were managing the issue. The trust responded in an open and honest way to the issues, once known, in relation to RTT data, processes and the inconsistent application of the trust patient

access policy. They produced an action plan to show how they were tackling the issue. However, there was some delay in informing CQC of the issue and this may have been because they were attempting to ascertain the scope and size of the problem.

Once the problem had been identified the trust set in motion an action plan which included the following: resourcing of experts to lead an improvement programme; validating underlying RTT data; clinical review of patients following validation of data; redrafting the patient access policy; training and retraining of clinical and non-clinical staff to improve RTT recording and ensure consistent application of the patient access policy; restructuring of trust wide patient tracking meetings; setting up an RTT improvement board chaired by the chief operating officer; on-going dialogue and reporting to NHS England and Monitor.

Culture within the trust

There was a very strong culture and ethos throughout the trust in every department, and without exception, of a commitment to deliver the highest quality of care in the most professional, efficient and caring way possible. There was a distinct child and young person centred culture within the trust. Staff we spoke with at all levels were focused on obtaining the best outcomes for the patients in their care. This culture and ethos was remarkable in its extent across all areas of the trust.

There was a strong team spirit from top to bottom with staff as diverse as consultants, cleaners, radiographers and nurses in all departments being very clear that they were all there for the care and best interests of their patients. Staff described and we saw for ourselves a spirit of openness in all the interactions that we saw between staff and between staff and patients and their families.

Staff spoke very positively about the high quality care and services they provided for patients and were proud to work for the trust. One of the most consistent comments we received was that the trust was a good place to work and people enjoyed working there.

There was a tangible culture centred on the needs and experience of families who use services centred on the trust mission statement. Staff projected a high level of professionalism at all times. The atmosphere on wards and outpatient areas across the trust felt friendly, calm and contained.

Public and staff involvement

Parent representatives were invited and sat on divisional management team meetings. They told us they felt listened to by trust leadership, who were responsive to issues raised. We saw evidence of ways in which the trust had used patient and family feedback to make service improvements.

Patients were engaged through feedback from the NHS Friends and Family test and complaints and concerns raised from PALS. Clinical governance meetings showed patient experience data was reviewed and monitored. Children and their families were engaged in the development and delivery of the service through their views being collected using in-house surveys for example in diagnostic imaging.

Following further validation of the data to understand the scale and detail of the referral to treatment (RTT) issues identified, the trust issued a public apology to any patients who potentially might have been affected by it.

The trust provided examples of how it had utilised social media sites to engage with adolescents. These included “Being a teenager at GOSH” and “Transition to adult services” web-page, Facebook and Twitter where young adults can contact others going through transition for help and advice.

We observed that clinical and non-clinical staff were skilled in engaging with children, young people and their families.

The staff we spoke with considered that they were actively engaged in the planning and delivery of services and in shaping the culture of the trust. Staff we spoke with had attended the chief executive open forum meetings, at which the future vision and strategy for the trust was shared.

Innovation, improvement and sustainability

Nurses, doctors and allied health professionals at the trust we spoke were highly motivated and focused on continually improving the quality of care. Innovation was encouraged from all staff members. Staff said that new ideas and analysis of the way things were being done was positively encouraged by managers.

Most teams had daily or weekly huddles to assist them plan short-term service delivery including exploring how problems or unexpected issues would be managed. During these huddles, staff worked together to identify critical safety issues in fast time and implement rapid solutions.

The learning disabilities champion implemented a learning process called ‘Better care – Healthier Lives’. This involved four principles of; engaging people with learning disabilities and their families, enabling the spreading of information and initiative through link

staff, showing compassion and knowing every life had worth and making cultural change and implementing innovation. The GOSH newsletters we examined (e.g. April 2015) showed how information about the care of children with learning disabilities for example was used to proactively improve care.

A member of trust staff had being involved in sharing transitional work developed in GOSH within London and nationally. The work completed, included a transitional to adult services care pathway, “Fight For Every Heartbeat” booklets and “Rhythmic Beats” which was an adolescent boot-camp to prepare young people for transition.

The trust was part of the Children’s Hospital Alliance for Real Innovation in Operating Theatres (CHARIOT) which is a partnership forum of specialist children’s hospitals in England. The group had looked at group procurement of specialist items for economic expediency. It had also more recently looked at competencies in theatres.

The trust took part in research into pain and palliative care through the National Institute for Health Research, Clinical Research Network – Children. This study included the effectiveness of different symptom control medications for various medical conditions across age ranges, the study also included massage therapy as a form of pain relief/distraction.

Overview of ratings

Our ratings for Great Ormond Street Hospital for Children NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding
Surgery	Good	Good	☆ Outstanding	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	☆ Outstanding	Good	Requires improvement	Good
Neonatal services	Good	Good	☆ Outstanding	Good	Good	Good
Child and adolescent mental health wards	Good	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Transition services	Good	Good	☆ Outstanding	☆ Outstanding	Requires improvement	Good
Overall	Good	☆ Outstanding	☆ Outstanding	Requires improvement	Requires improvement	Good

Our ratings for Great Ormond Street Hospital for Children NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	☆ Outstanding	☆ Outstanding	Requires improvement	Requires improvement	Good

Outstanding practice and areas for improvement

Outstanding practice

- Clinicians from other hospital services delivered specialist training on physical health issues for CAMHS staff. In return CAMHS staff provided training and expertise to other departments across the hospital, for example on learning disability and autism.
- Because the hospital is treating many patients that could be treated at very few hospitals in the UK it is developing ground breaking clinical guidance which it is sharing with clinical colleagues in the wider medical community.
- The hospital has developed a pocket-sized guide to help staff working with children with learning disabilities.
- The Feeding and Eating Disorders Service (FEDS) received 100 % approval in the latest Friends and Family test with 93% saying they were extremely likely and 7% saying they were likely to recommend the service.
- The Psychological Medicine team provided an outreach service across the country where necessary.
- Staff in CAMHS were actively involved in research in their specialist areas including Autism and Feeding and Eating disorders.
- CAMHS introduced a screening tool for mental health problems and the psychological medicine team conducted a study to improve the understanding of the patient experience, diagnosis, treatment and outcomes regarding non-epileptic seizures in children.
- The FEDS and MCU (Mildred Creak Unit) teams developed a policy around re-feeding syndrome to increase understanding of the issue.
- In critical care there were excellent mortality and morbidity meetings, and robust safety monitoring of all patients.
- The Intensive Care Outreach Network (ICON), and Clinical Site Practitioners (CSP) team are part of the hospital at night service and hold responsibility for any deteriorating child 24 hours per day, 7 days per week.
- In pharmacy services the chief executive receives monthly reports of prescribing errors; a daily check ensures all electronic prescriptions are screened before the end of each weekday (Monday to Friday) and patients are informed by text message when prescriptions are ready.
- In transitional care young people feel empowered by the Young Persons' Forum.
- Joint transitional care clinics are held with ongoing hospital providers.
- In outpatients weekly education sessions were protected to ensure staff maintained currency in mandatory areas and had the opportunity to take part in further specialist training from a clinical educator

Areas for improvement

Action the trust MUST take to improve

- Resume WHO checklist audits in surgery
- Ensure that there are clear arrangements for reporting transitional care service performance to the board.
- Ensure that its referral to treatment (RTT) data and processes are robust and ensure that staff comply with the trust's patient access policy in all cases.
- Ensure greater uptake of mandatory training relevant to each division to reach the trust's own target of 95% of staff completing their mandatory training.
- Ensure that, particularly in critical care, communication between senior nurses and senior medical staff is enhanced and that the contribution of nursing is fully reflected in the hospital's vision.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not complying with Regulation 17 2 (a) (c) and (f). Systems were not sufficiently established or operated effectively to ensure the provider was able to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk, which arise from carrying on of the regulated activity because: 1) Irregularities were discovered in the trust's management and recording of referral to treatment practice and data over several years meaning that the data was unreliable. This affected mainly but not uniquely the surgical and outpatient and diagnostic divisions. 2) The trust and also local divisions had not managed referral to treatment efficiently and the inefficiencies had not formally been picked up and managed and remedied at both local division and trust level. 3) At the same time the trust had not managed access to treatment for all patients in a consistent way in accordance with its own access to treatment policy.