Meeting of the Trust Board
Wednesday 25 May 2022

Dear Members

There will be a public meeting of the Trust Board on Wednesday 25 May 2022 at 2:30pm.

*Members of the public are welcome to attend via Zoom – please email Victoria.Goddard@gosh.nhs.uk

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**2:30pm**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	**Minutes of Meeting held on 30 March 2022**	Chair	**K**	
3.	**Matters Arising/ Action Checklist**	Chair	**L**	**2:35pm**
4.	**Patient Story**	Chief Nurse	**M**	**2:40pm**
5.	**Chief Executive Update**	Chief Executive	**N**	**3:00pm**
	ANNUAL REPORT AND ACCOUNTS			
6.	**GOSH Foundation Trust Annual Financial Accounts 2021/22 and Annual Report 2021/22 Including:** ○ **the Annual Governance Statement** ○ **the assurance committee annual reports** ○ **Draft Head of Internal Audit Opinion** ○ **Draft Representation Letter** **Draft Representation Letter**	Chief Finance Officer Company Secretary Audit Committee Chair	**O** **P**	**3:10pm**
7.	**Compliance with the Code of Governance 2021/22**	Company Secretary	**Q**	**3:20pm**
8.	**Compliance with the NHS provider licence – self assessment 2021/22**	Company Secretary	**R**	**3:25pm**
9.	**Quality Report**	Medical Director	**S**	**3:30pm**
	STRATEGY and RISK			
10.	**GOSH 2022/23 Budget**	Chief Finance Officer	**Verbal**	**3:40pm**
11.	**Board Assurance Framework Update**	Company Secretary	**U**	**3:50pm**
12.	**Health Inequality Update**	Chief Nurse	**V**	**3:55pm**
	PERFORMANCE			
13.	**Integrated Quality and Performance Report – Month 1 2022/23**	Medical Director/ Chief Nurse/ Chief Operating Officer	**W**	**4:05pm**

14.	**Month 1 2022/23 Finance Report**	Chief Finance Officer	**X**	**4:15pm**
15.	**Learning from Deaths Report Q4 2021/22**	Medical Director	**Y**	**4:25pm**
16.	**Safe Nurse Staffing Report (February - March 2022)** **Nursing Establishment Review**	Chief Nurse	**Z** **1**	**4:35pm**
	ASSURANCE			
17.	**Review of Ockenden Review**	Medical Director	**2**	**4:45pm**
18.	**Infection Control Update Q4 2021/22**	Chief Nurse/ Director of Infection, Prevention and Control (DIPC)	**3**	**4:55pm**
19.	**Annual Reports** • **Annual Health and Safety and Fire Report 2020/21** • **Guardian of Safe Working Report Q4 2021/22 and Annual Report 2021/22**	Director of Space and Place Guardian of Safe Working (Renee McCulloch)	**4** **5**	**5:05pm**
	GOVERNANCE			
20.	**Board Assurance Committee reports** • **Audit Committee update – April 2022 meeting and May 2022 (verbal)** • **Quality, Safety and Experience Assurance Committee update - April 2022 meeting** *There has been no meeting of the People and Education Assurance Committee and the Finance and Investment Committee since the last Trust Board in March 2022*	Chair of the Audit Committee Chair of the Quality and Safety Assurance Committee	**6** **7**	**5:15pm**
21.	**Council of Governors' Update – April 2022**	Chair	**8**	
22.	**Declaration of Interest Register (Directors and Staff)**	Company Secretary	**9**	**5:25pm**
23.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			**5:30pm**
24.	**Next meeting** The next confidential Trust Board meeting will be held on Wednesday 7 July 2021 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			

Attachment K

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 30 March 2022

Present

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

In attendance

Cymbeline Moore	Director of Communications
Zoe Asensio Sanchez	Director of Estates, Facilities and the Built Environment
Shankar Sridharan	Chief Clinical Information Officer
Mark Sartori	Trustee, GOSH Children's Charity
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Natalie Hennings	Deputy Company Secretary
Paul Balson	Head of Corporate Governance
Claire Williams*	Head of Patient Experience
Carly Vassar*	Head of Nursing and Patient Experience: Body, Bones and Mind
Christine*	Mother of GOSH patient
Blake*	GOSH patient
Daniel Wood*	Cancer Planet Programme Director
Pascale du Pre*	Consultant in Paediatric Intensive Care and Medical Lead for Child Death Reviews
4 members of staff (observers)	

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

180	**Apologies for absence**
180.1	No apologies for absence were received.
181	**Declarations of Interest**
181.1	No declarations of interest were received.
182	**Minutes of Meeting held on 2 February 2022**

182.1	The Board **approved** the minutes of the previous meeting.
183	**Matters Arising/ Action Checklist**
183.1	The actions taken since the previous meeting were noted.
184	**Chief Executive Update**
184.1	Matthew Shaw, Chief Executive thanked staff in the hospital who had supported the urgent care required for four patients who had travelled to GOSH from Ukraine. They had arrived in the UK as part of a group of 21 children and young people who were being treated by several hospitals in collaboration with the Department of Health and Social Care.
184.2	**Action:** The Ockenden Report had been published on 30th March 2022 and Matthew Shaw said that there would be points of learning for the NHS as a whole. It was confirmed that a report would be provided to the Board on the gaps identified at GOSH from the recommendations made.
184.3	Russell Viner, Non-Executive Director welcomed the focus on health inequalities in the Chief Executive Report. He said that UCLH was currently consulting on a new strategy and one of five proposed key areas of challenge was inequality. He suggested that this would be a welcome synergy between the organisations. Russell Viner said that there was considerable expertise in this area at the GOS UCL Institute of Child Health and recommended that further work took place to connect this with both the GOSH population and the local ICS population. He added that this would be a key area of focus after the pandemic.
185	**Portfolio Office Update**
185.1	Matthew Shaw said that the Trust had implemented portfolio management for its key strategic programmes which would support monitoring. The strategic principles were continuing to make progress and the Children's Cancer, GOSH Learning Academy and people planets were performing well and on track. There was additional pressure on planets 2 and 4: developing a future hospital and improving speed and access.
185.2	The Board noted the update.
186	**Patient Story**
186.1	The Board received a patient story from Christine whose son Blake had recently been discharged back to his local hospital from a 7 month stay at GOSH. She said that staff on Squirrel Ward had made her and Blake feel welcome and had been very supportive during their long stay away from friends and family. The facilities on the ward had been excellent, particularly the parent bed in the patient's room. Christine said that Blake's schooling during his time at GOSH had been excellent and Blake had been listened to by staff who were approachable.
186.2	Christine said that Blake had a complex medical history which required communication between a number of different services. This was often delayed which was frustrating for parents. Christine suggested that an overview of patients who were under a number of different specialties was required and this

	would support the coordination of communications between teams and reach out to local hospitals if required.
186.3	Christine said that facilities to do laundry were very important during a long stay in hospital and could have been improved with additional facilities. Fewer activities were available at the weekend and during the COVID19 pandemic patients were not able to play with one another which had been challenging. Christine said that it had been challenging to ensure that there was structure to Blake's days during the weekend and she felt that a structured play routine would have been beneficial.
186.4	James Hatchley asked whether Christine had used MyGOSH and whether it had been helpful. Christine said that she had used MyGOSH prior to and throughout Blake's stay. She had been able to show Blake a video of the ward before he arrived and communicate with teams during his stay which had been very beneficial.
186.5	Amanda Ellingworth, Non-Executive Director asked whether teams were as responsive to Blake's clinical requirements during weekends and Christine said that particularly during the weekends and also surges of the pandemic, nurses from different areas of the hospital or bank nurses had been shift caring for Blake. She said that it was important that nurses who knew Blake worked with him due, in particular, to his medication sensitivities and this had often not been possible, so she had been required to pass on important information to these clinical staff.
187	**Cancer Planet Update**
187.1	Daniel Wood, Cancer Planet Programme Director said that a new group was being implemented to consider cancer care future planning and key parts of the cancer strategy.
187.2	James Hatchley highlighted the work that was taking place around the cancer pathway and asked whether this involved national coordination. Daniel Wood said that there was considerable potential around research and there was a gap in terms of a national research strategy. He said GOSH was well placed to lead on this working collaboratively.
187.3	**Action:** Russell Viner said that the involvement of cancer research and the use of Proton Beam Therapy at UCLH was beginning to change referral pathways and therefore it was vital that GOSH was involved. It was agreed that this would be considered further at a Board development session to allow sufficient time for discussion.
188	**Planet Update: People and Culture - Making GOSH a great place to work including Staff survey results 2021**
188.1	Caroline Anderson, Director of HR and OD said that there had been a number of challenges for staff throughout the year, some of which, such as treating the backlog of patients, were known, and others, such as Vaccination as a Condition of Deployment (VCOD), had arisen in year. She thanked the trade unions that worked with GOSH, particularly Unite and Unison who had supported the work to insource the cleaning service and harmonise terms and conditions of employment.

188.2	The staff survey results were presented in the context of the seven promises of the NHS people plan which meant it was not possible to benchmark against previous years' results. However there had been a substantial improvement in a number of areas in terms of benchmarking against others in the Acute Specialist Trust group.
188.3	In 2018, GOSH's staff survey results were the lowest in its benchmarking group across nine out of ten survey themes and average on one theme. There had been incremental improvement in each of the following years and the 2021 results showed that GOSH was average for four themes and slightly below average for five themes. In terms of comparison against Trusts in North Central London (NCL), GOSH was above the NCL average for 6 themes, equal to the average in two themes and below the NCL average in one theme.
188.4	Akhter Mateen, Non-Executive Director acknowledged the improvements in the results but said that it was important to aspire to be closer to the best performing organisations. He asked how GOSH could do more to further improve results. Caroline Anderson said that although there had already been substantial improvement it was important to continue to make incremental improvements in areas where there had been longstanding issues.
188.5	Chris Kennedy noted that there had been an increase in staff reporting bullying and harassment by families and said that he had also experienced this in other organisations. He asked how staff would be protected from this. Caroline Anderson said that additional work was required in this area, particularly around patient experience. Matthew Shaw said that this was a London wide theme in the NHS and a number of Chief Executives had been tasked with driving improvement in this area.
188.6	**Action:** Amanda Ellingworth requested that a report was considered at the People and Education Assurance Committee on the staff survey results broken down by protected characteristics to identify whether improvements were being experienced by all groups of staff.
188.7	Sir Michael Rake said that although progress was being made both anecdotally and statistically, focus should be placed on becoming best in class. He said that staff were aware of the focus on culture and this must continue to be a priority.
189	**GOSH Annual Plan 2022/2023**
189.1	Helen Jameson, Chief Finance Officer said that there was considerable change in the NHS as a result of the introduction of Integrated Care Systems. She said that although GOSH had been working with the system it was likely that further planning guidance would be issued and this would require additional approvals from the Finance and Investment Committee and Board.
189.2	The financial plan for 2022/23, reflecting the current NHS England and North Central London contracts, was £41.9million deficit including a £15.5million Better Value Programme
189.3	The Board **approved** the annual plan 2022/23.
190	**Finance Report - Month 11 February 2022 data**

190.1	Helen Jameson said that there had been an in-month improvement in the financial position due to the timing of income for month 12 which had been received in month 11. This had not changed the projected year end outturn which remained a £6million deficit. NHS England was yet to confirm some additional income due and annual leave accrual was key. Cash remained strong and the capital plan was being delivered.
190.2	Sir Michael Rake highlighted non pay costs were £8.9million favourable to plan year to date driven partly by a lower than planned usage of high-cost drugs. He asked about the nature of the treatments which had not been delivered. Helen Jameson said that the Trust was required to make assumptions about the patients that would be treated at GOSH and in 2021/22 fewer patients had been treated with CAR T cell therapy which had let to a movement in non-pay costs.
190.3	James Hatchley welcomed the outturn given the volatility of the flow of finances throughout the year and particularly noted the work that had taken place to ensure that the Trust was funded for the reduced International and Private Care activity.
191	**Integrated Quality and Performance Report (Month 11) February 2022 data**
191.1	Sanjiv Sharma said that improved processes had begun to lead to increased performance and improvements in quality and safety metrics had been noted in each of the last three months. There had been substantial improvement in incident closures and there had been one overdue safety alert which had now been closed. Only three Serious Incident Actions were now outstanding. Duty of Candour compliance was now at 100% for stages one and two and there was only one overdue case at stage three due to an investigation which had been reopened.
191.2	Kathryn Ludlow, Non-Executive Director noted that a recommendation from a serious incident was around the use of a piece of equipment which was in use nationally but was not being used at GOSH. She emphasised the importance of ensuring that appropriate equipment was reviewed as part of standard practice.
191.3	John Quinn, Chief Operating Officer said that work continued to treat the backlog of patients however there had been a reduction in performance against the cancer target as a result of two patients being too unwell to receive treatment. He added that as the number of patients overall was small, two patients led to an impact on performance.
192	**Safe Nurse Staffing Report (December 2021 - January 2022)**
192.1	Tracy Luckett, Chief Nurse said that the report showed high levels of staff sickness due to a surge in the COVID19 pandemic and there had been 15 Datix reports related to staff sickness, none of which had led to patient harm.
192.2	Sir Michael Rake asked for a steer on nursing morale and pipeline and Tracy Luckett said that it was important to review nursing ratios as there was a view from some teams that additional nurses were required. She said that this view would be triangulated with patient experience and quality and safety metrics.
193	**Board Assurance Committee reports**

193.1	<u>Finance and Investment Committee Update –February and March 2022</u>
193.2	James Hatchley, Chair of the Finance and Investment Committee said that the items which had been discussed at the committee had also been covered by the Board. He said that there was considerable focus on the finances related to the Children's Cancer Centre.
193.3	<u>People and Education Assurance Committee Update – February 2022 meeting</u>
193.4	Kathryn Ludlow, Chair of the Finance and Investment Committee said that a staff story had been received from two nurses who gave feedback around the challenges of moving between wards. The GOSH Children's Charity had requested a review of the GOSH Learning Academy which had would take place in October 2022. A deep dive had taken place on recruitment following Britain's exit from the EU and the committee had noted that there had not been an impact on the number of staff recruited but had cautioned against becoming too domestically focused as this was likely to impact international recruitment. Matthew Shaw said that there were potential issues around visas and professional accreditation across boundaries and Sanjiv Sharma said that it was vital that mutual accreditation of training pathways remained in place. He said that he had raised the matter with the Secretary of State for Health and Social Care during a visit to the Trust and he had been receptive.
194	**Council of Governors' Update – February 2022 meeting**
194.1	Sir Michael Rake said that Governors had requested input into the Council of Governors' meeting agenda and had requested a focus on the executive summaries of papers. Governors were keen to understand how to engage with the membership and had asked to become more involved with the Trust's sustainability work.
195	**Learning from Deaths Report – March 2022**
195.1	Pascale du Pre, Consultant in Paediatric Intensive Care and Medical Lead for Child Death Reviews said that the way that reports were compiled had been updated to ensure that all child death review meetings were captured in reports as a result of the gap in time between the death of the patient and the review. She said that the outcome of the reviews identified areas of good practice as well as learning.
195.2	Russell Viner asked whether consideration was given to learning around communication with the family during the patient's treatment and whether there would be any legal implications going forward. Sanjiv Sharma said that it was important to focus on these broader aspects of learning and how they could be embedded into practice.
196	**Any other business**
196.1	There were no items of other business.

Attachment L

TRUST BOARD – PUBLIC ACTION CHECKLIST
March 2022

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
131.4	24/11/21	Matthew Shaw said that it was important to accelerate the Trust's work on health inequalities and it was noted that this would be discussed at the Trust Board Strategy Day. It was agreed that a further update would be discussed at the February 2022 Trust Board meeting. Sanjiv Sharma said that he was presenting at an education event on data around access to paediatric services broken down by elements such as gender, race and socioeconomic background. It was agreed that this would also be considered by the Board.	DD	May 2022	On agenda
160.11	02/02/22	An update had been provided to PEAC on apprenticeships and the committee had noted that this important project was funded by the GOSH Children's Charity. It was agreed that consideration would be given to reviewing this at Trust Board.	CA	July 2022	Not yet due
184.2	30/03/22	The Ockenden Report had been published on 30th March 2022 and Matthew Shaw said that there would be points of learning for the NHS as a whole. It was confirmed that a report would be provided to the Board on the gaps identified at GOSH from the recommendations made.	SS	TBC	On agenda
187.3	30/03/22	Russell Viner said that the involvement of cancer research and the use of Proton Beam Therapy at UCLH was beginning to change referral pathways and therefore it was vital that GOSH was involved. It was agreed that this would be considered further at a Board development session to allow sufficient time for discussion.	AF	June 2022	Noted and added to Board Development programme
188.6	30/03/22	Amanda Ellingworth requested that a report was considered at the People and Education Assurance Committee on the staff survey results broken down by protected	CA	June 2022	Passed to PEAC

Attachment L

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		characteristics to identify whether improvements were being experienced by all groups of staff.			

Attachment M

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25 May 2022

Patient Story: experiences of a family and their son who has severe learning disabilities **Submitted by** Tracy Luckett, Chief Nurse **Prepared by** Claire Williams, Head of Patient Experience	**Paper No: Attachment M** □ **For information and noting**

Purpose of report
The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, clinical teams, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories for the Trust Board. The stories ensure that experiences of patients and families are heard, good practice is shared and where appropriate, actions are taken to improve and enhance patient experience.

Summary of report
Max, aged 13, is under multiple specialties at GOSH including Dental, Cardiology and Gastroenterology. Max has severe learning disabilities and his mum, Laura, will share their experiences at GOSH. She will talk about:

- A lack of patient centred and compassionate care at GOSH for Max as a patient with severe learning disabilities
- A difficult appointment in which Laura was asked to restrain her son to assist in a review of his teeth
- Failure to understand Max's needs and his capacity to understand requests
- The process of raising a complaint at GOSH
- What has gone well and the difference this has made for Max

Laura's story will be filmed in advance and presented at Trust Board by Kate Oulton, Nurse Consultant for Learning Disabilities and Claire Williams, Head of Patient Experience and Engagement.

Action required from the meeting
For information

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

Strategic risk implications
Principle – safety and quality

Financial implications
Not Applicable

Attachment M

Implications for legal/ regulatory compliance • The Health and Social Care Act 2010 • The NHS Constitution for England 2012 (last updated in October 2015) • The NHS Operating Framework 2012/13 • The NHS Outcomes Framework 2012/13
Consultation carried out with individuals/ groups/ committees N/a
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Patient Experience and Engagement/ Nurse Consultant for Learning Disabilities
Who is accountable for the implementation of the proposal / project? Chief Nurse
Which management committee will have oversight of the matters covered in this report? Patient and Family Experience and Engagement Committee/ Quality Safety and Assurance Committee

Attachment N

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 25 May 2022	
Chief Executive's Report **Submitted by:** Matthew Shaw, Chief Executive	**Paper No: Attachment N** ☐ **For information and noting**
Purpose of report Update on key operational and strategic issues.	
Summary of report An overview of key developments relating to our most pressing strategic and operational challenges, namely: • Pandemic recovery: including expediting activity and access to care for children's and young people, including work with system partners • Stabilising our financial position: Financial sustainability and advocating for a fair settlement for children and young people with complex health needs • Transformation to improve systems, processes and capabilities: Projects and programmes that support our quadruple aim to improve access, quality and value and support our staff.	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust priorities ☐ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** ☐ **PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** ☐ **PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training** ☐ **PRIORITY 4: Improve and speed up access to urgent care and virtual services** ☐ **PRIORITY 5: Accelerate translational research and innovation to save and improve lives** ☐ **PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care** ☐ **Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** ☐ **Leadership, capacity and capability** ☐ **Vision and strategy** ☐ **Culture of high quality sustainable care** ☐ **Responsibilities, roles and accountability** ☐ **Effective processes, managing risk and performance** ☐ **Accurate data/ information** ☐ **Engagement of public, staff, external partners** ☐ **Robust systems for learning, continuous improvement and innovation**
Strategic risk implications BAF Risk 1: Financial Sustainability BAF Risk 4: GOSH Strategic Position	**Financial implications** **Not Applicable**

BAF risk 12: Inconsistent delivery of safe care	
Implications for legal/ regulatory compliance **Not Applicable**	**Consultation carried out with individuals/ groups/ committees** **Not Applicable**
Who is responsible for implementing the proposals / project and anticipated timescales? Executive team	**Who is accountable for the implementation of the proposal / project?** CEO
Which management committee will have oversight of the matters covered in this report? Executive team	

Reflection on our current position and priorities

At the start of this new financial year, we face an unprecedented set of challenges that will require us to make some difficult decisions. Against a backdrop of significant cost pressures, we have an obligation to drive up activity and accelerate our capacity to see more children as quickly as possible, while carefully managing the inevitable pressures on staff and the risks of burnout for a community who have worked so hard over the past two years.

Meanwhile, we must deliver on our commitment to drive forward our strategic programmes and to address longstanding issues, including estates compliance – currently a major focus for the organisation.

In this challenging environment it will be essential to re-profile our priorities and make tough choices about where to focus our efforts. Working with the executive team, we will be considering which activities need to be delivered quickly, which can be maintained at a slower pace and what will can be put on pause until we have stabilised.

Naturally, driving activity to support pandemic recovery is essential to ensuring that children and young people are not adversely affected by waiting for diagnosis and treatment. This work is being overseen by our clinical and operational leadership teams, with transformational elements overseen by the programme board for our 'planet' priorities 2 and 4 on Future Hospital and Access to Care. A key pillar of this work is efficiency – identifying how to make best use of our resources, our skilled teams and theatres, diagnostics, and clinic space. Without the ability to bring new staff on stream, making the most of what we have is essential. We are pleased to be joined next month by a Transformation Director, who will be working with our COO John Quinn to support us in assessing the potential of our transformation portfolio to expedite recovery.

Our ongoing work to stabilise income is also fundamental to providing us with the means to recover and transform. The NHS settlement, systemic financial pressures, the legacy of disruption and ongoing NHS structural reforms are clearly of real concern. However, there are opportunities, particularly in the international field, which are coming back online as the world starts to open up again. We are making some important progress to connect with national and international partners to explore these.

The other major priority that is 'non-negotiable' for this year is delivering our quality and safety agenda. Given the importance of culture in underpinning this work, we will be refreshing our quality and safety focus through our people programme (planet priority 1).

Finally, the pressures of rising costs make it more important than ever that we find a way of keeping our Cancer Centre programme on track. This will be a challenging programme to deliver, particularly with the increasing barriers to raising capital, but is essential to transforming our ability to increase access to innovative, safe, kind and personalised care for children and families.

Pandemic recovery

GOSH's activity data continues to benchmark well against the wider sector, but we clearly need to continue working hard to deliver the scale of need. There are some significant hotspots both in the system (including gastroenterology and mental health) and within GOSH (including cancer and cardiac). Our clinical and operational colleagues are working extremely hard to ensure we are doing all we can to bridge the gap. It is important that we bear in mind that with growing pressure to find efficiencies, a reduced capacity to invest in

workforce and facilities, and an as yet unpredictable scale of increased referrals coming back into the system, our recovery challenges will likely increase over the coming months.

In recent months we have hosted a number of key stakeholders who were keen to understand the issues affecting children and young people with rare and complex conditions and to hear first-hand about the experience our staff. We have been able to brief our visitors on what we perceived the impact of the pandemic had been on children needing healthcare and the importance of ensuring they were prioritised as we moved towards recovery.

Ruth May the Chief Nursing Officer, England and Rachel De Souza, the Children's Commissioner both spent some time with the families we are caring for from Ukraine as well as the staff looking after them. The Children's Commissioner also visited a number of other wards and heard from children and young people first-hand about their experiences. We are looking forward to setting up a follow-up meeting for her with our Young People's Forum as well as a visit to our school.

We also hosted Gillian Keegan, Minister for Care and Mental Health, who spent some time with our apprentices and our staff who lead and manage our multi award-winning programme.

Finally, The Rt Hon Sajid Javid, Secretary of State for Health and Social Care, returned to GOSH after his visit last Summer to host a roundtable on rare diseases. Here he heard from parents of children with rare diseases, charities, clinicians and researchers about the issues they face and potential solutions. The Health Secretary also spent some time on our Intensive Care Unit talking to staff and patients.

Working alongside our colleagues in the Children's Hospitals Alliance (ten of the largest paediatric trusts in England) we are developing a programme of work that builds on the success of the Paediatric Accelerator. Since it has not been possible to identify central funding, we have scaled this back through a self-funded model. We will be prioritising work to develop shared approaches to transformation for elective recovery, virtual hospital care, innovation, data sharing, analytics and tackling health inequalities.

An evaluation of the paediatric accelerator programme has been prepared by the PMO team and is shared with this report, which covers the following successes across the partnership:

- Delivering 101.6% of activity May-Nov 2021 - 38,000 more episodes than 2019-20
- £1m Artificial Intelligence project to identify children at risk of not attending – 7 out of 10 Trusts sharing data, tool at 80% accuracy
- 10 health inequalities intervention pilots, building on the AI tool: free transport; appointments in schools; access for patients with ADHD; new virtual models of care.
- Data and benchmarking; activity & finance; demand; impact of deprivation; ADHD / autism, inequalities data
- Super Saturdays: 2,000 additional appointments; trials of virtual reality in anaesthetics; outreach via a health bus; new multidisciplinary clinics, not to mention celebrating energy, enthusiasm and recognition for staff

Attachment 1: Paediatric Accelerator Evaluation – summary slides

Quality and safety - Ockenden report

We will cover the implications of this wide-ranging and incredibly detailed piece of work by Donna Ockenden and her team during today's agenda. I know that colleagues will join me in acknowledging the importance of the report as a piece of learning for the whole of the health

service, and the value of the insights from patients, families, clinical teams and others who contributed. I look forward to our discussion on how we should best reflect on, implement and monitor implementation of this learning at GOSH and would like to thank the quality and safety teams for their work to map this out for us. This is central to our ongoing journey to develop our safety culture, improve support and training for staff, listen to and work in partnership with families and learn lessons together wherever things have not gone as well as they should have.

National Paediatric Accelerator: Evaluation

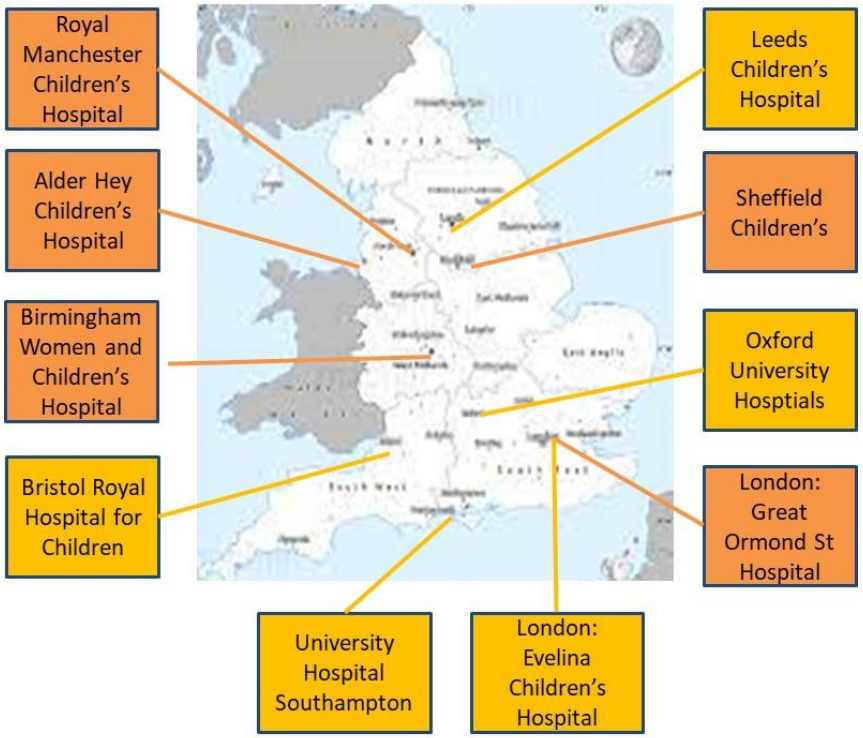
7 April 2022

How the Accelerator was formed

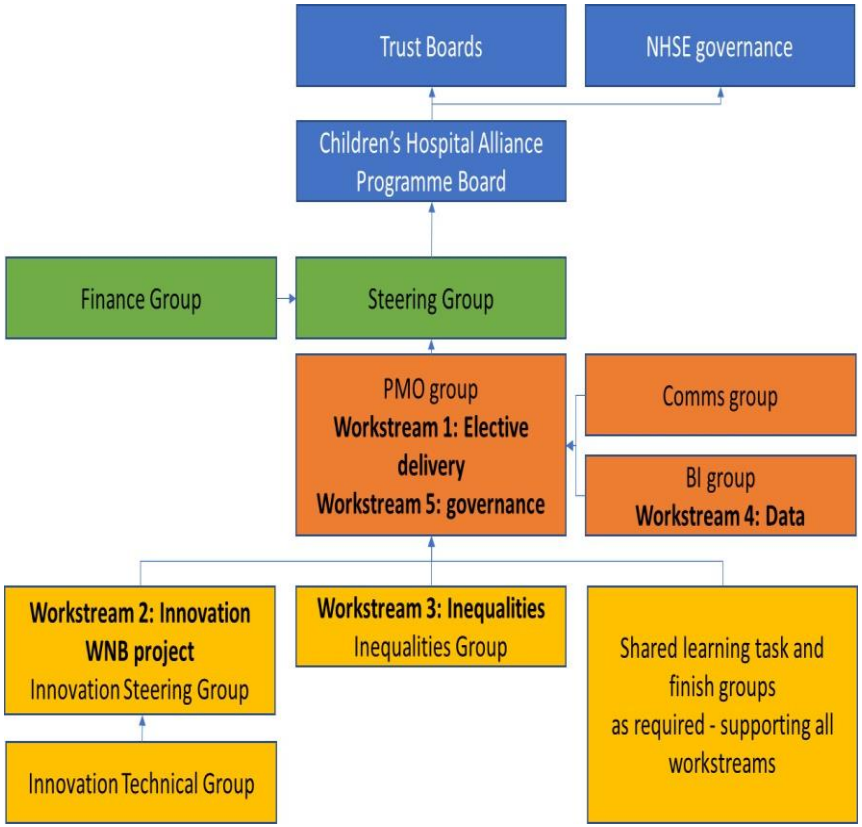
- **April 2021: NHS England announced £160m of ICS-level 'Accelerator' funding** for adult Covid recovery
- **The Children's Hospital Alliance secured £20m** of additional funding for children
- **The business case and the work programme** were drafted by a PMO assembled from the 10 Trusts:
  - £1m for a joint innovation project
  - £2.7m each for transformation in the larger Trusts who were part of the initial £15m bid (Alder Hey, Birmingham, GOSH, Manchester, Sheffield)
  - £1m each for transformation in the smaller Trusts following a successful second £5m bid (Bristol, Evelina, Leeds, Oxford, Southampton)
  - £0.5m for a joint PMO

Members and governance

Geography



Governance



6 main workstreams

Workstream 1: Additional elective activity

- **Objective**:
  - to deliver more than 130% of 2019-20 elective activity in the core Trusts;
  - revised (Sept 2021) to more than 100% of activity

- **We delivered 101.6% overall May-Nov 2021**
  - Core Trusts 103.8%
  - Additional Trusts: 94.7%

- **We delivered 38,000 episodes of activity more than 2019-20** in the core Trusts*

- **Each Trust has developed projects to transform care** as well as incentivising extra activity

** Some of the Accelerator funding was used to fund additional activity directly; some was used to fund enablers e.g. changes to clinical pathways or improvements to our estate. We therefore cannot disaggregate exactly what proportion of the Trusts' overall activity was funded by the Accelerator but it was an essential contributor to all Trusts' performance.*

Workstream 2: Innovation

- **Objective:**
  - to deliver a £1m innovation project across the 10 Hospitals, to help Trusts identify children at risk of not attending their appointments

- **Missed appointments are one of the top 10 avoidable causes of child death** and cost the 10 Trusts £13.4m per year

- **We rolled out an Artificial Intelligence tool to all 10 Trusts** by end March 2022 that allows Trusts to identify in advance which children are most at risk of not attending, so that they can support that child and their family

- **7 Trusts have shared data so far** and the tool is working to an 80% level of accuracy

Workstream 3: Inequalities

- **Objective:**
  - To better understand and reduce the impact of health inequalities in our Trusts
- **We have delivered:**
  - **10 pilot programmes which are directly reducing health inequalities,** building on the AI tool:
  - Birmingham and Sheffield: free transport
  - Leeds, Southampton and Oxford: appointments in schools
  - Manchester: access for patients with ADHD
  - Alder Hey and Evelina: clinician-led calls
  - Bristol and Great Ormond St: patient portals
  - **Data and benchmarking on the impact of deprivation; ADHD / autism, collection of inequalities data**
  - **A community of inequalities leads working together across the Trusts**

Workstream 4: Shared learning and shared delivery

- **Objective:**
  - To share learning between the Trusts to jointly improve delivery
  - To raise staff morale and recognise the contribution of our staff
- **We have delivered:**
  - **10 shared learning sessions** sharing ideas and best practice on e.g.
    - theatre productivity;
    - working with the independent sector;
    - International recruitment;
    - Tackling inequalities in access
  - **2 Super Saturdays**
    - >2000 additional appointments
    - Trials e.g. of virtual reality as an alternative to general anaesthetic; outreach via a health bus; new multidisciplinary clinics…
    - Energy, enthusiasm, and recognition for staff

Workstream 5: data and benchmarking

- **Objective:** provide the evidence base to support Trusts' service changes and quality improvement

- **We have developed monthly monitoring of activity and finance** that NHSE used in preference to their own

- **We have developed benchmarking on**
  - access for patients based on deprivation, ethnicity, and learning disability status
  - outpatients follow-up use across Trusts by specialty
  - Ethnicity data quality

- **We have built demand modelling** for
  - future waitlist growth,
  - future activity requirements,
  - future financial gaps

  which we are using to advocate for more funding for paediatrics services

Workstream 6: PMO and governance

- **Objective**: to establish clear governance and decision making

- **Programme overseen by 3 main groups:**
  - **Steering Group**: COOs from all Trusts. Decision making on all operational issues, met fortnightly
  - **Finance Group**: DoFs from all Trusts. Decision making on all financial issues, met fortnightly, then monthly
  - **PMO group**: Programme lead from each Trust, delivering the project at operational level, met fortnightly

- **Highly effective streamlined decision making**

- **Supported by PMO** with dedicated programme director, programme manager, inequalities lead and admin support

A few highlights from each Trust (1)

Alder Hey

- New ENT Consultant treated 670 additional outpatients & 100 inpatients
- Super Saturdays = 1170 additional OP, 24 theatre lists
- Ortho & Spinal = jointly ran an additional 50 weekend theatre lists

Birmingham

- piloted a High Impact Intensity Theatre list
- Established standby patient and patient call out processes
- Shared learning from Sheffield and GOSH supported a pilot for reducing GA use in MRI
- 200 additional operations and almost 2000 OP consultations

Bristol

- Increased activity by 10% on 2021/22
- Changes to flow in ED
- New MH roles
- New OP neurorehab service & improved allergy service
- New bed capacity in medical ward & new OP capacity

Evelina

- New pre-op assessment software
- 108 slots for neurosciences; reduced FU backlog by 24%
- Urology Fellow – 20 more clinics & extra capacity
- New endocrine consultant saw 570 patients

GOSH

- 13% increase in EL/DC from 19/20, 9% increase in OP
- New Theatre Cleaning Project increased flow
- Integrated rostering and EPR
- Capital investment in equipment increased capacity
- Extra capacity = able to provide mutual aid to Royal Free

A few highlights from each Trust (2)

Leeds

- New Outreach Team for deteriorating children
- New 'Accelerator' Matron
- New Complex Needs Team
- Additional LTV capacity
- Digital OPD room booking system
- 710 more surgeries, 1628 more OP compared w/ 19/20

Manchester

- New dental and day case theatre hubs on 2 sites
- Expansion of theatre Walk In Walk Out pathway
- Additional posts across multiple specialties
- 7,278 additional outpatient appointments and 1,466 elective procedures

Oxford

- 20 highly specialist spinal surgeries with very long waits completed with IS
- 7% increase in OP activity
- supported the Children's Hospital to deliver 106% of 19/20 outpatient activity overall

Sheffield

- Over 210 projects approved
- 130 new colleagues in various roles to support extra capacity
- 5 new permanent OP rooms
- Improvements to theatre suite
- Inequalities interventions eg Health Bus to reach deprived communities
- New joint models for clinics

Southampton

- Expansion of home sleep study service
- Trialled 'intelligent triage' model for dermatology
- New non-medical roles eg pharmacy-led clinics
- Saturday lists providing eg 188 additional elective orthopaedic procedures

National profile and media coverage

- **Objective**: to raise the profile of the Accelerator, with NHSE and our patients - strengthening our ability to advocate for children and recognising the achievements of our staff

- **Successful engagement with NHSE:**
  - contributed 4 case studies to national best practice database
  - Sheffield was filmed for NHSE's programme of media coverage of the Accelerator
  - at national seminar in November we were one of the top performing Accelerators

- **Media coverage focused around the Super Saturdays**
  - Widespread coverage in national and local media (The Independent, Evening Standard, Yorkshire Evening Post, Sheffield Star)
  - Broad reach on social media from participating Trusts
  - Engagement from clinicians and the families of patients – >120 tweets using #NHSSuperSaturday around March event


INDEPENDENT

Children's hospitals in 'Super Saturday' drive to deal with pandemic backlogs

Lego will be put to good use to try and make youngsters feel more comfortable.

William Janes • Saturday 05 March 2022 00:01

Lessons learned

- **Shared working has been energising** and has benefitted all Trusts
- **Need to be equitable going forward** in how we distribute funding
- **Recognise that not all Trusts can move at the same pace**; the smaller Trusts have fewer resources
- **Transparency has been a great strength**; we should do more benchmarking e.g. of waiting lists
- **Senior and operational leadership very successful;** need more clinical voice for the future
- **Next step is to reach out more into our ICSs and regions** – we need to take the benefits out to other Trusts

Next steps

Levels of need next year

- **The Accelerator has helped us control our WL much better than non-Accelerator Trusts** (14% growth overall compared with 22% in 2021*)
- **But 91,000+ children are currently waiting** for care across our Trusts**
- **And another 112,000 weren't referred for services** as we would have expected during Covid – about 67,000 of those are likely to return (based on NHSE assumptions of 60%)
- **We expect WL to rise to 174,000 (more than a 40% rise)** by the end of the year even if we meet all of our waiting list targets AND deliver 104% of activity in 2022-23
- **We will need to deliver more than 130% of activity by 2024-25** to get the WL down to 2019-20 levels

*22% increase in 7 months of 2021: Nuffield Trust 2021
**All other figures on this slide taken from internal CHA modelling

Working together going forward

- **Given the success of the Accelerator we have agreed to take forward the Children's Hospital Alliance** as a self-funded organisation

- **We will continue to work together** to tackle waiting lists and our other challenges

- **We have bid for additional funding** from NHSE, to help us build on momentum and tackle the gap in need following the end of the Accelerator funding – we are waiting to hear the outcome

- **With or without the NHSE funding we will take forward a work programme** that builds on successes to date while focusing more on advocacy for children and engagement with other national partners going forward

The work programme for next year

1. **Transformation for elective recovery**
   - Rolling out transformations that we know work
   - Developing models of surgical hubs and Community Diagnostic Centres for paeds

2. **Innovation**
   - Completing rollout of WNB innovation tool
   - Developing a 'national virtual children's hospital'

3. **Health inequalities**
   - Develop 10 'pledges' for Trusts
   - Research into health inequalities in our Trusts

4. **Insight and metrics**
   - Develop data and benchmarking partic on inequalities

5. **Advocacy**:
   - Raising profile of issues around paediatrics care nationally

6. **Communications:**
   - Developing information sharing between Trusts
   - Develop our brand

Acknowledgements

The programme is the sum of a year of hard work and enormous effort from staff across all of the 10 Trusts. Each of the transformation projects above represents hours of commitment from executive, clinical, managerial, operational, financial, HR, estates, and admin colleagues.

The PMO would like to extend huge thanks to everyone who has helped to make the Accelerator such a success; and in particular, to the leads at each of the Trusts who have worked together with such commitment, good humour and mutual support.

Thank you all.

Annex: Detail of GOSH activities

Great Ormond Street

Successfully Completed Projects under the GOSH Accelerator Programme

Enhanced Theatre Cleaning Project – reducing cleaning process by 2 hours to allow for better flow and utilisation

Integration of Rostering and Electronic Patient Record systems – Producing better objective information for the operational management of patient placement and nurse allocation using live data in the GOSH EPR system

Nurse Call System Improvements – Increasing theatre efficiency by linking the call system across all theatres

Capital Equipment Investment – Purchasing of two flow metres, a rapid Covid testing machine and a Manometry unit for Gastro leading to successful increase in patient activity, and reduced delays and disruption in theatres due to better and more convenient Covid testing

Mutual Aid – Shared resource and capacity led to GOSH supporting system partners

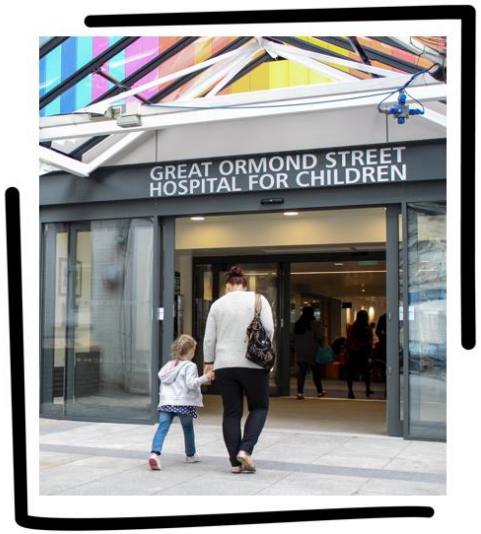
Tiva Pumps – Purchase and utilisation of Tiva pumps created an additional theatre list per day

Additional Administrative Capacity – Additional hours agreed and released increased capacity in validation and clinical support processes

AHU Upgrades – Increased air flow allowed for more spaces to remain accessible for patients

Impact of Projects: May 2021 – Feb 2022

- **42,616 Elective and day case appointments**
  - 1,093 above the Accelerator target, 109 average per month
- **170,149 Outpatient Appointments undertaken**
  - 6,769 above the Accelerator target, 677 average per month
- **Reduction in >52 week waiting list numbers by 54%**
- **Increased patient numbers against the 2019/20 baseline of:**
  - 13% - Daycase and Elective procedures
  - 9% - Outpatients



Attachment P

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street
London WC1N 3JH
T: +44 (0)20 7405 9200
www.gosh.nhs.uk

Deloitte LLP
3 Victoria Square
Victoria Street
St. Albans
AL1 3TF

8 June 2022

Our Ref: PS/AE/2022

Dear Sir

This representation letter is provided in connection with your audit of the annual financial statements and consolidation schedules (together "the financial statements") of Great Ormond Street Hospital for Children NHS Foundation Trust for the year ended 31 March 2022 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view of the financial position of Great Ormond Street Hospital for Children NHS Foundation Trust as of 31 March 2022 and of the results of its operations, other recognised gains and losses and its cash flows for the year then ended in accordance with the directions given by NHS Improvement - Independent Regulator of NHS Foundation Trusts in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006.

As Accounting Officer and on behalf of the board of directors, I confirm, to the best of my knowledge and belief, the following representations.

1. I understand and have fulfilled my responsibilities for the preparation of the financial statements in accordance with the directions given by NHS Improvement - Independent Regulator of NHS Foundation Trusts in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006 which give a true and fair view, as set out in the terms of the audit engagement letter.

2. The methods, the data, and the significant assumptions used by us in making accounting estimates and their related disclosures, including those assessing the impact of Covid-19 on the Trust, are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

3. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of *IAS24 "Related party disclosures".*

   With regard to the transactions and balances listed in the notes to the financial statements, we confirm that to the best of our knowledge and belief these transactions are not significant to the related party or to the Trust such that they would influence decisions made by a user of the financial statements.

4. All events subsequent to the date of the financial statements and for which the applicable financial reporting framework requires adjustment of, or disclosure have been adjusted or disclosed.

5. The effects of uncorrected misstatements and disclosure deficiencies are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements and disclosure deficiencies is detailed in the appendix to this letter.

6. We confirm that the financial statements have been prepared on the going concern basis and disclose in accordance with IAS 1 all matters of which we are aware that are relevant to the Trust's ability to continue as a going concern, including principal conditions or events and our plans. In making our going concern assessment we have adopted the 'continuing provision of service' approach and accordingly we are not aware of any material uncertainties related to events or conditions that may cast significant doubt upon the Trust's ability to continue as a going concern. There are no circumstances that we are aware of that would affect the appropriateness of the 'continuing provision of service' approach. We confirm the completeness of the information provided regarding events and conditions relating to going concern at the date of approval of the financial statements, including our plans for future actions.

7. We acknowledge our responsibility for ensuring the Trust has put in place arrangements for securing economy, efficiency and effectiveness in its use of resources.

8. We are not aware of any deficiencies in the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources.

9. All grants or donations, the receipt of which is subject to specific restrictions, terms or conditions, have been notified to you. We have evaluated whether the restrictions, terms or conditions on grants or donations have been fulfilled with and deferred income to the extent that they have not.

10. We confirm that we have accounted for all income streams from commissioners in accordance with the requirements of IFRS 15, Revenue from Contracts with Customers, assessing each arrangement under the IFRS 15 five step model to determine when revenue

should be recognised. We confirm that all deferred and accrued income balances in respect of transactions accounted for under IFRS 15 have been accounted for in line with our documented assessment of the IFRS 15 five step model (which we have shared with you for all transactions with other NHS bodies).

11. We confirm that where we have provided for potential fines and penalties due to commissioners we have not been notified that these amounts will be waived or forgiven.

12. We confirm that we do not consider there to be any material judgements in applying IFRS 15 that require disclosure in the financial statements.

13. We confirm that we consider all debtors recognised under IFRS 15 to be "contract receivables" and that there are no "contract assets" as at the year-end, as there are no debtors for which the Trust's right to consideration is conditioned on something other than the passage of time (including future performance).

14. Based on discussions with other NHS bodies, we consider that the resolution of disputed balances and accrued income will not result in a material adverse effect on the reported financial position.

15. With respect to the revaluation of properties in accordance with the Group Accounting Manual:

    a. the measurement processes used are appropriate and have been applied consistently, including related assumptions and models;

    b. the assumptions appropriately reflect our intent and ability to carry out specific courses of action on behalf of the entity where relevant to the accounting estimates and disclosures;

    c. we have considered whether any changes are required to the Modern Equivalent Asset assumed in the valuation for the impact of increased infection control requirements following the experience of the Covid-19 pandemic, and following consultation with our valuation experts do not consider any changes are required to assumptions at this time.

    d. we have considered whether any changes are required to the Modern Equivalent Asset assumed in the valuation to reflect changes to requirements as a result of climate change, and following consultation with our valuation experts do not consider any changes are required to assumptions at this time.

    e. the disclosures are complete and appropriate; and

    f. there have been no subsequent events that require adjustment to the valuations and disclosures included in the financial statements.

16. We confirm that we consider that depreciated historic cost is an appropriate proxy for the fair value of non-property assets, and are not aware of any circumstances that would indicate that these assets require revaluation.

17. We confirm we have included all temporary and agency staff used in the year, on a full time equivalent, annualised basis, in our calculation of the fair pay disclosures in the remuneration report, for both the current and prior years.

18. We do not currently have the power to govern, nor do we have control over any of the charities involved with Great Ormond Street Hospital for Children NHS Foundation Trust and as a result have not consolidated any of these charities in our financial statements.

Information provided

19. We have provided you with all relevant information and access as agreed in the terms of the audit engagement letter and required by the National Health Service Act 2006.

20. All transactions have been recorded and are reflected in the financial statements and the underlying accounting records.

21. We acknowledge our responsibilities for the design, implementation, and maintenance of internal control to prevent and detect fraud and error.

22. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

23. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the entity or involves:

    (i) management;

    (ii) employees who have significant roles in internal control; or

    (iii) others where the fraud could have a material effect on the financial statements.

24. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

25. We have disclosed to you all known instances of non-compliance, or suspected non-compliance, with laws, regulations, and contractual agreements whose effects should be considered when preparing financial statements.

26. All minutes of board and management meetings during the year and since the financial year have been made available to you.

27. We confirm that we have disclosed to the Trust all matters as may be necessary for the purpose of making the directors' remuneration disclosures required by the National Health Service Act 2006.

28. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the applicable financial reporting framework. On the basis of legal advice, we have set them out in the attachment with our estimates of their potential effect. No other claims in connection with litigation have been or are expected to be received.

29. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities reflected in the financial statements.

30. We confirm that:

    (i) we consider that the Trust has appropriate processes to prevent and identify any cyber breaches other than those that are clearly inconsequential; and

    (ii) we have disclosed to you all cyber breaches of which we are aware that have resulted in more than inconsequential unauthorised access of data, applications, services, networks and/or devices.

31. We have reconsidered the estimated remaining useful lives of fixed assets and confirm that the present rates of depreciation are appropriate to amortise the revalued amount less residual value over the remaining useful lives.

32. We confirm that no significant fixed assets have been sold or scrapped during the financial year other than those listed in the fixed asset register.

33. Except as disclosed in note 14 to the financial statements as at 31 March 2021, there were no significant capital commitments contracted by the Trust.

34. We have recorded or disclosed, as appropriate, all liabilities, both actual and contingent.

35. We have performed an assessment of the impact on the financial statements of events in Russia and Ukraine including consideration of the impact of sanctions and have disclosed the results of that assessment to you.

We confirm that the above representations are made on the basis of adequate enquiries of management and staff (and where appropriate, inspection of evidence) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

Yours faithfully

Matthew Shaw, Chief Executive Officer
Signed as Accounting Officer, and on behalf of the Board of Directors

Appendix 1

Schedule of Uncorrected Misstatements

Description	Assets DR / (CR) £	Liabilities DR / (CR) £	Equity DR / (CR) £	Income Statement DR / (CR) £
None noted				

Disclosure deficiencies:

#	Disclosure title	Description of the deficiency and explanation of why not adjusted	Amount (if applicable)
	None noted		

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 25 May 2022	
Compliance with the Code of Governance 2021/22 **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment Q** ☐ **For approval**
Purpose of report To present the annual review and supporting evidence against the provisions of the Code of Governance.	
Summary of report Monitor (now NHS Improvement) last revised the NHS Foundation Trust Code of Governance in July 2014. This code consists of a set of Principles and Provisions. Foundation trusts are required to report against the Code of Governance in their Annual Report on the basis of disclosure and compliance with the Code or an explanation where there is a gap in compliance.	
Action required from the meeting The Board is asked to note the review and **approve** the statement to be included in the 2021/22 annual report.	
Contribution to the delivery of NHS Foundation Trust priorities ☐ **Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** ☐ **Responsibilities, roles and accountability** ☐ **Effective processes, managing risk and performance**
Strategic risk implications Compliance with the Code is required in order to retain authorisation as a Foundation Trust	
Financial implications Not Applicable	
Implications for legal/ regulatory compliance Regulatory compliance – Code of Governance	
Consultation carried out with individuals/ groups/ committees Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary	
Who is accountable for the implementation of the proposal / project? The Board is responsible for ensuring continued compliance with the Code to retain authorisation as a Foundation Trust	

Compliance with the Code of Governance 2021/22

Introduction and Summary
Monitor (now NHS Improvement) last revised the NHS Foundation Trust Code of Governance in July 2014. This code consists of a set of Principles and Provisions. Foundation trusts are required to report against the Code of Governance in their Annual Report on the basis of either compliance with the Code or an explanation where there is a gap in compliance.

A review has been conducted against all the Code's provisions and an outline of the evidence to support compliance against each of the criteria is attached at **Appendix 1** (for information). The text in red highlights those criteria against which the Trust is required to explain any areas of non-compliance. The text in green relates to criteria that is required to be disclosed in the annual report. All of these green criteria are presented below

The review has found that the Board has applied the principles and met the requirements of Code of Governance during 2021/22. One provision to draw the Board's attention to is membership engagement (provision B.5.6). Whilst Governors did not personally canvass the opinion of Trust members in 2021/22 on the trust forward plan, Governors did provide comments on development of the GOSH operational plan in 2021/22 and 2022/23. The Trust has also consulted with the local community and patients on the design of the Children's Cancer Centre (a priority in its strategy) and presented plans for delivery of the strategy at the AGM in 2021. We consider these steps adequate to meet the provision taking into consideration the pandemic in 2021/22.

It is proposed that the text provided below is published in the annual report 2021/22 explaining the Trust's compliance with the relevant disclosures in the Code. The section (highlighted in yellow) outlines where in the annual report reference to the provisions of the Code are located that must be disclosed.

Code of Governance
Great Ormond Street Hospital for Children NHS Foundation Trust has applied the principles of The NHS foundation trust Code of Governance on a 'comply or explain' basis. The NHS foundation trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Throughout our annual report we describe how we meet the Code. A summary of where detail can be found on the issues we are required to disclose is given in the following table.

Code reference	Section of annual report
A.1.1	Accountability Report: Council of Governors (role of Council) Trust Board (role of Trust Board) Annual Governance Statement (role of Trust Board)
A.1.2	Accountability Report – Trust Board members 2021–22
A.5.3	Accountability Report – Governors' attendance at meetings 2021–22
Additional requirement (FT Annual Reporting Manual)	A statement about the number of meetings of the council of governors and individual attendance by governors and directors. Accountability Report – Trust Board members 2021–22 Accountability Report – Governors' attendance at meetings

Code reference	Section of annual report
B.1.1	Accountability Report – Trust Board members 2021–22
B.1.4	Accountability Report – Trust Board members 2021–22
Additional requirement (FT Annual Reporting Manual)	Brief description of the length of appointments of the non-executive directors, and how they may be terminated. Accountability Report – Trust Board members 2021–22
B.2.10	Accountability Report: Trust Board Nominations Committee Council of Governors' Nominations and Remuneration Committee
Additional requirement (FT Annual Reporting Manual)	Explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director. Accountability Report – Trust Board members 2021–22 Not applicable
B.3.1	Accountability Report – Trust Board members 2021–22
B.5.6	Accountability Report – Membership Engagement. Whilst Governors did not personally canvass the opinion of Trust members in 2021/22 on the trust forward plan, Governors did provide comments on development of the GOSH operational plan in 2021/22 and 2022/23. The Trust has also consulted with the local community and patients on the design of the Children's Cancer Centre (a priority in its strategy) and also presented plans for delivery of the strategy at the AGM in 2021.
Additional requirement (FT Annual Reporting Manual)	Governors having exercised their powers to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions. Not applicable in 2021-22.
B.6.1	Accountability Report – Evaluation of Board performance
B.6.2	Accountability Report – Evaluation of Board performance
C.1.1	Disclosures -Statement of the chief executive's responsibilities as the accounting officer of Great Ormond Street Hospital for Children NHS Foundation Trust
C.2.1	Annual Governance Statement – review of the effectiveness of its system of internal controls.
C.2.2	Accountability Report – Audit Committee Report
C.3.5	Not applicable for 2021-22
C.3.9	Accountability Report – Audit Committee Report
D.1.3	Accountability Report - Trust Board members 2021-22 Not applicable for 2021-22
E.1.4	Accountability Report – Contacting a Governor
E.1.5	Accountability Report - Trust Board and Council of Governors working together
E.1.6	Accountability Report - Membership constituencies and membership numbers 2021-22 and Membership Engagement
Additional requirement (FT Annual Reporting Manual)	Eligibility for being a member, membership statistics and membership strategy Accountability Report – Council of Governors
Additional requirement (FT	Details of company directorships or other material interests in companies held by governors and/or directors

Attachment Q

Code reference	Section of annual report
Annual Reporting Manual)	Accountability Report: Trust Board and Council of Governors Register of Interest (Directors) Register of Interests (Governors)

Action required from the meeting
The Board is asked to note the review and **approve** the statement to be included in the 2021/22 annual report.

Compliance with the Code of Governance 2021-2022

Key	
	Fully compliant with the requirement
	Partially compliant with the requirement
Red text	Criteria against which NHSI expects the Trust to explain any areas of non-compliance.
Green text	Criteria against which NHSI require disclosure in the annual report

Para	Code of Governance Requirement	Disclosure 2021/22
A.1.1	The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.	A schedule of matters is in place and was updated in September 2020 and approved by the Board and Council. The Constitution was revised in November 2021 in consultation with the Board and Council (update was regarding the tensures of NEDs). It includes an overview of how the Council and Board operates (standing orders).
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	The annual report identifies these individuals and outlines the number of meetings attended by Board members.
A.1.3	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	This statement is incorporated in the Trust's Annual Plan and is documented in the refreshed Trust Strategy.
A.1.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	The Board receives regular reports on quality, safety, patient experience and workforce and these are presented in an integrated report. A seperate report is presented on finance and activity. These reports monitor the Trust's plans and strategies. Corporate risks are reviewed at the Risk, Assurance and Compliance Group (an executive led group chaired by the CEO) and the actions shared with the Audit Committee, Quality, Safety and Experience Assurance Committee (QSEAC) and the People and Education Assurance Committee.. Assurance of the robustness of the controls in place to mitigate these risks is sought by these assurance committees. The annual report provides a summary of the adequacy of these systems. External sources of assurance are sought on high risk/ complex areas .
A.1.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and, in particular, in high risk or complex areas, independent advice, for example, from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	The Board receives regular reports on quality, safety, finance, patient experience and workforce. These include relevant metrics, milestones and measures. The assurance committees seek assurance of the robustness of the controls in place to mitigate risk and direct the internal audit function to provide assurance that these controls are robust. The assurance committees approve the internal audit and clinical audit plan every year.
A.1.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where, within the structure of the organisation, consideration of clinical governance matters occurs.	The Board receives an integrated quality and performance report at each Board meeting (see above). This has been subject to a review and update with streamlining of reporting to the Board and operational teams to support their performance management. The Quality, Safety and Experience Assurance Committee, a committee of the Board, seeks assurance of the adequacy of controls in place to manager quality risks and provides a summary report of matters considered at its last meeting to the next available Board meeting. The Patient, Safety and Outcomes Committee monitors the development and implementation of clinical risk management processes and evidence based standards and ensures that learning is disseminated and embedded across the Trust. PSOC items of significance are reported through to the QSEAC The Trust has approved a Quality Strategy and Safety Strategy.The Quality Report is published annually. Progress with the Quality and Safety Strategies are reviewed by the QSEAC. Compliance with CQC standards and other regulatory and statutory requirements are reported to the Risk Assurance and Compliance Group. An Assurance and Escalation Framework is in place. Learning from incidents, audits, reviews etc. is captured and cascaded by the Closing the Loop Group.
A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	The Chief Executive is aware of his role and responsibility as accounting officer for the Trust and signs the statement in the annual report.
A.1.8	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).	Standards of conduct are included in staff job descriptions. The Trust Board and Council of Governors' Code of Conduct was refreshed in 2019 and reflects these values (including the Trust's Always Values and accepted standards of behaviour in public life). The Code of Conduct has recently been reviewed and was approval at the Board and Council in May 2021 and July 2021 respectively.

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A.1.9	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.	See above on the Code of Conduct for directors and governors. The directors and governors are asked to submit an annual, mandatory declaration of interests using the new web portal reporting system and are prompted to declare any interests at the start of every Board meeting. The live register of interests for directors and governors is published on the GOSH website. The Trust Board ToR states: "Encourage and promote openness, honesty and transparency about performance with patients and their representatives, the public, staff, governors, members and other stakeholders;"

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A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	This cover is provided under the LTPS (NHSLA). The Trust has also arranged top up insurance to provide additional indemnity for risks not covered by the NHSLA e.g.: • Claims made against the Entity itself • Past Directors, Governors, Employees.
A.2.1	The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the board of directors.	The responsibilities of the Chair and Chief Executive are set out in writing in their Job Descriptions. A summary of these responsibilities are also documented.
A.2.2	The roles of chairperson and chief executive must not be undertaken by the same individual.	The Chair and Chief Executive roles are undertaken by two separate individuals.
A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	The Chair meets the independence criteria and has not been chief executive of the Trust.
A.4.1	In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	The senior independent director is Mr James Hatchley appointed by the Board in consultation with the Council in April 2017. The deputy chair is Akhter Mateen, appointed in April 2017. The SID attends Council meetings, is available to speak with governors individually and invites comments from governors on the appraisal of the Chair during the period.
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate.	The Chair held meetings with the NEDs during the year without the executives present. The Senior Independent Director (SID) lead the performance evaluation of the Chair and consults with the other NEDs, executives and the governors on his performance.
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	Any matters raised are recorded in the minutes of the meetings and the minutes reviewed and approved at the next relevant Board meeting.
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	The Council of Governors meets 4 times a year as a minimum (excluding extraordinary meetings). Governor attendance at meetings is recorded in the annual report. Governors are provided with regular reminders about meetings (including opportunities to observe Board and assurance committees) via the monthly Governor bulletin.
A.5.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the council of governors should be reviewed regularly as described in provision B.6.5.	The Council is made up of 27 governors. When revising the Constitution in July 2018, the Board and Council agreed that this was of a sufficient, representative size. The Trust undertakes annual elections where approximately a third of govenors seats are subject to election.
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	This information is recorded in the annual report which is published on the website. The Constitution includes an expectation of the number of meetings that governors should attend. A record of attendance for governors is maintained and is available in the annual report, as part of the information published for governors seeking re-election and on request throughout the year.
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	The annual report outlines the role and responsibilities of the Council, highlighting the responsibilities of the Council towards members and stakeholders. This is also included on the GOSH website and in other promotional material. The schedule of matters highlights the Council's responsibilities. This document was updated in September 2020.
A.5.5	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant director present at the meeting about the affairs of the NHS foundation trust.	The chief executive provides a written report at each Council meeting. Non-executive directors attend the Council meeting on a regular basis and answer questions from governors which is recorded in the Council meeting minutes. Executive Directors are invited to present on relevent reports. Governors receive feedback from the non-executive chairs of the Board assurance committees. Governors are invited to attend to observe the Board and assurance committee meetings.Governors are invited to NED Buddying meetings to discuss items raised at assurance committees. Governors hold a private meeting with the Chair prior to every Council meeting to discuss matters raised in the Council papers and ask questions.
A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the *new provider licence* or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director (see A.4.1).	The Constitution details how such issues will be managed. The SID is available to discuss concerns about the performance of the board of directors and/or compliance with licence requirements. All of the Non-Executive directors attend each Council meeting and are available to answer questions about performance matters. The Chair holds a private meeting with Governors prior to each Council meeting and provides the opportunity to ask any question and receive updates on key matters. Governors are invited to attend buddying sessions with NEDs.

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A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Governors are invited to attend the Board and observe the assurance committees. A monthly bulletin is sent to governors, updating them on development opportunities, requests for information, media news stories and the key meeting dates for diaries. The Trust seeks to spell out all acronyms in Council papers. A glossary of terms has also been circulated to governors. Governors are invited to attend buddying sessions with NEDs. Information is circulated to governors on significant issues arising between Council meetings via email. Governors are asked fo their views about topics for development sessions that take place before Council meetings. The Lead Governor asks Governors to comment on the proposed agenda for the next council of governors meeting and add any items for discussion.

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A.5.8	The council of governors should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	The Council will seek to engage with the Trust Board should this situation arise, through the Lead Governor and Senior Independnet Director.
A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example clinical statistical data and operational data.	At every meeting, the Council receives a report from the Chief Executive which includes information on key news and developments as well as finance and performance targets and quality indicators (covreing safety and patient experience) and workforce. Governors receive feedback from the non-executive chairs of the Board assurance committees. Governors are invited to attend to observe these assurance committee meetings. Governors who attended the Assurance meetings share their feedback with other Governors. Emails are sent to governors on significant matters arising between Council meetings. A monthly bulletin is sent out to governors, updating them on development opportunities, requests for information, media news stories and dates for diaries. The Chair of the Council holds a private meeting with governors prior to each Council meeting to answer any questions.
A.5.10	The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.	The Lead Governor holds a private meeting with other Governors on Council days to discuss the Council agenda and consider issues to raise at the Council meeting that day. Governors receive externally facilitated training on how to hold the NEDs to account for the performance of the Board. Governors make up the majority of members on the Council Nominations and Remuneration Committee whch is responsible for considering recommendations for appointment, removal, performance asessment and remuneration of the Chair and NEDs.
A.5.11	The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the *NHS Foundation Trust Annual Reporting Manual*: (a) the annual accounts; (b) any report of the auditor on them; and (c) the annual report.	These documents were presented to the Council at the Annual General Meeting and Annual Member's meeting in September 2021.
A.5.12	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	A new portal is being set up where Governors will have access to these documents at all times and can be easily found in one place abd provide a secure solution to share the private board minutes. The public agenda and papers are available on the Trust website and the link is sent to governors via the newsletter. Governors are invited to attend Board public meetings.
A.5.13	The council of governors may require one or more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the council of governors to decide whether to propose a vote on the trust's or directors' performance.	The executive directors (when appropriate) and non-executive directors attend most Council meetings and provide information about performance of the Trust. This includes updates from those non-executive directors who chair Board assurance committees (Audit Committee, Quality, Safety and Experience Assurance Committee, People and Education Assurance Committee and the Finance and Investment Committee).
A.5.14	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board of directors takes place before considering such a referral, as it may be possible to resolve questions in this way.	Governors are provided with a copy of the Code of Governance on appointment.
A.5.15	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the board of directors. These new voting powers require: • More than half of the members of the board of directors who vote and more than half of the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust. • More than half of governors who vote to approve a significant transaction. • More than half of all governors to approve an application by a trust for a merger, acquisition, separation or dissolution. • More than half of governors who vote, to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income. • Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions. NHS foundation trusts are permitted to decide themselves what constitutes a "significant transaction" and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.	The Constitution covers all of these rights and voting powers.

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B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the director: • has been an employee of the NHS foundation trust within the last five years; • has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust; • has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme; • has close family ties with any of the NHS foundation trust's advisers, directors or senior employees; • holds cross-directorships or has significant links with other directors through involvement in other companies or bodies; • has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or • is an appointed representative of the NHS foundation trust's university medical or dental school.	The annual report details the independence of all of the non-executive directors. It notes that one NED is nominated by University College London. All directors are asked to annually declare any interests, including the matters outlined under B.1.1. Directors are also prompted to declare any interests at the start of every Board meeting
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	The Board is comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London.
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	None of the directors on the GOSH Board are governors on the GOSH Council of Governors, nor a governor on another Trust's Council of Governors.
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	This information is included in the annual report (accountabiility report) and on the Trust website.
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them.	There are two nomination committees at GOSH: one for the appointment of the Chair and NEDs and one for the appointment of executive directors. The executives have in place a succession plan for executive positions.An analysis of Board skills, experience and knowledge audit as undertaken and presented at the Council and Board in June/July 2021. The Council of Governors approved the Succession Plan for NEDs at their meeting in November 2021 for those NEDs whose terms are coming to an end in 2022
B.2.2	Directors on the board of directors and governors on the council of governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations	The directors on the Board have all been required to sign a statement declaring that they meet the criteria of a 'fit and proper person'. Further checks are conducted with regards director disqualifications and bankruptcy and on an annual basis. Directors are subject to a DBS check on appointment and every 3 years. An annual report of complaince is presented to the Trust Board Remuneration Committee. Governors are asked to make a declaration about their fitness to hold the role of Governor and are subject to a DBS check every three years (and on appointment/ election).
B.2.3	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	There are two nominations committees - the Trust Board Nominations Committee and the Council Nominations and Remuneration Committee. A Board skills analysis is undertaken to enable the Board and Council to review the structure and composition of the Board. An analysis of Board skills, experience and knowledge audit as undertaken and presented at the Council and Board in June/ July 2021.
B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman.	The Council Nominations and Remuneration Committee is chaired by the chair of the Board and Council. The terms of reference of the Council Nominations and Remuneration Committee states that when the chair is being appointed or reappointed, the deputy chair shall take his or her place, unless he or she is standing for appointment, in which case another non-executive director shall be identified and agreed prior to the meeting to take his or her place. A majority of the committee is made up of governors (at meetings and at NED appointment panels). The Board Nominations Committee is chaired by the Chair of the Board.
B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors.	In 2021/22 the Council of Governors approved the following: • Chris Kennedy, Non-Executive Director was reappointed by the Council of Governors for a further three-year term from 1 April 2021. • Kathryn Ludlow, Non-Executive Director was reappointed by the Council of Governors for a further three-year term from 6 September 2021. • Akhter Mateen, Deputy Chair and Non-Executive Director's tenure was extended from 28 March 2021 until 30 June 2022.

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B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	The Council of Governors nominations and remuneration committee comprises the chair of the Trust, the deputy chair, lead governor, two governors from the public constituency and/or the patient and carer constituency, one staff governor and one governor from any constituency (patient and carer, public, staff or appointed). A majority of the committee is made up of governors (at meetings and on appointment panels).
B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The Council takes into account the views of the Board on the qualifications, skills and experience required for the a new NED position. For the reappointment of the NED, the committee considers the results of the NED's appraisal, attendance, input and engagement with stakeholders including the Council.
B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.	The annual report includes an overview of the process followed for appointment of new NEDs.
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	An independent external adviser is not a member of the nominations committees and does not have a vote. Independent external advisers are invited to attend the interview panels for all executive and NED appointments but do not have a vote.
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	This information is presented in the annual report. The Trust Board Nominations Committee and the Council of Governors' Nominations and Remuneration Committee Terms of Reference are published on the Trust website. The Board Nominations Committee terms of reference are currently under review
B.2.11	It is a requirement of the 2006 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	The Nominations Committee terms of reference details these requirements.
B.2.12	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	The Nominations Committee terms of reference details these requirements and are subject to review. The Council approved the appointment of the current Chief Executive in November 2018.
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors.	This process is documented in the Trust Constitution.
B.3.1	For the appointment of a chairperson, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. No individual, simultaneously whilst being a chairperson of an NHS foundation trust, should be the substantive chairperson of another NHS foundation trust.	The Chair JD and terms and conditions define the role and capabilities required including an assessment of the time commitment expected. The Chair's significant commitments are documented in the annual report and declared in the register of interests as well as presented to the Board. The Chair is not a chair of another NHS Foundation Trust.
B.3.2	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved and the council of governors should be informed of subsequent changes.	The terms and conditions of the NEDs were revised and approved by the Council in February 2020. Significant commitments and experience are presented to the Council when considering approval of the appointment. The non-executive directors' significant commitments are reported in the Trust annual report.
B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairperson of such an organisation.	None of the executives or the Chair have taken on a non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity. The Deputy Chair is also a NED on another Foundation Trust.
B.4.1	The chairperson should ensure that new directors and governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek out opportunities to engage with stakeholders, including patients, clinicians and other staff. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.	New directors and governors receive information as part of their induction and are required to attend a tailored Trust corporate induction programme. The Governor induction process has been refreshed including external speakers attending and training on roles and responsibilities. Governors receive information on an on-going basis via presentations to meetings and separate development sessions. The diector induction prgramee is curently under review. Directors have access to development programmes organised and run by NHS Providers, the Kings Fund, Deloitte etc.Governors are invited to attend similar external events and report back to the Council. The Board has a Board Development Progamme in place inviting external speakers to present on matters of risk, innovation, policy develeopment etc.
B.4.2	The chairperson should regularly review and agree with each director their training and development needs as they relate to their role on the board.	The Chair held appraisal meetings with the NEDs during the year and discussed their training and development as they relate to the Board.
B.4.3	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	New governors receive information as part of their induction and are required to attend a tailored Trust corporate induction programme. The Governor induction process includes external speakers attending and training on roles and responsibilities. Governors receive information on an on-going basis via presentations to meetings and separate development sessions.Governors are consulted on the content of their development programme. Governors attend meetings with other governors run by external organisations such as Deloitte and NHS Providers and report back to meetings.

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B.5.1	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	The Board agenda and information contained within the reports is under constant scrutiny to ensure that the appropriate level of information is available to directors. The Board receives an integrated quality and performance report at every public meeting. This has recently been subject to a review and update, streamlining the reports for Board and operational meetings. The communication team regularly send around press updates to the Board and the Council. The Board work calendar mirrors reporting around the Well Led KLOEs and Trust strategy. Any significant matters are communicated to the Board as soon as possible by email, rather than wait for the next board meeting. The Chair/ CEO emails governors between meetings on significant matters to ensure that information is shared in a timely way, rather than wait for the next Council of governors meeting. The Council of Governors receive a monthly ebulletin updating them on important matters, highlighting access to training events and other events where they can meet members.
B.5.2	The board of directors and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The non-executive directors request deeper analysis of high risk areas during Board and assurance Committee meetings. Access to external assurance/ advice is made available on request, for example legal advice around agreements regarding large scale development contracts or commercial matters.
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decisions to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Where requested, external advice is sought, for example legal advice or HR advice.
B.5.4	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	The Company Secretary, Deputy Company Secretary. Head of Corporate Governance, Trust Board Administrator and Stakeholder and Engagement Manger supports the duties of the Board, Council and their respective committees.
B.5.5	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the board, in particular making full use of their skills and experience gained both as a director of the trust and also in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of an NHS foundation trust as they would in other similar roles.	Non-executive directors provide feedback on information received at Board meetings. As a result and where necessary, additional information is provided/ professional and legal advice is sought. Non-executive directors complete the Annual Effectiveness survey for each Board Assurance Committee they are a member of and this includes questions on timeliness of information and appropriate challenge
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Whilst Governors did not personally canvass the opinion of Trust members in 2021/22 on the trust forward plan, Governors did provide comments on development of the GOSH operational plan in 2021/22 and 2022/23. The Trust has also consulted with the local community and patients on the design of the Children's Cancer Centre (a priority in its strategy) and also presented plans for delivery of the strategy at the AGM in 2021.
B.5.7	Where appropriate, the board of directors should take account of the views of the council of governors on the forward plan in a timely manner and communicate to the council of governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.	The Council fed comments into development of the GOSH operational plan 2022/23
B.5.8	The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan.	The Trust Board took account of the views of the Council of Governors on the NHS foundation trust's forward plan.
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.	As part of their routine scheduled inspection programme, the CQC conducted an independent well-led inspection of the Trust in October 2019 (reporting in January 2020) and during 2020/21, the Board monitored progress with the action plan. The Trust conducted a tender process to appoint an independent organisation to conduct a Well Led assessment of the Trust Board and Senior Management Team. The review commenced in March 2021, led by BDO LLP who have no other connection with the Trust. The purpose of the assessment is to provide assurance of the Trust's compliance with the framework and identify any gaps for improvement areas of good practice. The findings were considered by the Trust Board in July 2021 and an action plan is in place and progress monitored by the Trust Board. The Board assurance committees conduct annual self assessments and use the findings to review the terms of reference and workplans where relevant.
B.6.2	Evaluation of the boards of NHS foundations trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	The Trust conducted a tender process to appoint an independent organisation to conduct a Well Led assessment of the Trust Board and Senior Management Team. The review commenced in March 2021, led by BDO LLP who have no other connection with the Trust. The purpose of the assessment is to provide assurance of the Trust's compliance with the framework and identify any gaps for improvement areas of good practice. The findings were considered by the Trust Board in July 2021 and an action plan is in place and progress monitored by the Trust Board.
B.6.3	The senior independent director should lead the performance evaluation of the chairperson, within a framework agreed by the council of governors and taking into account the views of directors and governors.	The SID leads the performance evaluation of the Chair and discusses the Chair's performance with the executive directors, NEDs, external stakeholders and governors (via the Lead Governor). The Chair performance review process is aligned with guidance from NHSI.

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B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	All directors are subject to performance evaluation, identifying any personal professional development requirements. Non-executive directors individually attend professional development events held by the Kings Fund, the NHS Providers, auditor companies etc. The Board has a Board Development Progamme in place inviting external speakers to present on matters of risk, innovation, policy develeopment etc.
B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors. • communicating with their member constituencies and the public and transmitting their views to the board of directors; and • contributing to the development of forward plans of NHS foundation trusts. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.	An evaluation of the Council was conducted in January 2022 and the analysis of the results presented to the Council in February 2022 along with an action plan. The Council will be kept updated on the progress against the agreed actions. The structure and composition of the Council was reviewed and refreshed in 2018 at the time of the review of the Constitituion.The Constitution is reviewed at least once a year via the Constitution Working Group, including governor and Board members. Members can communicate with governors via the foundation trust GOSH email address (emails are sent on to the relevant governor) This information is also presented in the annual report. Governors have the opportunity to engage with their member constituents through the Get Involved Newsletter sent every quarter.
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	The Constitution details the process for removal of a governor including the requirements to attend a certain number of Council meetings and management of potential conflicts of interest. A Standard Operating Procedure outlining the process for managing governor attendance was agreed by the Council in November 2021.
B.7.1	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g., two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (e.g., two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.	Following the performance evaluation and at the time of reappointment, the chair confirms to the governors the performance of the individual proposed for re-appointment continues to be effective and demonstrates commitment to the role. In November 2020, the Council approved an amendment to the Constitution to allow for the extension of Chair and Non- Executive Director appointments beyond the usual 6 year maximum period (2 x three year appointments) in "exceptional circumstances". Any additional approved period will be reviewed by the Council annually. During 2021/22, the Council approved the following: •Chris Kennedy, Non-Executive Director was reappointed by the Council of Governors for a further three-year term from 1 April 2021. •Kathryn Ludlow, Non-Executive Director was reappointed by the Council of Governors for a further three-year term from 6 September 2021. •Akhter Mateen, Deputy Chair and Non-Executive Director's tenure was extended from 28 March 2021 until 30 June 2022.
B.7.2	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.	The Foundation Trust conducted a Council election in January 2022 for terms to commence from 1 March 2022. The information presented to members for the elected governors who wished to be re-appointed included information about their attendance at meetings and involvement in committees and other activities. The next Foundation Trust election is scheduled for November 2022 to January 2023.
B.7.3.	Approval by the council of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the chairperson and non-executive directors.	The Trust is compliant with this requirement. The Board's Nominations Committee Terms of Reference details the appointment process for executive directors. The ToR are currently under review.
B.7.4	Non-executive directors, including the chairperson should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	The Trust is compliant with this requirement. The process for appointing a new NED is subject to approval by the Council. The panel appointing a NED is made up of a majority of Governors and the Council approves the appointment.
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	The Trust complies with this requirement. A Council election was conducted in January 2022. Previously tenures available were staggered to prevent the turnover of the entire Council at the end of a 2 x 3 year tenure. All tenures going forward are now for up to 3 years (up to 6 years maximum).
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	The Board is aware of this requirement.
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	These statements are presented in the annual report.
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	This statement is presented in the annual report and states that the Trust is a going concern.
C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	The Trust publishes an annual report outlining financial, quality and operating objectives for the NHS foundation trust. The Council of Governors receives performance and financial information at each meeting and all directors attend Council meetings to answer any questions where required. The annual plan is consulted on with the Council. Public Board meetings and Council of Governors meetings are advertised and the papers are available on the GOSH website.

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C.1.4	The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.	The directors maintain an open dialogue with the regulators (both NHS Improvement and CQC), reporting any significant matters and ensuring that these are also flagged with the Council both between meetings and at the next relevant Council meeting.
C.2.1	The board of directors should maintain continuous oversight of the effectiveness of the NHS foundation trust's risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.	The Trust is compliant with preparing and reviewing the annual governance statement. The Risk Assurance and Compliance Group (RACG) comprises executives, quality, safety and also compliance leads. The Group is chaired by the Chief Executive and reports to the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. The RACG monitors the effectiveness of risk management systems and the control and assurance processes across the Trust, including the effectiveness of the controls cited to mitigate the strategic risks on the Board Assurance Framework (BAF) and the timeliness of the closure of gaps in controls and assurances of these risks. It considers the breadth of compliance requirements applied to the Trust and monitors responses to external and internal reviews of services and implementation of the policy governance framework. The NEDs meet once a year to focus on risk management, including how the Trust scans for emerging risks, risk appetite, escalation of risk and the relationship between incident reporting and risk management. The assurance committees (NED led) conduct deep dives into BAF risks at every meeting, with NEDs posing questions to seek assruance about the robustness of the controls cited and timeliness of the actions in place to close gaps.
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	The annual report presents this information.
C.3.1	The board of directors should establish an audit committee composed of at least three members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively, including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.	The Trust is compliant with this requirement. The Audit Committee presents an annual report within the Trust Annual Report.
C.3.2	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly. It should include details of how it will: • Monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them; • Review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems; • Monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements; • Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; • Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and • Report to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.	The Audit Committee's terms of reference outline its role and responsibilities and are published on the GOSH website.
C.3.3	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.	The Council was involved in the appointment of Deloitte LLP in 2018/19 and extended the contract for 1 year in January 2022 (within the terms of the original contract)
C.3.4	The audit committee should make a report to the council of governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable to council of governors to consider whether or not to re-appoint them. The audit committee should also make recommendation to the council of governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.	The Council receives an update from the Audit Committee Chair on the performance of the external auditors. The external auditors were appointed by the Council in 2018 via an open tender process and a working group including governors and Audit Committee members

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C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	This statement is not applicable for 2021/22
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.	Deloitte LLP have been appointed for up to 5 years from 2018/19, following a competitive tender process.
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	The Trust will be compliant with this requirement, should the situation arise. Deloitte were re-appointed as the Trust's external auditors following a competitive tender process. The Council was involved in the appointment of Deloitte LLP in 2018/19 and also agreed to extended the contract for 1 year in January 2022 (within the terms of the original contract)
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	This matter is the responsibility of the Audit Committee and documented in its terms of reference. The Committee receives a quarterly report on an whistle blowing and Freedom to Speak up cases and actions taken to address issues raised. The QSEAC considers any reports that are related to the quality of care arising from whistle-blowing/ Freedom to Speak Up. The PEAC receives an update on any reports related to staff issues from whistle blowing and seeks assurances of the Freedom to Speak Up service and processes.
C.3.9	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	The Trust Annual Report includes an Audit Committee annual report and covers the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed and the effectiveness of the external audit process. The Audit Committee considers application of the non audit services policy and reports this to the Council of Governors.
D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: i) The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate. iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	Executive directors are not awarded annual bonuses.The Remuneration Committee remuneration policy has the flexibility to consider whether an element of performance related pay will be included within senior manager contracts. This is consistent with NHSI guidance.

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D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	The terms and conditions of service of the Chair and the NEDs were updated in February 2020 and approved by the CoG. The Council of Governors' Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Council of Governors. The remuneration for the Chair and NEDs was last considered in April 2020 and agreed it would be reviewed in another three years. Therefore there has been no uplift applied to the Chair and NEDs' remuneration in 2021/22.
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	No executive director has been released on this basis during the period.
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	All executive director contracts require 6 months' notice period. The Chief Executive and executive director terms and conditions of employment are set by the Board Remuneration Committee (except for pension entitlements which are managed in accordance with the provisions of the NHS Pension Scheme). Contracts issued to directors allow the Trust to terminate employment in accordance with employment legislation (for instance, for unsatisfactory performance, capability, ill health). On termination due to poor performance, directors receive their right to notice of dismissal (except in cases of gross misconduct where dismissal without payment of notice can occur) and any other relevant contractual entitlement (such as payment of outstanding annual leave). Non-contractual payments on dismissal cannot occur without the authorisation of the Remuneration Committee and taking into account guudance from external bodies NHSI and the Treasury); the Committee, therefore, can ensure Directors are not financially rewarded (beyond their contractual entitlements) if their employment is terminated on the grounds of poor performance.
D.2.1	The board of directors should establish a remuneration committee composed of non-executive directors which should include at least three independent non-executive directors. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	The Trust Board has established a Remuneration Committee, chaired by a NED and including all non- executive directors as members (therefore complying with the requirement for at least three independent NEDs). Terms of reference are in place. A remuneration consultant was not employed during the period.
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.	The terms of reference of the Trust Board Remuneration Committee covers these areas. The Chief Executive determines the remuneration for non Board senior managers (first layer below Board) and reports this to the Remuneration Committee for monitoring purposes.
D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	The Council of Governors' Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Council of Governors. The remuneration for the Chair and NEDs was last considered in April 2020 and agreed it would be reviewed in another three years. Therefore there has been no uplift applied to the Chair and NEDs' remuneration in 2021/22.
D.2.4	The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson.	This is the case - see above.
E.1.1	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	The Patient and Family Experience and Engagement Committee is responsible for overseeing involvement of members, patients and the local community at large. Information from the committee is reported to the Board (via the integrated quality and performance report) and the Council. The Board has approved a Patient Experience Framework and assurance of progress is reported at the QSEAC..
E.1.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g. Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups)	A summary of patient and local community engagement activity is included in the annual report. The Trust has also approved a Stakeholder Engagement Strategy.
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	The Chair presents a summary report of the previous Council meeting to the Trust Board. The Chair holds a private meeting with governors prior to every Council meeting. NEDs (and executive directors) regularly attend Council meetings (including the SID). The NEDs provided opportunities for governors to meet with them via the buddying system (in addition to the normal general meetings) Emails from governors raising any concerns are shared with the executive and non-executive directors.
E.1.4	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	All governors are promoted on the Trust website and members can communicate with them via the foundation trust GOSH email address. This information is also presented in the annual report. Governors have been involved in drafting content for the Get Involved newsletter to Members. See B.5.6 for information about consultation held during the year with members.
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	All NEDs attend Council of Governors meetings and executives attend where required. The annual report outlines how the Board and the Council of Governors have worked together during the year.

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E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	The Membership Engagement, Recruitment and Representation Committee (MERRC) routinely reviews the representation of the membership and report this to the Council. This information is also presented in the annual report, at Council meetings and in the annual membership report. The new Trust Membership Strategy has been developed in consultation with MERRC andwill run from April 2022 for three years.
E.1.7.	The board of directors must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.	The Constitution details that there will be Board meetings held in public and provides for the exclusion of members of the public for special purposes. The annual meeting is also held in public.Due to COVID-19 and the need for social distancing, public Board meetings have been held virtually in 2021/22. Members of the public and governors are able to observe virtually. Agendas and papers are published on the GOSH website prior to the meeting.
E.1.8	The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting.	The annual members' meeting is held every year (September) and the directors present the annual report and accounts and the report from the auditors. The Lead Governor presented the Annual Membership Report. All governors, FT members and members of the public are invited.
E.2.1	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	A schedule of third parties is in place and maintained.
E.2.2	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	The Board and its committees and the executive team review the mechanisms in place for cooperating with third parties on a regular basis, including referrers, NHSI, CQC, commissioners, external auditors, the Charity etc. The Chief Executive and other directors regularly discuss attendance at key stakeholder meetings at the EMT. A Stakeholder Engagement Strategey has been approved by the Board. A section in the Annual Report details our key partners.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25 May 2022

Compliance with the NHS provider licence – self assessment **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment R** □ **For approval**

Purpose of report
To present the annual self-assessment of compliance with NHS Improvement ("NHSI") license conditions for providers of NHS services.

Summary of report
The NHS provider licence is NHSI's main tool for regulating providers of NHS services. The licence sets out important conditions that providers must meet to help ensure that the health system works for the benefit of NHS patients.

An FT Board is required by NHS Improvement to annually declare compliance or otherwise with a small number of FT licence conditions and one requirement under the Health and Social Care Act. It is good governance to assure the Board that these key conditions under the licence have been met.

Action required from the meeting
The Board is asked to **consider and agree** the Trust's response to the four conditions, taking into account the views of the governors.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
□ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** □ **PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** □ **PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training** □ **PRIORITY 4: Improve and speed up access to urgent care and virtual services** □ **PRIORITY 5: Accelerate translational research and innovation to save and improve lives** □ **PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care** □ **Quality/ corporate/ financial governance**	□ **Leadership, capacity and capability** □ **Vision and strategy** □ **Culture of high quality sustainable care** □ **Responsibilities, roles and accountability** □ **Effective processes, managing risk and performance** □ **Accurate data/ information** □ **Engagement of public, staff, external partners** □ **Robust systems for learning, continuous improvement and innovation**

Strategic risk implications
Providers are normally required to complete an annual self-certification that confirms their continued eligibility to hold an NHS provider licence.

Financial implications

Not Applicable
Implications for legal/ regulatory compliance Regulatory compliance – FT licence
Consultation carried out with individuals/ groups/ committees In April 2022, the Council of Governors were asked for their views on the attached conditions and evidence cited
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary and Chief Finance Officer
Who is accountable for the implementation of the proposal / project? The Board is responsible for ensuring continued eligibility to hold an NHS provider licence.
Which management committee will have oversight of the matters covered in this report? The Executive Management Team

Compliance with the NHS provider licence – self assessment

Introduction and Summary
The NHS provider licence is an NHS Improvement tool for supporting regulation of providers of NHS services. The licence sets out important conditions that providers must meet to help ensure that the health system works for the benefit of NHS patients. These conditions give the regulator the power to:

- set prices for NHS funded care in partnership with the NHS England and require information from providers to help them in this process.
- enable integrated care across the NHS system.
- safeguard choice and prevent anti-competitive behaviour which is against the interests of patients.
- support commissioners to protect essential health services for patients if a provider gets into financial difficulties; and
- oversee the way that NHS foundation trusts are governed.

An FT Board is required by NHS Improvement to annually declare compliance or otherwise with a small number of FT licence conditions and one requirement under the Health and Social Care Act. It is good governance to assure the Board that these key conditions under the licence have been met.

Licence condition	Deadline and comment
Condition G6(3): Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution.	The deadline for this declaration is **31 May 2022.** The G6 self-certification (G6(4)) also needs to be published within one month of sign off by the Board (By **30 June 2022**).
Condition CoS7(3): Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service.	The deadline for this declaration is **31 May 2022.**
Condition FT4(8): Providers must certify compliance with required governance standards and objectives	The deadline for this declaration is **30 June 2022.** Board is required to identify risks to achieving the governance standards and any mitigating actions taken to avoid those risks.
NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, as required in s.151(5) of the Health and Social Care Act to ensure that they are equipped with the skills and knowledge they need to undertake their role.	The deadline for this declaration is 30 **June 2022**.

Appendix 1 documents the evidence against the four conditions stating the executive directors' recommendations for each condition.

In previous years, NHSI have required an FT Board to take into account the views of governors when considering whether the Trust confirms compliance with the above declarations. In April 2022, the Council of Governors were asked for their views on the attached conditions and evidence cited. Governors were satisfied with the evidence cited and the Council agreed with the recommendations by the GOSH executive team to confirm compliance with all conditions.

Action required from the meeting
The Board is asked to note that the Executive Directors recommend compliance against all conditions. The Board is asked to **consider and agree** the response to the four conditions, taking into account the views of the governors outlined above.

Appendix 1: FT Licence self-certification – four requirements that must be signed off by the Board

The board must sign off on self-certification for the following licence conditions and H&SCA requirement, taking into account the views of governors.

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
G6 – Systems for compliance with licence conditions and related obligations (scope = past financial year 2021/22)	The Licensee shall take all reasonable precautions against the risk of failure to comply with the Conditions of this Licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS. The steps that the Licensee must take ….shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) regular review of whether those processes and systems have been implemented and of their effectiveness. A statement shall be provided for Monitor to certify compliance with this condition no later than 2	The Executive Team recommend *'confirmed'* compliance. *Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors*	The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance: The Trust's Assurance and Escalation framework, reviewed in January 2022 sets out how the organisation identifies, monitors, escalates and manages concerns and risks in a timely fashion and at an appropriate level. This comprise of 14 elements: • Risk Management Framework • Accountability Framework • Compliance Framework • Escalation Framework • Transparency and Openness • Policy Framework • Strategy and Planning Processes • Business Continuity • Performance Management • Quality Improvement • Workforce Analysis and Planning • Data Assurance Framework • Data Quality Kite Mark Process • Mechanisms for achieving transparency and openness

	months from the end of the financial year.		<u>Risk Management</u> The Trust has an established Risk Management Policy that sets out the framework for GOSH to systematically manage its risks and underpins the commitment by the Trust Board to ensuring a robust risk management system is in place. This extends across the organisation from the front-line service through to the Board to promote the reduction of clinical and non-clinical risks associated with healthcare and research and to ensure the business continuity of the Trust. A review of the Risk Management Policy is underway. The purpose of this review is to document the breadth of different risks managed by the Trust in the policy and improve the framework for escalating, monitoring and reporting on risk across all levels of the Trust. The Trust has a risk management meeting structure in place that enables the effective flow of risk management information. There are a series of operational risk committees, with delegated responsibility from the Executive Management Team. The Operational Board has oversight of trust-wide risks, including the proposal to include a risk on the register. The Board assurance committees scrutinise the effectiveness of the risk management framework and report to Trust Board. Risk Appetite statement: The Trust Risk Appetite statement was updated in May 2021. The approach taken for reviewing the Trust's Risk Appetite statement was based on the 'Risk Appetite Guidance Note' from the Government Finance Function and was led by the Risk Assurance and Compliance Group. Consideration was given to a review of the Trust Strategy and priorities and the context of the risks cited on the Board Assurance Framework. Each risk was considered at a strategic and operational layer, recognising risk appetite for different activities. The Audit Committee, an assurance committee of the Board receives an assurance report of compliance with the risk management policy.

			Board Assurance Framework (BAF) The Trust's Board Assurance Framework is used to provide the Board with assurance that there is a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF records the controls in place to manage the key risks and highlights how the control is operating. The BAF includes cross-references to assurance obtained from internal and external audits, and self-assessments of compliance with other regulatory standards. It has been monitored by the Board assurance committees and updated throughout the year. The Risk Assurance and Compliance Group (RACG) is the executive committee responsible for monitoring progress with the BAF. This includes a 'stress test' of BAF risks checking (using key performance indicators and external assurance information) whether the controls and assurances cited are working and appropriate. The Board Assurance Committees also undertake deep dives into each of their assigned BAF risks. **ASSURANCE**: In 2021, the Trust commissioned an independent, developmental Well-Led Review of its leadership and governance, led by BDO and Arden & GEM. The report highlighted the risk register and the risk appetite statement to be both good and comprehensive, detailing that they are adequately supported by effective active risk management at the Risk Assurance and Compliance Group (RACG). The findings went on to confirm that where potential significant risks have been identified, the Board has undertaken higher profile decision-making and scrutiny and is now rightly seen as being more directly involved with managers on understanding how key issues are being managed. NEDs make a key contribution to governance and assurance, with key reports on quality matters for example providing an opportunity for Board members to triangulate information and give greater confidence that all key risks and issues are known. **ASSURANCE**: In December 2021, KPMG the Trusts Internal Auditors conducted and internal audit into the GOSH BAF. The scope of the audit covered how the BAF is

			prepared and whether there are appropriate governance arrangements in place for monitoring the BAF to obtain assurance that risks are effectively managed. The auditors provided an assurance rating of '*Significant assurance'*(GREEN). Areas of good practice highlighted in the audit included: • A full review of the BAF takes place at least once a year by Board. • Risks are assigned both an Executive owner and a management owner to provide responsibility for implementation and monitoring of actions and oversight of the risk. • Assurance committees are assigned to each of the risks which undertake cyclical deep dives to assess the effectiveness with which the risks are being managed. • The current BAF is structured in a way which makes it clear what the risk is (including the cause, effect, and impact), the key controls in place and the associated assurances on those controls. Six low rated key findings were identified, and an action plan is in place with timelines for completion. This included formally identifying KPIs for each BAF risk and using these as a proxy to monitor the robustness of the controls cited (actioned). <u>Quality Governance</u> The Trust's Internal Auditors, KPMG conducted an Audit on Quality Governance in March 2022. This included reviewing the quality strategy and the ways in which the Trust has set quality objectives and the reporting of quality and safety performance from Board to ward. The Auditors provided an assurance rating of '*Partial assurance with improvements required*'. There was a number of management actions, and a plan has been developed with a timeframe for all of these to be completed by March 2023. The Quality Strategy for the 2021-2025 was developed and approved by the Trust Board in August 2020, however progress against this has been limited as the Trust responded to the pandemic. The Patient Safety Delivery Plan was created in April

			2021 as a consequence of Safety and Quality Strategies, towards redefining the shape and activity of the Patient Safety and Quality Teams and setting the direction of changes needed to take place within the organisation to improve safety. The Delivery Plan is monitored through the Transformation Implementation Board, which features representation from NHSE and the NCL ICS to ensure system collaboration and receives dedicated update reports from the relevant workstreams to ensure appropriate governance is in place. **ASSURANCE**: Whilst there were a number of areas to improve on as a result of the audit there were areas of good practice that were highlighted, and these included: • A Quality Strategy has been developed and approved during 2020, which provides a methodology to support the implementation and embedding of quality improvement. • Formal action plans have been developed to support the Trust in delivering these programmes of work set out in the strategy. The action plans set out for each programme the deadline and the officer responsible for delivery. • The strategy sets out key performance indicators which it will use to assess progress and • success in delivering the priorities laid out in the strategy. • Quality and Safety is a standing agenda item for the Board to discuss and monitor at all meetings and they are updated on the Integrated Quality and Performance Report (IQPR) which sets out performance against all key quality metrics. The Medical Director's Office have undertaken a quality governance structure review and has developed a Quality Governance Management Framework, which is going to the Executive Management Team and Quality, Safety and Experience committee for approval. The Closing the Loop Group which monitors and oversees the completion of actions and learning identified through patient safety investigations, complaints, harm, legal cases, and learning from deaths and this has proven invaluable to cascading learning.

			The 'Managing Internal/ External Review' standard operating procedure provides a clear process for approving the need for a review (internal or external). It also sets out the scope of the review to ensure that it is fair and proportionate, that staff are supported during the review, robust governance arrangements are in place, and recommended actions are implemented in a timely and appropriate way. Examples of the Trust response to external reviews include: 1. Following an MHRA inspection of pharmacy manufacturing facilities in 2019, a hospital pharmacy transformation programme was established. The Trust has since had a number of inspections, most recently in November 2021 and whilst the Trust remains under the scrutiny of the Inspection Action Group, this visit was more successful, and the Trust no longer has any critical findings. A letter received from the IAG on 9th December 2021 requires the Trust to seek third party consultancy support (MHRA approved) to review and improve aseptic processes. The Pharmacy team are seeking to engage such a resource. 2. A virtual inspection of Respiratory and Lung Function took place in December 2021 and no mandatory findings/actions identified. 3. A virtual inspection by the HTA of the renal and cardiothoracic teams took place in October 2021 this included the submission of documentation. An on-site inspection of both specialities took place in November 2021 this was attended by two HTA inspectors. This inspection related to the Trust's transplant licence and included inspectors following the pathway followed by transplant organs once they enter the organisation. The team has been informed that this inspection went well and the HTA were happy with the Trust's documentation submission; and a draft report is anticipated. The Quality Team also: • conduct internal reviews into specialty areas across the Trust. In 2021/22, this included endocrinology, critical care, ophthalmology, renal. The results are reported to the RACG and the actions managed by the relevant directorates.

			• Oversee responses to the Getting it Right First Time (GIRFT) reviews. In 2021/22 this included pathology, paediatric cranial neurosurgery, paediatric surgery, paediatric trauma and orthopaedics, paediatric critical care, dermatology, ophthalmology, hospital dentistry, imaging and radiology and spinal surgery. **ASSURANCE:** Verita undertook an independent review on the effectiveness of the Trusts safety procedures in February 2022; this included whether there are effective processes in place for managing safety risks in red complaints and in claims and inquest. The outcome of the review estimated the Trust are at the 'Reactive' level and suggested a number of improvements which will be considered by the Quality Safety Experience Assurance Committee. <u>Compliance</u> The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with the CQC registration standards. It is the responsibility of these staff to collate evidence of compliance with the standards. The Trust appointed a Director of Safety Surveillance in November 2021 to oversee safety compliance. The Director of Safety Surveillance reports on a monthly basis to the RACG on compliance matters. This report is considered and provides further assurance of the effectiveness of controls in place to manage clinical and non-clinical risks. A database supports monitoring of ongoing inspections, audits and self - assessments. The Director also submits a review of the regular Insight Report from the CQC on GOSH. This is a data rich report on various indicators mapped to the CQC standards. The Closing the Loop Group monitors actions arising from inspections and reviews.

			ASSURANCE: The Trust did not have any CQC enforcement notices during 2021/22. In December 2021, Trust participated in a pilot CQC inspection of dental services provided in a hospital setting; Initial feedback indicated that there were no concerns. <u>Information Governance</u> The Information Governance Steering Group monitors information governance risks and compliance with GDPR and this reports in Executive Management Team. There are clear roles and responsibilities with regards to the ownership of data security with a SIRO, a Caldicott Guardian and a (DPO) all in post. The Information Governance team provides assurance to the Audit Committee that controls are in place and actions identified in order to comply with seven key principles of GDPR and the Data Protection Act 2018. Data Protection Privacy Impact Assessments (DPIA) are undertaken for new projects and policies. All new systems require an appropriate security review by ICT with a focus on any personal data held offsite. A patient and carer privacy notice and research privacy notice is published on the website outlining how the Trust gathers, uses, discloses and manages patient data. Mandatory training on information governance is in place reminding staff of their requirements with regards to confidentiality and the processing of personal data. **ASSURANCE**: This year there have been four serious information governance incidents (classified at a reportable level using the Incident Reporting Tool within the DSPT). Details are as follows: • Personal data shared with the wrong individual: a clinic letter containing confidential information was sent to the incorrect email address. This was recalled but there was no confirmation if the recall was successful. The Local Authority were informed due to safeguarding concerns.

			• Personal data shared with the wrong individual: the address and telephone number was shared without consent during an outpatients appointment. The individual informed the Police due to safeguarding concerns. • Personal data shared with the wrong individual: a clinic letter containing personal information was shared with a patients nursery. Parts of the information should have been redacted. • Patient Record System Flagging System: there have been three incidents where confidential information has been shared across platforms including MYGOSH which is viewable to family members without consent and with potential safeguarding concerns. **ASSURANCE**: Data Security and Protection Toolkit (DSPT): Initially, the Trust did not achieve all standards under the DSPT 2020/21 and presented an action plan to close all gaps. The Trust has closed all outstanding actions and has been informed by NHSD that it is compliant in full against the standards. **ASSURANCE**: The Trust's Internal Auditors, KPMG conducted an Audit on data Security and Protection Toolkit in March 2022. This included assessing the overall design and operation of key mandatory data security and protection toolkit controls at the Trust. The findings of the audit provided *Significant assurance with minor improvement opportunities* (amber/green). The audit concluded there are robust controls in place over the preparation and governance of the DSP Toolkit and listed a number of areas of good practice. <u>Infection Control</u> The Infection Prevention and Control Committee (IPCC) meets monthly and reports to Patient Safety Outcomes Committee. A continuous advice service is provided by IPC Team / Consultant Microbiologists. The Director of Infection Prevention and Control meets regularly with the Chief Nurse. **ASSURANCE:** The Board receives an update on the Infection, Prevention and Control Board Assurance Framework across the year. The Director of Infection, Prevention

			and Control regularly reports to the Board, including compliance with Infection prevention and Control Board Assurance Framework. <u>Referrals with No Future Activity</u> The Trust has become aware of a backlog of open referrals with no future activity. Some of these are as a result of administrative issues within the Epic system. A Taskforce has been established to lead and manage the process to resolve this issue. The taskforce has representation from the Medical Director's Office, the Clinical Directorates, Data Assurance team, Performance Management, Clinical Operations and the EPR Team. The taskforce reports to the Operations Board and EMT. Audit Committee retain oversight of data quality related issues and QSEAC retain oversight of patient safety related issues. <u>Health and Safety</u> The Trust is committed to effectively minimising risks, controlling hazards and preventing harm to all. This is done through a proactive programme of risk assessment and audit. There are clear processes for incident reporting, and we encourage a culture in which staff report incidents. The Trust's governance structure ensures statutory compliance is undertaken within legislative requirements. Assurance via the Health and Safety Committee has been provided on a range of subjects such as sharps compliance, Control of Substances Hazardous, Impact of COVID-19, Ventilation, Fire Safety and Lone Working. Estate compliance remains a key risk for the organisation and is monitored through a risk on the Board Assurance Framework. There are several workstreams that are ongoing, covering areas such as ventilation, fire, management of legionella and these form a significant part of the Above and Beyond Programme for the Space and Place Directorate. The Audit Committee and Quality Safety Experience Assurance Committee continue to receive updates on progress in these areas. **ASSURANCE**: The Quality, Safety and Experience Assurance Committee receives a quarterly assurance report on management of health and safety at GOSH.

			<u>Safeguarding</u> The Strategic Safeguarding Committee, chaired by the Chief Nurse, oversees all safeguarding matters across the Trust and reports into the Patient Safety and Outcomes Committee (PSOC). **ASSURANCE**: In January 2021 a Safeguarding Governance Review was completed by the Head of Special Projects. The review made a number of recommendations split into four areas: 1. Safeguarding Service: Safeguarding Policy Development. 2. Safeguarding Service & Patient Experience 3. Human Resources: Embedding changes to the DBS Policy 4. Patient Experience & HR: Managing visitors on site Joint working across Human Resources, Safeguarding Service, Patient Experience and the Communication Team, resulted in all actions being completed during 2021 and the identified areas where relevant, were included as part of the Safeguarding Implementation Plan 2021/22 and contributed to the overarching Safeguarding Strategy 2021-2024. <u>Performance monitoring</u> Directorate performance reviews usually take place on a monthly basis and are attended by directorate management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused discussion across a number of key domains: Caring, Safe, Responsive, Well-Led (people, management and culture), Effective, Finance, Productivity. The information presented at the performance reviews include an integrated dashboard which provides a one-page summary of key metrics across the domains, allowing rapid identification of linked risks and issues. An integrated performance report is then scrutinised at each Trust Board meeting. This provides a summary of the key issues in each domain and actions planned to resolve, as well as an integrated dashboard – this provides trust level data using the same format as the directorate integrated dashboard reviewed in the monthly performance reviews.

			ASSURANCE: The Trust Board receives the latest data on operational performance and quality/ safety matters at every Trust Board meeting via the Integrated Quality and Performance Report. This tracks performance against key indicators, set nationally and internally at GOSH. The Board are assured by the quality of data reported following an internal audit in 2021/22 which provided an assurance rating of *'Significant assurance with minor improvement opportunities'* (AMBER-GREEN). Areas of good practice highlighted in the audit included: • Supporting evidence of clock stop and start dates was available in all instances. • External organisations are chased up to three times for supporting evidence to be provided. • There are a number of spot checks and audits completed by the Data quality team to help to reduce the number of errors identified. • NHSE guidance is followed for Referral To Treatment rules. • Data is frozen prior to reporting and validation. • There is oversight from the Data Quality Review Group who scrutinise the Referral To Treatment Data Quality Audit report outcomes. • Weekly Challenge Sessions with Directorates to review individual patient pathways, unblock barriers to bookings and monitor performance. • Daily Data Quality Metric Reviews by the Data Assurance Team to correct data and identify areas where additional training is required, or Epic can be enhanced. • Refresh and Relaunch of Referral To Treatment Training for Trust Staff in January 2021. <u>Business Continuity</u> The Major Incident Planning Group meets regularly and reviews implementation and testing of plans and business continuity plans are in place across all directorates/ departments in the Trust. In response to COVID-19, the Trust put in place a system of Gold, Silver and Bronze emergency planning meetings to manage the incident and scenario plan. Regular updates were provided to Board members at meetings and fortnightly between meetings. The Audit Committee retains responsibility for seeking assurance of the robustness of the emergency planning framework at GOSH

			throughout the year. Operating within a pandemic gradually became business as usual for the Trust as well as the rest of the NHS. The trust did not experience any significant business continuity issues during the year. We continuously reviewed and revised our business continuity plans to respond to the issues arising both internally and those affecting our partners **ASSURANCE:** The Trust has achieved NHSE Green status for compliance against the ISO 22301 Standard upon which the NHSE Business Continuity Management Framework is based. <u>Escalation</u> The Trust has systems and processes in place to support staff and patients in escalating concerns in provision of care or management of systems. These include the complaints process, PALS, Freedom to Speak Up Guardian, Guardian of Safe Working, Raising Concerns Policy, Duty of Candour process, Counter Fraud service etc. The Audit Committee seeks assurance, at every meeting, that controls are in place to support staff when raising concerns in accordance with the Raising Concerns at Work Policy. The Board receives a Guardian of Safe Working Report quarterly. The Executive Team actively monitor the responses to duty of candour and hold the directorates to account at performance reviews and via deep dives at Executive Management Team meetings. **ASSURANCE:** KPMG, the Trust internal auditors conducted an audit on the Trust's Freedom of Information framework. It provided a rating of *'Significant assurance with minor improvement opportunities'* (AMBER-GREEN). The audit concluded that the controls in place over recording, monitoring and responding to FOI requests to be well designed. The FOI policy is easily accessible for staff, clearly defines roles and responsibilities is compliant with the Act. Performance is monitored through weekly reporting to the Executive Management Team (EMT) and annually to QSEAC.

			<u>Freedom to Speak Up</u> The Freedom to Speak Up (FTSU) service is part of wider programme of speaking up within the Trust which includes Speak Up for Safety and Speak Up For Values. The service offers independent and confidential support to people so they can speak up and be heard when they feel unable to do so by other routes. The FTSU service is provided by a full-time FTSU Guardian and a small group of FTSU ambassadors. The Guardian works in partnership with the Speak Up programme manager and Associate Medical Director responsible for speaking up. The Guardian reports directly to the Medical Director and meets regularly with the Chief Executive and other senior leaders to provide updates, escalate concerns and provide an overview on thematic concerns. The Guardian also meets with the non-executive director (NED) who is responsible for FTSU and for Whistleblowing. The FTSU Guardian provides quarterly data to the National Guardians Office (NGO) and reports quarterly to the Quality, Safety & Experience Assurance Committee and the People & Education Assurance Committee. **ASSURANCE**: The 2021 staff survey results showed that the Trust has seen an improvement in people feeling secure to raise concerns about unsafe clinical practice at almost 80%. The Trust assesses compliance with the FT licence annually.
CoS7 – Availability of resources (scope = next financial year 2022/23)	The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources	The Executive Team recommend *'confirmed'* compliance. *Response to be considered by the board in light of assurance provided here and taking into account the*	The Trust sets its budget on an annual basis and actively manages and monitors its financial position and resource levels on a regular basis throughout the year through routine performance reporting to the Board and its Committees. The Executive Team actively monitors the finance position to ensure that the mitigations in place are effective and appropriate. The Trust has received NHSE guidance on the new funding arrangements for 2022/23. The current 2022/23 NHSE and NCL contracts have resulted in a fall from the 2021/22 levels of income. From April 2022 funding allocations will be reset to move systems to a fair share distribution of resources and the requirement to sign

	will not be available to the Licensee. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." OR (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might	*views of the governors*	contracts with commissioners will be reinstated. The Trust has set budgets for 2022/23 and worked closely with Directorates to refine these in line with their activity plans following NHSE guidance. No material agreements which might create a material risk have been entered into. Our International and Private Care (I&PC) directorate is an important component of the overall funding model. As part of the initial NHS response to the COVID-19 pandemic, our private wards suspended non-essential treatment and we worked closely with overseas sponsors to repatriate international patients who were able to travel. We have worked closely with overseas clinical teams, providing remote and virtual support. Some of the most seriously unwell and complex patients have still been able to travel for treatment, and the directorate has supported the treatment of NHS patients in spare capacity on the private wards. These global events have had a detrimental impact on the level of private income we receive through I&PC. The Finance and Investment Committee and Trust Board monitor this at every meeting. During 2022/23 the Trust plans for this activity to recommence as the pandemic resolves, although it will take over one year to return to pre-pandemic levels. To offset this and support improvement of care and development of future treatments the Trust continues to develop commercial income streams. Research remains strong with the renewal of the CRF contract, and the Trust is currently awaiting to hear whether it is successful in the BRC renewal process. The Trust's cash position remains strong entering the 2022/23 financial year (£124m) and therefore has enough resources available for the next 12 months. The Trust Audit Committee and Board will review for approval the 2021/22 annual report and accounts (25 May 2022), **[TBC]***on a going concern basis, confirming that the Directors have a reasonable expectation that the organisation has the required resources available for the next 12-month licence (a).*

	reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services". OR (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".		
FT4- NHS foundation trust governance arrangements (scope = next financial year 2022/23) **PLEASE NOTE – all four parts need to be confirmed for an overall 'confirmation'**	The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Executive Team recommend *'confirmed'* compliance. *Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors*	The Trust has a range of governance and assurance structures and systems in place including a Trust strategy, scheme of delegation, risk management framework, accountability framework, compliance framework, escalation framework, policy framework and assurance framework and a financial management framework (see controls and assurances above). Directors and governors are asked to sign a code of conduct and declare any interests annually for publication on a Register of Interests. Directors complete a self-assessment for the Fit and Proper Person Test (and are reviewed against the criteria annually). The Trust has a FPPT Policy, and an annual report is presented to the Nomination and Remuneration Committee. During 2021/22 all directors were compliant with the FPPT, and no issues were raised. All directors are subject to an annual appraisal.

			ASSURANCE: A self-assessment is prepared annually against the Code of Governance and will be reported to the Board in May 2022. The Trust Board considers that from 1 April 2021 to 31 March 2022 it was compliant with the provisions of The NHS foundation trust Code of Governance and proposes to explain its compliance (on a comply or explain basis) for the following criteria in the annual report: **B.5.6 Membership Engagement:** Whilst Governors did not personally canvass the opinion of Trust members in 2021/22 on the trust forward plan, Governors did provide comments on development of the GOSH operational plan in 2021/22 and 2022/23. The Trust has also consulted with the local community and patients on the design of the Children's Cancer Centre (a priority in its strategy) and also presented plans for delivery of the strategy at the AGM in 2021.
	The Licensee shall: (a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; (b) comply with the following paragraphs of this Condition.	The Executive Team recommend *'confirmed'* compliance. *Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors*	The Trust has regard to guidance on good corporate governance as issued by NHS Improvement.
	The Licensee shall establish and implement: (a) effective board and committee structures; (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to	The Executive Team recommend *'confirmed'* compliance. *Response to be considered by the*	The Board has a work programme, which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda.

	the Board and those committees; and (c) clear reporting lines and accountabilities throughout its organisation.	*Board in light of assurance provided here and taking into account the views of the governors*	The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to committees. There are three Board assurance committees - the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. These committees assess the assurance available to the Board in relation to risk management, review the Trust's non-clinical and clinical and quality risk management processes and review the structures and processes in place to deliver the Trust's vision for a supported and innovative workforce, an excellent learning environment and a culture that aligns with the Trust's strategy and always values. All three committees raise issues that require the attention of the Board. In addition to the three assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these assurance committees report to the Board and the Council of Governors following every committee meeting. The Trust has terms of reference and work plans in place for the Board, Council and assurance committees. The Board committees conduct annual effectiveness reviews (surveys) on the delivery of their terms of reference and running of the committees. Findings are reviewed and presented to the committee and where appropriate, changes to the terms of reference and workplans of the committees are made. The assurance committees receive summary reports from other assurance committees to prevent matters falling between them. These summary reports are also reported at the Board and the Council. At the Council, the chairs of the assurance committees present the summary reports and are held directly to account by the governors at the Council meeting. Governors are also invited to attend assurance committees and Board meetings throughout the year.

			The Trust's Assurance and Escalation Framework presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including: • Performance Management: The Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed. • The Trust's Risk Management Strategy sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level. • The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure on-going compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way. • Policy Framework: This provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust's policy framework is administered by the Policy Approval Group (PAG) and reported through to the Risk Assurance and Compliance Group. • Committee structure (as detailed above) • The Risk Assurance and Compliance Group monitors progress with the strategic risks on the Board Assurance Framework. There are seven directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Leadership Team meets weekly virtually (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operational Board made up of executives and senior operational

			managers from across the Trust meets fortnightly. The purpose of the Operational Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust and delivery of the operational performance against the Trusts strategic objectives. The Trust's risk management strategy sets out how risk is systematically managed. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust. **ASSURANCE**: The well-Led review in 2021 looked at governance and assurance and recognised that the Board is well-managed, and the quality of board and committee papers is excellent. Looking to the future the report recommended that in order to become a higher performing organisation, the leadership approach is considered by enabling a renewed external strategic focus amongst the executive team and at the same time providing directorates greater autonomy and focussed support to tackle operational issues and take great ownership and accountability. An action plan capturing all 13 recommendations of the review is in place and the Executive Management Team retain overarching responsibility for monitoring delivery of these actions and reporting assurance that the plan is on track and the actions are delivering the expected outcomes. Progress with the plan is also reported at Trust Board. The review also suggested reviewing the governance flow of meetings and the Corporate Affairs Team are currently undertaking a Corporate Governance Review looking into the number of meetings and their effectiveness, this will include Executive Management Team meeting and looking to make Operational Board become more of a decision-making forum. See further assurances on risk management as cited above including the findings of the Well-Led review.

	The Licensee shall establish and effectively implement systems and/or processes: (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	The Executive Team recommend *'confirmed'* compliance. *Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors*	The Board has agreed standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board. Each specialty and clinical directorate has an internal monitoring structure so teams regularly review their progress and identify areas where improvements may be required. Each directorate's performance is considered at monthly performance review meetings (see above). The Finance and Investment Committee reviews the operational, productivity and financial performance and use of resources both at Trust and directorate/ department level. The Board has a work programme which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda. The Board assurance committees scrutinise the strategic risks facing the trust on a rotational basis every year, with committee members reviewing the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner. Key performance indicators are presented on a monthly basis to the Trust Board. The report integrates quality and performance data and includes progress against external targets, internal safety measures, operational efficiency/process measures,

			well-led and other clinical quality measures such as complaints, incidents and reports from specific quality functions within the Trust such as the Patient Advice and Liaison Service (PALS). **ASSURANCE**: The external, independent assessors reviewed compliance with NHSI's Well led criteria. (Details provided in above sections).
s.151(5) of the Health and Social Care Act (not a licence condition) (scope = past financial year 2021/22)	NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, to ensure that they are equipped with the skills and knowledge they need to undertake their role.	The Executive Team recommend *'confirmed'* compliance. *Response to be considered by the board in light of assurance provided here and taking into account the views of the governors*	**Governor Induction and training and development:** During 2021/22 governors received mandatory training through a handbook that they were required to read and sign. Their completion of the training was then recorded onto our internal online training portal GOLD. This was monitored by the Head of Corporate Governance and governors were reminded and supported to complete the training during the year. The Trust also included an additional mandatory course for governors on COVID-19. For 2022/23, we will be working towards governors having an online profile on the GOSH DEN (Digital Education Network), this is an online educational platform which is part of our GOSH Learning Academy that would enable governors to complete their mandatory training interactively. Governor development sessions were developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure. A number of training courses were also delivered by NHSP GovernWell, and several Governors attended external training and events throughout the year and provided reports back to the Trust. To ensure that newly elected Governors (from March 2022) are provided with the skills and knowledge to fulfil their role, the Corporate Affairs Team and existing Governors co-produced an induction programme. Governors will be asked to complete an evaluation of the induction in June to ensure that the Trust can continuously improve the quality of induction provided.

			Ahead of each Council meeting, Governors meet in private with the Lead Governor/ Deputy Lead Governor. The session allows Governors an opportunity to discuss the key issues, network, and prepare for the private session with the Chair and the Council of Governors' meeting. Governors then also meet with the Chair in a private session. This gives Governors an opportunity to discuss any issues directly with the Chair and to gather information about the Trust and its activities and processes. To assist NEDs and Governors communicate outside of Council meetings and understand each other's' roles and views, Buddying sessions between NEDs and Governors were facilitated. This involved NEDs hosting two virtual tutorial style sessions focusing on a specific Trust Board or Assurance Committee subjects. Governors have the opportunity to observe Board Assurance Committees throughout the year. All future dates are circulated in advance and following the meeting governors have a private session with the NED Chair's to provide their feedback. This supports governors both in their duty to hold NEDs to account for the performance of the Board and also helps to support their knowledge and understanding of what's happening in the Trust. **ASSURANCE**: Our 2021/22 Governors effectiveness survey shows that 92% of governors agreed they were provided with sufficient opportunity to observe the assurance committees and see the NEDs in action. Governors are invited to join the Membership Engagement Recruitment and Retention Committee; this committee oversees the recruitment and retention of members and most importantly supports maximises engagement opportunities for the members. Through the committee, governors support the Trust to develop and engage with members to get them involved, am example over the last year was the 'Thinking about becoming a governor' workshop held as part of the governor election. Governors receive a regular newsletter from the Corporate Affairs Team containing items for action, Trust news items, key dates and development and training opportunities.

			Governors are also given the opportunity and supported to get involved in specific areas of interest. An example of is the Governors Sustainability Working Group which was set up following governors interest in understanding and being more involved in the Trusts sustainability agenda. Governors will also use this working group going forward to engage with their constituents on the sustainability objective within the Trusts Membership Strategy. **ASSURANCE**: The Council of Governors are asked to complete a self-assessment of effectiveness approx. every 18 months. Throughout 2021/22 the Council continued to work to deliver the actions of the previous survey where there were 19 proposed recommendations to improve Council effectiveness and shape the training and development needs were improved. Key actions closed during the year included: • Refined the buddying programme between NEDs and Governors to improve communication outside of Council meetings • Shared the Assurance Committee work plans for 2020/21 to allow Governors to make informed decisions about which meetings to observe. • Council development session content and format were informed on the results of the training needs analysis undertaken by governors The most recent survey undertaken in March 2022 proposed 11 recommendations which will be actioned during 2022/23. Responses specific to knowledge, understanding and training included: • 100% of Governors and NEDs and EDs agreed that Governors knew the difference between the roles of the Council and the Board • 100% of Governors and NEDs and EDs agreed that Governors knew the difference between the roles of a NED and an Executive Director • 92% of Governors agreed that they had a good understanding of their role and responsibilities with regards to holding the Non-Executive Directors to account and contributing to the development of the Trust Strategy, annual report and accounts.

Attachment S

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **25th May 2022**	
Quality Report 2021/22 **Submitted by:** Sanjiv Sharma, Medical Director	**Paper No: Attachment S**

Aims / summary

For information – progress update

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

The content of this Quality Account includes:

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

We are currently awaiting stakeholder and external assurance statements before final approval and publication.

Action required from the meeting

To note and review the report.

Due to timings, we would also like to request delegated approval for the Quality Report 2021/22 from the QSEAC NEDs.

Contribution to the delivery of NHS / Trust strategies and plans

Statutory Annual Quality Account submission

Financial implications

Not applicable

Legal issues

Not applicable

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

Responsible person – Jit Olk Draft completion by 26th May '22

Who is accountable for the implementation of the proposal / project

Jit Olk, Head of Quality

Great Ormond Street Hospital for Children
NHS Foundation Trust

Quality Report

2021-2022

Table of contents

What is the Quality Report?

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The content of the Quality Report includes:

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

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

Our strategy: To go above and beyond

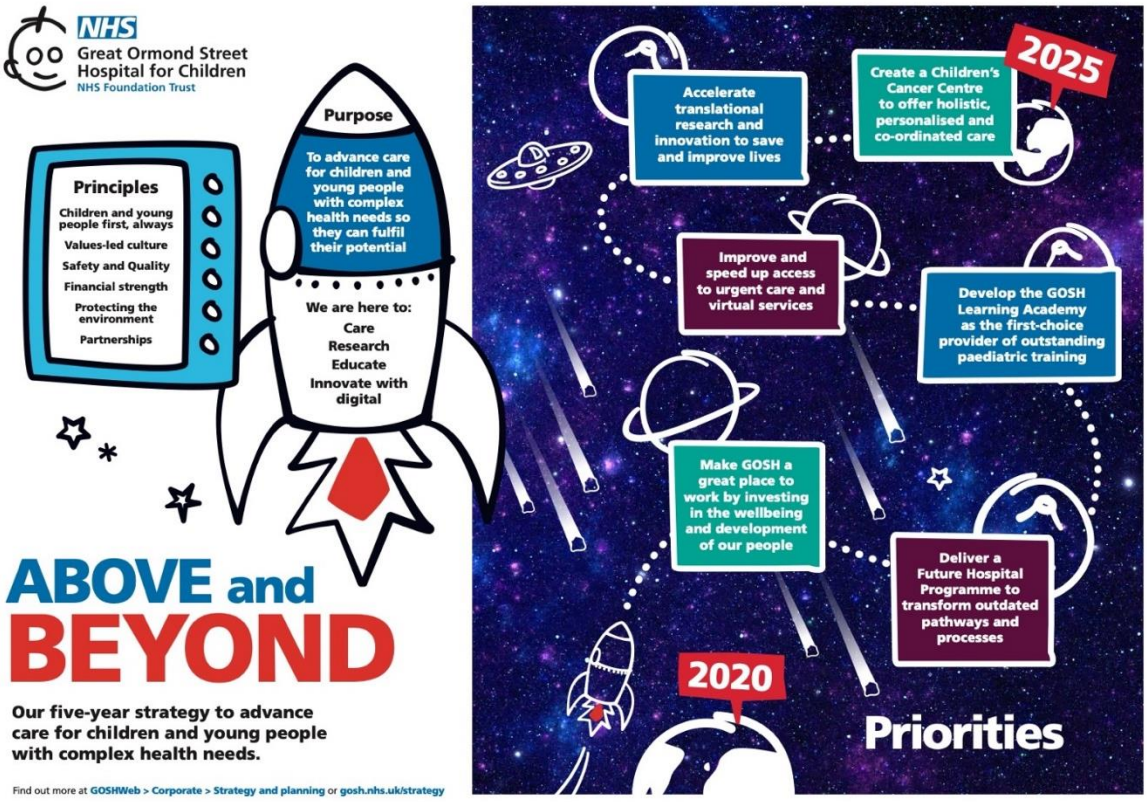
As a Trust we have a clear purpose which has endured since the Hospital first opened it's doors in 1852. We provide healthcare for children. How and what we deliver has always and will continue to be driven by the needs of our patients. With clarity about our purpose and the needs of our patients, we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

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

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

Above and Beyond

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



Our big six priorities for the next three years are:

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

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

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

- People
- Clinical business
- Research
- Education
- Transformation

Our Key achievements in 2021/22

- In April '21 Fiftieth patient receives thymus transplant at GOSH
- In May '21 ADA SCID gene therapy breakthrough
- In June '21 the Sight & Sound building opened
- In July '21 GOSH Den launched by the GLA
- In July '21 Brineura compassionate use programme started for Batten's disease world first sight saving treatment
- In Aug '21 Domestic services team brought in house significant service transition
- Sept '21 First GOSH gene therapy patient turned 21
- Sept '21 Launch of the Big Conversation
- Sept '21 Crown Prince of Abu Dhabi visits ZCR
- Sept '21 Virocell partnership to address the viral vector bottleneck for clinical trials
- Oct '21 Paediatric Accelerator Super Saturday to help tackle waiting lists
- Oct '21 Ride for their lives from London to Glasgow as we target net zero
- Oct '21 GOSH patient is youngest to receive 'mismatched heart' transplant
- Nov '21 2nd Anniversary of ZCR
- Nov '21 Largest ever stem cell clinical trial for children with Epidermolysis begins at GOSH
- Dec '21 GOSH wins Regional Large Employer of the Year at National Apprenticeship Awards
- Dec '21 12 winners at the GOSH Staff Awards
- Jan '22 Zolgensma pre screening results revealed
- Jan '22 GOSH research shows pre screening for SMA is possible through new born blood spot test
- Feb '22 GOSH 170 th birthday
- Feb '22 Children fleeing the war in Ukraine are treated at GOSH
- Mar '22 Paediatric Accelerator Super Saturday to help tackle waiting lists
- Mar '22 Secretary of S t ate for Health visits GOSH to discuss rare diseases

Our key strategic objectives for 2022/23 are:

To maximise successful delivery of the Above and Beyond strategy, the Trust has elected to implement portfolio management. This is a best practice methodology that enables visibility of delivery of the strategy and significantly increases the likelihood that
the strategic objectives and associated benefits are realised. The portfolio management framework underpins day-to-day running of the portfolio and provides a single, authoritative and up-to-date source of advice on delivery of the various initiatives.

As we enter year 3 of the Above and Beyond Strategy the key areas of work that the planet programmes for 2022/23 will be delivering and focusing on are as follows:

Make GOSH a great place to work by investing in the wellbeing and development of our people	Three key programmes of work (Health and Wellbeing, Diversity and Inclusion and Modernising HR&OD) are in place which aim to: • Promote GOSH as a creative, diverse and inclusive employer of choice • Create internal career paths and progression opportunities • Create a more inclusive work culture • Create channels and safe spaces which amplify the employee voice • Ensure that wellbeing is considered across the organisation • Provide occupational health and support services that meet the needs of our changing context • Ensure staff feel safe and secure while working Updated Frameworks for Health and Wellbeing and Diversity and Inclusion will also be a key deliverable for 22/23
Deliver a Future Hospital Programme to transform outdated pathways and processes **AND** **Improve and speed up access to urgent care and virtual services**	Five key transformation programmes have been established to deliver the future hospital and improve and speed up access to urgent and virtual services: • Clinical Pathway Redesign • Patient Flow • Outpatients • Theatres • Administration Plans are in place to continue to optimise and integrate electronic patient records and harness other technologies to support care including the function and use of MyGosh patient Portal. Teams will work closely with colleagues at our Digital Research Innovation Virtual Environment directorate (DRIVE) to harness new innovation and data.
Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training	The Gosh Learning Academy (GLA) will continue to develop its offering and move closer to becoming sustainable by: • Utilising the education voice • Broadening the education portfolio • Supporting educational research and innovation e.g. virtual reality • Ensuring education accessible for all • Optimising the Virtual Learning Environment (GOSH DEN) • Optimising patient safety simulation programmes • Collaborative working with DRIVE, ICS, HEE • Exploring commercial opportunities

	• Academic Education, • Clinical Apprenticeships • Clinical Simulation • Digital Learning • Leadership & Management Development • Speciality Training
Accelerate translational research and innovation to save and improve lives	Six key programmes of work have been designed to continue to transform GOSH into a Research Hospital, supporting the intent that every patient is a research patient and every bed is a research bed. Programmes are focussed on: • Developing the necessary supportive Culture, Infrastructure and Education • Harnessing Data sets, analytic capacity and innovation • Renewing NIHR funding to support our world-class Biomedical Research Centre and Clinical Research Facility • Establish and embed a fit for purpose commercial strategy • Supporting and developing clinical academic careers
Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care	Key area of focus for the CCC will include delivering the business case and the continued planning for future cancer services, and for the further clinical and support services that will be housed within the CCC. Planning will be clinically led and will include: • Meaningful patient and family engagement to inform design • Clear transparent governance between the Hospital and Charity • Early consideration of future digital and research innovations • Robust and proactive cost, programme and risk management • Sustainable approach to design incorporating nature

Part 1: A statement on quality from the Chief Executive

Statement being drafted

Mat Shaw
Chief Executive

Part 2a: Priorities for improvement

This part of the report sets out how we have performed against our 2021/22 quality priorities. These are made up of a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his 2008 NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare.

Safety

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

Clinical effectiveness

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

Experience

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

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

Reporting our quality priorities for 2021/22

In our previous Quality Report, we identified three priority areas for improvement in Safety (Improve identification and management of the deteriorating child), Clinical effectiveness (Developing and implementing ward accreditation) and Experience (Managing uncertainty in healthcare). These are reported below. We have also chosen to report on three further quality improvement initiatives which are related to our response to COVID-19. The six quality priorities reported for 2021/22 are:

Safety

- Improve identification and management of the deteriorating child
- 2nd Opinion

Clinical effectiveness

- Developing and implementing ward accreditation
- Quality Governance Framework

Experience

- Managing uncertainty in healthcare
- Out of Hours Activities

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

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

Safety: Improve identification and management of the deteriorating child

What we said we'd do
In recent years the Trust has identified key themes affecting the management of deteriorating patients:

- Upward trends identified across Serious Incidents, complaints and RCAs of missed identification/incomplete observations datasets/inadequate management/response to deterioration
- Increased number of respiratory arrests
- Challenges to sustainability of previous improvement interventions
- Changes to digital landscape since implementation of the new Electronic Patient Record system, presenting opportunity for improvement

This showed multifactorial concerns on how the Trust responds to patients who are deteriorating, affecting both patient safety as well as experience.

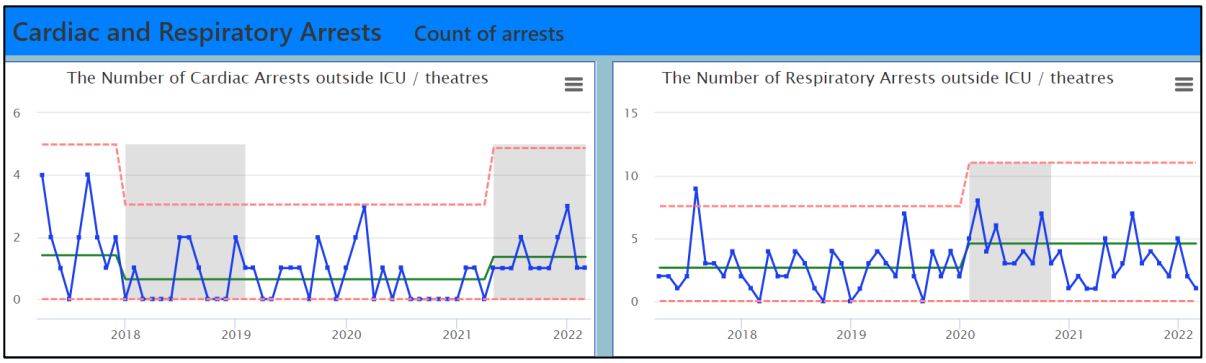
We said we would address the identification, documentation (including observations and early warning score tools (PEWS)), monitoring and appropriate escalation, timely management and review of the potentially deteriorating patient. We hoped to develop a care pathway that is responsive and appropriate; that supports the care giver in their decision making.

What we did
A programme was initiated by the Medical Director's Office to address this supported by the Quality Improvement team. A project Steering Group has been established with representatives from a range of clinical areas of expertise. The group reviewed current practices, how we can enhance these practices and identify anything we need to track or monitor through our governance processes. This will incorporate feedback from complaints, incidents, mortality review/learning from deaths.
The Steering Group has completed extensive diagnostics, contributing to programme design and creating smaller working groups with focus areas, with the aim of testing interventions to make improvements.

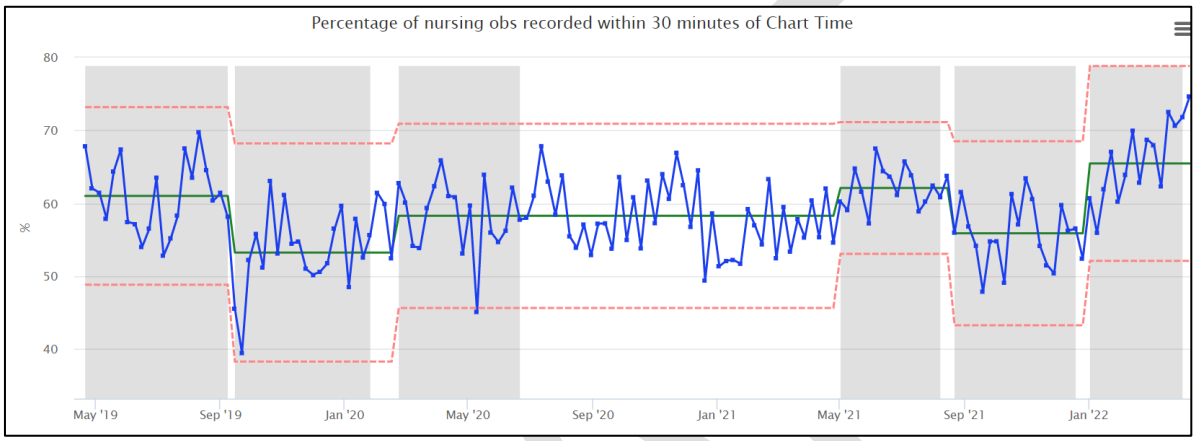
One working group is testing a technology and education combined intervention to improve timeliness of nursing observations. This is currently focussed on one ward. A second working group is testing an intervention to improve detection of deterioration. This has produced risk categorisation guidance to help consider all of the risks of the patient before identifying the overall risk. The guidance is at a very early stage, having adjustments made using ward staff feedback. The third group is formulating an intervention which supports multi-disciplinary escalation and response. This is currently not tested but will follow on from establishing the detection group's work.

What the data show
The improvement outcome and process measures will be monitored to see if the interventions are working once they are rolled out across the Trust. These include the number of mortality reviews/ Root Cause Analyses identifying inadequate response to patient deterioration.

Respiratory and Cardiac arrests outside are also monitored:



The intervention to improve timeliness of observation, started early December 2021, is showing effect on one ward where the intervention is being tested.



What's going to happen next

The current interventions which are being tested will be rolled out through iterative learning & adaptation cycles.

The learning and recommendations from the recent (December 2021) Healthcare Safety Investigation Branch (HSIB) report, is being reviewed by the steering group. Improvement opportunity around appreciating different skin tones of patients in identifying visual signs of deterioration is being scoped.

How this benefits patients

Timely recording of observations will ensure deterioration is effectively captured. It supports decision makers in recognising trends of deterioration in a timely manner. Also, the Electronic Patient Recording system can support staff in coordinating the care required for the patient in an effective manner as per its design. The risk categorisation is expected to improve the situational awareness of the bedside nurse as well as the wider ward team. Combined with the escalation pathway, both interventions will support staff to articulate their concerns in a standardised approach and align concern to the right support. Parental concern is also captured as part of the risk categorisation. Overall, this work is expected to improve the outcomes and experience for deteriorating patients as well their families/caregivers.

Safety: 2nd Opinion

What we said we'd do
To ensure that we have a standardised practice for obtaining expert second opinions whilst ensuring that we improve transparency in the options available and the processes followed for getting these expert second opinions with patients and their families.

What we did
Firstly we undertook some diagnostic work to understand both within GOSH and other paediatric units what their processes were for obtaining second options and explore their level of transparency with patients and their families. We approached neighbouring peadiatruc units and also surveyed colleagues within the National Children's Alliance.

The process/inquiry was repeated across the clinical units at GOSH.

Following this we then interviewed a select number of families and asked them what matteted to them? What information woukd they want? What criteria or principles were important when designing a process of seeking expert second opinions.
We repeated this process with a number of consultants and nurse specialists.

From the responses gathered we then sought to design a process and create a resource for families.

This new process was then tested when a second opinion was required following an action from a Serious Incident Review where a patient was misdiagnosed. In brief the process was as follows;

- The clinical teams identified an appropriate specialist unit with the expertise in treating the condition the patient had. There was only one other unit in the country
- The clinical lead within the receiving unit was approached and the need for the second ooinion and the suggested approach was discussed up front. The unit accepted.
- The parents were approached to ensure that they agreed with the second opinion and they were consulted in the design and subsequent refinement of the new process. Two senior members of the Medical Directors Office also met with the family regularly and repeatedly to update them and keep them abreast of the progress made.
- The referring unit sent relevant clinical information to the receiving unit in stages just as the original clinical team received it to make management decisions. After each aliquot of information was passed the receiving unit sent back a report on their discussion, thinking and conclusions.
- Each report was also forwarded to the family. What information they received and how they received it was discussed and agreed with the family before the second opinion formally started
- After the second opinion was complete the referring clinical team received all the reports as one document and discussed the findings in a multidisciplinary meeting. The agreed actions were then discussed with the family

What the data show
The replies interviews from neighbouring units and members of the National Children's Alliance revealed that the processes for obtaining expert second opinions were varied and in some units absent. Many units did not openly discuss the option of second opinions with patients. Finally there was no formal process or contractual agreements between the referringand receiving physicians, expert second opinions were conducted as discretionary effort or seen as a professional courtesy to fellow colleagues.

The results within GOSH were similar. Practices and transparency were widely variable. Some departments inadvertently sought expert 'second opinions from groups of colleagues when challenging cases were discussed at specialist or superspecialist national clinical peer group meetings for specific disease states.

On testing the new process the family were very supportive and appreciative of the process.
The receiving unit felt that the process lengthened the time taken to complete the second opinion but felt it was better at minimising bias if the team that would invariably have been introduced had they known from the start what the referring units final conclusions has been.

What's going to happen next
We hope to further test and refine our process before socialising and implementing across the trust.

We are planning to complete the resources for families.

How this benefits patients
The direct feedback from the family was that they valued the new process. It improved transparency and with it trust with their clinical teams. It also made them feel they their opinions mattered and they were being listened to.

Clinical effectiveness: Developing and implementing ward accreditation

What we said we'd do
Over the past years there had been a lack of clarity over the validation and assurance process of the Nursing Care Quality dashboards amongst the clinical directorates and the nursing quality team, leading to issues in governance and oversight. Limitations within the dashboards meant there was no visibility of trends over time and challenged shared learning, as well as recognise opportunity for improvement.

We initiated a project to improve visibility of quality metrics in the Trust which we think will improve the autonomy, learning and will for improvement/ assurance in the Trust. We said we would identify quality metrics for the Trust which assesses safe and quality care in the wards and source a varied approach of data collection which ensures a holistic approach. We said we would provide visibility of these metrics to the wards and introduce a structure of ward-based Quality Improvement (QI). The second phase of this project is expected to establish an accreditation programme for the Trust which celebrates high standard care provided by individual wards.

What we did
The project was initiated through the Chief Nurse and is supported by the Quality Team. Through extensive planning, discussions and options appraisals, the following has been achieved:

Standards, quality metrics and audit questions have been created utilising evidence from a variety of sources and through feedback from listening and engagement events. These standards are aligned to 7 pillars: Nursing Quality, Nursing Education, Nursing Workforce, Patient Experience, Infection Control, Quality and Safety and Joy at Work.

As mentioned above, two of the sources of data are currently being designed and tested: measures extracting evidence through the Trust Electronic Patient Recording (EPR) system and self-assessments conducted by ward staff through a digital application. The former includes a purpose-built dashboard, which supports clinical areas to look at areas for improvement, track trends in data, and create quality improvement initiatives to create sustainable changes. All these solutions are built by QI Developers. Six measures are made live on the Dashboard currently after validating and engaging each Ward Manager in the discussions.

The Quality Improvement team have created a QI package which is being rolled out on all wards. This is aimed at enabling meaningful change at all levels. The proposal includes a structured ward-based group discussion self-facilitated to identify areas for improvement and change ideas. Then these change ideas will be tested by the ward team, tracking progress on a visual board while capturing learning and successes.

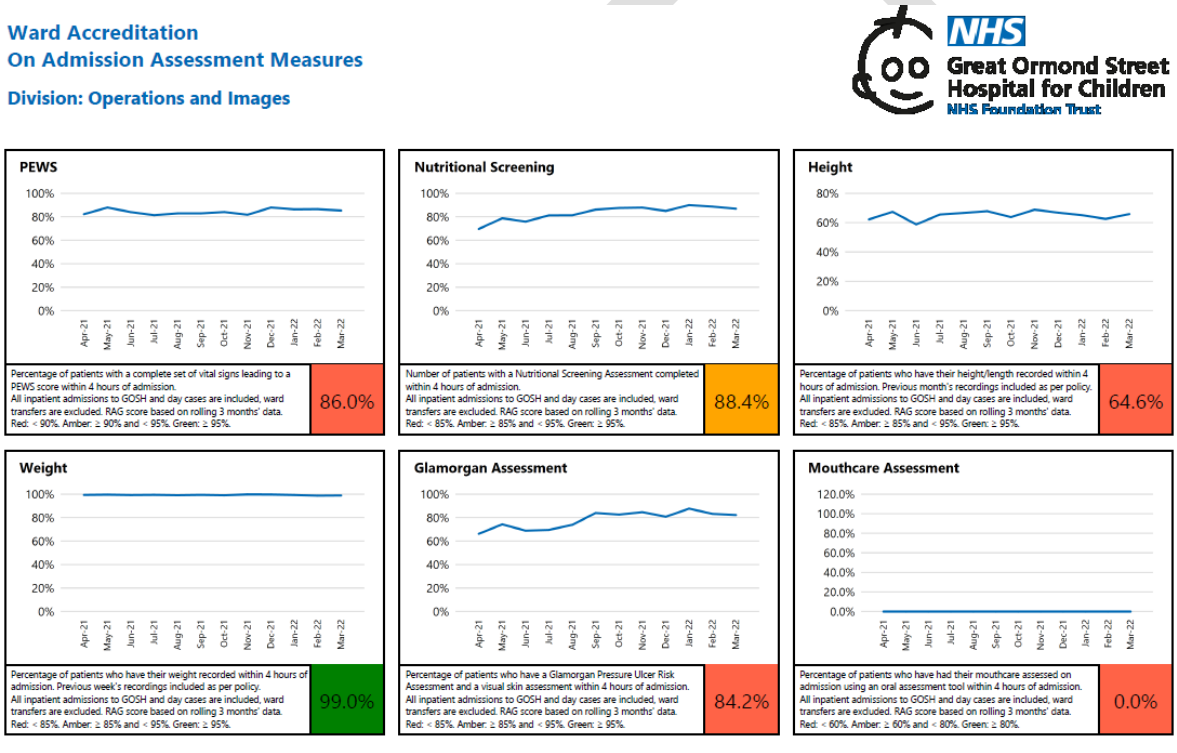
What the data show

The dashboard currently displays the following on admission measures (within four hours of admission), for each ward:

- Percentage of patients with a complete set of vital signs leading to a PEWS score
- Percentage of patients with a Nutritional Screening Assessment completed
- Percentage of patients with their height/length recorded
- Percentage of patients with their weight recorded
- Percentage of patients who have a Glamorgan Pressure Ulcer Risk Assessment and a visual skin assessment completed
- Percentage of patients who have had their mouthcare assessed

These measures are visible for all Trust staff and can be used to assess individual ward level scores. Data can be viewed as a three-month snapshot percentage score or on a trend chart, depending on the level of information/ narrative required. All these measures allow you to drill down to individual patient level information if required. A further Divisional view of the same data is available for higher level decision making.

An example of the Dashboard (divisional view)



What's going to happen next

The digital application will be used to collect self-assessment data following a test period.

Work will continue to add more measures to the Dashboard and complete rolling out the ward QI structure training for all clinical areas, promoting a multi-disciplinary team involvement.

As the third element of data capture, Peer Reviews will be designed, tested and rolled out.

The design of the Ward Accreditation programme (Phase 2) will be finalised for testing.

How this benefits patients

Ward teams will be well-placed to identify opportunities for improvement that will support better outcomes and experiences patients. This is by having a consistent set of standards which benchmark the

expected levels of care and quality, establishing improvement and support structures and celebrating achievements by the wards.

Clinical Effectiveness: Quality Governance Framework - Nikki

What we said we'd do
In early 2021, the Trust undertook a review and subsequent consultation regarding the team structures supporting both Quality and Safety at GOSH. Safety and Quality teams have existed for many years at GOSH, however, the way in which the teams are shaped, i.e. the structure, function and form, have been through several iterations. Most recently, since c2016, they were brought together under one lead for both areas. Throughout this period, these functions have continued to be within the Medical Director's portfolio. Whilst having unified leadership across both Safety and Quality Teams at the Trust had advantages at the time it was arranged in this way, the context at the Trust has changed, as has the national patient safety strategy direction of travel. There is now an imperative to deliver against renewed agendas in order to improve both safety of services, and consistent delivery of quality services to patients and families.

The ambitions of both functions within the Trust has recently been described in the GOSH Safety Strategy and GOSH Quality Strategy, both of which have been agreed by the Trust's Quality and Safety Assurance Committee and Trust Board. These strategies describe the ambitions that the Trust sets out to achieve, as healthcare exemplars in both of these domains. In order to achieve this, there is now a need for each area to have its own platform, and Safety and Quality must each must be seen as a purpose at GOSH and not as a priority. Both are essential foundations of a complex healthcare environment, underpinning the delivery of consistently excellent healthcare. In order to succeed within these domains in the way outlined through the Strategies and Operational Delivery Plans, the teams need to be sufficiently resourced and operationally shaped in the right way.

The evolution of safety and quality to a corporate team has seen a shift in the sense of ownership of these elements away from clinical teams. Whilst providing a central repository of expertise in these areas, this disaggregation of ownership and assurance from clinical teams has resulted, at times, in a sense of policing by a central team rather than ownership by the local team. Safety cannot and should not be a silo, but instead run through everything that we do. Only then will safety be sustained. The GOSH Safety Strategy, clearly describes the need for lines to be redrawn such that there is clinical ownership of safety and quality of clinical services, and the improvements which need to be made in anticipation of compromises in safety (risk management). A central team, who can help provide expertise, knowledge and understanding of the frameworks that exist to ensure high quality safety delivery of care, should support this local ownership.

What we did
Following this consultation, the Trust spilt the Quality and Safety Team into separate teams each reporting via a 'Head of' to their respective Associate Medical Directors. Once the internal change management processes had been completed, the Trust externally recruited into vacant posts and this has been on-going with the majority of appointees in post early in January 2022. In parallel we commissioned an external organisation to undertake an independent review of our governance arrangements around patient safety and to provide any recommendations on areas of improvement. Key findings from this report focused on perception, management of incidents, investigations, learning, Duty of Candour, the Patient Safety Team and Committees and Meetings in place.

In relation to Committees and Meetings, the following areas were identified:

- Hold many meetings in relation to patient safety – internal executive meetings, board assurance meetings, and meetings with external bodies such as NHS England.
- Stuck by the length of the papers for meetings – often 300 pages long. Meetings were long with large numbers of people involved. We also noticed that on occasion there were large numbers of deputies attending, often without saying much or anything in the meeting.

- Not immediately clear purpose of some of the meetings, and doubt whether some of the meetings would really achieve their objectives, even if they were clear.
- Concern that having a meeting itself was considered to be 'action' in response to a problem

In response to this, the Trust completed a review of all meetings in relation to patient safety and quality, looking at the terms of reference, attendees and effectiveness of the meetings and whether they still provided the anticipated outcomes. This review resulted in the redesign of the Quality Governance Management Framework in place at the Trust, which split out those meetings which provide either assurance or operational oversight, and also provided structured escalation routes through the Trust for any identified concern or 'bubble Ups.' This review has been taken through the Trust's existing governance structures and has been endorsed at both an Executive and Sub-Trust Board Committee level with some minor alterations.

What's going to happen next
Following discussion with some key members of the Trust Board and redrafting of the Terms of Reference, the new framework will be implemented across the Trust in June 2022. This will be supported by a new reporting mechanism to ensure that the right level of detail and information is provided to the right meeting in order to allow the meeting to fully discharge it's duties as per their terms of reference. Operational management and oversight will be through the existing operational structures, with escalation to the Executive Team Meeting as appropriate.

Following implementation, a further review will be undertaken in January 2023 to ensure the structure is effective.

How this benefits patients
This will benefit patients by having the dedicated structures in place across the Trust to ensure shared learning and oversight takes place of any safety event or quality [incident] and allows for those decision makers to be able to have the right level of information available to be able to make the right decisions at the right time. Plus, by ensuring greater oversight at the Trust Board, decisions will be taken as a holistic approach and in the best interests of the patients and their families we care for.

Experience: Managing uncertainty in healthcare

What we said we'd do

- Identify best practice guidelines in law, healthcare research and other research in communication.
- Monitor data sets such as Friends and Family Test responses, Pals and Complaints cases as well as Incident reports via Datix.
- Co-produce training programmes with both healthcare professionals and families.

What we did

- Lessons learned from a Serious Incident highlighted the complexities of managing uncertainty in healthcare.
- The Simulation team was approached to develop a training package to prepare teams to manage and discuss uncertain situations (e.g. uncertain risks from treatment, uncertain prognoses).
- A training survey was sent to staff in 2021- this sought to understand the needs of our teams and appreciate where staff might experience challenges.
- Continued engagement with patient and family via PALS supported the co-design of an evidence-based, half-day simulation training to meet the needs of our staff.
- The central teaching message of our small pilot study was: "It is not our job to fill the terrain with certainty, but nor is it to mask or avoid the uncertainty. Our task is to stand alongside the parent or patient and show them the uncertain terrain."
- This was delivered via**:** Brief, multi-disciplinary presentations; Reflective discussion; Collaboration with the GOSH Legal Dept; Bespoke simulation with professional actors.

What the data show

A small pilot study with a cohort of 5 (Nursing, Pharmacy, Dietetics) received positive feedback:
Quantitative Feedback (n=4)
How would you rate your confidence in this area before the course? Av. 3/5
How would you rate your confidence in this area after the course? Av. 4.25/5
How applicable was the learning to your clinical practice? Av 5/5
How would you rate the course overall? Av. 5/5
Qualitative Feedback (n=4) e.g. *"The simulations with the actors are very useful. The scenarios were very realistic and the actors really made me feel that I am actually in a real life situation. I wasn't expecting the scenarios were tailored to our professions and they were very thought provoking and enjoyable. I came away feeling I have acquired some skills and techniques that I can apply to my day to day practice."*

What's going to happen next

- The course will be trialled online in June 2022 to see how it works with slightly larger numbers.
- Discussion is ongoing about incorporating the course into a "Talking to Families" series, alongside "Talking to families when death is a likely outcome," with the aim of increasing the offer of communication-based simulation across the hospital.
- If all goes well online, we will open the course to external candidates.
- An upcoming Staff Acting Training day will hopefully lead to an available bank of staff actors, which will make it easier to run similar conversation-based simulations on wards.

How this benefits patients

Patients benefit from the continuity and quality of care that comes from a well-resourced workforce – providing regular opportunities for staff to voice and reflect on what makes their day difficult and how this can be supported is an essential component in ensuring staff feel validated enough to work sustainably in a safe and effective way.

By supporting staff to better sit with the unavoidable uncertainty that arises in their emotional work with patients and families, patients and families will hopefully, in turn, feel better validated, listened to and supported in their healthcare journey at GOSH.

Experience: Out of Hours Activities

What we said we'd do

- Virtual and in-person workshops: Running virtual activity workshops for patients and siblings whilst COVID restrictions are in place within the hospital, continuing to have a virtual offer once restrictions ease and in-person activity takes place to ensure that we are reaching more patients (e.g. patients in protective isolation who can't leave their rooms).
- Expand the programme so that it can also run throughout the year and no longer be limited to after-school and the holidays. Offer at least 15 weeks of activity throughout each year
- To work with at least 8 external organisations and visiting artists
- Engage adolescent mental health inpatients (MCU) with two sessions per week during holidays
- Since September 2021 - Bridging the digital divide: designing and run a stream of activity, working with external partners, to improve digital literacy and build technology skills amongst patients and siblings. This will be the first time that GOSH is strategically focusing on this area and there are no other children's hospitals driving digital play in this way.

What we did (events, online or face to face)

Over the past year, have hosted the following virtual workshops:

- Arts and crafts-based workshops:
- Clay modelling
- Calligraphy
- Modroc sculptures
- T-shirt/tote bag designing and printing
- Printmaking
- Sensory art
- Painting
- Drawing
- Collaging
- 3D paper sculpting
- Paper flower making
- Weaving
- DIY art materials
- Banksy inspired art
- Digital skills workshops:
- 3D Game Design
- Coding
- Music Tech
- Digital art
- Podcasting
- Micro:bit coding

Other workshop types:

- Creative writing (including spoken word poetry, riddles, short stories, monologues)
- Circus skills
- Inclusive dance
- Make-up and skincare

We have also been able to do some 1-1 sensory art sessions in person at points when COVID transmission has been low

What the data shows

- Over 180 patients and siblings participated in activities over the past year that we have been trialling and developing this programme
- 17 weeks of activity programmed already between Summer 2021-May 2022, some outside of school holiday periods to
- Collaborated with 12 external organisations/visiting artists over the past year to facilitate activities and support us in developing the programme
- 92% of participants agreed that they learned something new during the workshops and that the workshops had made their day better, with no participants submitting negative feedback
- 100% of participants included positive language in their feedback forms, including the words fun, uplifting, enjoyable, exciting, inspiring, interesting and amazing.

What's going to happen next

- A further expansion of the service so that we are able to offer more activity on weekends and evenings, as well as the holidays and increase participant numbers
- Building a small team dedicated to out-of-hours activities, including an Activity Coordinator and Bank Play Work staff to support
- Expand and widen the digital activity programme, running a 6-week dedicated course of activity over the Summer holidays purchasing state of the art digital equipment with support from ICT colleagues
- Re-opening the activity centre or a similar space once COVID restrictions ease
- Host virtual or in-person activity events

How this benefits patients

- Feedback quotes from Patients:

'Thank you so much for running the sessions. I loved them and they have inspired me to start writing for fun. They've also made my return to schoolwork next week seem a lot less daunting. I'm excited for the art ones too.' (feedback from patient)

'Inspirational. Appropriate for multiple ages.' (feedback from patient)

'Thank you for the session, I really enjoyed it, and so did lots of other people on the course too!' (feedback from patient)

'Aneira (creative writing tutor) is a brilliant teacher and has helped my confidence.' (feedback from patient)

- Feedback quotes from Families:

'The session was absolutely amazing, I'm still so amazed how well E responded. He honestly has such anxiety about meeting new people, but the activity was so up his street and he just wanted to chat to you both!!' (feedback from parent)

'Thank you so much again!! She loved her week with you!! Definitely a happier, more fulfilled child for it!!' (feedback from parent)

'M had an amazing time; it completely made her time here go extremely quick. She made a beautiful under the sea painting. Thank you so much' (feedback from parent)

Quality priorities for 2022/23

The following tables provide details of three of the quality improvement projects that GOSH will undertake in 2022/23. In common with previous quality reports these quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

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

Safety:

To eliminate avoidable harm

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Refine governance structures for the trust-wide use of medicines.	Embed sustainability of improvements made under the Programme of Work focusing on the most recent CQC Inspection and the 'Requires Improvement' findings for the trust-wide use of medicines. Understand and embed lines of reporting, assurance through vigilance and the identification and management of risk through the Medicines Safety Committee and the core audit programme. Reduces the risk of adverse findings at CQC inspection, promotes the journey towards an 'Outstanding' rating for Medicines Management and continually reduces patient risk and promotes the safe use of medicines	Local vigilance and structured audits demonstrates compliance with standards. Positive approach to reporting and learning from incidents through benchmarking with peer trusts and reduction in incidents that cause moderate and major harm. Reduced financial losses of medicines due to inappropriate storage of medicines. Improved staff utilisation due to best practice medicines handling processes. Progress will be monitoried through the trust medicines committees, specifically the Mediciens Safety and Medicines Optimisation Committees and the Medicines, Therapies Oversight and Assurance committee, through the the Patient Safety and Outcomes Committee

Experience:

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
MDT informed consent for tertiary and quaternary referrals	Updated Trust-wide policy and guidance notes regarding decision making & consent will explicitly set the expectations of healthcare professionals in how they support children, young people, their adults with parental responsibility, including their responsibility to record and evidence the decision making conversations that take place, and the information/ documents shared with their patients. Patients' electronic patient records will be updated to include a decision making & consent dialogue section which will aid healthcare professionals working in multi-disciplinary/ specialty care pathways to access/ review previous conversations between healthcare professionals and the patient to aid fluency between collaborating healthcare professionals. Children/ young people/ adults with parental responsibility will have access to review their decision making & consent dialogue and access patient information communicated digitally through the electronic patient records system. This will empower patients to have access to the relevant information to carry out shared decision making including the ability to ask their healthcare professionals questions. This digital recording of consent will enable formal consent to be taken prior to the day of planned intervention which will deliver improved patient flow / prioductivity.	Junior Doctor staff experience: Annual General Medical Council national training survey (GOSH was positioned 5th in England in 2021 with a **satisfaction score** of 86.81) https://www.hsj.co.uk/workforce/revealed-the-best-and-worst-trusts-to-be-a-junior-doctor/7030831.article Consultant staff experience: Annual NHS Staff Survey: **We are compassionate and inclusive** Medical & Dental roles (2021 score of 7.4 from 334 respondees) Advanced Nurse/ Allied Health Practitioner staff experience: TBC Patient satisfaction: Monthly NHS patient friends & family test responses (97.61% **positive experience measure** in April 2022) Patient dissatisfaction: Rolling 3 monthly summary of PALS cases by case subject: **Care advice** (31 cases over a 3 month period up to 10th May 2021) GOSH Clinical Outcomes hub Legal risk: Annual GOSH Annual **Clinical Negligence Scheme for Trusts (CNST)** contributions: (£7.15M in 2021, 1.26% of total operating costs) Productivity - Unwarranted theatre delays: Rolling 3 monthly volumes of reported theatres late starts by classification: **Pre-operative: Consent not completed on time** (48 reports in surgical dashboard over a 5 month period commencing September 2020)

Clinical effectiveness:

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Implementation of the National Patient Safety Syllabus level 1	Developed by the Academies for Medicine, in collaboration with HEE, this provides an overview of the fundamentals of patient safety relevant to all NHS staff – clinical and non-clinical. Mandatory for all NHS employees to undertake this training at Level 1. For teams who do not regularly access e-resources, a blended approach with robust evidence of content covered will be in place.	This will be added to individual mandatory training GOLD dashboards. Progress will be reported quarterly via GOLD reporting. New starters will be asked for evidence of this and their training records amended accordingly. Compliance and challenges will be reported via GLA Steering Group. Aim for 100%, as unintended positive consequence, we may see an increase in risk reporting and improved psychological safety in raising concerns.
Update and implementation of Duty of Candour education. Blended learning resources reflecting the needs of those engaged in the DOC process.	The statutory duty of candour aims to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. Regulated by the CQC, the statutory duty includes specific requirements for certain situations known as 'notifiable safety incidents'. This education will ensure all staff who encounter patients and families will have an understanding of Duty of Candour and what this means for them, for GOSH and to families and patients. E-learning: hosted on GOSH DEN, this provides a summary of the legislation, what it means to staff and patients and their families and the steps involved. This is ensure a level of organisational awareness however will not provide in depth education. For those involved in the Duty of Candour process require a more in depth level of education delivered via workshop sessions using using	Whilst not currently mandatory, it is strongly recommended that all clinical staff should undertake the e-learning as a minimum: monitored via activity metrics on GOSH DEN. Additional education for Senior leaders actively involved in DofC-aim for 100% compliance with both e-learning and DoC workshop. Compliance and challenges will be reported via GLA Steering Group.

	taught content, simulation based education and reflection on the experience and practice of saying sorry.	
Patient Safety Team development.	The diverse experience of the existing GOSH team means education must be adaptable and meet all needs. Both the Patient Safety Incident Response Framework and NHS Patient Safety Strategy signal significant changes to the approach to managing, learning from and understanding safety incidents. This includes the 'professionalisation' of patient safety team members; to achieve this, a formal programme as well as peer to peer and action learning sets will be implemented and will supplement the cycle of continuous learning that will form a cornerstone of this teams' ongoing development. **Learning from Safety/ GOSH partnership** a bespoke education and development programme: PSIRF- tools for implementation Change Leadership Patient/Public engagement in patient safety Psychological safety Safe Systems Design & Human Factors **Health Service Investigation Branch (HSIB)** Whole PS Team- complete Bronze award (04/22) Bespoke 'bolt on' modules: SEIPS (Systems Engineering Initiative for Patient Safety) Why do things go wrong? Family engagement **GOSH Simulation** Interviewing skills to enhance reliability and consistency of interviews and reports on safety incidents.	Monitoring and compliance and challenges will be reported via GLA Steering Group. Interview skills: Mixed method review of effectiveness. Confidence scoring and post intervention review of reports to assess compliance with HSIB interviewing recommendations.

Part 2b: Statements of assurance from the Board

This section comprises the following:

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

Review of our services

During 2021/22, GOSH provided and/or sub-contracted over 60 relevant health services. The income generated by these services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant services by GOSH for 2021/22. GOSH has reviewed all the data available to us on the quality of care in our services.

Participation in Clinical Audit

What is clinical audit?

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

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

Participation in National Clinical Audit

During 2021/22 twelve national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The data submissions have been outlined below for those audits.

Name of audit / clinical outcome review programme	**Cases submitted as a percentage of the number of registered cases required**
Cleft Registry and Audit Network (CRANE)	107/107 (100%)
Inflammatory Bowel Disease (IBD) Registry	GOSH patients are included in the IBD registry .It was not possible to submit new cases for 2021/22. A data processing agreement is required before new cases can be submitted, and this is being finalised at the time of writing.
Learning Disabilities Mortality Review Programme (LeDeR)	15/15 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)	31/31 (100%)
National Audit of Pulmonary Hypertension (NAPH)	692/692 (100%)
National Cardiac Arrest Audit (Intensive Care National Audit & Research Centre).	6/6 (100%)
National Audit of Cardiac Rhythm Management (National Institute for Cardiovascular Outcomes research)	138 cases submitted including • 65 ablations • 26 electrophysiology studies • 47 Devices *Correct at time or writing – but will need to be reconfirmed in May before final submission*
National Congenital Heart Disease (National Institute for Cardiovascular Outcomes research)	1031/1031 cases submitted including • 526 Cardiac Surgery • 466 Cardiology • 39 Support
National Paediatric Diabetes Audit (National Paediatric Diabetes Association)	66/66 (100%)
Paediatric Intensive Care Audit Network (PICANet)	1831/1831 cases submitted • 1151 NICU/PICU • 680 CICU *Correct at time or writing – but will need to be reconfirmed in May before final submission as PICANET offline till mid May*
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	194/198 (98%) (*4 patients have not consented to be on the Registry)*

UK Renal Registry (The Renal Association)	511/511 (100%)

The following national clinical audit reports and data were published from relevant mandatory national clinical audits in 2021/22. The relevance of those reports to GOSH performance and outcomes are described below.

UK Cystic Fibrosis Registry 2020 Annual Report (published in December 2021)

The report includes data about individual cystic fibrosis centres, to help the centres benchmark themselves against their peers.

The data shows that GOSH clinical outcomes are very good and all lie within expected variation or above the national average.
Key measures include

- Forced Expiratory Volume
- Age adjusted BMI percentile among patients aged 1-15 years
- Proportion of patients with chronic Pseudomonas aeruginosa
- Proportion of children started on appropriate inhaled therapy.

Further information about GOSH Cystic Fibrosis Clinical Outcomes, which includes reference to the report , can be found here

Cleft Registry and Audit Network (CRANE) 2021 Annual Report (published in December 2021)

Great Ormond Street Hospital (GOSH) hosts the North Thames Cleft Lip and Palate Service jointly with Broomfield Hospital in Essex. Clinical outcomes for the service can be seen at GOSH Cleft clinical outcomes

The GOSH cleft clinical outcomes internet page will be updated to included relevant data from the CRANE 2021 Annual Report in 2022/23.

A summary of the CRANE 2021 report for parents and carers can be found here

2021 National Congenital Heart Disease Audit report (published October 2021)

The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes. Predicted patient survival is determined for all centres using a calculation called PRAiS2, which adjusts for procedure, age, weight, diagnosis, and co-occurring conditions (co-morbidities).

The report shows that in the last 3 years, all centres have performed such that 30-day survival was as predicted or better than predicted, given the alert and alarm control limits, for aggregated outcomes after all surgical procedures in children.

"Two centres performed 'higher' than predicted – Great Ormond Street Hospital, London and Leeds General Infirmary, Leeds. This is indicative of good performance and represents an opportunity for sharing optimal practice across specialist centres"

National Congenital Heart Disease Audit (NCHDA) 2021 Summary Report (2019/20 data), NICOR: National Institute for Cardiovascular Outcomes research)

More information about this can be found on the NICOR website.

National Audit of Cardiac Rhythm Management (NACRM) 2021 report (published October 2021)

Cardiac rhythm management (CRM) is the treatment of arrhythmias (heart rhythm disorders). NACRM reports on data relating to CRM procedures at 174 implanting hospitals and 61 ablating hospitals from across the UK.

One key metric included in the report is the reintervention rate for pacemakers implanted in 2018/19. GOSH performed fifteen pacemaker implant procedures in 2018/19, and three (20%) were indicated as requiring reintervention within a year. That reintervention rate is indicated as "high" in the audit report but must be taken with some caution due to the low volume of procedures. The reintervention rate is also measured in comparison to adult centres. That is an important consideration since reinterventions in developing children may not necessarily be indicative of initial decisions making or of a complication or failure of the implant.
The reasons for those reinterventions have been reviewed by the clinical lead for the electrophysiology service at GOSH, and through the team's audit meeting and highlights:

- That in complex cases in children reinterventions may be necessary due to patient growth and the child's condition, rather than reflect operator expertise or performance
- Lead displacements are rare events and are monitored by the team to ensure that patterns are identified and if required practice change is actioned.

The Cardiology team review more recent data which includes reinterventions and rates of endocarditis at quarterly audit meetings.

National Cardiac Arrest Audit (NCAA)

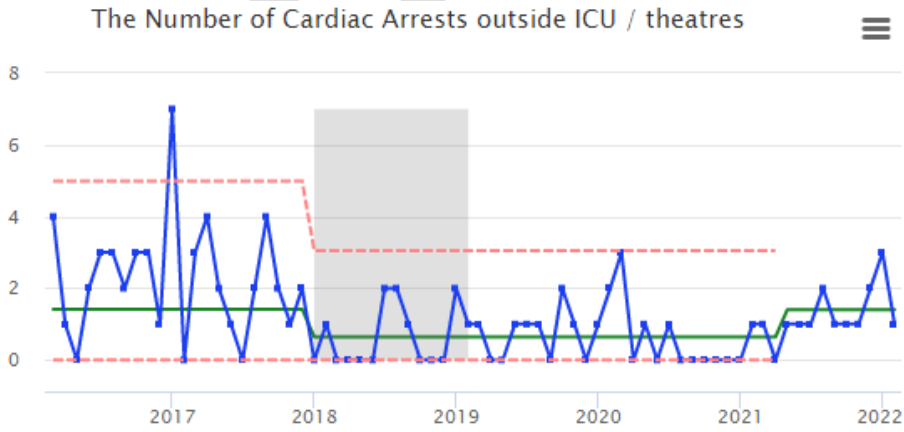
The NCCA usually publish quarterly reports at an organisational level to support benchmarking and to identify trends to inform practice and policy on both a local, and national level. However, for specialist hospitals (including all paediatric hospitals), where the cardiac arrest numbers are very low, a twice-yearly report may be provided instead to ensure meaningful analysis. GOSH has received a report for the first half of 2021 as NCAA has been involved in national covid 19 collection in ICUs nationally.

- The NCCA note the rate of cardiac arrest outside ICU at GOSH is 0.35 per 1000 admissions; this is the highest incidence of the comparable paediatric centres (only compared to 4 paediatric centres in the audit) but has fallen from 0.5 per 1000 admissions in 2017-2018.

- GOSH has an excellent rate of return of spontaneous circulation (ROSC)> 20 minutes in patients who have had a cardiac arrest (approximately 83% in this time period), and this is higher than expected.

- GOSH has the highest risk adjusted survival rate to hospital discharge for patients after a cardiac arrest, compared to similar centres (75% in this time period).

In addition, GOSH places close attention internally with real time monitoring and oversight of cardiac arrests outside of ICU.



- Resuscitation Services developed and led the "Just in Case" support programme for wards in March 2020 and the data suggests this programme has had impact. This work was recognised nationally at the Health

Service Journal Patient Safety Congress 2021 Awards, as an award winner in the *Recognising and Responding to the Deteriorating Patient* category.

- The number of cardiac arrests per month outside ICU is small in absolute numbers. We noted a small, but statistically significant, increase in the number of cardiac arrests outside of ICU since May 2021 (from .64 to 1.14 a month). In December 2021 the Head of Resuscitation Services reviewed the clinical documentation for each cardiac arrest between May 2021 and December 2021. This has highlighted themes around the completion of observations, and prompt escalation of the deteriorating patient prior to arrests which were fed into the GOSH Deteriorating Patient quality improvement project.

2021 National Comparative Audit of Blood Transfusion - NICE Quality Standard 138 (published in February 2022)

The audit measured practice against four quality statements. One statement was relevant for GOSH to compare practice.

The national audit reported that 63% of transfusion patients received information, whether verbal or written, in the pre-operative setting across all hospitals who provided data. GOSH submitted data on 20 patients, and 70% of patients were noted to have received information.

The audit report advises that sites should examine their procedures for providing written and verbal information to patients who may need transfusion, and this should include facilitating online access to patients to find accurate materials.

GOSH have written resources for patients and parents available including:

- Printed transfusion patient information leaflets available from the Transfusion Practitioner provided by NHSBT written for children
- Patient information on transfusion is available on the GOSH external website
- The same patient information is available on Epic so that staff can print it for parents and patients when making the decision to transfuse and when administering the blood.

<u>The following actions are to be taken in response to the audit at GOSH</u>

- Report the audit findings at the Hospital Transfusion Committee and discuss with clinical representatives how to improve both verbal and written transfusion information given to patients and parents (planned for May 2022)
- Review if transfusion information can be incorporated into the electronic patient record workflow ,as a tick box or reminder within any pre-operative discussions with a link to electronic copies (NB: not all surgical patients will require a blood transfusion)
- Ensure printed information is available in key areas for families to read (patient information leaflets have not been available in paper copies in general areas during the covid 19 pandemic)

2018 Audit of the use of Fresh Frozen Plasma, Cryoprecipitate, and Transfusions for Bleeding in Neonates and older Children (published in December 2021)

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This audit reviews the practice of the use of prophylactic fresh frozen plasma (FFP) and cryoprecipitate in neonates and older children, and of transfusions to treat bleeding and trauma

The audit measures four standards. These are listed below with the GOSH actions that have been identified following review of this audit by the GOSH Transfusion Practitioner

Standard	National performance	GOSH performance	Actions
Trusts have a policy/local guideline for the transfusion of FFP and cryoprecipitate to neonates and children	87.3% of sites with a neonatal unit had a policy/local guideline	GOSH has a policy/local guideline for the transfusion of FFP and cryoprecipitate to neonates	None required

	for transfusion to neonates		
Trusts do not have a policy of routinely checking coagulation screens on all pre-term neonates	70.2% (40/57) of sites met the audit standard	GOSH did not meet the audit standard	To review with CICU and NICU consider whether this should be set as part of GOSH
Coagulation tests are performed before giving prophylactic FFP and/or cryoprecipitate	63.1% (263/417) had a least one coagulation test known to be performed/reported within the 24 hours preceding the prophylactic FFP transfusion 61.7% (87/141) had a least one coagulation test known to be performed within the 24 hours preceding the prophylactic cryoprecipitate transfusion	87.5% (7/8) of children had at least one coagulation test performed within 24 hours prior to prophylactic FFP transfusion, and 80% (4/5) to prophylactic cryoprecipitate transfusion.	None required.
Reason for the use of FFP and cryoprecipitate is documented in the patient's notes	Reason was documented for 77.5% (323/417) of prophylactic FFP transfusion events Reason was documented for 66.0% (93/141) of prophylactic cryoprecipitate transfusion events	Reason documented in for 75% (6/8) of prophylactic FFP transfusion events, Reason documented for 60% (3/5) of prophylactic cryoprecipitate transfusion events.	Documentation on the reason for the transfusion and documentation on information provided when discussing the need for a transfusion (e.g. preoperatively) will be looked at as a wider piece of work on transfusion documentation within the electronic patient record

National Paediatric Diabetes Audit (NPDA) 2019/20 Report (published in June 2021).

The audit focuses on the measurement of care for type 1 diabetes. GOSH does not have sufficient numbers of typical type 1 diabetes to allow comparison of data in the report. 27% of GOSH cases included in the audit have complex forms of Type 1 diabetes, this is in comparison to 97.6 % of standard Type 1 and Type 2 diabetes in other centres. 73 % of GOSH cases included have rare forms of diabetes.

The report measures the seven key health checks. GOSH did not complete eye and foot checks in young people >12 years of age in the audit year. In response to this the GOSH service now has access to software to access patient eye screening reports. Chiropody training is to be arranged for the multi-disciplinary team in foot examinations through the University College London Hospital podiatry team.

Paediatric Intensive Care Audit Network Annual Report (PICANet) 2021 (published in February 2022)

The report covers the period from January 2018 to December 2020; this encompassed the first ten months of the Covid 19 pandemic.

Mortality

The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be 'adjusted' to consider the level of severity of the patients in respect of case mix.

The 2021 PICANet report compares Trusts Standardised Mortality Ratio[1] for the calendar years of 2018-20 .The data in this report shows GOSH ICU mortality as within what would be expected based around the case mix.

Number of nurses providing clinical care per bed

The Paediatric Intensive Care Society (PICS) Standards (2015), state a minimum number of 7.01 Whole Time Equivalent (WTE) qualified (registered) nurses are needed to staff one level 3 critical care bed. The audit reports data provided in November 2020, which shows only one PICU met the recommended standard nationally. GOSH P/NICU were reported as having just over 6 WTE nursing staff, Band 5-7, per bed. PICANet report that *"despite few PICUs meeting these standards, staffing data from the census shows that the units ensure that their staffing levels are appropriate for the number of children on the unit and their care requirements, despite NHS and staff working under pressure during the COVID-19 pandemic. This may be achieved by unit staff working flexibly, undertaking additional shifts or using bank or agency staff."*

Emergency re-admissions

The report highlights the relative 48-hour emergency readmission rate for each PICU for 2018-20. For 2018 and 2019 the relative rate for GOSH P/NICU was less than one, indicating a lower re-admission rate within 48 hours than the national average. In 2020 the relative re-admission rate within 48 hours rose to 1.64, indicating a higher - than average rate of re-admission. PICANet advise that caution should be taking in using emergency admission as quality indicator, as readmission may not be reflective of care provided, the timing or location of discharge, or prediction of the need for future intensive care.

The increase in 2020 reflects the high numbers of PIMS-TS patients that were admitted to GOSH PICU in the Covid 19 pandemic. The pathophysiology of this new disease was unknown at first and the wards were also struggling to source appropriate beds and clinical staff for these patients. A significant number of the PIMS-TS cohort were often quickly weaned off blood pressure support medication and were otherwise well, but then needed a little more support 24-48 hours later (usually for just a few hours). As knowledge and management of these patients improved it is expected that the 48-hour re-admission rate will drop in the next report.

PICANet advise that emergency readmission rates should be monitored on an ongoing basis. PICU/NICU emergency readmissions are monitored in real time via the PICU and NICU Mortality and Morbidity Meetings

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

Priority Clinical Audit plan

At GOSH we undertake audits to support learning from incidents, risk, patient complaints, and to investigate areas for improvement in both quality and safety. Some of our key priority audits completed in 2021/22 are outlined in this section of the report.

Retained guidewire following central venous line insertion

An incident occurred in 2020 where a central venous line was inserted to administer medications for a critically unwell patient on PICU. It was noted on x-ray imaging approximately ten hours later that the guidewire (used to help insert the catheter) was still inside the line- this should have been removed following confirmed placement of the central line.

Audit was completed in June 2021 to assess some of the learning points identified from the serious incident to ensure patient safety.

The audit found

- A central line insertion checklist was being appropriately used to guide and document practice
- All lines inserted had documentation that the guidewire removal was confirmed

We are planning to re-audit whether we have sustained practice in 2022/23

Medicine Storage Audit

This audit looks at standards to ensure the safe storage of medicine. This also includes a focus on areas of improvement that were highlighted by the GOSH CQC inspection report in 2020. Audit was completed in October 2021. Our overall level of performance with meeting all our standards for medicine storage was 87%.

Each ward audit identified learning, areas of good practice, and actions to be taken where standards were not met. Themes were reviewed by the Heads of Nursing at the October Nursing Quality Assurance meeting and actions agreed to address those themes (change of CD registers/ clarification of process for monitoring of temperature of medicine storage rooms).

This will be re audited further in 2022/23.

Clinical Audit – recording of implant lot numbers for embolisations undertaken in Interventional Radiology (IR)

A serious incident occurred in 2021 around a faulty batch of histoacryl glue which was used in five procedures. This was related to glue embolisation for arteriovenous malformations.

The audit reviewed the implementation of a recommendation from the serious incident investigation. This looked at whether lot numbers are being recorded where implants, particularly products which are not obviously implants (such as glue) are used for IR embolisations.

The audit identified that implant lot numbers were appropriately recorded in the electronic patient record for all IR embolisations that were reviewed in the audit.

Patient Safety Alert - (Eliminating the risk of inadvertent connection to medical air via a flowmeter).

Clinical audit was completed in January 2022 help us understand how effectively we have implemented this patient safety alert.

What the alert says

1. Trusts to purchase alternative devices that do not require medical air to be delivered via an air flowmeter.

2. All medical air outlets which are no longer required should be (reversibly) capped off.

What we found	What we are doing about it
Two wards were using air flowmeters to drive nebulisers	• Heads of Nursing have reviewed the number of nebulisers that are needed for each ward to have sufficient equipment • Ordering equipment and nebulisers to deliver medication in all setting where this is appropriate and safe
In 11/25 (44%) wards all medical air outlets were capped off as required.	• Confirmed a process to ensure missing air caps can be replaced and maintained effectively. Ensured all areas have air capped off where appropriate and safe.

As a result of the audit, a task and finish group has been established to make sure we fully implement the actions to make us compliant and eliminate the risk of patient harm or a Never Event, as far as we can.
We will undertake further audit in 2022/23 to provide assurance that we have improved our implementation of the alert

Speciality led Clinical Audit

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

114 clinical audits led by clinical staff were completed at GOSH during 2021/22. We aim to have over 100 completed specialty led clinical audits per year. We were able to meet this target for 2021/22, which is reflects an ability to engage in clinical audit and quality.
Some examples of excellent specialty led clinical audits completed in 2021/22 are described below.

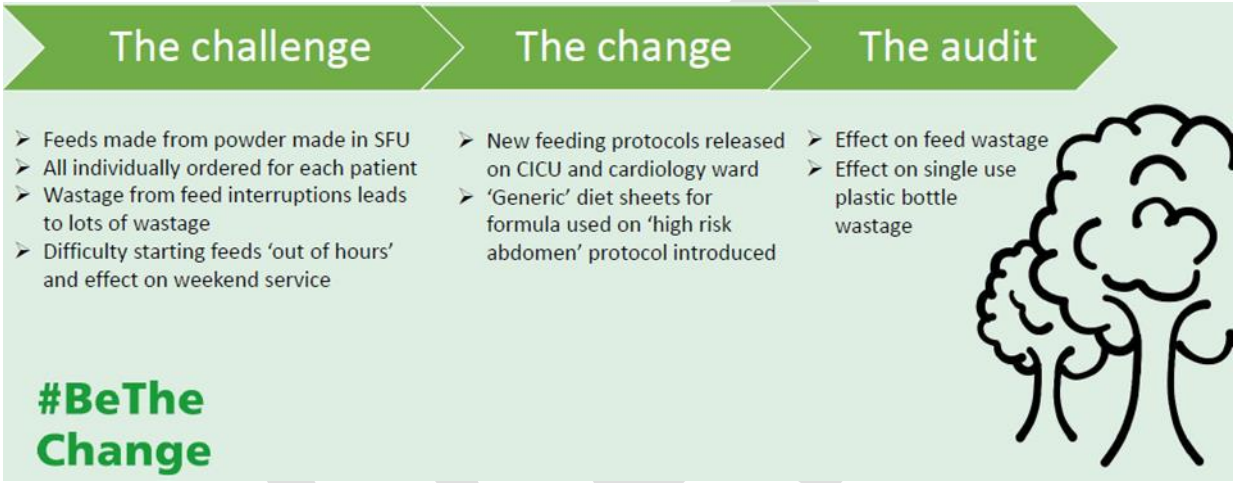
Specialty	Audit Title	What difference will this audit make to the work of the team and patient care?
Plastics	Assessing the Tongue Reduction Integrated Care Pathway	*"We have demonstrated that through teaching and the implementation of a poster we have improved the awareness of the Tongue Reduction Protocol. Our colleagues are now better informed on where to find and access the protocol. This piece of work has subsequently led to a Quality Improvement Stream and is currently under the Clinical Pathways Redesign Programme."*
NICU	Subgaleal shunts: post-operative complications and perinatal factors	*"It helped us to better understand the characteristics of our patients admitted for subgaleal shunt insertion and predict which adverse short and long term outcomes they might present."*
Neuromuscular	Prediction of loss of ambulation in Spinal Muscular Atrophy type IIIA using the ten-meter walk test	*"We found that our patients show a significant decrease in their final year leading up to loss of ambulation in their 10m walk test compared to previous years. A loss of more than 3.1 seconds in a year or a time of over 15.6 seconds over the 10m indicated a high risk of losing ambulation. We now ensure that for patients over these thresholds we that non-ambulant specific equipment is in place such as wheelchairs and standing frames."*
Dietetics	To determine whether the dietetic renal service is reviewing haemodialysis patients according to GOSH dietetic best practice guidelines	*"Improved results were seen in this audit compared to the audit done in 2017/2018 (80% vs 17% of in-centre HD patients received the recommended full dietetic reviews)."*

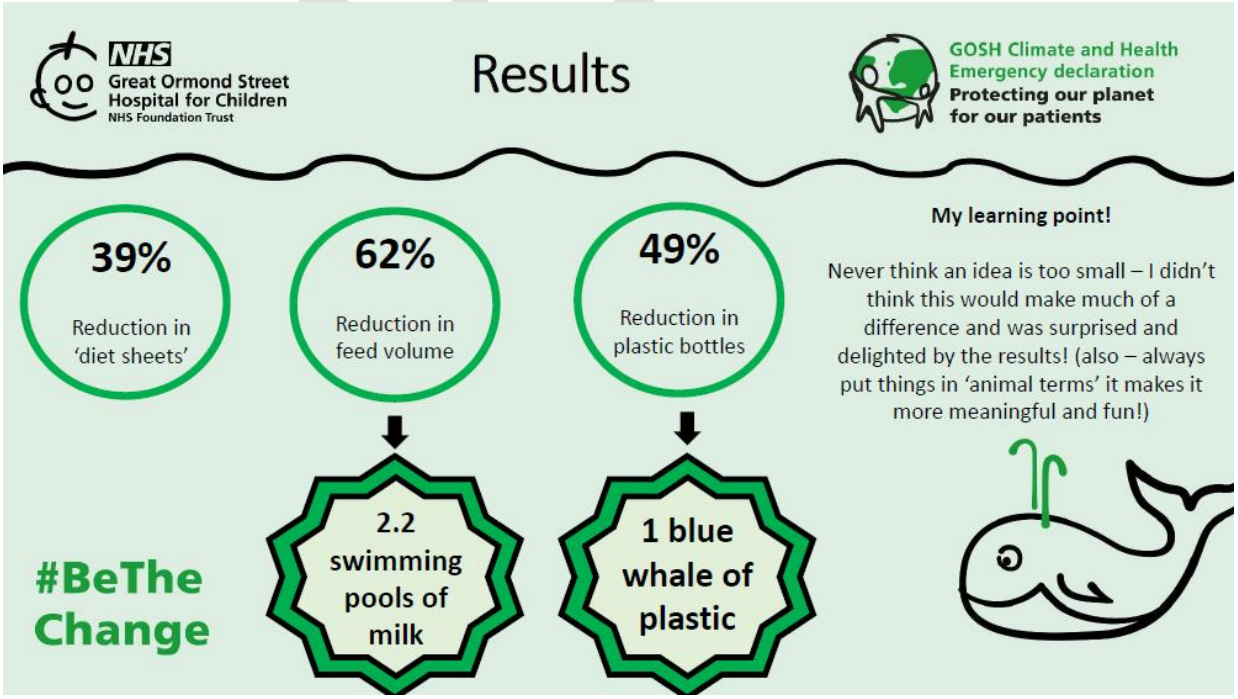
Urology	K-WIRE technique for nephro-stenting in Lap Pyeloplasty - safety and efficacy	*"This technique will be used as the standard for laparoscopic pyeloplasty stenting except for the select few who are unsuitable. Avoids a second anaesthetic for removal"*

Using Audit to lead improvement

Reducing feed waste in CICU and cardiology

On 22 February 2021, GOSH announced its official declaration of a Climate & Health Emergency (CHE). In doing so, GOSH became the first UK stand alone children's hospital and first London NHS Trust to declare. The declaration is a firm statement of intent and builds upon the hospital's existing sustainability programme to establish greater ambitions for climate action and environmental leadership. An example of an excellent piece of work, that used audit, that supports our efforts to protect the plant was led by Catherine Kidd, who is a Specialist Dietitian in CICU and Cardiology





Learning from deaths

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

Implementation of the Child Death Review Statutory Guidance

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

Case record reviews take place through two processes at GOSH:
1. **Mortality Review Group (MRG).** This was established in 2012 to provide a Trust level overview of all deaths to identify learning points, themes and risks and take action as appropriate to address any risks. This process is linked with local case reviews (Morbidity and Mortality Meetings) undertaken by specialty teams and provides an additional oversight of inpatient deaths in the Trust. This group continues to review deaths to ensure a thorough level of review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as identifying learning points and making referrals to other safety investigation processes at the earliest opportunity.
2. **Child Death Review Meetings (CDRM)**. Child Death Review Meetings are "a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death." They include clinicians or professionals from external providers. CDRM meeting should be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews. Child Death Review Meetings (CDRMs) are the final meeting to confirm actions and learning in the mortality review process following the completion of all necessary investigations and reviews

Deaths in 2021 and case record reviews

Between 1st January 2021 and 31 December 2021, ninety-one children died at GOSH.
Eighty-nine of those deaths have been subject to a case record review.

- Two are awaiting review at the mortality review group
- Sixty-eight CDRMs have taken place, and twenty -three have not been completed
    - Eight cannot take place until the completion of necessary coroner investigations. This in line with the Child Death Review Statutory Guidance.
    - One is not required as it relates to a patient over the age of 18
    - Fourteen are being planned at the time of writing and haven't yet taken place due to challenges in all relevant parties being able to be available to attend the meeting.

The table below is correct at the time of writing (4th April 2022). It is possible that Serious Incidents could be identified significantly later from the time of the incident they relate to, and therefore outside of this reporting period. In some cases, child death review meetings have not been concluded, which means that modifiable factors may be identified at a later stage, excellent practice may also be confirmed at later stage following conclusion of those meetings .

	Jan – Mar 2021	Apr –Jun 2021	July–Sep 2021	Oct –Dec 2021
Number of deaths	23	25	19	24

N reviewed by the Mortality Review Group	23	25	19	22
N reviewed at a Child Death Review Meeting	22	25	15	6
N where modifiable factors [2]around GOSH care were identified following the conclusion of a CDRM	1	0	0	0
N where excellent practice at GOSH was highlighted in the mortality review process[3]	20	18	13	9
N where Serious Incident investigations were declared	1	1	1	0

Deaths where serious incidents were declared , or modifiable factors indicated , and actions identified following the conclusion of those investigations are described below.

Incident	**Actions identified following the completion of the Serious Incident investigation**
<u>Serious incident (Faulty batch of histoacryl glue impacting patient outcomes</u> The CDRM concluded there were modifiable factors which were reviewed through the SI investigation. A Serious Incident was declared after a faulty batch of histoacryl glue was used in embolisation for arteriovenous malformation It will never be possible to determine for certain what impact the histoacryl glue had in this case. The learning and actions identified through the completed SI investigation were around the governance of safety alerts and recording of lot numbers.	The following actions have been completed • All-staff protected teaching time in theatre will be utilised to remind theatres staff (including scrub staff, anaesthetic staff, and surgeons) of the importance of recording lot numbers. The findings of this Serious Incident investigation will be discussed for learning purposes. • The EPR team will be asked to review how lot numbers are recorded on the patient record and to identify any enhancements to this system, in particular to identify whether a mechanical alert or notification can be added to remind staff when a lot number is not entered • A list of major stakeholders/partners who supply the Trust with products will be compiled. These companies will be contacted and informed of our new policy for management of safety alerts. They will be asked to copy in the safety alerts email address for any Field Safety Notice related communication. The following action is in progress • A policy will be drafted and agreed to outline the management process and pathway for all safety alerts, including Field Safety Notices The policy is in draft form and is currently being widely consulted with relevant stakeholders, including the membership of the Patient Safety and Outcomes Committee. It is anticipated that this will be finalised in Q1 2022/23

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

Serious Incident- Escalation of the antibiotic regime in a febrile neutropenic patient on chemotherapy treatment The Mortality Review Group identified concerns around the choice of antibiotics and persistent tachycardia prior to the cardiac arrest which led to a serious incident investigation. The conclusion of the CDRM in light of the SI investigation and inquest determined that there were no modifiable factors that would have changed the outcome in this case as the cause of death was not identified as sepsis on post-mortem or from any investigations (cultures etc)	The following actions have been completed • Teaching for the medical and nursing staff in the Blood, Cells and Cancer Directorate on sepsis in the immunocompromised patients, to highlight patients at a greater risk of infection and to identify early signs of sepsis • The Trust will review the need to undertake testing for the m.1555A>G gene in immunocompromised patients who are at high risk of sepsis • To work with the SIM (Simulation training) team to devise training scenarios for clinical staff in the Blood, Cells and Cancer directorate highlighting the benefits of trend recognition in early recognition of the deteriorating patient. The following actions are in progress • Update the Paediatric Haematology & Oncology: Supportive Care Protocols to reinforce that empirical antibiotic should be given regardless of the review being undertaken when infection is suspected. (due 31/5/22) • To work with the Epic team and train staff to have the timeline activity on their toolbar in Epic (due 30/6/22)
Serious Incident Major haemorrhage during cannulation for extracorporeal membrane oxygenation (ECMO) The patient died as a result of complications arising during the ECMO cannulation procedure. The patient had an underlying condition which placed them at high risk for mortality and increased the risks of cannulation. The investigation has not identified any causal factors in terms of care that was delivered or identified how the outcome could have been prevented.	The following actions have been completed • A sternotomy saw will be added to theatre trolley that it taken to CICU for procedures • A tip sheet will be written explaining additional equipment that will be required and rationale for use • Scrub staff who are new to the department will now spend a week in the Cardiac speciality as part of • Scrub staff who will be rotated into both weekend and night shift are encouraged to have a refresher day in Cardiac theatres • The CICU and cardiothoracic teams to develop a joint consent process where parental consent is obtained for patients being assessed for ECMO treatment by both teams • Review the rapid response algorithm for placing a patient on ECMO to clarify escalation policy and support staff in decision making during challenging ECMO cannulation procedures. • Ensure that all echo imaging is saved to facilitate further review and aid future learning The following actions are in progress • The CICU team brief check list to be reviewed and amended to include named additional equipment that maybe required and therefore guide the discussion (due 30/12/2021) • The cardiothoracic surgeons will develop a case mix risk stratification document with appropriate guidance on identifying and managing high risk patients requiring ECMO cannulation (due 31/3/22)

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

Some examples of excellence are noted below

- *Despite the Covid pandemic this child was repatriated to XXXXXX after death. The PICU team were credited for doing a great job in caring for this child and family. Attendance at the CDRM of GP, local hospital and GOSH teams was really helpful in coordinating the follow up for this family.*

- *Dedication, sensitivity of CICU nursing was humbling. Excellent MDT working in the face of a very challenging and complex case with progressive cardiac failure despite full VAD support. There were broad international and Berlin Heart team consultations. The GP was really grateful to the local and tertiary centres for all the care provided. Peer support, psychology support and one to one support available to CICU nursing team has been available.*

- *Very complex and emotionally challenging case. The nursing team were credited for their extraordinary achievements in sibling visitation prior to death and in repatriating this child and family back home after death despite the Covid pandemic. This has been fed back to the individuals involved via the GOSH PRAISE process.*

- *Excellent communication between GOSH and local team during the weeks prior to death including enabling the local team to visit at GOSH on the day of redirection of care. This communication was greatly appreciated by the local team, and this has been fed back to the PICU consultant responsible*

- *Evidence of good multi-disciplinary team working*

The learning points from case record reviews and actions taken are shared via quarterly Learning from Deaths reports at the Patient Safety and Outcomes Committee, and at Trust Board.

Participation in clinical research

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

In 2021/22, we have focused on recovering our research activity post-Covid and have led and published cutting edge research in a variety of specialties. For example, we have seen landmark results in gene therapy clinical trials for immune deficiencies, started world-first clinical trials into CRISPR/CAS9 CAR T therapy for leukaemia and developed heart surgery protocols that are changing and saving lives for young patients waiting for a heart transplant across the world.

Research activity

During 2021/22, we have run 700 research projects at GOSH/ICH. Of these, 232 were adopted onto the National Institute for Health and Care Research Clinical Research Network (NIHR CRN) Portfolio, a prestigious network that facilitates research delivery across the NHS (Figure 1). Our extensive research activity continues with the support of our NIHR Clinical Research Facility (CRF) and Biomedical Research Centre (BRC) awards, which began in April 2017, and, due to the COVID-19 pandemic, have been extended until September 2022 and November 2022 respectively. The BRC and CRF underpin our entire research infrastructure at GOSH, in collaboration with GOS-ICH and GOSH Children's Charity. Applications for a futher 5 years of funding for both the BRC and CRF were submitted in 2021, and in March 2022, it was confirmed that our CRF has received £4.8M, an increase of 58% on the previous award. Our BRC funding application has been shortlisted, with interviews taking place in April 2022.

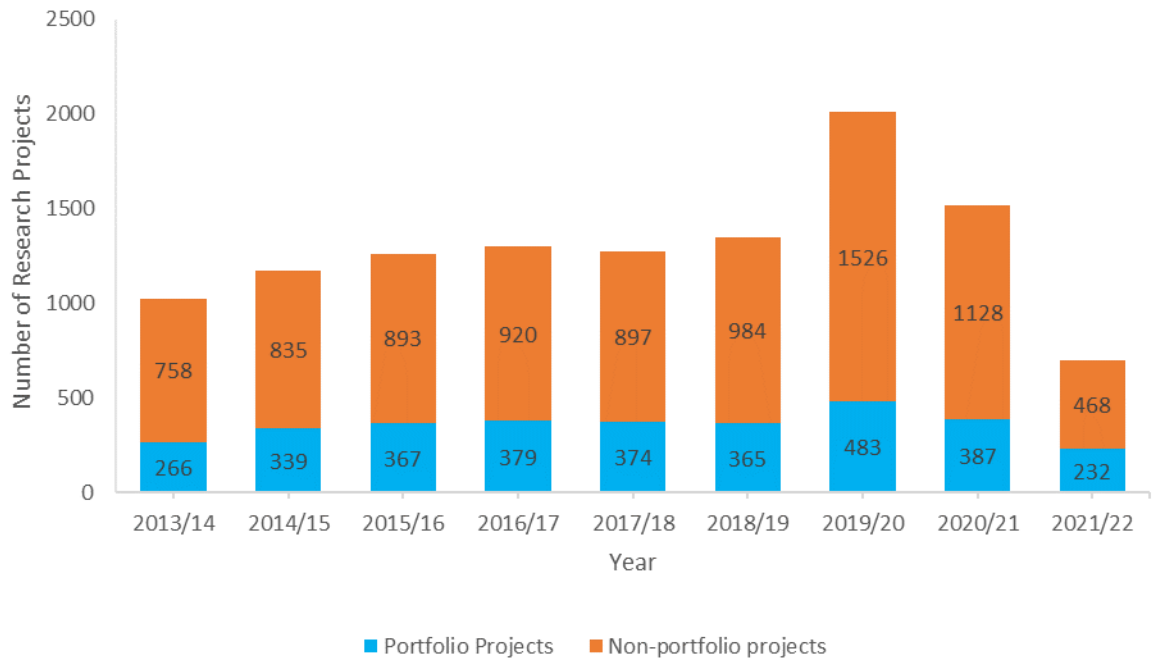


Figure 1: Number of research projects taking place at GOSH/ICH, highlighting the NIHR CRN Portfolio projects.

In 2021/22 we have continued to recover our research activity post-COVID, with a focus on high intensity studies with complex data requirements and a higher proportion of trials being early-phase in line with our NIHR CRF strategy. As a result, the overall trend for the CRF is for fewer studies to be hosted.

As Covid restrictions ease, participant vists to the CRF over the course of the year have increased compared to 2020/21; with a sharp rise in on-site participant visits in Q3, while alternative ways of working (remote visits and couriering of medication to patients' homes) are steadily decreasing. We also resumed overnight visits in the CRF at the end of Q2 with a total of 18 overnight visit taking place in 2021/22.

In 2021/22, we had over 2,600 participants in research at GOSH (Figure 2). All research undertaken is approved by the Health Research Authority (HRA), including Research Ethics Committee and Medicines and Healthcare products Relatory Agency (MHRA) approval as appropriate.

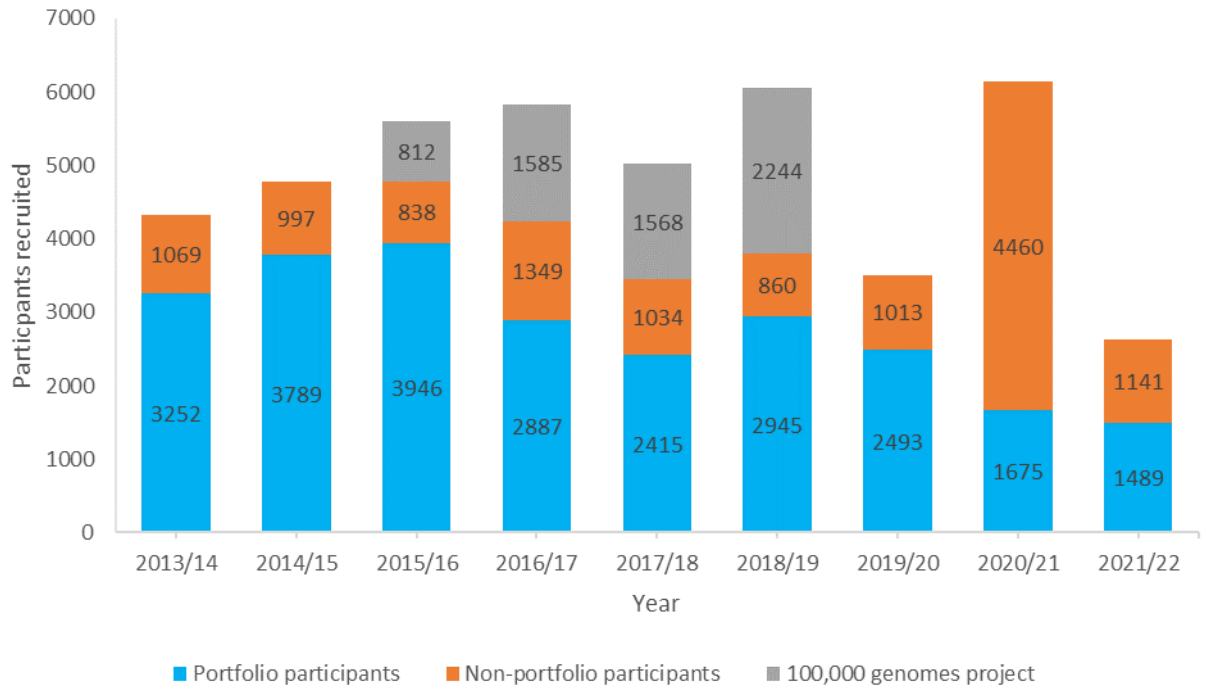


Figure 2: Number of research participants recruited at GOSH/ICH, highlighting the NIHR CRN Portfolio projects and those recruited to the 100,000 genomes project in previous years

Research highlights

Alongside a breadth of broad research activity in 2021-22, our programmes at GOSH continued to support the global effort to understand the COVID-19 pandemic by capitalising on our existing expertise.

In a recent publication from the GenOMICC study into Covid infections, 40% of the paediatric patients (100) had been recruited at GOSH and we expect our expertise in genomics to continue to contribute to, and lead, studies in this area. Using our unique cohort of patient data and significant expertise, we were also able to rapidly show the impact of COVID-19 on children and we were the only UK site able to contribute to a global consortium that identified and tracked different SARS-CoV-2 variants in children.

With Southampton Hospital, we recently opened the first two vaccine research study sites for immunocompromised children as an extension to the adult OCTAVE study.

We have also been able to delve deeper into the long-term outcomes of children with severe COVID-19. We were able to share data that reassured parents that most symptoms of severe infection with the Sars-CoV-2 virus are resolved in children after 6 months but, crucially, our teams were also instrumental in the growing understanding when those symptoms don't resolve: so called 'Long-COVID' in children. Our scientists and doctors spearheaded a study that determined an agreed, distinct research definition for the condition to improve research in this growing field.

Teams at GOSH who pivoted their skills towards the virus in 2020-21 were also able to share the first results of their work in 2021-22: from understanding how the unborn baby is protected from the virus in the womb by the placenta, to using stem cell expertise in the ZCR to grow 'mini-stomachs' and study the emerging gastric symptoms seen in children.

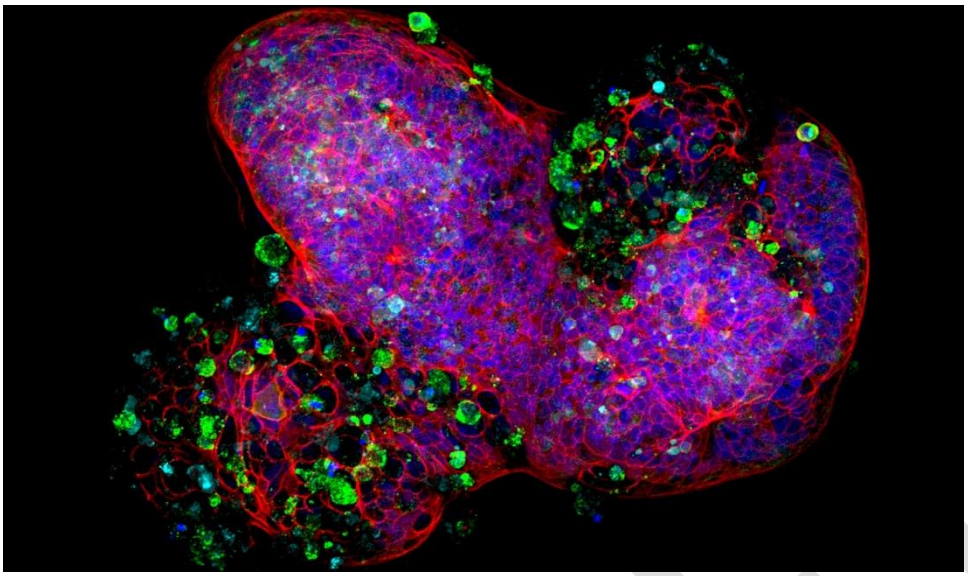


Image credit: Dr Giovanni Giobbe, mini-stomach organoid

Alongside this, we have delivered major breakthroughs in research from early stage science to clinical trials and virus manufacture. However, this has not been an easy year for research at GOSH – our staff have worked tirelessly to support the Hospital and the research effort but, as a result of added strains, we have not seen the growth in some areas that we had anticipated (active research studies and commercial research income).

COVID-19 research was prioritised alongside essential non-COVID research. The R&I research delivery team provided specialist support to deliver these Urgent Public Health research projects.

During the first wave, research delivery staff were redeployed across the organisation to provide support needed for frontline clinical care and vital operations. This resulted in re-deployment of 33% of staff (total headcount approximately 100 staff, redeployment represents 55% of nursing workforce) to provide frontline support for COVID-19.

In 2021 the CRF management team oversaw the set up and implementation of the GOSH staff vaccination programme. The research delivery team were critical to the successful vaccination of 73% of our workforce over threee 4-week periods. The R&I research delivery team brought key research skills such as consent, clinical competence and safety, working with novel drugs and methodical working practices to this Trust-wide project.

By changing the way we work we have ensured our patients continue to receive the research-related treatment they need whilst supporting the Trust COVID-19 response.

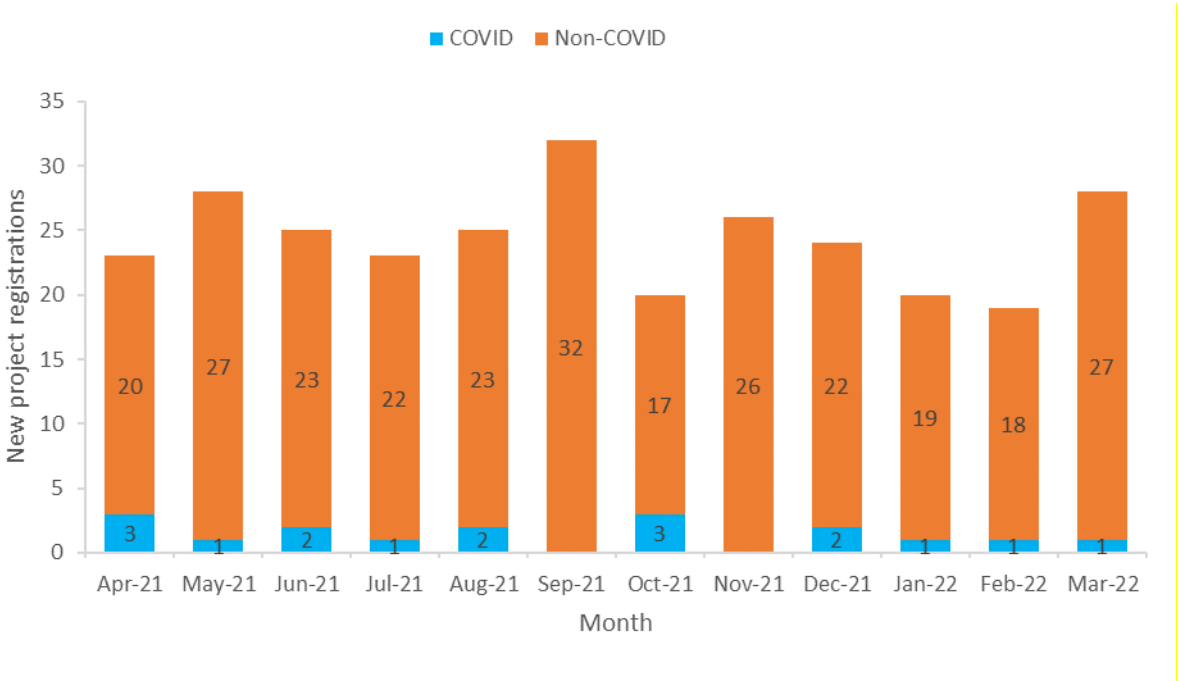


Figure 3: New Project Registrations in 2021/22

identifying further areas for expansion and development of research expertise.

Sample Bank

In 2019, we formally launched our GOSH Sample Bank initiative, enabling patients to donate their leftover samples to be used for vital child health research instead of them being thrown away. The samples will allow us to carry out more research to better understand rare conditions and develop new treatments. In 2021/22 we hit 1,000 recruits and are aiming to reach a target of 2,000 patients by the end of 2022 (Figure 4). Sample Bank is one of the key programmes of work being overseen by the Research Planet Delivery Board.

Sample Bank has been at the forefront of driving developments in Epic. It was chosen to pilot the use of MyGOSH to contact patients directly about research studies, with the aim of encouraging research participation. In addition, a rule has been created within Epic that identifies and flags samples from patients that have consented to Sample Bank to the lab team, allowing these samples to be kept and not thrown away. Once approved and in use, this will allow us to pilot retaining these samples in the immunology lab to give us a better indication of resources we will need for Sample Bank in the future.

The initiative is already giving researchers easier access to the samples they need. Scientists at GOSH are part of an international consortium of researchers working to improve the diagnosis of sepsis in adults and children, the SEPTIMET study. Current diagnosis methods can take days, so treatment is often given pre-emptively based on symptoms and the antibiotic treatments are broad to cover lots of infections. This study will use cutting edge genomic sequencing technology, known as Nanopore sequencing, to try and reduce diagnosis time to hours. Sample Bank has given the team access to vital blood samples from children with suspected sepsis infections without the need to ask for extra draws at an incredibly difficult time for families. They are also able to use blood samples from across the hospital from children without sepsis to provide vital comparisons within the study.

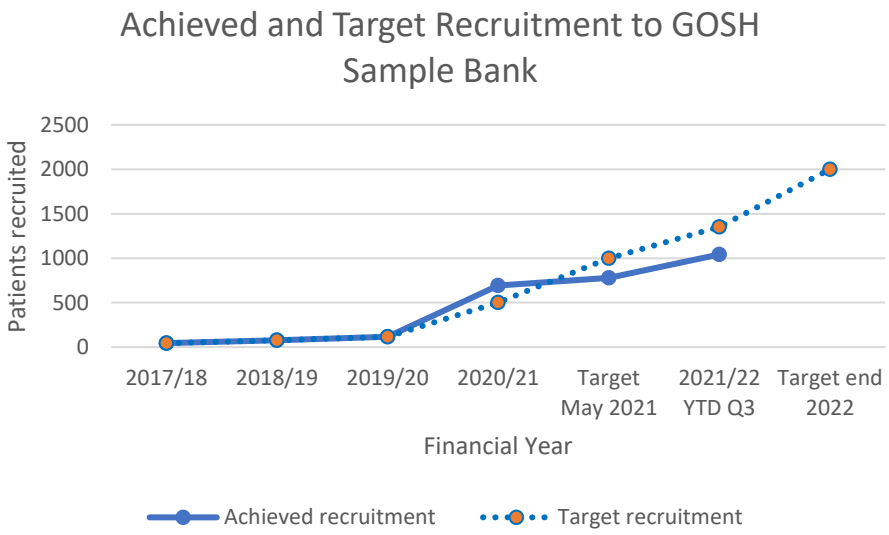


Figure 4: GOSH Sample Bank patient recruitment and targets

Research income

Although research income is still lower than in previous years, we have recovered a significant increase in commercial income towards the end of the financial year as our activity has increased. This year, despite a drop in income overall, we have ended the year on target, contributing more than £2m to the Trust over and above our core costs.

As we move into 2022/23, we are focusing on recovering and growing our research activity, in line with the Department of Health and Social Care's Recovery, Resilience and Growth Programme and in order to meet ambitious targets for income, continuing to ensure that we provide sufficient infrastructure to support research delivery across the Trust.

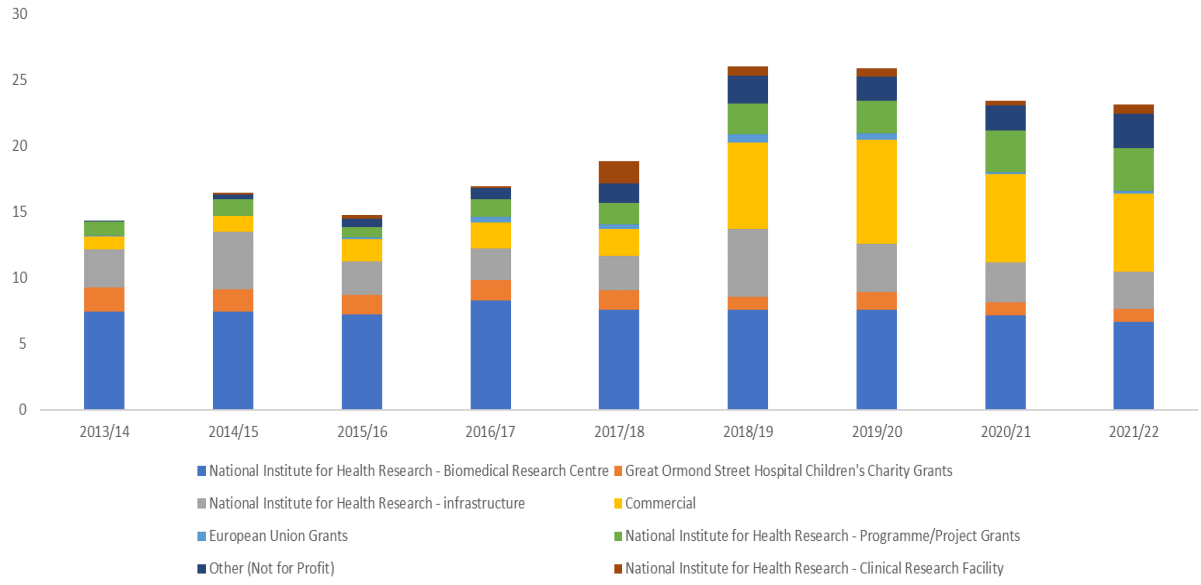


Figure 5: Research income (£m). NB final year end figures not yet validated.

Innovation

In 2021 the Trust approved a new business plan for the GOSH Data Research, Innovation and Virtual Environments (DRIVE) unit for for a 5 year period. This sets out the core business objectives that can

support GOSH to become an intelligent Research Hospital, where innovations in data and technology are improving patient outcomes and stakeholder experience. These core objectives are to:

- Bring all our data into a single Data Reporting Environment (DRE)
- Develop a Partnership Discovery Team to leverage value from our data and new technology
- Create an Innovation Hub that can rapidly evaluate innovations and safely deploy them within the hospital

The DRIVE business plan supports the Trusts' 'Above and Beyond' strategy in its aims to adapt a patient-centered 'digital first' approach, leveraging the power of our data and advancements in technology whilst responding to current operational challenges.

The team has expanded to includ data scientists, project managers, outcomes evaluation and communication professionals. Always acutely aware that Innovation cannot happen in isolation, in 2021/22 we have ongoing projects with a number of partners including:

- Aridhia – to support delivery of the GOSH DRE
- 3M (Mmodal)
- Royal Free London – piloting novel methodologies for innovation
- Sensyne
- Roche
- YouTube

Further to this, the Clinical Informatics Research Programme (CIRP), part funded by GOSH Charity, has transitioned in to its second phase, where it will build on success from phase one by expanding the £8 million PhD programme, data science support, internship opportunities and pursuing response mode funding.

Journal publications

In 2021/22 we published 973 papers, 696 of these were with our academic partners. In the five year period between 2012 and 2016, GOSH and ICH research papers together had the second highest citation impact (1.997) of comparable international paediatric organisations.

Education and Training

Training and education of the next generation of high calibre researchers in paediatric translational research is co-ordinated by the Career Development Academy (CDA) of the GOSH BRC and is monitored by our Research Planet Delivery Board with support from our Centre for Outcomes and Experience Research in Children's Health, Illness and Disability (ORCHID) and GOSH Learning Academy (GLA). Development of research careers remains a priority, and we continue to embed research and learning opportunities throughout careers at GOSH, to attract and retain research leaders.

Our unique programme of career development schemes for Early Career Researchers, including our Catalyst Fellowships and Nursing/Healthcare Professional internships, delivered in partnership with ORCHID, has led to an increase in individuals securing prestigious external fellowships. Four individuals were awarded career development awards in 2021/22, including a HEE/NIHR Pre-doctoral Clinical & Practitioner Academic Fellowship (PCAF), a NIHR Development & Skills Award, a Kidney Research UK Fellowship and a Lectureship at the Royal Free. Total funding awarded to these individuals was over £675K.

In March 2022, GOSH's Executive Management Team endorsed a proposal for a Clinical Academic Framework for non-medical staff. The proposal, a collaboration between ORCHID (Centre for outcomes

and experience research in Child Health, Illness and Disability), GLA (GOSH Learning Academy), and Research and Innovation, offers staff a structured 12-month programme following completion of doctoral studies, with dedicated time to undertake research activity (including preparing future grant proposals) embedded within their job plan.

We have an established clinical research delivery programme ensuring our clinical researchers provide high quality clinical research care. The Research Advanced Nurse Pratitioner leads on advanced practice focussed on supporting the workforce to develop the complex clinical skills required to deliver early-phase translational research. They have established a multidisciplinary programme to enable investigators and research nurses to achieve competence in complex procedures such as intrathecal drug administration resulting in a uniquely skilled workforce allowing us to carry out 4 complex first-in-child studies in 2021/22. The research education team continue to work incollaboration with investigators to identify training needs and develop training packages with particular emphasis on our earlyphase portfolio pipeline of advanced/gene therapy studies.

Patient Experience and Engagement

All of the examples included here indicate the quality of research at GOSH which has a direct benefit to and involvement of patients, families and the public. We continue to run a highly successful Young Persons' Advisory Group for research (YPAG) which continues to operate effectively in a virtual format for the last 12 months, as part of our wider strategy to deliver patient and public involvement and engagement (PPIE). Our PPIE highlights demonstrating progress against our strategy and impact case studies with examples of where, when and how our young people and families contributed to the development and implementation of the research can be found on the GOSH website, along with more information about YPAG.

Our patient and public involvement, experience and participation programme has been held up as an example of good practice repeatedly in our NIHR CRF and BRC annual report feedback. We are now in the process of refining our plans in line with our successful NIHR CRF award and BRC proposal, working closely with GOSH Children's Charity to align our activities in this area. Following a successful stakeholder engagement consultation in autumn 2021, we have now established a PPIEP steering group which will work across the BRC and CRF to drive our strategy in this area.

Patient experience is at the heart of our clinical research activity. All of our patients participate in research voluntarily and we understand the importance of play and play/distraction therapy in ensuring a child's research visit is a pleasant experience. We have a dedicated research Play Specialist who works with the delivery teams to ensure ensure that those patients involved in our early-phase trials have a positive research experience. We are also continually striving to improve our research participant patient experience. Each patient/family who takes part in research within the CRF is asked to complete a feedback form. During 2021/22 the response rate was 34.63% (Trust average 33.56%) with a 100% positive experience measure (Trust average 97.85%). Participant research experience is reviewed on a monthly basis and the directorate works with the GOSH School to ensure patients continue with their schooling, either in the CRF (with a teacher visiting) or in the School depending on their study protocol and condition.

We continue to share our research success stories internally and externally, with a few examples demonstrating our leadership in major breakthroughs that have changed the lives of those with rare and complex diseases world-wide listed on recently refreshed research webpages: Our commitment to live-changing research | Great Ormond Street Hospital (gosh.nhs.uk).

CQUIN payment framework

GOSH income in 2021-2022 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. As outlined in the finance and contracting arrangement guidance for 2021-22 the operation of CQUIN (both CCG and specialised) for Trusts was suspended for the period from April 2021 to March 2022.

CQC registration

GOSH is registered with the CQC as a provider of paediatric healthcare services, with Dr Sanjiv Sharma, Medical Director, registered as the Responsible Individual.

Due to the global pandemic, the CQC has not recently carried out an inspection of the Trust since its 2019 inspection (report published January 2020; services rated 'good' overall and 'outstanding' for the 'caring' and 'effective' domains). During the Pandemic, the Trust worked closely with the relationship manager from the CQC, amending our registration to provide care for patients requiring mental health support.

Over the past year, actions arising from that inspection have been monitored through to completion or are on track to be completed by Q1 of 2022/23. In 2021, the Trust commissioned an external organisation BDO LLP, in part, to undertake an independent review of the Trust against the 'Well-led' domain, primarily focussing on the Trust Board and senior management team. The findings of this review have been shared with the Board and NHS England (London Region) and have been incorporated into the Trust's delivery plan to maintain its Well-led compliance, which is on track to complete by April 2022.

As part of a pilot scheme focusing on dental care provided by NHS Trusts, in December 2021 the CQC undertook a virtual inspection of the Trust's Dentistry Service. This review was conducted by two CQC inspectors and their specialist Dental Advisor, although no report was issued as part of this pilot scheme, the Trust received feedback from the inspection team who stated they had received sufficient assurance from the inspection and no further action was required. Following appointment of the Director of Safety Surveillance, the Trust continues to ensure that the actions arising from the CQC's 2020 inspection report are embedded in practice.

Data quality

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

Highlights of the work completed in 2021/22 across Information Services, Data Assurance, Information Governance, and Clinical Coding include:

Information Services

- Statutory & Mandatory Returns datasets updated throughout the year as new versions and requirements released.
- Introduction and development of QlikSense & GOSHSense platforms to allow the Trust to have increased visibility and easy access to data
- Multiple datasets built in the EPR and HR data warehouses, QlikView and QlikSense to provide the Trust with oversight of various operational areas.
- Standards for both data warehousing and reporting development reviewed. Standards consistently followed by the team and shared with wider Trust data teams.
- Knowledge sharing and best practice collaboration with data teams across the Trust, including a Data Warehouse Architecture group to work on solutions suitable for multiple uses.
- Development of automated solutions for International & Private Care including submission of invoicing to UAE and PHIN Statutory datasets, with both internal (for validation) and external (for submission) reporting mechanisms.
- New processes developed for managing team workload to provide updates, assurance and easier prioritisation.

- New development planned and POC developed for reporting on data from non-EPR systems including GLH (Genetics) and GLA (Learning Academy).
- Advice & Deep Dive sessions on EPR Data Warehouse for the DHR Connect Project with Royal Marsden Hospital
- Submitted 569 Central and Statutory returns during 2020/21. The Government reduced the numbers of returns in April to June 2020 in order to concentrate efforts to manage the COVID pandemic, so submissions varied from 15 in June to 78 in December 2020.

Data Assurance

- GOSH achieved the recommendations on the 2021 data quality action plans from the internal KPMG audit covering Referral To Treatment (RTT)
- Has embedded data assurance workflows that covers daily, weekly and monthly data quality checks from integrated Epic data quality dashboards and Qlikview Patient Management reporting.
- Data assurance team works closely with the EPR team to develop training content, deliver training, standard operating procedures and data entry support for front-end users.
- Delivered Introduction to RTT refresher and new starter training to staff and core groups during 2021/22 include Central Booking Office and Medical Secretaries which can be deliver face to face or by e-Learning
- Developed and delivered PTL Queries Training to support staff managing patient tracking lists covering RTT guidance and application within Epic
- Integral part of Epic working groups and forums supporting the ongoing development of the Epic system in line with NHS standards
- Data Assurance team continue to ensure all dimensions of data quality criteria is met which includes full validation of all unknown RTT clock starts, RTT clock stop audit, administrative pathway audit, clinical prioritisation and statutory reporting (RTT, DM01, DID and SUS)

Secondary Uses Service

As required by NHS Digital, GOSH submitted records during 2021/22 to the Secondary Uses Service (SUS) for inclusion in the National Hospital Episode Statistics. These are included in the latest published data. The table below shows key data quality performance indicators within the records submitted to SUS.

Indicator	Patient group	Trust Score	Average national score
Inclusion of patient's valid NHS Number	Inpatients	94.5%	99.6%
	Outpatients	94.9%	99.7%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.9%	99.7%
	Outpatients	99.9%	99.6%

Notes:

- The table reflects data from year to date 2021-2022 at month 10 SUS inclusion date.
- Nationally published figures include our international private and Non-English patients, who are not assigned an NHS number. Therefore the published figures are consequently lower at 94.5% for inpatients and 94.9% for outpatients.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

Information governance

The Great Ormond Street Hospital (GOSH) completed an external audit by KPMG of the Data Security and Protection Toolkit (DSPT), GOSH have been awarded significant assurance with minor improvement opportunities. The improvement will be completed before the submission of (DSPT) in June 2022. The DSPT allows the Trust to demonstrate the controls in place to ensure the security and governance of data held by the GOSH. The completion of the DSPT ensures GOSH meets its statutory obligation and data protection legislation such as the General Data Protection Regulations (GDPR) and GOSH will maintain its status as a `Trusted Organisation' and therefore can share data with, conduct research and other data sharing activities with other NHS bodies and trusted partners.

The information Governance Team are manages the Trust Data Protection Impact Assessments (DPIA), A (DPIA) is a process to identify and minimise the data protection risks of a project. This is caried out when engaging with other organisation who wishes to work with GOSH and have access to personal identifiable data for the purpose of new trials, acquiring new technology/software, sharing research or new research. The team also manages the information asset register and overseeing all policies relating to Information Governance

Clinical coding

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

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

The clinical coding team continue to work towards a robust validation programme working with clinical teams across all specialties. The work that has already been undertaken was acknowledge by the auditor during the 2021/2022 DSPT audit.

The recent 2021 / 2022 audit for clinical coding for the compliance of the Data Security and Protection Toolkit showed results of over 96.0% accuracy for primary diagnostic coding, and 92.31% for primary procedure coding.

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

Area audited	Number of FCEs	Primary diagnosis accuracy	Secondary diagnosis accuracy	Primary procedure accuracy	Secondary procedure accuracy
Data security and protection toolkit	200	96.00%	99.41%	92.31%	91.48

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

- Quality of diagnoses coding is very good
- Quality of Neurosurgery coding is very good in particular
- Significant improvement in the secondary procedure coding from last year
- The full electronic patient records were available at the time of audit
- The medical records were all accessible electronically and are available in a timely manner to the coders

- Histology results were checked and updated
- There is currently no vacant posts in the department
- Encoder is in use, which allows coding 5th characters and coders can select source documents and add any relevant notes to the episode coded

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

- Coders not reading through full op notes to extract all information and assign codes to fully reflect the procedures undertaken. This resulted in the high number of secondary procedure coding inaccuracy.
- Incorrect application of COVID screening code
- Data quality errors in admission and discharge dates of patients and Consultant not matching the specialty the patient is admitted under
- Inconsistent diagnosis coding of Tracheo-cutaneous fistula
- Documentation issues – including the patients problem list not always being reviewed, op title being copied over from the pre-op notes as opposed to the actual procedure taken place resulting in incorrect code assignment by the coders.

Priority clinical standards for seven-day hospital services

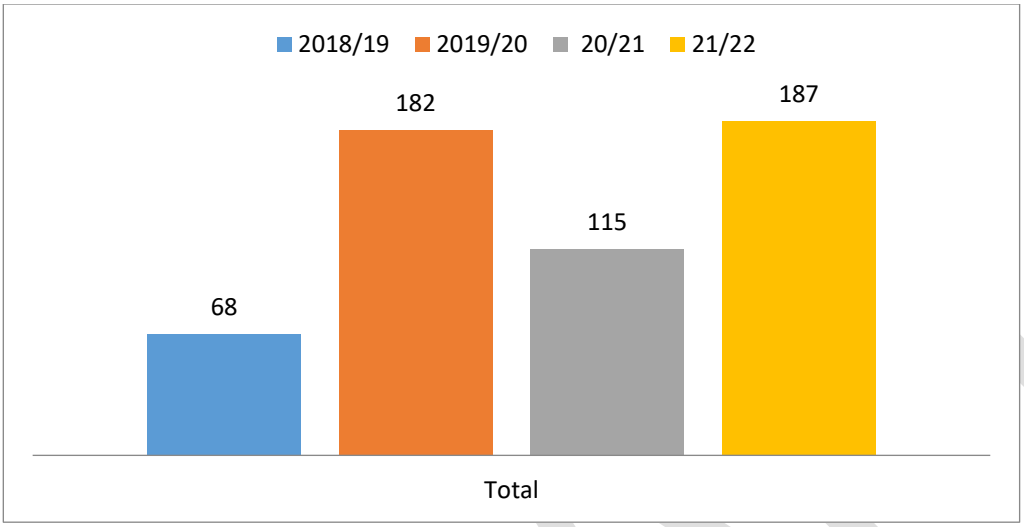
Participation in the NHS England seven-day service audit and self-assessment framework was suspended in March 2020 due to the unprecedented demand posed by the COVID-19 pandemic. We has not as yet been notified as to when it will resume.

Promoting safety by giving voice to concerns

Freedom to Speak Up Guardian

In 2021/22 the Freedom to speak up service recorded 187 cases of people speaking up about concerns related to patient safety/care or anything that affected peoples working lives at the Trust. This compares to 115 recorded cases in 2020/21. The service provides confidential and independent advice to support colleagues to raise concerns. It is one of several routes of speaking up in the Trust and supports staff through the whole process of raising a concern.

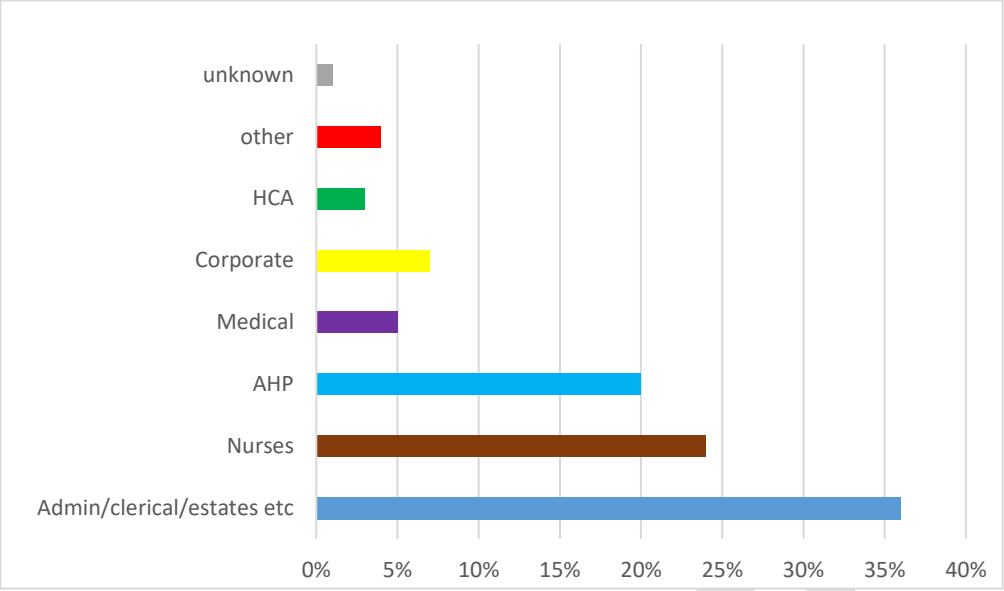
Number of cases raised with the FTSU service



Themes of concerns being raised with the FTSU service

Bullying and harassment was the most reported concern raised, with 39% of people reporting bullying and harassment as an element of their concern. These tended to be complex and multi-faceted and, on several occasions, involved HR processes and investigations. Patient safety and quality of care was the second highest concern raised (28%). Cases that had an element related to policy/procedures, staff wellbeing/safety and discrimination were the next highest reported concerns raised. Several concerns led to formal investigations under the Trust raising a matter of concern policy (whistleblowing).

Professional backgrounds of people raising concerns with the FTSU service



The FTSU Guardian reports quarterly data to the National Guardians Office (NGO), Quality, Safety & Experience Assurance Committee, and the People & Education Assurance Committee. This ensures that the work we are doing, themes around concerns, data and information is shared both internally and externally through a clear governance structure.

We ask everyone that uses the service for feedback and ask two questions related to peoples experience of using the service as well as speaking up in the Trust. 90% of those that gave us feedback said they would speak up in the future. People reported that accessing a confidential and independent colleague to discuss concerns with was helpful, empowering and allowed them to feel heard. Qualitative feedback highlighted how some people went on to share their experience of speaking up which empowered others to access the service.

Alongside the FTSU service, the Guardian also co-ordinates the i-speak up platform which was launched in October 2020 and allows people to provide feedback about a colleague's perceived unprofessional behaviour. For the financial year of 2021/22, 26 people raised concerns through this platform with 16 of those concerns leading to peer messenger conversations.

The service continues to promote awareness of FTSU pathways and supports the Trust to improve the culture of speaking up. Throughout the year, the Guardian attended a range of team meetings and Trust events to raise awareness. As part of the Trust speaking up training package, we embedded the NGO national online training modules for workers and managers into the Trust training portfolio for speaking up. It is an expectation that all new starters to the Trust complete the speak up training. We believe by making sure that all our new starters have access to information about how to speak up and be heard in the Trust, that we improve the care we provide our patients and make GOSH a better place to work.

Reducing rota gaps for NHS doctors and dentists in training

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

Supporting our staff during COVID-19
There is continuous challenge related to medical and dental 'rota gap' management across the NHS. At GOSH this has been directly related to a combination of vacancy management, increasing 'less than full time' working patterns and unexpected sickness exacerbated by the COVID pandemic.

During the COVID pandemic, the clinical workforce provision and requirement changed frequently and with very little advance notice. With the complex disease profile of children looked after at GOSH, the vulnerability for rota gaps impacting clinical care provision is clear.

Anticipating the requirement to provide an adaptive medical workforce to respond to COVID related absence and maintain urgent and elective clinical activity for 2021/22 was an anticipated issue and a priority for the Trust. An effective COVID 'first surge' response at GOSH clearly demonstrated that the development of medical rotas, supporting daytime service needs, out of hours safe staffing and ensuring both the well-being and education and training needs of junior doctors, requires specific senior clinician support.

The Medical Workforce Improvement Programme commenced in November 2020 post first COVID surge. The Medical Director's Office recruited six consultants as medical workforce leads (MWLs) to improve out of hour's operational infrastructure and to enable GOSH to deliver a flexible, responsive, safe, effective and clinically capable medical workforce to meet rapid change in demand due to the anticipated ongoing COVID staffing issues and expected 'high' clinical demand in a sustainable way. This rota support has been achieved by a dedicated team of professionals (medical workforce leads, rota coordinators, HR OD and operational teams) working closely together utilising systems such as Healthroster, doing the basics well and creating innovative approaches to rota gap management.

Key achievements in 2021/22:

1. **Rota Oversight and Operational Function**

- **Shared clinical, administrative and operational management of medical rotas:** interdependent specialty rotas require informed clinical leadership to support responsive and situational, pan Trust decision making ensuring safe delivery of OOH working.
- **Centralised rota coordination:** whole hospital oversight rather than individual doctors/specialty responsibility
- **Safety:**
    - Regular risk and safety meetings in place for OOH incident reflection, Datix management and change improvement work.
    - Ensure business continuity, preparedness, and adaptability for COVID response during escalating medical absence and scaling up patient services (for example for ICUs and PIMS TS services).
    - Improved medical bank structures for assurance and governance purposes
    - Improved data input, monitoring and analysis of medical absences
    - Developed medical workforce governance structures for short term internal speciality transfer
- **Handover:** consultant input to handover structure and governance to support learning and ensure patient safety.
- **Communication:** modern digital communication infrastructure to enable effective and efficient management including access to essential guidelines and completeness of resources available via the intranet.
- **Education and Training:** Increased support for Junior Doctors including leadership training, educational and wellbeing support.

- **Evaluation** of the financial benefit of real time medical workforce management when compared to sole management by band 5 rota coordinators.

2. COVID Medical Workforce Preparedness and Response

- Active Rota Management
    - Daily situational awareness briefing, absence monitoring and anticipatory planning during surges.
    - Daily senior clinician situational decision making and input 7 days per week
- Absence tracking structure and decision-making pathway established.
- Baseline education and skills survey – flexible workforce to inform cross speciality cover.
- Medical workforce internal redeployment management
    - Always with doctor agreement
    - No external redeployment or placement out of medical, surgical or dental area of work
    - Matched with skill set or training interest
- Upscale and redesign of rotas to meet response
    - ICUs
    - PIMs TS
    - 'Shadow' Back-up rotas staffed with 'bank' doctors
        - individual doctors' hours tested for safety and compliance
        - rota rules and regulation adhered to for all doctors (not only HEE trainees)
        - back-up payment for none-activated shifts; escalated rate for activated shifts.
- Wellbeing – 'check in' pathways in place.

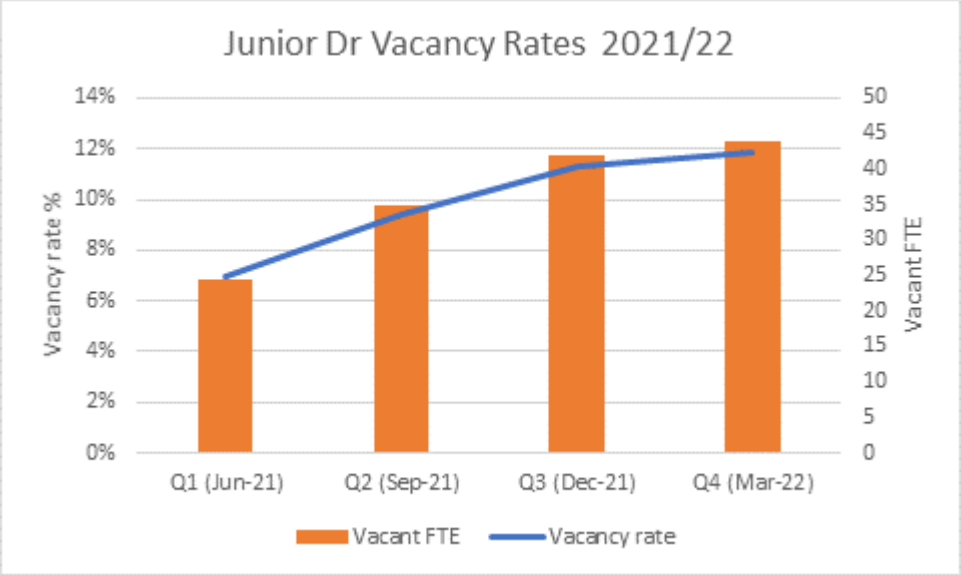
3. Continuing to deliver an operationally adaptive response to active rota gap management by:

- Working closely with managers, rota coordinators and specialty leads to implement a standard operational procedure for rota gap management
- Establishing the minimum numbers of doctors required to safely run specialty areas by day and OOH whilst making sure doctors get rest days and take annual and study leave.
- Maximising the efficiency of by ensuring all our doctors contribute to out of duties in the hospital at night team, developing a 'concertina' model that can safely cope with unexpected 'last minute' gaps on the night medical rota.
- Assessing rotas on a daily basis, using clinical situational awareness; real time decisions about whether the hospital at night team are able to safely absorb an unexpected rota gaps without the need to deplete day time staffing or request our doctors to work extra hours.
- Actively ensuring any known gaps are filled, either through agency or bank staff or requesting doctors move from days to night shifts (paid at locum rates for whole shift; all rota rules respected)
- Developing a Senior Medical Officer leadership role (with additional leadership and simulation training) to support more effective and collaborative team working across areas in anticipation of unexpected gaps.
- Supporting an enhanced governance and risk infrastructure for out of hours working which scrutinises rota gaps on a weekly basis and mitigates any risks identified

- Reporting into governance and regulation structures established through the Guardian of Safe Working Hours and the Director of Medical Education (Local Faculty Groups) to ensure both monitoring of rota gaps and communication of issues are heard at all levels.

Vacancy Rates

Vacancy rates reducing the numbers of doctors on specialist rota establishments have a major impact on the day-to-day experience of doctors. GOSH vacancy rate has varied between 6.9% and 12.2 % over 2021/22 (broadly similar to the previous year; range 6.8-12.1%) and continues to sit below the national average for paediatric rotas.



Variations in numbers of trainees sent to the Trust by the London School of Paediatrics impact significantly on our ability to plan and mitigate rota gaps. Short notice leaves insufficient time to recruit and, in addition to the limited availability of the UK paediatric workforce, it can be difficult to fill vacant posts quickly. In addition, the complexity and poor predictability of onboarding international medical graduates can result in an extended lag time impacting those already in post.

Continuous review and monitoring of the recruitment pipelines in anticipation of/ planning for rota gaps, and in some specialist areas, over-recruiting, is the approach taken at GOSH.

In Summary:

GOSH continues to offer agile solutions to rota gap management. The MWL team supports a rapid, unified and organised response to COVID related absence. By improving infrastructure, actively seeking out solutions and demonstrating a proactive approach to rota management, it encourages collaboration and offers a sense of assurance and support to the medical workforce.

Part 2c: Reporting against core indicators

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2021	2020	2019	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
The percentage of staff who would be happy with the standard of care provided by the organisation if a friend or relative needed treatment.	89.6%	91.5%	88.7%	89.6%	94.0%	69.1%	89.6%	The survey is carried out under the auspices of the DHSC, using their analytical processes. GOSH is compared with other acute specialist trusts in England. Source: NHS Staff Survey. Time period: September to November 2021.	The key actions associated with addressing staff survey findings have been incorporated into the GOSH People Strategy – with its four pillars: Capacity, Infrastructure, Skills and Culture & Engagement. Many of the survey questions changed in 2021 to align reponses to the NHS People Promise. Alongside these changes there was a focus on emotional resilience and wellbeing. While our results reflected the challenging circumstances in which our staff are working, there was some positive indicators of change and we have seen our position relative to our benchmark group of Acute Specialist trusts improve year on year. Results have been shared with local teams with a view to understand their staff experience, and develop an action plan alongside identified Trustwide priorities with the aim of "Making GOSH a great place to work. "
Percentage of staff who agreed that care of patients is the organisation's top priority.	87.5%	89.1%	86.5%	87.5%	90.1%	79.0%	87.4%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from managers in last 12 months.	13.3%	13.8%	16.3%	13.3%	8.2%	16.7%	10.5%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from other colleagues in last 12 months.	20.4%	20.9%	24.4%	20.4%	11.8%	25.2%	18.1%		
Percentage of staff who consider the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.	74.8%	76.4%	75.9%	74.8%	88.9%	68.2%	84.1%		

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2021-22	2020-21	2019-20	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Friends and Family Test (FFT) - % of responses (inpatient).	33%	33%	24%	33%	†	†	†	The rates are from NHS England Time period: 2021/22	GOSH continued FFT throughout the pandemic despite NHSE suspending the service. NHSE FFT reporting resumed in January 2021, however, the report no longer publishes response rates, only a comparison of the experience rating for inpatients and outpatients. GOSH has an internal target response rate of 25%.
FFT - % of respondents who recommend the Trust (inpatient).	98%	98%	97%	98%	100%	77%	94%		GOSH has an internal target of 95%.
FFT - % of respondents who recommend the Trust (outpatient)	95%	96%	93%	95%	99%	86%	93%		GOSH has an internal target of 95%.
Number of clostridium difficile (C.difficile) in patients aged two and over.	8	13	7	8	‡	‡	‡	The rates are from PHE Time period: 2021/22	Continuing to test stool samples for the presence of C.difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C.difficile in patients aged 2 and over (number of hospital acquired infections/ 100,000 bed days).	15.9	27.1	13.3	15.9	‡	‡	‡		
Note: C.difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. At GOSH, we test for C.difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported; where a request is made for enteric viruses; and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and									

above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Healthcare Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report.

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

Indicator	From local trust data			GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2021-22	2020-21	2019-20		
Patient safety incidents reported to the National Reporting and Learning System (NRLS):					
Number of patient safety incidents	6132	5915	5069	GOSH uses electronic incident reporting to promote robust reporting and analysis of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing. 2021/2022 was an outlier year in many ways due to the ongoing covid pandemic and subsequent reduction in patient on-site outpatient visits and inpatient stays.	Initiatives such as: Risk Action Groups, local training in root cause analysis, and "Learning from…" events and posters, improve the sharing of learning to reduce the risk of higher-graded incident recurrence. Initiatives are reported and monitored by the Patient Safety and Outcomes Committee.
Rate of patient safety incidents (number/100 admissions)	14.6	17.5	12.6		
Number and percentage of patient safety incidents resulting in severe harm or death	8 (0.13%)	9 (0.2%)	4 (0.1%)		
Of the four major harm incidents, 3 were declared SIs at GOSH and one was declared at another hospital with our input. Of the 3 GOSH SIs, one is closed and two are still being investigated.					

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

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

Part 3: Other information

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

Performance against key healthcare targets 2021-2022

Domain	Indicator	National threshold	GOSH performance for 2020/21 by quarter				2021/22 mean	Indicator met?
			Q1	Q2	Q3	Q4 (up to Feb 22)		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	100%	100%	100%	100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising: • surgery • anti-cancer drug treatments	94% 98%	100% 100%	92.86% 100%	85.71% 100%	70.0% 100%	86.36% 100%	No Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	Apr-21 71.27% May-21 74.92% Jun-21 77.67%	Jul-21- 78.31% Aug-21: 77.82% Sept-21: 77.42%	Oct-21: 76.7% Nov-21: 76.45% Dec-21: 75.34%	Jan-22: 75.39% Feb-22: 75.26%	Can't have a mean as this is a snaphot	No
Experience	Maximum 6-week wait for diagnostic procedures	99%	Apr-21 77.56% May-21 81.51% Jun-21 83.28%	Jul-21- 85.36% Aug-21: 81.06% Sept-21: 84.33%	Oct-21: 87.38% Nov-21: 90.24% Dec-21: 87.67%	Jan-22: 83.0% Feb-22: 86.43%%	Can't have a mean as this is a snaphot	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

* Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)

ADDITIONAL INDICATORS - PERFORMANCE AGAINST LOCAL IMPROVEMENT AIMS

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

Effectiveness	Inpatient mortality rate (per 1,000 discharges)+ *(From data submitted to Hospital Episode Statistics (HES))*		8.11	6.17	8.08	8.01	6.87	
Experience	Discharge summary completion time (within 24 hours)		80.60%	79.61%	80.07%	80.70%	80.25%	

Effectiveness	PICU discharges delayed by 8-24 hours		4	5	8	5	5.5	
Effectiveness	PICU discharges delayed by more than 24 hours		3	11	13	35	15.5	
Effectiveness	Last minute non-clinical hospital cancelled operations and breaches of 28-day standard* - Cancellations - breaches		62 5	107 6	130 10	26 4	81.25 6.25	
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge		2.6%	3.1%	2.0%	2.0%	2.4%	
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge		0.0%	0.0%	1.1%	2.3%	1.7%	

+Does not include day cases

*'Last minute' is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery.

Performance against key healthcare targets 2020-2021

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

* Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)

† Data is not amenable to calculating mean value.

Additional Indicators – Performance against local improvement aims

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

Domain	Indicator	GOSH performance for 2020/21 by quarter				2020/21 mean
		Q1	Q2	Q3	Q4	
Effectiveness	Inpatient mortality rate (per 1,000 discharges)	13.54	6.31	8.32	7.65	8.73
Experience	Discharge summary completion time (within 24 hours)	71.96%	79.11%	84.36%	80.21%	79.50%
Effectiveness	PICU discharges delayed by 8-24 hours	3	1	10	4	4.5

Effectiveness	PICU discharges delayed by more than 24 hours	8	9	15	7	9.75
Experience	Formal complaints investigated in line with the NHS complaints regulations	17	17	27	17	78 total
Effectiveness	Last minute non-clinical hospital cancelled operations and breaches of 28-day standard* - Cancellations breaches	34 7	31 4	41 2	22 0	32 3.25
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge	4.2%	3.7%	2.2%	3.2%	3.2%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge	0.0%	0.0%	2.4%	1.9%	4.8%
Safety	GOS acquired Central Venous Line related bloodstream infections (per 1,000 line days)	1.5	1.1	1.3	0.8	1.2

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

Annex 1:

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

Add narrative when received

Feedback from Members of the Council of Governors

Add narrative when received

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

Add narrative when received

Annex 2: Statements of assurance

Statement of Assurance to be drafted and added

By order of the board

Date
Chief Executive

Date
Chair

Attachment U

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25 May 2022

Update on the Board Assurance Framework **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment U**

The purpose of this paper is to provide an update on the Board Assurance Framework (BAF) and to remind Board members of the current status of risks on the BAF. A summary of all risks is presented at **Appendix 1**. All risks are in the process of being updated.

The Risk Assurance and Compliance Group monitors the BAF on a monthly basis, reporting to the Audit Committee, Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. The Audit Committee has oversight of all BAF risks and has made the following recommendations to the Board for amendment to the following BAF risks (based on recommendations from the Risk Assurance and Compliance Group - RACG):

BAF Risk 2: Recruitment and Retention: The risk score is 2 (Likelihood) x 5 (consequence). The Audit Committee agrees that recruitment remains a key existential risk in the NHS and as such the risk should remain on the BAF for now. Following a discussion at the People and Education Assurance Committee (PEAC) in February 2022, the risk statement was reviewed by the RACG and a proposal put to the Audit Committee for the focus of the risk to change from 'recruitment and retention' to 'workforce sustainability', taking in to account the pressures of sickness, maternity etc. and additionally reflecting on the risk of not providing an environment where staff feel supported and have the opportunity to develop (and be retained) within the organisation.

FOR APPROVAL: The Audit Committee recommends the following revised risk statement for approval by the Board:

Failure to attract, support and develop a sustainable and highly skilled workforce.

The People and Education Assurance Committee will review this risk on an ongoing basis.

BAF Risk 8: Business Continuity: In January 2022, the Audit Committee agreed to retain this risk on the BAF but agreed that the wording required a review to ensure that it was aligned to the risk of an interruption to services.

FOR APPROVAL: The Audit Committee recommends the following revised risk statement for approval by the Board:

Business continuity management plans are insufficiently robust to support uninterrupted delivery of services and critical functions.

The Audit Committee will review this risk on an ongoing basis.

BAF Risk 12: Inconsistent deliver of care: This risk has been reviewed and re-worded following the work undertaken to address the 'must' and 'should do's' from the CQC report in 2020, and to remove the duplication around infection, prevention and control and medicines management. The statement is broadened to include all areas regarding patient safety and quality, and to ensure that the data captured is reported and analysed appropriately and used to support continuous improvement across the Trust.

FOR APPROVAL: The Audit Committee recommends the following revised risk statement for approval by the Board:

Risk of (severe/serious) patient harm arising from a failure to follow safety standards, foster a culture of openness and transparency, and use data to support improvement

- *Patients are not consistently cared for within a comprehensive safety system which ensures they are protected from avoidable harm through compliance with regulatory standard*
- *The organisation does not consistently focus on openness, transparency and learning when things go wrong, or use the opportunity to learn from when things go well.*
- *The organisation does not use its own safety performance data as a tool to guide improvement, interventions or actions, training and learning.*

The Quality, Safety and Experience Assurance Committee will review this risk on an ongoing basis.

BAF risk 15: Children's Cancer Centre: In January 2022, the Audit Committee agreed that the risk statement required further review with a proposal to have a headline risk with associated risk factors documented underneath.

FOR APPROVAL: The Audit Committee recommends the following revised risk statement for approval by the Board:

Failure to build a new cancer centre and failure to deliver holistic, personalised and coordinated care.
The main risk themes to this are:

- *Transformational programme does not deliver holistic, personalised and coordinated care*
- *Delay in Full Business Case approval from NHSE/I*
- *The project not achieving Planning Permission*
- *Fundraising target not achieved*
- *Changes in clinical brief required to maintain Works Cost Limit or additional funds required to fund an increase over and above budget (including inflation pressures)*

The Audit Committee will review this risk on an ongoing basis.

Action required from the meeting
Board members are asked to note the update to the BAF and approve the recommended changes to the BAF risks/ new BAF risks.

Financial implications
None

Legal issues None
Who is responsible for implementing the proposals / project and anticipated timescales Risk Owners
Who is accountable for the implementation of the proposal / project N/A

Great Ormond Street Hospital for Children NHS Foundation Trust: Board Assurance Framework (May 2022)

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee
					L x C	T	L x C	T						
1	Financial Sustainability	**Principle 4: Financial Strength**		Failure to continue to be financially sustainable	5 x 5	**25**	4 x 5	**20**	**Cautious**	1-2 years	Chief Finance Officer	**Helen Jameson, Chief Finance Officer**	10/03/2022	Audit Committee
2	Workforce Sustainability	**Principle 3: Safety and quality**	**Priority 1: Make GOSH a great place to work/ Priority 3: Develop the GOSH Learning Academy**	Failure to attract, support and develop a sustainable and highly skilled workforce.	4 x 5	**20**	2 x 5	**10**	**Cautious**	1-2 years	Director of HR and OD	**Sarah Ottaway, Associate Director of HR and OD/ Caroline Anderson Director of HR and OD**	17/03/2022	People and Education Assurance Committee
3	Operational Performance	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme / Priority 3: Improve and speed up access to urgent care and virtual services**	Failure of our systems and processes to deliver efficient and effective care that meets patient/carer expectations and supports retention of NHS statutory requirements and the FT licence.	4 x 5	**20**	3 x 5	**15**	**Minimal**	1 year	Chief Operating Officer	**Sue Chapman, John Quinn, Rebecca Stevens/ Richard Brown**	16/05/2022	Audit Committee/ QSEAC
4	GOSH Strategic Position	**All Strategy Principles**	**All priorities**	Failure to optimise the Trust strategy under current and future NHS, financial, political and social frameworks.	**4 x 4**	**16**	**3 x 4**	**12**	**Cautious**	5-10 years	Chief Executive	**Matthew Shaw/ Ella Vallins**	18/03/2022	Audit Committee
5	Unreliable Data	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Failure to establish an effective data management framework:	4 x 4	**16**	4 x 3	**12**	**Minimal**	1-2 years	Chief Operating Officer	**Richard Brown, Chief Data Officer**	16/05/2022	Audit Committee
6	Research infrastructure	**Principle 3: Safety and quality/ Principle 4: Financial Strength**	**Priority 5: Accelerate translational research and innovation to save an improve lives**	The risk that the Trust is unable to accelerate and grow research and innovation to achieve its full Research Hospital vision due to not having the necessary research infrastructure.	3 x 5	**15**	3 x 4	**12**	**Minimal**	1-2 years	Director, Research & Innovation	**Jenny Rivers, Dep Dir, R&I**	28/02/22	Audit Committee
7	Cyber Security	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	The risk that the technical infrastructure at the Trust (devices, services, networks etc.) is compromised via electronic means.	5 x 5	**25**	3 x 5	**15**	**Averse**	1-2 years	Chief Operating Officer	**Mark Coker, Director of ICT/ John Quinn, COO**	03/03/2022	Audit Committee
8	Business Continuity	**Principle 3: Safety and quality/ Principle 5: Protecting the Environment**	**Priority 2: Deliver a Future Hospital Programme**	Business continuity management plans are insufficiently robust and understood to support delivery of services and critical functions.	4 x 5	**20**	4 x 3	**12**	**Averse**	1 year	Chief Operating Officer	**Rachel Millen, Emergency Planning Officer/ John Quinn, Chief Operating Officer**	07/03/2022	Audit Committee
9	Estates Compliance	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Inadequate maintenance of the estate affects the safety of the environment in which care is delivered by staff to patients and carers.	**5 x 4**	**20**	**5 x 4**	**20**	**Averse**	1 year	Director of Estates, Facilities and Built Environment	**Zoe Asensio-Sanchez, Director of Space and Place/ Bryony Freeman**	10/11/2021	Audit Committee

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee
					L x C	T	L x C	T						
10	Information Governance	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Personal and sensitive personal data is not effectively collected, stored, appropriately shared or made accessible in line with statutory and regulatory requirements.	4 x 5	**20**	3 x 5	**15**	**Averse**	1 year	Chief Operating Officer	**John Quinn, Chief Operating Officer / Richard Brown, Chief Data Officer**	04/03/2022	Audit Committee
11	Medicines Management	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.	5 x 5	**25**	4 x 5	**20**	**Averse**	1-2 years	Chief Operating Officer	**Stuart Semple, Chief Pharmacist/ Nick Towndrow, GM/ John Quinn, Chief Operating Officer**	04/03/2022	Quality, Safety and Experience Assurance Committee
12	Inconsistent delivery of safe care	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	BAF Risk 12: Risk of (severe/serious) patient harm arising from a failure to follow safety standards, foster a culture of openness and transparency, and use data to support improvement • Patients are not consistently cared for within a comprehensive safety system which ensures they are protected from avoidable harm through compliance with regulatory standard • The organisation does not consistently focus on openness, transparency and learning when things go wrong, or use the opportunity to learn from when things go well. • The organisation does not use its own safety performance data as a tool to guide improvement, interventions or actions, training and learning	4 x 4	**16**	3 x 4	**12**	**Averse**	1-2 years	Medical Director	**Sanjiv Sharma, Medical Director/ Nikki Fountain**	02/03/2022	Quality, Safety and Experience Assurance Committee
13	Service Transformation	**Principle 1: Children and young people first and always**	**Priority 2: Deliver a Future Hospital Programme**	Failure to embrace service transformation and deliver innovative, patient centred and efficient services.	4 x 4	**16**	3 x 4	**12**	**Open**	1-5 years	Chief Operating Officer	**John Quinn, Chief Operating Officer**	18/03/2022	People and Education Assurance Committee
14	Culture	**Principle 2: Values led culture**	**Priority 1: Make GOSH a great place to work**	There is a risk that GOSH fails to develop its culture and levels of staff engagement and motivation in alignment with its strategy and values,	4 x 4	**16**	3 x 4	**12**	**Averse**	1-5 years	Chief Executive	**Caroline Anderson Director of HR and OD**	17/03/2022	Trust Board/ People and Education Assurance Committee
15	Cancer Centre	**All Strategy Principles**	**Priority 6: Create a Children's Cancer Centre to offer holistic, personalised and coordinated care**	Failure to build a new cancer centre and failure to deliver holistic, personalised and coordinated care. This risk incorporates currently reflected on the CCC risk register and include: • Transformational programme does not deliver holistic, personalised and coordinated care • Delay in Full Business Case approval from NHSE/I • The project not achieving Planning Permission • Fundraising target not achieved • Changes in clinical brief required to maintain Works Cost Limit or additional funds required	**4x4**	**16**	**3x4**	**12**	**Averse**	1-5 years	Director of Estates, Facilities and Built Environment	**Zoe Asensio-Sanchez, Director of Estates, Facilities and Built Environment/ Gary Beacham, Children's Cancer Centre Delivery Director/Daniel Wood Children's Cancer Planet Director**	02/03/2022	Audit Committee

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee
					L x C	T	L x C	T						
				to fund an increase over and above budget (including inflation pressures)										
16	GOSH Learning Academy	**Principle 2: Values led culture / Principle 3: Safety and quality**	**Priority 1: Make GOSH a great place to work/ Priority 3: Develop the GOSH Learning Academy**	Risk of the GOSH Learning Academy not establishing a financially sustainable framework, impacting on its ability to deliver the outstanding education, training and development required to enhance recruitment and retention at GOSH and drive improvements in paediatric healthcare.	**4 x 3**	**12**	**3 x 3**	**9**	**Minimal**	1-2 years	Chief Nurse	**Tracy Luckett, Chief Nurse/ Lynn Shields, Director of Education**	07/03/2022	People and Education Assurance Committee

GOSH BAF Risks – Gross Scores May 2022

Likelihood		Consequences				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain					7. Cyber Security; 1. Financial Sustainability; 12. Medicines Management
	4 Likely				5. Unreliable data; 14: Culture; 12. Inconsistent delivery of safe care; 5. GOSH Strategic Position; 13. Service Innovation; 9. Estates Compliance	2. Recruitment & Retention; 8. Business Continuity; 10. Information Governance; 3. Operational Performance
	3. Possible					6. Research Infrastructure and resourcing
	2. Unlikely					
	1.Rare					

GOSH BAF Risks – Net Scores May 2022

Likelihood		Consequences				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain				9. Estates Compliance	
	4 Likely			5. Unreliable data; 8. Business Continuity		12. Medicines Management; 1. Financial Sustainability
	3. Possible				14: Culture; 5. GOSH Strategic Position; 6. Research Infrastructure and resourcing; 13. Service Innovation; 12. Inconsistent delivery of safe	10. Information Governance; 7. Cyber Security; 3. Operational Performance
	2. Unlikely					2. Recruitment & Retention
	1.Rare					

QSEAC & Audit Committee | QSEAC | Audit Committee | Trust Board | People and Education Assurance Committee

Attachment V

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25th May 2022

Health Inequalities Update **Submitted by: Tracy Luckett; Chief Nurse** **Written by: Polly Hodgson; Deputy Chief Nurse**	**Paper No: Attachment V** **□ For information and noting**

Purpose of report
To provide an update on the Trust's position in addressing health inequalities in Children and Young People highlighting the current national priorities.

To highlight the establishment of the Paediatric Accelerator Programme with its aims to:

- To understand Health Inequalities in Children and Young Children.
- To understand the impact of the COVID 19 pandemic
- To improve access to services, patient and family experience and patient outcomes.

To provide an overview of the status here at GOSH, identifying actions and projects undertaken to date and plans for next steps.

Summary of report
In recent years, there has been increasing recognition of the importance of early childhood in providing a strong foundation for later life and as a crucial opportunity for reducing inequalities. The health of young children has been affected by the COVID-19 pandemic, with negative effects felt disproportionately by disadvantaged children.

This report provides and overview work being undertaken by the Trust in assessing health inequalities including:

- The establishment of a Trust HI steering group, with the identification of 6 workstreams covering; access; experience; outcomes; awareness; accountability and insight
- Data analysis of patient demographics with regards to ethnicity and postcode data.
- Patient Portal project aimed at improving patient access and communication.

From the 6 workstreams 3 of the top priorities include:

- Extend data collection and analysis of patient demographic, including ethnicity and assessing deprivation.
- Provision of core information in alternative formats and languages.
- Encourage feedback (positive and negative) from hard to hear groups.

It is suggested that future work should include assessing deprivation in our families and establishing ways to provide further help and support where required.

Action required from the meeting

- To note the work that is currently being undertaken to help reduce/address health inequalities in our children and young people.

Attachment V

Contribution to the delivery of NHS Foundation Trust priorities **□ PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** **□ PRIORITY 4: Improve and speed up access to urgent care and virtual services** **□ PRIORITY 5: Accelerate translational research and innovation to save and improve lives** **□ Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** **□ Leadership, capacity and capability** **□ Vision and strategy** **□ Culture of high quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance** **□ Accurate data/ information** **□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**
Strategic risk implications Risk of not delivering aims in NHS Long Term Plan	
Financial implications Not Applicable currently.	
Implications for legal/ regulatory compliance Addressing Health Inequalities is a priority in a number papers: • The NHS Long Term Plan • The Department of Health and Social Care published its White Paper *"Integration and Innovation: working together to improve health and social care for all"*, sets out legislative proposals for a Health and Care Bill • The *2021/22 priorities and operational planning guidance* set the NHS priorities for the year ahead	
Consultation carried out with individuals/ groups/ committees Head of Patient Experience, Lead for Learning Disabilities and Autism	
Who is responsible for implementing the proposals / project and anticipated timescales? Deputy Chief Nurse	
Who is accountable for the implementation of the proposal / project? Chief Nurse	
Which management committee will have oversight of the matters covered in this report? The newly established Health Inequalities Steering group.	

1. Definition of Health Inequalities

Health Inequalities are avoidable and unfair differences in health status between groups of people or communities. Differences in health status and the things that determine it can be experienced by people grouped by a range of factors. In England, health inequalities are often analysed and addressed by policy across four factors; socio-economic factors, for example, income; geography, for example, region; specific characteristics including those protected by law, such as, sex, ethnicity or disability and socially excluded groups (Kings Fund, 2020).

2. Background

Future health and well-being have their origins in young children's health. In recent years, there has been increasing recognition of the importance of early childhood in providing a strong foundation for later life and as a crucial opportunity for reducing inequalities. This recognition comprises an understanding that health inequalities are a consequence of social inequalities (Marmot et al. 2010). Negative impacts on the health of young children are difficult to reverse with data showing that much poor health in young children is preventable.

Important work on child health inequalities including the NMCD report on Child Mortality and Social Deprivation and the Royal College of Paediatrics and Child Health (RCPCH) *State of Child Health* reports serve as an important reminder of the huge disparity across child health outcomes between the least deprived and most deprived communities. (RCPCH, 2020).

The NHS Long Term Plan (2019) sets out a strong commitment for action to improve wellbeing through tackling the wider factors that have an impact on health including social deprivation and inequalities.

3. National Priorities

In February 2021, The Department of Health and Social Care published its White Paper *"Integration and Innovation: working together to improve health and social care for all"*, set out legislative proposals for a Health and Care Bill. Throughout the White Paper there is a focus on tackling health inequalities and the wider determinates of health.

The *2021/22 priorities and operational planning guidance* set the NHS priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.

The Top national priorities are:

- **Priority 1:** Restore NHS services inclusively
- **Priority 2:** Mitigate against digital exclusion
- **Priority 3:** Ensure datasets are complete and timely
- **Priority4:** Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- **Priority 5:** Strengthen leadership and accountability

4. Children and Young People (CYP) Focus

A CYP version of the CORE20plus5 tool is being developed and should be available in the very near future.

The RCPCH is developing an action plan on Child Poverty which will cover:

- An RCPCH position statement on Child Poverty
- Internal RCPCH policies to keep health inequalities high on the agenda
- A pack for paediatricians covering:
    - What is child poverty?
    - What are the correlations between poverty and health?
    - How are these mediated?
    - What can we do about it?

Their approach will encourage clinicians to:

- Develop clinical skills on the core (not wider!) determinants of health; biopsychosocial approaches; empathy and curiosity in practice to help ensure families get the help they need
- Embrace QI to effect service change
- Develop signposting capabilities
- Harness data and flagging, without stigmatising

5. Pandemic Recovery

The health of young children is being affected by the COVID-19 pandemic, with negative effects felt disproportionately by disadvantaged children. While we still do not know all the impacts of COVID-19 on young children's health, three interrelated factors are having effects.

- The pandemic and associated lockdowns have had negative effects on young children's health, including insufficient physical activity and worsening mental health.
- Reduced health services for young children, prompted by the National Health Service (NHS) undergoing unprecedented demands— in particular, reduced health visiting services.
- The economic disruption, which creates conditions for poor health to proliferate among young children, including worsening parental mental health and increasing child poverty.

To address these issues the **Paediatric Accelerator Programme** was established with involvement from the following Trusts:

- Alder Hey
- Birmingham Women and Children's
- Bristol Royal Hospital for Children
- Evelina London Children's Hospital
- Gt Ormond St Hospital for Children
- Leeds Children's Hospital
- Oxford Children's Hospital
- Royal Manchester Children's Hospital
- Sheffield Children's Hospital
- Southampton University Children's Hospital

Aims

- To understand Health Inequalities in Children and Young Children and reduce variation in care across a national footprint and across local ICSs.
- To be able to evaluate our existing services and transform care in the longer term through innovation.
- Embedding best practice and shared learning.

Examples of the Paediatric Accelerator Programme objectives are included in Appendix 1.

Access

- Measure % variation on waiting list for characteristics such as ethnicity, deprivation, disability, age, neurodiversity.
- DNA % in clinic. A study has just been established to assess to impact of free public transport on outpatient attendance rates on 2 pilot sites (Sheffield and Birmingham Children's Hospitals) to capture the methodology and benefits to allow the Children's Hospital Alliance (CHA) to lobby government for a nationwide scheme. The study was completed in March 2022 and an evaluation is currently being undertaken.

Patient Experience

- Letters/communication as per patient choice, Braille, Language, Easy read.
- Improve Wayfinding: A meeting to share learning from good practice was set up in March 2022 and additional research is planned to be undertaken.
- Access to electronic records through a Patient Portal to improve communication between patient, parents/carers with their clinical teams.

Outcomes

- Use of finer thread in surgical procedures involving children with darker skin.
- One stop shop preventing multiple attendances.

6. Current Status at GOSH

GOSH recognises the importance of the health inequalities (HI) agenda and is actively engaged with the external environment such as the Children's Hospital Alliance (CHA). There are synergies that are pertinent across all children's services, including access to healthcare, outcomes and experience.

Whilst our aim is to work collaboratively on the issues such as access; identifying and progressing change on local HI priorities is paramount.

At present GOSH treats a disproportionately higher number of patients from deprived areas (~ 56% of our patients are from the bottom 50%) and from ethnic minorities (55% compared to national averages of 15%) – See data section below for more details.

6.1. Steering Group

Due to the important national focus on addressing HI in CYP and to ensure, as a Trust, we are making progress on addressing the many differing challenges CYP and their families can face, a HI Steering Group has been established. The purpose of this group is to oversee the delivery of the HI agenda locally to ensure we are proactively working to reduce health inequalities for our patients and families. An initial meeting was held in April, terms of reference and the aims and objectives for the group are currently being compiled with support from the PMO.

A long list of priorities has been identified from our patient and family feedback and themes identified nationally. These priorities have been divided in 6 main workstreams detailed below (Fig; 1):

Fig: 1. Health Inequalities Workstreams

Access	Experience	Outcomes	Awareness	Accountability	Insight
Recovery – clinical prioritisation	Learning disabilities	Sight loss.	Staff engagement & education	Data dashboard; Building on postcode data & other sources	Answering question: How do HIs affect GOSH patients now?
Was Not Brought (WNB) and AI	Wayfinding	Obesity	Conference	Governance Groups	Benchmarking with CHA
Transport & streamlining nos. of visits	Patient information - Language and formats	Live GOSH / ICH research	10 pledges	Policies	Patient engagement
Virtual care & digital exclusion.	Electronic Records - MYGOSH		Communities of practice		Adapting HEADSS tool - assessing patient deprivation
	Catering and facilities for families		Partnerships/ policy		Complaints analysis
	Family forum				

6.2. Data analysis

We have carried out an analysis of our patient demographics using both ethnicity data and postcode analysis matched to the Index of Multiple Deprivation (IMD), which is the official measure of relative deprivation in England. We also matched to the Income Deprivation Affecting Children Index (IDACI) which is a sub-set of the Income Deprivation domain that measures the proportion of all children aged 0 to 15 living in income deprived families.

Against the IMD, in 2019/20, at GOSH, children living in the most deprived 50% of areas in England accounted for 56% of planned spells. This matched with 57% of our spending for planned spells. Against IDACI it was 58% and 59% respectively. For Outpatients it was between 52% and 57%.

Regarding ethnicity 55% of GOSH outpatients were from minority groups compared to a national level of 15%.

The next step is to analyse the treatment of patients and how that may vary by level of depravation or ethnicity. We have found, for instance, that patients from the more deprived area are less likely to have virtual appointment that those from more affluent areas (54% v 58%). There was also a slightly higher

proportion of patients past their must be seen by date living in the most deprived areas (23%) compared to the least deprived (21%). We will extend this analysis to look at other aspects of treatment (e.g. waiting times, length of stay). Beyond this the next data to collect will be more qualitative in nature, to better understand the experience CYP and their families.

This analysis will then be used to help inform us with what interventions should be taken to ensure health inequalities are tackled to improve patient access, experience, and outcomes.

6.3. Patient Portal

As part of the national programme of work The Trust has been involved in a project looking at the use of a patient portal to improve access for patients and their families and to improve communication with families and clinicians. Outcomes and key learnings from this project are currently being evaluated. A further project is planned to establish if there is a correlation between patients and carers not accessing the patient portal and then not attending appointments.

7. Next Steps

Whilst we have identified the key workstreams and a long list of priorities, there are 3 areas of work that we need to prioritise as these have been identified from our own patient and family feedback through the Family Equality and Diversity Group (FED).

These three objectives form part of the **Family Equality and Diversity Strategy** which have been identified to address health inequalities for our children and families:

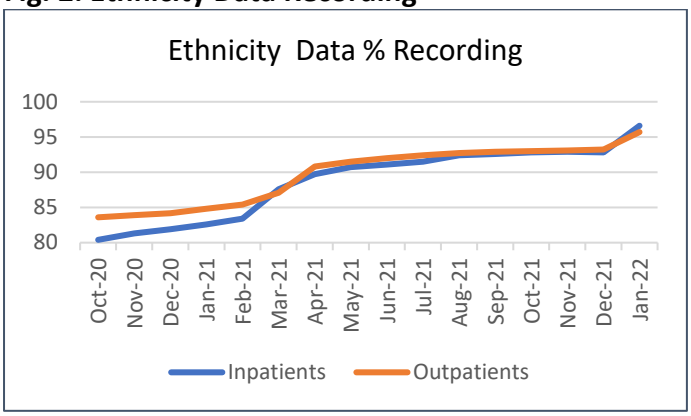
- Improving data collection.
- Provision of core information in alternative formats and languages.
- Encourage feedback (positive and negative) from hard to hear groups.

7.1 Extend data collection and integration to bring practical clinical benefits

Data collection throughout the NHS is inconsistent, as has been proved by recent initiatives to identify vulnerable patients requiring additional support through the COVID-19 pandemic. Previously, the emphasis has been on data collection as an activity with little or no detail about the benefits this brings to individual children, young people and families. Our aim is to demonstrate the real, tangible benefits of knowing all about our population and how we can best meet their needs.

One of the programmes we have been driving in the hospital is improving the quality of ethnicity recording. Over the last 18 months we have driven this up by ~15% from the low 80s to 96%, above the national average. (Fig.2)

Fig. 2: Ethnicity Data Recording



7.2 Provision of core information in alternative formats and languages

While we have the facility to offer information and support in alternative formats and languages, uptake of this has been minimal to date. Historically, provision of alternative formats and languages has been based on clinical need only, it has become clear that a core set of information is required for the diverse population we serve.

7.3 Encourage feedback (positive and negative) from hard to hear groups

This objective builds on work by the Patient Experience team to enhance the Friends and Family Test and respond in a timely manner to any comments/queries received. A Family Forum is being established to try and improve feedback and engagement from hard to hear parents and carers. The terms of reference are currently being drawn up for this forum.

Additionally, the introduction of MyGOSH and My Fingerprint modules within EPIC will enable us to be far more responsive to individual patient/family needs.

7.4 National conference

GOSH is hosting a Health Inequalities Conference on the 14thJune 2022. Objectives of the event are:

- To highlight the impact of poverty and socioeconomic inequalities on our patients and families and how our Trusts can support them within our own sphere of influence.
- To educate and share best practice including by looking at what some Trusts are doing well.
- To galvanise change by identifying:
    - Ways to support frontline staff in 'making every contact count'
    - Interventions that work to lower the barriers to accessing hospital services and improve experience and outcomes for the patients and families we care for
    - How we might work with partners at ICS and/or nationally level to effect change.

7.5 Links with NCL Integrated Care System (ICS)

Tackling health inequalities is one of the key purposes of the ICSs. As a Trust we need to develop our relationship with NCL, with regards to addressing health inequalities, to ensure all opportunities for sharing insight and information are fully exploited.

8. Children and Young People with Learning Disabilities (CYP with LD)

Research has shown children with learning disabilities experience more health inequalities and are more likely to have significantly more needs**,** including more health conditions, health technology dependencies, and family-reported issues.

To address these challenges The Trust Learning Disability team have identified some key themes as part of their strategy which include:

Theme
1. Ensuring the provision of local and national leadership
2. Ensuring our workforce has the necessary knowledge, competence and confidence to deliver high quality individualised care to CYP with Learning Disabilities
3. Ensuring that CYP with LD are given the opportunity to be involved in making decisions about their care and treatment and planning services to the best of their ability.
4. Ensuring that the needs of CYP with Learning Disabilities are met safely and that risks associated with being in hospital are mitigated through the implementation of reasonable adjustments.
5. Delivering an improved hospital experience for CYP with LD and their families, which includes ensuring that 'the little things that matter to them' are prioritised.

9. Future Plans

In line with the identified workstreams, assessing the deprivation of individual family's needs to be considered, to enable us to identify families requiring additional directed support.

9.1. Assessing deprivation

Paediatricians and other child health professionals have a key role in identifying, preventing, or mitigating the impacts of poverty (including digital poverty) on child health (Singh et al 2021). The first step in addressing child poverty in clinical settings is identification. However, questions regarding money, housing issues and food insecurity are often not consistently raised, with clinicians citing awkwardness and embarrassment. By contrast, the evidence suggests that most parents are happy to discuss these issues and want them to be addressed in consultations (Singh et al, 2021).

Therefore, establishing a set of questions for healthcare professionals to ask that tries to assess deprivation is important. One suggested approach is to adapt the HEADSS tool (original developed to assist in taking structured social and contextual history from young people) (Appendix 2). To undertake this piece of work will require:

- Working with the clinical teams to set the key questions and to provide training to core teams.
- Working with the EPIC teams to implement and establish ways of extracting meaningful data.
- Establish information to signpost families to provide further help and support where required.

To move forward with the health inequalities agenda within GOSH will require an education and awareness raising campaign to increase understanding of the impacts of health inequalities and encourage people to do what they can in their areas of practice – in particular, clinical teams who are the only professionals who can 'make every contact count'.

10. Governance and reporting

The Health Inequalities Steering Group will hold the main responsibility for monitoring and providing oversight for the Great Ormond Street Programme of works as it is developed and fully scoped. The metrics and baselining of said metrics will be established following the shortlisting and finalising of the Great Ormond Street Programme of works related to Heath Inequalities. Each project within the programme will define these and report centrally to the Steering Group.

The Health Inequalities Steering Group will report into EMT 6 monthly. Further reporting cycles on aspects of the programme including finance, PRMs and liaising with other existing programmes within the Trust will be established where needed, as the programme develops.

The Health Inequalities Steering Group will be chaired by the Chief Nurse and will be formed of a multi-disciplinary team of stakeholders, both internally from Great Ormond Street and externally where required expertise is not found within the Trust.

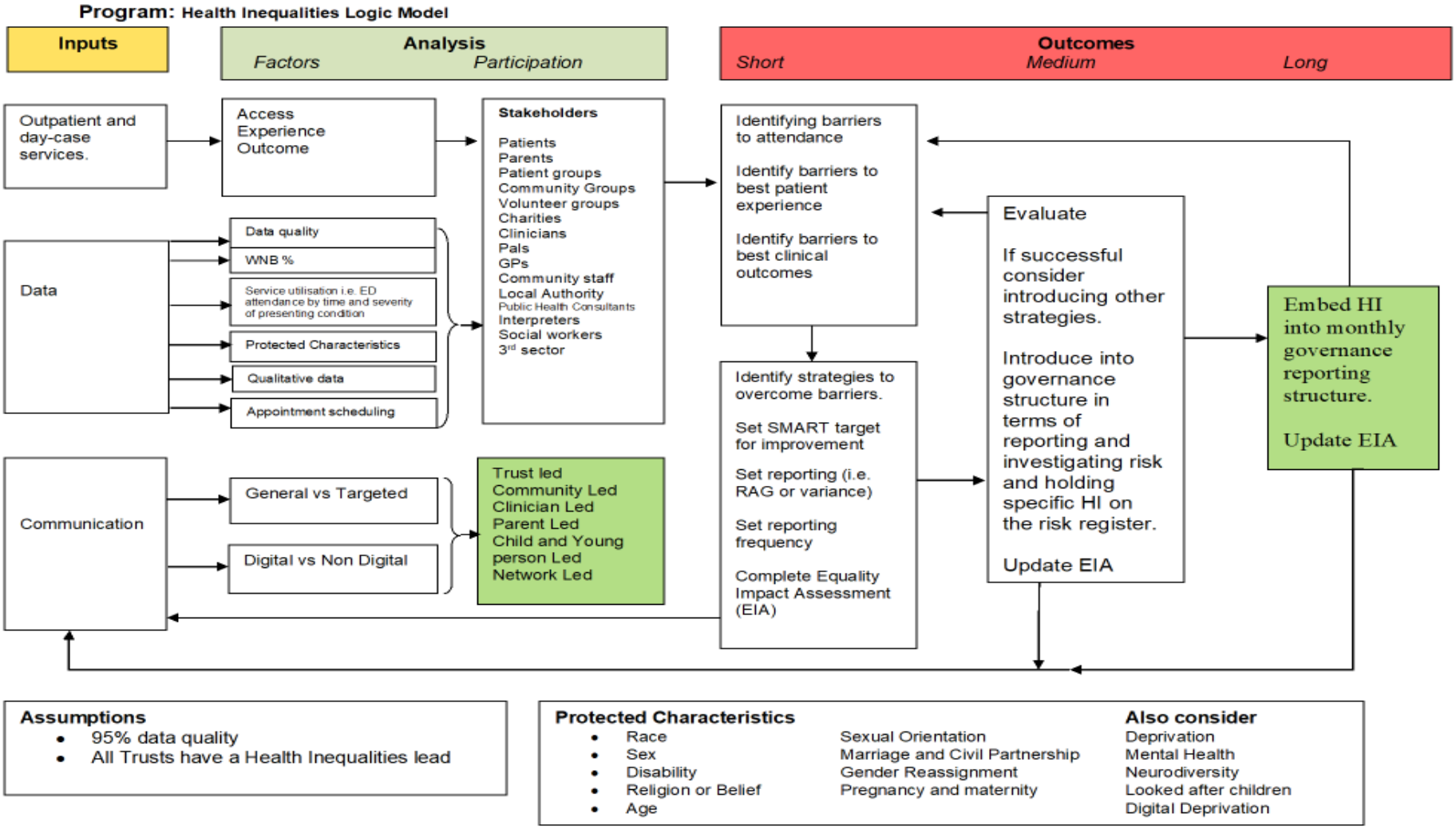
Project and working groups will provide regular reporting to the Health Inequalities Steering Group to enable scrutiny on utilisation of any resource including staff, capital, and revenue where applicable. Monitoring of the progress of the projects and working groups will be reported on by exception.

11. Summary

There has been increasing focus on the need to address health inequalities for children and young people at both a national and local level. At a national level work is being driven through the Children's Hospital Alliance with the National Paediatric Accelerator programme, the 3 main objectives being to improve access for disadvantage children and their families; improve on their experiences and improve on patient outcomes.

At a local level the Trust has already undertaken some pieces of work including improving data collection for ethnicity and postcodes and the use of a patient portal. However, to ensure we are making progress on addressing the many differing challenges CYP and their families can face, a HI Steering Group has been established to provide focus on overseeing the delivery of the HI agenda both, locally and as part of NCL, to ensure we are proactively working ogether to reduce health inequalities for our patients and families.

Appendix 1: Paediatric Accelerator Programme



Appendix 2: The adapted 'HEADSS' tool for poverty

Question	Red flags and cues for poverty
Home: Who lives at home with you? What is your house like?	Chronic physical or mental health problems, >3 young children, single parent. Housing concerns: pests, leaks, mould, cold, overcrowding.
Employment/Education Do you work? What is your job? How is your child doing at school?	►► Unemployment/Low income, asylum seekers, travellers. ►► Developmental delay, poor school attainment, poor attendance.
Activities: Do you have any hobbies? Have you been on holiday in the last year?	►► Lack of disposable income for hobbies, holidays or transport. ►► Social isolation.
Diet: What did you eat yesterday? In the last year, have you worried that your food would run out before you got money to buy more?	►► Lack of (healthy) food, unable to afford fresh fruit and vegetables. ►► Parents missing meals to feed children. ►► Free school meals. ►► Foodbank use
Safeguarding/Support Have you ever had a social worker? Has anyone ever hurt or threatened you?	►► Reasons for social worker could give insight into current and previous vulnerabilities. Consider what support they already have? Are they receiving benefits? ►► Physical, emotional, sexual abuse or neglect warrants further investigation and referral as per local pathways

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25 May 2022

Integrated Quality and Performance Report (April 2022 Data) **Submitted by:** Dr Sanjiv Sharma MD Tracy Luckett Chief Nurse John Quinn COO Caroline Anderson Director of HR & OD	**Paper No: Attachment W** □ **For approval** √ **For discussion** □ **For information and noting**

Purpose of report

Sept IQPR

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

Proposal for IQPR revisions

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

Summary of IQPR report

- Incidents in April saw a marginal decrease for both opened and closed, with numbers being with normal ranges.
- There were five open serious incident investigations, no overdue serious incidents but there are 12 overdue SI actions. These are being monitored through various channels with directorates
- Three new duty of candour cases were commenced in April, but this remains challenging for the Trust, particularly at stage 2. Out of five Stage 2 cases due, only one was sent on time. One Stage 3 case was due in April which was sent within the monitored timeframe.
- Infection control metrics are within the required thresholds and further detail will be provided with the quarterly board update.
- The Friends and Family Test response rate in April remained at 37% and is above the target of 25%. Targets for ratings of experience for inpatients (98%) and Outpatients (98%) were achieved. Feedback from patients and families have identified areas of improvement particularly around communication with patient on pre-admission and pre-appointment information.
- There were seven new formal complaints received in April 2022. One complaint was reported to the ICO and declared an SI. There are currently two open red/high risk complaints
- PALS contacts have decreased in April 2022 to 173, with 80% resolved within 48 hours which remains in line with previous months. Both Cardiology and Gastroenterology saw significant increases in PALS contacts.
- Sickness Absence further decreased to 3.7%, with 12.5% of absences related to Covid. Self-isolation decreased to an average of 13 episodes per day from 23 per day in February.
- RTT – Performance has slightly decreased to 75.2% and is 15% below trajectory. 52 Week waits increased by 9 patients to 151 at end of April. Bed pressures are still impacting performance; however, bed risks assessments are being completed to open socially distanced closed beds.
- DM01 – Decrease in the reported position for April 2022 at 84.1%, 2.7% decrease from March and is below trajectory. 6 Week breaches increased by 55 to 247. Challenges are being experienced within sleep study, MRI/Echo and CT sedation and MRI 5 Scanner capacity.

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

Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality & Performance Report

May 2022

Reporting April 2022 data

Sanjiv Sharma
Medical Director

Tracy Luckett
Chief Nurse

John Quinn
Chief Operating Officer

Caroline Anderson
Director of HR & OD

Integrated Quality & Performance Report, May 2022

Great Ormond Street Hospital for Children NHS Foundation Trust

Patient Safety

Safe

- Overview
- Incidents
- Infection Control
- Mortality and Cardiac Arrest
- SPC Trend Analysis

Patient Experience

Caring

- Overview
- Friends and Family Test
- Complaints
- PALS

Effective

- Overview

Well Led

Well Led

- Overview
- KPI Metrics
- SPC Trend Analysis

Patient Access

Responsive

- Overview
- RTT
- Clinical Prioritisation
- RTT Benchmarking
- Diagnostics
- SPC Trend Analysis

Integrated Quality & Performance Report, May 2022

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Patient Safety

Incidents		-
Serious Incidents		↘
Duty of Candour		↘
Infection Control		-
Mortality		-
Cardiac Arrest		-

Duty of Candour remains in red. Challenges are particularly within Stage 2. 1 out of 5 cases due in April were sent out on time, 3 have not been sent

Patient Experience

FFT Experience		↗
FFT Response		↗
PALS		↗
Complaints		-

FFT response rate remained at 37%. Rating of Experience is 98% for inpatients and Outpatients.

Effective

Clinical Audits		-
QI Projects		↗
Outcome reports		-

Spotlight: Improving identification and response to deteriorating patient project steering group completed extensive diagnostics

Well Led

Mandatory Training		↘
Appraisal (Non-Cons)		-
Appraisal (Cons)		↗
Sickness Rate		↘
Overall Workforce Unavailability		
Voluntary Turnover		-
Vacancy Rate – Contractual		-
Bank Spend		-
Agency Spend		-

Sickness rates: in April 2022 has reduced but remains above 3% target
Appraisal (Non-Cons): Not met 90% target for last 12 months, averaging 87% compliance

Patient Access

RTT Performance		-
52 Week Waits		↗
78 Week Waits		-
104 Week Waits		↗
DM01 Performance		↘
Cancer Standards		-
Cancelled Operations		↗
Theatre Utilisation		-

RTT 104 Week Waits: Increase in number waiting and is above trajectory. Complex patients but expecting reduction in May
RTT and DM01 Performance: Projecting plateauing performance at end of May
Cancelled Operations: Theatre overrun and bed unavailability were main drivers particularly in Orthopaedics and SNAPs

Patient Safety (incidents & risks)

Overview

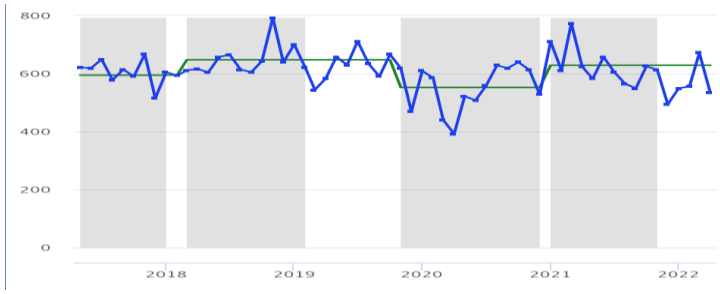
- **Incidents:** There was a slight decrease both in incidents opened and closed in April, within normal ranges.
- **Serious Incidents:** There were 5 open serious incident investigations in April 2022 relating to: a reporting error in Finance /Genomics, a wrong site surgery in S&S/CCS, a deteriorating patient in H&L, an Endocrine patient lost to follow-up and the care management of a patient group in Brain.
- **Duty of Candour:** Duty of candour remains a challenge, particularly at stage 2. The biggest delay in letters being sent on time is establishing degrees of harm as well as ensuring that the conversation happens in a sensitive and appropriate way.
- **Outcomes published –** An updated Outcome report has been published on Cystic Fibrosis. GOSH are performing well within the control limits.
- **Risks –** High risk review rate has dropped to 72% overall but there remains a strong focus to keep this under control

		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 months	RAG			Stat/ Target
New Incidents	Volume	583	657	607	566	550	626	616	495	546	556	661	532		No Threshold			Target
Total Incidents (open at month end)	Volume	1094	977	983	1154	1275	1434	1663	1781	1944	1531	1444	1477		No Threshold			Target
New Serious Incidents	Volume	3	2	1	1	1	1	3	0	2	1	2	2		No Threshold			Target
Total SIs (open at month end)	Volume	17	18	20	20	19	21	22	22	21	18	17	20					Target
Overdue Serious incidents	Volume	2	1	1	0	0	0	0	0	0	0	0	0		>1	=1	=0	Stat
Overdue SI Actions	Volume	51	39	41	50	50	61	59	63	35	15	16	12					Target
Incidents involving actual harm	%	25%	33%	25%	29%	31%	28%	23%	26%	28%	19%	22%	21%		>35%		<25%	Target
Never Events		0	0	0	0	0	0	1	0	0	0	0	0		>/=1		0	Stat
Pressure Ulcers (3+)		0	0	2	1	0	0	0	0	1	0	0	0		>1	=1	=0	Stat
Duty of Candour Cases (new in month)		5	4	5	7	10	11	4	1	5	3	3	3		No Threshold			Target
Duty of Candour – Stage 2 compliance	%	60%	82%	75%	66%	12%	33%	40%	60%	37%	100%	66%	20%		<75%		>90%	Target
Duty of Candour – Stage 3 compliance	%	0%	25%	0%	43%	17%	40%	75%	0%	60%	33%	33%	100%		<50%		>70%	Target
High Risks (% reviewed within date)	%	85%	89%	70%	76%	76%	75%	73%	69%	88%	94%	79%	72%		<80%		>90%	Target

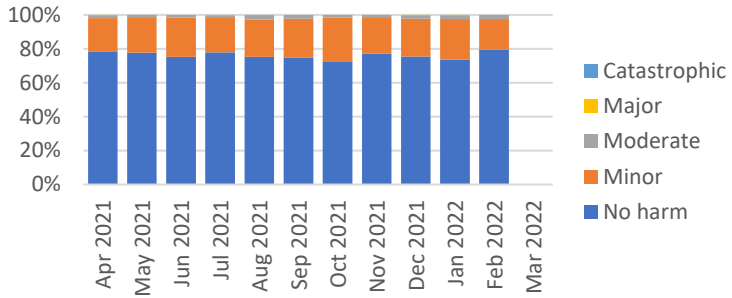
Patient Safety (incidents & risks)

Great Ormond Street Hospital for Children NHS Foundation Trust

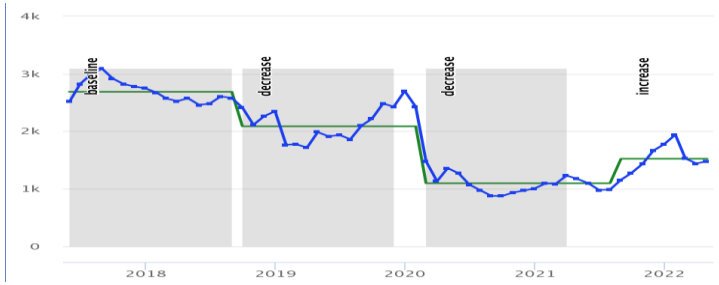
New Incidents



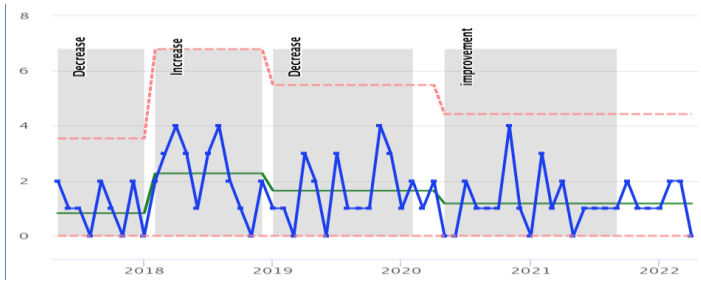
Incidents by Harm



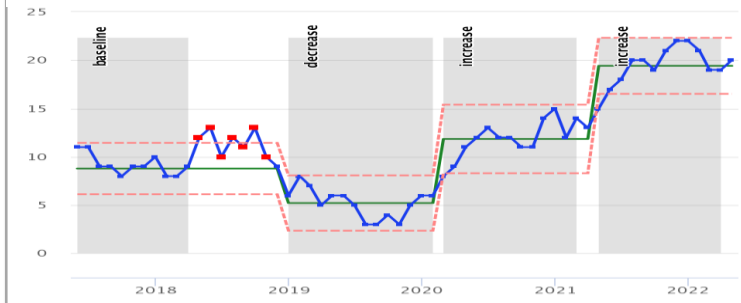
Open Incidents



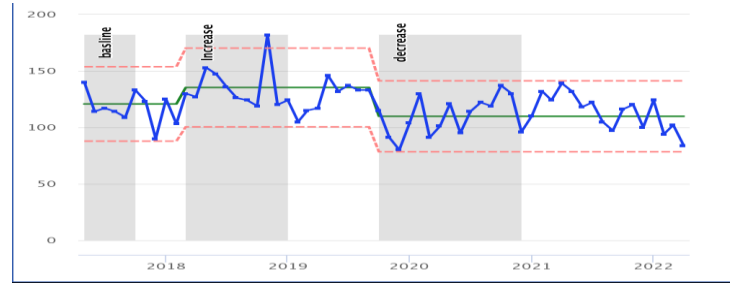
Serious Incidents



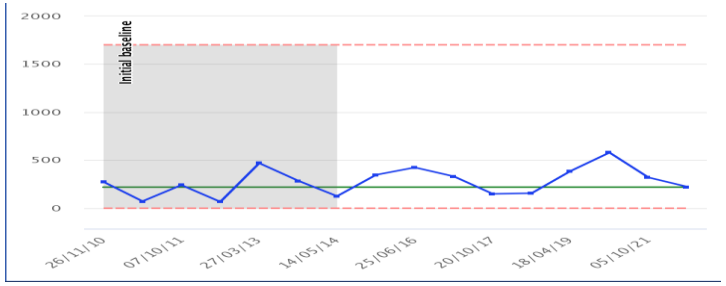
Open Serious Incidents



Medication Incidents



Days Since never events



Safe

Patient Safety (Infection & mortality)

Infection Control

		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	2022/23 YTD	Last 12 months	RAG (22/23 threshold)			Stat/ Target
C Difficile cases	In Month	0	1	3	2	1	0	1	0	0	0	0	0	0		>8	N/A	<=8	Stat
C difficile due to lapses	In Month	0	1	2	2	0	0	0	0	0	0	0	0	0		>8	N/A	<=8	Stat
MRSA	In Month	1	0	0	0	0	0	0	0	0	0	0	0	0		>0	N/A	=0	Stat
MSSA	In Month	2	1	0	0	4	0	3	2	3	0	2	2	2		No Threshold			
E.Coli	In Month	1	1	1	0	0	0	0	0	1	1	3	1	1		>8	N/A	<=8	Stat
Pseudomonas Aeruginosa	In Month	2	2	1	1	3	1	1	0	0	1	2	0	0		>8	N/A	<=8	Stat
Klebsialla	In Month	1	1	0	1	3	1	2	1	1	2	1	2	2		>12	N/A	<=12	Stat
Line Infections (note 1)	In Month	1.5	0.7	1.4	1.8	1.3	0.7	1.3	0.9	1.6	1.3	1.5	2.2	2.2		>1.6	N/A	<=1.6	T

1 GOSACVCRB (GOS acquired CVC related bacteraemias)

Mortality & Cardiac Arrest

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 months	RAG	Stat/ Target
Number of In-hospital Deaths	10	8	11	5	5	13	6	9	9	11	9	8		No Threshold	
Inpatient Mortality per 1000/discharges	9.2	7.2	9.0	5.0	4.1	13.5	4.7	9.6	9.6	9.5	7.8	8.1		No Threshold	
Inquests currently open	7	8	12	14	17	19	15	12	12	14	12	14		No Threshold	
Cardiac arrests outside ICU/theatres	1	1	1	2	0	1	1	3	4	1	1	1		No Threshold	
Respiratory arrests outside ICU/theatres	5	2	3	7	3	4	3	2	5	2	1	1		No Threshold	

Notes:

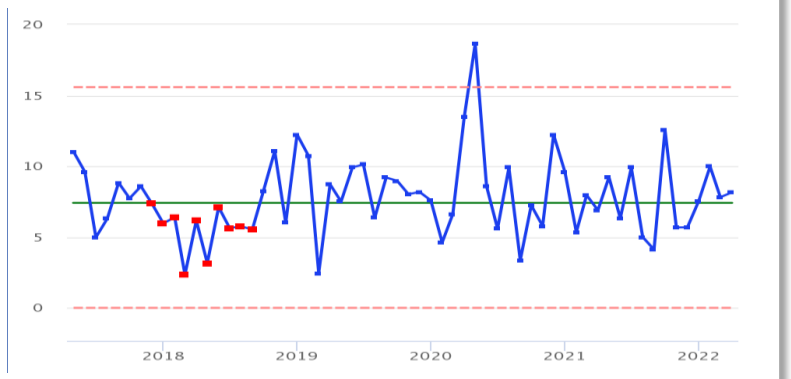
1. Mandatory Reporting: MRSA, MSSA, Ecoli, Pseudomas Klebsiella
2. GOSACVCRB (GOS acquired central venous catheter related bacteraemias)

Safe

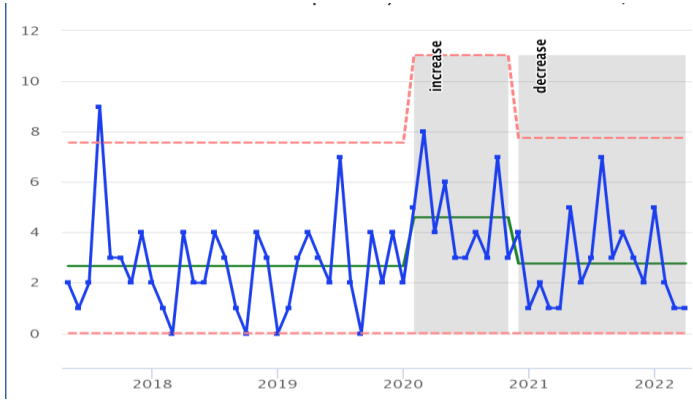
Patient Safety (Infection & mortality)

Great Ormond Street Hospital for Children NHS Foundation Trust

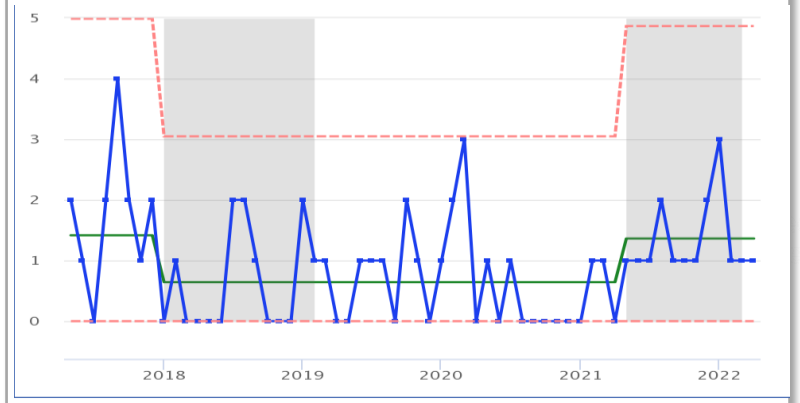
Inpatient Mortality Rate / 1000 Discharges



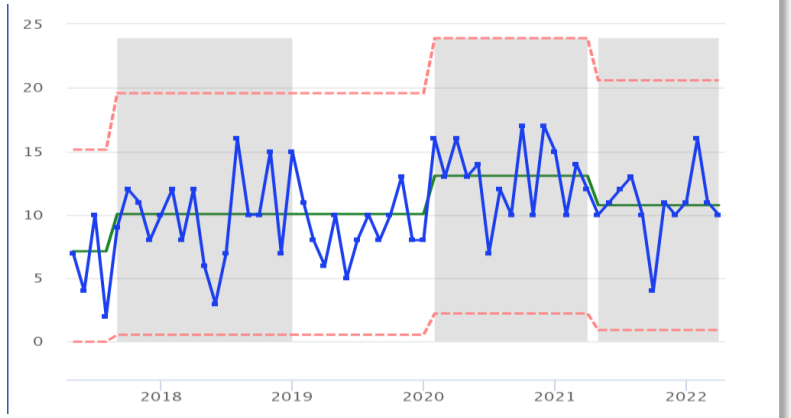
Respiratory Arrests outside ICU



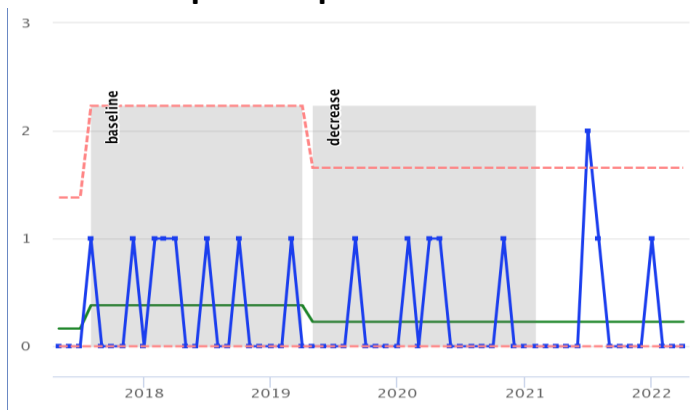
Cardiac Arrests outside ICU



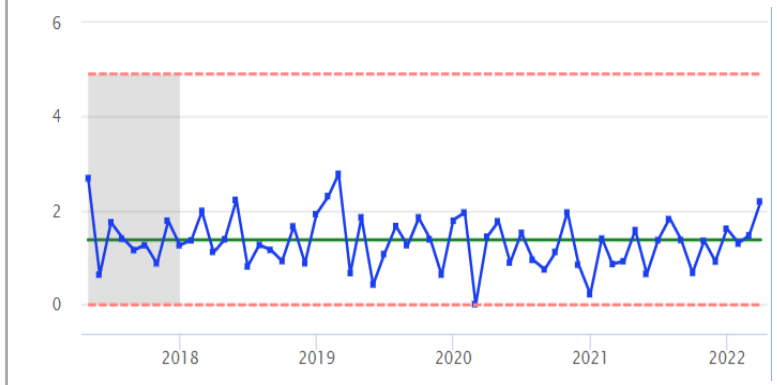
Non 2222 Patients transferred to ICU



Cat 3+ Hospital Acquired Pressure Ulcers



CV Line Infection / 1,000 line days



Safe

Effectiveness

April 2022 Spotlight: Quality Improvement – Improving identification and response to deteriorating patient

Background: The Project Steering Group has completed extensive diagnostics, contributing to programme design and creating smaller working groups.

Focus: improving nursing observations timeliness.

This working group is testing an intervention to reduce time between flowsheet chart time and when nursing observations are recorded. The nurses are instructed to add a column on flowsheets to specify accurate time of recording. This is currently being tested on Leopard Ward where the average percentage of observations recorded within 30 mins of chart time has improved from 56% in May 2021 to 73% in May 2022.

Impact on effectiveness: timely recording of observations has significant impact in understanding patients' clinical picture over time and therefore contributes to understanding the risk of deterioration. Accurate recording on Epic also facilitates timely advice, activating flags/ BPAs already programmed in Epic.

Next steps: rolling this intervention out widely in the Trust. The aim is also to understand the variation from 100% of timeliness, especially where human behaviour/ clinical judgment plays a role. This will contribute to policy decisions and assess additional support required.

Link to SPC charts: SPC Works

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 months
Speciality led clinical audits completed (actual YTD)	25	33	47	54	64	74	86	99	109	114	8	
Outcome reports published (YTD)	3	4	4	4	6	6	6	7	7	8	0	
QI Project completed	0	0	0	0	1	0	0	0	0	0	0	
QI Projects started	4	1	6	0	0	2	0	1	0	0	1	

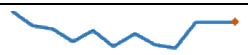
Safe

Patient Experience

Overview

- **FFT experience** response rate (37%) significantly exceeded the Trust target and inpatient submissions across the Trust increased. The ratings of experience (98% for in- and outpatients) were met.
- **PALS contacts** fell by 11% to 173. The majority of contacts (58%) related to requests for information with manty families citing difficulties in contacting clinical teams directly**.**
- **Complaints –** The complaints rate increased and a new red/ high risk complaint relating to an IG breach is being investigated as an SI. Seven complaints closed in April with four responses sent in the original timeframe agreed. The PHSO is investigating a historic complaint and two investigations (commissioned by NHSE/I) relating to complaints are underway.

Friend & Family Test

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 months	RAG		
FFT Experience rating (Inpatient)	99.0%	99.0%	98.0%	98.0%	98.0%	97.0%	97.0%	97.0%	97.0%	98.0%	97.0%	98.0%		<90%	90-94%	>=95%
FFT experience rating (Outpatient)	96.9%	97.0%	94.0%	97.0%	96.0%	94.0%	95.0%	95.0%	95.0%	98.0%	94.0%	98.0%		<90%	90-94%	>=95%
FFT - response rate (Inpatient)	42.6%	35.70%	34.0%	28.0%	33.0%	26.0%	32.0%	27.00%	25.00%	37.00%	37.00%	37.00%		<25%	N/A	>=25%

Complaints & PALS

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 months	RAG		
PALS - per 1000 episodes	9.3	10.33	9.96	8.44	9.75	8.45	6.47	6.32	7.56	8.42	7.44	8.1		No Threshold		
Complaints- per 1000 episodes	0.18	0.28	0.29	0.38	0.16	0.42	0.26	0.24	0.13	0.13	0.34	0.32		No Threshold		
Red Complaints -% of total (note 1)	11%	11%	11%	11%	10%	10%	10%	9%	10%	11%	8%	8%		>12%	10-12%	<10%
Re-opened complaints - % reopened (2)	5%	5%	5%	4%	4%	4%	3%	5%	6%	8%	9%	9%		>12%	10-12%	<10%
Red Complaints- No of Actions overdue	6	6	11	11	1	2	1	1	0	1	0	0		>2	1-2	=0

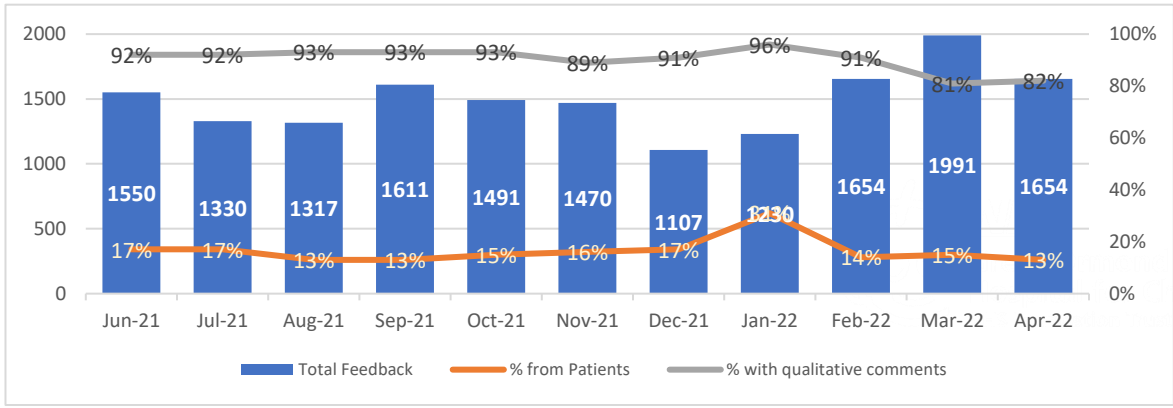
Notes:
1. Rolling 12 month average
2. Since April 2020

Caring

Friends and Family

Headline:

- Inpatient response rate – **37%** (no change from March)
- Experience measure for inpatients – **98%**
- Experience measure for outpatients – **98%**
- 13% of FFT comments are from patients
- 82% of responses had qualitative comments



Overview:

The volume of inpatient feedback increased. All directorates have met the inpatient response rate target and measure of experience score for April. The volume of outpatient responses reduced slightly, and the majority of the responses are still received by the Main Reception and Travel Reimbursement Desk. All directorates met the outpatient measure of experience, with the exception of Operations & Images.

Areas for improvement include:

- Pre admission information to be improved (NHS and Private Patients)
- Pre appointment data that is collected before appointments should be used in consultations
- Improve waiting times in outpatient and ambulatory areas
- Ward orientation
- Better response to telephone calls

Positive Areas:

- Friendly, kind and attentive staff
- Staff expertise
- Hospital cleanliness

Complaints

Headline: The Trust received 7 new formal complaints and the rate of complaints by combined patient activity rose to 0.38/1000 episodes.

One complaint (graded red/ high risk) relating to an information governance breach was reported to the ICO and declared an SI.

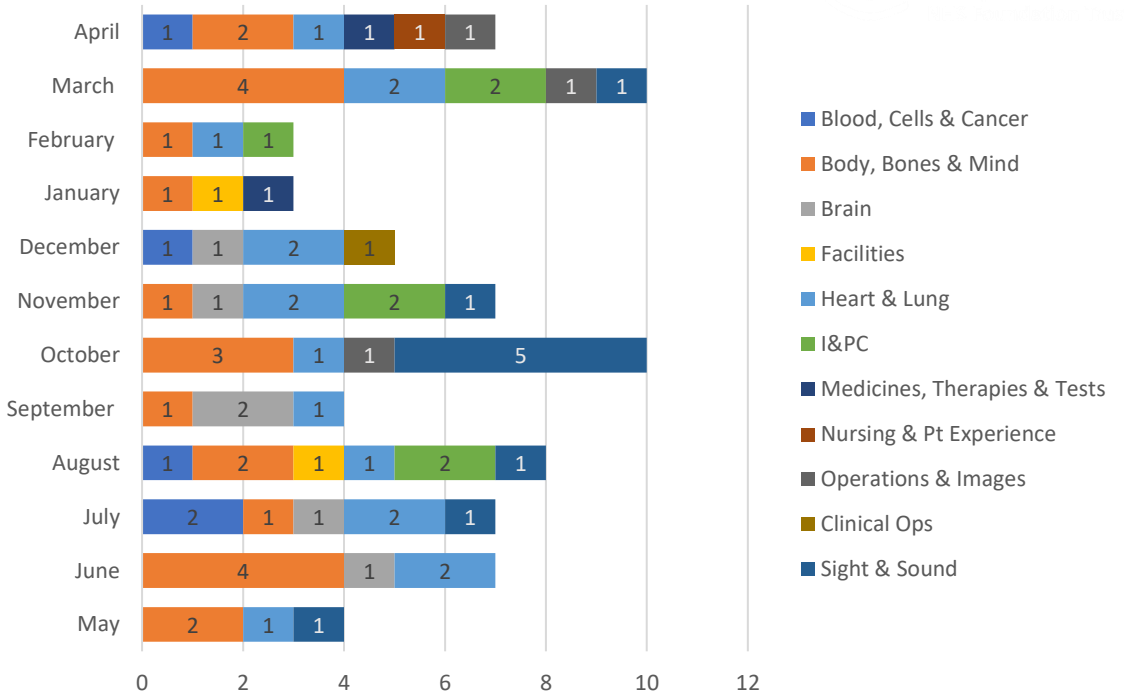
Concerns raised: In April families complained about:

- Clinic letters containing personal information which were sent to the wrong addresses.
- Potential misdiagnosis identified following transition to adult care.
- Delay in arrangement of an MDT meeting and a lack of communication resulting in a delayed transition to adult care.
- The safeguarding steps that were taken during an admission and the lack of transparency with parents around this.
- Multiple MRI cancellations and the lack of communication around this.
- Last minute surgery cancellation and the delay in communicating this.

Response times: 7 formal complaints closed in April 2022. 4 responses were sent within the original timeframes agreed with complainants and overall, the average response time was 51.14 days.

There are currently two open red/ high risk complaints.

Complaints by Directorate



PALS

Headline: Pals received 173 contacts in April (an 11% decrease from March). 58% of all contacts related to requests for information. Pals received two compliments, one of which praises a clinical staff member for his kind and patient-centric approach when calming an anxious patient ahead of an admission.

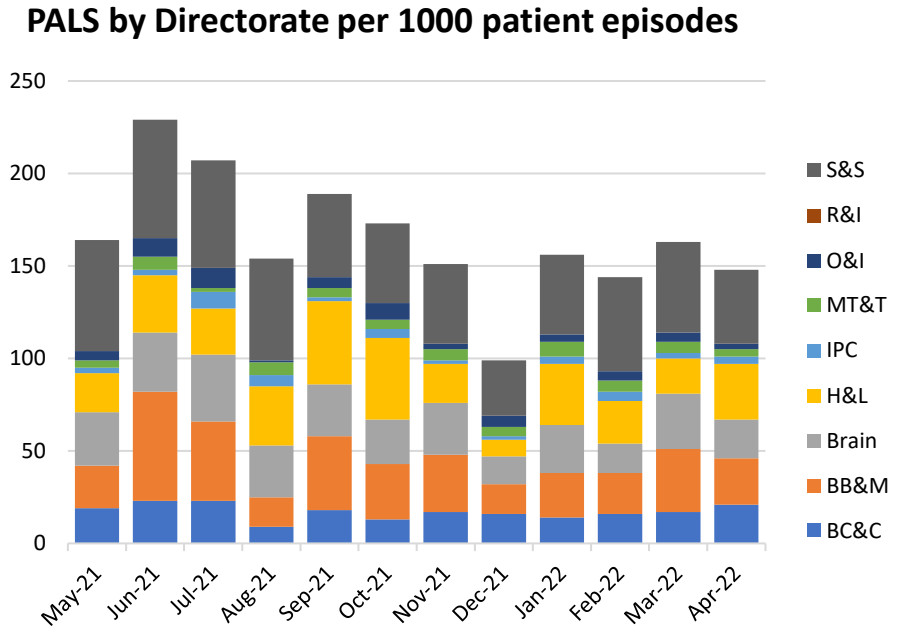
Response Rates - (response within 48 hours) at 80% (up from 78% in March)

Significant areas of focus:

Information: Families contacted Pals for support with requests for additional information and clarity on patient-specific care plans and the way in which these are delivered.

Cardiology contacts rose to 21 in April (up from 9) with approximately one-in three involving families citing frustrations when attempting to contact clinicians via phone in order to discuss medical concerns. Families state that following Pals escalation, prompt replies are often received, evidenced by 76% of contacts being responded to and resolved in under 48 hours after sharing.

Gastroenterology- Pals received 11 Gastroenterology contacts in April with a prominent theme focusing on families requesting updates regarding the timeframes of clinical reviews and further clarity on the tests involved in upcoming admissions. Gastroenterology service remains efficient at managing response times, demonstrated by 90% of contacts being resolved within 48 hours.



Overview

Contractual staff in post: Substantive staff in post numbers in March were 5387.5 FTE, an increase of 24.1 FTE since March 2022. Headcount was 5810 (an increase of 20 on the previous month).

Unfilled vacancy rate: Vacancy rates for the Trust increased to 6.9% in April from 4.9% the previous month. This was primarily driven by budget changes going into the new financial year. While the vacancy rate remains below the 10% target, it is higher than the 12 month average of 5.7%. Vacancy rates in the clinical directorates remained below target in April, with the exception of IPC.

Turnover: is reported as voluntary turnover. Voluntary turnover remained stable 12.1% in April. While it is stable and remains below the Trust target (14%), this is higher than the same month last year (11.1%), there is an expectation that turnover will increase during 2022. Total turnover (including Fixed Term Contracts) was stable at 14.7% in April.

Agency usage: Agency staff as a percentage of pay bill in April was 1.1%, This was slightly lower than the 2021/22 year end position of 1.2% and remains well below the local stretch target (2%). Agency use is almost exclusively taking place within Corporate Non-Clinical Directorates and amongst some Allied Health Professional disciplines. Bank % of pay bill increased in April to 5.5% of total pay spend.

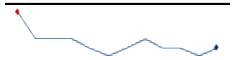
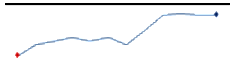
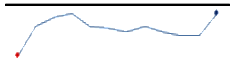
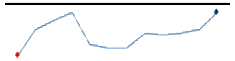
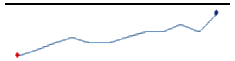
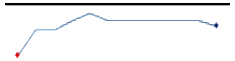
Statutory & Mandatory training compliance: The April training rate for the Trust increased to 93% which is above target with all bar 2 directorates achieving target (Property Services & Corporate Affairs). The Directorate Management and Learning teams are working to address gaps in compliance. The medical and dental staff-group are the only staff-group below the 90% target, at 86% for April. Across the Trust there are now 9 topics below the 90% target (including Information Governance where the target is 95%). Safeguarding Children Level 3 compliance for substantive staff is 93%. Across Resus training rates the compliance figure now sits at 79%. Honorary Contractors compliance remains a focus and work to improve compliance is ongoing.

Appraisal/PDR completion: The non-medical appraisal rate increased to 87% in April, however only 4 Directorates are achieving target. Individual Directorates are being liaised with to improve compliance. Consultant appraisal rates reduced to 87% in April , and is now below target.

Sickness absence: April sickness rates were 3.5%, a reduction from the March rate of 3.7%. While this is above pay bill the Trust target of 3%, and the sickness rate was above the target for the 10th month in a row, it is the lowest reported rate since August 2021. Sickness rates were highest in Property Services (6.9%) and Blood, Cells and Cancer (5.2%).

Well Led

Workforce Metrics Tracking

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 months	RAG Levels			Stat/Target
Mandatory Training Compliance	94.0%	93.0%	94.0%	91.0%	91.0%	91.0%	91.0%	92.0%	92.0%	93.0%	92.0%	93.0%		<80%	80-90%	>90%	Stat
Stat/Man training – Medical & Dental Staff	85.1%	86.2%	85.0%	86.0%	86.0%	84.0%	85.0%	87.0%	86.0%	86.0%	86.0%	86.0%		<80%	80-90%	>90%	Stat
Appraisal Rate (Non-Consultants)	91.0%	88.0%	88.0%	88.0%	87.0%	86.0%	87.0%	88.0%	87.0%	87.0%	86.0%	87.0%		<80%	80-90%	>90%	Stat
Appraisal Compliance (Consultant)	94.0%	93.0%	92.0%	94.0%	94.0%	95.0%	89.0%	91.0%	87.0%	89.0%	93.0%	87.0%		<80%	80-90%	>90%	Stat
Honorary contract training compliance	70.0%	74.0%	74.0%	76.0%	75.0%	75.0%	74.0%	78.0%	74.0%	78.0%	76.0%	76.0%		<80%	80-90%	>90%	Stat
Safeguarding Children Level 3 Training	89.4%	89.9%	89.0%	87.0%	85.0%	87.0%	86.0%	89.0%	89.0%	89.0%	89.0%	94.0%		<80%	80-90%	>90%	Stat
Safeguarding Adults Level 2 Training	98.4%	98.6%	89.0%	90.0%	89.0%	90.0%	91.0%	92.0%	91.0%	91.0%	92.0%	92.0%		<80%	80-90%	>90%	Stat
Resuscitation Training			86.0%	86.0%	84.0%	83.0%	83.0%	83.0%	82.0%	81.0%	80.0%	79.0%		<80%	80-90%	>90%	Stat
Sickness Rate	3.0%	3.0%	3.6%	3.5%	3.3%	3.8%	4.2%	5.9%	4.1%	4.0%	3.7%	3.5%		>3%	N/A	<3%	T
Overall Workforce Unavailability																	
Turnover Rate (Voluntary)	11.0%	11.3%	11.4%	11.5%	11.4%	11.5%	11.3%	11.7%	12.1%	12.2%	12.1%	12.1%		>14%	N/A	<14%	T
Vacancy Rate – Contractual	3.1%	5.8%	6.5%	6.9%	5.7%	5.6%	5.2%	5.8%	5.3%	4.9%	4.9%	6.9%		>10%	N/A	<10%	T
Vacancy Rate - Nursing	0.0%	3.6%	4.9%	5.8%	1.6%	1.0%	1.2%	3.0%	2.9%	3.1%	3.5%	5.9%		No Threshold			T
Bank Spend	4.8%	4.9%	5.0%	5.1%	5.0%	5.0%	5.1%	5.2%	5.2%	5.3%	5.2%	5.5%		No Threshold			T
Agency Spend	0.8%	1.1%	1.1%	1.2%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.1%		>2%	N/A	<2%	T

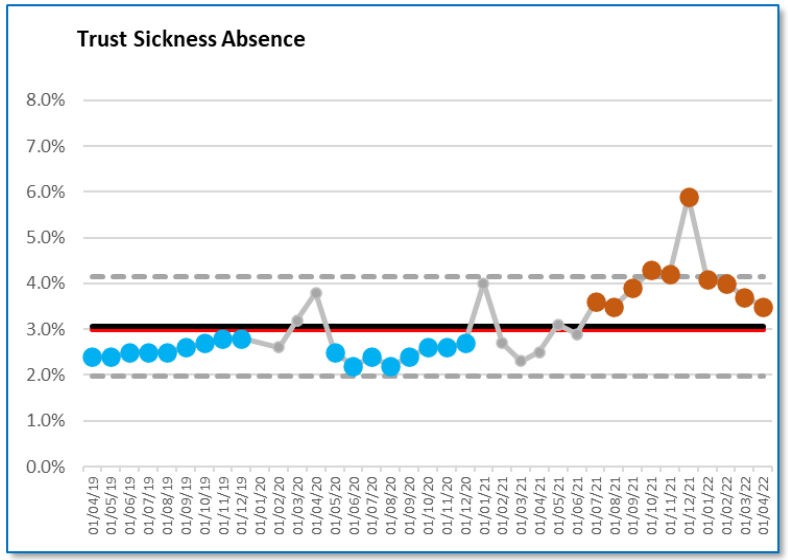
Directorate KPI performance April 2022

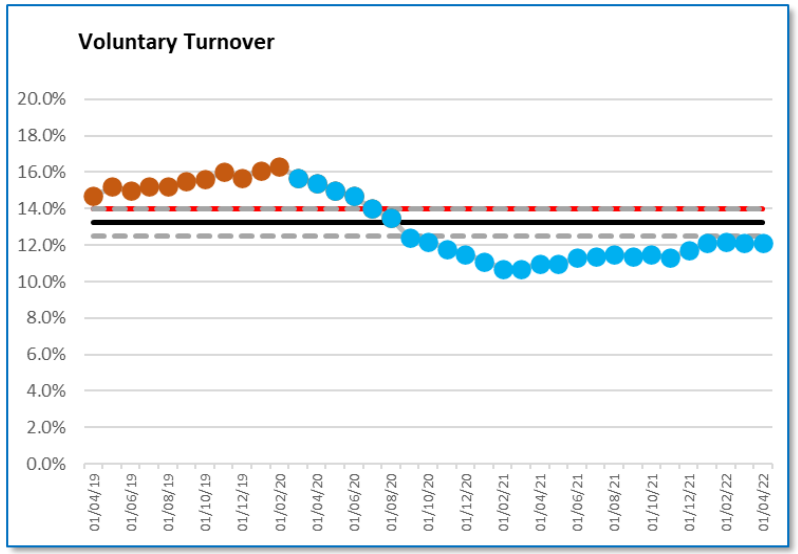
NHS Great Ormond Street Hospital for Children NHS Foundation Trust

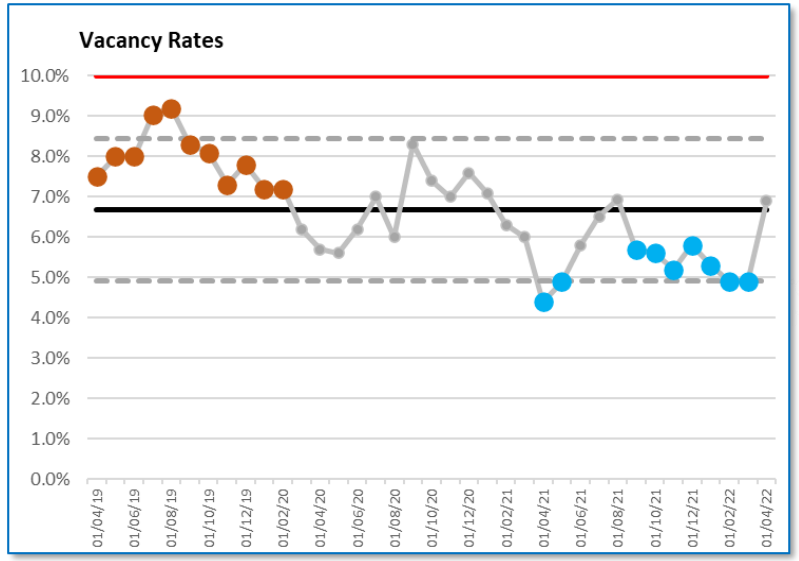
Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP	Genetics	Clinical Operations	Corporate Affairs	ICT	Property Services	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation	Transformation
Voluntary Turnover	14%	12.1%	12.3%	13.0%	8.9%	5.7%	12.5%	14.3%	10.6%	16.5%	5.7%	13.5%	7.4%	8.0%	5.6%	12.1%	18.0%	10.3%	9.8%	15.4%	31.3%
Sickness (1m)	3%	3.5%	5.2%	2.5%	2.5%	3.8%	3.2%	3.8%	3.0%	3.5%	1.6%	2.4%	0.4%	1.7%	6.9%	2.2%	1.1%	0.3%	2.5%	3.3%	1.5%
Vacancy	10%	6.9%	2.2%	-2.4%	1.1%	1.3%	-1.4%	6.3%	3.9%	17.0%	3.6%	7.1%	-17.7%	14.9%	10.00%	23.1%	5.6%	20.2%	1.3%	12.2%	15.9%
Agency spend	2%	1.1%	0.0%	0.0%	0.0%	0.4%	1.3%	0.6%	0.0%	1.9%	0.0%	5.0%	4.3%	5.8%	2.3%	15.7%	7.3%	6.3%	0.0%	0.2%	1.8%
PDR %	90%	87%	88%	91%	87%	88%	88%	84%	94%	88%	81%	83%	73%	57%	91%	92%	82%	69%	83%	85%	74%
Stat/Mand Training	90%	93%	92%	92%	94%	90%	96%	92%	95%	96%	98%	98%	86%	95%	80%	99%	98%	94%	97%	96%	98%

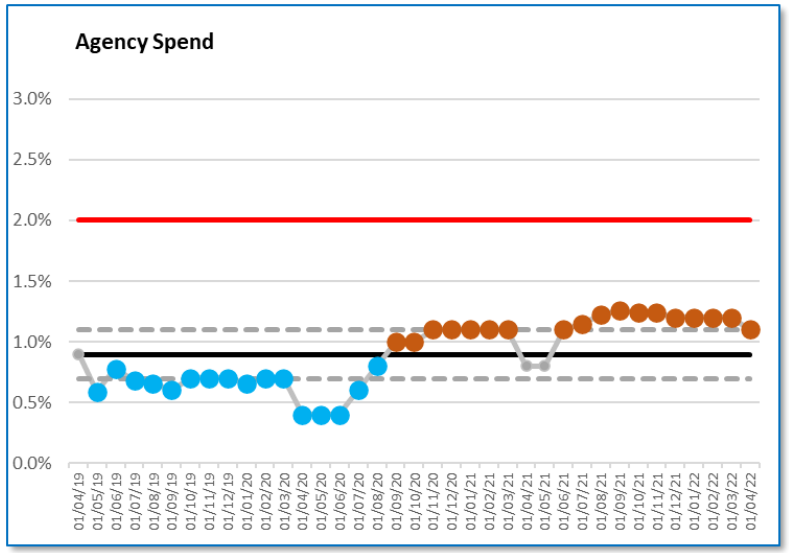
Key: Achieving Plan Within 10% of Plan Not achieving Plan

Workforce SPC Analysis

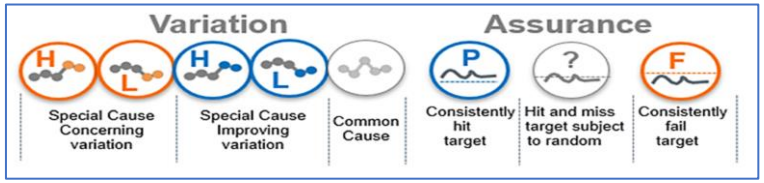








KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Trust Sickness Absence	Apr 22	3.5%	3.0%			3.1%	2.0%	4.2%
Voluntary Turnover	Apr 22	12.1%	14.0%			13.2%	12.5%	14.0%
Vacancy Rates	Apr 22	6.9%	10.0%			6.7%	4.9%	8.4%
Agency Spend	Apr 22	1.1%	2.0%			0.9%	0.7%	1.1%



Well Led

Patient Access

Overview

- **RTT:** Performance has slightly decreased to 75.2%. 104 Week waits increased this month, and complexity and cancellations due to patient illness remains a risk to meeting zero patient by end of June 2022. 52 Week waits have slightly increased from previous month. Over 18 weeks waits have also increased. The Easter period meant reduced activity which has affected performance this month.
- **DM01:** Performance decreased slightly to 84.1% and over 6 week waits increased to 247. Over 13 week waits increased to 31, a significant number are booked in May. Challenges are being experienced in capacity for sedation, MRI Scanner 5 and sleep studies.
- **Cancer Waits:** All five standards were achieved for March 2022. It is projected for April that all standards will be met.
- **Cancelled Operations and 28 Day Breaches**: Non-clinical cancellations increased in March, mainly driven by Orthopaedics and SNAPS. List overrun, ward bed unavailable and equipment/medicine unavailable are the main reasons.

Patient Access

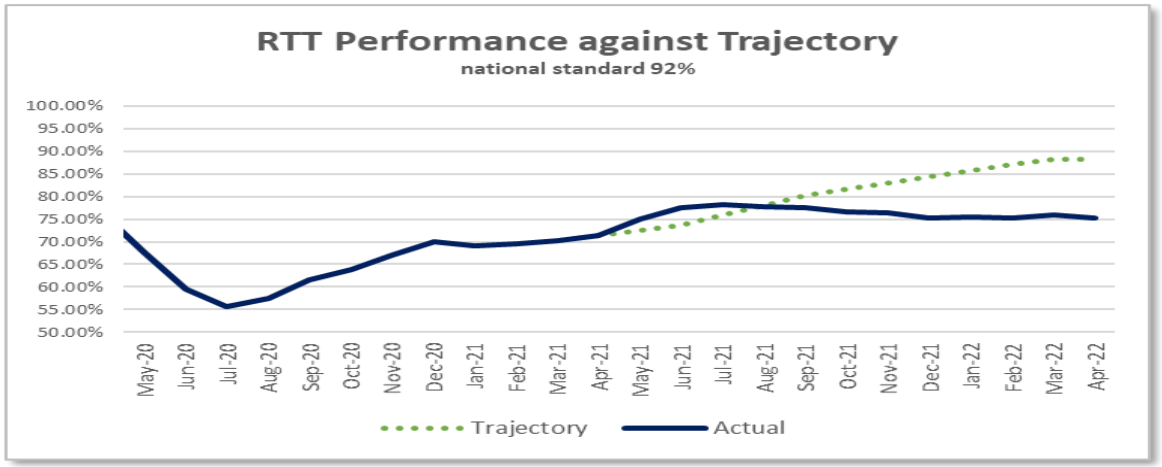
Great Ormond Street Hospital for Children NHS Foundation Trust

Access Metrics Tracking

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Trajectory	Last 12 months	RAG Levels			Stat/Target
RTT Open Pathway: % waiting within 18 weeks	74.9%	77.7%	78.3%	77.8%	77.4%	76.7%	76.4%	75.3%	75.4%	75.3%	76.0%	75.2%	Below		<92%	N/A	>=92%	Stat
Waiting greater than 18 weeks - Incomplete Pathways	1,738	1,536	1,565	1,576	1,593	1,617	1,605	1,711	1,688	1,731	1,635	1,733	-		No Threshold			-
Waiting greater than 52 weeks - Incomplete Pathways	369	291	272	247	219	194	202	194	176	169	142	151	Below		>0	N/A	=0	Stat
Waiting greater than 78 weeks - Incomplete Pathways	99	88	99	103	85	69	60	60	39	34	27	28	Below		TBC			T
Waiting greater than 104 weeks - Incomplete Pathways	12	17	11	12	12	8	7	5	7	9	5	7	Above		>0	N/A	=0	Stat
18 week RTT PTL size	6,929	6,878	7,214	7,107	7,055	6,940	6,814	6938	6858	7004	6811	7009	-		No Threshold			-
Diagnostics- % waiting less than 6 weeks	81.1%	83.3%	85.4%	81.1%	84.3%	87.4%	90.2%	87.7%	83.0%	86.4%	86.8%	84.1%	Below		<99%	N/A	>99%	Stat
Diagnostics- waiting greater than 6 weeks	305	230	201	243	188	170	124	159	237	194	192	247	-		No Threshold			-
Diagnostics- waiting greater than 13 weeks	99	47	42	40	25	28	13	12	14	19	21	31	-		No Threshold			-
Total DM01 PTL size	1,618	1,376	1,373	1,283	1,200	1,347	1,271	1,290	1,394	1,430	1,463	1,556	-		No Threshold			-
Cancer waits: 31 Day: Referral to 1st Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	*100%*	-		<85%	N/A	>85%	Stat
Cancer waits: 31 Day: Decision to treat to 1st Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	*100%*	-		<96%	N/A	>96%	Stat
Cancer waits: 31 Day: Subsequent treatment – surgery	100%	100%	100%	100%	80%	67%	88%	100%	75%	60%	100%	*100%*	-		<94%	N/A	>94%	Stat
Cancer waits: 31 Day: Subsequent treatment - drugs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	*100%*	-		<98%	N/A	>98%	Stat
Cancer waits: 62 Day: Consultant Upgrade	100%	100%	100%	100%	100%	100%	100%	*100%*	100%	100%	100%	*100%*	-		No Threshold			-
Cancelled Operations for Non Clinical Reasons (note 1)	26	32	32	29	46	77	31	22	11	15	34		-		No Threshold			-
28 day breaches	1	4	2	2	2	4	8	0	1	3	1		-		>0	N/A	=0	Stat
Main Theatre Utilisation	73.8%	74.2%	74.3%	70.4%	68.9%	65.3%	70.9%	70.6%	69.1%	72.5%	71.8%	71.7%	-		<77%	N/A	>77%	T
Number of patients with a past planned TCI date (note 4)	1,528	1,479	1,529	1,504	1,521	1,411	1,438	1,554	1,494	1,464	1,126	1,244	-		No Threshold			-
NHS Referrals received- External	2,498	2,605	2,691	2,319	2,646	2,590	2,767	2,391	2,439	2,490	2,818	2,470	-		No Threshold			-
NHS Referrals received- Internal	1,920	1,965	1,955	1,703	1,946	1,894	1,997	1,593	1,937	1,861	2,016	1,812	-		No Threshold			-
Total NHS Outpatient Appointment Cancellations (note 2)	5,736	6,651	7,380	7,046	7,016	6,643	6,727	6,560	6,483	6,605	7,637	6,704						-
NHS Outpatient Appointment Cancellations by Hospital (note 3)	1,716	2,073	1,973	1,878	1,734	1,734	1,675	1,684	1,790	1,793	2,156	1,690						-
Outpatient Clinic utilisation																		-

Responsive

Referral to Treatment times (RTT)



RTT:

75.2% ↓ -0.72%

People waiting less than 18 weeks for treatment from referral.

>52 Weeks:

151 ↑ 9

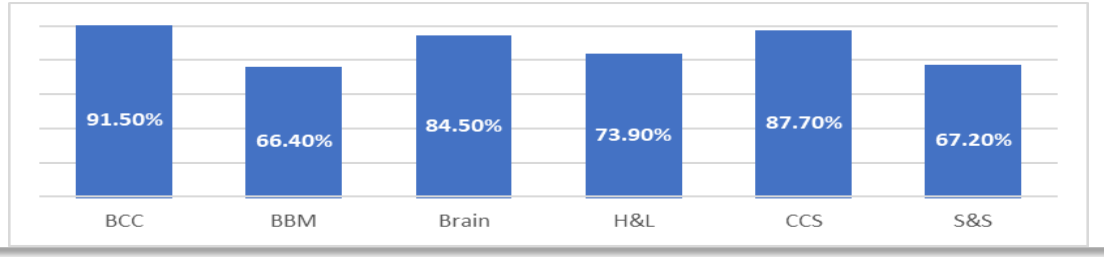
Patients waiting over 52 weeks

>104 Weeks:

7 ↑ 2

Patients waiting over 104 weeks

Directorates



Bottlenecks

Covid stepdown continuing to impact patients resulting in cancellations and deferring of booked appointments/TCI. Easter period annual leave, increased emergency work and bed closures have been challenging patient flow. Particularly 52 weeks and over waits

Avg. 25 bed closures a day decreasing available capacity

Increased emergency cases in Cardiology restricting the number of elective patients treated

Insufficient theatre capacity remains in Craniofacial, Plastic, Orthopaedics and Spinal to reduce long waits

Specialist surgeon activity particularly for joint cases and complex patients

Dental consultant availability

Community/local physiotherapy capacity for the SDR pathway

Actions

Bed closures being signed off by Senior Directorate Team

Weekly operational meeting with service leads and theatre team to ensure capacity is used appropriately

Weekly Access Meeting commenced chaired by COO to drive performance and activity

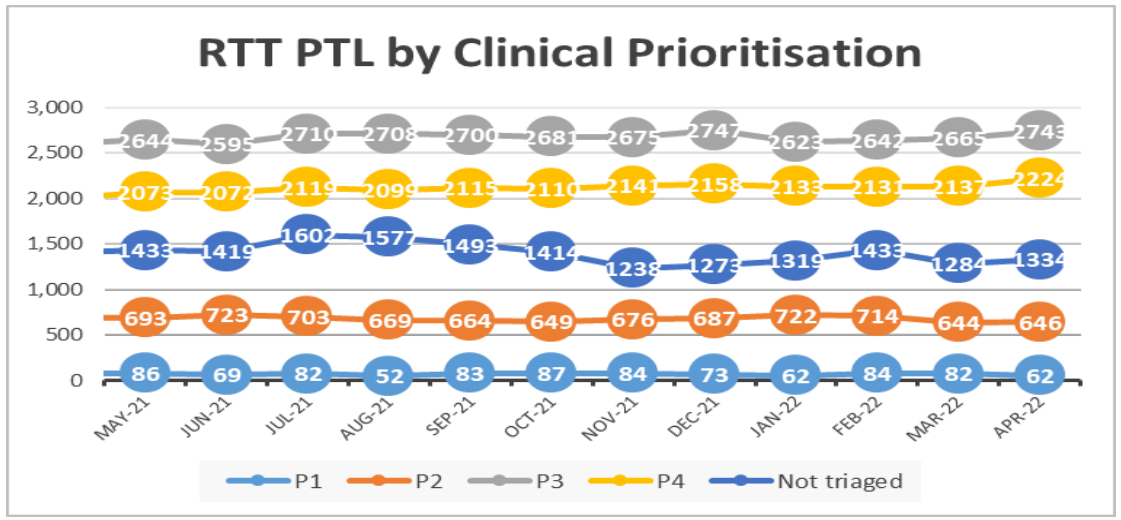
Weekly PTL challenge sessions with directorates

Continued focus on reduction of long wait patients.

RTT trajectories agreed for the majority of specialties

Responsive

RTT – Clinical Prioritisation



P2	P3	P4	Not Prioritised
646 ↑ 2	2743 ↑ 78	2224 ↑ 87	1334 ↑ 50

Clinical Prioritisation – past must be seen by date

P2	P3	P4
191 ↑ 33	503 ↑ 62	250 ↑ 19

Overview of PTL & Prioritisation

The current RTT PTL size is 7009 patients;

- 1334 require clinically prioritising with 1100 being under 18 week waits.
- P1a/P1b – 62 patients (0.88%), P2 – 646 (9.2%), P3 – 2743 (39.1%) and P4 – 2224 (31.7%).

It is recognised some sub-speciality areas including Plastic Surgery, Orthopaedics, Spinal and SDR have significant backlogs with many of these patients being within the clinical priority groups of 3 and 4.

The number of P2 patients waiting beyond their must be seen by date has increased to 191. Of these 109 (57%) are admitted and 82 (43%) are non-admitted.

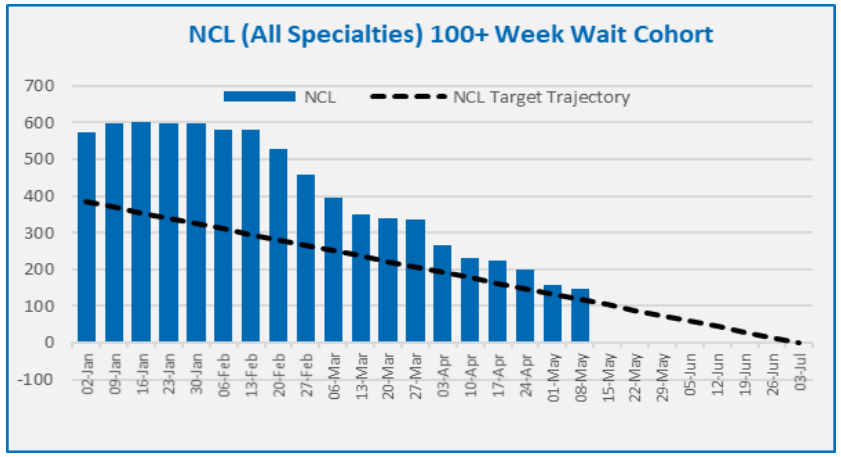
The largest volume of P2 breaching patients are within Cardiology (20), Nephrology (20), Cardiac Surgery (18), Audiological Medicine (13) , Urology (12), ENT (10), SNAPs (10) and Rheumatology (10). These make up 59% of the breached P2.

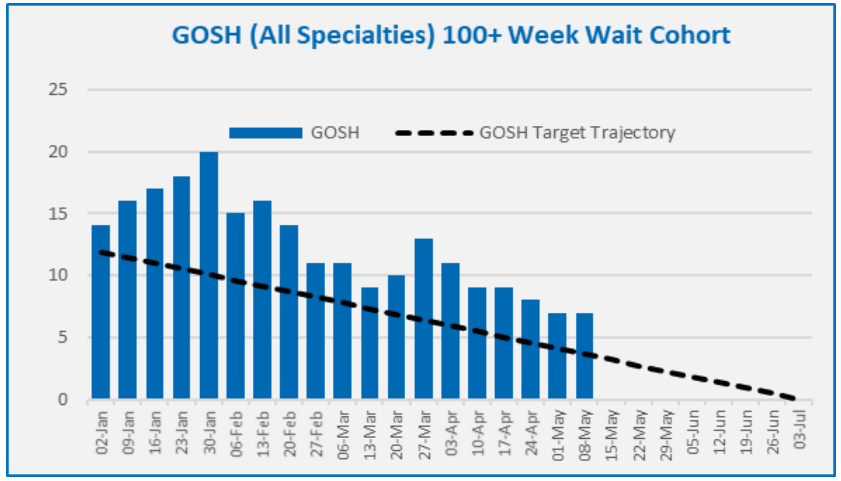
Responsive

RTT – GOSH & NCL Long Waits @ 8th May 2022

100+ Weeks - 147

52+ Weeks – 9,214

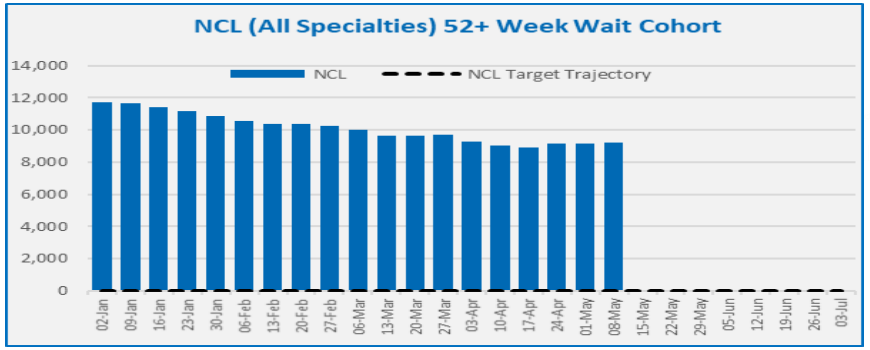


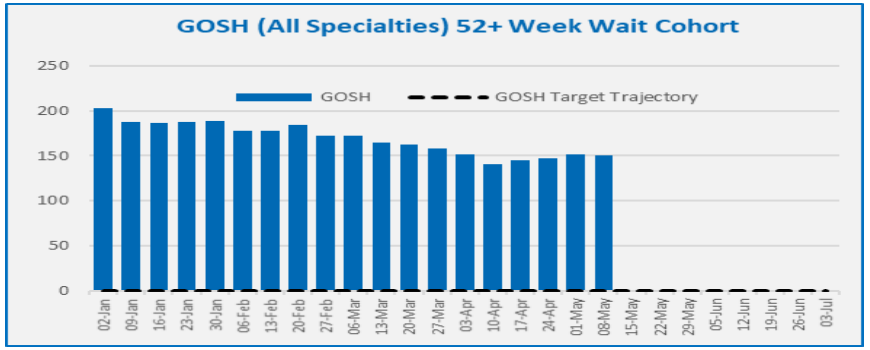


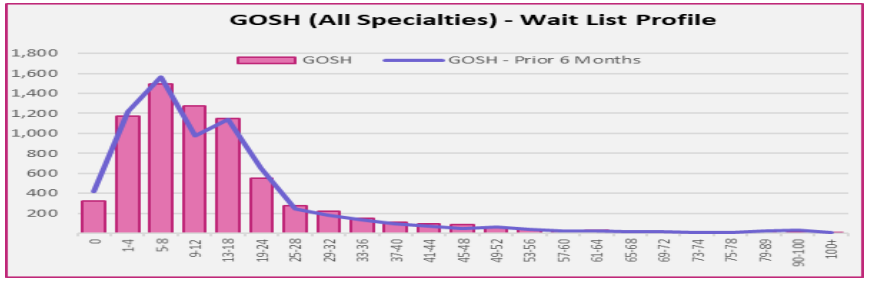
Overall for NCL the 100 week wait position is above projected plan by 29, at 147 patients. Mainly driven by RFH and UCLH numbers. GOSH is above trajectory by 3 patients.

Overall, the number of patients waiting 52 weeks for NCL is reducing. Royal Free and UCLH have the most significant volumes. GOSH is below the agreed 52 week trajectory submission.

NCL are seeing a stabilisation of the overall Provider PTL size and are in a strong position regionally with reducing long waits.







Responsive

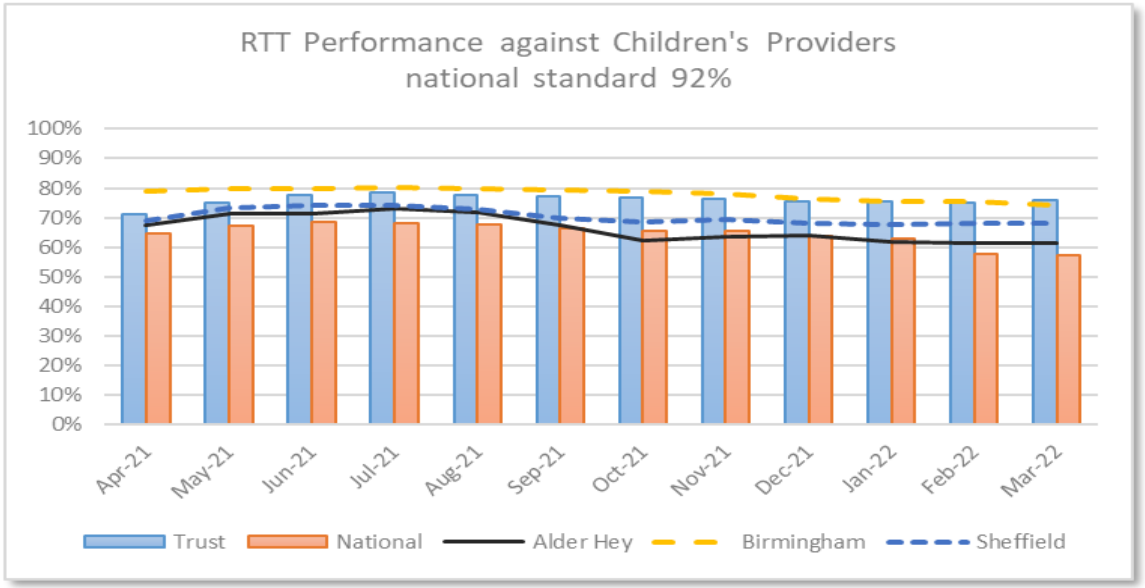
National RTT Performance and 52 week waits – March 2022

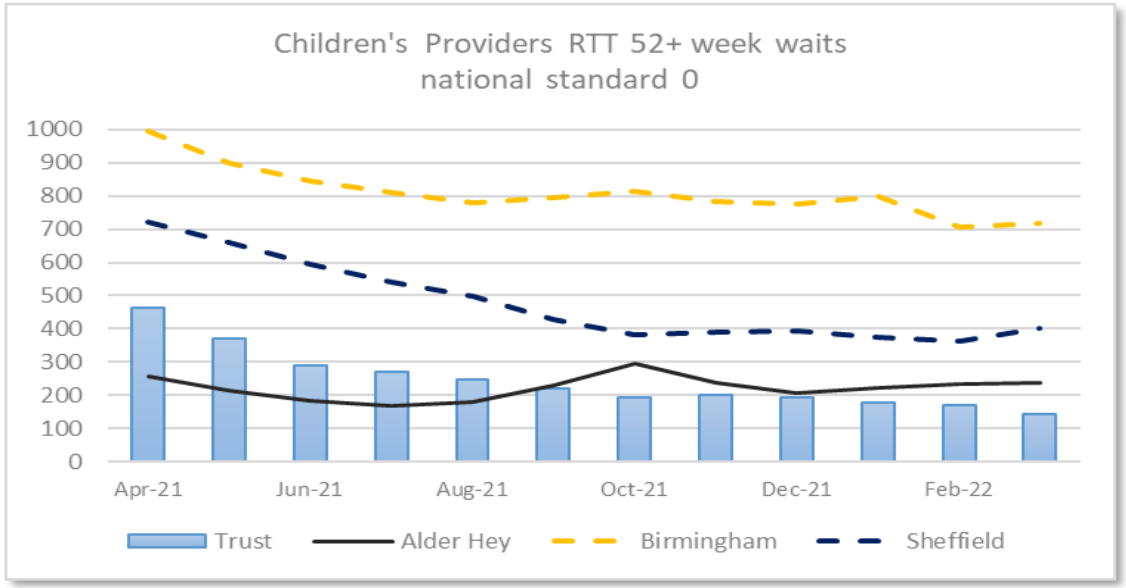
Nationally, at the end of March, 57.4% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks.

GOSH is tracking 18.5% above the national March performance at 76% and is inline with comparative children's providers. RTT Performance for Sheffield Children (68.0%), Birmingham Women's and Children's (74.4%) and Alder Hey (61.3%).

The national position for March 2022 indicates a slight increase of patients waiting over 52 weeks at 287,719 patients.

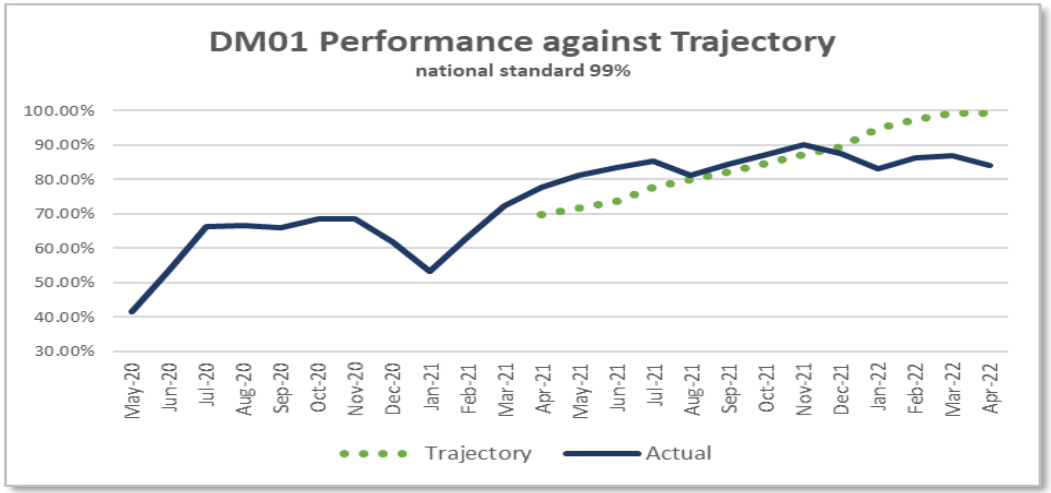
Compared to Alder Hey, Birmingham and Sheffield the number of patients waiting 52 weeks and over for GOSH is lower than all three providers for March.





Responsive

Diagnostic Monitoring Waiting Times (DM01)



Bottlenecks

Covid stepdown positive patients being contacted every two weeks for update on covid status and discuss rebooking but causing extended waits.

Easter break has impacted throughput

MRI sedation and MRI 5 capacity remains challenging and current demand exceeds available capacity

Dexa scanner breakdown will impact May waits but recovery expected by end of June.

Echo capacity remains limited for stress and sedated Echo.

Endoscopy patients bookings increased but access to capacity can be challenging

Respiratory staff long term absence and complex patient bed requirement impacting sleep study activity

DM01: 84.1%

People waiting less than 6 weeks for diagnostic test.

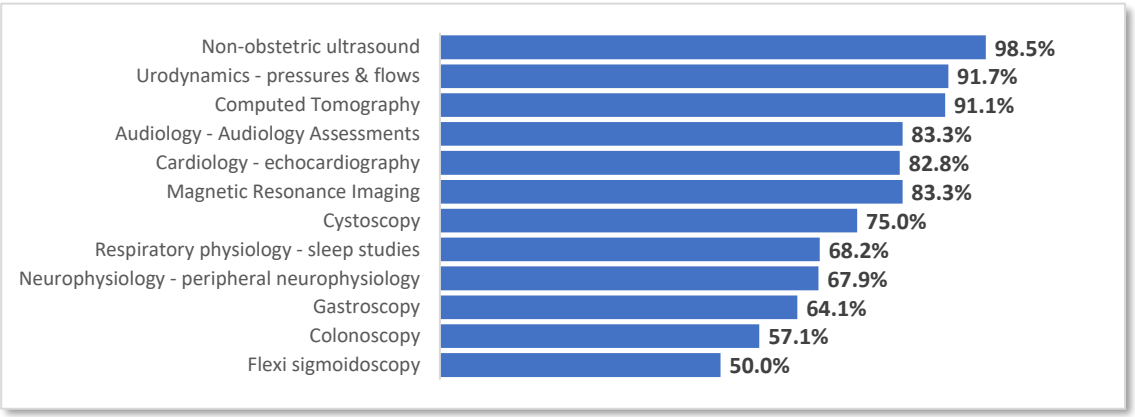
>6 Weeks: 247 ↑ 55

Patients waiting over 6 weeks

>13 Weeks: 31 ↑ 10

Patients waiting over 13 weeks

Modalities not meeting 99% standard



Actions

Weekly scheduling meetings for challenged areas to review utilisation, clinical prioritisation and long waits

Discussion with services on waiting list initiatives to reduce the backlog

Sleep Study action plan and sedation patient actions being drawn together

Participating in NHSE/I demand and capacity modelling for CT, MRI and Ultrasound

Responsive

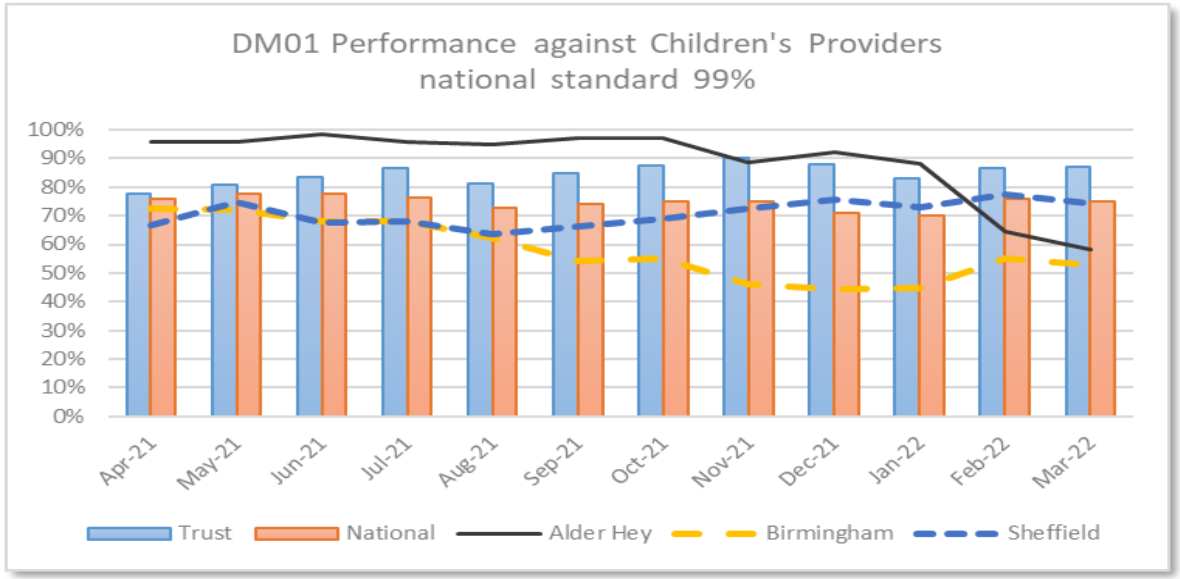
National Diagnostic Performance and 6 week waits – March 2022

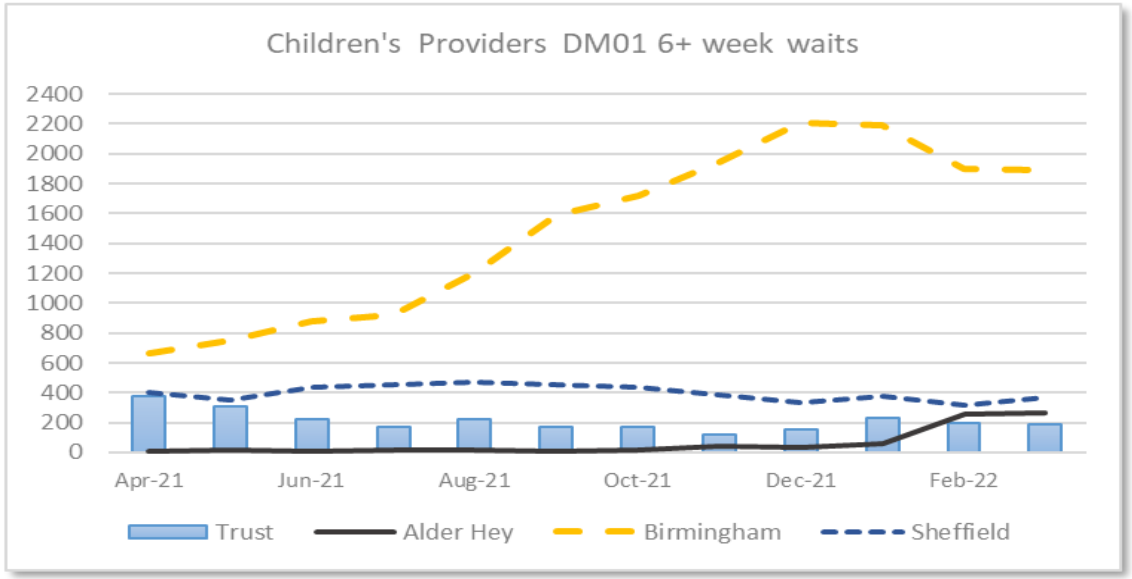
Nationally, at the end of March, 75.15% of patients were waiting under 6 weeks for a DM01 diagnostic test.

GOSH is tracking 11% above the national March performance and is inline with comparative children's providers. DM01 Performance for Sheffield Children (74.1%), Birmingham Women's and Children's (52.9%) and Alder Hey (58.3%).

The national position for March 2022 indicates a increase of patients waiting over 6 weeks at 389,855 patients.

Compared to Birmingham, Alder Hey and Sheffield the number of patients waiting 6 weeks and over for GOSH is lower than all these providers for March.

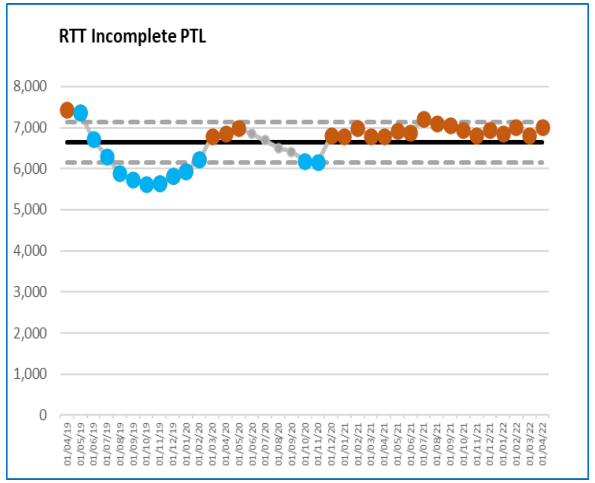


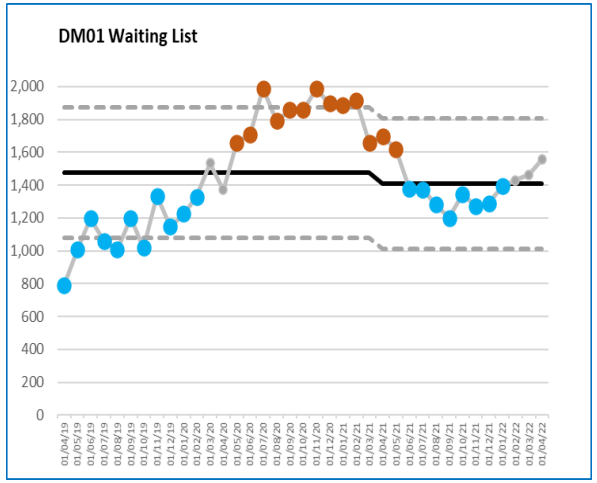


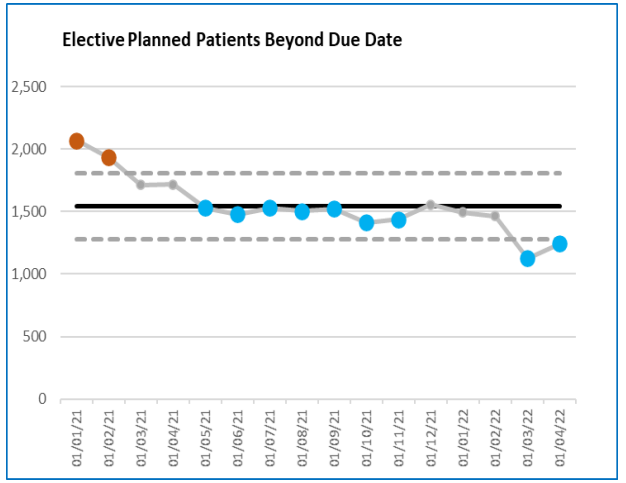
Responsive

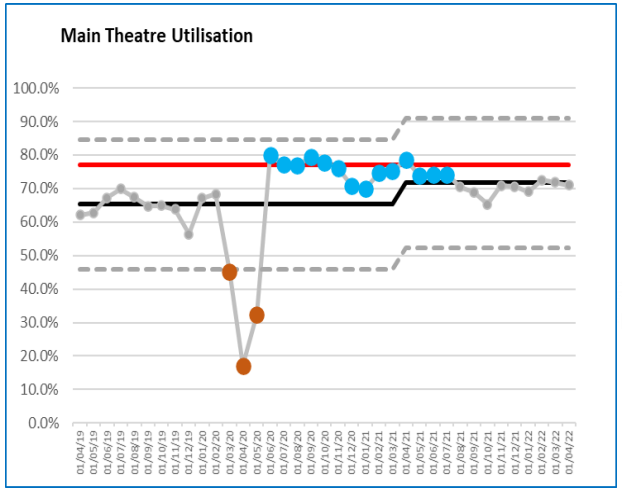
Patient Access SPC Trends

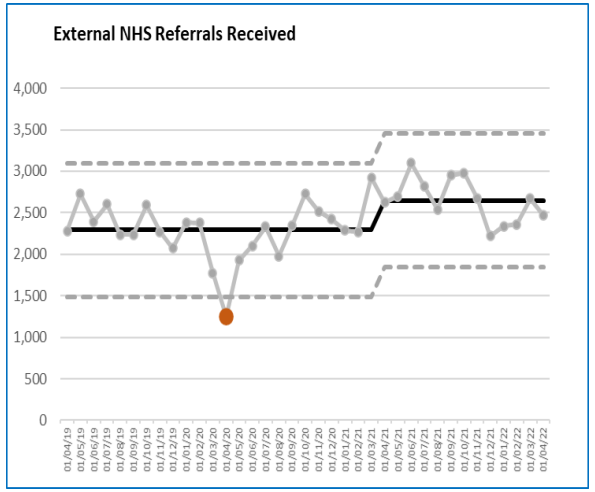
Great Ormond Street Hospital for Children NHS Foundation Trust

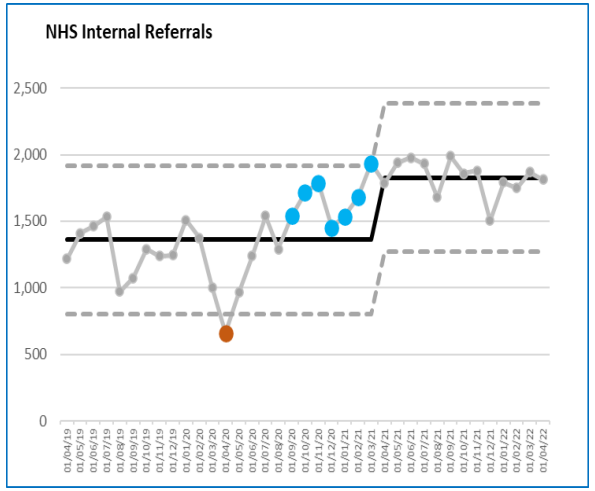


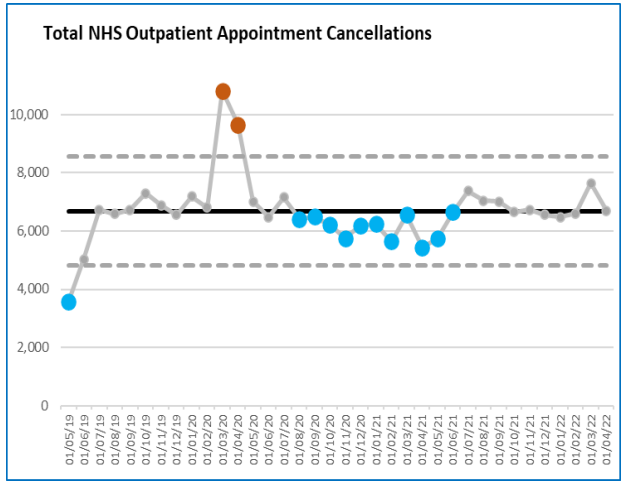


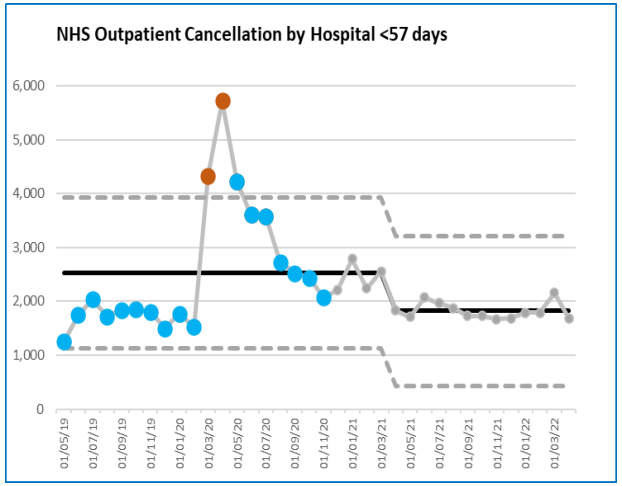












Responsive

Integrated Quality & Performance Report May 2022 (Reporting April 2022 data)

Attachment X

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25 May 2022

Finance Report Month 1 **Submitted by:** **Helen Jameson, Chief Finance Officer**	**Paper No: Attachment X** ☐ **For information and noting**

Purpose of report

This report is being presented in order to provide the Trust Board with an update on the financial position at Month 1. The report has been produced in a different format due to the fact that NHSE has extended the Business Planning process until the 20th June 2022 meaning that the draft plan approved by the Board has not been finalised. Reporting will return to the standard format for the next meeting.

The report provides the key parts of the Financial position for Month 1 along with an analysis of the run rate (M8-11 2021/22 trend).

Summary of report

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

1. NHS clinical income is £2.3m below trend due to a smaller block (including COVID funding) and ERF fund being allocated to the Trust. Further to this non NHS income support is no longer available to the Trust although this loss was offset by higher Private Patient income than had been seen at the end of the last financial year.
2. Pay costs in month are £1.0m adverse to trend largely due to the 2% pay inflation and the national NI increase. Additionally, a number of senior vacancies have been recruited to and levels of maternity leave remain high
3. Non pay is £1.4m adverse to trend. The main reason for this was in Months 8 to 11 the Trust saw continued payment of private patient aged invoices which led to a reduction in impairment of receivables averaging £1.0m a month during the period. Month 1 has seen the impairments to receivables increase totalling £0.8m.
4. Cash held by the Trust in Month 1 has remained strong at £119m. The Trust has only spent £0.8m of its capital plan, most of which is related to the CCC project.
5. The Statement of Financial Position has been updated for IFRS16 which has increased non current assets by £85m

Action required from the meeting

The Trust Board is asked to discuss and note the current Financial position of the Trust at Month 1

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
☐ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people**	☐ **Leadership, capacity and capability** ☐ **Vision and strategy** ☐ **Culture of high quality sustainable care** ☐ **Responsibilities, roles and accountability**

Attachment X

□ PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes **□ PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training** **□ PRIORITY 4: Improve and speed up access to urgent care and virtual services** **□ PRIORITY 5: Accelerate translational research and innovation to save and improve lives** **□ PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care** **□ Quality/ corporate/ financial governance**	**□ Effective processes, managing risk and performance** **□ Accurate data/ information** **□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**
Strategic risk implications	
Financial implications The impact of changes to payment methods and expenditure trends on financial sustainability	
Implications for legal/ regulatory compliance Not Applicable	
Consultation carried out with individuals/ groups/ committees This has been discussed at EMT	
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Finance Officer / Executive Management Team	
Who is accountable for the implementation of the proposal / project? Chief Finance Officer / Executive Management Team	
Which management committee will have oversight of the matters covered in this report? FIC	

Attachment X

Finance Report Month 1 (April 2022)

The Board has previously reviewed a draft budget at the March Board meeting. However, since this time the NHS has issued further planning guidance and have extended the planning deadline until 20th June 2022. As a consequence, this Board paper has been produced in a different format, but we will return to the standard presentation from the next meeting, alongside the final annual planning paper.

Statement of Comprehensive Income

As the NHS planning process is still ongoing the narrative in the Month 1 report compares the in-month position with the 2021/22 Month 8 to 11 trend and ***Appendix 1*** compares to the previous years profile. These months have been used to exclude any one-off changes in month 12 e.g. Pensions, annual leave.

At the end of April 2022 the Trust financial position is a deficit of £4.7m (Table 1) before adjustments for donations which is driven by a reduced clinical income due to changes in the national funding regime in 2022/23, whilst staffing costs and non-pay costs have increased from previous years levels.

Table 1: April 2022 Statement of Comprehensive Income

Income & Expenditure	Month 1
	Actual (£m)
NHS & Other Clinical Revenue	35.96
Private Patient Revenue	2.76
Non-Clinical Revenue	5.01
Total Operating Revenue	**43.74**
Permanent Staff	(27.84)
Agency Staff	(0.34)
Bank Staff	(1.64)
Total Employee Expenses	**(29.83)**
Drugs and Blood	(7.33)
Supplies and services - clinical	(3.12)
Other Expenses	(6.42)
Total Non-Pay Expenses	**(16.88)**
Total Expenses	**(46.70)**
EBITDA (exc Capital Donations)	**(2.97)**
Owned depreciation, Interest and PDC	(1.70)
Surplus/Deficit	**(4.66)**
Donated depreciation	(1.63)
Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	**(6.29)**
Impairments & Unwinding Of Discount	0.00
Capital Donations	0.47
Adjusted Net Result	**(5.82)**

Income and activity

NHS clinical income is £2.3m below trend due to a smaller block (including COVID funding) and ERF fund being allocated to the Trust. Further to this non NHS income support is no longer available to

the Trust although this loss was offset by higher Private Patient income than that seen at the end of the last financial year.

Overall activity in April has decreased per working day for all points of delivery with the exception of non-elective spells where there has been an increase of 0.26 spells per day (3%). The decreased day case and elective activity is largely a result of higher levels of bed closures (an average of 25 beds per day closed versus 13 in March).

Bed days for April 2023 are lower than March across both critical care beds and other beds.

Outpatient attendances have decreased 16% per working day overall versus March with reductions across both first and follow up attendances at 17% and 15% respectively. It is expected that attendances will increase as activity recording is finalised. There continues to be an increase in face to face activity with non-face to face attendances at their lowest levels since April 2021 at 32% of total attendances versus 34% in March

Pay

Pay costs in month are £1.0m adverse to trend largely due to the 2% pay inflation and the national NI increase. Additionally, a number of senior vacancies have been recruited to and levels of maternity leave remain high.

Table 2: Staffing levels

	M1 Actual WTE
Permanent Staff	5,196.8
Bank Staff	325.9
Agency Staff	38.6
TOTAL	**5,561.3**

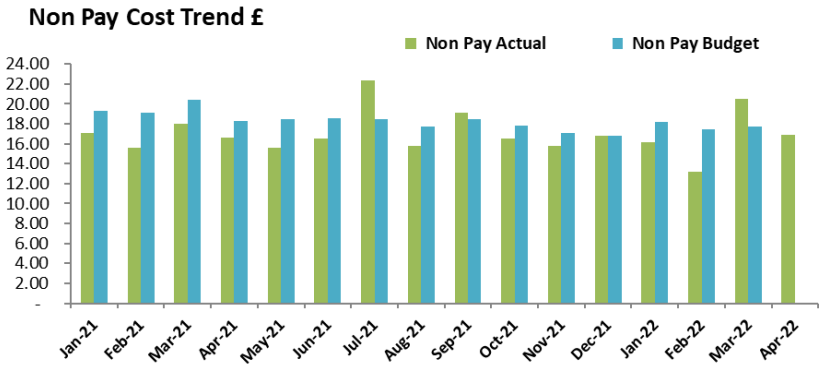
Permanent wtes have reduced by 12 in M1. This is offset by a rise in bank of 15wtes. Staff usage remains high due to continued (but reducing) levels of temporary staff usage in relation to Covid isolation and sickness backfill. The 30th April absence rate due to Covid was 0.5% of the permanent workforce which shows a continued improvement from 1.7% on 31st March. Agency staffing levels remain consistent at 39 wte and these are still required to provide additional senior assistance for the ICT, IPP & Finance directorates who are in the process of recruiting permanently to these roles.

When comparing Month 1 to trend the overall volume variance is only 4.00 wte with an increase in bank staff offset by a decrease in permanent staff.

Non -pay

Non pay is £1.4m adverse to trend. The main reason for this was in Months 8 to 11 the Trust saw continued payment of private patient aged invoices which led to a reduction in impairment of receivables averaging £1.0m a month during the period. Month 1 has seen the impairments to receivables increase totalling £0.8m. Costs were below trend in Clinical Supplies & Services and Services from NHS organisations.

Table 3: Non pay trend



Covid costs in month 1 are £0.5m with this being lower than previous months. The costs incurred by the Trust are associated with cleaning, testing and sickness cover. Going forwards the Trust is working to remove these costs now infection control guidelines have been updated.

Statement of Financial Position

Appendix 2 shows the Statement of Financial position. The key things to note are that this has been prepared under IFRS16 which has increased the non current assets by £86m. Cash has remained strong (£119m) a reduction of £5m from March 2022.

Further to this working capital performance can be seen in Table 4 below.

Table 4: Working capital performance

31-Mar-21	Working Capital	31-Mar-22	30-Apr-22	RAG	KPI
5.0	NHS Debtor Days (YTD)	4.0	2.0	G	< 30.0
288.0	IPP Debtor Days	131.0	118.0	G	< 120.0
27.1	IPP Overdue Debt (£m)	12.0	15.1	R	0.0
95.0	Inventory Days - Non Drugs	87.0	88.0	R	30.0
31.0	Creditor Days	34.0	32.0	A	< 30.0
41.6%	BPPC - NHS (YTD) (number)	43.0%	73.4%	R	> 95.0%
70.6%	BPPC - NHS (YTD) (£)	74.4%	82.3%	R	> 95.0%
83.4%	BPPC - Non-NHS (YTD) (number)	83.4%	88.2%	R	> 95.0%
88.9%	BPPC - Non-NHS (YTD) (£)	92.2%	96.0%	G	> 95.0%
81.7%	BPPC - Total (YTD) (number)	81.7%	87.4%	R	> 95.0%
87.4%	BPPC - Total (YTD) (£)	90.6%	94.7%	A	> 95.0%

Capital

Table 5 shows the in month capital position. Only £800k has been spent year to date with most of the programme relating to the CCC project.

Table 5: Capital expenditure

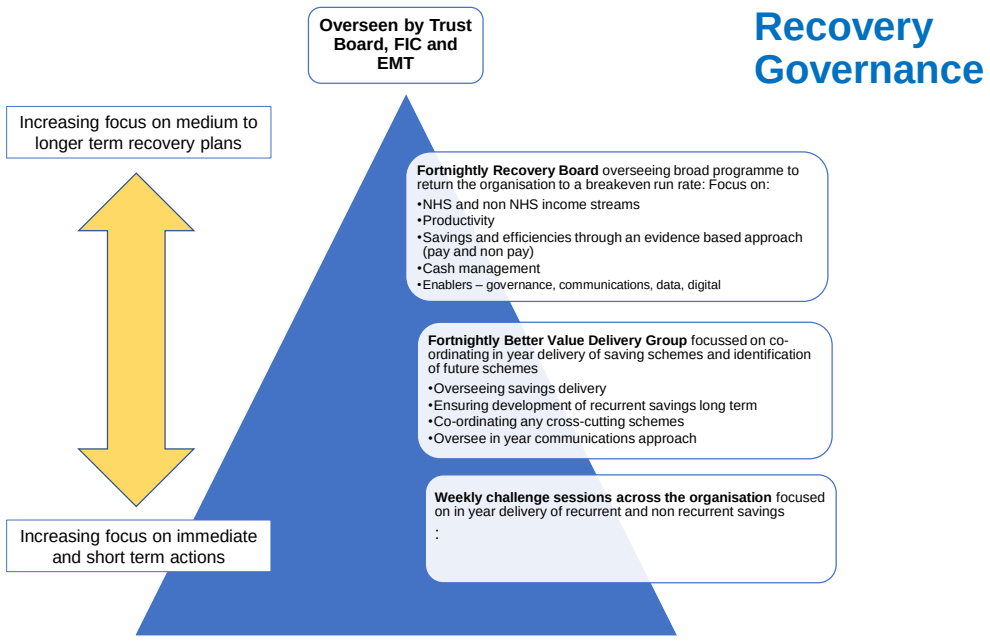
Capital Expenditure	YTD Actual 30 April 2022 £m	Forecast Outturn 31 Mar 2023 £m
Redevelopment - Donated	0.38	26.36
Medical Equipment - Donated	0.10	2.28
ICT - Donated	0.00	0.00
Total Donated	**0.48**	**28.64**
Redevelopment & equipment - Trust Funded	0.02	6.88
Estates & Facilities - Trust Funded	(0.01)	3.61
ICT - Trust Funded	0.27	4.49
Total Trust Funded	**0.28**	**14.98**
Total IFRS 16	**0.00**	**1.87**
Total Expenditure	**0.76**	**45.49**

Run rate

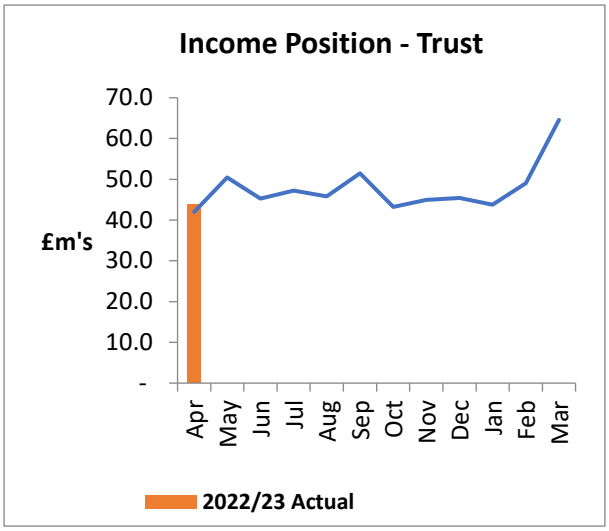
It is important that the Trust delivers it's savings programme in year and develops a financial recovery plan to bring the in month run rate back to breakeven, eradicating the underlying deficit. This needs to be a holistic approach covering:

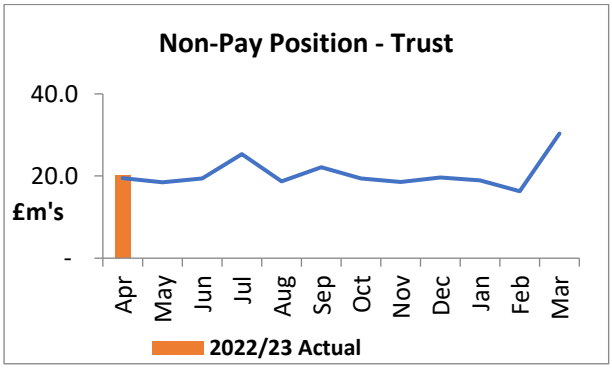
- Savings and efficiencies
- Commercial and income opportunities
- Review and strengthening of governance

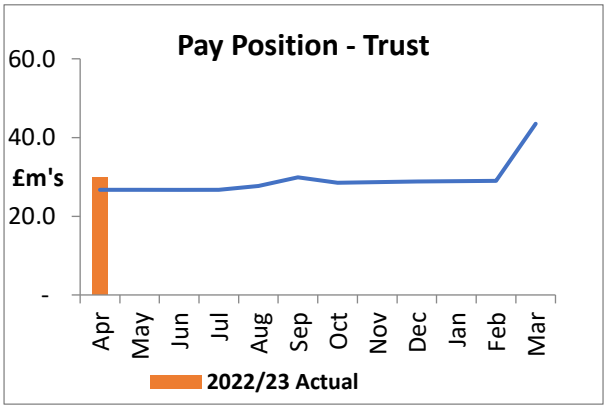
A Governance structure has been designed to oversee the programme to deliver this, which includes the creation of a Recovery Board which will report to EMT, FIC and the Board. Further information on this will be brought to the next FIC and Trust Board.

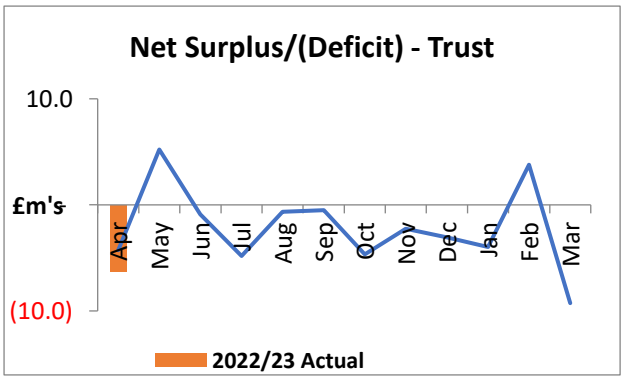


Appendix 1: April 2022 compared to 2021/22









Appendix 2

Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 1 2022/23
Statement of Financial Position

Unaudited Actual as at 31 Mar 2022		Actual as at 30 Apr 2022	*Change in month*
£000		£000	*£000*
	Non Current Assets		
539,298	Property, plant and equipment / Intangibles	541,367	*2,069*
0	Right of Use Assets (IFRS 16)	84,714	*84,714*
161	Other investments / financial assets	161	*0*
6,941	Trade and other receivables	6,839	*(102)*
546,400	**Total Non Current Assets**	**633,081**	**86,681**
	Current Assets		
11,712	Inventories	11,330	*(382)*
34,490	Contract receivables (IFRS15): invoiced)	32,567	*(1,923)*
11,515	Contract receivables (IFRS15): not yet invoiced)	13,461	*1,946*
(6,290)	Allowance for impaired contract receivables	(7,096)	*(806)*
1,516	Receivables due from NHS charities - capital	1,902	*386*
4,410	Other receivables - revenue	5,476	*1,066*
(190)	Allowance for impaired other receivables	(164)	*26*
0	PDC dividend receivable	0	*0*
5,854	Prepayments	7,644	*1,790*
566	VAT receivable	910	*344*
0	Investments	0	*0*
123,671	Cash and cash equivalents	118,924	*(4,747)*
187,254	**Total Current Assets**	**184,954**	**(2,300)**
733,654	**Total Assets**	**818,035**	**84,381**
	Current Liabilities		
(6,865)	Other trade payables - capital	(5,144)	*1,721*
(17,373)	NHS payables - revenue	(11,987)	*5,386*
(2,453)	Other trade payables - revenue	(2,137)	*316*
(5,463)	Other payables	(5,383)	*80*
(9,206)	Private Patient Cash on Account	(8,902)	*304*
(48,476)	Expenditure accruals	(53,057)	*(4,581)*
(473)	PDC dividend payable	(1,042)	*(569)*
(4,419)	Social Security costs	(4,544)	*(125)*
(4,084)	Other taxes payable	(3,597)	*487*
(4,394)	Deferred income: contract liabilities (IFRS15)	(8,857)	*(4,463)*
(1,917)	Deferred income: other (non IFRS15)	(2,099)	*(182)*
(499)	Lease incentives	(499)	*0*
(370)	Provisions for liabilites and charges	(357)	*13*
(105,992)	**Total Current Liabilities**	**(107,605)**	***(1,613)***
81,262	**Net Current Assets**	**77,349**	***(3,913)***
627,662	**Total Assets Less Current Liabilities**	**710,430**	***82,768***
	Non Current Liabilities		
0	Lease obligations (IFRS 16)	(27,163)	*(27,163)*
(2,927)	Lease incentives NCL	(2,894)	*33*
(2,440)	Provisions for liabilites and charges NCL	(2,435)	*5*
(5,367)	**Total Non Current Liabilities**	**(32,492)**	**(27,125)**
622,295	**Total Assets Employed**	**677,938**	***55,643***
	Financed by Taxpayers' Equity		
133,468	Public dividend capital	133,468	*0*
345,228	Retained earnings	396,954	*51,726*
(4)	Financial Asset reserve	(4)	*0*
143,603	Revaluation reserve	147,520	*3,917*
622,295	**Total Taxpayers' Equity**	**677,938**	***55,643***

Attachment Y

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25th May 2022

Learning from Deaths report Q4 2021/22 **Submitted by:** Dr Sanjiv Sharma, Medical Director Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews Andrew Pearson, Clinical Audit Manager	**Paper No: Attachment Y** For information and noting

Purpose of report

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

Summary of report

Child Death Review Meetings (CDRMs) are the final meeting to confirm actions and learning in the mortality review process following the completion of all necessary investigations and reviews. This report focuses on actions and learning from child death review meetings (CDRMs) concluded between 1st January 2022 and 31st March 2022 for children who died at GOSH.

Twenty-three GOSH CDRMs occurred between the 1st January 2022 and 31st March 2022.
The reviews highlighted:

- No review identified modifiable factors in care at GOSH. Modifiable factors are defined as those, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths.
- Additional learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience in **12** cases. Those learning points and any actions taken are described in the report. Two of those include actions identified following the conclusion of serious incident investigations.
  Themes identified in this report include

  At GOSH
  - Improvement in the communication between GOSH and local/referring hospitals with updates and notification around the child's death was identified in three cases ,and is a learning point for trust wide dissemination. There is currently some priority audit work to review the documentation of key elements of the *When a Child Dies Pathway* , which includes communication of death to local/referring hospitals.
    At local hospitals
  - Difficulties in accessing and unfamiliarity around the use of scavenger medications for babies with suspected hyperammonaemia was identified as a theme – in both cases training has already been put in place to increase nursing confidence in accessing emergency drugs locally.

Particular excellent aspects of care, the co-ordination of care and communication were highlighted by the CDRMs in **16** cases

Attachment Y

<table>
<tr><td colspan="2">Action required from the meeting
There are no recommendations or actions for the Board to consider</td></tr>
<tr><td>Contribution to the delivery of NHS Foundation Trust priorities
Quality/ corporate/ financial governance</td><td>Contribution to compliance with the Well Led criteria
Culture of high-quality sustainable care
Effective processes, managing risk and performance
Accurate data/ information
Robust systems for learning, continuous improvement and innovation</td></tr>
<tr><td colspan="2">Strategic risk implications
BAF Risk 12: Inconsistent delivery of safe care</td></tr>
<tr><td colspan="2">Financial implications
Not Applicable</td></tr>
<tr><td colspan="2">Implications for legal/ regulatory compliance
Meets the requirement of the National Quality Board to report learning from deaths to a public board meeting. Child Death Review Meetings (CDRM) are statutory following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019.</td></tr>
<tr><td colspan="2">Consultation carried out with individuals/ groups/ committees
This report has been reviewed by the Patient Safety and Outcomes Committee</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales?
Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project?
Medical Director</td></tr>
<tr><td colspan="2">Which management committee will have oversight of the matters covered in this report?
Patient Safety and Outcomes Committee</td></tr>
</table>

Learning from deaths report – May 2022

Aim of this report

This highlights learning from child death review meetings (CDRMs) concluded between 1st January 2022 and 31st March 2022 for children who died at GOSH.

Summary

Child Death Review Meetings (CDRMs) are the final meeting to confirm actions and learning in the mortality review process following the completion of all necessary investigations and reviews. This reports focuses on actions and learning from child death review meetings (CDRMs) concluded between 1st January 2022 and 31st March 2022 for children who died at GOSH.

Twenty three GOSH CDRMs occurred between the 1st January 2022 and 31st March 2022.
The reviews highlighted:

No review identified modifiable factors in care at GOSH. Modifiable factors are defined as those, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths.

Additional learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience in **12** cases. Those learning points and any actions taken are described in the report. Two of those include actions identified following the conclusion of serious incident investigations.
Themes identified in this report include

At GOSH

- Improvement in the communication between GOSH and local/referring hospitals with updates and notification around the child's death was identified in three cases , and is a learning point for trust wide dissemination. There is currently some priority audit work to review the documentation of key elements of the *When a Child Dies Pathway* , which includes communication of death to local/referring hospitals.

At local hospitals

- Difficulties in accessing and unfamiliarity around the use of scavenger medications for babies with suspected hyperammonaemia was identified as a theme – in both cases training has already been put in place to increase nursing confidence in accessing emergency drugs locally.

Particular excellent aspects of care, the co-ordination of care and communication were highlighted by the CDRMs in **16** cases.

28th April 2022
Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews
Andrew Pearson, Clinical Audit Manager

The mortality review process at GOSH

Mortality reviews take place through two processes at GOSH:

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

2.Child Death Review Meetings (CDRM) 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.Child Death Review Meetings are “a multi-professional meeting where all matters relating to a child’s death are discussed by the professionals directly involved in the care of that child during life and their investigation after death.” They include clinicians or professionals from external providers. CDRM meeting should be held within 12 weeks of the child’s death, following the completion of all necessary investigations and reviews.

Completion of mortality reviews

The focus of this report is on the outcomes of CDRMs. In addition we are also reporting on progress with completion of CDRMs for the most recent time period where this can be assessed.

Twenty four children died at GOSH between 1st October 2021 and 31st December 2021
Reviews (i.e.an MRG or a CDRM) have been completed for 23 deaths.
Eight CDRMs have taken place, and fifteen have not been completed.

- Four cannot take place until the completion of necessary coroner investigations. This in line with the Child Death Review Statutory Guidance.
- Eleven are being scheduled at the time of writing due to challenges in Consultant capacity to attend the meetings.

It is noted that there have been challenges with scheduling CDRMs due to GOSH consultant availability to attend meetings, particularly during the winter period.

The table below shows the summary of the deaths that occurred between 1st October 2021 and 31st December 2021 using NHS England reporting guidance.

Total number of inpatient deaths at GOSH between 1st October 2021 and 31st December 2021	24
Number of those deaths subject to case record review (either by the MRG, or at a CDRM)	23
Number of those deaths declared as serious incidents	0
Number of deaths where a modifiable factor was identified at GOSH that may have contributed to vulnerability, ill health or death.	0
Number of deaths of people with learning disabilities	0
Number of deaths of people with learning disabilities that have been reviewed	0
Number of deaths of people with learning disabilities where a modifiable factor was identified at GOSH that may have contributed to vulnerability, ill health or death.	0

In one death the Mortality Review Group have identified potential modifiable factors and has been referred to review at an Executive Incident Reporting Meeting (EIRM)

Learning points identified

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

Quarter of death	Location of learning	Learning /Actions taken
Q1 2020/21	Blood Cells and Cancer	It was identified at the CDRM that the local teams had not been notified of the child's death by GOSH. This is not an isolated issue and there is now a quality assurance audit being undertaken to review this led by the Bereavement Services Manager **Serious Incident-**Escalation of the antibiotic regime in a febrile neutropenic patient on chemotherapy treatment The Mortality Review Group identified concerns around the choice of antibiotics and persistent tachycardia prior to the cardiac arrest which led to a serious incident investigation. The conclusion of the CDRM in light of the SI investigation and inquest determined that there were no modifiable factors that would have changed the outcome in this case as the cause of death was not identified as sepsis on post- mortem or from any investigations (cultures etc) The following actions have been completed •Teaching for the medical and nursing staff in the Blood, Cells and Cancer Directorate on sepsis in the immunocompromised patients, to highlight patients at a greater risk of infection and to identify early signs of sepsis •The Trust will review the need to undertake testing for the m.1555A>G gene in immunocompromised patients who are at high risk of sepsis •To work with the SIM (Simulation training) team to devise training scenarios for clinical staff in the Blood, Cells and Cancer directorate highlighting the benefits of trend recognition in early recognition of the deteriorating patient. The following actions are in progress •Update the Paediatric Haematology & Oncology: Supportive Care Protocols to reinforce that empirical antibiotic should be given regardless of the review being undertaken when infection is suspected. (due 31/5/22) •To work with the Epic team and train staff to have the timeline activity on their toolbar in Epic (due 30/6/22**)**

Learning points identified

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

Quarter of death	Location of learning	Learning /Actions taken
Q2 2020/21	CICU/Trust wide	**Serious Incident -**Major haemorrhage during cannulation for extracorporeal membrane oxygenation (ECMO) The patient died as a result of complications arising during the ECMO cannulation procedure. The patient had an underlying condition which placed them at high risk for mortality and increased the risks of cannulation. The investigation has not identified any causal factors in terms of care that was delivered or identified how the outcome could have been prevented. **Key Learning Point for Trust Wide dissemination:** In extremely high-risk cases where an intervention does not happen on a regular basis, it is vital to carry out simulation training in order to be able to deal with problems that arise during the procedure. The following actions have been completed •A sternotomy saw will be added to theatre trolley that is taken to CICU for procedures •A tip sheet will be written explaining additional equipment that will be required and rationale for use •Scrub staff who are new to the department will now spend a week in the Cardiac speciality •Scrub staff who will be rotated into both weekend and night shift are encouraged to have a refresher day in Cardiac theatres •The CICU and cardiothoracic teams to develop a joint consent process where parental consent is obtained for patients being assessed for ECMO treatment by both teams •Review the rapid response algorithm for placing a patient on ECMO to clarify escalation policy and support staff in decision making during challenging ECMO cannulation procedures. •Ensure that all echo imaging is saved to facilitate further review and aid future learning The following actions are in progress •The CICU team brief check list to be reviewed and amended to include named additional equipment that maybe required and therefore guide the discussion (due 30/12/2021) •The cardiothoracic surgeons will develop a case mix risk stratification document with appropriate guidance on identifying and managing high risk patients requiring ECMO cannulation (due 31/3/22)

Learning points identified

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

Quarter of death	Location of learning	Learning /Actions taken
Q2 20/21	NICU/PICU	Health Visitor highlighted that their team were not updated/notified during the admission until child's death. This has previously been highlighted as a learning point in other cases where local referring teams were not regularly updated and already changes have been brought in (since this case) with correspondence for any long term (>4 weeks) PICU/NICU patients local/referring teams being notified with clinical updates. As an action from the CDRM this process will be amended to include GP and Health Visiting teams in this correspondence.
Q2 21/22	GOSH/local	1. Large liver mass possible liver infarct secondary to umbilical line, unfortunately baby was too unstable to have MRI and post mortem not done. Consideration of perimortem MRI (after death) might have provided diagnosis as a learning point. 2. Local team had some anxiety using scavenger medications due to unfamiliarity and training has already been put in place to increase nursing confidence in accessing emergency drugs locally. 3. Difficulties in running CVVH despite multiple vascath insertions by senior consultants (PICU and IR). Exchange transfusion was successful in bringing down the ammonia (peritoneal dialysis was not possible due to the liver mass) and identified as a learning point for the teams involved at the CDRM. 4. It was suggested by the local team that a conference call coordinated by CATS with all the relevant teams would have been helpful as a learning point. 5. An MDT with radiology and oncology was also suggested as something that might have been helpful in diagnosing the liver mass. 6. Local team have not received copy of the discharge (death) summary from GOSH PICU. This has been flagged to the PICU Admin team as an action. 7. The local band 7 NICU team have as system in place to routinely follow up on babies transferred to other hospitals and record any updates was identified as an example of good practice to be shared as a learning point.
Q2 21/22	GOSH	1. This child was extremely complex with a number of medical issues. Referral made to Associate Medical Director for Safety by the CDRM chair] to review this case in the context of the Deteriorating Patient quality improvement project. It was really striking how challenging it was for the team but how remarkable and amazing the respiratory team were in providing care for this child over a very lengthy admission. There was not felt to be anything modifiable that would have changed the outcome but this journey clearly had a huge impact on the high number of individuals involved and it is important to recognise that. 2 An earlier referral to the Ethics Committee was suggested.3.. Moving and handling events leading to two fractures of right femur and right humerus (RCA concluded)

Learning points identified

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

Quarter of death	Location of learning	Learning /Actions taken
Q2 21/22	GOSH/local/antenatal care	1. The dissemination of antenatal vein of galen malformation (VGAM) pathways with local hospital remains challenging. VGAM is a rare diagnosis and it remains a challenge to share this information widely due to the relative infrequency of this condition. The antenatal pathways have been shared with the local hospital medicine team as an action from the CDRM. 2. The constant information sharing (numerous phone calls caused stress and sadness) while awaiting the outcome of the coroners decision was distressing - this will be reflected on by the family liaison team at their team meeting as an action. 3. There were some issues around the mortuary (their time with baby was supervised due to Coroners involvement and they were told to leave as another family was coming down) which will be explored by the Bereavement Services Manager with the Mortuary. 4. The family found it very distressing to be separated from their baby for transfer to GOSH and the local team were commended for their efforts in getting the mother to GOSH the next day after baby died. This has identified the need for a clear pathway for supporting mothers postnatally and getting mothers of antenatally diagnosed VGAM babies across to GOSH postnatally (mothers will have had C/section which creates additional challenges) This is not an isolated action and has been raised with the antenatal VGAM lead [at XXXX] Any pathways identified will in all likelihood be helpful for other families with other diagnoses (not just VGAM) and can be shared more widely once established.
Q3 21/22	GOSH genetics	Genetics team have reflected on the timing of genetics follow up for bereaved families and have already started to provide parents ,as well as baby ,with a follow up appointment with a letter advising families to get in touch and request an earlier appointment if they are planning another pregnancy in the meantime. This is a change from previously when only an appointment for the baby was given and this was cancelled if the baby died, the new process ensures that bereaved parents have an appointment booked for follow up.
Q3 21/22	CICU	The local team were not informed that child had died until they were invited to the CDRM. This will discussed at Risk Action Group. This has been identified as event that has occurred before.
Q3 21/22	NICU/PICU	1. NICU (as opposed to PICU) were included in the discussions prior to transfer to GOSH. Local team found these discussions very helpful. However highlights the need for local teams to be aware of the differences in the two units and for NICU to please include the receiving team (in this case PICU) in these discussions which may be helpful in determining the possible (poor) outcomes prior to transfer to GOSH.
Q3 21/22	Haematology/ Oncology	The team reflected that there is some learning around what happens after death and the importance of identifying the role of the bereavement keyworker in continuing to support these families after death, it was presumed that this fell to the palliative care team. There is a teaching package on when a child dies and after care, and some quality improvement work to look at this process

Learning points identified

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

Quarter of death	Location of learning	Learning /Actions taken
Q3 21/22	SNAPS/PICU	Local team were advised by GOSH to perform rectal washouts but this was outside the nursing and medical skill set and the local team did not feel comfortable to do so. As an action from the CDRM teaching sessions will be facilitated via the North Thames Paediatric Network (NTPN) to be arranged by a GOSH Intensivist
Q3 21/22	PICU	This case identified the need for a clear pathway for getting mothers of antenatally diagnosed VGAM babies across to GOSH postnatally (mothers will have had C/section). Email sent to XXXX VGAM lead to coordinate plan for mothers Although genetic associations are rare and recurrence risk is low important to remind the VGAM/PICU team to send Genetics bloods on admission (was not done in this case. Action: email sent to PICU newsletter as a reminder.

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

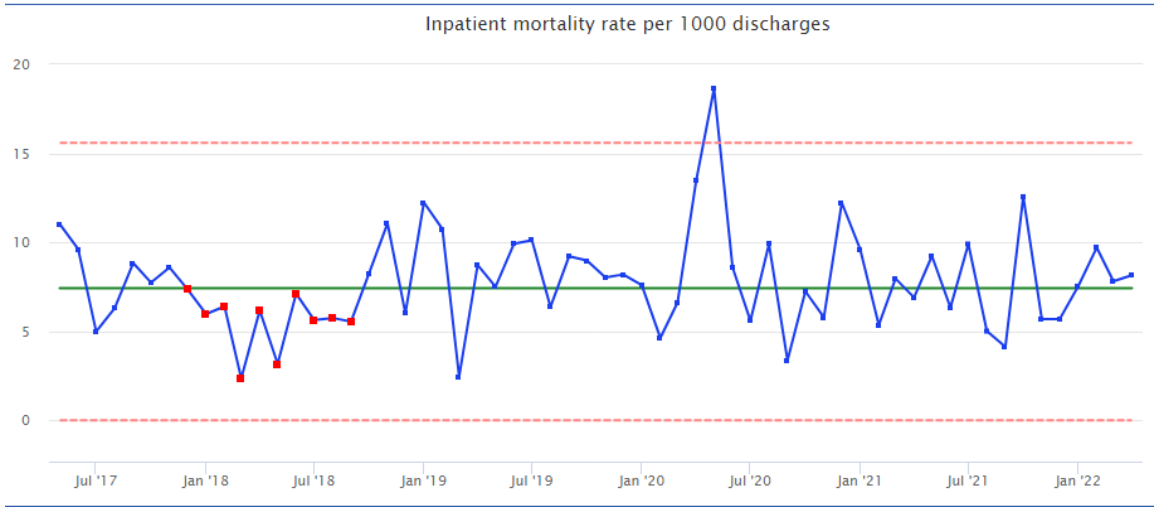
Quarter of death	Specialties	Summary
Q1 21/2	CICU/CATS	The local team were very grateful for the coordinated care and communication provided by the ECMO and CATS teams. This was an extremely unusual and challenging case with a high risk of death, yet the baby was transferred to GOSH, to CT scan and to theatre with a family who wanted everything to be done despite the incredibly high risk and it was an incredible achievement despite the sad outcome.
Q1 21/22	Haematology/Oncology	The community team identified the low platelets and this information was shared by the nursing team to their consultant over the weekend having recognised the significance (high suspicion of myeloid leukaemia with thrombocytopenia in a child with Trisomy 21) which was an example of excellent practice. The local team were able to speak directly with the consultant after the discussions with the registrar were not forthcoming and the local team were highly appreciative that they were able to do so as an example of good communication, escalation and good relationships between the local and the Consultant .This has been fed back as greatly appreciated by the team locally and the family.
Q2 21/22	CICU	Family really appreciated a particular CICU nurse and this was fed back to the individual at the CDRM. The nurse came in specially on an agency shift to accompany this family to the mortuary.
Q2 21/22	NICU	This was a challenging case with no definitive diagnosis despite MDT discussion internationally. Early recognition of palliative care involvement. Parents were very grateful for the care received describing it as "unparalleled" and thanked all those involved. Parents wedding was facilitated on NICU. Excellent relationships between NICU team and family during a long admission. NICU team enabled family to be resident during the last two weeks of life in the rainbow room with their child which was greatly appreciated. Staff have been supported with debriefs facilitated by Psychology. Family Liaison team helped support extended family travel to UK. Parents are being supported by bereavement keyworker, NICU family liaison nurse and continue to be supported fortnightly by Psychology even while they are overseas. Parents have visited the unit and have set up a library in order to support parents with reading to their babies while inpatients.
Q2 21/22	Haematology/Oncology	The family described that they felt 'safe' on Lion Ward at GOSH. Many aspects of excellent care particularly by the Lion team were highlighted with a particular individual [being credited by the family for his care. An action from the CDRM was to feedback this to the individual. Good coordination and communication between local and GOSH, they were regularly updated throughout the child's journey.
Q2 21/22	CICU/CATS	Challenging transfer of a very unstable child via CATS with ECMO team ready and waiting on arrival - very good teamworking. Feedback from ECMO team was supportive of the time on ECMO for the family despite no diagnosis and the team felt supported by the timely seeking of 2nd opinions Staff well supported by the PEERS and psychology debriefs.
Q2 21/22	CICU/Cardiology/CATS	Local team were highly appreciative of the conference call with CICU/Cardiology/CATS coordinated by CATS.(fed back to CATS) Baby was transferred by CATS within 5 hours of birth. Overall good and timely MDT working. Chaplain involved with family support. Excellent team work, timely and smooth use of ECMO.
Q2 21/22	PICU	Excellent consideration of ceilings of care at the time of rapid deterioration, discussed with family who were away and with the transport team.
Q2 21/22	NICU	Good MDT work. Social worker organised grant to enable the parents to take child back abroad for the funeral

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

Quarter of death	Specialties	Summary
Q2 21/22	Respiratory	The Respiratory team attended the local hospital to give an opinion and this was felt to be an example of good practice to share more widely with other clinical teams at GOSH (as it might for others avoid the need to transfer the child to GOSH). This child was extremely complex with a number of medical issues. The care was extremely well coordinated despite difficult interaction with the family. The team worked really hard to get this child home for a few days with a view to enabling family to spend quality time at home. It was really striking how challenging it was for the team but how remarkable and amazing the respiratory medical and nursing teams were in providing care for this child over a very lengthy admission and especially at the end of life
Q2 21/22	PICU/IR	The resuscitation in IR was well run and the PICU and theatre teams worked together really well and provided support for the father around stopping resuscitation. The theatre staff have been supported by the TRIM team (deaths in theatres are unusual). The local team were commended for their efforts in getting the mother across the next day after baby died despite logistical difficulties in airlines accepting mother immediately post C/section and a boat journey was arranged to circumvent this issue.
Q3 21/22	PICU/Neurosurgery	Neurosurgical Consultant was credited for being present in person to examine the child and speak to parents on their arrival despite being out of hours (this has been fed back to the individual involved). The local team appreciated the collaborative working between Neurosurgery/CATS/PICU. Debrief session in collaboration with local and Neurosurgical Consultant to talk through the events will be shared as an example of good practice.
Q3 21/22	CICU	Impressive attempts to try and identify cause of illness with several MDTs and evidently much thought and discussion trying to find out whether there was an underlying cause which could have explained the severity of her presentation. The Bereavement Keyworker was incredibly helpful in ensuring all the right people were invited to attend the CDRM (ambulance etc) in order to be able to answer the family's questions
Q3 21/22	Haematology/Oncology	Discussed in regional and with international colleagues and second opinions sought from UCLH to explore all possible treatment options. The care provided on Lion Ward meant the family felt safe and the child was clearly loved by all the team who attended the CDRM.
Q3 21/22	CICU, cardiology, palliative care, SNAPS	Excellent and continuous communication among CICU, Cardiology, Palliative care, SNAPS
Q3 21/22	PICU	A PICU (adult trained) nurse went in a black taxi to collect mother from XXX to enable her to be with her baby post C/section and for discussions around prognosis with the VGAM team. PICU team facilitated christening prior to redirection of life sustaining treatment.

Mortality rate

The crude mortality rate is within normal variation.



There have been no outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths. This is important as the majority of patient deaths at GOSH are in intensive care areas. Risk adjusted mortality is monitored weekly at the PICU/NICU Morbidity and Mortality meeting. The gold standard for measuring paediatric mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANET) .The most recent PICANET report was published in January 2022 and covers the calendar years 2018-2020. The report shows GOSH PICU/NICU and CICU risk adjusted mortality as within expected range

Attachment Z

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25th May 2022

Safe Nurse Staffing Report for reporting period February & March 2022 **Submitted by: Tracy Luckett, Chief Nurse.** **Prepared by: Marie Boxall, Head of Nursing - Nursing Workforce**	**Paper No: Attachment Z** **□ For information and noting**

Purpose of report

To provide the Board with an overview of the nursing workforce during the months of Feb & March 22 and in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing (2016) and further supplemented in 2018. It provides assurance that arrangements are in place to safely staff the inpatient wards with the right number of nurses with the right skills and at the right time.

Summary of report

- Central recruitment campaigns continue with 11 Newly Registered Nurses (NRNs) in April. 127 NRNs hold conditional offers for Oct 22 with a further 33 in Jan 23, subject to attrition rates.
- The Trust nursing vacancy rate was 3.52% in March 22 and remains below target (10%)
- Voluntary turnover was 13.45% in March and remains below the trust target (14%).
- Nursing sickness rates have reduced to 4.2% in March however remain over trust target (3%).
- Maternity/parenting rates were 4.9% in March and are demonstrating a downward trend.
- CHPPD for 15.84 (Feb) and 14.79 (March).
- There were 23 Datix incidents during this period Feb (4) and March (19) with no reported patient harm. 12 of the incidents reported in March were in O&I directorate and this is under review with action plan in place.

Action required from the meeting

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

Contribution to the delivery of NHS Foundation Trust priorities **□ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** **□ Quality/ corporate/ financial governance** Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.	**Contribution to compliance with the Well Led criteria** **□ Leadership, capacity and capability** **□ Vision and strategy** **□ Culture of high quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance** **□ Accurate data/ information** **□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**

Attachment Z

Strategic risk implications BAF Risk 2: Workforce Sustainability BAF Risk 12: Inconsistent delivery of safe care
Financial implications Already incorporated into 21/22 Directorate budgets.
Implications for legal/ regulatory compliance Safe Staffing
Consultation carried out with individuals/ groups/ committees Nursing Board, Nursing Workforce Assurance Group
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Nurse, Deputy Chief Nurse and Heads of Nursing
Who is accountable for the implementation of the proposal / project? Chief Nurse; Directorate Management Teams
Which management committee will have oversight of the matters covered in this report? People and Education Assurance Committee

Attachment Z
Safe Staffing Report (February and March 2022)

1. Purpose

To provide the Board with an overview of the nursing workforce and align with the National Quality Board (NQB) Standards and Expectations for Safe Staffing (2016) and further supplemented in 2018. It provides assurance that arrangements are in place to safely staff the inpatient wards with the right number of nurses with the right skills and at the right time and is aligned to the Staffing Assurance framework for Winter 2021/22 preparedness guidance. This report covers the reporting period for February and March 2022.

2. Vacancy and Turnover Rates

The Trust nursing vacancy rate increased to 3.52% in March 22 and remains below trust target (10%). Voluntary turnover has remained relatively stable and below the trust target (14%), at 13.45% in March 22.

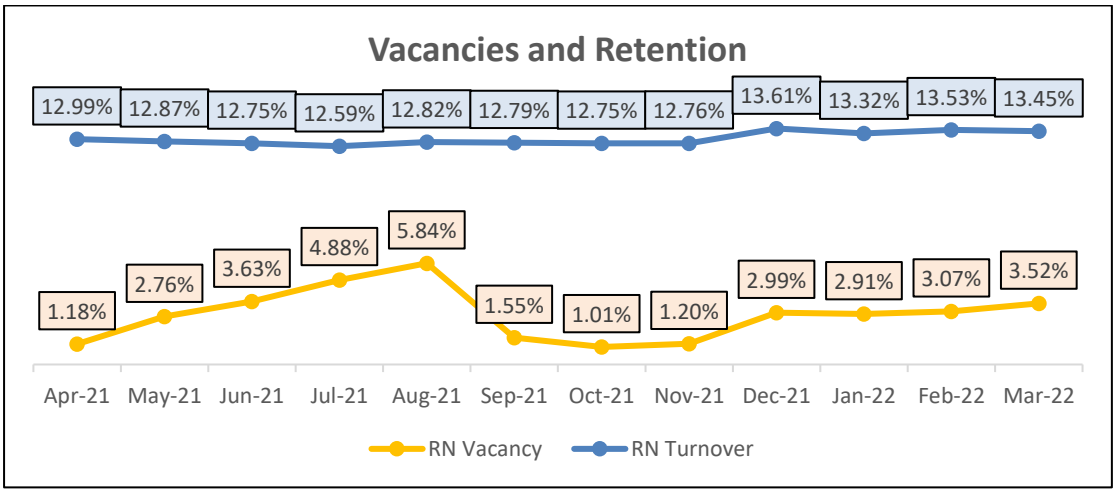


Fig.1 Registered Nurse vacancy and voluntary turnover rate (12-month view)

3. Recruitment

We continue to maintain several centralised recruitment pipelines, which are strategically timed throughout the year to coincided with predictable trends in workforce activity, to ensure the resilience and sustainability. Central recruitment led by the Nursing Workforce Team (NWT), is in addition to local recruitment led by clinical teams for specific roles.

<u>Central Recruitment Pipelines</u>

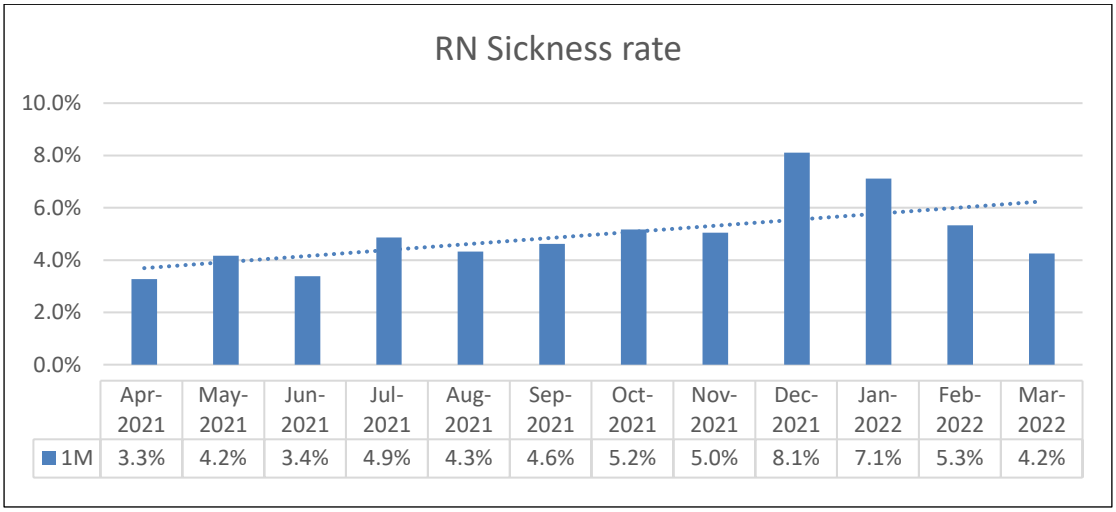
- 11 Newly Registered Nurses (NRNs) commenced employment in April, with a further 127 NRNs holding conditional offers for a planned start date in Oct 22 and 33 NRNs holding conditional offers for a planned start date in Jan 23. This follows a highly successful cost-free virtual recruitment open day in March 22, led by the NWF team. We anticipate an average attrition rate of 20% - 30% on those figures as often NRNs will hold multiple offers before

finally committing to a single offer, however we hope to reduce this rate through early engagement and confirmation of allocations.

- The new international nurse recruitment (IR) campaign in collaboration with the Capital Nurse Consortium commenced in March 22. Nine experienced paediatric critical care and oncology nurses have been recruited and are scheduled to arrive in May (3), July (3) and Sept (3).

2. Staff unavailability

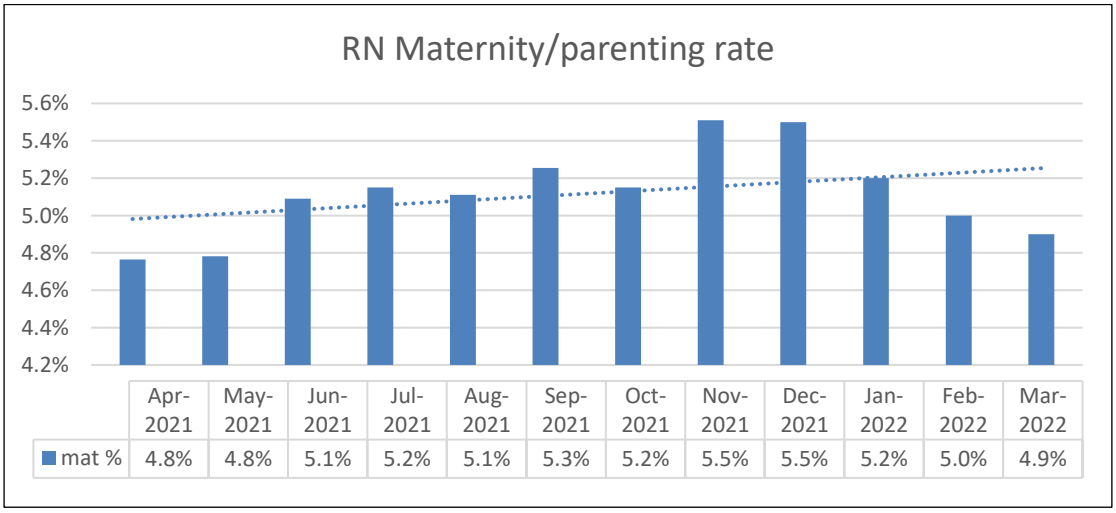
Short term sickness levels reduced over the reporting period to 4.9% in March, however, remains above Trust target (3%).



	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022
1M	3.3%	4.2%	3.4%	4.9%	4.3%	4.6%	5.2%	5.0%	8.1%	7.1%	5.3%	4.2%

Fig. 2 Sickness 12 month rolling trend.

Maternity rates have also reduced to 4.9% in March and are demonstrating a downward trend. Maternity rates at GOSH tend to be higher than our neighbouring trusts driven by the fact we have a predominantly young female workforce in comparison to others.



	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022
mat %	4.8%	4.8%	5.1%	5.2%	5.1%	5.3%	5.2%	5.5%	5.5%	5.2%	5.0%	4.9%

Fig. 3 Maternity/parenting rates 12 month rolling trend.

3. Temporary Staffing

The total shifts requested, excluding shifts requested then subsequently cancelled were 2,327 in Feb and 2,931 in March. This was predominantly driven by sickness, increased patient acuity and high levels of annual leave usage before the end of the financial year. Shift fill rate has improved to 84% in March, filled by our own substantive and/or regular bank nurses, with no external agency usage required during this period.

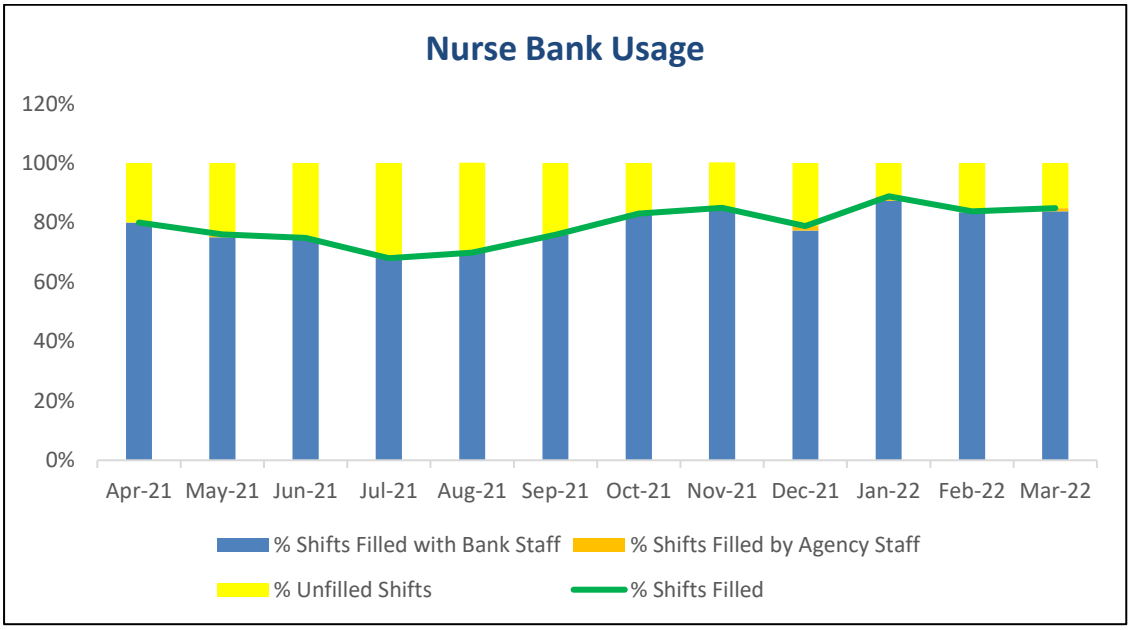


Fig.4 Nurse Bank Usage (12-month view)

4. Care Hours Per Patient Day (CHPPD)

CHPPD is the national principal measure of nursing, midwifery, and healthcare support staff deployment in inpatient settings including ICUs. Alongside clinical quality and safety outcomes measures, CHPPD can be used to identify unwarranted variation and support delivery of high quality, efficient patient care.

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

The reported CHPPD for Feb 2022 was 15.84 including 14.03 RN and 1.81 HCA Hours. In March 2022 the figure was 14.79 in total, including 13.01 RN and 1.78 HCA Hours.

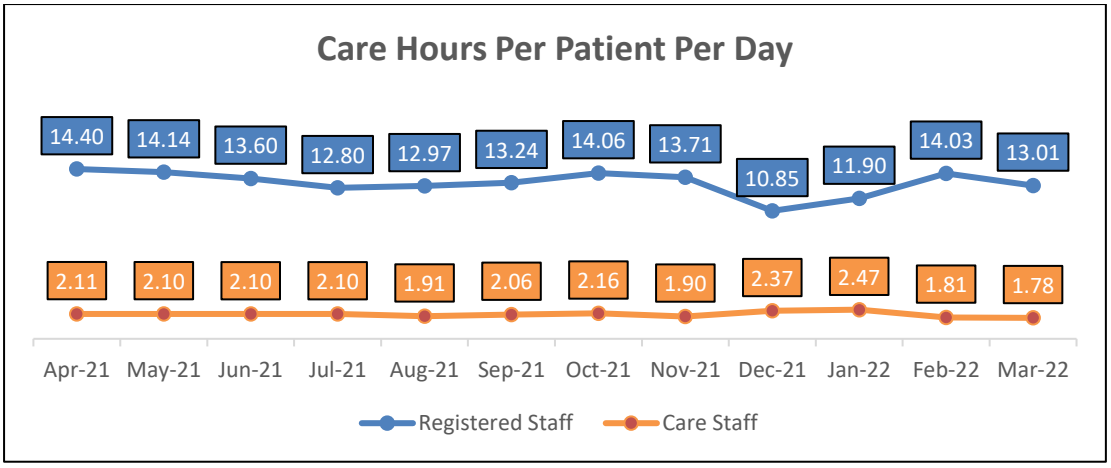


Fig. 5 Care Hours per Day – Breakdown (12-month view)

5. Safe Staffing Incident Reporting

The number of Datix reports in relation to staffing levels were 4 in February and 19 in March. Assurance has been provided by the Directorate Heads of Nursing that no patient harm occurred as a result of any of the incidents. The increase observed in O&I is under review and the senior leadership team have confirmed that this is driven by a number of factors. These include a rise in leavers from the anaesthetics department, concerns regarding skill mix, and staff unavailability attributable to a combination of short- and long-term sickness and parenting leave. An action plan is in place to address these issues. A staff consultation has also taken place with some changes implemented.

Directorate	Feb 22	March 22	Total
BBM	3	2	**5**
BCC	0	2	**2**
H&L	1	2	**3**
O&I	0	12	**12**
S&S	0	1	**1**
Brain	0	0	**0**
R&I	0	0	**0**
I&PC	0	0	**0**

Fig. 6 Datix incidents per directorate

6. Data Cleanse

As part of our continued improvement processes working in collaboration with the Roster Manager, the Head of Nursing (Workforce) is reviewing all roster templates with each of the directorate Heads of Nursing to ensure they are accurate and reflect the actual staffing requirements to deliver a safe service. This exercise has now been completed with the new templates going live in May 22, reporting of accurate 'Actual versus planned' fill rate will resume with the new data reflected in the July Trust board report onwards.

Appendix 1 – Workforce metrics by Directorate
Feb 2022

Directorate	CHPPD (Inc ICUs)	RN Vacancies (FTE)*	RN Vacancies (%)*	Voluntary Turnover* %	Sickness (1 mo) %
Blood, Cells & Cancer	12.0	9.7	4.2%	13.9%	6.2%
Body, Bones & Mind	12.6	-0.1	-0.1%	7.5%	4.5%
Brain	13.1	3.7	2.8%	12.2%	3.8%
Heart & Lung	22.0	-2.2	-0.4%	14.9%	4.0%
International***	15.9	11.8	12.3%	15.2%	6.1%
Operations & Images	N/A	10.6	4.4%	13.4%	5.7%
Sight & Sound	13.4	3.5	4.3%	16.3%	3.6%
Research & Innovation**	N/A	13.9	23.6%	20.5%	6.4%
Trust*	15.8	47.0	3.1%	13.5%	4.7%

March 2022

Directorate	CHPPD (Inc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover* %	Sickness (1 mth) %
Blood, Cells & Cancer	11.2	7.2	3.1%	13.5%	5.6%
Body, Bones & Mind	11.8	3.1	1.6%	8.5%	5.2%
Brain	12.5	5.1	3.8%	11.5%	3.9%
Heart & Lung	20.9	3.7	0.7%	14.6%	3.9%
International***	13.5	13.8	14.3%	13.2%	3.5%
Operations & Images	N/A	6.9	3.1%	12.6%	4.6%
Sight & Sound	13.2	4.1	5.0%	16.9%	4.2%
Research & Innovation**	N/A	12.9	22.0%	22.6%	1.4%
Trust*	14.8	54.4	3.5%	13.4%	4.2%

NB Relates to all RN grades. Trust totals within the narrative may include nursing posts from other directorates e.g. Nursing and Patient Experience, not listed in the tables above.*

***High vacancy rates in R&I are due to reduced activity as staff are recruited based on funded activity as needed and does not pose a risk to patient safety. Recruitment is currently underway.*

****High vacancy rates in International are driven by the reintroduction of the Hedgehog Ward establishment budget however this ward is currently closed with staff redeployed over Butterfly and Bumblebee and does not pose a risk to patient safety.*

Attachment 1

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25th May 2022

Safe Nursing Establishment March 22 **Submitted by: Tracy Luckett, Chief Nurse.** **Prepared by: Marie Boxall, Head of Nursing - Nursing Workforce**	**Paper No: Attachment 1** ☐ **For assurance**

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

Summary of report

- The review found that reconfiguration of the existing workforce must be considered to ensure staffing establishments are safe as this is currently being mitigated using temporary staffing, reduced bed base and limiting some activity.
- Discrepancies in budgeted establishments for BBM, BCC and O&I to be rectified.
- Consideration of the additional need to support a 'Green pathway' on Eagle Ward.
- Review of roster templates to ensure effective use of nursing resource during peak activity.
- The assurance process is compliant with the Developing Workforce Safeguards guidance (NHSE/I 2018)

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

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
☐ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** ☐ **Quality/ corporate/ financial governance** Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.	☐ **Leadership, capacity and capability** ☐ **Vision and strategy** ☐ **Culture of high quality sustainable care** ☐ **Responsibilities, roles and accountability** ☐ **Effective processes, managing risk and performance** ☐ **Accurate data/ information** ☐ **Engagement of public, staff, external partners** ☐ **Robust systems for learning, continuous improvement and innovation**

Strategic risk implications
BAF Risk 2: Workforce Sustainability
BAF Risk 12: Inconsistent delivery of safe care

Financial implications
Already incorporated into 21/22 Directorate budgets.

Attachment 1

Implications for legal/ regulatory compliance Safe Staffing
Consultation carried out with individuals/ groups/ committees Nursing Board, Nursing Workforce Assurance Group
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Nurse, Director of Nursing and Heads of Nursing
Who is accountable for the implementation of the proposal / project? Chief Nurse; Directorate Management Teams
Which management committee will have oversight of the matters covered in this report? People and Education Assurance Committee

Purpose

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

Introduction

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

The NQB guidance states that providers:

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

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

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

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

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

Methodology for Calculating Nursing Numbers

The Children's & Young People's Safer Nursing Care Tool (C&YP SNCT), has been fully implemented across all inpatient services within the trust with the most recent collection of data gathered over a 4-week period in Jan/Feb. The C&YP SNCT is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013 which has been used successfully in many organisations. It has been developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing in Children's and Young People's in-patient wards. The tool, when used with key data such as Nurse Sensitive Indicators (NSIs) and Red Flag Events (NICE 2014), is a reliable evidence-based method to determine safe staffing establishments. Professional judgement must be applied if using on a ward with 12 beds or less to ensure safe staffing levels on a 24/7

basis and applies to a large proportion of our wards. Day case units and outpatient departments rely on professional judgement as no validated tool currently exists.

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

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

- Data on the existing budgeted staffing establishment
- Bed base including HDU bed numbers/Telemetry beds
- Safer Nursing Care Tool (SNCT) calculations for guidance based on patient acuity
- Calculations based on national guidance for that specialism e.g., Association for Perioperative Practice (AfPP), Paediatric Intensive Care Standards (PICS),
- Registered/unregistered nursing workforce skill mix proportions
- Variance between data sets and recommended numbers
- Overview of Datix incidents reported since the last review, to identify any themes, trends, or areas of concern.
- Quality metrics
- Patient & family feedback including complaints
- Roster management
- Temporary Staff usage
- Professional Judgement (as determined by HoNs and clinical teams)

Staffing Establishments

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

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

The overarching assurance required is -

- The directorate nursing establishments are safe for the current funded bed base.
- The directorate nursing establishment is correct

Review outcomes

The review found that current establishments are safe. However, with increasing acuity and challenges with skill mix some areas will need to consider reconfiguration of their workforce to maintain quality and safety. Individual directorates are outlined as follows:

Sight and Sound (S&S) – The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Panther ENT** The current staffing establishment was safe and provides care for 2 HDU beds, however if the number of HDU beds were to increase the establishment would need to be reviewed to support this.
- **Panther Urology** The current staffing establishment was safe and provides care for 2 HDU beds, however if the number of HDU beds were to increase the establishment would need to be reviewed to support this. Both wards have merged on occasions to maintain safe staffing levels and improve skill mix.
- **Outpatients** The current staffing establishment was safe, however the skill mix is under review due the challenges of delivering services across four sites.

Body, Bones and Mind (BBM) – The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Squirrel Gastro** The staffing establishment is safe based on the funded bed base.
- **Chameleon** Once corrected the staffing establishment (42.2 WTE) is safe based on funded beds and reduced weekend activity. Increased unplanned weekend activity has been mitigated through use of temporary staffing, and if this activity is maintained will need to be reflected in the establishment.
- **Eagle** To maintain a 'Green Pathway' for transplant patients' 2 WTE additional staff are required. This is currently mitigated through temporary staffing usage.
- **Sky Ward** The staffing establishment is safe based on pre-pandemic activity however this speciality is experiencing growing backlogs, with greater complexity and increasing acuity of patients with additional mental health needs. Based on professional judgement and to maintain activity, an increase of 2 WTE will support safe staffing levels.
- **Mildred Creek Unit (MCU)** The staffing establishment is safe based on the current bed base and unit location. However, if the unit relocates the establishment will need to be reviewed to reflect the changes in nursing needs because of an altered physical environment.

Brain - The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Koala** The current staffing establishments are safe and aligns with national staffing recommendations including telemetry, HDU and SNCT score.
- **Possum Ward** was closed at the time of the review and scoring exercise.
- **RANU (Alligator)** – The current staffing establishment is safe
- **Squirrel Endo-met** – The current staffing establishments are safe based on the existing bed base. Skill mix was highlighted as a concern and plans discussed to provide additional educational support.
- **Kingfisher** – The current staffing establishment is safe.

International and Private Care (I&PC) - SNCT scoring is designed for NHS activity rather than private experience and expectations. Professional judgement is therefore applied to reflect additional challenges such as cultural differences, language barriers and service user expectation, which impact on direct and indirect care in this area. The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Butterfly** The current staffing establishments are safe.
- **Bumblebee** The current staffing establishments are safe. The existing Hedgehog nursing staff have been incorporated into the Bumblebee workforce.
- **Hedgehog** Ward is currently closed.

Blood, Cells and Cancer (BCC) – The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Lion, Giraffe and Elephant –** The current staffing establishments are safe and due to the small sizes of these wards, nurses are deployed, and patient acuity distributed to maintain safety with cross cover from ward managers as required.
- **Pelican (inpatient)** and **Pelican (ambulatory)**. Once corrected the staffing establishment (27 WTE) is safe based on the funded bed base and ambulatory activity. The SNCT scoring demonstrates an increasing trajectory in the patient acuity.
- **Fox** and **Robin** The current staffing establishments are safe.
- **Safari** As a day case unit the current staffing levels were safe however once the ward is split across two sites and relocated on Cheetah this will require additional nursing resource and a review of establishment needed.

Heart & Lung (H&L) – The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Bear** The current establishments are safe however we continue to observe increasing patient acuity. As a large ward with the additional challenge of single cubicles and a junior skill mix, a review of the current workforce design is required to support increasing activity while maintaining quality and safety.
- **Leopard** The current staffing establishments are safe.
- **Kangaroo** The current staffing establishments are safe.
- **Intensive Care Units – NICU, Flamingo (CICU), PICU**
  The current establishments are safe based on the funded bed base. The establishments for PICU and CICU are slightly lower than the recommended national critical care guidance (which includes a 25% headroom, compared to the GOSH standard of 22%) and are not determined by SNCT scoring.

Operations and Imaging (O&I) – AfPP guidance and professional judgement is used to determine recommended staffing establishments in theatres, SNCT is not applicable. A workforce consultation is currently underway. The Directorate HoN in discussion with the clinical teams confirmed the following:

Interventional Radiology Based on professional judgement the current establishment is not safe due to the challenges of the physical environment, increasing the risk when working in isolation. This is currently being mitigated through use of temporary staffing and reduced activity.

Scrub Based on AfPP recommendations and existing activity levels, the directorate HoN has indicated that the current establishment needs to be increased by 6 WTE to maintain safety and reduce reliance on temporary staffing.

Anaesthetics Based on professional judgement the current establishments are not safe due to the challenges of the physical environment and increasing complexity of cases. A dedicated piece of work is currently underway to address a number of issues in this department including training, recruitment and changing working practices.

Recovery The current staffing establishment is safe.

APOA The current staffing establishment is safe.

Conclusion

The review found that reconfiguration of the existing workforce must be considered to ensure staffing establishments are safe as this is currently being mitigated using temporary staffing, reduced bed base and limiting some activity. As activity and acuity continue to increase and if new services are added, establishments in those areas will need to be reviewed and adjusted accordingly. The assurance process is compliant with Developing Workforce Safeguards guidance (NHSE/I 2018) and will continue to evolve and improve through triangulation of data and intelligence.

Recommendations from the previous report

1. To achieve improved the triangulation methodology of Nurse Sensitive Indicators with the implementation of the Ward Accreditation scheme – **Pending full implementation of Ward Accreditation**
2. Deep dive review in to the BBM directorate nursing establishment – **Completed**
3. Focused review of patient acuity on Bear Ward - **Completed**
4. Focused review of patient acuity and nursing establishment once Pelican relocates to single site – **Completed as part of this review**
5. O&I to conduct a review of current establishments with an emphasis on ensuring the right people with the right skills are in the right place – **Currently underway**

Recommendations ahead of next review

1. For the HoNs to consider reviewing existing workforce configurations to ensure the right staff with the right skills are in the right place at the right time.
2. Discrepancies in budgeted establishments for BBM, BCC and O&I to be rectified.
3. Consideration of the additional need to support a ‘Green pathway’ on Eagle Ward.
4. Review of roster templates to ensure effective use of nursing resource during peak activity.
5. Progress a further analysis of current establishments using benchmarking data from other children’s hospitals, incorporating skill mix and remodelling of roles.

Attachment 2

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25 May 2022

The Ockenden Report – summary of findings, considerations and actions at Great Ormond Street Hospital **Submitted by:** **Claire Harrison, Director of Safety Surveillance** **Presented by Dr Sanjiv Sharma, Medical Director**	**Paper No: Attachment 2** ☐ **For discussion** ☐ **For information and noting**

Purpose of report:
This paper summarises the findings of the Ockenden report 'Findings, Conclusions, and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust' and seeks to provide the Board with assurance in relation to the report's 75 recommendations and actions in their widest application beyond a Maternity setting.

Summary of report:
A summary of current actions, arrangements and processes in place or planned to mitigate the concerns identified by the report is provided, to give detailed assurance of suitable and appropriate mitigations under each of the major themes:

- Safe staffing levels – medical and nursing
- A well-trained workforce
- External and internal review – challenge and assurance
- Learning from incidents
- Listening to families

Further themes identified within these relate to support for staff, escalation of concerns, speaking up and psychological safety, culture and leadership, using audit to improve processes and safety, and specific recommendations for Neonatal care, which is clearly relevant to GOSH. The comprehensive work and processes already effective and in place, in addition to actions in development and planned for implementation, should provide assurance that the risks of similar events arising as reviewed by the Ockenden report, are well mitigated. Further assurance may be monitored by way of future reports to QSEAC.

Action required from the meeting:
The Board is asked to note the comprehensive assurance provided and considerable work underway, as well as further work planned, to address the themes in the report.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
☐ **PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes**	**x Leadership, capacity and capability** **x Vision and strategy** **x Culture of high-quality sustainable care** **☐ Responsibilities, roles and accountability** **x Effective processes, managing risk and performance** **☐ Accurate data/ information**

Attachment 2

	□ Engagement of public, staff, external partners x Robust systems for learning, continuous improvement, and innovation
Strategic risk implications: The contents within this paper link to BAF 12 in relation to quality and safety delivery.	
Financial implications: There are no direct financial implications.	
Implications for legal/ regulatory compliance The contents of this paper currently have no implications currently for legal or regulatory compliance.	
Consultation carried out with individuals/ groups/ committees Non-Applicable.	
Who is responsible for implementing the proposals / project and anticipated timescales? Director of Safety Surveillance, Head of Patient Safety, Head of Legal Services, Head of Patient Experience and Engagement.	
Who is accountable for the implementation of the proposal / project? Medical Director, Associate Medical Director for Safety and Resuscitation, Deputy Medical Director and Chief Nurse.	
Which management committee will have oversight of the matters covered in this report? Quality, Safety and Experience Assurance Committee, Patient Safety Outcomes Committee and Patient and Family Experience and Engagement Committee	

The Ockenden Report – summary of findings, considerations and actions at Great Ormond Street Hospital

Document Information	
Status	Final
Author	Claire Harrison, Director of Safety Surveillance
Directorate Area	MDO

Introduction:

This paper summarises the findings of the Ockenden report 'Findings, Conclusions, and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust', published on 30 March 2022. The paper identifies themes from the findings, and recommendations of relevance or application to Great Ormond Street Hospital. A summary of actions, arrangements and processes in place or planned to mitigate the concerns identified by the report, regardless of the report's maternity focus, is provided, to give detailed assurance of suitable and appropriate mitigations.

1 Origin of the report and vital statistics

An independent review of maternity services at Shrewsbury & Telford NHS Trust, commissioned in summer 2017 by then Secretary of State for Health Jeremy Hunt, following actions and efforts of two bereaved families, initially looking at 23 'cases of concern'. The report was led by senior midwife Donna Ockenden, in collaboration with a huge multidisciplinary/professional team incorporating obstetricians (more than 20), midwives (more than 25), neonatologists (20), paediatricians (3), anaesthetists(3), intensivists (2), a neurologist and cardiologist, representatives of charities/support groups (15), administrators, HR/Employment law advisor, with communications, legal, finance and IT support. Time to publication was inevitably affected by the pandemic as well as logistics of documentation review.

The report is huge in scale and scope. It reviews the care of 1468 families in the period 2000-2019. It considers 1592 clinical incidents (some families had multiple incidents) with the earliest case from 1973 and the most recent from 2020. A further 170 families from pre-2000 and 15 families from post-2019 were included with agreement from NHSE/I. Families were offered support through psychological support services, Listening Ear, SANDS, Bereavement Training International, Child Bereavement UK and others. The review team interviewed 60 current and former members of staff. 84 staff completed a questionnaire - some subsequently withdrew their participation, so those voices were "lost".

2 The report identifies three overarching themes in the findings

i. Patterns of repeated poor care
ii. Repeated errors in care leading to injury

iii. Failures in governance and leadership

3 The report identifies a further group of issues contributing to those themes

i. Safe staffing levels
ii. A well-trained workforce
iii. External and internal review – challenge and assurance
iv. Learning from incidents
v. Listening to families

4 Recommendations from the report for GOSH to consider as actions

The review undertaken for this paper has identified groups of findings from the 75 recommended actions (locally-applied and beyond). While many of the recommendations related to specific aspects of maternity care delivery and staffing, from these, many can be extrapolated to be relevant to other specialties.

4.1 Improving management of patient safety incidents

- Appropriate harm grading
- Allocation of dedicated time and resource for investigations, multi-professional team NOT a single individual or profession
- Individuals involved in incident should not investigate
- Escalation of overdue SIs to Board
- Three yearly training for governance teams
- Adherence to HSIB guidelines for report accessibility
- Learning to inform delivery of local MDT training plan
- Needs of those affected are primary concern - families to be invited and encouraged to be part of investigations

4.2 Support for staff

- Process to ensure investigation of all safety concerns raised by staff, with feedback
- Staff supported during investigations and consider employing a clinical psychologist

4.3 Best practice in complaints handling

- Empathetic and kind complaint responses. Patient groups involved in design and implementation of relevant, appropriate response template
- Complaints themes and trends monitored and actions shared with families
- Training in complaints handling
- Ensure that complaints which meet SI threshold are investigated as such.

4.4 Audit and guidelines to support improvements in practice

- Multidisciplinary audit meetings; all staff groups actively encouraged to attend
- Actions arising from SIs involving change in practice to be audited to ensure change has occurred within 6 months. Monitoring of actions by governance team

- Audits demonstrate systematic review against national/local standards ensuring recommendations address the identified deficiencies
- Matters arising from clinical incidents must contribute to annual audit plan
- Co-leads for developing guidelines
- Ensure guidelines are up-to-date and amended in line with new national guidelines

4.5 Escalating concerns, leadership and culture

- Escalating concerns: clear line of communication to supervising consultant at all times. Consultant support and on call availability 24/7.
- Leadership and culture: senior clinicians including nurses must receive training in civility, human factors and leadership.
- All clinicians work towards establishing compassionate culture where staff learn together rather than apportioning blame.
- Staff encouraged to speak out when they have concerns about safe care.
- Mechanisms to support the emotional and psychological needs of staff, at individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.

4.6 Safer staffing

- Clear escalation and mitigation policy where staffing falls below the minimum staffing levels for all health professionals.
- Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, minimum staffing levels include a locally calculated uplift, representative of three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.

4.7 Training

- Robust preceptorship programme
- Succession planning gap analysis of all leadership and management roles to include supportive organisational processes and relevant practical work experience.
- Multidisciplinary team attend regular joint training, governance and audit events. Allocated time in job plans to ensure attendance, which is monitored.
- Multidisciplinary training must integrate local handover tools into teaching.
- Annual human factors training for all staff to include principles of psychological safety and civility in the workplace, ensuring staff are enabled to escalate clinical concerns.
- Regular multidisciplinary skills drills and on-site training for managing emergencies
- Lessons from clinical incidents inform delivery of local multidisciplinary training plan.

4.8 Escalation and accountability

- Staff able to escalate concerns so units are staffed by suitably-trained staff at all times. Clear guidelines for non-resident consultant attendance.
- Where middle grade or trainee doctors manage without direct consultant presence, an assurance mechanism to ensure trainee competence for role.

- Compassionate, individualised, high quality bereavement care for families experiencing perinatal loss, using guidance such as National Bereavement Care Pathway. System to ensure that families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.

4.9 Neonatal care

- Clear pathways for provision of neonatal care
- Recommendations endorsed from Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop workforce and enhance experience of families.
- Neonatal Operational Delivery Networks must ensure that staff in provider units have opportunities to share best practice and education to prevent units operating in isolation from local network. For example, senior medical, ANNP and nursing staff must have opportunities for secondment to other network units to maintain clinical expertise and avoid working in isolation.
- Each network must report to commissioners annually its measures in place to prevent units from working in isolation
- Neonatal providers must define processes which enable telephone advice and instructions where needed during neonatal resuscitations. When anticipated that a consultant is not immediately available (eg out of hours), mechanism for real-time dialogue directly between consultant and resuscitating team if required
- Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national specifications.

4.10 The role of external and internal reviews – challenge and scrutiny

The report does not make explicit recommendations in respect external or invited reviews, internal reviews, the role of Royal Colleges and regulators, or other potential challenge in the surrounding healthcare system. Clearly there is potential for messages to be lost in the wider healthcare system; oversight mechanisms and bodies should distinguish between reassurance and assurance in respect of safety, experience and governance.

5 How is GOSH addressing these recommendations?

To provide assurance, leads and subject matter expert for each of the key themes have provided detailed information to give assurance of the existence, or plans for, actions and processes which address the recommendations in the report in as much they can be applied to GOSH.

Actions already underway, in place and effective are indicated ✓.

Actions yet to be fully developed, or opportunities for action, are indicated as ➢

- **May:** Grand Round presentation of Ockenden report by Safety Surveillance, team, Education for Patient Safety and two Associate Medical Directors: what it is, could it happen here, what does this mean to you, how safe do you feel, psychological safety and a positive culture, participant engagement (use of polls to answer questions)

5.1 Learning from incidents

5.1.1 Management of patient safety incidents

- ✓ Well-resourced Patient Safety Team supported by an Associate Medical Director and indirectly, the Director of Safety Surveillance as part of wider MDO team.
- ✓ Active system of identifying incidents of concern through daily incident review, weekly safety meeting, incident review meetings for more serious concerns – MDT input
- ✓ All completed SIs reviewed by NHSE. Duty of Candour for 'phase 3' sharing the findings.
- ✓ Regular MDT Child Death Overview Panels with documented outcomes.
- ✓ Root Cause Analysis training with four cohorts to date
- ➢ Safety Transformation programme under development with MDO to capture themes here and align with the wider programme under its core workstreams, also taking into account recommendations of the Verita report. Work continuing in relation to our partnership with Patient Safety Learning, co-designing development programme for the Patient Safety Team over the next twelve months.
- ➢ Quality Governance Management Framework launching featuring changes in the way information and data is presented across the Trust; will ensure that most appropriate information is presented to the right forum to facilitate discussion and provide assurance and escalation where required. QSEAC will be presented with themes and implications of incidents and complaints at each meeting through the Quality and Safety metrics.
- ➢ Further work underway to review both the quality and safety strategies and to ensure that key metrics and associated actions are aligned within the new framework.
- ➢ National Patient Safety Strategy rolling out 2022 – 2023 with Patient Safety Incident Response Framework, Learn from Patient Safety Events and inception of Patient Safety Partners to support high quality, targeted investigation and other learning approaches

5.1.2 Audit and guidelines to support improvements in practice

- ✓ Head of Quality in post, opportunity for quality framework including annual audit plan with specific detail to reflect the findings from investigations, learning and SI actions
- ✓ Quality measured through clinical outcomes, clinical audit, and patient safety experience indicators to encourage continuous improvement in safety and quality and establish mechanisms for recording and benchmarking clinical outcomes.
- ✓ Clinical Audit at GOSH supports the Quality framework outlined in the Trust Quality Strategy ("doing the right thing")
- ✓ Audits support learning from incidents, risk, patient complaints, and to investigate areas for improvement in both quality and safety.

- ✓ In addition to priority clinical audit plan, support clinical teams to engage in clinical audit to review and assess quality of care and identify improvements
- ✓ Systems and processes to monitor mortality, highlight positive practice and identify learning to improve quality, the co-ordination of care, or patient and family experience.
- ✓ Implementation of Child Death Review Statutory Guidance (statutory NHS requirements for child death reviews for all child deaths occurring after 29th September 2019 - multi-disciplinary Child Death Review Meeting (CDRM) where child's death is discussed by professionals directly involved in care during life and investigation after death. At GOSH a Medical Lead for Child Death Reviews is supported by a Child Death Review Coordinator. Assistance with data analysis and reporting from Clinical Audit Manager.
- ➢ Quality Improvement specialists at GOSH support, enable and empower teams to continuously improve quality of care across GOSH - will be assigned to work with individual Directorates in Business Partner capacity through an integrated Quality Improvement Programme.
- ➢ GOSH nursing team (with support from the Quality Improvement team) has developed a Ward Accreditation Programme: structured method for self and peer review of ward processes which we hope to test, refine and roll out over the next 12 months. Programme will be aligned to other quality assurance processes, triangulating different sources of data to highlight areas for improvement.
- ➢ New Quality Review Group will be part responsible for review of actions six months post completion to ascertain whether actions are embedded
- ➢ Review of Guidelines management underway

5.2 Listening to families - best practice in complaints handling

- ✓ Complaints team endeavour to speak to all complainants, to better understand their concerns, explain process, explore any adjustments required or support needed during process, and signpost other support including advocacy services, AvMA, GOSH Bereavement Services (where appropriate) and others.
- ✓ Families involved in agreeing scope of investigation/terms of reference of reviews.
- ✓ Complaints team also work with families to understand outcomes they are seeking and explain pathways within the hospital to resolve concerns.
- ✓ All complaints risk assessed on receipt, any potential patient safety or risks issues identified by Complaints team are flagged to Patient Safety team to determine if they have been reported as incidents and any further action required from safety perspective.
- ✓ Complaints assessed as high risk reviewed to determine if they meet SI criteria
- ✓ Complaints subject to comprehensive and robust review with sign off by directorate senior management, Complaints team, Chief Nurse and Chief Executive. Reviews ensure concerns addressed in clear, transparent, evidence-based and compassionate way
- ✓ Guidance in Trust Complaints Policy and complaints training supports and highlights importance of empathetic and kind responses.
- ✓ Where applicable, complaint responses detail actions to address issues and learn
- ✓ Completion of actions monitored by Complaints team and reported via PFEEC.
- ✓ Learning from complaints reviewed regularly with Clinical Audit Manager to identify where audits can offer further assurance

- ✓ All families contacted to determine how they would like to receive their complaint response and all responses offer a meeting with relevant staff as well as signposting PHSO as final stage in NHS Complaints process.
- ✓ For "Red" complaints, families contacted six months after complaint response to update on actions completed in response to complaint and how we have learned from this.
- ✓ Complaints training delayed during COVID but will resume and meanwhile ad hoc training sessions, weekly complaints surgeries, and 1-1 support offered to staff investigating complaints to ensure that responses meet Trust's expectations (which incorporate principles of good complaints management including PHSO guidance) around content and tone.
- ✓ Complaints themes and trends reviewed and monitored through PFEEC and QSEAC via the IQR, Patient Experience Overview report and Annual Complaints Report.
- ✓ All complainants sent survey requesting anonymous feedback on process and areas for improvement. Whilst feedback received is low, it informs changes to process.
- ✓ Reopened complaints and referrals to PHSO monitored through PFEEC along with learning from PHSO investigations
- ➢ Patient involvement in review of complaint responses/templates
- ➢ Complaint response timeframes being incorporated into IQR Patient Experience Metrics to be monitored via PFEEC and QSEAC.
- ➢ Additional training and wider shared learning from complaints
- ➢ Some principles of new PHSO Complaint Standards already part of process, will be explicitly referenced in Complaints Policy (for review June 2022).
- ➢ Work to look at whether actions arising from complaints have resulted in long term change including family engagement to obtain feedback on changes made.

5.3 Safe staffing levels

5.3.1 Nursing staffing

- ✓ Operational measures: twice daily (AM and PM) meeting chaired by HoNs to assess daily staffing levels, with mitigations to address shortfalls through either internal redeployment, or use of temporary staffing measures (Bank) or bed closures. Outcomes fed to situational meeting (twice daily)
- ✓ Use of Shelford Group Children and Young Person's Safer Nursing Care tool (NHSE/I recommended tool) to measure acuity
- ✓ Monthly nursing workforce assurance group. Review of workforce metrics and incidents in relation to safe staffing and patient harm to identify themes and trends and request further information with actions if relevant. Temporary staff usage analysed for correlation with patient care and safety – most temporary staff needs met by GOSH substantive staff doing extra work or regular Bank staff (almost no agency).
- ✓ Care Hours Per Patient Per Day (CHPPPD) benchmarking metric recommended by Carter review > high levels of care hours delivered
- ✓ Safer Nursing Care Policy with escalation process for areas with sub-optimal staffing
- ✓ Future roster availability assessed to anticipate gaps and shortfalls eg planned leave (Maternity, annual leave) to put in capacity and address unplanned sickness
- ✓ Bi-monthly Safe Staffing report goes to Trust Board – via Nursing Board, PEAC and EMT

- ✓ Bi-annual staffing establishment review – regulatory and contractual requirement using evidence-based tool triangulated against professional judgement and quality indicators
- ✓ Vacancy rates 3.1% currently vs target of 10%, turnover below 14% target, currently 13%.

5.3.2 Medical staffing

No national benchmark for what 'safe' looks like for paediatric medical (including 'surgical') workforce (apart from PICs for PICU). In October 2020 MDO asked *'how many doctors with what capabilities, do we need to provide safe, timely and effective care for our patients?'* Recommendations for three different clinical scenarios, three tiers identified:

1. Staffing of wards by day, Monday to Friday – medical ward team
2. Staffing to maintain wards by day weekends and public holidays – weekend medical ward team
3. Medical staffing for hospital by day and night –medical team on call

   Tier 1: competent clinical decision maker – capable of assessing patient

   Tier 2: senior clinical decision maker – 'medical registrars' – capable of prompt clinical diagnosis and identifying need for specific investigations and treatments

   Tier 3: expert clinical decision makers – consultants - overall responsibility for care

- ✓ Model recognises tasks and duties previously domain of consultants and doctors in training now undertaken by non-medical personnel (Tier 1). Considerations used when estimating minimum medical workforce numbers included:
- ✓ Services to identify staffing numbers in scenario 1; Medical Workforce Leads determined numbers on some specialised medical services on joint rotas.
- ✓ In interests of safety, staffing calculations based on 80% of maximum activity. 30-70% of medical staff time spent on indirect patient care, external patient coordination, leadership and management of care.
- ✓ Workforce numbers for consultants included estimates based on running core clinical service. Includes continuing current levels of urgent and 'elective' work.
- ✓ Clear lines of accountability and escalation processes
- ✓ GOSH has not experienced a speciality without safe consultant cover – even during COVID all specialities ensured 24/7 consultant supervision available, reducing less urgent work volume, day and night cover rather than 24 hour model
- ✓ ER system to flag 'immediate safety concerns'. Only one ER related to not being able to access a consultant OOH (switchboard failure): managed by Clinical Site Practitioners
- ✓ Dashboard metrics linked to health roster to increase awareness of safe medical staffing numbers/ flag concerns – rota coordinators work to minimum numbers identified
- ✓ If medical staffing numbers fall below minimum - local and trustwide contingency plans activated to manage and prioritise patient safety and workflow – since March 2020, medical workforce leads link staffing to clinical situational awareness.
- ✓ Regular review of estimated minimum safety numbers to gather knowledge and evidence; adapted using exception reporting and scrutinising bank spend. High volume daytime spend in surgical SHO rotas identified risk of falling below minimum on regular basis – information used to support business case.
- ✓ Used minimum numbers to model rotas – ensuring staffing on each establishment does not fall below minimum. Where required, cross cover to maintain safe staffing

- ➢ If numbers fall below consistently this will be identified in weekly meetings and action plans established. Rota coordinators will contact rota leads to flag problems early
- ➢ Deep understanding of medical establishments but no accurate real time data for highly accurate clinical situational assessment. Working with HR/ Finance/ data analytics to create 'smart' dashboard.

5.4 A well trained workforce

- ✓ GOSH Learning Academy
- ✓ Strong governance process with dashboards/monitoring KPIS and targets to provide assurance, reporting up to Trust Board via PEAC, monthly steering group and bi-monthly programme board, quarterly into PEAC, exception reports
- ✓ Recognition of 'latent error' through Datix reporting > full team "rehearsals" through simulation, to instigate learning immediately - Simulation team reporting to PSOC
- ✓ Use of Safety CODE (part of induction training for all staff)
- ✓ Simulation courses focus on Human Factors, Psychological Safety, Navigating Ambiguity in Healthcare, Raising Concerns, Professional Conversations, Speaking Up
- ✓ Academic module for Caring for the Neonate in a ward environment
- ✓ Capital Nurse kitemarked 1 year preceptorship programme for all nursing professionals – preceptorship programme for AHP has commenced
- ✓ Simulation team includes a psychologist (one of first in country)
- ✓ Skills training through mandatory training – overall compliance monitored by HR/OD and reported to People Planet
- ✓ 'Just in Time' training for potential deterioration with intensive prep for management
- ✓ All in-situ simulation training multi-professional in all areas, eg major haemorrhage in Theatres, full ECMO training, in situ in cardiac unit
- ✓ Head of Education for Patient Safety in post supporting learning and addressing training needs - sharing and embedding learning to improve clinical practice is key objective
- ➢ Deputy Chiefs of Service have remit around Patient Safety; working to develop bespoke education programme for skills for high level patient safety and to conduct investigations in addition to duties around Duty of Candour
- ➢ GOSH commitment to culture of learning especially from events with life-changing impact on families
- ➢ Training in human factors and safety investigation for certain groups of staff
- ➢ Patient Safety syllabus to become mandatory for all staff
- ➢ In line with National Patient Safety Strategy, working to develop the professionalisation of Patient Safety Team through a programme to develop expertise, skills and knowledge in patient safety, so they are professionals in their own right
- ➢ Introducing professional Nurse Advocacy programme - part of clinical restorative supervision
- ➢ Opportunity to better structure transfer of lessons from investigations into training eg Simulation
- ➢ Scoping underway for human factors project focussing on 'How GOSH learns from patient safety incidents and embeds learning to support change in clinical practice' (details still being developed)

5.5 Accountability and support for families; Speaking up, Psychological Safety and a strong safety Culture; Escalating concerns, leadership and culture, support for staff

*** Bereavement services manager worked with the West Mercia Police family liaison team who are carrying out Operation Lincoln following the Ockenden report, to guide them through various types of support and recommendations of charities supporting baby loss. These links are from a network at the Metropolitan police of which manager is member***

- ✓ GOSH has own Bereavement pathway and influenced conception of national bereavement care pathway developed for maternity/neonatal service by SANDs. Recognised that children's hospitals have own bereavement standards which GOSH co-wrote as active members of national Children's Hospital Bereavement network
- ✓ Bereavement team providing support to families. Medical follow up offered 6-8 weeks post or when family ready. Often bereavement key worker guides timing with family. Memory work offered ie remembrance photography, hand/footprints and memory kits
- ✓ Team works closely with national Child Death Helpline (CDH) and signposts families as required. GOSH jointly manages CDH; part of bereavement packs offered to all families with information around further support. Includes NHS' When a Child Dies ' explaining Child Death Review process
- ✓ Role of Bereavement key worker for families, also involved in CDRP. First Bereavement keywork supervision
- ✓ Bereavement parent survey - going digital from paper copy. Thematic review of areas of learning across the trust
- ✓ Cards sent on 1st and 2nd anniversary enable keep in touch. Families engage at a later date for bereavement emotional support
- ✓ Yearly Memorial service and Remembrance book
- ✓ Emotional support and care to staff as well as families.
- ✓ Using relationship with Learning Academy to develop simulation to support staff and leaders to have challenging conversations. Two clinical simulations offered: 'Having Difficult Conversations' and 'When a Child Dies ', and Palliative care foundation course. Bespoke session on unit as required.
- ✓ Report completed by MDO Fellow looking at psychological safety among junior doctors, accepted as poster at RCPCH conference (digital presentation).
- ✓ Report methodology to be adapted for use with AHPs, testing interventions to support future roll-out of psychological safety work across GOSH
- ✓ Patient Safety Awareness week featured case studies from safety events. Vlog published by AMDs for Leadership and Wellbeing, and Regulatory Affairs and Culture discussing experiences and thoughts around Patient Safety.
- ✓ Key element of Deteriorating Patient workstream – work prompted by audit of staff experience of speaking up, and barriers encountered
- ✓ Freedom to Speak Up Guardian in post and engagement increasing
- ➢ Further work to do around safety culture and perceptions, supported by Grand Round programme and future activities supporting education in patient safety

- Commitment to organisational culture that is inclusive, supports learning and encourages challenges to how we work, behave and treat each other.
- Create safe environment to increase intellectual friction whilst decreasing social friction to allow us to maintain high quality patient care.
- Opportunity for innovation and personal development, aligned with Quality and Safety strategies.

5.6 Neonatal care

- ✓ GOSH has representation on North Central and North East London Operational Delivery Network (ODN) – governance and directorate (quarterly) and twice yearly mortality meetings and an active partner within ODN
- ✓ Consultant Neonatologist contributed to National Neonatal Critical Care Review as one of two London representatives, advised on safe medical staffing levels and chaired Thames Regional Perinatal Group
- ✓ Improved care for neonates across the Trust through the appointment of seven (soon to be eight) Consultant neonatologists and operationally separated the consultant cover on the Paediatric and Neonatal Intensive Care units – also providing neonatal outreach support and clinical input for babies throughout the Trust
- ✓ Training programme for Neonatal ACPs (Advanced Clinical Practitioners) at GOSH – two currently going through training, one now fully trained and on Fellow rota
- ✓ Neonatal College Speciality Advisory Committee accredited Neonatal training at GOSH for trainees on neonatal grid training pathway – two ST7 trainees at GOSH for first time
- ✓ Two Consultant posts rotate between UCLH and GOSH
- ✓ GOSH has already responded to recommendations in respect of staffing numbers as of May 2022 with investment to ensure recommended number of Consultants per RCPCH and also British Association Perinatal Medicine guidance. All Fellows have spent significant time on Neonatal Intensive Care units, compared to previously when may have been an adult care trainee intensivist – always two Fellows on shift at any one time

5.7 The role of external and internal reviews – challenge and scrutiny

- ✓ Use of regular external assessment (eg GIRFT, UKAS and others) and invited review (eg Urology) as tools to reduce variation and highlight necessary improvement actions; use of internal reviews to provide granular and nuanced feedback for services, highlighting strengths to build on and weaknesses to address

Conclusion and Next Steps

This paper has set out the key points in relation to the findings of the Ockenden report and has taken the recommendations in their widest sense, applying them where relevant to GOSH.

The comprehensive work and processes already effective and in place, in addition to actions in development and planned for implementation, should provide assurance that the risks of similar events arising as reviewed by the Ockenden report, are well mitigated. Further assurance may be monitored by way of future reports to QSEAC.

Attachment 3

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25 May 2022

Regular DIPC Infection Prevention & Control Report to Trust Board Quarter 4- 2021-2022 **Submitted by: Helen Dunn, Director of Infection Prevention Control**	**Paper No: Attachment 3** **□ For discussion** **□ For information and noting**

Purpose of report
To provide the board with an overview of Infection Control activities, associated metrics, and any identified risks throughout the period of Quarter 4 2021-2022.

Summary of report
This short report covers the IPC activity over the last quarter of 2021-22. IPC metrics over the last year show no areas of concern and it must be remembered that there is a significant increase in workload than the previous year resulting in more overall tests conducted.
Line infection rates remain stable, as do hand hygiene. Work is underway to improve documentation within epic about the care of all devices.

Three top achievements since last report:

1. Sepsis- update on clinical guideline, new build within Epic and training created.
2. Paediatric IPC module created, and first module completed at Southbank.
3. Continuation of covid risk assessments for staff alongside general clinical work.

Three significant ongoing risks

1. Ongoing adenovirus outbreak on Robin/Fox ward. Requested to be added back onto the risk register for oversight. Regular meetings held with the team to monitor compliance with control measures and observe for any further cases.
2. Ability to maintain estate in line with HTM guidance, in particular water and ventilation. This has been added to the risk register. Oversight at the Water Safety Group and Ventilation Safety Group.
3. Lack of medical representation at the Infection Control Committee (IPCC). Raised with the executive lead for IPC and medical directorate and an appropriate representative is under consideration.

Action required from the meeting
None

Contribution to the delivery of NHS Foundation Trust priorities **□ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** **□ PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** **□ PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training** **□ PRIORITY 4: Improve and speed up access to urgent care and virtual services**	**Contribution to compliance with the Well Led criteria** **□ Leadership, capacity and capability** **□ Vision and strategy** **□ Culture of high-quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance** **□ Accurate data/ information** **□ Robust systems for learning, continuous improvement and innovation**

PRIORITY 5: Accelerate translational research and innovation to save and improve lives **PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care** **Quality/ corporate/ financial governance**	
Strategic risk implications BAF Risk 12: Inconsistent delivery of safe care	
Financial implications Not applicable	
Implications for legal/ regulatory compliance Work is underway by the Space Team to ensure that ventilation and water systems are managed in line with HTM guidance and that evidence is available to demonstrate this.	
Consultation carried out with individuals/ groups/ committees Board report shared with Chief nurse who is the executive lead for IPC.	
Who is responsible for implementing the proposals / project and anticipated timescales? Not applicable	
Who is accountable for the implementation of the proposal / project? Not applicable	
Which management committee will have oversight of the matters covered in this report? IPCC	

Attachment 3

Regular DIPC Infection Prevention & Control Report to Trust Board
Quarter 4- 2021-2022

Three top achievements since last report:

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3. Lack of medical representation at the Infection Control Committee (IPCC). Raised with the executive lead for IPC and medical directorate and an appropriate representative is under consideration.

Report

1. Infection Prevention and Control (IPC) team

- Team is now fully staffed, with all staff in post.

2. Health care associated infection (HCAI) statistics

HCAI Mandatory national reporting:

	2021/22		**Last financial year- 2020/21**	
	Developed while in hospital	**Admitted with**	**Developed while in hospital**	**Admitted with**
MRSA bacteraemia	**1**	**0**	**2**	**0**
MSSA bacteraemia	**13**	**6**	**7**	**11**
E. coli bacteraemia	**5**	**3**	**12**	**5**
P. aeruginosa bact	**8**	**5**	**9**	**5**
Klebsiella sp. bact	**11**	**5**	**8**	**4**
	Reported	**Trust assigned**	**Reported**	**Trust assigned**
C. difficile infection	**8**	**5**	**10**	**3**

HCAI non-mandatory internal reporting – infection and significant colonisation:

	2021/21		**Last financial year 2020/21**	
Infection:				
GOS acquired CVC related bacteraemia	**1.2/1000 line days (66 infections)**		**1.2/1000 line days (63 infections)**	
	Developed in hospital	**Admitted with**	**Developed in hospital**	**Admitted with**
Respiratory viral infection	**245**	**1005**	**88**	**383**
Enteric viral infection	**107**	**127**	**60**	**71**
Colonisation:				
MRSA colonisation	**6**	**196**	**12**	**153**

Attachment 3

	2021/21		Last financial year 2020/21	
MDR GN (non CPO) colonisation	**107**	**134**	**93**	**120**
Carbapenemase producing (CPO) GN*	**12**	**13**	**12**	**16**
Vancomycin resistant enterococci	**17**	**21**	**11**	**10**
MDR GN = Multi antibiotic resistant gram negative 'alert' organism ; CPO = carbapenemase producing organism				

Issue: Increase in VRE colonisation acquired whilst in hospital
Control activity: investigation into acquired colonisations
Risk: There may be an environmental source which has not been identified.
Assurance: monthly monitoring at IPCC and outbreak meetings underway. Majority of cases detected in BCC so asked to add to risk register for monitoring.

3. Major outbreaks or preventable high risk exposure events.

Date	Organism and issue	Ward/ Department	Outcome
Aug 2022	Patient safety alert issued regarding valved FFP3 masks	Trust wide	Valved FFP3 removed from clinical areas where sterile fields are used as standard (e.g. theatres) and staff re-fit tested.

4. Infection prevention and control regular audits and data display

- Hand hygiene data remains stable at between 75-85% compliance and good compliance with bare below the elbows (>95%).
- Care bundle data demonstrates the need to improve documentation on EPR with regard to invasive devices.
- MRSA and stool screening compliance remains below the expected standard but is improving. Stool screening sits at 30-40% after 72hrs of admission and MRSA screening for patients admitted over 24hrs is around 80% compliant.

5. Estate and facilities – issues

- Specialist ventilation schedule is at risk of falling behind plan. Action plan in place to ensure all areas are verified and plated as appropriate.
- Standard ventilation- Chilled beams not maintained in line with HTM. Work underway to develop and carry out a decant plan to facilitate this.
- Legionella identified in RHILM, managed by UCLH with oversight from GOSH estates compliance team.

6. IPC Training- 10/05/2022

Trust compliance with level 1 training 89%
Trust compliance with level 2 training 88%
Covid training level 1 85%
Covid training level 2 89%

Actions: Trust wide push to increase compliance to over 90% in place.

Helen Dunn
Consultant Nurse IPC and DIPC

12/05/2022

Attachment 4

Trust Board **25th May 2022**	
Health and Safety and Fire Safety Annual Report **Submitted by: Zoe Asensio-Sanchez Director of Space & Place**	**Paper No: Attachment 4** ☐ **For discussion** ☐ **For information and noting**
Purpose of report To present an annual review of fire safety and health and safety annual arrangements for the Trust. To provide the Board with assurance that it is meeting its statutory requirements for health and safety and fire safety.	
Summary of report The report reviews the health and safety and fire safety performance for the Trust over the last 12 months. Positive outcomes include the introduction of site walkarounds and the introduction of a new fire safety specialist contractor to help the Trust to meet its statutory requirements. An area of concern highlighted in the report were a lack of compliance with mask wearing in non-clinical areas.	
Action required from the meeting Recommendations or actions for the Board to consider	
Contribution to the delivery of NHS Foundation Trust priorities ☐ **Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** ☐ **Effective processes, managing risk and performance**
Strategic risk implications BAF Risk 12: Inconsistent delivery of safe care	
Financial implications N/A	
Implications for legal/ regulatory compliance The Trust could be prosecuted if it fails to complete its statutory duties.	
Consultation carried out with individuals/ groups/ committees The paper has been presented in 2 separate papers (Fire Safety and Health and Safety) reports to the Health and Safety Committee.	
Who is responsible for implementing the proposals / project and anticipated timescales? Chris Ingram – Fire, Health and Safety Manager	
Who is accountable for the implementation of the proposal / project? Zoe Asensio-Sanchez - Director of Space & Place	
Which management committee will have oversight of the matters covered in this report? Health and Safety Committee	

Health and Safety and Fire Safety Annual Report 2021 - 2022

The Fire, Health and Safety team support the Trust management and employees to meet their statutory duties in relation to controlling the risks and precluding the chance of harm to patients, visitors and staff.

The table below highlights work that has been completed by the team during the year which enables the Trust to meet its statutory requirements:

Description of work	Progress and lead	Timescale	Original RAG rating	Current RAG rating
The Trust reports Health and Safety incidents on Datix. The team also administer and approve all Security incidents.	875 (1078 last year) health and safety incidents were reported from 1/4/21 – 31/3/22. This included 75 patient safety accidents. The decrease can be attributed to COVID 19 particularly the reaction to the vaccine. 875 is in line with previous year's figures. **Fire, Health and Safety Team**	The team aims to reply to each H&S incident within 1 working day.		
False Fire Alarm Activations and Fire Incidents	The Trust had 92 fire alarm incidents during this reporting period. The London Fire Brigade (LFB) attended once for a false alarm in this reporting period. This was to the Clinical Research Facility. Security and Works attended with LFB. No signs of fire or smoke and LFB confirmed a stand down call soon after arriving. The remaining 91 were false alarms caused by shower steam, accidental activations, faulty devices, dust etc	Incidents are monitored on a daily basis through Datix		
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - Any incident that involves a staff member being away from the Trust for more than 7 days, results in a serious injury or has occupational exposure to a	19 incidents were reported under RIDDOR. This is an increase from 14 in the previous year. This can be attributed to reporting more incidents following exposure to COVID 19. **Fire, Health and Safety Team**	Incidents must be reported under RIDDOR within 15 days.		

Description of work	Progress and lead	Timescale	Original RAG rating	Current RAG rating
named disease must be reported under RIDDOR.				
Train 90% of staff in Health and Safety and Fire Safety. Health and Safety training is completed through E-Learning and has not been affected by COVID 19. Fire Safety Training is completed face to face although this can sometimes be done via Zoom.	On 1st of April 2022 compliance with Health and Safety training was 96% (98% in 2021). On 1st April 2022 Fire Safety Training was 93% compliance for bi-annual training and 85% for annual training. The decrease in annual compliance has partly been caused by over 400 new domestic staff joining the Trust **Fire, Health and Safety Team**	Monitored monthly. Email sent out to all those who are not compliant on the 1st of each month by the training Department.		
Other Fire Safety Training. • Fire Response Team Training • Evacuation Chair Training • Fire Warden Training • Tabletop Evacuation Training • Site Specific Training • Live Fire Simulations	The Fire & H&S Team deliver several different Fire Safety Training Packages. Most notably Live Fire Simulations of vacant wards in conjunction with the Simulation Team. These have taken place in Sight and Sound and IMRI in this reporting period. This session is always well received. The next of these sessions is booked for 5/5/22. These exercises involve artificial smoke, site specific patients, parents and carers and input from the LFB. As this is not possible in 'live' areas a tabletop evacuation theory exercise can be completed.	Regular training is completed 3 times a week. Bespoke training is available on request. Compliance is monitored at the monthly Fire Safety Committee.		
Safer Sharps - The Trust is required to comply with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 (the regulation), which is	A working group has met over the reporting period to discuss and implement actions relating to safer sharps. The Clinical Procurement Team are now attending the Health	Monitored at the Health and Safety Committee (Bi-monthly).		

Description of work	Progress and lead	Timescale	Original RAG rating	Current RAG rating
monitored by the Health and Safety Executive (HSE).	and Safety Committee which allows greater scrutiny. All products have a risk assessment completed for them. These have been sent to the Ward Managers. During the recent COSHH Audit these assessments were not available. An action plan has been put in place and is being monitored at the Health and Safety Committee. **Clinical Procurement and Health and Safety Team**			
Lone Working – An annual lone working audit highlighted significant issues with the arrangements in some of our departments.	Audit presented at Health and Safety Committee in September 2021. Further presentations have been completed at senior Trust committees highlighting deficiencies and providing an action plan to improve the arrangements. **Health and Safety Team and Security Team**	Monitored at Health and Safety Committee (Bi-monthly).		
All Control of Substances Hazardous to Health (COSHH) information has been updated across the clinical and areas. All relevant non-clinical areas such as Estates have also been completed.	Audit completed in March 2022 and will be presented to the Health and Safety Committee in May 2022. **Department Managers and Health and Safety Team**	Assessments are updated and audited on an annual basis.		
Redevelopment projects – The team is asked to comment on/ review all new redevelopment and commissioning projects within the Trust. Fire Safety and Health and Safety training sessions happen in all new buildings.	Projects worked on this reported period: • Sight and Sound Centre, • Pharmacy, • TPN, • Alligator Ward, • Theatres Staff Change, • CRF, • PAHMS: Life Safety Systems successfully	Monthly reports are presented to the Fire Safety Committee		

Description of work	Progress and lead	Timescale	Original RAG rating	Current RAG rating
	handed over and commissioned • Children's Cancer Centre, • Gene and Cell Therapy, • Main Nurses Home Switch Room, • West Link Levels 3 and 4 • Levels 8 and 9 Nurses Home: Early Engagement and input into design, method and materials used.			
Hands, Face, Space and Place Audit – Audit to ensure compliance with infection control measures due to COVID 19 have taken place throughout the year.	The Health and Safety Team completes the audit on a bi-monthly basis and reports into the Health and Safety Committee. This is currently being graded as amber due to non-compliance with mask wearing. This has been escalated through the Trust's Governance Structure.	Monitored at Health and Safety Committee (Bi-monthly).		
Health and Safety Walkaround	Following a Fire Risk Assessment, the Fire Officer highlighted an issue with waste and housekeeping in non-clinical areas of the Trust. A weekly walkaround of these areas has resulted in the areas being managed much more proactively and lots of hazards have been removed from site. The walkaround has now expanded to include some clinical areas.	Information is shared with key stakeholders on a weekly basis. An update is contained in the Health and Safety Report provided to the Health and Safety Committee.		
Fire Risk Assessments	As of 1st April 2022 96% of fire risk assessments have been completed in clinical areas. 100% of fire risk	Monthly – Reported as part of the E&F KPIs.		

Description of work	Progress and lead	Timescale	Original RAG rating	Current RAG rating
	assessments have been completed in non-clinical areas.			
Policies	In this reporting period the team have reviewed updated the following policies: • Health and Safety Policy – Jann 22 • Fire Safety Policy – Agreed at PAG 25/4/22 • Lone Worker Policy – Due for review July 2022.	Policies are updated every 3 years		
Fire Safety – Compliance of the GOSH Estate	The Fire Safety Team have been working with a new Fire Safety Contractor (FISK) on compliance of the estate. A full list of compliance information will be presented over the next reporting period to the Audit Committee.			

Impact of COVID 19

- Fire Safety Training is now being completed over Zoom. This does not allow training in actual departments removing a chance for staff to become familiar in their area. Onsite/in-person training is slowly starting to happen particularly in clinical areas.
- The team is now part of the Workspace Strategy Group to ensure we use our available space in a safe and efficient manner.
- Increased reporting under RIDDOR.
- Increased musco-skeletal injuries due to a lack of ergonomic facilities available when staff are working from home.

Main aims for 2022/2023

- The team will play a vital role in ensuring that the Trust adapts safely to working under conditions imposed by COVID 19. This will include staff returning to site in a safe and controlled manner.
- Maintain health and safety training above 90% and improve fire safety compliance.
- Respond to all Health and Safety incidents within 1 working day.
- Ensure that our new buildings meet high safety standards and are safe for our staff and patients to move into before they are used.
- Incorporate increased numbers of clinical areas into the walkaround process.

- Develop Operating Theatre Fire Evacuation Manual
- Full Fire Alarm System Cause and Effect Review
- CCC Construction to commence with minimal impact on fire safety across adjoining buildings
- Installation of new refuge system within Weston House

Attachment 5

Trust Board 25 May 2022	
Guardian of Safe Working report **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment 5**

Aims / summary

This report is the Q4 report of 2021/22 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1st January to 31st March 2022 inclusive.

Action required from the meeting

- Note surgical SHO rota issues – high bank spend to support day time compliance

Contribution to the delivery of NHS Foundation Trust strategies and plans

The Guardian of Safe Working (GOSW) supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.

Financial implications

- Continuing payment for overtime hours documented through the exception reporting practice
- Note bank rate increment for unsociable working hours to commence April 1st 2022

Who needs to be told about any decision?

n/a

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

Dr Renee McCulloch, Guardian of Safe Working, Associate Medical Director: Workforce
Mr Simon Blackburn Deputy Medical Director for Medical & Dental Education

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

Dr Sanjiv Sharma, Medical Director

Attachment 5

Guardian of Safe Working
Q4: 1st January 2022 – 31st March 2022

1 Purpose

To inform the board on issues arising relating to the junior doctors working at GOSH and the work of the Guardian of Safe Working (GOSW). The GOSW is directly accountable to the trust board.

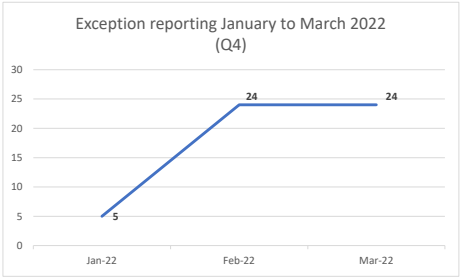
2 Background

See Appendix 1

3 Exception Reporting: High Level Data

3.1 Number of exception reports (ER) at GOSH remain low reflecting cohort a) senior trainees b) non-UK Trust doctors c) poor engagement with ER system

3.2 Average exceptions per month decreased from Q3 (19 per month to 17.6 per month)



3.3 53 ERs submitted in the period January to March

- 46 ER: extra hours worked.
- 5 Service Support
- 1 Educational
- 1 Pattern
- 17 doctors submitted the reports (12 SPR, 5 SHO)
- **3 ERs related to immediate safety concerns – all Surgical SHOs due to falling below minimum staffing numbers**
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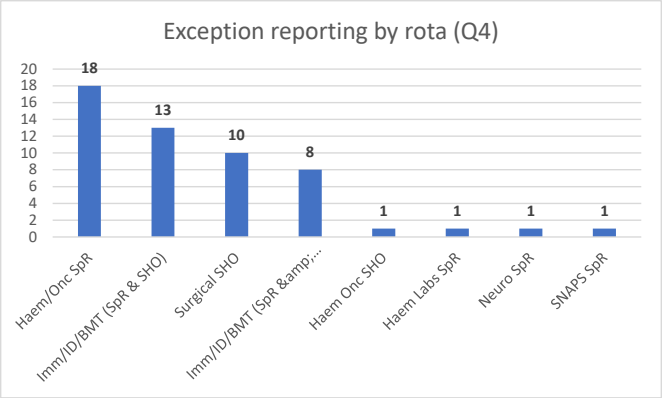
- ER reports across 8 rotas



- *Overtime. Critical staffing. One SHO covering Immunology, no registrars.*
- *Consultant ward round finished after 17:30, so needed time to wrap-up with WR jobs and then handover to evening team*
- *.. minimum number of SHOs to cover the wards on SNAPS should be three ..two SHOs were assigned ..however, one SHO was required to assist in managing a busy theatre list.*
  This left myself and one (Physician's Associate) PA to cover the ward, and eventually just myself after 16:00 when the PA left. ***Immediate safety concerns identified: clinically urgent and time critical tasks not completed. Non-urgent tasks were disregarded affecting patient care.***

- *Asked to assist covering urology due to no SHO on urology and nil else available in the trust to cover at last minute as every department was at or less than minimum staffing*
- *I am one of the senior fellows, and when new people join, I need to help them and show them how EPIC works and explain some things and support them (for example, linking orders in EPIC, requesting a line insertion, etc.) which takes more time but it is necessary…..but it occupied two hours of the clinical work on the ward.*
- *Due to understaffing had to stay 3 hours extra to finish ward round and new admission*

3.4 Exception report outcomes

Outcome	Outcome
Initial decision upheld	6
No further action	8
Payment	33
TOIL	6
Grand Total	53

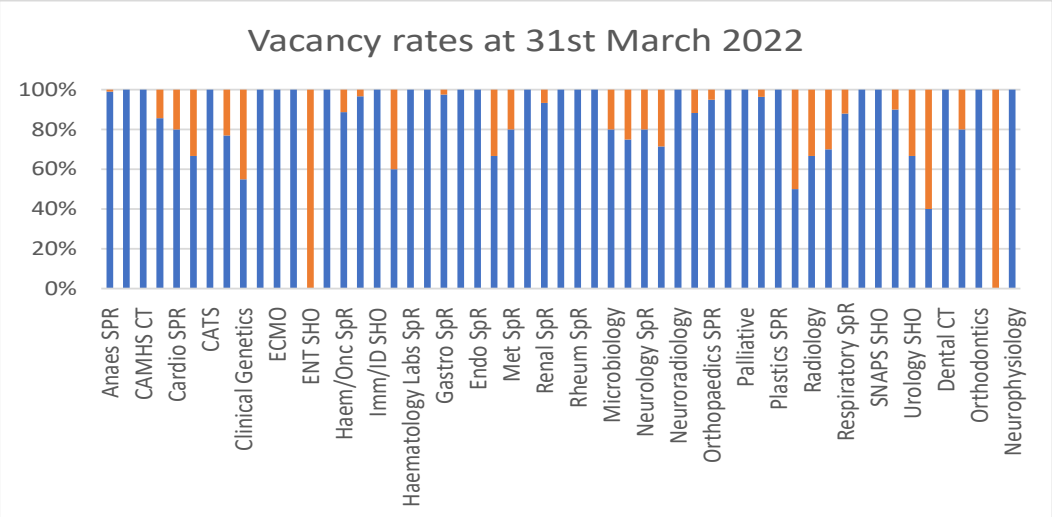
3.4.1 Action:

3.4.1.1 Immunology and Bone Marrow Transplant – increased establishment by 2 doctors from March 2022

3.4.1.2 *Surgical SHOs – plan to increase establishment by 3 doctors to maintain minimum numbers for safe staffing and increase weekend daytime to 3 SHOs.*

4 Vacancy Rates

4.1 The overall vacancy rate across junior doctor rotas as of 31st March is 11.9% with **44 FTE vacant out of a total of 369 FTE** establishment. This is an increase of 0.6% since December 2021 (11.3%)

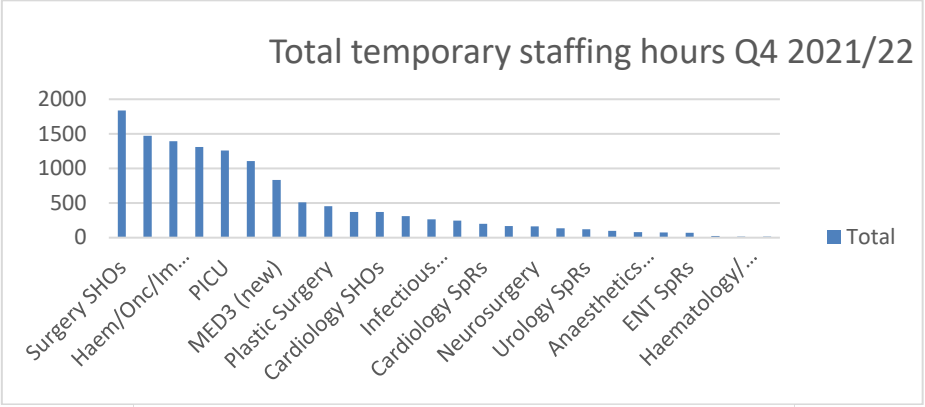


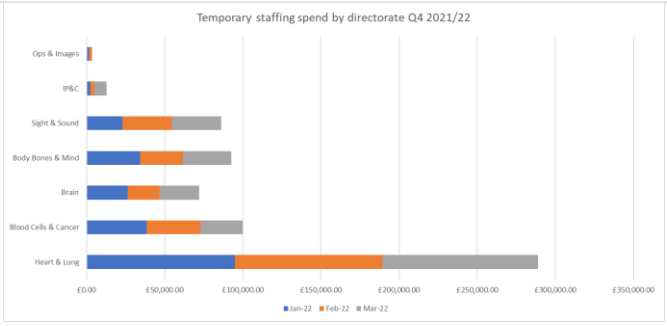
5 Finance, Bank and Agency data

5.1 The Trust spent £655,914 on junior doctor temporary staffing in Q4. This was a reduction from Quarter 3 (17%). Of this £18,127 (2.4%) was Agency- this was a reduction from 4% in Q 3.

5.2 When looking at shifts booked in the period, the surgical SHO rota was the most frequent rota using temporary staff with 187 shifts filled followed by CICU (117 shifts). Heart and Lung is the highest spending directorate due to ICU bank spend.

Attachment 5





5.2.1 Surgical SHO rota patterns have been extensively reviewed due to high day time bank spend with low vacancy rates. Specialty cross cover requirement to support minimum numbers has led to unsafe staffing. A business case is in progress.

5.2.2 CICU bank spend is due to increased vacancy with the requirement to meet nationally established minimum numbers for safe staffing.

5.3 Triangulating rota-gap data with analysis of day and night spend supports further interrogation of bank data. **(see Appendix 2)**

6 COVID Management Omicron Surge Q4

6.1 Over the Christmas and New Year holiday period emergency plans were put in place to ensure safe medical staffing and counter the unknown impact of the Omicron variant over the 10 day holiday period. Many doctors had leave booked over the festive period and safe staffing was a priority. The Medical Workforce Leads, supported by specialty rota leads, identified volunteers who agreed to be on a 'shift back up' retainer fee of £10/ hr. If activated this would be escalated to normal bank rates. 17 back up shifts were activated between 24-12-21 and 03-01-22 across the Trust. Higher levels of absence have been supported with the existing Hospital at Night system put into place following the first surge and managed by the MWLs.

6.2 The rota coordinators and MWLs stepped up to manage unexpected gaps over the 10 day holiday period, working over bank holidays and weekends for the second year of COVID pandemic.

7 Ongoing Compliance Issues:

7.1 Surgical SHO rota is a rota of concern. The surgical SHO establishment is assigned to cover SNAPs, plastics, urology, orthopaedics and ENT specialties and share an out of hours rota across all surgical services. Even with managed cross cover between specialities it is difficult (impossible in some areas) to maintain minimal staffing numbers. Frequent cross cover across multiple areas leads to lack of continuity and patient safety can be affected. Core surgical trainees must be supported to attend education and training commitments.

7.2 Plastics registrars had inadvertently breached compliance by arranging their own cover to fill vacant posts. This has been rectified.

8 Junior Doctors Forum (JDF)

8.1 JDF, supported by the Medical Director's Office, has negotiated new bank rates for unsocial out of hours working to commence on April 1st, 2022. Locum/ bank rates for junior doctors had remained static since at

least 2012. It is anticipated that increasing bank/ locum rates will improve rota gaps fill rates, offer more competitive remuneration and assurance for continued patient safety out of hours. Importantly it will maintain goodwill and improve morale amongst GOSH non-consultant grade doctors, essential for reputation, recruitment and retention and as such, maintaining safe staffing at GOSH

9 Summary

9.1 All GOSH rotas are developed to be compliant to the 2016 TCS – compliance breeches occur with high volume workload and/ or unfilled gaps.

9.2 Challenge continues with respect to vacancy rates and gap management. To deliver safe patient care daily situational assessment related to workforce availability and clinical demand. Unexpected gap management due to COVID- related absence has required ongoing management by the MWLs.

9.3 Surgical SHO rota is a rota of concern and is being managed by the Operational Divisions of Body Bones Mind (BBM) and Sight and Sound (SS).

9.4 Improved data recording has supported better scrutiny and understanding of financial spend and vacancy/ gap analysis.

9.5 An increase in bank rates for unsocial hours has been agreed for April 2022

Attachment 5

Appendix 1 Background Information for Trust Board
In 2nd October 2017 all junior doctors in training transferred to the new contract with 2016 Terms & Conditions (TCS).

The 2016 TCS clearly indicate the importance of appropriate working hours and attendance at training and education for junior doctors. Both issues have a direct effect on the quality and safety of patient care.

The statutory role of 'Guardian of Safe Working' (GOSW) was introduced in the 2016 and includes;

- overseeing the safeguards outlined in the 2016 contract
- ensuring that issues of compliance with safe working hours are addressed by the doctors and/or the employer
- facilitating the reporting structures
- overseeing the wellbeing of the junior doctors
- a requirement to provide quarterly reports to Trust board.

Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

Exception reports are submitted electronically by doctors to their educational supervisor. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The outcome of an exception report may be compensation, in the form of time off in lieu or payment for additional hours worked, or an adjustment to the work schedule of the post.

Whilst exception reporting is a mechanism of the 2016 contract for doctors in training, GOSH has elected to extend the use of the system to doctors employed under local (non-training) TCS, in order to encourage safe working practices for all doctors, provide equity and obtain a more comprehensive view of junior doctors working hours across the Trust.

The 2016 contract requires that a Junior Doctors Forum (JDF) is established in every Trust. The JDF primarily represent trainees and offers a forum for addressing concerns pertaining to working hours and conditions and education and training. This is in place and meets every month.

There are 45 different rota patterns currently in place within the Trust.

Publication of Amendments 2016 TCS September 2019:
Context for 2018 contract review

The new junior doctor contract was introduced in England without the BMA's agreement in 2016. The intention of the negotiations on this new contract was to introduce for doctors in training new, improved safe working arrangements, more support for their education and a new modernised pay system. The BMA and NHS Employers agreed during negotiations on this contract to jointly commission in August 2018 a review of its efficacy, to identify any areas for improvement to the contract terms. In 2019 a new referendum of the BMA Junior Doctor membership accepted the 2016 contract, including the amendments that have been negotiated.

TCS contract includes but is not limited the following amendments:

a. Weekend frequency allowance maximum 1:3
b. Too tired to drive home provision
c. Accommodation for non-resident on call
d. Changes to safety and rest limits that will attract GoSW fines.
e. Breaches attracting a financial penalty broadened to include:
    1) Minimum Non-Resident overnight continuous rest of 5 hours between 2200-0700
    2) Minimum total rest of 8 hours per 24-hour NROC shift
    3) Maximum 13-hour shift length
    4) Minimum 11 hours rest between shifts
f. Exception Reporting

1) Response time for Educational Supervisors - must respond within 7 days. GoSW will also have the authority to action any ER not responded to
2) Payment must be made within 1 month of agreement or on next available payroll. No extra admin burden should occur
3) Conversion to pay - 4-week window from outcome agreed to identify a shift before the end of the placement for TOIL to be taken. If this doesn't happen, payment should automatically be given. At the end of a placement, any untaken TOIL should be paid

g. Time commitment and administrative support for GOSW.

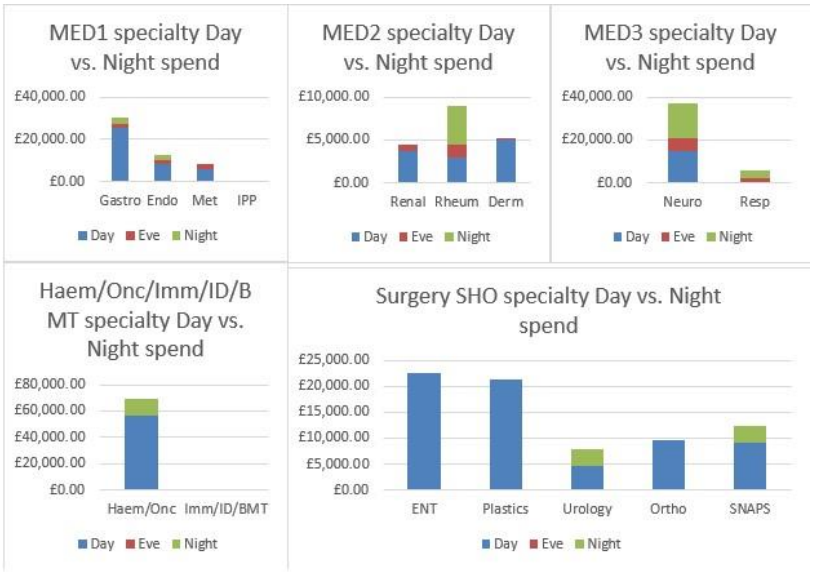
Attachment 5

Appendix 2: Supporting Data Analysis Related to Rota Gaps:

Table 1: Reasons for Bank Spend

Bank Spend Break Down				
category	Row Labels	Sum of Total Duty Cost	%	Group %
Vacancy	Vacancy	£230,949.61	35.21	35.21
COVID	COVID-19 - Isolation	£29,580.44	4.51	10.51
COVID	COVID19	£28,118.17	4.29	
COVID	Sickness - COVID19	£11,230.89	1.71	
Health related	Staff Sickness - Short T	£39,115.77	5.96	11.45
Health related	Staff Sickness - Long Te	£4,267.25	0.65	
Health related	Occ. Health	£31,699.33	4.83	
leave	Annual Leave	£15,916.16	2.43	7.04
leave	Study Leave	£6,556.24	1.00	
leave	Special Paid Leave	£6,995.43	1.07	
leave	Special Unpaid Leave	£12,446.90	1.90	
leave	Compassionate Leave	£2,890.93	0.44	
leave	Carers Leave	£1,350.88	0.21	
rotation cover	LTFT	£40,771.86	6.22	12.88
rotation cover	Induction Cover	£43,731.72	6.67	
additional	Special Projects	£3,131.70	0.48	9.46
additional	Activity Initiative	£1,616.00	0.25	
additional	Accelerator Programm	£12,862.33	1.96	
additional	Increased Activity	£33,381.46	5.09	
additional	Short term projects	£5,301.85	0.81	
additional	Supernumerary Shift	£5,151.04	0.79	
additional	Increased Patient Load	£631.25	0.10	
Other	Pre-employment chec	£87,460.77	13.33	13.45
Other	MWL Approved Not Fil	£378.10	0.06	
Other	Redeployed	£378.10	0.06	
	Grand Total	£655,914.18	100.00	100.00

Graphs Differentiating Between Day and Night bank spend:



- Data analysis shows that vacancy (unfilled posts) is the most common reason for bank requirement.
- Bank spend can therefore be offset by salary saving to some extent (also true for less than full time working patterns)
- COVID related absence, other reasons for staff sickness and activity-related staffing requirements are each associated with approximately 10% spend**.**
- Other reasons for bank spend remediation and review are:
    - study and annual leave which should be prospectively covered.
    - Process related to onboarding: preemployment checks and induction
- Of note is the preservation of night cover prioritised by the medical workforce leads to support safe staffing overnight

Trust Board 25 May 2022	
Guardian of Safe Working report **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment 5**
Aims / summary This report is the Q4 report of 2021/22 (covering the period 1st January to 31st March 2022 inclusive) and the Annual Report (to year end March 31st, 2022) providing assurance to the Board regarding Junior Doctor working practice at GOSH.	
Action required from the meeting to note: • surgical SHO rota– high bank spend to support daytime compliance; safety concerns highlighted • improvement in data intelligence to inform rota gap management	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working (GOSW) supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications • Continuing payment for overtime hours documented through the exception reporting practice • Bank rate increment for unsociable working hours to commence April 1st 2022	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working, Associate Medical Director: Workforce Mr Simon Blackburn Deputy Medical Director for Medical & Dental Education	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Medical Director	

Attachment 5

Guardian of Safe Working
Q4: 1st January 2022 – 31st March 2022

1 Purpose

To inform the board on issues arising relating to the junior doctors working at GOSH and the work of the Guardian of Safe Working (GOSW). The GOSW is directly accountable to the trust board.

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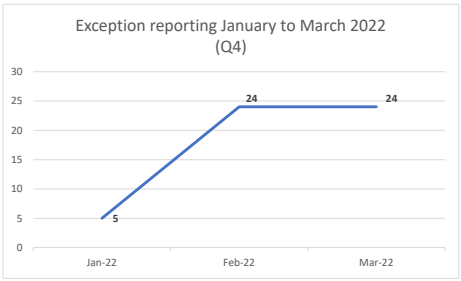

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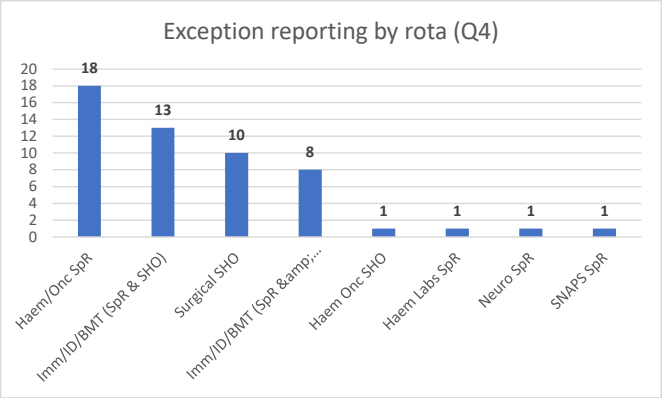

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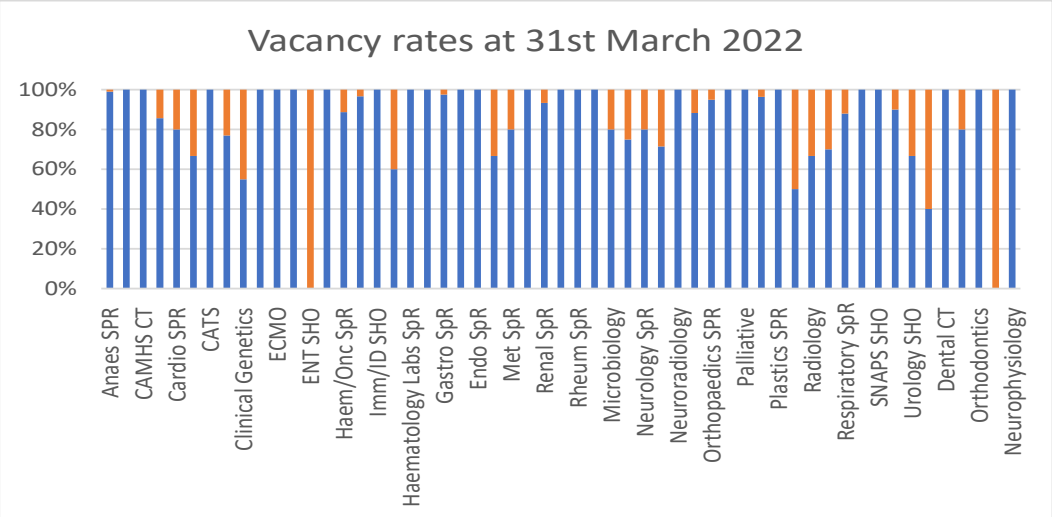

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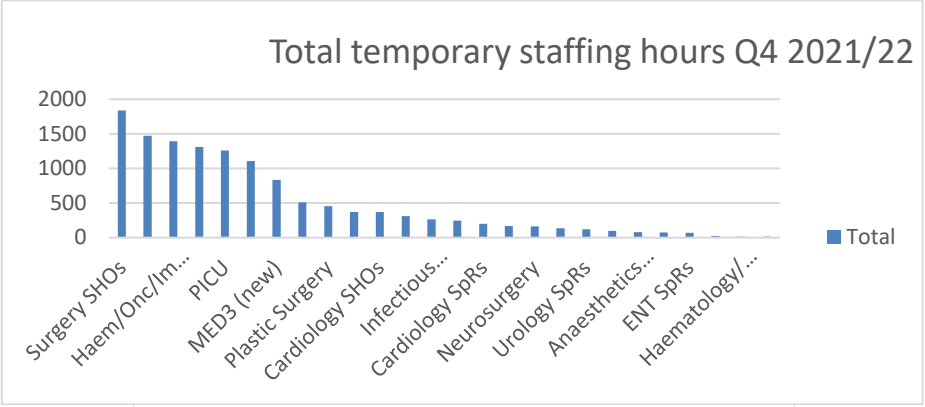

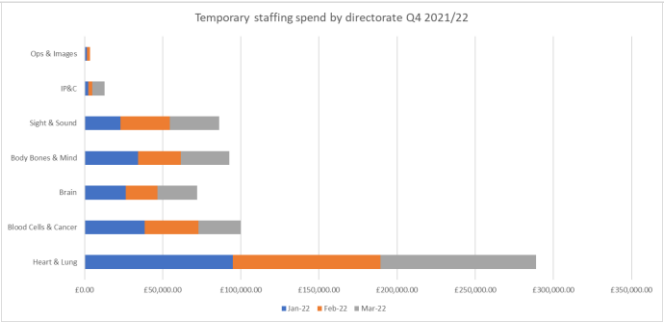

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5.2.2 CICU bank spend is due to increased vacancy with the requirement to meet nationally established minimum numbers for safe staffing.

5.3 **Triangulating rota-gap data with analysis of day and night spend supports further interrogation of bank data**. It is important to note, that in most cases a large proportion of the hours filled by bank are 'daytime' hours and not out of hours. This suggests that there may not be the numbers required within specialty to maintain safe staffing levels during the day **(see Appendix 2)**

6 COVID Management Omicron Surge Q4

6.1 Over the Christmas and New Year holiday period emergency plans were put in place to ensure safe medical staffing and counter the unknown impact of the Omicron variant over the 10 day holiday period. Many doctors had leave booked over the festive period and safe staffing was a priority. The Medical Workforce Leads, supported by specialty rota leads, identified volunteers who agreed to be on a 'shift back up' retainer fee of £10/ hr. If activated this would be escalated to normal bank rates. 17 back up shifts were activated between 24-12-21 and 03-01-22 across the Trust. Higher levels of absence have been supported with the existing Hospital at Night system put into place following the first surge and managed by the MWLs.

6.2 The rota coordinators and MWLs stepped up to manage unexpected gaps over the 10 day holiday period, working over bank holidays and weekends for the second year of COVID pandemic.

7 Ongoing Compliance Issues:

7.1 Surgical SHO rota is a rota of concern. The surgical SHO establishment is assigned to cover SNAPs, plastics, urology, orthopaedics and ENT specialties and share an out of hours rota across all surgical services. Even with managed cross cover between specialities it is difficult (impossible in some areas) to maintain minimal staffing numbers. Frequent cross cover across multiple areas leads to lack of continuity

and patient safety can be affected. Core surgical trainees must be supported to attend education and training commitments.

7.2 Plastics registrars had inadvertently breached compliance by arranging their own cover to fill vacant posts. This has been rectified.

8 Junior Doctors Forum (JDF)

8.1 JDF, supported by the Medical Director's Office, has negotiated new bank rates for unsocial out of hours working to commence on April 1st, 2022. Locum/ bank rates for junior doctors had remained static since at least 2012. It is anticipated that increasing bank/ locum rates will improve rota gaps fill rates, offer more competitive remuneration and assurance for continued patient safety out of hours. Importantly it will maintain goodwill and improve morale amongst GOSH non-consultant grade doctors, essential for reputation, recruitment and retention and as such, maintaining safe staffing at GOSH

9 Summary

9.1 All GOSH rotas are developed to be compliant to the 2016 TCS – compliance breeches occur with high volume workload and/ or unfilled gaps.

9.2 Challenge continues with respect to vacancy rates and gap management. To deliver safe patient care daily situational assessment related to workforce availability and clinical demand. Unexpected gap management due to COVID- related absence has required ongoing management by the MWLs.

9.3 Surgical SHO rota is a rota of concern and is being managed by the Operational Divisions of Body Bones Mind (BBM) and Sight and Sound (SS).

9.4 Improved data recording has supported better scrutiny and understanding of financial spend and vacancy/ gap analysis.

9.5 An increase in bank rates for unsocial hours has been agreed for April 2022

Attachment 5

Appendix 1 Background Information for Trust Board
In 2nd October 2017 all junior doctors in training transferred to the new contract with 2016 Terms & Conditions (TCS).

The 2016 TCS clearly indicate the importance of appropriate working hours and attendance at training and education for junior doctors. Both issues have a direct effect on the quality and safety of patient care.

The statutory role of 'Guardian of Safe Working' (GOSW) was introduced in the 2016 and includes;

- overseeing the safeguards outlined in the 2016 contract
- ensuring that issues of compliance with safe working hours are addressed by the doctors and/or the employer
- facilitating the reporting structures
- overseeing the wellbeing of the junior doctors
- a requirement to provide quarterly reports to Trust board.

Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

Exception reports are submitted electronically by doctors to their educational supervisor. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The outcome of an exception report may be compensation, in the form of time off in lieu or payment for additional hours worked, or an adjustment to the work schedule of the post.

Whilst exception reporting is a mechanism of the 2016 contract for doctors in training, GOSH has elected to extend the use of the system to doctors employed under local (non-training) TCS, in order to encourage safe working practices for all doctors, provide equity and obtain a more comprehensive view of junior doctors working hours across the Trust.

The 2016 contract requires that a Junior Doctors Forum (JDF) is established in every Trust. The JDF primarily represent trainees and offers a forum for addressing concerns pertaining to working hours and conditions and education and training. This is in place and meets every month.

There are 45 different rota patterns currently in place within the Trust.

Publication of Amendments 2016 TCS September 2019:
Context for 2018 contract review

The new junior doctor contract was introduced in England without the BMA's agreement in 2016. The intention of the negotiations on this new contract was to introduce for doctors in training new, improved safe working arrangements, more support for their education and a new modernised pay system. The BMA and NHS Employers agreed during negotiations on this contract to jointly commission in August 2018 a review of its efficacy, to identify any areas for improvement to the contract terms. In 2019 a new referendum of the BMA Junior Doctor membership accepted the 2016 contract, including the amendments that have been negotiated.

TCS contract includes but is not limited the following amendments:

a. Weekend frequency allowance maximum 1:3
b. Too tired to drive home provision
c. Accommodation for non-resident on call
d. Changes to safety and rest limits that will attract GoSW fines.
e. Breaches attracting a financial penalty broadened to include:
    1) Minimum Non-Resident overnight continuous rest of 5 hours between 2200-0700
    2) Minimum total rest of 8 hours per 24-hour NROC shift
    3) Maximum 13-hour shift length
    4) Minimum 11 hours rest between shifts
f. Exception Reporting

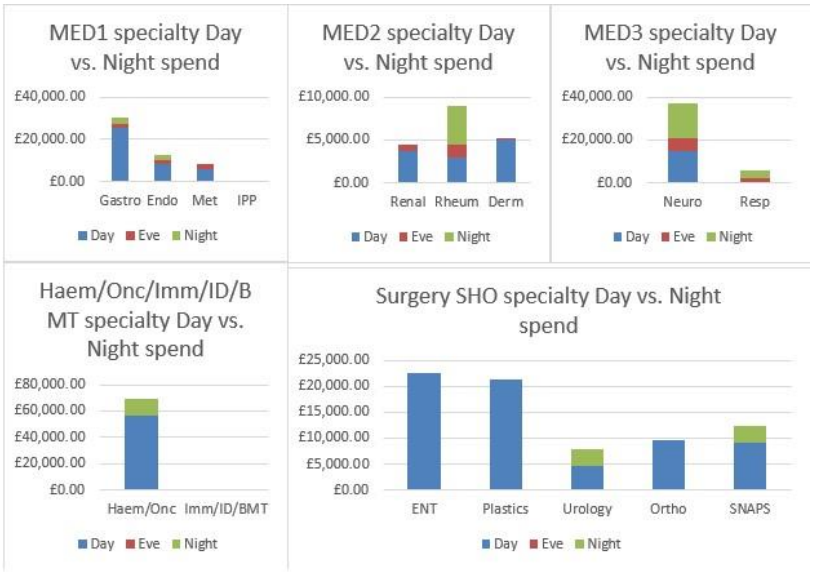
1) Response time for Educational Supervisors - must respond within 7 days. GoSW will also have the authority to action any ER not responded to
2) Payment must be made within 1 month of agreement or on next available payroll. No extra admin burden should occur
3) Conversion to pay - 4-week window from outcome agreed to identify a shift before the end of the placement for TOIL to be taken. If this doesn't happen, payment should automatically be given. At the end of a placement, any untaken TOIL should be paid

g. Time commitment and administrative support for GOSW.

Attachment 5
Appendix 2: Supporting Data Analysis Related to Rota Gaps:
Table 1: Reasons for Bank Spend

Bank Spend Break Down				
category	Row Labels	Sum of Total Duty Cost	%	Group %
Vacancy	Vacancy	£230,949.61	35.21	35.21
COVID	COVID-19 - Isolation	£29,580.44	4.51	10.51
COVID	COVID19	£28,118.17	4.29	
COVID	Sickness - COVID19	£11,230.89	1.71	
Health related	Staff Sickness - Short T	£39,115.77	5.96	11.45
Health related	Staff Sickness - Long Te	£4,267.25	0.65	
Health related	Occ. Health	£31,699.33	4.83	
leave	Annual Leave	£15,916.16	2.43	7.04
leave	Study Leave	£6,556.24	1.00	
leave	Special Paid Leave	£6,995.43	1.07	
leave	Special Unpaid Leave	£12,446.90	1.90	
leave	Compassionate Leave	£2,890.93	0.44	
leave	Carers Leave	£1,350.88	0.21	
rotation cover	LTFT	£40,771.86	6.22	12.88
rotation cover	Induction Cover	£43,731.72	6.67	
additional	Special Projects	£3,131.70	0.48	9.46
additional	Activity Initiative	£1,616.00	0.25	
additional	Accelerator Programm	£12,862.33	1.96	
additional	Increased Activity	£33,381.46	5.09	
additional	Short term projects	£5,301.85	0.81	
additional	Supernumerary Shift	£5,151.04	0.79	
additional	Increased Patient Load	£631.25	0.10	
Other	Pre-employment chec	£87,460.77	13.33	13.45
Other	MWL Approved Not Fil	£378.10	0.06	
Other	Redeployed	£378.10	0.06	
	Grand Total	£655,914.18	100.00	100.00

Graphs Differentiating Between Day and Night bank spend:



- Data analysis shows that vacancy (unfilled posts) is the most common reason for bank requirement.
- Bank spend can therefore be offset by salary saving to some extent (also true for less than full time working patterns)
- COVID related absence, other reasons for staff sickness and activity-related staffing requirements are each associated with approximately 10% spend**.**
- Other reasons for bank spend remediation and review are:
    - study and annual leave which should be prospectively covered.
    - Process related to onboarding: preemployment checks and induction
- Of note is the preservation of night cover prioritised by the medical workforce leads to support safe staffing overnight

Attachment 5

Executive Summary

- This paper summarises progress to the year end 31 March 2022 in providing assurance that non-consultant (junior) doctors at Great Ormond St Hospital (GOSH) are safely rostered and enabled to work hours that are safe and compliant, with opportunity to access training and education.

- Rota gap management due to the ongoing COVID pandemic has continued to bring to challenge to safe medical staffing.

- Ongoing robust medical workforce management implemented following the first surge of the COVID pandemic has provided a systematic, responsive and effective approach to rota gap management.

- Improved data intelligence has enabled the Trust to fully understand the dependencies and requirements of the junior medical workforce and deliver financial recommendations and efficiencies

- Compliance with 2016 TCS: Implementation of the New Amendments October 2019
  - All rotas include calculation for safe minimal staffing numbers set by departments.
  - Provision for both study and annual leave allowance is factored into all rotas.
  - Rota coordinators check compliance with all rota changes

- Exception reporting (ER) is available to all non-consultant grade medical staff and continues to monitor compliance with 2016 contractual obligations of the Trust. Doctors struggle with the reporting process and the closing of exception reports by educational supervisors is often slow. The GoSW can facilitate closure of ERs and does so frequently as many breach for time responses.

- GOSH vacancy rates have varied between 7 and 11.9% over 2021/21, in line with Trust averages, and continue to be below the national average

- Only fine has been levied. It is likely that this signifies low reporting rates rather than assuring compliance.

- Bank rates for non-consultant doctors working unsociable hours have been increased from April 1st 2022

Attachment 5

GOSH Guardian of Safe Working Annual Trust Board Report April 1st 2021 to March 31st 2022

1. Purpose

This paper provides assurance to the Board on progress being made to ensure that doctors working hours are safe for the year ending March 2022.

The Board is asked to report information on rota gaps and the plan for improvement in the Trust's Quality Account and publish the details of Guardian fines in the Trust's annual accounts.

2. Introduction

2.1. The 2016 Terms and Conditions of Service (TCS) highlight the importance of appropriate working hours and attendance at training and education opportunities for junior doctors. Both issues have a direct effect on the quality and safety of patient care with increasing recognition on the negative effect of rota gaps on junior doctor training and wellbeing.

2.2. The 2016 TCS set firm limits to the number of hours trainee doctors can spend on duty. GOSH works within these limits for all doctors despite differing contractual arrangements across the establishment. The 2016 TCS guides safe working hours with principles that must apply to all.

2.3. Contractually every Trust has a Guardian of Safe Working (GoSW), a senior appointment who ensures that issues of compliance with safe working hours are addressed and provides assurance to the Board of the employing organisation that doctors' working hours are safe.

3. COVID-19: Continued Response from Medical Workforce in 2021-22

3.1. GOSH stepped on to new, fully compliant rotas on June 22nd 2020. As part of the COVID recovery plan five Medical Workforce Leads were appointed to continue to develop and improve out of hours working in November 2020.

3.2. The MWLs ensure:

- Daily situational awareness briefing and anticipatory planning for rota gaps
- Absence monitoring and oversight
- Medical workforce deployment management
- Communication to and from the Out Of Hours (OOH) System
- Support to OOH safety and risk process
- Activation of alternative OOH systems during pandemic surge
- A flexible 'one team' approach to out of hours working

3.3. The medical workforce, consultants and junior doctors, escalated a rapid and organised response to COVID related absence for the precipitous Omicron surge In Dec/ Jan 2022

3.4. During the holiday period of Christmas and New Year an additional volunteer doctors agreed to be 'shift back up' with a retainer fee of £10/ hr. If activated the shift rate would be escalated to bank rates. 17 additional shifts were activated between 24-12-21 and 03-01-22 across the Trust.

3.5. Overall COVID related absence has contributed to approximately 10% of the annual bank spend. Other than the holiday period management (3.4) higher than usual absence rates has been managed effectively through the medical workforce leads on our standard rotas.

4. Patient Safety

4.1. During 2021/22 there has been seven immediate safety concerns reported directly through the exception reporting ER system. Two were created in error, four associated with surgical SHO rota and one immunology- all related to unsafe staffing levels and were escalated to operational teams.

4.2. **Rest provision** contributes to safe patient care by ensuring staff are making safe effective decisions. GOSH has increased bed availability on site from 12 to 21 beds in 2021. In 2021 17 foldaway beds were purchased and made available in accessible rooms (such as seminar rooms) for 'feet-up rest' for those working on shifts.

5. Work Schedules

5.1. NHS employers mandate that doctors in training should receive schedules of work that are safe for patients and safe for doctors and should be finalised and available 8 weeks prior to commencement of the new post. In 2021/22 all work schedules were available and published within the necessary time frames.

5.2. Delayed international medical graduate recruitment due to COVID has caused rota gaps in haematology and oncology with trainees reporting additional duty hours through the exception reporting system. In response working schedules were reviewed with the depletion in posts.

6. High level Data* as of 31st March 2022

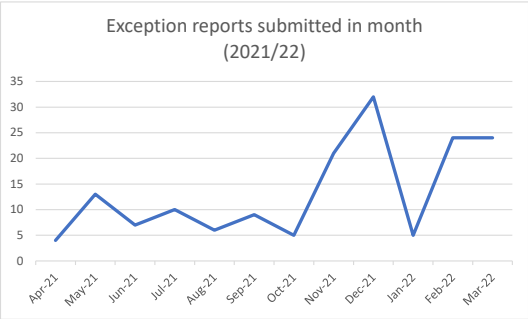
Number of trust doctors	256 (includes Education and Research Fellows)
Number of training doctors	127
Number of vacant unfiled posts	44 out of a total of 369 rota slots (11.9%)

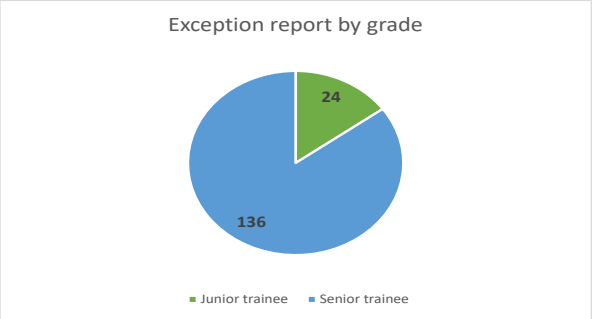
*Numbers indicate full time equivalent posts

7. Exception Reporting

7.1. Exception reporting (ER) is the mechanism by which doctors are able to report safety concerns in the workplace and as such GOSH enables both Health Education England (HEE) trainees and non-training (trust) grade doctors to exception report at GOSH. All GOSH junior doctors can receive either financial compensation or time off in lieu of additional work performed if either preauthorised or when validated by a clinical manager.

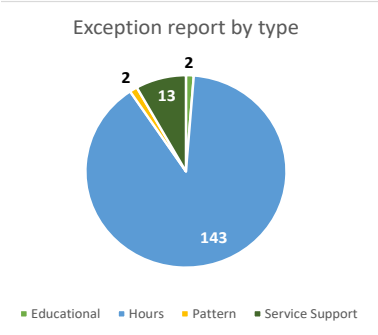
7.2. In 2021/22 GOSH received 160 exception reports (up from 73 in 2020/21) submitted by a total of 36 individual doctors. There was an average of 13 reports each month. While the volume of reports is an increase on the previous year (no ERs submitted during COVID pandemic Q1 2021), it is broadly in line with the 2019/20 numbers (149 reports submitted by 31 doctors).



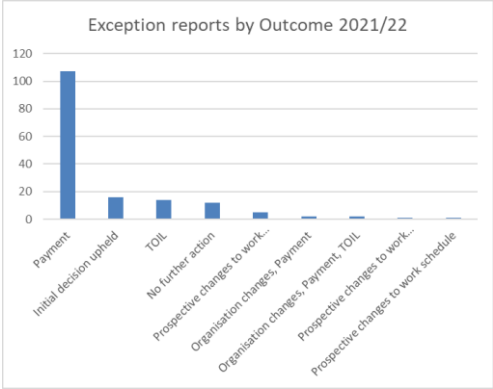


7.3. Presented monthly less than 1% of the junior doctor workforce are submitting ERs. This is a very small proportion of doctors but aligns with the national knowledge and our local ER survey in January 2020.

7.4. The majority of ERs are related to additional hours work and submitted by senior Trust grade (non-training) doctors.



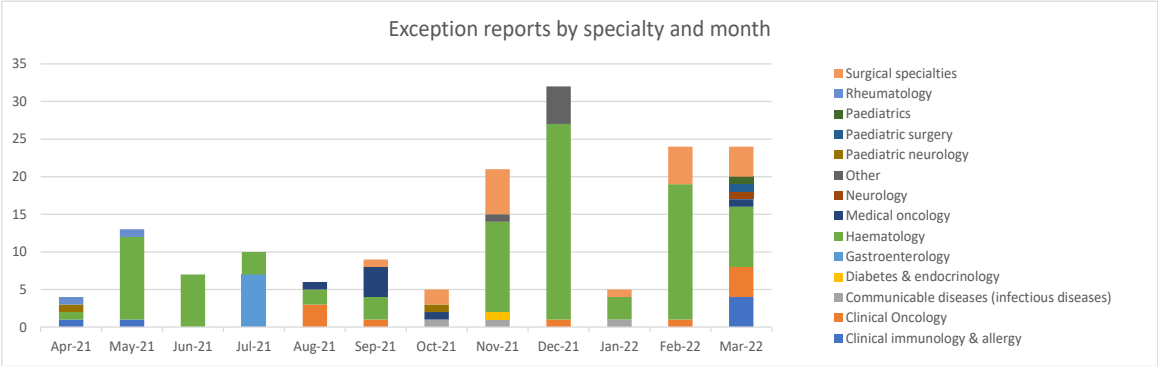
7.5. Most ERs resulted in financial compensation. One doctor has an outstanding work schedule review



7.6. ERs have been presented by multiple specialties. Variation in reporting pattern is seen through the year. Incidence of reporting can be seen in some specialities that have experienced vacancies with subsequent high-volume workflow resulting in additional hours:

7.6.1. 30-40% reduction in baseline establishment in haematology/oncology in Autumn 2021 due to delays in onboarding International Medical Graduates which is reflected in ER numbers.

7.6.2. Immunology and Infectious Disease (ID) (also can be reported through a 'haematology' label as some doctors rotate) also had considerable work volume issues. The Immunology/ ID establishment was increased by 2WTE in March 2022.



8. Fines

8.1. One fine has been levied with current ERs to date. This was associated with unintended additional bank duties for a surgical SHO. Fines only apply for the doctors on the 2016 TCS.

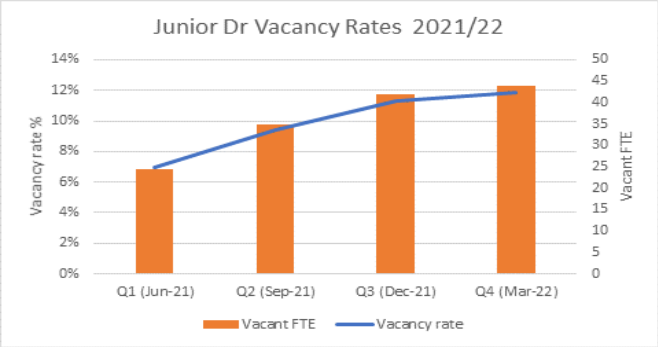
8.2. Current ER system does not automatically identify breaches as the system is dependent on the doctors to report breaches which they are often reluctant to do.

9. Rota Gaps and Vacancy Rates

9.1. Rota gaps have been highlighted as an organisational pressure. Measures are being taken to mitigate the situation at GOSH include:

- appointing Medical Workforce Leads to closely support rota management
- implementation of a standard operation procedure for rota gaps
- establishing minimal numbers of doctors required to safely staff speciality areas
- devising rotas that factor in minimum numbers and allowance for annual and study leave
- allocating managerial oversight providing cross organisation rota coordination and support
- supporting increase bank rate for JD unsocial hours from April 2022

9.2. GOSH vacancy rate has varied between 7% and 11.9% over 2021/22 (broadly similar to the previous year; range 6.8-12.1%) while it continues to sit below the national average, it saw an increase each quarter.



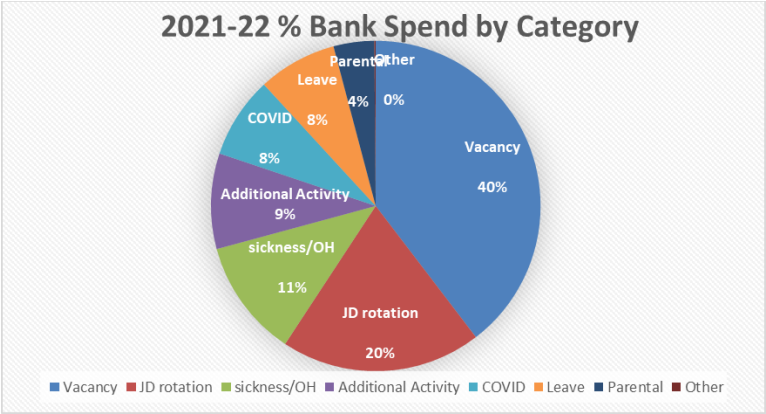
9.3. Vacancy rates and rota gaps reflect the end point of multiple workforce issues including:

- short term unplanned absence
- delays in recruitment process, particularly timeframes for onboarding international medical graduates
- variations in numbers of trainees sent to the Trust by the deanery
- national reduction in the medical paediatric workforce.

9.4. Categorisation of Banks Spend Linked to Rota Gap management

9.4.1. Data cleansing has improved categorisation of bank spend on Health Roster. This has informed our understanding of the reasons for rota gaps and what can be targeted for improvement.

9.4.2. Vacancy was given as the most common reason (40%) for bookings followed by JD rotation (induction/ delays in onboarding/ less than full time working) followed by non-COVID staff sickness (11 %).

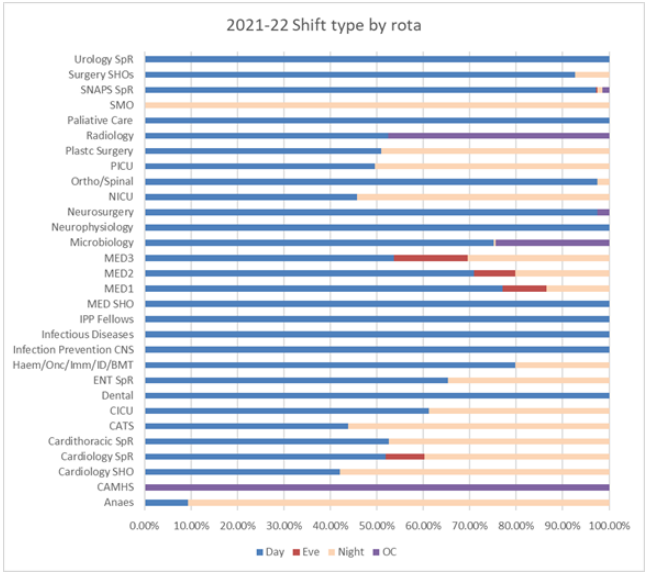


10. Bank Hours

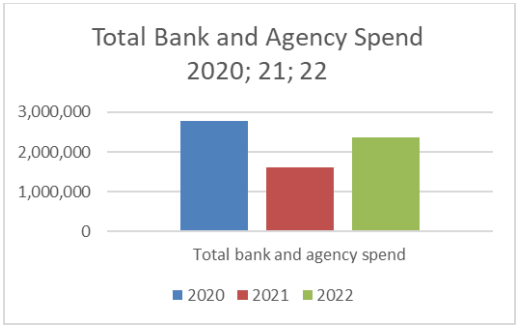
10.1. Bank shifts are primarily filled 'in house' as opposed to locum agencies. There is significant reliance on internal 'bank' locums to cover both short- and long-term gaps in junior medical staff rotas across the Trust.

10.1.1. If doctors wish to do work additional shifts, they must be aware of breaching safe working hours. Doctors themselves have a responsibility and duty of care for regulating their own hours of working, in addition to the organisation. Some organisational oversight is achieved through the rota coordinators who check additional bank shifts for compliance.

10.1.2. It is important to note, that in most cases a large proportion of the hours filled by bank are 'daytime' hours and not out of hours. This suggests that there may not be the numbers required within specialty to maintain safe staffing levels during the day

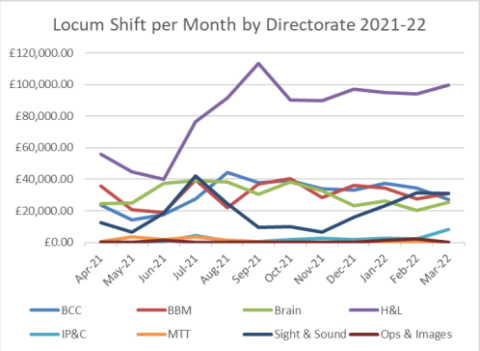


10.2. Year to Date bank and agency spend is £2.34 million (of which Agency spend was £96,030 (4%).

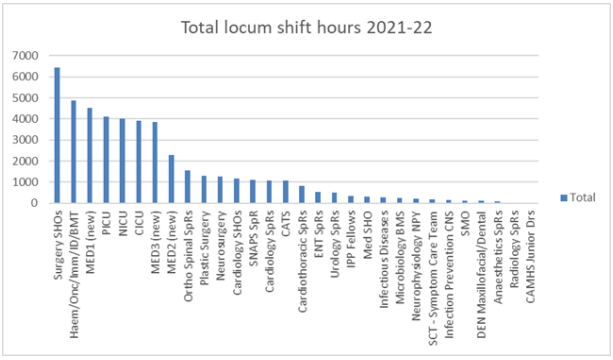


10.2.1. Spend related to COVID-19 (8% compared to 2020-21 spend of 3.9%) and additional 'accelerator' activity may indicate why bank costs are higher compared to 2020/21 data. It is important to note that bank spend during COVID first surge (Q1 2020) was exceptionally low due to COVID rota management.

10.2.2. Bank costs must be triangulated with salary savings related to vacant posts. This data has not been offset by salary savings for vacant posts



10.3. Whilst Finance data reports spend against cost centres rather than rotas, when looking at shifts booked across the rotas, the Surgery SHO rota accounted for the largest number (19.6% of the total) followed by Haem/Onc/Imm/ID/BMT at (18.3%). MED 1,2,3 include combination of different medical specialities.



11. Junior Doctors Forum (JDF)

11.1. The JDF continue to run monthly with good attendance. Junior medical staff are represented as 'JDF Reps' in each directorate attending management meetings. Access to extended leadership training has been offered to JDF reps.

11.2. The JDF successfully negotiated an increase in bank rates for unsocial working hours – effective from April 2022. It is anticipated that increasing bank/ locum rates will improve rota gaps fill rates, offer more competitive remuneration and assurance for continued patient safety out of hours

11.3. General engagement with the junior doctors across the organisation is good. Improvement in new messaging platforms, such as the new intranet is likely to reach more junior medical staff.

12. Matters for the Board:

12.1. Development of the Medical Workforce Lead role has provided safety infrastructure and improvement to OOH working.

12.1.1. Note achievement managing a safe and effective medical workforce during COVID pandemic.

12.2. Clinical input to rota management and improved data capture of junior medical workforce bank costings has resulted in opportunity to deliver a Better Value culture.

12.3. Unfortunately, risk related to poor compliance assurance offered by the exception reporting system should continue to be acknowledged. Most assurance is determined by good clinical leadership, open communication and infrastructure management by the MWLs and rota coordinators.

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Audit Committee meeting held on 6th April 2022

Counterfraud Update and Annual Report 2022/23

A green rating had been forecast for GOSH in the Government Functional Standard for Counter Fraud. A green rating was predicted in all areas with the exception of declarations of interest as a 100% compliance rate was required in this area which was challenging to achieve by many Trusts. The Committee welcomed the outcome which was an improvement on the previous year. The Committee reviewed the draft Counter Fraud Workplan for 2022/23. It was agreed that an updated version would be presented to the Committee at the May meeting as updates were required

Matters arising

The Committee received an update on the financial impact of the work that had taken place to improve cyber security at GOSH. The Committee welcomed the proportion of spend which had been on bank and agency staff rather than consultancy services.

Work was taking place working with an expert external organisation to understand the options for USB port blocking. It was vital that good communication was in place and an exercise was taking place to be clear about all devices which were plugged into USB ports to ensure that there was no impact on medical devices.

Discussion took place around contingency plans for single suppliers of clinical equipment. The Trust was in a joint procurement service with other organisations which used the same products and mutual aid had been provided during surges of the pandemic.

Trust Board assurance committee updates

The Committee noted the following assurance committee updates:

- Quality, Safety and Experience Assurance Committee –20 January 2022
- Finance and Investment Committee – February 2022 and March 2022
- People and Education Assurance Committee – February 2022

Board Assurance Framework Update

The Committee considered the following updates to BAF risks as recommended for approval by the Risk Assurance and Compliance Group:

- Risk 2: Recruitment and Retention – The committee approved a revised risk statement ensuring that focus was placed on workforce sustainability.
- BAF Risk 5: Unreliable data – Given the work around referrals with no future activity it was agreed that a further update would be considered at the May meeting following discussion at RACG.
- BAF Risk 8: Business Continuity – A revised risk statement was reviewed which highlighted the risk around service interruption. The committee requested that a further review of the risk took place and emphasised the importance of plans being understood by the organisation and the identification of the sub elements of the risk.
- BAF Risk 12: Inconsistent delivery of care – The committee approved a revised risk statement which removed duplication with other risks and widened the breadth of patient safety and quality areas.
- BAF risk 15: Children's Cancer Centre – The Committee approved a revised risk statement noting that the BAF risk also incorporated the risk assessment for the Children's Cancer Centre.

The Board would receive an updated version of the BAF for final approval in May 2022.

Board Assurance Framework Deep Dives:

- BAF Risk 1: Financial Sustainability

There had been a delay to the transfer of specialist commissioning to Integrated Care Systems which was positive, however the proposed block contract was not sufficient to cover required activity and therefore work was taking place to ascertain what was incorporated in the block and identify any unintended consequences. It was vital to understand the interaction between the increase in International and Private Care income and the requirement to deliver more NHS activity. Commercialisation was a key priority going forward. The Committee expressed concern about the transparency of current and future processes around allocation of funding. The importance of good asset utilisation and better value was emphasised.

- BAF Risk 6: Research Infrastructure

The Competition for NIHR BRC funding was ongoing and was key to the Trust's research capacity. The Committee discussed the implications of a reduction or loss of funding as an outcome of the competition. Following work to align the GOSH Children's Charity and Trust's research priorities this was becoming embedded with weekly meetings taking place. A five-year business plan for activity in the Zayed Centre for Research. The Committee asked the RACG to review the rating of the risk once feedback from the BRC interviews had been received.

BAF Risk 5: Unreliable data – Update on No Future Activity (NFA)

There had been a good reduction in the number of referrals with no future activity and changes had been made to the Epic system. Additional outpatient appointments would be required to review patients, but the number required was not yet clear. No patient harm had been identified so far.

BAF Risk 9: Estates Compliance

Considerable work had taken place since the completion of an external assessment of estates compliance and a joint Audit Committee and QSEAC meeting would be taking place to discuss the matter further. An issue had arisen in a building which was partially occupied by GOSH staff and patients but owned by another London Trust. The importance of ensuring that assurance data was received from other organisations as required was emphasised. The Committee highlighted the importance of ensuring that reports showed consistent information and reflected any critical sub issues which required attention.

Assurance of compliance with risk management strategy

The existing risk management strategy had been updated and a revised strategy was also being developed which would consider risk across all areas of the organisation. The Committee discussed the levels of awareness of Trust Wide Risks at the assurance committee level. It was noted that the RACG would escalate issues as necessary.

- Assurance of compliance with centralised reporting of incidents via NRLS

The Committee agreed that the reporting of incidents and near misses was positive and in line with the Trust's speak up for safety initiative.

Write offs

Processes were being introduced in pharmacy to reduce the recent increase in expired drugs.

External Audit 21/22 Progress update

Timings had been agreed around the audit of the accounts in relation to the year end Audit Committee meeting and auditors were in the early stages of their work. Weekly meetings were taking place to discuss key

matters. There were issues with audit resource constraints however it was anticipated that the planned timelines would be achievable subject to unforeseen circumstances.

Internal Audit Progress Report (February 2022 – March 2022) and Technical Update including recommendations update

Three final reports were received: Quality Governance which received an assurance rating of 'partial assurance with improvements required' and Freedom of Information and Data Security and Protection Toolkit which both received assurance ratings of 'significant assurance with minor improvement opportunities'. It was noted that the Quality Governance report would be discussed at QSEAC.

- Internal Audit Annual Report including Draft annual HOIA

The draft Head of Internal Audit Opinion had been issued and was 'significant assurance with minor improvement opportunities' which was in line with the previous year.

- Internal Audit Annual Operational Plan 2022/23

The plan had been reviewed with the Executive and Non-Executive Directors and updates made following feedback received. The Committee approved the plan.

Year-End Update

A first principles valuation of land and buildings had taken place and the potential impact of climate change was being taken into consideration.

IFRS 9 Update

The committee approved the suggested provision proposal based on a revised methodology.

Raising Concerns in the Workplace Update

One case of whistleblowing was currently under investigation and the committee requested that the PEAC review assurance around staff confidence levels to raise concerns.

Audit Committee Effectiveness Survey – results

Overall responses to the effectiveness survey had been positive. Themes had arisen around paper authors being supported to write assurance papers which was in line with results from other assurance committee effectiveness surveys.

Procurement Waivers

The committee welcomed the continued improvement in the number of waivers received.

Attachment 7

Summary of the Quality, Safety and Experience Committee meeting held on 20th April 2022

Quality and Safety at GOSH – Medical Director Report

An independent review was being commissioned by the Department of Health and Social Care of the causes of disagreements in the care of critically ill children. The Committee agreed that it was important that GOSH provided input into this work given that it made the most court applications in the UK in this context. Discussions were beginning with North Central London (NCL) Integrated Care System (ICS) about a forum for focusing on quality and safety which had previously taken place with NHS England. Monthly engagement meetings were taking place with the CQC to ensure transparency on an ongoing basis. A review was being undertaken of all claims over the past three years to provide oversight of the learning identify and ascertain whether this had been embedded across the Trust.

Patient Safety and Outcomes Committee (PSOC) Report

Further work was taking place on an updated Central Alerting System (CAS) alert policy as a result of learning from an historical incident. The PSOC had highlighted the importance of the early identification of deterioration, and this would be taken forward by the Deteriorating Child Group.

Patient and Family Experience Overview Report for Q4

Complaints had reduced and in particular there had been a reduction in red complaints based on the same period in the previous year. A theme was emerging around communications between departments and administration processes were being reviewed. PALS contacts were consistently high and work was taking place to ascertain why families contacted PALS rather than clinical teams. The Committee discussed the timelines associated with complaints and it was noted that a large proportion required an extension of the deadline after this had been agreed with the family. Work would take place to identify the reasons for the delays.

Quality Governance Management Framework

The Committee welcomed a presentation on a revised quality governance management framework which would support better reporting of the right information to the appropriate committee. Discussion took place on the importance of committee chairs to ensure that agendas were appropriately compiled and meetings managed. It was agreed that it was important to ensure that training was available in this area.

Safeguarding Update (Exceptions Report)

New safeguarding training had been rolled out Trust wide and this was now a full day of training. Discussion took place around chaperoning which was a risk on the safeguarding risk register. An audit had highlighted low compliance with the chaperone policy however observation showed that chaperones were being offered and used but this was not being documented. The policy had been promoted and an auditable area had been created in Epic (the electronic patient record). The Committee discussed the use of artificial intelligence (AI) to identify safeguarding risks for patients and it was noted that GOSH was the pilot provider to use the Patient Centred Information System (PCIS) for scheduled care to identify whether patients were the subject of child protection orders.

Update on quality impact of Better Value Schemes

Quality Impact Assessments and Equality Impact Assessments had been brought together and the process had incorporated recommendations from the internal audit on Better Value. The Committee discussed the communication of the programme to staff and agreed that it was important to balance the messaging around saving money, recovering the backlog and staff welfare. It was noted that improved efficiency of processes was likely to improve patient and staff experience alongside saving money. The importance of ensuring that

equal access to services was not impacted through schemes was emphasised.

Internal Audit Progress Report and 2022/23 Internal Audit Plan
The internal audit plan for 2021/22 had been completed and a Head of Internal Audit Opinion of 'significant assurance with minor improvement potential' had been issue which was in line with the previous year. The Committee discussed the report on the review of Quality Governance which had provided a rating of 'partial assurance with improvements required'. It was noted that this was in line with the team's expectations and the existing action plan would be amended to include the recommendations. The internal audit plan for 2022/23 had been approved by the Audit Committee.

Freedom to Speak Up Guardian Update
Cases would be presented by exception to QSEAC where concerns had been raised about quality and safety. It was noted that concerns had been raised by a particular group of staff who were experiencing substantial change in their area. The Committee emphasised the importance of investigating the concerns raised irrespective of other issues.

Whistleblowing update
There was one whistleblowing case which was being actively managed.

Research Hospital Update (from a governance and quality/ patient experience perspective)
A research dashboard was being developed to monitor research metrics and support benchmarking. Focus was being placed on staff engagement and measuring staff satisfaction.

Transition Update
Work had been taking place with the Young People's Forum to understand their experience of transition and their transition preferences. The Transition Steering Group had been re-established and KPIs were being agreed. The Committee expressed disappointment that previous work such as 'Growing Up and Gaining Independence' had not been sufficiently successful in making improvements.

Quality Account
A complete draft of the report was almost ready and would be provided to Non-Executive Directors for comment before being submitted to the May 2022 Trust Board for approval.

Health and Safety Update
A small fire had broken out in the staff nursery. Evacuation processes had worked well and the London Fire Brigade had congratulated staff. The highest number of RIDDORS had been reported as a result of staff being exposed to a COVID19 risk. The Committee requested consideration of items reported as part of the update and requested further focus on emerging risks.

Update from the Risk Assurance and Compliance Group on the Board Assurance Framework
BAF risk 5: Unreliable data would continue to be discussed at RACG given the work that was taking place on referrals with no future activity. The estates risk had been updated but would continue to be discussed on an ongoing basis. The Committee highlighted the risk statement for BAF risk 12: inconsistent delivery of safe care and emphasised that care for patients beyond regulatory standards was required.

QSEAC Effectiveness Survey Results
Responses from paper authors had shown that they were not always clear about the purpose for attending different committees to discuss a matter and the new governance framework would streamline the escalations of these matters. Support was also required for paper authors to write assurance-based reports.

Governor feedback

Discussion took place around transition and in particular the Transition Steering Committee. It was noted that the committee did not have a parent representative and it was agreed that this would be valuable given that many young people continued to need the support of their families to express their wishes. It was agreed that this feedback would be provided to the Chief Nurse.

Discussion took place around the changing responsibilities of Governors once Integrated Care Systems became statutory bodies and it was noted that training would be provided to Governors about this.

Attachment 8

Summary of the Council of Governors' meeting held on 27th April 2022

Overview of Trust strategy: Above and Beyond

The Council received an overview of the Trust's Strategy and they way in which it was developed including the consultation involved. Protecting the environment was a key element which was new to the strategy and feedback had been received from staff and young people that this was an important area of focus. An update on progress with the planets was provided and it was noted that the progress of some planets had been slowed by the COVID19 pandemic but some continued to make good progress.

Chief Executive Report

The hospital was operationally challenged but was performing well in terms of activity and benchmarking well against other Trusts in North Central London. GOSH was liaising with other children's hospitals and humanitarian organisation to support patients from the Ukraine. Work was taking place to reduce the number of referrals without future activity and as a result two patients had been identified who required further review and this would take place. The Council discussed the importance of cyber security in the context of the war in Ukraine.

People Planet Update: Staff survey results 2021

The results of the 2021 staff survey had been structured around the 7 themes of the NHS people promise and therefore it was not possible to continue with trend data from previous years. Progress had been made when benchmarking against GOSH's peers and in 2018 the Trust's had been the lowest in almost all areas. There had been incremental improvements year on year and GOSH now compared well with others. Progress with the People Strategy continued to be monitored at the People and Education Assurance Committee.

Introduction to Tracy Luckett, Chief Nurse

The Trust's Chief Nurse gave an update on her priorities since she joined GOSH in February 2022. Areas of focus for improvement were communications with patients and families and health inequalities.

Governor requested item: How are we seeking to reduce waiting lists and maintain safety and deliver a good patient experience?

Waiting lists were a key area of challenge and focus for the NHS as a whole as they had grown significantly throughout the COVID19 pandemic. Patients had been categorised by clinical priority had GOSH had succeeded in maintaining activity for high priority patients including cancer patients. A harm review process was in place for all patients who waited more than 52 weeks and there had been no incidents in which patients had suffered moderate or severe harm as a result of the prioritisation process. The number of patients who had waited 52 weeks had reduced from its peak and those waiting 104 weeks would reach zero by July 2022. Positive feedback continued to be received through the Friends and Family Test. Governors emphasised the importance of communicating effectively with patients and families about waiting times and ensuring that focus was also placed on diagnostic waits.

Children's Cancer Centre (CCC) Project Update

The Full Business Case for the CCC was in development and would be considered by the Board for approval in September 2022. It would also require approval from the Council of Governors as a significant transaction. Work on RIBA 3 was concluding and moving on to RIBA 4. Considerable work had taken place with the Local Authority and local residents on planning permission which was progressing well and would be submitted at the end of May 2022. Discussion took place about the considerable risk around inflation and it was confirmed that a detailed schedule of costs would be received as part of the project report at the end of RIBA 3. Allowances had been made for inflation but would require review.

Attachment 8

Update on Transition

The transition policy had been updated and work was taking place with Epic to ensure that the EPR was appropriately set up for transition. A trust wide scoping survey was beginning to ascertain a benchmark for performance and identify the barriers and facilitators to transition. The Council emphasised the importance of making improvements to transition and discussed the use of the emergency health care plan (ECHP) as part of planning for transition.

Finance Report (February 2022 data)

The Trust had ended 2021/22 with a deficit of £4.4million against a forecast of £5.9million deficit and a strong cash position of £124million. Regular changes had been made to the way in which funding flowed throughout the year and this would also be the case for 2022/23.

Reports from Board Assurance Committees

The Council noted the following updates from Assurance Committees:

- Quality, Safety and Experience Assurance Committee (April 2022)
- Audit Committee (April 2022)
- Finance and Investment Committee (February & March 2022)
- People and Education Assurance Committee (February 2022)

Update from the Young People's Forum (YPF)

The YPF had discussed a potential food delivery app which was being considered by the catering team. There had also been a presentation from the Caldecott Guardian about data protection. YPF members had been concerned about the risk of cyber attacks which could impact the confidentiality of patient data. The Council requested an assurance paper on the use of data during data sharing.

Governor Update – activities between meetings

Some Governors had taken part in a tour of the hospital and it was noted that further dates for tours would be scheduled.

Appointment of a Non-Executive Director

The Council approved the appointment of a Non-Executive Director who would join the Board as an Associate NED prior to moving into the substantive role once existing NEDs had stepped down.

Process for electing the Lead Governor and Deputy Lead Governor

The Council noted the role description for the lead and deputy lead governor and approved the process for election.

Draft Council of Governors' section in GOSH Annual Report 2021/22

Governors noted the Council of Governors' section in the 2021/22 annual report.

Compliance with the NHS provider licence – self assessment

The Council noted the requirement from NHS Improvement for Trust to annually declare compliance, or otherwise, with a small number of Foundation Trust licence conditions and one requirement under the Health and Social Care Act. The Council reviewed the evidence against each condition and confirmed that they were supportive of declaring compliance against each.

Membership of Council Committees

Committee membership continued to be reviewed annually to support a wide range of Governors to become involved. Governors would be invited to express interest in sitting on the committees through the May 2022 Council newsletter.

Attachment 8

Governance Update

The Council approved the Governors' Code of Conduct which would be circulated for signing. Governors emphasised the importance of returning to meeting face to face and it was noted that there was likely to be a change to some infection prevention and control guidance in the NHS which could facilitate meeting in person.

Update from the Membership Engagement Recruitment and Retention Committee

There had been an increase in members in the public constituency and work was taking place to promote membership and deliver the activity plan.

Attachment 9

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
25th May 2022

Declarations of Interests (Directors and Staff) **Submitted by: Anna Ferrant, Company Secretary**	**Paper No: Attachment 9** **For information and noting**

Purpose of report
This paper provides the annual summary of the management of declarations of interests, gifts, hospitality and sponsorship at GOSH and compliance with the policy in 2021/22. The Directors' Register of Interests is attached. A link is provided to the public register to access all staff and director declarations here: https://gosh.mydeclarations.co.uk/declarations

Summary of report
As part of the guidance issued by NHS England on staff and directors declaring interests and gifts and hospitality, Trusts are required to define 'Decision Making Staff'. These are individuals who have been determined to "*have influence in spending tax-payers' money*" and are required to make a positive or nil declaration about their interests at least annually. In 2018 GOSH's Declaration of Interests, Gifts, Hospitality and Sponsorship Policy was updated in line with this guidance.

As of 23rd May 2022, 96% of Decision-Making Staff had made a positive or nil declaration in 2021/22. Under Government counterfraud standards, the Trust is required to have a 100% return rate for decision making staff captured by the Policy, returning a declaration of interest or NIL return to demonstrate compliance

In line with the NHS contract GOSH is required to publish the names and role title of Decision-Making Staff who have not made a declaration in 2021/22.

A communication programme has run throughout 2021/22 defined to remind all staff to declare and to highlight the need for annual declarations for Decision- Making staff.

Action required from the meeting
The Board is asked to note the report including the register of directors' interests (attached) and the public register available on DECLARE showing staff interests.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
☐ **Quality/ corporate/ financial governance**	☐ **Effective processes, managing risk and performance** ☐ **Accurate data/ information** ☐ **Engagement of public, staff, external partners**

Strategic risk implications
Staff must ensure they are not placed in a position that compromises their role or may give the appearance that their role has been compromised, or that compromises the position of the Trust with regard to its statutory duties.

Financial implications Under the Bribery Act 2010 unlimited fines can be levied against the Trust.
Implications for legal/ regulatory compliance The Bribery Act 2010 came into effect on 1 July 2011. The Act makes it a criminal offence to give, promise or offer a bribe, and to request, agree to receive or accept a bribe. The maximum penalty for bribery will be 10 years imprisonment for individuals engaging in bribery and an unlimited fine for the hospital.
Consultation carried out with individuals/ groups/ committees Revised definition for Decision Making Staff approved at EMT Presentations given to SLT Emails sent to all Decision Makers
Who is responsible for implementing the proposals / project and anticipated timescales? Victoria Goddard, Trust Board Administrator
Who is accountable for the implementation of the proposal / project? Anna Ferrant, Company Secretary
Which management committee will have oversight of the matters covered in this report? Executive Management Team

Attachment 9

Great Ormond Street Hospital for Children
NHS Foundation Trust

Compliance with the Declaration of Interests, Gifts, Hospitality and Sponsorship Policy 2021/22

Background

In 2017 NHS England issued guidance for NHS Trusts, CCGs and NHS Foundation Trusts on staff and directors declaring interests and gifts and hospitality. Whilst this has the status of 'guidance', NHS England recently emphasised has Trusts are required to adopt the guidance and this requirement is included in the NHS contract; NHS England issued a template policy.

The Trust's Declaration of Interest and Gifts, Hospitality and Sponsorship Policy was updated in 2018 in line with this guidance which included the requirement to define 'Decision Making Staff' - those staff who "*have influence in spending tax-payers' money*". These individuals are required to make a declaration about their interests at least annually (or where there are no interests, to make a nil return).

Decision Making Staff definition*
Executive and Non-Executive Directors
All staff at band 8c and above
All budget holders at any band
All doctors irrespective of grade
Governors on the GOSH Council of Governors.

**Includes bank, agency, interim and relevant honorary staff in any of the categories.*

During the year EMT agreed that as a result of the role of Doctors in Training and their work under supervision from consultants, Junior Doctors should no longer be considered Decision Making Staff as they do not have the final level of authority to have influence in spending taxpayers' money. It was also agreed that, in line with the approach taken for mandatory training compliance figures, staff on maternity leave, external secondment and/or career break would be excluded from declaration of interest compliance figures but continue to be reminded to report on their return. In addition, work is underway to understand specifically which honorary consultants have influence over spending taxpayers' money in their roles at GOSH.

Compliance with the policy in 2021/22

The Trust adopted an online system called DECLARE in 2019 which enables all staff to declare and manage their own declarations. A communication programme has been in place throughout the year to remind Decision Makers of their requirement to declare including emails from the Declare system, reminders for cascade to teams via the Senior Leadership Team meetings and emails from executive directors and the Chief Executive.

In line with the NHS contract GOSH is required to publish the names and role title of Decision-Making Staff who have not made a declaration in 2021/22.

As of 23rd May 2022, there were 924 active Decision-Making Staff on DECLARE of which 96% had made at least one positive or nil declaration in the calendar year. Declarations were made as set out in the table below.

Decision Maker Declarations 2021/22

Interest type	Number of Declarations
Nil declaration	911
Charitable money donations	4
Clinical private practice	84
Gifts and donations of equipment	8
Hospitality	15
Loyalty interests	25
No change to existing declarations*	161
Outside employment	122
Patents	0
Shareholding and other ownership interests	16
Sponsorship events	34
Sponsored posts	2
Sponsored research	23
Total	1,405

*No change to existing declarations will encompass a wide variety of different categories of interest.

The Trust's Counter Fraud Service reviewed GOSH's performance against the Declarations of Interests, Gifts, Hospitality and Sponsorship Policy for 2021/22 as part of the Counter Fraud Functional Standard Return and provided an amber rating. This was as a result of the requirement from the NHS Counter Fraud Authority that 100% of Decision-Making Staff make a positive or nil declaration in year.

Register of Directors' interests

The Register of Directors' Interests is attached at **Appendix 1**.

Register of staff interests

The public register is available at the following link https://gosh.mydeclarations.co.uk/declarations

Attachment 9

Register of Interests 2021-22
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors
Non – Executive Directors (Voting)

Name	Declared Interests
Sir Michael Rake	Chair, Newday Ltd Vice President, Royal National Institute of Blind People Chair, Majid Al Futtaim Holdings (UAE) Member, International Business and Diplomatic Exchange Advisory Board Chair, Phoenix Global Resources Director, (owner) MDVR Services Ltd Director, University College London Partners (UCLP) Chair, Wireless Logic Limited Director, Trust Payments Limited Chair, Ola UK Limited Citigroup, Adviser
Akhter Mateen	Non-Executive Director CABI (Centre for Agriculture and Biosciences International) Trustee, Developments in Literacy (DIL) UK Non-Executive Director, Kings College Hospital NHS Foundation Trust Trustee – Malala Fund UK
James Hatchley	Until 11th May 2022 Group Strategy Director 3i Group Plc Member of the 3i Group plc Investment Committee Board member of Scandlines Infrastructure ApS, a Danish Ferry business of which 3i own 35%. From 12th May 2022 Group Finance Director Designate and member of the 3i Group plc Board Director of a number of other 3i Group plc entities
Lady Amanda Ellingworth	Director, Plan International Inc Trustee, Plan International UK Deputy Chair, Sir Ernest Cassel Education Trust Non-Executive Director, Catholic Safeguarding Standards Authority
Chris Kennedy	Chief Operating Officer and Chief Financial Officer ITV Plc Non-Executive Director, Whitbread PLC Non-Executive Director, The EMI Archive Trust Ltd
Kathryn Ludlow	Trustee of the International Rescue Committee Trustee of The Hall for Cornwall Member of International Advisory Panel for Woodsford Group Founder and Director of Kathryn Ludlow and Associates Limited
Prof Russell Viner	President and Trustee, Royal College of Paediatrics and Child Health (until 15 May 2021) Consultant (Honorary), UCL Hospitals NHS Foundation Trust Professor, University College London Member of Sage – Government Office for Science, and of subgroups Spi-B (behavioural science) and SPI-Children, In each of these I advise Government on

Attachment 9

Register of Interests 2021-22
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors

Name	Declared Interests
	COVID-19 re children and young people. Member of Advisory Board, Children's Commissioner for England Member of Advisory Board, Science Media Centre

Executive Directors (Voting)

Name	Declared Interests
Mr Matthew Shaw, Chief Executive	Director, UCL Partners Director, AS Residents' Association Executive Director Board Member, NCL Provider Alliance Partner – Consultant Anaesthetist at GOSH
John Quinn, Chief Operating Officer	None
Caroline Anderson, Director of HR and OD	None
Tracy Luckett, Chief Nurse	None
Dr Sanjiv Sharma, Medical Director	Member, Board of Governors, Haverstock School Board member, University of Stirling Management School Business Advisory Board Director, Greenberry House. Apartment block with 9 flats, each with a share of freehold. Partner – works at GOSH working within the Chief Nurse Directorate (GOSH Learning Academy)
Helen Jameson, Chief Finance Officer	None

Other Directors (Non-Voting)

Zoe Asensio-Sanchez, Director of Estates, Facilities and the Built Environment	None
Prof David Goldblatt	None
Cymbeline Moore	Elected Parent Governor, Rushmore Primary School