Meeting of the Trust Board
Wednesday 6 July 2022

Dear Members

There will be a public meeting of the Trust Board on Wednesday 6th July 2022 at 1:30pm.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**1:30pm**
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.				**1:35pm**
2	**Minutes of Meeting held on 25 May 2022**	Chair	**K**	
3.	**Matters Arising/ Action Checklist**	Chair	**L**	
4.	**Chief Executive Update**	Chief Executive	**M**	**1:40pm**
5.	**Patient Story**	Chief Nurse	**N**	**1:50pm**
6.	**Clinical Directorate presentation: Heart and Lung Directorate**	Chief Operating Officer/ Senior Leadership Team for Directorate	**O**	**2:10pm**
	PERFORMANCE			
7.	**Integrated Quality and Performance Report: May 2022 data**	Medical Director/ Chief Nurse/ Chief Operating Officer	**S**	**2:30pm**
8.	**Annual Safeguarding Report 2021/22**	Head of Safeguarding	**U**	**2:40pm**
9.	**Independent Review of the effectiveness of the Trust's Safety Procedures**	Medical Director	**4**	**2:50pm**
10.	**Finance Report Month 2 (2022/23)**	Chief Finance Officer	**T**	**3:00pm**
	STRATEGY AND PLANNING			
11.	**Sustainability at GOSH: Annual Sustainability report 2021/22**	Director of Estates, Facilities and Built Environment	**P**	**3:10pm**
12.	**2022/23 Business Plan and Budget**	Chief Finance Officer	**Q**	**3:20pm**
13.	**National cost collection submission**	Chief Finance Officer	**R**	**3:30pm**
	ASSURANCE			
14.	**Responsible Officer Annual Report 2021/22**	Responsible Officer/ Medical Director	**V**	**3:40pm**
15.	**Board Assurance Committee reports** • **Quality, Safety and Experience Assurance Committee – 30 June 2022 meeting** • **Audit Committee Assurance Committee Update – 25 May 2022 meeting**	Chair of QSEAC Chair of Audit Committee	**Verbal** **X**	**4:00pm**

	• **Finance and Investment Committee Update – 21 June 2022 meeting** • **People and Education Assurance Committee Update – 22 June 2022 meeting**	Chair of the Finance and Investment Committee Chair of the People and Education Assurance Committee	**Y** **Z**	
	GOVERNANCE			
16.	**Register of Seals**	Company Secretary	**1**	**4:15pm**
17.	**Draft Code of Governance and Draft *Addendum to Your statutory duties – reference guide for NHS foundation trust governors***	Company Secretary	**2**	**4:20pm**
18.	**Appointment of Deputy Chair and Senior Independent Director**	Company Secretary	**3**	**4:25pm**
19.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			**4:35pm**
20.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 21 September 2022.			

Attachment K

DRAFT Minutes of the meeting of Trust Board on 25th May 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
Kate Oulton*	Nurse Consultant for Learning Disabilities
Chris Ingram*	Fire, Health and Safety Manager
Helen Dunn*	Director of Infection Prevention and Control
Josh Hardy	Governor (observer)
Constantinos Panayi	Governor (observer)
Jackie Gordon	Governor (observer)
4 members of the public (observers)	

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

13	**Apologies for absence**
13.1	No apologies for absence were received.
14	**Declarations of Interest**
14.1	No declarations of interest were received.
15	**Minutes of Meeting held on 30 March 2022**

15.1 15.2	Minute 193.4: Kathryn Ludlow to be noted as Chair of PEAC rather than Finance and Investment Committee. Subject to the above amendment, the Board **approved** the minutes of the previous meeting.
16	**Matters Arising/ Action Checklist**
16.1	The actions taken since the previous meeting were noted.
17	**Patient Story**
17.1 17.2 17.3 17.4 17.5 17.6	The Board received a patient story via video from Laura, the mother of Max, aged 13 and under a number of specialties at GOSH. Laura said that Max had severe learning disabilities and described the challenges of experiencing hospital appointments which did not interact with Max in a way he could engage with. Laura highlighted the importance of clinicians familiarising themselves with information about patients, such as disability passports, in advance of appointments. Laura explained a difficult appointment in which she had been asked to restrain Max due to a failure to understand Max's needs and his ability to understand requests. She said that she had made a complaint about this appointment which had resulted in action being taken to conduct a dental appointment during an existing appointment for a general anaesthetic and this had been very positive. Laura said that it was vital to understand that patients who did not communicate with words were still able to communicate and engage with their care if this care was patient centred James Hatchley, Non-Executive Director said that the key theme from the story was that parents were experts in their care of their children. He added that the story had highlighted the value that a coordinator role for complex patients would add. Kate Oulton, Nurse Consultant for Learning Disabilities said that she was in the process of developing a risk assessment tool to consider the risks associated with hospitalisation of patients with a learning disability in order to support the advanced identification of patients' needs. Discussion took place about the importance of clinicians reading information about their patients prior to appointments and Sanjiv Sharma emphasised that this was a professional responsibility. **Action:** Russell Viner, Non-Executive Director said that transition in neuro-disability was complex partly as a result of the lack of appropriate adult receiving hospitals. It was agreed that consideration would be given to discussing the matter with the Children's Hospital Alliance.
18	**Chief Executive Update**
18.1	Matthew Shaw, Chief Executive thanked staff in the organisation who were working hard as a result of high levels of activity. He said that the Trust had a challenging financial position and many staff would also be challenged by the cost of living increase.

18.2	Work had been taking place with the Children's Alliance to discuss the balance of funding between adult and children's services and a virtual hospital which was planned and would be launching a large number of virtual beds but would not include any paediatric provision.
18.3	The Trust had received a visit from the national COVID19 response lead for nursing, midwifery and care and the Children's Commissioner for England who had visited the patients who had come to GOSH from Ukraine to understand their experience.
18.4	Kathryn Ludlow, Non-Executive Director welcomed the positive work that was taking place with the Children's Alliance and supported the work that was being done to build on the success of the Paediatric Accelerator.
19	**GOSH Foundation Trust Annual Financial Accounts 2021/22 and Annual Report 2021/22**
19.1	Helen Jameson, Chief Finance Officer said that the annual accounts had been developed in the context of the two financial frameworks which had been in place for 2021/22. A year end outturn of £4.2million deficit against the control total had been delivered. The deficit position had primarily been driven by the change in financial framework for the second half of the year. Cash remained strong at year end at £124million. Over the year, clinical income had remained static in comparison to the previous year but there had been a reduction in international and private care (I&PC) income as a result of the closure of travel corridors throughout the pandemic. The Trust had been able to reduce I&PC debt by £11million during the year.
19.2	Sir Michael Rake, Chair said that GOSH had made a substantial contribution across the network over the year. He emphasised that it was vital to ensure that quality and safety remained the principal priorities of the organisation and highlighted the importance of being clear about the specialist nature of the Trust and the funding required to carry out the required activity.
19.3	Akhter Mateen, Chair of the Audit Committee said that the committee had reviewed the Annual Report, Annual Accounts and Annual Governance Statement as well as the draft letter of representation and recommended the documents to the Board for approval. The Trust's external auditors had reported that their work was ongoing and remained on track to be complete by the end of the first week of June 2022. They had not raised any concerns about their findings so far and had reported that they did not anticipate any concerns to be raised going forward. He said that unless any material findings were made it was proposed that authority was delegated to the Chief Executive and Chief Finance Officer to approve and sign the Annual Accounts. Deloitte had been positive about the audit process and their experience of working with the GOSH finance team.
19.4	**Action**: Akhter Mateen said that the Head of Internal Audit Opinion was 'significant assurance with minor improvement opportunities' which was in line with the previous year. The Trust had undertaken a review of the Trust's exposure around contractual relationships with Russia and had found no exposure. The Committee had asked this to be formalised in a short paper.
19.5	**Action:** Amanda Ellingworth, Non-Executive Director suggested that further emphasis was required in the forewords to the annual report on the work that had

19.6	been done on safety and the actions taken when things go wrong. She said that GOSH was working to become a leader in this area and suggested that this should be highlighted. The Board **approved** the following documents and agreed that if any significant changes were required authority to approve would be delegated to the members of the Audit Committee. • A copy of the annual accounts 2021/22 • A copy of the annual report 2021/22 incorporating: o Annual Governance Statement o Assurance committee annual reports o Draft Head of Internal Audit Opinion • Draft representation letter
20	**Compliance with the Code of Governance 2021/22**
20.1 20.1	Anna Ferrant, Company Secretary said Foundation Trusts were required to report compliance with the Code of Governance in the Annual Report on a 'comply or explain' basis. She proposed that GOSH complied with all areas with the exception of one around Governors liaising with members about the forward plan. Engagement with the membership had reduced as a result of the pandemic however there had been involvement in the Children's Cancer Centre development. The Board **approved** the statement for inclusion in the annual report.
21	**Compliance with the NHS provider licence – self assessment 2021/22**
21.1 21.2 21.3 21.4	Anna Ferrant said that Foundation Trusts were required 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 assurance around each condition had been discussed by the Executive Team and it was proposed that the Trust would confirm compliance with all areas. The Council of Governors had reviewed the document at the April 2022 meeting and had been satisfied with the assurance provided. **Action:** Chris Kennedy, Non-Executive Director said that the annual report had defined going concern as being asked to provide services but the provider license self assessment defined it as having sufficient resources to move forward. It was agreed that the definitions in each document would be aligned. The Board **agreed** the Trust's responses taking into account the view of the Council of Governors.
22	**Quality Report**
22.1 22.2	Sanjiv Sharma, Medical Director said that the Trust was required to publish a quality report which would go before Parliament as part of the Annual Report. He said that some gaps remained in the report due to the submission deadlines. The Board **agreed** to delegate authority to approve the Quality Report to the non-executive director members of the Quality, Safety and Experience Assurance Committee (QSEAC).

	Suzanne Ellis, Non-Executive Director welcomed the clarity of the report. She noted that there had been an increase in arrests and asked if sufficient focus was being placed on the area. Sanjiv Sharma said that the Trust had early warning processes in place. He said that the learning from deaths process also considered whether a change in practice was required. Deaths within ICU were aggregated nationally through PICANET and it had been confirmed that GOSH remained within acceptable limits when adjusted for case mix.
23	**GOSH 2022/23 Budget**
23.1	Helen Jameson said that a draft budget had previously been discussed at Board however the Trust's allowance had now been received and new guidance had been issues which was being reviewed. An update would be provided to the Board at the July 2022 meeting. The Board acknowledged the extremely challenging financial environment.
24	**Board Assurance Framework Update**
24.1 24.2 24.3 24.4 24.5 24.6 24.7 24.8 24.9 24.10	Anna Ferrant said that the Audit Committee had recommended updates to four BAF risk statements for approval. BAF risk 2: Recruitment and Retention The Audit Committee had recommended that the focus of the risk should change from 'recruitment and retention' to 'workforce sustainability' taking into account the staffing pressures of sickness and maternity leave. The Board **approved** this recommendation. BAF risk 8: Business Continuity The Audit Committee recommended that the wording of the risk statement was updated to ensure that it reflected the risk of an interruption to services. The Board **approved** the update. BAF risk 12: Inconsistent Delivery of Care The risk had been updated following the work to complete the actions arising from the CQC inspection in 2020 and to reduce the duplication with infection prevention and control and medicines management. The Board **approved** the revised risk statement. BAF risk 15: Children's Cancer Centre The Audit Committee had recommended the risk statement contained a headline risk with associated risk factors documented underneath. The Board **approved** the update. **Action:** Amanda Ellingworth said that it was important to note that the Children's Cancer Centre would not be delivered for a number of years and there was also a risk around it continuing to be relevant and fit for purpose. It was agreed that this would be made explicit as part of the BAF risk.
25	**Health Inequality Update**
25.1	**Action:** Tracy Luckett, Chief Nurse said that the Children's Hospital Alliance had been considering health inequality which was particularly pertinent following the pandemic as there had been an impact on the physical and mental health of children and young people. Focus at GOSH was being placed on specific areas

	including access, experience and outcomes and a set of priorities had been developed into an action plan. Data was being captured and work was taking place to improve the quality of this data. It was agreed that updates would be provided to the Board on a 6 monthly basis.
25.2	Russell Viner welcomed the focus on inequality and said that long term focus would be required in partnership with other organisations to make real and sustained changes. He said that it was important to consider how GOSH could reduce the impact of inequality particularly through improving access to services. He said that gender inequality would also be an important consideration notwithstanding the age of GOSH's patients.
25.3	**Action:** James Hatchley expressed concern about the ability of families to cover the costs associated with attending appointments at GOSH and asked what action was being taken to support families. Tracy Luckett said that the patient experience team was reviewing the available options. John Quinn, Chief Operating Officer said that families had begun to raise concerns about the costs associated with attending follow up appointments or revisiting the hospital when appointments had been cancelled. Sir Michael Rake asked whether the Trust had flexibility to provide financial assistance to families and Matthew Shaw said that paying for families' travel costs would be outside of policy but added that it was important to consider the support that could be provided in partnership with the GOSH Children's Charity. Russell Viner said that there were a large number of families who would have been significantly impacted by the rise in the cost of living and would have financial pressures which would not previously have existed.
25.4	Suzanne Ellis said that it would also be important to consider the diversity of the team who were carrying out the work in order to achieve the best outcomes.
26	**Integrated Quality and Performance Report – Month 1 2022/23**
26.1	Sanjiv Sharma presented the report which was in a new format. Work was required on Duty of Candour and although 100% compliance had been achieved at stage 1, the level of compliance reduced for stage 2. Work was taking place to identify the most appropriate data to give an accurate representation of the position as although the Trust was currently at 20% compliance for stage 2 of Duty of Candour, three new cases had arisen in month. Russell Viner welcomed the format of the report and the achievement of 100% compliance with level 3.
26.2	**Action:** Amanda Ellingworth noted that there were a number of actions arising from Serious Incidents which were overdue and asked when they would be complete. It was agreed that a paper would be considered at the next QSEAC meeting as these actions had been poorly framed and in some cases were based on systems which no longer existed.
26.3	Tracy Luckett said that patient experience indicators were green rated and Friends and Family test response rates had improved however there had been an increase in complaints on the theme of transport which was being monitored.
26.4	John Quinn said that considerable focus was being placed on activity recovery and data on this would be added to the next report. Compliance with the 18-week referral to treatment target had been approximately 76% for a number of weeks and access meetings were taking place to focus on increasing performance against the 18 week target. All patients who had waited over 104 weeks had

	appointments booked and Trusts were required to see these patients by the end of July 2022. The focus would then move to patients who had waited 78 weeks.
26.5	John Quinn said that issues had arisen from the staff survey results in International and Private Care (I&PC) and the action plan for the directorate was being monitored. Caroline Anderson, Director of HR and OD said that the results were partly driven by the changes that staff had experienced throughout the pandemic and the requirement to move around the hospital. She said that the directorate leadership had worked hard to support staff but this had not overridden the team's uncertainty around the future of the service.
26.6	**Action:** John Quinn said that a summary page had been included at the beginning of the IQPR in response to feedback from Non-Executive Directors and asked that feedback was provided outside the meeting.
27	**Month 1 2022/23 Finance Report**
27.1	Helen Jameson said that the Trust's financial position was challenging at £4.1million deficit in month at month 1 which was indicative of the challenge over the coming year. She said that cash remained strong but had deteriorated post year end. I&PC activity had increased but at levels which were below plan.
28	**Learning from Deaths Report Q4 2021/22**
28.1	Sanjiv Sharma said that patients who had died during the reporting period had been reviewed by a multidisciplinary team at GOSH. In three cases it had been felt that communication could have been improved.
28.2	It was noted that Suzanne Ellis had queried the increase in cardiac arrests which had been shown in the Quality Account and Sanjiv Sharma said that the learning from deaths review process ensured that data was interrogated to identify themes and the Trust had shown good internal processes for interrogating data which was outside of normal levels.
29	**Safe Nurse Staffing Report (February - March 2022)**
29.1	Tracy Luckett, Chief Nurse said that there had been 23 Datix incidents related to staff submitted in February and March 2022. Each occurrence had been investigated and no patient harm had been identified however some staff shortages were being experienced in theatres. A plan was in place to manage this and the leadership for theatres were working well.
29.2	Matthew Shaw said that a listening event had taken place in theatres based on concerns which had been raised to the Freedom to Speak Up Guardian. He said that there was a national shortage of theatre staff.
29.3	Nursing Establishment Review
29.4	Tracy Luckett said that staffing in each clinical area had been reviewed. She said that whilst there were vacancies in some areas, in general staffing was sufficient in order to safely fulfil activity.

30	**Review of Ockenden Review**
30.1	Sanjiv Sharma said that the final report from the Ockenden Review had been published on 30th March 2022 and contained a large number of recommendations which were relevant to the healthcare environment as a whole. GOSH had split the recommendations into themes and Sanjiv Sharma confirmed that many had already been captured as part of the safety transformation programme.
30.2	Amanda Ellingworth asked how the recommendations would be monitored and Sanjiv Sharma said that they would be added to the action plan for the quality and safety transformation programme.
30.3	James Hatchley asked whether the work on cultural transformation was in the relevant context to meet the recommendations of the report. Matthew Shaw said that progress had been made with cultural change however areas of poor behaviour remained. Chris Kennedy asked where the most work was required and Sanjiv Sharma said that focus was being placed on psychological safety which would also support the speak up for safety programme.
30.4	Russell Viner asked if there were areas of the Trust in which treatment methods were in opposition within teams and Matthew Shaw said that this had potential to arise in areas in which there was minimal evidence about the right course of action. Sanjiv Sharma said that information was triangulated where possible in order to identify issues such as these including information from the Freedom to Speak Up Guardian. He said that currently three teams were receiving support to have better conversations.
31	**Guardian of Safe Working Report Q4 2021/22 and Annual Report 2021/22**
31.1	Sanjiv Sharma said that the team had managed a safe and effective medical workforce throughout the pandemic which was a significant achievement however exception reporting was not at sufficiently high levels to provide the required assurance around Junior Doctor working practice. The Board discussed the reasons for the low reporting levels and Amanda Ellingworth said that she had attended a meeting of the Junior Doctors' Forum and comments were received that doctors in training felt they were discouraged from reporting as they moved towards the point of a consultant career.
31.2	Russell Viner said that a number of years ago Health Education England had raised concerns about the training provided by GOSH to Junior Doctors in some specialties and asked whether these concerns remained. Sanjiv Sharma said that GOSH was ranked in the top three hospitals nationally for training but added that there were some areas of the Trust in which colleagues' experience was not as good.
31.3	Matthew Shaw highlighted that the Trust had a greater number of consultants and doctors in training than there were beds and said that it was important to consider workforce modernisation going forward.
32	**Board Assurance Committee reports**
32.1	Audit Committee update – April 2022 meeting and May 2022 (verbal)

32.2	Akhter Mateen, Chair of the Audit Committee said that the May meeting had been held on the morning of Trust Board and had focused on year end reporting and the annual accounts. The Committee continued to review estates compliance at each meeting as well as the risk associated with referrals with no future activity. 32.3 Quality, Safety and Experience Assurance Committee update - April 2022 meeting 32.4 Amanda Ellingworth, Chair of QSEAC said that a new Medical Director's report had been presented to the Committee which provided context as to the key issues being managed in the hospital. The Committee had received a presentation on a new Quality Governance Framework and Amanda Ellingworth said that it was anticipated that this would be a step change in the way that information flowed through the organisation and assurance was provided to Board Committees. 32.5 Discussion had taken place on transition which was also a key issue for Governors and the Committee had agreed to continue to monitor this. 32.6 The Committee had noted that a small fire had broken out in the staff nursery. No staff or children had been hurt and the London Fire Brigade had congratulated the team on their evacuation processes.
33	**Annual Health and Safety and Fire Report 2020/21**
3.1	Chris Ingram, Fire, Health and Safety Manager said that a new fire safety contractor was working with the Trust to improve compliance and a weekly health and safety walkaround had resulted in the removal of hazards and previous issues with waste and housekeeping being manged more proactively. 33.2 There were challenges in the Trust around compliance with mask wearing and this had been escalated through the Trust's governance structure. 33.3 Chris Kennedy asked how the fire, health and safety team were informed of maintenance requested or incidents when they were logged to ascertain whether they represented a safety risk. Chris Ingram said that the works team informed the health and safety team through a group email. 33.4 **Action:** James Hatchley noted that sharps continued to be RAG rated amber and asked how this would be moved to green. Zoe Asensio Sanchez, Director of Space and Place said that communication about the sharps system had taken place but this had not gained traction with staff. She said that procurement processes were in place. Matthew Shaw said that this had been an ongoing issue and asked that an assessment took place to identify the issues and the action required to ensure that the matter progressed. James Hatchley recommended identifying the barriers in one area and using this to roll out improvements elsewhere.
34	**Infection Control Update Q4 2021/22**
34.1	Helen Dunn, Director of Infection Prevention and Control said that considerable work had taken place, alongside updates on Epic, to update the sepsis clinical guideline and develop a training package. A practice educator role had also been created and the team was now fully established for the first time.

34.2 34.3 34.4 34.5	The team continued to manage a considerable workload related to COVID19 and had carried out several hundred risk assessments each month in the reporting period alongside the team's standard clinical work. The team continued to monitor Adenovirus on Robin and Fox Wards and this would be added to the local risk register to maintain oversight. A business case had been approved for whole genome sequencing for patients who contracted adenovirus. Helen Dunn said that there was excellent nursing engagement at the Infection Prevention and Control Committee and focus would be placed on ensuring that there was also medical representation. There had been an increase in Vancomycin Resistant Enterococci (VRE) acquired in the hospital and meetings were taking place with the directorate to discuss this.
35	**Council of Governors' Update – April 2022**
35.1	Sir Michael Rake said that a number of new Governors had joined the Council following elections earlier in the year. Governors were keen to fulfil their responsibility to members and to have more of an in-person presence in the hospital and work was taking place to ensure this could happen going forward. Focus was being placed on the content of papers and Governors were keen to synthesise key information into summaries with further content provided for information only.
36	**Declaration of Interest Register (Directors and Staff)**
36.1 36.2	Anna Ferrant said that the Trust had identified approximately 1000 staff who were considered to be 'Decision Makers' under the GOSH policy as a result of the influence on spending taxpayers' money incumbent in their role. These members of staff were required to make an annual declaration of interest and as of 25th May 2022, 94% of these staff had done so. Work was taking place to contact those whose declarations were outstanding to ask them to declare. The NHS contract required Trusts to publish the names of those decision makers who had not made declarations in year. Discussion took place about the publication of staff names on the Trust's website and Anna Ferrant said that staff were being actively encouraged to declare and had been made aware that the Trust was required to publish their names. She said that, in line with presentation of mandatory training data, staff who were on maternity leave and external secondment were not included in the data.
37	**Any other business**
37.1	Sir Michael Rake said that it was Akhter Mateen's last Board meeting. He thanked him for his work as the Deputy Chair and Chair of the Audit Committee and for all he had done for GOSH throughout his tenure.

Attachment L

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 2022

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
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	To be considered for September 2022 Board meeting
17.6	25/05/22	Russell Viner, Non-Executive Director said that transition in neurodisability was complex partly as a result of the lack of appropriate adult receiving hospitals. It was agreed that consideration would be given to discussing the matter with the Children's Hospital Alliance.	MS	July 2022	On agenda under CEO report
19.5	25/05/22	Amanda Ellingworth, Non-Executive Director suggested that further emphasis was required in the forewords to the annual report on the work that had been done on safety and the actions taken when things go wrong. She said that GOSH was working to become a leader in this area and suggested that this should be highlighted.	AF	June 2022	Actioned in annual report
21.3	25/05/22	Chris Kennedy, Non-Executive Director said that the annual report had defined going concern as being asked to provide services but the provider license self assessment defined it as having sufficient resources to move forward. It was agreed that the definitions in each document would be aligned.	AF	June 2022	Actioned – annual report entries reviewed and aligned.
24.10	25/05/22	Amanda Ellingworth said that it was important to note that the Children's Cancer Centre would not be delivered for a number of years and there was also a risk around it continuing to be relevant and fit for purpose. It was agreed that this would be made explicit as part of the BAF risk	AF, Gary Beacham	July 2022	To review at the July 2022 Risk, Assurance and Compliance Group
25.1	25/05/22	It was agreed that updates on health inequalities would be provided to the Board on a 6 monthly basis.	TL	November 2022	Not yet due
25.3	25/05/22	James Hatchley expressed concern about the ability of families to cover the costs associated with attending appointments at GOSH and asked what action was being taken to support families. Tracy	TL	July 2022	An update on support for patients, families and staff is provided on the

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		Luckett said that the patient experience team was reviewing the available options. John Quinn, Chief Operating Officer said that families had begun to raise concerns about the costs associated with attending follow up appointments or revisiting the hospital when appointments had been cancelled. Sir Michael Rake asked whether the Trust had flexibility to provide financial assistance to families and Matthew Shaw said that paying for families' travel costs would be outside of policy but added that it was important to consider the support that could be provided in partnership with the GOSH Children's Charity.			Council of Governors agenda on 7 July 2022.
26.2	25/05/22	Amanda Ellingworth noted that there were a number of actions arising from Serious Incidents which were overdue and asked when they would be complete. It was agreed that a paper would be considered at the next QSEAC meeting as these actions had been poorly framed and in some cases were based on systems which no longer existed.	SS	July 2022	Actioned: On QSEAC agenda in July 2022
26.6	25/05/22	John Quinn said that a summary page had been included at the beginning of the IQPR in response to feedback from Non-Executive Directors and asked that feedback was provided outside the meeting.	Committee members	June 2022	Noted
33.4	25/05/22	James Hatchley noted that sharps continued to be RAG rated amber and asked how this would be moved to green. Zoe Asensio Sanchez, Director of Space and Place said that communication about the sharps system had taken place but this had not gained traction with staff. She said that procurement processes were in place. Matthew Shaw said that this had been an ongoing issue and asked that an assessment took place to identify the issues and the action required to ensure that the matter progressed. James Hatchley recommended identifying the barriers in one area and using this to roll out improvements elsewhere.	ZAS/ TL	October 2022	Actioned: Update on progress with sharps compliance presented at the QSEAC under the Health and Safety Update in July 2022

Attachment M

Trust Board 6 July 2022	
Chief Executive's Report **Submitted by: Matthew Shaw, Chief Executive**	**Paper No: Attachment M** **☐ 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 3: Operational performance BAF Risk 4: Strategic Position BAF Risk 14: Culture	**Financial implications** Not Applicable

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

Supporting pandemic recovery

As ever, our teams continue their amazing work to maximise activity and we continue to deliver high levels of activity and work with our system partners to recover backlogs of care.

Virtual care is critical to the national recovery effort and we were delighted to be visited by the Secretary of State for Health and Social Care, The Rt Hon Sajid Javid on 29 June as part of the national launch of the Plan for Digital Health Social Care. The Secretary of State was impressed by our digital services and education facilities and met with patients, families and staff to talk about a wide range of topics from the benefits of the MyGOSH app to the future of specialised commissioning.

We are also delighted to be working with colleagues across the Children's Hospitals' Alliance, NHS England and the Children and Young People's Transformation Programme to develop proposals for a networked approach across our 11 hospitals and their local systems. We hope this will help ensure that children and young people can benefit from the significant national investment into virtual wards.

Visits from family and friends have been restricted by Covid for a significant period of time, so we were delighted that following new NHSE guidance issued last month enabled us to welcome more friends and family into the hospital once again. We are maintaining simple precautions to protect our vulnerable patients from an outbreak of the virus – for example by continuing to ask that visitors do not come to the hospital if they feel unwell.

Supporting our people

As expected, the rail strikes last month caused significant disruption to the transport network and we owe a real debt of gratitude to our staff who pulled together to plan for and mitigate the impacts. We stood up our Gold and Silver command structures to co-ordinate efforts and although we had to reduce non-urgent activity on-site during strike days, were able to continue to run services safely with the minimal level of impact on patients and families.

Despite our efforts to share the latest information, work with the local authority on parking and provide financial assistance for taxis and accommodation, this episode naturally caused significant inconvenience and in many cases an expense for staff who are already working so hard to keep essential services running. We shared a video message to thank them for all they continue to do for children and young people.

The executive team has just approved a series of measures to support staff with cost of living issues, recognising that the UK's economic challenges and rising global costs will have an impact on colleagues' wellbeing over the coming months. The strategy will be taken forward and overseen by a sub-group of the Health and Wellbeing steering group and will look at accelerating and enabling access to financial support by:

- Developing communications that bring all the support available into places that people can access
- Engaging with people across the organisation to know what other support they would find most helpful – including though Engaging with Trade Unions and Staff Networks
- Setting up a hardship fund for people struggling to manage – including discussing options with the GOSH Charity.

Our colleagues' health and wellbeing is of the utmost importance to GOSH (aligned with our strategic priority of 'making GOSH a great place to work'), and in turn it underpins high quality and safe patient care.

Healthcare inequalities

As the Board is aware, we are running a reset phase to review our Trust-wide approach to healthcare inequalities and have established a steering group under the leadership of our Chief Nurse. We were delighted to host a webinar on 14 June for the 11 trusts across the Children's Hospitals' Alliance and their partners entitled *Healthcare Inequalities – What is the Role for Children's Hospitals*?

The event was accredited for CPD by the RCPCH based on the following learning objectives:

- Developing an understanding of health inequalities and considering how to take action to mitigate the impact on patients and families in terms of access, experience and outcomes.
- Learning about key policies and progress from the national health inequalities team at NHS England and the Royal College of Paediatrics and Child Health, exploring why health inequalities are so important to the child health community.
- Hearing what colleagues around the Children's Hospitals Alliance have been doing to address health inequalities and how to get involved – from participating in a shared research programme to connecting with colleagues across the network.

It was inspiring to hear from colleagues who have delivered progress on this agenda through funding from the Paediatric Accelerator programme, to listen to the views of our partners in NHS England and the RCPCH, and to share insights from Professor Dame Elizabeth Anionwu on a career championing the need for research into Sickle Cell and our in-house GOSH expert on healthcare inequalities associated with Learning Disabilities, Kate Oulton.

A recording of the conference is available from the GOSH Learning Academy.

The cost of living crisis is something that we are very aware of as part of this agenda and the Board has previously raised concerns about the ability of families to cover the costs associated with attending appointments at GOSH and asked what action is being taken to support families. A report on the support currently available for patients and families (which comes predominantly from the GOSH Charity) has been prepared by our patient experience team for discussion with our Council of Governors this week. We understand that our team has negotiated an increased rate for family and patient travel costs, which we hope will have an impact. Information about support for staff is also included in the report to the Council.

The full range of measures will also be considered by the Health Inequalities Steering Group and we will provide an update on any decisions at our next board meeting.

GOSH Play Street – Advocating for clean air

On Thursday 16 June, Sadiq Khan Mayor of London, visited our hospital when the street was transformed into a giant play area for Clean Air Day. The Mayor joined patients and local school children who enjoyed a range of activities on Play Street – including a rainbow race track, accessible bikes and the chance to dress up as a scientist, design a hospital robot and learn about research and innovation at GOSH.

In celebration of Clean Air Day, Great Ormond Street was closed for the afternoon and patients, families and the local community enjoyed the space usually reserved for cars. The Mayor spoke to patients, parents and our staff about the importance of clean air on the health of children. He also learnt about GOSH's air quality initiatives and saw how the hospital street could look if permanently closed to traffic.

Alongside his visit, the Mayor published his response to the Government's consultation on legal limits for air quality, encouraging action to improve children's health.

We were delighted to meet with the mayor and other local authority colleagues to share our view that children should have the right to clean air, especially when they are coming to hospital. This is an important issue for GOSH because the air pollution on Great Ormond Street is above WHO safe limits the majority of the time and air pollution is linked to serious health conditions such as asthma and childhood cancer and greatly increases the risk of developing chronic conditions such as cardiovascular disease later in life.

New director of UCL Great Ormond Street Institute of Child Health

We are delighted that the UCL Great Ormond Street Institute of Child Health (UCL GOS ICH) have announced that Professor Helen Cross, an Honorary Consultant in Paediatric Neurology at GOSH, will take up the post of Director of the institute from 1 September 2022.

The UCL GOS ICH is our primary research partner and together we form the largest centre for paediatric medical research outside North America.

As well as her role as an Honorary Consultant in Paediatric Neurology at GOSH, Professor Cross is The Prince of Wales's Chair of Childhood Epilepsy and Head of the Developmental Neurosciences Research and Teaching Department at UCL GOS ICH. The primary focus of her research has been optimising outcomes in the early onset epilepsies, working extensively with patient advocacy groups.

Helen is passionate about our Research Hospital vision and we look forward to working with her even more closely as we continue the excellent relationship that brings to life our vision for children at GOSH and around the world.

Celebrating the first anniversary of our Sight and Sound Centre

Last month we celebrated the first anniversary of our Sight and Sound Centre, the UK's first dedicated medical facility for children with sight and hearing loss.

The Centre was designed with children and young people with sensory loss and includes a sensory garden with plants that children can see, touch, smell and hear. Bespoke and engaging artworks especially commissioned for children with sensory loss feature in the new centre alongside state-of-the-art clinical facilities such as soundproofed booths for hearing tests, an eye imaging suite, a dispensing opticians and other testing facilities.

Supported by Premier Inn, the Centre and is a testament to our charity partnerships the hard work of our development and facilities teams as well as our clinical and operational staff. Over 7500 ophthalmology patients (both inpatients and outpatients) have now visited the centre; over 1440 have been treated by Speech and Language Therapy (SLT) specialists; over 600 have been treated for cochlear implants and 5,000 have been treated by the Ear Nose Throat (ENT) team.

We were also delighted that the building received a birthday present – winning a European Healthcare Design Award for in their healthcare design category and a 'highly commended' in the art and interior design category.

Ends

Attachment N

Trust Board
6 July 2022

Patient Story: Transport and facilities in the hospital **Submitted by** Tracy Luckett, Chief Nurse **Prepared by** Claire Williams, Head of Patient Experience	**Paper No: Attachment N** ☐ **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

Connie, aged 15, has cerebral palsy, and is under multiple specialties including Gastroenterology, Ophthalmology and Dental. She has been attending GOSH for the last 14 years. Connie's mum, Emma, will share her experiences of:

- The transport service and a complaint made about delays and communication
- Persistent problems with lifts not functioning in the hospital and the problems this causes for Connie who uses a wheelchair
- Lack of changing facilities for Connie when attending the hospital as an outpatient
- Exceptional care and how the nurses make Connie and Emma feel part of a family

Emma's story will be filmed in advance and presented at Trust Board by Claire Williams, Head of Patient Experience and Engagement and a representative from Space and Place.

Action required from the meeting

For information

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

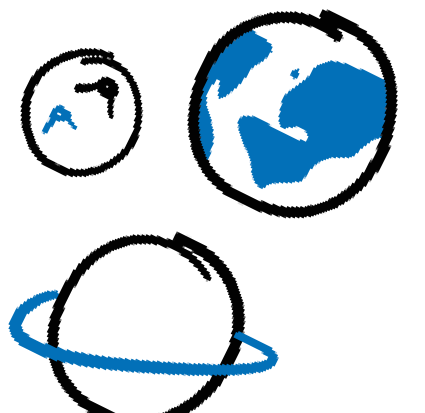
Strategic risk implications

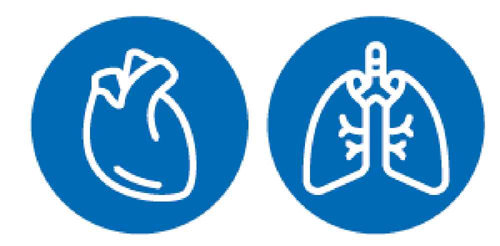
BAF Risk 12: Inconsistent delivery of safe care

Financial implications

Not Applicable

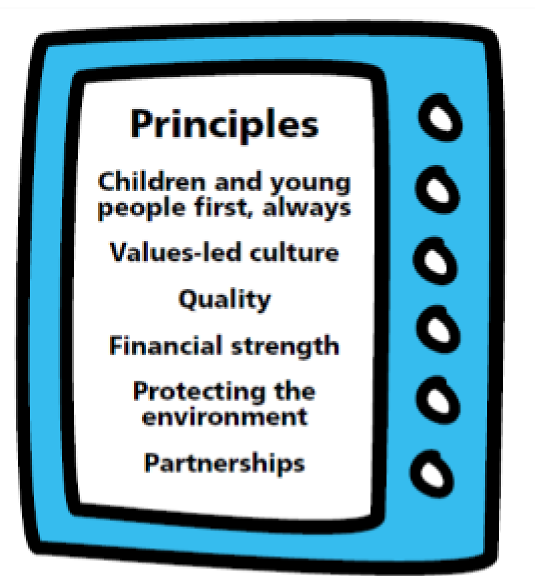
Implications for legal/ regulatory compliance • The Health and Social Care Act 2010 • The NHS Constitution for England 2012 (last updated in October 2015) • The NHS Operating Framework 2012/13 • The NHS Outcomes Framework 2012/13
Consultation carried out with individuals/ groups/ committees N/a
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Patient Experience and Engagement/ 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





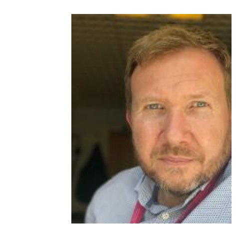
HEART & LUNG (H&L) DIRECTORATE REVIEW

Trust Board July 2022



Matthew Fenton – Chief of Service
David Chatterton – General Manager
Dagmar Gohil – Head of Nursing and Patient Experience
Sophie Skellet and Peter Sidgwick – Deputy Chief of Service

Team Organogram

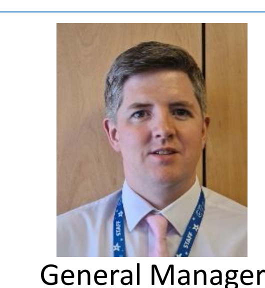


Chief of Service

Matthew Fenton

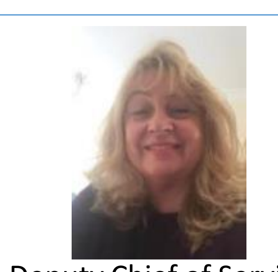
Head of Nursing and Patient Experience

Dagmar Gohil



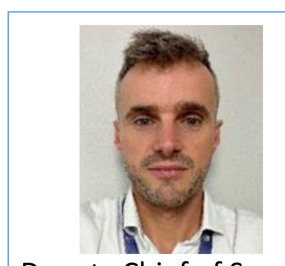
General Manager

David Chatterton



Deputy Chief of Service

Sophie Skellet



Deputy Chief of Service

Peter Sidgwick

CICU
Cho Ng

Cardiac Surgery
Martin Kostolny

Cardiology
Mike Burch

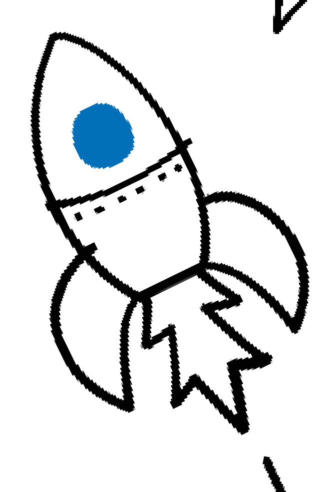
PICU/NICU
Sophie Skellet / Simon Hannam

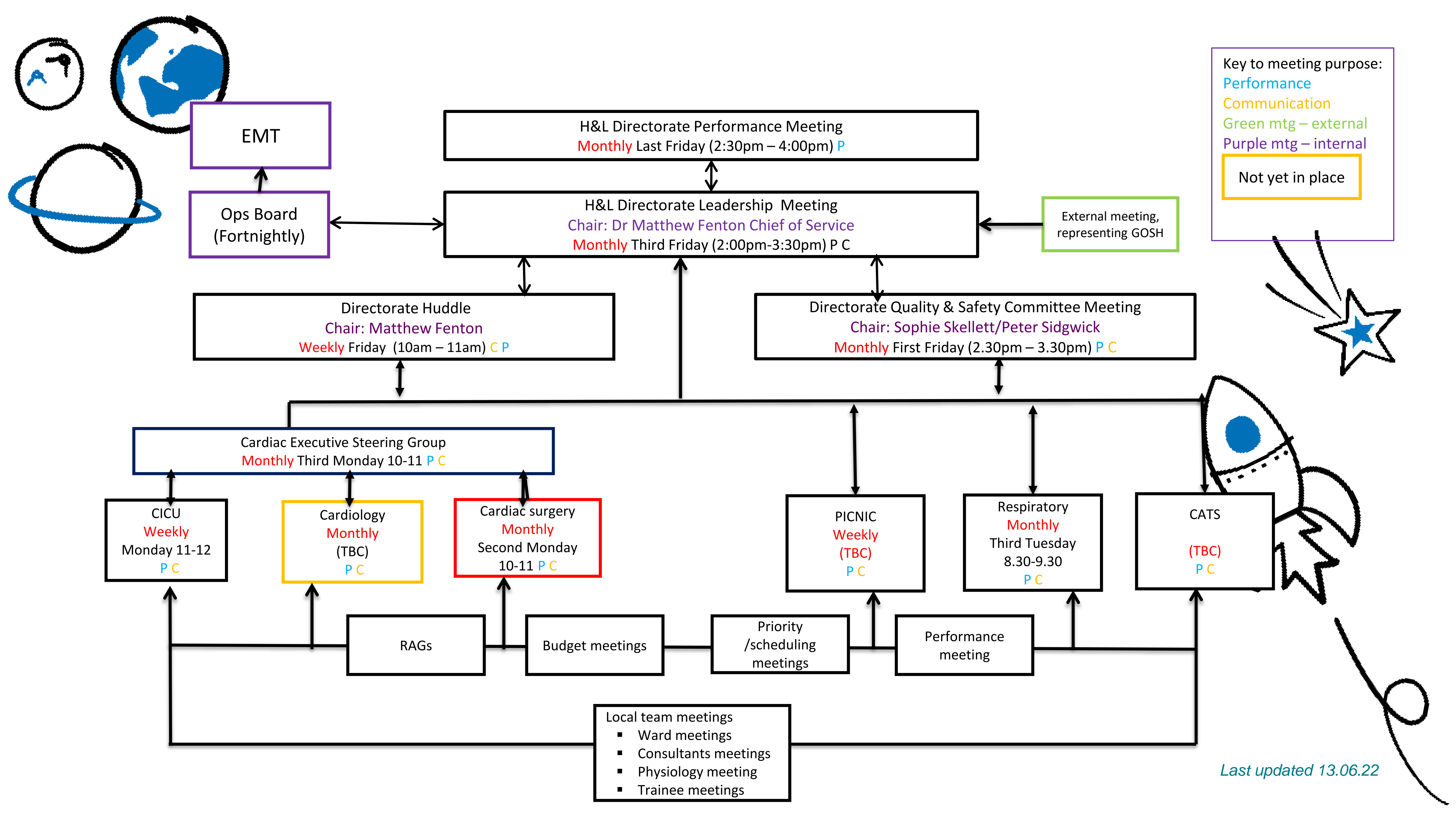
CATS
Linda Chigaru

Respiratory
Elaine Chan

Matrons
Anne MacNiven
Deborah Lees
Bridget Leavey

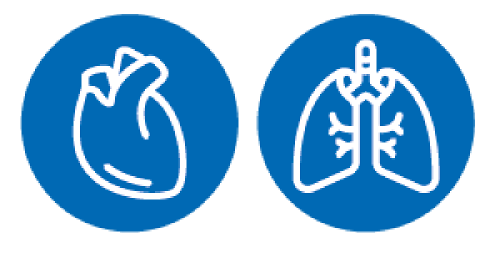
Service Manager
Alissa Angelova
Samu Orava
Charlotte Bexson (Trainee)





EMT
Ops Board
(Fortnightly)
H&L Directorate Performance Meeting
Monthly Last Friday (2:30pm – 4:00pm) P
H&L Directorate Leadership Meeting
Chair: Dr Matthew Fenton Chief of Service
Monthly Third Friday (2:00pm-3:30pm) P C
External meeting, representing GOSH
Key to meeting purpose:
Performance
Communication
Green mtg – external
Purple mtg – internal
Not yet in place
Directorate Huddle
Chair: Matthew Fenton
Weekly Friday (10am – 11am) C P
Directorate Quality & Safety Committee Meeting
Chair: Sophie Skellett/Peter Sidgwick
Monthly First Friday (2.30pm – 3.30pm) P C
Cardiac Executive Steering Group
Monthly Third Monday 10-11 P C
CICU
Weekly
Monday 11-12
P C
Cardiology
Monthly
(TBC)
P C
Cardiac surgery
Monthly
Second Monday
10-11 P C
PICNIC
Weekly
(TBC)
P C
Respiratory
Monthly
Third Tuesday
8.30-9.30
P C
CATS
(TBC)
P C
RAGs
Budget meetings
Priority /scheduling meetings
Performance meeting
Local team meetings
Ward meetings
Consultants meetings
Physiology meeting
Trainee meetings
Last updated 13.06.22

Directorate Profile



Our Budget

- Annual Budget 21/22: £54.7 million

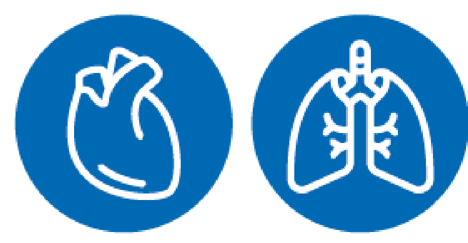
Our Clinical Spaces

- **Bear**– 24 cardiology beds, of which 8 are HDU
- **Walrus** – physiology investigations, 7 cardiac daycase beds, and cardiac surgery preadmission
- **Kangaroo** – 7 beds for Long Term Ventilated, CF, and sleep
- **Leopard** – 14 beds for, of which 4 are HDU
- **CICU** – Cardiac ICU with nationally commissioned services
- **PICU & NICU** – 17 bed PICU, 10 beds NICU
- **Respiratory sleep unit** – 5 beds for sleep studies
- **Lung Function** – outpatient respiratory physiology investigations
- **XMR –** hybrid cardiac catheter lab and cardiac MRI suite
- **Fetal cardiology department** – adult outpatient space for expectant mothers
- **Outpatients department** – Outpatient consultations primarily in Falcon with co-located cardiac and respiratory physiology
- **Cardiology outreach** – 24 hospitals
- **Cystic Fibrosis outreach and respiratory community care**
- **CATS**

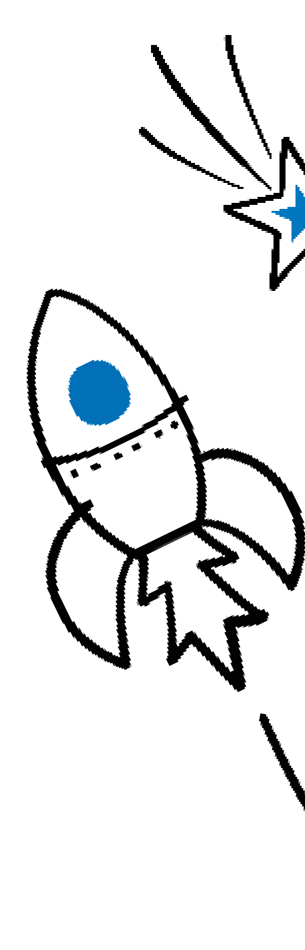
Our Staff – 60% rostered posts

Staff Group	WTE
Ward-based Nursing Qualified	437.39
Junior Doctors	113.00
Non-Ward-based Nursing Qualified	113.32
Admin	60.05
Other	0.19
Consultants	80.52
Housekeepers	17
Nursing Unqualified	41.02
Scientific Therap Tech	60.29
Grand Total	**922.78**

Areas of expertise



Cardiology, including fetal cardiology, inherited cardiology, and CMRI	Cardiothoracic surgery & Perfusion	Cardiothoracic transplantaion	Pulmonary hypertension
Tracheal surgery	ECMO	Respiratory, including cystic fibrosis	CATS
PICU, NICU, CICU	Respiratory sleep unit (LTV)	Lung function	Cardiac physiology, especially echocardiography and ECG



Top three successes

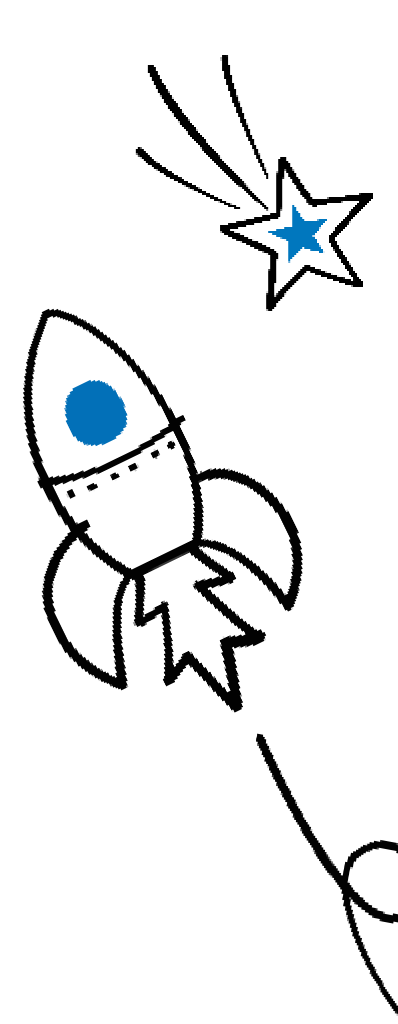
- CATS support of bronchiolitis surge in winter 21/22
- Quality and safety improvement journey
- Nursing recruitment to vacancy level of only 1%

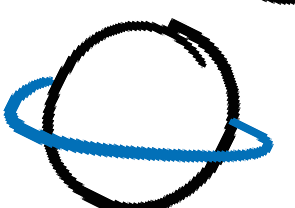
Top three challenges

- Cardiac surgery backlog
- Meeting the IP&C objectives
- Matching our resource capacity to the demands on our services

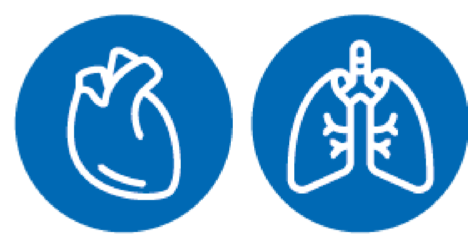
Top three priorities

- Return to a steady state in cardiac, thoracic, and tracheal surgery
- To provide an experience for our patients, not just a service
- To use commissioning changes to our, and our partners', advantage





Research and Innovation – new projects/awards



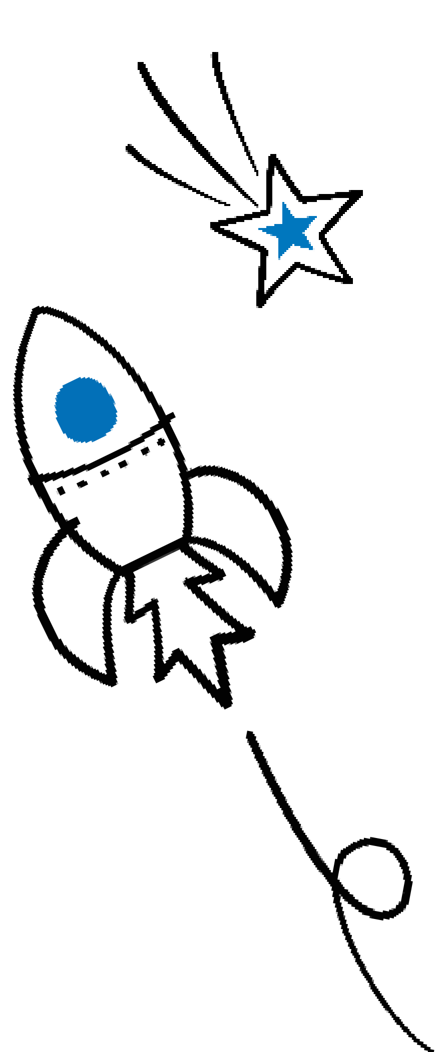
£5.36 million

- Randomised trials

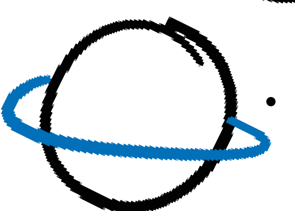
1) PRESSURE opened in PICU- CICU HTA grant £1.7m (Mark Peters)
2) Destiny trial (first cardiac surgery trial in UK) BHF grant £250k (Birmingham with Martin Kostolny)
3) Gastric awarded, Nurse led trial, £1.9m from NIHR HTA (Mark Peters, Kate Brown)

- Translational research

1) T Cell Regulation after Heart Transplant, BHF grant £400k (Mike Burch)
2) Why do children develop hypertension after coarctation repair - BHF Intermediate Fellowship, £1m (Michael Quail)
3) Using proteomic approaches to investigate the role of plasma and urine biomarkers for disease stratification in childhood hypertrophic cardiomyopathy. £114k Action Medical Research (Juan Kaski)



Research and Innovation – delivery



- GOSH largest site in SandWiCh Trial, FIRST-ABCx2 Trials, Oxy-PICU Trials 14,000 paediatric ICU patients in the UK

  Mark Peters, Padmanabhan Ramnarayan, Lauran O'Neill with PICU/CICU teams

- RECOVERY and ISARIC GOSH was largest paediatric contributor

  PICU and CICU teams

- Data Science UCL CHiMERA hub Collaborative Healthcare Innovation through Mathematics, EngineeRing £1.3m EPSRC

  Mark Peters, Sam Ray

- First UK cohort study of multi-centre follow up of neurodevelopment in infants with congenital heart disease completed £200k GOSHCC

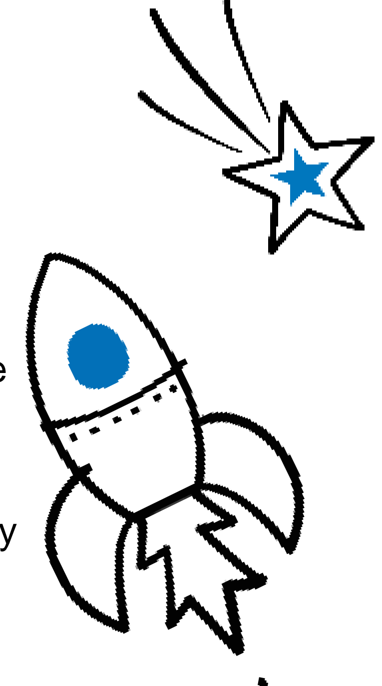
  Kate Brown, Jo Wray

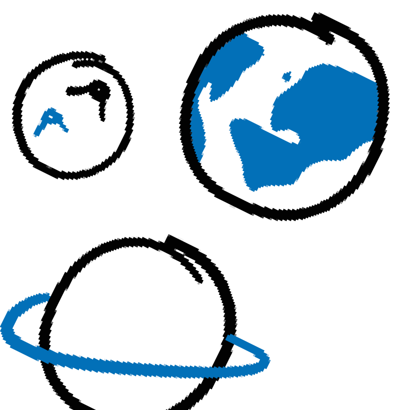
- Pulmonary hypertension team are the top recruiting site BHF funded national cohort of idiopathic pulmonary arterial hypertension

  Shahin Moledina

- Non invasive ventilation adherence in children and young people - first UK mixed-methods study to look at adherence in children on NIV GOSHCC £58k

  Elaine Chan, Jo Wray





Research and Innovation – impact

Increasing Heart transplant Donor availability

DCD and Transmedics

ABO mismatch

Heart transplant team

Randomised trials in liberation of respiratory support.

Mark Peters, Lauran O'Neill, Sam Ray, Suzan Kakat

COVID research papers from GENOMIC and RECOVERY trials reported in Lancet and Nature

PICU team

Understanding outcomes in children with single ventricle anatomy

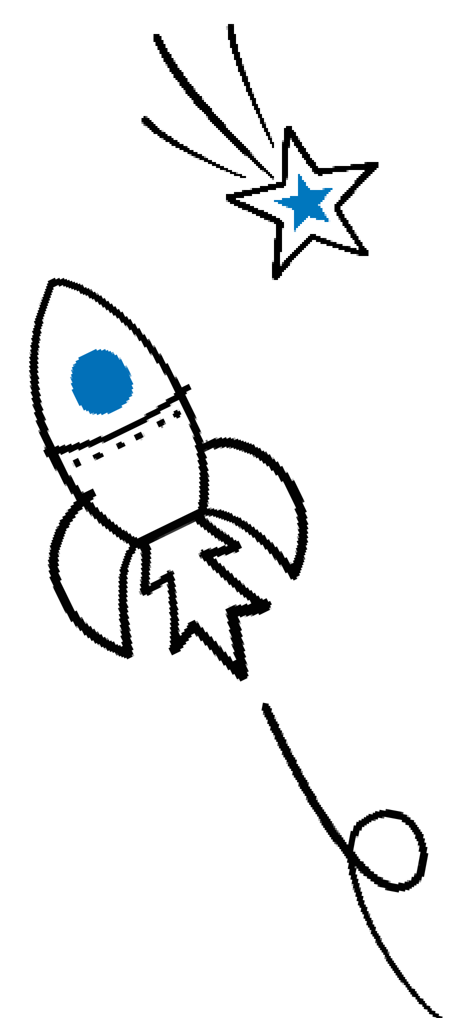
Kate Brown, Victor Tsang

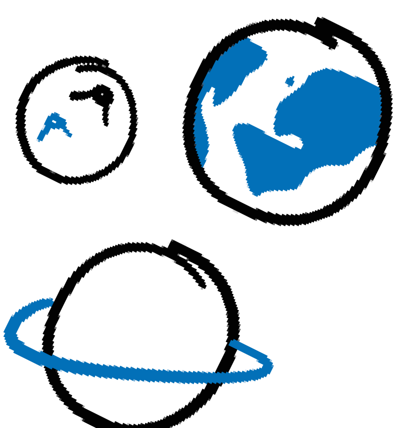
20 year outcomes in a national paediatric pulmonary hypertension service published in AJRCCM

Shahin Moledina

Clinical features and natural history of preadolescent non-syndromic hypertrophic cardiomyopathy published in JACC

Juan Kaski, Gabrielle Norrish





Principle 1: Children and young people first, always

Innovations from adversity

- Monitoring and diagnostics in the patient's home
  - Sleep studies
  - Home Spirometry
  - Remote monitoring for ventilated patients
  - Hub and spoke service models
  - Virtual clinics

Cutting edge clinical excellence

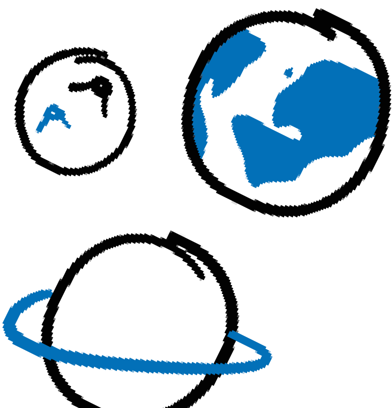
- ABO mismatched transplantation
- DCD organ donation

Doing the right thing

- Reducing cardiothoracic surgical cancellation
- Asking for mutual aid

Implementing best practice approaches

- GIRFT, working in partnership within networks, to make sure that patients are put first



Paediatric Surgery 2018-21

- Survival much higher than predicted
- Survival higher than predicted
- Survival as predicted
- Survival lower than predicted
- Survival much lower than predicted

Survival ratio (actual/predicted)

1.03
1.02
1.01
1.00
0.99
0.98
0.97
0.96

FRE (575) | GRL (675) | BRC (793) | SGH (760) | OLS (962) | ACH (1032) | LGI (998) | NHB (747) | GUY (1053) | BCH (1180) | GOS (1582)

Centre (surgical episodes)

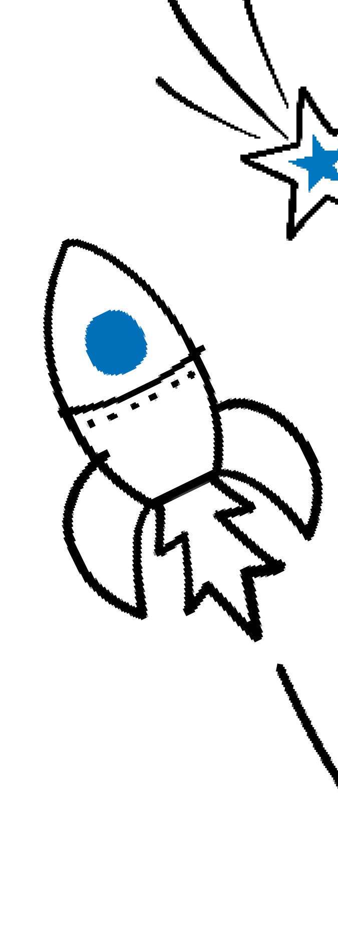
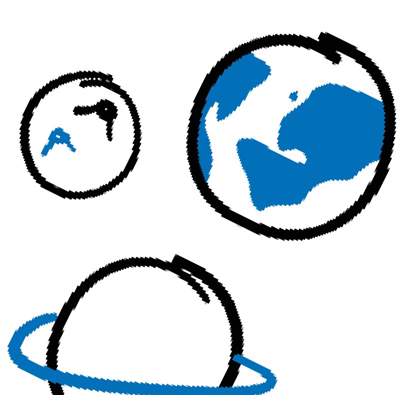


Figure 7. Number of patient initiated and hospital-initiated cancellations for cardiac surgery (Jan 2021 – May 2022)

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Hospital Initiated	28	33	25	23	22	24	31	37	61	53	40	31	14	14	14	21	32
Patient Initiatied	1	1	2	1	1	4	3	3	3	3	2	1	4	1	1	2	4

No. of Patients (0–70)

Hospital Initiated — Patient Initiatied



Cardiothoracic waiting list

Waiting list size

250
200
150
100
50
0

Waiting list change

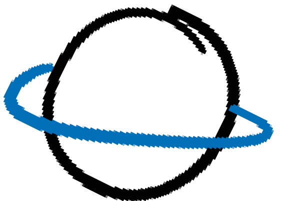
40
35
30
25
20
15
10
5
0
-5
-10
-15

04-Jan-21
04-Feb-21
04-Mar-21
04-Apr-21
04-May-21
04-Jun-21
04-Jul-21
04-Aug-21
04-Sep-21
04-Oct-21
04-Nov-21
04-Dec-21
04-Jan-22
04-Feb-22
04-Mar-22
04-Apr-22
04-May-22
04-Jun-22

Waiting list size
Net WL change

Principle 2: A values-led culture

Autonomy Mastery & Purpose



Strong sense of purpose

Work is challenging

I can develop my skills

Enjoy working in team

Well defined roles

PDRs were done but not useful for a third

Life-work balance poor

41% work additional hours

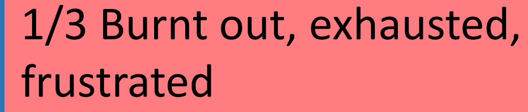
- Get the demand capacity right
- Create fairness in…..
  - Remuneration
  - Education
  - Opportunity

Lack of Autonomy

½ feel unwell due to stress

About half enjoy going to work

¾ have worked for free!

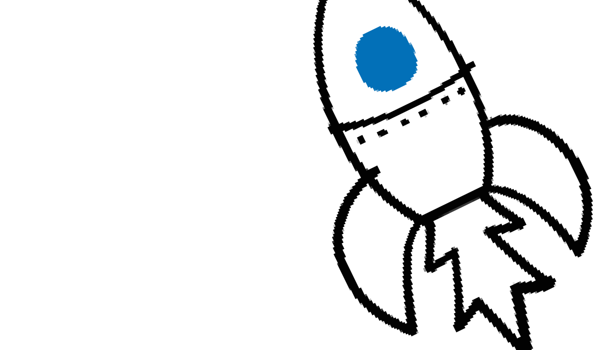


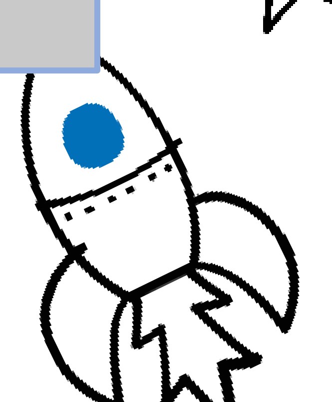
1/3 Burnt out, exhausted, frustrated

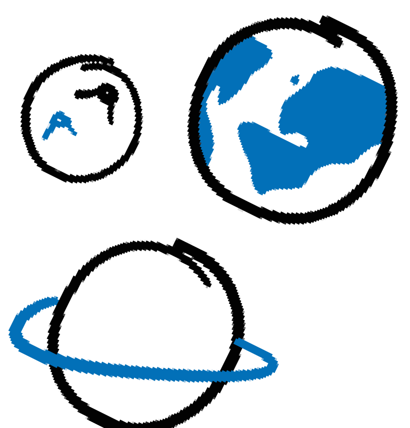
2/3 feel psychologically safe

½ have come to work when not well

40% experienced abuse from those they care for







Development of Trust

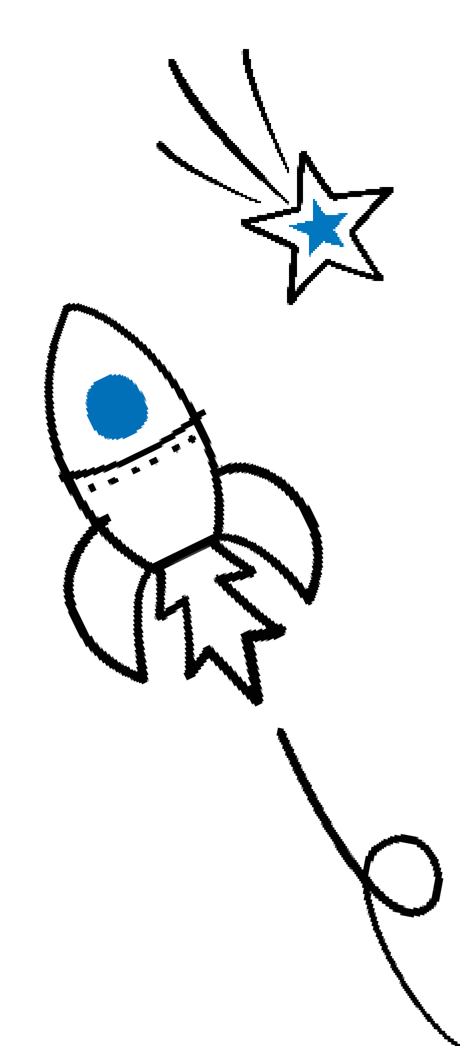
Psychological Safety

Demand debate

Commit to process

Accountability

Results



Adapted from Patrick Lencioni:
Five dysfunctions of a team

https://www.civilitysaveslives.com/

"Nearly everybody who experiences workplace incivility responds in a negative way, in some cases overtly retaliating. About half deliberately decrease their effort or lower the quality of their work."

Christine Porath
The Price of Incivility, January 2013

"I saw incivility really impact the performance of an experienced registrar in theatre, that then caused all of the other theatre staff to make mistakes. It has a massive negative impact on performance"

JOE
January 10, 2017

INCIVILITY
THE FACTS

WHAT HAPPENS WHEN SOMEONE IS RUDE?

80% of recipients lose time worrying about the rudeness

38% reduce the quality of their work

48% reduce their time at work

25% take it out on service users

Less effective clinicians provide poorer care

WITNESSES

20% decrease in performance

50% decrease in willingness to help others

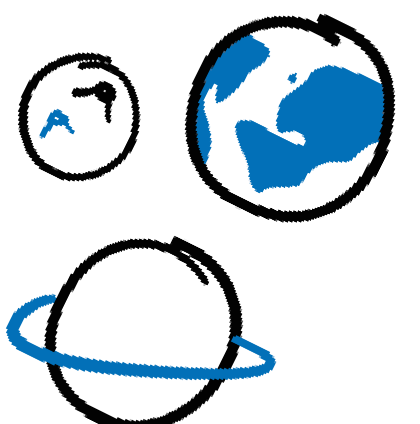
SERVICE USERS

75% less enthusiasm for the organisation

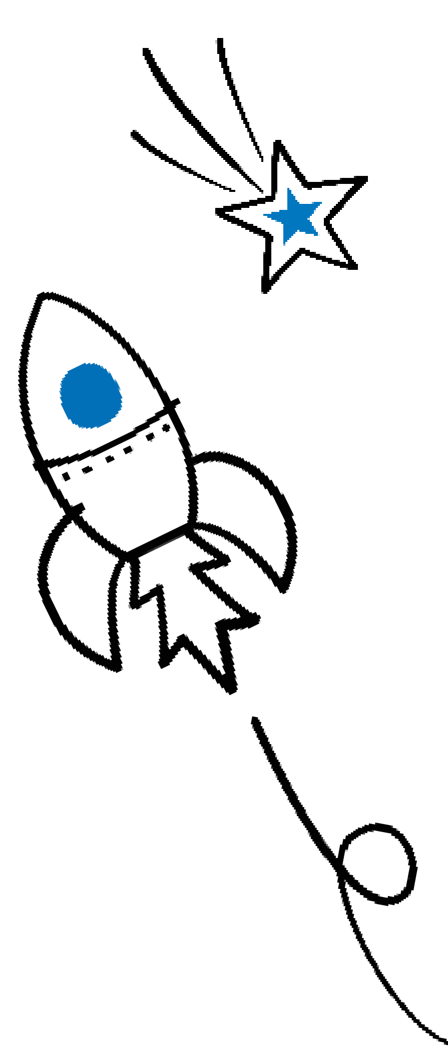
Incivility affects more than just the recipient
IT AFFECTS EVERYONE

CIVILITY SAVES LIVES

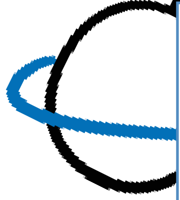
The price of incivility. Porath C, Pearson C, Harvard Business Review 2013 Jan-Feb;91(1-2):114-21, 146



- High degrees of social sensitivity to each other
- Social connectedness is the key
- Helpfulness outperforms intelligence
- We assume that getting to know people happens naturally – it doesn't
- Invest sharing time with others "Swedish Fiika and Danish Janteloven"
- Only people have ideas not companies
- It takes time for candour and openness to develop
- Replace rivalry with connection



Principle 3: Quality



Quality & Safety Improvements:

- Reset our governance structure to make good quality outcomes part of business as usual
- Use of KPIs to reinforce, not guide, our senses
  - Indicators for incidents, complaints, and duty of candour timeliness well under control
  - Consistently high BCMA scanning
- Good outcomes in national audits (NICOR, PICANET), with low surgical complication rates
- Improved peer review for Pulmonary Hypertension

Work in progress

- Project to explore improvements in management of deteriorating patients within cardiothoracic services
- Project to improve booking practices for admissions across cardiology and cardiac surgery including aims to mitigate themes across complaints and improve overall efficiency
- Communication and dissemination of learning from adverse events
- Improving communication between our services and patients

Principle 4: Financial strength

Successes 21/22

- For the second half of the year paid close attention to the driver of variances through waterfall analyses, and were therefore able to forecast to a high degree of accuracy
- The most important influenceable drivers identified were IP&C activity (£5.2m)
- Other exceptional drivers amounted to (3.6m)

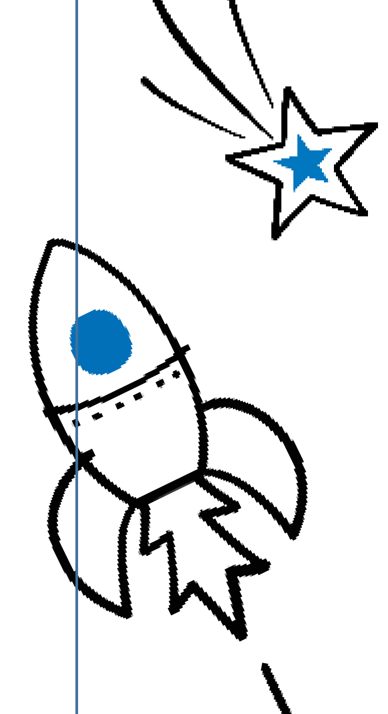
Value 22/23

Target - £3.3m

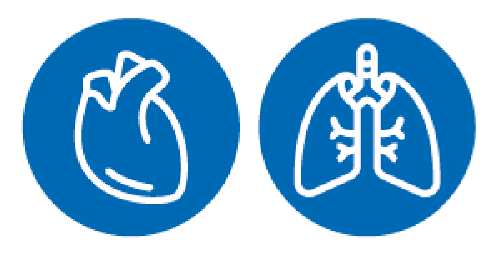
Schemes identified – £1.3m

2021/22 Looking forward

- **Private Income –** Monthly strategy and management forum instigated with IP&C directorate to drive activity
- **Pay Budget-** £59.3m
- **Non-Pay –** £8m
- **Sharing the challenge –** Messages on financial challenge were shared early through the directorate governance structure, and efficiency is a standing item on team meetings



Principle 5: Protecting the Environment



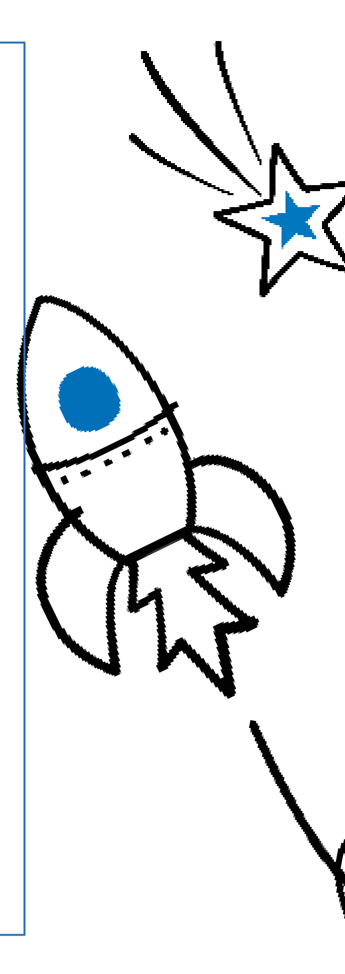
"Earlier and quicker testing, detection and intervention is key" - Delivering a 'Net Zero' National Health Service

- 50% of CHD diagnoses detected antenatally
- Inherited cardiac conditions screening

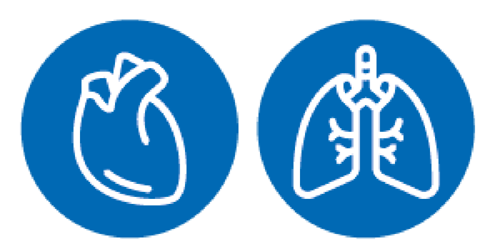
Sustainable models of care

- The directorate will be working to implement GIRFT recommendations for Intensive care
- Delivering networked care, close to home:
    - Cystic Fibrosis
    - Congenital Heart Disease
    - Long term ventilation / non-invasive ventilation
    - Remote diagnostics (holter monitors, home spirometry, home sleep studies)

Environment representative on the Directorate Board



Principle 6: Partnerships

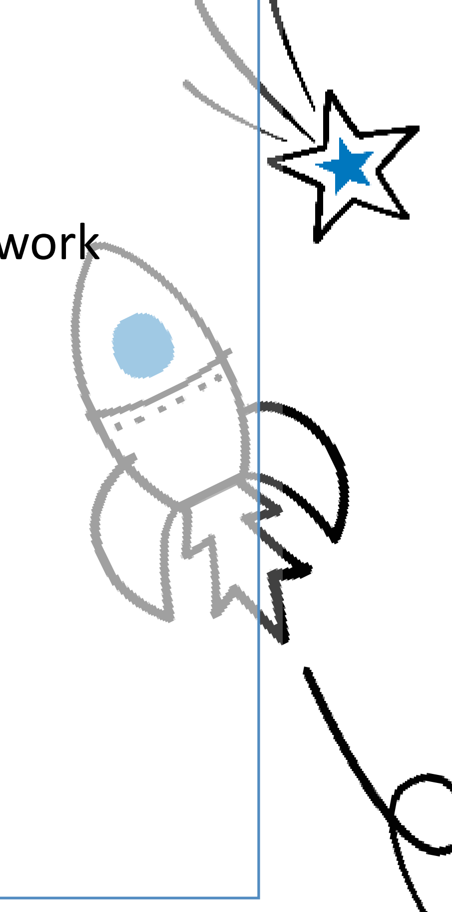


New relationships

- NCL's Startwell programme
- Reciprocal collaboration with Evelina London surgical on call
- Functional relationship with East of England ICS on critical care retrievals

Network relationships

- One Heart Network
- North Thames paediatric network involvement on:
  - Long term ventilation
  - Paediatric critical care
  - Neonatal care
- CATS

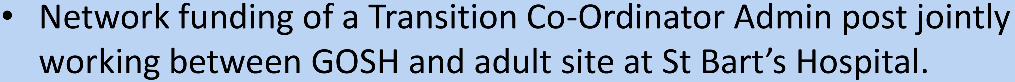


Network Work - Collaboration and Engagement

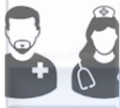
Education

- Frequent Education webinar programme attended and recognised nationally and internationally - run in partnership between Network and GOSH cardiac educator team (circa 150-500 delegates per session)
- Network investment in an Echo training programme to uplift current provision and provide Echo training more widely on a Network level

Transition



- Network funding of a Transition Co-Ordinator Admin post jointly working between GOSH and adult site at St Bart's Hospital.
- Psychology Lead as part of Network transition programme to advise and support on gaps in Transition support for patients.



Nursing

- Network funded development of 'NECS' (Nurses with Expertise in Cardiology) in the outreach DGH hospitals. Programme to uplift the care locally and closer to home and provide additional support to the local 'PECS' (Paediatricians with an Expertise in Cardiology)

Pathways

- CICU representation on Pan London surge escalation calls and surge planning.
- Network collaboration to review and improve pathways and develop Hub and Spoke model.
- Network support with transport education and issues e.g. PaNdr

Patient and Public Voice

- Patient and Parent Representation on education webinars and Network Board meetings.
- Involvement of patients in developing Transition videos.
- Hosting Network PPV events

Digital and Innovation

- Network and GOSH Epic project to improve digital links and create a Network wide registry of CHD patients.
- Increased registration of patients to 'My GOSH' by utilising Network contacts and communication

Attachment S

<table>
<tr><td colspan="2">Trust Board
6th July 2022</td></tr>
<tr><td>Integrated Quality and Performance (May 2022 Data)

Submitted by:
John Quinn COO
Co-Authors
Dr Sanjiv Sharma MD
Tracy Luckett Chief Nurse
Caroline Anderson Director of HR & OD</td><td>Paper No: Attachment S

☐ For approval
√ For discussion
☐ For information and noting</td></tr>
</table>

Purpose of report

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.

Summary of IQPR report

The Board Integrated Quality and Performance Report has been updated to include the following amendments:

- Effective - Better Value scheme indicators
- Well-Led – Quarterly Staff Survey Metrics and Care Hours per Patient Day
- Activity Monitoring
- Combined national and NCL RTT benchmarking information

Key Messages

- Duty of Candour is seeing improvements. For Stage 2, 3 out of 3 cases due in May were sent out on time. However, challenges remain in stage 3 with 2 out of 6 cases being sent within the timeframe.
- There were four new serious incidents declared and no overdue serious incidents. Overdue actions have continued to reduce. These are being monitored through various channels with directorates.
- Infection control metrics are within the required thresholds. CV Lines infection rates have increased, however, is within normal variation. This is being monitored through the Trust Safety meetings.
- 77.8% of the £20.9 million Better Value Target has been identified. Weekly meetings continue to monitor the position.
- The Friends and Family Test response rate in May remains above the target of 25%. Targets for ratings of experience for inpatients (98%) and Outpatients (97%) were achieved. Feedback from patients and families via FFT, PALs and Complaints has identified transport issues as particular area on concern. This is being directly addressed with the transport provider.
- Appraisals: Both metrics have not met 90% target. 6 directorates below 80% and plans are being worked up by directorates with support from the HR&OD team
- RTT Performance has slightly increased to 76.8%. 52 Week waits have further increased to 160 at the end of May. New trajectories have been worked up at a specialty level where required. 3 patients are projected to be 104 Week Waits at the end of June, all are dated in July.
- DM01 Marginal increase in the reported position for May 2022 at 84.7%. 6 Week breaches decreased slightly to 239. Main challenges are in capacity and patient complexity.

Action required from the meeting

The Board are asked to note the report.

Attachment S

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

Integrated Quality & Performance Report

June 2022

Reporting May 2022 data

John Quinn
Chief Operating Officer

Tracy Luckett
Chief Nurse

Sanjiv Sharma
Medical Director

Caroline Anderson
Director of HR & OD

Integrated Quality & Performance Report, June 2022

Safe

Patient Safety

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

Caring

Patient Experience

- Overview
- Friends and Family Test
- Complaints
- PALS

Effective

- Overview

Well Led

Well Led

- Overview
- KPI Metrics
- SPC Trend Analysis

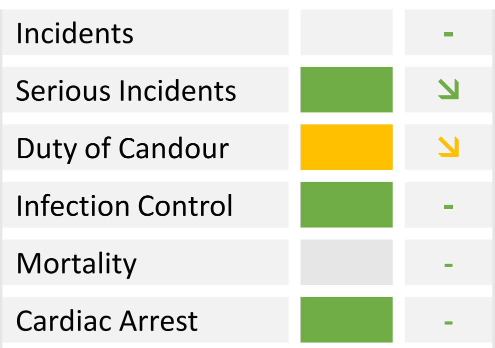
Responsive

Patient Access

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

Integrated Quality & Performance Report, June 2022

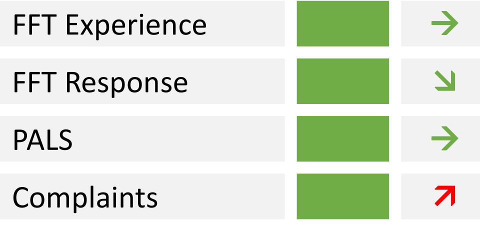
Patient Safety



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

Duty of Candour: For Stage 2, 3 out of 3 cases due in May were sent out on time. However, challenges remain in stage 3 with 2 out of 6 cases being sent within the timeframe.
CV Line Infections: The last two months has seen an increase in the rate, however, remains within statistical normal range. This is being monitored through the weekly safety meetings.

Patient Experience



Patient Experience		
FFT Experience		→
FFT Response		↘
PALS		→
Complaints		↗

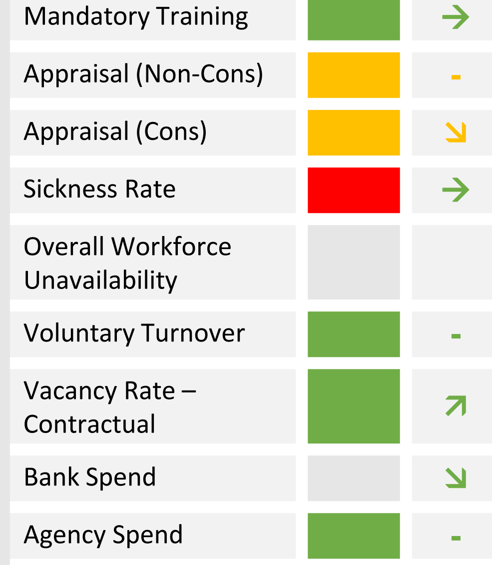
Themes: Transport concerns have risen via Complaints, FFT, Pals and Datix incidents. Actions being taken to address are underway.
Complaints: Significantly increased in June (17 received as at 28/06 against a monthly average of 7)

Effective

Effective		
Clinical Audits		-
QI Projects		↗
Outcome reports		-
Better Value		-

Better Value: £16.3m schemes identified, with a current gap of £4.6m

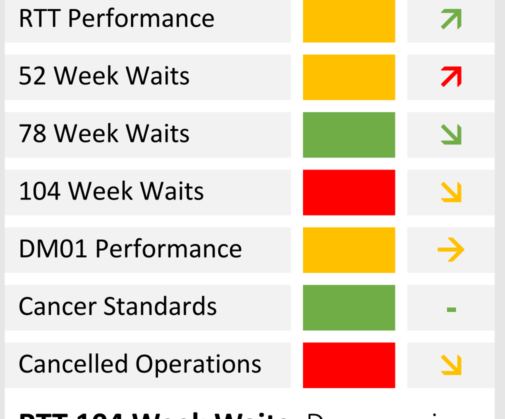
Well Led



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 May 2022 has remained at 3.5% and above 3% target
Appraisals: Both metrics have not met 90% target. 6 directorates below 80% and plans are being worked up by directorates with support from the HR&OD team

Patient Access



Patient Access		
RTT Performance		↗
52 Week Waits		↗
78 Week Waits		↘
104 Week Waits		↘
DM01 Performance		→
Cancer Standards		-
Cancelled Operations		↘

RTT 104 Week Waits: Decrease in number waiting but remains above trajectory. Currently projecting 3 104 waits at the end of June, dated in July.
RTT and DM01 Performance: Concern on the continued plateauing performance. RTT Trajectories completed. Action plans for DM01 being produced.
Cancelled Operations: Non-clinical cancellations decreased but staff availability and list overruns main driver.

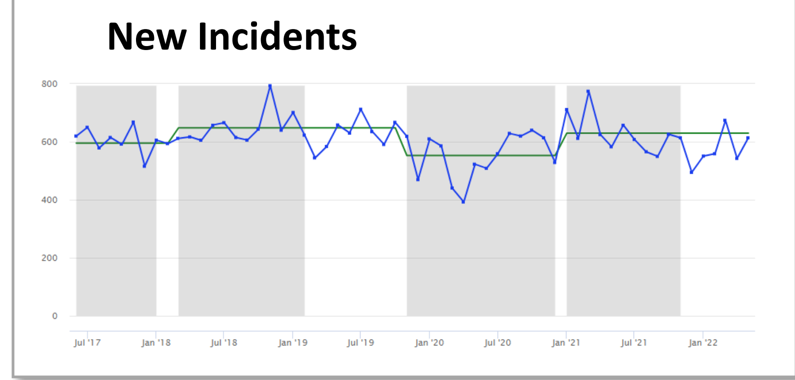
Patient Safety (incidents & risks)

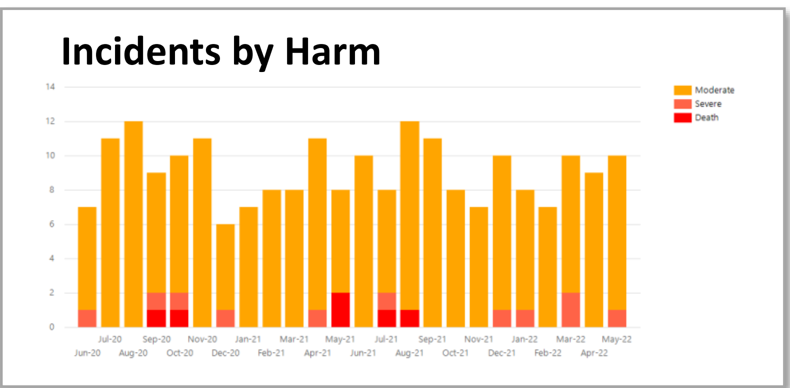
Overview

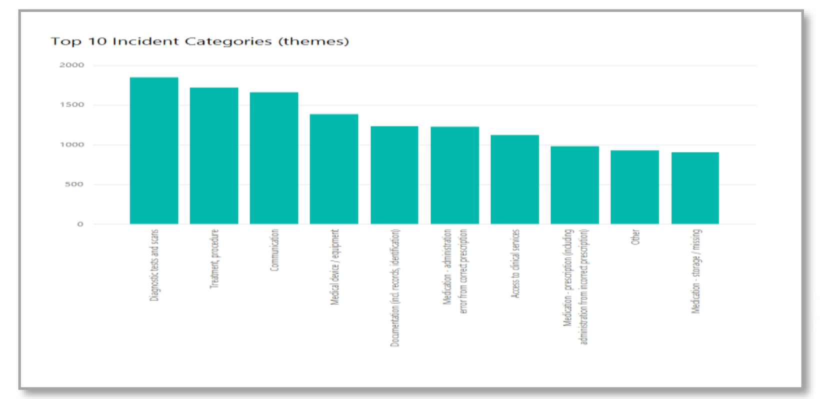
- **Incidents:** Incident numbers were consistent with what would be typical for this period. Percentage of incidents resulting in harm has declined since January suggesting improved reporting culture.
- **Serious Incidents:** Four new serious incidents were declared, two relating to information governance breaches (one involving a staff systems access request, one relating to a clinic letter being sent to a relative), one relating to a surgical patient and delays in their treatment, and one relating to the management of a vein of galen baby who subsequently died.
- **Duty of Candour:** Three stage 2 duty of candour letters were sent in May, all within timeframe.
- **Risks –** High risk review rate has dropped to 68% overall but there is a focus on this through RAGs and Performance Review Meetings.

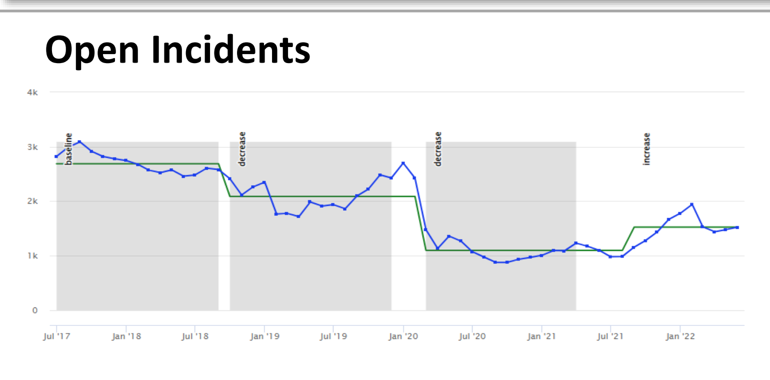
		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 months	RAG			Stat/ Target
New Incidents	Volume	657	607	566	550	626	616	495	546	556	661	532	608		No Threshold			Target
Total Incidents (open at month end)	Volume	977	983	1154	1275	1434	1663	1781	1944	1531	1444	1477	1522		No Threshold			Target
New Serious Incidents	Volume	2	1	1	1	1	3	0	2	1	2	2	4		No Threshold			Target
Total SIs (open at month end)	Volume	18	20	20	19	21	22	22	21	18	17	20	18					Target
Overdue Serious incidents	Volume	1	1	0	0	0	0	0	0	0	0	0	0		>1	=1	=0	Stat
Overdue SI Actions	Volume	39	41	50	50	61	59	63	35	15	16	12	12		>5	1 - 5	=0	Target
Incidents involving actual harm	%	33%	25%	29%	31%	28%	23%	26%	28%	19%	22%	21%	18%		>35%	25%-35%	<25%	Target
Never Events	Volume	0	0	0	0	0	1	0	0	0	1	0	0		>/=1		0	Stat
Pressure Ulcers (3+)	Volume	0	2	1	0	0	0	0	1	0	0	0	1		>1	=1	=0	Stat
Duty of Candour Cases (new in month)	Volume	4	5	7	10	11	4	1	5	3	3	3	7		No Threshold			Target
Duty of Candour – Stage 2 compliance (case due in month)	%	82%	75%	66%	12%	33%	40%	60%	37%	100%	66%	1 / 5	3/3		<75%	75%-90%	>90%	Target
Duty of Candour – Stage 3 compliance (case due in month)	%	25%	0%	43%	17%	40%	75%	0%	60%	33%	33%	1 / 1	2/6		<50%	50%-70%	>70%	Target
High Risks (% overdue for review)	%	11%	30%	24%	24%	25%	27%	31%	12%	6%	21%	28%	32%		>20%	10% - 20%	<10%	Target

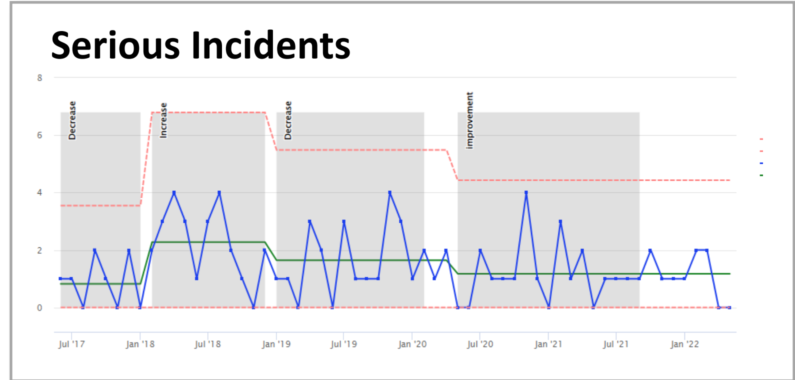
Patient Safety (incidents & risks)

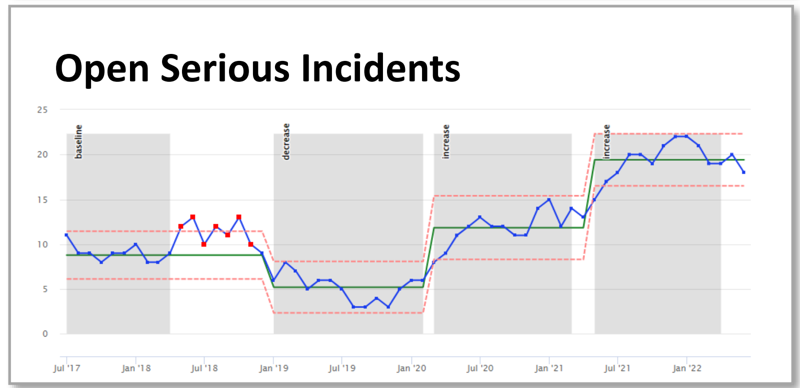


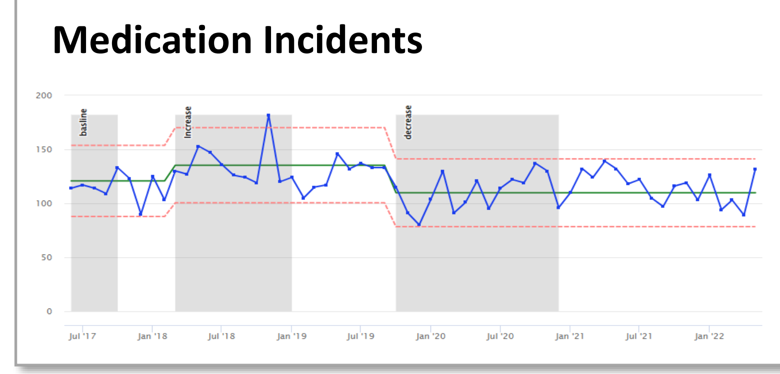


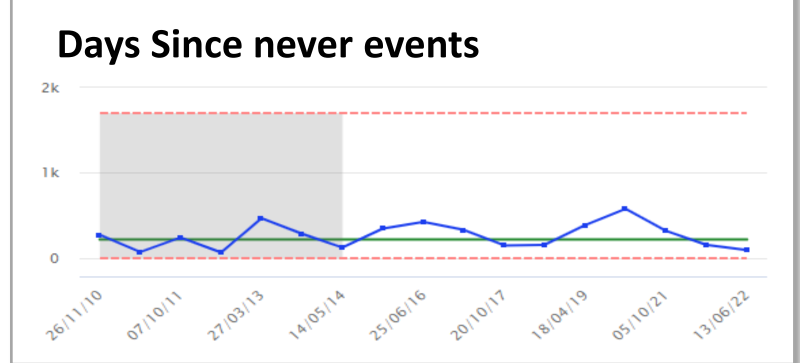












Safe

Patient Safety (Infection & mortality)

Infection Control

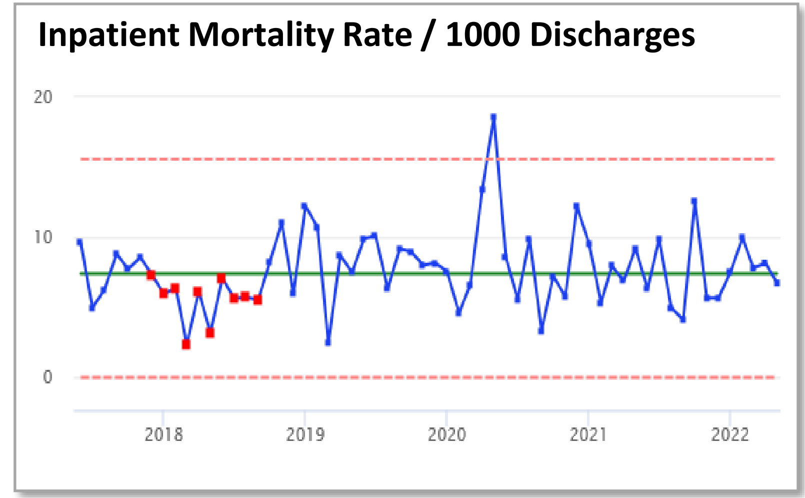
		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23 YTD	Last 12 months	RAG (22/23 threshold)			Stat/ Target
C Difficile cases	In Month	1	3	2	1	0	1	0	0	0	0	0	1	1		>8	N/A	<=8	Stat
C difficile due to lapses (note 2)	Annually	Cases will be reviewed in March 2023														>8	N/A	<=8	Stat
MRSA	In Month	0	0	0	0	0	0	0	0	0	0	0	0	0		>0	N/A	=0	Stat
MSSA	In Month	1	0	0	4	0	3	2	3	0	2	2	3	5		No Threshold			
E.Coli Bacteraemia	In Month	1	1	0	0	0	0	0	1	1	3	1	3	4		>8	N/A	<=8	Stat
Pseudomonas Aeruginosa	In Month	2	1	1	3	1	1	0	0	1	2	0	2	2		>8	N/A	<=8	Stat
Klebsiella spp	In Month	1	0	1	3	1	2	1	1	2	1	2	6	8		>12	N/A	<=12	Stat
CV Line Infections (note 1)	In Month	0.7	1.4	1.8	1.3	0.7	1.3	0.9	1.6	1.3	1.5	2.2	1.7	1.8		>1.6	N/A	<=1.6	T

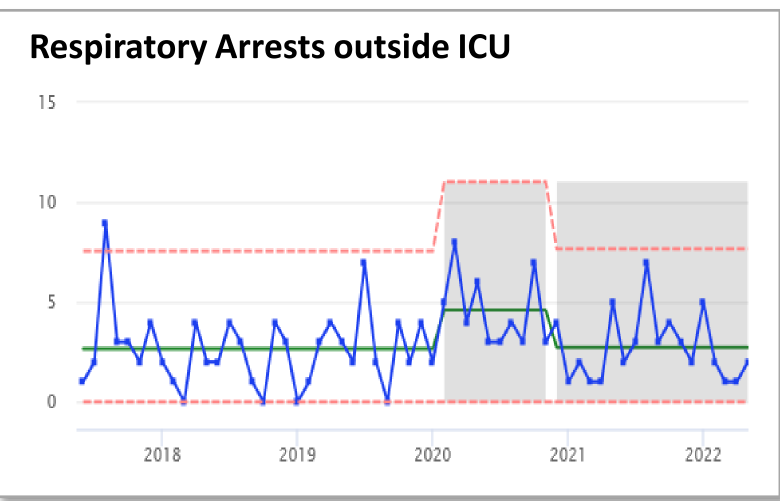
1 GOSACVCRB (GOS acquired CVC related bacteraemias)
2 Lapses of care are reviewed annually with NCL

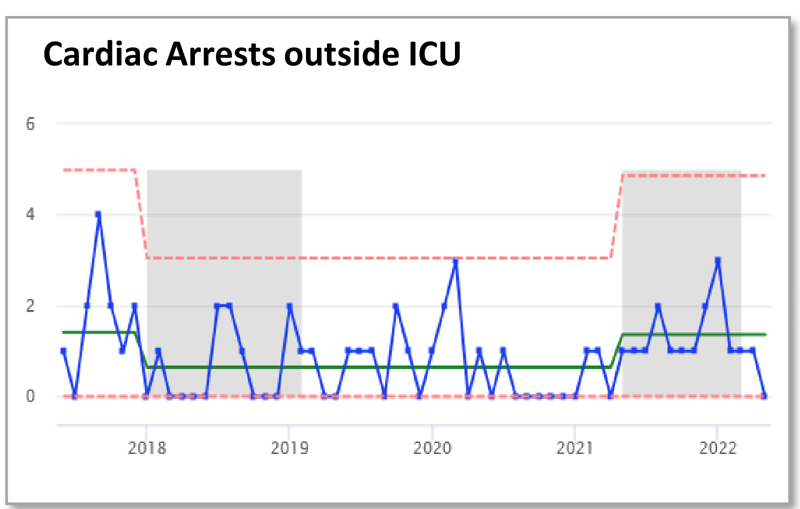
Mortality & Cardiac Arrest

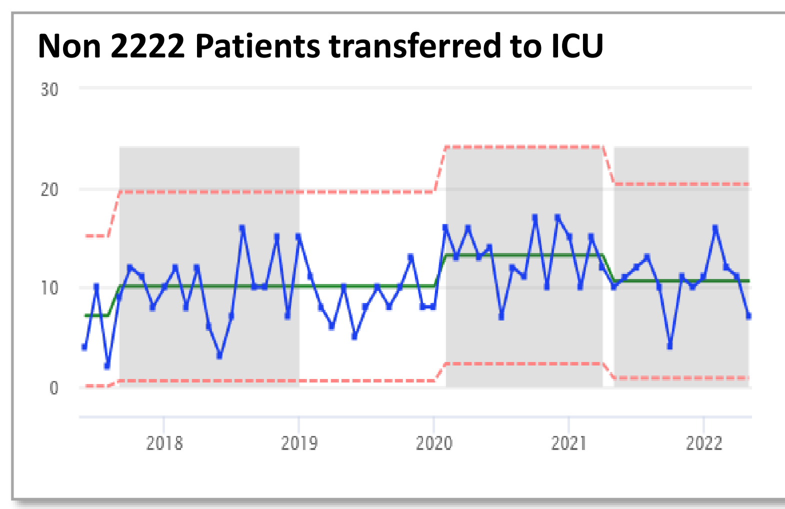
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 months	RAG
Number of In-hospital Deaths	8	11	5	5	13	6	9	9	11	9	8	7		No Threshold
Inpatient Mortality per 1000/discharges	7.2	9.0	5.0	4.1	13.5	4.7	9.6	9.6	9.5	7.8	8.1	6.7		No Threshold
Inquests currently open	8	12	14	17	19	15	12	12	14	12	14	13		No Threshold
Cardiac arrests outside ICU/theatres	1	1	2	0	1	1	3	4	1	1	1	0		No Threshold
Respiratory arrests outside ICU/theatres	2	3	7	3	4	3	2	5	2	1	1	2		No Threshold

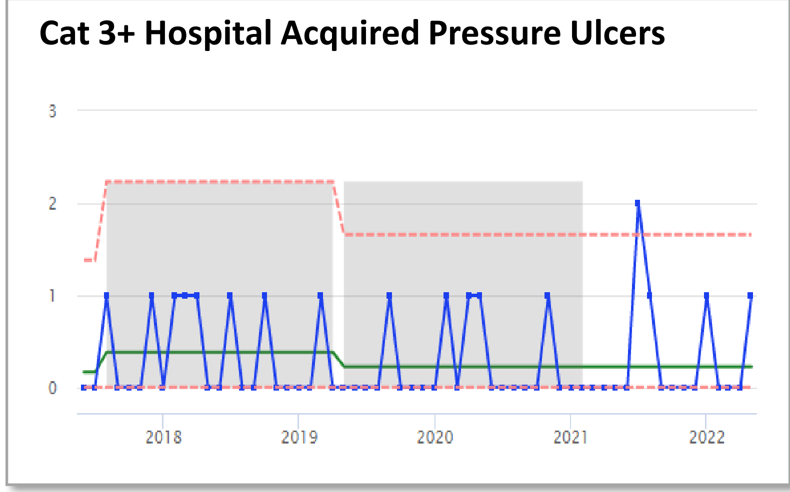
Patient Safety (Infection & mortality)

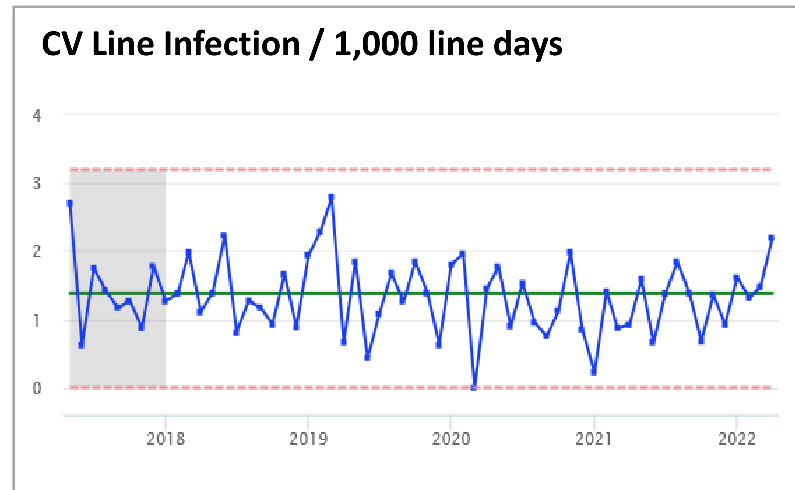












Safe

May 2022 Spotlight: Clinical Audit

A central clinical audit plan describes the areas of priority for clinical audit work to investigate areas for improvement in quality and safety whilst supporting the organisation's learning from incidents, risks and complaints.

The following audits are prioritised at the time of writing:

- Retained guidewire following central venous line insertion on PICU (SI)
- Learning from complaint (18/093). PICU documentation of updates to families
- Patient Safety Alert -(risk of inadvertent connection to medical air via a flowmeter).
- Misdiagnosis of blocked stent leading to delay in treatment (SI 2021/19865)
- Medicines Audit plan- quarterly CD audits and storage of medicines audits which include a focus on areas for improvement highlighted by the GOSH 2020 CQC inspection

In the last month audit has been completed to support Bereavement Services to identify whether there is documentation in Epic of the completion of the key checks of the When a Child dies process at GOSH. The outputs of this work will be used this to scope and guide any areas for improvement as part a Quality Improvement project which has been established to look at this pathway.

Further information The clinical audit part of our quality hub shows what work our specialties are doing in clinical audit, and the learning from completed audits.

Better Value:

The Trust's Better Value target for 2022/23 is £20.9 million. As at May 22, the total value of schemes identified is £16.3 million. There is a gap of circa £4.6 million.

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 months
Speciality led clinical audits completed (actual YTD)	33	47	54	64	74	86	99	109	114	8	16	
Outcome reports published (YTD)	4	4	4	6	6	6	7	7	8	0	0	
QI Project completed	0	0	0	1	0	0	0	0	0	0	0	
QI Projects started	1	6	0	0	2	0	1	0	0	1	1	
% value of schemes identified compared to their Better Value target											77.8%	
Number of schemes identified											80	
Number of schemes fully signed off and EQIA assessed											4	
Number of schemes identified but not signed off											76	

Safe

Patient Experience

Overview

- **FFT experience** response rate (35%) significantly exceeded the Trust target. The ratings of experience (98% for inpatients and 97% for outpatients) were met. CYP feedback reduced.
- **PALS contacts** rose by 14% to 197. The majority of contacts (46%) related to requests for information with many families requesting clarification on updated COVID requirements
- **Complaints –** Seven new complaints were received with concerns about transport, communication and aspects of care. Since April 2022 average response time is 36 days
- **TRANSPORT-** concerns about transport (communication, delays, reliability of the service and resulting cancellation of procedures) were raised via Complaints, FFT, PALs contacts and Datix incidents. This is being addressed directly with the transport provider through contract review and an upcoming workshop with staff and the transport provider to identify and resolve external and internal causes for the service issues.

Friend & Family Test

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 months	RAG		
FFT Experience rating (Inpatient)	99.0%	98.0%	98.0%	98.0%	97.0%	97.0%	97.0%	97.0%	98.0%	97.0%	98.0%	98.0%		<90%	90-94%	>=95%
FFT experience rating (Outpatient)	97.0%	94.0%	97.0%	96.0%	94.0%	95.0%	95.0%	95.0%	98.0%	94.0%	98.0%	97.0%		<90%	90-94%	>=95%
FFT - response rate (Inpatient)	35.70%	34.0%	28.0%	33.0%	26.0%	32.0%	27.00%	25.00%	37.00%	37.00%	37.00%	35.00%		<25%	N/A	>=25%

Complaints & PALS

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 months	RAG		
PALS - per 1000 episodes	10.33	9.96	8.44	9.75	8.45	6.47	6.32	7.56	8.42	7.44	8.1	7.59		No Threshold		
Complaints- per 1000 episodes	0.28	0.29	0.38	0.16	0.42	0.26	0.24	0.13	0.13	0.34	0.32	0.27		No Threshold		
Red Complaints -% of total (note 1)	11%	11%	11%	10%	10%	10%	9%	10%	11%	8%	8%	6%		>12%	10-12%	<10%
Re-opened complaints - % reopened (2)	5%	5%	4%	4%	4%	3%	5%	6%	8%	9%	9%	9%		>12%	10-12%	<10%

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

Caring

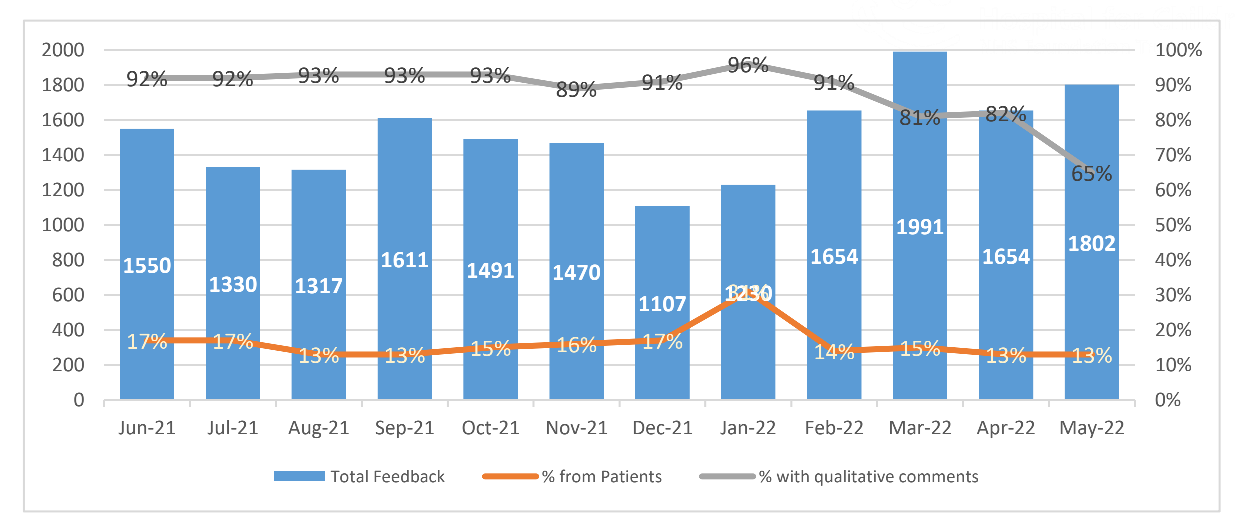
Friends and Family

Overview:

All directorates met the experience score target for May. The response rate was also met by all directorates, with the exception of Blood Cells and Cancer.
The majority of the outpatient responses again came from the Main Reception and Travel Reimbursement Desk.
All directorates met the outpatient measure of experience, with the exception of Core Clinical Services.
Overall there was a reduction in the number of qualitative comments in May (64%) and also a reduction of comments from Children and Young People (13%). This will be closely monitored by the Patient Experience Team.

Headline:

Inpatient response rate – 35% (2% decrease from April)
Experience measure for inpatients – 98%
Experience measure for outpatients – 97%
13% of FFT comments are from patients
64% of responses had qualitative comments



Positive Areas:

- Outstanding care.
- Staff dedication and professionalism.
- Staff friendliness.
- Play staff and the distractions provided to patients.

Areas for Improvement:

- Communication – internal and external communication and pre, during and post-admission. MyGOSH is also limited and can be confusing.
- Ward orientations and clear ward rules.
- Transport delays.
- Pharmacy delays.

Complaints

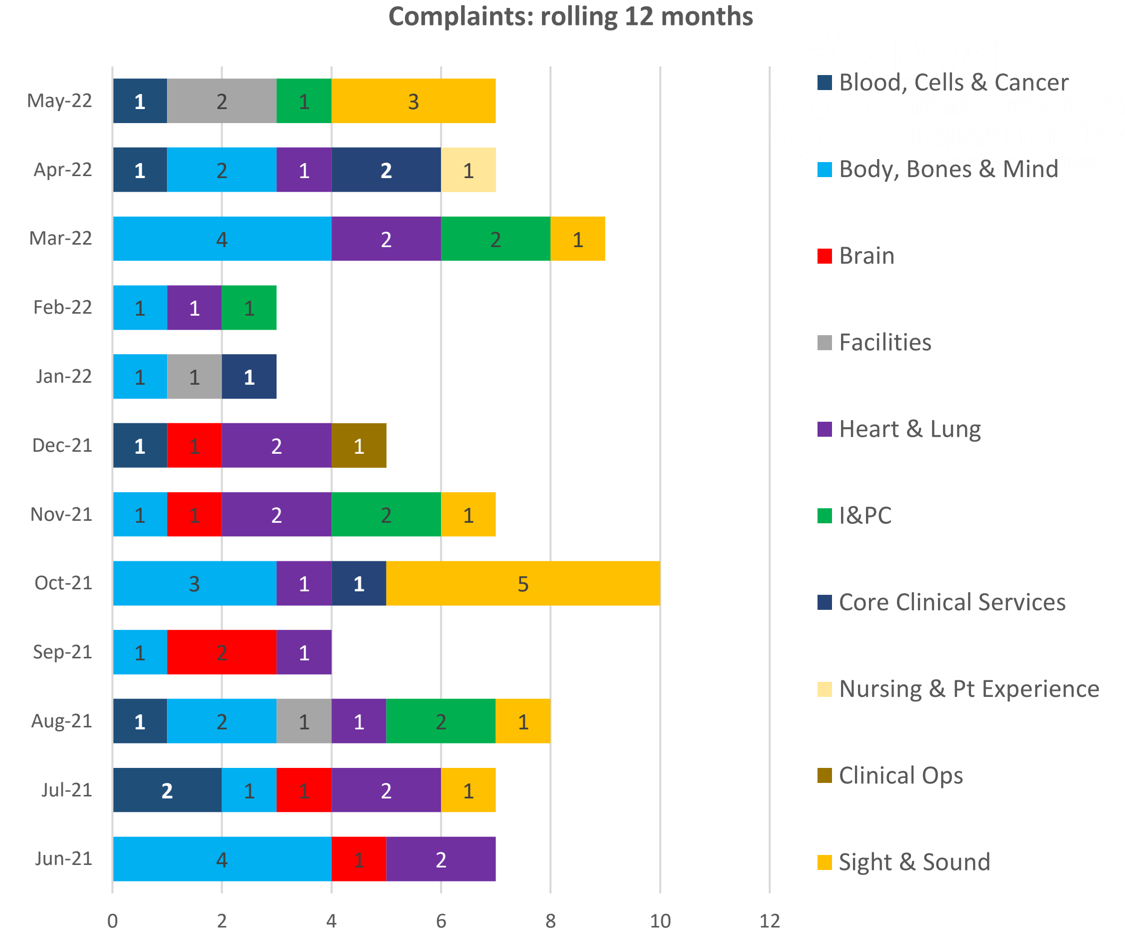
Headline: The Trust received 7 new formal complaints including two about transport. Several families had previously raised concerns via Pals and having experienced the same issues again, opted to make formal complaints.

Concerns raised: In May families complained about:

- The attitude and inappropriate communication from a member of staff causing distress and upset
- Lack of communication, consent, information regarding medications and delayed responses to clinical queries
- Poor infection control on ward
- Transport- poor communication between wards and transport desk, delays resulting in late arrival to appointments and some cancelled procedures
- A misdiagnosis, the lack of acknowledgement and apology around this and also the manner in which their child was discharged from clinic.
- Lack of communication between recovery and ward areas- delay (of several hours) in updating family on patient's condition and location.
- comments and questions that were asked by a clinician during a consultation.

Response times: 6 formal complaints closed in May 2022 (4 responses were sent within the original timeframes agreed with complainants). Since April 2022, the average response time was 36 days.

There are currently two open red/ high risk complaints.



Caring

PALS

Headline: Pals received 197 contacts in May (an 14% increase from April). 46% of the total contacts in May relate to clinical/general information requests from families. Pals received one compliment from a patient praising their ward and clinical teams for the *'patience and kindness'* shown during a recent admission.

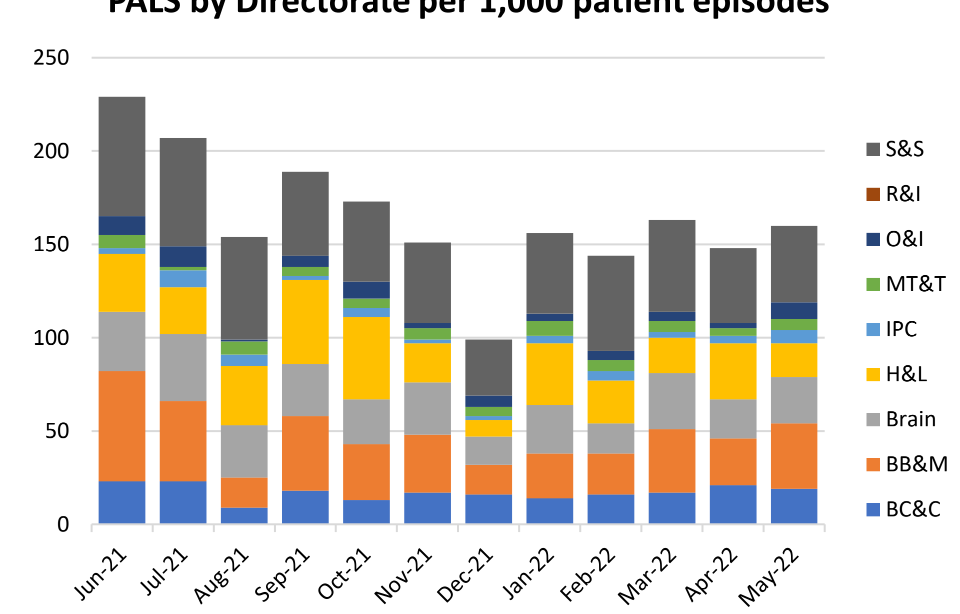
Response Rates - (response within 48 hours) at 78% (down from 80% in April)

Significant areas of focus:

Information: Families contacted Pals for support with assurance and confirmation of clinical treatment plans and clarity on any potential relaxation of Covid guidelines and impact this may have on visiting the Trust.

Transport: contacts rose to 24 in May (up from 13) with these focusing on various aspects of the service, including delays, driver conduct and vehicle suitability. Examples include a mother questing her daughter's eligibility for a standard 'walker' car and a father sharing concerns after a pre-booked vehicle failed to arrive, causing his son to miss a long-awaited clinical review.

Spinal Surgery - PALS received 9 Spinal Surgery contacts in May with many of these involving families describing challenges when attempting to contact members of the secretarial and administrative teams, often to request updates on surgical plans and clinical reviews. Pals continue to work alongside senior management, providing weekly thematic reports on recurring and newly emerging themes.



Caring

Well Led

Contractual staff in post: Substantive staff in post numbers in May were 5,378 FTE, a decrease of 8 FTE since April 2022. Headcount was 5,802 (an decrease of 8 on the previous month).

Unfilled vacancy rate: Vacancy rates for the Trust increased to 7.1% in May from 6.9% the previous month. While the vacancy rate remains below the 10% target, it is higher than the 12 month average of 5.9%. Vacancy rates in the clinical directorates remained below target in May, with the exception of IPC (15%).

Turnover: is reported as voluntary turnover. Voluntary turnover increased slightly in May to 12.2%. While it is broadly stable and remains below the Trust target (14%), this is higher than the same month last year (11.0%), and there is an expectation that turnover will increase during 2022. Total turnover (including Fixed Term Contracts) remained stable at 14.7% in May.

Agency usage: Agency staff as a percentage of paybill in May increased to 1.2%. This was in line with 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 paybill increased in May to 5.7% of total pay spend, this is the highest % since December 2020.

Statutory & Mandatory training compliance: The May training rate for the Trust remained at 93% which is above target with all bar 1 directorates achieving target (Property Services, which following the August insourcing of the domestic staff reduced to 49%, the rate for May was 82% and is likely to achieve the target in the coming months.) Aside from Estates staff, the medical and dental staffgroup are the only staffgroup below the 90% target, at 86% for May. Across the Trust there are now 8 topics below the 90% target (including Information Governance where the target is 95%). Safeguarding Children Level 3 compliance for substantive staff is 94%. Across Resus training rates the compliance figure now sits at 77%. Honorary Contractors compliance remains a focus and work to improve compliance is ongoing.

Appraisal/PDR completion: The non-medical appraisal rate reduced to 86% in May with only 3 Directorates achieving the 90% target. A proposal to improve the process and compliance is being worked up by the HR&OD team. Consultant appraisal rates reduced to 86% in May, and is now below target.

Sickness absence: May sickness rates were 4%, a reduction from the April rate of 4.3% but significantly higher than the May 2021 rate of 3.3%. 4% is e above the Trust target of 3%, and the sickness rate was above the target for the 11th month in a row. Sickness rates were highest in Property Services (8.7%) and Clinical Operations (5.3%). COVID accounted for 20% of sickness (down from 24% in April).

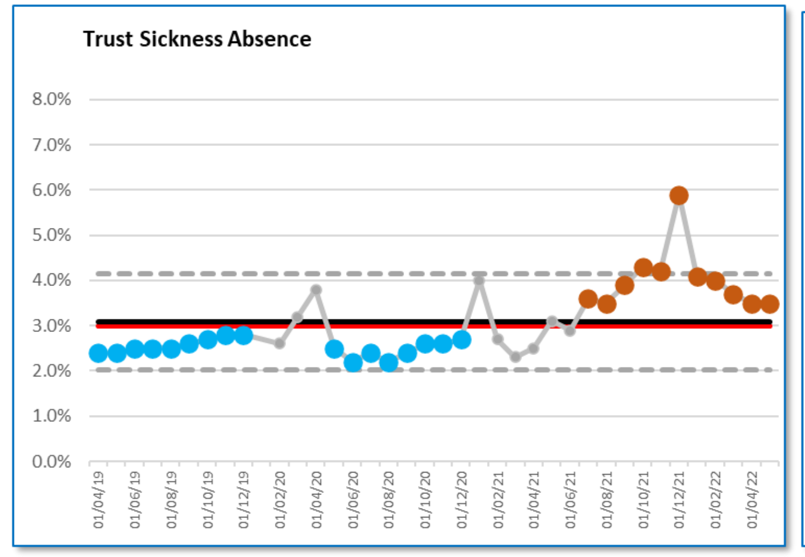
Well Led

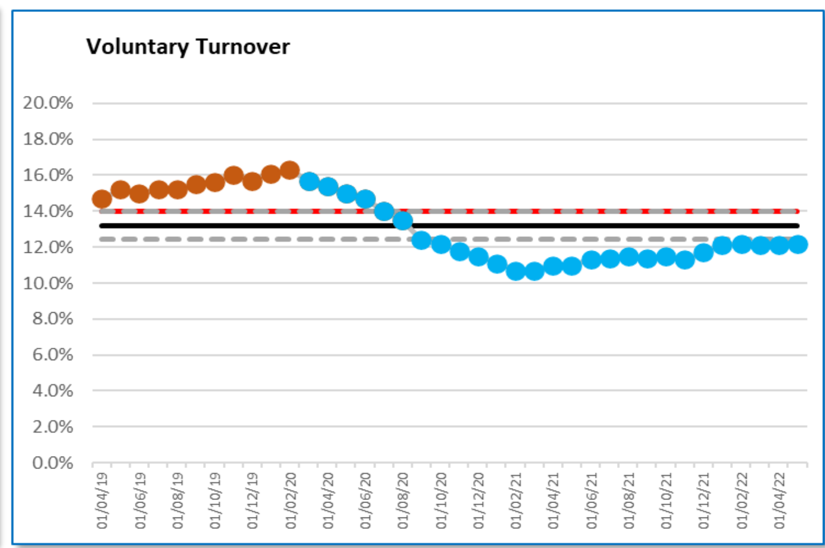
Well Led Metrics Tracking

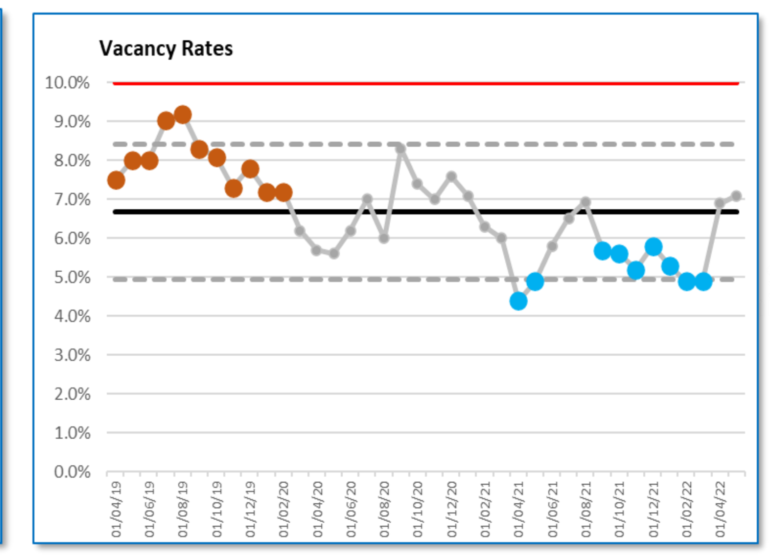
Well Led Metrics Tracking	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 months	RAG Levels			Stat/Target
Mandatory Training Compliance	93.0%	94.0%	91.0%	91.0%	91.0%	91.0%	92.0%	92.0%	93.0%	92.0%	93.0%	93.0%		<80%	80-90%	>90%	Stat
Stat/Man training – Medical & Dental Staff	86.2%	85.0%	86.0%	86.0%	84.0%	85.0%	87.0%	86.0%	86.0%	86.0%	86.0%	86.0%		<80%	80-90%	>90%	Stat
Appraisal Rate (Non-Consultants)	88.0%	88.0%	88.0%	87.0%	86.0%	87.0%	88.0%	87.0%	87.0%	86.0%	87.0%	86.0%		<80%	80-90%	>90%	Stat
Appraisal Compliance (Consultant)	93.0%	92.0%	94.0%	94.0%	95.0%	89.0%	91.0%	87.0%	89.0%	93.0%	87.0%	86.0%		<80%	80-90%	>90%	Stat
Honorary contract training compliance	74.0%	74.0%	76.0%	75.0%	75.0%	74.0%	78.0%	74.0%	78.0%	76.0%	76.0%	74.0%		<80%	80-90%	>90%	Stat
Safeguarding Children Level 3 Training	89.9%	89.0%	87.0%	85.0%	87.0%	86.0%	89.0%	89.0%	89.0%	89.0%	94.0%	94.0%		<80%	80-90%	>90%	Stat
Safeguarding Adults Level 2 Training	98.6%	89.0%	90.0%	89.0%	90.0%	91.0%	92.0%	91.0%	91.0%	92.0%	92.0%	94.0%		<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%	77.0%		<80%	80-90%	>90%	Stat
Sickness Rate	3.0%	3.6%	3.5%	3.3%	3.8%	4.2%	5.9%	4.1%	4.0%	3.7%	3.5%	3.5%		>3%	N/A	<3%	T
Overall Workforce Unavailability																	
Turnover Rate (Voluntary)	11.3%	11.4%	11.5%	11.4%	11.5%	11.3%	11.7%	12.1%	12.2%	12.1%	12.1%	12.2%		>14%	N/A	<14%	T
Vacancy Rate – Contractual	5.8%	6.5%	6.9%	5.7%	5.6%	5.2%	5.8%	5.3%	4.9%	4.9%	6.9%	7.1%		>10%	N/A	<10%	T
Vacancy Rate - Nursing	3.6%	4.9%	5.8%	1.6%	1.0%	1.2%	3.0%	2.9%	3.1%	3.5%	5.9%	6.2%		No Threshold			T
Bank Spend	4.9%	5.0%	5.1%	5.0%	5.0%	5.1%	5.2%	5.2%	5.3%	5.2%	5.5%	4.2%		No Threshold			T
Agency Spend	1.1%	1.1%	1.2%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.1%	1.2%		>2%	N/A	<2%	T
Care Hours per Patient Day (CHPPD)	15.7	14.9	14.9	15.3	16.2	15.6	13.2	14.4	15.8	14.8	14.1	15.7		No Threshold			T
Quarterly Staff Survey - I would recommend my organisation as a place to work											65%			No Threshold			T
Quarterly Staff Survey - I would be happy with the standard of care provided by this organisation											88%			No Threshold			T
Quarterly Staff Survey - Overall Staff Engagement (scale 0-10) See note 1											7.5			No Threshold			T
Quarter Staff Survey - Communication between senior management and staff is effective See note 1											46.0%			No Threshold			T

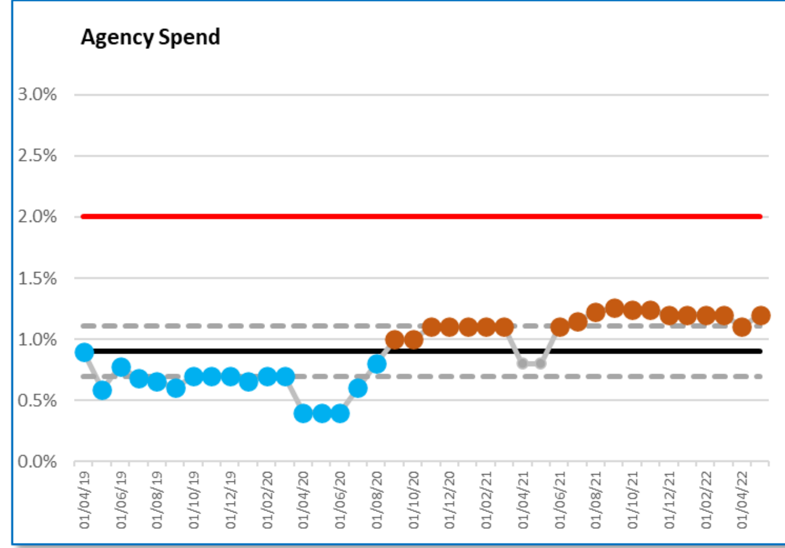
Note 1 - Survey runs in January, April and July.

Workforce SPC Analysis

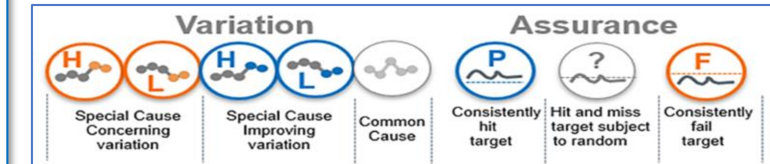








KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Trust Sickness Absence	May 22	3.5%	3.0%			3.1%	2.0%	4.1%
Voluntary Turnover	May 22	12.2%	14.0%			13.2%	12.5%	14.0%
Vacancy Rates	May 22	7.1%	10.0%			6.7%	5.0%	8.4%
Agency Spend	May 22	1.2%	2.0%			0.9%	0.7%	1.1%



Well Led

Performance Metrics

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Access Metrics Tracking

Access Metrics Tracking	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Trajectory	Last 12 months	RAG Levels			Stat/Target
RTT Open Pathway: % waiting within 18 weeks	77.7%	78.3%	77.8%	77.4%	76.7%	76.4%	75.3%	75.4%	75.3%	76.0%	75.2%	76.8%	Below		<92%	N/A	>=92%	Stat
Waiting greater than 18 weeks - Incomplete Pathways	1,536	1,565	1,576	1,593	1,617	1,605	1,711	1,688	1,731	1,635	1,733	1,638	-			No Threshold		-
Waiting greater than 52 weeks - Incomplete Pathways	291	272	247	219	194	202	194	176	169	142	151	160	Below		>0	N/A	=0	Stat
Waiting greater than 78 weeks - Incomplete Pathways	88	99	103	85	69	60	60	39	34	27	28	24	Below			TBC		T
Waiting greater than 104 weeks - Incomplete Pathways	17	11	12	12	8	7	5	7	9	5	7	4	Above		>0	N/A	=0	Stat
RTT Priority 2 patients	723	703	669	664	649	676	687	722	714	644	646	558	-			No Threshold		
RTT Priority 2 patients beyond fail safe date	203	207	191	176	179	163	187	177	184	158	191	188	-			No Threshold		
18 week RTT PTL size	6,878	7,214	7,107	7,055	6,940	6,814	6938	6858	7004	6811	7009	7070	-			No Threshold		-
Diagnostics- % waiting less than 6 weeks	83.3%	85.4%	81.1%	84.3%	87.4%	90.2%	87.7%	83.0%	86.4%	86.8%	84.1%	84.7%	Below		<99%	N/A	>99%	Stat
Diagnostics- waiting greater than 6 weeks	230	201	243	188	170	124	159	237	194	192	247	239	-			No Threshold		-
Diagnostics- waiting greater than 13 weeks	47	42	40	25	28	13	12	14	19	21	31	35	-			No Threshold		-
Total DM01 PTL size	1,376	1,373	1,283	1,200	1,347	1,271	1,290	1,394	1,430	1,463	1,556	1,565	-			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%	80%	67%	88%	100%	75%	60%	100%	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)	32	32	29	46	77	31	22	11	15	34	23		-			No Threshold		-
28 day breaches	4	2	2	2	4	8	0	1	3	1	2		-		>0	N/A	=0	Stat
Number of patients with a past planned TCI date (note 4)	1,479	1,529	1,504	1,521	1,411	1,438	1,554	1,494	1,464	1,126	1,244	1,398	-			No Threshold		-
NHS Referrals received- External	2,605	2,691	2,319	2,646	2,590	2,767	2,391	2,439	2,490	2,818	2,470	2,603	-			No Threshold		-
NHS Referrals received- Internal	1,965	1,955	1,703	1,946	1,894	1,997	1,593	1,937	1,861	2,016	1,812	2,023	-			No Threshold		-
Total NHS Outpatient Appointment Cancellations (note 2)	6,651	7,380	7,046	7,016	6,643	6,727	6,560	6,483	6,605	7,637	6,704	6,626	-			No Threshold		-
NHS Outpatient Appointment Cancellations by Hospital (note 3)	2,073	1,973	1,878	1,734	1,734	1,675	1,684	1,790	1,793	2,156	1,690	1,473	-			No Threshold		-

Note 1 - Elective cancelled operations on the day or last minute
Note 2 - Patient and Hospital Cancellations (excluding clinic restructure)
Note 3 - Hospital non-clinical cancellations between 0 and 56 days of the booked appointment
Note 4 - Planned Past TCI date includes patients with no planned date recorded

Referral to Treatment times (RTT)

Overview of PTL & Prioritisation

The current May RTT PTL size is 7010 patients with performance being 76.8%

- As the Trust continues to book long waits reductions in 78 and 104 week waits have been seen.
- 52 Weeks have increased but are below trajectory.
- Within the PTL, 1457 require clinically prioritising with 1238 being under 18 week waits
- P1a/P1b – 60 patients (0.85%), P2 – 558 (7.8%), P3 – 2754 (38.9%) and P4 – 2241 (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 slightly decreased to 188. Of these 120 (63%) are admitted and 68 (36%) are non-admitted.

The largest volume of P2 breaching patients are within Cardiology Specialties (51), Urology (12), Orthopaedics (11), Audiological Medicine (11), SNAPS (11) and Nephrology (11). These make up 56% of the breached P2.

For specialties where an RTT recovery trajectory is required, 20 have been signed off with 10 being on track or above trajectory. The Trust revised trajectory is being finalised.

Bottlenecks

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

P2 capacity for Cardiac specialty patients

Non-Admitted Inherited Cardiology Service capacity

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 chaired by COO to drive performance and activity

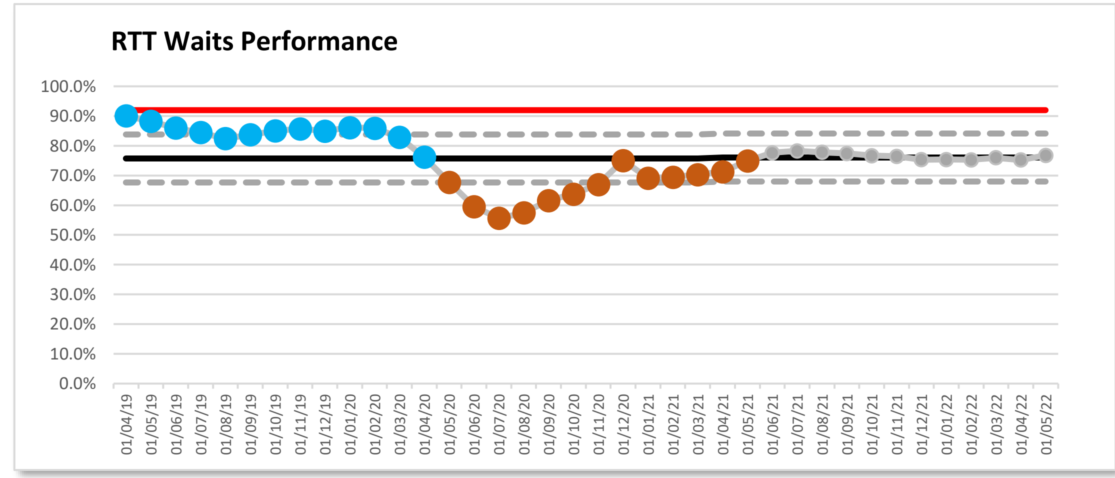
Weekly PTL challenge sessions with directorates

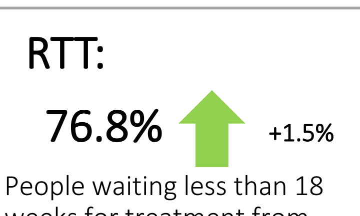
Continued focus on reduction of long wait patients

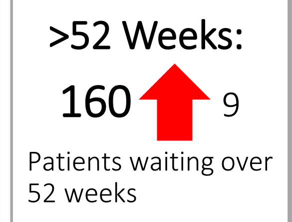
Mutual aid discussion with the Evelina regarding Cardiac P2 patients

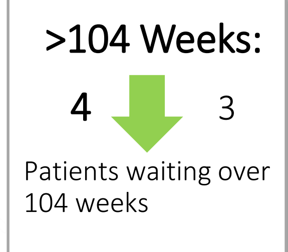
Review of Inherited Cardiology Service pathway to reduce waits

Referral to Treatment times (RTT)

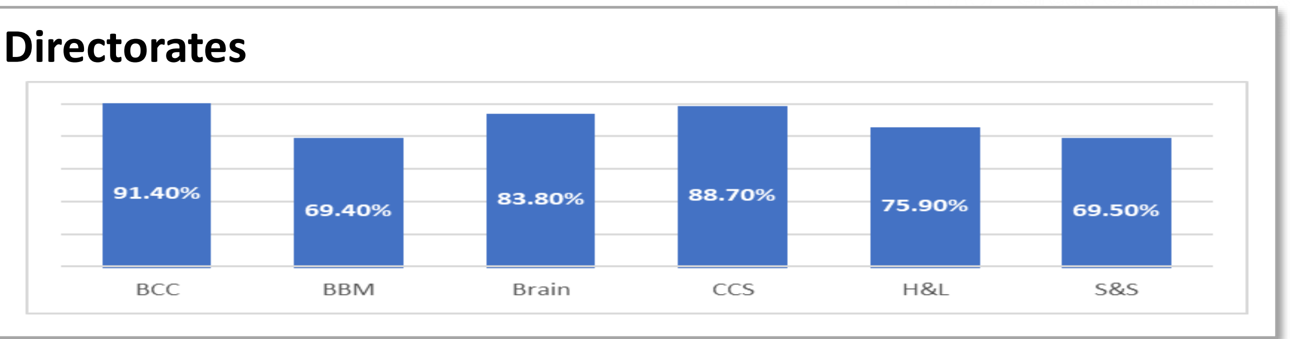


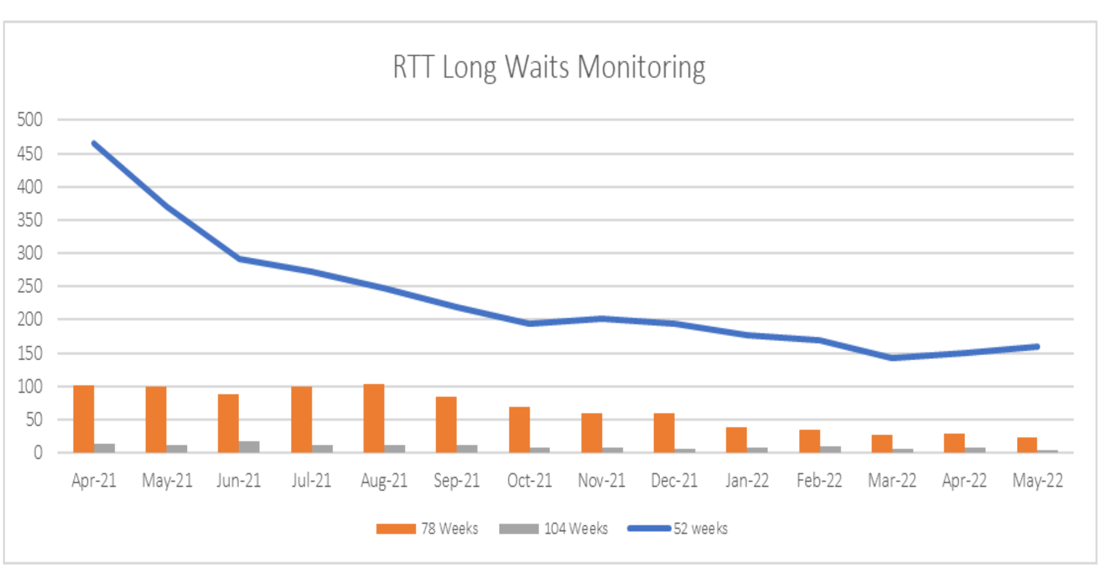




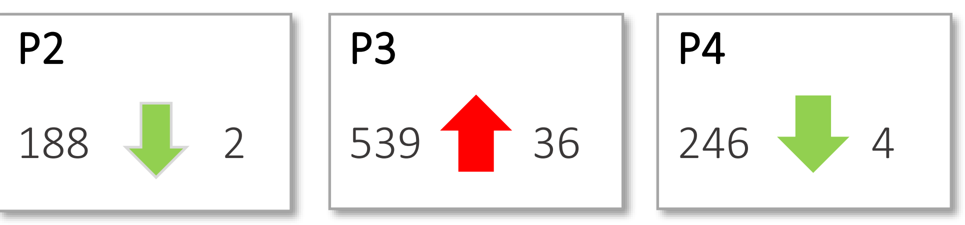


Directorates



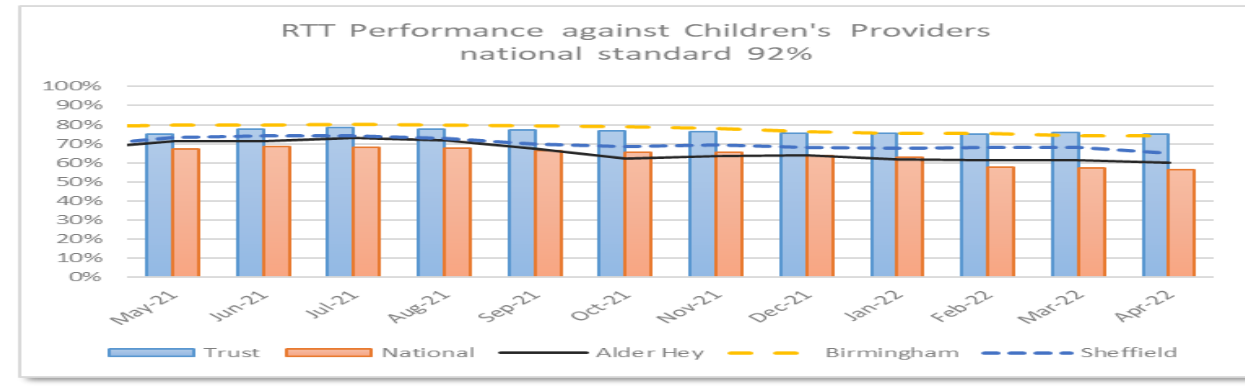


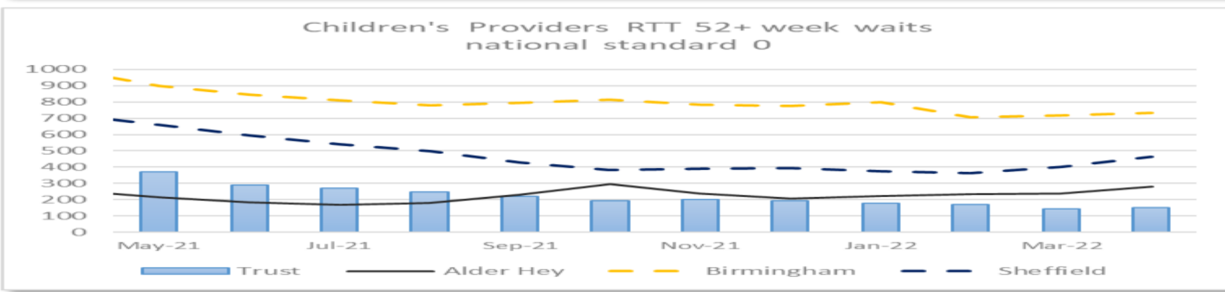
RTT PTL Clinical Prioritisation – past must be seen by date



Responsive

National and NCL RTT Performance – April 2022





Nationally, at the end of April, 56.6% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks.

GOSH is tracking 18.6% above the national April performance at 75% and is inline with comparative children's providers. RTT Performance for Sheffield Children (65.2%), Birmingham Women's and Children's (74.1%) and Alder Hey (60.0%).

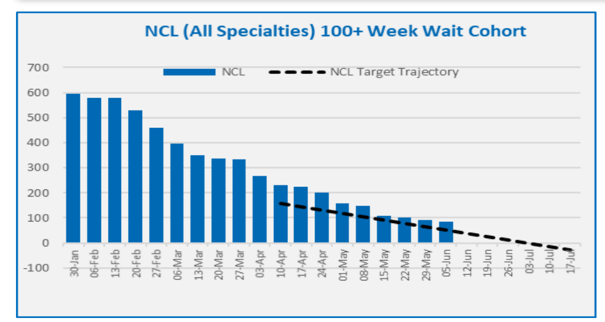
The national position for April 2022 indicates an increase in patients waiting over 52 weeks at 304,728 patients.

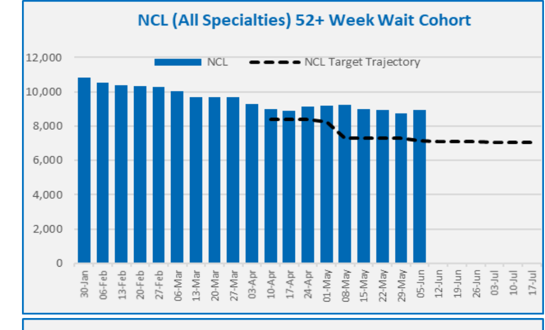
Compared to Alder Hey, Birmingham and Sheffield the number of patients waiting 52 weeks and over for GOSH is lower than all three providers for April.

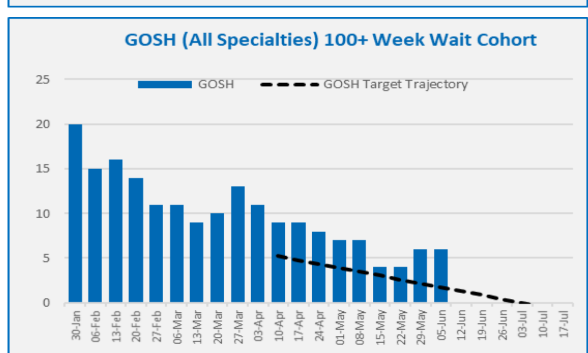
Overall for NCL the 100 week wait position is above projected plan by 32, at 85 patients. Mainly driven by RFH and UCLH numbers. GOSH is above trajectory by4 patients.

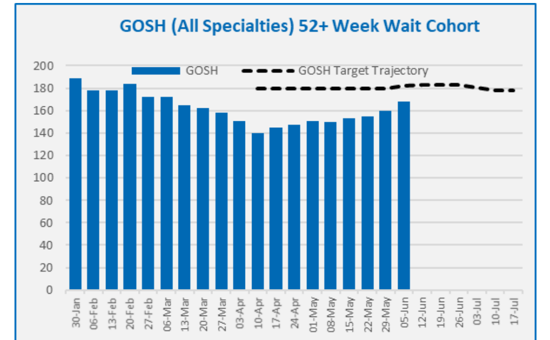
Overall, the number of patients waiting 52 weeks for NCL is reducing. Royal Free and UCLH have the most significant volumes. GOSH is below the agreed 52 week trajectory submission.

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



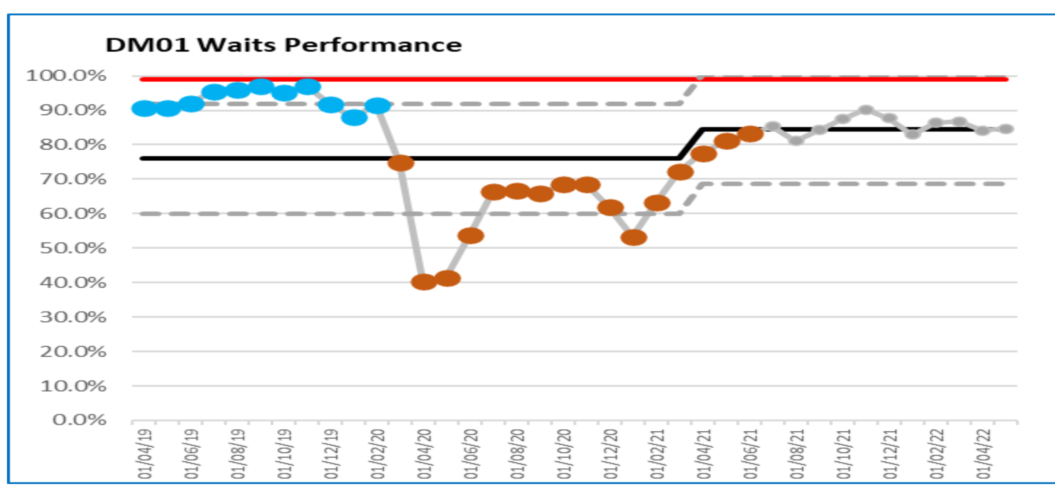






Responsive

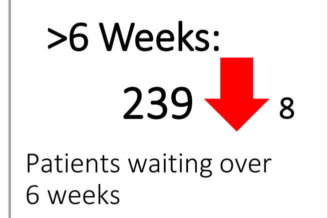
Diagnostic Monitoring Waiting Times (DM01)

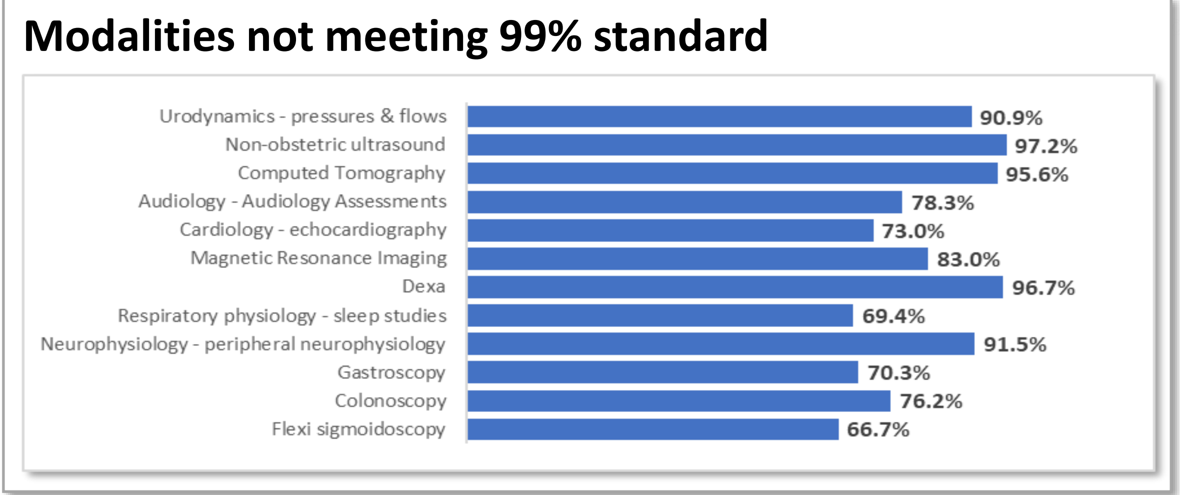


DM01:

84.7%

People waiting less than 6 weeks for diagnostic test.





Bottlenecks

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

Dexa scanner breakdown impacted May waits and continue into June but recovery expected by end of July.

Echo capacity remains limited for stress and sedated Echo.

Endoscopy patients bookings have increased but access to capacity can be challenging

Respiratory complex patient bed requirement impacting sleep study activity

Booking team annual leave and illness has impacted volume of bookings, directorates are reviewing plans to cover reduction

Actions

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

Focus on diagnostics in weekly challenge sessions

Sleep Study action plan and sedation patient actions pulled together and being implemented

Trajectories being completed and reviewed

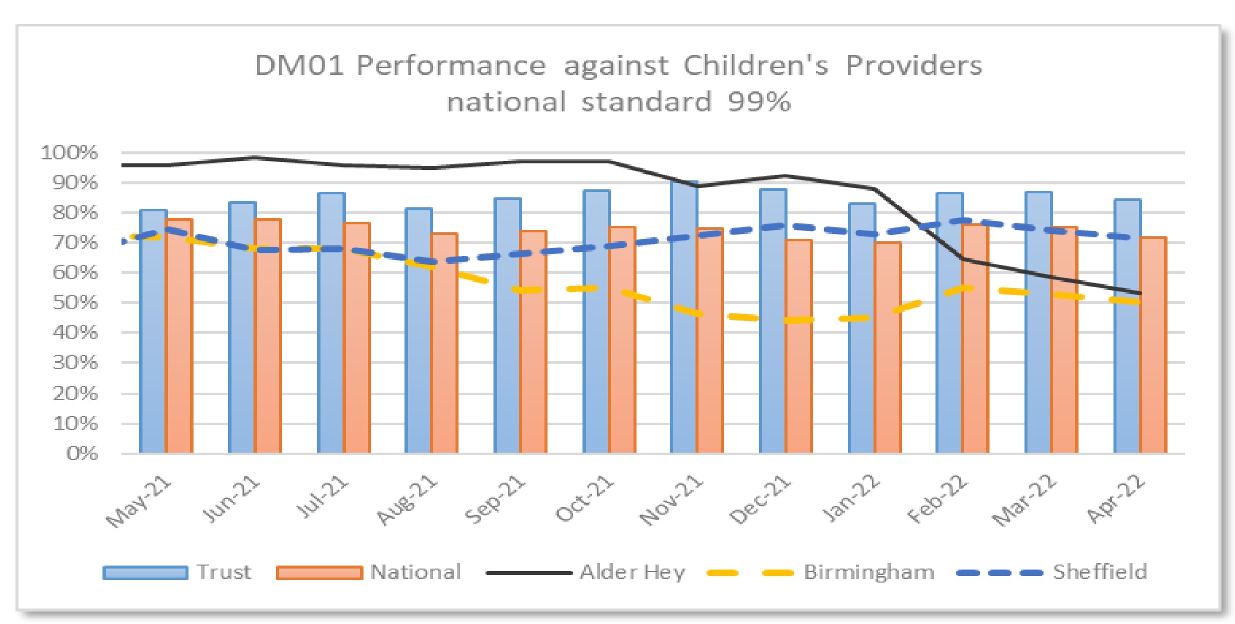
National Diagnostic Performance and 6 week waits – April 2022

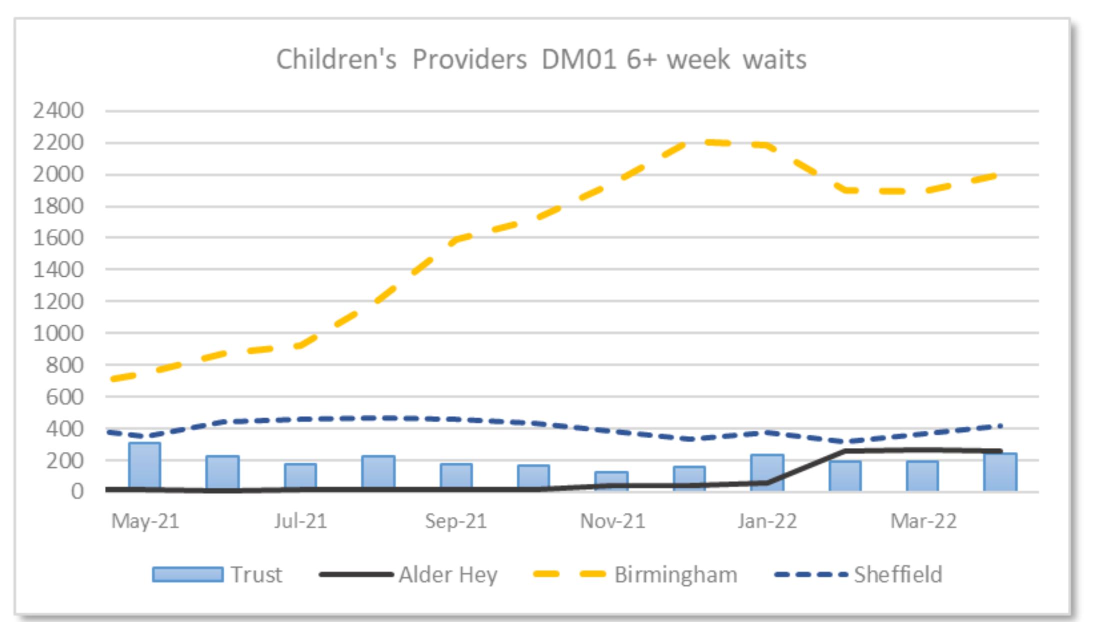
Nationally, at the end of April, 71.6% of patients were waiting under 6 weeks for a DM01 diagnostic test.

GOSH is tracking 12% above the national April performance and is inline with comparative children's providers. DM01 Performance for Sheffield Children (71.5%), Birmingham Women's and Children's (50.4%) and Alder Hey (53.4%).

The national position for April 2022 indicates a increase of patients waiting over 6 weeks at 439,306 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 April.





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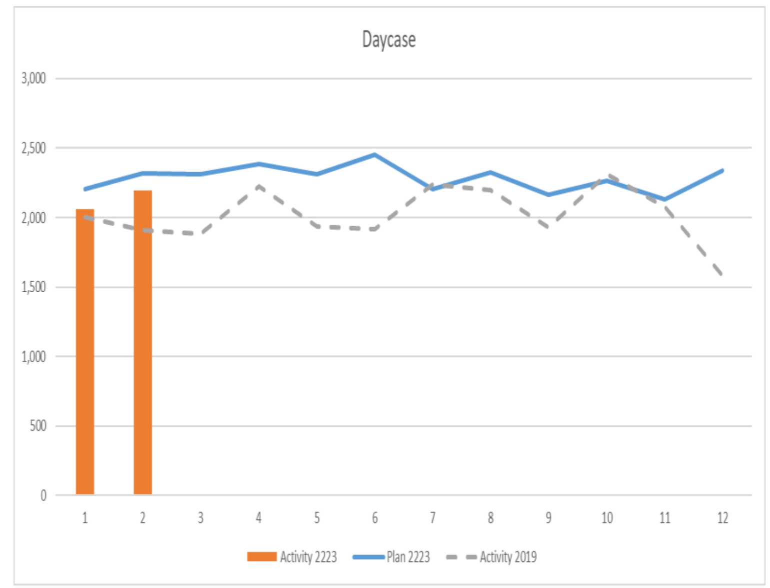
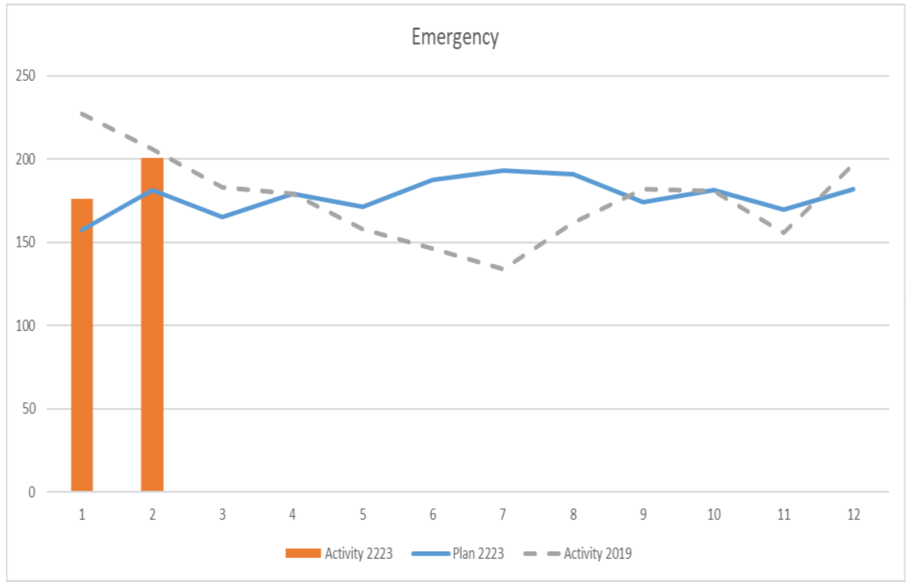
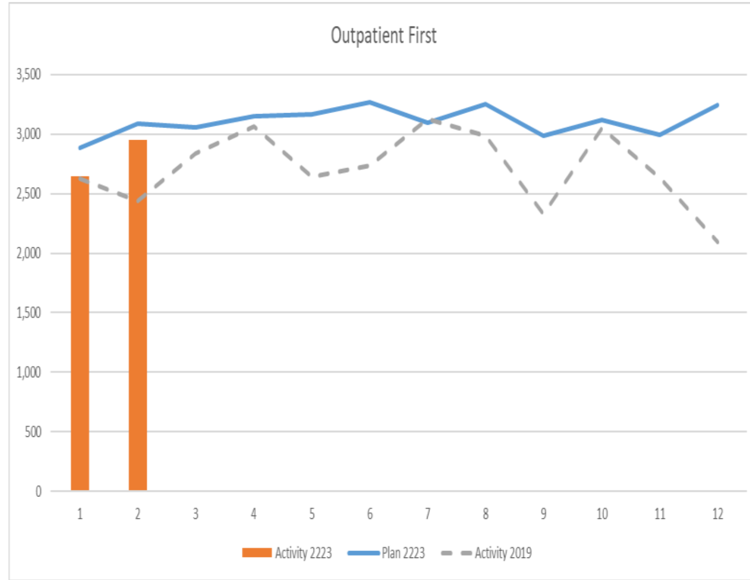
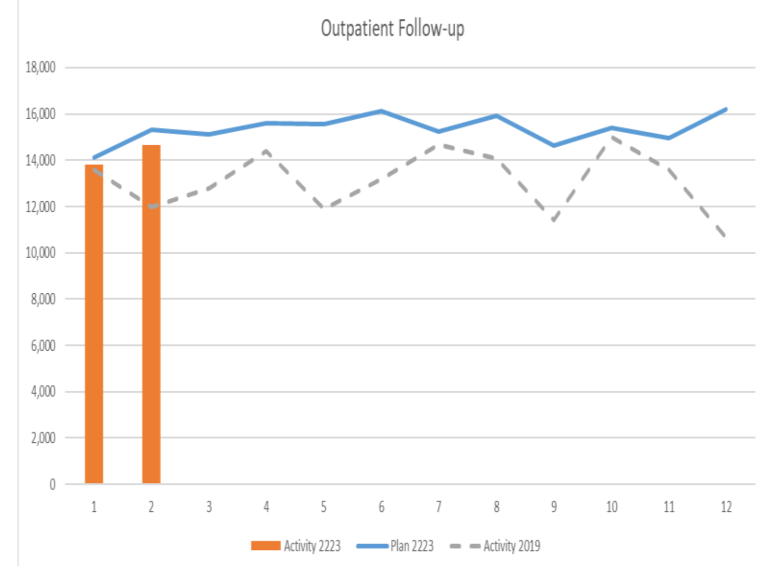
Activity Monitoring







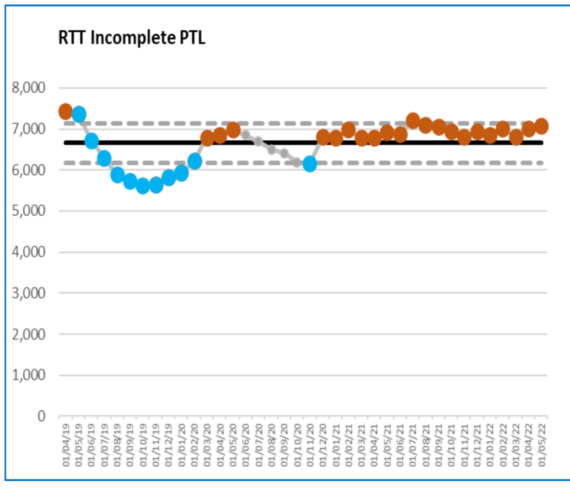


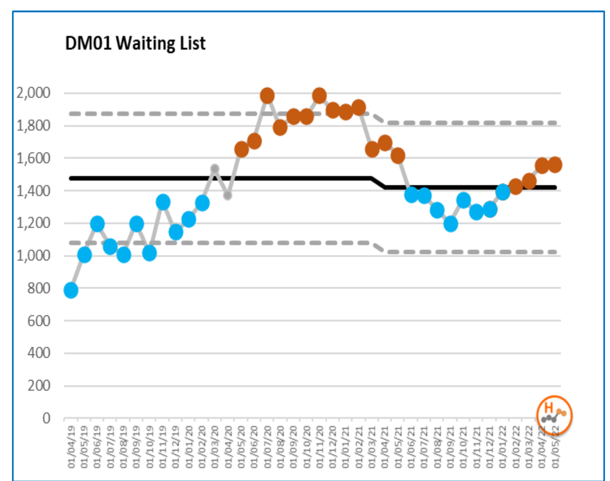
Overview

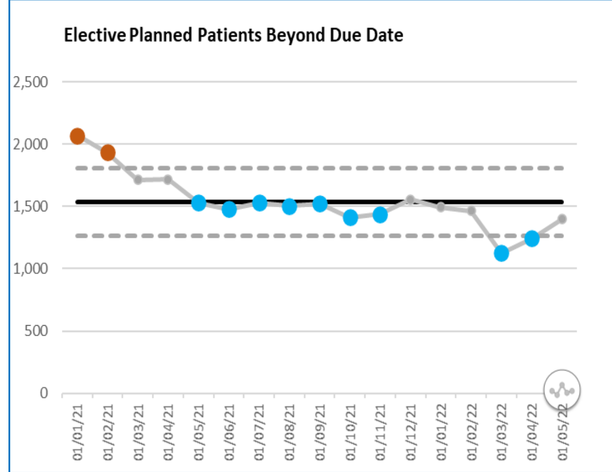
POD	Plan 2223	Activity 2223	Activity 2019	% of 19/20	% of Plan
Daycase	4,522	4,254	3,912	108.7%	94.1%
Elective	2,285	1,809	2,077	87.1%	79.2%
Emergency	339	377	433	87.1%	111.3%
Outpatient First (Inc Telephone)	5,978	5,597	5,068	110.4%	93.6%
Outpatient Follow-Up (Inc Telephone)	29,420	28,443	25,588	111.2%	96.7%
Grand Total	**42,544**	**40,480**	**37,078**	**109.2%**	**95.1%**

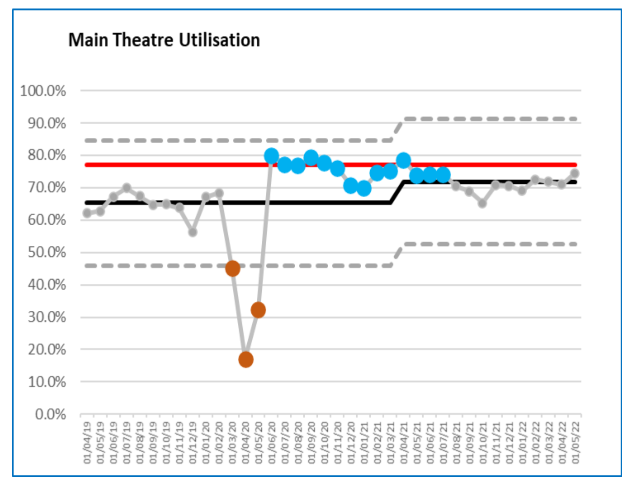
Responsive

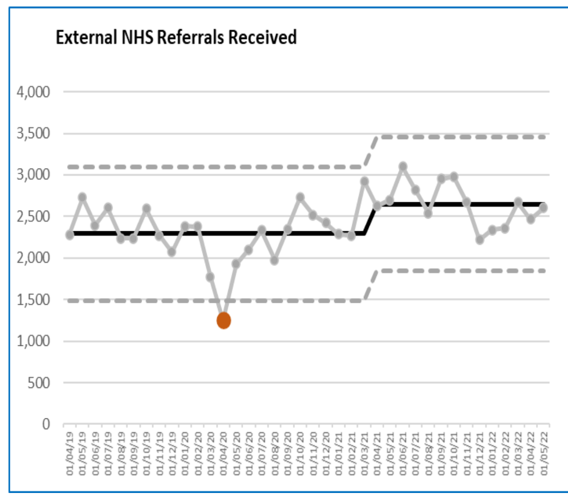
Patient Access SPC Trends

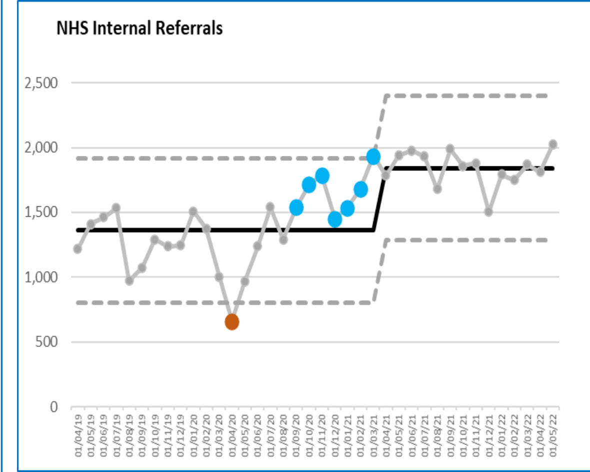


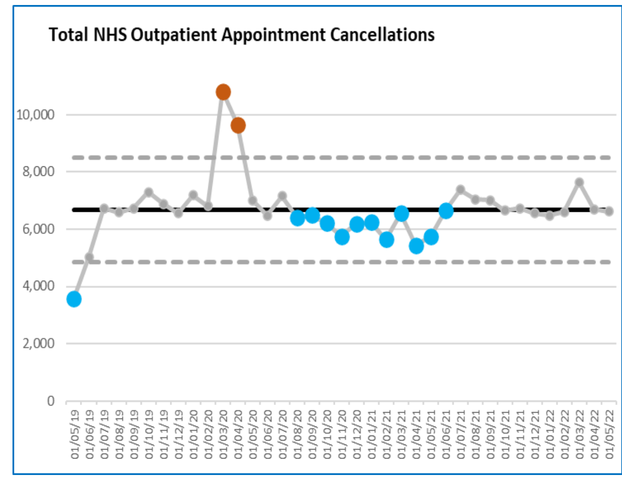


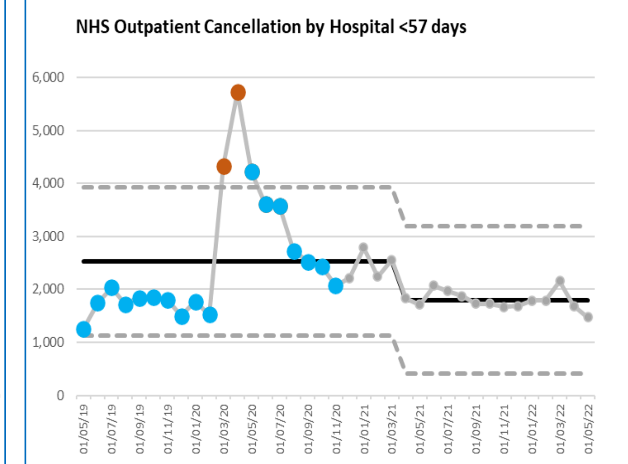












Responsive

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

Attachment U

Trust Board
6th July 2022

Safeguarding Annual Report 2021-22 **Lead Executive:** Tracy Luckett Chief Nurse (Executive Lead for Safeguarding) **Submitted by** Michelle Nightingale, Nurse Consultant for Safeguarding/ Named Nurse	**Paper No: Attachment U**

Aims / summary

To provide assurance to the Board that GOSH has robust processes and structures in place to provide a comprehensive safeguarding service.

Action required from the meeting: Noting only

The Annual Report 2021- 2022 provides the Committee with an overview of the performance and activities of the GOSH Safeguarding Service.

It builds on the internal Safeguarding Governance Review in response to Operation Sheppey and demonstrates the strategy direction to implement a robust and sustainable systems focused response to the national increase in the vulnerabilities, abuse and neglect of the children, families and adults who use our services.

a. Leadership (page 4)
- **a.** There have been a few changes to the leadership of the service, plus the creation of a new role. Team members represent the Trust at various internal and external meetings, as well as advocating for professionals and stakeholders, which enables them to influence, share best practice and network across the multi-agency network.

b. Service Update & Schemes of work:
- **a.** Page 5 provides highlights of the performance and achievements over the last year
- **b.** Page 17 details the key priorities, projects, and proposed audits for 2022/23.

c. External Independent Safeguarding Review Update:
- **a.** As of 17 June 2022 – There were initial delays with the procurement process, which resulted in delays in the commencement of the Review. The Tender process is now nearing completion.

d. Challenges in 2022/23

The main challenge will be the impact of the cost-of-living crisis for those using our services with the strong correlation between social deprivation and increased child abuse, neglect, mental health conditions and domestic abuse. There will be an additional strain on those families experiencing chronic ill-health and disabilities, such as the Trust's stakeholders, including our staff members.

The Safeguarding Service are working within the ICS and nationally, to respond as a needs-led supportive provision from early intervention to child and adult protection, to help families cope.

Contribution to the delivery of NHS / Trust strategies and plans

Keeping children, young people, and adults safe is a primary objective of the Trust

Financial implications

All initiatives currently funded.

Legal issues N/A
Who is responsible for implementing the proposals / project and anticipated timescales: Named Professionals
Who is accountable for the implementation of the proposal / project? Chief Nurse

ANNUAL REPORT 2021 - 2022

SAFEGUARDING CHILDREN, YOUNG PEOPLE & ADULTS

Michelle Nightingale
Nurse Consultant
Safeguarding/Named Nurse

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

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3	Performance & achievements overview	5
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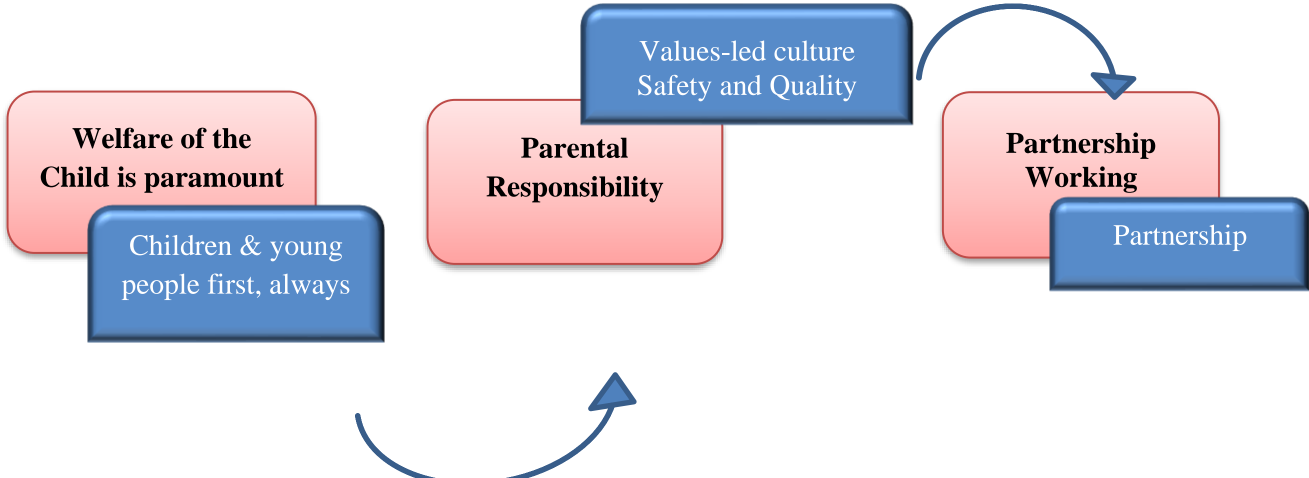
1. Introduction

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

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



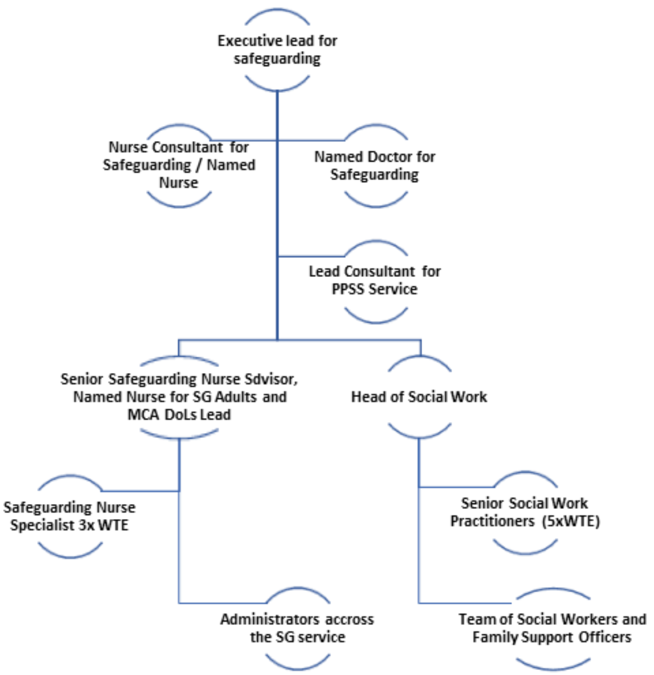
Children & young people first, always
The focus of care must be in the child's best interest, including consideration for their views, wishes and feelings, where appropriate. Recommendations from national and local Child Safeguarding Practice Reviews highlight the need to listen to children and involve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

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

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

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

2. Safeguarding Service Structure



Safeguarding Service Structure 2021/22

The Trust's safeguarding governance structure is in line with NHS England & Improvement Safeguarding Accountability & Assurance Framework (2019). At Board level, the Chief Nurse is the Executive Lead for Safeguarding Children, Adults at Risk and Prevent, and in addition there is a Non-Executive Director with the safeguarding portfolio. The Chief Nurse is a standing member of the Camden Safeguarding Adults Board (SAB) and Camden's Safeguarding Children's Partnership Executive Board (LSCP).

The Board reviews safeguarding arrangements via quarterly reports to the Quality, Safety and Experience Assurance Committee; annually, the Trust Board will receive a Safeguarding Annual Report. The Chief Nurse receives assurance quarterly via the Strategic Safeguarding Committee, which is also attended by the Designated Professionals from North Central London Clinical Commissioning Group (CCG). The Designates are then able to provide assurance to the CCG and NHS England & Improvement.

Safeguarding Service Leadership

During 2021/22, the Safeguarding Service has evolved and developed to meet the increasing needs of patients and their families post the Covid 19 pandemic. Streamlining and joining the two separate teams of the GOSH Social Work team and the Safeguarding Nursing team, under the one umbrella of the Safeguarding Service, has been led by the first Nurse Consultant for Safeguarding in this role.

The remit has been to develop a four-year Safeguarding Strategy, which responds to both the local and national agendas, identifying gaps, challenges, best practice and raising the profile of safeguarding across the Trust.

The Safeguarding Leadership team has provided assurances during the transition to the new Chief Nurse and Executive Lead for Safeguarding, Tracy Luckett who commenced in February 2022. We said a fond farewell to Dr Alison Steele, who retired from GOSH in October 2021 and welcomed Dr Jo Begent to replace her. We also welcomed Charlotte Barran, the first Safeguarding Practice Educator for GOSH.

The current SLT consists of the following professionals

- **Nurse Consultant Safeguarding/Named Nurse**: Michelle Nightingale
- **Named Doctor**: Deborah Zeitlin
- **Head of Social Work:** Elleni Ross
- **Perplexing Lead Consultant, Perplexing Presentation Support Service:** Jo Begent commenced in post 15 November 2021
- **Senior Safeguarding Nurse Advisor (Children & Adults) and Named Nurse for Adult Safeguarding/MCA/DoLs**: Lauren Whyte
- **Lead Safeguarding Practice Educator**: Charlotte Barran, commenced in post in February 2022

The Safeguarding Service includes a substantive skill mix team of non-statutory social workers, family support officers, safeguarding nurse advisors and doctors, with strong working links to other teams within the Trust, including the Legal Team, General Paediatrics, Clinical Site Practitioners, Patient Experience and Quality and Safety Teams.

The Safeguarding SLT represent the Trust at several external meetings or use their subject matter expertise to advocate for their professional colleagues and other stakeholders, including:

- London Safeguarding Children Procedures Editorial Board
- NHS England & Improvement Clinical Reference Group for Liberty Protection Safeguards
- NHS England & Improvement London Named Safeguarding Professionals Forum
- Camden Safeguarding Adults Board
- Camden Safeguarding Children Partnership and its subgroups
- Learning Disability Mortality Review - LeDeR Steering Group, Camden

Internally, there is representation from across the service at the:

- Ethics Committee
- Nursing Board
- Mortality Review Group Meeting
- Records Management
- Risk & Quality Meetings
- Aggregated Analysis Group (risks, complaints, claims and safety)
- Closing the Loop: Learning from Restrictive Practice Episodes Committee
- Reducing Restrictive Practice Working Party

3. Performance and achievements

During 2021/22 we:

- Commissioned a new Safeguarding Dashboard to measure and evidence actions against the CQC Key Lines of Enquiries and the Safeguarding Strategy.
- The Safeguarding Service have referred 167 patients to Local Authority social services. This is a slight increase on the number of referrals made in 2020/21.
- In preparation for the implementation of the Liberty Protection Safeguards (LPS), 14 professionals from safeguarding, social work and learning disabilities, were trained to become Best Interest Assessors (BIA).
- In February 2022 launched a six-month Chaperone Pilot in the Outpatient Department.
- Co-ordinated the social and safeguarding needs of 215 children subject to Child Protection Plans (CPP)
- Completed the safeguarding guidance for the Patient-Initiated Follow Up (PIFU) in the Headache Service (Neurology)
- Reduced the Safeguarding Risk Register to 2 identified risks from 5, with extensive cross discipline planning and outcomes.
- Launched a Domestic Abuse campaign to raise awareness and improve response, including 16 Days of Activism in November, a multi-agency Task & Finish Group and commissioning of Hestia to enhance the corporate response to the subject.
- Contributed to the Missing Child Policy
- Recruited the first Lead Safeguarding Practice Educator in NCL.
- Launched the new Safeguarding Training Programme in April 2022.
- The Team attended 279 virtual external child protection related meetings to represent or support staff.
- Trained Social Workers and Nurse Advisors in standardised Safeguarding Supervision.
- Joint assurance review of Volunteer KPMG 2019 audit, to prepare for volunteers returning to site.

4. Service Delivery

With a national increase in the number of children and vulnerable adults experiencing domestic abuse, social deprivation, mental health issues and hidden harm, particularly as a result of confinement of the Covid 19 restrictions, the impact has been reflected in the wider additional safeguarding complexities faced by the children, young people and adults using the Trust's services.

During 2020, a GOSH porter was arrested and then convicted in Spring 2021 for sexual abuses against children (Operation Sheppey). An internal Safeguarding Governance Review commenced in 2020 following this case and identified areas of improvement, making a number of recommendations, including the commissioning of an Independent Review.

In response to those recommendations and the delivery of the service, a four-year system focused Safeguarding Strategy (April 2021 – 2025) began to be developed, to enable a longer-term sustainable, needs led delivery. This will allow the service to respond to the increases in abuse and neglect expected to be seen post the Covid -19 pandemic.

The team have successfully met the Strategy's Year 1 outcomes (2021/22) and continues to build on achieving the proposed operational and strategic outcomes in the coming three years.

Training & Development for team and wider organisation	Governance & Systems	Specific projects
• Trust wide new Training Programme • In-trac safeguarding Supervision training for safeguarding service • Best Interest Assessor (BIA) training and qualification • Launch of Some • Child Abuse Review Meetings (CARM) • Recruitment of Lead Safeguarding Practice Educator	• Compliance with S11 • Compliance with CQC KLOE – Dashboard introduction • EPIC Optimisation planning including flags for all vulnerable patients • Annual Trust Declaration • Missing Child Policy	• Child A (City & Hackney) recommendations and learning presentations. • Promotion of Was Not Brought • Promotion of Chaperone Policy

1. Partnership Working

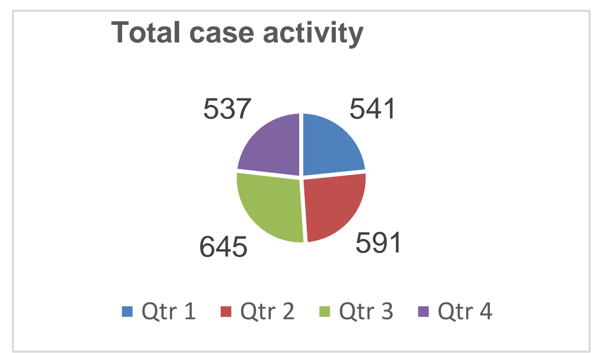
The team are working closely with the EPIC Optimisation and Performance teams to update the activity tracking functions, to reflect and enhance demographics, as well as thematic trends. It is hoped this will provide a clearer understanding of the needs, issues and gaps affecting our registered patients, to better inform the strategic direction of preventative plans and decision making.

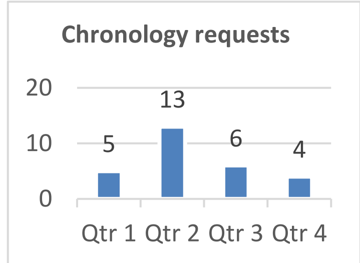
Since the two teams of Social Work and Safeguarding have merged, there is a greater emphasis on joined up working on cases. Work is on-going with EPIC to make is easier to make referrals into the service using one referral, rather the two currently required, which this report reflects.

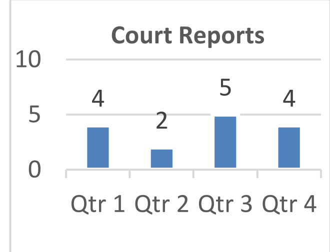
1.1. Safeguarding Interventions

In January 2022, GOSH recorded **835** children who were subject to a Child Protection Plan, and **907** children who were Looked After Children.

The tables below reflect the activities of the team.

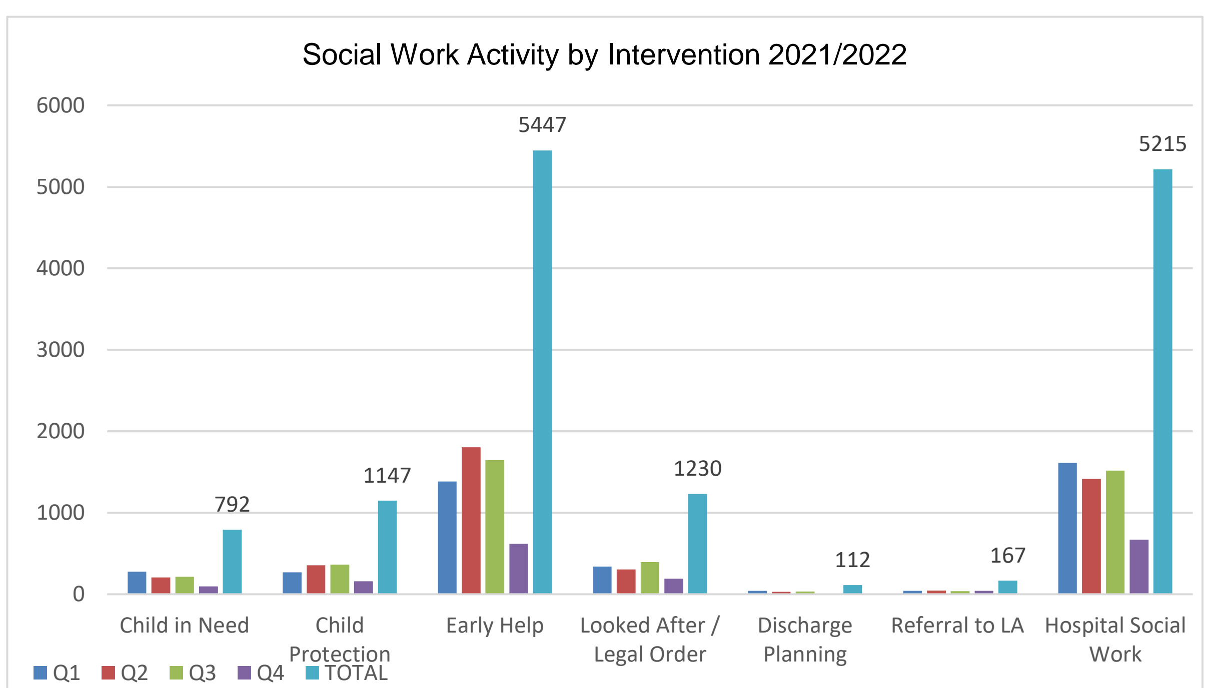






The Safeguarding Service provides safeguarding chronologies for case reviews, as well as court reports when requested by the Local Authority or Courts in-conjunction with the Legal team.

1.2. GOSH Social Work Activity



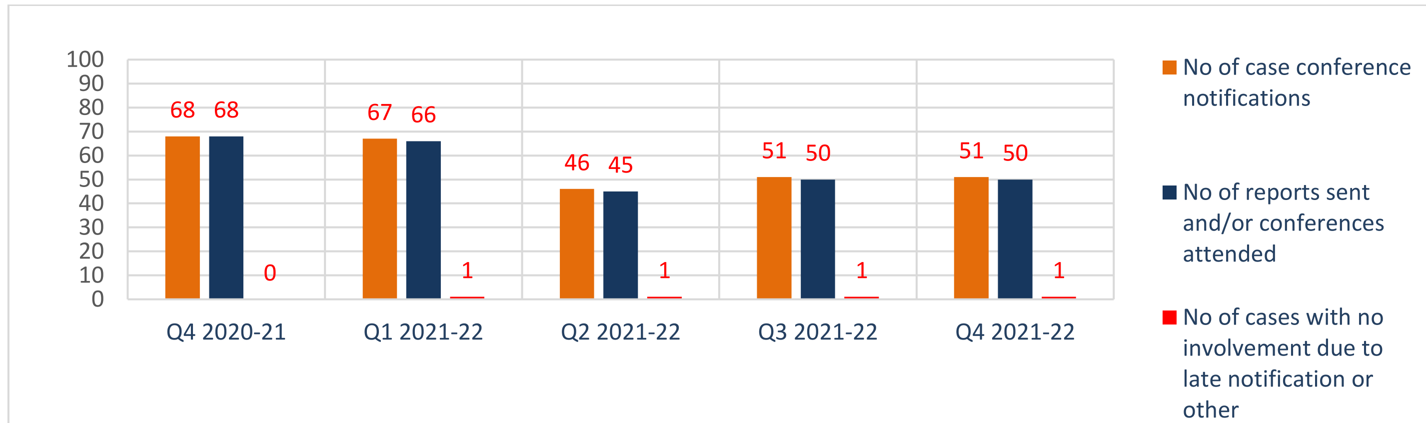
1.3. Children subject to a Child Protection Plan (CPP)

GOSH is the first scheduled Tertiary Centre in the UK to pilot the Child Protection Information Sharing (CP-IS) digital platform via NHS Digital. CP-IS enhances information sharing between health and social care of vulnerable children subject to a Child Protection Plan (CPP) or is a Looked After Child (LAC), from any Local Authority across the country, who attend non-scheduled health care such as an Emergency Department (ED) or Urgent Care.

Although GOSH does not have an ED, it has several non-scheduled emergency admissions a year for children transferred from ED departments via the CATs team, to the Intensive Care Units for suspected Non-Accidental Injuries (NAI), suicide attempts and significant deterioration in clinical presentation.

During Q2 2022-23, we will be launching the implementation of new FYI flags on the EPIC system to better collate the above data, as not all children referred to safeguarding for serious injuries are subject to a CPP or LAC.

Figures below provide data of CP Conference notifications and attendance.

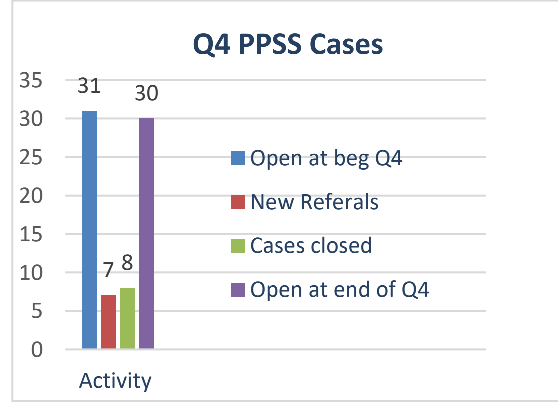


1.4. Perplexing Presentation Support Service (PPSS)

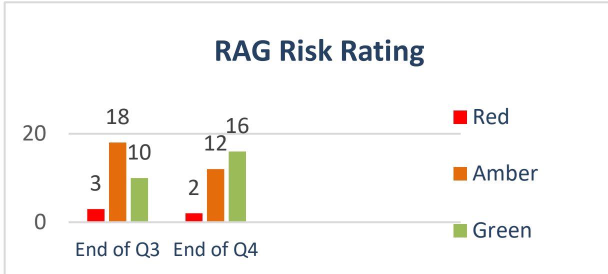
The core team includes the Trust Lead for Perplexing Presentations, Lead General Paediatrician, Head of Social Work, Safeguarding Nurse Specialists and the team Co-ordinator, the meetings have continued running bi-weekly as indicated by the needs of the service.

PPSS Core Multi-Disciplinary Team (MDT) occurs once every other week to discuss ongoing cases.

The original pilot concluded in September 2021, and whilst it continues in service, it is currently being reviewed by the new Lead Consultant.



There have been 7 new cases referred into the service during Q4.
Within this quarter the team have been able to **close 8 cases** where clarity was gained and concerns were resolved, or the case was discharged, and information appropriately handed over to local health teams.
At the end of Q4 the service has **30 active cases** where clarity is required with regard to health.



Cases are risk rated (RAG):
Green - cases where concerns are at a low level but ongoing requiring monitoring and communication with the MDT.
Amber – cases rated as medium risk but ongoing requiring input and communication with the MDT
Red – cases agreed to be at high risk either there is an active section 47 enquiry ongoing, are on a CP plan where GOSH are leading with medical care/input and there are new/fresh significant concerns arising of a perplexing nature.

There is ongoing progression of the cases that have been supported by the service. It illustrates a stepping down of the risk from high, where we have gained further clarity and closing cases where a health consensus has been agreed.

1.5. Joint Working: Psychological and Mental Health Services (PAMHS) and Safeguarding Service

Joint working continues with PAMHS, within the Body, Bones and Mind Directive. The Safeguarding Service attend MDT and multi-agency meetings, as well as attendance at psycho-social meetings.

Recorded therapeutic restraints in Mental Health Services

	Q1 (2021-22)	Q2 (2021-22)	Q3 (2021-22)	Q4 (2021-22)
No of Unplanned Restraints	0	0	1	0
No of Planned Restraint	42	0	0	3

Q1- Q3 context

There was **1** unplanned restraint during 2021/22, which was low level support (less than 30 seconds), guided prevention of absconding.

In total there were **42** planned restraints.

Q4 context

In total there were 3 planned restraints through Quarter 4, and 0 episodes needing unplanned intervention.

Currently there are operational IT challenges with data collection on EPR of all planned restraints, therefore, whilst this is being rectified all will be recorded in the local restraint register.

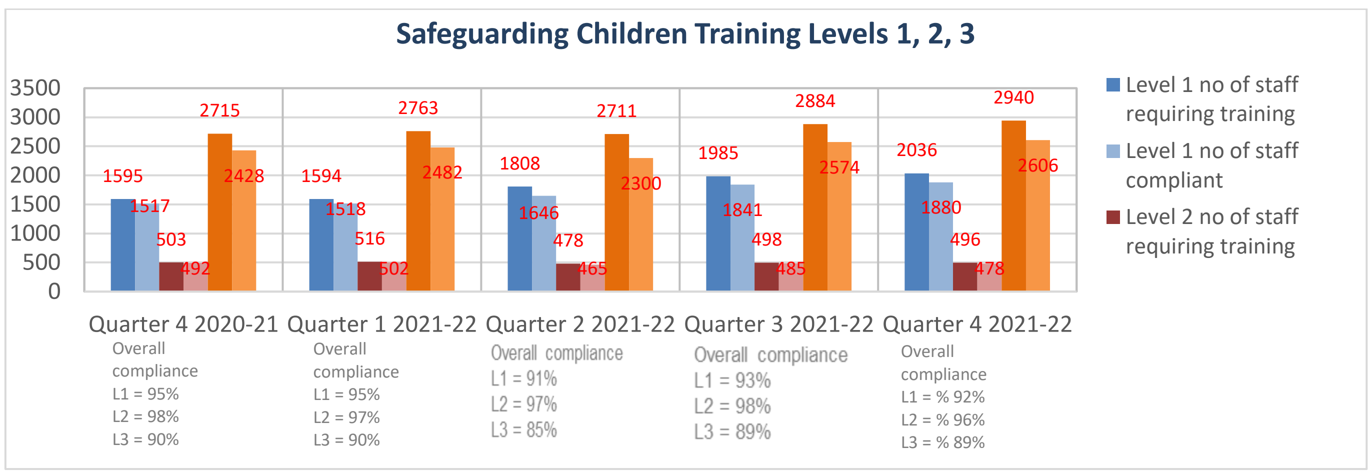
All reporting via Mental Health Services Data Set Restrictive Interventions Reporting continues as per requirements.

Governance of restrictive interventions is monitored by the *Closing the Loop: Learning from Restrictive Practice Episodes Committee*, which is chaired by the Chief Nurse/Deputy Chief Nurse/Director of Nursing. The group has delegated authority to monitor compliance with all of the statutory, regulatory, mandatory requirements that the Trust is obliged to adhere to. *Reducing Restrictive Practice Working Party* a sub-group of this committee.

5. Training

On April 1st, 2022, GOSH will be moving from the current delivery of safeguarding training to a comprehensive programme over the next 3 years, incorporating a blended, creative and innovative training strategy. This is part of the overall plan by the Gold Learning Academy to move training to the national NHS learning management system OLM accessed through ESR, which means that in order for the Trust to be aligned with the majority of other NHS Trust, the training will move to a 3-year refresher period for Level 3, and then for Level 2.

Staff access statutory and mandatory training via the Gold Academy Learning Site, with all training in line with the *Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff* (2019). The compliance remained high with an over 90% rate during Q3 and Q4.

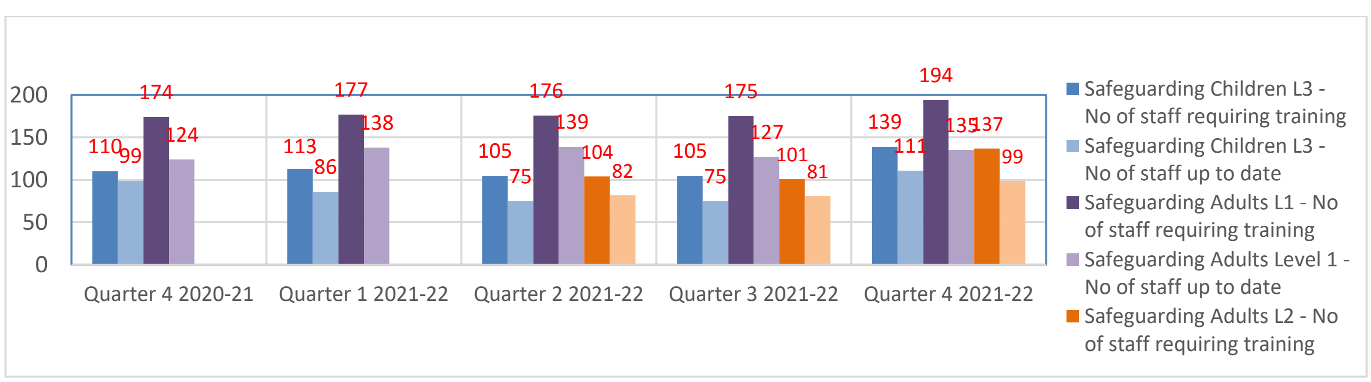


Honorary Contracts

A project was commenced in conjunction with HR to review the honorary contract holders, who were identified as a staff group with the lowest mandatory safeguarding training compliance. Compliance continues to be monitored ensuring evidence is either provided from their host trusts, or relevant training is completed through GOSH. In March 2021 a renewed focus on compliance in this cohort led to a year end compliance rate of 90% for Safeguarding Children Level 3.

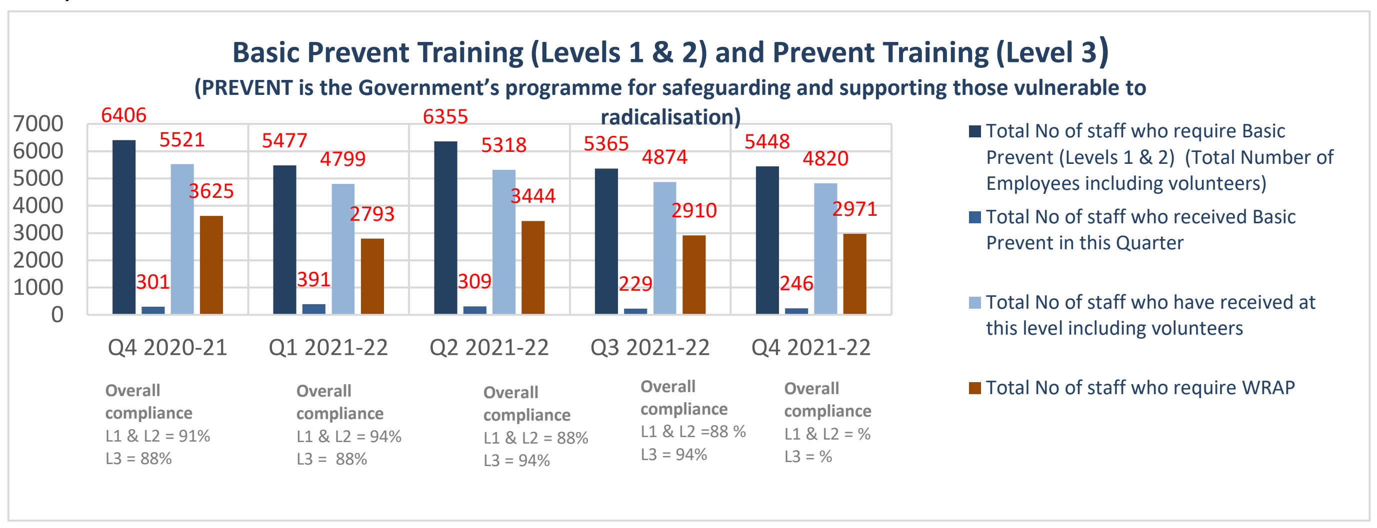
Honorary Consultants are required to provide evidence of safeguarding training via their substantive Trust; if unable to they are also able to access training via the Gold Academy.

HR and Learning & Development (L&D) have been reviewing the process of monitoring and cleansing the data to identify those who are non-compliant. The Honorary Contract policy is under review with recommendations being presented to the Executive Management Team.



Prevent training

This training programme is line with the Prevent Training and Competencies-Framework (NHS 2017) to meet the Prevent Duty (2015). The Framework is used in conjunction with the Intercollegiate Document (2019) to ensure consistency in training and competency development, identifying staff groups that require Basic Prevent Awareness (BPA) and those who are required to attend the Workshop Raising Awareness of Prevent (WRAP) or equivalent approved e-learning package (NHS 2017). Overall compliance has been at 90% or over.



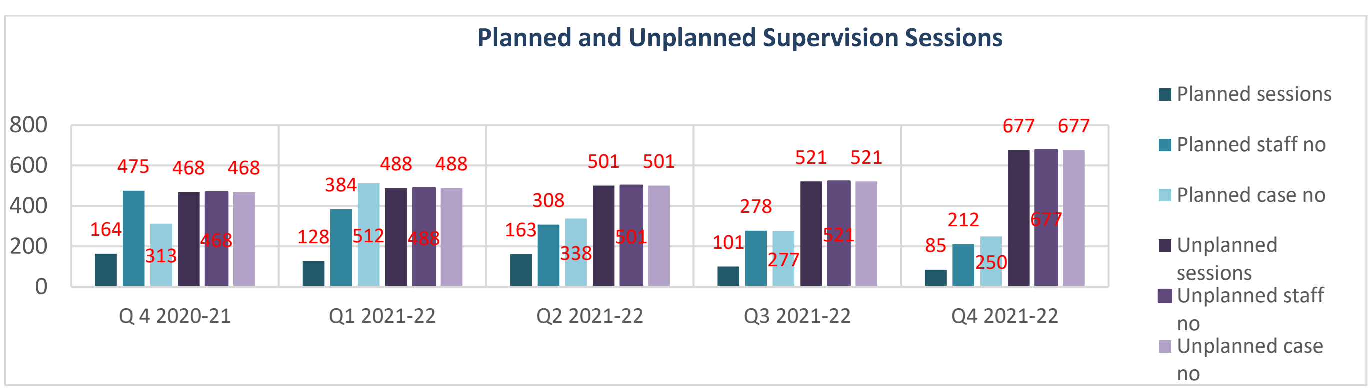
6. Safeguarding Supervision

The Trust follows the Competency Framework as described in the Intercollegiate Document (2019), which aligns staff groups to the appropriate levels of competence. The subject matter experts who deliver the training are part of the Trust's Safeguarding Service. The team bring a wealth of qualifications, skills and experience, including social work, family support, health visiting, school nursing, specialist clinical nursing, and two consultant paediatricians.

However, evidence shows that safeguarding training alone is not sufficient to embed learning into practice and can be enhanced by safeguarding supervision. Working Together to Safeguard Children *states that 'effective practitioner supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect critically on the impact of their decisions on the child and their family.'*

Therefore, to ensure delivery of standardised supervision model across the Trust, the safeguarding team require updated training from a reputable source. This specialist evidence-based training was provided during Q4. Ideally it should be offered approximately every 3 – 4 months, with 2 hours protected time dependent on team.

A review of the Safeguarding Supervision process and policy, including a mapping of teams is underway during 2021/22, to enhance practice and confidence with safeguarding cases. The table below demonstrates the increase in supervision sessions and staff accessing it.



7. Serious Incidents

7.1. Child Safeguarding Practice Reviews (CSPR), Serious Case Reviews (SCRs)

- The Trust currently has 3 open Serious Case Reviews (SCRs). Of these, 1 was published with 26 multi-agency recommendations and the learning from this has been presented internally.
- The remaining 2 SCRs are yet to be published. The delay continues due to on-going police investigations or criminal proceedings.
- There are currently 2 open Child Safeguarding Practice Reviews (CSPR).
- 1 CSPR was closed during 2021/22 with all recommendations completed.

Local Learning Reviews

- There are currently 2 open Child or Young person local reviews.
- 1 Local Learning Review was closed during 2021/22 with no actions or learning for GOSH.
- There are currently 2 open Adult Safeguarding Partnership reviews.

A number of learning events will be organised, following sign off by the local Safeguarding Children Partnerships or Adult Safeguarding Partnership.

7.2. People in a Position of Trust

The Trust is compliant with the guidance in Working Together to Safeguard Children (2020 update), which states that an allegation may relate to a person who works with children who has:

- *behaved in a way that has harmed a child, or may have harmed a child*
- *possibly committed a criminal offence against or related to a child*
- *behaved towards a child or children in a way that indicates they may pose a risk of harm to children*
- *behaved or may have behaved in a way that indicates they may not be suitable to work with children*

7.2.1 Internal Allegations against Staff or Volunteers (ASV).

The ASV process is led by a small group of senior leads, which investigates allegations whether internal or external, that may have an impact on their suitability to practice in whichever department they are based.

All investigations remain strictly confidential and are filed electronically in a restricted access file within safeguarding. Where it is necessary to liaise with the statutory agencies (i.e., children's social care or the police), this is completed in confidence via the Local Authority Designated Officer (LADO).

In Q4 there has been 1 such allegation. There were 2 meetings held in Q4 relating to open cases.

Total cases for 2021/22 to end of Q4 = **7** (Total cases for 2020/21 to end of Q4 = 8)

7.2.2. The Disclosure and Barring Service (DBS)

The Trust DBS policy was updated in December 2020, in line with national guidance and includes the Adult Barred List.

To review the effectiveness of the policy and process changes introduced in the last 12 months an audit will commence in Q2 2021/22, this will look at the operation of the Trust policy and review the DBS checking processes of selected contractors as per the policy monitoring guidance.

HR reported at SSC in March 2022 that they are currently doing the audit hope to complete in the next quarter.

7.2.3. Persons Who Pose a Risk

The Safeguarding Service works closely with the Risk, Social Work, Security and Directorate Nursing Teams to ensure a safeguarding perspective is included in the risk assessment where there are concerns about a parent, carer or someone known to the family, under the person who may pose a risk process. This includes participation in meetings of cases of those who pose a risk, safeguarding and safe and respectful behaviour.

8. Safeguarding Adults

GOSH treat a growing number of adult patients aged 18 years and over, who present with additional needs and safeguarding concerns. The Named Nurse for Adult Safeguarding is the Trust MCA Lead and works closely with the Learning Disabilities Team This section provides an overview of the safeguarding adults (SGA) service and activity across the Trust.

8.1. Training

Level 2 Safeguarding Adults training is mandatory for all qualified staff at GOSH. This is currently a 30-minute assessed e-learning module.

Compliance with Safeguarding Adults Training: Level 1 = 88% Level 2 = 92%

Additional Safeguarding Briefings have been delivered to the specialties with the most adult patients.

8.1.2 Supporting the local safeguarding system

There is over 90% attendance at the Camden Safeguarding Adults Partnership Board meetings and the Quality and Performance Sub-group.

Quarterly reports are provided to Camden Clinical Commissioning Group to provide assurance of compliance with the North Central London Sustainability and Transformation Partnership's Safeguarding Adults Quality Assurance Framework.

The Named Nurse for Adult Safeguarding, represents GOSH at the London Safeguarding Adults Provider Forum and MCA/DoLS Network.

Adult patients seen at GOSH during 2021/22

Type of contact	Numbers		
	2021/22	**2020/2021**	**2019/2020**
Admitted as an inpatient. (This includes cardiac MRI) *	968	560	582
Outpatients	4105	2837	5600
TOTAL	**5073**	**3397**	**6182**
Top 5 admitting specialties: Cardiology Urology Dental & Maxillary Facial Neurology Plastic Surgery Spinal Rheumatology Immunology Neuromuscular Gastroenterology Oncology	 507*	 384 14 128 48 13 17 24 21 4	 332 6 13 33 6 13 19 19 6
*This figure is no longer collated as individual specialities.			

8.1.3 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs)

A trust wide MCA Audit in 2018 identified a number of issues with MCA and DoLs at GOSH. The following measures are to mitigate the risk of non-compliance:

a) Implementation of e-consent is pending in EPIC optimisation which is part of the Trust's transformation strategy.

b) Increased training on MCA/DoLs and adult safeguarding will be incorporated into the forthcoming Safeguarding Training Strategy.

c) In addition, targeted updates/information sessions for relevant clinical teams have been provided by the safeguarding, LD and legal team.

d) There has been a Grand Round and presentation at SLT (Senior Leadership Team) and the Consultants Forum on the subjects and the implementation of LPS.

e) There is a daily duty system reviewing all inpatients over 16 years to assess whether the patient has an impairment of their mind or brain an whether MCA or DoLs is required. This is managed by the safeguarding and learning disability teams. This includes collaborative work with the legal team for joint targeted work with clinical teams where this is required.

f) A Growing up and Gaining Independence advice and support document has been created for families to support transition strategy.

g) Documents to support MCA, Best Interests and DoLs assessments are now embedded into the Trust's EPR system.

h) The Trust is now accurately reporting safeguarding adult data quarterly as part of the new safeguarding metrics for Camden.

i) The MCA Policy has been updated to reflect a Supreme Court ruling relating to the deprivation of liberty of young people aged 16 & 17 years.

Policy and procedures

I. The Safeguarding Adults Policy was updated in June 2021

Service Improvement:

Since the introduction of an MCA and DoLs daily duty system we have been able to ensure that capacity has been assessed on a number of patients which may have previously been sought directly from their parent or carer. This helps to promote independence and support transition which assists in supporting the patient experience. See table below:

MCA/DoLs Activity 2021/22				
Number of Records Reviews in MCA/DOLS Duty	Number of duty reviews of impatient aged 16+	Number of Duty reviews patients requiring MCA assessment	Number of duty reviews patients requiring DoLs assessment	Number of Dols Applications made
4728	**1332**	**362**	**231**	**7**

8.1.4. Liberty Protection Safeguards (LPS)

The implementation of Liberty Protection Safeguards (LPS) has been deferred and it there is public consultation currently underway, therefore it is not expected until 2023. Preparatory work has been done and further work will be required once the Code of Practice and Statutory Guidance are published, to ensure that GOSH is able to take on the new roles and responsibilities that are required of hospitals under the Mental Capacity (Amendment) Act 2019.

In preparation in line with NHS England guidance 14 members of staff have commenced the Best Interest Assessor Module and they will qualify by December 2022 with an expectation that this qualification will be transferable in the new LPS guidance expected in 2023.

In the interim it is understood that court of protection deprivation of liberty applications are now required for young people aged 16+17 who lack capacity following the case of D (a child) 2019. These are being manages by the trusts interim arrangements as outlined above.

8.1.5. Safeguarding Adult Reviews (SARs)

GOSH have not had any patients that require a contribution to any new Safeguarding Adult Reviews during 2021/22.

9. Audits

Internal Audits

Internal audits are completed to review new pilots and the effectiveness of service delivery. Due to the development of the Safeguarding Strategy key projects and implementation of new or enhanced procedures, no audits were completed in 2021/22.

External Audits

1. The Safeguarding Team were asked to participate in the Camden LSCP Multi-agency audit on 'Safeguarding children at risk / or from of neglect (and cross-cutting abuse) during the pandemic and social distancing measures'.

   Only one case was known historically to GOSH, but this was outside of the 18-month scoping period.

2. In Q2 the Safeguarding Team completed the Safeguarding Adults Partnership Audit Tool (SAPAT) as part of the Camden Safeguarding Adults Partnership Board.

10. Key Priorities 2022/23

The overarching priorities for the 2022/23 are to raise the profile of safeguarding across the organisation, so that it is the golden thread that runs across every service. At all levels staff will be encouraged to be professionally curious, seek guidance, risk assess and use the internal and external escalation processes appropriately.

With the implementation of the Integrated Care Partnerships across NCL, GOSH Safeguarding Service and the GOSH Learning Academy (GLA) will build on its relationships with partner agencies, including the Local Safeguarding Children Partnerships, Safeguarding Adults Boards and the North Thames Paediatric Network, to develop an ambitious programme of income generating projects, research, learning events and Safeguarding Conferences. This will include utilising the skills and knowledge of national and international expert speakers in specialist safeguarding fields to enhance practice and knowledge.

10.1. Key Priorities

- External Independent Review of GOSH safeguarding arrangements.
- Completion of Safeguarding Strategy (including review of mandatory training and supervision policy).
- Update of Safeguarding Children Policy
- Further developments in the Domestic Abuse strategy including recruitment of Independent Domestic Violence Advocate (IDVA)
- Readiness for the Implementation of Liberty Protection Safeguards.
- Safeguarding Conference in February 2023
- Enhanced alerting in the EPR system for FYI 'safeguarding concern' flags as part of EPIC Optimisation to improve data and thematic collation.
- Development of adolescent services including improved transition.

10.2. Key Projects planned

- Chief Nurse Junior Fellow for Safeguarding
- Link Health Visitor
- Safe Discharge Planning Pathway
- Was Not Brought (WNB) process review
- Including young people in the safeguarding groups and committees
- Self-Harm Pathway

10.3. Proposed Audits in 2022/23

1. Chaperone Pilot in Outpatients - July 2022
2. Looked After Children audit to measure against the new NICE Clinical Guidelines for LAC in Q3.

11. References

- Think child, think parent, think family: Introduction - Think Family as a concept, and its implications for practice (scie.org.uk)
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing (rcn.org.uk)
- prevent-training-competencies-framework-v3.pdf (england.nhs.uk)
- Mental Health Services Data Set - NHS Digital
- Reducing the need for restraint and restrictive intervention (publishing.service.gov.uk)

Attachment 4

Trust Board **6 July 2022**	
An independent review of the effectiveness of the Trust's safety procedures **Submitted by:** **Dr Sanjiv Sharma, Medical Director**	**Paper No: Attachment 4** ☐ **For discussion** ☐ **For information and noting**

Purpose of report:
The Verita review was independent review of the effectiveness of the Trust's safety procedures commissioned by GOSH in 2021 to assess the organisation's approach, response and management of patient safety incidents and investigation, as well as to better understand the prevailing safety culture, identifying where relevant opportunities for improvement through cultural change and training.

The review was intended to supplement existing work already in train as part of the Trust's commitment to patient safety and an ongoing programme of engagement with national patient safety partners.

Summary of report:
The review is presented for information.
It follows the board development session in May where the review, its findings and recommendations, were considered.

The Board has committed to making a statement on the importance of a well-developed patient safety culture and associated processes. This will be agreed in due course.

The Verita review is fundamental in its contribution to the Trust's Safety Transformation programme, with a series of actions within several of the domains in the programme which directly arise from the content and recommendations made by the review.

Action required from the meeting:
Note the content of the paper

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria** **x Leadership, capacity and capability** **x Vision and strategy** **x Culture of high-quality sustainable care** **x Effective processes, managing risk and performance** **x Robust systems for learning, continuous improvement, and innovation**

Strategic risk implications:
This paper/report relates to BAF 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

Financial implications:

Nil
Implications for legal/ regulatory compliance Nil
Consultation carried out with individuals/ groups/ committees Board development session
Who is responsible for implementing the proposals / project and anticipated timescales? Medical Director and team
Who is accountable for the implementation of the proposal / project? Medical Director
Which management committee will have oversight of the matters covered in this report? QSEAC

An independent review of the effectiveness of the Trust's safety procedures

A report for
Great Ormond Street Hospital for Children NHS Foundation Trust

May 2022

Authors:
Kieran Seale
Ed Marsden
Chris Brougham

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1. Introduction

1.1 Dr Sanjiv Sharma, medical director, at Great Ormond Street Hospital for Children NHS Foundation Trust[1] asked Verita to undertake an independent review of how the trust responds when things go wrong, and how the responses could be improved. The work was commissioned after a number of families raised concerns with the trust about how particular patient safety incidents were responded to. The families' unhappiness was so great that they felt they had no choice but to engage with the media to raise their concerns. One of the outputs of this engagement was a BBC radio programme which questioned whether GOSH properly investigated when things went wrong. The trust would like to learn from these events and improve their current systems and processes. In this report we focus on practical improvements which we believe can help Great Ormond Street to move forward in a positive way.

1.2 Verita is a consultancy specialising in the conduct of investigations and reviews and helping organisations to improve. The team consisted of Ed Marsden, the founder of Verita, Chris Brougham and Kieran Seale, both directors of Verita. Jo Gillespie, a safety expert and Verita associate, acted as peer reviewer. We also liaised with Helen Hughes, chief executive of Patient Safety Learning who is carrying out work for the trust. Scarlett Whitford Webb provided administrative support. The team will be referred to in this report as 'we'. Biographies are in appendix A.

[1] Variously referred to in this report as 'Great Ormond Street', 'GOSH', 'the hospital' or 'the trust'

2. Terms of reference

2.1 The following is a summary of the terms of reference for this work. The full terms of reference are at Appendix B.

2.2 The Verita team will undertake a review of the following matters:

- How hospital staff engage with families following an incident which has caused significant harm.
- Whether there are effective and timely processes in place for managing serious incidents from reporting, investigation and approval through to learning/system improvement to avoid recurrence, including incorporation of feedback from external stakeholders such as NHS England/Improvement.
- Whether there are effective processes in place for managing safety risks in red complaints from identification, investigation and approval through to learning/system improvement, to avoid recurrence.
- Whether there are effective processes in place for managing safety risks in claims and inquests from identification through to learning/system improvement, to avoid recurrence.
- Whether the level of investigation undertaken by GOSH is proportionate to the incident/complaint raised.
- To understand if the processes for investigation enable and support GOSH to identify and act on critical safety issues in a timely way.
- To identify if there is sufficient evidence of the 'golden thread' of safety in the governance and reporting processes from 'ward to board' and with key external stakeholders.
- To identify if processes are supported by a sufficient culture of openness, curiosity and transparency; this includes compliance to Duty of Candour obligations.
- To evaluate whether appropriate support systems are in place for patients, families and staff.
- How GOSH are progressing their action plans following the Care Quality Commission focussed inspection on Serious Incidents and Red Complaints.

3. Executive Summary and Recommendations

3.1 Verita were commissioned to undertake an independent review of how Great Ormond Street responds when things go wrong, and how the responses could be improved. The main focus of our work has been to come up with practical ideas for how things can be changed for the better.

3.2 There were three main elements to or work:

- Conversations with people both inside and outside the hospital
- Attending internal trust meetings (virtually)
- Reviewing documentation.

3.3 The terms of reference asked us to look at a number of specific areas:

- Safety culture
- Serious incidents
- The 'Golden Thread' of safety
- Engagement, support for patients and families and the duty of candour
- Safety risks - in complaints, claims and inquests.

3.4 Patient Safety Learning's 'Blueprint for Action' provides a benchmark against which organisations can measure their 'patient safety maturity'. The document gives a framework for reviewing the trust on the following scale:

- Minimal – aiming to meet statutory and regulatory requirements
- Reactive – plans in place to meet statutory and regulatory requirements
- Active – actively seeking to improve patient safety
- Proactive – reducing harm, supporting staff, plans to deliver a patient-safe future
- Patient-safe future – patient safety in integrated care, minimal avoidable harm, safety is a core purpose, safe for staff

3.5 Our estimate would be to put Great Ormond Street at the 'Reactive' level. In our experience, the key steps for improvement are:

- recognise the problem
- accept responsibility
- develop solutions
- implement
- embed.

3.6 We believe that the leadership at Great Ormond Street accepts that that it can learn and improve, and that doing so is a priority for the organisation. We hope that what follows will help with implementation and embedding change.

Building the patient safety culture

The role of the Board

3.7 Culture starts at the top. The first step in building the patient safety culture is therefore for those in leadership positions to demonstrate that it is a priority for them. While it is not the role of the board to get involved in management of the organisation they can help to deliver the trust's strategy by setting the tone. The following are some ideas of how that could be done:

- Demonstrating that safety is a priority by talking about it. For example, by issuing a board statement about the importance of safety and ensuring that it is talked about in board meetings.
- Bolstering the role of the non-executive who has the specific remit for patient safety, enhancing their role as patient safety champion to support the board's executive patient safety lead.
- Visibility – the presence of non-executive directors 'on-the-ground' demonstrating that they care about safety and setting out the trust's ambitions can send a powerful message.

Strengthening the golden thread

3.8 Communication is key to the effective flow of information from 'ward to board'. That includes both formal and informal channels.

3.9 For the formal channels, patient safety should be considered in all business decisions. Board papers currently have to state whether there are risk, legal or financial implications – patient safety should also be considered.

3.10 For informal channels, safety concerns emanating from lower down the organisation must be able to reach board members. It is welcome that the trust has a Freedom to Speak Up Guardian. The trust should ensure that it takes the full benefit from this resource and that the role is widely understood throughout the organisation. Another way of demonstrating the importance of patient safety is ensuring that it is included in job roles for staff across the organisation.

3.11 Technology should be used to support these changes e.g. electronic screens in theatres.

Openness about risk and safety

3.12 Human beings make mistakes – that is a fact of life. The best systems sometimes fail. The only question is how organisations respond to these facts. A starting point would be for people at the hospital to talk more about when they have made errors, what they did about it and how they felt. This should start from the top – chair, board members, chief executive and senior clinicians.

Directorate risk & safety champions

3.13 Giving people specific responsibility for promoting risk management and patient safety can be an effective way of promoting good practice. These individuals can help drive the safety management function deeper into the organisational structure and provide informed safety support to the chiefs of service and the patient safety team.

Developing the role of the patient safety team

3.14 Strengthening the patient safety function will be an important part of developing the culture of patient safety at Great Ormond Street. We think that the 'fix it' element of the patient safety function should be increased so that the work of the team is more dynamic and rewarding and is able to help deliver improvement more directly.

Creation of a central patient safety hub

3.15 The focus of much safety work is often on the past – looking back at things that have already gone wrong. Safety, however, is about the 'here and now' – making sure what happens today is the best it can be. A central patient safety hub and database with live data about safety issues should be developed. This would not only ensure that the full learning value is drawn from the data that the trust collects but enable things to be put right.

Openness and family engagement

3.16 Family engagement is seldom easy. Everyone involved in a case may have a different perspective. It can be challenging for those who spend their lives in a clinical environment to really understand what things look like for those coming to the experience fresh.

3.17 The key to good family liaison is listening. Understanding what is important to families and to engaging with their priorities is crucial. Asking families what they would prefer – and responding to it – demonstrates respect and helps to build a positive relationship. Some issues can be difficult to focus on simply because they are not a priority for professionals. Creating a listening culture is the way to address this.

3.18 Complexity is a feature of many cases at Great Ormond Street. Many children cared for by the trust have numerous co-morbidities - the simultaneous presence of other diseases/medical conditions. We heard of cases with up to eleven co-morbidities. The trust could do much more to help patients and families with this complexity. The trust should consider the development of a 'system navigator' function for children with complex needs, so that families have a single point of contact despite being engaged with multiple specialities. We suggest that the trust considers setting up a working group to determine

how this sort of role might work best. The group should draw on the experience of the International & Private Care directorate who already have a similar role.

3.19 We recommend the trust works with a small number of families to pioneer a more active role for them in the safety of care and treatment. This could be supported by technology.

Improving investigations

3.20 The main purpose of investigations should be to find out what happened and why, so that there can be learning. Senior management needs demonstrate that learning and improvement are priorities and the starting point for investigations.

3.21 Often it is also important to find out what happened to inform those affected – both a moral, and legal, duty. Declaring a serious incident should therefore be seen as a 'neutral act', with the aim of finding out what really happened, not an exercise in apportioning blame.

3.22 Investigating serious incidents is important. The trust needs to demonstrate that it is a priority by allowing time in job plans for investigation and safety improvement.

3.23 The new national Patient Safety Incident Response Framework (PSIRF) sets out how healthcare providers should respond to patient safety incidents. The framework puts an emphasis on the quality of investigations, rather than the quantity of them. This offers an opportunity for Great Ormond Street to develop a new approach to patient safety incident investigation. We believe that the response to an incident should be seen in terms of a range of possible interventions, the aim being to get the one that fits the needs of each incident best. Possible interventions include:

- After-action reviews - discussion by clinical teams followed by a write-up of what has been discussed. A prerequisite of an after-action review is that everyone feels able to contribute without fear of blame or retribution. Those affected by the incident (patient or family) can be invited to attend alongside the clinical team so that their views and perspective can be heard and considered. Following the discussion, a facilitator will record actions identified and a learning log. An

action plan is then developed to put any solutions in place. The process has many benefits – they can happen quickly, they can help to promote an open and just culture and reduce the burden of carrying out traditional investigations. Another benefit of the process is that staff involved in the incident can actively participate in the review and those affected by the incident hear first-hand about what went wrong (if anything) are listened to and supported. Reviews can also be used to discuss good care to better understand how it was delivered.

- Structured judgement reviews - initial reviews are carried out by front line reviewers with a second stage review if any care problems are identified which rate care as 'poor' or 'very poor'. The approach contributes to the promotion of an open and just culture, while reducing the burden of investigations. Staff involved in the incident also actively participate in the review and the solutions, and families can be provided with the outputs.
- Fault tree analysis - this approach identifies the causes of system failure and helps to proactively minimise risk in the future.
- Thematic reviews – these can be used where there are a number of incidents to consider. They focus on identifying common elements for improvement and can be perceived by staff as being less intimidating than other approaches.
- Full patient safety incident investigation – under the PSIRF framework, these will be called 'Patient Safety Incident Investigations'. The new approach may lead to fewer investigations, but it will be even more important to ensure that those that are carried out are done well. Any activity which people carry out only intermittently can be challenging and sometimes frustrating. In our experience, people who are asked to carry out an investigation after a long gap often struggle to remember much about the process. It is therefore sensible to look for tools which can support investigators and guide them through the process [d*eclaration of interest – Verita is currently working with Microsoft to develop a tool of this sort*].

3.24 In common with many organisations, we believe that Great Ormond Street could further improve their process for collecting, organising and analysing data from incidents and investigations to make it more systematic. This is a rapidly developing field, but one that presents great opportunities for helping decision making around what to learn and how to respond to incidents.

Improving risk management

3.25 Risk management is an important part of patient safety. The consistent measurement of future and current risk exposure is an essential part of the process. We have identified several methodologies, models and tools for risk management, each with specific applications. They include:

- Tabular risk matrices
- Event risk classification
- Bow-tie modelling
- Observational safety audits
- Hazard logs

3.26 Each have a role to play, and we set out in the report how they could be used to improve patient safety at Great Ormond Street.

Improving safety training

3.27 High quality training is essential if many of the changes in this report are to be delivered. The Learning Academy is an important asset for the trust and we believe it should be central to the trust's ambitions to improve and professionalise patient safety. The academy should be asked to develop a patient safety syllabus covering areas such as human factors, leadership and communication. Training could be another way of addressing the difficulty of acknowledging that thing go wrong even in an organisation that provides the best care, through sessions that address the issue of being *"Exceptional but Fallible".*

Conclusion

3.28 Great Ormond Street has great strengths as an institution and a reputation for taking on the hardest cases and challenges that other hospitals can't meet. But it also faces significant challenges. Some of these challenges are shared across the NHS and are exacerbated by COVID. Others arise out of the characteristics of the hospital and its patients. We believe that a concerted organisational effort to address the safety of care and services will have a significantly positive impact on patients and families, aid staff

recruitment and retention and serve to enhance the trust’s reputation as a world-class provider.

4. Methodology

4.1 Our first step was to gather evidence. There were three main elements to that work:

- Conversations with people both inside Great Ormond Street and outside
- Attending internal trust meetings (virtually)
- Reviewing documentation.

4.2 We used a number of benchmarks, including those produced by Patient Safety Learning in their document *Patient Safety: A Blueprint for Action.* The benchmarks have helped inform our assessment, conclusions and recommendations and are discussed in the next section.

Interviews

4.3 We were keen to make sure that we had input into our work from a wide range of voices. Within the trust we spoke to:

- Senior managers, including the chief executive, medical director, (out-going) chief nurse and chief operating officer
- Those responsible for the management of quality and safety, including associate medical directors and the interim head of quality and safety
- Staff responsible for patient experience, bereavement and freedom to speak up
- Patient safety managers (meeting them in groups)
- Chiefs of service
- Heads of nursing
- Non-executive directors.

4.4 Outside the trust, we spoke to three people in NHS England who have direct experience of working closely with Great Ormond Street. We also spoke to the safety team at Titan Airways about their use of technology to assess past, present and future risk.

4.5 In addition, we had a conversation with the parents of a patient who had a difficult experience with the trust. We are very grateful for them taking the time to speak to us. This is not the place to review their individual case, but what they told us has important

lessons for the hospital and we hope will contribute to the development of Great Ormond Street.

4.6 With the agreement of the trust, we exchanged views and ideas with Helen Hughes, chief executive of Patient Safety Learning during our work. She held a development session with the Board in April 2021 and kindly shared the outputs with us. We would like to thank Helen Hughes for her input. Any errors or omissions, however, are entirely our own.

4.7 We would like to thank all those who spoke to us, whether inside the trust or outside. Those we spoke to are listed in Appendix C.

Meetings

4.8 We observed internal meetings relevant to the issues of safety and quality. These were:

- **Quality Safety & Experience Assurance Committee** – a committee of the board, which provides assurance on issues relating to quality and safety
- **Patient & Family Experience & Engagement Committee** – which is responsible for giving the Quality, Safety and Experience Assurance Committee assurance on compliance with legislative and regulatory requirements around patient experience and giving oversight of the trust's patient and family experience agenda
- **Patient Safety & Outcomes Committee** – which aims to monitor compliance relating to clinical governance and provide assurance that issues contributing to quality, safety and effectiveness in the trust are effectively managed
- **Closing the Loop** – a sub-committee of the Patient Safety and Outcomes Committee which aims to ensure that actions from previous incidents, complaints and learning from death reviews are implemented
- **Risk Assurance & Compliance Group** – which monitors risk and compliance issues, including the GOSH Board Assurance Framework and progress with recommendations from the Care Quality Commission
- **Executive Incident Review Meeting** – whose role is to review incidents to decide on an appropriate response, e.g. whether a Serious Incident should be declared, and an investigation carried out

- **Clinical Quality Review Group** – a liaison meeting with the NHS England, the commissioner of GOSH's services, about current clinical issues.

4.9 We met with the trust's medical director and the associate medical director for safety to give them an initial idea of our proposals and we refined our approach based on their comments.

Documents

4.10 We requested, and were provided with, many documents, which we subsequently reviewed. They included:

- Papers for committee meetings
- Trust policies, including incident reporting, complaints, duty of candour, raising concerns and risk management
- Job descriptions
- Safety Strategy
- Framework for Patient and Family Experience
- Patient Safety Strategy.

4.11 More details of the documents are given in Appendix D.

4.12 We also reviewed a number of the trust's SI reports. An analysis of those is in Appendix E.

4.13 We discuss the current situation in section 5. Our proposals for further improving patient safety are outlined in section 6.

5. The current situation

5.1 The terms of reference asked us to look at a number of specific areas:

- Safety culture
- Serious incidents – the process of managing incidents and investigations and implementation of actions
- The 'Golden Thread' of safety
- Engagement, support for patients and families and the duty of candour
- Safety risks - in complaints, claims and inquests.

5.2 We were also asked to look at inquests and claims but were advised that there were no ongoing cases at the time of our review.

Being 'world-class' and its implications

5.3 We start by highlighting that the hospital is a world-renowned institution which provides care and carries out research to the highest standards. Staff who work at GOSH have a highly specialist skill base. We were struck by the deep complexity of many of the cases we heard about. We heard that it is common for Great Ormond Street to take on cases that other hospitals simply cannot, including cases from other parts of the world.

5.4 There are important implications of this status.

The danger of the 'superstar' reputation

5.5 Having a reputation as a world-leading institution can be double edged. In our work over the years looking at examples of where things go wrong in health providers across the country, the 'cult of the superstar' is a recurring issue[1]. Across the NHS we have seen a number of instances where the status of individuals is so high that others are afraid to challenge them or to raise concerns if things go wrong. This is no criticism of the

[1] Verita's work on the subject of doctors with superhero status has previously been published in the Guardian, see - https://www.theguardian.com/society/2017/aug/26/rogue-doctors-use-superhero-status-abuse-patients-ian-paterson-myles-bradbury

organisation concerned, it is simply a fact of life – the greater someone's expertise, the harder it can sometimes be to question their decisions. In cases we have seen in other places this reticence can lead to serious lapses in safety with harm to patients and reputational damage resulting. In contrast, effective teamwork in health-care delivery has an immediate and positive impact on patient safety. Being in an effective team means any worker should feel empowered to admit a mistake or speak up about something that gets in the way of delivering safe, high quality care.

5.6 A world-leading reputation raises wider questions about when things do go wrong:

- Can things ever go wrong in a world-class institution?
- Can highly skilled individuals with world-wide reputations ever make mistakes?

5.7 The answer to both these questions is, yes. Things go wrong in all systems – especially where people are involved. And Great Ormond Street is a particularly complex environment – providing children who have challenging conditions with innovative treatments. Mature organisations know that things sometimes go wrong, put systems in place to minimise the number of times they occur, and mitigate the damage that this causes when they do. Mature organisations also have good systems in place to learn from such errors which feed into the preventative actions. Organisations that don't recognise that things sometimes go wrong foster a culture of denial. This ultimately leads to worse patient care.

Patient safety culture at Great Ormond Street

5.8 Creating a culture of safety is an essential foundation to delivering safe and reliable care. Ensuring that patient safety is at the heart of all care delivered can minimise the chances of things going wrong. A strong patient safety culture will have the following characteristics:

- Individuals and teams have a constant and active awareness of the potential for things to go wrong.
- A culture that is open and just, one that encourages people to speak up about mistakes – being open and just means sharing information openly with patients

and their families balanced with fair treatment for staff when an incident happens.

- Both the individual and organisation can acknowledge mistakes, learn from them and take action to put them right.

5.9 We asked Jo Gillespie, the peer reviewer of this report and a well-known safety expert from aviation, to describe organisational safety for Great Ormond Street. This is drawn from literature and his own extensive experience. It is as follows:

> *'Organisational safety is a by-product of experience gained from every element of the organisation – people, equipment, facilities, procedures, leadership, tasks, successes and failures – that informs a resilience to recognise the unsafe and correct it before harm is done, at the same time acknowledging and promoting good practice. It is directly related to the culture or 'common law' of the organisation.'*

5.10 We are pleased to report that the people we spoke to explained that there is a widely shared view that Great Ormond Street has come a long way in recent years in improving its safety culture, and that there is strong commitment from the leadership to continuing that progress. We heard and saw many specific instances of things that have been improved in recent years – notably through the leadership team's commitment to patient safety and its communication of that commitment. Having spoken to them, we are convinced of the desire of the leadership team to improve things further.

5.11 Many people agree, however, that there remains some way to go if the trust is to have a strong patient safety culture. We have heard a number of people telling us the following:

- Some clinicians haven't been given enough protected time to deliver the patient safety aspect of their job.
- There is a concern that patient safety issues are only taken seriously if there is a metric or target attached to it.
- Issues that have been placed on the risk register don't always get monitored or mitigated.
- Staff with patient safety responsibilities don't always feel that they are being listened to.

When things go wrong

5.12 We reviewed the trust's incident reporting and management policy. We looked at whether there are effective and timely processes is in place for managing serious incidents. This includes reporting, investigation and approval, through to learning and system improvement to avoid recurrence.

5.13 Many people that we spoke to within Great Ormond Street understand that a positive patient safety culture acknowledges that there is always the potential for things to go wrong. Systems can therefore be put in place to minimise the chances of that happening. However, we believe that it is sometimes culturally difficult within Great Ormond Street to accept that things can go wrong and to respond appropriately. We were told that some see the organisation as '*bullet-proof*' in the face of criticism. There is also a view outside the trust that some clinicians at Great Ormond Street can find it difficult to accept that something had gone wrong. Some believe that this reflex is deeply ingrained. This is potentially indicative of a culture of defensiveness. Acknowledging this trait is the first step on the road to changing it.

5.14 In addition, we have seen strong indications that it is often part of the culture at Great Ormond Street to think that something going wrong means that someone must have done something wrong. We have heard comments after an event such as "*this doesn't need to be investigated because no-one has done anything wrong*". We have also seen the mirror image of that argument - a reluctance to declare a serious incident because it will be interpreted as an admission of failure by the individuals concerned. This is unhelpful to creating the right environment for understanding harm and improving systems and processes. The assumption amongst many people that investigation and blame inevitably go together is implicit, but present in the trust.

5.15 In our experience, people who are blamed can become closed and fearful; they will be reluctant to help investigators understand the safety aspects of an incident. This can create a culture of concealment which limits the opportunity for learning and improvement. NHS policy makes it is clear that inappropriate blame is extremely damaging to individuals and an organisation's safety and culture.

The science lab

5.16 Research is another key aspect of Great Ormond Street's work. Some describe this as "*GOSH as half hospital, half a science lab*". The cultures of research and clinical practice are not the same, not least because in clinical practice the need for clinicians to be in dialogue with patients and families is a priority.

5.17 We were told that some practitioners at Great Ormond Street see a focus on safety conflicting with innovation. Others told us that they feel that the hospital sometimes puts too much emphasis on pushing the boundaries of science. They are concerned may lead to a culture where some prioritise innovation over safety in their practice.

5.18 We heard indications that there are some clinicians for whom an interest in research is their primary motivation. They may therefore put less emphasis on the communication aspects of their role.

5.19 Getting the right balance between safety and innovation is an issue across the NHS. It is particularly important in an institution like GOSH where the proportion of innovative research work is much higher than in most UK hospitals.

Incident investigation at Great Ormond Street

The process

5.20 The trust policy defines an incident as:

> *"Any unintended or unexpected incident that could have, or did, lead to harm for one or more patients receiving healthcare".*

5.21 The policy states:

> *"Those incidents which meet the threshold of a serious incident will be investigated following the National Serious Incident Framework".*

5.22 The process used at the trust is similar to those used across the NHS, but one aspect that we found different is that investigators rely on the staff involved in serious incidents to provide written statements, rather than carrying out interviews. Whilst this approach is acceptable for less serious incidents, our recommended approach to investigations, is to collect evidence by talking to people. Done well, this should allow people to be put at their ease and to explain things in their own time. Investigators are also likely to obtain more reliable information.

5.23 An external interviewee told us that they felt that the trust appeared to struggle to get reports completed, perhaps because too much of a perfectionist approach is taken to the reports. However, this means that there is often a long gap between initial drafts and reports being sent to NHS England. People in the trust told us that they thought investigation reports could be too long and detailed, rather than getting to the point. We were also told that some people focussed unduly on the process of investigations, rather than the actual learning and clinical improvement that should follow.

Review of a sample of reports

5.24 We reviewed five reports of serious incident investigations carried out by the trust. We found the reports to be good quality. All five reports set out a good description of the incident and provided a readable account of what happened. Each of the reports highlighted at least one care delivery problem (care delivery problems are issues that arise during care – usually actions or omissions by staff).

5.25 The identification of the contributory, influencing, underlying or causal factors that contributed to the incident is also a key part of the process. Although the contributory factors framework was used, more effort could be made to drill down to the underlying causes.

5.26 There may be occasions when nothing could have prevented the incident and no root causes are identified. However, in our experience there are often lessons to learn and safer practice issues may be identified which did not materially contribute to the incident. It wasn't clear from some of the reports whether the term 'lessons learned' was being correctly used. It would be helpful for reports to make clear which lessons learnt are

incidental findings and recommendations and which are from something that contributed towards the incident.

5.27 The recommendations in a serious incident report should address all the root causes and any contributory factors. They should be designed to significantly reduce the likelihood of recurrence and/or severity of outcome be clear and concise and kept to a minimum wherever possible. All the reports we reviewed contained recommendations. On the whole these were good and related well to the contributory factors highlighted in the report.

The decentralisation of the management of serious incidents to directorates

5.28 An important question in any serious incident process is the extent to which it is centralised or localised. Under the current approach, investigations are largely carried out by the central patient safety team, with support from directorates. Change to the process to have more local involvement in carrying out investigations is under consideration and was being discussed at the time we were collecting evidence. The proposal is that directorates take on responsibility for incident investigating with a central team able to provide theoretical safety expertise. The drive for 'ownership' of safety to be held by directorates with investigations supported by the patient safety team who have a key coordination and report construction role is welcome.

5.29 The advantage of a decentralised process is that it allows investigations to be carried out by people close to the service where the incident happened. This means that they will have a good understanding of the systems in place and are more likely to be able to tailor recommendations to ensure that they are implementable. However, a decentralised approach relies on staff who might only carry out investigations relatively infrequently. Staff told us of a concern that local investigation risks bias because teams haven't been trained in serious incident investigation and will be "*marking their own homework*". At the time of writing this remained an issue that many people had real concerns about. We also heard from staff that they were worried that there wouldn't be enough resources allocated to the directorates to take on the responsibility of managing serious incident investigations.

Learning from serious incident data

5.30 Serious incident investigations produce valuable data, but it is important that the data is analysed and then disseminated properly. Safety culture should be visible throughout the organisation, and information should flow from care providers up through the governance structure to the board, and back down to the front line (this linkage is known as "the golden thread").

5.31 The full value of data from investigations will not be realised unless it is collected in a systematic and organised way. Doing so helps to reduce the need to investigate incidents in ways that are burdensome. We do not believe that there is currently a supply of data which is organised systematically to make it easy to interrogate.

5.32 Once data is collected, it is important to ensure that it is properly disseminated. In some ways this is the most important part of the serious incident process – it does not matter how much information has been collected and how much time has been spent investigating if nothing happens to the outputs. Findings of serious incident reports are reported within the trust and the 'Closing the Loop' meeting has specific responsibility for chasing up the actions from investigations. However, it was less clear to us that there was a good system for passing on lessons from investigations to staff more generally.

Disseminating learning from serious incidents

5.33 We were told by a lot of staff that the trust's mechanisms for disseminating learning from incidents do not work well and some have fallen into disuse in recent times. Current mechanisms include:

- Cascade briefings from meetings e.g. PSOC
- Learning events – including lectures and lunchtime sessions
- Email summaries & reminders

5.34 All of them require staff to act to gather and assimilate the information offered.

5.35 One group of senior staff told us that it was most unlikely a band 5 nurse would be familiar with the serious incident process or know about changes to clinical practice

recommended in response. They also said that changes to practice often didn't 'stick' and old clinical habits soon re-emerge. In short, safety messages don't easily get to the ward and when they do, don't necessarily result in sustained improvement in clinical practice.

5.36 Several people we spoke to told us that the learning from incidents was very specific to particular teams and didn't have wider application to the hospital. That might be the case in some instances, but generally the learning from investigations has a generic element which might be of use to others. The idea that much learning doesn't have wider applications should be looked at closely. Otherwise there is a danger that wider learning is lost.

5.37 We saw indications that the board is remote from patient safety issues. While to some extent that is natural – it is not their role to get involved in the day-to-day running of the trust – we think that the board can play a major role in demonstrating the importance of the patient safety agenda. We will address this further in the next section.

Family engagement and the duty of candour

5.38 The terms of reference for this review ask us to see how hospital staff engage with families following an incident which has caused significant harm. Great Ormond Street has always worked in a complex social environment, but we heard from a number of people about how that environment is evolving. One interviewee commented to us that there is generally less willingness in society to accept mortality, particularly when it involves children. While some people may have less respect for authority, others may have higher expectations about what those in authority can deliver. The greater willingness of some people to speak up, facilitated by social media, is also an important trend. Together these societal factors make Great Ormond Street's role increasingly challenging, especially if things go wrong.

5.39 We recognise also from our interviews with staff that staff work hard to ease the burden on families, and support children and young people through complex and sometimes life-saving treatment on a daily basis. Many families are happy with the care and treatment provided.

5.40 Apart from interviewing staff, we met with a family who had experienced problems with how the trust had managed a serious incident. We also listened to the BBC radio programme that led up to our appointment.

5.41 Staff in the trust acknowledged that there were problems at times with family engagement. They also recognised that this is a significant issue for Great Ormond Street as public confidence is important to uphold.

5.42 The duty of candour is an important aspect of this communication agenda.

5.43 The legislation relating to duty of candour[1] states:

1. *Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.*

2. *As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must— a) notify the relevant person that the incident has occurred…*

5.44 It goes on to discuss notifiable safety incidents and how they should be handled.

5.45 We saw evidence that duty of candour is not consistently understood within Great Ormond Street. Some staff interpret duty of candour as meaning that if there is a notifiable incident, they have a duty to be open and transparent, but if there isn't, they don't. We saw instances where staff thought said that they needed to "*check if anyone did anything wrong*" before deciding on whether the duty of candour applied to that case, rather than it just being part of their everyday job. Clearing up any ambiguity in this area is important – all regulated healthcare staff have a duty to be open and transparent and that should be their first instinct, whatever the circumstances of the case. The trust may have additional processes for when there has been harm, but this shouldn't be confused with the general duty all staff have to be open with patients and families.

[1] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

Risk appetite

5.46 No procedure, or decision not to carry out a procedure, is risk free. Organisations must consider what level of risk is acceptable to them and how that level is calculated.

5.47 One driver of the acceptability of taking a risk is the consequence of not taking an action. When the life of a child is in the balance, a high level of risk may be acceptable. Great Ormond Street might therefore be expected to have a risk appetite that is relatively high.

5.48 There is no objective level of risk that is correct, however. The risk that is acceptable will vary with the circumstances and people involved. What is essential is that there is dialogue between clinicians and families so that families know what risk is being taken and that choices are being made consciously. Working through that dialogue can take time and effort, but it is essential if long term issues are to be avoided.

5.49 Alternatively, significant new diagnostic tests, procedures or treatments could be subject to risk assessment in advance of implementation. Prospective investigation of this sort could be of significant benefit when new tests, technology or procedures are a feature.

The patient safety team

5.50 The patient safety team have a responsibility to lead, develop and implement patient safety systems, processes and initiatives within the trust. They also act as lead investigator on complex/serious incident investigations and are responsible for ensuring that investigations are carried out within the allocated time.

5.51 The time of our review coincided with a period of change for the patient safety team. We did not therefore look closely at how the team currently operates as anything we would have said may be out of date.

5.52 Going forward we believe that it is important that the team continues to focus on improving the patient safety culture in addition to carrying out/supporting serious incident investigations. If these are to be carried out within the directorates, they will have

important role to play in supporting the process of investigation however it is delivered in future.

Committee meetings

5.53 In common with much of the NHS, Great Ormond Street holds many meetings in relation to patient safety – internal executive meetings, board assurance meetings, and meetings with external bodies such as NHS England. We were 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.

5.54 Meetings can have many functions:

- Exchanging ideas
- Generating ideas
- Disseminating information
- Providing assurance that things are being done as agreed.

5.55 In some instances, it wasn't immediately clear to us what some of the meetings we observed were trying to achieve. We doubt whether some of the meetings would really achieve their objectives, even if they were clear. There is a concern that having a meeting itself was considered to be '*action*' in response to a problem.

5.56 More thought is needed about what the current committees are trying to achieve and, and whether the current range of meetings is the best way of achieving them. This process should start by defining a list of objectives – gathering information, sharing information, agreeing conclusions, dissemination of conclusions – and identifying the best way of achieving them (which may not always include a meeting).

Communication, communication, communication

5.57 Communication is key to finding an acceptable way forward on many of the issues that we have discussed.

5.58 Communication with staff is important both to show why investigating incidents is important and, more generally, to demonstrate the importance that the trust places on having a good safety culture and systems. As well as good clear communication coming down from the leadership, junior staff need to feel empowered to raise issues with those higher up in the organisation. A culture of openness and good communication between staff is a key feature of a safe organisation.

5.59 Communication with families is also crucial. Choices about care are often complex and involve trade-offs. There may simply be no objectively 'right answer' to how much risk is acceptable in the choice between one action and another, or of not acting at all. Ensuring that families feel empowered and listened to is essential, so that they give their backing for whatever decision is ultimately made.

5.60 We were told that there are some staff who struggle with the communications aspects of their role and admit that they are not a *"people person".* Even if all involved are effective communicators and have a desire to be open, the complexity of cases makes good communication a challenging task. This task is only going to get harder as the advance of medical science makes treatment options ever more technically complex and the resulting moral issues grow. The task of engaging with patients and families and explaining what is happening and what choices need to be made has to be priority within the trust. Staff should be supported and incentivised to be as open as possible, with time set aside for them to do so.

Overall comment

5.61 Patient Safety Learning's 'Blueprint for Action' provides a benchmark against which organisations can measure their 'patient safety maturity'. It covers the following areas:

- Shared learning for patient safety
- Professionalising patient safety
- Data and insight for patient safety
- Leadership for patient safety
- Patient engagement for patient safety
- Culture for patient safety.

5.62 The document gives a framework for reviewing the trust on the following scale:

- Minimal – aiming to meet statutory and regulatory requirements
- Reactive – plans in place to meet statutory and regulatory requirements
- Active – actively seeking to improve patient safety
- Proactive – reducing harm, supporting staff, plans to deliver a patient-safe future
- Patient-safe future - patient safety in integrated care, minimal avoidable harm, safety is a core purpose, safe for staff.

5.63 Our estimate would be to put Great Ormond Street at the 'Reactive' level.

5.64 In our experience, the key steps for improvement in any organisation are:

- recognise problem
- accept responsibility
- develop solutions
- implement
- embed.

5.65 We believe that the leadership at Great Ormond Street accepts that that it can learn and improve and that this is a priority for the organisation. Some solutions have been developed internally and in the next section we propose some additional ones. We also hope that what follows will help with implementation and embedding change.

6. Proposals for change

6.1 The focus of our work has been on developing ideas for further improvement. We recognise that the trust is implementing the patient safety strategy, however we have some practical ideas of what could be done to build on this work.

a) Building the patient safety culture

6.2 As we have described earlier in this report, patient safety culture is an essential base on which to build safety improvements. There are a number of elements to growing such a culture.

The role of the Board

6.3 As a world-class hospital, Great Ormond Street's excellent care and treatment should be matched by world-class patient safety. This ambition should be the goal of the trust over the next five years.

6.4 Culture starts at the top. The first step in building the patient safety culture is for those in leadership positions to demonstrate that it is a priority for them. An observer who attended NHS board meetings across the country would probably reach the conclusion that the top priority for most trust boards is finance - because that is what they appear to be most interested in. They would probably be right![1].

6.5 While it is not the role of the board to get involved in management of the organisation they can help to deliver the trust's strategy by setting the tone. There are a number of ways in which that could be done. The following are some ideas:

- Demonstrating that safety is a priority – the most obvious ways in which the board can show that safety is a priority is by talking about it. That might begin by issuing a board statement about the importance of safety and continue by ensuring that it is talked about in board meetings. The statement should invite

[1] Board meetings begin with hearing about patient experience at the trust. This is welcome but is not a substitute for having a patient safety focus.

staff to see their daily work as having two parts: delivering excellent care and improving the safety of the trust's systems and processes. It should emphasise that the two go hand in hand.

- Bolstering the role of the non-executive with the specific remit for patient safety, enhancing their role as patient safety champion to support the board's executive patient safety lead. This role could bring a degree of independent, supportive challenge to the oversight of patient safety.

- Visibility – specialty/directorate visits have obviously been curtailed by Covid, but the presence of non-executive directors 'on-the-ground' demonstrating that they care about safety and setting out the trust's ambitions would send a powerful message to the organisation. All specialties should be visited over the next eighteen months and on a planned, regular basis for the future.

6.6 The trust has initiated a patient safety network with the five children's hospitals with which it works most closely. This is welcome and should be prioritised to ensure that it is used to share information and discuss key safety challenges.

Strengthening the golden thread

6.7 Communication is key to the effective flow of information from ward to board. That includes both formal and informal channels.

6.8 For the formal channels, patient safety should be considered in all business decisions. Board papers currently have to state whether there are risk, legal or financial implications. They could be required to state whether there are patient safety implications as well. This will help to ensure that patient safety is considered and included in all decisions. There are already formal trust meetings whose role is to discuss patient safety - Quality, Safety & Experience Assurance Committee at board level and Patient Safety Outcomes Committee. These meetings tend to have a mass of paperwork and might benefit from time spent discussing patient safety issues in a freer way than just reviewing a series of reports. Other meetings about routine matters should start with a brief discussion about the pressing safety issues of the day e.g. 'what safety concerns are there today in the trust?'. Executives should ensure this happens.

6.9 In terms of informal channels, safety concerns emanating from lower down the organisation must be able to reach board members. It is welcome that the trust has a Freedom to Speak Up Guardian. The trust should ensure that it takes the full benefit from this resource and that the role is widely understood throughout the organisation. Another way of demonstrating the importance of patient safety is ensuring that it is included in job roles for staff across the organisation.

6.10 The trust should establish a baseline assessment of the current culture – ideally from existing resources. Progress should be monitored regularly. Time should also be taken to celebrate successes when they occur.

Openness about risk and safety

6.11 Human beings make mistakes – that is a fact of life. The best systems sometimes fail. The only question is how organisations respond to these facts.

6.12 A starting point would be for people in the organisation to talk more about when they have made errors, what they did about it and how they felt. This should start from the top – chair, board members, chief executive and senior clinicians. Talks could be given to groups of staff about human performance, safety and blame. These events should be organised to make it easy for staff to attend. They could be badged *'Exceptional but fallible'* - that is, making it clear in the title that even the best hospital can have incidents of avoidable harm. An external speaker, such as an eminent psychologist, clinician or a human factors specialist, could also be invited to speak on the same topic.

6.13 It would be beneficial to encourage dialogue when things go wrong. Experience of senior people talking about such circumstances should help, together with alternative approaches to investigation which encourage dialogue – both internally and externally (see discussion of alternatives to investigation, below). The trust should start to examine what leads to so much good care. How is it achieved? Are there key ingredients? How are these best incorporated into good clinical practice?

6.14 More generally, the trust should accept that it is inevitable that it receives criticism from the media and, from time to time, from families. It should ensure that it responds to this proactively and is prepared to be open with people when things go wrong. Admitting mistakes should be seen for what it is – a strength – not as a weakness.

Directorate risk & safety champions

6.15 Identifying people with responsibility for promoting risk management and patient safety can be an effective way of promoting good practice. These individuals will help drive the safety management function deeper into the organisational structure and provide informed safety support to the chiefs of service and patient safety team. These roles could be taken on by deputy chiefs of service or by people who report to them. They should be provided with additional training in some or all the risk management tools described in this report.

Developing the role of the patient safety team

6.16 Strengthening the patient safety function will be an important part of developing the culture of patient safety at Great Ormond Street. We were told that in the past the patient safety function concentrated too much on process. We think that the 'fix it' element of the role should be increased, so that the work of the team is more dynamic and rewarding and is able to help deliver improvement more directly. The team should be trained in a range of patient safety techniques to facilitate this.

Creation of a central patient safety hub

6.17 The focus of much safety work is often on the past – looking back at things that have already gone wrong. Safety, however, is about the 'here and now' – making sure what happens today is the best it can be. Data and technology offer great opportunities for developing this perspective. A central patient safety hub and database with live data about safety issues should be developed to ensure not only that the full learning value is drawn from the data that the trust collects, but to ensure that things can be put right. This would help move safety onto a dynamic footing and refocus it from the past to the present.

6.18 The trust should trial new ways of ensuring that safety messages reach clinical staff and teams quickly. These messages should be specific, simple and targeted. Eye-catching infographics would be a good medium. Importantly, they should be timed to arrive at a time that they can readily influence the clinical task. They could include, for example:

- reminders about prosthetic packaging changes at the beginning of a theatre list
- prompts to label syringes after drugs have been drawn up
- reminders to read diagnostic test results
- safety messages to support ward huddles.

6.19 The trust should build on how other industries routinely communicate and impart important information to 'deskless workers' with a view to learning from them.

6.20 Technology should be used to support these changes e.g. electronic screens in theatres. Dissemination of knowledge should eventually be run by directorates with the support from their directorate safety partner. Initially, key messages should be gathered from the last ten serious incident investigations and any national safety alerts and be used as the basis for this work. This work should be formally evaluated by research commissioned by the charity. The research should focus on establishing, for example, what impact on behaviour the messages have and how that varies depending on the nature of the message and the time at which it is sent.

b) Openness and family engagement

6.21 Family engagement is seldom easy. Everyone involved in the process may have a different perspective and it can be challenging for those who spend their lives in a clinical environment to really understand what things look like for those coming to the experience fresh. We heard evidence that some at Great Ormond Street sometimes find family engagement difficult. We think that the reasons for this lie partly in the cultural issues we identified earlier. Striking the right balance between being an authoritative expert while open to the possibility of error and the need to learn, is a difficult one. Some of our foregoing suggestions about changing the safety culture will address this issue, but there are further steps that can be taken.

6.22 Changing attitudes of the public to health, and the availability of social media which can bring together groups of people with concerns make this issue increasingly complex. The trust needs to be prepared to respond to these issues in an open and receptive way.

6.23 The key to good family liaison is active listening. We were told that not enough time at Great Ormond Street is spent sitting down with families and listening to them. Identifying what is important to families and to engaging with their priorities is crucial. For example, we heard discussion about whether patient names should be used in Serious Incident reports. There is no right or wrong answer to that question. Many may not think it is an important issue. But it can matter to some families. Asking families what they would prefer – and responding to it – demonstrates respect and helps to build a positive relationship. Issues can be difficult to focus on simply because they are not a priority for professionals. Creating an active listening culture is one way to address this. When there has been engagement with families about their concerns, keeping a good record in the patient notes is particularly important in ensuring that families are provided with clear and consistent information.

6.24 Complexity is a feature of many cases at the hospital and we heard a great deal of evidence to this end. Many children cared for by the trust have numerous co-morbidities i.e. the simultaneous presence of other diseases/medical conditions (we heard of cases with eleven co-morbidities). That is significant for staff, but an even more so for patients and families. Although complexity is something that has to be dealt with across the NHS, it is a bigger issue in Great Ormond Street given the particular case mix. The trust could do much more to help patients and families in this area. We propose that Great Ormond Street considers the development of a 'system navigator' function for children with complex needs, so that families have a single point of contact despite being engaged with multiple specialities. We think this may be a responsibility suitable for an experienced senior nurse. While this will involve extra work for the person dealing with an individual patient, across the system as a whole it should be more efficient than having multiple people providing information to families. We suggest that the trust considers setting up a working group to determine how this sort of role might work best.

6.25 We were told that there is currently a two-month waiting list for bereavement counselling. There may be good reasons behind why the backlog has built up but addressing this as a priority to demonstrate that the needs of families are being prioritised.

6.26 We recommend the trust works with a small number of families to pioneer a more active role for them in safety of care and treatment. This could be supported by technology.

c) Improving investigations

6.27 As with many processes in the NHS, there is a danger that serious incident investigation focuses on the process itself, rather than on what it is trying to achieve. The first step with investigations should be to establish what the objective is and what can be gained from the investigation to help move the organisation forward.

6.28 The main purpose of investigations should be to find out what happened and why, so that there can be learning. Often it is also important to find out what happened to inform those affected – both a moral, and legal, duty.

6.29 Declaring a serious incident should therefore be seen as a 'neutral act', not an exercise in apportioning blame. It is rare for investigations to form the basis for disciplinary action, but if this is an issue in a particular case, communication with the relevant staff should be prioritised. It is important for senior management to demonstrate that learning and improvement are priorities for the organisation (as discussed above). The trust also needs to demonstrate that investigation is itself a priority - by allowing realistic time in job plans for investigation and safety improvement. Talking to staff across the NHS we hear of people who carry out investigations in their spare time or at weekends. If investigations are treated as a spare time activity, they will be perceived as such.

6.30 Investigations can be big or small: some events need in-depth detailed study; others would benefit from a quick review, allowing learning to be captured immediately and all involved to move on. The new NHS Patient Safety Incident Response Framework (PSIRF) sets out how healthcare providers should respond to patient safety incidents and how and when an investigation should be conducted. The framework puts an emphasis on the quality of investigations, rather than the quantity of them. This offers an opportunity for Great Ormond Street to develop a new approach to patient safety incident investigation. We propose that the response to an incident should be seen in terms of a range of possible interventions, the aim being to get the one that fits the needs of each incident best. Possible interventions include:

- After-action reviews
- Structured judgement reviews
- Fault tree analysis
- Thematic reviews
- Full patient safety incident investigation

After-action reviews

6.31 We suggest that the trust adds after-action reviews to its repertoire. The technique relies on discussion by clinical teams followed by a write-up of what has been discussed. NHS England describe after-action reviews as "*a structured approach for reflecting on work of a group and identifying strengths, weaknesses and areas for improvements*". The approach involves getting as many people as possible who were involved in an incident together so they can discuss their viewpoints on what happened with the support of an independent external facilitator. After-action reviews can be used in many circumstances:

- An incident
- A near miss
- A complaint
- At the end of a project.

6.32 A prerequisite of an after-action review is that everyone feels able to contribute without fear of blame or retribution. They are about learning, not holding people to account. The role of the facilitator is to guide the group through the discussion and help create a safe and open atmosphere. Discussions tend to last a maximum of an hour. The facilitator will take the group through a series of questions:

- What happened that we want to learn from? - creating a common understanding of the experience under review
- What did we set out to do?
- What happened?
- Why were there differences?
- What went well and why?
- Reflecting on the successes and failures: what could have gone better? Why?

6.33 If an after-action review takes place following an incident, those affected by the incident (patient or family) can be invited to attend alongside the clinical team so that their views and perspective can be heard and considered. Following the discussion, the facilitator will record actions identified and a learning log. An action plan is then developed to put any solutions in place. Possible outcomes could be:

- Initiation of immediate action to mitigate further harm
- No action required
- A celebration of excellent care
- Identification of a learning need
- A conventional audit or further investigation is needed
- Sharing the learning.

6.34 The process has many benefits. One is that the reviews can happen quickly. That is both a benefit for learning (as the facts are fresh in people's minds), but it also demonstrates to families that the incident is being taken seriously (the delay within the serious incident process alone is corrosive of many of its benefits). The use of after-action reviews can help to promote an open and just culture as well as reducing the burden of carrying out traditional investigations. Another benefit of the process is that staff involved in the incident can actively participate in the review and those affected by the incident hear first-hand about what went wrong (if anything) are listened to and supported. This helps to ensure that the duty of candour is met.

Structured judgement reviews

6.35 Structured judgement case note reviews can be used for a wide range of incidents and complaints. An important feature of this approach is that the quality and safety of care are evaluated and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that was problematic.

6.36 There are two stages to the review process:

a. Reviews carried out by front line reviewers. These are members of the team who are trained to undertake reviews within their own service or directorate.

b. A second-stage review takes place if care problems have been identified by a first stage reviewer and care has been rated as 'poor' or 'very poor'. This second-stage review is usually undertaken within the hospital governance process and normally uses the same review method.

6.37 The approach has several benefits. Much care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care. Another benefit of using this approach is that the Child Death Review panel works in an analogous way with any perceived deficiencies in care referred for consideration through a root cause analysis of serious incident (if the threshold is met). It is thus a familiar process to clinical staff.

6.38 The approach also contributes to the promotion of an open and just culture, while reducing the burden of investigations. Staff involved in the incident also actively participate in the review and the solutions, and families can be provided with the outputs.

Fault tree analysis

6.39 Fault tree analysis can be used for all types of system level risk assessment process. The purpose of this approach is to identify the causes of system failure and to proactively minimise risk in the future. This is a useful tool for complex systems that visually displays the logical way of identifying the problem.

Thematic reviews

6.40 Where there are a number of incidents to consider, thematic reviews can be useful. With their focus on identifying common elements for improvement, these can be perceived by staff as being less intimidating. The contributory factors framework provides a model which could be used to provide consistency in approach.

Full investigations

6.41 Under the PSIRF framework, investigations which are now known as 'Root Cause Analysis' will be called Patient Safety Incident Investigations. The new approach may lead to fewer investigations, but it will be even more important to ensure that those that are carried out are done well.

6.42 In our experience, investigations that are poorly conducted in their early stages often result in a much bigger use of management time and resources in the long run.

6.43 The use of staff directly involved in clinical practice to carry out investigations is important as it ensures that both the investigation, and any subsequent action plan, directly addresses the problem from the practitioner point of view. However, a system of this kind often results in long gaps between any individual carrying out one investigation and another as incidents in a particular speciality only come around infrequently. Any activity which people carry out only intermittently can be challenging and sometimes frustrating. In our experience, people who are asked to carry out an investigation after a long gap often struggle to remember much about the process. While training is important, often a long time has passed between the training and the use of the investigation skills. At the same time, providing extensive training on skills which staff use only rarely is not a good use of resources. It is therefore sensible to look for tools which can support investigators and guide them through the process [declaration of interest – Verita is currently working with Microsoft to develop a tool of this sort].

Recognising good practice

6.44 While attention is typically focussed on when things go wrong, there are benefits of a systematic approach to identifying good practice and outcomes and so that there can be learning from them. We recommend that a process should be put in place at Great Ormond Street to capture and share such learning.

Promoting learning from incidents

6.45 Learning from incidents is of no use unless there is a good process in place for getting what has been learnt to those who are on the front line. We do not believe that presenting papers to committees and expecting those present to disseminate the key points is an effective way of promoting learning. We suggest that more attention be given to getting messages out, possibly led by the patient safety team creating a rolling programme of communications. Methods for getting key messages across could include:

- Having electronic boards which displaying key messages, e.g. in theatres before a list
- Sending text messages to selected staff
- Lunchtime learning events
- Talks in academic settings
- Patient safety managers or senior managers carrying out walkabouts
- Setting up a safety hub and database with live data about safety issues which is fed through to staff (as discussed earlier).

Better use of data

6.46 In common with many organisations, we believe that Great Ormond Street could further improve their process for collecting, organising and analysing data from incidents and investigations to make it more systematic. There are currently systems in place which generate a large amount of data - to the point that many people feel overwhelmed by the quantity of it. The difficultly comes in organising it so that it can be easily interrogated. Technology offers a solution to this problem. It can help to identify subtle variations by factors such as time of day, week or year, etc. This is a rapidly developing field, but one that presents great opportunities for helping decision making around what to learn and how to respond to incidents.

Implementing improvements

6.47 The response to an incident should not be seen as a binary issue – serious incident investigation, yes or no. The new world of investigation offers flexibility and choice. That also presents challenges as decisions will need to be made about what it appropriate in what context. Thought will need to be given to what the objective of the response is. All this will require the development of internal policies and training on how it works. Technology could help staff charged with these responsibilities.

d) Improving risk management

6.48 Risk management is an important part of patient safety. The consistent measurement of future and current risk exposure is an essential part of the process. We have identified several methodologies, models and tools for risk management, each with specific applications. They include:

Tabular risk matrices

6.49 Risk matrices in the form of a tabular matrix, often with scales of 1 – 5 along the *x* and *y* axes, using terminology such as *very unlikely* to *very likely* and *negligible* to *catastrophic*, are widely used in the NHS.

Event risk classification

6.50 Event risk classification is used to assess the risk of past occurrences and incidents. It is based around two simple questions:

1. How bad could this have been?
2. What safeguards prevented it being so bad?

6.51 The answers offer insights into the magnitude of risk exposure and into the effectiveness of current mitigations, known as '*barriers*'. Event risk classification is also

based around a type of matrix, which also generates a numerical risk value for organisational risk exposure monitoring.

Bow-tie modelling

6.52 'Bow-tie' models are used to map out and visualise *threats* (root causes), *mitigations* (barriers) and *outcomes*. They derive their name from the shape of the diagram which is used to represent them with threats and outcomes centred on an event. Bow-tie models are best applied to the analysis of new procedures, new equipment or organisational changes, to identify what new risks those changes could introduce, how bad the risk outcomes could be and how effective any mitigations might be in protecting against them. Used retrospectively, bow-ties can also map out the evolution of serious incidents to help determine where existing mitigations failed and where new mitigations should be developed. Because the process is resource demanding it should only be applied to major risk concerns.

Observational safety audits

6.53 This is a process in which trained and knowledgeable 'auditors' observe a number of similar activities or procedures to identify common threats, errors and good practices. The observations are always unattributed and made only with the permission of those being observed. The output is a bank of aggregated data indicating areas of excellence and opportunities for improvement for a service, rather than focusing on any individual. Because of the sensitive nature of the collected data, strong data protection protocols are required.

Hazard logs

6.54 Similar in format and function to corporate risk registers, hazard logs can be raised to catalogue all identified hazards associated with a specific activity, area or procedure. Familiarisation with these hazards and the applied mitigations prior to commencement, allows practitioners to be aware of the level and sources of risk they may encounter.

6.55 These approaches are summarised in table 1 (Appendix F).

e) Improving safety training

6.56 High quality training is essential if many of the changes set out in this report are to be delivered. Delivery of regular training in areas such as serous incident investigation is particularly important (a number of people we spoke to identified the lack of training in recent years as an important issue).

6.57 The Learning Academy is an important asset for the trust and has received significant funding from the charity. We believe it should be central to the trust's ambitions to improve and professionalise patient safety. We propose that the academy should be asked to develop a patient safety syllabus that covers training in the following:

- Human factors
- Human error theory
- Human performance
- Building a safety culture
- Building resilient teams
- Leadership for safety
- Communication, duty of candour and supporting families after incidents
- Investigating incidents using technology
- Interviewing during investigations
- After-action review & other investigative techniques
- Developing solutions after incidents

6.58 Appendix G provides a short description of each of these courses.

6.59 In addition to these measures, the trust should ensure that staff are registered to attend the Healthcare Safety Investigation Branch (hsib.org.uk) programme on investigating.

6.60 As we set out above, training could be another way of addressing the difficulty of acknowledging that thing go wrong even in an organisation that provides the best care, through sessions that address the issue of being *"Exceptional but Fallible".*

7. Next steps and conclusion

7.1 Using the Patient Safety Learning – A Blueprint for Action maturity index referred to in paragraph 5.59 above, Great Ormond Street should aim to move from Reactive to Active in [X] years and from Active to Proactive in [Y] years [*timescales to be discussed*].

7.2 An Active approach is a healthcare organisation that is *'actively seeking opportunities to improve patient safety'*. The conditions to be met include:

- Patients actively engaged in the safety of their care
- Safe staffing
- Patient advocates
- Staff training on systems and human factors
- Safety culture assessment
- Patient safety impact assessments

7.3 Achieving this first goal will require a considerable effort, including agreeing the details of each condition to be met. The executive and the board should monitor progress regularly.

7.4 We have set out a variety of proposals in this report, ranging from culture change across the organisation, to specific measures that could be implemented quickly and will help achieve this first milestone. We would welcome the opportunity to support the trust in the implementation of any of the measures set out here.

7.5 Great Ormond Street has great strengths as an institution and a reputation for taking on the hardest cases and challenges that other hospitals can't meet. But it also faces significant challenges. Some of these challenges are shared across the NHS and are exacerbated by COVID. Others arise out of the particular characteristics of the hospital and its patients. We believe that a concerted organisational effort to address the safety of care and services will have a significantly positive impact on patients and families, aid staff recruitment and retention and serve to enhance the trust's reputation as a world-class provider.

Appendix A

Team biographies

Ed Marsden

Ed Marsden has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management. He combines his responsibilities as Verita's founder with an active role in leading complex consultancy. He worked with Kate Lampard to provide independent oversight of the 40 or so investigations carried out by the NHS into allegations about Jimmy Savile. He and Kate wrote a lessons learnt report for the Secretary of State for Health arising from the publication of the Savile investigations. Recently, he was appointed by the global board of G4S PLC to investigate the concerns raised by BBC Panorama in their programme about Brook House immigration removal centre at Gatwick airport. The report was published in December 2018. Ed has advised the Jersey government about the inquiry into historical child abuse. He is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration. He is the founder of a new healthcare tech company called Eva (www.evaapplications.com).

Chris Brougham

Chris has worked for Verita for 12 years. She is an experienced investigator and has conducted some high-profile investigations and reviews over the years. Chris is a qualified mental health nurse and an experienced manager. She has previously worked as a director of nursing in a large mental health trust and has also worked at the National Patient Safety Agency working collaboratively across the whole health community to promote patient safety and improve investigations into serious incidents in the NHS. Recently Chris has been working with Icotech services to develop Eva, a technology to help healthcare organisations conduct patient safety investigations.

Kieran Seale

Kieran Seale joined Verita in 2014 and was appointed a director in 2018. Governance is a particular area of expertise for Kieran. He has led a number of reviews of conflict of interest

and governance issues for NHS England and in the charity sector. He also leads Verita's work in the field of complaints management. He also runs training courses on complaints management and regularly speaks at conferences on the subject. Other notable investigations that Kieran has worked on include an investigation following the suicide of a nurse at Imperial NHS Trust, an investigation into safeguarding concerns for the Green Party and an investigation into whistle-blowing allegations at a charity. He has an interest in health policy and regularly writes blogs on health and technology issues.

Terms of reference

Background

Dr Sanjiv Sharma, Medical Director (MD), at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has asked Verita to undertake an independent review of the Trust's safety procedures, with a view to finding out whether they are effective and fit for purpose.

This follows on from various concerns expressed by parents about how effectively the Trust investigates patient safety incidents. These culminated in a BBC radio 'File on 4' current affairs programme broadcast in March 2020 which was critical of the Trust.

The Trust would like to learn and improve their current systems, processes and approach to investigating the complex care and treatment of children.

Terms of reference

The Verita team will undertake a review of the following matters:

1. How hospital staff engage with families following an incident which has caused significant harm. Verita will establish whether there are appropriate levels of engagement to reinforce comprehensive and open communication with parents, families and carers. Verita will examine the processes for working with families when things have gone wrong and identify if they are clear, compassionate and empathetic. Where national frameworks and guidance exist they will be used as the standard; outside of this opinion and judgement will be used.
2. Whether there are effective and timely processes in place for managing serious incidents from reporting, investigation and approval through to learning/system improvement to avoid recurrence, including incorporation of feedback from external stakeholders such as NHS England/Improvement.
3. Whether there are effective processes in place for managing safety risks in red complaints from identification, investigation and approval through to learning/system improvement, to avoid recurrence.

4. Whether there are effective processes in place for managing safety risks in claims and inquests from identification through to learning/system improvement, to avoid recurrence.
5. Whether the level of investigation undertaken by the Trust is proportionate to the incident/complaint raised.
6. To understand if the processes for investigation enables and supports the Trust to identify and act on critical safety issues in a timely way.
7. To identify if there is sufficient evidence of the 'golden thread' of safety in the governance and reporting processes from ward to Board (including but not exclusive of Trust Board assurance committees) and with key external stakeholders, specifically in relation to Serious Incidents, Red Complaints, Claims, Inquests and Mortality Reviews. This should include consideration of the role of the Patient Safety Specialist, and the plans set out in the Safety Strategy and Operational Delivery Plan.
8. To identify if processes are supported by a sufficient culture of openness, curiosity and transparency; this includes compliance to Duty of Candour obligations.
9. To evaluate whether appropriate support systems are in place for patients, families and staff. This will include an evaluation of confidence amongst all parties in the Trust's ability to be fair, honest and transparent in a culture of learning without blame.
10. How the Trust are progressing their action plans following the Care Quality Commission focussed inspection on Serious Incidents and Red Complaints.

The work will involve consideration of relevant documents, including examples of investigations, correspondence with families, the terms of reference of relevant committees and minutes/agenda as appropriate.

The work will also comprise interviews with families who are/have been through an investigation process, key members of staff and relevant external stakeholders (e.g. NHS England/Improvement - NHSEI, North Central London Integrated Care System – NCL ICS).

This will include one or two investigators/teams who are carrying out 'live' investigations and also talking to investigation 'approvers'. This will give a better understanding of how Trust staff conduct the work and how reports are signed off.

Verita will attend the Trust's Executive Incident Review Meeting (EIRM) and SI panel review meetings. The purpose of this will be to see how investigations are commissioned and quality assured.

There will be attendance of a selection of Risk Action Groups (RAG) and Directorate Governance meetings to evaluate how actions arising from serious incidents and red complaints are implemented at a Directorate level.

Verita will attend a meeting of Trust's Patient Safety Outcomes Committee (PSOC) , Patient and Family Experience and Engagement Committee (PFEEC) and Closing the Loop (CtL) to get an understanding of how learning and actions from Serious Incidents and Complaints are implemented at a broader Trust Level.

Verita will carry out one or two focus groups with families. This could include participants who have no experience of a serious incident (as per previous point this is a narrow reading of what we hope to be looked at - families may have experience of the SI process, red complaints and inquest etc) investigation and others who do.

Findings will be developed with reference to operational delivery plans the Trust has developed for their 2020 Safety and Quality strategies to ensure that these delivery plans are fit for purpose in relation to safety investigations and improvement processes.

Regular feedback will be provided to the Trust. Any patient safety concerns will be raised immediately outside of these regular updates.

On completion of the work Verita will produce a written report, following a factual accuracy check process with the Trust. Verita will also produce a slide-set report outlining findings, with recommendations as appropriate. A workshop-style event will be held to discuss the findings, conclusions and next steps. This will be on two levels – firstly a highlight presentation for the Executive Group and, secondly, a more detailed workshop event for the Safety Team, Complaints Team, Deputy Chiefs of Service (DCoS) and Heads of Nursing (HoN). This will be jointly facilitated by the Trust and Verita.

Verita will engage extensively with the Trust, especially the patient safety and complaints team and the directorate management teams. This will help ensure that the

recommendations meet the needs of the organisation and are shared with those who will need to implement them at the earliest opportunity.

In the interests of transparency, the Executive Summary and Recommendations will be shared at the Public Trust Board and resulting action plans to appropriate designated assurance committee. Contributors to the report, including families, NHSEI and NCL ICS), as well as external regulatory bodies (including the CQC) will also be provided with Executive Summary and Recommendations.

Appendix C

Interviewees

GOSH

- Sanjiv Sharma, medical director
- Alison Robertson, chief nurse
- Matthew Shaw, chief executive
- Anna Ferrant, company secretary
- David De Beer, associate medical director for safety
- Pascale du Pre, death reviews
- Andrew Pearson, death reviews
- Amanda Ellingworth, non-executive
- Kathryn Ludlow, non-executive
- Claire Williams, head of patient experience
- Hussein Khatib, interim head of quality and safety
- Andrew Pearson, clinical audit manager
- Patient Safety Managers (1)
- Patient Safety Managers (2)
- Rachel Cook, head of bereavement team
- Renee McCullogh, associate medical director of welfare
- Dan Sumpton, Freedom to Speak Up guardian
- John Quinn, chief operating officer
- Daljit Hothi, associate medical director for leadership and coaching
- Russel Viner, non-executive

NHS England

- Simon Barton, medical director for NHS commissioning in London
- Angela Lennox, deputy medical director
- Jess Peck, clinical quality manager

Groups

- Heads of Nursing
- Chiefs of Service

Families

- The parents of a child who had been treated at Great Ormond Street.

Appendix D

Documents reviewed

- Papers from internal committees, including:
    - Trust Board
    - Quality Safety and Experience Assurance Committee
    - Patient Safety Outcomes Committee
    - Patient and Family Experience and Engagement
    - Closing the Loop
    - Executive Incident Review Meeting
- Integrated Quality and Performance Reports, and proposed changes to the report
- Safety and Quality Team Restructuring Consultation Document
- Safety Strategy 2020 - 2025
- Framework for Patient and Family Experience
- Trust policies, including:
    - Being Open and Duty of Candour Policy
    - Complaints Policy
    - Incident Reporting and Management Policy
    - Learning from Deaths Policy
    - Risk Management Strategy
- A selection of five trust Serious Incident Reports
- Well Led Review, July 2021
- Job Descriptions
- Reports from the Care Quality Commission
- NHS Patient Safety Strategy 2019.

Appendix E

GOSH Serious incident/ Red complaint reports

We reviewed five incident investigation reports to find out whether there are effective and timely processes in place for managing serious incidents investigations and red complaints:

- Report 1 - An investigation into a retained guidewire following central line insertion.
- Report 2 - A patient who experienced loss of renal function in their left kidney.
- Report 3 - A portacath (a small device that provides direct central venous access) was inadvertently left in situ.
- Report 4 - a complaint made about the care of a 4-month-old baby.
- Report 5 - The patient suffered a catastrophic pulmonary hemorrhage at home less than two days after discharge.

Analysis of the reports

The reports are written following a template like those used in other trusts. The purpose of using a template is to promote consistency. This template mirrors the NHS Root Cause Analysis investigatory process.

Terms of reference and scope of the investigation

The terms of reference are important because they set out the scope, purpose, boundary and the lines of enquiry of the investigation. This helps the investigation team to keep focused and on track.

All reports explain the scope of the investigation, i.e. what episode of care is being examined. Each report sets out generic terms of reference. These describe the process of the investigation rather than the purpose. There are also specific questions, some of which are from families for the investigation team to answer. The terms of reference could be further improved if specific terms of reference were devised for each incident so that the purpose and lines of enquiry are clear.

Describing what happened

All five reports set out a good description of the incident/ complaint and provide a readable account of what happened.

Identifying care delivery problems

Care Delivery Problems arise in the process of care – usually actions or omissions by staff e.g. care deviated beyond safe limits of practice, failure to monitor, observe, act. Every report highlighted at least one care delivery problem. This section of the report could be further improved by making sure that the description of the care delivery problems is in relation to the failing and not the cause.

Contributory/ underlying factors

A fundamental component of the RCA investigation and analysis is the identification of the contributory/ influencing/underlying and causal factors that contributed to the incident. This can prove to be a difficult part of the investigation, especially when investigating aspects of complex care. There is a framework/taxonomy which was developed to use across the NHS to help the investigators with this part of the investigation. The trust uses the NHS framework and there are references to it in all five reports.

The investigation reports could be further improved by making sure that any analysis in this section is linked to a care delivery problem and not the incident as a whole.

Lessons learnt

There may be occasions when nothing could have prevented the incident and no root cause(s) are identified. There are always lessons to learn and key safer practice issues may be identified which did not materially contribute to the incident. Lessons learned may be described as 'key safety and practice issues identified which did not materially contribute to the incident'.

It wasn't clear from some of the reports whether the term was being correctly used. It would be helpful for the reader of GOSH investigation reports to know that lessons learnt are incidental findings rather than lessons learnt from something that contributed towards the incident.

Recommendations

The recommendations should address all of the root causes and any contributory factors. They should be designed to significantly reduce the likelihood of recurrence and/or severity of outcome, be clear and concise and kept to a minimum wherever possible. All reports contained recommendations. On the whole these were good and related well to the contributory factors highlighted in the report.

Appendix F

New investigation techniques for Great Ormond Street Hospital

Current NHS policy position

The NHS Patient Safety Strategy published in July 2019 says that:

> *'Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS definition of quality in healthcare, alongside effectiveness and patient experience.'*

The NHS Patient Safety Incident Response Framework (PSIRF) 2020 sets out how healthcare providers should respond to patient safety incidents and how and when a patient safety incident investigation (PSII) should be conducted. It is a key part of the overall NHS strategy.

The ambition of PSIRF is improve the quality of PSIIs by:

- *'refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues*
- *focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents*
- *transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning'*

The emphasis of the policy change is to make more effective use of current resources and focus on improving the quality of investigations and making a more proportionate response to avoidable harm.

The policy and Great Ormond Street Hospital

We believe that the guidance is sufficiently permissive to offer an opportunity for Great Ormond Street Hospital to develop its own approach to patient safety incident investigation. This includes having a range of interventions available to provide deep insight into patient

safety incidents. Some of the interventions we suggest are based on current methods in healthcare and in use in the trust. Others are drawn from high-risk industries and would need to be adapted to suit healthcare. We believe that this is feasible in partnership with Verita.

Investigation

The current investigative methods in use at the trust focus on events that have already happened and include the comprehensive Serious Incident investigation and root cause analysis.

In this report we have suggested that the trust adds after-action review to its repertoire for the better understanding of selected near—misses and good practice. This technique relies on discussion by clinical teams followed by a write-up. A review seeks to answer five key questions:

1. What was supposed to happen?
2. What did happen?
3. What went well?
4. What did not go well?
5. What should be changed for next time?

After-action reviews are conducted by a person trained in the method. The assessment allows teams and leaders to learn what happened and why, reassess direction and review successes and challenges. It is flexible and focuses on tasks and goals that were to be accomplished. An after-action review can take between 15 minutes and 2 hours to conduct. They have such information readily available and being actively used. It should be able to demonstrate this to families, staff and regulators. All the tools and interventions listed above can be embedded into software

Table 1 - potential safety investigation techniques for Great Ormond Street Hospital

Purpose	Investigation techniques	Application	Resource demand	Training needed	Amenable to being accommodated in software	Questions answered
Measuring and managing future risk	Tabular risk matrices	Analysis of new treatments, procedures, equipment and diagnostic tests	Knowledgeable assessors and SMEs[1]	Half-day training in the methodology	✓	What risk is attendant on proposed activities?
Understanding and managing past encountered risk	Event risk classification	Investigation of clinical near-misses, incidents and Serious Incidents	Knowledgeable assessors and SMEs	Half-day training in the methodology	✓	What was our risk exposure? How well did our mitigations work?
In-depth analysis	Bow-tie model	Improving safety of clinical practice and mapping	Trained practitioners and (ideally) Bow-tie	1 – 2 days training in the methodology	✓	What does a proposed new activity look

[1] SME - subject-matter expert

		investigations of serious clinical incidents	XP or similar software	and (if used) the software		like in terms of threats, mitigations and outcomes? What worked and what failed in the development of an incident?
Good practices and process deviations	Observational safety audits (anonymised)	Identifying strengths & weaknesses in clinical teams and processes	Knowledgeable, trained assessors whom colleagues trust plus full management support	3 days assessor training plus 2 hour brief for managers and short (on-line?) explanation for participants	✓	What are the common threats, errors and good practices embedded in our routine activities?
Cataloguing and tracking hazards, mitigations and risks over time	Hazard logs	Managing hazards and risks associated with organisational changes and high-risk activities	Departmental risk/safety champions	1 day initial training for champions and half-day	✓	How can we be sure no hazards are overlooked and applied?

				annual recurrent		
Embedding safety and investigation deeper into the organisation	Departmental safety/risk champions	Knowledgeable SMEs embedded in departments to support investigations	Motivated existing departmental SMEs	1-day initial training (including hazard logs above) plus half-day annual recurrent	✕	Does the organisational investigation process have enough local informed insight?

Appendix G

Safety training courses

Human performance

Human performance is about how and why people do what they do. If we can understand the motivations, capabilities and limitations of those around us we can help maximise successful performance and safely manage the less successful. This programme would focus on human factors to enhance clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities so that this can be applied in clinical settings

Human error theory

A programme which would focus on the theory behind human error so that clinicians can understand how and why they make mistakes and what can be done to mitigate them.

Building a safety culture

This programme will explore the steps needed to create a culture of safety to promote the delivery of safe and reliable care and ensure that patient safety is at the heart of all care delivered.

Building resilient teams

This course focuses on the importance of developing and maintain resilient teams and how effective teamwork is essential for patient safety.

Leadership for safety

This programme examines how leadership and management styles have an effect on staff, work and work environments which all in turn have an effect on clinical safety outcomes.

Communication, duty of candour and supporting families after incidents

This course helps participants to unpick the elements of duty of candour so that those affected by an incident are properly informed and supported.

Investigating incidents using technology

This course shows participants how digital solutions can be used to carry out patient safety incident investigations in healthcare and make data on safety events easier to access.

Interviewing during investigations

Investigative interviewing is a technique to help the person who has been involved in the incident to remember as much as possible about the incident. This programme focuses on the steps of investigative interviewing and the need for interviewers to provide an enduring record of the interview.

After-action review & other investigative techniques

This programme provides participants with information on how to investigate or review less serious incidents using techniques such as an after-action review or structured judgement reviews.

Developing solutions after incidents

This course looks at learning from patient safety incident investigations and how sustainable solutions can be put in place to reduce the chances of the same thing recurring.

Attachment T

Trust Board **6th July 2022**	
Finance Report Month 2 **Submitted by:** **Helen Jameson, Chief Finance Officer**	**Paper No: Attachment T** ☐ **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 2. The report has been produced in a different format to the report that Trust Board would normally receive due to the fact that NHSE extended the Business Planning process until the 20th June 2022 meaning that the this report was finalised prior to the submission of the Plan. Reporting will return to the standard format for the next meeting. The report provides the key parts of the Financial position for Month 2 along with an analysis of the run rate (M9-11 2021/22 + M1 2022/23 trend). M12 is excluded as it contains one off adjustments which would not be representative of the true trend. The Dashboard has been updated for the high-level Trust wide plan for 2022/23.	
Summary of report The Trust position at Month 2 is a £8.2mn deficit. This is £2.4m adverse to the plan at Month 2. Key points to note within the financial position are as follows: 1. NHS clinical income in month is £0.5m below trend due to a smaller block (including COVID funding) and ERF funding being allocated to the Trust. Further to this non NHS income support is no longer available to the Trust in 2022/23. This loss continues to be offset by higher Private Patient income than had been seen at the end of the last financial year. 2. Pay costs in month are £1.1m 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 costs in month are £1.8m adverse to trend. £1.2m of this is additional pass through expenditure which is offset by additional income. Additionally Clinical Supplies and Services was £0.8m higher than trend. 4. Cash held by the Trust in Month 1 has remained strong at £114m. The Trust has spent £2.7m of its capital plan, most of which is related to the CCC project. 5. The Statement of Financial Position has been updated for IFRS16 and continues to reflect an increase in non-current assets of £85m in 2022/23.	
Action required from the meeting The Trust Board is asked to discuss and note the current Financial position of the Trust at Month 2 (2022/23).	
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**	**Contribution to compliance with the Well Led criteria** ☐ **Leadership, capacity and capability** ☐ **Vision and strategy** ☐ **Culture of high quality sustainable care**

☐ 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**	**☐ 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	
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	

Finance and Workforce Performance Report Month 2 2022/23

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KEY PERFORMANCE DASHBOARD

ACTUAL FINANCIAL PERFORMANCE

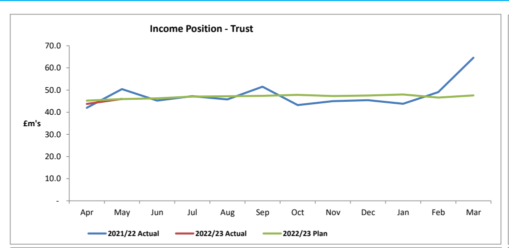
	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	£45.9m	£46.0m	green	£91.1m	£89.7m	amber
PAY	(£29.2m)	(£30.2m)	amber	(£58.6m)	(£60.0m)	amber
NON-PAY inc. owned depreciation and PDC	(£19.5m)	(£19.3m)	green	(£38.4m)	(£37.8m)	green
Surplus/Deficit excl. donated depreciation	(£2.8m)	(£3.5m)	red	(£5.8m)	(£8.2m)	red

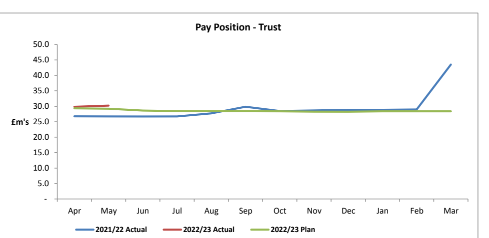
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red
YTD Plan is comprised of H1 Actual and H2 plan

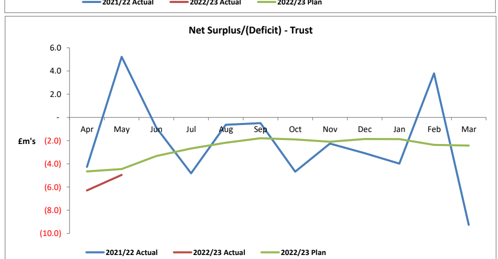
AREAS OF NOTE:

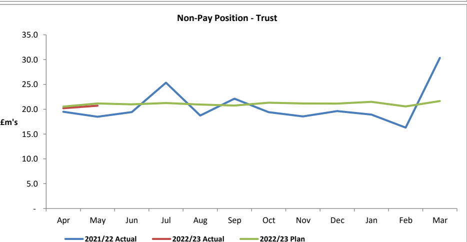
The NHS planning process was completed on the 20th June with NCL submitting a breakeven plan. This board report contains the plan that was submitted by GOSH on the 20th June. Due to the timing of the report the comparisons throughout this report have been made using trends with a summary against the plan on this page.

The Trust in month position is a £3.5m deficit and YTD it is a deficit of £8.2m, which is £2.4m adverse to plan. Income is YTD £1.4m adverse to plan due to lower then planned charitable, R&D and other non clinical income, which are partially offset in expenditure. It is expected that these will pick up in later months. Pay is £1.5m YTD adverse to plan due to Covid costs and additional costs of increasing activity and reducing the waiting lists. Non pay (including owned depreciation and PDC) is £0.5m YTD Favourable to plan largely due to payment in month of aged invoices within IPP reducing impairment of receivables partly offset by increased spend on consumables linked to increased levels of activity. In addition the Trust Better value programme is behind plan by £0.8m. This is associated with scheme lead in time taking longer than initially planned.







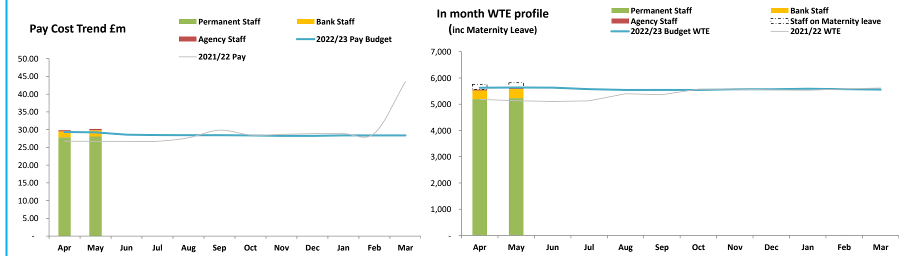


PEOPLE

	M2 Plan WTE	M2 Actual WTE	Variance
Permanent Staff	5,585.8	5,232.9	352.9
Bank Staff	50.9	345.6	(294.7)
Agency Staff	0.0	41.7	(41.6)
TOTAL	5,636.7	5,620.1	16.6

AREAS OF NOTE:

Staff usage remains high due to continued (but reducing) levels of temporary staff usage in relation to Vacancies, Covid isolation and sickness backfill with Bank and Agency. The 31st May absence rate due to Covid was 0.3% of the permanent workforce which shows a continued improvement from 0.5% on 30th April. Agency staffing levels remain consistent 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.

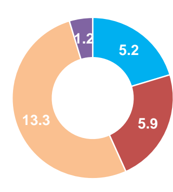


CASH, CAPITAL AND OTHER KPIs

Key metrics	Apr-22	May-22
Cash	£118.9m	£114.3m
IPP debtor days	118	109
Creditor days	32	33
NHS Debtor days	2	4
BPPC (£)	95%	92%

Capital Programme	YTD Actual M2	Full Year F'cst
Total Trust-funded	£1.3m	£15.0m
Total IFRS 16	£0.0m	£1.9m
Total Donated	£1.4m	£28.6m
Total Grant-funded	£0.0m	£0.0m
Grand Total	£2.7m	£45.5m

Net receivables breakdown (£m)



AREAS OF NOTE:

1. Cash held by the Trust decreased in month from £118.9m to £114.3m.

2. Capital expenditure for the year to date was £2.7m, aligned with the plan phasing. The Trust funded forecast outturn is as the plan.

3. IPP debtors days decreased in month from 118 to 109. Total IPP debt (net of cash deposits held) decreased in month to £13.3m (£14.3m in M1). Overdue debt also decreased in month to £14.4m (£15.1m in M01).

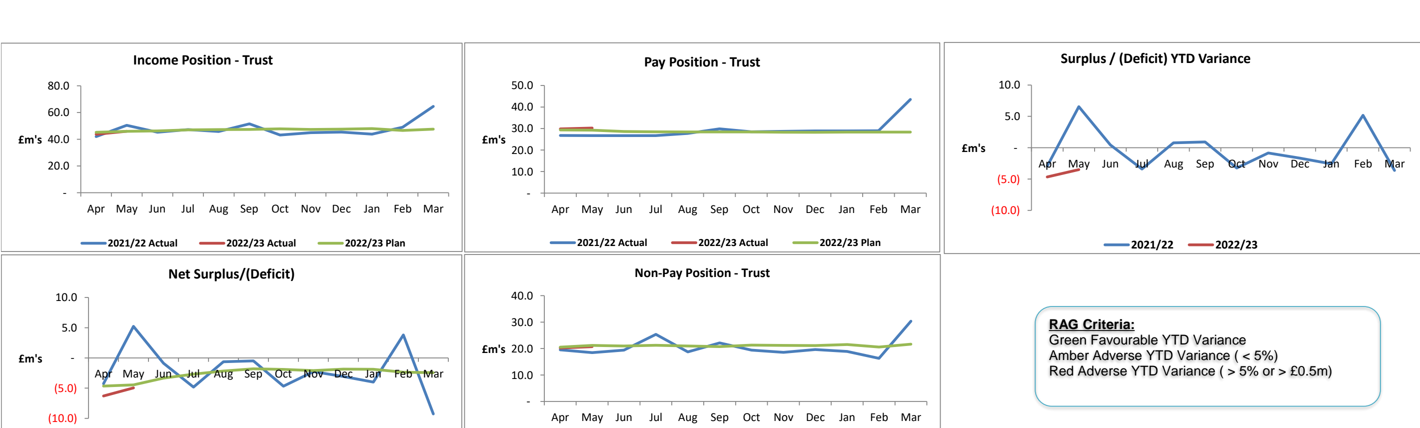
4. Creditor days increased in month from 32 to 34 days.

5. NHS debtor days increased in month from 2 to 4 days.

6. In M02, 92% of the total value of creditor invoices were settled within 30 days of receipt; this represented 83% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.

Trust Income and Expenditure Performance Summary for the 2 months ending 31 May 2022

Annual Plan (£m)	Income & Expenditure	Month 2 Plan (£m)	Month 2 Actual (£m)	Month 2 Variance (£m)	Month 2 Variance %	Year to Date Plan (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	Rating YTD Variance	Notes	2021/22 Actual M2 (£m)	2022/23 Plan YTD (£m)	2022/23 Plan In-month M2 (£m)
452.02	NHS & Other Clinical Revenue	37.50	37.91	0.41	1.08%	74.19	73.87	(0.32)	(0.43%)	A	1	43.82	74.19	37.50
46.12	Private Patient Revenue	2.89	3.14	0.25	8.75%	5.87	5.91	0.03	0.56%	G	2	1.83	5.87	2.89
65.65	Non-Clinical Revenue	5.54	4.93	(0.61)	(11.00%)	11.08	9.94	(1.14)	(10.31%)	R	3	4.76	11.08	5.54
563.78	**Total Operating Revenue**	**45.93**	**45.98**	**0.05**	**0.11%**	**91.14**	**89.72**	**(1.43)**	**(1.57%)**	R		**50.41**	**91.14**	**45.93**
(342.91)	Permanent Staff	(28.96)	(28.05)	0.91	3.13%	(58.04)	(55.90)	2.14	3.69%	G		(25.24)	(58.04)	(28.96)
(0.00)	Agency Staff	(0.00)	(0.37)	(0.37)		(0.00)	(0.71)	(0.71)		R		(0.23)	(0.00)	(0.00)
0.50	Bank Staff	(0.26)	(1.79)	(1.53)	(591.22%)	(0.51)	(3.44)	(2.92)	(569.97%)	R		(1.25)	(0.51)	(0.26)
(342.41)	**Total Employee Expenses**	**(29.22)**	**(30.22)**	**(1.00)**	**(3.42%)**	**(58.55)**	**(60.04)**	**(1.49)**	**(2.55%)**	R	4	**(26.71)**	**(58.55)**	**(29.22)**
(94.54)	Drugs and Blood	(7.95)	(8.75)	(0.80)	(10.09%)	(15.55)	(16.09)	(0.54)	(3.45%)	R		(7.72)	(15.55)	(7.95)
(41.17)	Supplies and services - clinical	(3.49)	(4.09)	(0.60)	(17.15%)	(7.10)	(7.21)	(0.11)	(1.56%)	A		(2.46)	(7.10)	(3.49)
(70.99)	Other Expenses	(6.21)	(4.75)	1.46	23.45%	(12.04)	(11.18)	0.87	7.20%	G		(5.41)	(12.04)	(6.21)
(206.71)	**Total Non-Pay Expenses**	**(17.65)**	**(17.60)**	**0.06**	**0.32%**	**(34.69)**	**(34.47)**	**0.22**	**0.63%**	G	5	**(15.59)**	**(34.69)**	**(17.65)**
(549.12)	**Total Expenses**	**(46.87)**	**(47.81)**	**(0.94)**	(2.01%)	**(93.25)**	**(94.52)**	**(1.27)**	(1.36%)	R		**(42.30)**	**(93.25)**	**(46.87)**
14.66	**EBITDA (exc Capital Donations)**	**(0.94)**	**(1.84)**	**(0.89)**	**(94.95%)**	**(2.10)**	**(4.80)**	**(2.70)**	**(128.22%)**	R		**8.12**	**(2.10)**	**(0.94)**
(25.27)	Owned depreciation, Interest and PDC	(1.84)	(1.66)	0.19	10.19%	(3.69)	(3.35)	0.33	9.05%			(1.56)	(3.69)	(1.84)
(10.60)	**Surplus/Deficit**	**(2.79)**	**(3.49)**	**(0.71)**	**(25.35%)**	**(5.79)**	**(8.15)**	**(2.36)**	**(40.83%)**			**6.55**	**(5.79)**	**(2.79)**
0.00	PY PSF post accounts reallocation	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
(21.01)	Donated depreciation	(1.66)	(1.46)	0.20		(3.31)	(3.10)	0.22				(1.33)	(3.31)	(1.66)
(31.62)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(4.45)**	**(4.96)**	**(0.51)**	**(25.35%)**	**(9.11)**	**(11.25)**	**(2.15)**	**(40.83%)**				**(9.11)**	**(4.45)**
0.00	Impairments & Unwinding Of Discount	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
29.61	Capital Donations	2.47	0.95	(1.52)		4.94	1.42	(3.51)				0.47	4.94	2.47
(2.01)	**Adjusted Net Result**	**(1.98)**	**(4.01)**	**(2.03)**	**(102.20%)**	**(4.17)**	**(9.83)**	**(5.66)**	**(135.69%)**			**5.69**	**(4.17)**	**(1.98)**



Summary

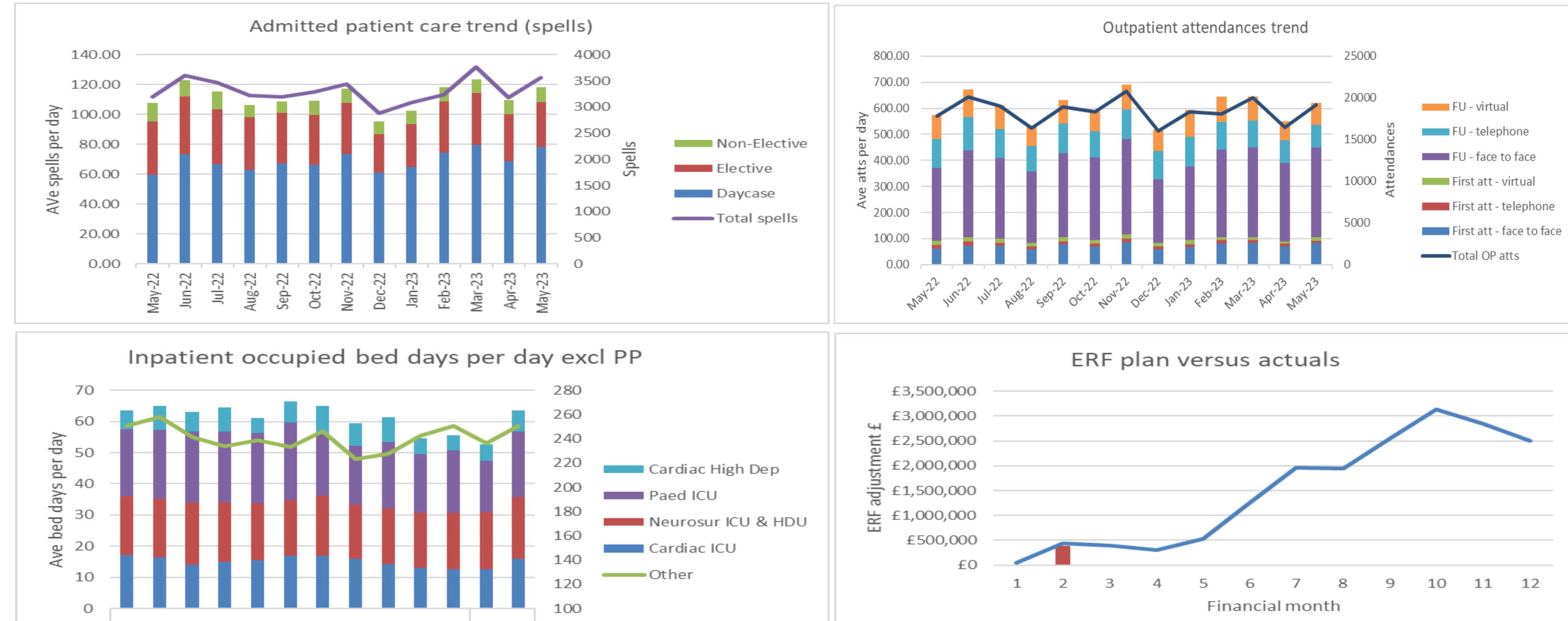
- The in month Trust financial position at Month 2 is a deficit of £3.5m.
- As at Month 2 the NHS planning process is still ongoing and so the plan has not been agreed with NHSE. As a consequence the narratives in this report compare Month 2 with trend (defined as Month 9 to 11 2021/22 + Month 1 2022/23 average). Month 9-11 is used as a recent period without year end adjustments (e.g. Pensions).
- The in month deficit is due to a combination of reduced clinical income due to changes in the national funding regime in 2022/23, increased drugs costs and higher than usual spend on clinical supplies and services.

Notes

1. NHS clinical income is £0.5m below trend due to a number of factors including system efficiency, reduced levels of funding for ERF and Covid and the loss in 2022/23 of non NHS income support.
2. In Month 2 non clinical income is £0.4m below trend driven by reduced levels of product manufacturing in GMP labs, reduced levels of HEE income, outreach clinic SLA income and CEA funding.
3. Private Patient income in month is significantly above trend and likely to be on plan when this is agreed.
4. Pay costs in month are £1.1m adverse to trend largely due to the 2% pay inflation and 1% NI increase. Additionally a number of senior vacancies have been recruited to and levels of maternity leave remain high.
5. Non pay in month is £1.8m adverse to trend. £1.2m of this is additional pass through expenditure which is offset by additional income. Clinical Supplies and Services was £0.8m higher than trend. This is driven by high spend on reagents in Pathology, Bacteriology and Main Chem Path Lab, surgical instruments in Neurosurgery, patient appliances in Orthopaedic Surgery and Craniofacial Helmeting (new service in Sight & Sound). Costs were below trend in Services from NHS organisations due to the absence of Barts MRD expenditure as NHSEI have not yet confirmed funding for this service.
6. Covid costs in month are £0.5m which is significantly lower than the last six months of 2021/22. The costs incurred by the Trust are associated with cleaning, testing and sickness cover.

2022/23 Overview of activity trends for month ending 31 May 2022

Great Ormond Street Hospital for Children NHS Foundation Trust

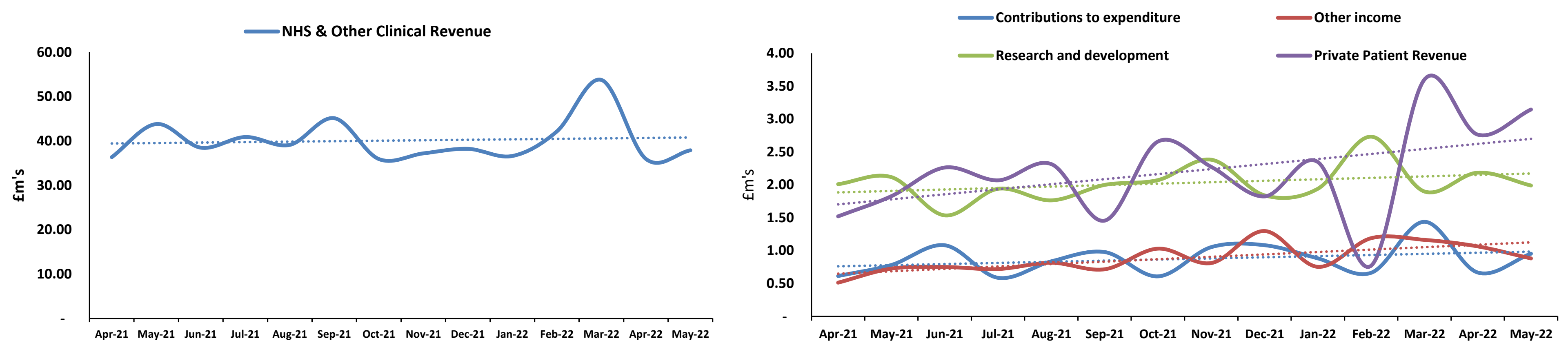


Summary

- Overall activity in May has increased per working day for all points of delivery with the exception of elective spells where there has been a decrease of 1.6 spells per day (5%). The decreased elective activity is largely a result of higher levels of bed closures and increased non-elective activity (0.97 spells per day).
- Bed days for May 2022 reflect the overall increase in activity per working day of 8% versus April across both critical care and other bed days.
- Outpatient attendances have increased 12.8% per working day overall versus April with increases across both first and follow up attendances at 18% and 1% respectively. There continues to be an increase in face to face activity however non-face to face attendances per day have increased with 191 per working day versus 179 per working day in April.
- Clinical supplies and services have increased versus April excluding pathology reagents (£2.4m to £2.9m) reflecting the increase in activity seen in May.
- The mechanism for calculating the elective recovery fund and the baseline that actual performance will be measured against remain subject to confirmation. On the basis of current information, estimated year to date May performance is £385.8k versus a plan of £436.4k, an adverse variance of £50.6k, however this may change as activity data and the basis for calculation is finalised.

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

2022/23 Income for the 2 months ending 31 May 2022



<u>**Summary**</u>

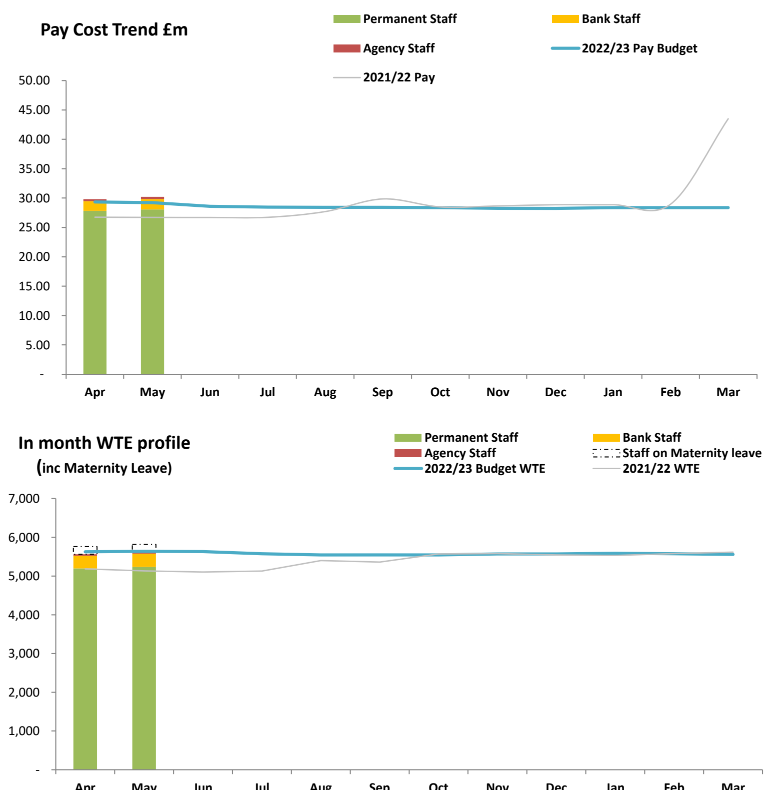
- NHS clinical income in month is £0.5m below trend (Months 9 to 11 2021/22 + Month 1 2022/23 average). This is due to significant increases to income in Month 11 for release of genetics deferral and Battens income which is offset by higher cost and volume pass through drugs in Month 2.
- In Month 2 non clinical income is £0.4m below trend driven by reduced levels of product manufacturing in GMP labs, reduced levels of HEE income, outreach clinic SLA income and CEA funding.
- Private Patient income in month is significantly above trend and likely to be on plan when this is agreed.

Workforce Summary for the 2 months ending 31 May 2022

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

£m including Perm, Bank and Agency	2021/22 actual full year			2022/23 actual			Variance			RAG
Staff Group	FY (£m)	FY Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	61.7	1,251.7	49.3	11.1	1,288.6	51.5	(0.8)	(0.3)	(0.5)	R
Consultants	63.5	396.0	160.4	11.2	399.6	167.5	(0.6)	(0.1)	(0.5)	R
Estates & Ancillary Staff	10.6	323.6	32.9	2.4	438.7	33.5	(0.7)	(0.6)	(0.0)	R
Healthcare Assist & Supp	11.3	322.5	35.2	1.9	314.4	36.3	(0.0)	0.0	(0.1)	G
Junior Doctors	31.6	385.4	82.0	5.7	385.5	88.2	(0.4)	(0.0)	(0.4)	A
Nursing Staff	93.8	1,623.3	57.8	16.0	1,632.1	58.8	(0.4)	(0.1)	(0.3)	A
Other Staff	0.8	15.3	53.9	0.2	17.0	53.0	(0.0)	(0.0)	0.0	G
Scientific Therap Tech	60.2	1,039.5	57.9	10.8	1,074.5	60.0	(0.7)	(0.3)	(0.4)	R
Total substantive and bank staff costs	**333.6**	**5,357.4**	**62.3**	**59.1**	**5,550.6**	**63.9**	**(3.5)**	**(2.0)**	**(1.5)**	R
Agency	4.2	35.8	116.0	0.7	40.2	106.4	(0.0)	(0.1)	0.1	G
Total substantive, bank and agency cost	**337.8**	**5,393.2**	**62.6**	**59.8**	**5,590.7**	**64.2**	**(3.6)**	**(2.1)**	**(1.5)**	R
Reserve*	0.5	0.2		0.2	0.0		(0.1)	(0.1)	0.0	A
Additional employer pension contribution by NHSE	13.6	0.0		0.0	0.0		2.3	0.0	2.3	G
Total pay cost	**351.8**	**5,393.4**	**65.2**	**60.0**	**5,590.7**	**64.4**	**(1.4)**	**(2.2)**	**0.8**	R
Remove maternity leave cost	(4.1)			(0.5)			(0.2)	0.0	(0.2)	A
Total excluding Maternity Costs	**347.6**	**5,393.4**	**64.5**	**59.5**	**5,590.7**	**63.9**	**(1.6)**	**(2.2)**	**0.6**	R

Plan reserve includes WTEs relating to the better value programme



Summary

- Pay costs in month are £1.1m adverse to trend (M9-11 2021/22 and M1 2022/23 average) largely due to the 2% pay inflation and 1% NI increase.
- May has seen a further reduction in the number of staff absent from the Trust due to Covid with the number falling from 0.5% on the 30th April to 0.3% on the 31st May. This shows the reduced impact that Omicron is now having on the Trust staffing levels.
- Although staff costs to cover staff absence has fallen the Trust has seen continued costs relating to reducing the waiting lists.
- The Trust continues to see high levels of maternity leave which is contributing to the higher than planned levels of temporary staffing across the Trust.
- Directors & Senior Managers staff costs are higher than trend in Month. This is largely driven by recruitment to vacancies in the North Thames Paeds Network, the Quality & Safety team and the drive expansion business case. The costs of the latter are covered by new commercial agreements.
- Both agency and bank wtes are above trend in M2 which is a concern as both are going to be formally monitored.
- When comparing year to date wte to trend the overall volume increase is 37 wte spread over a number of services, including Brain, Pharmacy and Nursing & Patient Experience and is due in part to recruitment to vacant posts. The staff groups that have seen the majority of the wte increases are Directors & Senior Managers and Scientific,Therapeutic and Technical staff.
- The price variance has remained mainly the same although M2 has increased in line with the accrual for pay inflation as expected.

Non-Pay Summary for the 2 months ending 31 May 2022

Non Pay Cost Trend £

Non Pay Actual · Non Pay Budget

Drugs & Blood · Plan

Purchase of healthcare from Non-NHS and NHS · Plan

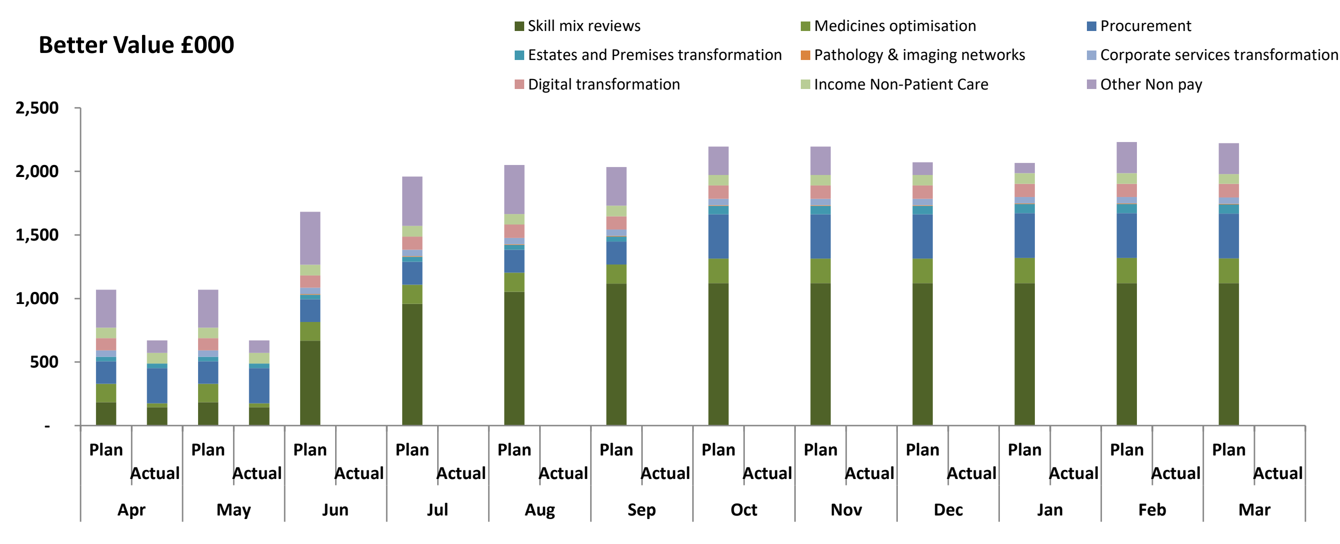
Supplies and services - general & clinical · Plan

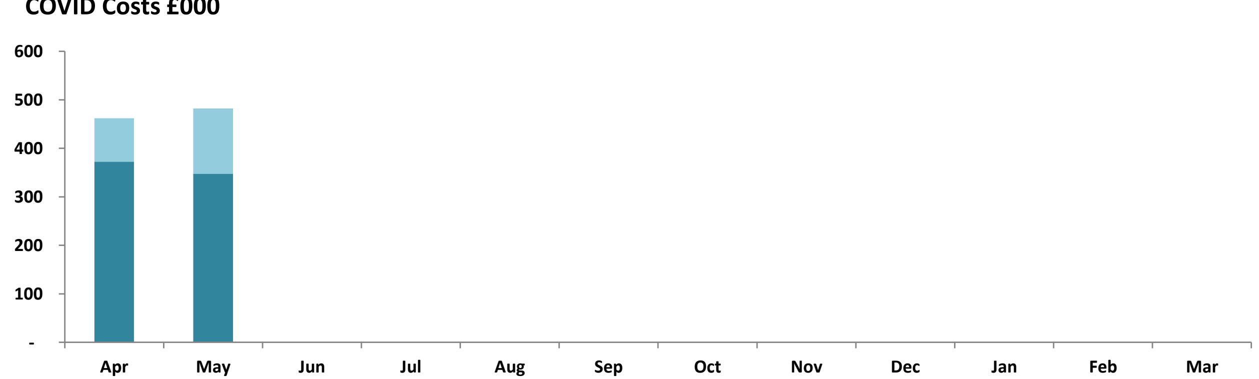
Premises costs - Business rates · Premises costs and business rates · Plan

Summary

- Non pay on Month 2 is £1.8m adverse to trend (M9 - 11 2021/22 + M1 2022/23 average).
- In month Supplies and Services - Clinical was £0.8m higher than trend. This is driven by high spend on reagents in Pathology, Bacteriology and Main Chem Path Lab, surgical instruments in Neurosurgery, patient appliances in Orthopaedic Surgery and Craniofacial Helmeting (new service in Sight & Sound).
- Premises costs are £0.2m higher than trend due to increased gas and electricity prices.
- In month Services from NHS organisations was £0.3m lower than trend largely because we are no longer accounting for any Barts MRD expenditure as NHSEI have not yet confirmed whether they will continue to fund this service.
- Pass through expenditure was higher than trend in month by £1.2m but this will be offset by additional income.
- Impairment of receivables was lower than trend due to the payment in month of aged invoices previously provided for. This offsets spend on drugs which is higher than trend.

Better Value and COVID costs for the 2 months ending 31 May 2022





Better Value and Covid-19 costs

- The Trust is currently developing it's better value programme for 2022/23 and is holding weekly Directorate / PMO meetings to finalise the schemes to be included in the programme. A tracker is under development which will record the schemes and monitor delivery against the plans. At month 2 £1.3m of the £2.1m plan has been delivered. The plan was for £0.9m of recurrent savings, which have been delivered while £0.4m of the £0.9m non recurrent savings have been delviered.

- Covid costs in month are £0.5m which is significantly lower than the last six months of 2021/22. The costs incurred by the Trust are associated with cleaning, testing and sickness cover. It is planned for all covid costs to be removed by the end of Q2 and this report will track progress with this each month.

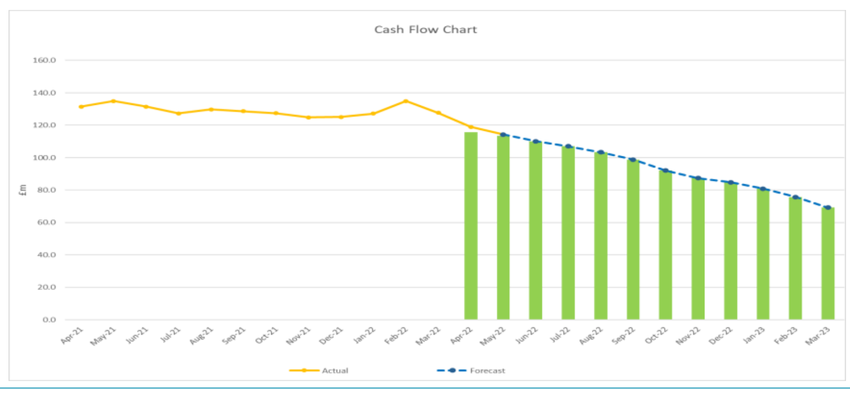
31 Mar 2022 Audited Accounts £m	Statement of Financial Position	YTD Actual 30 Apr 22 £m	*YTD Actual 31 May 22* £m	In month Movement £m
546.40	Non-Current Assets	629.16	628.65	(0.51)
62.22	Current Assets (exc Cash)	66.03	70.86	4.83
123.67	Cash & Cash Equivalents	118.92	114.31	(4.61)
(104.63)	Current Liabilities	(110.22)	(113.98)	(3.76)
(5.37)	Non-Current Liabilities	(29.87)	(29.83)	0.04
622.29	**Total Assets Employed**	**674.02**	**670.01**	**(4.01)**

31 Mar 2022 Audited Accounts £m	Capital Expenditure	YTD Actual 31 May 2022 £m	Forecast Outturn 31 Mar 2023 £m	RAG YTD variance
6.12	Redevelopment - Donated	1.19	26.36	G
1.61	Medical Equipment - Donated	0.23	2.28	G
-	ICT - Donated	0.00	0.00	G
7.73	**Total Donated**	**1.42**	**28.64**	G
0.32	**Total Grant funded**	**0.00**	**0.00**	G
12.05	Redevelopment & equipment - Trust Funded	0.16	6.88	G
1.44	Estates & Facilities - Trust Funded	0.29	3.61	G
3.17	ICT - Trust Funded	0.83	4.49	G
-	Contingency	0.00	0.00	G
(0.74)	Disposals	0.00	0.00	G
15.92	Total Trust Funded	1.28	14.98	G
0.16	**Share allocation**	**0.00**	**0.00**	G
-	**Total IFRS 16**	**0.00**	**1.87**	G
1.53	**PDC**	**0.00**	**0.00**	G
25.66	**Total Expenditure**	**2.70**	**45.49**	G

31-Mar-22	Working Capital	30-Apr-22	31-May-22	RAG	KPI
4.0	NHS Debtor Days (YTD)	2.0	4.0	G	< 30.0
131.0	IPP Debtor Days	118.0	109.0	G	< 120.0
12.0	IPP Overdue Debt (£m)	15.1	14.4	R	0.0
87.0	Inventory Days - Non Drugs	88.0	83.0	R	30.0
34.0	Creditor Days	32.0	33.0	A	< 30.0
43.0%	BPPC - NHS (YTD) (number)	73.4%	63.0%	R	> 95.0%
74.4%	BPPC - NHS (YTD) (£)	82.3%	81.1%	R	> 95.0%
83.4%	BPPC - Non-NHS (YTD) (number)	88.2%	84.1%	R	> 95.0%
92.2%	BPPC - Non-NHS (YTD) (£)	96.0%	93.6%	A	> 95.0%
81.7%	BPPC - Total (YTD) (number)	87.4%	83.4%	R	> 95.0%
90.6%	BPPC - Total (YTD) (£)	94.7%	92.2%	A	> 95.0%

RAG Criteria:
NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 95%); Amber (90-95%); Red (under 90%)
IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (over 150 days)
Inventory days: Green (under 21 days); Amber (22-30 days); Red (over 30 days)

Method	Mar-22	Apr-22	May-22
Current Ratio (Current Assets / Current Liabilities)	1.8	1.7	1.6
Quick Ratio (Current Assets - Inventories - Prepaid Expenses) / Current Liabilities)	1.7	1.6	1.5
Cash Ratio (Cash / Current Liabilities)	1.2	1.1	1.0
Liquidity days Cash / (Pay+Non pay (incl Trust funded capital))	77.5	75.6	72.1



Comments:

1. Capital expenditure for the year to date was £2.7m, aligned with the plan. The Trust funded forecast outturn is as the plan.
2. Cash held by the Trust decreased by £4.8m to £114.3m.
3. Total Assets employed at M02 decreased by £4.0m in month as a result of the following:

- Non current assets decreased by £0.5m to £628.6m. This includes £87.7m which relates to the impact on additions to Non Curren t assets for leases transferred to the Statement of Financial Position (IFRS16).
- Current assets excluding cash totalled £70.9m, increasing by £4.8m in month. This largely relates to the following: Accrued income (£3.5m higher in month); Contract receivables including IPP which have been invoiced (£1.2m higher in month); capital receivables was £0.9m higher in month and inventories (£0.5m higher in month). This is offset against the decrease in other receivables (£1.3m lower in month).
- Cash held by the Trust totalled £118.9m, decreasing in month by £4.6m.
- Current liabilities increased in month by £3.7m to £113.9m. This includes expenditure accruals (£3.1m higher in month); other payables (£0.4m higher in month) and deferred income (£0.6m higher in month). This is offset against the decrease in Capital creditors (£0.4m lower in month)

4. IPP debtors days decreased in month from 118 to 109. Total IPP debt (net of cash deposits held) decreased in month to £13.3m (£14.3m in M1). Overdue debt also decreased in month to £14.4m (£15.1m in M01).
5. In M02, 83% of the total number of creditor invoices were settled within 30 days of receipt; this represented 92% of the tota l value of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.
6. By supplier category, the cumulative BPPC for Non NHS invoices (by number) was 84% (88% in M01). This represented 94% of the total value of invoices settled within 30 days (96% in M01). The cumulative BPPC for NHS invoices (by number) was 63% (73% in M01). This represented 81% of the value of invoices settled within 30 days (82% in M02).
7. Creditor days increased in month from 32 to 34 days.

Attachment P

Trust Board 6th July 2022	
Sustainability at GOSH: Annual Sustainability report 2021/22 **Submitted by:** **Nick Martin, Head of Sustainability and Environmental Management and Francine Hill, Associate Director, Strategy, Quality and Safety for Space and Place**	**Paper No: Attachment P** **☐ For discussion**

Purpose of report

1. To present an annual report of sustainability progress across 2021/22 and highlight provisional targets for the year ahead
2. To act as a starting point for discussion around Board expectations from future annual reports
3. To highlight current challenges to delivery and next steps to addressing them

Summary of report

1. In March 2021 GOSH declared a Climate & Health Emergency and committed to two Net Zero emissions targets for 2030 and 2040. A delivery and governance structure has been put in place to help achieve this and wider benefits to GOSH. The report outlines progress during 2021/22.
2. To meet these commitments, especially the more pressing estate-based emissions by 2030 some key actions must be taken by the Trust. These include finalising our emissions baseline and conducting the analysis required to commit to effective emissions reduction pathways and to the actions they entail. The report outlines this.
3. There is currently a mismatch between what the organisation has committed to, and the progress made by the Space and Place Directorate/Sustainability Team towards achieving this. The report covers this and the necessary next steps.

Action required from the meeting

1. Comments on future annual sustainability report content/format requested
2. Comments on next steps proposed and mismatch between commitment made and progress achieved to date

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 4: Improve and speed up access to urgent care and virtual services** **☐ 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**

Strategic risk implications
Company Secretary to complete

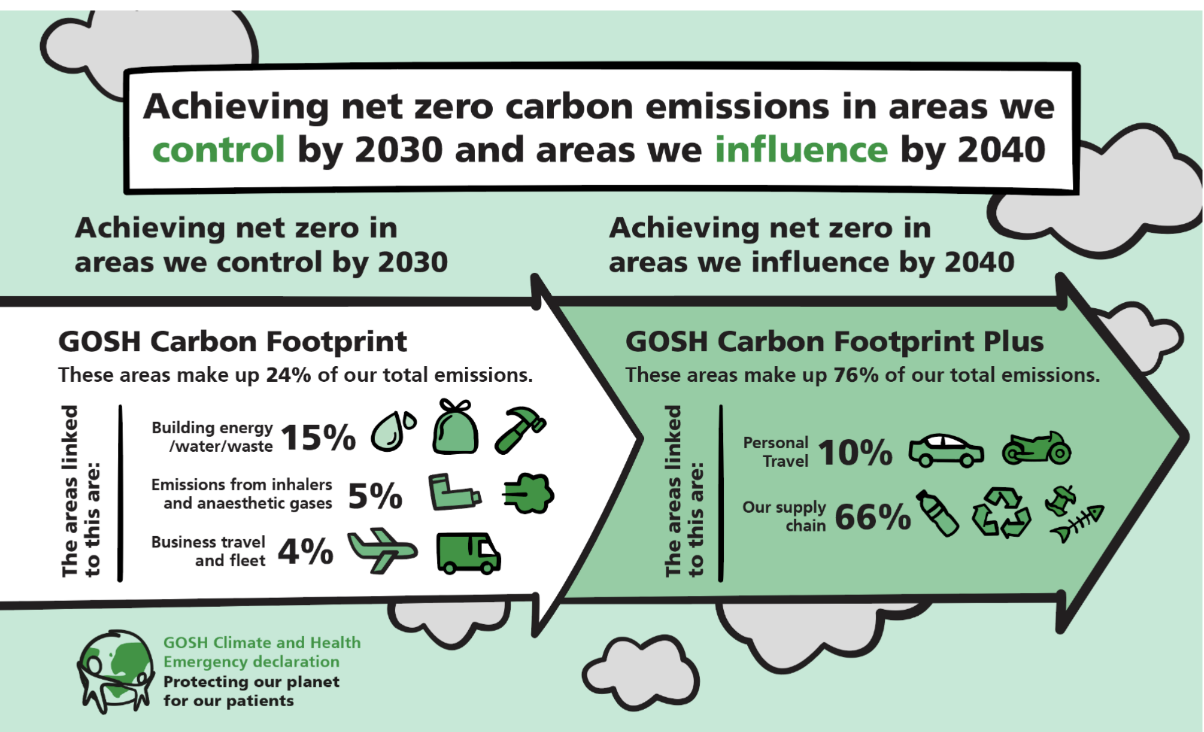
Financial implications N/A
Implications for legal/ regulatory compliance N/A
Consultation carried out with individuals/ groups/ committees The report has been to EMT. Its creation involved input from the sustainability programme of work areas
Who is responsible for implementing the proposals / project and anticipated timescales? Nick Martin, Head of Sustainability and Environmental Management and Francine Hill, Associate Director, Strategy, Quality and Safety for Space and Place
Who is accountable for the implementation of the proposal / project? Zoe Asensio-Sanchez, Director of Space and Place
Which management committee will have oversight of the matters covered in this report? Executive Management Team

Sustainability at GOSH: 2021/22

'Protecting the Planet for our patients'

Introduction

In February 2021, GOSH formally declared a Climate & Health Emergency (CHE), becoming the first London-based NHS trust and the first standalone children's hospital nationally to do so. Our declaration acknowledges our special responsibility to respond to the Climate and Health Emergency and offers a clear recognition that we are not looking after our children if we aren't protecting the planet. The declaration was accompanied by a pair of formal net zero emissions targets, as expressed below:



Emissions Targets

1. Net Zero for the emissions we control by 2030
2. Net Zero for the emissions we can influence by 2040

Wider sustainability benefits and provisional targets

A holistic approach to our Climate & Health Emergency response is required. We'll measure the progress of projects towards meeting *our Net Zero emissions targets as well as towards realising **6 further overarching benefits to the organisation.***

We have set provisional 5-year targets *(adjustment likely in line with further analysis)* for each of the 7 benefits to ensure progress is measured.

1) **Net Zero Emissions as above**
2) **Decreasing waste, consumption & pollution**
   - 5-year target waste: Increasing total waste recovery and recycling rates from 29% to 35% with Zero waste to landfill target.

- 5-year target medical gas consumption: Reducing emissions impact by 50% overall. E.g Desflurane consumption from 361ml to 0 and associated increase in IV procedures.
- 5-year target air pollution pm2.5/hr: From 9.7mg/m3 to 5 mg/m3 (WHO safe level)
- 5-year target air pollution No2/hr: From 19.67 mg/m3 to 10 mg/m3 (WHO safe level)

3) **Increase GOSH standing and influence on sustainability and Child health**
   - 5-year target media monitoring: From 5 sector/media events or articles to 50/quarter
4) **Attract funding**
   - 5-year target: Work with Charity and Trust to agree funding target
5) **Decreased hospital operating costs**
   - 2% p/a reduction
6) **Increased staff satisfaction and professional development opportunities**
   - 5-year target satisfaction survey: From 0 to 1000 staff members
   - 5-year target professional development: From 0 to 300 interventions
7) **Increased community contribution and anchor institution impact**
   - 5-year target: From 0-50 impacts p/a

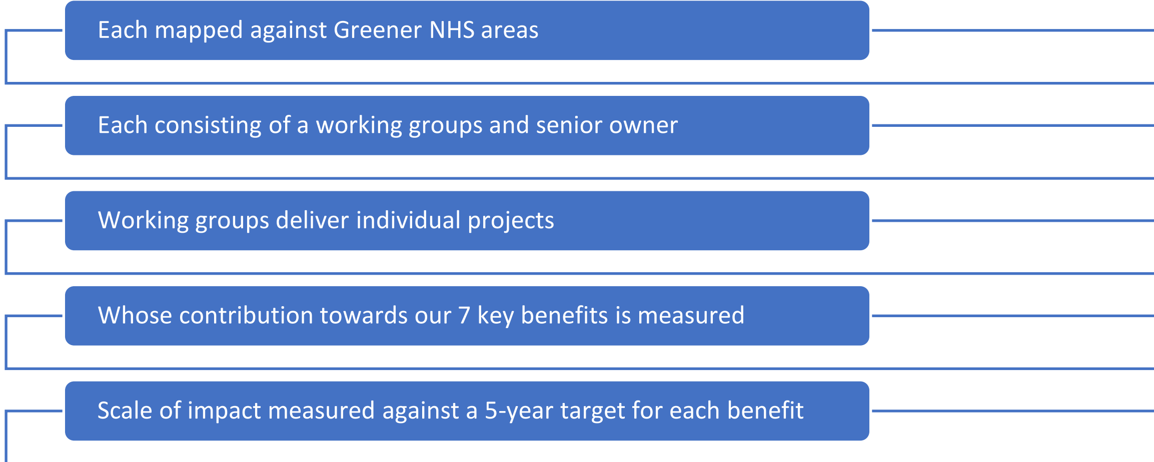
Achieving our Targets and Realising our benefits to GOSH

To help ensure that we achieve these targets we have put a series of robust, new structures into place.

- **New online platform**: For our growing Green Champions community
- **Linked into 10 Programme of Work (POW) areas** and Working Groups
- **Director level ownership**
- **Sustainability Steering Group offers guidance**
- High level **Sustainability Programme Board** support & Oversight (SPB)
- Evolving **baseline emissions** picture
- Evolving emissions and wider 'benefits' **reporting process**

A holistic response

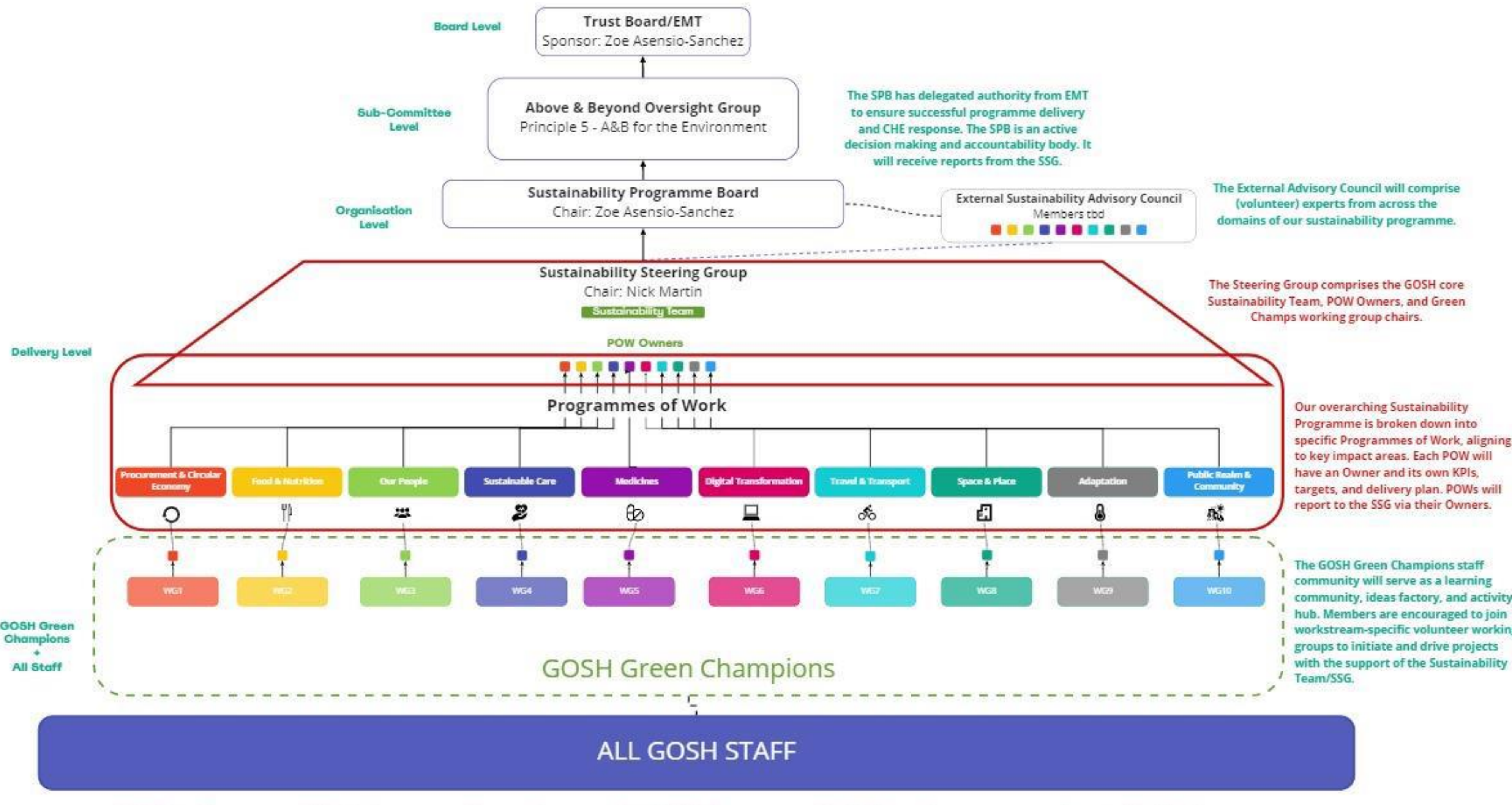
Our Climate & Health Emergency response is made up of 10 Programme of Work (POW) areas.



Sustainability Delivery and Governance structure

The above is encompassed in our new structure. The organogram below illustrates the connection between the GOSH Green Champions Staff Community and the 10 new programme of work areas. Each areas has a working groups with senior owner. These then feed into the Sustainability Steering Group, Sustainability Programme Board and wider GOSH Committees.

GOSH Sustainability



All GOSH staff have a responsibility (and an opportunity) to contribute to our Sustainability Programme and the fulfillment of our net zero commitments. We will endeavour to identify and empower Climate & Health Emergency Responders (CHERs) across the Trust, to act as ambassadors and grasp opportunities to embed sustainability within their own teams and areas of work. "Professionalising" our organisational commitment to addressing the Climate & Health Emergency should include the delivery of sustainability education and incorporation into recruitment and appraisal processes.

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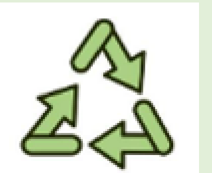
Programme of Work area progress and provisional targets

Sustainable Care



To embed net zero principles across clinical services, considering the ways in which care is delivered.

Promote lower carbon and lower waste interventions, provision of care closer to home, and changes to medical practices and material usage, PPE for example.

Target for 2022/23

- **100% removal of Desflurane and non-use policy agreed**

Achievements during 2021/22

Emissions reduction from medical gases

Across the NHS, anaesthetic gases are commonly used as a part of everyday surgery and these gases alone account for over 2% of all NHS emissions. Amongst anaesthetic gases, desflurane is one of the most common, but also one of the most harmful to the climate. A project by the Sustainable Care working group has resulted in a 98.4% reduction in use of Desflurane.

Progress within our main theatres is shown in the graph below.

Liquid Agent Volume & CO_2e

Between 1/1/2020 and 9/5/2022 by quarter

Quarter	Desflurane CO_2e	Desflurane
Q1 2020	26,082.6 kg CO_2e	7,009.38mL
Q2	6,808.72 kg CO_2e	1,829.76mL
Q3	11,332.16 kg CO_2e	3,045.38mL
Q4	9,309.67 kg CO_2e	2,501.86mL
Q1 2021	3,974.51 kg CO_2e	1,068.1mL
Q2	4,935.96 kg CO_2e	1,326.48mL
Q3	2,350.66 kg CO_2e	631.71mL
Q4	175.08 kg CO_2e	47.05mL
Q1 2022	1,343.69 kg CO_2e	361.1mL
QTD	406.31 kg CO_2e	109.19mL

0 5,000 10,000 15,000 20,000 25,000 30,000

Travel & Transport

To reduce the environmental impact of travel by people and the transport of goods and services.

Increase active and sustainable travel (business and commuting, patients and families), invest in zero-emission vehicles, engage with suppliers to reduce fleet emissions, and maximise transport efficiencies.

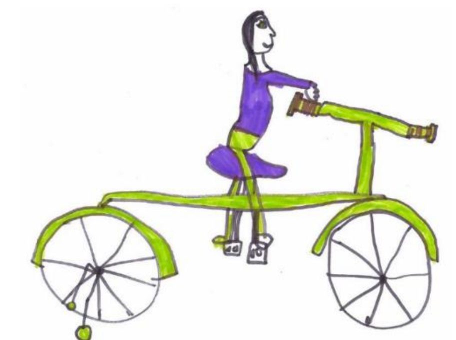
Targets for 2022/23

- **Updated Travel Plan and broad ranging targets**

- Cargo bike delivery pilot and impact analysis
- Yearly staff travel survey

Achievements during 2021/22

Ride for their lives



In October 2021, GOSH staff, together with other healthcare workers, cycled from Great Ormond Street Hospital for Children in London all the way to the Royal Hospital for Children in Glasgow to coincide with the UN Climate Change Conference (COP26). There were 70 riders overall, with 23 riding the full distance and the others joining for various stages of the journey.

Our mission was to raise awareness about the ways air pollution and climate change are causing illness and death, especially in children. We carried an open letter to world leaders, signed by organisations around the globe representing 45 million health professionals, and the World Health Organization's COP26 Special Report on Climate Change and Health. Both spelled out the many and inseparable links between climate and health and called for urgent action.

Rose and Toby from our Young Peoples Forum took part in the ride. They are passionate about making a difference and feel that, while the climate and health emergency affects us all, the impact will be particularly significant for children and young people. We have much to do to keep highlighting the ongoing challenge we face for patients and families visiting or staying in central London hospitals, and the global impact of climate change on children's health.

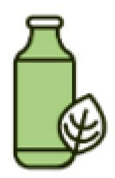
The climate crisis is absolutely a health crisis, the two are intertwined.

Toby, Vice-Chair of the Young People's Forum.

Brand new electric 'Peter Panbulances' arrive at GOSH

During the year, four new fully electric Peter Panbulances, decorated with images of Peter, Tinkerbell, Captain Hook and friends, joined the fleet transporting children and young people being treated at GOSH.

With zero tailpipe emissions and fitted with Econometers to help teams drive in a more energy-efficient way, the Panbulances form part of GOSH's drive to improve air quality around the hospital, using the Clean Air Hospital Framework, and to becoming a net zero emissions organisation by 2040.

Medicines 	To examine and seize opportunities to reduce carbon emissions and address the wider environmental and social impacts associated with prescribing and using medicines and medical products. Reduce wastage, optimise usage, consider lower impact alternatives.

Target

- **Programme of sustainable medicines projects delivered. (includes patient supply and waste)**
- **Presentation at National Conference on Sustainable Medicines**

Achievements during 2021/22

- The Medicines Sustainability pathfinder team has created a comprehensive project delivery plan covering a variety of key project areas
    - These include Purchasing reviews, inhaler education, review of supply service delivery, reuse of MDI plastic, patient surveys, blister pack recycling, reduced water contamination and changing disease profiles

Our People

To engage, educate and develop our workforce in defining and delivering carbon reduction initiatives and achieving our broader sustainability goals.

Foster an organisational culture of sustainability through working groups and committees, employee engagement, training, education and investment in staff.

Targets for 2022/23

- **10% of staff complete sustainability and climate leadership programme**
- **Sustainability apprenticeship and fellowship programmes designed**
- **10% staff signed up as Green Champions and on the MS teams community**
- **10 POW working groups meeting regular and running projects**

Achievements across 2021/22

Sustainability and Climate leadership training programme

In April and May 50 key leaders undertook the live interactive training sessions culminating in a health focussed special insight session. The programme included

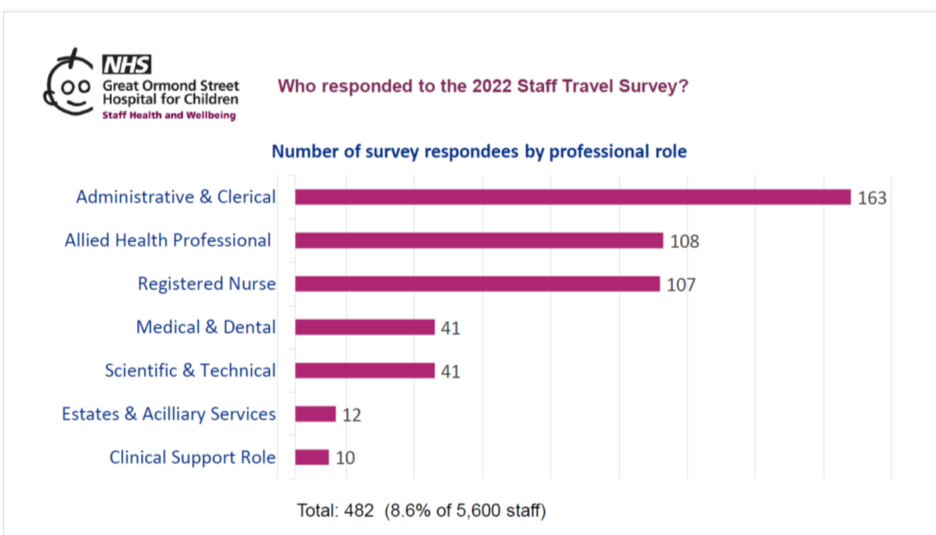
Course Content & Calendar

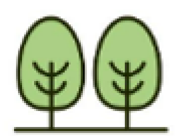
- Session 1 | Carbon, tipping points and our simplest solutions
- Session 2 | Nature, soil and the future of food
- Session 3 | Population, pollution and finding a balance
- Session 4 | How do we fix this? Making the impossible possible
- **Expert Insight Session for Great Ormond Street Hospital for Children**

These sessions will form part of a broader engagement programme that will reach 25% of staff this year.

Staff travel survey

Our new staff travel survey received 482 responses and its results are being fed into our targets for the new Trust travel plan.



Community Realm	To reach out beyond GOSH to ensure our sustainability efforts benefit, and benefit from, the communities of which we are a part.
	Develop a community engagement plan, continue liaison and partnership with local stakeholders, including neighbours and local authorities, develop a process for tracking community benefits, and deliver a transformed green and child-friendly Great Ormond Street. Key internal partners will include Space & Place and external communications.

Targets for 2022/23

- **Annual Play Street programme**
- **10% reduction in cars on Great Ormond Street through traffic calming interventions**
- **Healthy Hospital Street redesign to RIBA 2 level**
- **5% Clean air Hospital framework scoring improvement**

Achievements during 2021/22

The Clean Air Hospital Programme

In 2019, working with environmental charity Global Action Plan, we created the world's first 'Clean Air Hospital Framework' as a blueprint to help guide us and other hospitals away from polluting the local environment. The aims of the framework are to:

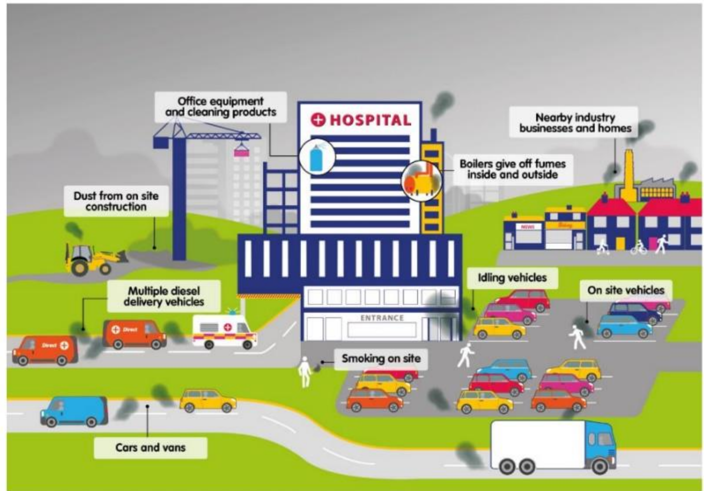


Figure 1: Sources of air pollution in and around a hospital

Figure 2: Example features of a clean air hospital

- Reduce the amount of air pollution directly created by the hospital
- Reduce the amount of air pollution staff, patients and visitors are exposed to
- Help the hospital increase its impact by mobilising others

The Clean Air Hospital Framework is now a recommended piece of evidence under the NHS Premises Assurance Model (PAM). Thirty NHS Trusts have now downloaded the framework and committed to becoming Clean Air Hospitals.

The framework includes a points system so hospitals can track the progress they are making to become Clean Air Hospitals. The actions we have taken so far include:

- Creation of a Clean Air Hospitals Framework Tool
- Development of a Clean Air Policy
- Drawing up an initial action plan for tackling air pollution from our buildings
- Beginning migration to ultra-low emission vehicles

As a result of the actions we have put in place over the last few years, GOSH has increased its outcome score from ‘Starting Out’ at 15% to ‘Getting There’ at 35% in 2022. Over the coming years, we aim to progress to ‘Good’ (50-70%) and then ‘Excellent’ (70% and above).

Parklet on Great Ormond Street:

GREAT ORMOND STREET HOSPITAL PARKLET
3D VISUAL
16.11.21

- 2 -

Great Ormond Street Transformation: Concept Design

Great Ormond Street // Existing View

Great Ormond Street // Concept View

Space and Place	To focus on our own estates, facilities, and built environment, which account for 60% of core emissions. Identify opportunities for energy and water efficiency interventions, seek to achieve 100% renewable energy purchasing, deliver a sustainable Children's Cancer Centre, and embed sustainability considerations in all design brief templates and guiding documents for capital projects.

Targets for 2022/23

- **Agree estates decarbonisation pathways**
- **Create a transition and funding strategy**
- **20% reduction in Nitrous Oxide wastage**

Achievements during 2021/22

Energy

- We switched to a Clean renewable energy tariff reducing our energy related emissions foot printing by 14%
- Energy Manager recruited
- High level energy baselining completed
- New 'total waste management' contract tendered and offered.

Nitrous Oxide (anaesthetic gas)

We have formed a working group with multiple internal partners and key external stakeholders, including BOC (our medical gas supplier) and Greener NHS representatives, to focus on nitrous dioxide usage and leakage. The initiative, which is in its early stages, covers interventions in relation to the maintenance, behaviour, and equipment replacement needed to reduce Nitrous waste and the related environmental impact.

Digital Transformation	To focus on ways to harness digital technology and systems to streamline service delivery and support efforts to track and reduce carbon emissions and the Trust's environmental impacts. Use EPIC and ERIC data to indirectly monitor carbon emissions and target interventions, expand the use of telemedicine and use digital systems to reduce paper usage and postage.

Targets for 2022/23

- **Analysis of virtual versus face-to-face appointments complete**
- **Sustainability emissions portal in place**

Achievements during 2021/22

The impact of COVID-19 on outpatient appointments and sustainability

There have been a number of challenges faced by staff and patients and their families during the pandemic. These have forced us to work differently to ensure we have been able to care for as many children and young people as possible.

Between May 2019 and March 2022 (inclusive), there have been:

126,970

virtual outpatient appointments

Adding up all the outpatient virtual appointment return journeys gives a total of:

9,701,432

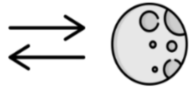
patient journey **miles not travelled**

That's the equivalent number of miles to go:

390

times around the **Earth**!
(around the equator)

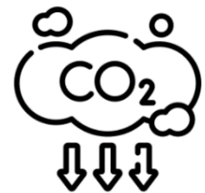
Or



20

times to the
moon and back!

Using typical travel methods via road and rail, these journeys would have produced:



2,979,954

kg of carbon dioxide
equivalent in emissions

That's 2,980 metric tons of CO_2 equivalent we avoided being emitted into our atmosphere to heat up the planet! This is the equivalent in mass to:

Food and Nutrition	To consider ways to reduce the impact, including carbon emissions, of the food that is procured, prepared, processed and served at GOSH. Reduce overall food waste and ensuring provision of healthier, locally sourced and seasonal menus high in fruits and vegetables. Opportunities exist to reach out to improve community access to healthy food, as well as local growing.

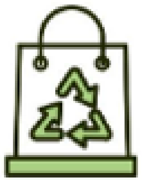
Targets for 2022/23

- **Adopt the Global Green & Healthy Hospital's Cool Food Pledge**
- **Remove all plastic bottles from Lagoon**
- **15% reduction in food waste**
- **Kitchen equipment inventory and energy audit**

Achievements during 2021/22

- Working group in place

Procurement & Circular Economy:	To consider GOSH's purchase of goods and services and find ways to use buying decisions and supplier engagement to reduce our climate footprint. Promoting sustainability more broadly in line with the goals and procurement best practice shared by NHSE/I.



Advance the circular economy and promote waste hierarchy principles to improve resource efficiency.

Targets for 2022/23

- **Procurement team delivering the Greener NHS Net Zero Supplier Roadmap**
- **Supplier engagement programme created and implemented across Trust**
- **Complete a catering procurement analysis**
- **Comparison of emissions analysis between current Trust procurement spend and via a life cycle assessment approach**

Adaption

This workstream is concerned with plans to mitigate the effects of climate change and extreme weather on GOSH's functioning.

Commit to planning and projects to mitigate the impact of heatwaves on Trust infrastructure, patients, and staff. This workstream is to ensure GOSH is a "future fit" organisation that is adaptable and resilient to the effects of climate change.

Target for 2022/23

- **Trust Climate & Health Emergency Adaptation plan complete**
- **Risk register and related policies formally updated in line with adaptation plan**

Key next steps: Gaining clarity on our pathways to Net Zero.

1) Finalise our baseline emissions footprints relating to both our 2030 and 2040 targets
2) Our Net Zero emissions target for 2030 includes estate emissions under our direct control.
To meet this, it is necessary to understand in more detail the emissions reduction pathways available to us and what following them entails for GOSH.

Establishing our Pathway to 2030
An assessment of the interventions required to reduce emissions across the estate will provide GOSH leadership and key teams with the insights needed to prepare for the transition. Therefore, creating a *2030 Estate Emissions Transition and funding strategy* is necessary to guide us through the transition process.

Gaining the insight required to build this strategy will involve an initial piece of work to assess the current and required position of the estate in terms of emissions. It will involve exploratory surveys of mechanical plant for heating, cooling and ventilation. Assessments of energy monitoring/controls systems and the site wide Building Management System as well as understanding links into cyclical maintenance, refurbishment and new build.

This decade is expected to be unprecedented in human history and widely accepted by global governments (including the UK) as key to meeting their binding national targets and to mitigating wider societal & economic challenges/collapses. This strategy will prepare GOSH for this challenge.

Considerations

This analysis of our current position will be comprised of a package of interventions that will supply us with the insight, data and holistic view of the journey ahead. Various pathway options will result, each involving different interventions at points across the decade. However, the end goal in 2030 remains the same. A net zero estate where our GHG emissions are hugely reduced and any remaining are balanced out by an equal amount of removals. The results gained from deploying this package of interventions will inform the *2030 Estate Emissions Transition and funding strategy*. This will inform our upcoming Estates Strategy and Master Planning process.

Trust Board
6th July 2022

GOSH 2022/23 Budget Setting Update **Submitted by:** **Helen Jameson, Chief Finance Officer**	**Paper No: Attachment Q**

The 2022/23 NHS planning round has required plans to be submitted at a system level. Therefore, the GOSH plan formed part of the NCL ICS submission. After the original system submissions (April 2022) the process was extended, and additional national guidance issued. The GOSH plan has been updated in line with these and the updated assumptions the system is working to. The final system submission was made on 20th June 2022.

This paper provides an overview of the GOSH financial plan that made up part of the ICS submission. The key points to note are:

1. The Trust has been working with NCL to submit a plan that ensures that the NCL ICS plan is breakeven in line with NHS planning guidance. The GOSH plan within this submission is a £10.6m deficit.
2. Finance, activity and workforce assumptions were triangulated as part of the process to develop the plan. Where the activity plan exceeds the Elective Recovery Fund target additional income has been assumed in the plan
3. NHS contracts are still under negotiations with ICSs outside of NCL.
4. The Better Value programme for 2022/23 is for £22.9m, the Trust has identified schemes for £16.2m and is working on identifying the remaining £6.7m.
5. The Trust CDEL for 2022/23 is £15.0m, the Trust also has additional planned CDEL of £1.9m under IFRS 16 which would have been leases under IAS17.
6. The donated asset expenditure for 2022/23 is £29.6m and includes expenditure on medical equipment and the Children's Cancer Centre.
7. The Trusts Cash and cash equivalents at the start of 2022/23 are £126.2m, this falls to £69.2m by the end of the financial year. Recognising this drop more detailed analysis on cash flow will be added to the monthly finance report.

Action required by the meeting
Following the review of the plan by the Finance and Investment Committee the Trust Board are asked to approve the Trusts 2022/23 financial plan which forms part of the wider NCL ICS plan.

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

Financial implications
The plan for 2022/23, better value savings requirement and the cash required to proceed with CCC.

Legal issues
N/A

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

GOSH ANNUAL PLAN
Financial Planning
2022/23

Financial Planning

2021/22 saw pressure on the NHS due to Covid-19 and 2022/23 will see an improvement with the lifting of Covid-19 restrictions and the subsequent reduction in costs previously incurred by the Trust. In contrast the Trust is expected to increase activity above pre Covid-19 levels in order to reduce waiting lists that have increased throughout the pandemic. This means that GOSH will not only need to reverse changes it put into place to respond to Covid-19 but also make additional changes to deliver additional activity and reduce patient waiting lists.

The trust has received NHSE guidance on the new funding arrangements for 2022/23, these NHSE and NCL contracts have resulted in a fall from the 2021/22 levels of income despite the increased levels of activity expected from the Trust. The contracts contain the ability to earn additional income at marginal rates for overachieving the increased activity plans.

Due to the pressures facing both GOSH and the wider NHS the planning process was extended from the end of March to the 20th June. This extension was put in place to allow the NHS ICSs to develop balanced plans. As part of this process GOSH has worked to minimise its deficit and proposes a £10.6m deficit plan to the Board for approval.

In setting a Trust wide financial plan there were a number of assumptions that the Trust worked to and these have been updated as guidance has been released, these are:

- The Trust should have an approved business plan and budget for 2022/23
- The plan will need to be signed off by the Trust Board
- The Trust plan will need to triangulate with NCL ICS
- The financial, workforce and activity plans will need to triangulate
- The Trust will need to minimise any deficit
- The Trust will need to demonstrate financial controls
- NHS Income will align with NHSE/I and the NCL ICS allocations
- The 2021/22 Trust annual budgets from September 2021 will be used a base line for the 2022/23 plan (£8.0m deficit)
- Inflation to be applied is pay 2.0% plus NI increase, Drugs 4.1% and non-pay 2.0%.
- Contracts with above included inflation to be detailed (e.g. Energy).
- The Trust will identify a better value savings programme (this has been finalised at £22.9m).

Approach to Financial Planning

Budget Setting overview

In order to set the budgets for the Trust in 2022/23 the 2021/22 budgets were used as a baseline. This was done to take advantage of the fact that the budgets had been updated to reflect H2 and by using them the Trust could take account of all the handwork put in across the directorate to set the 2021/22 plan. Higher level assumptions were then applied (e.g. inflation). The Directorates have then worked to refine their budgets inline with the activity plans that they have pulled together following NHS guidance. The private patient income has been reviewed in line with it’s recovery plan through reviewing patient referrals and the

reduction of Covid-19 restrictions. NHS income has been reviewed in line with national guidance, NHSE and NCL ICS. In addition, a Better Value has been developed to deliver the efficiencies required by the Trust in order to cover financial pressures such as inflation.

Profiling

The Trust has profiled the 2022/23 plan in order to take account of the Better Value programme, activity related income and the private patient recovery plan. The profiling includes:

- Profiling of NHS activity
- Private patient recovery plan phasing to align with reduced Covid-19 measures, increased referrals bed availability.
- Directorate plan alignment in line with expectations relating to recruitment, activity and turnover.
- Business Cases and Pay / Non-Pay etc. have been reviewed and phased according to updated local modelling.
- The Better Value programme has been phased to align to the expected commencement of the programmes and the expected monthly savings from each scheme.

Summary Financial Statements 2022/23

The statements below outline the 2021/22 outturn and the 2022/23 directorate bottom-up plans required to be submitted to NHSE on 20th June 2022.

The proposed plan is a £10.6m deficit and includes the impact of IFRS16 in 2022/23 (£0.9m), with the expectation that NHSE will cover these costs.

It is important to note that this year the Trust 2022/23 plan submission needs to align with the plan submitted by the NCL ICS, the Trust has been working closely with NCL to ensure that areas that need consistency across the ICS are agreed and the system understands the movement in the plans.

Statement of Comprehensive Income

	2021/22 Outturn £m	2022/23 Plan £m
NHS Clinical Revenue	464.2	447.1
Non-NHS Clinical Revenue	35.0	51.1
Non-Clinical Revenue	60.6	65.6
Total income	**559.8**	**563.8**
Pay Expenses	(338.2)	(342.3)
Non Pay Expenses	(206.8)	(206.8)
Total Expenditure	**(545.0)**	**(549.1)**
EBITDA	**14.8**	**14.7**
Owned depreciation, Interest, Tax	(19.2)	(25.3)
Surplus/Deficit exc Donations	**(4.4)**	**(10.6)**
Donated Depreciation	(16.7)	(21.0)
Net (Deficit)/surplus exc Cap Don	**(21.1)**	**(31.6)**
Capital Donations	8.1	29.6
Impairment	(4.3)	-
Total Deficit	**(17.3)**	**(2.0)**

Statement of Financial Position

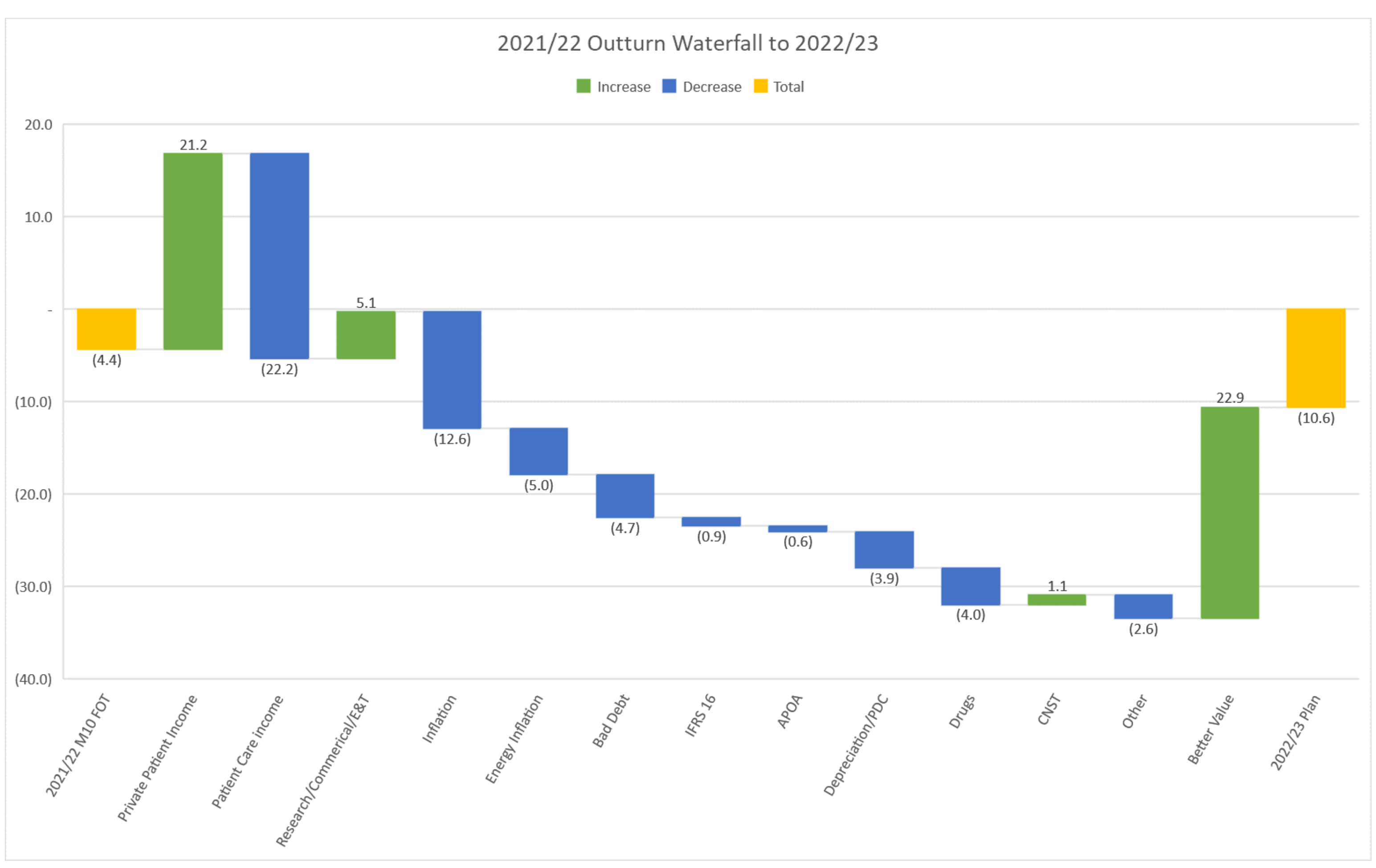
	2021/22 FOT £m	2022/23 Plan £m
Non-Current Assets	546.4	637.7
Inventory	11.7	11.9
Debtors	50.5	68.7
Cash	123.7	69.2
Creditors	(104.6)	(81.4)
Provisions and Non-Current Liabilities	(5.4)	(28.3)
Total Assets Employed	622.3	677.8
PDC Reserve	133.5	133.5
I&E Reserve	345.2	400.7
Financial Assets at FV through OCI reserve	(0.0)	(0.0)
Revaluation Reserve	143.6	143.6
Total Taxpayers' Equity	622.3	677.8

Statement of Cash Flows

	2021/22 FOT £m	2022/23 Plan £m
<u>**Cash flows from operating activities**</u>		
Operating (deficit)/surplus - excluding charitable contributions	(11.7)	(24.7)
Impairment and reversals	(6.2)	0.0
Charitable capital expenditure contributions	8.0	29.6
Operating (deficit)/surplus	(9.9)	4.9
<u>**Non-cash income and expense**</u>		
Depreciation and amortisation	28.3	39.4
Impairments and Reversals	6.2	0.0
Gain on disposal	0.0	0.0
(Increase)/decrease in trade and other receivables	4.5	(17.8)
(Increase)/decrease in inventories	0.0	(0.2)
Increase/(decrease) in trade and other payables	(3.6)	(24.6)
Increase/(decrease) in other current liabilities	1.3	(0.8)
Increase/(decrease) in provisions	(0.7)	(0.1)
Net Cash inflow/(outflow) from operating activities	**36.0**	**(4.1)**
<u>**Cash flows from investing activities**</u>		
Interest received	0.1	0.2
Purchase of property, plant and equipment and intangibles	(24.1)	(45.7)
Net cash used in investing activities	**(24.0)**	**(45.5)**
<u>**Cash flows from financing activities**</u>		
Public Dividend Capital received	1.5	0.0
PDC Dividend paid	(6.1)	(6.8)
Interest element of lease payments	0.0	(0.3)
Capital element of lease payments	0.0	(2.6)
Net cash outflows from financing activities	**(4.6)**	**(9.8)**
Increase/decrease in cash and cash equivalents	**(2.7)**	**(54.6)**
Cash and cash equivalents at period start	126.2	123.7
Cash and cash equivalents at period end	**123.7**	**69.2**

Bridging/Planning Assumptions

Due to the drive to reduce waiting lists, Inflation and the changes to NHS clinical income the 2022/23 plan is for a deficit that is higher than the 2021/22 deficit. The bridge below shows the key movements that are included in the plan and show the deterioration in the Trusts financial position.



The key movements in the waterfall are summarised below.

Heading	Actual	Notes
2021/22 M10 FOT	(£4.4m)	This is the outturn for 2021/22
Private patients	£21.2m	Increase in Private patient income. This only represents a partial recovery on pre Covid -19 levels.
Patient Care income	(£22.2m)	Loss of NHS patient care income including lost non NHS top up, ERF, MFF and reductions in Tariffs
Research/Commercial/E&T	£5.1m	Increased income from Non clinical activities
Inflation	(£12.6m)	Impact of inflationary increases in pay, Drugs and non-pay including above inflation contract increases
Energy Inflation	(£5.0m)	Impact of high levels of inflation for both Gas and Electricity
Bad debt	(£4.7m)	With the increase in Private patient activity and the debt paid in 2021/22 the 2022/23 moves back to breakeven in year.
IFRS 16 impact	(£0.9m)	Impact to the Trust of implementing IFRS 16
APOA	(£0.6m)	2022/23 impact of the APOA business case
Depreciation/PDC	(£3.9m)	Increase in depreciation and PDC (excluding impact of IFRS16).
Drugs	(£4.0m)	Increase in Drug costs to deliver the activity plans.
CNST	£1.1m	Increase in Drug costs to deliver the activity plans.
Other	(£2.6m)	Increase in costs to deliver Activity plans.
Better Value Programme	£22.9m	Trust better value programme that was calculated at a 4.9% saving
2022/23 Plan	(£10.6m)	

NHS Income

The 2022/23 plan for NHS income reflects the latest funding guidance and however it should be noted that negotiations are ongoing with out of area commissioners to reach agreement on certain elements of the contract. Negotiations are continuing with support from the local system to ensure that funding in line with national guidance is paid.

The current contracts that have been negotiated see a significant reduction in the income from 2021/22. This includes income associated with ERF as per the contract of delivering 104% value weighted activity. The plan assumes that the Trust will deliver above this level of activity and therefore will receive additional ERF. It should be noted however that the new ERF

payments include marginal rates so underperformance will still receive 25% of the payment and overperformance will only attract 75%.

Better Value 2022/23 (£22.9m)

The Better Value programme is a significant contributor to the Trust's overall financial plans and recovery. It focuses on actions to reduce waste, improve productivity and efficiency, and make best use of our money to maximise the amount available to fund our key priorities and services.

The Trust has made substantial progress in identifying a significant Better Value programme since the last report to the FIC, with schemes amounting to £16.2m having been identified to-date, and work continuing to confirm further actions to bridge the remaining £6.7m gap to meet the target in full. The programme is formed of a combination of local "business as usual" cost improvement schemes plus larger cross-cutting pan-Trust schemes covering areas such as procurement, pharmacy, workforce, benefits from vacating leasehold office space, etc.

Governance

The last report to FIC described revised mechanisms to oversee the scoping and delivery of the Better Value programme for the coming year, and these have been further refined in the context of the Trust's overall Recovery Programme. We have now embedded:

- weekly challenge meetings with directorates focused on Better Value scoping and delivery;
- a fortnightly COO/CFO chaired Better Value Delivery Group coordinating in year delivery of schemes and identification of future schemes, paying particular attention to larger cross-cutting schemes and oversight of the communications approach to support the programme;
- a fortnightly CEO chaired Recovery Board overseeing the broader recovery programme to ensure the Trust run rate returns to breakeven over the next 24 months.

For each project to proceed they will require an equality and quality impact assessment to be approved by the Medical Director and Chief Nurse, to ensure the scheme will not impacting negatively on equality, quality or patient safety. Detailed reporting will be received by Quality, Safety and Experience Assurance Committee (QSEAC) on this process.

At high level, the plan is currently constructed as follows:

"Local BAU" savings identified by directorates and incorporated (or ready for incorporation) into their budget files	£7.8m
Identified workforce proposals against the additional challenge target, which are ready for incorporation into budget files	£3.2m
Cross cutting procurement programme identified schemes being actively pursued by our procurement partners, Smart Together	£1.5m
Drugs savings and price reduction programme	£1.5m
Other smaller cross-cutting schemes ready for sign off	£0.4m
Further local schemes currently being worked up by directorates for inclusion in the programme	£1.8m

Key themes and schemes
The programme spans a broad range of opportunities as previously outlined to the FIC, including:

Procurement and non-pay savings including cross-cutting work with the Smart Together team, and local actions in directorates, such as reviews of maintenance and service contracts, savings from our new Patient Transport Service provider and reductions of laboratory consumables within the Genetics service	£3.2m
Savings from service redesign including the Centralised Booking Office and a review of renal DSA send-away blood tests	£0.3m
Savings related to built assets, including benefits from moves out of leased accommodation and from enhanced use of combined heat and power units	£2.2m
Workforce savings including skill mix review, addressing over payments, correction of consultant on call supplements, removal of posts through the additional challenge process, holding of some vacancies	£5.1m
Clinical and corporate support savings including IMT benefits (including review of software contracts post-EPR implementation), drugs savings programme, electronic communication with GPs, reduced costs associated with the Well-Led review	£3.1m
Income schemes that meet the criteria for inclusion in the programme, including contributions from genetics, innovation as well as from outreach clinics agreed and signed off by the relevant commissioners	£2.3m

Directorates have been required to identify as many recurrent schemes as possible in the programme, in recognition of the fact that short term non-recurrent savings have the potential of making the financial and recovery challenge even tougher in future years. The Better Value programme currently has £16.3m of identified schemes with a gap of £6.7m, this gap is made up of unidentified schemes and areas of identified opportunity which are being worked up into identified schemes. Weekly challenge meetings and the Better Value Delivery Group will be working with directorates to consider over the Summer whether the non-recurrent schemes could be made recurrent and, where it is agreed this is not possible,

what other actions can be taken to maintain the same value of ongoing savings for the remainder to ensure that this risk is mitigated. For future years

Capital Plan

The Trust has completed a five-year capital plan on a scheme-by-scheme basis, with the first year's expenditure profile shown monthly in the submission. Capital expenditure is funded from a combination of Trust funds and charity funds, almost exclusively donated by the Great Ormond Street Hospitals Children's Charity (GOSHCC). Charity funding assumed in this plan has been allocated based on GOSHCC Grants Committee approvals of business cases and specific known schemes.

The budget for Trust-funded capital expenditure is based upon the level of forecast depreciation for the year and in accordance with the CDEL allocation by NCL ICS. NCL ICS has now advised the Trust of the CDEL funding limit to be used in the draft Operating Plan for years 2022/23, 2023/24 and 2024/25. However, in accordance with the ICS instructions, the Trust has treated these limits as placeholders until the national and regional allocations are complete and the allocations are confirmed. As previously assumed, the CDEL for 2022/23 is £15.0m; in addition to this, the Trust has planned for £1.9m of expenditure under IFRS 16 in respect of right of use leases signed in the year which would have been operating leases under IAS 17.. In each of 2023/24 and 2024/25, the notified provisional limits are £35.2m.

In each of 2023/24 and 2024/25, the Trust will be contributing £10m to the cost of the Children's Cancer Centre development, which is the major redevelopment project over the five years of the plan. While the remainder of the development cost will be paid for from donations from the GOSH Children's Charity, the substantial Trust contribution requires the Trust to conserve cash and therefore carefully prioritise expenditure on other proposals.

From 1 April 2022 new leases will count against CDEL and these are expected to be an allowable exclusion from CDEL where they were previously categorised as an operating lease under IAS17 (£1.9m). No change to the £15m CDEL allocation for 2022/23 is expected, but if the confirmed amount is less, the Trust would have to review its plan and remove or reschedule capital expenditure proposals based on a relative risk assessment.

The Trust's assumed CDELs and IFRS16 spend for 2022/23 to 2026/27 are shown below:

	2022/23	2023/24	2024/25	2025/26	2026/27
	£m	£m	£m	£m	£m
CDEL excluding IFRS 16 impact	15.0	35.2	35.2	27.5	16.7
IFRS 16 impact assumption notified	1.9	0.3	0.5	12.1	0.6
Total CDEL	16.9	35.5	35.7	39.6	17.3

Trust Funded Schemes (£16.9m)

Schemes proposed for 2022/23 have been reviewed and prioritised within the assumed Trust funding envelope of £15.0m plus £1.9m in relation to IFRS 16. All proposals were assessed to determine the risks requiring the scheme to be undertaken and the degree to which completion of the scheme would mitigate those risks. Where proposed schemes could not be accommodated within the available funding the residual risks were assessed to determine whether they were at an

acceptable level. Only schemes which are already contractually committed or in the top priority group could be included in the plan, due to affordability, and some of the latter have been re-phased partially or completely into 2023/24 or beyond. The following allocations have been agreed:

- Schemes already approved in prior years (£2.0m)
- New schemes in the top priority group (£12.6m)
- Contribution to Children's Cancer Centre design (£0.5m)
- IFRS16 leases (£1.9m) – this only relates to right of use leases which would have been operating, rather than finance leases under IAS 17.

Donated funding (£29.6m)

The GOSH Children's Charity is the source of donated funding. The decision to grant donated funding to capital schemes is made by the Charity Grants Committee in response to requests from the Trust. These grants may cover a single purchase or extend over multiple years in the case of larger projects.

Projects funded by the GOSHCC for 2022/23 are estimated at £29.6m and currently fall into the following groups:

- The Children's Cancer Centre and enabling works to other buildings to accommodate decanted services.
- Medical equipment. The timing of expenditure in each year will be determined by the Trust's Equipment Replacement Plan which continues to be developed.

The draft plan is presented in the table below:

Funding	Area	2022/23	2023/24	2024/25	2025/26	2026/27
		£m	£m	£m	£m	£m
Trust	Equipment	5.3	5.2	8.0	7.3	2.5
	Estates	3.6	11.6	13.1	3.4	8.6
	ICT	4.5	6.2	3.9	5.0	5.6
	Redevelopment including CCC	1.6	12.1	10.1	11.7	0.0
	Share allocation	0.0	0.1	0.1	0.1	0.0
Trust Total		15.0	35.2	35.2	27.5	16.7
IFRS 16	IFRS 16	1.9	0.3	0.5	12.1	0.6
Donated	Equipment	3.2	2.3	2.3	2.3	2.3
	Redevelopment	26.4	23.3	79.8	78.6	36.3
Donated Total		29.6	25.6	82.1	80.9	38.6
Grand Total		46.5	61.1	117.8	120.5	55.9

<table>
<tr><td colspan="2">Trust Board
6th July 2022</td></tr>
<tr><td>2021-22 National Cost Collection (PLICS submission)

Submitted by: Helen Jameson, Chief Finance Office</td><td>Paper No: Attachment R

☐ For approval
☐ For discussion</td></tr>
<tr><td colspan="2">Purpose of report
To provide an overview of the mandatory 2021/22 national cost collection</td></tr>
<tr><td colspan="2">Summary of report
1. This paper provides the pre-submission report mandated by the national guidance. The national cost collection is being prepared in line with national guidance for submission on week commencing 8th Aug 2022. A final submission report should also be presented to Board however as there will be no Board it is proposed in line with the recommendation by FIC that the final sign-off is by EMT. Also it is proposed the final report should be presented to the FIC in autumn.
2. The quantum of costs based on the audited accounts is showing an increase of £7.9m (2%) when compared to the 2020-21 submission, largely due to increased staff costs, offset by the transfer of the cost of the CATS services to an exclusion from the cost collection.
3. Ongoing refinement of the model and validation of the model will continue to ensure the accuracy of the costing data including comparison to other specialist paediatric providers (e.g., Alder Hey Children’s Hospital).</td></tr>
<tr><td colspan="2">Action required from the meeting
The Board are requested to approve delegation (as recommended by FIC) of the responsibility for approving of the final national cost collection submission to be submitted in the week beginning 8th August 2022 to EMT.</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
☐ Responsibilities, roles and accountability
☐ Accurate data/ information</td></tr>
<tr><td colspan="2">Strategic risk implications
BAF Risk 1: Financial Sustainability</td></tr>
<tr><td colspan="2">Financial implications
Not applicable</td></tr>
<tr><td colspan="2">Implications for legal/ regulatory compliance
The national cost collection is a requirement of the Trust’s license</td></tr>
<tr><td colspan="2">Consultation carried out with individuals/ groups/ committees
EMT</td></tr>
</table>

Who is responsible for implementing the proposals / project and anticipated timescales? Chief Finance Officer
Who is accountable for the implementation of the proposal / project? Chief Finance Officer
Which management committee will have oversight of the matters covered in this report? Finance and investment committee

2021-22 National Cost Collection Submission

1. Executive Summary

Nationally all Trusts are mandated to report the annual National cost collection and GOSH has been allocated week beginning 8th August for submission. This is in line with submission timescales for the 2018/19 collection but is earlier than 2019/20 and 2020/21 as these were delayed owing to the impact of Covid.

This paper outlines the 2021-22 National cost collection, consisting of Patient Level costing collection (PLICS and Reference Costs) prepared in accordance with the NHSI Approved Costing Guidance.

This paper is being presented to meet the national cost collection guidance that stipulates a pre-submission report should be presented to the Board providing assurance on the costing process as detailed below. A final submission report should also be presented to Board however as there will be no Board or FIC to allow this, the Board is being asked to delegate the final sign-off to EMT as recommended by FIC. Also it is proposed the final report is presented at the FIC in autumn.

2. 2021/22 National cost collection changes

The Trust continues to produce the return in line with national guidance. The key changes to the 2021/22 collection are listed below:

- Critical care services were previously submitted under the relevant service currencies within the Reference cost return however from 2021/22 it is a mandatory requirement that these services are submitted as part of PLICS. GOSH did participate in the pilot submission in the 2020/21 return therefore this will be the second year of us returning patient level critical care costs.
- CAMHS services will also move to a patient level submission as part of the separate PLICS Mental Health feed.
- CATS services (patient transport for critically ill children) have previously been submitted as cost and activity under critical care however with the move to a mandatory patient level submission and there being no national currency for this activity, it will now be treated as an excluded service and the costs will be removed from the submission (c£5.7m).

2.1 Compliance with NHSI costing standards

The annual cost collection will be prepared in line with the national costing standards and collection guidance. Changes to the treatment and allocations of costs have been updated in line with changes to costing standards where applicable. There has been continuous engagement from services to review PLICS and improve the activity and cost data. On completion of the costing exercise a costing compliance tool will be completed and submitted that assesses the quality of costing and this will be used to identify any areas of development for the next year.

2.2 Quantum of Cost

The starting point for calculating the quantum of costs for the collection is the audited operating expenditure for the Trust. In 2021-22 this was £591m, which is an increase of £25m (4%) versus 2020-21. Following on from this there are a number of prescribed technical adjustments to this value to arrive at the total quantum of cost of delivering NHS activity that will be submitted in the national cost collection. The main adjustments are: -

- Removing the cost and depreciation for donated assets
- Removing costs of impairments
- Adding PDC dividend
- Removing income that is not allowable under costing guidance
- Remove the cost of hosted services (genetics)
- Removing the costs of services excluded from the national cost collection including home care drugs, private, devolved and overseas patients

The total quantum for NHS patients after these technical adjustments has increased by £7.9m from £401.0m in 2020-21 to £408.9m in 2021-22 (a 2% increase). This could be subject to change owing to changes to the costs of excluded services as the model is refined leading up to submission. The detailed reconciliation can be seen in Appendix 1.

The key drivers of this increase are: -

- Non-NHS activity including private patients continues to be lower than in 2019-20 owing to the ongoing impact of Covid on travel restrictions and national lockdowns and payment of historic debt (c£5.0m). Consequently, private patient costs are c£9.0m lower than 2020-21 with these costs being absorbed by NHS patient activity.
- Increased pay costs because of inflation and higher WTEs.
- These increases have been partially offset by higher property impairment charges (£5.0m increase) and removal of the cost of CATS services (£5.7m) netting the quantum down.

The quantum of cost for the submission has been reconciled to the audited year end accounts and this has been validated with Financial Accounts.

The return includes all activity and costs for 2020-21. Admitted patient care (APC) and non-APC activity has been reconciled to Trusts nationally reported activity datasets in line with guidance and any variances have been documented.

Costs and activity will be reviewed against the Trust's 2020-21 submission, national averages and costs for Specialist Children Alliance Trusts to sense check and benchmark GOSH costs with any necessary adjustments being made with the approval of the Chief Finance Officer.

3. Future changes to the National Cost Collection

There are plans to move cancer MDTs, chemotherapy delivery and procurement, palliative care and renal dialysis to a patient level submission for the 2022/23 collection. To assess the feasibility of this change there will be a voluntary pilot collection undertaken in Autumn 2022 that GOSH will aim to take part in.

It will be a requirement for the 2022-23 cost collection that the Board has approved the final submission.

4. Recommendation

- To **note** the changes to the National cost collection process for the 2021-22 return.
- FIC are recommending to the Board that they **Delegate** the approval of the final national cost collection submission to EMT in the week beginning 08 August 2022 as owing to the submission deadline being bought forward from October to August there is no Board or FIC scheduled to approve the return.

Appendix 1: 2021-22 Reconciliation of National Cost Collection Quantum to the Trust Audited Annual Accounts

	National cost collection 2021/22 as per statement	National Cost Collection 2020/21 as per statement	Variance	Variance (%) Change
	£	£	£	%
1. Operating Expenditure	£591,140,955	£566,148,412	-£24,992,543	4%
Charitable Donation to Expenditure - Charitable Donations - to Cap Ex is	-£10,610,349	-£5,177,399	£5,432,950	105%
Education and Training	-£10,432,123	-£9,380,476	£1,051,647	11%
Research and Development	-£24,208,300	-£24,383,938	-£175,638	-1%
Other Operating Income	-£15,312,721	-£60,566,510	-£45,253,789	-75%
COVID19 Remburisement income - top up income	£0	£49,903,093	£49,903,093	-100%
Impairments (See Note 2)	-£6,221,555	-£1,194,000	£5,027,555	421%
COVID-19 National Adjustment		-£870,000	-£870,000	-100%
COVID-19 PPE Exp adjustment	-£1,176,959	-£2,721,152	-£1,544,193	-57%
Depreciation - Donated or Government Granted NCAs (See Note 3)	-£16,693,677	-£15,038,100	£1,655,577	11%
Finance Income	-£124,604	£0	£124,604	
Finance expenses - unwinding of discount	£40,693	-£51,377	-£92,071	-179%
PDC Dividends Payable	£6,772,000	£6,749,000	-£23,000	0%
Operating Expenditure Total *(after National Cost collection Adjustment*	**£513,173,361**	**£503,417,553**	-£9,755,808	2%

Cost of fully absorbed excluded services to be removed as per Reference Cost Guidance form costing system	**Fully Absorbed Service Costs Removed from Operating Expenditure**	**Fully Absorbed Service Costs Removed from Operating Expenditure**	**Variance**	**Variance (%) Change**
Home delivery of drugs and supplies: administration and associated cos	-£230,720	-£112,831	£117,889	104%
Home delivery of drugs and supplies: drugs, supplies and associated cos	-£51,177,779	-£50,088,410	£1,089,369	2%
Hospital travel costs scheme	-£188,620	-£86,766	£101,854	117%
Patient transport services (PTS)	-£2,786,506	-£2,624,875	£161,631	6%
Screening programmes - New-born Screening	-£2,499,574	-£2,660,357	-£160,783	-6%
Specified hosted services - Genetics Laboratory	-£13,326,102	-£11,540,703	£1,785,399	15%
Critical Care Transport Service - CATS	-£5,668,205	£0	£5,668,205	
Actual cost of non-NHS private patients	-£20,343,151	-£29,346,170	-£9,003,018	-31%
Actual cost of non-NHS overseas patients (non-reciprocal)	-£263,742	-£393,879	-£130,137	-33%
Actual cost of other non-NHS patients	-£7,746,670	-£5,582,152	£2,164,518	39%
Reference Cost Quantum of delivering NHS Care	**£408,942,292**	**£400,981,411**	£7,960,881	2%

Attachment V

Trust Board
6th July 2022

Responsible Officer's Report **Submitted by: Dr Philip Cunnington, Associate Medical Director and Responsible Officer**	**Paper No: Attachment V** **☐ For information and noting**

Purpose of report
To provide the Board with assurance that the statutory functions of the Designated Body and Responsible Officer are being appropriately discharged.

Summary of report

- The purpose of medical appraisal and revalidation is to support and develop our medical workforce through reflection on clinical practice, whilst complying with GMC and NHSE&I guidelines and frameworks.
- Appraisal compliance slightly improved at 91%
- Increase in wellbeing training and focus for appraisal well received
- Successful External Quality Assurance Review, with recommendations for Trust to action over 2022/2023.

Action required from the meeting
The Board is asked to note the contents of the update, and agree that the Chief Executive is able to sign the Statement of Compliance (attached)

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
☐ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people **☐ Quality/ corporate/ financial governance**	**☐ Leadership, capacity and capability** **☐ Responsibilities, roles and accountability** **☐ Effective processes, managing risk and performance** **☐ Accurate data/ information** **☐ Engagement of public, staff, external partners** **☐ Robust systems for learning, continuous improvement and innovation**

Strategic risk implications
BAF Risk 12: Inconsistent delivery of safe care

Financial implications
Not Applicable

Implications for legal/ regulatory compliance
The Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013) & NHS England Framework of Quality Assurance for Responsible Officers and Revalidation are the relevant pieces of legislation and guidance.

- Implications of non-compliance are that we fail to ensure that every doctor connected to GOSH:
  1. Receives an annual medical appraisal meeting nationally agreed standards;

2. Undergoes the appropriate pre-engagement/employment background checks to ensure that they have qualifications and experience appropriate to the work performed; 3. Works within a managed system in which their conduct and performance are monitored, with any emerging concerns being acted upon appropriately and using nationally agreed processes and standards; 4. Has a recommendation made to the GMC regarding their fitness to practise every five years, on which their continuing licence to practise is renewed. • Risk of non-compliance: 1. We fail to support and develop our medical staff to enable them to continue to deliver the highest quality care; 2. For those who do not engage in the appraisal process the personal risk is that they will lose their licence to practise; 3. We expose our patients and ourselves to risks concerning safety, if our pre-employment checks are not up to standard; 4. We fail to address poor performance and behaviour promptly and in a manner that is consistent and following nationally agreed standards; 5. We fail to support the wellbeing of our colleagues.
Consultation carried out with individuals/ groups/ committees Not Applicable
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Sanjiv Sharma
Who is accountable for the implementation of the proposal / project? Medical Director
Which management committee will have oversight of the matters covered in this report? Medical Appraisal and Revalidation Committee

Annual Responsible Officers' Board Report

2022

1. Purpose of the Paper

The purpose of this paper is to inform Board members of Medical Appraisal and Revalidation arrangements within GOSH, to provide assurance that the Responsible Officer and the Designated Body are discharging their statutory responsibility, and to highlight current and future issues with action plans to mitigate potential risks.

This report describes the progress against last year's action plans, issues during the reporting year, and sets out actions on further developing the quality of appraisals and support.

2. Summary

All doctors are required to participate in an annual appraisal process, which reflects their complete scope of work. For those doctors in training posts this happens through the Annual Review of Competency Progression (ARCP) process. These annual processes help doctors satisfy the requirements for revalidation, which occurs every five years. For doctors arriving at our organisation who may be new to the National Health Service, this is a new process to get to grips with, as is the role of the GMC as the health regulator.

During the 2020/2021 reporting period a decision was taken by the GMC to defer all doctors due for revalidation between March 2020 and March 2021 for 12 months. A further decision to defer doctors due for revalidation between April 2021 and July 2021 for four months in response to the pandemic was subsequently taken. These doctors would remain "Under Notice" for revalidation, allowing recommendations to be made where the requirements for revalidation have been met. This was designed to ease any pressure within the system. Since then, the GMC has taken the decision to increase the revalidation notice period from 4 months to 12 months, so doctors go "Under Notice" 8 months earlier than they did previously. This does help provide focus on the areas that need to be completed in order to secure a positive recommendation for their revalidation.

The Annual Organisational Audit (AOA) has now been cancelled for all established Designated Bodies. A revised Board Report Template has been circulated and this is in Annex A, which requires signing by the Chief Executive and returning to NHS England.

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) had 675 doctors connected to it as a Designated Body on 31st March 2022. This is an increase of 31 on the previous year. We are seeing a steady increase in connections – we believe this is down to three reasons:

1) Doctors are now more aware of the need to connect to GOSH as their Designated Body on commencement of their employment (this is also highlighted in their induction training);
2) More doctors using honorary contract status when they leave and, if they are not employed elsewhere, are entitled to connect to GOSH;
3) While we are not obliged to be the designated body for Bank doctors it was agreed at the Medical Appraisal and Revalidation Committee that where a doctor is providing regular service, and has done so within the preceding three months, they may connect to us and we will provide access to appraisal and revalidation support, and software.

2.1 Medical Appraisal

Category	2021/22 Appraisal Status	No.	%
1	Completed Appraisal	515	76.3%
2	Approved Incomplete or Missed Appraisal	99	14.7%
3	Unapproved Incomplete or Missed Appraisal	61	9%

Categories 1 and 2 give a compliance rate of 91% overall, a slight improvement on last year. However, of the 61 in category 3, 32 have since completed their appraisal –after the 31st March 2022 cut-off date.

There were 99 doctors classed as having an Approved Incomplete or Missed Appraisal (AOA Category 2) and the reasons are shown below:

- 90 joined the Trust from abroad and had been employed for less than 12 months on 31st March 2022 and were therefore not yet due an appraisal – this is nearly double compared to last year's figure. We believe this could be due to earlier engagement with doctors coming from abroad in their induction advising them of the need to connect to GOSH as their designated body;
- 1 had an agreed postponement due to long term sick leave or compassionate leave;
- 8 had an agreed postponement due to maternity leave;

Of the 61 listed in Category 3:

- 32 appraisals have since been completed with a meeting date after 31st March 2022;
- 4 doctors have since left the Trust;
- 25 remain overdue and are being addressed through local processes.

NHS England released guidance for restarting appraisals advising that the focus for appraisal should be supportive and reflective conversations, with less emphasis on written documentation during 2020. The appraisal input form on the PReP (Premier IT e-Portfolio Revalidation Management Software) was amended to incorporate the new guidance including a "Health and Wellbeing" section. This more supportive approach has been well received according to feedback collected by the appraisal office.

Directorate Breakdown of Appraisals due 1 April 2021 – 31 March 2022

	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	IPC	Medicine, Therapies & Tests	Ops & Images	Sight & Sound	Corp	Total
Cat 1	**86**	**64**	**87**	**115**	**8**	**27**	**77**	**48**	**3**	**515**
Cat 2	**20**	**14**	**6**	**32**	**1**	**2**	**8**	**11**	**5**	**99**
Cat 3	**13**	**3**	**10**	**20**	**2**	**1**	**5**	**6**	**1**	**61**
Total	**119**	**81**	**103**	**167**	**11**	**30**	**90**	**65**	**9**	**675**
Compliance % (Cat 1&2)	**89.1%**	**96.3%**	**90.3%**	**88.1%**	**81.8%**	**96.7%**	**94.5%**	**90.7%**	**88.9%**	**91%**

The appraisal rate for each directorate is monitored at Directorate Performance Reviews.

2.2 Appraisers

The Trust had 167 trained appraisers on 31st March 2022. There are a further 27 Educational Supervisors who have been given appraiser access on PReP to allow them to appraise their trainees only.

New Appraiser Training took place during the year, securing the Trust a further 16 appraisers, and 48 appraisers completed their refresher training.

24 Appraisers received "Wellbeing Training for Appraisers" to further support the changes on the appraisal inputs regarding Health and Wellbeing.

2.3 Revalidation

Between 1st April 2021 and 31st March 2022, 236 doctors for whom GOSH is the Designated Body were due to have Revalidation Recommendations made to the GMC, of which 149 were revalidated, and 87 were deferred due to insufficient evidence. Of the 87 deferred, the reason for the majority of those deferrals was for Patient Feedback – this has been the biggest issue following COVID measures nationally.

A further 16, who had revalidation submission dates deferred, have had positive Revalidation Recommendations made during the period as a result of having sufficiently complete portfolios.

The remaining 71 were deferred until 2022/2023.

2.4 Quality Assurance

Appraisers are scored by their appraisees, this is done anonymously at the end of their appraisal following acceptance of their Appraisal Output Form. To maintain anonymity a report is produced for the appraiser once they have completed a minimum of three appraisals. The report is attached to their portfolio for reflection in their own appraisal. The report covers nine different aspects of appraisal and also includes areas for free typed comments.

In addition to the above, the Trust held their first External Quality Assurance Review since 2017. The review started in December 2021 and completed in March 2022, with the final outcome report published in May 2022. There have been a number of significant improvements since the original review, including an improvement in scoring for appraisee inputs and appraiser outputs, but suggestions and recommendations have been and an action plan has been initiated. This will be addressed over the coming year.

2.5 Responding to Concerns and Remediation

In the past year there have been no completed Maintaining High Professional Standards (MHPS) investigation reports, and there is one ongoing MHPS investigation. In addition, there is one formal grievance procedure taking place where formal mediation has failed to improve relations.

In the past year we have had seven doctors either currently working, or who have worked at the Trust, undergoing fitness to practise investigations by the General Medical Council, some of which have now been concluded.

Of those currently still working in the Trust:

One has had their fitness to practise investigation completed and is working with undertakings on their practice with a workplace supervisor and is fully compliant with them.

One has had their fitness to practise investigation completed and has received a warning regarding their conduct which will remain publicly available for two years.

One is undergoing a fitness to practise investigation with regards to their professional conduct but has no restrictions on their clinical practice.

The remaining four doctors no longer work in the Trust:

One has had their fitness to practise investigation concluded and no further action deemed necessary. This related to clinical work undertaken at a previous Trust.

One doctor who is undergoing a fitness to practise investigation and has supervisory restrictions imposed on their practice has left the Trust. The concerns were regarding work undertaken at a previous Trust.

One doctor is undergoing a fitness to practise investigation regarding their probity. This relates to work conducted outside of the Trust and we were only alerted of this concern after the doctor had left the Trust. Subsequent enquiries have identified some concerns regarding their clinical practice whilst employed at the Trust and these have been shared with the GMC are being triaged.

One doctor has had their fitness to practise investigation completed and has been referred to the Medical Practitioner Tribunal Service (MPTS) for a formal hearing. This relates to concerns raised whilst employed by the Trust.

A retired former employee who was undergoing a professional conduct investigation has had their application for voluntary erasure from the medical register accepted and their case closed.

Two doctors have had complaints about them made to the GMC and neither have been investigated, merely asked to reflect on the episode in their next appraisal.

Designated Body Annual Board Report

Section 1 – General:

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust can confirm that:

1. **An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

> **Action from last year**: Continue supporting the new Responsible Officer
>
> **Comments**: RO was fully trained and continues to attend update meetings with GMC.
>
> **Action for next year**: None.

2. **The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

> Yes
>
> **Action from last year**: None
>
> **Comments**: Recommendation from Miad EQA to consider part-time support for Revalidation and Appraisal Manager to ensure continuity of support for the RO and mitigate risk, and succession planning.
>
> **Action for next year**: Will review recommendation to see if required.

3. **An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.**

> **Action from last year**: Continue maintaining accurate records
>
> **Comments**: In addition to the leavers and starter reports from workforce, we now regularly review bank doctors' connections/shifts to ensure they are appropriately connected. The GMC confirmed that bank contracts do not obligate a designated body to maintain a connection, however our Medical Appraisal and Revalidation Committee took the decision to support bank doctors who are regularly providing GOSH with service and allow that connection where they have completed shifts within the preceding 3 months.
>
> **Action for next year**: Continue monitoring connections and maintaining accurate records.

4. **All policies in place to support medical revalidation are actively monitored and regularly reviewed**.

Action from last year: Review policy when new appraisal requirements are confirmed nationally.

Comments: Medical Appraisal and Revalidation Policy is current, and not due for renewal at this time. However, there are changes to Good Medical Practice guidelines currently in discussion. In addition, Physician Associates are due to fall under GMC regulation at some point and will therefore need inclusion in the policy.

Action for next year: Monitor national changes with a view to updating the local policy as and when required.

5. **A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.**

Actions from last year: None

Comments: Our previous External Quality Assurance was conducted in December 2017. We commissioned a further EQA to monitor the changes since that time and ensure the Trust was meeting its obligations in full. Significant improvements were recorded in the report as well as praise for initiatives such as well-being training for appraisers. Some of the recommendations issued will be worked on over the coming year and will be reported to Board under 2022/2023.

Action for next year: Submit action plan to Medical Appraisal and Revalidation Committee and work through the recommendations of the report.

6. **A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

Action from last year: To continue to support the ongoing work as needed.

Comments: Short term placements are provided with access to conduct appraisals when required, irrespective of time within the Trust, and their appraisal due date is set to one year after their previous appraisal.

Action for next year: Continue this support and professional development.

Section 2a – Effective Appraisal

1. **All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.**

Action from last year: The electronic system used for appraisal is due for renewal, and during the tender process we will review what capability any potential new system may have for incorporating such information.

Comments: We have renewed with the current provider for one further year. They introduced a "MAG Lite" version of the appraisal input form on their system which was activated for all our doctors. While it is still expected to see some evidence to support their full scope of work, the input form itself is less burdensome for doctors (there is no longer the need to reflect on the four Good Medical Practice domains), and a Wellbeing section has been introduced. This has been further supported by some of our appraisers receiving "wellbeing" training for appraisers.

Action for next year: Look to extending the wellbeing training and continue supporting all doctors to hold reflective appraisals. Conclude tender process for electronic system.

2. **Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.**

Action from last year: To reduce the number of appraisals that are overdue by over three months using targeted education of appraisees and appraisers, and the processes in place within the Trust.

Comments: Flow chart of appraisal process with timelines and Trust action/requirements for deferred appraisal added to intranet. Compliance has increased slightly on last year.

Action for next year: Continue reducing the number that exceed their appraisal due date through education.

3. **There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).**

Action from last year: Review policy in the event of substantial requirement changes.

Comments: The Appraisal Policy was approved on the 23rd November 2020 and the GOSH intranet updated. There are some changes being discussed for appraisal requirements, as well as the inclusion of Physician Associates coming under regulation by the GMC, but nothing definitive yet and so no need to update the policy at this point.

Action for next year: Monitor national changes and review the policy when appropriate.

4. **The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.**

Action from last year: New Appraiser Training session to be held to bolster the number of trained appraisers, replace those leaving/retiring in the near future and to ease the burden in those departments with insufficient appraisers

Comments: 16 new appraisers trained in year and Educational Supervisors whose accreditation is up to date have access on PReP to appraise their trainees.

Action for next year: Maintain number of appraisers depending on the number of appraisers who step down from the role, or who leave the Trust.

5. **Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).**

Action from last year: Appraiser Refresher training to be held for all appraisers.

Comments: 48 appraisers received refresher training. 24 appraisers received "Wellbeing Training for Appraisers"

Action for next year: Increase number of appraisers receiving refresher and wellbeing training. Restart Appraiser Forum meetings for information sharing.

6. **The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.**

Action from last year: None

Comments: Internal assurance is provided by the following sources:

- RO reports to Board

- RO and Appraisers continue to update their skills in Revalidation and Appraisal matters and are subject to feedback from appraisees which is used as part of their own reflection within appraisal.

External Quality Assurance was provided by MIAD.

Action for next year: Implement changes suggested by External Quality Assurance.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Great Ormond Street Hospital for Children NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	**675**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**515**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**160**
Total number of agreed exceptions	**99**

Section 3 – Recommendations to the GMC

1. **Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.**

Action from last year: Continue bringing revalidations up to date.

Comments: Monthly Medical Appraisal and Revalidation meetings are held to confirm those decisions due in the month(s) ahead and recommendations submitted by the RO after the meeting.

Action for next year: Continue process.

2. **Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Action from last year: Maintain current process.

Comments: In advance of the revalidation recommendation, if deferral or non-engagement is likely the Medical Revalidation Manager advises the doctor in good time to allow corrective action to be taken or simply to make the doctor aware (if there is no time for correcting issue). At the time of the recommendation online the RO emails the doctor confirming the recommendation made, if positive the RO reflects on their evidence/commitment etc. and if deferral is required RO explains the reasons why and provides a timeline to complete any outstanding issues.

Action for next year: Continue process.

Section 4 – Medical governance

1. **This organisation creates an environment which delivers effective clinical governance for doctors.**

Action from last year: Continue to develop robust medical governance within the organisation.

Comments: With assistance from NHSR we are collaborating with other centres to share what is best practice for the structure and composition of our groups dealing with conduct and capability issues. This will ensure greater consistency in decision making and engage the tri-partite leaders from each directorate in then embedding learning and cultural values within their teams. We wish to review cases across all the professions at GOSH to ensure consistency of threshold for interventions, and to review each case with respect to how policies were followed, especially with respect to timeliness.

Action for next year: Liaise with other centres regarding sharing best practice, and review cases for both consistency and timeliness.

2. **Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

Action from last year: Continue to work with Medical Employee Relations team to develop peer support for both managers and those involved in cases.

Comments: There are strong effective working relations between the RO and Medical Employee Relations Team. Training in managing and investigating conduct and capability issues in line with MHPS has been provided to the new Chiefs and Deputy Chiefs of Service by NHSR aiming to expand our organisational ability and knowledge to conduct rapid, effective reviews. We will collaborate with other organisations to review our Medical Employee Relations Meeting, in terms of composition of its members and how it interfaces with other sources of concerns e.g., the Freedom to Speak Up Guardian service. Not all teams have clinical outcomes available and so we will explore how personal and team outcome data can be developed.

Action for next year: develop in-house expertise for exploring concerns, review governance structure of Medical Employee Relations Meeting, Appraisal revalidation Committee and liaised with Quality and Safety so that data from incidents and outcomes is available.

3. **There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

Action from last year: Continued peer support to reinforce the Trust's consistent approach to collective leadership when addressing concerns.

Comments: Medical Employee Relations remains the forum at which concerns are discussed. These may be brought by individual Chiefs or by the FTSUG. The decision is made as to how to proceed, and the policies mentioned are followed with a range of interventions being used. Advice is sought from NHSR as required. Attendance from some is poor and so the structure and composition is being reviewed as outlined earlier.

Action for next year: review structure and composition of Medical Employee Relations Meeting and ensure Action Log of cases reviewed includes clear detail of policies followed and timelines.

4. **The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.**[2]

Action from last year: Liaise with HR OD to ensure quality assurance and detailed demographic data analysis.

Comments: Over the last year of those discussed at Medical Employee R elations meetings 16 were male and 9 were female. Of the males 10 were white British, or any other white background, and of the females 7 were white British, or any other while background. In terms of the types of referrals 22 concerned conduct/behaviour and 3 concerned clinical capability. One case has moved to a formal MHPS investigation, the others have been managed informally. The remaining demographics are available but to protect anonymity have not been included in this report.

Action for next year: continue to review the data to ensure transparency and fairness.

5. **There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.**[3]

Action from last year: Ensure robust SOPs for on-boarding staff, especially to our Bank and when granting practice privileges.

Comments: The new SOP for on-boarding staff is working and subject to review. The RO has close links with IPP who have reviewed their processes for awarding practising privileges. The MPIT form allows transfer and receipt of information, as do local RO networks and relationships with local private hospitals which have proved useful when addressing mutual problems during the last year.

Action for next year: continue review of processes.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

6. **Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).**

> **Action from last year:** Continue to develop this work and review demographic data.
>
> **Comments**: All concerns are discussed at Medical Employee Relations meeting to ensure consistency. We are looking to alter the composition of this group to make this more robust and to involve directorate chiefs in this process. Relative numbers are small but we will keep collecting the demographic data.
>
> **Action for next year**: Review sample of cases at Medical ER 'M and M' and continue to collect demographics.

Section 5 – Employment Checks

1. **A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.**

> **Action from last year**: Monitor the implementation of the SOP
>
> **Comments**: The recruitment policy was recently refreshed and provides guidance on the pre-employment checks that should be undertaken for substantive staff and bank workers. Internal audits are in place to monitor this.
>
> **Action for next year**: continue robust checks and sharing of information between Trusts.

Section 6 – Summary of comments, and overall conclusion

> Most of the actions from 2021/22 are complete, except for the tendering process for the current appraisal software (this is still ongoing) and refresher training for <u>all</u> appraisers.
>
> It was decided not to go to full tender, and to incorporate job planning and appraisal/revalidation into one software system with the aim of being more cost effective. This is continuing into 2022/23; A number of appraisers did receive refresher training; however, the number will be increased over this year.
>
> The use of MS Teams and Zoom has increased staff engagement in using the appraisal system, as it has facilitated easier reciprocal interactions for both the Appraisal and Revalidation Team and Appraiser/Appraisee. Continued use of these platforms over the forthcoming year should further increase compliance.
>
> There are recommendations from the EQA that will be taken forward in the year ahead. However, the main report does show significant improvement in both process, engagement, inputs, outputs, monitoring and reporting in the appraisal and revalidation processes. This was

a highly positive report which the authors felt was of the highest standard. This success is down to the hard work of the Appraisal and Revalidation manager, the foundations built by previous ROs, and the support of the Medical Director.

There has been very positive feedback received from both appraisees and appraisers regarding the increased focus on Health and Wellbeing within the appraisal – this change in emphasis has been very much welcomed; the general consensus is that doctors feel they are being treated more "like a human being" and that the appraisal process is all about them and their professional development, and each year is being seen as less of a tick box exercise.

Section 7 – Statement of Compliance:

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[Chief Executive]

Official name of designated body: Great Ormond Street Hospital for Children NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Attachment X

Summary of the Audit Committee meeting
held on 25 May 2022

Trust Board assurance committee updates
The Committee noted updates from the following assurance committees:
- Quality, Safety and Experience Assurance Committee –20 April 2022
- Finance and Investment Committee – February 2022 and March 2022

Chief Financial Officer's review of the Annual Financial Accounts 2021/22, including the Going Concern assessment
GOSH's year-end outturn was a £4.4million deficit against the Control Total and the Trust had moved to a deficit position in the second half of the year as a result of changes made to the way in which the value of the block contract had been calculated. Clinical income had remained broadly in line with previous years however International and Private Care (I&PC) income had reduced from £39million to £25million. Cash had remained strong throughout the year. The committee emphasised the importance of being clear about costs given considerable inflationary pressures for future tariff discussions.

Annual Financial Accounts 2021/22
There had been an onsite valuation of land and buildings as required on a quinquennial basis which had resulted in an increase in the value. The Committee agreed to recommend the Annual Accounts to the Trust Board for approval.

GOSH Draft Annual Report 2021/22
The Committee provided feedback on areas of the annual report and, subject to some minor amendments, agreed to recommend the annual report, annual governance statement and annual audit committee report to the Board for approval.

Internal audit: Head of Internal Audit Opinion and Internal Audit Charter
The Head of Internal Audit Opinion was significant assurance with minor improvement opportunities and had been update based on feedback from Committee members at a previous meeting. The Committee welcomed the request from the Executive Team to broaden the Terms of Reference for the review of referral to treatment access targets in the 2022/23 plan to include consideration of the harm review process.

Status report to the Audit Committee on the 2021/22 audit
The Committee noted that the audit was not yet complete and the target for completion was 8th June which the auditors felt remained achievable as the work was substantially progressed. The review of Value for Money was also on-going, and no concerns had been raised from any of the work which had been undertaken thus far. The letter of representation was consistent with that of previous years with the exception of the reference to the war in Ukraine. The risk around I&PC had been downgraded as a result of the reduction in I&PC income, debtors and provisioning. The Committee requested a short paper on the action that had been taken to confirm that the Trust did not have any contractual relationships with Russia.

Board Assurance Framework Update following the Risk Assurance and Compliance Group (RACG)
An update would be provided to the May 2022 Trust Board meeting on some changes to risk statements which had been recommended for approval by the Audit Committee at its April 2022 meeting.

Board Assurance Framework Deep Dives: BAF Risk 4: GOSH Strategic Position
A key challenge was around the system focus on providing services for the local population in the context of

GOSH's national and international reach. Substantial work was taking place to raise this issue regionally and nationally. The Committee emphasised the importance of ensuring that GOSH was represented on North Central London Boards where possible and maintaining the Trust's position as a world leading children's hospital.

BAF Risk 5: Unreliable data

- No Future Activity (NFA)

Work continued to reduce the number of referrals for which there was no future activity (NFA) and to make updates to Epic to prevent additional NFAs developing whilst ensuring that there were no unintended consequences of these updates. There was a capacity challenge around the clinical review of NFAs and a review of the process would be taking place with a view to improving efficiency.

- Data quality kite marking

Discussion took place around national learning about the Epic system and the committee requested an overview of this and the key challenges related to Epic in the Trust at the next meeting.

BAF Risk 9: Estates Compliance

Good progress was being made around fire safety in partnership with a new contractor however some areas of work would require decant before they could be completed. The decant plan to undertake work on ventilation had been confirmed and would take place in June 2022 and an independent risk assessment from an infection prevention and control perspective was being sought. The Committee noted the importance of ensuring the appropriate skill mix was in place in the estates team and ensuring there was a continuity of resource.

Preparedness: Update on Emergency Planning/ Business Continuity

Business continuity plans were now being updated annually and work was taking place to improve compliance. The operational hub was now fully established to manage major incidents and loggist training continued to be rolled out.

Local Counter Fraud Specialist (LCFS) updates

The Committee approved the counter fraud workplan for 2022/23 and noted the annual report for 2021/22. It was agreed that it was important to increase the visibility of counter fraud and the focus on training.

Review of Non-Audit work conducted by the External Auditors

It was noted that one low value piece of non-audit work had been conducted by GOSH's external auditors.

Assurance of compliance with the Bribery Act 2011

The Committee noted the action that had been taken to comply with the bribery act.

Freedom to Speak Up cases – non-clinical cases for Audit Committee

Discussion took place around the cases that had been raised around lack of, or delayed, payment for clinical work undertaken for I&PC. There had been a number of technical issues and payments were now being made manually. The Committee suggested that communication should be issued to relevant clinical staff highlighting the action that was being taken to rectify the issue.

Raising Concerns in the Workplace Update

The Committee noted the low number of whistleblowing cases under investigation at the Trust but agreed that it should be considered in the context of the total number of concerns raised including to the Freedom to Speak Up Guardian and Counter Fraud.

Attachment Y

Finance and Investment Committee Update

The Finance and Investment Committee (FIC) held a regular scheduled meeting on 21 June 2022.

Additionally, on 30 May 2022 the Non-Executive Director and one Associate Non-Executive Director members of FIC held the first of several extra sessions with the CCC Programme Director to help shape the Children's Cancer Centre Full Business Case (CCC FBC).

Key issues

Joining the UCL Health Alliance update

The Committee reviewed the proposal for GOSH to joining the North Central London collaborative of providers called: UCL Health Alliance. Joining presents an opportunity for GOSH to collaborate with other provider organisations across NCL on priorities which are best addressed through collective action at system level.

GOSH 2022/23 Budget Setting Update

The Committee reviewed the final version of the 2022/23 financial plan that aligned with the NCL plan and requirements for the system to breakeven in year. The plan presented a £10.6m deficit.

The Better Value programme for 2022/23 is for £22.9m with £16.2m of schemes identified with ongoing work to identify the remaining £6.7m.

Finance report Month 2

At Month 2 the Trust reported a year to date deficit position of £8.2m. The cash position remains strong although it has reduced to £114m. To date the £2.7m has been spent on capital investment, with the majority of this relating to the CCC programme.

Integrated Performance Report Month 2

The Committee received the month 2 report and requested further information on the increase in 'Clinic Letters not sent' and more detail on the directorates with challenging RTT performance.

CCC Full Business Case meeting

On 30 May 2022 the NEDs received a briefing on the CCC Team's planned approach to activity, workforce and financial modelling - highlighting the key assumptions being used for each element of the CCC FBC.

Following the meeting, the Outline Business Case (OBC) was recirculated to members. The next meeting was scheduled for 27 June where the draft Strategic case (including the output of activity modelling), draft management case would be reviewed.

Suzanne Ellis – Associate Non-Executive Director was also introduced to the Committee NEDs at this meeting.

2021-22 National Cost Collection (PLICS submission)

The Committee noted the National cost collection process for the 2021-22 return and agreed to recommend to the Trust Board the delegation of the approval of the submission to the Executive team.

I&PC recovery

The committee received an update on the approaches to recovering activity in International and Private Care after the impact of the pandemic and associated travel restrictions.

Insurance update

The Committee noted the proposed timetable for dealing with renewal and the scope of the insurances proposed to be purchase. The Committee asked the Audit Committee to review the conditions embedded in the Trust's Cyber Security coverage.

Annual procurement report

The Committee received the annual report on the procurement service and requested future reports had more detailed on sustainability.

Major projects

The Committee noted progress on all major projects at the Trust.

Feedback from Governors

The Chair sought feedback from Governors in observance at the end of the June meeting.

2022/23 forward plan

The Chair and Associate NED (Suzanne Eilis) agreed to scheduled a meeting to review the Finance and Investment Committee's workplan for the next year.

Thanks to Akhter and Helen

The Chair and other Committee members thanked Akhter Mateen, NED and Helen Jameson, Chief Finance Officer for their work for the Committee. The June meeting was their last.

End of report

Summary of the People and Education Assurance Committee held on 22 June 2022

The Committee noted summaries of the following assurance committees:

- Quality, Safety and Experience Assurance Committee (April 2022)
- Audit Committee (April 2022)
- Finance and Investment Committee (February 2022 and March 2022)

Focus of Meeting

PEAC meetings will now focus on a specific theme. The focus of this meeting was the **"Seen and Heard (Diversity & Inclusion)"** part of the People Strategy.

Preliminary Observations

The Trust is approaching a perfect storm of issues which will be challenging for staff: rising prices leading to financial hardship for many; a more pressured environment within the hospital with a greater focus on better value; the decant programme which will be unsettling. The Trust must focus on what is within its control and how it can mitigate the effect of unavoidable events. The Charity has agreed to set up a hardship fund for staff and the governors asked for this to be put on the agenda for their next meeting.

People Strategy Update

The Committee heard about the array of activity happening on Diversity and Inclusion (D&I) and the "Impact Tracker" shows small but positive progress on various measures. However there are still improvements that need to be made: for example, the gender pay gap has increased from 15.4% in September 2021 to 16.9% in May 2022 and white staff are still 2.06 times more likely to be appointed than BAME applicants (decreasing from 2.09 times in 2020 and 2.25 in 2021). It was acknowledged that a lot more work is needed on the Workforce Race Equality Standard (WRES) data, and the Committee discussed getting staff more involved in discussions on D&I, making it clear on what is expected and making changes in the language used, for example dropping use of the term "BAME".

Diversity Annual Report and Update

A presentation was made on the mid-year summary update to the D&I report (which is published in November). GOSH has staff from 115 nations; our BAME staff representation has increased by 7% in two and a half years but at 36% is still below the London average of 48.1%. The Committee asked for more clarity on the position in different roles at the Trust.

Next steps are to focus on repositioning the staff networks, debiasing recruitment and promoting allyship. It is difficult to say where GOSH stands in comparison with other Trusts since all Trusts are at a different stage in their journey. However, BAME background candidates are now happier to apply to GOSH and some of our processes have inspired other Trusts.

The Head of Diversity and Inclusion felt the Trust has got better at having difficult conversations and people are less scared about saying the wrong thing. The staff forums are functioning well and feeling more supported; we would like to see our estates and clinical colleagues joining more of the conversations. The Chief Nurse observed that, from her experience of other Trusts, the work which GOSH is doing in this space is exceptional; it takes real effort, and we need to keep it up.

Debiasing Recruitment
A paper was presented about the work of the Debiasing Recruitment Working Group, set up in December 2021 to seek a fairer and more open recruitment process. The Chief Executive observed that another Trust has seen a change of mindset following a requirement that recruitment panels need to justify to the Chief Executive the non-selection of a minority background candidate.

Annual Staff Survey
There were small improvements in many measures in the November staff survey and generally good benchmarking against other Trusts. The Committee felt this had somewhat been overshadowed by results in an April pulse survey which showed a % negative drop in each question. It was observed that the hospital is a very different place in April – running very hot – than it was in November and pulse surveys need to be repeated regularly to be meaningful.

The Committee observed that averages can hide issues at the extreme end and in particular places. Tours of the hospital showed that staff happiness was radically different in some parts than others. Generally HR found no surprises and will continue work in line with the programme where delivery will be critical over the next 12 months.

Staff Stories
The Committee welcomed Rory Philbin, an Advanced Nurse Practitioner in General Surgery who has chaired the Pride network since December 2021, and Lakiesha Ward, Mortuary Manager and Chair of REACH (Race, Ethnicity and Cultural Heritage).

Lakiesha said that people ask her “what is the point” of doing work through REACH as nothing will change. She does not accept this. She thinks there just need to be more conversations. However, members of estates and lower banded staff did feel it difficult to advance. She encouraged the Board to keep staff updated about the work being done. She encouraged the Charity to put more photos of people from ethnic backgrounds on their website and the Director of Communications confirmed that work is underway on the website.

Rory said they also found it difficult to see change. However, things were getting better – it is just a long journey. They felt pleased that two For example, asked about the statistic that a far lower number of BAME staff think they have opportunity for career progression than do white staff, she wanted to let people know her story which enabled her to progress to Band 8 by taking the opportunities on offer. trans staff had recently felt able to come out, which they had not done previously, and be reassured by Rory that the Trust “had their backs”. The challenge is to get to the next stage which will need resources. It is about getting people to be themselves, to be authentic and, as a result, more productive at work. It is about intersectionality – we are all individuals. We need to try to understand how others feel. The Director of Communications added that there is a huge impact on children who can see role models who are comfortable in themselves and this, in turn, gives them confidence. Rory observed that to reach all groups in the hospitals there needed to be targeted communications plans rather than “catch all” which will not reach some elements of the workforce.

The Non-Executive Directors asked for a follow up meeting with Rory and Lakiesha.

Diversity & Inclusion Champion Observations
Amanda Ellingworth, Non-Executive Director and D&I Champion had heard from individuals with protected characteristics suffering discrimination and felt the Board needed to be aware. She felt the online D&I presentations are not reaching the majority of people and these could be better

communicated. The Head of Diversity and Inclusion has done great work and it is important to continue this momentum to increase awareness and continue conversations.

Workforce Metrics
The Committee heard that sickness rates have been creeping up and the Trust should expect 4-4.5% to be common. Despite the increases in sickness rates over the last year, the Trust has benchmarked favourably against the London average sickness rates of 5.9% for March 2022 (GOSH 3.9%). The workforce has increased by 31 FTE (0.6%), but there are some expected reductions over the year following changes to the vacancy authorisation process.

Nursing Workforce
The Committee were updated on the stable position. Whilst the Trust is not experiencing higher turnover, we need to keep up recruitment efforts so that we can avoid possible shortages. There has been an increase in BAME nursing staff, especially at Band 5.
Going forward the Committee requested that the report focuses less on a high-level overview but rather give a detailed picture of where particular issues exist. In addition to nurses we need to look at who else we can upskill to deliver parts of the services and ensure staff are in the right places and doing the right things. The Committee needs to encourage and track a plan for the modernisation of the future workforce.

Freedom to Speak up Guardian and AHP Update
Due to a technical problem the meeting ended, and we agreed to reconvene to complete the final agenda items.

Attachment 1

Trust Board
6th July 2022

Register of Seals

Submitted by: Anna Ferrant, Company Secretary

Paper No: Attachment 1

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

Date	Description	Signed by
16/03/2022	Lease relating to Barclay House (formerly known as York House) 37 Queen Square London	MS, JQ
16/03/2022	Deed of Surrender relating to Barclay House (formerly known as York House) 37 Queen Square London	MS, JQ
16/03/2022	Lease (Counterpart) relating to 8 and 9 Long Yard London WC1	MS, JQ
30/03/2022	Lease relating to Ground, First and Second floor premises at 55-57 Great Ormond Street, London, WC1N 3JQ	MS, JQ

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

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

Financial implications
N/A

Legal issues
Compliance with Standing Orders and the Constitution

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

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

Attachment 2

<table>
<tr><td colspan="2">Trust Board
06 July 2022</td></tr>
<tr><td>Draft Code of Governance and Draft Addendum to Your statutory duties – reference guide for NHS foundation trust governors

Submitted by:
Dr Anna Ferrant, Company Secretary</td><td>Paper No: Attachment 2

☐ For information and noting</td></tr>
<tr><td colspan="2">Purpose of report
A draft Code of governance for NHS providers was issued by NHS England (NHSE) on 27 May 2022 and is out for consultation until 8 July 2022.

The new code will replace the NHS Foundation trust code of governance which was last updated in 2014. This paper provides the Board with an overview of the code and its requirements, with a focus on what has changed or is new. We have also included a comparison to show which disclosures have been amended, added or removed.</td></tr>
<tr><td colspan="2">Summary
The code has been updated to reflect:

• its application to NHS trusts, following the extension of the NHS Provider licence to them
• changes to the UK Corporate Governance Code in 2018
• the legal establishment of integrated care systems (ICSs) under the Health and Care Act 2022
• the evolving NHS System Oversight Framework, under which trusts will be treated similarly regardless of their constitution as a trust or foundation trust.</td></tr>
<tr><td colspan="2">Action required from the meeting
The board is asked to note the publication of the draft Code of Governance and the initial highlights.</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
☐ Leadership, capacity and capability
☐ Vision and strategy
☐ Culture of high-quality sustainable care
☐ Responsibilities, roles and accountability
☐ Effective processes, managing risk and performance
☐ Engagement of public, staff, external partners</td></tr>
<tr><td colspan="2">Strategic risk implications
Compliance with the Code is required in order to retain authorisation as a Foundation Trust</td></tr>
<tr><td colspan="2">Financial implications
Not Applicable</td></tr>
</table>

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

Draft Code of Governance and Draft Addendum to *Your statutory duties – reference guide for NHS foundation trust governors*

Introduction

A draft Code of governance for NHS providers was issued by NHS England (NHSE) on 27 May 2022 and is out for consultation until 8 July 2022. The new code will replace the NHS Foundation trust code of governance which was last updated in 2014 and unlike before will now apply to all NHS Trusts (previously it applied to NHS foundation trusts only).

The code

In general, the provisions of the code do not greatly differ from the 2014 version since the Health and Care Act 2022 does not change the statutory role, responsibilities and liabilities of provider trust boards. However, there are some important additions that reflect the change in NHS landscape since 2014 and the Trust will need to consider how these are taken forward and reported.

To enable trusts the flexibility to ensure their structure and processes work well now and, in the future, the code is designed to provide all the requirements for good governance which have been designed with the interests of patients, service users and the public in mind. Directors and governors both have a responsibility for ensuring that 'comply or explain' remains an effective basis for this code.

The code is set out in five sections and describes principles of good governance and the provisions (based on the principles) with which the Trust must comply or explain.

1. Section A: Board leadership and purpose
2. Section B: Division of responsibilities
3. Section C: Composition, succession and evaluation
4. Section D: Audit, risk and internal control
5. Section E: Remuneration

The Company Secretary and Deputy Company Secretary will undertake a full review of the documents released including the draft Code of governance for NHS providers; draft guidance on good governance and collaboration; and draft Addendum to your statutory duties – reference guide for NHS foundation trust governors in the meantime the below themes have been pulled out as highlights.

Highlights

There are some themes underlying the key changes now included in the code for the first time:

1. There is a requirement for the Trust Board to assess the trust's **"contribution to the objectives of the Integrated Care Partnership (ICP) and Integrated Care Board (ICB), and place-based partnerships"** as part of its assessment of its performance.

2. The inclusion of the Trust Board's role in **assessing and monitoring the culture of the organisation and taking corrective action as required, alongside "investing in, rewarding and promoting the wellbeing of its**

workforce". The previous code only mentioned wellbeing in the context of the finances of the organisation.

3. A new **focus on equality, diversity and inclusion**, among board members but also training in equality, diversity and inclusion should be provided for those undertaking director-level recruitment, including trust governors. The Trust Board should have a succession plan in place for the board and senior management of the organisation to reflect the diversity of the local community or workforce, whichever is higher.

4. **Greater involvement for NHSE in recruitment and appointment processes**, including utilising NHSE's Non-Executive (NED) Talent and Appointments team in preference to external recruitment consultancies and/or having representation from NHSE on NED recruitment panels.

5. The **Council of Governors duty to represent the interest of members** now includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS.

6. It is suggested that the Council of Governors may look at the nature of the Trust's collaboration with system partners **as an indicator of organisational performance**.

Summary

There are no initial surprises in the draft code; the majority of changes represent the changes to the system wide landscape we are now working within. A thorough review of the draft documents will be undertaken, and a further paper will be presented. This will detail the changes that will need to be implemented at GOSH in response to the final published code (for the Trust Board, management teams and Council of Governors); the areas where matters are already covered at GOSH; and highlight the additional reporting elements that will be required in the annual report going forwards.

The Council of Governors will be informed of the draft guidance and updated following the review to ensure they understand how the changes affect the role of governors and the Council as a whole.

An initial review has been conducted by NHS Providers who welcome the refreshed version of the code, and their briefing is attached as **Appendix 1.**

27 May 2022

Consultation on the new draft Code of governance for NHS provider trusts

Introduction

A draft *Code of governance for NHS providers* was issued by NHS England (NHSE) on 27 May 2022 and is out for consultation until 8 July 2022. The new code will replace the *NHS Foundation trust code of governance* which was last updated in 2014. For the first time, the code will apply to all trusts. This briefing provides an overview of the code and its requirements, with a focus on what's new or different, and includes brief summaries of its general provisions. Following the terminology in the code, 'trusts' here will apply to trusts and foundation trusts unless otherwise stated.

NHS Providers has welcomed being involved in shaping the code and commenting on early drafts, and we will be responding to the consultation. Please send any questions or feedback to: izzy.allen@nhsproviders.org so that we can reflect a wide range of views in our response and ensure the code is as helpful as possible.

Summary

The code has been updated to reflect:

- its application to NHS trusts, following the extension of the *NHS Provider licence* to them
- changes to the *UK Corporate Governance Code* in 2018
- the legal establishment of integrated care systems (ICSs) under the Health and Care Act 2022
- the evolving *NHS System Oversight Framework*, under which trusts will be treated similarly regardless of their constitution as a trust or foundation trust.

Code-based governance has been adopted across the UK in the corporate sphere and was translated to the NHS when foundation trusts were introduced. The NHS foundation trust code provided guiding principles with the flexibility for foundation trusts to adopt alternative practices where it was right for them: so long as they were able to explain how they were meeting the core principles of good governance. The revised code helpfully takes the same approach but although the code is issued as guidance, it does contain some statutory requirements because they are enshrined in legislation elsewhere – these are indicated in the new code.

Disclosures to NHSE in relation to the 'governance condition' (Condition 4) of the *Provider licence* and to the code itself will be used by them to make determinations about adherence to the provider licence in terms of having safe, effective, outcomes-focused governance arrangements.

What's new?

In general, the provisions of the code do not greatly differ from the 2014 version since the Health and Care Act 2022 does not change the statutory role, responsibilities and liabilities of provider trust boards of directors. However, there are some themes underlying the key changes, most of which should come as no surprise to trusts but are now included in the code for the first time:

- Incorporation of the requirement for **boards of directors to assess the trust's "contribution to the objectives of the Integrated Care Partnership (ICP) and Integrated Care Board (ICB), and place-based partnerships"** as part of its assessment of its performance, and "system and place-based partners" are highlighted as key stakeholders throughout.
- The inclusion of the **board's role in assessing and monitoring the culture of the organisation** and taking corrective action as required, alongside "investing in, rewarding and promoting the wellbeing of its workforce". The previous code only mentioned wellbeing in the context of the finances of the organisation.
- A new **focus on equality, diversity and inclusion**, among board members but also training in EDI should be provided for those undertaking director-level recruitment. The board should have a plan in place for the board and senior management of the organisation to reflect the diversity of the local community or workforce, whichever is higher.
- For foundation trusts, potentially greater **involvement for NHSE in recruitment and appointment processes**, including utilising NHSE's Non-Executive (NED) Talent and Appointments team in preference to external recruitment consultancies and having representation from NHSE on NED recruitment panels. When setting remuneration for NEDs, including the chair, foundation trusts should use the *Chair and non-executive director remuneration structure*.

Terminology has been updated (for example because since the new Act, Monitor is no more) and there are links to other relevant frameworks, manuals, and guidance (such as the *Well-led framework*). More detail about key changes below.

The code

Set out in five sections, the code describes principles of good governance and the provisions (based on the principles) with which provider trusts must comply or explain. The required disclosures are then set out in tables, depending on what they require of the trust (commentary in the annual report, publication on their website etc.). There are appendices covering the role of the company secretary,

principles and provisions related to councils of governors (for foundation trusts only), and how the code relates to other regulatory requirements.

Section A: Board leadership and purpose

The principles here are updated to align with current NHS policy. They stress the importance of an effective, diverse and entrepreneurial board which sets the trust's vision, values and strategy. It should do so with regard to the triple aim duty of better health and wellbeing for everyone, better quality services, and the sustainable use of resources. There is now also specific reference to the trust's role in reducing health inequalities, assessing and monitoring culture, and investing in, rewarding and promoting the wellbeing of its workforce.

Ensuring effective management of resources, risk management through internal controls, and stakeholder engagement (which now includes system partners) are part of the role of the board. The provisions now include that boards should have systems and processes in place to assess the contribution of the trust to the objectives of the ICS as well as assessing the performance of the trust in relation to effectiveness, efficiency and economy and focusing on quality, risk management, clinical governance and stakeholder engagement, making use of independent advice as required. The trust's vision and values should now include the trust's role "with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives."

The metrics and measures used to assess performance should now be disaggregated by ethnicity and deprivation where relevant. The new code is more specific that while the chair should ensure the board as a whole has a clear understanding of the views of stakeholders (including system partners), the committee chairs now have particular responsibility for stakeholder engagement on significant matters within their purview. When the chair undertakes their own engagement with stakeholders, they should now do this in a "culturally competent" way. The annual report should describe how the interests of system and place-based partners have been considered in decisions, and set out key "partnerships for collaboration" that the trust is part of.

Section B: Division of responsibilities

Section B sets out the role of the chair and notes the need for clear division between the leadership of the board and executive leadership of the trust's operations. The board's collective responsibility for the performance of the trust and infrastructure and resources needed to function is specified, along with the role of the non-executives and their need for sufficient time to meet their board responsibilities. The provisions remain almost unchanged from the previous code, however the

appointment and removal of the company secretary becomes a matter for the board as a whole, rather than the chair and chief executive jointly.

Section C: Composition, succession and evaluation

The principles here cover the need for formal, rigorous and transparent procedures for making board appointments. The board should be constituted, in terms of size, diversity of skills etc. to undertake its duties, and an annual evaluation of its effectiveness undertaken.

There is a new requirement for the board to have published plans "for how the board and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher" and consideration of diversity is now included within the annual board evaluation.

The code now refers to the *Well-led framework* and *Competency Frameworks – NHS Senior Leadership Onboarding and Support* to support evaluation of the board's effectiveness. It adds an expectation that directors should engage with their evaluation process and take appropriate action when development needs are identified. The code also strengthens the fit and proper persons requirement from "abide by Care Quality Commission (CQC) guidance" to "have a policy for ensuring compliance". Any extension of the chair's term beyond nine years should be agreed with NHSE.

Annual reporting on the work of the nominations committee includes the new provision to describe the trust's policy on diversity and inclusion including in relation to disability, reference to indicator nine of the *NHS Workforce Race Equality Standard*, and the gender balance of senior management and their direct reports. Directors or governors involved in recruitment should receive training in equality, diversity and inclusion, including unconscious bias.

For foundation trusts, the inclusion of the expectation to involve NHSE in advertising and on selection panels is new, though there is the "and/or" option of having a representative from a relevant ICB on recruitment panels. If external recruitment consultancies are used instead, they should be identified in the annual report along with any connection they have with the trust or its directors. There is new provision for trusts to set a lower threshold for a council of governors' vote to remove a governor from the council and the code describes the limited circumstances in which NHSE may act to remove a governor. In addition, "foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients".

Section D: Audit, risk and internal control

This section sets out the principles around having independent and effective internal and external audit functions, and procedures for managing risk and determining long-term risk appetite. Changes are minimal. Smaller trusts are now able to establish an audit committee of only two non-executives (the previous code stipulated a minimum of three) and neither the vice chair nor senior independent director should chair the committee. The code extends the maximum external auditor contractual period for foundation trusts to ten years, though it still recognises that audit services should usually be refreshed more frequently, and the requirement to include the value of external audit services in a trust's annual report has been removed.

Foundation trusts may note that the council of governors' role in appointing the auditor is not mentioned here, though it remains their statutory duty, and audit committees should now report to the board on how they have discharged their responsibilities, not the council of governors.

Section E: Remuneration

Section E covers suitable remuneration, pay, and benefit arrangements, including performance-related pay and the role, responsibilities and composition of remuneration committees. The principles now refer trusts to NHSE's pay frameworks for very senior managers and, for NHS trusts, *Guidance on senior appointments in NHS trusts*. The code states trusts should await notification and instruction from NHSE before implementing any cost of living increases and it now sets expectations for all trusts around adhering to the *Chair and non-executive director remuneration structure*. Executive director bonuses and incentives are now limited "to the lower of £17,500 or 10% of basic salary". Director-level severance payments should be discussed with NHSE regional directors at the earliest opportunity.

Schedule A: Disclosure of corporate governance arrangements

The disclosures pull together the provisions from the commentary above, setting out the provisions that trusts should comply with or explain how alternative arrangements comply. The disclosures are broken down into sections depending on what trusts should do. The various requirements are:

- provide a supporting explanation of compliance or explain non-compliance in the annual report
- "basic" comply or explain – where trusts are welcome but not required to provide statements of compliance but should explain where they have deviated from the code (most provisions fall into this category)
- provide information to the governors or make information available to members (FTs only).
- make information publicly available.

Appendices

A: The role of the trust secretary

The significance of the role and its responsibilities for corporate administration and providing advice on all governance matters is retained from the previous code. As noted, the appointment/removal of a company secretary is now a matter for the whole board instead of the chair and chief executive.

B: Council of governors and the role of the nominated lead governor

Many provisions relating to councils of governors are now only included in appendix B rather than the body of the code and the disclosures section. The role and responsibilities of councils in law does not change with the new act, and so there is very little to note here for foundation trusts save:

- The description of councils of governors' duty to represent the interests of the "public at large" is fleshed out: "this includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS."
- A new suggestion that the council may look at the nature of the trust's "collaboration with system partners" as an indicator of organisational performance
- A clarification of the council's role in relation to approving significant transactions, mergers and acquisitions so that "to withhold its consent, the council of governors would need to provide evidence that due diligence was not undertaken." This was always the intention of their role in this regard however this perhaps sets it out more explicitly than previous guidance.

C: The code and other regulatory requirements

NHSE sets out the priority of compliance with relevant legislation as set out in the 2006 Act (as amended by the 2012 Act) and reflected in the NHS provider licence. They also explain how the code's disclosure requirements sit alongside the corporate governance statement required in the annual plan (a forward-looking statement of arrangements for the coming year) and the annual governance statement required in the annual report (a backward look over the past year). These are both distinct requirements, not related to the code. The code disclosures provide an additional evaluation of corporate governance arrangements over the preceding year and are included within a trust's annual report.

NHS Providers view

The draft code is out for consultation until 8 July and we would encourage provider trusts to respond during the consultation period and to share feedback with us to inform our response.

We argued for the code to be updated, and on balance we welcome this refreshed version which reflects best governance practice as described in the UK corporate code. The application of the code to NHS trusts is also welcome in providing a firm, transparent and consistent basis for good corporate governance across the sector and with regard to NHSE assessments about trusts' performance and leadership. NHS trusts new to the code should keep firmly in mind that most provisions are guidance, and they may demonstrate how they are applying the core principles of good governance in different ways.

We are pleased to see the new focus on diversity and inclusion, alignment with the *Workforce Race Equality Standard* and reference to disability and gender because we know what a positive difference diversity makes in the leadership of provider trusts, supporting better decision-making and outcomes for patients. We also welcome the inclusion of reference to the board's responsibilities regarding the wellbeing of our hard-working, hard-pressed NHS workforce.

Foundation trusts may need to adapt to the new expectations to involve NHSE in recruitment and selection, equally NHSE should not seek to impose a candidate upon a trust and be aware that the statute in respect of appointments remains unchanged.

We welcome the proposal that trust secretaries should be appointed and subject to removal by the board as a whole. It is crucial that trust secretaries can have robust and frank conversations about effective governance in their trust and feel protected in doing so.

References to system working in the code are also concise and not overly prescriptive which is helpful and welcome. We are however continuing to work with NHSE to ensure the read across to the addendum to the guide to governors with regard to system working remains sufficiently reflective of the legislative basis of the governor role.

Overall, we welcome this consultation on the updated code which seems to mark a helpful step forward in updating its provisions in light of the changing context for trusts, and to introduce a more consistent, transparent approach across the sector. We look forward to working with trusts and NHSE as the code is finalised and implemented.

Contacts: John Coutts, Governance Adviser john.coutts@nhsproviders.org
Izzy Allen, Governance Support Manager izzy.allen@nhsproviders.org

Attachment 3

<table>
<tr><td colspan="2">Trust Board
6 July 2022</td></tr>
<tr><td>Appointment of Deputy Chair and Senior Independent Director

Submitted by:
Dr Anna Ferrant, Company Secretary</td><td>Paper No: Attachment 3

□ For approval</td></tr>
<tr><td colspan="2">Purpose and summary of report
The purpose of this paper is to discuss and support the appointment/s of the Deputy Chair following Akhter Mateen stepping down from the Trust Board on 30 June 2022; support the proposal for appointment to the Deputy Chair from 01 October 2022 and approve the appointment of the Senior Independent Director from 01 October 2022.</td></tr>
<tr><td colspan="2">Action required from the meeting
The Board is asked to:
To consider and support the appointment of James Hatchley as Deputy Chair of the Trust Board and Council of Governors from 01 July 2022 until the end of his tenure.
To consider and support the appointment of Amanda Ellingworth as Deputy Chair of the Trust Board from 1 October 2022 until the end of her tenure.
To approve the proposal to appoint Amanda Ellingworth as Senior Independent Director from 1 October 2022 until the end of her tenure.</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

□ Leadership, capacity and capability</td></tr>
<tr><td colspan="2">Strategic risk implications
Not Applicable</td></tr>
<tr><td colspan="2">Financial implications
Not Applicable</td></tr>
<tr><td colspan="2">Implications for legal/ regulatory compliance
Regulatory compliance – Code of Governance</td></tr>
<tr><td colspan="2">Consultation carried out with individuals/ groups/ committees
Not Applicable</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales?
Company Secretary</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project?
Trust Chair</td></tr>
<tr><td colspan="2">Which management committee will have oversight of the matters covered in this report?
The Board and Council of Governors are responsible for ensuring compliance with the positions required on the Trust Board in accordance with regulatory compliance.</td></tr>
</table>

Appointment of Deputy Chair and Senior Independent Director

1.0 Introduction

Following Akhter Mateen's tenure as Deputy Chair and Non-Executive Director coming to an end on 30 June 2022, the Council of Governors need to appoint, with the support of the Trust Board, a new Deputy Chair to commence from 01 July 2022 and again from the 01 October 2022.

Following James Hatchley's tenure as Senior Independent Director and Non-Executive Director coming to an end on 30 September (subject to his tenure being extended by the Council of Governors at their meeting on 07 July 2022), the Trust Board need to appoint, with the support of the Council of Governors, a new Senior Independent Director to commence from 01 October 2022.

2.0 Appointments to the Trust Board

2.1 Appointment of Deputy Chair (until 30 September 2022)

The Deputy Chair is a requirement of paragraph 26 of the Trust's Constitution which states that the Council of Governors shall appoint one of the Non-Executive Directors as the Deputy Chair. The Standing Orders for the Trust Board (Annex 9 of the Constitution) and the Council of Governors (Annex 8) state that the Deputy Chair will chair the Board and the Council of Governors meeting and members' meetings (Annex 10) should the Trust Chair be absent or disqualified from participating due to a conflict of interest. The Deputy Chair is also a member of the Council of Governors Nominations and Remuneration Committee.

The Board are asked to consider and support the approval of James Hatchley for the appointment as Deputy Chair of the Trust Board and Council of Governors following Akhter Mateen's tenure as Deputy Chair and Non-Executive Director coming to an end on 30 June 2022.

James is our longest serving Non-Executive Director (since May 2015), he has over 25 years of executive-level experience working in the financial services industry, previously as European Chief Operating Officer of Kohlberg Kravis and Roberts, a US-listed global investment firm and more recently as Group Strategy Director at 3i. James brings a wealth of expertise in corporate governance best practice, budgeting, capital projects, strategic planning and decision making, and complex financial analysis. James is currently Chair of the Finance and Investment Committee and Senior Independent Director.

The Council of Governors are responsible for approving this appointment and will consider this at their meeting on 7 July 2022.

The Board should feel assured that there is no potential conflict of interest in the same person holding the position of Deputy Chair and Senior Independent Director. This is supported by The Foundation Trust Code of Governance (The Code) which states:

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.***

ACTION FOR TRUST BOARD: To consider and support the appointment of James Hatchley as Deputy Chair of the Trust Board and Council of Governors from 01 July 2022 until the end of his tenure.

2.2 Appointment of the Deputy Chair (from 01 October 2022)

Upon James Hatchley's tenure coming to an end on 30 September 2022 (subject to Council of Governor's approval) the Board are asked to consider and support Amanda Ellingworth as Deputy Chair from 01 October 2022.

Amanda has been a Non-Executive Director at GOSH since January 2018, she has over 13 years of non-executive level experience and a background as a senior social worker focusing on children and families. Amanda received a positive appraisal last year. Amanda is Chair of the Quality, Safety and Experience Committee and is the Trust's Diversity and Inclusion Guardian.

The Council of Governors are responsible for approving this appointment and will consider this at their meeting on 7 July 2022.

ACTION FOR TRUST BOARD: To consider and support the appointment of Amanda Ellingworth as Deputy Chair of the Trust Board from 1 October 2022 until the end of her tenure.

2.3 Appointment of the Senior Independent Director (from 01 October 2022)

In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders.

Following conversations held by the Chair, the Trust Board are asked to approve that Amanda Ellingworth is appointed as Senior Independent Director for the same reasons as above.

ACTION FOR TRUST BOARD: To approve the proposal to appoint Amanda Ellingworth as Senior Independent Director from 01 October 2022 until the end of her tenure.