Meeting of the Trust Board
Wednesday 1 February 2023

Dear Members

There will be a public meeting of the Trust Board on Wednesday 1 February 2023 at 1:15pm held on Zoom

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**1:15pm**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2	**Minutes of meeting held on 23 November 2022**	Chair	**H**	
3.	**Matters Arising/ Action Checklist**	Chair	**I**	
4.	**Chief Executive Update**	Chief Executive	**J**	**1:25pm**
5.	**Patient Story**	Chief Nurse/ Head of Patient Experience	**K**	**1:40pm**
6.	**Directorate presentation: Core Clinical Services**	Chief Operating Officer/ Senior Leadership Team for Directorate	**L**	**2:25pm**
	STRATEGY			
7.	**GOSH Clinical Strategy**	Chief Operating Officer	**M**	**2:55pm**
8.	**Patient Safety Statement and Transformation: How We Listen, Lead and Learn**	Chief Medical Officer	**N**	**3:10pm**
	PERFORMANCE			
9.	**Integrated Quality and Performance Report (Month 9 - December 2022 data)**	Medical Director/ Chief Nurse/ Chief Operating Officer	**O**	**3:20pm**
10.	**Finance Report - (Month 9 - December 2022 data)**	Chief Finance Officer	**P**	**3:35pm**
	ASSURANCE			
11.	**Guardian of Safe Working Report Q3 2022/23**	Guardian of Safe Working – Renee McCulloch	**R**	**3:45pm**
12.	**Board Assurance Committee reports** • **Quality, Safety and Experience Assurance Committee update – January 2023 meeting** • **Finance and Investment Committee Update – January 2023**	Chair of the Quality, Safety and Experience Assurance Committee Chair of the Finance and Investment Committee	**Verbal** **S**	**3:55pm**

	• **Audit Committee Assurance Committee Update – January 2023 meeting (including Board Assurance Framework Update)** • **People and Education Assurance Committee Update – December 2022 meeting**	Chair of Audit Committee Chair of the People and Education Assurance Committee	**T** **U**	
13.	**Council of Governors' Update – November 2022 meeting**	Chair	**V**	
	GOVERNANCE			
14.	**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.)			**4:15pm**
15.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 30 March 2023 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			

DRAFT Minutes of the meeting of Trust Board on 23rd November 2022

Present

Amanda Ellingworth	Non-Executive Director
James Hatchley	Non-Executive Director
Chris Kennedy	Non-Executive Director
Kathryn Ludlow	Non-Executive Director
Professor Russell Viner	Non-Executive Director
Gautam Dalal	Non-Executive Director
Matthew Shaw	Chief Executive
Tracy Luckett	Chief Nurse
John Quinn	Chief Operating Officer
Prof Sanjiv Sharma	Chief Medical Officer
John Beswick	Chief Finance Officer
Caroline Anderson	Director of HR and OD

In attendance

Cymbeline Moore	Director of Communications
Dr Shankar Sridharan	Chief Clinical Information Officer
Margaret Ashworth*	Interim Chief Finance Officer
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Renee McCulloch	Associate Medical Director and Guardian of Safe Working
Luke Murphy*	Head of PALS
Matteo*	Parent of GOSH patients
Clarissa Pilkington*	Chief of Service, Blood, Cells and Cancer
Anupama Rao*	Deputy Chief of Service, Blood, Cells and Cancer
Esther Dontoh*	General Manager, Blood, Cells and Cancer
Emma Gilbert*	Interim Head of Nursing and Patient Experience
Darren Darby*	Deputy Chief Nurse
Quen Mok	Governor (observer)
Jacqueline Gordon	Governor (observer)
Mark Hayden	Governor (observer)
Constantinos Panayi	Governor (observer)
Sapna Talreja	Governor (observer)
1 member of GOSH staff	

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

122	**Apologies for absence**
122.1	Apologies for absence were received from Sir Michael Rake, Chair. Amanda Ellingworth, Deputy Chair chaired the meeting.
123	**Declarations of Interest**
123.1	No declarations of interest were received.

124	**Minutes of Meeting held on 21 September 2022**
124.1	The Board **approved** the minutes of the previous meeting.
125	**Matters Arising/ Action Checklist**
125.1	Minute 92.4: John Quinn, Chief Operating Officer said that a key driver of last minute cancellations was bed closures and discussions were taking place with Chiefs of Service about ways to minimise this. Amanda Ellingworth, Chair said that feedback had been received from staff on the walkround prior to Trust Board that the Trust was not sufficiently proactive in terms of reminding patients and families about their appointments and this was contributing to instances of 'was not brought'. John Quinn said that GOSH was part of a national 'was not brought' initiative which considered how Trusts were performing and ways in which processes could be strengthened.
125.2	Minute 94.4: Staff had raised the issue of a delayed replacement of a fridge during a previous walkround and John Quinn confirmed that the case for replacement would be heard at Capital Investment Group on 30th November 2022.
126	**Chief Executive Update**
126.1	Matthew Shaw, Chief Executive said that the GEMS awards (GOSH Exceptional Members of Staff) had been relaunched at an Extraordinary Big Brief in October and would celebrate an outstanding individual and team each month. Children's hospitals across England continued to be extremely busy and PICU occupancy levels had been very high with almost all Children's Hospital Alliance Trusts at 100% capacity. Matthew Shaw said that GOSH had a large number of PICU beds and it was important to ensure they remained open and patients could be accepted.
126.2	GOSH had been successful in being awarded funding for the National Institute of Health Research Biomedical Research Centre for the coming 5 years which was extremely positive. Work was taking place to close the existing BRC at the end of December 2022 and open the new BRC in January 2023. The Board welcomed this achievement.
127	**Feedback from NED walkrounds**
127.1	Suzanne Ellis, Non-Executive Director said that she had visited International and Private Care wards and outpatients. Staff were engaged and managing well with the substantial increase in activity reporting that they felt supported by the hospital. Colleagues had emphasised the importance of continuing to recruit staff in order increase capacity and had reported that the service was able to recruit excellent staff however they often chose to specialise and move to other areas of the Trust. Whilst it was positive that GOSH was able to retain these colleagues it was important to continue to recruit. Suzanne Ellis said that discussion had taken place with staff about whether systems and processes were in place to enable the team to continue to increase activity and they had confirmed that they were.

128	**Patient Story**
128.1	Matteo attended the Board via Zoom to give a patient story about his 10-year-old daughters' experience of food at GOSH when they were inpatients receiving Bone Marrow Transplants. Ophelia had been admitted to GOSH first and had been offered her meals in the normal way, choosing from a menu the previous day. The food had been poor quality and poorly prepared and Ophelia had not been able to eat the meals. Matteo said that his food had also been poor quality and he had chosen to buy and cook his own food despite the stress of doing so whilst caring for a sick child. This had continued for several weeks until a pilot had launched whereby Ophelia had been able to choose her meals on the day and they had been well prepared. Ophelia had been able to eat this food and as a result had not needed as much nasogastric feeding. She had recovered well within a week. Giada had been admitted to GOSH at a later date when the pilot scheme had already begun and had never stopped eating throughout her stay. She had not received as much nasogastric feed and was able to leave hospital two weeks before her sister.
128.2	Matteo emphasised the importance of children and young people's ability to enjoy food for both psychological and physical wellbeing throughout their time in hospital. He said that he felt that the focus of the standard meal provision was on staff convenience, in terms of ordering the food the previous day, the preparation of the meal and the time the meal was served. He said that feedback from patients in the form of uneaten food had not been considered. Under the pilot, patients had been able to provide feedback and this was incorporated into future meals. Staff were not able to taste test the food that they had produced for patients so there had been no quality assurance process. Matteo said that regardless of whether the pilot was taken forward it was vital that the patient was at the centre of the process and that their feedback was considered. He highlighted that nutrition was a vital part of a patient's medical treatment.
128.3	**Action:** The Board agreed that the pilot scheme should be rolled out as business as usual and that the Board would have a range of patient meals for lunch at the next Trust Board meeting.
128.4	Gautam Dalal asked whether the same foods were available under the previous meal provision and the pilot scheme and Matteo said that his daughters had preferred simple foods during their time in hospital and they had been available under both schemes so it had been possible to make a direct comparison. He said that on one occasion the team had provided salmon which hadn't ordinarily been available however the key difference for his daughters had been better quality, better prepared food.
128.5	Tracy Luckett, Chief Nurse said that NHS England was clear that food for children and young people was a priority and added that it was important to learn from the pilot and scale up the work.
128.6	The Board thanked Matteo for his extremely valuable feedback.
129	**Directorate presentation: Blood, Cells and Cancer**
129.1	Clarissa Pilkington, Chief of Service for Blood, Cells and Cancer said that the Directorate was comprised of a wide range of medical specialties and made a substantial contribution to research and innovation in the Trust. Focus was being

	placed on psychological safety to ensure that teams were reviewing complaints and incidents with a view to learning and embedding changes in practice.
129.2	Concerns continued around the environment on Safari Outpatient Daycare Unit which was a suboptimal environment which had an adverse impact on patient, family and staff experience. It was anticipated that improvements would be experienced in 2023 as air conditioning had been installed in some areas, but other estate issues remained. There was limited capacity to isolate patients which could lead to delays and the ward was in an isolated location which had relatively frequent issues with lifts. There had been challenges meeting the Directorate Control Total and almost 50% of the identified Better Value schemes were rated as high risk.
129.3	GOSH was currently the only centre in the world carrying out thymic transplants and the BCC Lead Practice Educator had designed and written the only module in the UK for treatment of children and young people with a particular cancer treatment. Clarissa Pilkington said that the Children's Cancer Centre was key to the Directorate's progress and there had been excellent clinical engagement in creating the vision and design. The team had also continued to meet the 100% targets for cancer waits which was a significant achievement.
129.4	Matthew Shaw congratulated the team on their work in a challenging year. He acknowledged the challenges around Safari Daycare for patients, staff and families and said that it was important to reflect as a Board on the redevelopment decisions which had been taken throughout the years and whether they had addressed the most critical estates needs at the time. He added that work was taking place to review Palliative Care funding and a business case was currently being written to submit to NHS England. John Quinn said that although cancer services in the directorate were high profile there were a number of other world class services such as dermatology. He added that BCC was the first directorate in the Trust to deliver the 'Referral to Treatment' target which was a significant achievement.
130	**Feedback from NED walkrounds**
130.1	Chris Kennedy had visited Mildred Creek Unit and the team had been positive about their upcoming decant and had been engaged in the process. Members of staff had been engaged and inspiring and a positive discussion had taken place with the team. Matthew Shaw said that NHS England would be visiting to review the unit at the end of November 2022. The service model was unusual compared to other centres and consideration was required about how this would be delivered in future. A mental health strategy was being developed which would be very important in supporting this decision making. Russell Viner agreed that there were very few centres nationally which could support patients with both complex mental and physical health needs and said this was an important resource.
130.2	**Action:** Kathryn Ludlow said that she had taken part in a walkround of the hospital at night and had been impressed by the work of the Clinical Site Practitioners. She had also met a vascular access nurse and noted that there were only 4 in the Trust which was a barrier to improved productivity. Matthew Shaw said that one of the business cases which was being prioritised was around veinous access as there was recognition of the improvements this would make. Kathryn Ludlow said that she had visited the gastroenterology wards and staff highlighted challenges in the way the estate was set out. A parent had been very positive about the treatment received at GOSH but felt that communication

	between teams was challenging. Staff reported that patients' discharge were being delayed by local services requesting additional evidence about the care package required.
130.3	**Action**: It was agreed that a report would be considered at QSEAC on the outreach clinics undertaken by GOSH and the model of care involved as well as consideration of the level of risk under the mode. Suzanne Ellis would attend the QSEAC discussion if possible.
131	**Integrated Quality and Performance Report (Month 6 2022/23) September 2022 data**
131.1	Sanjiv Sharma, Chief Medical Officer said that there had been a rise in overdue Serious Incident actions between August and September which had been caused by a large number of actions becoming due and these were being reviewed. The Duty of Candour policy had been updated in October 2022 and the timeframes were being updated to ensure they were achievable.
131.2	Tracy Luckett said that there had been an increase in the number of complaints received with 75 received year to date for 2022/23 against 78 received for the whole of 2021/22. There had also been an increase in PALS contacts around cancellations and discussion was taking place at EMT.
131.3	Caroline Anderson, Director of HR and OD said that there had been an increase in staff turnover which was consistent with the NHS as a whole and this was being monitored. There had also been an increase in staff sickness however this remained below the level of other Trusts.
131.4	**Action:** John Quinn said that a high level of activity was taking place in the hospital however RTT remained broadly stable. Chris Kennedy expressed some concern that activity was high and would increase further during winter and it was agreed that this would be discussed at the Finance and Investment Committee. Matthew Shaw said that good progress had been made on delayed discharge which had reduced by a third but activity continued to increase as did the waiting list and focus was being placed on long waiting patients. Sanjiv Sharma said that colleagues in the Integrated Care System were keen for GOSH to support the system by accepting patients from other organisations, particularly younger children. He said that whilst the Trust was clear that patients must receive the best care it was important to balance this with ensuring that complex patients who could only be treated at GOSH could access services. Matthew Shaw said that the was a tension between moving forward with the Trust's strategy and serving the local population.
131.5	Russell Viner highlighted that mandatory training by honorary contract holders was extremely low and Caroline Anderson confirmed that a proposal was being developed on how this would be managed.
132	**Finance Report (Month 7 2022/23)**
132.1	John Beswick, Chief Finance Officer said that the month 7 position was £5.5million adverse to plan year to date. Income was ahead of plan and pay costs had reduced however there was pressure on non-pay spend.
132.2	Margaret Ashworth, Interim Chief Finance Officer said that the Trust had been

	discussing the process for reforecasting the year end outturn in year with NHS England and this had now been confirmed. The Trust was planning to deliver a £16million Better Value programme and focus was now being placed on the delivery of existing schemes. There was a good level of confidence that the programme would be delivered. There had been a deterioration in cash however this had been mitigated by a focus on debtors.
132.3	Chris Kennedy welcomed the low level of bank and agency spend and Margaret Ashworth said that this would continue to be monitored.
132.4	Suzanne Ellis highlighted that as a result of the Trust's financial circumstances a number of business cases had been paused and asked how the team was ensuring that essential cases were considered. Matthew Shaw said that cases which related to quality and safety had been prioritised and the team had requested they be developed into Full Business Cases. John Quinn confirmed that they would be considered as part of the current business planning cycle and a similar process had been developed for capital spend.
133	**Learning from Deaths report- Child Death Review Meetings – Q2 2022/23**
133.1	Sanjiv Sharma said 26 patient deaths had been reviewed as part of the child death review process. He said that the process was complex at GOSH as a result of the involvement of professionals from throughout the patient's care pathway. As GOSH provided national services these professionals were often located throughout the country. The Child Death Review Meetings identified one case in which there were modifiable factors in terms of national learning outside of GOSH and no cases in which modifiable factors had been identified in the care provided at GOSH. Areas for improvement in practice were identified in 12 cases and areas of excellent practice identified in 18 cases.
133.2	Chris Kennedy asked how the national learnings were disseminated and Sanjiv Sharma confirmed that learning for outside of GOSH is shared with NHS England to take forward. Gautam Dalal asked how the Trust worked with a patient's family when a modifiable factor was identified and Sanjiv Sharma said that previously a modifiable event had been found to meet the threshold for a Serious Incident and this had been communicated with the family and investigated in the usual way.
134	**Guardian of Safe Working**
134.1	Renee McCulloch, Associate Medical Director and Guardian of Safe Working said that the vacancy rate for whole time equivalent posts was increasing over the previous 18 months and was currently 13%. There had also been an increase in exception reporting as a result of encouraging particular teams to report to provide an overview of their working patterns. Work was taking place to understand bank usage in the context of the vacancy rate and the proportion of a vacant post which was being filled by bank staff.
134.2	GOSH rotas were complex with many interdependencies as a result of a large number of small and highly specialised teams. Only a small number of areas were able to stand up their own rotas.
134.3	**Action:** Renee McCulloch said that it was important to ensure that onboarding processes were as efficient as possible particularly as the vacancy rate was increasing. She added that there were challenges in filling posts in some areas as

	a result of the reduction in European colleagues applying for roles in the UK. Matthew Shaw said that a plan on the way in which the junior doctor vacancy rate would be reduced would be brought to Board. He said that the General Medical Council would be changing national policy to pilot allowing hospitals to sponsor doctors to enter the specialist register and it was possible that GOSH could act as a pilot site for this. It was agreed that this would be considered.
135	**Nursing Workforce Assurance Report**
135.1	Tracy Luckett said that a varied approach was being taken to nurse recruitment and this had been successful with the Trust's vacancy rate being 9% in September which was one of the lowest in the North Central London Integrated Care System. There were some hotspots with higher-than-average vacancies including Bear Ward and work was taking place with the Head of Nursing for the Directorate.
135.3	**Action:** Amanda Ellingworth, Chair highlighted that there had been 20 Datix reports related to safe staffing levels and noted that this would encompass a variety of issues on a spectrum of severity and it was difficult to ascertain the actual level of risk which was related to each one. It was agreed that consideration would be given to how this data could be presented in a more helpful way to show the issues and associated risk trending over time. Tracy Luckett said that she was meeting with Heads of Nursing and Clinical Site Director to set out the meaning of unsafe in the GOSH context.
136	**Health Inequality Update**
136.1	Darren Darby, Deputy Chief Nurse said that there had been good progress on the initial programme of work and GOSH had been working with the Children's Hospital Alliance and the Integrated Care System. Three key initial projects had been established to support a better understanding of the patient population and a health inequalities dashboard had been developed in order to review deprivation data. All patients had now been profiled against key metrics. Data was also being collected around digital access and whether patients were able to access videoconferencing equipment. The final project was a health inequalities education programme and this had been presented to the GOSH Learning Academy Board.
136.2	The programmes of work would be undertaken by five working groups. Their focus would reflect the national priorities and would be overseen by a steering group and an assurance framework would be implemented with assurance reports would be provided to the Board going forward.
136.3	Russell Viner noted that 58-60% of GOSH's patients were from the lowest socioeconomic groups and said that it was also important to consider whether patients from lower socioeconomic groups also received intensive and technology dependent treatment in the same way as their peers from other socioeconomic groups. He added that it was important to consider a pathway-based approach.
136.4	Suzanne Ellis welcomed the work that had taken place so far and said that it was important to also consider staff from a wellbeing perspective. She emphasised the importance of ensuring there was appropriate diversity of the steering committee and working groups and added that consideration should be given to involving the Council of Governors in this area.

137	**Annual Planning 2023/24**
137.1	**Action:** John Beswick said that the annual plan was being developed and would be presented to the Board for approval at the end of March 2023. He said that it was important that the plan was appropriate for GOSH and its patients, but he added that it must also form part of the required position for the integrated care Board. John Quinn said that planning guidance had not yet been received and a note would be sent to the Board on the impact of the guidance once it had been published.
138	**Seen and Heard annual report 2022**
138.1	Caroline Anderson said that the Trust had continued to move forward with the priorities set out in the Seen and Heard Framework despite the challenging context, and excellent work had been undertaken by the staff networks which had supported this progress. She said that work had taken place to develop internal career pathways and this remained a priority going forward. A new diversity and inclusion lead had been appointed and would join the Trust on 4th December 2022.
138.2	Matthew Shaw agreed that incremental change had been made but said that it was important to improve progress. Discussions had taken place with another London Trust about their work in this area and Matthew Shaw said that it was vital that GOSH continued to challenge itself to do more.
138.3	Chris Kennedy asked for a steer on the accuracy of the data and Caroline Anderson said that in general good quality data was being collected however there were hotspots which required additional focus, particularly around disability and long-term sickness. She said that it was clear from the staff survey that considerably higher numbers of staff self-declared a disability than was captured by the Trust. Amanda Ellingworth emphasised the importance of staff feeling safe to make these declarations as well as those related to LGBTQ+ status.
139	**Update on Board Assurance Framework**
139.1	<u>Quality, Safety and Experience Assurance Committee – November 2022</u>
139.2	The Board noted the update from the QSEAC.
139.3	<u>Audit Committee</u>
139.4	Gautam Dalal, Chair of the Audit Committee said that a good quality and succinct paper had enable a particularly nuanced discussion on BAF risk 1: Financial Sustainability.
139.5	<u>Finance and Investment Committee Update – September 2022</u>
139.6	Suzanne Ellis, Chair of the Finance and Investment Committee said that a full update from the September meeting had been given at the November Council of Governors' meeting. The next FIC meeting was being held on 25th November 2022.
139.7	<u>People and Education Assurance Committee Update – September 2022 meeting</u>

139.8	Kathryn Ludlow, Chair of the PEAC said that a full update had been given at the November meeting of the Council of Governors.
140	**Council of Governors' Update**
140.1	Amanda Ellingworth said that Sir Michael Rake's tenure as Chair would end on 23rd October 2023 and the process to appoint a new Chair had been approved by the Council at the meeting.
140.2	**Action:** Suzanne Ellis said that an update had been received about the improvements made to Wi-Fi in the hospital however negative feedback continued to be received from patients and families. She asked when follow up action would be taken. Matthew Shaw said that there was a disconnect between the perception of the ICT team and patient and families and it was agreed that a Directorate story would be given by the ICT team on the work that had taken place. Amanda Ellingworth emphasised the important of Wi-Fi availability to patients and families.
141	**Register of Seals**
141.1	The Board **endorsed** the use of the Company Seal.
142	**Any Other Business**
142.1	Caroline Anderson gave an update on the nursing strike action as information had been becoming available during the meeting. GOSH was one of 23 hospitals in London which had voted for strike action by the Royal College of Nursing. No strike dates were available yet however it was anticipated that this would take place prior to Christmas. Business continuity was being reviewed at a directorate level and two new groups had been established to review areas which would be derogated. She said that GOSH supported staff to take lawful action within the parameters of the Trust being able to provide safe essential care. The Trust would continue to work with staff and their union representatives.

Attachment I

TRUST BOARD – PUBLIC ACTION CHECKLIST
February 2023

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
125.1	23/11/22	John Quinn, Chief Operating Officer said that a key driver of last minute cancellations was bed closures and discussions were taking place with Chiefs of Service about ways to minimise this. Amanda Ellingworth, Chair said that feedback had been received from staff on the walkround prior to Trust Board that the Trust was not sufficiently proactive in terms of reminding patients and families about their appointments and this was contributing to instances of 'was not brought'. John Quinn said that GOSH was part of a national 'was not brought' initiative which considered how Trusts were performing and ways in which processes could be strengthened. It was agreed that data on cancellations would be presented as part of the IQPR and a plan for reduction would be presented at QSEAC.	JQ	January 2023	Verbal Update
128.3	23/11/22	The Board agreed that the catering pilot scheme should be rolled out as business as usual and that the Board would have a range of patient meals for lunch at the next Trust Board meeting.	AF	March 2023	Not yet due: Planned for March 2023 Board meeting.
130.3	23/11/22	It was agreed that a report would be considered at QSEAC on the outreach clinics undertaken by GOSH and the model of care involved as well as consideration of the level of risk under the model. Suzanne Ellis would attend the QSEAC discussion if possible.	JQ	May 2023	Actioned - Passed to QSEAC
131.4	23/11/22	John Quinn said that a high level of activity was taking place in the hospital however RTT remained broadly stable. Chris Kennedy expressed some concern that activity was high and would increase further during winter and it was agreed that this would be discussed at the Finance and Investment Committee.	JQ	February 2023	Passed to the Finance and Investment Committee
134.3	23/11/22	Renee McCulloch said that it was important to ensure that onboarding processes were as efficient as possible particularly as the vacancy rate for junior doctors was increasing. She added that there were challenges in filling posts in some areas as a result of the reduction in European colleagues applying for roles in the UK.	Renee McCulloch	February 2023	Actioned – on agenda under Guardian for Safe Working plus verbal update.

Attachment I

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		Matthew Shaw said that a plan on the way in which the junior doctor vacancy rate would be reduced would be brought to the Board. He said that the General Medical Council would be changing national policy to pilot allowing hospitals to sponsor doctors to enter the specialist register and it was possible that GOSH could act as a pilot site for this. It was agreed that this would be considered.			
135.3	23/11/22	Nursing Workforce Assurance Report: Amanda Ellingworth, Chair highlighted that there had been 20 Datix reports related to safe staffing levels and noted that this would encompass a variety of issues on a spectrum of severity and it was difficult to ascertain the actual level of risk which was related to each one. It was agreed that consideration would be given to how this data could be presented in a more helpful way to show the issues and associated risk trending over time.	TL	March 2023	Not yet due
137.1	23/11/22	John Beswick said that the annual plan was being developed and would be presented to the Board for approval at the end of March 2023. He said that it was important that the plan was appropriate for GOSH and its patients, but he added that it must also form part of the required position for the integrated care Board. John Quinn said that planning guidance had not yet been received and a note would be sent to the Board on the impact of the guidance once it had been published.	JQ, JB	January 2023	Verbal Update
140.2	23/11/22	Suzanne Ellis said that an update had been received about the improvements made to Wi-Fi in the hospital however negative feedback continued to be received from patients and families. She asked when follow up action would be taken. Matthew Shaw said that there was a disconnect between the perception of the ICT team and patient and families and it was agreed that a Directorate story would be given by the ICT team on the work that had taken place. Amanda Ellingworth emphasised the important of Wi-Fi availability to patients and families.	JQ	May 2023	Not yet due

Attachment J

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 2 February 2023	
Chief Executive's Report **Submitted by: Matthew Shaw, Chief Executive**	**Paper No: Attachment J** **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.	
Patient Safety Implications • No direct implications (relating to this update in isolation).	
Equality impact implications • No direct implications (relating to this update in isolation).	
Financial implications • No direct implications (relating to this update in isolation).	
Action required from the meeting • None – for noting	
Implications for legal/ regulatory compliance Not Applicable	**Consultation carried out with individuals/ groups/ committees** Not Applicable
Who is responsible for implementing the proposals / project and anticipated timescales? Executive team	**Who is accountable for the implementation of the proposal / project?** CEO
Which management committee will have oversight of the matters covered in this report? Executive team	

Part 1: Operational updates

Industrial action

In December we had two days of nursing strikes, an ambulance strike and multiple train strikes. Inevitably these affected our performance. However, the hard work of the operational teams and dedication of clinical staff mitigated the impacts, with more outpatient appointments moving to virtual and inpatient activity rescheduled. Activity was down to approximately 80% for the 2 weeks of the strike and the main access indicators dropped (RTT down 2.3% to 70.9%, diagnostic waits down 6.9% to 82.3%, 52 week waits up 29 to 248). These key indicators remained above the national averages.

The strikes had a negative impact on some patients and families in spite of our efforts to minimise disruption. Patient Experience generally remained high with Inpatient experience remaining at 98% positive but Outpatients dropped to 93% from 97% in September, mainly related to last minutes changes in appointments and clinicians.

Although strikes inevitably involve significant operational challenges, we fully respect the right of staff to take part in lawful industrial action and will work hard with colleagues across the trust and trade unions to facilitate action while keeping the hospital safe. Our teams were able to negotiate effective derogations to the strikes to ensure essential services were able to continue. It is really positive that the RCN has fed back that our way of working with them has been really constructive and the strike days were conducted very amicably.

The Chartered Society of Physiotherapy (CSP) industrial action took place on Thursday 26 January in response to a dispute about pay and retention. We've continued to work closely with The Chartered Society of Physiotherapists (CSP) and our physiotherapy colleagues at GOSH to support planned strike action while also continuing to deliver essential patient care. We requested derogations for some physiotherapy services on PICU, NICU, CICU, Leopard ward and other respiratory outliers and for physio assessments to inform decisions around chemotherapy dosage.

Looking ahead, we have also had notice that RCN members across England and Wales, including at GOSH will strike again for 12 hours on both Monday 6 and Tuesday 7 February 2023. This will require significant planning to minimise disruption. We currently have a live ballot from Unison which closes on 2nd February and the BMA, covering Junior Doctors, which closes on 20th February. We are also anticipating ASLEF industrial action will cause significant disruption to some rail services on Wednesday 1 and Friday 3 February, and TfL services may also be impacted on those days.

Our staff communications on the strikes have been pro-active with signposting to a regularly updated FAQ on GOSH web. We will continue to keep the Board updated on the impacts as the situation develops.

Cumulative paediatric demand and winter pressures

The Board will be aware that over recent months in particular have seen rising levels of pressure across the NHS, with unprecedented numbers of urgent and emergency

presentations across England. This creates upstream pressure on beds – including capacity in paediatric ICUs – and on whole-system ability to drive patient flow and discharge back into the community.

GOSH does not have an emergency department, so the operational pressures have not been as acute here as they have for other trusts. However, the paediatric sector has less resilience to scale up than the adult sector, and there is growing evidence that performance within children's services is falling behind. We have certainly experienced the knock-on effects of this at GOSH, with increasing demand for urgent admissions and critical care; increasing numbers of patients referred who have already been waiting for long periods; and growing difficulties with safely discharging patients back to the care of teams closer to their homes.

Our staff are also having to deal with the wider impacts on the health and wellbeing of our young people and families who may have experienced distress caused by waiting and wider disruption to their lives, and with increasing complexity of physical and mental health presentations.

They are doing an amazing job to balance these seemingly ever-increasing pressures and working towards our shared aspiration never to decline referral requests for children who need our help – all while maintaining high levels of elective activity to keep on top of waiting lists and meeting the wider biopsychosocial needs of our complex patient cohort.

Supporting our staff

To support our staff in dealing with these demands in the context of a cost of living crisis, we provided simple hot meals for free during December and January and tea, coffee and sugar supplies in staff rest areas. This bolsters our staff hardship fund offer and we will continue to speak to staff, monitor the impact of these interventions and consider other ways we can help them – where it is in our power to do so.

This year we will also be setting up a Staff Advice and Liaison hub (SALS), which is a one-stop shop for staff support, and we're also going to review our People Strategy and values to make sure they reflect what matters most to our staff.

Part 2: Financial position going into 2023/24

The central message of the NHS Priorities and Operational Planning Guidance for 2023/24[1], is that NHS trusts will continue to be expected to continue to deliver more with the same resources, driving efficiencies and whole-system flow, as well as supporting the widespread reforms represented by the new Integrated Care Systems and the NHS Long Term Plan (2019).

NHS organisations will be expected to deliver against this wider spectrum of priorities and a more challenging set of targets without increased investment and with limited agency to address many of the pivotal issues affecting our workforce.

Our Better Value programme for 2022/23 is putting the Trust in a strong position to contribute to the system total, with £16.3m of savings identified from our £22.8m target and £11.2m delivered to date. This is a huge credit to our finance,

[1] NHS England » 2023/24 priorities and operational planning guidance

transformation and operational management teams who will continue to work hard to ensure that quality of care is not impacted.

Private patients are showing some very promising signs of recovery with a good pipeline. However, we have an outstanding issue with the resolution of underpayment by the ICS for this financial year, which has the potential to destabilise our position significantly in the longer term if not recurrently resolved. We have flagged this outstanding 'technical issue' to system colleagues and will continue to work with our ICS and colleagues to work towards resolution.

Ends

Attachment K

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
1 February 2023

Patient Story	**Paper No: Attachment K**
Submitted by Tracy Luckett, Chief Nurse **Prepared by** Claire Williams, Head of Patient Experience	□ **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
Alice, aged 2, was under the care of the Bone Marrow Team at GOSH. After a successful bone marrow transplant in March 2018, her condition deteriorated, and she was readmitted to GOSH in September 2018. Alice sadly died in November 2018 and her family made a complaint in March 2019. Following the complaint investigation, NHS England commissioned an external review to optimise learning from the experiences of Alice and her family.

Kerry, Alice's mum, will attend Trust Board via zoom and will talk about:

- The care Alice received during her first admission and how this differed when she was readmitted
- Communication with staff, support and her experiences following Alice's death
- Her experience of making a complaint and the subsequent external learning review
- Her desire for learning to drive improvements in care and other important aspects of experience for other families

Patient Safety Implications
There have been significant changes since 2018 in the Trust's approach to risk and safety management. A restructure of the Quality, Safety and Risk function, introduction of the Safety Surveillance team and review of the risk management policy have addressed patient safety issues identified through the review. Any outstanding safety issues and actions to address them are being monitored through a Steering Group reporting into QSEAC.

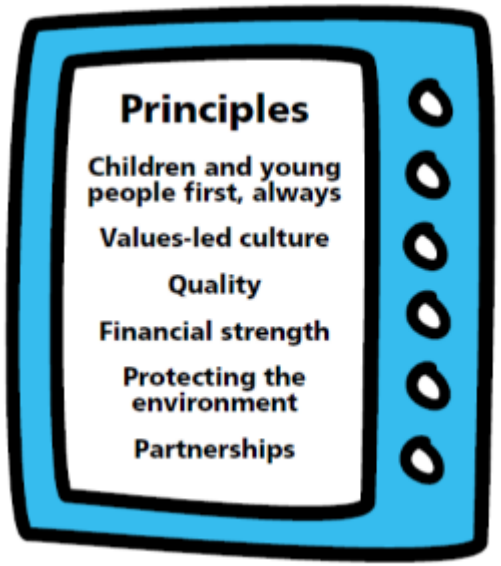
Equality impact and experience implications
Comprehensive actions plans are being collated to address the issues identified through the external learning review. This will be monitored via a Steering Group which reports into QSEAC.

Action required from the meeting
For information

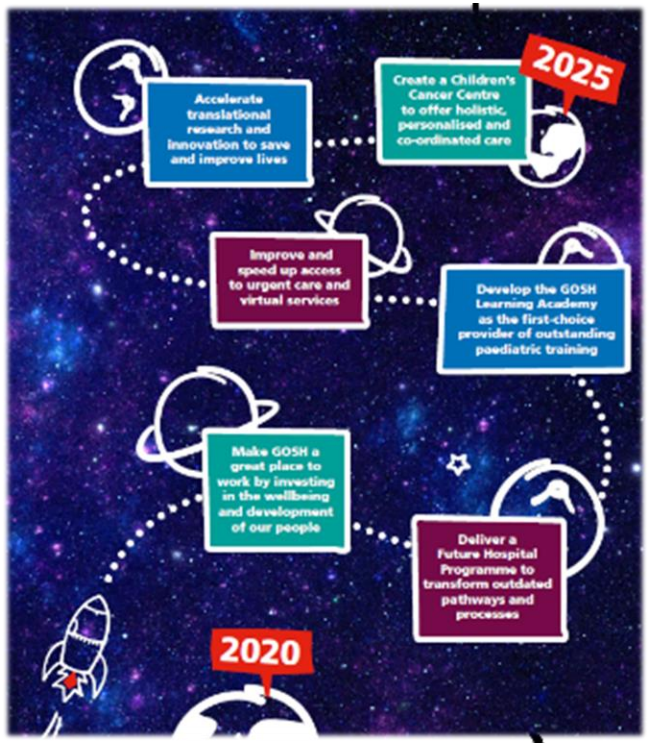
Attachment K

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

Core Clinical Services
DIRECTORATE REVIEW



Trust Board
1st February 2023



Chief of Service - Dr Tim Liversedge

Deputy Chief of Service - Adeboye Ifederu

General Manager - Ruth Leighton

Interim Head of Nursing and Patient Experience - Desamparados Piquer

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Corporate partners

HR Business Partner
Niamh McDonnell

Finance business partner
Shama Bhat

Senior Performance Manager
Rachel Watson

Directorate Safety partner
Iain Keers

Dr Tim Liversedge
Chief of Service

Ade Ifederu
Deputy Chief of Service
directorate lead for quality & safety

Core Clinical Services

Hannah Thatcher
Senior Directorate PA

Desamparados Piquer
Head of Nursing

Ruth Leighton
General Manager

Anaesthesia & Pain

Anaesthesia Speciality Lead
Dr Hilary Glaisyer

Pain Speciality Lead
Dr Glyn Williams

Service Manager
Joel Cullen

Biomedical Engineering

Clinical Leads for Biomedical Engineering
Claire Beckwith
Stuart Stagg

Clinical Genetics

Speciality Lead
Dr Munaza Ahmed

Lead Genetic Counsellor
Anita Bruce

Service Manager
Dayani Balasubramaniyem

Imaging

Lead Radiographer
Clare Simcock

Body radiology speciality lead
Dr Alistair Calder

Neuro-radiology speciality lead
Dr Kshitiji Mankad

Interventional radiology speciality lead
Dr Samantha Chippington

Service Manager
Ellis Wells

Pharmacy

Chief Pharmacist
Jayne Ballinger

Deputy Chief Pharmacist x2
Vacant

Lead Governance
(Hong Thoong)

Operational Lead (dispensary/stores)
Karen Matthews

Director Children's Medicines Centre
Steve Tomlin

Laboratory Medicine

Chief of Laboratory Medicine
Kimberly Gilmour

Lead Laboratory Manager
Christine Morris

Business Manager
vacant

Theatres

Matron
Ivona Ojo

Matron
Maria Quiazon

Service Manager
Joel Cullen

Therapies

Head of Dietetics
Philippa Wright

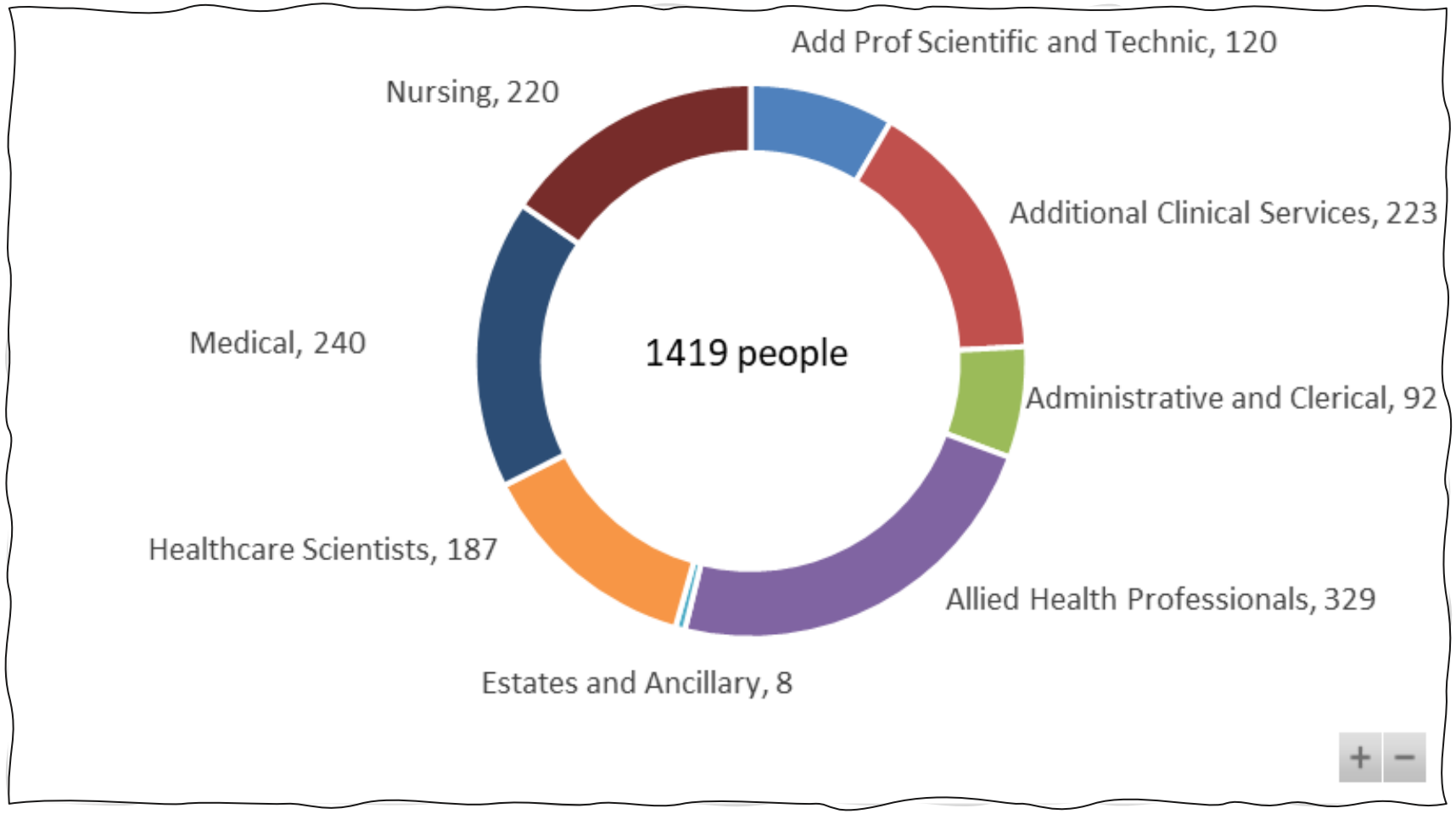
Interim Head of Physiotherapy
Louisa Hill
Sue Malliard

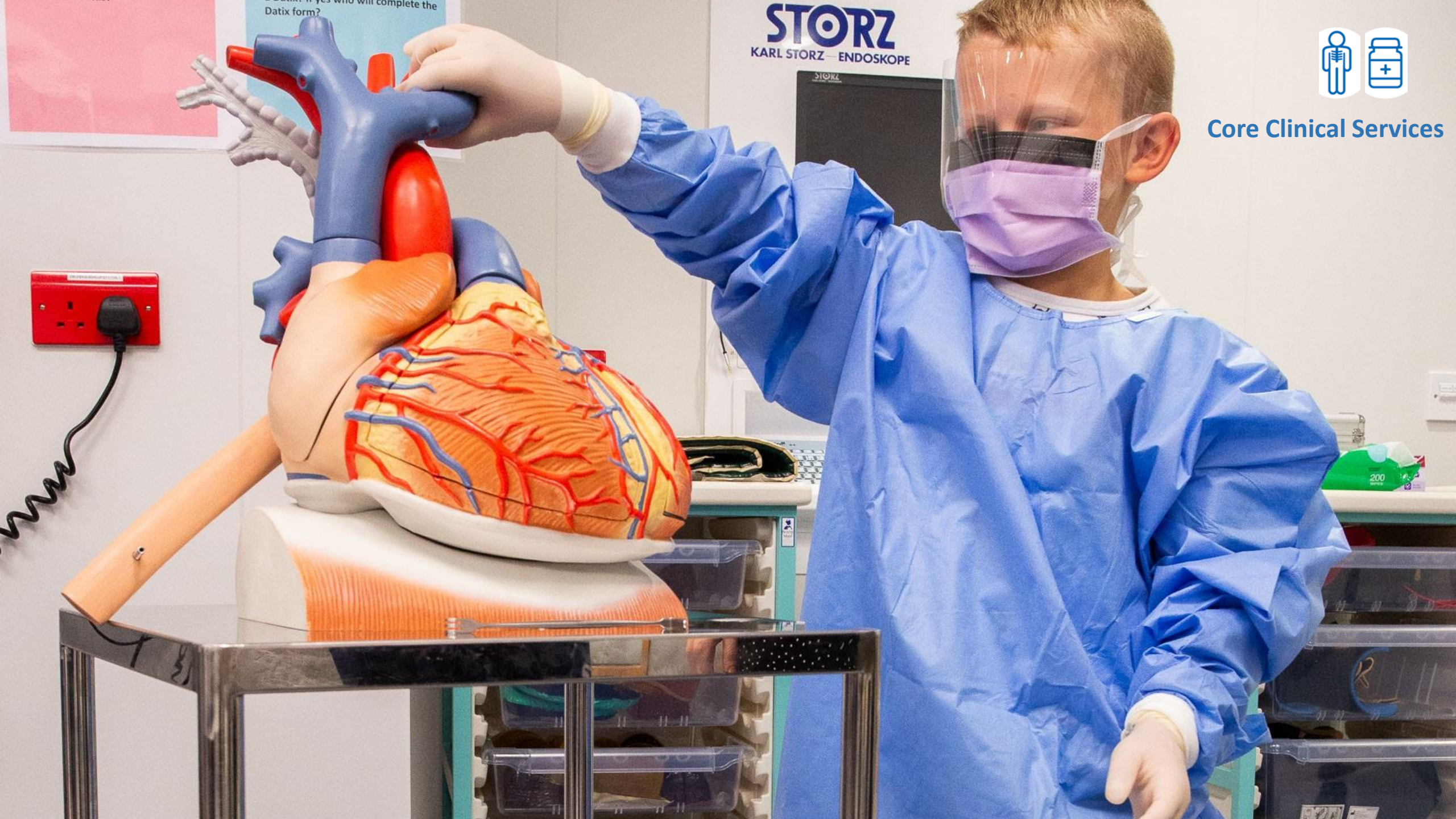
Head of Speech & Language Therapy
Lesley Cavalli

Head of Occupational Therapy
Anne Addison
Alex Bultitude

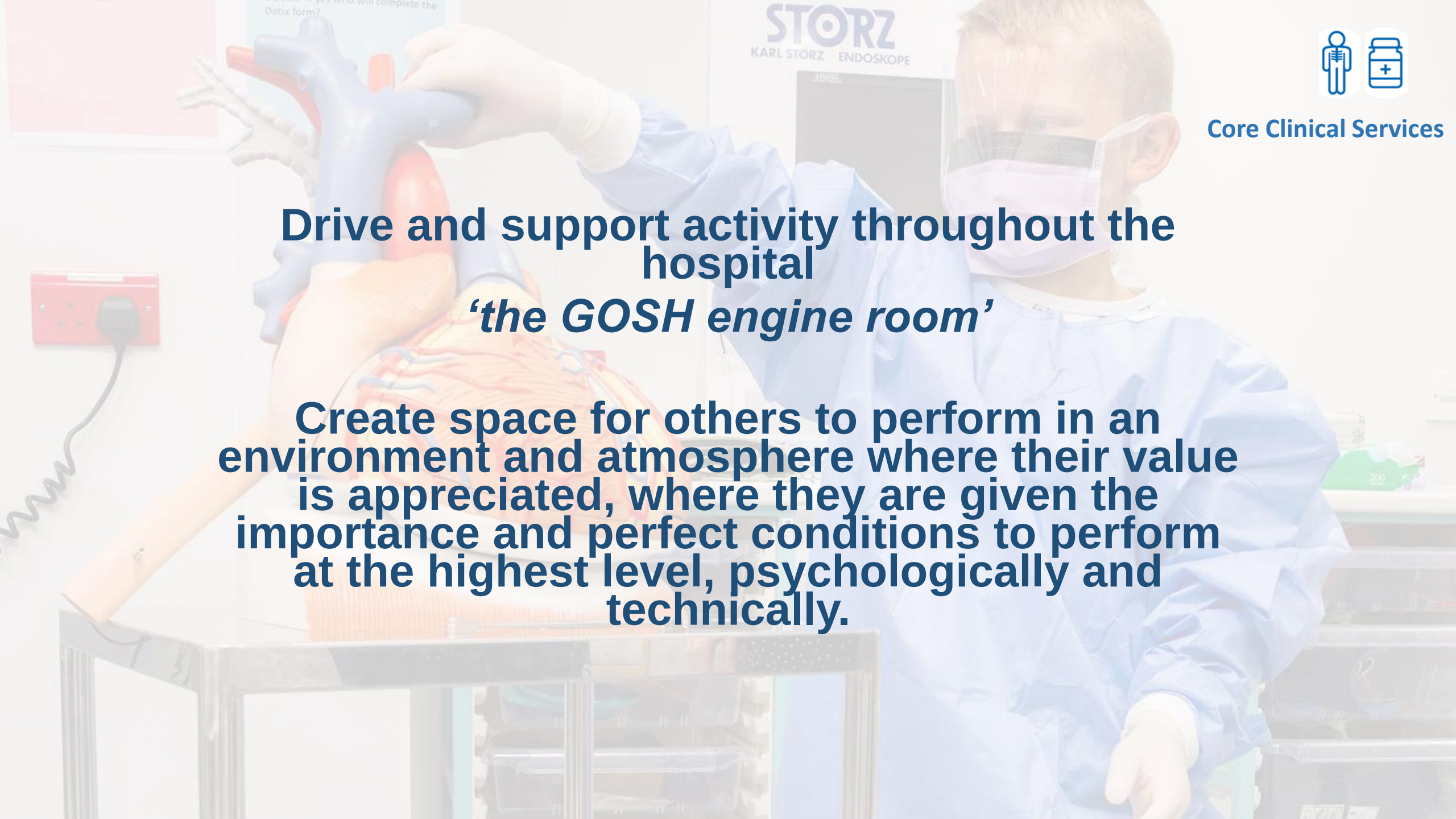
Service Manager
Dayani Balasubramaniyem

Who we are


Add Prof Scientific and Technic, 120
Nursing, 220
Additional Clinical Services, 223
Medical, 240
1419 people
Administrative and Clerical, 92
Healthcare Scientists, 187
Allied Health Professionals, 329
Estates and Ancillary, 8



Core Clinical Services



Core Clinical Services

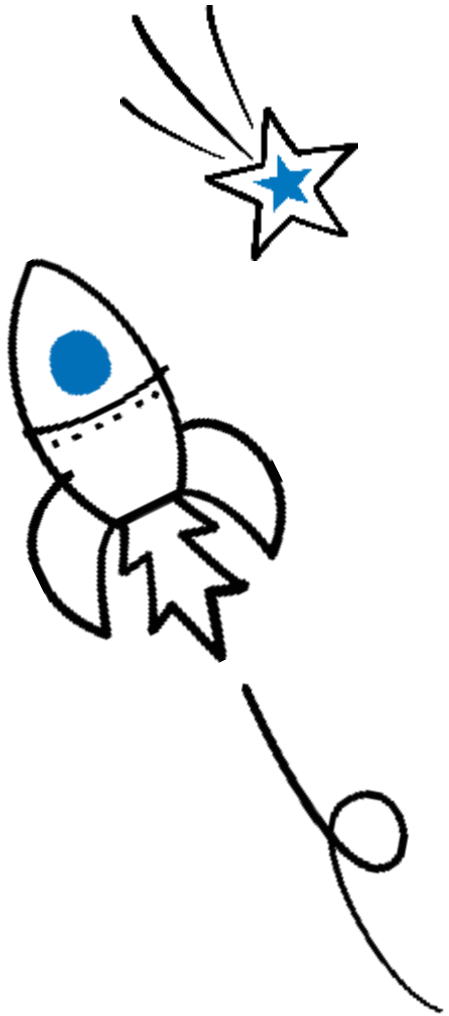
Drive and support activity throughout the hospital

'the GOSH engine room'

Create space for others to perform in an environment and atmosphere where their value is appreciated, where they are given the importance and perfect conditions to perform at the highest level, psychologically and technically.

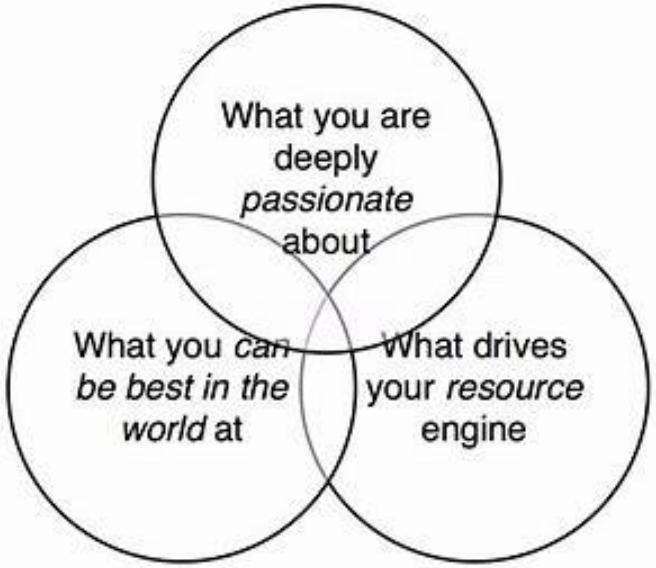
Areas of expertise

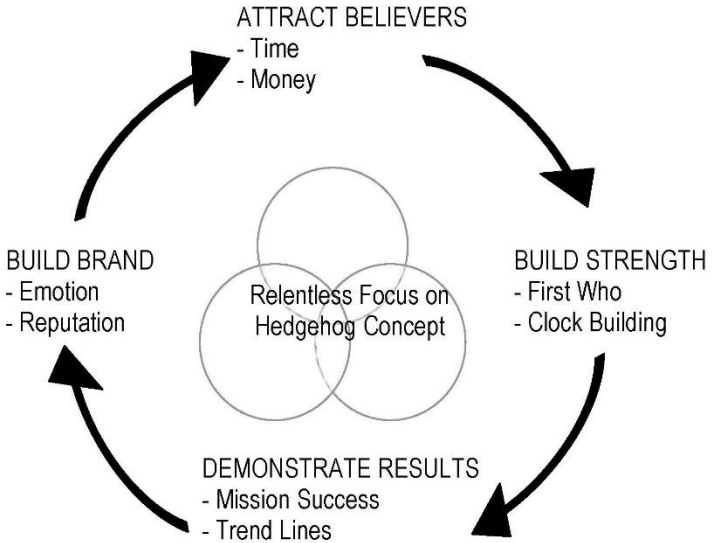
Anaesthesia	Biomedical Engineering	Clinical Genetics	Chemical pathology	Dietetics
Haematology and blood transfusion	Histopathology	Imaging	Immunology	Medicines safety
Medicines manufacturing	Microbiology, bacteriology and infection control	Occupational therapy	Pain Management	Pharmacy support to clinical trials
	Physiotherapy	Speech and Language therapy		

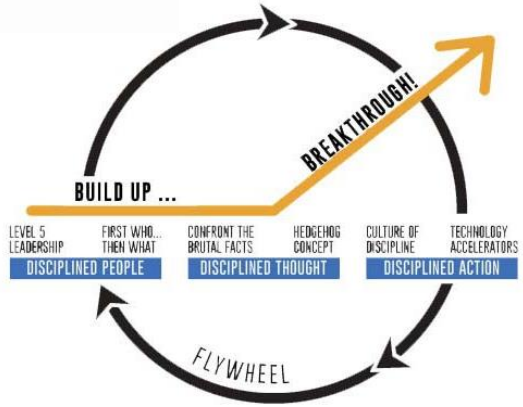


Values led culture

Principle 2







CIVILITY SAVES LIVES

"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

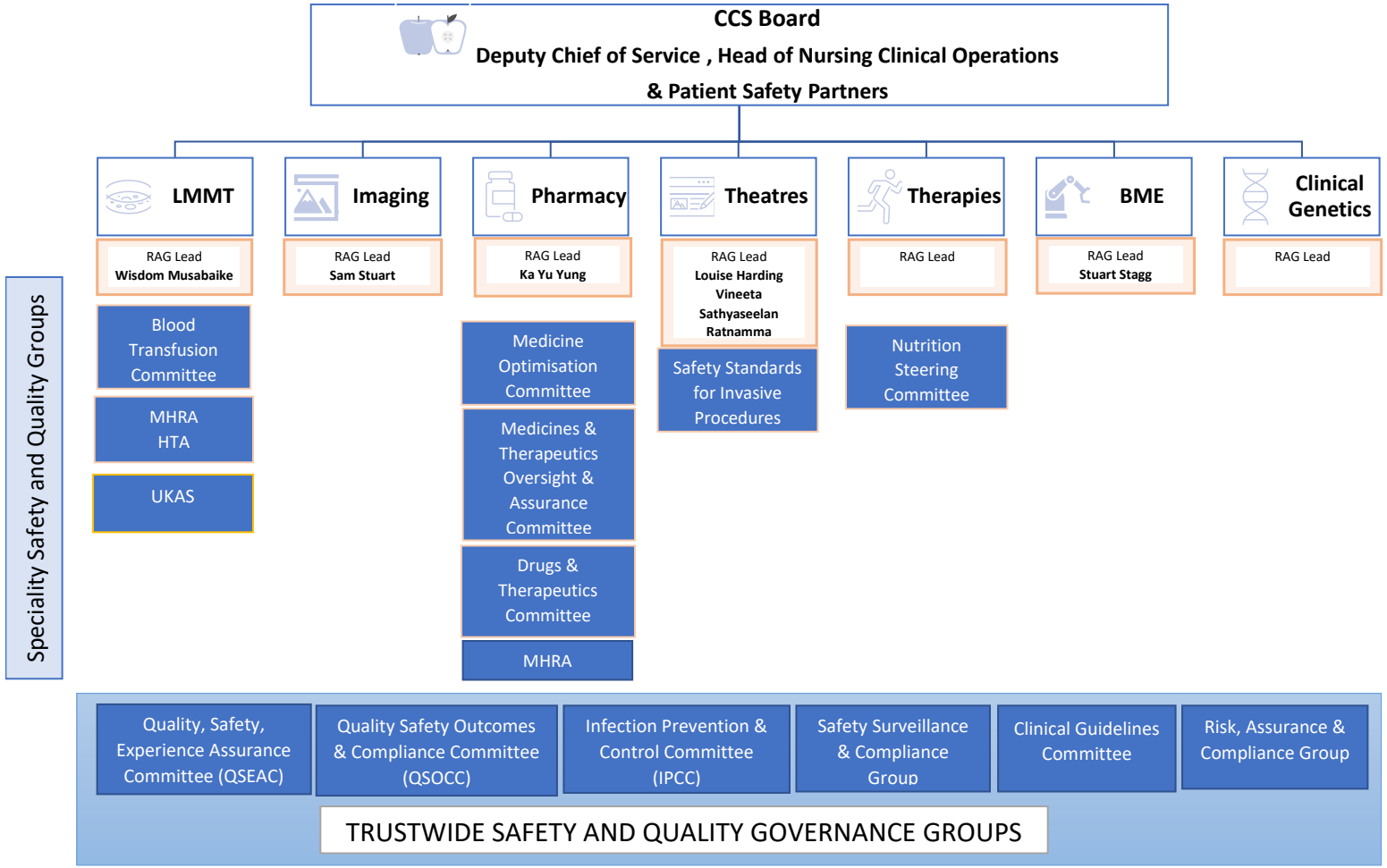
"I saw incivility really impact the performance of an experienced registrar in theatre, that then caused all of the other theatre staff to make mistakes. It has a massive negative impact on performance"

JOE
January 10, 2017

https://www.civilitysaveslives.com/

How do we ensure safe services?

Principle 3: Quality



Financial strength

Principle 4

Annual Budget: £85,600,651

Successes 22/23

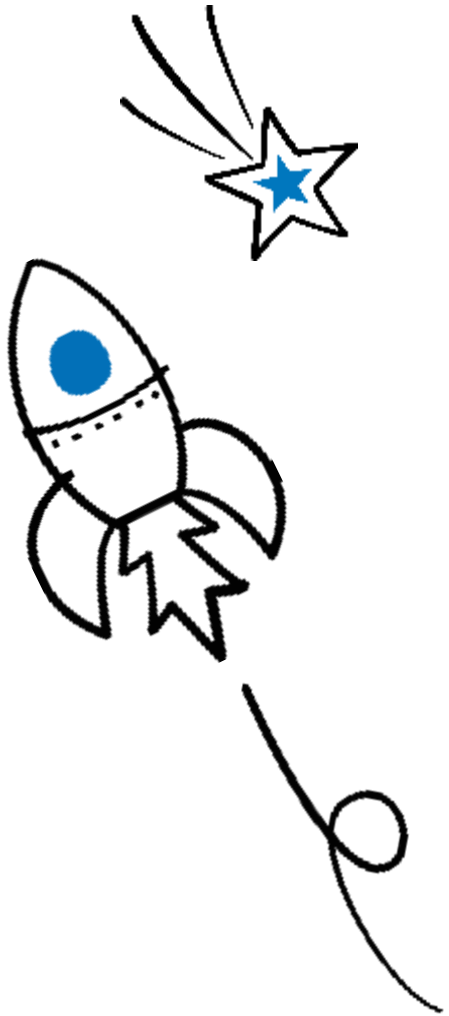
- **BME** supported the procurement and roll out of:
  - 323 Patient monitors (£2.56m)
  - 120 ward beds (£234k)
  - 35 ICU beds (£701k)
  - 700 infusion pumps – equivalent cost £1.4m
    obtained free via distribution of equipment acquired by DHSC to form the national covid loan stock
- Improved Pathology Test income
  both activity driven and improved process
- Pathology research income improvements

20/23 Looking forward

- **Private + Research Income-** Clinical trial income in pharmacy is £500k YTD against a £339k target YTD.
- **Pay Budget –** £70,965,519
- **Non-Pay -** £20,296,810
- **Sharing the challenge –** Messages on financial challenge were shared early through the directorate governance structure, and efficiency is a standing item on team meetings

Better Value 22/23

- Target of £4,393,592
- c£2.5m in identified schemes
- c£2.1m delivered
- £1.0m in medicines savings delivered
  Control of our pharmacy inventory, this having been a major challenge since EPIC go-live.



Protecting the Environment

Principle 5

Imaging and Theatres:

Reducing volatile usage
Eradicating Desflurane
TIVA
Working towards re-useable laryngoscopes
Overnight theatre shutdown

Pharmacy + Theatres:

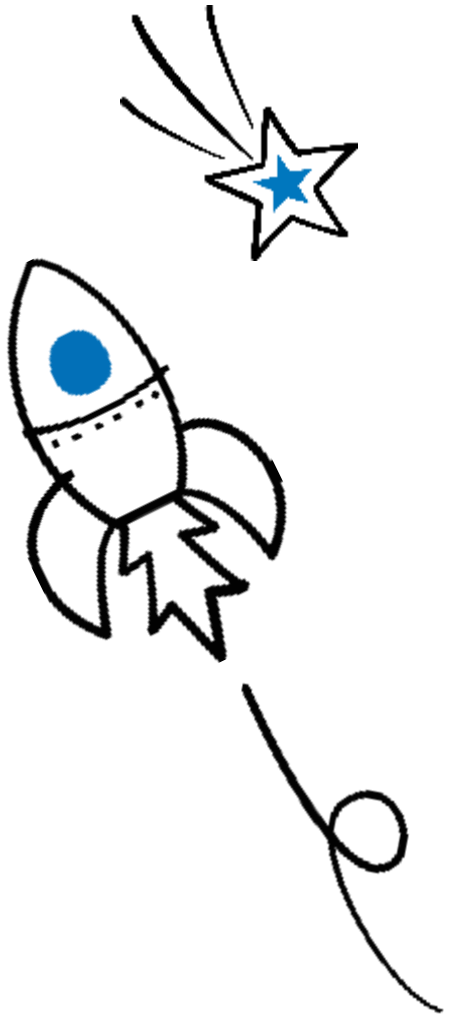
Nitrous oxide group

Labs+ Infection control:

Gloves off campaign

Dietetics:

Special feed unit project to recycle feed bottles and reduce plastic waste



Partnerships

Principle 6

New and established relationships

- NCL Startwell programme
- Contribution to NCL CDCs
- Potential Royal Free Gastro
- Birmingham histopathology
- NCL diagnostics
- NCL pharmacy manufacturing group

Network relationships

US pathology network

Medicines Information queries integrated within MyGOSH to improve communication with patients/parents and carers

NCL diagnostic quality + safety Group

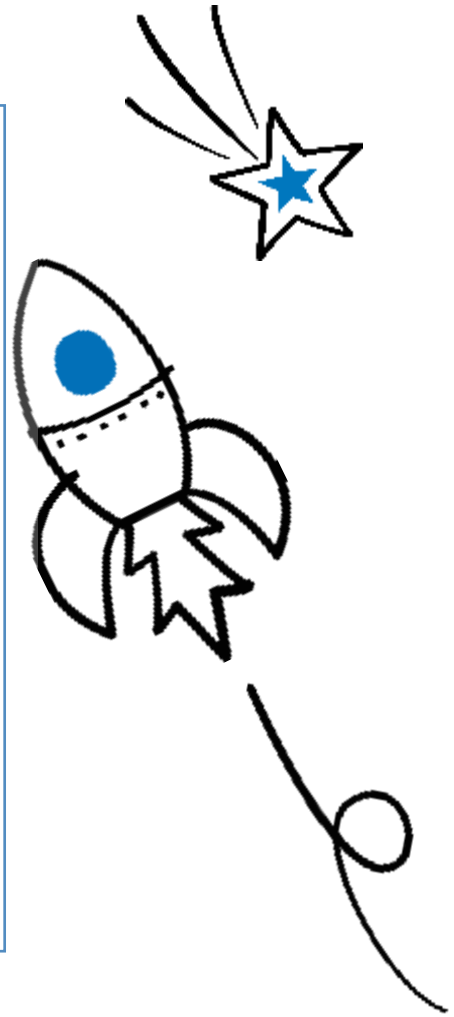
Amanda Kelsey Co-chair

Dr Barnacle gave Josef Roesch lecture at CIRSE 2022

NCL Advanced Clinical Practise Group

Emma Rose Co-Chair

Dr Chippington appointed Head of School, London School of Radiology, HEE



Research and Innovation – a sample

Imaging

- Radiology research group
- Dr Susan Shelmerdine - c£1m funding – NIHR using AI to identified fractures in children.
- Doctors Are Pioneering a Better Way to Perform Autopsies on Kids | WIRED UK
- Owen Arthurs appointed professor of radiology
- Successful bid for MRI acceleration software to enable faster image acquisition

Laboratory medicine

- Histopathology Research Quality and Improvement Committee
- Micro/virology work around paediatric hepatitis
- Immunology/cell therapy/haematology– gene therapy CAR T cells and treatment for rare diseases– over 20 trials supported
- Tom Jacques (+Neil Sebire) £900k+ MRC grant – Mapping the maternal fetal interface at a single-cell resolution to interrogate the aetiology of severe pre-eclampsia and identify potential disease
- > 50 publications last year from histopath alone

Therapies

- ***Dietetics*** surgical neonatal nutrition pathway (>1000 surgical bed days/yr saved)

Pharmacy

- CMC: This clinical academic unit is starting to take off.
    - 2 current PhD and 4-5 more interviewed and awarded for 2023
    - Partnership agreement on Real World Data with UCL-SOP
    - Partnership agreements being drawn up with Proveca Ltd and Novolabs
    - Leading on Medicines Sustainability for NCL ICB
    - Leading the Research Network for Allied Professionals and Scientists

- Supported 44 new studies so far this year (30 commercial)
    - Reaching sponsor's global recruitment targets in high stake studies; Mission EB, Longwing & Admiral
    - Leading on paediatric studies for rare genetic diseases and childhood cancers.
    - Contribution to CAR T-cell and other ATIMP trials
    - Management of over 250 CTIMP studies, 60% are commercial studies that generate income for the department.

Top three operational successes

Supporting activity recovery after COVID

Bed replacement program

Monitor replacements

Top three operational challenges

Ageing radiology equipment

Space

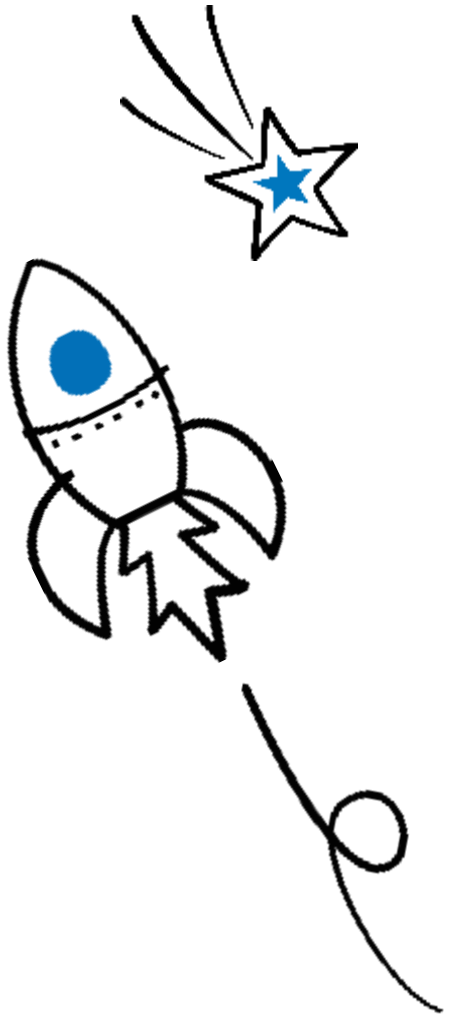
Responding to strike action (nursing/train/physio/amber blood shortage/supply chain)

Top three operational priorities

Operationalise our new directorate structure

Eradicate incivility at work

Support the future hospital



Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 1st February 2023	
GOSH Clinical Strategy **Submitted by: Ella Vallins, Head of Strategy and Planning**	**Paper No: Attachment M** □ **For approval**

Summary of report

The Trust's corporate strategy, Above and Beyond 2020- 2025, launched in September 2020, Above and Beyond clearly states that Great Ormond Street Hospital NHS Foundation Trust's (GOSH) role and purpose is to focus on children who rely on specialist care – those who are seriously ill – those who have complex needs and those with rare or undiagnosed conditions. Whilst Above and Beyond's articulated purpose remains steadfast and evergreen, the context and landscape in which GOSH resides has changed substantially, particularly in terms of policy, legislation, financing, and because of the COVID-19 pandemic. The clinical strategy was commissioned to address key questions and to consider what this means for the hospital clinically considering these changes, now and for the future.

The Clinical Strategy for Great Ormond Street Children's Hospital NHS Foundation Trust (GOSH) was brought to the Executive Management Team (EMT) on 17th October 2022, and subsequently to the Board Strategy Away Day on 2nd November 2022 where it was presented alongside an approach for Transformation to deliver upon the clinical strategy's strategic guidance, and how our new approach to Data will help us know if we are.

Following the decision on the 17th October 2022, we were asked to take the document away and further socialise the strategy across the organisation with key groups to understand how it is received, and to take and consider feedback in regard to next steps, with a view for it to return to The Board on the 1st February 2023 for formal approval as a strategic clinical direction for the Trust .

We have worked through a program of engagement and believe that this strategy reflects a widely held cohesive strategic clinical direction of the organisation. By following this as our clinical strategic direction we will be continuing to ensure our patients who rely on us for their complex and rare conditions and healthcare needs continue to receive the best care available.

The attached document - the Clinical Strategy outlines the strategic thinking of the strategy, an update as to how Transformation and an OKR approach will assist in its delivery will follow in March 2023 which was agreed as the next step in October of 2022.

Patient Safety Implications
N/A

Equality impact implications
N/A

Financial implications
N/A

Strategic Risk
Relevant to all BAF risks

Action required from the meeting Approval of the Clinical Strategy
Consultation carried out with individuals/ groups/ committees Please see attached paper outlining consultation process.
Who is responsible for implementing the proposals / project and anticipated timescales? An update as to how Transformation and an OKR approach will assist in its delivery will follow in March 2023's Trust Board.
Who is accountable for the implementation of the proposal / project? The Executive

Attachment M

Summary

The Trust's corporate strategy, Above and Beyond 2020- 2025, launched in September 2020, Above and Beyond clearly states that Great Ormond Street Hospital NHS Foundation Trust's (GOSH) role and purpose is to focus on children who rely on specialist care – those who are seriously ill – those who have complex needs and those with rare or undiagnosed conditions. Whilst Above and Beyond's articulated purpose remains steadfast and evergreen, the context and landscape in which GOSH resides has changed substantially, particularly in terms of policy, legislation, financing, and because of the COVID-19 pandemic. The clinical strategy was commissioned to address key questions and to consider what this means for the hospital clinically considering these changes, now and for the future.

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During **November and December 2023,** a period of intense socialisation and engagement occurred across the hospital. This followed the form of both structured formal briefings, roundtables, and more informal conversations with key audiences and stakeholders – clinical and ops staff, governors/members and patients and their families.

Formal Briefings

Each of the current 6 Chiefs of Service (CoS) held clinical strategy socialisation and engagement sessions at their Directorate boards, and with their specialty leads and teams This meant that a broad range audience of clinical and operational staff were involved and engaged with, some of whom were involved in the formulation of the strategy itself.

In addition to clinically led briefs by the CoS, formal briefings were held as follows:

- Chiefs Briefing - **1st November 2022**
- GMs on the **15th of November 22**
- Senior Nursing on **16th November 22**
- Pharmacy on the **17th of November 22**
- AHP Heads on **13th December 22**

Each group were taken through the clinical strategy in depth. Support and suggestion to help them in translating the strategy for their professional groups was provided alongside a Q+A session. The action resulting from the session were for each individual and lead to take the strategy into their directorates and professional groups and feedback via their Chief of Service, or directly to the Head of Strategy. A slide deck was provided on request. An update was also given by the Head of Strategy and Planning and the Chiefs of Services at Operations Board on Wednesday 7th December 2022

Overall, through this process we engaged with a wide range of staff. We received good engagement and feedback.

Informal Briefings

Key corporate leaders were briefed in one-to-one sessions. which include:

- Deputy Director, Research and Innovation
- Commercial Director
- Innovation Director
- Strategy and Policy Lead, Children's Hospital Alliance
- Chief Operating Officer North Thames Genomic Laboratory Hub
- PMO Director
- Chief Data Officer
- Head of Internal Communications.

In addition to widely circulating the document to those leading key strategic projects in the Trust such as the Cancer Planet Programme Director and Programme Lead - Heart & Lung, Children's Cancer Centre & HDU who is also project managing the GOSH Start Well group.

The clinical strategy was discussed at the weekly Senior Management Team (SMT) meeting. This group includes the triumvirates and leads across the operational teams who were again encouraged to continue the conversation and provide feedback as to whether their teams are aligned to their overall clinical strategic direction as the clinical leaders for the organisation.

Outside the planned briefing sessions, Strategy has attended several away days, and huddles to work with teams closer to the front line – such as senior theatres nursing.

We continue to encourage clinical leaders to modify and personalise the clinical strategy, focusing on areas that are most applicable and relevant to them, as a continued exercise rather than a time based one as strategy is not a static discipline.

Overarching Themes from Feedback

The feedback we have received has aligned to the strategic thinking, in addition to leading to some interesting debates and discussions. Overall, the direction have been aligned across the organisation and the feedback has been really helpful in sharpening our thoughts on future plans and strategic direction but has predominantly focused on what follows the strategy, rather than the strategy itself.

The key themes from the feedback are:

- Colleagues felt it reflected the 'whole' of GOSH, and the contribution of a multidisciplinary team (rather than being focused upon 4 pillars, which masks the complex interplay and contribution of specialities)

- Colleagues felt that the themes helped put into context the external and internal challenges and opportunities and felt that this approach provided the flexibility to make strategic choices in a turbulent system. Colleagues welcomed the inclusiveness of the clinical themes.

- Clinicians of all different professions felt that they were represented – and especially enjoyed the spirograph. They found representing the complex interplay between all of the specialities reflected and how they could take this forward, and what the implications could be for things like traditions

- Colleagues felt the bringing back of the *'Child First and Always'* felt right. and often remarked they had never taken it off their email signature, expressed delight that the Trust were considering a return to this after a departure which they didn't fully understand, and spoke passionately of why this resonates, and of personal motivation to them.

Engaging with Patients, Families and Governors

Two formal roundtables were held which were attended by a cross section of our parent/carer, public and appointed constituencies who were able to provide their thoughts and comments from different perspectives.

These were held on:

- Thursday 1 December between 12:30pm and 2:30pm
- Tuesday 13 December between 3:30-5:30pm
- In addition, with support from the Deputy Company Secretary, a call out for insight from Members in regard to Access to elicit some insights and thoughts around the clinical strategy.

The **key feedback was**:

Governors were very supportive of the approach and felt the themes were better aligned to capture GOSH more broadly.

- We were asked to consider health inequalities; a suggestion was made to consider renaming one of the themes 'Expediting equitable access' Which we feel is a very important and rich insight. This feedback will shared in depths at the forthcoming Health Inequalities Steering Group Meeting chaired by the Chief Nurse, who is overall accountable and responsible for Health Inequalities at the Trust, for further discussion before assimilation. Although, Strategy has started to explicitly use the concept of equitable access as key proponent of making strategic choices in briefings.

- They advised that we ensured the strategy direction is communicated clearly with our staff and that these conversations are on-going and supported and reinforced by clear strategic choices and Executive decision making.

- They echoed the feedback of internal groups felt it was very important that we continued with the 'Child, First and Always' approach.

Further engagement with the Young Peoples Forum (YPF) was planned as part of the November Super Saturday, but this was unfortunately postponed until March 2023. As we iterate and prioritise the strategy, we suggest that this forms part of the agenda, and on-going engagement happens as we iterate and plan, especially in terms of the delivery.

Clinical Strategy and the NHS Operational Guidance and Direction

To provide additional assurance, the *2023/24 Priorities and Operational Planning Guidance* released on the 23rd of December 2022 aligns to the strategic thinking, guidance and to the four cross-cutting themes in the GOSH Clinical Strategy. The guidance also reflects the freedom for local decision making as next year will be

the first full year that statutory Integrated Care Systems (ICSs) will have been in place, and this provides an opportunity for GOSH to explore partnerships within the local system, for ongoing operational issues, but also its model for future clinical service delivery, as set out in the Clinical Strategy – particularly in regards to expediting access.

The 2023/24 Priorities and Operational Planning Guidance and its predecessor in 2022/23 make it clear that the focus of NHSE in 2023/24 and beyond will continue to be recovery with a particular focus on increasing activity. This is reflected in the GOSH's new Clinical Strategy with the two themes of 'Expediting Access' and 'Accelerating Diagnostics.' The Clinical Strategy highlights that access to GOSH is unique in that it has no 'front door', and that it needs to explore rapid access pathways to seamlessly provide quick access to children that need to be seen here. It also notes that it is important for GOSH to reflect on new models of care to create capacity and improve productivity by highlighting the interdependencies that exist between services which can streamline delivery of services and increase productivity, recognising the shift towards more day cases, and explicitly mentioning the role of virtual wards as a solution to alleviating capacity constraints and increasing access to GOSH. The guidance puts a specific focus on diagnostics, where GOSH recognises it can offer the local system expertise on paediatric diagnostics within the Clinical Strategy.

With the guidance pushing local ICSs to develop system level activity plans, it is increasingly vital for GOSH as a local and national player to understand its role within paediatrics now and in the future and to pursue opportunities that develop, and the new Clinical Strategy helps GOSH where to do so. The Clinical Strategy notes that the average age of patients at GOSH is decreasing as interventions take place earlier in life, and this is where the theme of 'Pioneering Novel Treatments and Therapies' fits. The co-location of multiple specialisms allows GOSH to be the unique hub where novel treatments and therapies are accelerated from clinical trials to practice, and by focusing on these cures and treatments, GOSH plays its part in creating capacity for more children that need to be seen by its specialists. We know that GOSH needs to position itself for the future and that surgery has always been one of its core capabilities. We advocate as part of the last theme of 'Advancing the Frontiers of Surgery' that GOSH pursues foetal surgery to capitalise on capturing its patient cohort earlier in life and improve outcomes for them to lead fuller lives.

Clinical Strategy and Operational Annual Planning

For annual planning, the Clinical Directorates have been asked to submit an activity plan, budget, and a Plan on a Page, summarising their key objectives for the next year. As part of planning, we also asked

Directorates to consider the thematic of the Clinical Strategy when considering their plan for the next year in order to start to turn strategic thinking into strategic action. In addition, we wanted to ensure alignment with NHSE's operational focus of recovery and access, and so the Clinical Directorates have been asked to consider how that could work and new models of care from the prism of the clinical strategy. This work is ongoing, in terms of setting their objectives for next year, but we are already seeing Clinical Directorates using our analysis of interdependencies between specialties to resolve capacity issues through cross-Directorate working, expanding new models of care alongside novel treatments and therapies, and exploring partnerships to ensure that pathways exist to resolve ongoing bed issues – all of which are rooted in the new Clinical Strategy and are a reflection of the strategy ability to guide

To date, and key next steps

At the Board Strategy Away on the 17th October 2022, it was agreed that a plan should be developed through the plan for delivering against key aims of the clinical strategy, and that the Trust should consider using 'Objectives and Key Results' (OKRs) as a methodology to focus who we maximise outputs.

To date:

1) As part of the recommendation by the Board in October 2022, we have identified some external expert help to guide us in the implementation of OKRs.
2) They have recommended that we need to do some work first with the teams we need to help lead the implementation of OKRs, and an initial preparation workshop was held on the 18th of January 2023 led by the Head of Strategy and the PMO Director.
3) We have held discussions with the Chiefs of Service to identify what the first OKR(s) should be, ensuring they are closely aligned with the clinical strategy, and considering how the work needs to be developed in such a way that their wider teams are properly engaged.
4) We will be providing an update report to the March Board, detailing how we intend to roll out the approach as part of our planning for 2023/24.

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

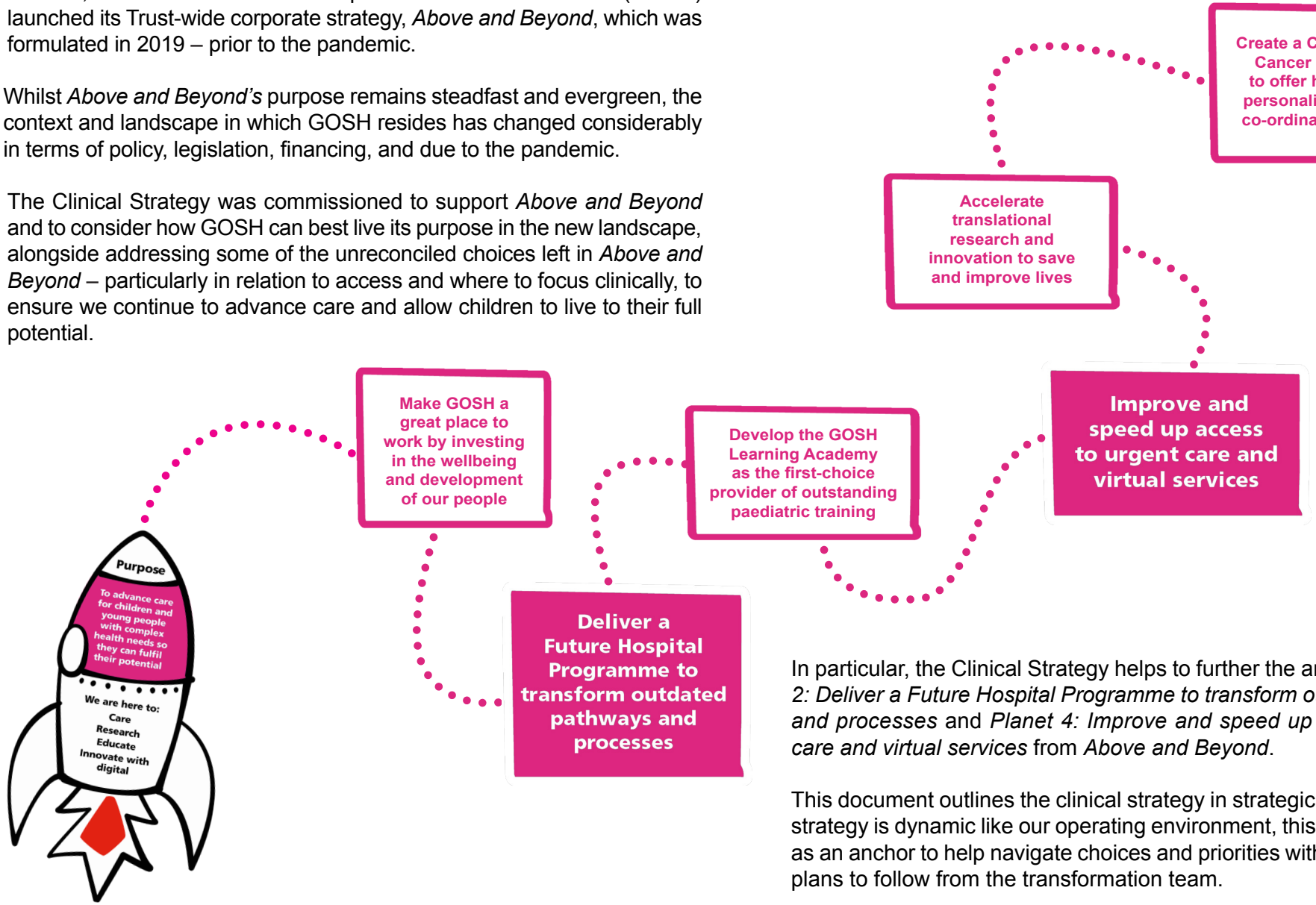
CLINICAL STRATEGY

Foreword

In 2020, Great Ormond Street Hospital NHS Foundation Trust (GOSH) launched its Trust-wide corporate strategy, *Above and Beyond*, which was formulated in 2019 – prior to the pandemic.

Whilst *Above and Beyond's* purpose remains steadfast and evergreen, the context and landscape in which GOSH resides has changed considerably in terms of policy, legislation, financing, and due to the pandemic.

The Clinical Strategy was commissioned to support *Above and Beyond* and to consider how GOSH can best live its purpose in the new landscape, alongside addressing some of the unreconciled choices left in *Above and Beyond* – particularly in relation to access and where to focus clinically, to ensure we continue to advance care and allow children to live to their full potential.



In particular, the Clinical Strategy helps to further the ambitions of *Planet 2: Deliver a Future Hospital Programme to transform outdated pathways and processes* and *Planet 4: Improve and speed up access to urgent care and virtual services* from *Above and Beyond*.

This document outlines the clinical strategy in strategic thinking form. As strategy is dynamic like our operating environment, this document serves as an anchor to help navigate choices and priorities with detailed delivery plans to follow from the transformation team.

Methodology

In formulating the Clinical Strategy, led by the Chiefs of Service, we have sought the insight, input and endorsement of multidisciplinary profession groups, alongside conducting extensive qualitative and quantitative measures, methodologies and research:

QUANTITATIVE RESEARCH	• Market share, competitor profiling and review and benchmarking analysis • Patient demographic and trend analysis • Performance analysis • Complexity analysis • Project with DRIVE – the creation of a living map of specialties that support other specialties at GOSH so we can model the impact of what we want to do more or less of, making our decisions data driven.
QUALITATIVE RESEARCH	• Literature reviews on models of care and the future of medicine • Thematic reviews • Horizon scanning to scope opportunities that GOSH can capitalise on • Monthly Strategic Development sessions with the Chiefs of Service • Pan-GOSH Strategy Away Day – 5th November 2021, 3rd December 2021 • Clinical Strategy Workshops on the outstanding questions from the Trust's *Above and Beyond* Strategy – 4th May 2022, 1st June 2022 • Interviews, insight, conversation and engagement sessions with the entire multidisciplinary teams • Strategic frameworks to frame internal and external factors

Since we began the journey in November 2021, we have spoken to the entire breadth of multidisciplinary representation at GOSH:

DOCTORS & SURGEONS

NURSES

PHARMACISTS

DIAGNOSTICS & IMAGING

SCIENTISTS & GENETICISTS

THERAPISTS

CLINICAL ACADEMICS

The Child, First. Always.

> **“The Child, First. Always is at the centre our clinical strategy for an important reason. To serve both as a reminder, and as an invitation ...”**

The *Child, First and Always* is our founding and enduring principle. It has been Great Ormond Street Hospital NHS Foundation Trust’s (GOSH) north star since our inception in 1852, and continues to serve as both a cultural principle, and as an instruction to us as the current custodians of GOSH.

What *The Child, First. Always* really invites us to consider in the strategic choices that we make, is to consider the holism of GOSH. It is of fundamental importance in designing the strategy, but arguably even more important in determining how we collectively might next deliver upon it.

The phrase *The Child, First and Always* provides guidance of where to look. It also tells us what we must consider in all endeavours. Starting of course, with *The Child* themselves, in their totality – their clinical, their social, their educational needs, and that in turn means we must consider the child’s relationships – their parents, carers, their siblings, their friends. To meet these needs and to best serve these all relationships means in addition, we need to consider the experiences of everyone involved in providing comprehensive care – the doctors, the nurses, the allied health professions, the researchers, the scientists. To ultimately put *The Child, First*, we must pay due regard to the systems and the infrastructure underlying it all, to things like the environment in which caregivers and patients interact, and to the relationships between those on the frontline, and those providing the crucial logistical, managerial, and financial support.

The Child, First. Always also recognising that that children’s healthcare needs are distinctly different to adults. It therefore directs our attention outwards, and instructs us to advocate for children, especially those with rare and complex conditions, to ensure that there is a systemic societal recognition of that difference, and in the resources required to service them. It implicitly encourages us to utilise the full weight and strength of GOSH to ensure that children get the equity they need and deserve, and to ensure GOSH is using its voice to speak for children when they can’t.

In addition, *The Child, First. Always*, directs our attention inwards. It has been instrumentally in in devising and shaping solutions that best meets the needs of *The Child*, both now and for the future. To honour that principle, requires our strategy to consider how we can ensure that children who need to access care at GOSH, come to GOSH, and to ensure that GOSH’S expertise is always accessible, whenever a child needs us. That means we must get there first, to intervene as early as possible, to improve the outcomes for children with rare and complex conditions – by diagnosing them, and by treating them as early as possible, by finding the cures of tomorrow and by doing so continue to reach and benefit more children across the continuum of child health.

The Child, First. Always as an instruction, delivers us unambiguously in the realm of strategy, but it does so by bringing culture with us. It tells us that everyone has an important role to play in ensure that GOSH is always there, now and for the future for children with rare and complex conditions who need us most.

Introduction

The Trust's corporate strategy, *Above and Beyond*, clearly states that Great Ormond Street Hospital NHS Foundation Trust's (GOSH) role and purpose is to focus on children who rely on specialist care – those who are seriously ill, those who have complex needs and those with rare or undiagnosed conditions.

At the time of its writing, *Above and Beyond* contained a set of unanswered questions that divided opinions:

- Should GOSH have an A&E or not?
- What's GOSH's place in the system – locally or nationally?
- What is the scope and scale of our offer – more generalist or more specialist?

In helping to arrive at the clinical strategy, the essence of these unanswered questions was taken and reframed to better reflect the changes in the external environment:

How we improve access for children with complex and rare conditions to the specialist care that GOSH provides?

How do we maintain relevance in a localist system, as a national resource?

Where should GOSH focus clinically?

In previous iterations of its clinical strategy, GOSH had opted to focus on four clinical priorities: cardiac, cancer, neurosciences and rare diseases. Whilst this is one way of attempting to bring focus and clarity to the choices the organisation makes, this clinical strategy has opted to take a different approach in the same pursuit.

In formulating the clinical strategy, a set of Clinical Tenets (pg. 4) were developed to help guide strategic decision-making. Harnessing GOSH's purpose and uniqueness, the tenets articulate the components we need in order for our multidisciplinary[1] specialist teams to deliver the comprehensive care that children with complex and rare conditions require in order to improve their outcomes

The clinical strategy will not specifically call out individual specialities, but instead introduce four cross cutting clinical themes:

Expediting Access

Accelerating Diagnostics

Pioneering Novel Therapies and Treatments

Advancing the Frontiers of Surgery

By doing so, this fresh approach allows us to live our unique selling point (USP)[2], address the obstacles facing GOSH in the new landscape, provide direction to capitalise on GOSH's opportunities, whilst ensuring that we continue to fulfil the vital niche that only we occupy in order to best serve the children who need us most. These four cross-cutting clinical themes are applicable and relevant to each and every directorate and team at GOSH, enabling us to harness our collective strength, and come closer together to continue our evergreen mission.

[1] A multidisciplinary team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients, as defined by the NHS Data Model and Dictionary. Often includes doctors, nurses, allied health professionals, and managers in the delivery of patient care.

[2] A unique selling point, or USP as it is commonly abbreviated, is a feature of a product or service that makes it different or better than other similar products or services.

The Clinical Tenets

In devising the clinical strategy, taking into account GOSH's purpose and the changes in the external landscape, the Chiefs of Service considered the following three questions:

How we improve access for children with complex and rare conditions to the specialist care that GOSH provides?

How do we maintain relevance in a localist system, as a national resource?

Where should GOSH focus clinically?

Collectively, the Chiefs felt that to arrive at an answer, GOSH needed a unified way of assessing all strategic options and opportunities that are afforded to us, by ensuring that any decision that GOSH makes has been interrogated through the same lens. Therefore, six Clinical Tenets have been devised to shape our approach to current and future strategic activities. The Clinical Tenets will help us to articulate the opportunities that we need to focus on, the decisions that we need to make and the benefits that they will bring about, tying together the various threads of GOSH and continuing to enhance our core purpose to focus on children who rely on specialist care – those who are seriously ill, those who have complex needs and those with rare or undiagnosed conditions.

THE CLINICAL TENETS
We are a highly specialist tertiary and quaternary hospital with a global reach
We provide multidisciplinary specialist care for children with complex and rare diseases
We discover novel treatments and expedite translation into clinical practice
We ensure that every child has the opportunity to be part of, or contribute to research
We accelerate the progress of complex medical care through the sharing of expertise
We foster a culture of innovation so that we are always moving ahead

THE EVERGREEN STRATEGY

GOSH's Evergreen Strategy

Since our inception in 1852 by our founder, Dr. Charles West, Great Ormond Street Hospital (GOSH) has thrived on having a strategy of always been first, and by ensuring that we are child-centric in all our endeavours.

GOSH was the first inpatient paediatric hospital in the English-speaking world.

GOSH was the first to tackle health inequalities of children, by providing them the means to access recognise that children's healthcare needs are distinct and different from those of adults.

GOSH has and continues to be the first in a whole host of pioneering medical breakthroughs.

GOSH is the first and only specialist Biomedical Research Centre (BRC) focusing on paediatrics in England and partnering with the UCL Institute of Child Health, it is the largest paediatric research and teaching hospital in the world.

GOSH was the first hospital to use a diversified financial model to sustain itself.

The strategy of the first has been with GOSH since the very beginning and continues to serve us as we expand horizons for children with complex and rare conditions.

THE FIRSTS AT GOSH

1947 The UK's first heart and lung unit opens at GOSH

1957 The UK's first genetics research department opens at GOSH

1959 The UK's first children's neuroscience unit opens at GOSH

1961 The UK's first leukemia research department opens at GOSH

1962 GOSH pioneers the first heart and lung bypass machine for children

1967 GOSH leads the first UK clinical trials of the Rubella vaccine

1979 The first successful bone marrow transpant takes place at GOSH

2000 GOSH launches first gene therapy trials for children born without functioning immune systems

2001 GOSH introduces technique to replace faulty heart valves without the need for open heart surgery using a collapsible stent

2015 GOSH is the first hospital in the world to use CAR-T cells to treat 'incurable' leukaemia

2017 GOSH leads the development of Brineura and Nusinersen, the former slows disease progression in CLN Batten disease and the latter slows disease progression in spinal muscular atrophy

2019 GOSH leads development of Dojolvi, the first and only drug to treat long chain fatty acid disorder

2020 GOSH leads development of Lumasiran, a drug that treats primary hyperoxaluria without kidney damage and the need for a transplant

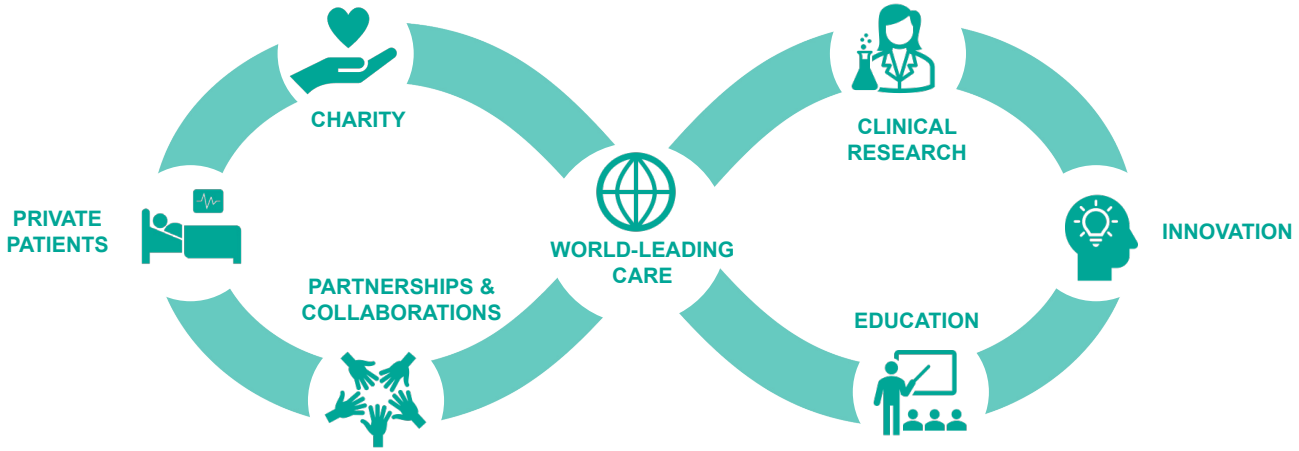
2021 GOSH leads the first trials in a novel approach to reduce seizures in drug resistant epilepsy

2022 GOSH is first in the world to test a treatment that could prevent blindlness in children with CLN2 Batten disease, a rare and fatal genetic disorder

GOSH's Evergreen Strategy

The essence and drivers behind what make GOSH, GOSH have previously been considered tripartite: world-leading care, clinical research, and education, but nestled amongst them has always been a fourth driver – innovation. Innovation speaks both to our legacy and captures our pioneering spirit of wanting to, and needing to, do things differently to benefit more children, and it speaks how to make our future, and the future for children with complex and rare conditions brighter, in our current landscape.

These four pillars, and the foundational firsts that support them, are not individual pursuits, these are mutually enhancing and reflect the holism of the ecosystem of GOSH.



The legacy, and indeed the strategy of the first, lives on in all that we have done, and all that we will do, and it is at the core of who we are. The original strategy of 1852, has endured, evolved, and thrived. Our responsibility as the current custodians of GOSH, is to continue to advance this strategy, and to do so within the context of our current external and internal environment.

GOSH OF THE NOW

An Introduction to GOSH

Great Ormond Street Hospital NHS Foundation Trust (GOSH) is a national and international paediatric specialist hospital that focuses on world-class tertiary and quaternary care of children with complex and rare conditions. GOSH's unique selling point (USP) has always been the co-location of multiple specialties and the clinical expertise of its multidisciplinary specialist workforce on which GOSH has built its reputation as the only UK hospital in the top three best paediatric specialist hospitals in the world.[3] GOSH is the first, and only, specialist Biomedical Research Centre (BRC) focusing on paediatrics in England and in partnership with UCL, The Institute of Child Health is the largest paediatric research and teaching hospital in the world.

The size of GOSH's specialist paediatrics offer is second to none. Today, GOSH offers 67 different specialties (Table 1). It is the designated provider for 20 highly specialised services and the only provider commissioned nationally for four of these services (Table 2). In terms of size, GOSH has 446 actual beds, out of which 400 are staffed.[4] Between Q4 2020/21 and Q1 2022/23, GOSH had the largest available overnight general and acute beds among standalone specialist paediatrics providers and the second largest across all acute paediatric trusts, making it the largest paediatric provider in London based on available beds (Appendix 1). GOSH also has the highest number of day beds out of all standalone paediatric providers.

Table 1: Services by Directorate at GOSH

BODY, BONES & MIND

Child and Adolescent Mental Health
Gastroenterology
General Paediatrics
Nephrology
Neuropsychology
Trauma & Orthopaedics
Psychological Medicine
Specialist Neonatal & Paediatric Surgery
Spinal Surgery

BLOOD, CELLS & CANCER

Bone Marrow Transplant
Dermatology
Haematology
Haemophilia
Immunology
Infectious Diseases
Oncology
Palliative Care
Rheumatology

BRAIN

Bardet Biedl
Clinical Neurophysiology
Endocrinology
Epilepsy
Metabolic Medicine
Neurodisability
Neurology
Neuromuscular
Neurosurgery

CORE CLINICAL SERVICES

Anaesthesia
Biomedical Engineering
Clinical Genetics
Chemical Pathology
Dietetics
Haematology
Histopathology & Mortuary
Immunology
Microbiology
Pharmacy
Occupational Therapy
Physiotherapy and Orthotics
Radiology
Speech & Language Therapy
Theatres

HEART & LUNG

Cardiac Surgery
Cardiology
Cardiothoracic Transplantation
Children's Acute Transport Service
Cardiac Intensive Care Unit
Cystic Fibrosis
Extra Corporeal Membrane Oxygenation
Foetal Cardiology
Long-Term Ventilation
Neonatal Intensive Care Unit
Paediatric Intensive Care Unit
Pulmonary Hypertension
Respiratory Medicine
Transitional Care

SIGHT & SOUND

Audiological Medicine
Cleft
Cochlear Implant
Craniofacial
Dental
Ear Nose & Throat
Maxillofacial
Ophthalmology
Orthodontics
Plastic Surgery
Urology

Table 2: Highly Specialised Services List

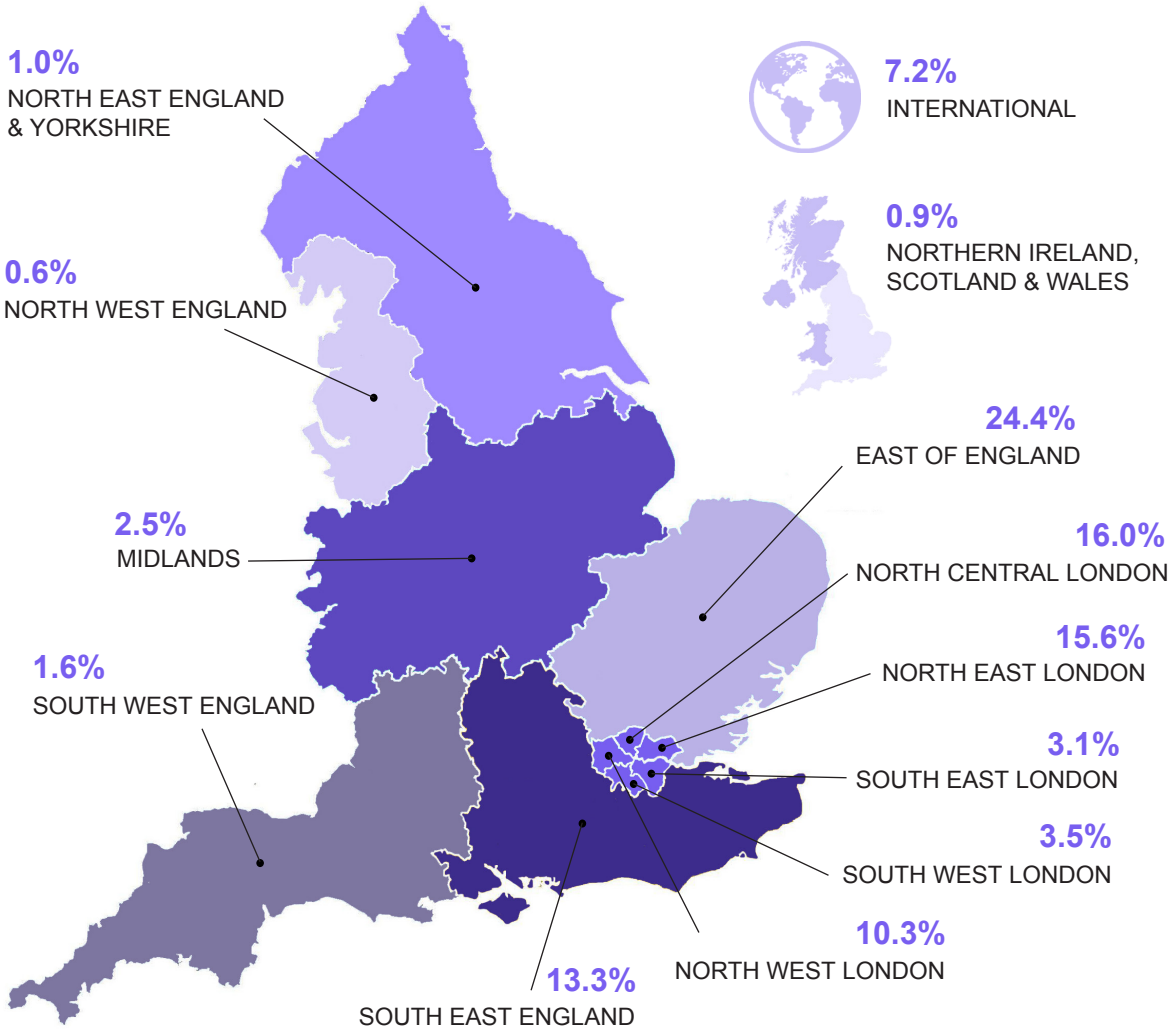
Auto Immune Gut Disorders
Bardet-Biedl Syndrome Beckwith Wiedemann with Macroglossia Service* Bladder Exstrophy
Complex Tracheal Disease* Complex Osteogenesis Imperfecta Congenital Hyperinsulinism Craniofacial
Extracorporeal Membrane Oxygenation (ECMO) Epidermolysis Bullosa
Heart and Lung Transplants
Inherited White Matter Disorders
Lysosomal Storage Disorders
Mechanical Support to Heart Transplant Multiple Sclerosis Management Service
Paediatric Intestinal Pseudo-Obstructive Disorders* Pulmonary Hypertension*
Rare Neuromuscular Disorders
Severe Combined Immune Deficiency
Vein of Galen

*Only provided at GOSH

[3] Newsweek (2022). *World's Best Specialized Hospitals 2023*. Available at: https://www.newsweek.com/worlds-best-specialized-hospitals-2023/pediatrics
[4] Figures as recorded on 14 September 2022. Includes all inpatient, ICU and day case beds at GOSH including closed wards with the exception of Alligator, which is being used as a decant ward.

Our Patient Profile

As a specialist paediatric hospital, GOSH attracts a large volume of patients nationally. From England, its largest volume of patients, nearly a quarter of its total activity, comes from East of England. GOSH is also a pan-London hospital albeit more a North Thames hospital than South Thames, with North Central London and North East London attracting nearly the same volumes of activity. It is also worth noting that GOSH's international activity was 7.2%, while the remaining was from the rest of the United Kingdom.

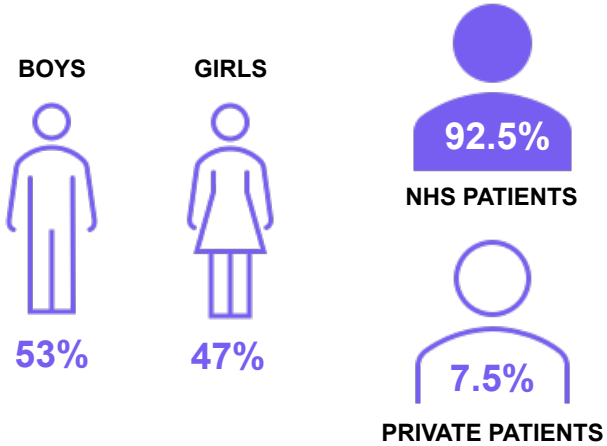


Average Age of GOSH Patients

OUTPATIENTS	YEAR	INPATIENTS
6.3	2017/18	6.9
6.0	2018/19	6.5
6.0	2019/20	6.2
5.8	2020/21*	5.8
5.8	2021/22	6.1

The average age of patients at GOSH continues to decline year-on-year. The average age for our first outpatients has decreased from 6.3 to 5.8, while the average age of our inpatients has gone down from 6.9 to 6.1.

*2020/21 was the year of the COVID-19 pandemic so any anomalies in this year should be discounted.



Data Source: GOSH Information Services, Data from 2017 - 2022.

Activity

Activity at GOSH is growing each year. In fact, GOSH saw its highest levels ever of day cases and outpatient appointments (Figures 1 & 2) in 2021/22. While the growth in outpatients is in part due to recovery of activity after the pandemic, especially as growth is seen in follow up appointments as opposed to first appointments, the increase in day cases demonstrates our core purpose of pioneering novel therapies and treatments at work as we perform more and more interventions without the need of an inpatient stay. Appendix 2 shows the drastic shift of inpatient procedures towards day cases, looking at procedures in 2017/18 against 2021/22.

During the same period, elective activity at GOSH and associated average length in patients[5] (Figure 3) has remained constant. In terms of GOSH's outpatient activity, the volume of first appointments has also remained consistent and when looking at our peers, GOSH has a higher inpatient conversion ratio, which once again reflects the complexity of patients that come to GOSH for treatment. The same is also reflected in our low DNA figures when compared to our peers (Table 3).

Table 3: DNAs and Inpatient Conversion Rates (Peers)

TRUST	DNAs	INPATIENT CONVERSION
GREAT ORMOND STREET HOSPITAL NHS FOUNDATION TRUST	6.5%	11.9%
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	11.4%	11.2%
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	*	6.6%
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	7.6%	10.8%
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	11.3%	9.8%
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	7.8%	8.8%
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	11.1%	7.7%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	11.2%	7.4%
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	10.1%	9.7%
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	7.9%	7.7%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2.2%	7.8%
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	6.1%	*

Data Source: Telstra Health UK Ltd. (Dr. Foster Platform), Data from 2019-2020.

Figure 1: Day Cases and Electives

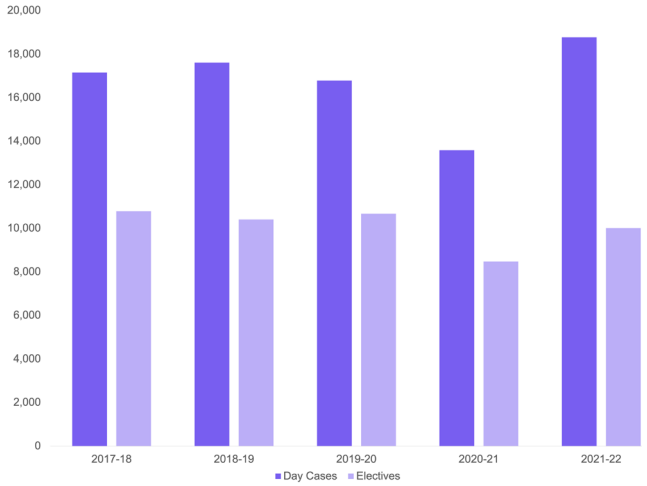


Figure 2: Outpatient Firsts and Follow Ups

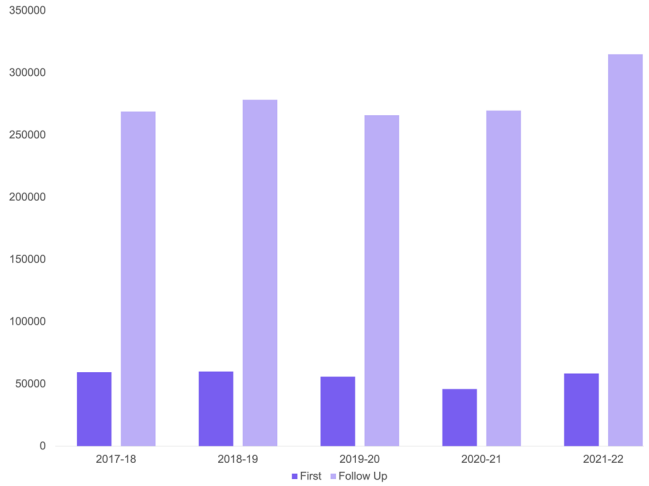
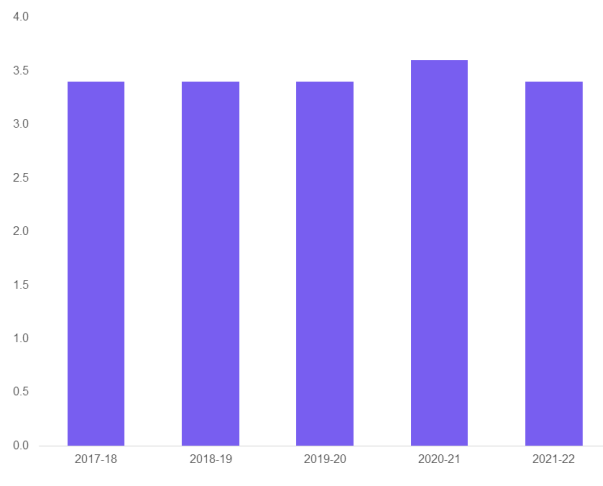


Figure 3: Average Length of Stay Electives



Data Source: GOSH Information Services, Data from 2017 - 2022.

[5] Long-stayers have been excluded from the average length of stay calculation. The NHS Data Dictionary defines a long stayer as a patient that has had an inpatient stay of 21 days or longer.

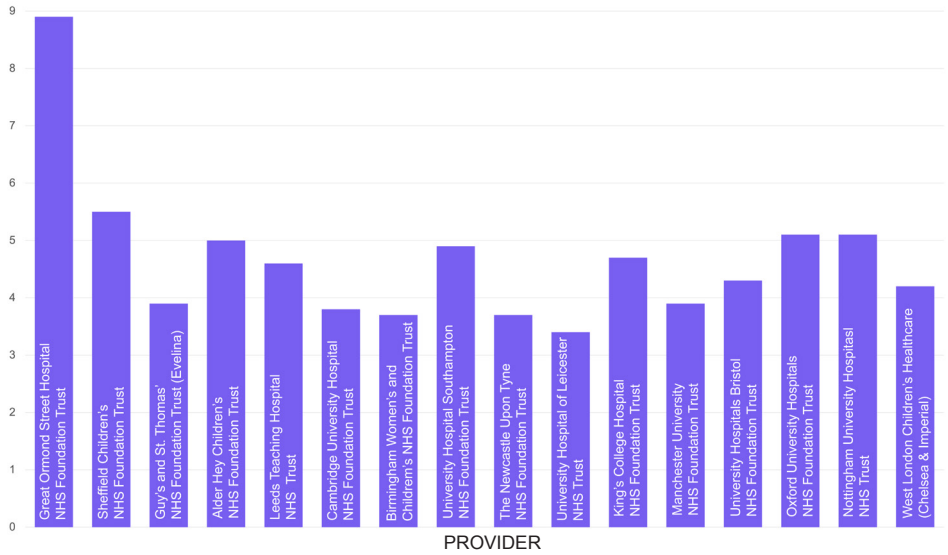
Complexity and Interdependency

GOSH is often the only provider where patients with complex and rare conditions can come to seek comprehensive care, and the number of patients keeps growing. The increase in the number of day cases combined with steady elective activity and elective length of stay figures implies that the complexity in patients that are referred to GOSH has also remained.

In fact, GOSH's paediatric patients have the highest complexity nationally and this is evident in a comparison against our peers. Our patients have the highest average diagnoses per finished consultant episode (Figure 4) as well as a significantly large number of patients with a comorbidity score[6] of 1 or higher and an even greater number of patients with a score of 6 or higher (Table 4).

Treating patients with an increasingly complex case-mix and high acuity requires more specialist input. This is particularly relevant when looking at the volume of long-stayers[7] at GOSH – over 3,200 children in the last five years. These are prime examples of patients with multiple comorbidities with care often spanning multiple specialties.

Figure 4: Average Diagnoses Per Finished Consultant Episode (Peers)



Data Source: Civil Eyes Research, Data from Q1-Q3 2021/22.

Table 4: Comorbidity Scores (Peers)

Comorbidity score	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST
0 (none)	29420	70680	43640	42630	37330	29675	28860	25625	23065	18950	19525	15845
1	202	160	200	150	140	55	10	75	25	65	25	35
2	0	0	0	0	0	0	0	0	0	0	0	0
3	176	200	225	180	210	150	70	145	35	80	100	75
4	1098	3805	2090	1930	2410	1220	960	1260	1560	1855	1230	955
5	16	20	25	0	15	10	0	0	0	0	0	0
6-9	7807	4615	1015	865	1500	565	225	1305	535	1875	470	500
10-19	1975	1575	1565	1670	1370	365	90	930	730	740	605	770
20-49	892	590	255	125	130	40	10	260	80	135	80	155
TOTAL	**41586**	**81645**	**49015**	**47550**	**43110**	**32075**	**30220**	**29595**	**26030**	**23700**	**22030**	**18340**
Score 1 or more	29%	13%	11%	10%	13%	7%	5%	13%	11%	20%	11%	14%
Score 6 or more	26%	8%	6%	6%	7%	3%	1%	8%	5%	12%	5%	8%

Data Source: Telstra Health UK Ltd. (Dr. Foster Platform), Data from 2019-2020.

[6] A comorbidity score measures the ten-year survival of a patient with multiple conditions. It is based on the Charlson Comorbidity Index, which is a list of 17 conditions that have been identified from diagnoses codes and each condition is assigned a weight from 1 to 6. The score is a sum of the weights of all identified conditions. A score of 0 represents no comorbid conditions, while a higher score represents a greater level of comorbidity.

[7] The NHS Data Dictionary defines a long stayer as a patient that has had an inpatient stay of 21 days or longer.

Complexity and Interdependency

GOSH's USP is its co-location of specialities, which helps it provide the world-leading tertiary and quaternary care necessary for children with rare and complex conditions. In order to do so the input of multiple specialities is required and involved in providing that care. Whilst the interdependencies are well known anecdotally, understanding the inter and intradependencies of GOSH's unique ecosystem, is fundamental in order give us data-driven insights to help us arrive at decisions both now and in the future.

Figure 5 demonstrates just how complex and interconnected we are at GOSH. Figure 6 shows high resource dependencies[8] between specialties. Appendix 5 explains the methodology behind this work and outlines detailed directorate-to-directorate interactions, highlighting the specialties that support another specialty.

Figure 5: Directional Dependencies

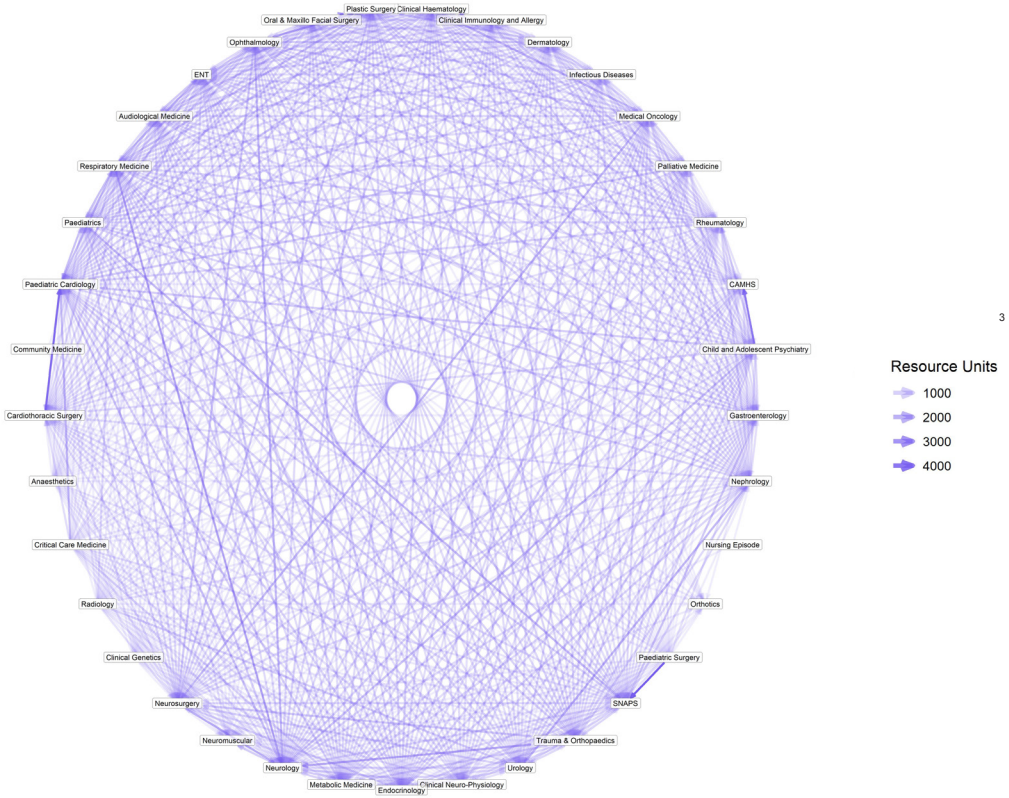
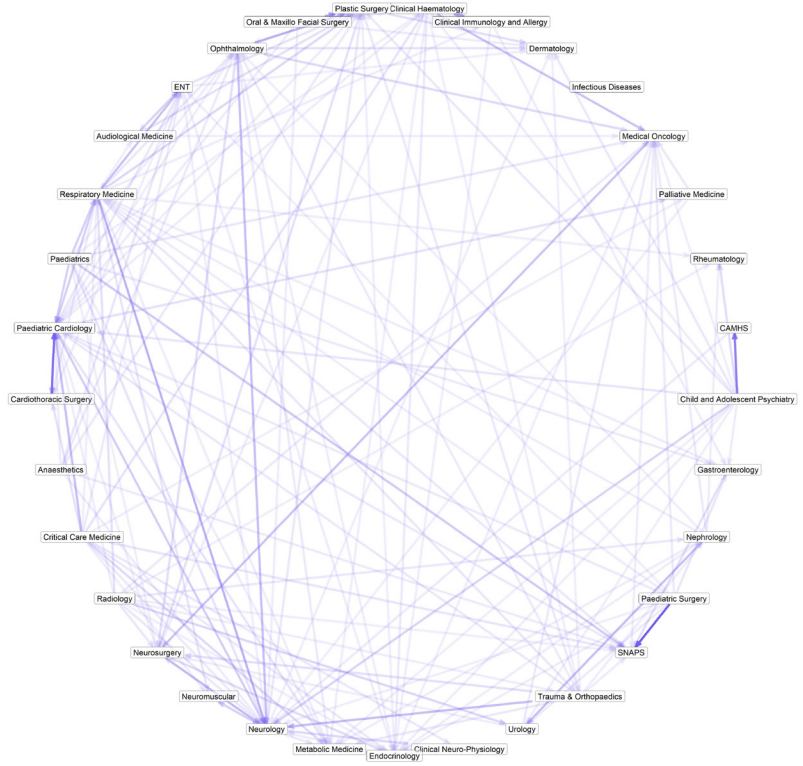


Figure 6: High Resource Directional Dependencies



Data Source: GOSH Information Services, Data from 2019 - 2021. Data analysis and illustrations by Dr. William A, Bryant, Senior Data Scientist, Data Research, Innovation and Virtual Environments (DRIVE), GOSH.

[8] High resource directional dependencies are when activity less than the equivalent of one bed used for 6 months is removed from the analysis. Further details in Appendix 4.

THE EXTERNAL LANDSCAPE

The Key Drivers in the External Landscape

The external landscape has been turbulent and changeable during the last few years and this has had a major effect on GOSH. The key drivers impacting specialist providers like GOSH include:

POLITICAL

Integrated Care Systems
The shift to ICSs does not account for the effect on specialist providers such as GOSH that operate outside the local geographic boundaries.

Changes in Commissioning
Starting in 2023/24, ICBs will lead the commissioning of primary, community, secondary and tertiary services including 65 specialised services – 40 of these services are those that GOSH offers.

Political Turbulence
The NHS is affected by changes in the political domain. In the last 18 months, there has been four different Health Secretaries with differing priorities.

ECONOMIC

Financial Deficit
GOSH faces significant cost pressures, reporting a deficit in 2022/23.

Funding Structure
ICSs will receive and allocate providers funding based on system population needs, posing a challenge to GOSH as it operates outside the system.

Economic Crisis & Inflation
Costs of energy and goods are rising due to Brexit, the aftermath of the COVID-19 pandemic and ongoing Ukraine-Russia conflict.

NHS Pay and Workforce Costs
Wages are set at a national level and latest pay increase was considerably less than rate of inflation, posing a threat to recruitment and retention of staff in the face of high cost of living, particularly in London. For trusts, workforce costs are up to 66 per cent of the total budget and specialist trusts require specialist staff, who are often paid at a premium for their skill set.

SOCIAL

Systems & Population Health
The motive behind the creation of ICSs was a push towards population health management in order to diagnose and intervene early with care closer to home. The design of which has been predominantly focused on adult health care needs and as yet does not recognise the differences between adult care and paediatric need.

Demographic Changes
The ONS estimated that by mid-2030 children (0-15) will make up 11.6% of the overall UK population, which is a decrease of around 1%. GOSH's local catchment area is extremely ethnically diverse and many of the genetic and complex conditions GOSH specialises in are more likely among certain ethnic groups.

TECHNOLOGICAL

Digitalisation
All NHS providers are expected to meet a core level of digitalisation by March 2025.

Technological Advancement
There is a push for further advancement in healthcare in four main areas – mobile computing, telemedicine/virtual wards, use wearables/sensors, and AI.

Research and Innovation
A key aim of NHSE is to advance research and innovation to drive outcomes improvement. At a national level, it is seeking to invest in transformative areas like genomics, increasing the number of 'test beds' in the NHS, and accelerating the adoption of proven and affordable innovation.

Changes in Health Policy

> **As funding flows from policy, financial allocations are now going to be set at population level prevalence ... Specialised commissioning, specifically for complex and rare diseases, caters to a small proportion of the national population ... so it is exceedingly difficult to account for, and to be paid accordingly, and yet the need to run the service consistently and continuously remains.**

NHS England (NHSE) has embarked upon an era of consolidation and de-centralisation, and post-covid, has expedited its ambition to bring together NHS providers, local authorities, the voluntary sector, and other local partners to plan and deliver joined up care for their local populations with a strong focus on personalisation and prevention, as outlined in NHSE's Long Term Plan (2019). As a result of the Health and Care Act 2022, GOSH is now part of the North Central London (NCL) ICS, which means it has a duty to collaborate and partner with other providers within NCL to cater to the needs of the local population - as well as continue to provide services from outside of NCL's geographic boundary. It also means that GOSH needs to plan its activity and finance in the context of the local system, and any changes to funding to NCL will influence GOSH. So, GOSH's organisational sovereignty has been curtailed by the changes to the legislation.

As funding flows from policy, financial allocations will now be set at population level prevalence. More recently in June 2022, NHSE announced that from 2023/24 the vast majority of specialist commissioning will be devolved from its national purview to local ICSs. As per the policy, ICB's will be in charge of commissioning specialist services based on the needs of their local populations. Specialised commissioning, specifically for complex and rare diseases, caters to a small proportion of the national population. Rare diseases, although large in their totality, often have varying disease prevalence year on year, so it is exceedingly difficult to account for, and to be paid accordingly, and yet the need to run the service consistently and continuously remains.

There has always been a systemic risk around the degree to which NHSE can fund specialist work and improve sustainability. To mitigate this, GOSH has always maintained a blended financial model and relied upon its international and private care offer, its innovative research credentials, and charitable donations to support its operations in the delivery of care.

During the pandemic, GOSH's ability to harness these strengths was impacted and therefore combined with the fiscal effects of policy changes, it finds itself currently in a brave new world of financial challenges and for the first time in its history, has posted a deficit.

North Central London and Start Well Programme

In accordance with the changes to health policy and a move towards population health, North Central London (NCL) is already planning for the health requirements of children in its five boroughs through its Start Well programme. Launched by NCL in November 2021, Start Well is a long-term programme that aims to address the needs of paediatric, maternity and neonatal services across the sector, aligning with NHSE's ambition to ensure that it gives every child the best start in life possible, from birth to their transition into adulthood. While at the time of writing Start Well is at an initial stage, GOSH remains involved to serve as the voice of children with complex and rare diseases in the programme as it entails areas of work in which GOSH can contribute quite significantly.

One of the aims of the programme is to ensure sufficient neonatal care in the right places. This is on the back of the fact that NCL has identified that neonatal intensive care capacity across the sector is at the maximum threshold as set in the NHS neonatal service specifications. GOSH and University College London Hospitals NHS Foundation Trust offer care to the most premature and unwell babies, and our units are often full, which means that babies that require the highest levels of care are sent to other providers further away from home, even across local systems. Moreover, while this joint model of care is world-class in its nature, as it is the only site commissioned in the United Kingdom to offer foetal surgery, the model is not devoid of risks, particularly around delivering the baby on one site and then transferring it to another for care, separating mum and baby. GOSH believes that neonatal care is an area where it can expand to help alleviate pressure resulting from sector demand while mitigating the risks.

The Start Well programme will also focus on the reorganisation of paediatric surgical care across the sector. There are currently 4,300 children in NCL waiting for a planned operation and this list is growing. In fact, NCL claims that nearly 1 in 5 children that needed to be transferred to a different hospital for emergency surgery were sent to a hospital outside the sector, while the majority of children requiring a transfer came to GOSH. NCL recognises that only a proportion of these children may have required the specialist care that GOSH delivers, and the rest could have been treated in a local hospital if its teams were equipped with the right surgical and anaesthetic skills. GOSH believes that it can impart its clinical expertise to develop such skills while addressing the gap in paediatric anaesthetist provision across the sector.

Other workstreams in Start Well will aim to resolve issues within transition services and address staffing challenges, specifically in nursing and allied health professionals. GOSH can contribute to the work on transition services as its complex patients require a more detailed and comprehensive pathway for a successful transition to adult services. In terms of staff shortages, GOSH recognises its role in providing paediatric diagnostics for the sector but is limited by the shortages in staff, and it can voice the need to develop this skill set within the local sector.

MAP OF ACUTE PROVIDERS NORTH CENTRAL LONDON

1. Barnet Hospital, Royal Free NHS Foundation Trust
2. Chase Farm Hospital, Royal Free NHS Foundation Trust
3. Royal National Orthopaedic Hospital NHS Trust
4. North Middlesex University Hospital NHS Trust
5. Whittington Health NHS Trust
6. Royal Free Hospital, Royal Free NHS Foundation Trust
7. University College London Hospitals NHS Foundation Trust
8. Great Ormond Street Hospital NHS Foundation Trust
9. Moorfields Eye Hospital NHS Foundation Trust

GOSH OF THE FUTURE

Recapping Our Strengths, Weaknesses, Opportunities and Threats

Often when looking at an organisation's strengths, weaknesses, opportunities and threats, there is a misconception that each fits squarely in one category. However, this is not the case as sometimes an opportunity can become a threat and a weakness can transform into a strength. We need to be conscious of these factors as we set forth GOSH's new Clinical Strategy.

STRENGTHS

Co-location of Multiple Specialties
GOSH offers the widest range of paediatric services in the UK, covering all organs of the body with the exception of the liver.

Clinical Expertise
Our clinicians are specialists in their fields, working in multi-disciplinary teams to offer the best possible care.

Brand
GOSH is an internationally renowned. *Newsweek* ranks it as the only UK hospital in the top three paediatric hospitals in the world.

Our Heritage
GOSH's global reputation is rooted in its history of cutting-edge research, to many medical breakthroughs, or firsts. It is strongly supported by its own charity, which provides the additional funding to be able to retain this tradition.

WEAKNESSES

Organisational Structure
In order to capitalise further on our unique selling point (USP) of multidisciplinary specialist teams, due regard should be paid to optimise and reflect this in the organisation's structure. New skills, ways of working and talent should be fostered to continue facilitate our uniqueness.

Limited Estates
GOSH is an island site in Camden which limits local expansion.

Tracking Long-Term Priorities
Like other NHS organisations who work on an annual planning cycle, GOSH's leadership often is not able to adhere to long-term strategic priorities.

Limited Leverage of Brand
GOSH should be front and centre in advocating for the interests of children with rare and complex conditions by using its voice where they can't. In addition, leveraging our brand to its maximum potential.

OPPORTUNITIES

Accelerate Translation of Research into Practice
GOSH has pioneered the most paediatric medical breakthroughs in the UK. We want to continue the drive to expedite more therapies and treatments from discovery to clinical trials to commissioned services.

Partnership Opportunities
There are multiple local options available to GOSH that have arisen due to the move towards ICSs, as well as a host of other international and commercial opportunities.

Harness Technological Advancements
GOSH should use the most innovative technologies to disseminate its expertise and reach a larger number of children. This also aligns with NHSE's ambition to provide care closer to home and ensures that only children that need to be at GOSH are at GOSH.

THREATS

Less Autonomy
As a foundation trust and one that had services commissioned by NHSE directly, GOSH is not used to decisions taking place at a local level, especially as a national resource.

Changes to Health Policy
The devolution of specialised commissioning to ICSs is a significant cause for concern. Local systems often lack knowledge of specialist services as patient volumes are low.

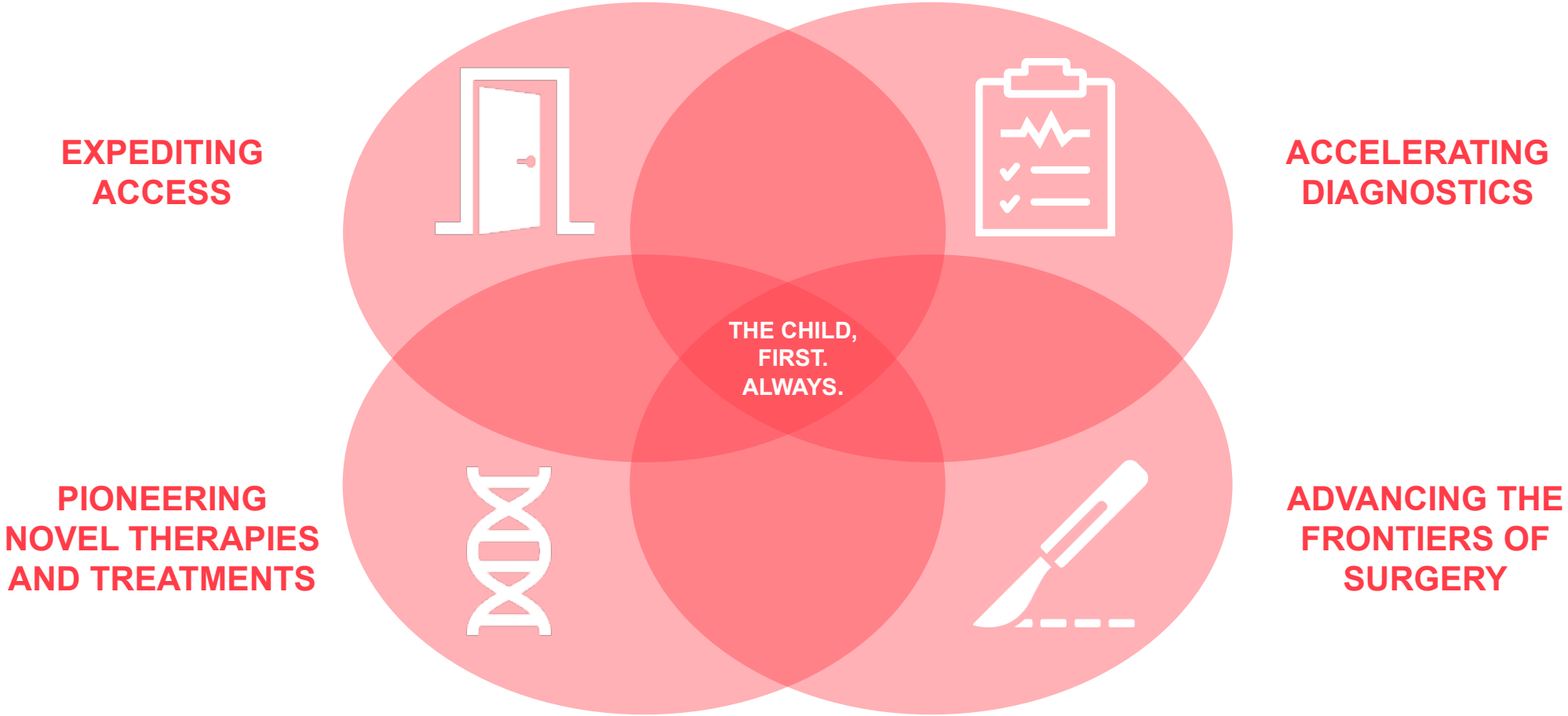
Financial Instability
Providers in NCL, including GOSH, are projected to post the largest deficit in London for 2022/23. GOSH has historically relied on international and private care income to provide financial support, which has severely been impacted by the pandemic.

Changes in Geographic Boundaries
GOSH faces a challenge to its activity from all directions.

Living Our Purpose

Taking into consideration GOSH's evergreen strategy of world leading care, clinical research, education and innovation and the implications that the child first and always invites us to consider. In addition to the demand and the effects of the external environment, and our own internal uniqueness and strengths, four cross-cutting themes for our Clinical Strategy have been developed to enable us to drive our purpose forward.

These themes build upon each other and work together, and are applicable across all directorates, enabling us to harness our unique strength, capitalise on the co-location of our multi-specialities and expertise, and at the same, recognise the importance of the whole of GOSH in providing care, cognisant of the needs of children with rare and complex conditions and their families.



Expediting Access

> **“Expediting access to our patients, who often need us long term, is a key and important strategic priority for us.”**

Although access to care in paediatrics is a national problem – one that has grown year-on-year for the last decade with performance targets declining to their lowest rates ever exacerbated by COVID-19, access to GOSH poses its own unique challenges and opportunities.

As the only specialist paediatrics trust without a traditional A&E front door, “access” to care for GOSH’s patients – those with rare and complex conditions – is often via other secondary or other tertiary providers. So, when a GOSH child needs to come back into GOSH, they often need to be first admitted into a local secondary care provider, before being transferred over to GOSH’s care. This is a highly convoluted process, which delays access to the specialist care GOSH provides and that the child needs, and in addition, results in a frustrating experience for patients and their families while taking away the clinical time from a patient at the secondary or tertiary provider that it can actually help.

In solving this, it is important that we anchor ourselves in our own unique space and do what only we can do best, ensuring that we are persistent in the application of our resources to these endeavours in pursuit of that purpose. Therefore, there is cohesive clinical consensus that an A&E on site, does not fit GOSH’s profile of providing tertiary and quaternary care. That said, solving access is not just about entry to GOSH, but also about exit. It is imperative that consider how we can make this work as a whole, not just as elemental parts.

We want any child who needs to come to GOSH to be able to come to GOSH, and to be seen expediently. The solution most in keeping to our skills and expertise is the creation of a Rapid Access Unit on site for GOSH patients. A Rapid Access Unit enables GOSH to deliver upon the NHS mandate of the right care at the right place at the right time.

The benefits of doing this are:

- Offers GOSH a “front door” which is in line with our expertise and specialisms;
- Allows our patients to be able to access GOSH and the multidisciplinary specialists care they need in a timely manner;
- Provides better patient and clinician experience;
- Gives us a bedrock for virtual wards – releasing capacity and extending our reach allowing for remote monitoring and earlier discharge, in support of the overarching NHSE goals to bring care closer to home;
- Enables operational transformation in regarding planning and flow;
- Releases burden on secondary and tertiary care provider so that they can allot their skills and resources in the most optimal manner.

Note: It should be noted that GOSH is no stranger to the rapid access model as it already has two such existing pathways, one is theRapid Assessment Neurology Unit (RANU) and the other is the Rapid Assessment for Infectious Diseases (RAID). Both of these pathways add multiple benefits to a child’s care.

Accelerating Diagnostics

Building on a foundation of expediting access, accelerating diagnostics is another key strategic pursuit. We know that earlier diagnosis expedites earlier intervention which leads to better outcomes and this is even more important for children.

Our ability to diagnose as a scientific community is rapidly advancing. Diagnostics covers a broad spectrum of activities. As a tertiary and quaternary provider, GOSH is uniquely placed to be able to discover the cures of tomorrow and focusing on discovery and new diagnostics today will be the cornerstone of advancing care for children with complex and rare conditions.

For GOSH to maintain its' reputation as a world class children's hospital it will need to embrace the opportunities afforded by genomic medicine. By making advancements in genomic diagnosis we can tailor treatments and put surveillance in place for earlier diagnoses of other health complications associated with the underlying genomic aetiology. We can also open up the opportunity of early adoption of novel treatments, which is another key strategic aim for GOSH.

Whilst we can contribute globally, GOSH is also best placed to continue to uniquely contribute to the national effort to help deliver on the NHS's aims to be the first national health care system to offer whole genome sequencing and functional validations. This national endeavour is already delivering results for seriously ill children with early indications that at least one in four people suffering from a rare disease will have a diagnosis they would not previously have received, and this identification is shaping the future of research, and gene therapies.

Diagnostics more broadly could also be a key contribution to our local system. Diagnostics has been identified as significant in contributing to the recovery efforts post pandemic and to fulfil the NHS direction of bringing care out of hospitals, and closer to home.

GOSH is uniquely placed to offer paediatric diagnostics to NCL and to provide its skills and expertise, and in addition, its hardware resources to the sector. Due to the specialist nature of services at GOSH, it can offer to share its clinical expertise with other providers in the sector, tailoring its high-quality education programmes to provide the training to help bridge the knowledge between adult and paediatric specialist knowledge. GOSH is also well-placed to support complex care from other providers, both locally and nationally.

In addition, our Clinical Genetics service is a regional department which serves patients at all stages of life from foetus to late adulthood, and is already a key player in healthcare within NCL. We should maximise on the potential of the already existing relationship between GOSH Clinical Genetics and the other NCL institutions.

The benefits for doing so are:

- GOSH has a strong track record and pedigree in this area;
- Provides the bedrock for advancing pioneering treatment, which helps accelerates discovery to clinical trials, to commissioned services to overall improved health for children with complex and rare conditions;
- An offer to the international, national, and regional local system that addresses a critical population health need.

Pioneering Novel Therapies and Treatments

GOSH has always been at the forefront of discovering the cures and treatments of tomorrow. We are uniquely placed to do so due to the co-location of our specialties and the multidisciplinary expertise of our staff, resulting in a critical mass of children with complex and rare diseases seen here.

GOSH has pioneered more medical breakthroughs and innovations than any other paediatric institution in the world and in doing so, it has been able to help some of the sickest children, most of them with complex and rare conditions, lead fuller lives – locally, nationally and internationally. We want to be able to give more children their lives back, and this is possible if we can further expedite research into clinical practice.

Many of the children that pass through the doors of GOSH have life-limiting or life-threatening conditions, requiring tailored cures and treatments. GOSH is the only hospital in the UK that can provide them with the comprehensive care they need for their conditions. Our children are the most complicated nationally with 8.9 average diagnoses per finished consultant episode. So, it is our duty to improve outcomes for these children and develop novel therapies and treatments to allow them to lead more complete lives because if we won't – who will?

As a research hospital with a critical mass of children with complex and rare conditions, only we are best placed to produce world-leading translational and patient-oriented research on such disorders and introduce it into clinical practice as cures and treatments.

However, we need to ensure that all parts of the cog work seamlessly together to expedite the process from discovery to clinical trials, and to commissioned services for us to improve future outcomes for these children.

Access and diagnostics plays a major role in this regard, particularly our ability to diagnose and identify those with complex and rare conditions but also carriers of disease before onset. Together with the UCL Institute of Child Health, we have the clinical and academic expertise to use such discoveries from to develop novel therapies and treatments for the rarest disorders.

A focus on curing the rare will provide benefits across the continuum of paediatric health, especially if we can develop personalised, one and done therapies and treatments. We don't wish our children to spend the entirety of their childhood in a hospital setting and such therapies will help us.

The benefits of doing so are:

- Harnesses our key strengths, our unique selling point (USP) in a space that only GOSH can own;
- Caters to our range of specialities and multidisciplinary clinical expertise;
- Allows us to ensure that only the children that need to be at GOSH, come to GOSH;
- Carries forward our legacy of developing breakthroughs in medicine;
- Firms our reputation as a global leader in the treatment of children with complex and rare diseases.

Advancing the Frontiers of Surgery

> **In the same way that advancements in diagnostics are cellular, innovations in surgical techniques are allowing interventions to take place earlier in life.**

Continuing to advance the frontiers of surgery is core to GOSH and is vital in advancing care for children with complex and rare conditions. GOSH has a great tradition of pioneering surgical advancements and enhancing our surgical capabilities by being the first to utilise interoperative imaging, and other novel techniques. This is another key space that GOSH uniquely owns and is vital to advance.

One key area of expansion to explicitly call out is foetal. In the same way that advancements in diagnostics are cellular, innovations in surgical techniques are allowing interventions to take place earlier in life. The strategic intent is to intervene earlier and improve outcomes for babies and enable them to lead much fuller lives.

The future direction of foetal will focus not only on improving outcomes of current procedures but also expanding types of foetal interventions to include in utero stem cell therapy and in utero gene therapies.

GOSH is in a good place to capitalise on these advancements but will need to move fast to do so. There is increasing competition in this area, with the decline in birth rate, it is of strategic importance that GOSH should capture its patients young and retain them. Diving deep into GOSH's patient demographics, we can already see that the average age of our inpatients has decreased from 6.9 in 2017/18 to 6.1 in 2021/22.

The main driver behind this skew is a growth in activity in the infant age group, aligning with the idea that advancements in medicine are allowing complex interventions to take place earlier in life and that the earlier we intervene, the better the outcomes.

Other providers are targeting the nexus between maternity and neonates, and whilst there is a skills gap for them to bridge, their colocation of maternity services gives them an advantage we must seek to bridge, to remain ahead and we need to do this expediently. Whilst continuing to ensure that the foetus has the co-located services they require, we need to consider how we can keep mothers with their babies – which we know too improves outcomes.

The benefits of doing so are:

- Allows GOSH to intervene earlier and improve outcomes, allowing babies to lead their lives to fullest;
- Supports our legacy as a centre of surgical excellence that provides the most cutting-edge interventions, leading to shorter recovery times and better patient experience;
- Gives GOSH a strategic advantage in surgery for this age group and ensures our pipeline of children so we can continue the work that we do and bring benefits to the wider child health continuum;
- Maintains our position globally as one of the top three paediatric hospital.

Note: The Getting It Right First Time (GIRFT) recommendations for neonatology include optimising transfer pathways for high-risk babies requiring early postnatal transfer and minimising separation of mum and baby. GIRFT is a national programme by NHSE to improve the efficiency of treatment and care of patients in acute trusts by reviewing health services.

APPENDIX

Appendix 1: Paediatric Bed Base

Between Q4 2020/21 and Q1 2022/23, GOSH had the largest available overnight general and acute beds among standalone specialist paediatrics providers and the second largest across all acute paediatric trusts, making it the largest paediatric provider in London based on available beds.

The only available data in order to make this comparison is bed availability data collected by NHS Digital through the quarterly KH03 return and daily UEC SitRep return. The KH03 data is displayed in Table 5 and shows the breakdown between overnight and day beds. The KH03 data does not specify the split between adult and paediatrics, so all providers that cater to both cohorts have been excluded. The UEC SitRep data is shown in Table 6 and provides an overview of average paediatric available beds per month across all providers.

We are unable to provide an analysis on paediatric critical care beds as some providers so not provide the split between paediatric and neonatal ICU beds.

Table 5: General and Acute, and Day Bed Base for Standalone Paediatric Trusts

Provider	General and Acute - Overnight Beds Available																			
	2017/18				2018/19				2019/20				2020/21				2021/22			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Great Ormond Street Hospital For Children NHS Foundation Trust	285	279	290	286	283	281	280	281	274	299	228	250	335	304	259	229	229	272	260	278
Sheffield Children's NHS Foundation Trust	139	139	139	139	140	138	138	138	138	138	138	138	138	134	142	147	134	131	136	134
Alder Hey Children's NHS Foundation Trust	227	227	229	233	235	234	217	217	214	210	239	211	214	173	219	221	219	219	219	218
Provider	General and Acute - Day Beds Available																			
	2017/18				2018/19				2019/20				2020/21				2021/22			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Great Ormond Street Hospital For Children NHS Foundation Trust	66	70	69	74	74	72	72	75	64	73	58	57	60	71	80	64	63	72	58	75
Sheffield Children's NHS Foundation Trust	13	19	19	19	14	14	13	13	13	16	16	16	5	15	17	18	18	19	19	22
Alder Hey Children's NHS Foundation Trust	25	27	27	27	26	26	26	27	25	27	26	27	25	27	27	27	21	27	27	27

Table 6: Paediatric Inpatient Bed Base for Acute Trusts

Provider	Dec-20	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	Jun-22	Jul-22	Aug-22
Great Ormond Street Hospital For Children NHS Foundation Trust	279	242	247	247	254	253	264	251	255	260	259	260	241	252	261	257	246	246	247	237	233
Manchester University NHS Foundation Trust	247	244	247	250	274	281	284	286	283	289	288	292	292	286	299	300	304	308	308	293	290
Birmingham Women's and Children's NHS Foundation Trust	193	199	226	222	222	226	226	225	230	229	243	249	229	227	247	242	236	241	240	239	227
Guy's and St Thomas' NHS Foundation Trust	120	108	103	118	120	120	120	120	120	119	120	119	120	120	120	120	120	120	120	120	120
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	181	179	167	175	178	178	177	167	160	166	181	180	174	151	163	164	159	166	170	166	158
University Hospitals of Leicester NHS Trust	117	105	89	91	106	118	118	118	114	108	100	102	109	99	101	106	106	107	106	107	107
Chelsea and Westminster Hospital NHS Foundation Trust	72	49	44	47	43	44	44	44	45	46	44	43	43	47	48	43	38	41	40	41	38
Alder Hey Children's NHS Foundation Trust	194	178	179	192	195	206	207	198	202	202	205	206	206	201	210	211	210	209	209	207	205
Imperial College Healthcare NHS Trust	38	34	37	42	44	39	42	40	38	38	37	36	37	39	37	38	37	36	40	39	37
Sheffield Children's NHS Foundation Trust	135	133	140	140	143	143	143	141	141	139	143	146	145	143	145	146	144	148	147	142	147
Cambridge University Hospitals NHS Foundation Trust	78	75	75	79	80	79	80	78	79	78	78	77	76	74	79	77	76	77	75	77	74
University Hospitals Bristol and Weston NHS Foundation Trust	0	111	124	125	126	129	125	126	127	131	132	130	134	150	145	142	142	147	149	148	145

Data Source: NHS Digital. (2022). *Bed Availability and Occupancy*. Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy

Appendix 2: Growth in Day Case Procedures

We have pointed out in the main document that there has been significant growth in day cases at GOSH in the last five years. We believe that this growth is indicative of GOSH's move to make more novel therapies and treatments mainstream, and the shift to move more inpatient procedures to day case procedures.

Table 7 shows a select list of procedures, day case and inpatient, that took place at GOSH in 2017/18 and 2021/22. The purpose of comparing these two years is to demonstrate the shift of inpatient procedures to day case procedures, as shown by the percentage of day cases in each year. The list is includes only procedures with a volume of 20 or more. Out of the 115 procedures that made the list, there was only eight procedures where the proportion of day cases versus inpatients was lower in 2021/22 than 2017/18.

As an example, if we look at procedure 'A577 - Injection of therapeutic substance into cerebrospinal fluid', there were 248 procedures in 2017/18 and 49 per cent of them were day cases but in 2021/22, there were 264 procedures and 98 per cent of them were day cases. This increase in proportion demonstrates a move to make more inpatient procedures as day cases. While it may seem that volumes are lower in 2021/22 in this list of selected procedures, it demonstrates that a higher proportion of all of them are now performed as day cases versus inpatient procedures.

Table 7: Paediatric Inpatient Bed Base for Acute Trusts

Procedure List	2017/18		2021/22	
	Total	%Daycases	Total	%Daycases
A113 - Monitoring of pressure in tissue of brain	34	0%	21	5%
A148 - Other specified other operations on connection from ventricle of brain	2	0%	515	90%
A331 - Implantation of cranial nerve neurostimulator	44	5%	25	28%
A542 - Injection of therapeutic substance into cerebrospinal fluid	476	28%	261	78%
A559 - Unspecified diagnostic spinal puncture	582	32%	179	72%
A577 - Injection of therapeutic substance around spinal nerve root	248	49%	264	98%
A841 - Electroencephalography NEC	516	27%	121	74%
A842 - Electromyography	436	44%	99	74%
A844 - Evoked potential recording	154	38%	63	86%
C125 - Destruction of lesion of eyelid NEC	12	42%	23	70%
C664 - Laser photocoagulation of ciliary body	62	31%	22	68%
C743 - Mechanical lensectomy	28	4%	20	10%
C751 - Insertion of prosthetic replacement for lens NEC	118	10%	44	36%
C791 - Vitrectomy using anterior approach	48	4%	35	9%
C792 - Vitrectomy using pars plana approach	56	13%	37	19%
C866 - Examination of eye under anaesthetic	78	31%	24	63%
D013 - Excision of preauricular abnormality	62	32%	23	61%
D031 - Reconstruction of external ear using graft	146	1%	30	3%
D033 - Pinnaplasty	14	43%	20	65%
D141 - Tympanoplasty using graft	30	0%	27	41%
D151 - Myringotomy with insertion of ventilation tube through tympanic membrane	230	43%	58	67%
E083 - Correction of congenital atresia of choana	64	3%	26	4%
E096 - Laser destruction of lesion of external nose	46	50%	41	78%
E204 - Suction diathermy adenoidectomy	246	4%	83	28%
E342 - Microtherapeutic endoscopic resection of lesion of larynx NEC	156	0%	53	6%
E348 - Other specified microtherapeutic endoscopic operations on larynx	132	1%	70	9%
E379 - Unspecified diagnostic microendoscopic examination of larynx	692	1%	278	4%
F022 - Destruction of lesion of lip	38	47%	27	74%
F104 - Extraction of multiple teeth NEC	280	38%	134	81%
F347 - Bilateral coblation tonsillectomy	612	0%	204	1%
G214 - Intubation of oesophagus NEC	230	25%	182	42%
G345 - Attention to gastrostomy tube	918	34%	306	65%
G451 - Fibreoptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion of upper gastrointe	330	26%	338	74%
G475 - Insertion of nasogastric tube	0	0%	68	34%

Procedure List	2017/18		2021/22	
	Total	%Daycases	Total	%Daycases
G802 - Wireless capsule endoscopy	124	25%	78	32%
H221 - Diagnostic fibreoptic endoscopic examination of colon and biopsy of lesion o	360	12%	321	15%
H412 - Peranal excision of lesion of rectum	72	24%	38	45%
H463 - Intubation of rectum for pressure manometry	182	37%	98	56%
H568 - Other specified other operations on anus	72	33%	31	55%
L352 - Arteriography of cerebral artery	88	5%	61	13%
L912 - Insertion of central venous catheter NEC	18	11%	77	17%
L913 - Attention to central venous catheter NEC	30	20%	29	69%
L914 - Removal of central venous catheter	422	38%	267	69%
L915 - Insertion of tunnelled venous catheter	230	12%	76	22%
L923 - Thrombolysis of access catheter	4	25%	42	52%
L943 - Percutaneous transluminal insertion of subcutaneous port	204	25%	127	32%
L948 - Other specified therapeutic transluminal operations on vein	2	0%	78	88%
L997 - Percutaneous transluminal peripheral insertion of central catheter	316	6%	167	16%
M141 - Extracorporeal shock wave lithotripsy of calculus of kidney	64	34%	58	67%
M293 - Endoscopic removal of tubal prosthesis from ureter	62	35%	81	48%
M323 - Endoscopic injection of inert substance around ureteric orifice	42	38%	21	43%
M459 - Unspecified diagnostic endoscopic examination of bladder	152	26%	49	49%
M478 - Other specified urethral catheterisation of bladder	96	50%	32	84%
M492 - Change of suprapubic tube into bladder	24	33%	44	93%
M731 - Repair of hypospadias	186	1%	116	2%
M765 - Endoscopic destruction of urethral valves	70	1%	30	3%
N092 - One stage orchidopexy NEC	94	34%	70	64%
N094 - Second stage orchidopexy NEC	32	13%	20	60%
N303 - Circumcision	72	15%	28	18%
N328 - Other specified other operations on penis	30	27%	48	77%
S065 - Excision of lesion of skin of head or neck NEC	218	40%	102	78%
S069 - Unspecified other excision of lesion of skin	180	42%	46	78%
S091 - Laser destruction of lesion of skin of head or neck	1118	50%	441	74%
S092 - Laser destruction of lesion of skin NEC	396	49%	152	76%
S131 - Punch biopsy of lesion of skin of head or neck	10	50%	28	93%
S132 - Punch biopsy of lesion of skin NEC	178	48%	132	94%
S152 - Biopsy of lesion of skin NEC	44	41%	26	88%
S511 - Injection of sclerosing substance into subcutaneous tissue	364	45%	30	73%

Procedure List	2017/18		2021/22	
	Total	%Daycases	Total	%Daycases
S604 - Refashioning of scar NEC	42	45%	35	83%
S608 - Other specified other operations on skin	8	13%	21	81%
T193 - Ligation of patent processus vaginalis	30	37%	33	61%
T203 - Primary repair of inguinal hernia using sutures	182	21%	113	39%
T243 - Repair of umbilical hernia using sutures	44	20%	28	61%
T811 - Percutaneous biopsy of muscle	58	28%	27	59%
T928 - Other specified other operations on lymphatic tissue	66	29%	84	64%
U135 - Plain x-ray of bone	0	0%	23	48%
U199 - Unspecified diagnostic electrocardiography	2	50%	20	100%
U217 - Plain x-ray NEC	0	0%	27	63%
U221 - Electroencephalograph telemetry	392	1%	400	39%
U262 - Uroflowmetry NEC	240	50%	126	100%
U264 - Urodynamics NEC	2422	50%	1171	99%
U288 - Other specified other diagnostic tests on skin	0	0%	101	89%
U292 - Insulin secretion glucagon test	38	39%	55	85%
U293 - Glucose tolerance test	190	18%	36	56%
U298 - Other specified diagnostic endocrinology	1516	14%	587	32%
V132 - Alveolar bone graft to maxilla	92	2%	44	2%
W365 - Diagnostic extraction of bone marrow NEC	928	32%	440	84%
W901 - Aspiration of joint	102	45%	42	90%
W903+IMAGE+KNEE - NULL	174	49%	27	93%
X213 - Correction of syndactyly of fingers using skin graft	54	2%	23	52%
X216 - Amputation of supernumerary finger NEC	52	44%	35	91%
X292 - Continuous intravenous infusion of therapeutic substance	366	32%	551	78%
X332 - Intravenous blood transfusion of packed cells	6	33%	20	65%
X352 - Intravenous chemotherapy	56	25%	69	86%
X353 - Intravenous immunotherapy	0	0%	33	15%
X368 - Other specified blood withdrawal	0	0%	1042	94%
X376 - Intramuscular hormone therapy	12	50%	173	98%
X383 - Injection of hormone for local action NEC	2	50%	69	97%
X384 - Subcutaneous chemotherapy	30	40%	103	88%
X386 - Subcutaneous injection for local action NEC	0	0%	22	77%
X391 - Oral administration of therapeutic substance	294	48%	65	86%
X403 - Haemodialysis NEC	582	10%	172	96%

Data Source: GOSH Information Services, Data from 2017/18 and 2021/22.

Appendix 3: Complexity and Interdependency
Methodology

Patient activity over a single one-year period (1 April 2019 to 31 March 2020) was used to understand the dependencies that exist across multiple specialties due to the rare and complex patient case mix at GOSH.

Dependencies were quantified by an approximate aggregate measure of activity across inpatients and outpatients, allowing for direct comparisons between specialties and specialty dependencies.

Identification of patient "main" specialties was done in various ways to assess the best fit with known patient activities, and a definition based on referral data from Epic (reaching back into the legacy period) was used.

Dataset

Patient data were extracted from the DRE Agile Data Warehouse incorporating legacy and Epic clinical administrative data covering the period 1 April 2019 to 31 March 2020.

These included the following data types:

- Patient demographics,
- Outpatient activity,
- Hospital admissions and ward stays,
- Episodes of Care, and
- Referrals.

These were extracted using the DRE Standard Data Extraction process which provided data in the internal "Research Data View" data model.

Patient activity calculations

Patient activity was measured by counting the number of outpatient appointments attended, and the number of bed days split by ICU/non-ICU bed location.

Each bed day/outpatient visit was assigned a specialty based on either the clinic lead (for outpatients) or the specialty of the Episode of Care at the point of the bed stay (for inpatient activity).

'Resource units' were assigned by summing activity across outpatient appointments, inpatient non-ICU bed days, and inpatient ICU bed days, weighted by relative resource intensity of each activity.

From experience in the DRE team based on pricing for each of these resources, the weighting was as follows:

- 1 outpatient visit = 0.5 resource units,
- 1 non-ICU bed day = 1 resource unit, and
- 1 ICU bed day = 2 resource unit.

This provided a single score per patient per specialty with which to analyse specialty interactions at an aggregate level.

No time dependencies have been accounted for in this work, but rather overall activity for each patient has been calculated, split solely by specialty.

'Main' specialty assignment

There is currently no facility to indicate a "main" specialty in Epic, except implicitly through initial activity in the Trust or through referrals data.

However, there are a number of issues around defining initial relevant referral including potentially multiple concurrent referrals occurring at the same time and multiple overlapping referrals to the same specialty.

Therefore the main specialty was defined as the earliest referral that was still open at the beginning of the period of analysis, excluding certain support specialty referrals.

Where multiple referrals started at the same earliest date, the one which remained open the longest was used.

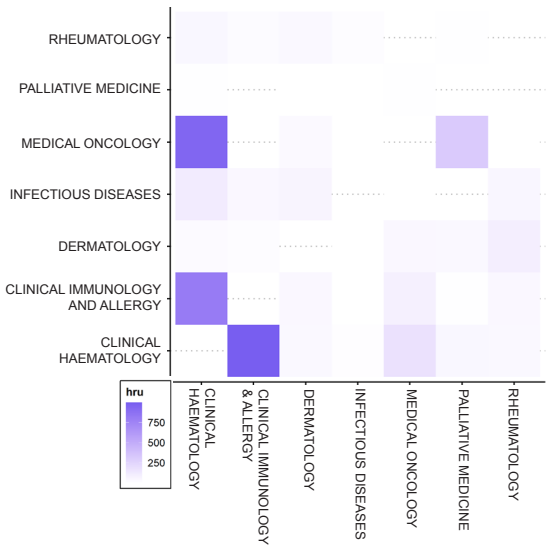
Cross-specialty dependencies

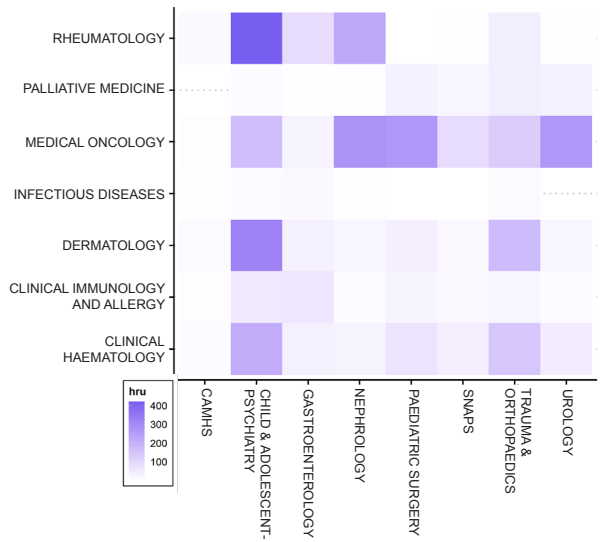
Cross specialty dependencies were calculated as the sums of resource units for all patients in a specific main specialty who had activity in another specialty in the year of data being analysed.

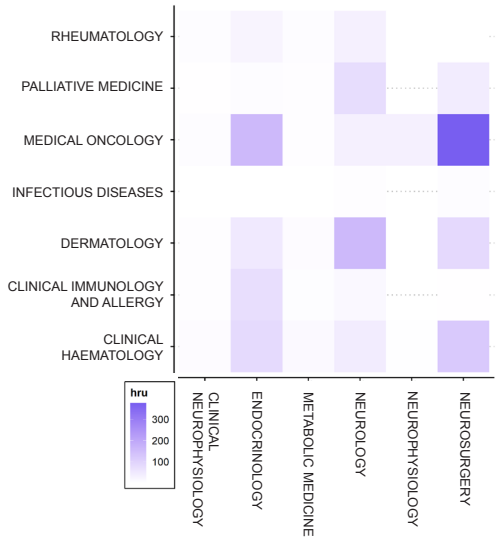
[2] Supporting specialties include critical care medicine, anaesthetics, radiology, etc.

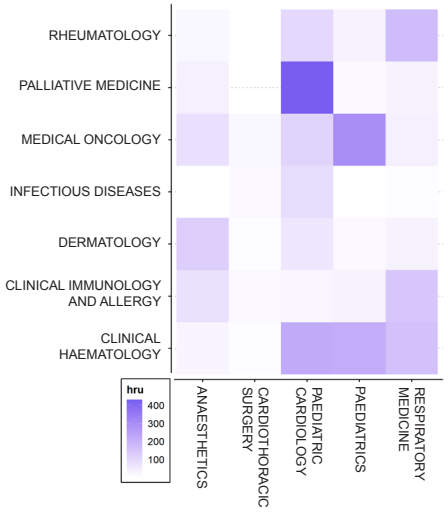
Appendix 3: Complexity and Interdependency
Blood, Cells & Cancer

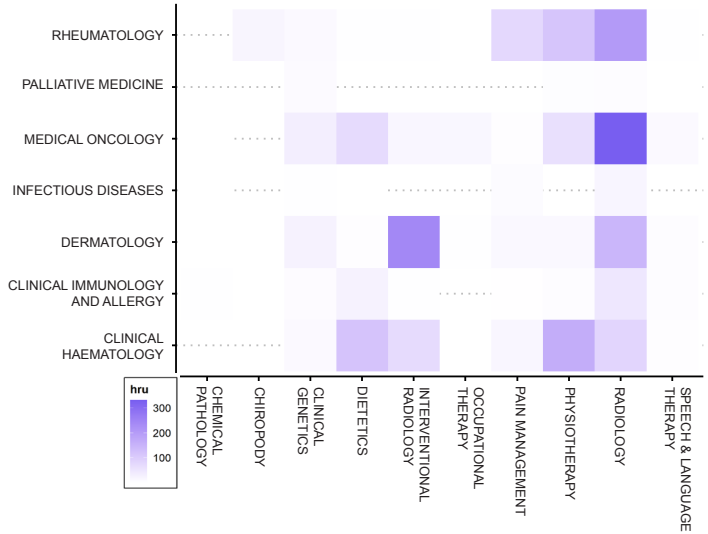
The charts below map dependencies between specialities in the Blood, Cells & Cancer (BCC) Directorate and supporting specialties in the same Directorate or other Directorates at GOSH. Dependencies have been measured in Resource Units, an approximate measure that takes into account outpatient and inpatient activity in a balanced way but does not represent full economic cost. For BCC, we can see the highest dependency is within Directorate with Clinical Immunology and Allergy supporting Clinical Haematology.

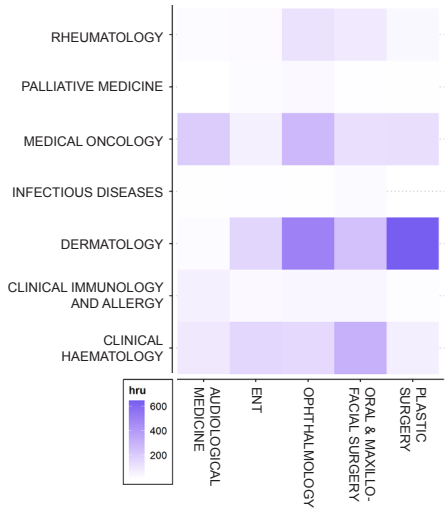








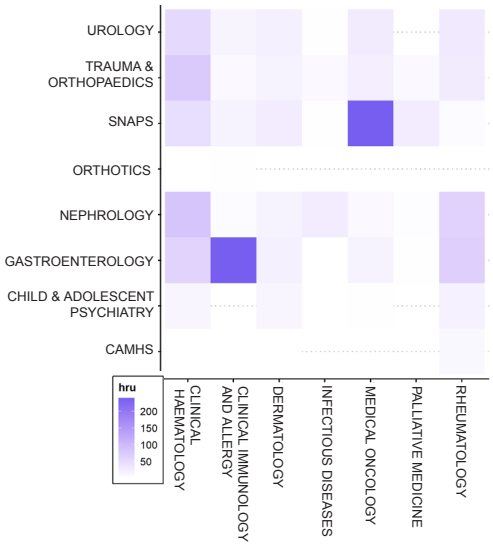


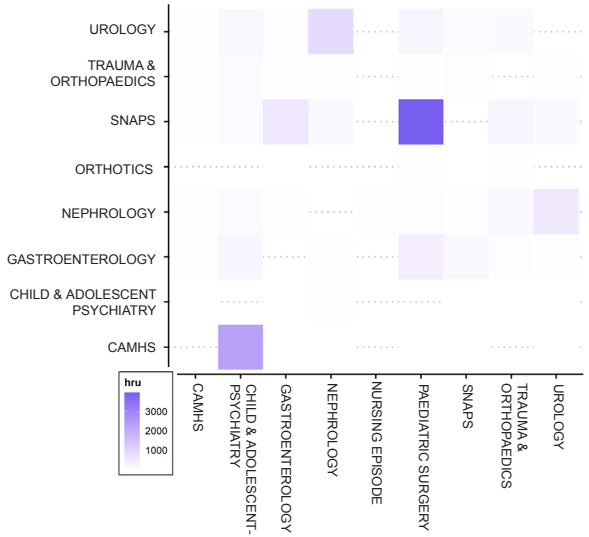


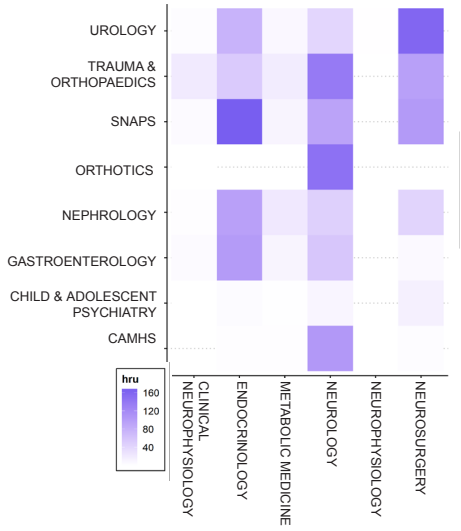
Data Source: GOSH Information Services, Data from 2019 - 2021. Data analysis and illustrations by Dr. William A, Bryant, Senior Data Scientist, Data Research, Innovation and Virtual Environments (DRIVE), GOSH.

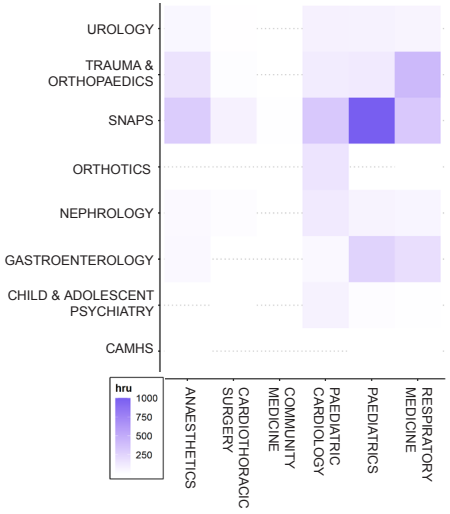
Appendix 3: Complexity and Interdependency
Body, Bones, & Mind

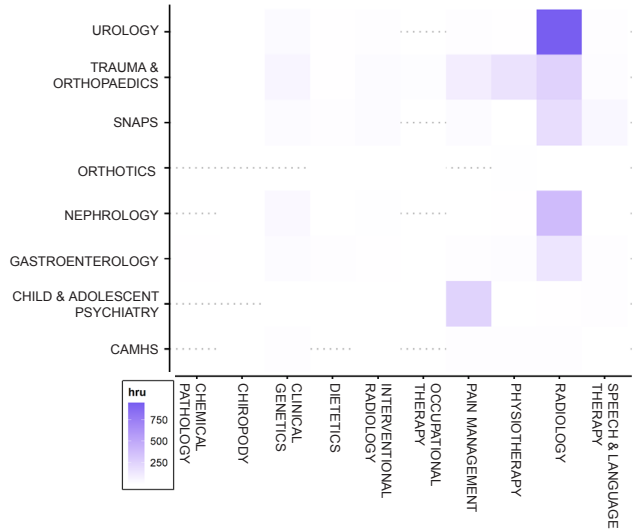
The charts below map dependencies between specialities in the Body, Bones & Mind (BBM) Directorate and supporting specialties in the same Directorate or other Directorates at GOSH. Dependencies have been measured in Resource Units, an approximate measure that takes into account outpatient and inpatient activity in a balanced way but does not represent full economic cost. For BBM, we can see the highest dependency is within Directorate with Paediatric Surgery supporting SNAPS.

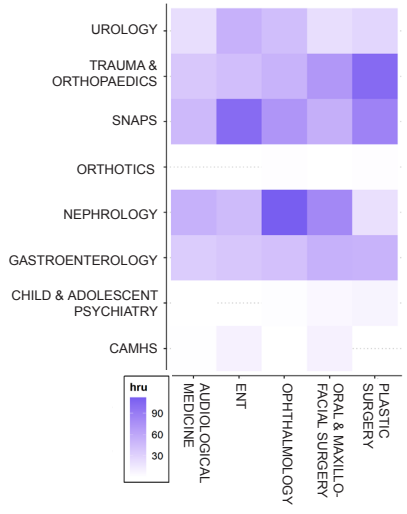








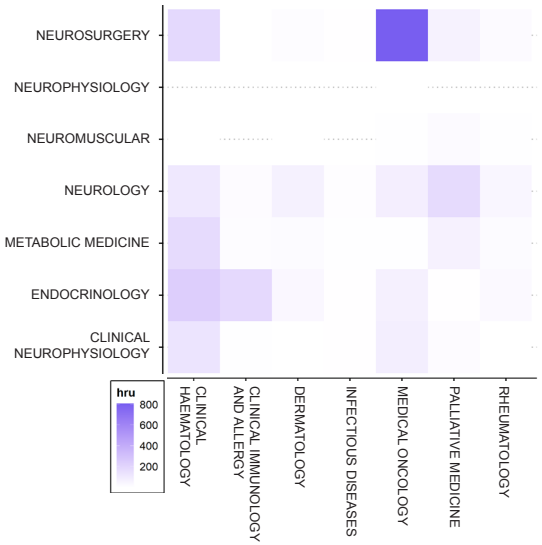


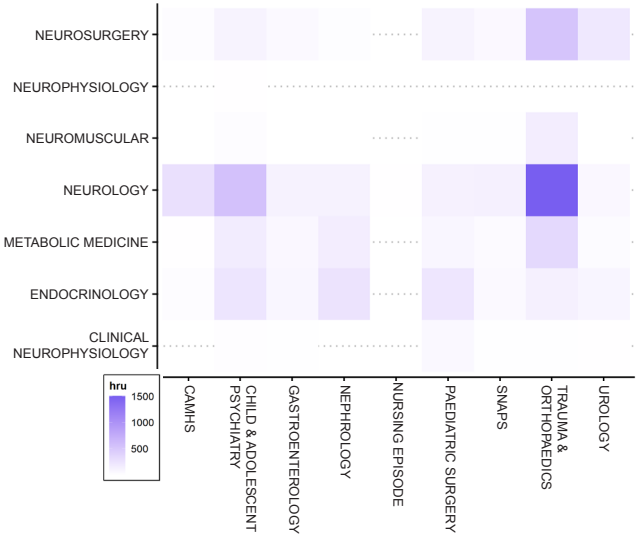


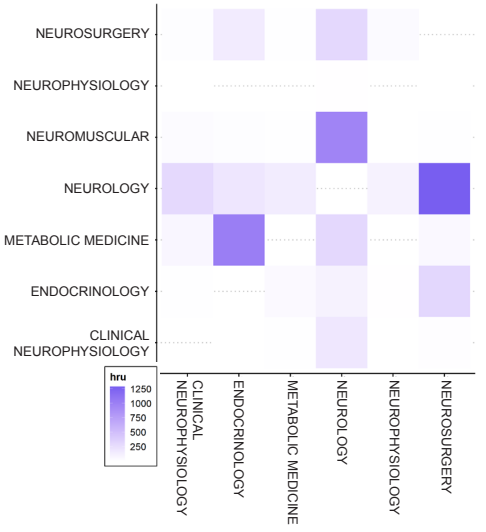
Data Source: GOSH Information Services, Data from 2019 - 2021. Data analysis and illustrations by Dr. William A, Bryant, Senior Data Scientist, Data Research, Innovation and Virtual Environments (DRIVE), GOSH.

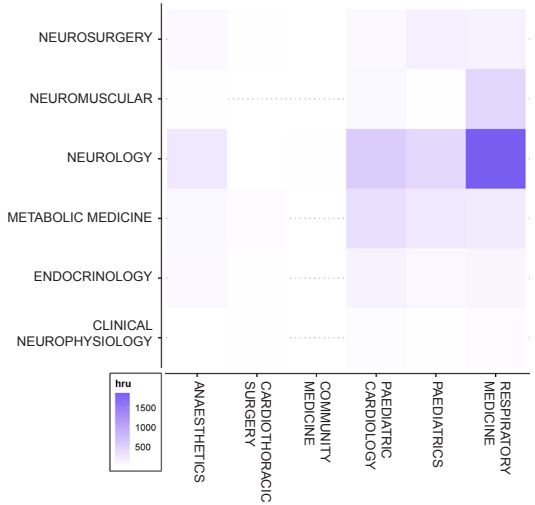
Appendix 3: Complexity and Interdependency
Brain

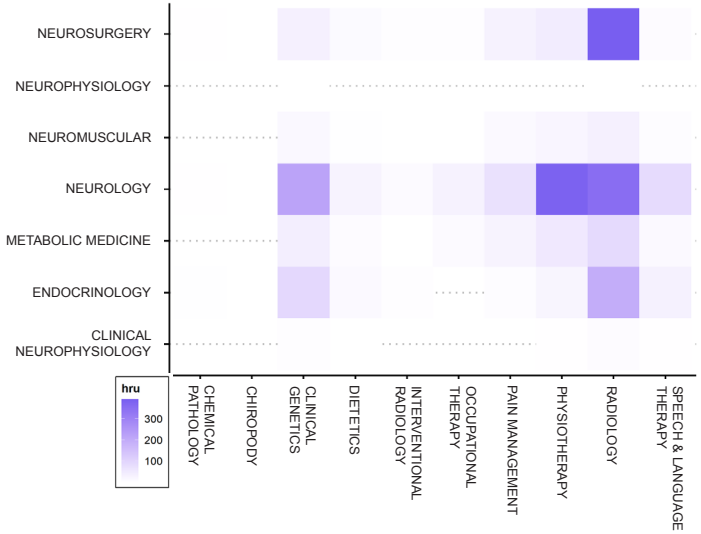
The charts below map dependencies between specialities in the Brain Directorate and supporting specialties in the same Directorate or other Directorates at GOSH. Dependencies have been measured in Resource Units, an approximate measure that takes into account outpatient and inpatient activity in a balanced way but does not represent full economic cost. For Brain, we can see the highest dependency is with BBM and H&L with Trauma & Orthopaedics and Respiratory Medicine both supporting Neurology.

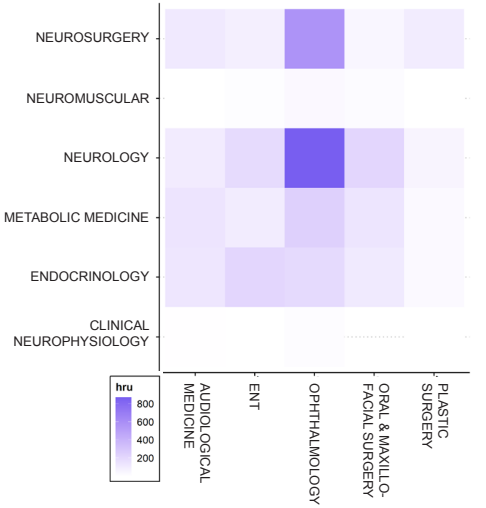








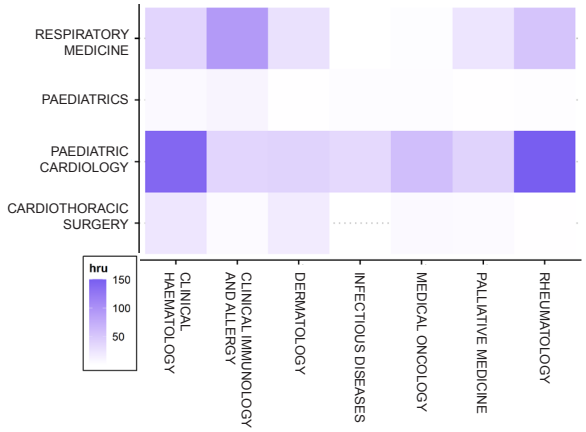


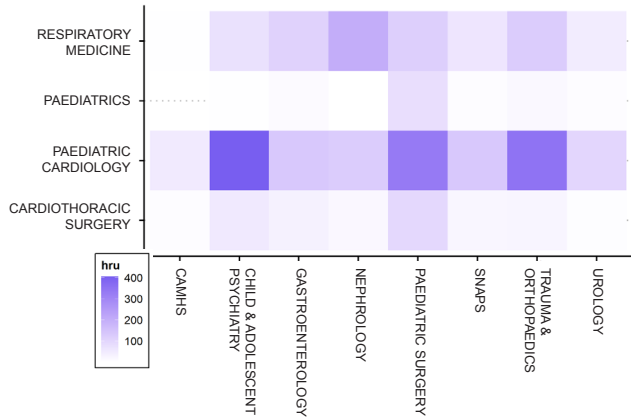


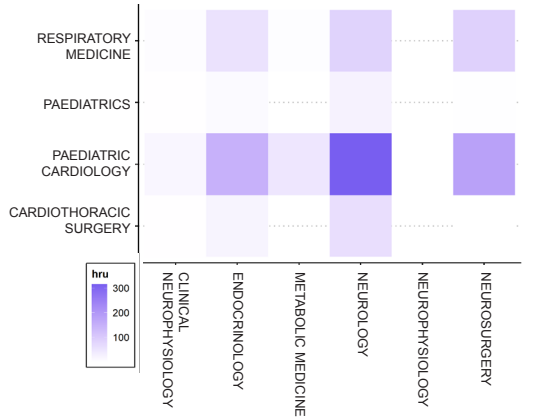
Data Source: GOSH Information Services, Data from 2019 - 2021. Data analysis and illustrations by Dr. William A, Bryant, Senior Data Scientist, Data Research, Innovation and Virtual Environments (DRIVE), GOSH.

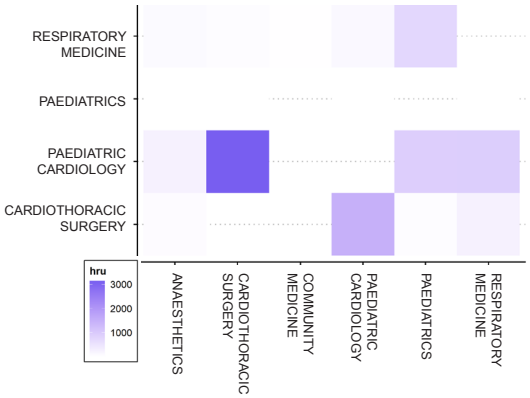
Appendix 3: Complexity and Interdependency
Heart & Lung

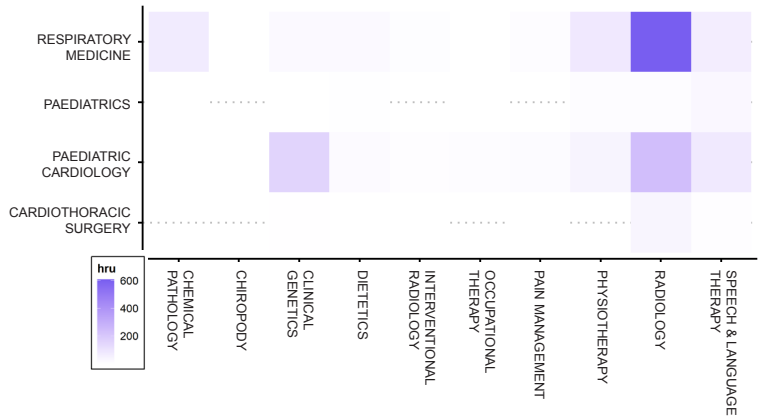
The charts below map dependencies between specialities in the Heart & Lung (H&L) Directorate and supporting specialties in the same Directorate or other Directorates at GOSH. Dependencies have been measured in Resource Units, an approximate measure that takes into account outpatient and inpatient activity in a balanced way but does not represent full economic cost. For H&L, we can see the highest dependency is within Directorate with Cardiothoracic Surgery supporting Paediatric Cardiology.

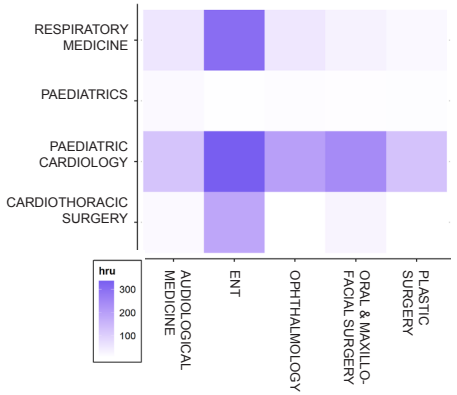








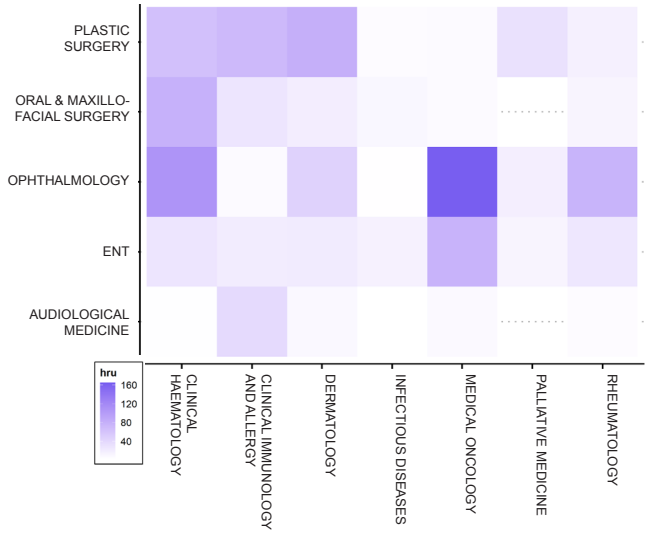


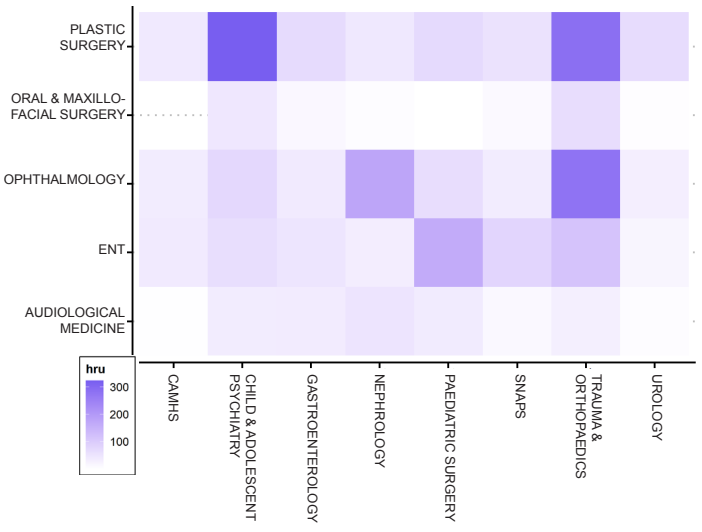


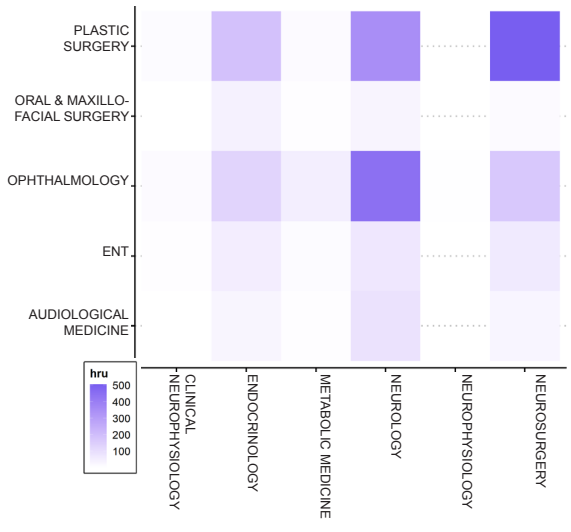
Data Source: GOSH Information Services, Data from 2019 - 2021. Data analysis and illustrations by Dr. William A, Bryant, Senior Data Scientist, Data Research, Innovation and Virtual Environments (DRIVE), GOSH.

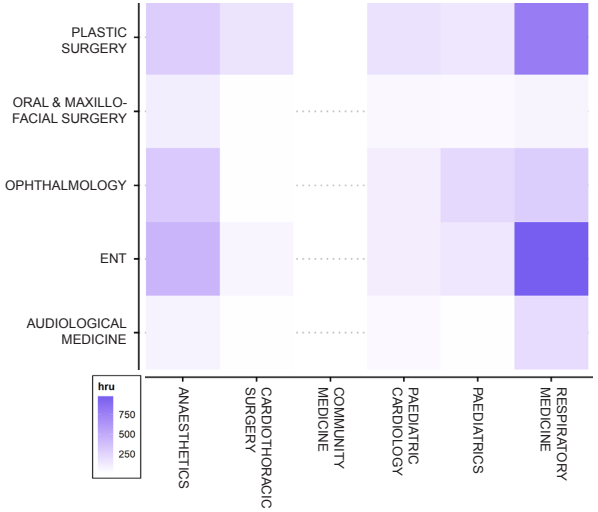
Appendix 3: Complexity and Interdependency
Sight & Sound

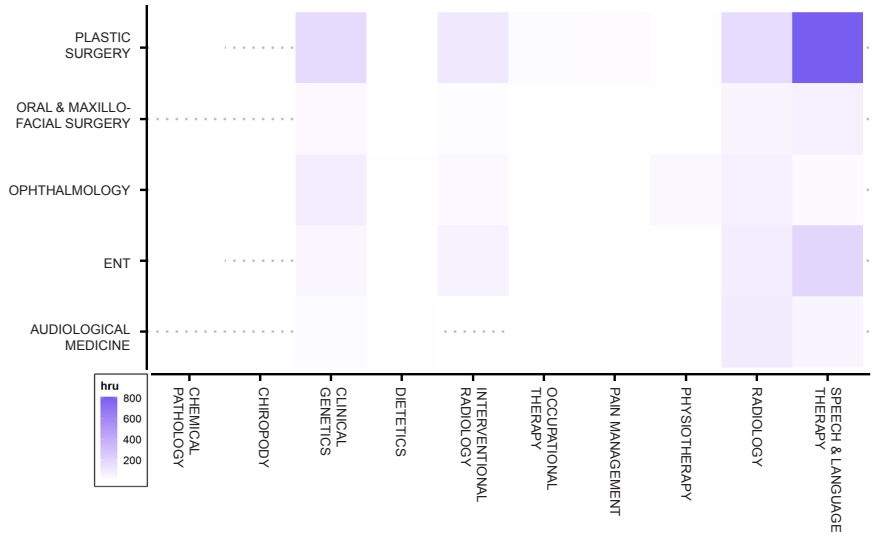
The charts below map dependencies between specialities in the Sight & Sound (S&S) Directorate and supporting specialties in the same Directorate or other Directorates at GOSH. Dependencies have been measured in Resource Units, an approximate measure that takes into account outpatient and inpatient activity in a balanced way but does not represent full economic cost. For S&S, we can see the highest dependency is within Directorate with Oral and Maxillo-Facial Surgery supporting Plastic Surgery.

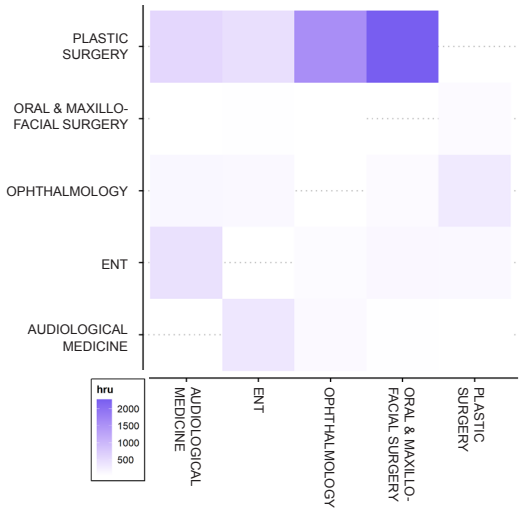












Data Source: GOSH Information Services, Data from 2019 - 2021. Data analysis and illustrations by Dr. William A, Bryant, Senior Data Scientist, Data Research, Innovation and Virtual Environments (DRIVE), GOSH.

Authors:
Ella Vallins, Head of Strategy, Great Ormond Street NHS Foundation Trust
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With input from:
Matthew Fenton, Chief of Service - Heart & Lung Directorate, Great Ormond Street NHS Foundation Trust
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For further queries on the content within this document, please contact strategyandplanning@gosh.nhs.uk

Attachment N

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
1st February 2023

Patient Safety Statement and Transformation: How We Listen, Lead and Learn **Submitted by:** Amanda Ellingworth, Non-Executive Director, Chair of the Quality, Safety and Experience Assurance Committee (QSEAC) and Sanjiv Sharma, Chief Medical Officer	**Paper No: Attachment N** ☐ **For approval** ☐ **For information and noting**

Purpose of report

To present the draft Patient Safety Statement to the Trust Board for approval, and to provide an update on the progress of year one actions of the Safety Transformation Plan, with details how the Trust is going to incorporate the themes from high level public reports into the plans for 2023.

Summary of report

If approved, February 2023 will see the publication of the Patient Safety Statement at the Trust Board and will incorporate the key messaging regarding how GOSH is going to Listen, Lead and Learn within Safety both internally and externally.

The Safety Transformation Plan brought together the actions from both the Safety and Quality Strategies, as well as the requirements from the NHS National Patient Safety Strategy. It is an ambitious programme, with over 155 high level actions described, and has been amended to incorporating learning from significant independent investigation reports over the past nine years: notably the Francis Review, Ockendon and the review into East Kent Maternity Services.

Collectively, the Ockendon and East Kent reviews considered the care provided to over 1,600 families and provides a number of recommendations and actions for the Health Service to consider in order to improve patient care, not just in Maternity Services, but across all aspects of Health. Four high level themes are evident from the reports which focus on: Monitoring Safe Performance, Values and Behaviours, Teamworking and Culture, and Organisational Behaviours which will form the basis of the activities planned for 2023.

51% of the year one actions within the Safety Transformation Plan have either been completed or are on track to be completed by the original completion date. Only 15% are delayed with 2% of which being critically delayed and require intervention to resolve which relates to the management and oversight of clinical guidelines.

The trust is also hosting the first paediatric focused Patient Safety and Human Factors Conference on the 16th March to support international learning and development.

Patient Safety Implications

There are no specific implications from this paper however, with the approval of the patient safety statement the Trust will make a formal and public commitment that Patient Safety is our purpose here at Great Ormond Street.

When there is good practice of things go wrong, we listen to the people involved from which we learn and lead change in practice at an organisational or national level.

Attachment N

Equality impact implications None
Financial implications None
Action required from the meeting The Board is asked to: • **Approve** the Patient Safety Statement • **Note** the progress to date on the Safety Transformation Plan • **Note** the activities and messaging in relation to Listen, Lead and Learn for 2023.
Consultation carried out with individuals/ groups/ committees Discussions have taken place at the Risk, Assurance and Compliance Group and the Quality, Safety and Experience Assurance Committee, both of which have endorsed the Patient Safety Statement and have noted the progress made to date.
Who is responsible for implementing the proposals / project and anticipated timescales? Nikki Fountain, Business Manager; David De Beer, Associate Medical Director for Safety and Claire Harrison, Director of Safety Surveillance
Who is accountable for the implementation of the proposal / project? Sanjiv Sharma, Chief Medical Officer

Attachment N

Patient Safety Statement and Transformation: How We Listen, Learn and Lead

Document Information	
Status	Final
Author	Nikki Fountain, Business Manager to the Chief Medical Officer and Medical Director's Office
Prepared For	Trust Board
Discussed At	Risk, Assurance and Compliance Group (RACG); and the Quality, Safety and Experience Assurance Committee (QSEAC)
Date Prepared	12th January 2023
Directorate Area	Medical Director's Office

Introduction:

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

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

This singular action plan has been developed to ensure that the Trust has oversight of all relevant actions which are pertinent to patient safety.

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

This report provides an update on progress of the plan, demonstrates the steps taken to ensure that the recommendations provided in the external reports are used to help develop the plan and that where gaps may exist in process and procedures, oversight, or assurance that actions are developed to resolve these.

This report sets out the Trust's commitment to Patient Safety, in the form of the Patient Safety Statement, and the next steps for safety transformation at GOSH, the activities and steps that will be taken to ensure that we continue to provide safe high-quality care for our patients and their families, whilst ensuring that our staff are able to work in a psychologically safe environment, without fear when speaking up.

Draft Patient Safety Statement:

Patient Safety at Great Ormond Street is our purpose not just our priority, ensuring that our patients and their families receive safe high-quality care. We will achieve this through ensuring that as a Trust, and as individuals, we Listen, Learn and Lead.

Listen: *We will involve and engage with our patients and families about what is happening within the Hospital, discuss their choices and listen to their experiences. We will foster a culture of openness and curiosity when things go wrong and speak with our patients, families, and staff about why errors have been made in timely an honest, and transparent way. We will listen to our patients, families, and staff about their ideas to improve or enhance patient safety*

Learn: *We will operate robust processes for identifying and learning from patient safety events, both when things go wrong but also when things go right. When things have gone wrong, we will try our hardest to understand why and facilitate a culture amongst our staff of learning without blame. Noting the complexities and rarity of much of the work we do at GOSH not only will we share the learning from our successes but, also where we have sought external expertise and advice to support further improvements. We will embed learning into our working practices, policies, systems, processes, and teaching.*

Lead: *We will collectively lead a psychologically safe organisation, where staff feel able and are supported to 'Speak Up' openly about concerns without fear of rebuttal or retribution. We will support the implementation of the ambitious safety culture and transformation programmes at GOSH. We will share what we have learnt and improved, to lead on patient safety in the field of paediatrics nationally and internationally. Our leadership style will be one of openness and transparency, and we will ensure that this is reflected throughout the organisation.*

Transformation Plan – 2022 End of Year Review:

The plan incorporates 155 separate, high-level actions which span over three years and is based on the standards developed by Patient Safety Learning and covers the seven areas identified in the diagram to the left.

At the time of completing the review for those actions due in year one, 51% have either been completed or are on track with only 15% are being recorded as being delayed – 2% of which are 'Critically Delayed' and require intervention in order to rectify as shown in the diagram below.

Some of the actions that have been completed include:

- Delivered Incident Investigation training to the Patient Safety Team and Deputy Chiefs of Service, improved the accuracy and terminology used in investigation reports and implemented a standardised report design and sign off process
- Designed and published a new eLearning package in relation to Duty of Candour, and partnered with AvMA (Action Against Medical Accidents) to deliver bespoke training around the application of Duty of Candour with Empathy
- Issued new guidance on Medical Consultant Job Planning and procured a new electronic system to support
- Evaluated and redesigned the Quality Governance Management Framework for the Trust and implemented new meeting structures to improve the flow of information from Ward to Board and to ensure the correct level of accountability and oversight is in place.

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

Learning From Others:

The Ockendon Report was commissioned in 2017, following the perseverance of two bereaved families. The review is huge in scale and scope, considers the care of over 1,400 families over a period of 19 years, interviews over 84 members of staff (24 of which subsequently withdraw their consent for fear of speaking up) and reviews over 1,500 clinical incidents. With the identification of pattens of repeated poor care, repeated errors in care leading to injury; and failures in governance and leadership.

These themes, on review of the final report, are a result of wider Trust themes around Organisational Culture, and Leadership, Teamwork and Management. In the case of the East Kent Report, the review spanned 11 years and considered 202 individual cases and identifies the following five themes failure of Teamwork and professionalism, failures of compassion, failures to listen, failures after safety incidents, and failure in leadership.

Rather than make specific recommendations, the report highlights that independent reviews with numerous published recommendations have taken place since 1967, and have resulted in minimal, if any, prevention of similar failures across the NHS. Therefore, the report presents four areas for action where improvements are needed: identification of poorly performing units; giving care with compassion and kindness; teamworking with a common purpose; and responding to challenge with honesty.

The Verita report commissioned internally following concerns expressed by families and via a BBC broadcast. The report makes a number of initial findings, however there is a widely shared view that Great Ormond Street Hospital 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. Notably through the leadership team's commitment to patient safety and its communication of that commitment, and individuals are convinced of the desire of the leadership team to improve things further.

In a thematic review completed by NHS England Specialised Commissioning, where they considered 16 Serious Incidents declared at GOSH between April 2021 and February 2022, they identified themes in relation to Information Governance, communication and teamworking.

Throughout the reports detailed above, the following are consistent themes which have been identified as needing improvements and/or interventions: teamwork, safety culture, variable clinical practice, leadership, governance, and oversight of safety metrics.

The focus for 2023 will be on these consistent themes and have been combined into the following four actions which underpin the activities and discussions taking place. The themes have been reframed to be more aspirational rather than focusing on the negatives. The four key themes for 2023 will be to focus on:

- Monitoring Safe Performance
- Values and Behaviours
- Teamworking and Culture
- Organisational Behaviours

2023 – How we Listen, Lead and Learn

Starting the process will be the publication of the Trust's Patient Safety Statement which has been proposed as part of this paper and will provide the foundation for the Safety Transformation Plan.

Listen, Learn and Lead around the 'Big Conversation':

Following the publication of the above statement, we will utilise consistent and clear messaging focusing on 'Listen, Lead and Learn' as detailed above. These will be incorporated into a detailed communications and engagement plan with both internal and external activities, and which will be overseen by the Safety Transformation Board, chaired by the Chief Medical Officer.

Each month the activities, discussions and listening events will revolve around a particular theme with March focusing on 'Monitoring Safe Performance', April being on 'Values and Behaviours', May being on 'Teamwork and Culture' and lastly June which will focus on 'Organisational Behaviour.' The format for each month will be:

- **Listen**: Listening Events will take place where we discuss work in train and hear from staff about how things are working or any ideas for improvement. Will encourage staff to comment using the forums on 'OurGOSH', have themes within the Virtual Big Brief where possible to encourage further questions and set up specific threads on #AskYourColleagues.
- **Learn**: The month will end with the Executive Director publishing a blog / update on 'OurGOSH' highlighting what they have learnt about the theme over the past four weeks, and what the next steps are to ensure that we maintain momentum.
- **Lead**: A 'Big Conversation' event will take place, hosted by members of the Executive Team, and supported by a Non-Executive Director which will open the theme of the month with staff across the Trust.

Where possible we will invite external speakers to facilitate the listening events, or to share their thoughts and insights around the specific topics. We have approached 'Surviving in Scrubs' which was launched by Dr Becky Cox and Dr Chelcie Jewitt to raise awareness around the culture of misogyny in medicine, following a survey by the BMA in 2021 where 55% of respondents said they had received unwanted verbal comments relating to their gender.

To be held in March, GOSH will be hosting the first ***Paediatric Patient Safety and Human Factors Conference***, which will bring together experts to consider the challenges of patient safety in paediatrics and explore human behaviours that influence safety in healthcare as well as ways to improve safety for CYP.

Attachment N

Accountability and Oversight:

The actions and communications plan as described in this update will be monitored and overseen by the Safety Transformation Board, which will report through to the Quality, Safety, Outcomes and Compliance Committee on a Monthly basis, with a quarterly report into RACG and QSEAC for assurance.

Action:

The Board is asked to:

- **Approve** the Patient Safety Statement
- **Note** the progress to date on the Safety Transformation Plan
- **Note** the activities and messaging in relation to Listen, Lead and Learn for 2023.

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
1st February 2023

October Integrated Quality and Performance Report (December 2022 Data) **Submitted by:** John Quinn COO **Co-Authors** Dr Sanjiv Sharma MD Tracy Luckett Chief Nurse Caroline Anderson Director of HR & OD	Paper No: Attachment O ☐ For discussion

Purpose of report

To present the Integrated Quality and Performance Report 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 report

The Board Integrated Quality and Performance Report has one amendment this month which relates to the Trust Sickness rate being monitored against the national average from November 2022.

The December strikes unavoidably affected performance; however, operational teams were highly prepared which resulted in effective derogations for essential services, movement of outpatient appointment to virtual where possible and carefully planned inpatient admissions. 70 admissions and 550 appointments were recorded as rescheduled. The feedback from the RCN was that our way of working with them has been really positive and the strike days were conducted very amicably.

Klebsiella and E-coli bacteraemia's remain above normal levels. A review of RCAs from directorates is expected at the January IPCC to identify any common themes within specialities.

The Trust has delivered £11.2m Better Value year to date and overall has identified £17.7m as confident of delivery.

Well-led remains a focus for the Trust improvements have been seen in training and appraisal rates. Sickness rates have stabilised at 4% and are below the national average.

Activity overall is below the internal 2022/23 plan but remains above 2019/20 figures. RTT and Diagnostics saw a reduction in performance as a result of the strike days, however, Cancer targets continue to be met for December.

Patient Safety Implications

The IQPR includes metrics and analysis on Patient Safety.

Equality impact implications

There are no specific metric on equality, but the report includes metrics on Access, Freedom to speak up and patient experience.

Financial implications

The IQPR only includes metrics on Better Value and no other specific metrics on Finance, but access and activity performance will have implications on revenue.

Attachment O

Action required from the meeting None
Consultation carried out with individuals/ groups/ committees Reviewed at EMT
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Operating Officer
Who is accountable for the implementation of the proposal / project? Chief Executive

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality & Performance Report

January 2023

Reporting December 2022 data

John Quinn
Chief Operating Officer

Tracy Luckett
Chief Nurse

Sanjiv Sharma
Medical Director

Caroline Anderson
Director of HR & OD

Contents

Executive Overview

December saw two days of nursing strikes, an ambulance strike and multiple train strikes. Inevitably this affected performance, however, the hard work of the operational teams preparing for this, and dedication of clinical staff meant that the impact was highly mitigated with more outpatient appointments moving to virtual and inpatient activity rescheduled. The preparation also meant the Trust was well prepared, with effective derogations to the strike, to ensure essential services were able to continue. The feedback from the RCN was that our way of working with them has been really positive and the strike days were conducted very amicably.

As a result activity was down to approximately 80% for the 2 weeks of the strike. This has meant that the main access indicators have seen a reduction (RTT down 2.3% to 70.9%, Diagnostic waits down 6.9% to 82.3%, 52 week waits up 29 to 248). The key indicators, though, all still remain above national averages.

Quality and safety indicators mainly do not show a significant change during this time. Patient Experience generally remains high with Inpatient experience remaining at 98% positive but Outpatients has dropped slightly in month however there is a decline since September. The key issues being related to last minutes changes in appointment and clinicians, which is largely due to the disruption caused by the strike action.

The Better Value programme has now identified £17.7m with £11.2m delivered to date. And, in the Well Led domain, we have seen improvements in both training and appraisal rates across all categories. Sickness levels remain stable at 4%, and whilst above the Trust target, the rate is well below the national average of 5.8%.

Looking forward there has been recovery in patient access and back to more normal activity. Also RTT has dropped but again is recovering. There are though further industrial action by more staff groups over the next months as well as continued strike action of trains and soon to be teachers. All of these have the risk they will affect the ability either for staff to work or patients to be able to get to the Hospital.

Integrated Quality & Performance Report, December 2022

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Patient Safety

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

Effective

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

Patient Experience

FFT Experience		→
FFT Response		↗
PALS		→
Complaints		→

Well Led

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

Patient Access

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

Patient Safety - Incidents & Risks

Overview

- **Incidents:** A concerted effort to reduce numbers of overdue incidents has reduced the total open incidents from 1523 to 1367.
- **Serious Incidents:** One new serious incident was declared relating to an unexpected death on Koala Ward. The report is due on 23 March 2023.
- **Duty of Candour:** Two stage 2 duty of candour letters were due in December and both were sent, though one was late. Two of three stage 3 duty of candour letters were sent on time. The one remaining stage 3 is to be completed but has been delayed due to availability of staff in the Tissue Viability team to carry out the root cause analysis (RCA).
- **Risks:** Performance dropped this month as many risk action groups (RAGs) were cancelled in December. There was also a change in the grading of high risks to include risks rated 15 and above (previously 12 and above) which reduced the number of high risks from 64 to 26. This reflects common practice across other NHS organisations.

Patient Safety - Incidents

		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Last 12 months	RAG			Stat/ Target
New Incidents	Volume	546	556	661	532	608	577	675	620	600	617	592	498		No Threshold			Target
Total Incidents (open at month end)	Volume	1944	1531	1444	1477	1522	1687	1922	2109	2181	2013	1523	1367		No Threshold			Target
New Serious Incidents	Volume	2	1	2	2	4	1	4	2	1	1	1	1		No Threshold			Target
Total SIs (open at month end)	Volume	21	18	17	20	18	14	15	10	12	3	3	3					Target
Overdue SI Actions	Volume	35	15	16	12	12	25	14	4	18	20	15	16		>20	10 - 20	0 - 9	Target
Incidents involving actual harm	%	28%	19%	22%	21%	18%	15%	12%	13%	11%	10%	13%	11%		>25%	15%-25%	<15%	Target
Never Events	Volume	0	0	1	0	0	0	0	1	0	0	0	0		>/=1		0	Stat
Pressure Ulcers (3+)	Volume	1	0	0	0	1	0	0	0	1	1	1	0		>1	=1	=0	Stat
Duty of Candour Cases (new in month)	Volume	5	3	3	3	7	3	8	7	7	3	4	1		No Threshold			Target
Duty of Candour – Stage 2 compliance (case due in month)	%	37%	100%	66%	1/5	3/3	3/5	1/3	1/5	3/6	3/5	3/4	1/2		<75%	75%-90%	>90%	Target
Duty of Candour – Stage 3 compliance (case due in month)*	%	60%	33%	33%	1 / 1	2/6	2/2	1/3	0/0	0/0	2/4	2/5	2/3		<50%	50%-70%	>70%	Target
High Risks (% overdue for review)**	%	12%	6%	21%	28%	32%	5%	5%	40%	9%	4%	5%	35%		>20%	10% - 20%	<10%	Target

* This measure reflects the total number of Stage 3 DOC and SI reports due in month. Both investigations have a 60 working day compliance, after review of the measure through the DoC policy review process. As of October, this figure will indicate all DoC incidents where internal sign off was completed on time.

** From December 2022 onwards this figure will include risks rated 15+ (previously 12+)

Patient Safety - Infection Control & Inpatient Mortality

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Overview

- CV Line infections remained within normal variation for the month of December (please note that one child was responsible for 3 of the counts). Klebsiella and E-coli bacteraemia's remain above normal levels. A review of RCAs from directorates is expected at the January IPCC to identify any common themes within specialities. It should be noted that nationally there is an increase in gram negative bacteraemia's, in particular klebsiella species. There was higher that normal incidence of MSSA bacteraemia's, the RCAs on these are still awaited to determine any themes. A higher than usual proportion of C-Diff was reported and treated but no clusters or outbreaks were identified.
- Both the number of cardiac arrests and respiratory arrests outside of ICU/theatres are within normal variation.
- The inpatient mortality rate is within normal variation .Whilst it is useful for understanding the frequency of inpatient deaths, compared to activity, however we recognise that it is not risk adjusted data. That is, it doesn't account for how unwell the patient was on admission and the likelihood of death as a potential outcome. There are two additional processes by which we can effectively understand our mortality outcomes at GOSH. The gold standard for measuring paediatric mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANet). The most recent PICANet report was published in January 2022 and covers the calendar years 2018-2020. The report shows GOSH PICU/NICU and CICU risk adjusted mortality as within expected range. There have been no outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths through M+Ms . This is important as the majority of patient deaths at GOSH are in intensive care areas

Infection Control

		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	2022/23 YTD	Last 12 months	RAG (22/23 threshold)			Stat/ Target
C Difficile cases	In Month	0	0	0	0	1	2	1	0	1	1	1	3	9		>8	N/A	<=8	Stat
C difficile due to lapses (note 2)	Annually															>8	N/A	<=8	Stat
MRSA	In Month	0	0	0	0	0	0	0	0	0	1	0	0	1		>0	N/A	=0	Stat
MSSA	In Month	3	0	2	2	3	3	2	2	0	1	2	5	20		No Threshold			
E.Coli Bacteraemia	In Month	1	1	3	1	3	2	0	3	2	2	2	2	17		>8	N/A	<=8	Stat
Pseudomonas Aeruginosa	In Month	0	1	2	0	2	1	0	2	2	1	1	0	9		>8	N/A	<=8	Stat
Klebsiella spp	In Month	1	2	1	2	6	3	1	3	0	2	5	3	25		>12	N/A	<=12	Stat
CV Line Infections (note 1)	In Month	1.6	1.3	1.5	2.2	1.7	1.5	2.4	5.4	2.5	2.4	1.8	2.6	2.5		>1.6	N/A	<=1.6	T

Inpatient Mortality & Cardiac Arrest

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Last 12 months	RAG	Stat/ Target
Number of In-hospital Deaths	9	11	9	8	7	7	10	8	7	12	4	9		No Threshold	
Inpatient Mortality per 1000/discharges	9.6	9.5	7.8	8.1	6.7	6.6	9.0	7.3	6.6	11.6	3.8	10.2		No Threshold	
Cardiac arrests outside ICU/theatres	4	1	1	1	0	0	1	1	2	2	0	2		No Threshold	
Respiratory arrests outside ICU/theatres	5	2	1	1	2	3	0	2	2	2	0	1		No Threshold	
Inquests currently open	12	14	12	14	13	13	14	15	10	12	12	9		No Threshold	

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Effectiveness

Better Value:

The Trust's Better Value target for 2022/23 is £22.8 million. The total value of schemes identified is £17.7m; £15.92m has been identified and acknowledged on the finance tracker, with a YTD performance of £11.15m (as of 13/01/23). Good progress is being made with delivering schemes signed off into the live tracker, with a current year end forecast outturn of £15.5m. A further £153k of schemes under development are green in planning and being finalised for the ledger with Finance.

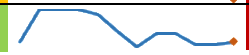
The Better Value Delivery Group are now in the process of ensuring that the delivery of green schemes are completed. The PMO are working to continue moving schemes from amber and red to green. The Strategy and Planning team are now in the process of producing the 23/24 annual plans which will in turn help to inform the Better Value Programme for next year.

Effectiveness	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Last 12 months
Speciality led clinical audits completed (actual YTD)	109	114	8	16	24	32	48	66	80	90	100	
Outcome reports published (YTD)	7	8	0	0	0	2	2	3	5	7	7	
QI Project completed	0	0	0	0	10	0	1	3	9	2	1	
QI Projects started	0	0	1	1	28	7	15	6	2	14	17	
NICE guidance currently overdue for review							0	0	0	0	0	
Better Value YTD Actual						£3,706,440	£4,633,985	£6,010,393	£8,681,000	£9,848,000	£11,152,000	
% value of schemes identified compared to their Better Value target				77.8%	83.0%	80.4%	89.9%	78.0%	82.4%	77.8%	77.6%	
Number of schemes identified				80	97	102	110	119	125	125	125	
Number of schemes fully signed off and EQIA assessed				4	26	45	46	75	118	118	118	
Number of schemes identified but not signed off				76	71	57	64	34	7	7	7	

Patient Experience

Overview

- The FFT response rate and Inpatient experience rate met Trust targets in December. The outpatient experience rate narrowly missed the target. Negative feedback from outpatient areas related to appointment venue changes at the last minute and poor communication about other appointment investigations. There were comments about not seeing the clinician families were expecting to see. In addition, pre-appointment questionnaires were deemed by families to be a waste of time as they were not used. There were also comments about the relevant blood tests not being requested on the Patient Management System prior to appointments.
- Pals contacts and formal complaints highlighted concerns about referral processes including information requirements, delays and clarification on the remit and management of referrals.

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Last 12 months	RAG		
FFT Experience rating (Inpatient)	97.0%	98.0%	97.0%	98.0%	98.0%	98.0%	98.0%	99.0%	99.0%	98.0%	98.0%	98.0%		<90%	90-94%	>=95%
FFT experience rating (Outpatient)	95.0%	98.0%	94.0%	98.0%	97.0%	97.0%	97.0%	97.0%	97.0%	95.0%	94.0%	93.0%		<90%	90-94%	>=95%
FFT - response rate (Inpatient)	25.0%	37.0%	37.0%	37.0%	35.0%	29.0%	23.0%	28.0%	28.0%	24.0%	24.0%	25.0%		<25%	N/A	>=25%
PALS - per 1000 episodes	7.56	8.42	7.44	8.1	7.59	9.25	12.37	9.46	10.46	9.74	9.51	9.75		No Threshold		
Complaints- per 1000 episodes	0.13	0.13	0.34	0.32	0.27	0.95	0.38	0.43	0.58	0.36	0.55	0.51		No Threshold		
Red Complaints -% of total (note 1)	10%	11%	8%	8%	6%	5%	5%	7%	7%	6%	6%	6%		>12%	10-12%	<10%
Re-opened complaints - % reopened (2)	6%	8%	9%	9%	9%	8%	8%	10%	9%	9%	9%	8%		>12%	10-12%	<10%

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

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Well Led Headlines: December 2022

Contractual staff in post: Substantive staff in post numbers in December were 5347.57FTE a decrease of 28.03 FTE since November 2022. Headcount was 5,764 (-39 on the previous month).

Unfilled vacancy rate: Vacancy rates for the Trust increased to 7.7% in December (up from 7.1% in November. The vacancy rate remains below the 10% target, and is 1.% higher than the same month last year (5.8%). Vacancy rates in Nursing & Patient Experience (32%), research & Innovation (44.1%) and Transformation(60.1%) are the highest outliers

Turnover: is reported as voluntary turnover over a rolling 12 month period. Voluntary turnover decreased in December, to 14.%, from 14.3% in the previous month., and is currently within the trust target. There are a number of directorates that are either under the trust target or within 1% of the target, the main outliers to this trend are HR (28.7%), Corporate Affairs (28.3%), research & Innovation (20.9%)

Agency usage: Agency Usage for December has remained stable at 1.1% and is within the 2% trust target, corporate areas such as finance (9.3%), Medical Directorate (5.7%), ICT (5.1%) and HR (5%) are the biggest outliers. Bank spend was 5.3% for December, however directorates such as Space and place (14.2%) and International (8.2%)are well above the average

Statutory & Mandatory training compliance: The December training rate for the Trust has remained stable at to 94%, for the second consecutive month, with all directorates meeting the target.

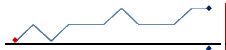
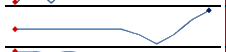
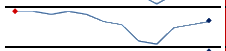
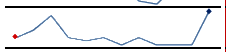
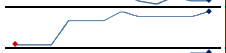
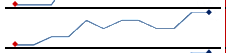
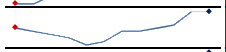
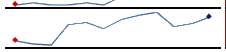
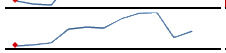
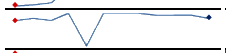
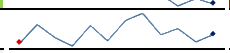
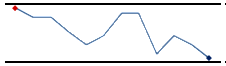
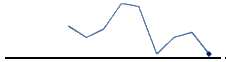
Appraisal/PDR completion: The non-medical appraisal rate has risen from 83% in November to 84%, however only Finance (91%), Medical directorate (91%) and Research a& Innovation (91%) are above the trust target, Consultant appraisal rate has increased to 94% this month.

Sickness absence: December sickness rates were reported at 4.5%, which is lower than the same month last year (5.9%). In order to benchmark GOSH sickness more accurately, and provide a more realistic target the Trust will be incorporating the national NHS sickness rate into it's RAG rating (see Well led page for details.) The national rate for December was 5.8% and GOSH reported sickness rates were 4.5%. The highest areas of sickness for December was Space & Place (6.7%), Clinical Operations (6.5%) and International (6%).

Freedom to Speak Up.: The service received 10 contacts in December which was an decrease from the previous month. The main theme being raised in December related to concerns around quality and safety of care. Those raising concerns came from a range of professional backgrounds.

Well Led

Well Led Metrics Tracking

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Last 12 months	RAG Levels			Stat/Target
Mandatory Training Compliance	92.0%	93.0%	92.0%	93.0%	93.0%	93.0%	94.0%	93.0%	93.0%	93.0%	94.0%	94.0%		<80%	80-90%	>90%	Stat
Stat/Man training – Medical & Dental Staff	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	85.0%	83.0%	85.0%	88.0%	90.0%		<80%	80-90%	>90%	Stat
Appraisal Rate (Non-Consultants)	87.0%	87.0%	86.0%	87.0%	86.0%	84.0%	83.0%	78.0%	77.0%	82.0%	83.0%	84.0%		<80%	80-90%	>90%	Stat
Appraisal Compliance (Consultant)	87.0%	89.0%	93.0%	87.0%	86.0%	87.0%	85.0%	87.0%	85.0%	85.0%	85.0%	94.0%		<80%	80-90%	>90%	Stat
Honorary contract training compliance	74.0%	78.0%	76.0%	76.0%	74.0%	72.0%	71.0%	69.0%	68.0%	70.0%	69.0%	69.0%		<80%	80-90%	>90%	Stat
Safeguarding Children Level 3 Training	89.0%	89.0%	89.0%	94.0%	94.0%	94.0%	96.0%	95.0%	95.0%	95.0%	95.0%	96.0%		<80%	80-90%	>90%	Stat
Safeguarding Adults Level 2 Training	91.0%	91.0%	92.0%	92.0%	94.0%	93.0%	94.0%	94.0%	93.0%	93.0%	95.0%	95.0%		<80%	80-90%	>90%	Stat
Resuscitation Training	82.0%	81.0%	80.0%	79.0%	77.0%	78.0%	81.0%	81.0%	82.0%	83.0%	87.0%	87.0%		<80%	80-90%	>90%	Stat
Sickness Rate see note 3	4.1%	4.0%	3.7%	4.3%	3.6%	3.6%	3.3%	3.3%	3.6%	3.5%	4.0%	4.5%		>5.3%	3-5.3%	<3%	T
Turnover Rate (Voluntary)	12.1%	12.2%	12.1%	12.1%	12.2%	12.1%	12.6%	12.5%	13.6%	13.9%	14.3%	14.0%		>14%	N/A	<14%	T
Vacancy Rate – Contractual	5.3%	4.9%	4.9%	6.9%	7.1%	6.5%	7.5%	7.8%	8.2%	6.7%	7.1%	7.7%		>10%	N/A	<10%	T
Vacancy Rate - Nursing	2.9%	3.1%	3.5%	5.9%	6.2%	6.1%	7.8%	8.8%	9.0%	4.5%	5.6%	7.0%		No Threshold			T
Bank Spend	5.2%	5.3%	5.2%	5.5%	4.2%	5.5%	5.5%	5.5%	5.4%	5.4%	5.4%	5.3%		No Threshold			T
Agency Spend	1.2%	1.2%	1.2%	1.1%	1.2%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%		>2%	N/A	<2%	T
Care Hours per Patient Day (CHPPD)	14.4	15.8	14.8	14.1	15.7	14.5	16.1	16.7	15.0	15.5	14.4	15.0		No Threshold			T
Quarterly Staff Survey - I would recommend my organisation as a place to work				65%			62%							No Threshold			T
Quarterly Staff Survey - I would be happy with the standard of care provided by this organisation				88%			87%							No Threshold			T
Quarterly Staff Survey - Overall Staff Engagement (scale 0-10) See note 1				7.5			7.0							No Threshold			T
Quarter Staff Survey - Communication between senior management and staff is effective See note 1				46.0%			41%							No Threshold			T
Number of people contacting the Freedom To Speak Up Service	21	19	19	16	13	15	20	20	11	15	13	10		No Threshold			T
Number of Themes of concerns raised as part of Freedom to Speak Up Service (note 2)				25	21	24	33	32	15	21	23	15		No Threshold			T

Note 1 - Survey runs in January, April and July.
Note 2 - people contacting the service can present with more than one theme to their concern
Note 3: Sickness rate target has changed to the national average from Nov 22

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Performance Metrics

Access Metrics Tracking

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trajectory	Last 12 months	RAG Levels			Stat/Target
RTT Open Pathway: % waiting within 18 weeks	75.4%	75.3%	76.0%	75.2%	76.8%	75.3%	73.7%	72.3%	71.8%	72.4%	73.2%	70.9%	Below		<92%	N/A	>=92%	Stat
Waiting greater than 18 weeks - Incomplete Pathways	1,688	1,731	1,635	1,733	1,638	1,765	1,900	2,006	2,023	2,012	1,944	2,154	-		No Threshold			-
Waiting greater than 52 weeks - Incomplete Pathways	176	169	142	151	160	177	177	196	202	206	219	248	Above		>0	N/A	=0	Stat
Waiting greater than 78 weeks - Incomplete Pathways	39	34	27	28	24	24	20	25	30	28	28	45	Above		TBC			T
Waiting greater than 104 weeks - Incomplete Pathways	7	9	5	7	4	3	0	0	1	1	3	5	Above		>0	N/A	=0	Stat
18 week RTT PTL size	6858	7004	6811	7009	7070	7150	7239	7229	7176	7295	7264	7401	-		No Threshold			-
Diagnostics- % waiting less than 6 weeks	83.0%	86.4%	86.8%	84.1%	84.7%	82.6%	83.9%	84.1%	83.5%	88.4%	89.2%	82.6%	Below		<99%	N/A	>99%	Stat
Total DM01 PTL size	1,394	1,430	1,463	1,556	1,565	1,489	1,506	1,480	1,463	1,714	1,747	1,767	-		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	75%	60%	100%	100%	100%	100%	100%	100%	100%	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)	11	15	34	23	31	28	43	28	33	38	53		-		No Threshold			-
Cancelled Operations: 28 day breaches	1	3	1	2	4	4	4	4	2	5	1		-		>0	N/A	=0	Stat
Number of patients with a past planned TCI date (note 4)	1,494	1,464	1,126	1,244	1,398	1,256	1,261	1,347	1,112	1,193	1,270	1,261	-		No Threshold			-
NHS Referrals received- External	2,439	2,490	2,818	2,470	2,603	2,673	2,607	2,431	2,611	2,901	2,920	2,453	-		No Threshold			-
NHS Referrals received- Internal	1,937	1,861	2,016	1,812	2,023	1,767	1,883	1,789	1,820	2,124	2,198	1,625	-		No Threshold			-
Total NHS Outpatient Appointment Cancellations (note 2)	6,483	6,605	7,637	6,704	6,626	6,816	7,352	7,472	6,910	6,352	6,368	6,449	-		No Threshold			-
NHS Outpatient Appointment Cancellations by Hospital (note 3)	1,790	1,793	2,156	1,690	1,473	1,499	1,569	1,493	1,707	1,441	1,366	1,576	-		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

Patient Access - Activity Monitoring at Month 9

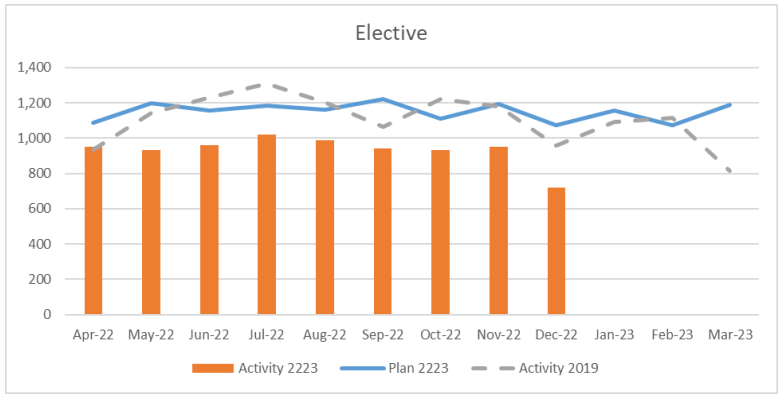
Overview:

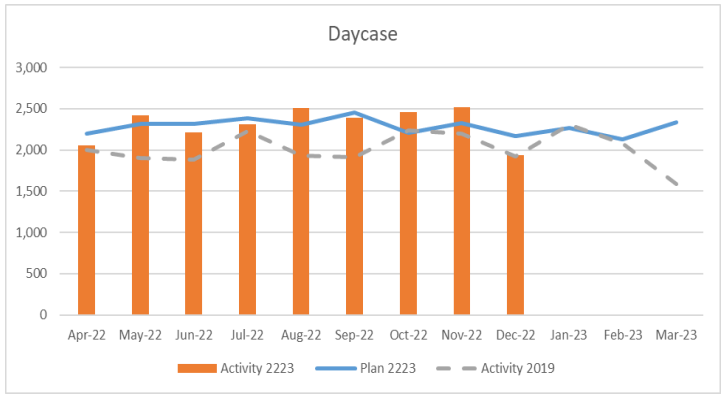
Elective activity continues to be significantly down (at 81%) against 22/23 plan and 19/20. As previously described this is driven by a number of factors including bed closures (due to staffing and patient case-mix), day-cases being on inpatient wards, and planning assumptions.

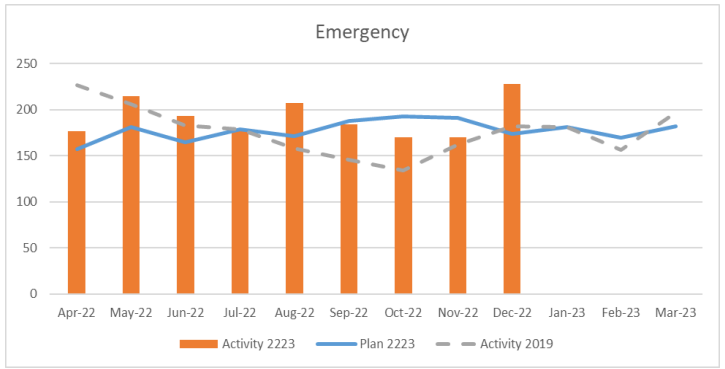
For the month of December activity was below 20/23 plan across the elective PODs, this was as consequence of the strike action and Christmas period.

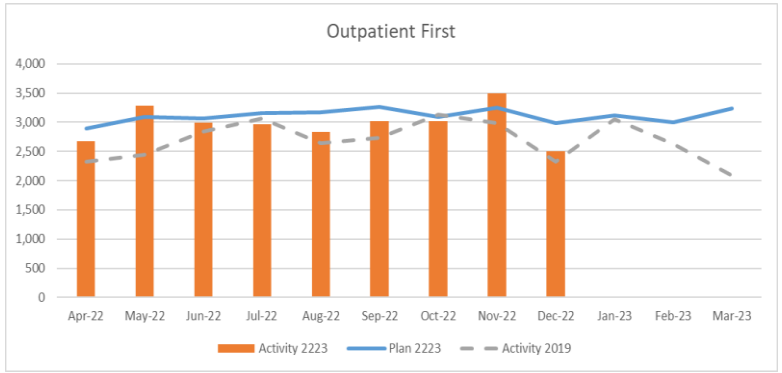
Both First and Follow-up outpatient activity is above 19/20 (13.3%) but below plan (4%). This is mainly driven by a reduction in follow-ups.

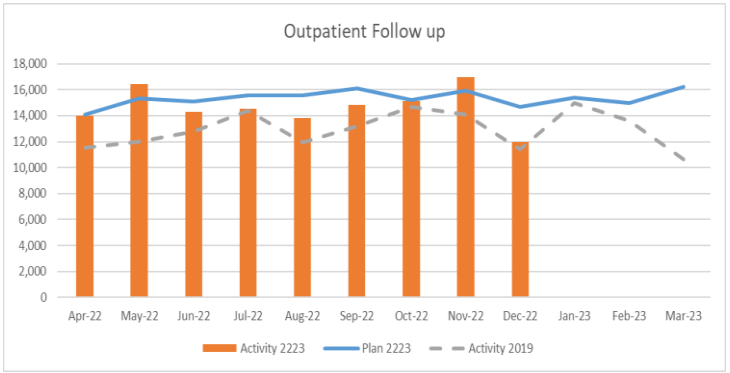
With strikes, Christmas and New Year period, and bed closures this has impacted the delivery of RTT and DM01 waiting time improvements. Continued focus remains on optimising bed capacity and theatres.











Overview YTD M9

POD	Plan 2223	Activity 2223	Activity 2019	% of 19/20	% of Plan
Daycase	20,679	20,815	16,309	127.63%	100.66%
Elective	10,393	8,392	10,248	81.89%	80.75%
Emergency	1,600	1,723	1,577	109.26%	107.70%
First OPA	27,959	26,766	24,479	109.34%	95.73%
Follow-up OPA	137,591	131,913	115,909	113.81%	95.87%
Grand Total	**198,222**	**189,609**	**168,522**	**112.51%**	**95.65%**

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Responsive

Patient Access - Waiting Times Overview

Overview

Waiting times across the three main national areas of focus remains challenging. The volume of activity being carried out has been impacted due to bed closures, strikes, staff absence and continued volume of inpatient last minute cancellations.

- RTT Performance for December 22 was **70.9%,** 2.3% decrease from last month and remains below trajectory. The overall PTL has increased by 137 pathways (1.8%) from the previous month. None of the directorates met the 92% standard this month. As predicted, RTT performance in December declined due to the national rail strikes, the Royal College of Nursing industrial action, inherited breaches and reduced activity during the Christmas and New Year period.
- There are now five patients who are waiting above **104 weeks** compared to the three patients we reported last month. Two patients tipped over to the 104+ weeks wait cohort in December, a dental patient and a spinal patient. Out of the five patients, one patient has already been treated whilst three of them have TCIs scheduled in late January and Early February. One patient (Dental) still needs to be dated. **78 week waits** increased significantly to 45 and remains above trajectory. **52 week waits** have increased to 248 and are above trajectory. The long waiters are predominantly in Orthopaedics (54), Plastic surgery (42), ENT (25), Dental (17), Craniofacial (16), Ophthalmology (16), Spinal Surgery (15) and Cardiology (12). For specialties where an RTT recovery trajectory is signed off, 4 out of 22 are on track or above trajectory. Sight & Sound and Body, Bones and Mind are most challenged.
- Achieving zero patients at March 2023 for 78 week waits is a significant risk.
- DM01 performance for December 2022 was **82.3%**, a decrease of 6.9% from the previous month. The number of 6 week breaches has increased this month to 307, compared to 190 last month. 13 week breaches have seen a slight decrease to 28 compared to 29 last month. Trajectories for MRI, CT, Ultrasound and Sleep Study have been produced with Sleep Study being marginally above plan. The other three modalities are either on or below plan.
- **Cancer:** All five standards were achieved for November 2022. It is projected for December that all five standards will also be met. However, we are forecasting at least two 31 day subsequent surgery & drug breaches in January.

Bottlenecks

Consultant availability in particular for Dental, Orthopaedics and SNAPS

National Rail strikes and Royal College of Nursing Industrial Action resulted in reduced activity

Reduced activity due to Christmas ad New Year period.

Specialist surgeon availability predominantly for joint cases and complex patients

Community/local physiotherapy capacity for the SDR pathway

Increases in inherited waits above 52 weeks

Challenges in diagnostic capacity particularly for MRI 5, MRI sedation, Endoscopy and Echo (stress and sedated echo)

Respiratory complex patient bed requirement impacting sleep study activity

Ward decants for required cleaning in some instances reducing bed base for the service

Bed closures due to combination of patient acuity and staff sickness

Actions

Reopening of Hedgehog ward supporting both NHS and Private work

Continuation of Weekly Access Meeting with General Managers chaired by COO

Continuation of Weekly PTL challenge sessions with directorates

Continued focus on reduction of long wait patients

Additional clinics for Endocrinology during December and January

Additional Stress Echo list being run in December

Discussion on mutual aid for Orthopaedics with RNOH and UCLH

Review of theatre lists from half day to full day for some services

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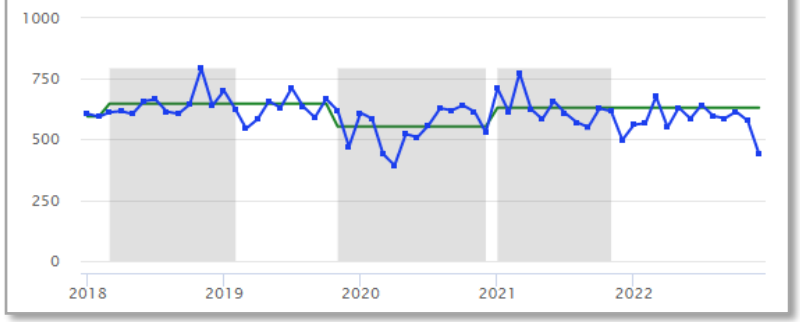
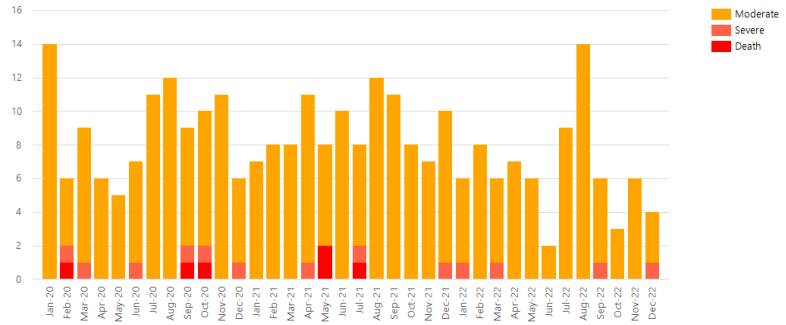
Appendix
Integrated Quality & Performance Report

Appendix 1: Patient Safety (incidents & risks)

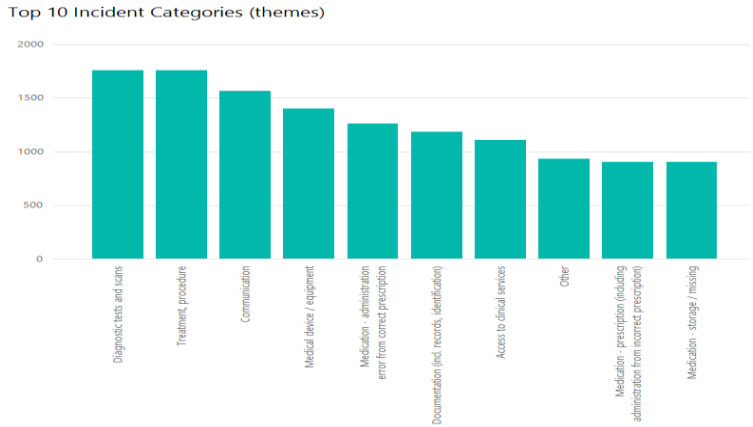
New Incidents



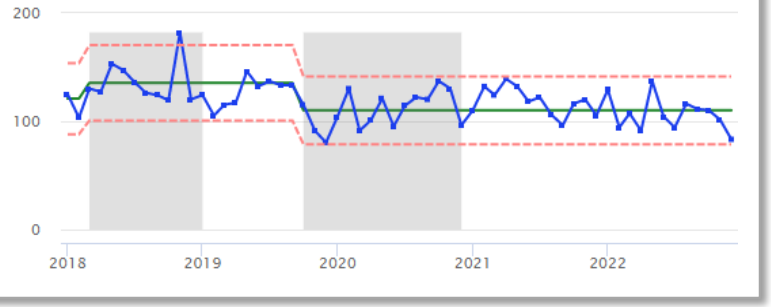
Incidents by Harm



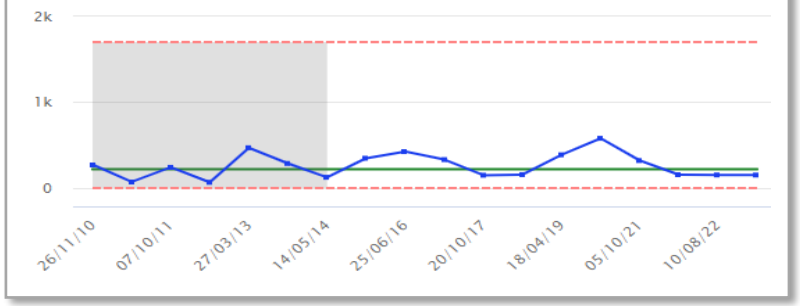
Top 10 Incident Categories (themes)



Medication Incidents



Days Since never events

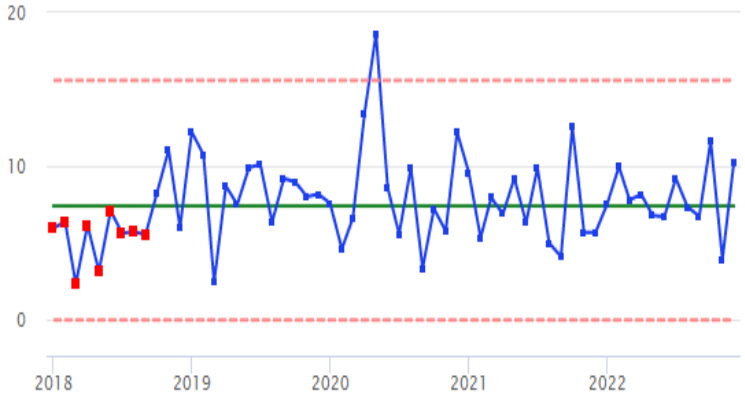


Safe

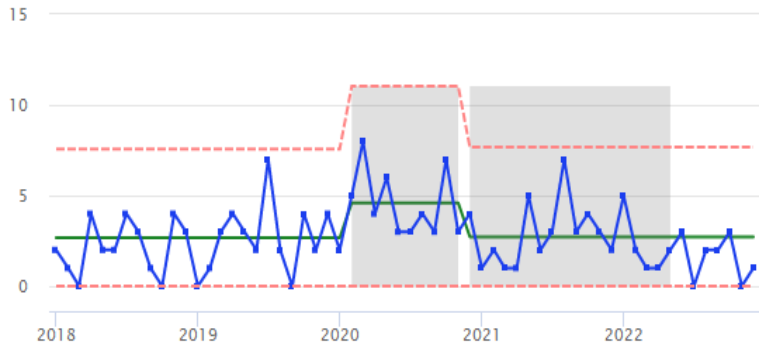
Appendix 2: Patient Safety (Infection & mortality)

Great Ormond Street Hospital for Children NHS Foundation Trust

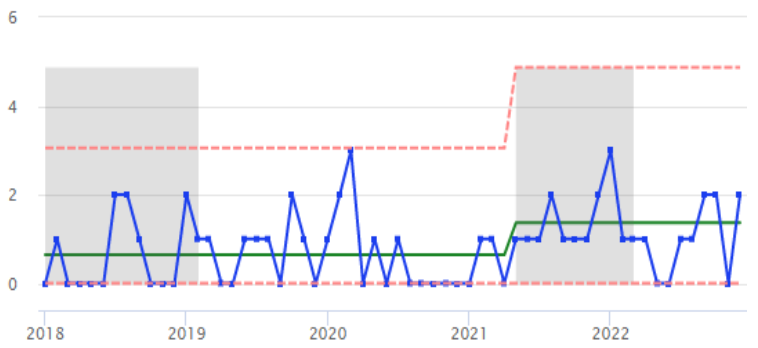
Inpatient Mortality Rate / 1000 Discharges



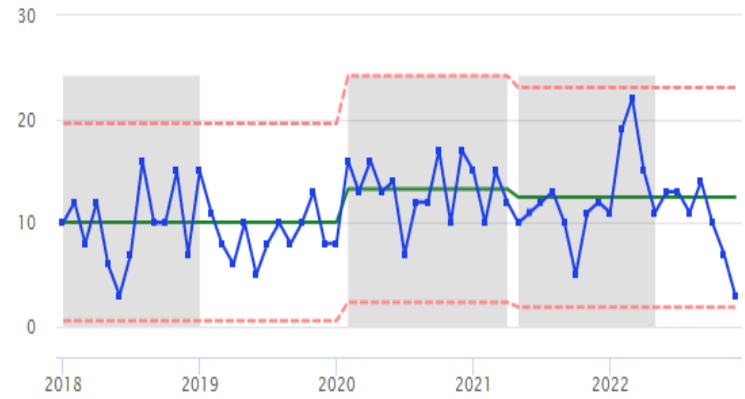
Respiratory Arrests outside ICU



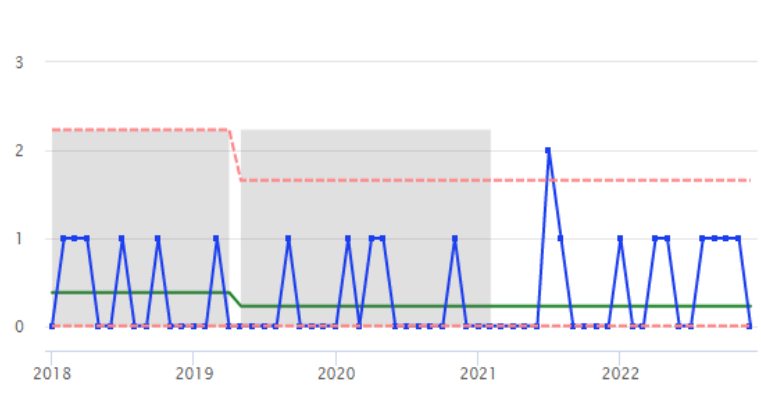
Cardiac Arrests outside ICU



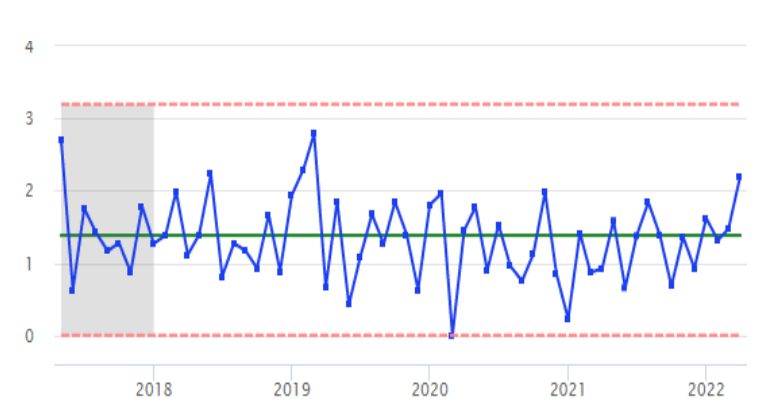
Non 2222 Patients transferred to ICU



Cat 3+ Hospital Acquired Pressure Ulcers



CV Line Infection / 1,000 line days



Safe

Appendix 3: Friends and Family

Overview:

The inpatient experience score for December was above the Trust target, scoring 98%, however, outpatients scored below the target at 93%. All directorates met the inpatient experience score target. However, within outpatients, Blood Cells and Cancer had no responses and Core Clinical Services scored 80% which is below the Trust target. The inpatient response rate met the Trust target this month after falling below Target in October and November (25%).

Headline:

Inpatient response rate – 25% (increased from November).

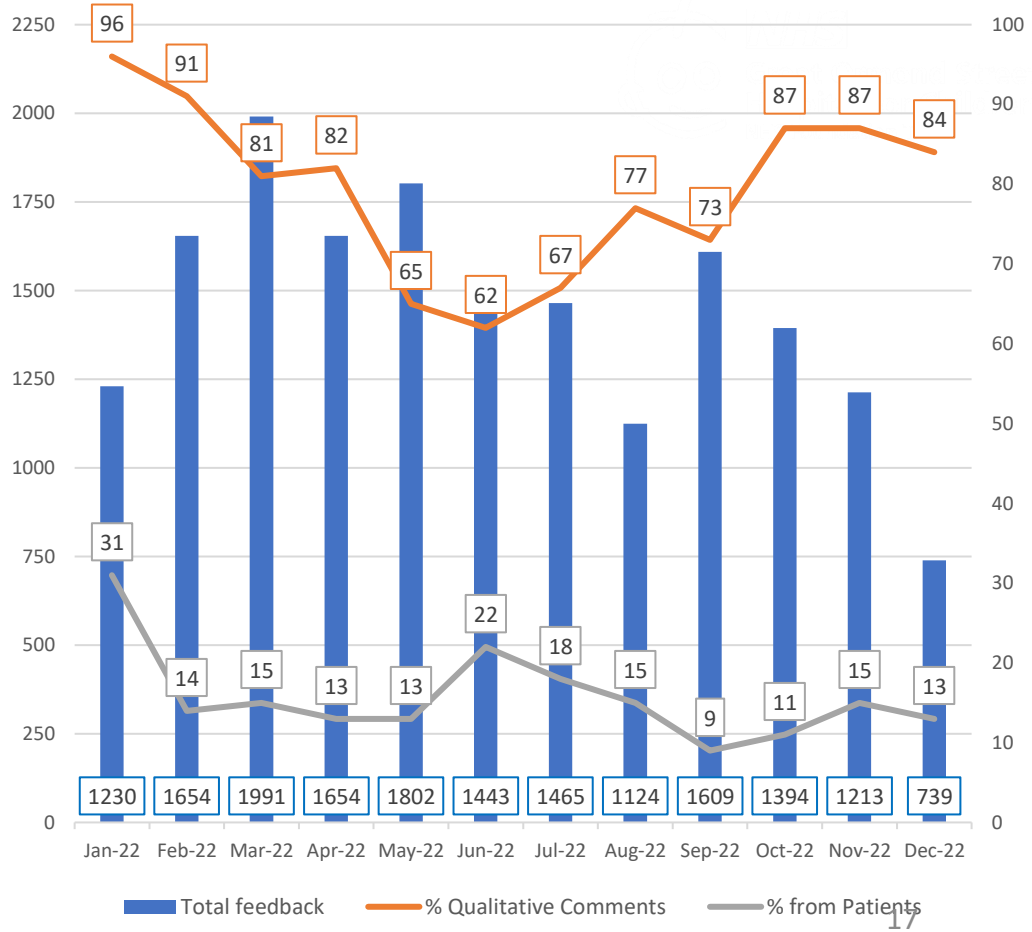
Experience measure for inpatients – 98% (same as November).

Experience measure for outpatients – 93% (decreased from November).

Total comments received – 739 (decreased from November).

13% of FFT comments are from patients.

84% of responses had qualitative comments.



Positive Areas:

- Staff going above and beyond.
- Play team.
- Friendly and caring staff.
- Staff expertise and knowledge.
- Kindness of staff.
- Reassuring staff.
- Communication with patients about their condition.
- Staff empowering patients.

Areas for Improvement:

- Changes to appointment locations.
- Lack of hospital orientation, where to buy food etc.
- Ward orientation.
- Breakfast not offered to a patient.
- Cleaning within some ward areas.
- Lack of privacy.
- Noise at night on the wards.
- Delays in waiting for treatment to start.
- Playrooms being closed.
- Crockery and cutlery to be available to parents.
- Communication and organisation of surgery.
- Access to ward for parents.
- Transport.

Appendix 3: Complaints

Headline: The Trust received 9 new formal complaints in December. This brings the number of complaints received since April 2022 to 102 (24 more that the total of complaints received in the whole of 2021/22).

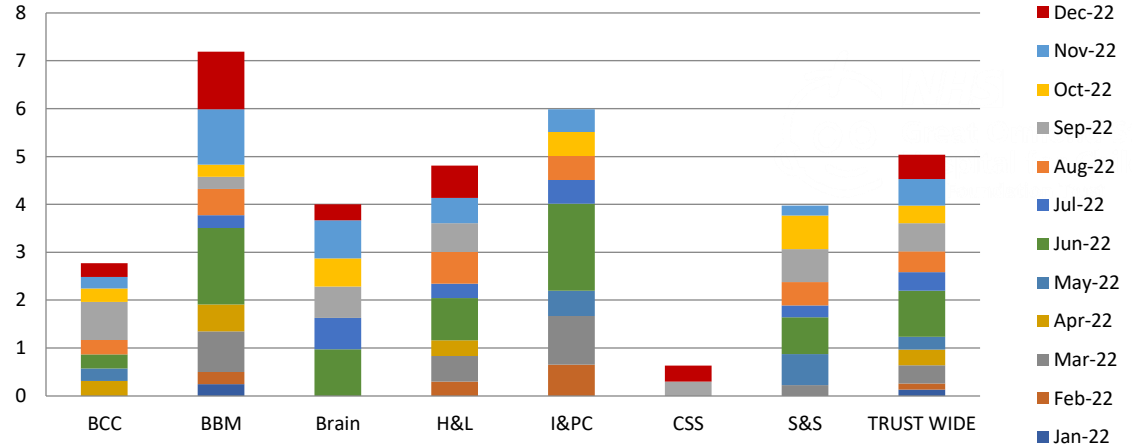
Concerns raised: In December families complained about:

- **Aspects of Dermatology care** including whether this was correct and whether additional problems and a lengthy admission could have been prevented. The family also question the ack of review, advice and failure to accept the patient at GOSH.
- **Numerous cancellations** including the lack of empathy when this was communicated to the family, and the inconvenience and significant expense incurred.
- **Management of a referral** to Feeding and Eating Disorder Service including lack of clarification of information required, delays and deterioration in the patients' condition..
- **A preventable procedure cancellation** due to delays in taking consent which led to distress and inconvenience for the patient and family.
- **Cancellation of a PEG insertion**, contradictory explanations for this and poor communication.
- **Lack of investigation of patient's symptoms**
- **Care under CAMHS** including the virtual appointment and consent processes, screening process, communication of diagnosis and the content of the report from an appointment.
- **Lost test results** following a software issue necessitating the test to be completed again, family are seeking reimbursement and costs.
- **Care under Spinal** including misdiagnosis and differing clinical opinions.
- **Communication, clinical care, lack of engagement and culture with GOSH.**

Closed complaints since April 2022

92 complaints have been closed with 30 requiring extended response times.

Complaints per 1,000 combined patient episodes



Learning actions/ outcomes from complaints closed in November 2022 included:

- Improvements to the transition of patients. More specifically, the service are creating a standardised Epic letter which is given to patients with an information sheet, to explain the transition process and which Trust/consultant is responsible for the patients' care at each exact point. In addition, when a young person is referred for transition to another clinician, that clinician will be added to the Epic 'Care Team' so that they are automatically informed of key changes to the patients care at GOSH. This changes are being updated within the service's SOP and will be monitored via an audit.
- A clinical audit is taking place to monitor that information within discharge summaries (following an insertion of a central venous line) obtains key information from the operation note and that this is shared with local hospitals where relevant.
- Patient and families experience around consent is being shared with the project looking at the e-consent functionality within EPIC for consideration and learning.

Appendix 3: PALS

Headline: Pals contacts fell by 26% from November to December (n=189). However, this was a 42% increase on Pals contacts in December 2021. Contacts this month related to families seeking assistance with referral outcomes, cancellations of outpatient appointments (OPA) and admissions and clarification on treatment plans from clinical teams.

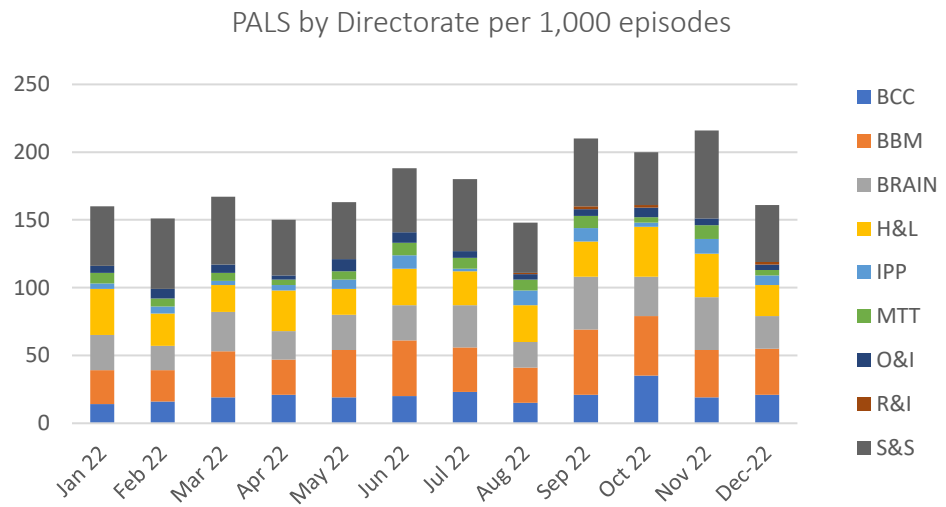
Families reported difficulties in getting through to clinical teams, which is in part attributed to reduced staffing in December. Review of clinic letters shows that contact details are correct but that many services are also including Pals information resulting in higher contacts directly to Pals.

Pals also received 1 compliment in December for the Oncology team.

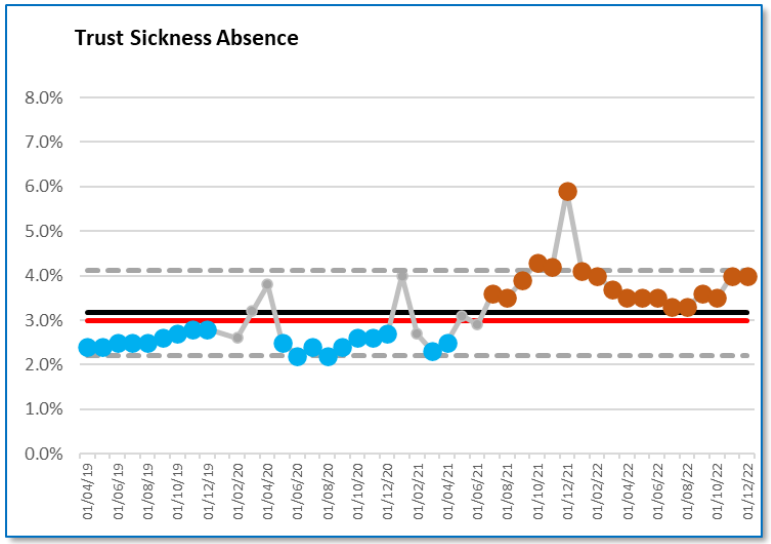
Contacts resolved within 48 hours increased from 64% in November to 69% in December which reflects the complex nature of the month's contacts.

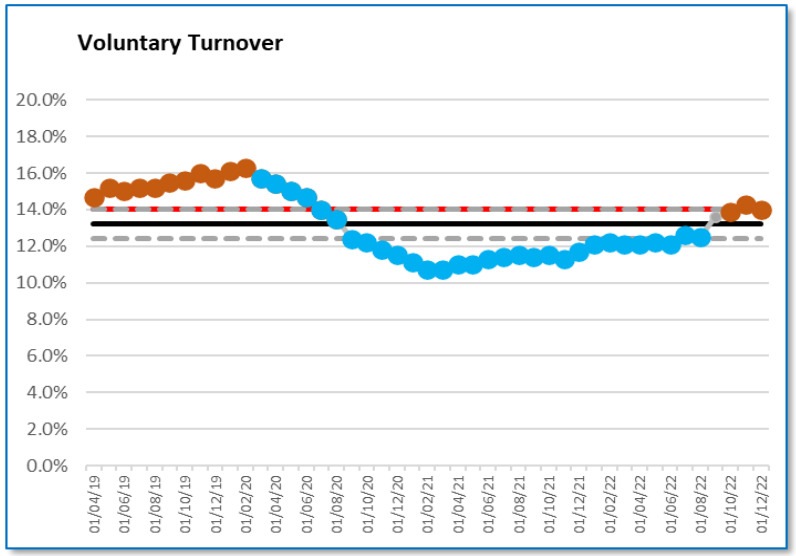
Significant areas of focus:

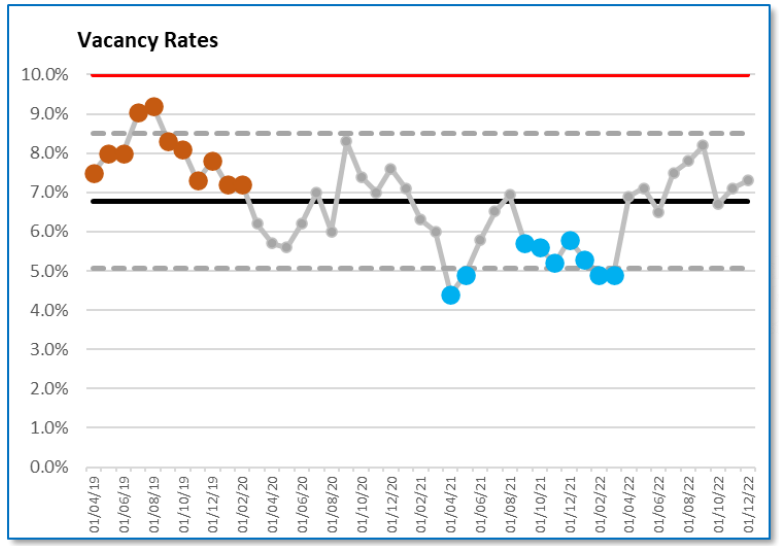
- **Gastro:** Pals recorded 17 cases in December (up by 7 from November) Contacts centred around requesting clarity on treatment plans both inpatient and outpatients, OPA information, surgery cancellations, chasing test results and referral and admission enquiries.
- **Cardiology:** Pals recorded 13 cases in December (down by 8 cases in November). The majority focus on admission enquiries and cancellations, outpatient enquiries, chasing test results and referral enquiries.
- **Urology**- Pals recorded 9 cases in December (up by 1 in November). Contacts included referral enquiries, unable to get through to admin team, admission enquiries, incorrect info on clinic letter, prescription enquiry and OPA cancellation.

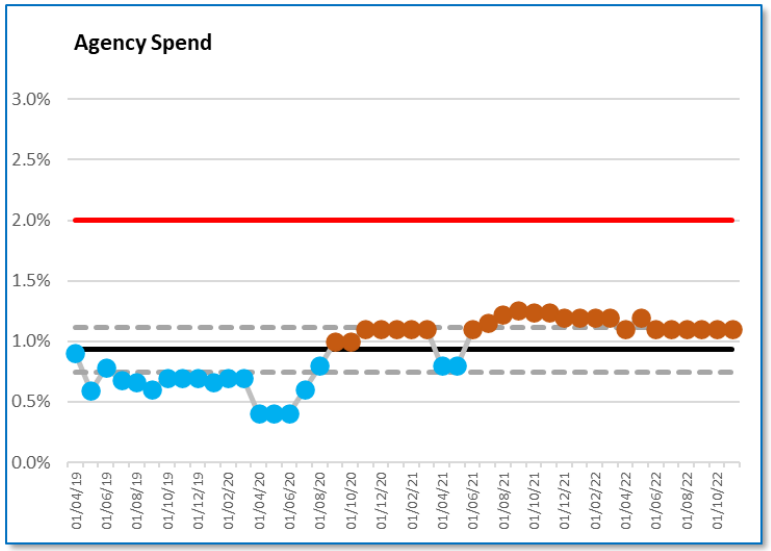


Appendix 4: Workforce SPC Analysis

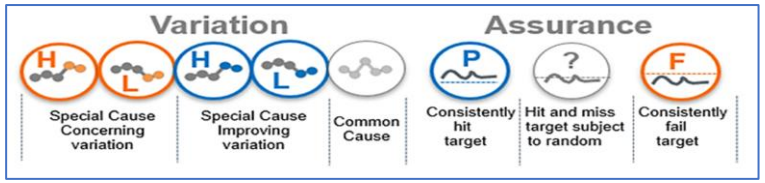






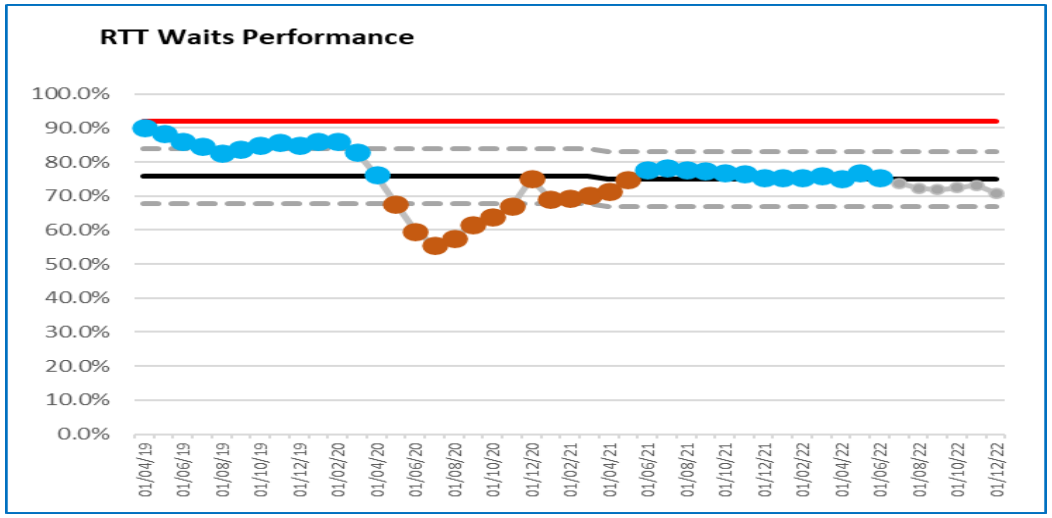


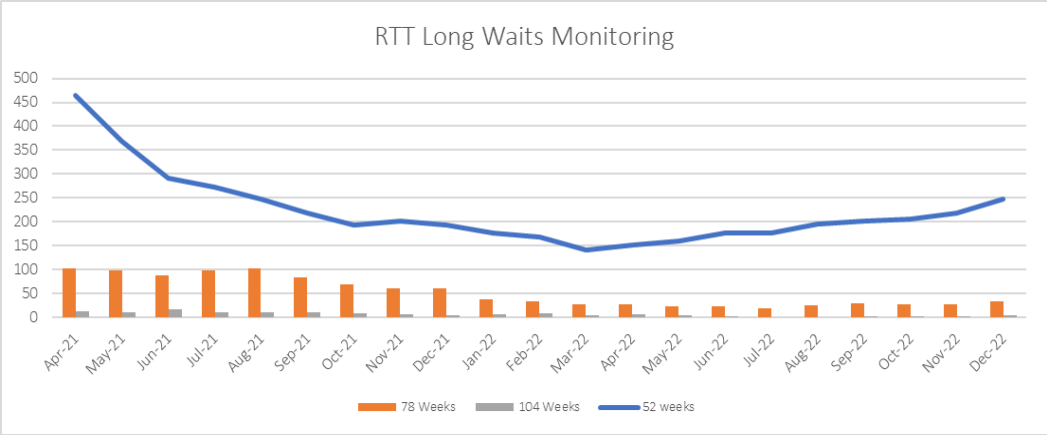
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Trust Sickness Absence	Dec 22	4.5%	3.0%			3.2%	2.2%	4.2%
Voluntary Turnover	Dec 22	14.0%	14.0%			13.2%	12.4%	14.0%
Vacancy Rates	Dec 22	7.7%	10.0%			6.8%	5.0%	8.5%
Agency Spend	Dec 22	1.1%	2.0%			0.9%	0.8%	1.1%



Well Led

Appendix 5: Referral to Treatment times (RTT)





RTT:

70.9% ↓ 2.3%

People waiting less than 18 weeks for treatment from referral.

>52 Weeks:

248 ↑ 29

Patients waiting over 52 weeks

>78 Weeks:

45 ↑ 17

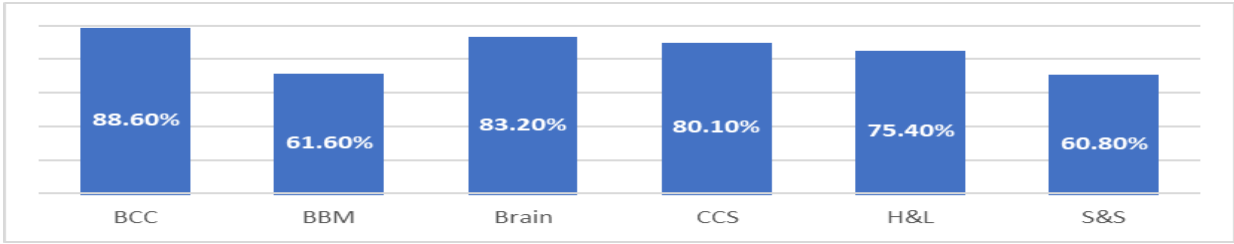
Patients waiting over 78 weeks

>104 Weeks:

5 ↑ 2

Patients waiting over 104 weeks

Directorates



RTT PTL Clinical Prioritisation – past must be seen by date

P2

205 ↑ 9

P3

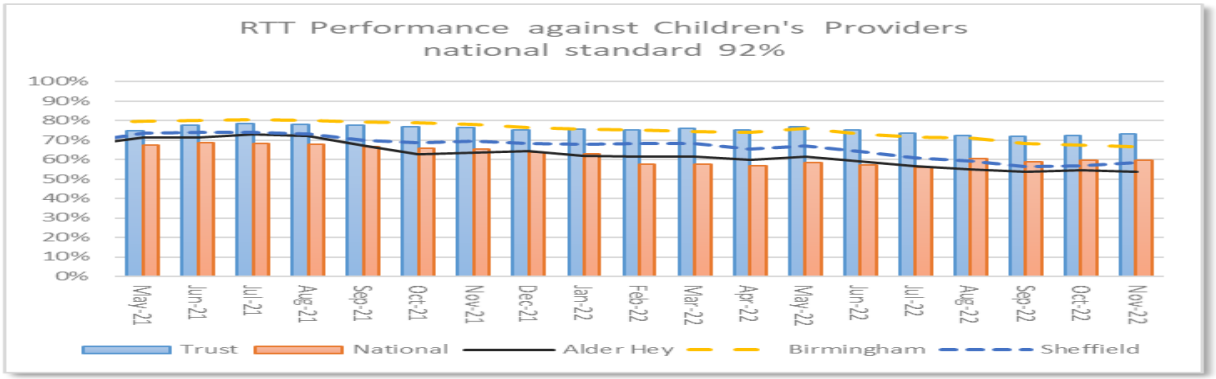
653 ↑ 39

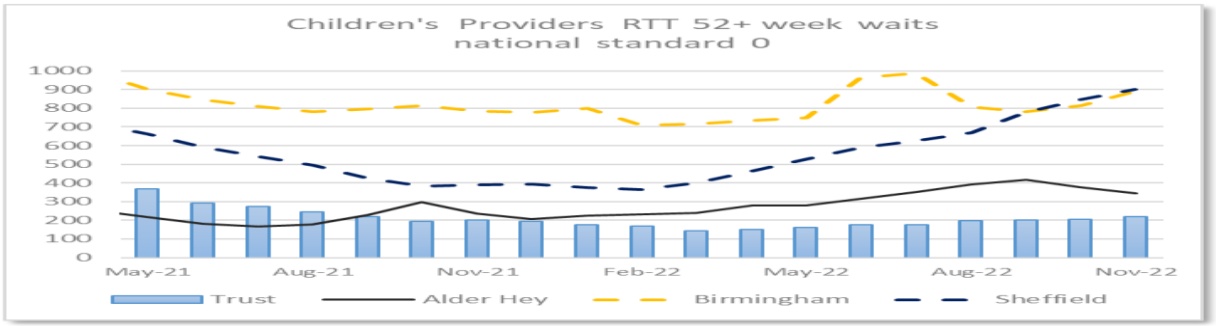
P4

463 ↑ 61

Responsive

Appendix 5: National and NCL RTT Performance –November 2022





Nationally, at the end of November, 59.6% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks.

GOSH is tracking 13% above the national November performance at 73.2% and is inline with comparative children's providers. RTT Performance for Sheffield Children (58.3%), Birmingham Women's and Children's (66.6%) and Alder Hey (53.9%).

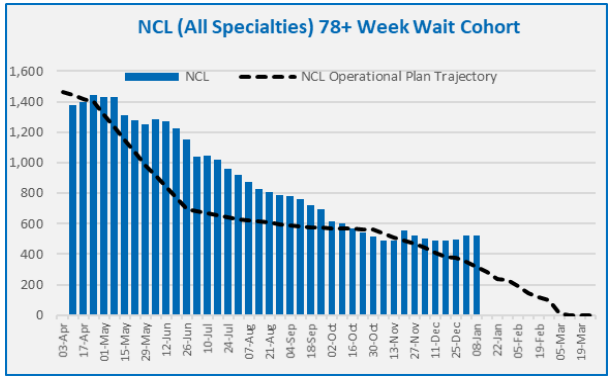
The national position for November 2022 indicates a decrease in patients waiting over 52 weeks at 362,226 patients.

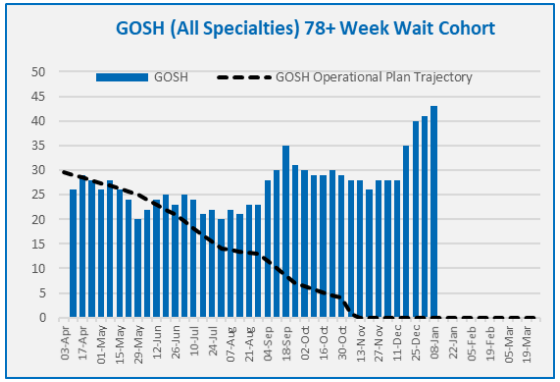
Compared to Alder Hey, Birmingham and Sheffield the number of patients waiting 52 weeks and over for GOSH is lower than all three providers for November. All 4 providers have seen increases in 52 week waits.

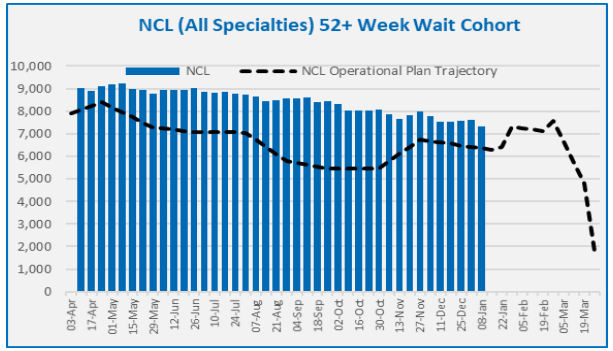
Overall for NCL the 78+ week wait position is above projected plan at 316 patients but has decreased by 1000 from April 2022. GOSH is above trajectory by 43 patients.

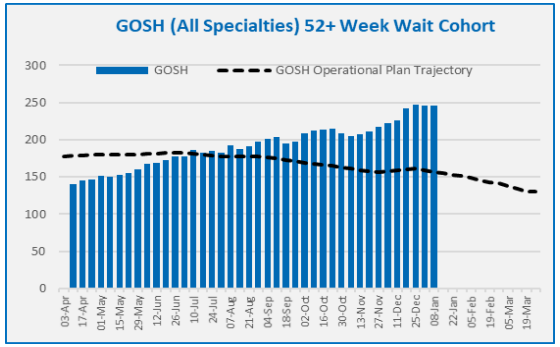
Overall, the number of patients waiting 52 weeks for NCL is reducing. Royal Free and UCLH have the most significant volumes. GOSH is above the agreed trajectory submission at 30th November 2022.

NCL are in a strong position regionally with reducing long waits. However, risk remains with inter provider transfers of patients above 52 weeks.



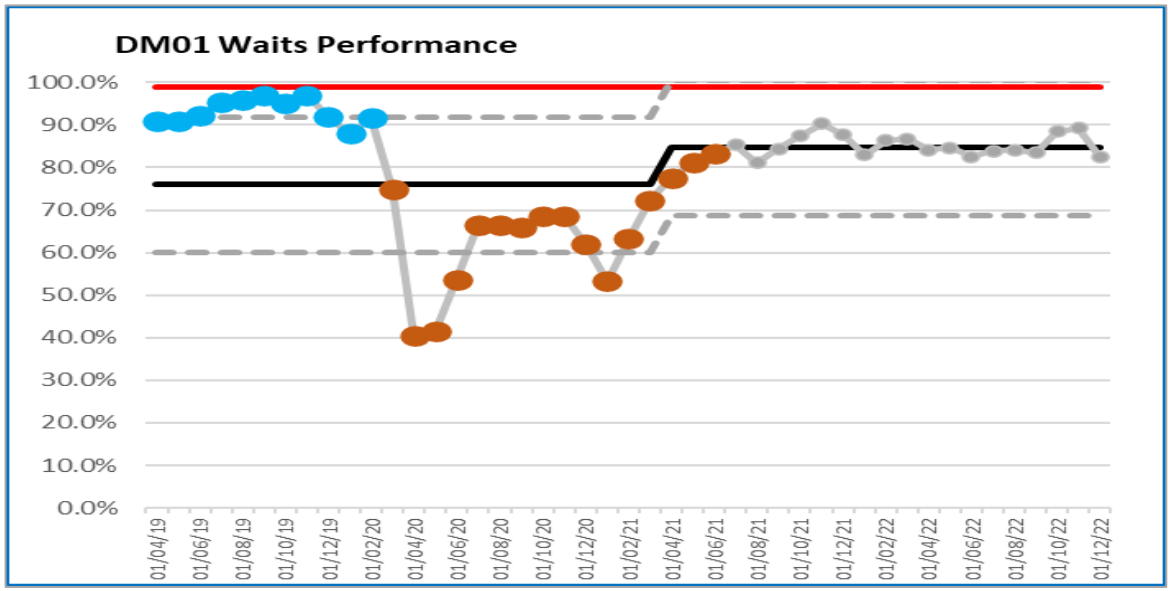


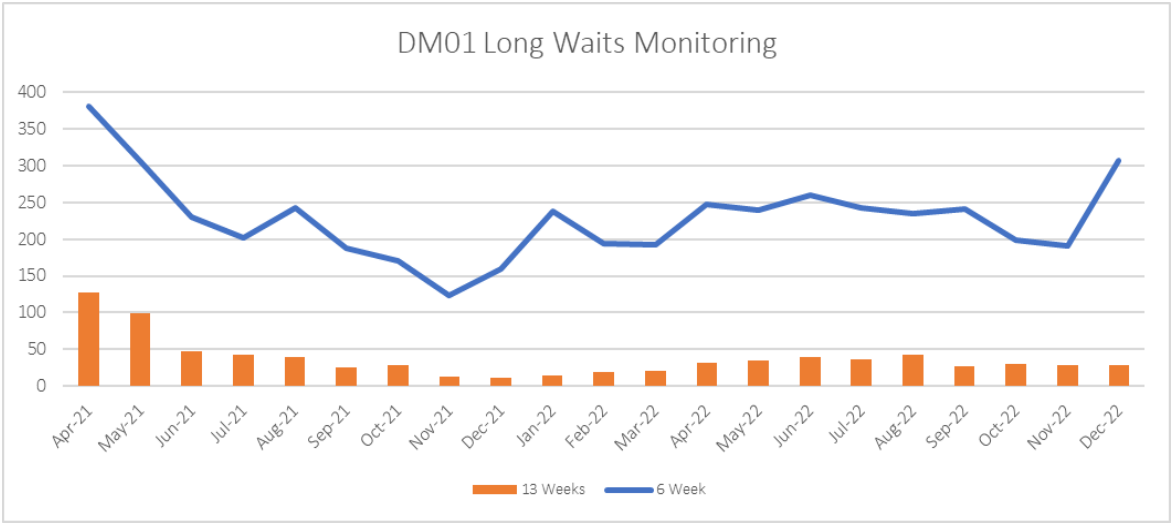




Responsive

Appendix 6: Diagnostic Monitoring Waiting Times (DM01)





DM01:

82.6% ↓ 6.9%

People waiting less than 6 weeks for diagnostic test.

>6 Weeks:

307 ↑ 117

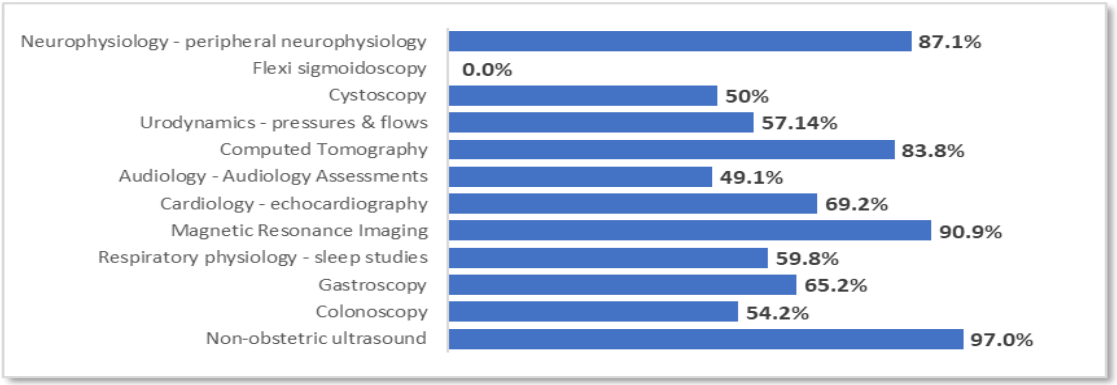
Patients waiting over 6 weeks

>13 Weeks:

28 ↓ 1

Patients waiting over 13 weeks

Modalities not meeting 99% standard



Responsive

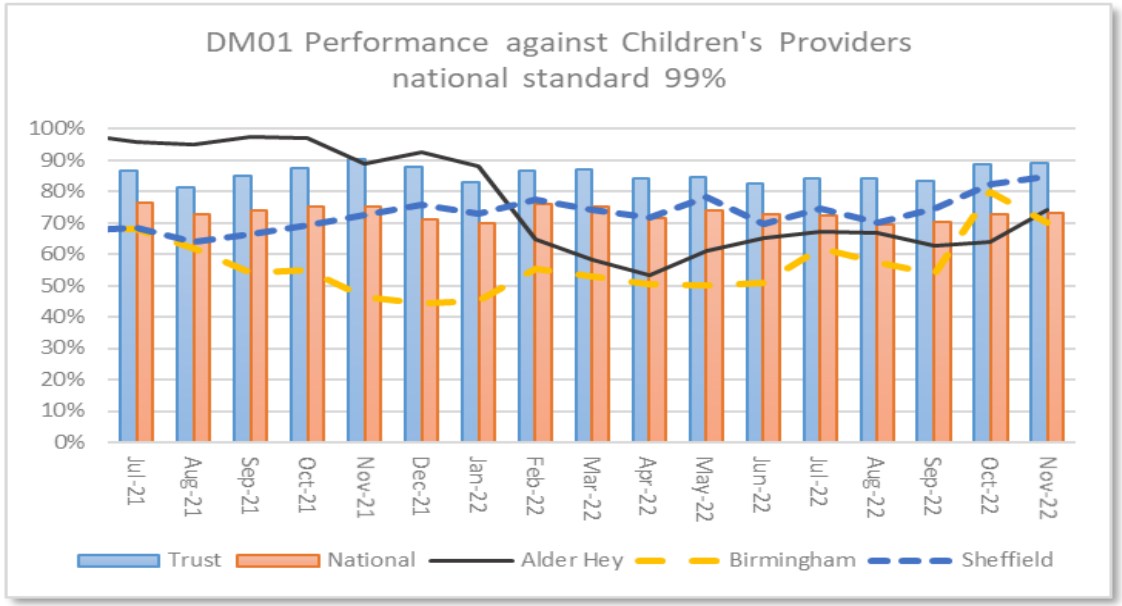
Appendix 6: National Diagnostic Performance and 6 week waits – November 2022

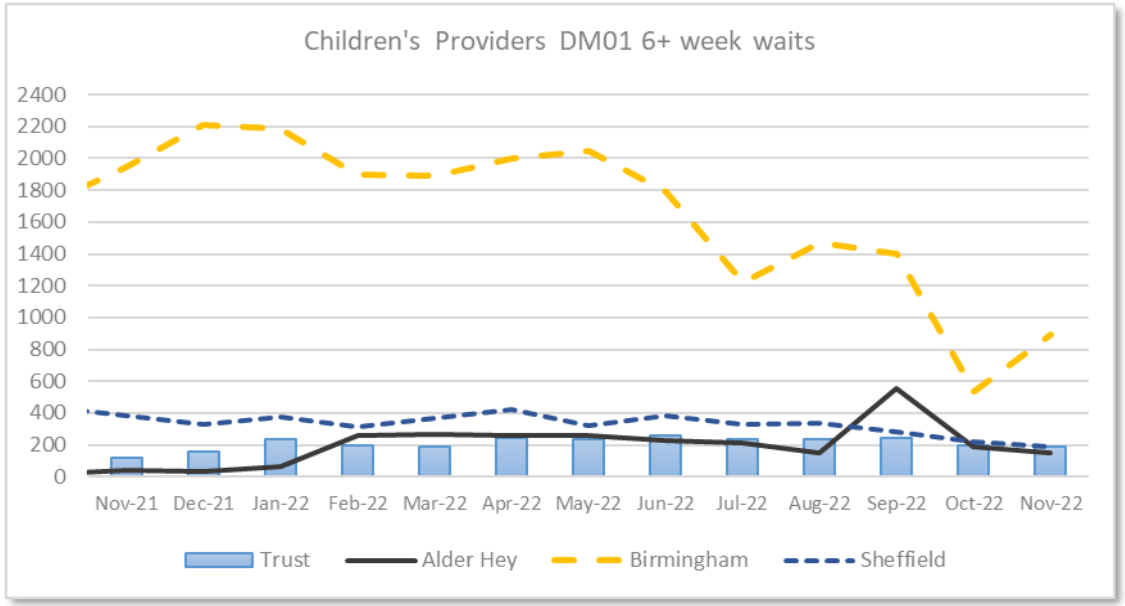
Nationally, at the end of November, 73.1% of patients were waiting under 6 weeks for a DM01 diagnostic test.

GOSH is tracking 16% above the national November performance and is inline with comparative children's providers. DM01 Performance for Sheffield Children (84.7%), Birmingham Women's and Children's (69.8%) and Alder Hey (74.2%).

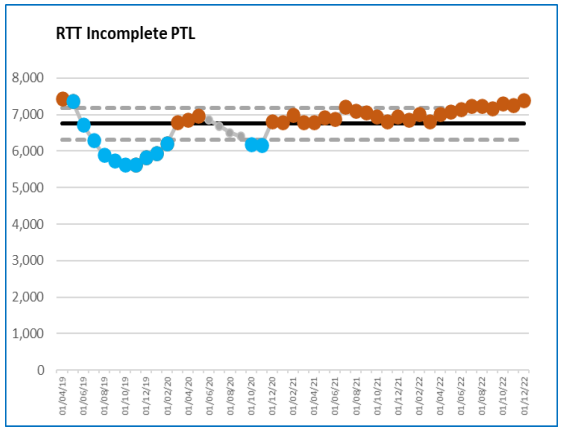
The national position for November 2022 indicates an increase of patients waiting over 6 weeks at 1,165,057 patients.

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

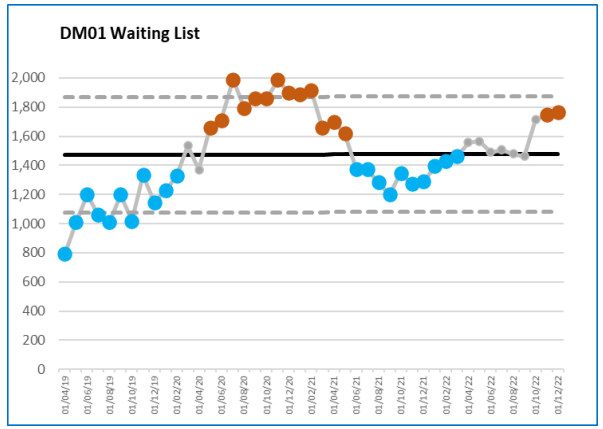




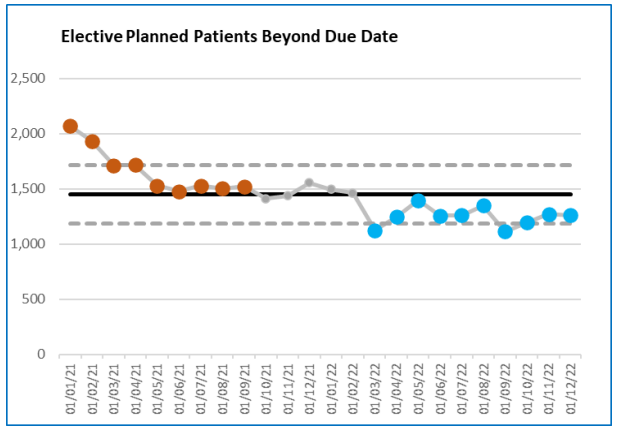
Appendix 7: Patient Access SPC Trends



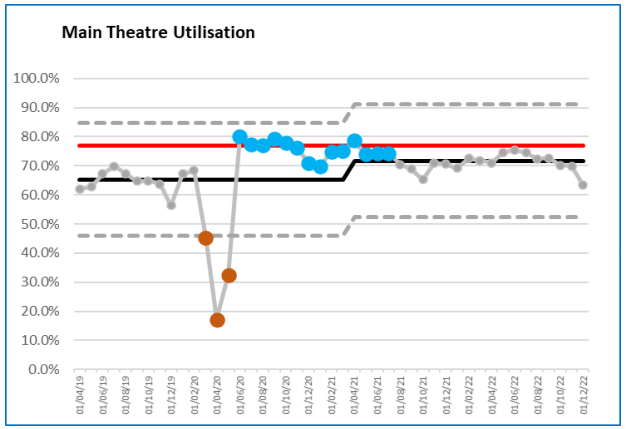
Special cause variation



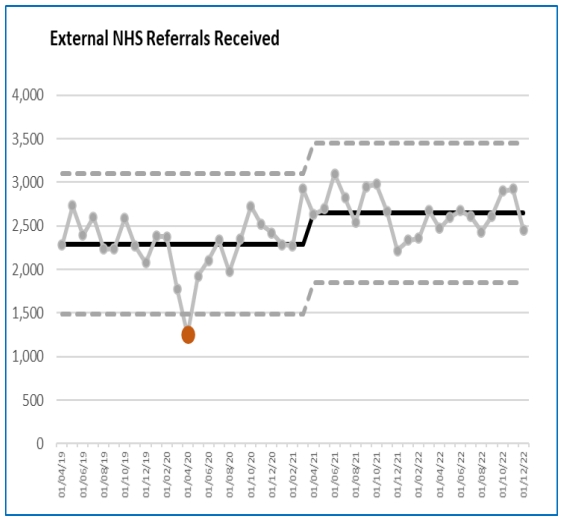
Increase seen, application of planned wait rules



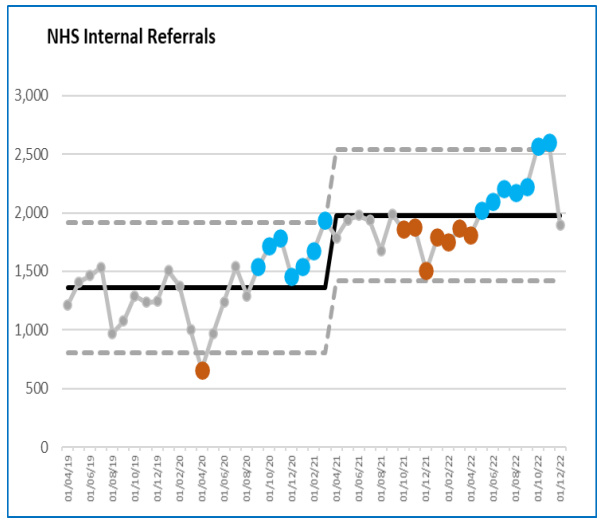
Improving variation



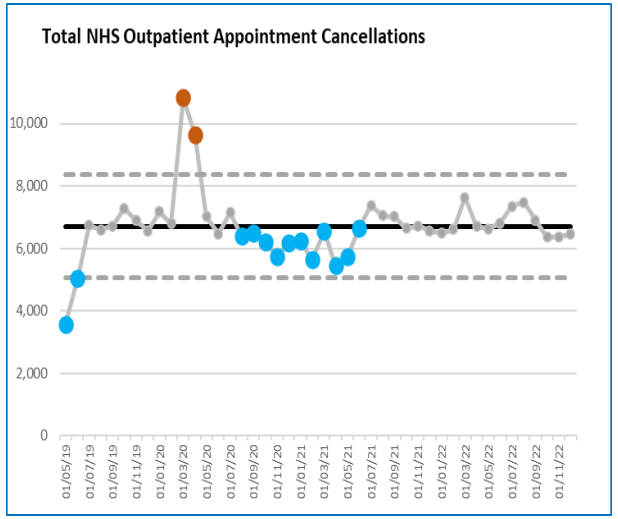
No Significant variation



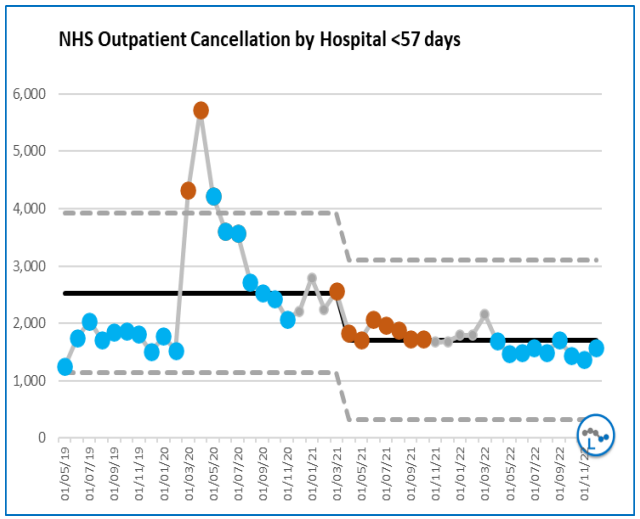
No significant variation, common cause



Significant variation, common cause



No significant variation, common cause



Improving variation

Responsive

Integrated Quality & Performance Report January 2023 (Reporting December 2022 data)

Attachment P

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
1st February 2023

Finance Report Month 9	**Paper No: Attachment P**
Submitted by: **John Beswick, Chief Finance Officer**	☐ **For information and noting**

Purpose of report

The table below outlines the trust financial position at Month 9.

	In Month			Year to Date		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	47.5	48.7	1.2	421.6	44.1	12.5
Pay	(28.2)	(29.8)	(1.6)	(257.3)	(273.1)	(15.8)
Non-Pay	(17.1)	(19.4)	(2.3)	(155.7)	(164.6)	(8.9)
Finance Costs	(2.2)	(1.6)	0.6	(18.0)	(14.9)	3.1
Surplus/(Deficit)	**(0.0)**	**(2.1)**	**(2.1)**	**(9.4)**	**(18.5)**	**(9.1)**

The Trust Better Value programme summary:

- Better Value programme has identified £16.3m of the £22.8m target
- At month 9 £11.2m has been delivered YTD out of the £16.3m YTD target.

Summary of report

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

1. NHS & other clinical income is £10.8m favourable to plan YTD due to increased passthrough drugs income (offset by expenditure), genomics funding, long term ventilated patient income, higher than planned overseas income and the increased pay award income to offset the additional costs.
2. Private patients' income is £3.5m favourable to plan YTD due to increased levels of activity. International private patient income saw an improvement linked to increased activity from the referral pipeline with overperformance against plan.
3. Pay costs are £15.8m adverse to plan YTD which is being driven by the underperformance of the Trust's Better Value programme, additional costs for WLI/RTT to deliver the activity plan and higher levels of sickness cover across the Trust including the domestic team where pay is £2.2m adverse YTD. The higher than planned pay award has resulted in a £4.2m increase in expenditure above plan which is offset by increased income.
4. Non pay costs are £8.9m adverse to plan YTD due to underperformance on the Better Value programme and additional pass-through drugs expenditure (offset by income). In addition, the Trust has seen increases in software licence costs for the Trust EPR system and in ward maintenance/ventilation costs and in month catch up on business rates costs.
5. The Trust cash balance at the 31st December was £88.6m which was a reduction of £2.6m from the prior month.

6. CDEL (Capital departmental expenditure limit) expenditure for the year to date was £6.2m, £1.6m less than plan. The Trust funded forecast total outturn for the year is per plan (£15.0m).

   NHSE has released a protocol that outlines the manner in which a Trust/ICB can update their forecast. The Trust has updated its forecast to reflect the updated costs and income identified by the Trust, the Forecast outturn remains a £10.6m deficit. The Trust is working with the ICB on both the GOSH and ICB forecast in line with the new NHS protocol.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust is £88.6m which is £2.6m lower than last month.
NHS Debtor Days	NHS debtor days remained the same in December as they were in November which was 4 days.
IPP Debtor Days	IPP debtor days increased from 196 days in November to 198 days in December.
Creditor Days	Creditor days has decreased from 26 days to 24 days.

Action Required:
Trust Board are asked to note the Trust's financial position at month 9, cash flows and finance metrics.

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 1: Financial Sustainability

Financial implications

Implications for legal/ regulatory compliance
Not Applicable

Consultation carried out with individuals/ groups/ committees
This has been discussed with EMT

Attachment P

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 9 2022/23

Contents

Trust Performance Summary for the 9 months ending 31 Dec 2022

KEY PERFORMANCE DASHBOARD

ACTUAL FINANCIAL PERFORMANCE

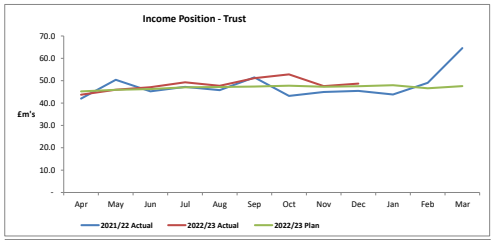
	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	£47.5m	£48.7m		£421.6m	£434.1m	
PAY	(£28.2m)	(£29.9m)		(£257.3m)	(£273.1m)	
NON-PAY inc. owned depreciation and PDC	(£19.3m)	(£20.9m)		(£173.7m)	(£179.5m)	
Surplus/Deficit excl. donated depreciation	(£0.0m)	(£2.1m)		(£9.4m)	(£18.5m)	

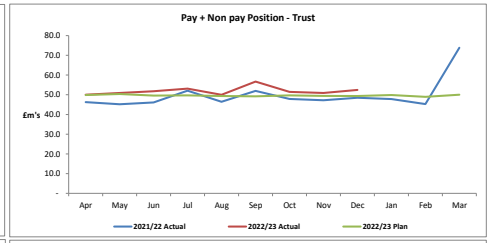
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

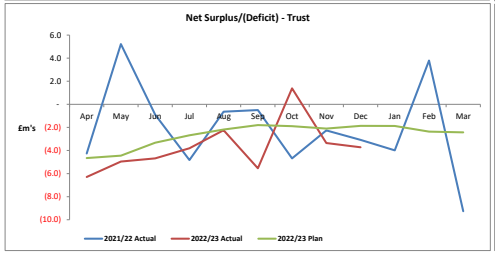
AREAS OF NOTE:

The YTD financial position for the trust is a £18.5m deficit which is £9.1m adverse to plan. This is driven mainly by delays in the delivery of the Trust Better Value programme, outreach clinics, and commercial income being behind plan.

Income is £12.5m favourable YTD mainly due to increased income for passthrough drugs (£1.7m), long term ventilated patients (£1.7m), Overseas (0.8m) and pay award funding (£4.2m). Private patient income has seen an improvement in activity over the last few months which is forecast to continue going forward, Non clinical income is also forecast to improve as contracts are finalised with commercial and NHS bodies. Pay is £15.8m adverse YTD due to additional costs associated with increasing activity, pay award, reducing the waiting lists and delays in the Better Value programme. Non pay (including owned depreciation and PDC) is £5.8m adverse YTD largely due to higher levels of Passthrough Drugs (offset with Income). The Trust Better value programme is behind plan by £5.1m. This is associated with scheme lead in time taking longer than initially planned. The Trust has put additional challenge programmes into place to increase the delivery of the overall programme and has expanded its methods of engagement with all staff across the Trust.







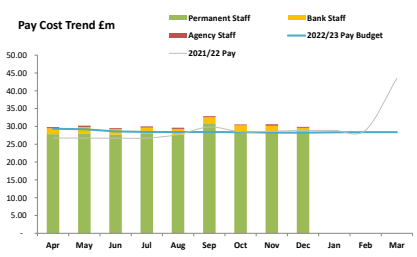
PEOPLE

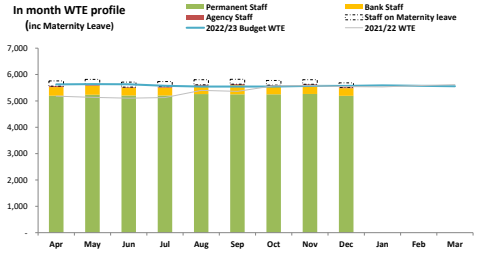
	M9 Plan WTE	M9 Actual WTE	Variance
Permanent Staff	5,522.7	5,190.5	332.2
Bank Staff	42.2	289.6	(247.4)
Agency Staff	4.7	32.9	(28.2)
TOTAL	**5,569.5**	**5,513.0**	**56.6**

AREAS OF NOTE:

Month 9 WTEs decrease in comparison to Month 8, largely within Bank for Admin and Substantive Estates and ancillary. Although Substantive staff is below planned levels the use of bank remains high due to continued (but reducing) levels in relation to Vacancies, Covid isolation and sickness backfill. The Trust has seen significant levels of sickness within the domestic team and is working to reduce this and ensure the service continues without interruption.

The 31st December absence rate due to Covid was 0.3% of the permanent workforce which shows an static percentage prior month, 0.3% on 30th November.



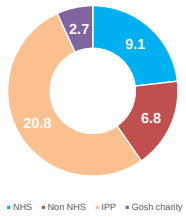


CASH, CAPITAL AND OTHER KPIs

Key metrics	*Nov-22*	*Dec-22*
Cash	**£91.2m**	**£88.6m**
IPP debtor days	**£196.0m**	**£198.0m**
Creditor days	**26**	**24**
NHS Debtor days	**4**	**4**
BPPC (£)	**0.901**	**0.907**

Capital Programme	*YTD Plan M9*	*YTD Actual M9*	*Full Year F'cst*
Total Trust-funded	**£7.8m**	**£6.2m**	**£15.0m**
Total PDC	**£0.0m**	**£0.0m**	**£0.1m**
Total IFRS 16	**£0.6m**	**£0.1m**	**£0.6m**
Total Donated	**£14.6m**	**£7.8m**	**£29.7m**
Total Grant-funded	**£0.0m**	**£0.0m**	**£0.0m**
Grand Total	**£23.0m**	**£14.1m**	**£45.4m**

Net receivables breakdown (£m)



AREAS OF NOTE:

1. Cash held by the Trust decreased in month from £91.2m to £88.6m.

2. Capital expenditure for the year to date was £14.1m, £8.8m less than plan. The Trust funded forecast total outturn is per plan.

3. I&PC debtors days increased in month from 193 to 198. Total I&PC debt (net of cash deposits held) increased in month to £24.0m (£23.8m in M08). Overdue debt increased in month to £21.4m (£20.8m in M08).

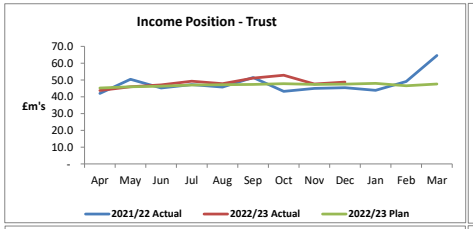
4. Creditor days decreased in month from 26 to 24 days.

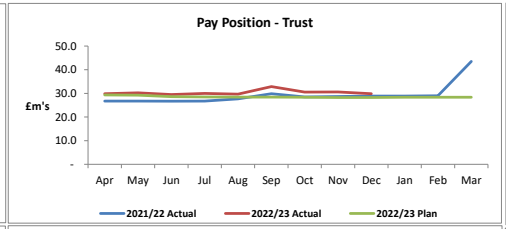
5. NHS debtor days remained the same as the previous month at 4 days.

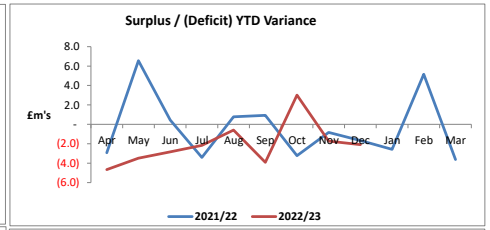
6. In M09, 91% of the total value of creditor invoices were settled within 30 days of receipt; this represented 81% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.

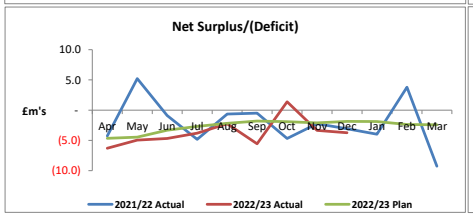
Trust Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

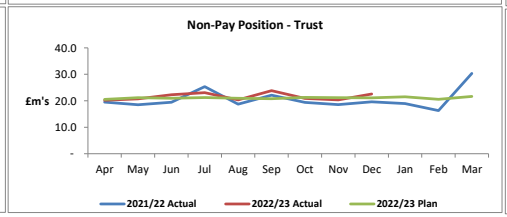
2022/23 Annual Plan (£m)	Income & Expenditure	Month 9 Plan (£m)	Month 9 Actual (£m)	Month 9 Variance (£m)	Month 9 Variance %	Year to Date Plan (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	Rating Variance	Notes	2021/22 Actual M9 (£m)	2022/23 Plan YTD (£m)	2022/23 Plan In-month M9 (£m)
452.02	NHS & Other Clinical Revenue	37.96	38.44	0.49	1.29%	339.75	350.54	10.79	3.18%	G	1	38.23	339.75	37.96
46.12	Private Patient Revenue	4.18	5.66	1.48	35.41%	32.31	35.75	3.44	10.64%	G	2	1.82	32.31	4.18
65.65	Non-Clinical Revenue	5.39	4.60	(0.79)	(14.58%)	49.56	47.81	(1.74)	(3.52%)	R	3	5.36	49.56	5.39
563.78	**Total Operating Revenue**	**47.53**	**48.71**	**1.18**	**2.49%**	**421.61**	**434.10**	**12.48**	**2.96%**	G		**45.41**	**421.61**	**47.53**
(322.02)	Permanent Staff	(26.65)	(28.18)	(1.52)	(5.72%)	(241.59)	(255.61)	(14.02)	(5.80%)	R		(26.92)	(241.59)	(26.65)
(3.65)	Agency Staff	(0.26)	(0.27)	(0.01)		(2.88)	(2.90)	(0.02)		G		(0.31)	(2.88)	(0.26)
(16.74)	Bank Staff	(1.34)	(1.44)	(0.10)	(7.50%)	(12.84)	(14.58)	(1.75)	(13.59%)	R		(1.64)	(12.84)	(1.34)
(342.41)	**Total Employee Expenses**	**(28.24)**	**(29.88)**	**(1.63)**	**(5.78%)**	**(257.31)**	**(273.10)**	**(15.79)**	**(6.14%)**	R	4	**(28.86)**	**(257.31)**	**(28.24)**
(94.54)	Drugs and Blood	(7.82)	(8.54)	(0.72)	(9.19%)	(71.16)	(76.01)	(4.85)	(6.82%)	R		(7.34)	(71.16)	(7.82)
(41.17)	Supplies and services - clinical	(3.41)	(3.87)	(0.45)	(13.26%)	(31.00)	(32.75)	(1.74)	(5.62%)	R		(3.41)	(31.00)	(3.41)
(71.02)	Other Expenses	(5.86)	(6.95)	(1.09)	(18.64%)	(53.50)	(55.88)	(2.38)	(4.44%)	R		(6.02)	(53.50)	(5.86)
(206.74)	**Total Non-Pay Expenses**	**(17.09)**	**(19.35)**	**(2.26)**	**(13.24%)**	**(155.67)**	**(164.64)**	**(8.97)**	**(5.76%)**	R	5	**(16.77)**	**(155.67)**	**(17.09)**
(549.15)	**Total Expenses**	**(45.34)**	**(49.23)**	**(3.90)**	(8.59%)	**(412.97)**	**(437.73)**	**(24.76)**	(6.00%)	R		**(45.64)**	**(412.97)**	**(45.34)**
14.64	**EBITDA (exc Capital Donations)**	**2.19**	**(0.52)**	**(2.71)**	**(123.89%)**	**8.64**	**(3.64)**	**(12.28)**	**(142.13%)**	R		**(0.22)**	**8.64**	**2.19**
(25.27)	Owned depreciation, Interest and PDC	(2.23)	(1.57)	0.66	29.44%	(18.02)	(14.88)	3.15	17.45%			(1.43)	(18.02)	(2.23)
(10.63)	**Surplus/Deficit**	**(0.04)**	**(2.10)**	**(2.06)**	**(5,151.85%)**	**(9.38)**	**(18.51)**	**(9.13)**	**(97.33%)**			**(1.65)**	**(9.38)**	**(0.04)**
(20.99)	Donated depreciation	(1.82)	(1.62)	0.20		(15.57)	(14.69)	0.87				(1.43)	(15.57)	(1.82)
(31.62)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(1.86)**	**(3.72)**	**(1.86)**	**(5,151.85%)**	**(24.95)**	**(33.21)**	**(8.26)**	**(97.33%)**			**(3.08)**	**(24.95)**	**(1.86)**
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	4.22	0.70	(3.52)		14.58	7.83	(6.75)				0.66	14.58	4.22
(2.01)	**Adjusted Net Result**	**2.36**	**(3.02)**	**(5.38)**	**(228.33%)**	**(10.38)**	**(25.38)**	**(15.01)**	**(144.62%)**			**(2.42)**	**(10.38)**	**2.36**

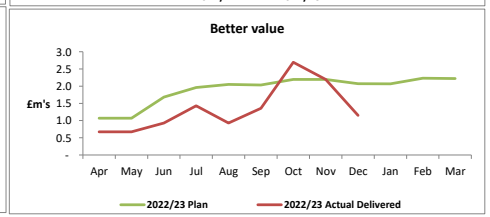












Summary

- The YTD Trust financial position at Month 9 is a deficit of £18.5m which is £9.1m adverse to plan.
- The deficit is due to a combination of reduced clinical income linked to changes in the national funding regime for 2022/23, increased drugs costs and higher than planned spend on pay and maintenance of software.

Notes

1. NHS clinical income is £10.8m favourable to plan YTD due to increased income for passthrough drugs (offset with expenditure), other NHS clinical income, overseas income linked to additional activity, funding for long term ventilated patients and pay award funding.
2. Private Patient income is £3.4m favourable to plan YTD which is due to increased levels of activity seen over the last two months.
3. Non clinical income is £1.7m adverse to plan YTD. This is mainly driven by reduced levels of Commercial income, Charity income and outreach clinics. The Trust is continuing to work on increasing the income from these later in the year.
4. Pay costs are £15.8 adverse to plan YTD mainly due to high levels of bank usage linked to sickness, additional shifts to reduce the waiting lists, national pay award and a delay in the delivery of the Better Value programme.
5. Non pay is £8.9m adverse to plan YTD largely due to increase in pass through expenditure (£1.6m) which is offset by additional income, Drugs costs (£1.8m), Clinical supplies (£2.7m) largely on reagents.

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

Trust Income and Expenditure Forecast Outturn Summary for the 9 months ending 31 Dec 2022

2022/23						
Income & Expenditure					Rating	
	Plan (£m)	Forecast (£m)	Variance (£m)	Variance %	YTD Variance	Straight Line
NHS & Other Clinical Revenue	452.02	474.41	22.39	4.95%	G	1,051.61
Private Patient Revenue	46.12	47.12	1.00	2.18%	G	107.24
Non-Clinical Revenue	65.65	68.10	2.45	3.73%	G	143.44
Total Operating Revenue	**563.78**	**589.63**	**25.84**	**4.58%**	G	**1,302.29**
Permanent Staff	(322.02)	(340.94)	(18.92)	(5.87%)	R	(766.84)
Agency Staff	(3.65)	(3.79)	(3.79)	(103.92%)	R	(8.70)
Bank Staff	(16.74)	(19.33)	(19.33)	(115.47%)	R	(43.74)
Total Employee Expenses	**(342.41)**	**(364.06)**	**(21.65)**	**(6.32%)**	R	**(819.29)**
Drugs and Blood	(94.54)	(101.36)	(101.36)	(107.21%)	R	(228.04)
Supplies and services - clinical	(41.17)	(41.24)	(41.24)	(100.16%)	R	(98.25)
Other Expenses	(71.02)	(72.69)	(72.69)	(102.36%)	R	(167.63)
Total Non-Pay Expenses	**(206.74)**	**(215.29)**	**(8.55)**	**(4.14%)**	R	**(493.92)**
Total Expenses	**(549.15)**	**(579.35)**	(30.20)	**(5.50%)**	R	(1,313.20)
EBITDA (exc Capital Donations)	**14.64**	**10.28**	**(4.36)**	**(29.80%)**	R	**(10.92)**
Owned depreciation, Interest and PDC	(25.27)	(20.90)	4.37	17.28%		(44.63)
Surplus/Deficit	**(10.63)**	**(10.63)**	**0.00**	**(0.13)**	G	**(55.54)**
Donated depreciation	(20.99)	(22.24)	(1.25)	(5.97%)		
Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	**(31.62)**	**(32.87)**	**(1.25)**	**(3.95%)**		
Impairments	0.00	0.00	0.00			
Capital Donations	29.61	29.69	0.08	0.27%		
Adjusted Net Result	**(2.01)**	**(3.18)**	**(1.17)**	**(58.25%)**		

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

Summary

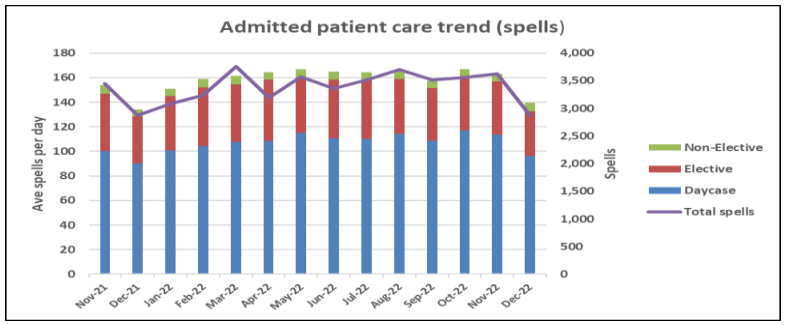
- In support of the ICS delivering a breakeven position at the end of the year the Trust control total is a £10.6m deficit.
- The NHS has released a new set of protocols that outline the manner in which a forecast can be updated. The Trust is working with teh ICB on reviewing the forecast in line with the ICB and protocol.

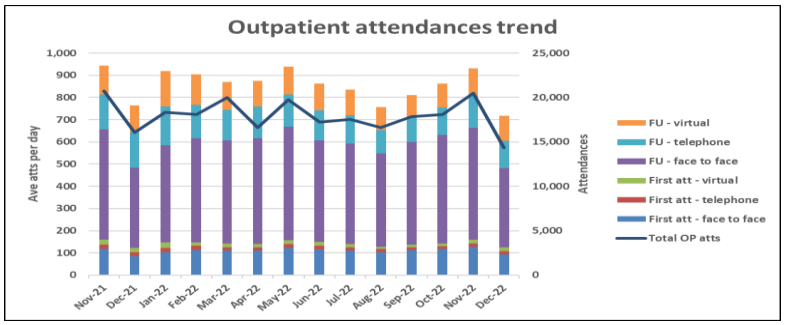
Notes based on £10.6m deficit

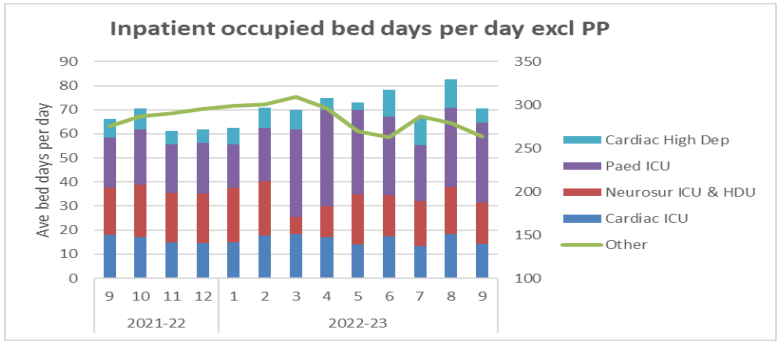
1. The forecast for NHS & other clinical revenue is above plan due to additional income related to updated pay award, pass through drugs and overseas income.
2. Private Patient income is forecast to achieve £47.1m with the Trust continuing to work on its Recovery plan in order to delvier additional activity and bring in the current referrals within the pipeline.
3. Pay is forecast to be £21.7m above plan due to the cost of delivering the activity levels, sickness and the aditional pay award. All pay inflation has been offset with income.
4. Non Pay is £8.6m above plan linked to additional pass through costs (offset by income) and clinical supplies linked to additional actiivty.

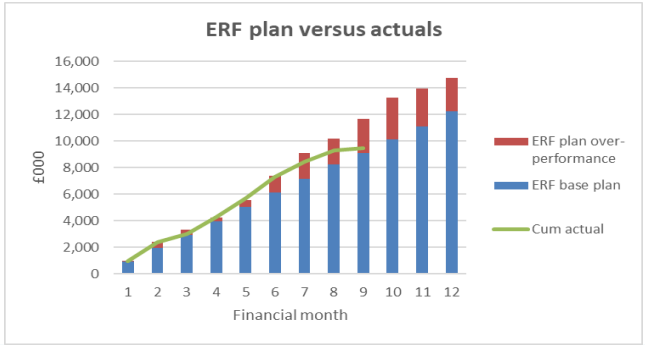
2022/23 Overview of activity trends for the 9 months ending 31 Dec 2022

Great Ormond Street Hospital for Children NHS Foundation Trust







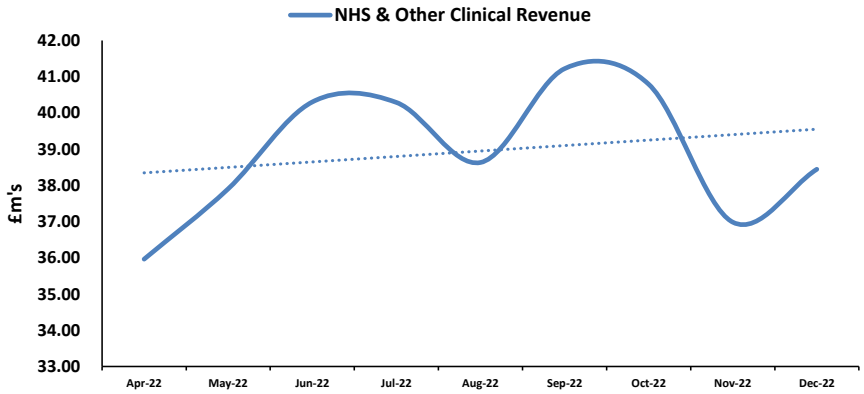


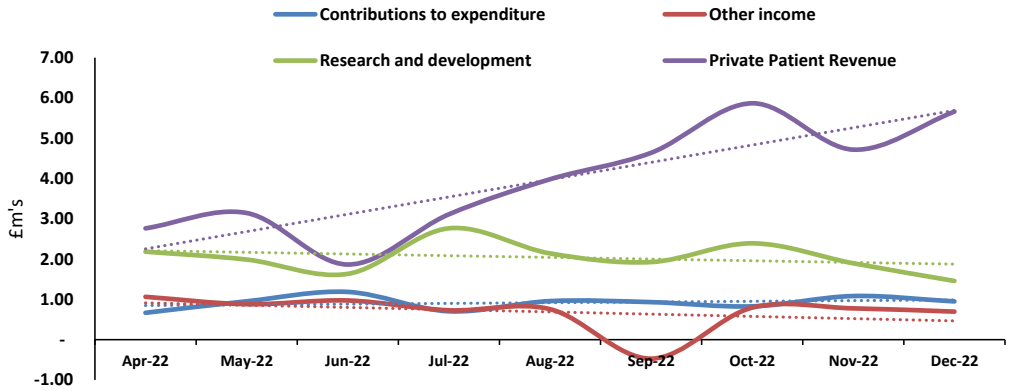
Summary

- Admitted patient care activity in December is lower than November by 14.1% overall for all points of delivery with daycases and elective decreasing by 15.6% and 16.0% respectively and non-elective increasing by 29.8%. This follows a similar profile to 2021 and equates to reductions in spells per working day of 17.81 and 6.89 for daycases and elective respectively with an increase of 1.69 for non-elective activity.
- Bed days for December 2022 have decreased in line with activity per working day with critical care decreasing by 12.2 days and other bed days by 15.3 days per working day versus November.
- Outpatient attendances decreased per working day versus November across both first and follow up attendances at 21.24% (33.69 attendances) and 23.39% (180.55 attendances) respectively. Face to face % activity levels have stablised since August, at circa 70% face to face and 30% non-face to face. The number of outpatient attendances may increase as activity is finalised.
- Clinical supplies and services have increased versus November (£3.5m to £3.4m) whereas activity levels are lower for each point of delivery. This is driven by higher costs for reagents and labroatory consumables across laboratories and newborn screening.
- On the basis of current information, estimated year to date December performance for ERF is £9,481k versus a plan of £11,648k giving an under-performance of £2,167k against the total plan consisting of baseline ERF funding and planned over-performance This this may be subject to change as activity is finalised. This is a deterioration versus November of £1,278k with the estimated impact of the nursing strikes being £620k and the balance being due to a larger than planned reduction for Christmas. Assuming plan is delivered to the end of the year, this would give us a gap of £1.3m versus the forecast outturn however the March plan is prudent.

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

2022/23 Income for the 9 months ending 31 Dec 2022





Summary

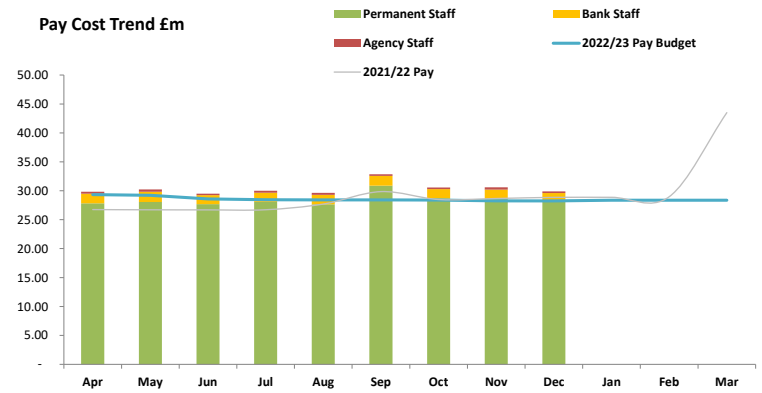
- Income from patient care activities excluding private patients is £10.8m favourable to plan YTD. This is due to significant increases income for pass through drugs, additional genomics funding, long term ventilated patients and high cost patients for devolved nations.
- Non clinical income is £1.7m adverse to plan YTD. Mainly driven by lower commercial activity, Charity income and awaiting finalisation of contracts.
- Private Patient income is £3.5m favourable to plan YTD. This is due to increased activity levels over the last couple of months and work is being done to increase activity level further. Private patient income has increased and strong referrals are leading to the expected continued increase in private income.

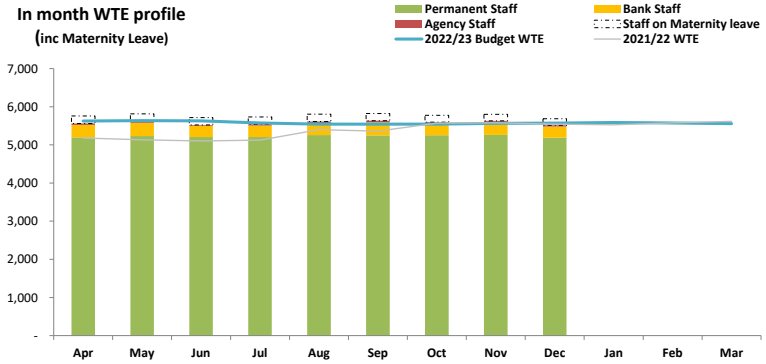
Workforce Summary for the 9 months ending 31 Dec 2022

*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	50.5	1,285.2	52.4	(4.3)	(1.2)	(3.0)	R
Consultants	63.5	396.0	160.4	50.1	395.6	168.7	(2.4)	0.1	(2.5)	R
Estates & Ancillary Staff	10.6	323.6	32.9	11.7	443.2	35.1	(3.7)	(3.0)	(0.7)	R
Healthcare Assist & Supp	11.3	322.5	35.2	8.8	310.8	37.7	(0.3)	0.3	(0.6)	A
Junior Doctors	31.6	385.4	82.0	25.8	393.7	87.5	(2.1)	(0.5)	(1.6)	R
Nursing Staff	93.8	1,623.3	57.8	73.0	1,617.0	60.2	(2.6)	0.3	(2.9)	R
Other Staff	0.8	15.3	53.9	0.7	17.8	54.0	(0.1)	(0.1)	(0.0)	A
Scientific Therap Tech	60.2	1,039.5	57.9	48.7	1,080.6	60.1	(3.6)	(1.8)	(1.8)	R
Total substantive and bank staff costs	**333.6**	**5,357.4**	**62.3**	**269.2**	**5,543.8**	**64.8**	**(19.0)**	**(8.7)**	**(10.3)**	R
Agency	4.2	35.8	116.0	2.9	36.7	105.3	0.2	(0.1)	0.3	G
Total substantive, bank and agency cost	**337.8**	**5,393.2**	**62.6**	**272.1**	**5,580.6**	**65.0**	**(18.8)**	**(8.8)**	**(10.0)**	R
Reserve*	0.5	0.2		0.9	0.0		(0.6)	(0.6)	0.0	R
Additional employer pension contribution by NHSE (M12)	13.6	0.0		0.0	0.0		0.0	0.0	0.0	G
Total pay cost	**351.8**	**5,393.4**	**65.2**	**273.1**	**5,580.6**	**65.2**	**(19.4)**	**(9.4)**	**(10.0)**	R
Remove maternity leave cost	(4.1)			(2.5)			(0.6)	0.0	(0.6)	R
Total excluding Maternity Costs	**347.6**	**5,393.4**	**64.5**	**270.6**	**5,580.6**	**64.7**	**(20.0)**	**(9.4)**	**(10.7)**	R

Plan reserve includes WTEs relating to the better value programme



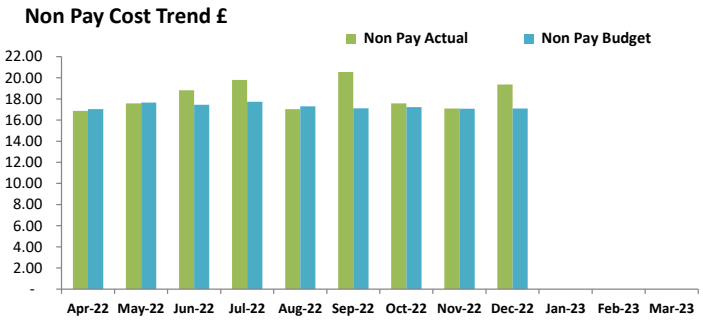


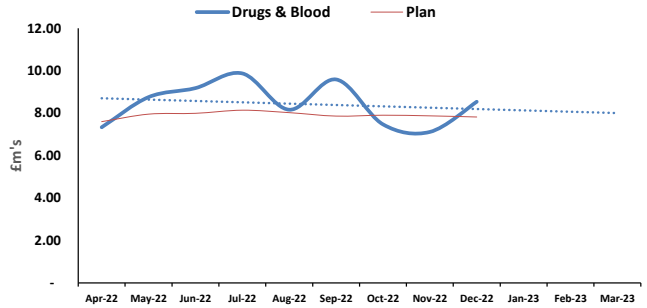
Summary

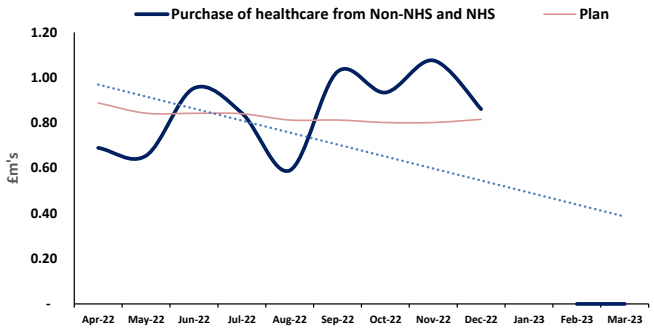
The table compares the actual YTD workforce spend in 2022/23 to the full year workforce spend in 2021/22 prorated to the YTD.

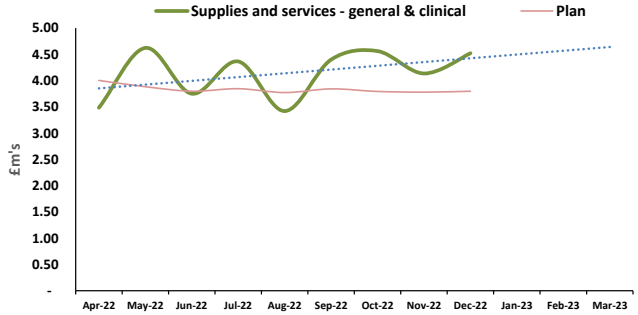
- Pay costs are above the 2022/23 plan YTD by £15.8m and when compared to the 2021/22 extrapolated actual it is £19.0m higher. This increase from 2021/22 is being driven by volume increase (£9.4m) and price increase (£10.7m). The price variance is driven by the NHS pay award and increase in NI payments. The largest element of the volume increase is driven by the full year insourcing of the cleaning service.
- December has seen the number of staff absent from the Trust due to Covid remain the same with 0.3% for both 30th November and 31st December.
- The Trust continues to see high levels of maternity leave (172 WTE) which is contributing to the higher than planned levels of temporary staffing across the Trust.
- Consultants & Junior Doctors are £4.8m adverse YTD to plan due to rota compliance and an increase in WLIs and on call cover to deliver the Trust activity plans. .
- Estates & Ancillary are £1.9m adverse YTD to plan due to high levels of sickness in within the cleaning service. When compared to 2021/22 the key driver of the increase is the level of sickness and the full year insourcing of the service.
- Scientific Therapeutic and Technical Staff are £1.5m adverse to plan YTD due to Agency usage within Pharmacy.

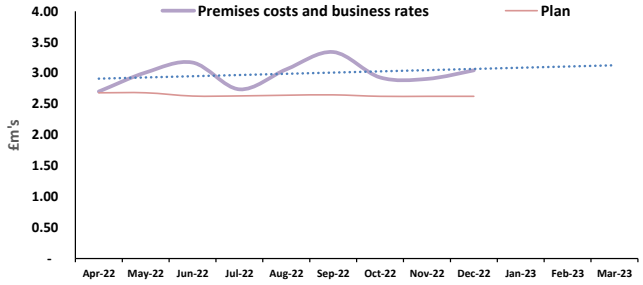
Non-Pay Summary for the 9 months ending 31 Dec 2022





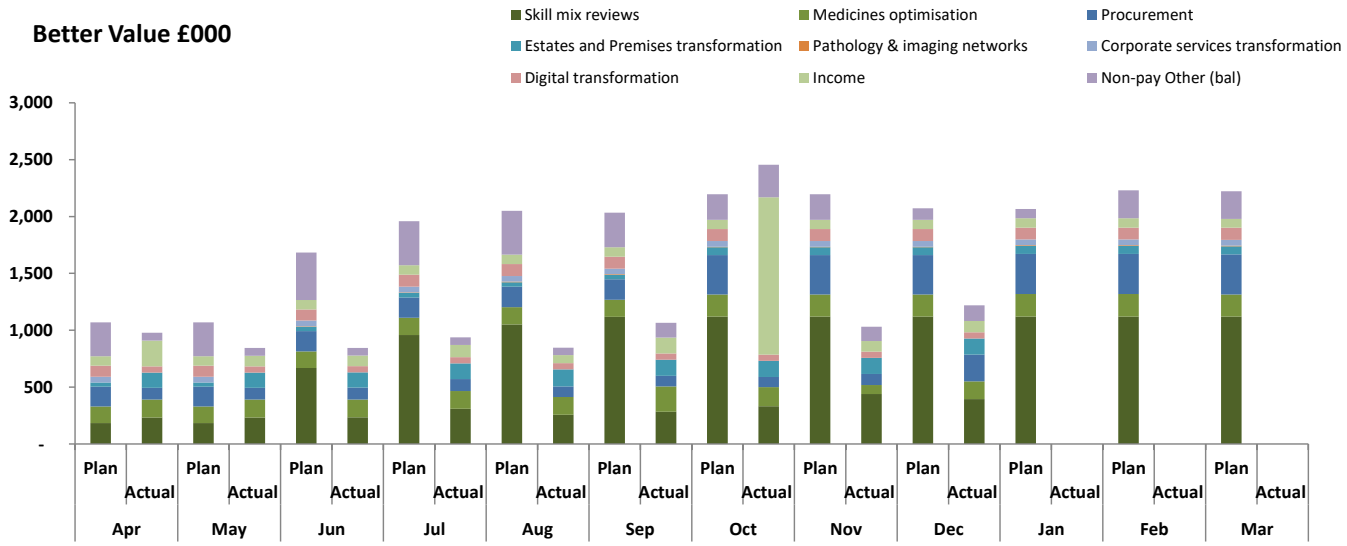


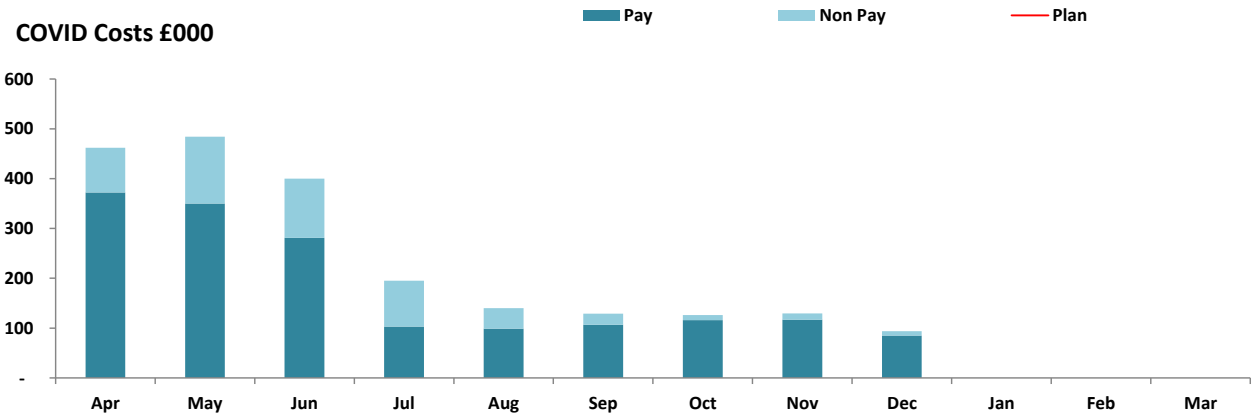




Summary

- Non pay is £2.3m adverse to plan in month and £8.9m adverse to plan YTD.
- Pass through expenditure is £1.6m adverse to plan YTD but this offsets by additional income.
- Premises costs are £1.4m adverse to plan YTD due to increased costs associated with the expanded Trust EPR system, ward refurbishment and ventilation works
- Supplies & Services Clinical costs increased in month due to reagents ordering, leading to clinical supplies as £2.7m adverse position
- Drugs costs are £1.8m adverse to plan YTD due to increase in costs for CAR-T
- Impairment of receivables is £0.4m adverse to plan YTD due to the bad debt increased.





Better Value and Covid-19 costs

- The Trust is continuing to develop it's better value programme for 2022/23 and continues to hold weekly Directorate / PMO meetings to finalise the schemes and develop new ones. In addition the Trust held additional workshops and meetings to drive bottom up scheme development across the Trust.
  - Month 9 £11.2m of the £16.3m plan has been delivered.
  - Month 9 plan was for £10.9m of recurrent savings, Trust has delivered £8.1m.
  - Month 9 plan was for £5.5m of non recurrent savings, Trust has delivered £3.1m.

- Covid costs in month are £0.1m which is significantly lower than the last six months of 2021/22 and it is continuing to reduce. The costs incurred by the Trust are associated with cleaning, testing and Covid premium payments. It is planned for all covid costs to be removed and this report will track progress with this each month. The main costs in month are associated with pre-screening of patients and the uplifted bank rates.

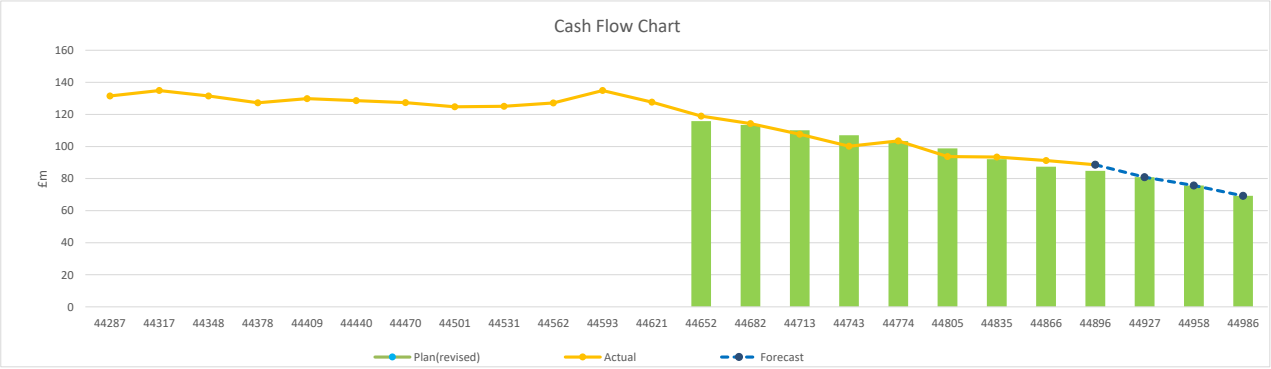
31 Mar 2022 Audited Accounts £m	Statement of Financial Position	YTD Actual 30 Nov 22 £m	*YTD Actual 31 Dec 22 £m*	In month Movement £m
546.40	Non-Current Assets	617.94	616.40	(1.54)
62.22	Current Assets (exc Cash)	89.85	91.59	1.74
123.67	Cash & Cash Equivalents	91.17	88.57	(2.60)
(104.63)	Current Liabilities	(116.77)	(117.58)	(0.81)
(5.37)	Non-Current Liabilities	(26.19)	(26.00)	0.19
622.29	**Total Assets Employed**	**656.00**	**652.98**	**(3.02)**

31 Mar 2022 Audited Accounts £m	Capital Expenditure	YTD plan 31 December 2022 £m	YTD Actual 31 December 2022 £m	YTD Variance £m	Forecast Outturn 31 Mar 2023 £m	RAG YTD variance
6.12	Redevelopment - Donated	12.36	5.82	6.54	26.44	R
1.61	Medical Equipment - Donated	2.21	2.00	0.21	3.25	G
-	ICT - Donated	0.00	0.00	0.00	0.00	G
7.73	**Total Donated**	**14.57**	**7.82**	**6.75**	**29.69**	R
0.32	**Total Grant funded**	**0.00**	**0.00**	**0.00**	**0.00**	G
12.05	Redevelopment & equipment - Trust Funded	1.88	1.31	0.57	5.45	A
1.44	Estates & Facilities - Trust Funded	2.96	1.61	1.35	3.29	R
3.17	ICT - Trust Funded	2.91	3.29	(0.38)	5.26	A
-	Contingency/unallocated	0.00	0.00	0.00	0.98	G
(0.74)	Disposals	0.00	0.00	0.00	0.00	G
15.92	**Total Trust Funded**	**7.75**	**6.21**	**1.54**	**14.98**	A
0.16	**Share allocation**	**0.00**	**0.00**	**0.00**	**0.00**	G
-	**Total IFRS 16**	**0.64**	**0.10**	**0.54**	**0.64**	R
1.53	**PDC**	**0.00**	**0.00**	**0.00**	**0.08**	G
25.66	**Total Expenditure**	**22.96**	**14.13**	**8.83**	**45.39**	A

31-Mar-22	Working Capital	30-Nov-22	31-Dec-22	RAG	KPI
4.0	NHS Debtor Days (YTD)	4.0	4.0	G	< 30.0
131.0	IPP Debtor Days	196.0	198.0	R	< 120.0
12.0	IPP Overdue Debt (£m)	20.8	21.4	R	0.0
87.0	Inventory Days - Non Drugs	79.0	80.0	R	30.0
34.0	Creditor Days	26.0	24.0	G	< 30.0
43.0%	BPPC - NHS (YTD) (number)	46.2%	47.8%	R	> 95.0%
74.4%	BPPC - NHS (YTD) (£)	78.5%	79.8%	R	> 95.0%
83.4%	BPPC - Non-NHS (YTD) (number)	81.1%	81.7%	R	> 95.0%
92.2%	BPPC - Non-NHS (YTD) (£)	92.0%	91.8%	A	> 95.0%
81.7%	BPPC - Total (YTD) (number)	83.2%	80.5%	R	> 95.0%
90.6%	BPPC - Total (YTD) (£)	90.1%	90.7%	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)

Mar-22	Liquidity Method	Nov-22	Dec-22	RAG	Mar-23	RAG
1.8	Current Ratio (Current Assets / Current Liabilities)	1.6	1.5	G	1.8	G
1.7	Quick Ratio(Current Assets - Inventories - Prepaid Expenses) / Current Liabilit	1.4	1.4	G	1.6	G
1.2	Cash Ratio(Cash / Current Liabilities)	0.8	0.8	R	0.8	R
77.0	Liquidity days Cash / (Pay+Non pay excl Capital expenditure)	58.3	56.6	A	44.0	A
127.0	Liquidity Days (Payroll)(Cash / Pay)	96.9	94.1	G	73.0	G



Comments:

1. Capital expenditure for the year to date was £14.1m; the Trust-funded programme is £1.5m less than plan and right of use £0.5m less than plan; the donated programme is £6.8m less than plan. The Trust funded forecast total outturn is as the plan.
2. Cash held by the Trust decreased from £91.2m to £88.6m.
3. Total Assets employed at M09 increased by £0.3m in month as a result of the following:
   - Non current assets increased by £3.0m to £620.9m.
   - Current assets excluding cash totalled £92.0m, increasing by £2.1m in month. This largely relates to Charity capital receivables (£0.4m higher in month); Inventories (£0.8m higher in month) and Other receivables (£0.9m higher in month).
   - Cash held by the Trust totalled £88.6m, decreasing in month by £2.6m.
   - Current liabilities increased in month by £0.8m to £117.6m. This includes expenditure accruals (£2.1m higher in month); and deferred income (£1.6m higher in month). This is offset against the decrease in Capital creditors (£1.6m lower in month); other payables (£0.4m lower in month) and NHS payables (£0.9m lower in month)
   - Non current liabilities totalled £27.6m which is £1.4m higher in month. This includes lease borrowings of £25.2m.
4. I&PC debtors days increased in month from 193 to 198. Total I&PC debt (net of cash deposits held) increased in month to £24.0 m (£23.8m in M08). Overdue debt increased in month to £21.4m (£20.8m in M08).
5. In M09, 91% of the total value of creditor invoices were settled within 30 days of receipt; this represented 81% 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.
6. By supplier category, the cumulative BPPC for Non NHS invoices (by number) was 82% (81% in M08). This represented 92% of the total value of invoices settled within 30 days (92% in M08). The cumulative BPPC for NHS invoices (by number) was 48% (46% in M08). This represented 80% of the value of invoices settled within 30 days (79% in M08).
7. Creditor days decreased in month from 26 to 24 days.

Trust Income and Expenditure by Direcorates Summary for the 9 months ending 31 Dec 2022

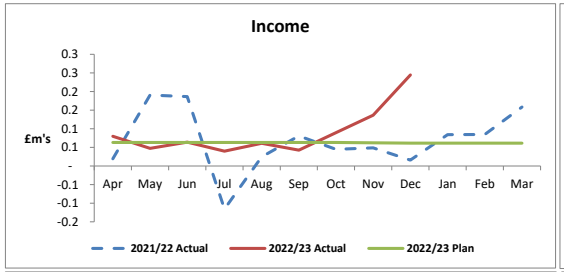
2022/23										
Annual Plan (£m)	Direcorates	In Month				Year to Date				
		Plan (£m)	Actual (£m)	Variance (£m)	Variance %	Plan (£m)	Actual (£m)	Variance (£m)	Variance %	YTD Variance
(33.74)	Blood Cells & Cancer	(2.91)	(2.75)	0.16	5.44%	(25.25)	(26.57)	(1.31)	(5.20%)	R
(29.75)	Body Bones & Mind	(2.47)	(2.73)	(0.26)	(10.61%)	(22.39)	(25.17)	(2.78)	(12.40%)	R
(22.44)	Brain	(1.86)	(2.04)	(0.18)	(9.59%)	(16.89)	(17.79)	(0.90)	(5.33%)	R
(85.60)	Core Clinical Services	(7.15)	(7.81)	(0.66)	(9.19%)	(64.15)	(69.18)	(5.03)	(7.84%)	R
(51.50)	Heart & Lung	(4.15)	(4.33)	(0.18)	(4.33%)	(39.36)	(45.67)	(6.30)	(16.02%)	R
13.10	International Private Patients	1.31	2.12	0.81	61.71%	8.65	13.37	4.73	54.70%	G
0.86	Research And Innovation	0.08	(0.13)	(0.20)	(268.59%)	0.72	1.72	1.00	137.48%	G
(28.14)	Sight & Sound	(2.34)	(2.54)	(0.20)	(8.40%)	(21.12)	(22.53)	(1.41)	(6.66%)	R
(6.11)	Clinical & Medical Operations	(0.51)	(0.49)	0.02	3.02%	(4.58)	(4.55)	0.03	0.65%	G
(3.31)	Corporate Affairs	(0.27)	(0.25)	0.02	8.08%	(2.49)	(2.38)	0.11	4.44%	G
(5.71)	Finance	(0.47)	(0.27)	0.20	43.34%	(4.28)	(3.44)	0.85	19.75%	G
(17.44)	Genetics	(1.47)	(0.56)	0.92	62.13%	(13.02)	(4.79)	8.23	63.23%	G
(5.21)	Hr & Organisational Developmen	(0.43)	(0.57)	(0.14)	(32.20%)	(3.91)	(3.95)	(0.05)	(1.18%)	G
(11.68)	Ict	(0.97)	(1.14)	(0.17)	(17.32%)	(8.76)	(9.07)	(0.31)	(3.55%)	A
(1.52)	Innovation	(0.13)	(0.20)	(0.07)	(55.32%)	(1.13)	(0.84)	0.30	26.24%	G
(6.41)	Medical Director	(0.55)	(0.51)	0.04	7.22%	(4.76)	(4.42)	0.34	7.10%	G
(3.70)	Nursing And Patient Experience	(0.21)	(0.37)	(0.16)	(75.77%)	(2.72)	(1.18)	1.54	56.70%	G
(43.49)	Space And Place	(3.62)	(4.25)	(0.62)	(17.18%)	(32.62)	(35.36)	(2.74)	(8.39%)	R
(10.06)	Transformation	(0.84)	(0.77)	0.07	8.00%	(7.54)	(7.70)	(0.15)	(2.04%)	A
341.22	Central Corporate	28.94	27.49	(1.50)	0.00%	256.22	250.95	(5.25)	0.00%	R
(10.63)	**Surplus/Deficit**	**(0.04)**	**(2.10)**	**(2.06)**	**(5,434.46%)**	**(9.38)**	**(18.51)**	**(9.11)**	**(97.09%)**	R

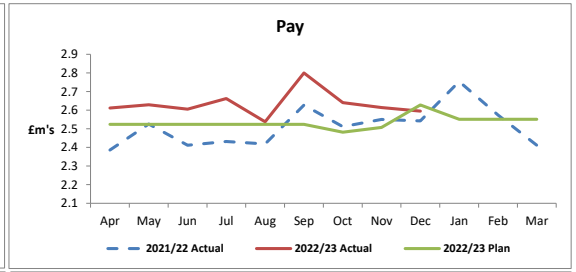
Appendices

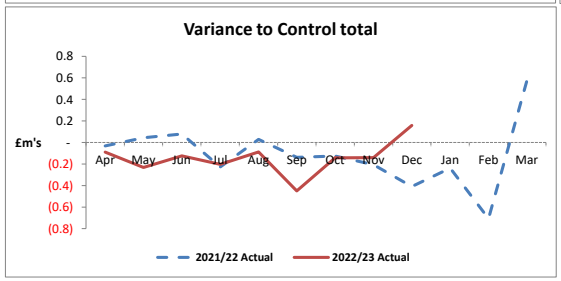
Blood Cells & Cancer Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

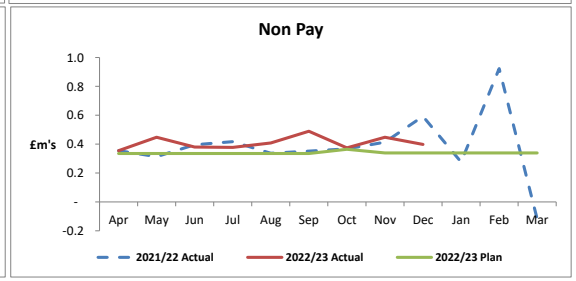
2022/23										2021/22	CY vs PY	
Annual	Income & Expenditure	Month 9				Year to Date				YTD	Var to PY	
Plan	Blood Cells & Cancer	Plan	Actual	Variance		Plan	Actual	Variance		Actual		
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0%
0.17	Private Patient Revenue	0.01	0.21	0.19	1,377.51%	0.13	0.39	0.26	208.14%	0.02	0.37	1,499.52%
0.58	Non-Clinical Revenue	0.05	0.04	(0.01)	(23.14%)	0.44	0.41	(0.02)	(5.62%)	0.47	(0.06)	(12.02%)
0.75	**Total Operating Revenue**	**0.06**	**0.24**	**0.18**	**298.74%**	**0.57**	**0.81**	**0.24**	**42.31%**	**0.50**	**0.31**	**62.56%**
(29.83)	Permanent Staff	(2.58)	(2.47)	0.11	4.34%	(22.31)	(22.45)	(0.14)	(0.63%)	(21.20)	(1.24)	(5.87%)
0.00	Agency Staff	0.00	0.00	0.00	0%	0.00	(0.01)	(0.01)	0%	0.02	(0.03)	(125.81%)
(0.59)	Bank Staff	(0.04)	(0.12)	(0.08)	(178.35%)	(0.46)	(1.24)	(0.79)	(172.73%)	(1.22)	(0.02)	(1.63%)
(30.42)	**Total Employee Expenses**	**(2.63)**	**(2.59)**	**0.03**	**1.26%**	**(22.76)**	**(23.70)**	**(0.93)**	**(4.10%)**	**(22.41)**	**(1.29)**	**(5.75%)**
(0.62)	Drugs and Blood	(0.05)	(0.06)	(0.00)	(9.54%)	(0.47)	(0.69)	(0.22)	(48.04%)	(0.50)	(0.19)	(37.35%)
(1.15)	Supplies and services - clinical	(0.10)	(0.14)	(0.04)	(41.14%)	(0.86)	(1.11)	(0.25)	(28.64%)	(0.86)	(0.25)	(28.94%)
(2.30)	Other Expenses	(0.19)	(0.21)	(0.01)	(7.10%)	(1.72)	(1.87)	(0.15)	(8.62%)	(2.18)	0.31	14.02%
(4.07)	**Total Non-Pay Expenses**	**(0.34)**	**(0.40)**	**(0.06)**	**(17.11%)**	**(3.06)**	**(3.68)**	**(0.62)**	**(20.31%)**	**(3.54)**	**(0.13)**	**(3.74%)**
(33.74)	**Control total**	**(2.91)**	**(2.75)**	**0.16**	**5.44%**	**(25.25)**	**(26.57)**	**(1.31)**	**(5.20%)**	**(25.45)**	**(1.11)**	**(4.37%)**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Summary

The directorate YTD position overall is £1.3m adverse to plan and £0.2m favourable in month. The key contributor to the YTD position is the £0.9m unallocated Better Value target, £0.3m unfunded pay awards as well as junior doctor's & nursing spend.

Notes

Income

- Overall Income is £0.2m favourable as number of SLA's recently signed and a PP Thymus Transplant in month.

Pay

- Overall YTD pay is £0.9m adverse to plan of which the unidentified Better Value target is £0.5m and £0.3m is impact of unfunded pay awards. The remainder of the overspend is driven by the junior doctor and nursing staff groups.
- Junior doctor £0.2m adverse and reflects the impact of several gaps in the junior doctor rota due to maternity leave & high sickness levels.
- While unbudgeted Nursing bank spend is £0.4m adverse, over the past 3 months in particular it has been running at 50% less compared to Q1 average levels. This is due to a combination of less vacancies and reduced sickness levels. This reduced level of bank spend is expected to continue.

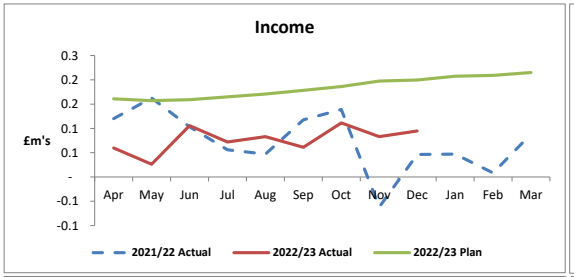
Non-Pay

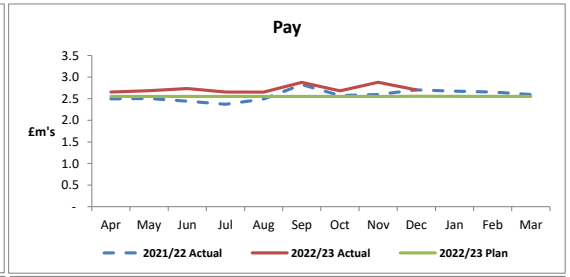
- Non-Pay is £0.6m adverse to plan of which the unidentified Better Value target is £0.4m and unfunded blood inflation £0.1m.

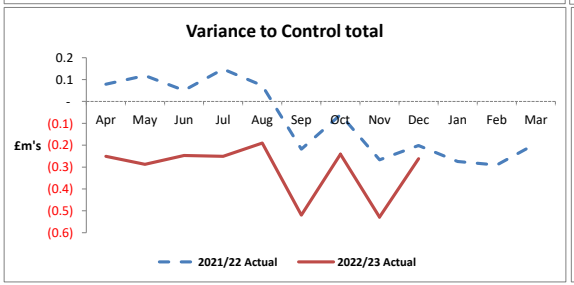
Body Bones & Mind Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

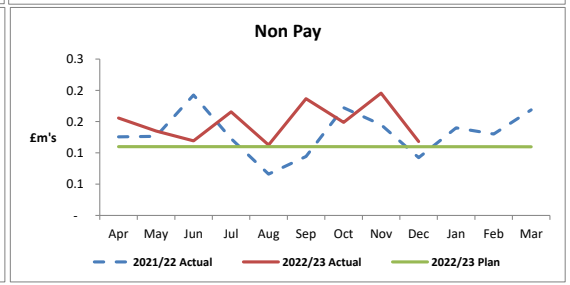
2022/23										2021/22	CY vs PY	
Annual	Income & Expenditure	Month 9				Year to Date				YTD	Var to PY	
Plan	Body Bones & Mind	Plan	Actual	Variance		Plan	Actual	Variance		Actual		
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.08	(0.08)	(100.00%)
1.78	Private Patient Revenue	0.16	0.03	(0.13)	(78.71%)	1.25	0.38	(0.87)	(69.45%)	0.35	0.03	8.49%
0.43	Non-Clinical Revenue	0.04	0.06	0.02	68.07%	0.32	0.31	(0.01)	(2.11%)	0.29	0.02	6.36%
2.21	**Total Operating Revenue**	**0.20**	**0.09**	**(0.10)**	**(52.52%)**	**1.57**	**0.70**	**(0.88)**	**(55.74%)**	**0.73**	**(0.03)**	**(4.52%)**
(30.36)	Permanent Staff	(2.53)	(2.56)	(0.03)	(1.20%)	(22.77)	(23.07)	(0.30)	(1.30%)	(21.49)	(1.58)	(7.34%)
0.00	Agency Staff	0.00	(0.00)	(0.00)	0%	0.00	(0.01)	(0.01)	0%	(0.03)	0.03	76.94%
(0.28)	Bank Staff	(0.02)	(0.14)	(0.12)	(506.29%)	(0.21)	(1.46)	(1.25)	(596.44%)	(1.49)	0.04	2.46%
(30.64)	**Total Employee Expenses**	**(2.56)**	**(2.71)**	**(0.15)**	**(5.81%)**	**(22.98)**	**(24.53)**	**(1.55)**	**(6.75%)**	**(23.02)**	**(1.52)**	**(6.58%)**
(0.07)	Drugs and Blood	(0.01)	(0.00)	0.00	33.37%	(0.05)	(0.05)	0.01	15.40%	(0.06)	0.01	23.91%
(0.99)	Supplies and services - clinical	(0.08)	(0.03)	0.05	57.56%	(0.74)	(0.69)	0.05	7.30%	(0.47)	(0.21)	(45.23%)
(0.26)	Other Expenses	(0.02)	(0.08)	(0.06)	(265.69%)	(0.20)	(0.61)	(0.41)	(210.14%)	(0.61)	(0.00)	(0.12%)
(1.32)	**Total Non-Pay Expenses**	**(0.11)**	**(0.12)**	**(0.01)**	**(7.67%)**	**(0.99)**	**(1.34)**	**(0.35)**	**(35.24%)**	**(1.14)**	**(0.20)**	**(17.56%)**
(29.75)	**Control total**	**(2.47)**	**(2.73)**	**(0.26)**	**(10.61%)**	**(22.39)**	**(25.17)**	**(2.78)**	**(12.40%)**	**(23.42)**	**(1.75)**	**(7.46%)**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Summary - Jeremy Nobes - General Manager

The directorate financial position is £2.8m adverse to Plan YTD

Private patient income and non-substantive pay costs (Bank Costs) are the main drivers

Notes

Income

- Private patient incomes remains behind plan YTD by £0.87m.This is mainly due to an ambitious plan and fact that we are using possible IPP beds to cover NHS demands.

Pay

- £1.55m adverse to Plan YTD with £786k driven by the gap in the directorates efficiency programme as part of the trust better value programme.
- Unfunded Additional Pay award is £346k YTD and direct Payroll costs for maternity and sickness £185k; thus £531k
- The remaining £0.3m of underlying budget overspends are being driven mostly by medical staffing and in particular Junior Doctor bank (£299k YTD) where required to cover rota gaps and vacancies.
- Bank spend on nursing is high but on the whole is being offset by vacancies.

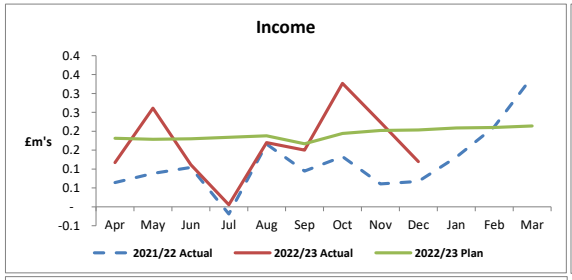
Non-Pay

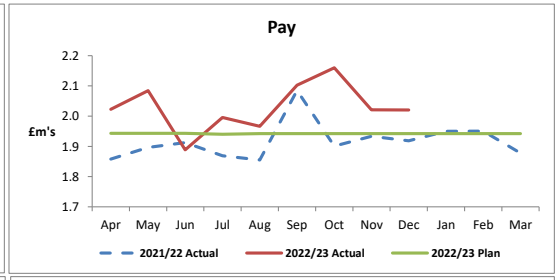
- Overspent by £0.35m YTD which is commensurate with the directorates' unidentified savings target of £336k.

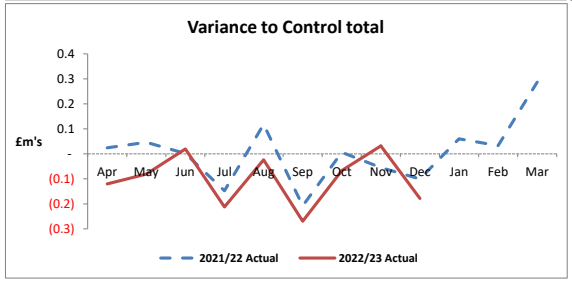
Brain Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

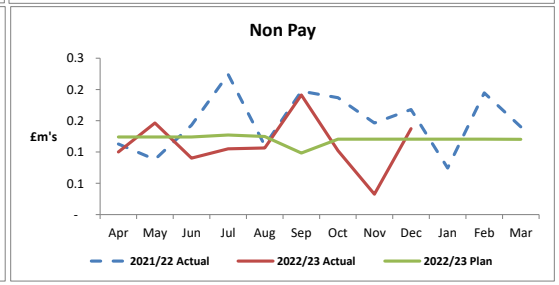
2022/23										2021/22	CY vs PY	
Annual Plan (£m)	Income & Expenditure Brain	Month 9 Plan (£m)	Month 9 Actual (£m)	Month 9 Variance (£m)	Month 9 Variance %	Year to Date Plan (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	YTD Actual (£m)	Var to PY (£m)	Var to PY %
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.09	(0.09)	(100.00%)
1.21	Private Patient Revenue	0.11	0.06	(0.05)	(47.73%)	0.86	0.93	0.08	8.77%	0.42	0.51	122.77%
1.10	Non-Clinical Revenue	0.09	0.06	(0.03)	(32.93%)	0.82	0.55	(0.27)	(32.62%)	0.25	0.30	119.40%
2.31	**Total Operating Revenue**	**0.20**	**0.12**	**(0.08)**	**(41.08%)**	**1.68**	**1.49**	**(0.19)**	**(11.52%)**	**0.76**	**0.73**	**95.75%**
(23.31)	Permanent Staff	(1.94)	(1.92)	0.03	1.35%	(17.48)	(17.15)	0.33	1.90%	(16.16)	(0.99)	(6.15%)
0.00	Agency Staff	0.00	0.00	0.00	0%	0.00	(0.01)	(0.01)	0%	(0.02)	0.01	58.37%
0.00	Bank Staff	0.00	(0.10)	(0.10)	0%	0.00	(1.10)	(1.10)	0%	(1.06)	(0.05)	(4.49%)
(23.31)	**Total Employee Expenses**	**(1.94)**	**(2.02)**	**(0.08)**	**(4.02%)**	**(17.48)**	**(18.26)**	**(0.78)**	**(4.46%)**	**(17.23)**	**(1.03)**	**(5.99%)**
(0.04)	Drugs and Blood	(0.00)	(0.01)	(0.01)	(362.85%)	(0.03)	(0.04)	(0.01)	(50.36%)	(0.04)	(0.01)	(15.68%)
(1.02)	Supplies and services - clinical	(0.09)	(0.08)	0.01	6.29%	(0.77)	(0.63)	0.13	17.37%	(0.69)	0.05	7.79%
(0.38)	Other Expenses	(0.03)	(0.04)	(0.01)	(33.93%)	(0.29)	(0.34)	(0.05)	(16.26%)	(0.65)	0.32	48.62%
(1.45)	**Total Non-Pay Expenses**	**(0.12)**	**(0.14)**	**(0.02)**	**(13.91%)**	**(1.08)**	**(1.01)**	**0.07**	**6.69%**	**(1.38)**	**0.37**	**26.51%**
(22.44)	**Control total**	**(1.86)**	**(2.04)**	**(0.18)**	**(9.59%)**	**(16.89)**	**(17.79)**	**(0.90)**	**(5.33%)**	**(17.85)**	**0.06**	**0.33%**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Summary - Martin Tisdall, Chief of Service

The directorate is £0.18m adverse to plan in month and £0.9m adverse to plan YTD.

Notes

Income

- Private patient income is above plan YTD. The in month position is adverse, £0.05m in month as a result of activity being lower than planned. The favourable £0.08m YTD position is, mainly due to the private patient activity being ahead of plan in Neurosurgery.
- Non-clinical revenue is adverse to plan £0.3m YTD. The adverse variance is because some SLA's still need to be signed.
- R&D income is adverse to plan in month and YTD; £20k in month and £97k YTD, income has been lower than expected due to reduced trials.

Pay

- In month and YTD pay position is adverse £0.08m and £0.8m YTD. In month adverse position is because £30k relates to pay rise uplifts of which the budget sits centrally. The remaining YTD variance is mainly due to Consultant budgets not being set accurately causing an overspend.
- There are some vacancies mainly in nursing and which are being offset by bank costs.

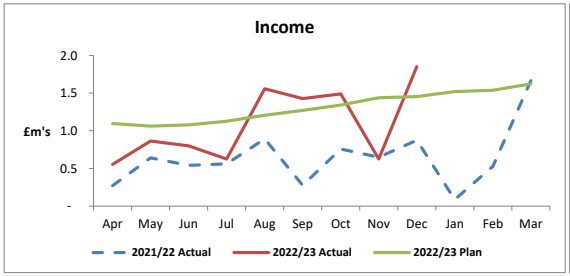
Non-Pay

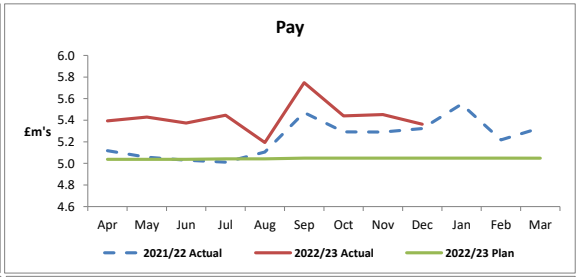
- Non-pay costs are adverse to plan this month £0.02m and favourable YTD, £0.7m. Spend on medical & surgical supplies (i.e. electrodes) and services received from other organisation is lower than planned YTD.

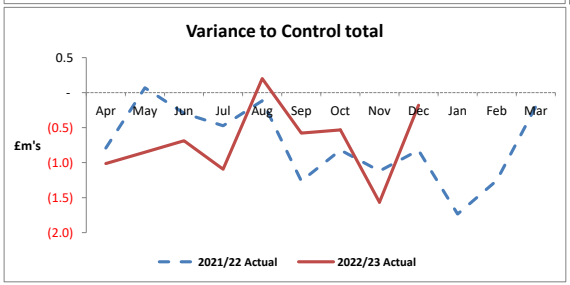
Heart & Lung Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

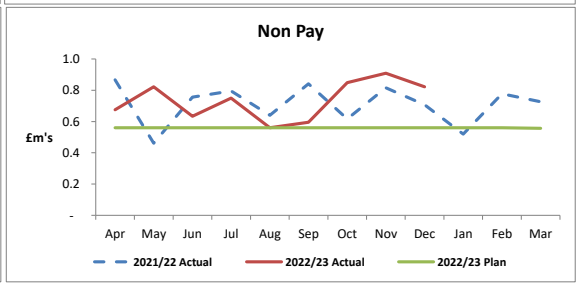
2022/23										2021/22	CY vs PY	
Annual Plan	Income & Expenditure Heart & Lung	Month 9				Year to Date				YTD Actual	Var to PY	
		Plan	Actual	Variance		Plan	Actual	Variance				
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	9.70%
15.17	Private Patient Revenue	1.40	1.80	0.40	28.65%	10.70	9.37	(1.33)	(12.39%)	5.00	4.37	87.33%
0.58	Non-Clinical Revenue	0.06	0.05	(0.00)	(7.67%)	0.38	0.42	0.04	9.61%	0.46	(0.05)	(9.96%)
15.75	**Total Operating Revenue**	**1.45**	**1.85**	**0.40**	**27.26%**	**11.07**	**9.79**	**(1.29)**	**(11.61%)**	**5.47**	**4.32**	**79.08%**
(60.28)	Permanent Staff	(5.03)	(5.01)	0.02	0.30%	(45.20)	(45.36)	(0.16)	(0.35%)	(43.20)	(2.15)	(4.99%)
0.00	Agency Staff	0.00	(0.01)	(0.01)	0%	0.00	(0.17)	(0.17)	0%	(0.15)	(0.02)	(12.13%)
(0.26)	Bank Staff	(0.02)	(0.34)	(0.32)	(1,477.47%)	(0.19)	(3.31)	(3.12)	(1,622.36%)	(3.34)	0.03	0.92%
(60.54)	**Total Employee Expenses**	**(5.05)**	**(5.36)**	**(0.31)**	**(6.23%)**	**(45.39)**	**(48.84)**	**(3.44)**	**(7.59%)**	**(46.70)**	**(2.14)**	**(4.59%)**
(0.94)	Drugs and Blood	(0.08)	(0.10)	(0.02)	(22.03%)	(0.71)	(0.99)	(0.28)	(39.77%)	(0.87)	(0.12)	(13.98%)
(4.93)	Supplies and services - clinical	(0.41)	(0.48)	(0.07)	(17.88%)	(3.70)	(3.96)	(0.26)	(6.95%)	(3.70)	(0.26)	(7.03%)
(0.84)	Other Expenses	(0.07)	(0.24)	(0.17)	(242.50%)	(0.64)	(1.67)	(1.04)	(162.83%)	(1.94)	0.27	13.71%
(6.72)	**Total Non-Pay Expenses**	**(0.56)**	**(0.82)**	**(0.26)**	**(46.81%)**	**(5.04)**	**(6.62)**	**(1.57)**	**(31.23%)**	**(6.50)**	**(0.12)**	**(1.77%)**
(51.50)	**Control total**	**(4.15)**	**(4.33)**	**(0.18)**	**(4.33%)**	**(39.36)**	**(45.67)**	**(6.30)**	**(16.02%)**	**(47.73)**	**2.07**	**4.33%**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Summary - David Chatterton - General Manager

The directorate financial position is £6.3m adverse to Plan YTD (this excludes £1.2m LTV BV scheme as Income not sitting in H&L directorate)

Private patient income, pay inflation and non-substantive (Bank) pay costs are the main drivers

Notes

Income

- Though showing improvement versus the trend from 2021/22, Private patient income is £1.3m behind Plan YTD (M8 £1.7m adv). We are currently looking into the low M8 amount and the FOT FY is in line with plan

Pay

- Pay costs are £3.4m overspent YTD
- High costs for consultant and junior doctor bank usage are being borne that are unbudgeted, about £1.4m YTD (but this incl the additional pay award of £246k per below)
- Nursing overspend of £0.7m YTD due to bank usage for covering beds not budgeted, as well as maternity and sickness (but this incl the additional pay award of £359k per below)
- Unfunded Additional Pay award is £733k YTD and direct Payroll costs for maternity and sickness £348k; thus £1.1m
- The directorate has a £1.9m pay saving ask for the year as part of the trust better value programme and the unallocated portion of this YTD equates to £1.2m

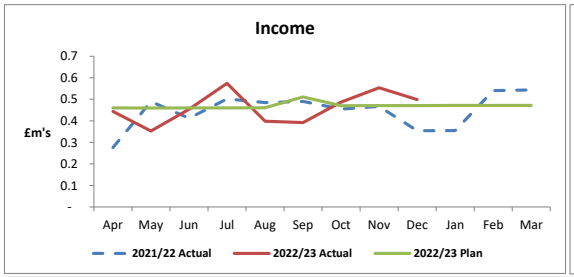
Non-Pay

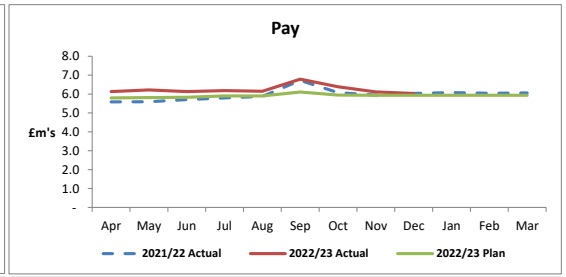
- Overspent by £1.57m YTD which is mainly made up by the directorates' unidentified savings target (£944k YTD).
- Main other areas of concern are for unfunded Blood Costs at £0.3m and Work Permits at £151k overspend YTD.

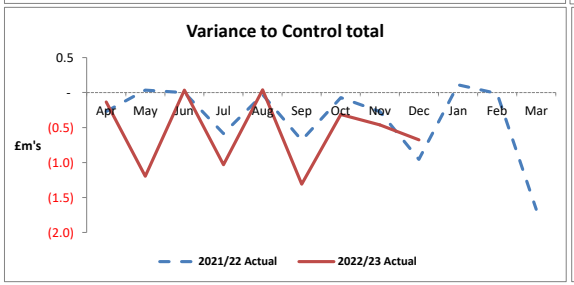
Core Clinical Services Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

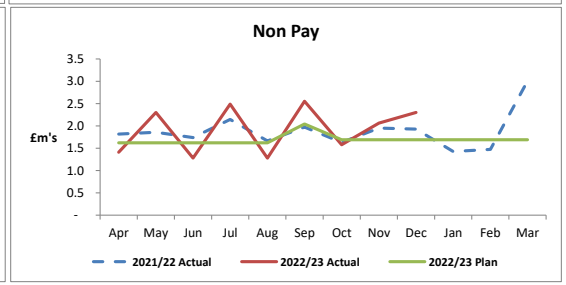
2022/23										2021/22	CY vs PY	
Annual Plan (£m)	Income & Expenditure Core Clinical Services	Month 9 Plan (£m)	Month 9 Actual (£m)	Month 9 Variance (£m)	Month 9 Variance %	Year to Date Plan (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	YTD Actual (£m)	Var to PY (£m)	Var to PY %
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.01	(0.01)	(100.00%)
0.12	Private Patient Revenue	0.01	(0.01)	(0.02)	(187.79%)	0.08	0.00	(0.08)	(99.76%)	0.07	(0.07)	(99.73%)
5.52	Non-Clinical Revenue	0.46	0.51	0.05	10.62%	4.14	4.15	0.02	0.38%	3.85	0.31	8.00%
5.64	**Total Operating Revenue**	**0.47**	**0.50**	**0.03**	**6.01%**	**4.22**	**4.15**	**(0.07)**	**(1.60%)**	**3.93**	**0.22**	**5.70%**
(70.16)	Permanent Staff	(5.87)	(5.76)	0.11	1.83%	(52.55)	(53.24)	(0.69)	(1.31%)	(50.65)	(2.60)	(5.12%)
0.00	Agency Staff	0.00	(0.08)	(0.08)	0%	0.00	(0.76)	(0.76)	0%	(0.71)	(0.05)	(7.36%)
(0.81)	Bank Staff	(0.07)	(0.19)	(0.12)	(189.12%)	(0.61)	(2.12)	(1.51)	(247.52%)	(1.97)	(0.15)	(7.64%)
(70.97)	**Total Employee Expenses**	**(5.94)**	**(6.03)**	**(0.09)**	**(1.60%)**	**(53.16)**	**(56.12)**	**(2.96)**	**(5.56%)**	**(53.32)**	**(2.80)**	**(5.25%)**
(0.52)	Drugs and Blood	(0.04)	(0.15)	(0.10)	(232.39%)	(0.39)	(0.59)	(0.20)	(50.42%)	(0.29)	(0.30)	(104.51%)
(18.16)	Supplies and services - clinical	(1.51)	(1.86)	(0.34)	(22.76%)	(13.62)	(14.18)	(0.56)	(4.11%)	(14.23)	0.04	0.31%
(1.61)	Other Expenses	(0.13)	(0.30)	(0.16)	(121.97%)	(1.21)	(2.48)	(1.27)	(105.12%)	(2.19)	(0.29)	(13.02%)
(20.30)	**Total Non-Pay Expenses**	**(1.69)**	**(2.30)**	**(0.61)**	**(36.04%)**	**(15.22)**	**(17.25)**	**(2.03)**	**(13.31%)**	**(16.71)**	**(0.54)**	**(3.25%)**
(85.63)	**Control total**	**(7.16)**	**(7.83)**	**(0.68)**	**(9.45%)**	**(64.16)**	**(69.22)**	**(5.05)**	**(7.87%)**	**(66.10)**	**(3.12)**	**(4.72%)**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Summary - GM's Nick Towndrow & Ruth Leighton

The CCS Division is £0.68m adverse in M9 and £5.5m adverse YTD. The directorate expenses in month is £7.8m

Notes

Income

- £28k favourable in M9 and £68k adverse YTD. The in-month position is driven by catch up to Pathology and Pharmacy income and the YTD position is driven by an underachievement on Pathology Lab test income.

Pay

- £94k adverse in M9 and £2.9m adverse YTD driven by additional Pay award across main staffing groups, Underachievement of the Better values/CIP target Overspend on Consultant and SpR lines within Radiology, business case funding and establishment is under review. Agency Pharmacy and Radiographer to cover vacancies.

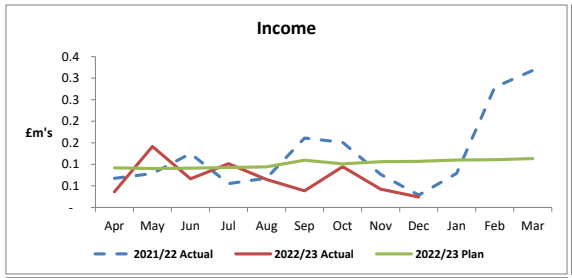
Non-Pay

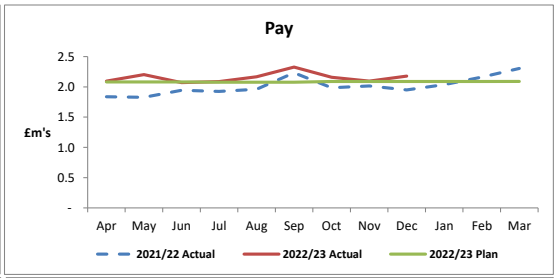
- £0.6m adverse in M9 and £2.02m adverse YTD.
- The in-month position is mainly due to Reagents, increase in Variable Blood Costs Surgical Instruments, Equip Maintenance Contracts and Send Away Tests - Various NHS Trusts, including Barts.
- The YTD adverse position is due to overspends on Reagents, Lab Consumables, Lab Equipment, Stock Clinical, Surgical Instruments and Equip Maintenance Contracts

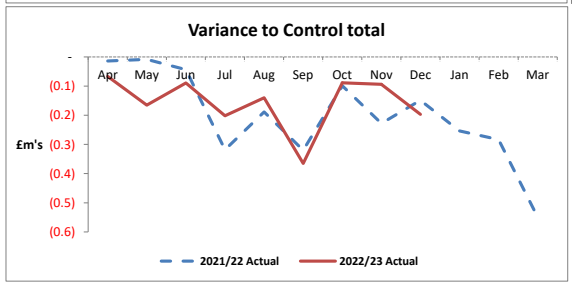
Sight & Sound Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

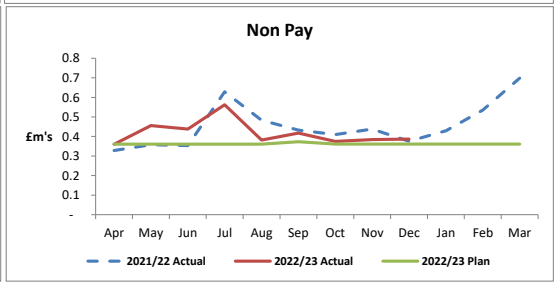
2022/23										2021/22	CY vs PY	
Annual Plan	Income & Expenditure	Month 9				Year to Date				YTD Actual	Var to PY	
	Sight & Sound	Plan	Actual	Variance		Plan	Actual	Variance				
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0%
0.75	Private Patient Revenue	0.07	0.01	(0.06)	(86.97%)	0.53	0.43	(0.10)	(19.71%)	0.67	(0.25)	(36.60%)
0.47	Non-Clinical Revenue	0.04	0.02	(0.02)	(59.66%)	0.35	0.18	(0.17)	(47.82%)	0.14	0.04	31.93%
1.22	**Total Operating Revenue**	**0.11**	**0.02**	**(0.08)**	**(77.40%)**	**0.88**	**0.61**	**(0.27)**	**(30.94%)**	**0.81**	**(0.20)**	**(24.81%)**
(24.50)	Permanent Staff	(2.05)	(2.08)	(0.03)	(1.50%)	(18.35)	(18.25)	0.10	0.57%	(16.23)	(2.02)	(12.44%)
0.00	Agency Staff	0.00	(0.00)	(0.00)	0%	0.00	(0.00)	(0.00)	0%	(0.01)	0.01	75.18%
(0.51)	Bank Staff	(0.04)	(0.10)	(0.06)	(145.12%)	(0.39)	(1.13)	(0.74)	(188.48%)	(1.43)	0.31	21.34%
(25.01)	**Total Employee Expenses**	**(2.09)**	**(2.18)**	**(0.09)**	**(4.26%)**	**(18.74)**	**(19.38)**	**(0.63)**	**(3.38%)**	**(17.67)**	**(1.71)**	**(9.65%)**
(0.03)	Drugs and Blood	(0.00)	(0.00)	0.00	44.09%	(0.02)	(0.02)	0.00	16.84%	(0.03)	0.01	35.52%
(3.52)	Supplies and services - clinical	(0.29)	(0.28)	0.01	3.28%	(2.66)	(2.74)	(0.09)	(3.26%)	(2.84)	0.10	3.44%
(0.79)	Other Expenses	(0.07)	(0.11)	(0.04)	(51.32%)	(0.58)	(1.00)	(0.42)	(71.91%)	(0.93)	(0.06)	(6.69%)
(4.34)	**Total Non-Pay Expenses**	**(0.36)**	**(0.39)**	**(0.03)**	**(7.02%)**	**(3.26)**	**(3.76)**	**(0.50)**	**(15.33%)**	**(3.81)**	**0.05**	**1.20%**
(28.14)	**Control total**	**(2.34)**	**(2.54)**	**(0.20)**	**(8.40%)**	**(21.12)**	**(22.53)**	**(1.41)**	**(6.66%)**	**(20.67)**	**(1.86)**	**(9.01%)**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Summary - Allesa Baptiste, General Manager

The directorate YTD position overall is £1.4m adverse to plan and £0.2m adverse in month. The key contributors to the YTD position are the £0.9m unidentified Better Value target, £0.3m unfunded pay awards and £0.2m adverse on non-pay particularly Optical Appliances & Craniofacial Helmets both of which are activity related.

Notes

Income

- Overall Income is £0.3m adverse due to a number of SLA's are pending sign off. It is envisaged by during Q3 these SLA will be signed and the position will therefore improve.

Pay

- Overall YTD pay is £0.6m adverse, the key drivers are £0.5m attributed to the unidentified Better Value target & £0.3m due to unfunded pay awards.

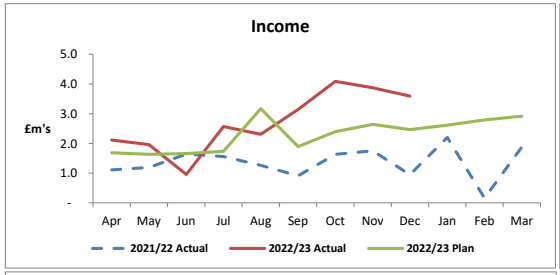
Non-Pay

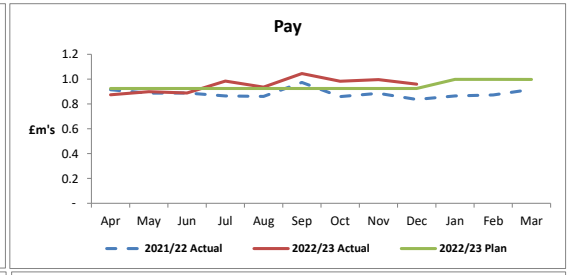
- Non-Pay is £0.5m adverse to plan attributed to the unidentified Better Value target of £0.3m and £0.2m adverse on non-pay particularly Optical Appliances & Craniofacial Helmets both of which are activity related.

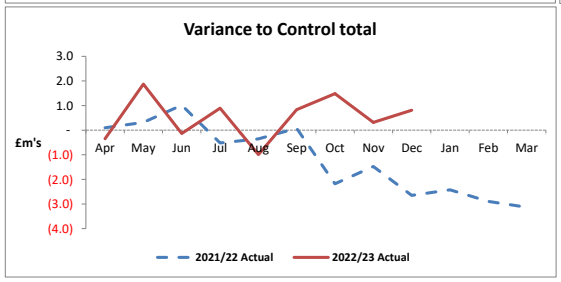
International Private Patients Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

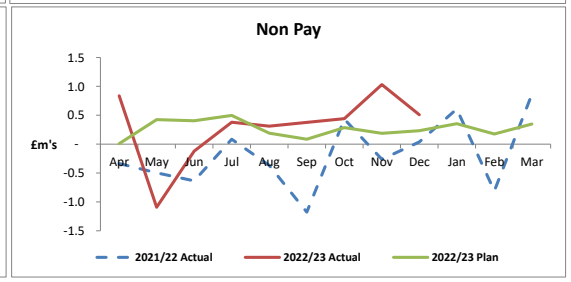
2022/23										2021/22	CY vs PY	
Annual Plan	Income & Expenditure	Month 9				Year to Date				YTD Actual	Var to PY	
	International Private Patients	Plan	Actual	Variance		Plan	Actual	Variance				
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0%
26.91	Private Patient Revenue	2.41	3.56	1.15	47.64%	18.76	24.25	5.48	29.23%	11.65	12.59	108.03%
0.70	Non-Clinical Revenue	0.06	0.03	(0.03)	(44.13%)	0.52	0.37	(0.16)	(29.81%)	0.35	0.01	3.81%
27.61	**Total Operating Revenue**	**2.47**	**3.59**	**1.12**	**45.48%**	**19.28**	**24.61**	**5.33**	**27.63%**	**12.01**	**12.60**	**104.96%**
(11.20)	Permanent Staff	(0.92)	(0.84)	0.07	8.11%	(8.24)	(7.55)	0.68	8.31%	(7.55)	(0.01)	(0.07%)
0.00	Agency Staff	0.00	(0.03)	(0.03)	0%	0.00	(0.32)	(0.32)	0%	(0.08)	(0.24)	(320.10%)
(0.12)	Bank Staff	(0.01)	(0.09)	(0.08)	(812.83%)	(0.09)	(0.70)	(0.61)	(705.15%)	(0.35)	(0.35)	(98.98%)
(11.32)	**Total Employee Expenses**	**(0.92)**	**(0.96)**	**(0.03)**	**(3.76%)**	**(8.32)**	**(8.57)**	**(0.24)**	**(2.92%)**	**(7.97)**	**(0.59)**	**(7.45%)**
(0.45)	Drugs and Blood	(0.04)	(0.01)	0.03	68.31%	(0.34)	(0.19)	0.15	45.14%	(0.17)	(0.01)	(6.48%)
(0.91)	Supplies and services - clinical	(0.07)	(0.08)	(0.01)	(8.99%)	(0.66)	(0.59)	0.07	10.03%	(0.27)	(0.32)	(117.37%)
(1.83)	Other Expenses	(0.12)	(0.42)	(0.30)	(246.84%)	(1.32)	(1.89)	(0.58)	(43.72%)	3.17	(5.06)	(159.81%)
(3.19)	**Total Non-Pay Expenses**	**(0.23)**	**(0.51)**	**(0.28)**	**(120.21%)**	**(2.32)**	**(2.67)**	**(0.36)**	**(15.43%)**	**2.72**	**(5.39)**	**(198.26%)**
13.10	**Control total**	**1.31**	**2.12**	**0.81**	**61.71%**	**8.65**	**13.37**	**4.73**	**54.70%**	**6.76**	**6.62**	**97.97%**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Summary

The I&PC directorate is £0.8m favourable to Control Total Plan in-month and £4.7m favourable YTD. The Trust's private revenue position YTD is £5.5m ahead of the Revenue Plan.

Notes

Income

- The directorate's Private Patient Revenue in-month is £1.2m favourable to the NHSE Plan.
- The YTD position is £5.3m favourable to the Total Operating Revenue Plan.
- Favourable variance driven by buoyant Inpatient activity in the directorate, facilitated by the reopening of Hedgehog ward ahead of plan. Back-dated (to 1 Aug) charging for Intensive Care admissions has also contributed to the revenue performance.

Pay

- Staff costs are £0.03m higher than NHSE Plan, mainly driven by opening inpatient beds on Hedgehog Ward earlier than planned and temporary resources required to support transformation in the directorate's finance function and other productivity workstreams.
- Permanent Staff costs YTD are £0.07m favourable to Plan due to holding vacancies within the directorate whilst activity was below plan in H1.

Non-Pay

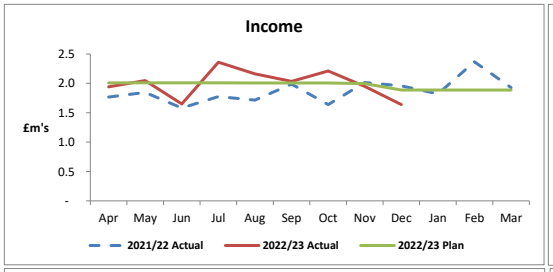
- Non-Pay variance of £0.3m is driven by the continued provision for increase in bad debt £0.2m. This was partially offset by lower than planned spends in Drugs and Blood £0.03m.

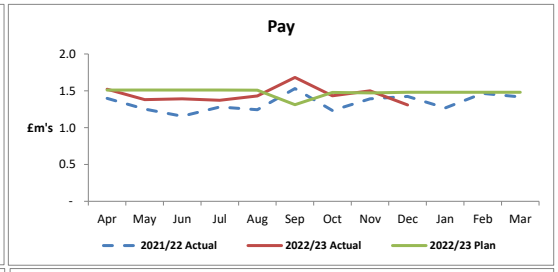
Note - The performance shown here excludes private patient income occurring in NHS Directorates and

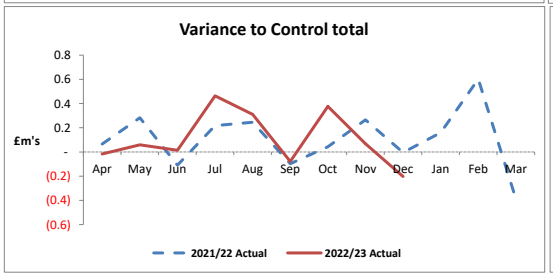
Research And Innovation Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

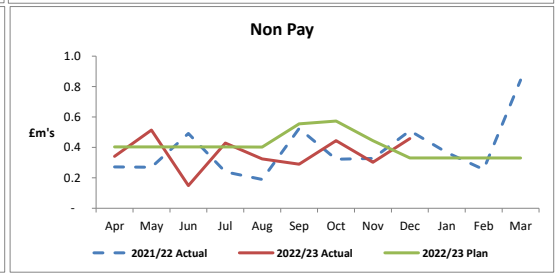
2022/23										2021/22	CY vs PY	
Annual Plan	Income & Expenditure Research And Innovation	Month 9				Year to Date				YTD Actual	Var to PY	
		Plan	Actual	Variance		Plan	Actual	Variance				
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.16	0.16	0%	0.00	0.45	0.45	0%	0.00	0.45	0%
0.00	Private Patient Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0%
23.59	Non-Clinical Revenue	1.89	1.47	(0.41)	(21.85%)	17.93	17.54	(0.39)	(2.19%)	16.28	1.26	7.76%
23.59	**Total Operating Revenue**	**1.89**	**1.64**	**(0.25)**	**(13.12%)**	**17.93**	**17.99**	**0.05**	**0.31%**	**16.28**	**1.71**	**10.50%**
(17.68)	Permanent Staff	(1.48)	(1.30)	0.18	11.90%	(13.25)	(12.91)	0.34	2.60%	(11.76)	(1.15)	(9.82%)
0.00	Agency Staff	0.00	0.00	0.00	0%	0.00	(0.00)	(0.00)	0%	0.00	(0.00)	0%
(0.05)	Bank Staff	(0.00)	(0.01)	(0.00)	(90.42%)	(0.04)	(0.11)	(0.07)	(189.00%)	(0.15)	0.05	30.81%
(17.73)	**Total Employee Expenses**	**(1.48)**	**(1.31)**	**0.17**	**11.62%**	**(13.29)**	**(13.02)**	**0.27**	**2.06%**	**(11.91)**	**(1.11)**	**(9.32%)**
0.00	Drugs and Blood	0.00	(0.16)	(0.16)	0%	0.00	(0.45)	(0.45)	0%	(0.13)	(0.32)	(241.97%)
(0.88)	Supplies and services - clinical	(0.05)	(0.07)	(0.02)	(29.99%)	(0.73)	(0.95)	(0.22)	(30.40%)	(0.62)	(0.33)	(52.48%)
(4.03)	Other Expenses	(0.28)	(0.23)	0.05	19.05%	(3.19)	(1.86)	1.34	41.87%	(2.39)	0.54	22.47%
(4.91)	**Total Non-Pay Expenses**	**(0.33)**	**(0.46)**	**(0.13)**	**(38.42%)**	**(3.92)**	**(3.25)**	**0.67**	**17.02%**	**(3.15)**	**(0.11)**	**(3.37%)**
0.95	**Control total**	**0.08**	**(0.13)**	**(0.20)**	**(268.59%)**	**0.72**	**1.72**	**1.00**	**137.48%**	**1.22**	**0.49**	**40.35%**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Summary - Jenny Rivers - Deputy Director

The directorate has a £0.13m deficit in M9 driven by reduced Commercial income

Notes

Income

- Total income of £1.6m is below plan and run rate due to commencement of new 5 Year BRC award. The funding is phased lower in the opening 4 months as we hire new positions and non-pay spend is reduced.
- Gross Commercial income of £0.3m is low due to reduced billing due to seasonality. It is £0.3 down vs prior month and plan

Pay

- Overall pay of £1.3m - £0.2m savings vs budget and run rate due to phased BRC hiring internally and at UCL. saving does not equate to bottom line (IAS20 cost = income)

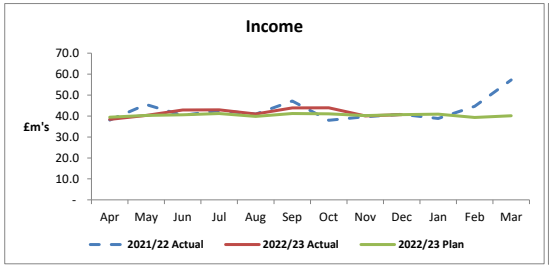
Non-Pay

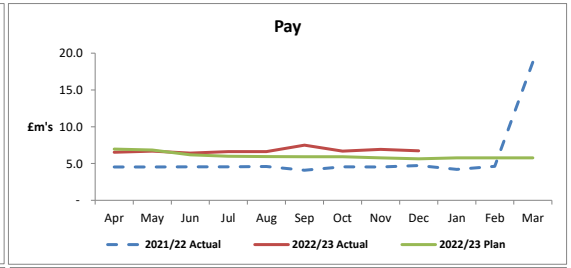
- Non-pay is £0.1m over budget due to drug infusions on Mission EB project (no margin impact as cost is reclaimed from NHSE via ETC process)

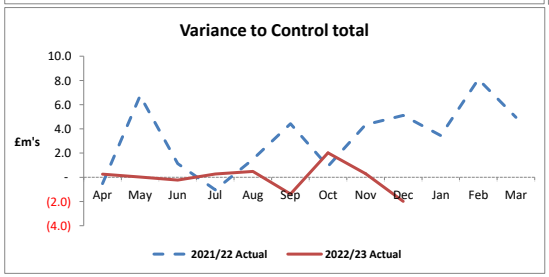
Corporate and Others Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2022

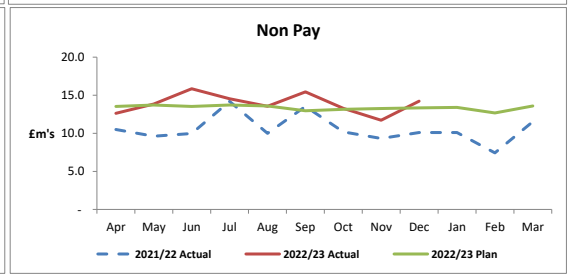
2022/23										2021/22	CY vs PY	
Annual	Income & Expenditure	Month 9				Year to Date				YTD		
Plan	Corporate and Others	Plan	Actual	Variance		Plan	Actual	Variance		Actual		
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%
452.02	NHS & Other Clinical Revenue	37.96	38.28	0.32	0.85%	339.75	350.09	10.34	3.04%	355.00	(4.91)	(1.38%)
(0.00)	Private Patient Revenue	0.00	0.00	0.00	100.00%	0.00	(0.00)	(0.00)		0.00	(0.00)	0%
32.69	Non-Clinical Revenue	2.72	2.36	(0.35)	(13.00%)	24.65	23.87	(0.78)	(3.16%)	18.00	5.87	32.60%
484.71	**Total Operating Revenue**	**40.68**	**40.64**	**(0.03)**	**(0.07%)**	**364.40**	**373.96**	**9.56**	**2.62%**	**373.00**	**0.96**	**0.26%**
(54.70)	Permanent Staff	(4.26)	(6.23)	(1.97)	(46.40%)	(41.43)	(55.64)	(14.21)	(34.28%)	(37.62)	(18.02)	(47.89%)
(3.65)	Agency Staff	(0.26)	(0.14)	0.11		(2.88)	(1.64)	1.24		(1.83)	0.19	10.63%
(14.13)	Bank Staff	(1.13)	(0.35)	0.78		(10.86)	(3.41)	7.44		(1.18)	(2.23)	(188.85%)
(72.48)	**Total Employee Expenses**	**(5.64)**	**(6.72)**	**(1.08)**	**(19.14%)**	**(55.17)**	**(60.69)**	**(5.52)**	**(10.01%)**	**(40.64)**	**(20.05)**	**(49.35%)**
(91.86)	Drugs and Blood	(7.60)	(8.04)	(0.45)	(5.89%)	(69.15)	(73.00)	(3.85)	(5.57%)	(68.45)	(4.55)	(7%)
(9.60)	Supplies and services - clinical	(0.81)	(0.85)	(0.03)	(4.31%)	(7.27)	(7.89)	(0.63)	(8.60%)	(6.48)	(1.41)	(21.76%)
(58.97)	Other Expenses	(4.94)	(5.34)	(0.40)	(8.00%)	(44.36)	(44.17)	0.19	0.43%	(22.49)	(21.68)	(96.42%)
(160.44)	**Total Non-Pay Expenses**	**(13.35)**	**(14.23)**	**(0.88)**	**(6.57%)**	**(120.78)**	**(125.06)**	**(4.28)**	**(3.55%)**	**(97.42)**	**(27.65)**	**(28.38%)**
251.79	**EBITDA (exc Capital Donations)**	**21.69**	**19.70**	**(1.99)**	**(9.16%)**	**188.45**	**188.20**	**(0.25)**	**(0.13%)**	**234.95**	**(46.74)**	**(19.90%)**
(25.27)	Owned depreciation, Interest and PDC	(2.23)	(1.57)	0.66	29.44%	(18.02)	(14.88)	3.15	17.45%	(13.57)	(1.31)	(9.65%)
226.52	**Control Total**	**19.46**	**18.13**	**(1.33)**	**(6.84%)**	**170.43**	**173.33**	**2.90**	**1.70%**	**221.38**	**(48.05)**	**(21.71%)**
(20.99)	Donated depreciation	(1.82)	(1.62)	0.20	10.75%	(15.57)	(14.69)	0.87	5.62%	(12.64)	(2.05)	(16.22%)
205.53	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**17.64**	**16.50**	**(1.14)**	**(6.44%)**	**154.86**	**158.63**	**3.77**	**2.44%**	**208.73**	**(50.10)**	**(24.00%)**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%









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

Notes

NHS & Other Clinical Income

- All NHS income has been centralised. NHS income is predominantly under a block contract. The trust is £10.3m favourable to plan YTD. This is due to significant increases to income for passthrough drugs which offset with expenditure, pay award funding and increase in genomics income.

Pay

- The pay position is £5.5m adverse to plan YTD due to delays in recruitment and pay award higher then planned, in addition higher use of domestic staff.

Non-Pay

- Non pay is £4.3m adverse to plan YTD. This is mainly driven by increase in drugs due to CAR-T (£1.3m) and pass through (£1.6m) expenditure which offsets with income. In addition, due to increase in impairment (£0.2m) and higher EPR costs (£0.7m).

Statement of Financial Position as at 31 Dec 2022

Audited Actual as at 31 Mar 2022		Actual as at 30 Nov 2022	Actual as at 31 Dec 2022	Change in month
£000		£000	£000	£000
	Non Current Assets			
539,298	Property, plant and equipment / Intangibles	531,140	530,016	*(1,124)*
-	Right of Use Assets (IFRS 16)	82,965	84,172	*1,207*
161	Other investments / financial assets	5	5	-
6,941	Trade and other receivables	3,833	6,750	*2,917*
546,400	**Total Non Current Assets**	**617,943**	**620,943**	***3,000***
	Current Assets			
11,712	Inventories	11,854	12,640	*786*
35,723	Contract receivables (IFRS15): invoiced)	43,433	43,581	*148*
7,105	Contract receivables (IFRS15): not yet invoiced)	19,963	20,051	*88*
(6,319)	Allowance for impaired contract receivables	(6,402)	(6,595)	*(193)*
1,516	Receivables due from NHS charities - capital	7,068	7,428	*360*
6,315	Other receivables - revenue	5,970	6,563	*593*
(161)	Allowance for impaired other receivables	(136)	(135)	*1*
-	PDC dividend receivable	-	-	-
5,761	Prepayments	7,177	7,453	*276*
566	VAT receivable	925	1,006	*81*
-	Investments	-	-	-
123,671	Cash and cash equivalents	91,169	88,570	*(2,599)*
185,889	**Total Current Assets**	**181,021**	**180,562**	***(459)***
732,289	**Total Assets**	**798,964**	**801,505**	***2,541***
	Current Liabilities			
(6,864)	Other trade payables - capital	(5,071)	(3,500)	*1,571*
(17,641)	NHS payables - revenue	(12,421)	(11,554)	*867*
(3,237)	Other trade payables - revenue	(3,213)	(2,042)	*1,171*
(5,103)	Other payables	(5,671)	(5,755)	*(84)*
(8,410)	Private Patient Cash on Account	(7,870)	(7,931)	*(61)*
(47,223)	Expenditure accruals	(55,191)	(57,272)	*(2,081)*
(468)	PDC dividend payable	(1,138)	(1,707)	*(569)*
(4,419)	Social Security costs	(4,178)	(4,173)	*5*
(4,081)	Other taxes payable	(3,689)	(3,702)	*(13)*
(4,394)	Deferred income: contract liabilities (IFRS15)	(12,109)	(13,388)	*(1,279)*
(1,917)	Deferred income: other (non IFRS15)	(2,805)	(3,176)	*(371)*
(500)	Lease incentives	(433)	(400)	*33*
(370)	Provisions for liabilites and charges	(357)	(357)	-
-	Borrowings	(2,620)	(2,620)	-
(104,627)	**Total Current Liabilities**	**(116,766)**	**(117,577)**	***(811)***
81,262	**Net Current Assets**	**64,255**	**62,985**	***(1,270)***
627,662	**Total Assets Less Current Liabilities**	**682,198**	**683,928**	***1,730***
	Non Current Liabilities			
-	Borrowings	(21,116)	(22,620)	*(1,504)*
(2,927)	Lease incentives NCL	(2,693)	(2,627)	*66*
(2,440)	Provisions for liabilites and charges NCL	(2,377)	(2,368)	*9*
(5,367)	**Total Non Current Liabilities**	**(26,186)**	**(27,615)**	***(1,429)***
622,295	**Total Assets Employed**	**656,012**	**656,313**	***301***
	Financed by Taxpayers' Equity			
133,468	Public dividend capital	133,468	133,468	-
345,228	Retained earnings	379,100	379,401	*301*
(4)	Financial Asset reserve	(159)	(159)	-
143,603	Revaluation reserve	143,603	143,603	-
622,295	**Total Taxpayers' Equity**	**656,012**	**656,313**	***301***

Notes

Current assets excluding cash at 31 December totalled £92.0m, £2.1m higher than M08). This is largely due to the following:

- Inventories (increased by £0.8m in month) to £12.6m
- Charity Capital receivables (increased by £0.4m in month to £7.4m).
- Other receivables (increased by £0.9m in month).

Current Liabilities at 31 December totalled £117.6m, which is £0.8m higher than the previous month. The movement in month includes the following:

- Capital payables decreased by £1.6m in month.
- Deferred income increased by £1.6m in month.
- Other payables decreased by £0.4m in month.
- Expenditure accruals increased by £2.1m in month.
- NHS payables decreased by £0.9m in month).

- The Property, Plant and Equipment (PPE) and Intangibles balance decreased by £1.5m in December due to capital expenditure of £1.4m, less depreciation of £2.9m.
- NHS Debtor days remained the same as the previous month at 4 days in month and this falls within target of 30 days.
- I&PC debtors days increased in month from 193 to 198. Total I&PC debt (net of cash deposits held) increased in month to £24.0m (£23.8m in M08). Overdue debt increased in month to £21.4m (£20.8m in M08).
- Creditor days decreased in month from 26 to 24 days.
- Non-Drug inventory days increased in month to 80 days (79 at M08).

Statement of Cash Flows for the 9 months ending 31 Dec 2022

	Actual For YTD Ending 31 Mar 2022 £000	Actual For YTD Ending 30 Nov 2022 £000	Actual For YTD Ending 31 Dec 2022 £000	Change in month £000
Cash flows from operating activities				
Operating deficit - excluding charitable capital expenditure contributions	(11,728)	(25,918)	(29,325)	(3,407)
Impairment and Reversals	(6,221)	-	-	-
Charitable capital expenditure contributions	8,052	7,128	7,825	697
Operating deficit	**(9,897)**	**(18,790)**	**(21,500)**	**(2,710)**
Non-cash income and expense				
Depreciation and amortisation	28,358	22,802	25,686	2,883
Impairments and Reversals	6,221	-	-	-
Proceeds on disposal	24	14	34	20
(Increase)/decrease in trade and other receivables	4,514	(27,711)	(28,656)	(945)
(Increase)/decrease in inventories	38	(142)	(928)	(786)
Increase/(decrease) in trade and other payables	(3,610)	2,119	2,315	196
Increase in other current liabilities	1,304	8,302	9,853	1,551
Decrease in provisions	(749)	(76)	(87)	(11)
Net cash inflow from operating activities	**36,100**	**5,308**	**8,216**	**2,908**
Cash flows from investing activities				
Interest received	125	1,115	1,367	252
Purchase of financial assets	(165)	-	-	-
Purchase of property, plant and equipment and Intangibles	(24,109)	(14,570)	(17,394)	(2,824)
	(24,149)	**(13,455)**	**(16,027)**	**(2,572)**
Cash flows from financing activities				
Public Dividend Capital received	1,526	-	-	-
PDC dividend paid	(6,096)	(3,882)	(3,882)	-
Capital element of lease payment	-	(1,537)	(1,745)	(208)
Interest element of lease payment	-	(146)	(164)	(18)
Net cash outflows from financing activities	**(4,570)**	**(5,565)**	**(5,791)**	**(226)**
Decrease in cash and cash equivalents	**(2,516)**	**(32,502)**	**(35,101)**	**(2,599)**
Cash and cash equivalents at period start	**126,187**	**123,671**	**123,671**	**-**
Cash and cash equivalents at period end	**123,671**	**91,169**	**88,570**	**(2,599)**

Notes

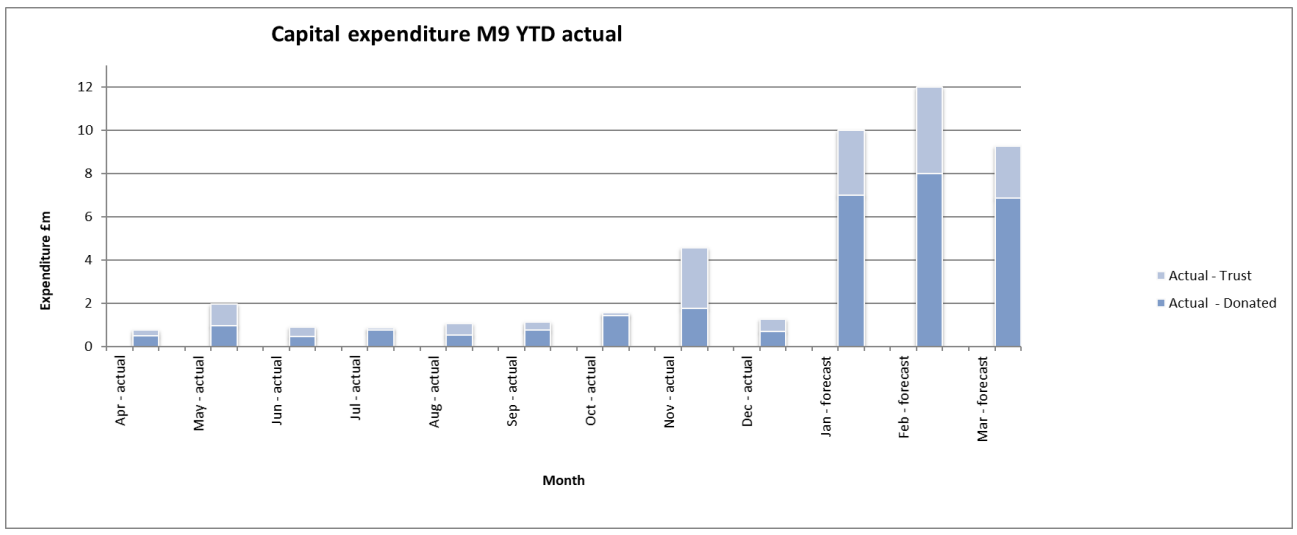
1. The closing cash balance was £88.6m, £2.6m lower than M08.
2. Depreciation charge for the month was £2.9m, which is £0.6m less than plan due to slippage on completion of new assets.
3. In M09, 91% of the total value of creditor invoices were settled within 30 days of receipt; this represented 81% 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.
4. By supplier category, the cumulative BPPC for Non NHS invoices (by number) was 82% (81% in M08). This represented 92% of the total value of invoices settled within 30 days (92% in M08). The cumulative BPPC for NHS invoices (by number) was 48% (46% in M08). This represented 80% of the value of invoices settled within 30 days (79% in M08).

Capital for the 9 months ending 31 Dec 2022

		YTD				Full year 2022/23			
		Plan	Actual	Variance		Plan	Forecast	Variance	
		£000	£000	£000		£000	£000	£000	
Estates and Facilities	Trust-funded	2,960	1,606	1,354	a	3,610	3,286	324	
	Total Estates & Facilities	**2,960**	**1,606**	**1,354**		**3,610**	**3,286**	**324**	
Information Technology	Trust-funded	2,906	3,293	(387)	b	4,492	5,262	(770)	e
	Donated	0	-	0		-	-	-	
	Total IM&T	**2,906**	**3,293**	**(387)**		**4,492**	**5,262**	**(770)**	
Medical Equipment	Trust-funded	400	313	87		5,281	3,828	1,453	f
	Donated	2,211	2,000	211		3,251	3,251	-	
	Total Medical Equipment	2,611	2,313	298		8,532	7,079	1,453	
	Trust-funded	**342**	**-**	**342**		**455**	**455**	**-**	
Children's Cancer Centre	Donated	4,765	4,129	636		7,004	7,004	-	
	Total Redevelopment other	5,107	4,129	978		7,459	7,459	-	
	Trust-funded	**0**	**16**	**(16)**		**-**	**16**	**(16)**	
Redevelopment enabling	Donated	7,599	1,615	5,984	c	19,356	19,356	-	
	Total Redevelopment enabling	7,599	1,631	5,968		19,356	19,372	(16)	
	Trust-funded	**1,141**	**977**	**164**	d	**1,141**	**1,150**	**(9)**	
Redevelopment other	Donated	0	81	(81)		-	79	(79)	
	Total Redevelopment	1,141	1,058	83		1,141	1,229	(88)	
	Total share allocation	**0**	**-**	**0**		**-**	**-**	**-**	
Unallocated	**Enabling works Charity contribution (Trust)**	**0**	**-**	**0**		**-**	**-**	**-**	
Book value of disposals	**Total Trust-funded**	**7,749**	**6,205**	**1,544**		**14,979**	**14,979**	**-**	
Total	**IFRS 16**	**640**	**98**	**542**		**1,872**	**640**	**1,232**	h
	Total Grant funded	**0**	**-**	**0**		**-**	**-**	**-**	
	PDC funded	**0**	**-**	**0**		**-**	**75**	**(75)**	
	Total Donated	**14,575**	**7,825**	**6,750**		**29,611**	**29,690**	**(79)**	
	Grand Total	**22,964**	**14,128**	**8,836**		**46,462**	**45,384**	**(154)**	

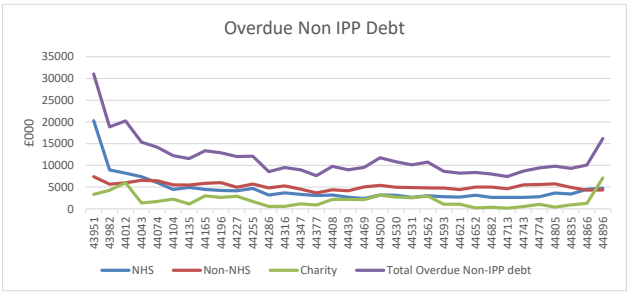
Notes on YTD variance

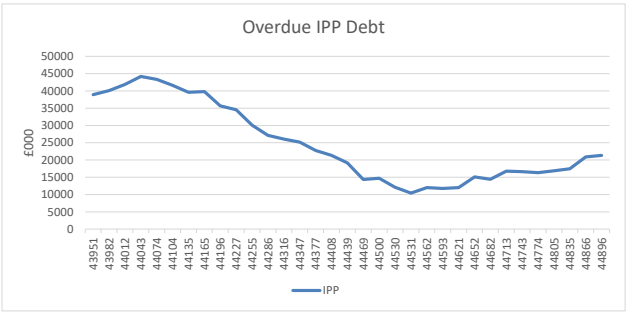
a	Delay to commencement of LV electrical works to Main Nurses Home (£0.3m); lift refurbishment slippage (£0.4m); and other projects.
b	Although some projects have been cancelled, additional projects have been approved and delivered to offset: PACS (£1.1m); Network Intrustion Protection (£0.5m), and deliveries delayed from 21/22 orders
c	Enabling programme has been redesigned to reduce overall expenditure, Southwood works start therefore delayed
d	Electrical infrastructure works delayed due to delayed approval/start (£0.2m)
e	PACS replacement now in Trust funded programme following FIC approval (add £1.2m); several smaller ICT projects reduction in forecast outturn but offset by additional project approvals
f	Spinal navigation system removed from Trust forecast following approval of support by GOSHCC (£1.2m); IR3 and MR1 procurement and installation cannot be achieved in 22/23 (£4.1m). Additional equipment agreed following Ops Board initiative (£3.7m)
g	Unallocated funds
h	PACS replacement removed from IFRS 16 right of use funding following approval in Trust funded programme (£1.2m)

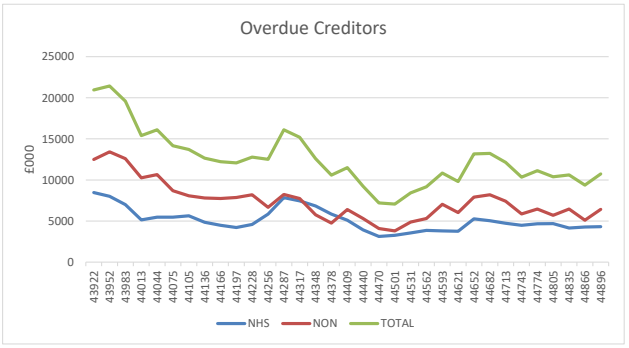


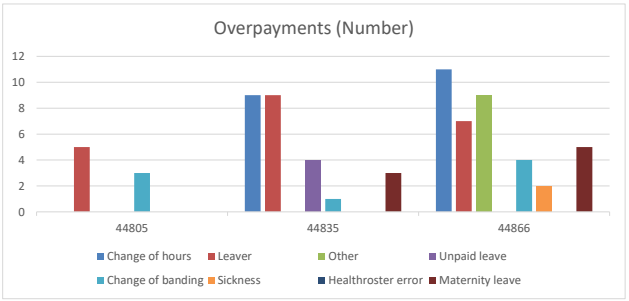
31 Mar 2021 Audited Accounts £m	Capital Expenditure	YTD plan 31 December 2022 £m	YTD Actual 31 December £m	YTD Variance £m	Forecast Outturn 31 Mar 2023 £m	RAG YTD variance £m
6.12	Redevelopment - Donated	12.36	5.82	6.54	26.44	R
1.61	Medical Equipment - Donated	2.21	2.00	0.21	3.25	G
-	ICT - Donated	-	-	-	-	G
7.73	**Total Donated**	**14.57**	**7.82**	**6.75**	**29.69**	R
0.32	**Total Grant funded**	**-**	**-**	**-**	**-**	G
12.05	Redevelopment & equipment - Trust Funded	1.88	1.31	0.57	5.45	A
1.44	Estates & Facilities - Trust Funded	2.96	1.61	1.35	3.29	R
3.17	ICT - Trust Funded	2.91	3.29	(0.38)	5.26	A
-	Contingency/unallocated	-	-	-	0.98	G
(0.74)	Disposals 0	-	-	-	-	G
15.92	Total Trust Funded	7.75	6.21	1.54	14.98	A
0.16	**Share allocation**	**-**	**-**	**-**	**-**	G
	Total IFRS 16	**0.64**	**0.10**	**0.54**	**0.64**	R
1.53	**PDC**	**-**	**-**	**-**	**0.08**	G
25.66	**Total Expenditure**	**22.96**	**14.13**	**8.83**	**45.39**	A

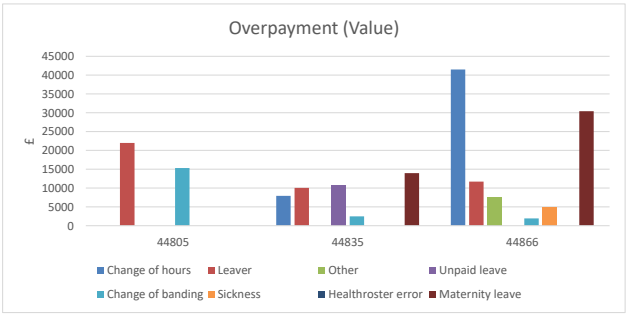
Overdue Debtors and Creditors as at 31 Dec 2022











Overdue Non-I&PC Debt

Non-I&PC overdue debt was £16.1m at 31 December 2022 (£10.1m in M08); of this £4.7m related to NHS (£4.5m in M08), £4.3m related to Non-NHS (£4.3m in M08) and £7.1m related to GOSHCC (£1.3m in M08).
Overdue NHS debtors increased by £0.2m in month. The increase largely relates to invoices becoming overdue in month due from four ICBs which totalled £0.2m. North Central London ICB currently has the largest overdue balance (£0.4m).

Overdue non-NHS debtors remained the same as the previous month at £4.3m.
The debtor with the largest overdue balance is UCL (£0.5m which is £0.4m higher than M08).

Overdue debt with GOSH Charity is £7.1m (£1.3m at M08). The increase relates to invoices in for the Children's Cancer Centre enabling works becoming overdue in month.

Overdue I&PC Debt

Overdue I&PC debt was £21.3m at 31 December 2022 (£20.9m in M08).
Overdue Embassy debt totals £17.3m (£17.0m in M08). This category includes the debtor with the largest overdue balance in both M09 (£6.1m) and M08 (£6.0m).

The total overdue debt due from I&PC other is £0.1m (£0.1m in M08); Insurance companies is £3.0m (£2.8m in M08); and Self funded customers is £0.9m (£1.0m in M08).

Overdue Creditors

Overdue creditors totalled £10.7m at 31 December 2022 (£9.4m in M08). This is made up of amounts due to NHS organisations which totalled £4.3m (£4.3m in M08) and Non NHS organisations of £6.4m (£5.1m in M08).

Overdue Non NHS creditors increased by £1.3m since the previous month.
This is largely made up of amounts becoming overdue in M09 for Sectra (in relation to an IT capital project) £0.9m higher than M08; Playfords Ltd (in relation to work carried out in the Nurses building) £0.1m higher than M08; and Hunter Healthcare Resourcing (in relation to agency staff costs) £0.1m higher than M08.

The 3 Non NHS organisations with the largest balances were Sectra (as mentioned above); UCL (£0.5m which is £0.1m lower than M08 and this relates to invoices for salary recharges and research activity); The Anthony Nolan Trust (£0.4m which is £0.1m higher than last month and their invoices relates to patients tests); and Becton Dickinson UK Ltd (£0.4m which is the same as last month and their invoices relates to the purchase of clinical consumables.

Salary overpayments

There were 29 overpayments identified in month (38 in M08). Of this total, recovery plans have been agreed for 22 individuals (covering 3 - 6 month periods). Three individuals are currently on maternity leave and this will be discussed with the individuals concerned when they return to work.
It is expected that the invoices for the 4 leavers will be raised in January and sent to these individuals.

The overpayments in month totalled £109k (£98k in M08).

The highest number of overpayments related to late notification of change of hours (11 overpayments which totalled £24k) and 7 related to other reasons such as salary advances not recovered (total £11k). The amounts overpaid to staff who have left the Trust totalled £58k (for 4 individuals) and for those which related to late notification of maternity leave totalled £14k (for 5 individuals).

Attachment R

Trust Board 1 February 2023	
Guardian of Safe Working report **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment R**

Aims / summary

This report is the combined Q2 & Q3 report of 2022/23 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1st July to 31st December 2022 inclusive.

Action required from the meeting

- Note changes to the implementation of fines related to submission of exception reports by Trust Grade doctors
- JDF is working alongside the LNC and the Trust regarding the ballot for industrial action.

Contribution to the delivery of NHS Foundation Trust strategies and plans

The Guardian of Safe Working (GOSW) supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.

Financial implications

- Continuing payment for overtime hours documented through the exception reporting practice – extended to non- training doctors

Who needs to be told about any decision?

n/a

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

Dr Renee McCulloch, Guardian of Safe Working, Associate Medical Director: Workforce
Mr Simon Blackburn Deputy Medical Director for Medical & Dental Education

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

Dr Sanjiv Sharma, Medical Director

Attachment R

Guardian of Safe Working Hours Report

Q2 & 3: 1st July 2022 – 31st December 2022

1 Purpose

To inform the board on issues arising relating to the junior doctors working at GOSH and the work of the Guardian of Safe Working (GOSW). The GOSW is directly accountable to the Trust Board.

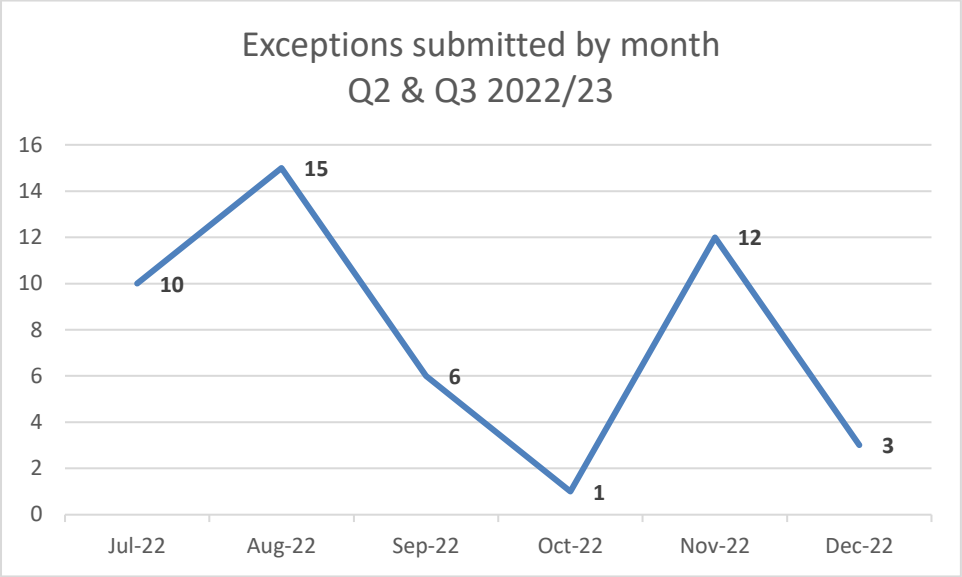
2 Background

See Appendix 1

3 Exception Reporting: High Level Data

3.1 Number of exception reports (ER) at GOSH are generally low reflecting cohort of senior trainees and non-UK Trust doctors alongside poor engagement with ER system

3.2 Average exceptions per month have reduced from Q1 (27.6 per month) to 10.3 per month in Q2 and reduced further in Q3 (5.3 per month). This correlates with the rotational change of doctors.

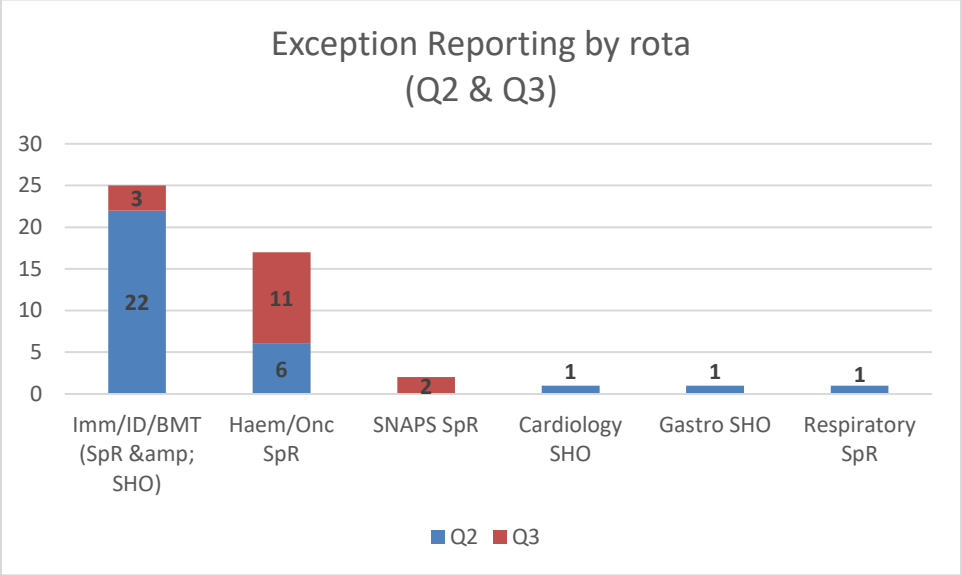


3.3 47 ERs submitted in the period July to December 2022

- 43 ER: extra hours worked.
- 2 Pattern
- 2 Educational

- 23 doctors submitted the reports (22 SPR, 1 SHO)
- 8 doctors reported more than once in the period (1 reported 9 times)
- ER reports across 6 rotas

Attachment R



3.4 Exception report outcomes

Outcome	Outcome
TOIL	11
Payment	30
Fines (all for exceeding 13 hours continuous work on shift)	3
No further action	3
Grand Total	47

- *"No night SHO to handover to. Stayed 1½ hr late to mop up prescribing jobs in advance"*
- *"urology PA is off due to a covid contact …other SHO on annual leave therefore I am covering urology on my own (minimum staffing is 2). ENT locum cancelled for today, therefore I was asked to also cover ENT too"*
- *"Leaving late constantly because of high number of complex patients. Not enough doctors. Ward round starting and finishing late".*

3.4.1 Action:

3.4.1.1 Immunology and Bone Marrow Transplant –increase to establishment from September 2022 should support improvement in rota.

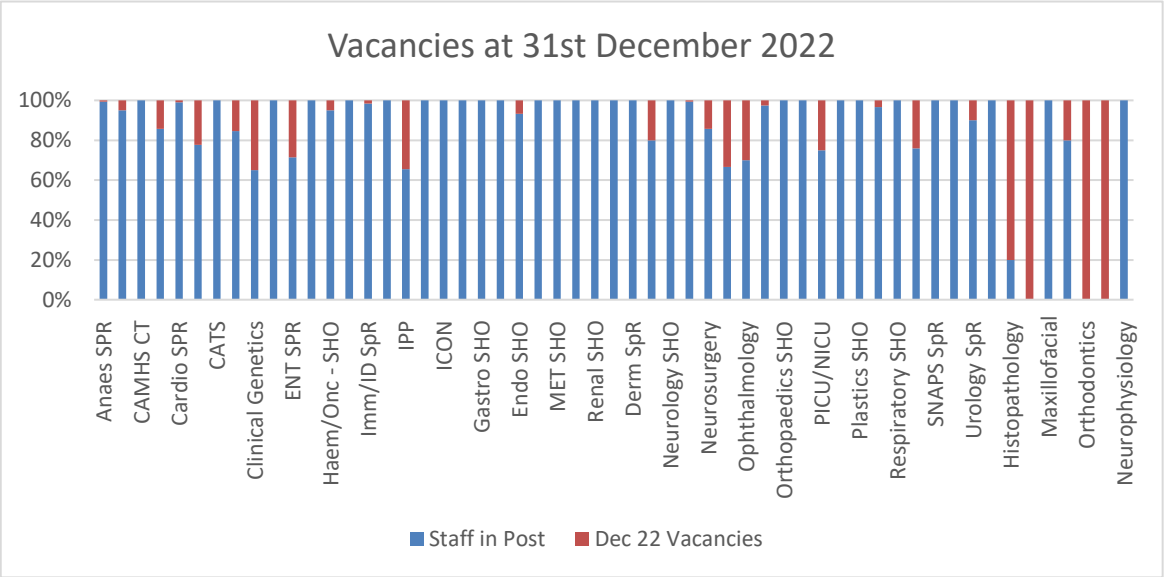
3.4.1.2 Surgical SHO rota has been reconfigured from August 2022 – improved cross specialty cover and increased weekend daytime numbers

4 Vacancy Rates

4.1 The overall vacancy rate across junior doctor rotas as of December 2022 is 36.1 FTE (36.1 FTE vacant). This is an improvement on the Q2 figure (30th Sept 2022 10.7%) but is higher than the Trust average vacancy rate of 7%.

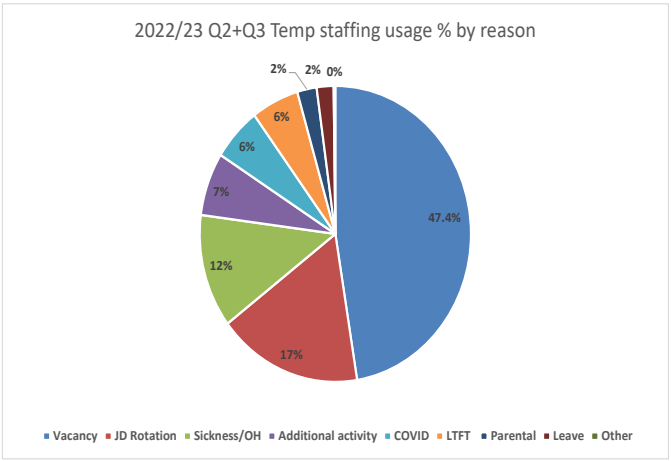
4.2 The Associate Medical Director for Workforce is exploring opportunities to improve the recruitment and onboarding process for Trust Grade doctors.

Attachment R

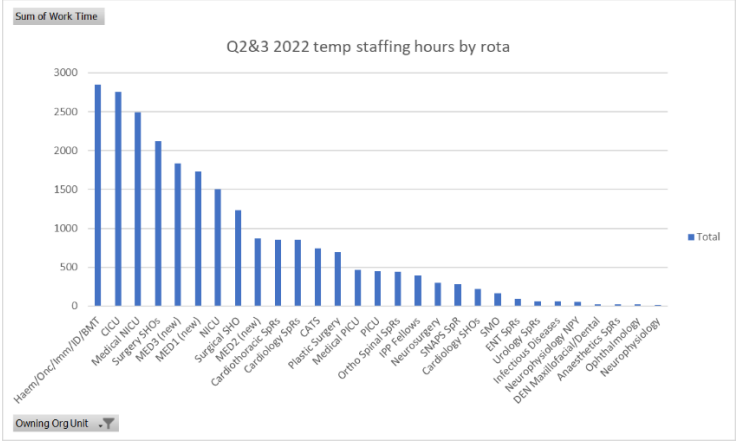


5 Bank and Agency usage

5.1 In the 6 months of Q2 and 3 (July to December 2022), almost half (47.4%) of the temporary staffing hours were due to Vacancy, followed by Junior Dr rotation (17.4%) and Sickness/Occ Health (12.4%)



5.2 The Haem/Onc/Imm/ID/BMT rota was the most frequent rota using temporary staff with 241 shifts filled (an average of 40.2 per month), followed by the Surgery SHO rota with 235 (39.2 average) and NICU (of 226 shift (37.7 average). 16 of the 25 rotas used an average of 10 or less temporary shifts per month.



5.3 When looking at shifts booked in the period, 99.7% of shifts in the period were Bank shifts with 5 Agency shifts booked in the last 6 months.

6 Compliance with 2016 TCS: Implementation of the New Amendments October 2019 – August 2020:

6.1 Rotas are compliant.

6.2 Rest facilities are available: both residential rooms for 24-hour non-resident on call (recently refurbished) and feet-up rest (fold down beds) in multiple quiet areas in the hospital.

7 Extension of breeches attracting a financial penalty broadened to include non-consultant (Trust grade) doctors

7.1 Due to the high proportion of Trust Grade medical staff, it was agreed in October 2022 at the Local Negotiating Committee that exception reports submitted by all doctors (including non-consultant grade doctors) will be eligible for fines if hours are in breach of the 2016 TCS. This intervention recognises the unique demographic of the medical workforce at GOSH, creates an equitable approach and above all improves the monitoring and regulation of safe staffing. Further process to determine fine costings is currently being finalised and teams will be informed of these changes from April 1st 2023.

8 Junior Doctors Forum (JDF).

8.1 JDF are working with the Trust and Local Negotiating Committee regarding the notice to ballot by the British Medical Association related to potential industrial action.

9 Summary

9.1 All GOSH rotas are compliant – challenges continue with respect to vacancy management and unexpected gaps.

9.2 All submitted exception reports will be reviewed for application of potential fines as per the 2016 TCS from 1st April 2023

9.3 Junior doctors are well engaged and working closely with Trust on all matters including potential industrial action.

Attachment R

Appendix 1 Background Information for Trust Board
In 2nd October 2017 all junior doctors in training transferred to the new contract with 2016 Terms & Conditions (TCS).

The 2016 TCS clearly indicate the importance of appropriate working hours and attendance at training and education for junior doctors. Both issues have a direct effect on the quality and safety of patient care.

The statutory role of 'Guardian of Safe Working' (GOSW) was introduced in the 2016 and includes;

- overseeing the safeguards outlined in the 2016 contract
- ensuring that issues of compliance with safe working hours are addressed by the doctors and/or the employer
- facilitating the reporting structures
- overseeing the wellbeing of the junior doctors
- a requirement to provide quarterly reports to Trust board.

Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

Exception reports are submitted electronically by doctors to their educational supervisor. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The outcome of an exception report may be compensation, in the form of time off in lieu or payment for additional hours worked, or an adjustment to the work schedule of the post.

Whilst exception reporting is a mechanism of the 2016 contract for doctors in training, GOSH has elected to extend the use of the system to doctors employed under local (non-training) TCS, in order to encourage safe working practices for all doctors, provide equity and obtain a more comprehensive view of junior doctors working hours across the Trust.

The 2016 contract requires that a Junior Doctors Forum (JDF) is established in every Trust. The JDF primarily represent trainees and offers a forum for addressing concerns pertaining to working hours and conditions and education and training. This is in place and meets every month.

There are 45 different rota patterns currently in place within the Trust.

Publication of Amendments 2016 TCS September 2019:
Context for 2018 contract review

The new junior doctor contract was introduced in England without the BMA's agreement in 2016. The intention of the negotiations on this new contract was to introduce for doctors in training new, improved safe working arrangements, more support for their education and a new modernised pay system. The BMA and NHS Employers agreed during negotiations on this contract to jointly commission in August 2018 a review of its efficacy, to identify any areas for improvement to the contract terms. In 2019 a new referendum of the BMA Junior Doctor membership accepted the 2016 contract, including the amendments that have been negotiated.

Attachment R

TCS contract includes but is not limited the following amendments:

a. Weekend frequency allowance maximum 1:3
b. Too tired to drive home provision
c. Accommodation for non-resident on call
d. Changes to safety and rest limits that will attract GoSW fines.
e. Breaches attracting a financial penalty broadened to include:
    1) Minimum Non-Resident overnight continuous rest of 5 hours between 2200-0700
    2) Minimum total rest of 8 hours per 24-hour NROC shift
    3) Maximum 13-hour shift length
    4) Minimum 11 hours rest between shifts
f. Exception Reporting
    1) Response time for Educational Supervisors - must respond within 7 days. GoSW will also have the authority to action any ER not responded to
    2) Payment must be made within 1 month of agreement or on next available payroll. No extra admin burden should occur
    3) Conversion to pay - 4 week window from outcome agreed to identify a shift before the end of the placement for TOIL to be taken. If this doesn't happen, payment should automatically be given. At the end of a placement, any untaken TOIL should be paid
g. Time commitment and administrative support for GOSW.

Finance and Investment Committee update

The Finance and Investment Committee (FIC) held a formal meeting on Friday 20 January 2023 as well as an extraordinary meeting on 4 January 2023 to discuss the Trust's approach to submitting its 2022/23 forecast to the Integrated Care Board.

Top issues to take away

Children's Cancer Centre

- Following a review of the rationale and evaluation of the risks, the realigned approval timetable for the Children's Cancer Centre Business Case was approved - the timetable allows time for sufficient review and assurance.
- The Business Case will be reviewed and considered for approval at the 8 March 2023 Board to Board meeting with the Charity. Planning was underway for the other GOSH approvals required in advance of this (e.g. the Council of Governors' approval of a 'Significant' Transaction').
- The Committee reviewed the assumptions that underpinned the revenue costs for the Trust when the CCC opens and a 10 year Business As Usual (BAU) position forecast.
- The Committee discussed options for optimising future activity and income, for example: what the CCC enabled for the Trust's waiting list, International & Private Care, options for the decanted space in the hospital, plus: optimisation of energy and costs.
- This will be returned to as a future topic to understand if the construction of the CCC provides potential flexibility to incorporate any new sustainability technologies identidied during the build phase or what the future pipeline of improvements might be.
- Local engagement and work with Camden Council was also discussed as well as the necessary land and funding agreements with the Charity.

Forecast Outturn (FOT) 23/24 submission

- The purpose of the extraordinary meeting on 4 January 2023 was to obtain confirmation that the Non-Executive Directors had reviewed the details of the forecast outturn position for the Trust in line with the NHSE "protocol" guidance.
- The Commitee agreed to the basis of the forecast, however, at the 20 January meeting the CFO provided an update on recent discussions with the NCL FInance teams whereby the forecast outturn position for the ICB would be coordinated into the period 10 financial returns. The Trust continues to work towards delivering its financial year 22/23 budget position.

Planning for 2023/24

- Guidance for planning was issued on 23 December 2022 which was being reviewed by the finance and planning teams. Initial reviews strongly pointed to a system wide focus on productivity.

Other items

Impact of strike on activity

Despite productive work with the unions to minimise the impact on Trust activity, the recent strike activity did have an adverse impact. Although there were signs of recovery, it was noted that as strikes continue, it would become increasingly difficult to recover as quickly.

Finance report Month 8

The Trust's year to date financial position was a £16.4m deficit which was £7.1m adverse to plan. This was driven mainly by delays in the delivery of the Trust Better Value programme, outreach clinics, and commercial income being behind plan.

The Trust Better Value programme has identified £15.9m of the £22.8m target and at month 8 had delivered £9.8m of the £14.3m YTD target.

Integrated Performance Report Month 6

Although the Trust's performance in the activity and constitutional standards remained under pressure, there were several positive movements.

The Committee congratulated the Trust for achievement of the cancer performance standards.

Trust focus was on increasing productivity and the Committee requested a deep dive into utilisation at a future meeting of FIC.

Major projects

The Committee noted progress on all major projects at the Trust.

Annual self-assessment of effectiveness

The Committee agreed to pause the planned effectiveness review given recent changes to Committee leadership and participate in the review of how all Assurance Committees conduct effectiveness reviews next year.

Feedback from Governor observers

Two Governors observed the meeting and provided post-meeting feedback to the Chair and other Non-Executive Directors:

- The questions and areas of probing gave assurance that the hospital was "in safe and capable hands".
- The NEDS were asked how assured they were that the Trust's Better Value (BV) schemes would not have an adverse impact on quality of care or lead to a reduction in scope for the sustainability agenda. The Chair informed the Governors that although QSEAC reviews and monitors better value schemes which provided assurance and oversight on their quality and safety impact; there were no sustainability key performance indicators at present, or a lead assurance committee for their monitoring.
- The NEDS were asked if current contingency plans considered the impact on decanted services if CCC constructions overran. The NEDs informed the Committee that the well-being of decanted services was a priority for them.
- When using the multidirectional camera, some speakers could not be heard. The Chair and Committee facilitator agreed to flag this with speakers and consider other technical solutions.

End

Attachment T

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Audit Committee Meeting held on 20th January 2023

Matters arising - Timeline for delivery of internal audit actions on sustainability

The Board welcomed the improvements that had been made to the quality of Sustainability Programme Board meetings which were now more action focused. The revised timelines for completing the internal audit actions were noted and it was agreed that sustainability would be considered by the Board on a six-monthly basis.

Trust Board assurance committee updates

The Committee noted updates from the following assurance committee meetings:

- Quality, Safety and Experience Assurance Committee – November 2022
- People and Education Assurance Committee - December 2022
- Finance and Investment Committee – November 2022.

Board Assurance Framework Update

The scoring matrix of the BAF had been updated in line with the risk management policy and as a result there were six high risks. A summary of the actions arising from the Board risk management meeting in December 2022 was presented and the Risk Assurance and Compliance Group would be focusing on these actions at its February meeting. The risk statement for BAF risk 14: Culture had been updated as the previous statement had been very time specific. The Committee recommended the updated statement for approval for the Trust Board.

Action: The Trust Board is asked to approve the revised BAF risk statement on Culture. If approved the associated controls and assurances will be updated and reviewed by the People and Education Assurance Committee:

There is a risk that GOSH fails to develop a culture where our people are well led, well managed, supported, developed, and empowered to be their best.

Write offs

Discussion took place about the causes of write offs with other NHS organisations and it was noted that it was often challenging to evidence work that had taken place; this feedback was provided to clinicians. The Committee requested a flow chart of the process.

External Audit 2022/23 Progress update

The interim audit would begin in February 2023 and as in previous years there remained some risk to the audit timetable working towards the year end Audit Committee and Trust Board meetings on 8th June. The Committee agreed that should a delay occur, the accounts would be approved by the Board subject to final approval by the External Audit partner and Audit Committee chair.

Board Assurance Framework Deep Dives:

- BAF Risk 6: Research infrastructure

Discussion took place around the transformation of cancer services and the integration of research in the Children's Cancer Centre and emphasised the importance of developing a cancer strategy. The Committee discussed the use of data as part of research and noted that comprehensive DRIVE business plans were in place to support this work and national conversations were taking place around the value of data. Work was required to move forward with a culture that recognised the co-existence of research and treatment. The Committee emphasised the importance of reducing the barriers to research for clinicians and Allied Health Professionals.

- BAF Risk 8: Business Continuity

A silver command simulation exercise had taken place which enabled the testing of the secondary incident control room. Learning had been identified which was being implemented. The Trust was part of the North Central London and regional emergency planning networks and buddied with another North London Trust to increase resilience.

Risks were managed on a learning basis and where specific issues were raised, subgroups were established. Business continuity plans were currently 97% complaint.

Update on EPIC

GOSH was using a good level of functionality in the Epic system and benchmarked as the leading user in the UK in terms of functionality. The Trust continued to work to optimise the system. Focus was being placed on using Epic to support the Trust's transformation programme and a clinical lead for transformation would be established. It was noted that although the system collaboration with another NCL Trust had realised the financial benefits, the non-financial benefits would take longer than anticipated to materialise.

Internal Audit Progress Report (December 2022 – January 2023) including Financial Sustainability Audit and recommendations update

The outcome of the Data Protection and Security Toolkit had been positive and GOSH was mostly above the standard of other organisations when benchmarked. The Committee welcomed the progress that had been made in the area. All Trusts had been required by NHS England to carry out an internal audit of NHS financial sustainability and the committee noted the checklist had been completed diligently and the Trust had a good level of control.

Counterfraud Update

The functional standard tracker currently showed 7 green and 7 amber metrics. The Trust had a path to green and the committee noted that it was anticipated that a green submission would be made. It was likely that one metric around declarations of interest would remain amber due to the strict requirements of the NHS Counter Fraud Authority however this would not hinder an overall green rating.

Year End Update

The Committee approved the accounting policies and approach to year end and noted that an update on management judgement of key items such as IFRS16 would be considered at the March meeting.

Update on Claims

The sums paid by NHS Resolution on behalf of the Trust were significantly less in 2021/22 than in the previous financial year. There were an increasing number of claims being brought around potential breaches of the Human Rights Act. There was often a delay in resolution of cases whilst children and young people grew older and their needs were identified so that the value of the claim was clear. This did not impact the workload of the legal team as this was managed externally.

Audit Committee Effectiveness Survey – an update

The Committee agreed that an effectiveness survey of the Audit Committee would not be undertaken in 2022/23 because of recently appointed new NED Committee members. A review of the Terms of Reference would be undertaken to ensure they were aligned with external guidance.

Attachment T

Update on revision to Whistle- blowing process

The whistleblowing process was being reviewed but had been delayed by the resources required around the strikes.

Governor feedback

Governors welcomed the robustness of the conversation during the meeting. Discussion took place around the management of the risks around the staff strikes and the ability of Trusts to influence the resolution of strike discussions with government.

Attachment U

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the People and Education Assurance Committee held on 07 December 2022

The Committee noted the summary from the Quality, Safety and Experience Assurance Committee, Finance and Investment Committee and Audit Committee held in November 2022.

Focus of Meeting
People and Education Assurance Committee meetings now focus on a specific theme. The focus of this meeting was **Culture and Engagement** as part of the People Strategy.

People Strategy Update
The Committee was provided with an update on all areas of the People Strategy. It noted that the majority of activities undertaken over the last quarter had been focused on the upcoming strike action and staff's health and wellbeing. Other areas of progress included the debiasing recruitment programme with the launch of a toolkit. The staff recognition scheme and the 'Thank You' week which launched in September and the consolidation of financial wellbeing support for staff.

The current People Strategy is nearing the end of its third year it will be refreshed over the next quarter. The context for GOSH has changed considerably over the last 3 years and the activities prioritised in the Strategy going forward will reflect this.

The staff survey closed on 30 November 2022, there was a lower response rate to last year which is consistent with the downward trend expected across the whole NHS.

Leadership and Development
The Committee received an overview on the current leadership and management development offering from the GLA with a summary of the evaluation and impact of the programmes. In early 2023 a full review of non-clinical specific leadership programmes will be conducted to understand current needs and challenges and the review's output will feed directly into adjusting existing programmes or the development of new programmes and pathways. The Committee recognised the importance of maximising the impact of the programmes and supporting those participating into becoming leaders of the future.

Future developments of Speaking Up
The Committee was updated on the progress of embedding the new National Speaking Up policy into GOSH's own local policy. It is important that the revised policy makes it clear for staff to understand all the different processes available for speaking up which have sometimes been confused in the past. The finalised policy will be brought to the Committee.

Staff Voice: Union Representatives
The Committee welcomed Nerrine Brown, Brand Secretary for Unison and Medical PA and Christine Pierce, Chair of the Local Negotiating Committee (LNC) and Intensive Care Consultant on the Paediatric Intensive Care Unit.

Nerrine explained she her role as the main link between GOSH and the National Unison Office, she is also Chair of the Staff Partnership Forum. She meets regularly with members and looks at a lot of cases; whilst her roles require a lot of prioritisation, she felt supported by her managers and is given protected time for her Unison role.

In recent weeks Nerrine has been giving a lot of support ahead of the nurse strike action. Whilst the strike is being run by the Royal College of Nursing (RCN), as it is their first national strike Unison have been supporting with the planning and helping staff with their queries.

The Committee also heard how Nerrine led on the insourcing of domestic services and their harmonisation earlier this year. It was a huge project that required GOSH and the Unions to work together very closely and it is ongoing, with HR, the Unions and Estates colleagues meeting regularly.

Christine explained that her role as LNC Chair is to engage with consultants and doctors across the Trust and make sure they know when meetings are taking place and receive the minutes afterwards. Christine felt that engagement has increased as more staff are now interested in aspects such as pensions, retirement and returning and junior doctor locum rates.

With Nerrine and Christine the Committee discussed a number of issues that are impacting on staff such as the cost of parking and hot meals and also recognised that staff morale has decreased due to the difficult circumstances of both the pandemic and now the economic crisis.

Annual report on the relations with staff partners and union representatives
The Committee received a report which detailed the key areas of partnership working with Staff Side and Trade Unions over the last 12 months.

Whistleblowing Update
The Committee heard how a number of issues are being raised as whistleblowing concerns when they are in face related to people management and a breakdown in relationships. This highlighted the importance of ensuring there is a clear definition of Whistleblowing within the revised Freedom to Speak Up policy, so it is clearer for staff.

Update on the Board Assurance Framework (BAF)
A review of all BAF risks had been conducted by the Risk Assurance and Compliance Group (RACG) and the Committee received an update on the four BAF risks over which PEAC has oversight, namely workforce sustainability, service transformation, culture and the GOSH learning academy. The Committee was content for the wording of the revised Culture risk to be presented to the Annual Risk Management meeting for approval. The Committee noted that RACG will consider lowering the risk score for the GOSH Learning Academy following the recent success of securing ongoing funding from the GOSH Charity.

Deep Dive of BAF Risk 2: Workforce Sustainability
Discussion took place on consultant recruitment and whether this had been impacted by BREXIT. The Committee was told that recruitment of EEA Nationals remains possible in principle and the process relatively straightforward.

The Trust continues to look at different options to support the recruitment of International staff, particularly options used in North America and Australia to attract talented individuals in a competitive market ensuring GOSH is able to keep its own identity.

The Trust continues to work on supporting staff through performance reviews and using these as a supportive welfare check. Whilst the Trust has a low vacancy and turnover rate the trust would like to improve their exit questionnaires so they can identify any themes arising from those staff who are leaving.

Workforce Metrics Update
The Trust has six key workforce metrics and in October achieved and exceeded target against four (vacancy, turnover, agency spend and statutory and mandatory training). There was an increase in voluntary turnover in the last quarter. Whilst this is still below target it is the highest since July 2022 and is expected to increase over the next month. Sickness absence remains above target at 3.5% but is considerably lower than the national average. PDRs continue to be below target but almost all directorates are achieving over 80%.

Nursing Workforce Assurance Report
The Committee received and noted the report.

Lone Worker Update
The Committee heard that the Trust has processes in place proactively to manage staff who are lone workers, but the challenge is ensuring that staff are aware of them. The Health and Safety Team is planning to conduct the next Lone Worker Audit in January and February 2023 and it is hoped that there will be improved results from last year's audit. The audit will be presented at the Health and Safety Committee where any actions identified will be monitored.

Internal Audit Update
The Committee received the People Planet Internal Audit and confirmed that it had received an overall assurance rating of 'significant assurance with minor improvement opportunities' which was in line with management expectations. The audit will be used to help inform the refresh of the People Strategy by understanding the areas of good practice and learning from the actions.

PEAC Effectiveness Survey 2022
The Committee received the proposed questions for the annual survey and was asked to feedback any comments. The survey will be issued later this month and the results presented to the Committee at its next meeting.

Attachment V

Great Ormond Street Hospital for Children
NHS Foundation Trust

Summary of the Council of Governors' meeting held on 9th November 2022

Declarations of interest – Register of Governors' Interests

The Council noted the register of Governors' interests and the importance of ensuring that declarations were up to date given the upcoming vote on a significant transaction.

Matters arising

Discussion took place around the upcoming strike action which had been called by the Royal College of Nursing. Governors emphasised the importance of maintaining critical services and flow through the hospital as much as possible to support these critical services. It was noted that the Trust would work hard to ensure that the required services were derogated and would continue. Governors also highlighted potential tension which could arise between striking and non-striking colleagues and the importance of managing this.

Governor requested item: Update on staff welfare, satisfaction and retention

Work on the People Strategy had been accelerated. Work was taking place with staff networks and Citizen's Advice. A hardship fund for staff had also been established.

CQC and the new Single Assessment Framework

A single assessment framework would be introduced by the CQC in 2023 and would focus on quality statements which were articulated from the point of view of patients and families. The Trust had moved to a focus on 'being a good hospital everyday' rather than preparing for inspections. Governors welcomed this change and welcomed the inclusion of sustainability in the inspection process.

Children's Cancer Centre (CCC) Programme Update

Governors had undertaken a walk round of the existing estate for cancer services and the footprint of the Children's Cancer Centre and had noted that the case for change was clear. Focus was being placed on the balance between optimising the sustainability of the building and ensuring that the building was completed in an efficient timeframe given the significant inflationary pressures. Discussion took place around the fundraising and Governors expressed some concern about the impact of the external environment on the ability to fundraise, however they noted that good progress had been made so far. Governors emphasised the importance of maintaining the quality of care of existing services during the build and giving staff sufficient notice of the requirement to decant where required.

Chief Executive Report

Activity levels were high and staff were experiencing the Trust as very busy and Governors welcomed the work to ensure that a balance was struck between treating the backlog of patients and maintaining staff wellbeing. There had been an increase in complaints and PALS contacts and a theme had arisen around transport. Focused work had taken place in this area and the number of complaints was reducing as a result.

- Finance Report (August 2022 data)

The Trust was continuing to deliver an overall deficit and work was taking place to identify and invoice all activity which was delivered outside the block contract. International and Private Care (I&PC) had made excellent progress to increase their activity.

Attachment V

Update from the Young People's Forum (YPF)

The first in-person meeting had taken place following the pandemic and the forum had elected a new Chair and Vice Chair. A YPF podcast had been developed with the support of the play team.

Reports from Board Assurance Committees

The Council noted updates from the following assurance committees:

- Quality, Safety and Experience Assurance Committee (November 2022)
- Audit Committee (November 2022)
- Finance and Investment Committee (September 2022)
- People and Education Assurance Committee (September 2022)

GOSH Chair Recruitment Process

The process would be led by the Senior Independent Director and had been recommended for approval by the Council of Governors' Nominations and Remuneration Committee. It was agreed that reference to the integrated care system and partnerships would be strengthened and subject to this amendment the Council approved the Terms and Conditions, appointment process and timetable for the Chair recruitment.

Review of Constitution and Trust Board Standing Orders

The Council approved the proposed changes to the constitution and standing orders.

Governance Update

The Sustainability Working Group had met and discussed the governance structure and programmes of work. The Constitution Working Group had agreed that all actions arising from the Council of Governors' effectiveness review were now closed. A proposal to streamline the process of buddying between Governors and Non-Executive Directors would be discussed outside the meeting.

Update from the Membership Engagement Recruitment and Retention Committee

Discussion had taken place about recruitment activity in the areas where additional members were required and work would be taking place with staff networks to support this activity. The Council approved an amendment to the MERRC Terms of Reference to reduce the quorum given the reduction in MERRC members.

Non-Executive Director Appraisals

The Council approved the outcome of the NED appraisals.

Any other business

Governors requested a staff story at Council of Governors and a tour of the sight and sound building.