Meeting of the Trust Board
Thursday 8 June 2023

Dear Members

There will be a public meeting of the Trust Board on Thursday 8 June at 2:45pm held in the Charles West Room, Barclay House, Great Ormond Street.

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**2:45pm**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	**Minutes of Meeting held on 30 March 2022**	Chair	**M**	
3.	**Matters Arising/ Action Checklist**	Chair	**N**	**2:50pm**
4.	**Patient Story**	Chief Nurse	**O**	**2:55pm**
5.	**Chief Executive Update**	Chief Executive	**P**	**3:10pm**
	ANNUAL REPORT AND ACCOUNTS			
6.	**Quality Report 2022/23**	Chief Medical Officer	**Q**	**3:20pm**
7.	**GOSH Foundation Trust Annual Financial Accounts 2022/23** **and** **Annual Report 2022/23 Including:** ○ **the Annual Governance Statement** ○ **the assurance committee annual reports** ○ **Draft Head of Internal Audit Opinion** **Draft Representation Letter**	Audit Committee Chair Including Chief Finance Officer Company Secretary	**R**	**3:30pm**
8.	**Compliance with the NHS provider licence – self assessment 2022/23**	Company Secretary	**S**	**3:50pm**
	PERFORMANCE			
9.	**Integrated Quality and Performance Report – Month 1 2023/24**	Chief Operating Officer/ Chief Medical Officer/ Chief Nurse	**T**	**3:55pm**
10.	**Month 1 2023/24 Finance Report and update on GOSH 2023/24 Budget**	Chief Finance Officer	**W**	**4:10pm**

11.	**Nursing Workforce Assurance Report** **Nursing Establishment Review**	Chief Nurse	**X** **Y**	**4:20pm**
	ASSURANCE			
12.	**GOSH Staff Survey Results / Action Plan 2022**	Director of HR and OD	**Z**	**4:35pm**
13.	**Annual Reports** • **Annual Health and Safety and Fire Report 2022/23** • **Guardian of Safe Working Report Q4 2022/23 and Annual Report 2022/23** • **Freedom to Speak Up Guardian Annual Report 2022/23**	 Director of Space and Place Guardian of Safe Working Chief Medical Officer	 **1** **2** **3**	**4:45pm**
	GOVERNANCE			
14.	**Board Assurance Committee reports** **Audit Committee update – March 2023 meeting and June 2023 (verbal)** **Quality, Safety and Experience Assurance Committee update – March 2023 meeting** **People and Education Assurance Committee – May 2023 meeting** **Finance and Investment Committee – March 2023 and May 2023 meetings**	 Chair of the Audit Committee Chair of the Quality and Safety Assurance Committee Chair of People and Education Assurance Committee Chair of Finance and Investment Committee	 **4** **5** **6** **7**	**5:00pm**
15.	**Council of Governors' Update – April 2023 and May 2023**	Chair	**8**	
16.	**Register of Seals**	Company Secretary	**9**	**5:15pm**
17.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			**5:20pm**
18.	**Next meeting** The next confidential Trust Board meeting will be held on Thursday 6 July 2023 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			

Attachment M

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 30th March 2023

Present

Sir Michael Rake	Chair
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
Suzanne Ellis	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
Jason Dawson	Director of Space and Place
Prof David Goldblatt	Director of Research and Innovation
Dr Shankar Sridharan	Chief Clinical Information Officer
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Prof Andrew Taylor	Director of Innovation
Prof Neil Sebire	Chief Research Information Officer
Claire Williams*	Head of Patient Experience
Dilys Addy	Governor (observer)
1 member of GOSH staff	

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

186	**Apologies for absence**
186.1	No apologies for absence were received.
187	**Declarations of Interest**
187.1	No declarations of interest were received.
188	**Minutes of Meeting held on 1 February 2023**
188.1	The Board **approved** the minutes of the previous meeting.
189	**Matters Arising/ Action Checklist**
189.1	Actions taken since the previous meeting were noted.

190	**Chief Executive Update**
190.1	Matthew Shaw, Chief Executive said that staff strikes had been having a significant impact on the Trust both in terms of the strikes themselves and the resources required for planning and recovery. There had been a challenging context for staff completing the staff survey and there had been a reduction in scores across the NHS. Matthew Shaw said that it was important to ensure that a greater impact was achieved from action being taken to support staff wellbeing.
190.2	It would be Professor David Goldblatt's last Trust Board meeting before leaving the Trust after 20 years. Matthew Shaw thanked him for his work to further research at the Trust and bring substantial impact to patients.
191	**Feedback from NED walkrounds**
191.1	Suzanne Ellis, Non-Executive Director said that she had visited the physiotherapy team which had been positive. The team had a relatively new environment however they had expressed concern about the Children's Cancer Centre decant as their location remained unresolved. There were particular anxieties about their large gym area, offices and staff room and staff felt that this had led to a feeling of a lack of belonging.
191.2	**Action:** A key issue raised had been about the heavy fire doors on the way to the service which were not automatic. Matthew Shaw said that whilst this would be rectified in the Children's Cancer Centre, it was important that the current access was improved to ensure that patients with limited mobility had equal access.
191.3	Suzanne Ellis said that risk management had been discussed with the team and they had explained how the function worked in practice in the service. Consideration had also been given to a more deliberate use of volunteers.
191.4	Amanda Ellingworth, Non-Executive Director said that the team had been particularly positive about the artwork in their area which had been important for staff and patient wellbeing.
191.5	Kathryn Ludlow, Non-Executive Director said that she had visited the laboratories and had met with a senior member of staff who have been with the Trust for 22 years. She said some of the samples tested were for GOSH patients, but a large number were also for patients around the world. She said that staff had been positive overall but had raised concerns about only one drinking water tap being operational in the building and issues around removal of waste. They had also expressed concern about access to the mortuary for undertakers during the Children's Cancer Centre development.
191.6	Chris Kennedy said that there were a number of lower banded members of staff in the service who were suffering financial hardship due to the cost-of-living increase. He said that the team had discussed Epic and its integration with the specialist equipment used in the service.
192	**Patient Story**
192.1	Claire Williams, Head of Patient Experience presented a patient story via pre-recorded video. Zakiriya, aged 5 had been a patient at GOSH since he was three months old and had been under the care of multiple specialities and undergone

	multiple procedures. The complexity and rarity of Zakiriya's condition led to him and his family receiving support from the SWAN (Syndromes Without A Name) team at GOSH. Zakiriya's mum Ayesha said that it was extremely difficult to have an undiagnosed illness and it was particularly difficult to understand the way forward for Zakiriya and to be able to discuss this with clinicians. Ayesha said this had felt very isolating but the SWAN team had provided invaluable support. The team knew Zakiriya well and Ayesha said that she could rely on them to explain his condition to others. The team was supportive in coordinating complex care and had helped with the arrangements which ensured that Zakiriya was accepted into a hospice as well as following up with teams and about appointments.
192.2	Kathryn Ludlow asked how many people were in the SWAN team and Claire Williams said that whilst there was currently only one team member, funding had recently been secured for an additional post.
192.3	Sir Michael Rake highlighted that there were a large number of GOSH patients who were under many different teams. He asked how these patients and families were supported to navigate their complex care and Amanda Ellingworth said that this had been an important consideration for some time. Sanjiv Sharma, Chief Medical Officer said that along with the HDU options appraisal and access, this was a key project. He added that once the HDU project was complete, work would begin on complex care.
192.4	Suzanne Ellis said that the SWAN nurse had been instrumental to Ayesha's experience at GOSH and added that it was important to ensure as far as possible that roles such as these had low turnover rates.
193	**Research and Innovation at GOSH**
193.1	<u>Update on research and progress with the Research Planet</u>
193.2	Professor David Goldblatt, Director of Research and Innovation gave a presentation about the changes in research at GOSH since he joined the Trust in 2003. There had been substantial growth in the team from 3 to 45 staff members and a joint research strategy had been established between the hospital, GOSH Charity and GOS UCL Institute of Child Health. There had also been a significant increase in the number of papers published and citation impact which was critical in terms of charity fundraising.
193.3	<u>Update on Innovation at GOSH</u>
193.4	Professor Andrew Taylor, Director of Innovation and Neil Sebire, Chief Research Information Officer gave an overview of the outcomes of the areas within the innovation directorate including cell and gene therapy and DRIVE and the work to build commercial partnerships. Suzanne Ellis congratulated the team on their data journey. She said that it was important to ensure that outcomes over the next 12 months were tangible by formalising some of the KPIs to ensure that progress could be monitored. Andrew Taylor said that discussion at the digital strategy group was around ensuring there were tangible benefits.
193.5	Russell Viner asked whether there were sufficient skills within the hospital to take the work forward and Andrew Taylor that this was currently a challenge. Neil Sebire, Chief Research Information Officer said that there was a national issue around the availability of data scientists and clinical informaticians which was a key clinical role in the United States but was not sufficiently developed yet in the

	UK. He said that within the next decade every leading hospital internationally would have established a clinical informatics unit however there were currently issues with developing the required skills. He said that the data scientist role was not part of agenda for change and there was little career pathway within the NHS which made retention challenging. Amanda Ellingworth said that it would be important to advocate for a national solution.
193.6	Chris Kennedy noted that a visit had taken place to a hospital in Israel which was at the forefront of digital innovation and asked how the partnership was moving ahead. Andrew Taylor said that a Memorandum of Understanding (MOU) was in place but, as importantly, the hospital in Israel had shown that GOSH's aspirations were achievable within an achievable budget. He added that it was important to consider the financial vehicle within which the Trust could take this forward and how this could be developed, and this was being explored with the GOSH Charity. Neil Sebire said that GOSH had an excellent data platform and it would be important to capitalise on this.
193.7	Chris Kennedy asked how far GOSH had progressed with its research hospital aims and David Goldblatt said that the programme was ambitious and involved ensuring that all patients and families had an understanding of research, and all appropriate children and young people were enrolled on a trial. He said that for research treatment to be routine, skills were also required on the wards.
194	**Update on GOSH Annual Plan 2023/2024**
194.1	John Beswick, Chief Finance Officer said that the Board had approved the annual plan for 2023/24 and had agreed delegated authority to the Finance and Investment Committee to review and approve any amendments required as a result of updated guidance from NHS England. Chris Kennedy said that the Board was clear that it was a stretch plan.
194.2	Matthew Shaw said that he was appreciative of the collaborative working with the Integrated Care Board to find a solution to a technical issue with GOSH's funding. John Quinn, Chief Operating Officer said that the activity targets set out in the plan were also stretch targets.
195	**Integrated Quality and Performance Report - Month 11 (February 2023 data)**
195.1	John Quinn said that although quality and performance metrics were broadly strong, there were challenges around access and the focus for 2023/24 would be on long waiting patients. A plan had been submitted to NHS England to reduce the number of patients who had waited 65 weeks and the Trust was working on a previously submitted plan to reduce 78 week waits.
195.2	Suzanne Ellis said that the Board had previously discussed the national targets around follow up appointments and had agreed that this would not be in the interests of many GOSH patients. She asked how this would be taken forward and John Quinn said that the target would not be implemented as a Trust policy but would work would take place to reduce follow ups where appropriate.
195.3	Sanjiv Sharma said that the most recent PICANET report had been published for on 9th March 2023 covering data from 2019-21 and had shown that GOSH ICU risk adjusted mortality continued to be within the expected range. He said that the key priorities for the patient safety team were the upgrade of the incident

	reporting system and the introduction of learning from patient safety events (LFPSE) and the patient safety incident response framework (PSERF).
195.4	Kathryn Ludlow highlighted the increase in staff turnover and Tracy Luckett, Chief Nurse said that it was important to monitor this and to consider ways in which retention could be improved.
195.5	Sir Michael Rake noted the significant work that had taken place to manage the ongoing strikes and thanked executives and their teams.
196	**Finance Report - Month 11 (February 2023 data)**
196.1	John Beswick said that the financial outturn of month 11 was in line with plan and a strong recovery had been made in International and Private Care leading to a £6.2million surplus to plan. The Trust continued to forecast that the year-end outturn would be in line with the plan of £10.6million deficit. Sir Michael Rake noted that the cash balance remained strong.
197	**Learning from Deaths report- Child Death Review Meetings – Q3 2022/23**
197.1	Sanjiv Sharma said that holding child death review meetings was often complex for GOSH patients and a result of the large geographical reach of patients and the requirement for all healthcare professional involved in their care to be involved.
197.2	Eighteen child death review meetings had taken place in the reporting period of which 6 cases had identifiable factors around practice and quality. Themes were around conversations with families around end on life. He said that given the patient story which had been received at the last meeting had similar themes, it was important to support teams to have good quality conversations.
197.3	Suzanne Ellis noted that 19 of 34 delays to child death review meetings were because of consultant scheduling and said that this was high. Sanjiv Sharma agreed that said that this was a clear professional obligation for consultants. He added that there were areas in which engagement had been poor and this was being managed.
197.4	Russell Viner said that there had been a national increase in mortality following the COVID19 pandemic and asked whether this increase had also been identified in children. Sanjiv Sharma said that there had not been an increase at GOSH and whilst the overall numbers were small, they did constitute a substantial proportion of paediatric deaths nationally.
198	**Nursing Workforce Assurance Report**
198.1	Tracy Luckett said that the Trust continued to be in a good position in terms of nursing vacancy rates however as discussed there had been a continued slight increase in staff turnover. She said that this was in line with that of other organisations however it was important to focus on reducing turnover and consideration was being given to launching a project in this area.
198.2	There had been an increase in the acuity of patients, but teams had also experienced newly qualified nurses with a lack of confidence in their practical skills after training. Training had been disrupted by the COVID19 pandemic and

	practice educators were present on wards but were reporting that this was becoming challenging. Tracy Luckett said that GOSH's workforce was the youngest nationally and this led to a different set of requirements and culture. She said that work was also taking place to identify people's reasons for remaining at GOSH.
198.3	Chris Kennedy asked how improvements had been made in International and Private Care staffing which had previously been challenging and Tracy Luckett said that there was good new leadership in the area and international recruitment had been successful.
199	**Staff Survey Results 2022**
199.1	Matthew Shaw said that GOSH's staff survey results had deteriorated, and it was important to be open to exploring the reasons for this and to identify updates which could be made to the staff wellbeing plan to prioritise the support that was being provided and achieve impact. He said that it was important to engage a much broader section of the workforce and discussion about this would begin at the next Executive Management Team meeting.
199.2	Caroline Anderson, Director of HR and OD said that whilst the results were disappointing, she felt it was an accurate reflection of the Trust's current position. She said that it was important to consolidate the existing staff wellbeing initiatives and focus on a smaller number of high impact areas, particularly around behaviour and values.
200	**Board Assurance Committee reports**
200.1	<u>Quality, Safety and Experience Assurance Committee update – January 2023 and March 2023 meeting</u>
200.2	Amanda Ellingworth, Chair of QSEAC said that the most recent meeting had taken place on 29th March and had shown evidence of the work that GOSH was doing to become proactive in terms of safety. Updates had been made to the way in which papers had been written to better interrogate the data and support the identification of themes and systemic issues.
200.3	An options appraisal was taking place of HDU care in the Trust and good clinical engagement had been established.
200.4	A disappointing internal audit report had been received on the harm review process which had provided a rating of partial assurance. This was being followed up by the executive team and an audit process would be implemented to ensure that the harm review process had been embedded across specialties.
200.5	A very positive report had been received from the Trust's authorising fire engineer and good progress had been made on safer sharps.
200.6	<u>Finance and Investment Committee Update – February 2023</u>
200.7	Suzanne Ellis, Chair of the Finance and Investment Committee said that said that the committee had discussed the monthly and year-end financial outturn as well as the plan for 2023/24. She said that the linen contract had also been reviewed and the preferred bidder recommended to the Board.

200.8 200.9 200.10 200.11	<u>Audit Committee Assurance Committee Update – March 2023 meeting</u> Gautam Dalal, Non-Executive Director said that a large proportion of the meeting had focused on the Board Assurance Framework and the committee had agreed the wording of a risk around GOSH's operation as part of an integrated care system. It had also been agreed that the information governance risk would be removed from the BAF and would continue as a Trust Wide Risk. A Root Cause Analysis was being undertaken into two power interruptions and the committee received an interim report on this. Learning so far was around ensuring that up to date planned preventative maintenance was in place and moving forward with the Computer Aided Facility Management system. A deep dive had also taken place into the cyber security risk and the committee had agreed to ask the Trust's internal auditors to review GOSH's penetration testing arrangements. <u>People and Education Assurance Committee Update – February 2023 meeting</u> Kathryn Ludlow, Chair of the PEAC said that a verbal update of the same meeting had been presented at the last Board meeting and a written update was now included in the papers.
201	**Council of Governors' Update – February 2023 meeting**
201.1	Sir Michael Rake said that the Council of Governors continued to be a constructive and supportive group. Since the last Board meeting the Council had approved the significant transaction for the Children's Cancer Centre. They were keen to ensure that the Trust continued to make progress with its sustainability targets and had requested a session with Russell Viner, Non-Executive Director on research at GOSH.
202	**Update on Board Assurance Framework**
202.1 202.2 202.3 202.4	Anna Ferrant, Company Secretary said that the Audit Committee had reviewed the wording of three new risks and had recommended the wording to the Board for approval: • Integrated Care System (ICS) • Climate health emergency • Mental health services **Action:** Amanda Ellingworth said that it was important to be clear that GOSH was a collaborative partner in the ICS and it was agreed that the wording would be further updated to reflect this. Subject to the above amendment, the Board **approved** the wording of three new risks. The Board **approved** the proposal to remove the Information Governance risk from the BAF as recommended by the Audit Committee and noted that it would become a Trust wide risk.
205	**Declarations of Interest and Gifts and Hospitality Register**
205.1	Anna Ferrant said that the Trust had 829 active decision-making staff who were required to make a positive or nil declaration about their interests at least annually as a result of their influence on spending tax payers' money. There were currently

	23 staff who were yet to make their declaration and therefore there was 97% compliance for 2022/23. Sir Michael Rake said that it was important that staff were committed to transparency and made their declarations and Matthew Shaw said that for consultants this was also required by the GMC.
205.2	The Board **noted** the Board members' register of interest.
206	**Compliance with the Code of Governance 2022/23 and update on the new Code of Governance**
206.1	Anna Ferrant said that a review had taken place of the Trust's compliance with the current Code of Governance (2014) which provided a set of principles and provisions against which Foundation Trusts were required to report compliance in their annual report on a 'comply or explain' basis.
206.2	A revised Code of Governance would apply from April 2023 and a comparison review had taken place to identify the changes between the two codes. Several changes had been made, primarily in light of the new NHS landscape and giving greater emphasis to equality, diversity and inclusion.
206.3	The Board reviewed the evidence and **approved** the proposal that the Trust was fully compliant with all principles and provisions of the Code of Governance 2014.
207	**Revised Trust Board Terms of Reference**
207.1	Anna Ferrant said that the Board's Terms of Reference had been reviewed in the context of the revised Code of Governance. Updates had been made to reference the Integrated Care System, the Trust's commitment to the patient safety statement and the commitments made around environmental sustainability.
207.2	**Action:** It was agreed that clarification would be given to the meaning of a 'place based system'.
207.3	Subject to the above amendment the Board **approved** the revised terms of reference.
208	**Any Other Business**
208.1	There were no other items of business.

Attachment N

TRUST BOARD – PUBLIC ACTION CHECKLIST
8 June 2023

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
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.	VG	July 2023	Being arranged for July 2023 Board meeting
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	July 2023	Not yet due
191.2	30/03/23	A key issue raised by staff during the walkround to physiotherapy had been about the heavy fire doors on the way to the service which were not automatic. Matthew Shaw said that whilst this would be rectified in the Children's Cancer Centre, it was important that the current access was improved to ensure that patients with limited mobility had equal access.	JD	June 2023	Actioned and in progress: As the facility has multiple services the existing layout was designed to ensure that area is secure and that access to the building controlled. Following a walk round attended by the service lead and the Capital Team, the Physiotherapy team will meet to discuss any downside or changes to their current operational procedures that automating the doors will have. If the decision from this meeting is that they wish to proceed with the works, the proposed design will be taken forward via the usual route.

Attachment N

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
202.2	30/03/23	Amanda Ellingworth said that it was important to be clear that GOSH was a collaborative partner in the ICS and it was agreed that the wording of the new BAF risk on the ICS would be further updated to reflect this.	MS and AF	June 2023	Risk rephrased: *Whilst participating fully in the North Central London Integrated Care System, there is a risk of erosion of the Trust's ability to maintain highly specialised services for patients nationally and internationally and deliver its strategy 'Above and Beyond' because of NHS system complexity, localised delivery of healthcare and an evolving statutory environment.*
207.2	30/03/23	It was agreed that clarification would be given to the meaning of a 'place based system' in the revised Board Terms of Reference.	AF	June 2023	Actioned: Reference amended to 'integrated care partnerships'

Attachment O

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
8 June 2023

Patient Story- Music Therapy	**Paper No: Attachment O**
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, PALS, and the Complaints and Patient Safety Teams to identify, prepare and present 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

In March 2019 a new Music Therapy service joined the Play department (part of the Nursing and Patient Experience directorate). Music therapy is the use of music to reach non-musical goals including but not limited to preparation for a procedure, support with anxiety, rehabilitation, speech and language development, emotional processing and expression and supporting positive family experiences. A typical session might include the use of familiar songs, improvised music making, sensory play, music technology, song writing, and music listening. Every activity is tailored specifically to the individual child, maintaining focus on what they can do rather than any limitations. A film of a music therapy session can be accessed via the QR code or on https://www.gosh.nhs.uk/wards-and-departments/departments/clinical-support-services/music-therapy/about-music-therapy/

Joshua (aged 16) and his mother, Kristel, will attend the Trust Board Meeting in person along with Katya Herman, Music Therapist. Joshua, who is under Respiratory, ENT and Ophthalmology at GOSH, and Kristel will talk about their:

- Experiences of music therapy including how his has inspired Joshua's decision to study music at college;
- The care provided during regular two-week admissions on Leopard ward;
- Challenges of being admitted onto other wards, of managing a rare condition which means that support can be limited and having two children at GOSH at the same time.

Patient Safety Implications

N/a

Equality impact and experience implications

N/a

Action required from the meeting

For information

Attachment O

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 **N/a**	
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	

Attachment P

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 8 June 2023	
Chief Executive's Report **Submitted by: Matthew Shaw, Chief Executive**	**Paper No: Attachment P** **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	

Thank you to Sir Mike Rake and appointment of the new Chair

I want to start by saying a huge 'thank you' to Sir Mike for his support since I took over as CEO in December 2018 and it is with sadness I acknowledge that his term as chair comes to an end towards the end of this year. I have found our weekly catch-ups and both scheduled and impromptu conversations invaluable. It's been an extremely challenging time in the hospital's long history – and it's fair to say that things have not gone quite the way that either of us would have expected! Myself and the rest of the executive team are so grateful to you for your steadfast support through some very difficult times and for your leadership and support to help us shape our strategy and re-frame our place in the wider system.

I am pleased to formally share that we have appointed a successor, Ellen Schroder, who brings a wealth of public sector experience to the role, including 20 years at board level for large, complex NHS organisations. For the last seven years, Ellen has Chaired East and North Hertfordshire NHS Trust. Previously she was Vice Chair and lay member of the Camden Clinical Commissioning Group and, before that, a non-executive director of Imperial College Healthcare NHS Trust and its predecessor St Mary's NHS Trust. Prior to her roles in healthcare, Ellen spent 25 years in the City working in corporate finance for the investment banks Dresdner Kleinwort Benson and Wood Gundy Inc.

Ellen is also a GOSH mum and previously served as a member of our Clinical Ethics Committee.

With all the structural changes taking place in the NHS landscape and our need to ensure we are on a solid financial footing, Ellen's understanding and experience of the evolving NHS framework and her commercial experience will prove invaluable.

Impact of industrial action

Unions have announced that further industrial action will be taking place at a number of hospitals in the coming months, including the British Medical Association, which represents junior doctors, has announced it will strike for 72 hours from 7am on 14 June.

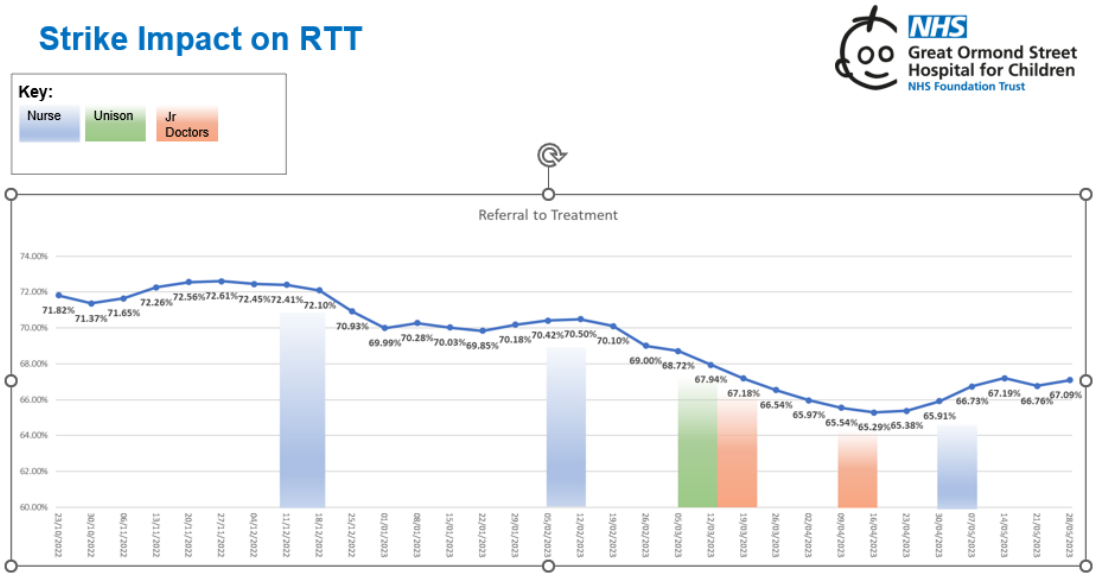
This will include staff at GOSH and will naturally cause our patients and families to worry about planned appointments or care they are receiving in the hospital – and for some patients there will inevitably be some disruption and delay.

We completely respect the right of staff to take part in lawful industrial action. Pay is obviously a matter for Government and the trade unions. We value and respect our staff enormously and see every day how essential it is that they receive good pay and conditions and can focus on their challenging work delivering services for our patients and families. Our first responsibility is always to the children who depend on us, and we will continue to work closely with our union representatives to minimise the impact.

It is important to be open about the cumulative impact that strikes are having on the organisation, our staff, and our ability to deliver on our performance commitments. Every strike affects our ability to see patients and causes a huge amount of work for staff in terms of covering shifts, optimising capacity and re-organising the flow of

patients. Each one yields a notable dip down in our RTT position (as demonstrated in the graph below). We are also having to prioritise urgent cases which means that our P3&4 patients end up waiting even longer. We are currently not meeting out 78 week target - partly due to late referrals, but any restrictions on our throughput inevitably contributes to us not being able to see patients as quickly as we should.

To help us plan for the BMA strike, our command-and-control management structure has been stood up and we will continue to do all we can to mitigate.



Looking after our People

As we've discussed in previous meetings, the constant demands of driving activity, finding savings, navigating industrial action and dealing with a cost-of-living crisis is really taking its toll on our people. We must look after our staff so that they in turn can look after our patients, so the executive team have decided to make staff our key priority for the coming financial year.

We are focussing on four key areas: wellbeing; equality, diversity, and inclusion; career progression; and reward and recognition. This will involve re-instating staff awards and long service recognition; continuing to support our active diversity and inclusion networks and taking further steps to provide really practical support for our people. Our new staff advisory service in the Lagoon will provide a one-stop-shop for direct support (including clinics) and signposting for wellbeing, financial assistance, citizens advice and information on how to Speak Up.

Our senior teams have been asked to speak to their colleagues across the organisation to understand what can be done to improve staff enjoyment and wellbeing at work. There is some sense of disconnect between the executive team and some of our middle management teams which we will also seeking to understand better over the coming weeks.

Gender Dysphoria in Children and Young People

Work continues across both the Southern and Northern Hubs to develop the two new nationally networked services in line with the recommendations and advice from the

The Cass Review. The new national service will be commissioned against the updated interim service specification which is due to be published in the coming months following the formal public consultation, which generated over 5,000 responses.

It is anticipated that the early stages of service provision will begin in the South in the Autumn of this year, with the Northern hub mobilising in 2024. The Phase 1 Service Providers will also be supported with additional Trust's which sees Bristol Royal Hospital for Children (part of University Hospitals Bristol and Weston NHS Foundation Trust) working in partnership along with NHS England.

Attachment Q

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 8th June	
Quality Report 2022/23 **Submitted by:** Dr Sanjiv Sharma, Chief Medical Officer Jit Olk, Head of Quality	**Paper No: Attachment Q** ✓ **For discussion**
Purpose of report To present the annual GOSH Quality Report 2022/23.	
Summary of report A Quality Report is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Reports are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive and patient feedback about the care provided. The Department of Health and Social Care requires providers to submit their final Quality Report to the Secretary of State by 30 June each year, by uploading it to Our GOSH.	
Patient Safety Implications None	
Equality impact implications None	
Financial implications None	
Strategic Risk None	
Action required from the meeting Recommendations or actions for the Trust Board to consider	
Consultation carried out with individuals/ groups/ committees This Quality Account provides a summary of quality data from a wide range of services across GOSH	
Who is responsible for implementing the proposals / project and anticipated timescales? Jit Olk – Head of Quality	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma – Chief Medical Officer	

Great Ormond Street Hospital for Children NHS Foundation Trust

Quality Report

2022-2023

Table of contents

Attachment Q

What is the Quality Report?

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

What does it include?

The content of the Quality Report includes:

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

Since its inception in 1852, Great Ormond Street Hospital NHS Foundation Trust (GOSH) has had a clear 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. What has allowed GOSH to set it apart from other specialist paediatric Trusts is its co-location of multiple specialties and the clinical expertise of its multidisciplinary staff. These have helped the Trust drive forward world-leading care, clinical research, education and innovation to secure its position as the only UK hospital in the top three best paediatric hospitals in the world.

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

Attachment Q

Our strategy: To go above and beyond

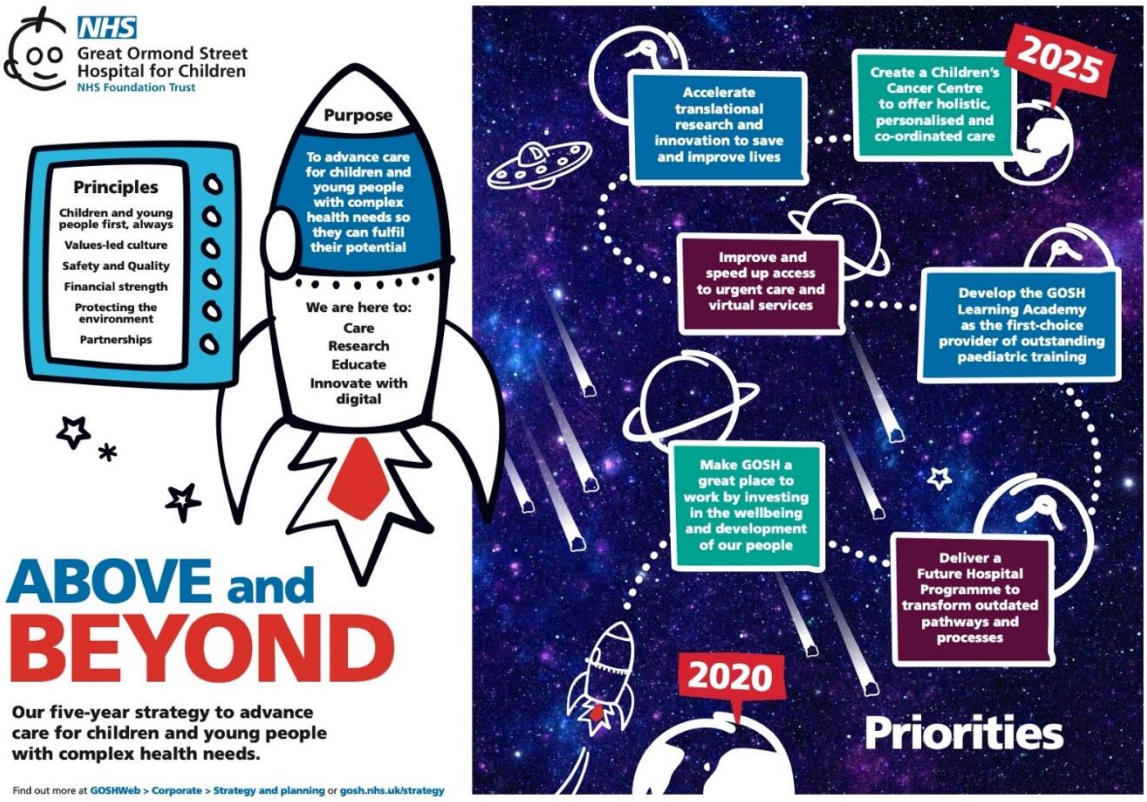
As a Trust we have a clear purpose which has endured since the Hospital first opened its doors in 1852. We provide healthcare for children. How and what we deliver has always and will continue to be driven by the needs of our patients. With clarity about our purpose and the needs of our patients, we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

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

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

Above and Beyond

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



Our big six priorities for the next three years are:

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

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

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

- People
- Clinical business
- Research
- Education
- Transformation

A look back at 2022/23

- 2022/23 was a challenging year for GOSH as it focused on recovering activity to pre-pandemic levels while facing industrial action from various staff groups. Yet, despite these challenges, GOSH continued to deliver safe and efficient care to its paediatric patients and witnessed several achievements throughout the year.
-
- In terms of performance in 2022/23, GOSH continues to be ranked in the top quartile of Trusts for RTT and the second quartile for diagnostic waiting times nationally, comparing strongly against NCL providers and peers. Our cancer standards compliance was 100%. During challenged periods and supporting our commitment to reducing health inequalities, GOSH has ensured patients can access the care they need by seeing 32% of patients in a virtual outpatient setting, where possible. To date, GOSH's overall activity is 8% above 2019/20 levels, which confirms the Trust's commitment to reducing backlogs following the pandemic.
-

In 2022/23, GOSH also delivered its highest better value programme in the Trust's history with £16m in savings. In February 2023, the London Borough of Camden granted GOSH planning permission to proceed with the Children's Cancer Centre, and following this, in March 2023, the Electronic Patient Record team at GOSH successfully launched the shared Epic EPR system with the Royal Marsden NHSE Foundation Trust.

Attachment Q

Our Strategy:

In 2023/24, GOSH enters year 4 of the Trust's corporate strategy, Above and Beyond, which outlines six bold and ambitious programmes of work, or planets as we call them, to help GOSH deliver better, safer, kinder care and save and improve more lives:

- Making GOSH a great place to work by investing in the wellbeing and development of our people
- Delivering a Future Hospital Programme to transform outdated pathways and processes and improving and speeding up access to urgent care and virtual services
- Developing the GOSH Learning Academy as the first-choice provider of outstanding paediatric training
- Accelerating translational research and innovation to save and improve lives
- Creating a Children's Cancer Centre to offer holistic, personalised and coordinated care
- Focusing on sustainability by integrating 'Protecting the Environment' into all planets.

The key areas of work that the six planet programmes will be delivering and focusing on in the next financial year are:

Make GOSH a great place to work by investing in the wellbeing and development of our people	A refresh of the **GOSH People Strategy** will be published by Q1 23/24. The refreshed strategy will build on the solid foundations established by the previous strategy and will have delivery plans shaped around four themes: • **Building a Sustainable Workforce:** focusing on recruitment, retention, and workforce planning with increased emphasis on fair and open recruitment, onboarding, careers pathways and progression, along with service redesign to support increased productivity through differently utilising exiting skills, adapting skill mix and the introduction of new roles • **Skills and Capability:** continuing to build on our well-established education and development offer from the GOSH Learning Academy, new programmes will be developed focusing on system working, financial and digital literacy, and leadership and line management • **Process Systems and Infrastructure:** focusing on improving processes around business planning, demand and capacity planning and business development. Upgrading our systems and tools to improve collaborative working and decision making – while maximising opportunities to consolidate, standardise and automate corporate service processes • **Culture and Engagement:** The work programmes from our Equality, Diversity & Inclusion, and Health & Wellbeing frameworks will continue from the solid progress made over the last two years. New areas of work will include a review of our values and a cultural change programme to embed speaking up and psychological safety
Deliver a Future Hospital Programme to transform outdated pathways and processes AND improve and speed up access to urgent	Learning from leading organisations, we will be adopting 'Objectives & Key Results (OKR)' to ensure our efforts are prioritised and coordinated to embed the clinical, operational and technical changes needed for Transformation. The first pilot OKRs are anticipated to be live by the start of the 2023/24 financial year, with oversight at the Future Hospital and Access to Care Board. Second stage OKRs will be agreed during Q1 to support this annual plan, the Recovery Plan and Clinical Strategy delivery. Evaluation of the first pilot OKRs will take place during Q2, identifying lessons learned to inform future rollout over the second half of the year.

care and virtual services	The Future Hospitals programme will harness learnings of COVID and EPR go-live to use the best of those experiences to rally the organisation to deliver on key, meaningful, measurable changes that matter to children, families and GOSH. Linked to this, benchmarking information, coupled with information from our newly established Clinical Intelligence Unit, shows where there is potential to do better. Targeted transformation teams equipped with skills to deliver and share learning about successful change will ensure patient, family, carer and staff perspectives are embedded in solutions to allow us to deliver them quickly and effectively. NHS benchmarking data provides insight into areas where others have found efficiencies that can be adopted by GOSH. Our transformation activities will support GOSH to treat as many children who need our services as possible, within the resources and capacity at our disposal: **GOSH2HOME**. Getting patients back to their home or community quickly can be achieved by reducing length of stay, implementing virtual wards, remote monitoring and shared care, and an increase in day surgery and procedures, with the added benefit of also reducing the carbon footprint of their care and reducing costs. Current work to address day services will expand to include not using ward beds, improved pre-procedure pathways and EPR improvements to reduce the need for children to stay in hospital overnight unnecessarily. **Flow and Theatre Utilisation**. While GOSH2HOME will allow us to find savings it can also support improved flow through the hospital, increased theatre utilisation and more timely discharge, to help GOSH get back to and improve upon pre-pandemic performance. Further embedding of estimated discharge dates, optimising the use of our critical care and high dependency beds, and an enhanced role for the Operations Hub coupled with improved partner repatriation agreements will allow us to enable more timely discharge, ensuring more children are cared for closer to home when that is the most appropriate setting and reducing average length of stay, freeing up hospital bed capacity which could potentially be used to care for more patients requiring care at GOSH. **Virtual Rounds** will be a key safety tool to ensure earlier discharges are not adversely affecting patient outcomes.
Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training	As a key planet within GOSH's *Above & Beyond Strategy*, we are here to educate**,** with an overall aim to develop the GOSH learning Academy to be the first-choice provider of outstanding paediatric education. With this driving our ambition, we have set out strategic aims with cross cutting themes to measure our success: • GLA recognised as preferred provider of paediatric healthcare education and training • GLA sought by national bodies for educational interactions and interventions supporting the care of children and young people • Develop a bigger pool of high potential leaders with the knowledge, skills, and attitudes to ensure we are a compassionate, inclusive organisation. As we progress into year four of the above and beyond strategy our six key priorities remain unchanged.

	• **Academic Education** – We plan to increase our reach by working with an increased number of Higher Education Institutes (HEI), developing a national MSC Paediatric Advanced Clinical Practice award, and aiming to have a year on year 10% increase in external candidates undertaking academic education with us. • **Apprenticeships –** Further develop clear career pathways for clinical and non-clinical staff utilising apprenticeships as an effective tool. Feedback from all staff groups suggests they would like clear guidance on how to grow and develop in their role. Established career pathways provide this guidance and demonstrate how GOSH invest in staff to ensure we deliver high quality care. • **Clinical Simulation –** We will continue to develop, deliver, and expand a sustainable simulation service, providing relevant, high-fidelity, and contemporary learning experiences for our multi-professional workforce. We aim to attain Association for Simulated Practice in Healthcare (ASiPH) accreditation, allowing us to benchmark ourselves against leading organisations worldwide. • **Digital Learning –** The population of content and expansion of the Virtual Learning Environment will continue to be seen in Year 4, with the aim to create sustainable delivery methods and content creation for the future, positioning GOSH as a leader in this area. In partnership with DRIVE the GLA will develop and implement new education technology, particularly virtual and augmented reality (VR and AR). Potential facilities development would work in tandem with the uptake of these technologies within newly developed clinical simulation spaces and contemporary learning environments e.g., multimedia space. • **Leadership and Management –** We will continue to build programmes that are linear in progression and aligned to our leadership framework to provide the opportunity for all colleagues to develop their leadership capabilities. • **Speciality Training –** Within GOSH the GLA will continue to prioritise the development of speciality training across all specialities. Development of new programmes of work such as the Oliver Magowan Training will be a key focus Educators from across the GLA continue to deliver expertise and content to support our international collaborations resulting in global impact to paediatric healthcare outcomes.
Accelerate translational research and innovation to save and improve lives	Three key transformational areas have been identified for this financial year to reach the Research Hospital ambition: • Transitioning research studies into clinical care • Education, particularly clinical and non-clinical academic careers • Development and expansion of Sample Bank Running alongside these workstreams will be projects to improve the quality of research data and reporting, as well as financial transformation, the development

	of research culture at GOSH, and innovation to develop the use of data and digital technology.
Create a Children's Cancer Centre to offer holistic, personalised and coordinated care	**Full Business Case Approval** The final Full Business Case was approved by the Trust Board and Council of Governors in March 2023. Following this, the document will be issued to NHSI/E for approval which we are hoping to receive in Spring 2023. **Planning Permission** The application for Planning Permission was submitted to the London Borough of Camden (LBC) on the 20th May 2022. This commenced the formal review process of the scheme and invited comments from the local community and statutory organisations on the project. The resubmission of the clarification report and further information was submitted to LBC on Friday 21st October 2022. LBC approved the project and granted GOSH permission to build the Children's Cancer Centre in February 2023. **RIBA 4 Design Stage** The RIBA 4 design stage commenced in October 2022 and is scheduled to complete in November 2023. This is the detailed design stage which, when complete will produce design information to a level which can be built which includes room loaded plans, full equipment list and mechanical and electrical strategy. This period will include significant clinical engagement, patient, and family engagement to progress the detailed designs, strong patient and family engagement to ensure the project delivers on the patient led design brief and robust enabling, engineering design to develop a building that functions as efficiently as possible. There is a Cost Check Gateway planned for April 2023 which will see the designs frozen in order to work up a detailed cost plan to ensure the project remains within the affordability limits stipulated by the Trust Board.
Sustainability	As a key principle within GOSH's *Above & Beyond Strategy the GOSH Climate & Health Emergency response aims to integrate 'Protecting the Environment' into all the planets.* In March 2021 GOSH acknowledged that we face a Climate & Health Emergency that will impact negatively on children and young people. That the organisation must play its part to respond and move *towards Net Zero for the emissions we control by 2030 and those we can influence by 2040. To do this full integration across the hospital and our partners is required.* The changes required to reach this point will be challenging but will bring multiple benefits to the organisation including enhanced operational resilience, reputation, and patient care. As we progress into year four of the above and beyond strategy the need for the organisation to become fully aligned with the change required has never been greater. Therefore, we will prioritise work on the following activities.

Emissions baselining and Trust wide Sustainability Strategy

- The new 'Towards a Greener 2030' strategy will be signed off by key trust Boards.
- The associated high-level trust wide 'action plan' will follow. This will allocate responsibility for delivery of key emissions reduction programme areas across the organisation.
- Our evolving emissions baseline data and emissions reduction pathways are incorporated into the strategy and action plan and all hospital communications.
- Ongoing baselining data optimisation programme is in place
- Through RIBA phase 4 the Children's Cancer Centre's sustainability credentials will be optimised along with its integration into wider estate decarbonisation

GOSH Carbon Footprint 2030 Target

This is a primary focus area for the year covering:

1) Building energy/estate decarbonisation – Working with engineering team to develop and sign off project delivery plans/business cases for key projects across each programme area – including a heat/cooling strategy and BMS programme
2) Sustainable Travel/transport – A focus on the CCC and wider estate, staff active travel, CATS and Non-emergency transport etc.
3) Waste – Food waste baselining and support for a series of wider waste pilot projects including sustainable sharps, offensive waste and furniture refurbishment.
4) Medical Gas – Continue programme of emissions reduction

Areas of core interest (not 2030 target)

Innovation and delivery - Priority areas:

1) Climate Adaptation plan
2) Clean Air Hospital Framework & monitoring
3) Healthy Hospital Street delivery
4) Support for 10 Programme of Work areas within the sustainability delivery structure

Long term projects

1) Sustainable procurement transformation programme commences
2) Staff Climate & Health engagement programme ongoing

To further support Above and Beyond, the new GOSH Clinical Strategy was approved by the Trust Board in 2022/23. The new Clinical Strategy aims to help GOSH understand how it can live its purpose with the advent of the local decision making, while addressing the issue of access and where to focus clinically, to

ensure that it continues to advance care and allows children to live to their full potential. It introduces a set of Clinical Tenets that will help guide strategic-decision making at GOSH:

- 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 we are always moving ahead

The Clinical Strategy also introduced four-cross cutting clinical themes that will allow GOSH to live its unique selling point, address the challenges facing it in the new landscape and provide direction to capitalise on opportunities, while staying true to its founding and enduring principle of putting the The Child, First. Always. These four cross-cutting themes are:

- Expediting Access
- Accelerating Diagnostics
- Pioneering Novel Therapies and Treatments
- Advancing the Frontiers of Surgery

These four clinical themes are applicable to each and every directorate and team at GOSH, enabling us to harness our collective strength and come closer together to continue to provide care to children with rare and complex diseases.

Part 1: A statement on quality from the Chief Executive

Mat Shaw
Chief Executive

Part 2a: Priorities for improvement

This part of the report sets out how we have performed against our 2022/23 quality priorities. These are made up of a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his 2008 NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare.

Safety

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

Clinical effectiveness

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

Experience

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

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

Attachment Q

Reporting our quality priorities for 2022/23

In our previous Quality Report, we identified three priority areas for improvement in Safety (Improve identification and management of the deteriorating child), Clinical effectiveness (Developing and implementing ward accreditation) and Experience (Managing uncertainty in healthcare). These are reported below:

Safety

- Refine governance structures for the trust-wide use of medicines

Clinical effectiveness

- MDT informed consent for tertiary and quaternary referrals

Experience

- Implementation of the National Patient Safety Syllabus level 1
- Update and implementation of Duty of Candour education
- Patient Safety Team development

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

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

Safety: Refine governance structures for the trust-wide use of medicines

What we said we'd do

The Trust has identified key themes affecting the safety of patients relating to medicines. To eliminate avoidable harm we propose to refine governance structures for the trust-wide use of medicines. In order to achieve this the following was to be considered and undertaken:

- Embed sustainability of improvements made under the Programme of Work focusing on the most recent CQC Inspection and the 'Requires Improvement' findings for the trust-wide use of medicines.
- Understand and embed lines of reporting, assurance through vigilance and the identification and management of risk through the Medicines Safety Committee (MSC) and the core audit programme.
- Continually reduce patient risk and promote the safe use of medicines. Promote the journey towards good practice and an 'Outstanding' CQC rating for Medicines Management

We said we would focus and address the most recent CQC inspection findings which "Requires Improvement", develop and monitor a core audit programme through the MSC, and promote the safe use of medicines working towards an "Outstanding" CQC rating for Medicines Management.

What we did

The new medicines governance structure is in place and is currently being embedding across 2023-24. The focus over the past year (2022-23) has been to assure medicines safety and DTC as the priority governance meetings. Both have an established meeting, approved TOR and a programme structure in development. To improve medicines governance support for the clinical team in the use innovative treatments, we have introduced scheduled urgent DTC meetings in addition to unscheduled emergency DTC meetings.

Within the MSC workstream, in collaboration with key stakeholders, we have developed and are currently embedding local vigilance with a programme of structured audits demonstrating compliance with standards. Audits undertaken include the safe storage of medicines and controlled drugs (CDs) audit, Patient and Carer self administration of inpatient medicines audit, and the DTC urgency level audit.

Embedded within the MSC workplan are learning from incidents and measures to prevent future similar incidents. The team have participated in the Trust safety podcast, lunchtime safety teaching sessions, and are involved in the medication administration review work. In addition, we have undertaken a CQC peer review assessment with UCLH.

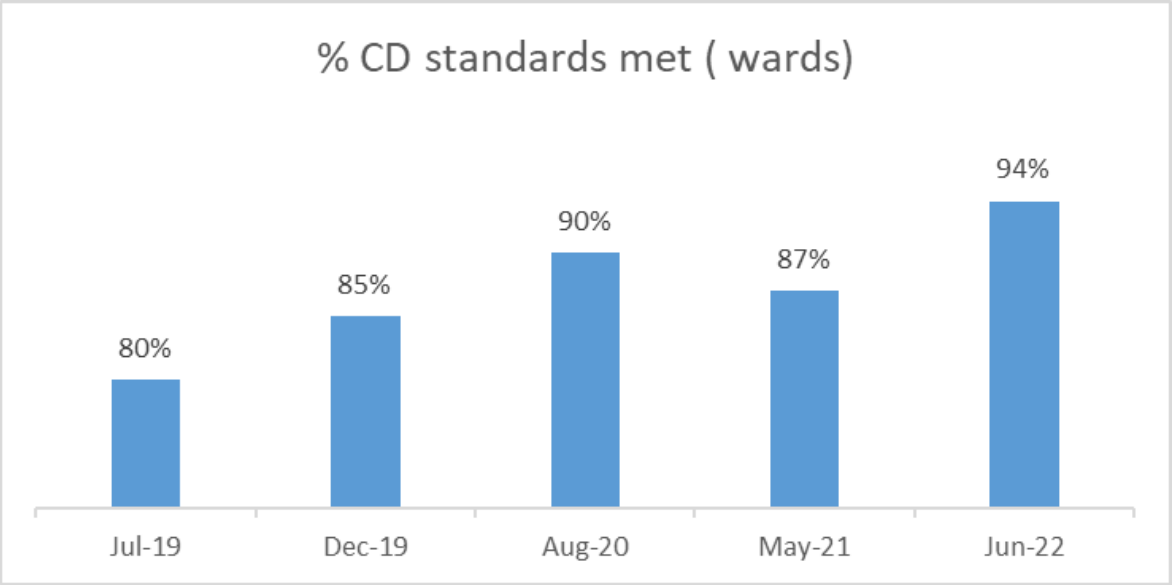
We aim to reduce financial losses of medicines due to inappropriate storage of medicines and improve staff utilisation due to best practice medicines handling processes. In pharmacy we have focused on our inventory control. This includes:

- Critical drug list to control inventory management
- Establishing a procurement team.
- Routine cycle counts (cycle counts are an audit tool to ensure inventory is correct). At the stock take inventory control is now at 82% accuracy (see details below in what the data show section).
- Expired drugs – Through better inventory control we have been able to reduce the volume and therefore, cost of expired drugs. For financial year 2022-23 the value is £224,711, compared to 2021-22 value was £304,065.

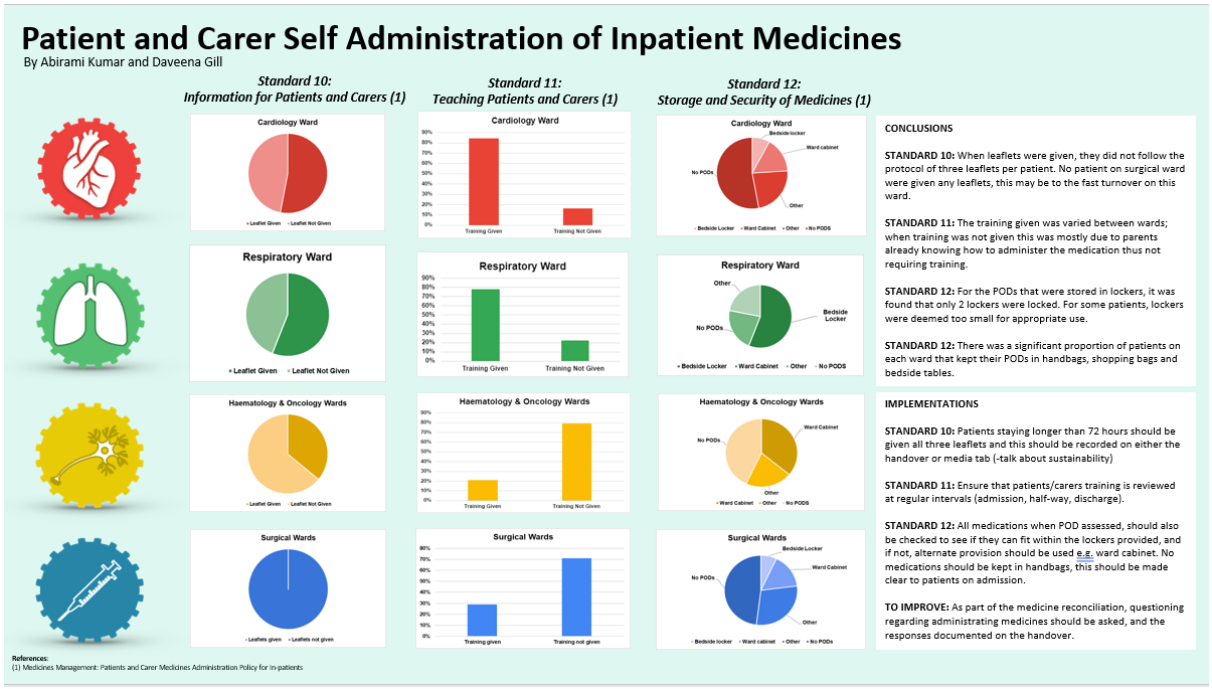
Attachment Q

What the data show

Safe storage of Medicines and CDs audit was undertaken in June 2022. The mean performance with all standards for CD documentation and storage was 94%. These are positive when compared to previous audit results.
Respiratory and Cardiac arrests outside are also monitored:

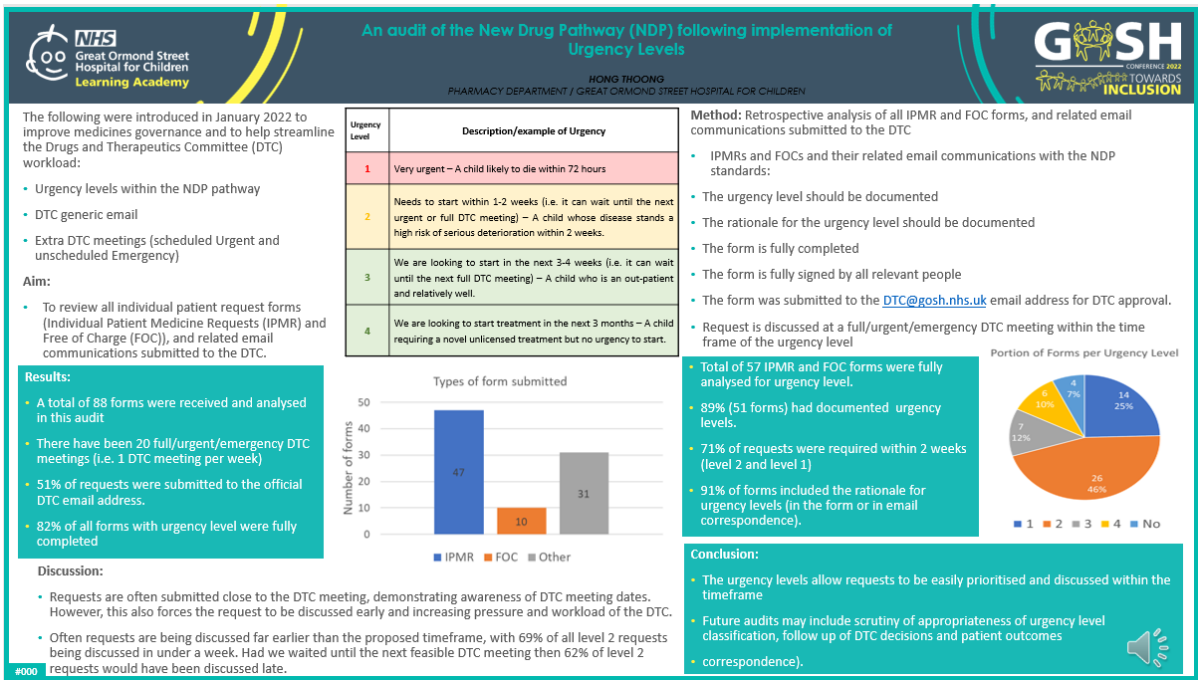


Patient and Carer Self Administration of Inpatient Medicines was undertaken December 2022 and demonstrates that there is variability in practice regarding patient and carer self administration.



The New Drug Pathway urgency levels audit was undertaken between January and May 2022 and demonstrated that there was an increase need for scheduled urgent and emergency DTC meetings.

Attachment Q



CQC peer review assessment was undertaken in January 2023 and the findings demonstrated that for the areas reviewed, we scored well for treatment room access, CD storage and oxygen cylinder storage, and not well on patients own medicines and discharge medicines (TTOs) and fluid storage.

Outcome and Actions

- Red/Amber/Green rating of issues with key themes and suggested solutions
- Findings presented to:
  - Pharmacy department
  - Good Hospital Group
  - Trust Medicines Safety Committee
- Replication of CQC peer review at other NCL sites

✓	Treatment Room access
✓	Controlled Drug storage
↔	Medicines storage
↔	Medicines waste / returns
✗	Patients Own medicines and TTOs
↔	Temperature monitoring
✗	Fluid Storage
✓	Oxygen cylinder storage

<u>Stock take results (undertaken in Mar 2023)</u>

- 4163 drugs stock take transactions (counted)
- 3414 drugs have the same quantity entered into Epic (no stock level change)
- 749 drugs had a change in stock value
- Stock accuracy value (3414/4163*100) = 82.00%

What's going to happen next

Planned audits for 2023-24 include clinical appropriateness audit and a repeat medicines storage audit once locked medicines cupboards have been reinstated within the Trust.

Financial focus will be in improving reporting and transparency of pricing through the adoption of average pricing. Focus for2023-24 will be to establish a correct mapping of drugs to cost codes, embedding of RX-Info Refine, Define and Exend, and adoption of Epic homecare module. Cycle counts will focus on high cost drugs in 2023-24.

The CQC peer review is planned to be extended to other clinical areas in the hospital and also to be rolled out to other North Central London hospitals.

How this benefits patients

By ensuring that good medicines management is in place and CQC recommendations are undertaken, we will improve the quality of our service and mitigate any foreseeable harm to our patients. Therefore, ensuring that patients receive a first class service from our expert clinical teams.

Attachment Q

Clinical Effectiveness: MDT informed consent for tertiary and quaternary referrals

What we said we'd do

Updated Trust-wide policy and guidance notes regarding decision making & consent will explicitly set the expectations of healthcare professionals in how they support children, young people, their adults with parental responsibility, including their responsibility to record and evidence the decision-making conversations that take place, and the information/ documents shared with their patients.
Patients' electronic records will be updated to include a decision making & consent dialogue section which will aid healthcare professionals working in multi-disciplinary/ specialty care pathways to access/ review previous conversations between healthcare professionals and the patient to aid fluency between collaborating healthcare professionals.

What we did

From May 2021 to September 2022 a GOSH multi-disciplinary project board, led by the Deputy Medical Director analysed this and other professional guidance, experiences of staff and young people at GOSH to identify weaknesses in current practice and to formulate recommendations for best practice addressing our delivery of healthcare and research.

Key project outputs are:

- Revised Trust Consent Policy (approved in October 2022)
- Updated induction/ mandatory training products to inform healthcare professionals of their responsibilities (Due April 2023)
- Enhanced electronic patient record functionality to record what matters to a patient, and other decision making dialogue between a healthcare professional & patient/ family (Due June 2023)
- Enhanced electronic patient record functionality to record a patient's consent for a clinical intervention electronically (Due June 2023)

Successful implementation of the revised policy through GOSH Legal & Learning Academy produced online training, supported by clinical leadership across Consultant, Junior Doctor and Advanced Clinical Practitioner roles is anticipated to deliver the following outcomes:

- More patients satisfied by their clinical intervention outcomes and experience of receiving care, through enhanced quality of shared decision making and patient engagement.
- Enhanced experience of healthcare professionals co-operating as one team to deliver the Trust's purpose (To advance care for children and young people with complex health needs so they can fulfil their potential) through consistent information management.
- Increased productivity through reduction in late theatre starts owing to delays in recording a patient's consent for a procedure.
- Decreased legal costs through a reduction in the number of cases submitted to GOSH legal team where a patient's decision making & consent process is poorly documented
- Enhanced quality of training through positive experience of junior doctors rotating through placements at GOSH
- Enhanced reputation through engagement and case study communication via the General Medical Council

Attachment Q

What's going to happen next

A key deliverable of the project is digital functionality within patient electronic patient records to provide patient/ consenter access to written decision making dialogue and the provision of digital consent forms (which could be reviewed and signed in the comfort of a patient's home, rather than in a time-limited interaction in the hospital). The GOSH electronic patient record system is not currently capable of delivering a resilient electronic consent product, however an upgrade expected in Autumn 2023 is anticipated to deliver a functionality which would enable updates to electronic consent forms to be made, and new signatures collected.

How this benefits patients

Children/ young people/ adults with parental responsibility will have access to review their decision making & consent dialogue and access patient information communicated digitally through the electronic patient records system. This will empower patients to have access to the relevant information to carry out shared decision making including the ability to ask their healthcare professionals questions. This digital recording of consent will enable formal consent to be taken prior to the day of planned intervention which will deliver improved patient flow / productivity.

Attachment Q

Experience: Implementation of the National Patient Safety Syllabus level 1

What we said we'd do

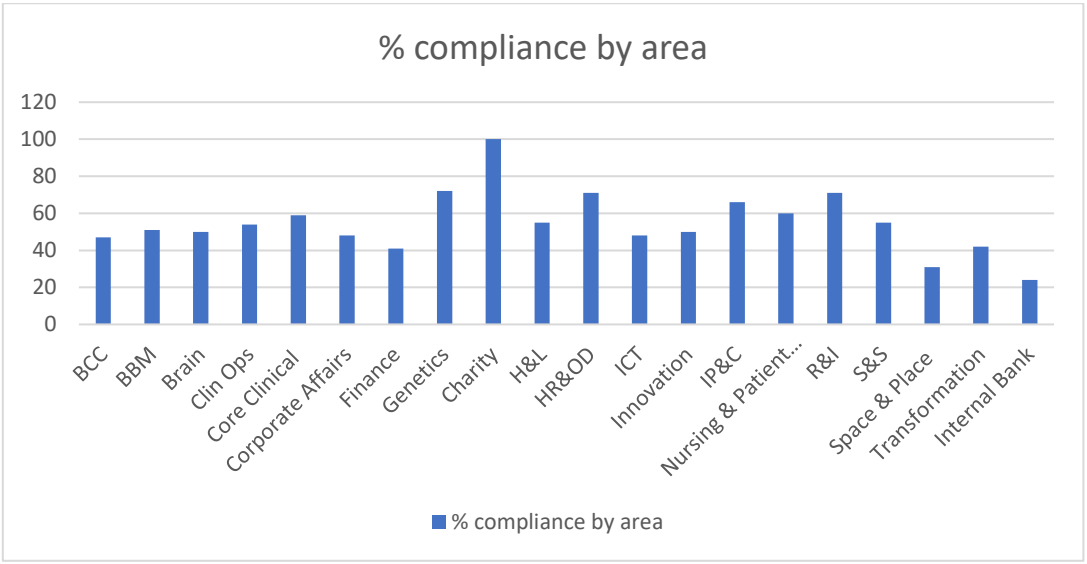
Implement Level I of the NHS Patient Safety Syllabus on GOSH GOLD and each Trust member's mandatory training dashboard in line with NHS England and HEE's requirements.

What we did

Following submission for approval via the GLA Statutory and Mandatory Training Steering Group, this was added to individual GOSH GOLD mandatory training dashboards. Trustwide promotion of this training as well as and negotiation with individual teams as to how some 'hard to reach' areas who do not routinely access the intranet was undertaken. For the groups described, an on-going programme of face-to-face sessions is in progress. Whilst resource heavy, this gives a chance for those in the organisation who do not always have a voice in patient safety to speak and be involved in this conversation.

As of March 2023, Trust-wide compliance is 52%. Compliance, meaning those who have undertaken the training, has been incremental and consistent, with a small jump month on month. To this time, it has not been possible to demonstrate staff undertaking this in another organisation unless this was accessed via HEE's Learning Management System, e-learning for health. In this instance we do not currently have the capability to automatically reflect this information in GOSH GOLD records. It is hoped that the planned upgrade of GOSH GOLD will enable this.

What the data show



What's going to happen next

This remains on individual staff member's dashboards and compliance will continue to be monitored. Reminders and encouragement will continue. The increasing emphasis on Patient Safety, including the Trust Communications Strategy's 'Big Conversation' around patient safety will continue this focus. When compliance reaches 60%, Level II will be launched. NHS England set out its intent that this should be accessed by all staff in Bands 7 and above, and those involved more closely with patient safety decision making. NHS England guidance is that this is not mandatory, instead it is hoped that there be a willingness to engage with the subject matter as part of an individual's role and their annual appraisal.

Attachment Q

How this benefits patients

The increased engagement and on-going requests for patient safety education, as well as significant compliance with Level I reflects positively on the organisation. We feel assured that the content delivered and the engagement from across the organisation is beneficial to patients and their families. There is a growing sense of purpose around patient safety, with the wide engagement of teams in this education leading to, we believe, improved safety awareness and culture. From this it is hoped that patients will benefit. The invisible nature of cultural change means demonstrating true impact is difficult in such a short period of time.

Attachment Q

Experience: Update and implementation of Duty of Candour education

What we said we'd do

Engage significant numbers of the organisation in Duty of Candour education after revising course content and embedded on GOSH DEN. Targeting senior members of the organisation and those who are likely to carry out Duty of Candour conversations or participate in the process.

What we did

The DoC eLearning package was peer reviewed, updated to reflect the GOSH policy changes and moved from GOLD to the DEN. This was actively promoted via education channels, through SLT and other patient safety updates.
Bespoke, face to face DoC education was also promoted and offered as part of senior team training. GOSH had previously commissioned AvMA to deliver DoC with Empathy training, the remaining session also took place during this time.

What the data showed

Face to Face	GOSH delivered: n. 45
	AvMA n. 9
eLearning	DEN: course commenced n. 80
	DEN course completed: n. 27

What's going to happen next

This remains a significant part of the educational offering for patient safety and will be actively promoted as such. It is difficult to balance the significant training demands of the workforce which must always be taken into account when considering compliance. As we move towards PSIRF implementation, the focus on patient safety education will grow and DoC will remain a significant aspect of this.

How this benefits patients

Whilst the numbers of those undertaking this training are not large, the impact on patients will be significant. The inherent value of this type of programme is the role modelling good practice is engenders. Honestly and openness with families in central to this, which can only be beneficial to families. Saying sorry with honesty, openness and a willingness to learn and share about incidents will impact positively on both affected families and others.

Attachment Q

Experience: Patient Safety Team Development

What we said we'd do

A number of educational endeavours were set out to begin the process of 'professionalisation' of the Patient Safety team, as prescribed by the National Safety Strategy. Significant factors were taken into account when planning and delivering this work; the diverse experience and expertise of the team, their previous roles and ensuring the education plan meets the needs of the team and the organisation.

In terms of specific plans, these involved bespoke Investigative Interviewing Skills, undertaking Bronze level HSIB training and targeted sessions for tasks such as using the SEIPS model for safety investigations.

What we did

Investigative Interview Skills, delivered in partnership with the Simulation team. To begin this work, the Patient Safety team agreed a new model for interviews and accompanying SOP. This was based on some previous experience of this work including use of the PEACE investigation model (P-planning & prep, E-engage & explain, A- account, clarification & challenge, C- closure, E- evaluation).
The team then undertook bespoke simulation training using trained simulation actors, to practice conducting a number of interviews.

HSIB Bronze, completed by all team members. This enables an enhanced level of understanding of many facets of the investigation process, as well as safety science and systems thinking.

SEIPS model. The team had varying levels of understanding of this model and all have attended updates on its use in deepening safety event understanding.

What the data show

Completion of the training as set out.

Anecdotal feedback suggests high satisfaction with the investigative interviewing approach and a recommendation form the team that this be rolled out to Deputy Chiefs of Service and others in senior roles who may need to carry out similar conversations. A deeper narrative with greater uniformity in terms of content and style have been observed. This has been welcomed by the team and those in receipt of reports as it aids understanding of the issues being explored and the incident as a whole.

What's going to happen next

Investigative Interviewing Skills. Following feedback from the Patient Safety team, this has begun to be rolled out to the Deputy Chiefs of Service. This is with a view to the Directorate's Safety Partner and Deputy Chief of Service interviewing together, furthering strengthening the partnership approach to patient safety. Next steps are for this to be rolled out to the wider Trust, targeting those who will be involved in challenging and sensitive interviews with colleagues relating to patient safety. This is all in collaboration with the Simulation team.

Ongoing education programme: the Patient Safety Team continue to be invited to attend relevant educational opportunities, for example the Patient Safety & Experience Grand Round, or those delivered in partnership with Patient Safety Learning. This programme, aimed primarily at the Deputy Chiefs of Service involves expert speakers joining a webinar on a monthly basis. These sessions are part didactic and part 'how to implement this at GOSH/ as part of our roles?'.

How this benefits patients

Attachment Q

The National Patient Safety strategy sets out the imperative for increased knowledge, skills and expertise of those in patient safety roles. The rationale being that enhanced decision making and understanding around safety events will improve our organisational approach to patient safety. For individual patients and families, this will lead to better insights into their experiences and, we hope, more satisfactory responses to concerns. All of this will, in turn, be reflected in the education delivered by the patient safety team to the organisation- sharing insights, themes and valuable patient stories to illustrate the importance of acting for patient safety.

Attachment Q

Quality priorities for 2023/24

The following tables provide details of three of the quality improvement projects that GOSH will undertake in 2023/24. In common with previous quality reports these quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

Quality Priorities for 2023/24 have selected with input from membership of the newly formed Quality Review Group. After consideration, consensus was reached and the following Quality Priorities were agreed upon.

Safety:

To eliminate avoidable harm – Owner Jit Olk

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Development of overarching governance system to enhance awareness, data intelligence, action delivery, outcomes and decision making in quality, safety, and compliance.	There is an opportunity to introduce a single governance system to overcome the need for multiple systems (e.g. incident, audit, compliance, staff training, activity) A single system can enable: • Reduction of effort and time spent by directorate staff to manage and have oversight of safety, compliance, and quality information • Increased oversight and ability to understand and manage actions required to support good governance • Triangulation of multiple intersecting data sources to improve early signalling of a pattern or trend that may require further investigation to support and improve safety No system would replace the need for thorough investigation, including detailed thematic analysis. But it could crucially enable a focusing of resource to areas of 'signal'. This would support the delivery of the Patient Safety Incident Response Framework in its ambitions to enable Trusts to locally decide where to put their investigation efforts based on safety themes uniquely relevant to them.	Develop and implement a Quality Management System (QMS) at GOSH by Q3 2025

	This would involve the key elements of an overarching QMS "A fundamental part of the future development of the Quality function at GOSH will be to implement a Quality Management System. Having a QMS will be a critical component of supporting GOSH achieve the aims of its "Above and Beyond" strategy as it provides a framework for an organisation to critically define, execute and evidence that it is doing what it is saying it is doing" GOSH Quality Strategy	

Attachment Q

Experience:

To deliver kind and compassionate care and communicate clearly to build confidence and ease – owner Dr Sanjiv Sharma

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improving the co-ordination of care of children cared for by multiple specialties at GOSH - including communication with local hospitals, between GOSH teams, and parents/carers/ young people and children	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 number of diagnoses per finished consultant episode as well as a significantly larger number of patients with a comorbidity score of 1 or higher and an even greater number of patients with a score of 6 or higher (GOSH 2023 Clinical Strategy) We have data showing how often patients move between specialties and how often care could be more effectively co-ordinated We also have learning from complaints and incidents related to coordination of multi-specialty care. We can harness opportunities for delivering coordinated and seamless care to: • Reduce obstacles and frustrations for healthcare teams to enable whole system flow resulting in effective co-ordination of care • Improve experience of care by parents/carers. While parents/carers play a key role in the coordination of care, communication and coordination of care may be unduly held by families, and that burden is greatest where the number of specialties involved is high • Improve coordination in terms of actual intervention - better management of care and communication between teams. • Seek opportunities to combine investigations, cluster consultations and understand common goals e.g. facilitating simple procedures such as	Project to be established 2023-24 Explicit outcomes measures would need to be defined within a specific project group

	combining blood tests or scan appointments, booking clinic appointments on the same day (where possible) • Ensuring local hospitals are kept informed	

Attachment Q

Clinical effectiveness:

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Quality Improvement approach - QI to support what really matters Reducing failure demand (i.e., demand due to failure to do something or failure to do it right) and optimise value demand (i.e., what provides value to patients)	Measure failure demand – resource/time spent fixing failure (re-work), work that is consistently failing – common themes to reduce failure (Right first time) Ensure our approach to Quality Improvement and allocation of QI support is about enabling and supporting improvements that address and reflect ward priorities and work with the clinical directorates to enable them. QI priorities will be co-designed through the Quality Review Group. The QRG will establish a systematic, reliable process for determining where there is value in initiating quality improvement activities that ultimately serves the needs of the organisation.	Monitoring of Key Performance Indicators yet to be clarified

Attachment Q

Part 2b: Statements of assurance from the Board

This section comprises the following:

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

Attachment Q

Review of our services

During 2022/23, GOSH provided and/or sub-contracted over 60 relevant health services. The income generated by these services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant services by GOSH for 2022/23. GOSH has reviewed all the data available to us on the quality of care in our services.

Attachment Q

Participation in Clinical Audit

What is clinical audit?

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

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

Participation in National Clinical Audit

During 2022/23 thirteen national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The data submissions have been outlined below for those audits.

Name of audit / clinical outcome review programme	**Cases submitted as a percentage of the number of registered cases required**
Cleft Registry and Audit Network (CRANE)	Data for 69 GOSH patients for GOSH submitted
Inflammatory Bowel Disease (IBD) Registry	GOSH patients are included in the IBD registry. It was not possible to submit new cases for 2022/23. A data processing agreement is required before new cases can be submitted, and this is being worked on between the Gastroenterology service and Information Governance
Learning Disabilities Mortality Review Programme (LeDeR)	11 deaths notified
Maternal, Newborn, and Infant Clinical Outcome Review Programme Confidential enquiries of perinatal morbidity and mortality	22/22 required cases notified
National Audit of Pulmonary Hypertension (NAPH)	543 Consultations 157 Exercise test 9 Diagnostic Catheters
National Cardiac Arrest Audit (NCAA)	14/14 required cases submitted
National Audit of Cardiac Rhythm Management (CRM)	178/178 CRM procedures submitted
National Congenital Heart Disease (CHD)	1038/1038 cases submitted
National Paediatric Diabetes Audit (NPDA)	52/52 cases required
Paediatric Intensive Care Audit Network (PICANet)	689 CICU admissions 1092 PICU/NICU admissions
UK Renal Registry Chronic Kidney Disease Audit	512/512 required cases submitted
Transition from child to adult health services [National Confidential Enquiry into Patient Outcome and Death (NCEPOD)]	GOSH returned 14/20 (71%) of clinician case record reviews which were requested. NCEPOD have advised that this is very good return rate compared to other hospitals and the role GOSH has played in returning cases to support the study

Attachment Q

The following national clinical audit reports and data were published from relevant mandatory national clinical audits in 2022/23. The relevance of those reports to GOSH are described below.

National Audit of Cardiac Rhythm Management (NACRM) (published in June 2022)

Cardiac rhythm management (CRM) is the treatment of arrhythmias (heart rhythm disorders). The National Audit of Cardiac Rhythm Management 2022 audit report was published in June 2022 and reports on data relating to CRM procedures at implanting hospitals and ablating hospitals from across the UK.

The data shows that the GOSH reintervention rate is within expected controls. For first implants performed for 2020/21 no patient with simple devices and no patients with complex devices had a reintervention within one year in a different hospital.

National Audit of Pulmonary Hypertension, 13th Annual Report

The National Audit of Pulmonary Hypertension is an audit of processes and outcomes, and all eight designated centres participate. The audit uses national standards to measure clinical practice.
GOSH exceed the standard for two of the three of the measures that were compared to other centres in the 2021-22 data

Standard	National	GOSH
95% of patients should be diagnosed within 6 months	95%	98%
80% of new patients should begin drug therapy within 12 weeks of referral	83%	100%
95% of patients receiving a PH drug should have an annual consultation	96%	94%

National Cardiac Arrest Audit (NCAA) annual report 2021-2022

The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland.
All GOSH cardiac arrest data are shared with the NCAA so GOSH can benchmark survival from cardiac arrest against hospitals who have similar patient admission numbers across the UK.

The 2021/22 report was published in July 2022 and has been reviewed by the Head of Resuscitation Services, and the Education Lead for Resuscitation Services and reported to the Quality Safety Outcomes and Compliance Committee (QSOCC).
The key audit findings as they relate to GOSH are outlined below

- NCAA looks at cardiac arrest calls attended by 2222 teams and does not include those occurring in ICU areas.
- The incidence of cardiac arrests was 0.34 per 1000 patients in 2021-22, this figure has fallen since 2017-18 when it was > 0.5 per 1000 patients (hospital admissions). This is favourable despite increasing patient complexity but does not suggest that the sicker patients are being admitted to ICU earlier before they suffer a cardiac arrest.
- There are only four paediatric hospitals noted for comparison in this audit and GOSH had the second highest incidence of cardiac arrest. The definition of a paediatric centre is about to change in NCAA so more comparative data should be available in future reports.
- The incidence of cardiac arrests on the wards dipped in 2019-2020 and early 2020-2021 but is now 0.31 per one thousand hospital admissions which is little changed from 2017-2018.
- Looking at outcomes when risk adjusted for patient severity of illness
    - GOSH achieves better than expected return of spontaneous circulation rates

GOSH is indicated as having slightly lower than expected rates of survival to hospital discharge for patients who suffer a cardiac arrest outside of ICU. Approximately half of the patients who suffered a cardiac arrest and were attended by a 2222 team survived to hospital discharge in the one-year period 2021-2022.

Attachment Q

2022 National Congenital Heart Disease Audit report

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

For 2018-21 risk-adjusted survival rates for paediatric cardiac surgery are defined as 'higher than predicted". More information about this can be found on the Cardiothoracic Clinical Outcomes page

Paediatric Intensive Care Audit Network Annual Report (PICANet) 2022 (published in March 2023)

The report covers the period from January 2019 to December 2021

The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be 'adjusted' to consider the level of severity of the patients in respect of case mix.
The 2022 PICANet report compares Trusts Standardised Mortality Ratio [1] for the calendar years of 2019-21. The data in this report shows GOSH ICU mortality as within what would be expected based around the case mix.

The clinical teams will be reviewing the significance of all benchmarked data and this will be made available publicly on the Intensive Care Clinical Outcomes page in June 2023

National Paediatric Diabetes Audit (NPDA) 2021/22 Report (published in March 2023)

The report focuses on the completion of seven key health checks for type 1 diabetes. GOSH does not have sufficient numbers of typical type 1 diabetes to allow meaningful comparison of data in the report (GOSH data is included for five patients over the age of 12).

For GOSH the data shows that we did not complete eye and foot checks in young people for those five patients in the audit year.

- In 2021/22 changes to the service were made so that GOSH has software access to patient eye screening reports; in addition, requests made to patient GPs to send the reports. The team have added foot checks to their standard clinic visit. It is expected that the impact of these will be noted in the 2022/23 NPDA reportReview if transfusion information can be incorporated into the electronic patient record workflow, as a tick box or reminder within any pre-operative discussions with a link to electronic copies (NB: not all surgical patients will require a blood transfusion).
- Ensure printed information is available in key areas for families to read (patient information leaflets have not been available in paper copies in general areas during the covid 19 pandemic).

UK Cystic Fibrosis Registry 2021 Annual Report (published in September 2022)

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

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

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

- Forced Expiratory Volume
- Age adjusted BMI percentile among patients aged 1-15 years
- Proportion of patients with chronic Pseudomonas aeruginosa

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

UK Renal Registry

The UK Renal Registry report was published in July 2022 and includes analyses of paediatric data to the end to the 31st of December 2020. Clinical Outcome measures for the Nephrology service at GOSH can be found on the Nephrology Clinical Outcomes page and include analyses of key benchmarked metrics identified in the report

Attachment Q

Priority Clinical Audit plan

At GOSH we undertake audits to support learning from incidents and to investigate areas for improvement in both quality and safety. Some of our key priority audits completed in 2022/23 are outlined in this section of the report.

Re-audit - Documentation of central venous line insertion on PICU Background

A Serious Incident (SI) occurred in 2020 where a central venous line (CVL) was inserted to administer medications for a critically unwell patient on PICU. It was noted on x-ray imaging approximately ten hours later that the guidewire was still inside the line- this should have been removed following confirmed placement of the central line. Audit completed in June 2021 highlighted that the SI recommendations around CVLs on PICU had been implemented.

Aim of audit
To understand if practice has been sustained following the initial audit. An audit of the documentation of thirty consecutive CVL insertions took place in June 2022.

Conclusion
Key recommendations have been sustained:

- Checklist completion for PICU central line insertions (100%).
- Second person being present to assist with the procedure (100%).
- Confirmation that the guidewire has been removed (100%).

Documentation of management of External Ventricular Drains (EVD)

Aim of audit
To check whether best practice is followed for documenting cerebrospinal fluid loss, electrolyte balance, and the position of EVDs in line with the GOSH EVD Clinical Guideline and following learning from an SI.

Background
An SI was concluded in 2022 where concerns were raised that the patient's fluid management prior to cardiac arrest may have contributed to this event. The SI investigation included broader learning points around clear treatment plans for external ventricular drains in neurosurgical outliers.

Key findings
The audit supports that we are practicing within trust guidelines in the areas where children are routinely cared for with an EVD (Koala and PICU). One I+PC EVD admission was included in the audit period. The audit of the I+PC admission highlighted that there could be improvement in the frequency with which the height of the EVD is documented.

This has been shared with the I+PC senior nursing team and reviewed at the I+PC Risk Action Group. Educational support has been offered to the I+PC team around the recording of height from the Neurology practice educators. I+PC EVD admissions are being audited to review progress.

March 2023 - Recording of implant LOT numbers for Interventional Radiology (IR) Embolisations

Background
An SI occurred in 2021 around a faulty batch of histoacryl glue which was used in five procedures. This was related to glue embolisation for arteriovenous malformations.

Aim of audit

Audit was identified as part of the SI process to review the implementation of a recommendation from the serious incident investigation. This looked at whether lot numbers are being recorded where implants, particularly products which are not obviously implants (such as glue) are used for IR embolisations.

Key findings
Audit in 2022 identified that implant lot numbers were appropriately recorded in the electronic patient record for all IR embolisations that were reviewed in the audit.
This was re-audited in March 2023 and provided assurance that good practice and learning had been sustained.
This audit was presented Trust wide as part of the Patient Safety and Experience Grand Round in March 2023, as an exemplar of how clinical audit can be used to support and sustain patient safety learning.

Quality of medical documentation

Aim of the audit
To understand the quality of our medical documentation across the Trust from a doctor's perspective, to gain insight of where we are doing well, and where we might have broader themes for improvement.

Methodology
An audit tool was created based on GMC principles, national standards, from consultation with our Deputy Chiefs of Service, and from a pilot audit completed in 2021. Audits were completed by doctors who volunteered to complete the audit and supported by the Clinical Audit Manager. Audit data was collected for 151 cases in fourteen specialties by sixteen doctors in December 2022 and January 2023.Inpatient medical documentation was reviewed for inpatients or recently discharged patients at GOSH.

Key points
The audit results are positive, and suggest areas where there could be improvements, rather than significant deficits that are concerning and represent significant risk.

Our critical question.
"It is 3.am and you have been asked to provide input into the care of this patient. Would the documentation for this patient support you to effectively do that?"

77% of cases reviewed by doctors supported this

Where we are doing well
Clear why the patient is at GOSH (84%)
Good up to date information on problems (89%)
Clear management plan up to date (99%)

Where we can improve
Emergency plans being accurate and accessible (62%)
Evidence of plans being communicated to the family/patient (77%)

Next steps
An action plan in response to this audit was agreed at the Medical Advisory Group in April, and also approved by QSOCC.

Action plan
Short one page guidance to be created and shared in relevant forums with our medical staff to include:

- What are our principles of good practice for medical documentation
- What does our audit tell us?
- Guidance on critical places to document key information in order to support safe and effective documentation and cross specialty working.

This work was possible with the expertise, time, and input of some of our junior doctors including: Adem Polat, Ananth Kumar, Anuj Khatri, Flora Ogugua, Harsha Lochan, Hussein Hussein, Jewel John Ponvelil, Kirsi Malmivaara, Nadja Bednarczuk, Premala Muthukumarasamy, Sam Morrish, Sara Fara, Simran Kundan, Victor Ambrose, Yeu Jye Pang, Thomas McGrath

MDT Terms of Reference Audit

Background
Learning from a 2019 Learning from Prevention of Future Deaths report resulted in GOSH actions to ensure appropriate attendance and documentation at MDTs.
In March 2021 a clinical audit report was shared at Patient Safety and Outcomes Committee (PSOC) which highlighted limitations in assurance about demonstration of quoracy and whether the correct people were present in the decision-making process.

Following review of the audit report the Patient Safety and Outcomes Committee (PSOC) confirmed that MDTs should implement ToR.To support teams to create ToR a Trust MDT ToRs template was developed by Andrew Pearson and Chris Jephson in consultation with the Deputy Chiefs of Service and the Patient Safety and Outcomes Committee.

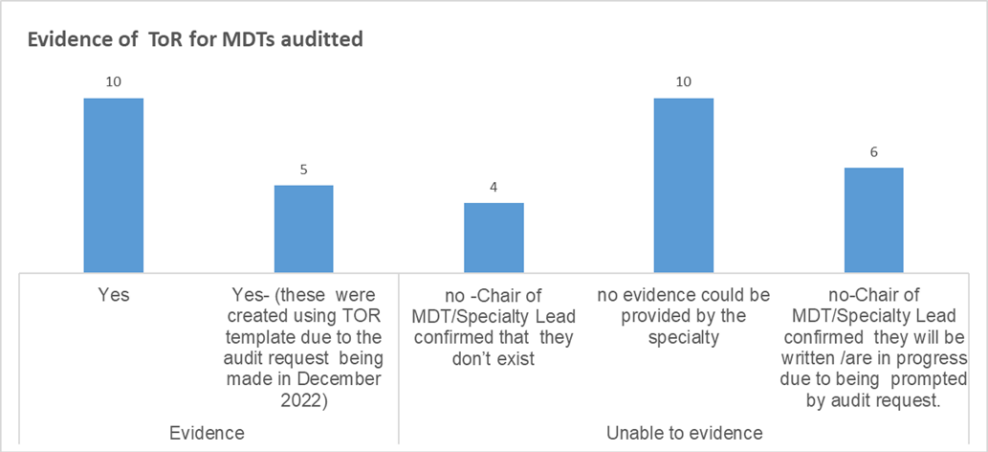
A request was made in June 2022 via PSOC, the Interim Head of Patient Safety and with the Deputy Chiefs of Service, to ask teams to identify if MDT meetings had terms of reference and to use the template guidance to support implementation if not. This audit evaluated progress with implementation.

Methodology of audit

- 116 different MDT meetings identified as taking place during September and October 2022.
- All meetings where more than 50 patients were discussed in that period were included in the audit (n 35).

Key findings
There was evidence of ToR for 15/35 (43%) of MDTs included in the audit.

Attachment Q



Next steps

The audit recommendations were reviewed and supported by the April QSOCC.

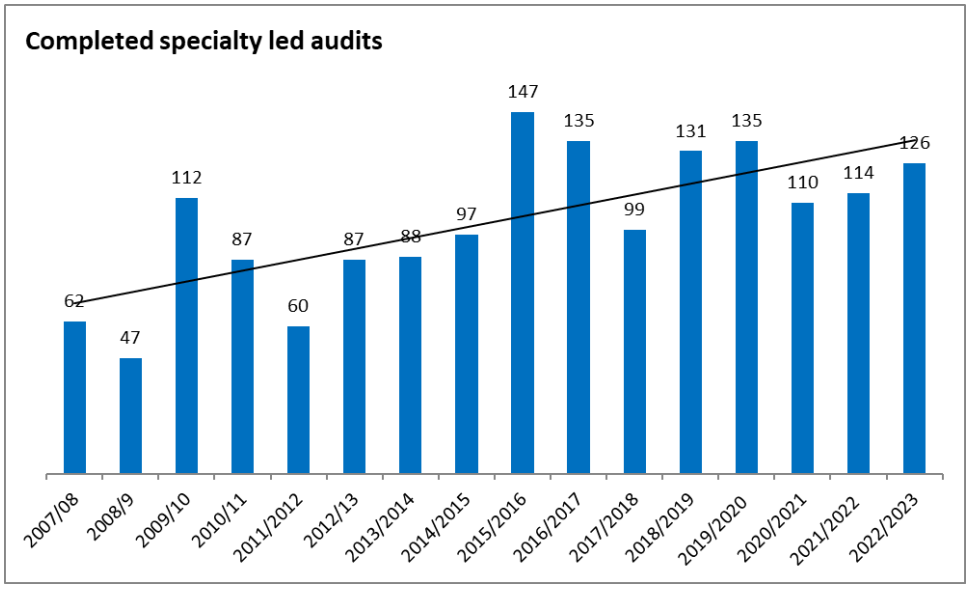
- Directorates Deputy Chiefs of Service to request MDTs than do not have ToR to create them using the template guidance by the end of August 2023.
- Follow up audit to start in September 2023.
- Oversight of actions to be monitored via QSOCC.

Attachment Q

Speciality led Clinical Audit

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

126 clinical audits led by clinical staff were completed at GOSH during 202/23. We aim to have over 100 completed specialty led clinical audits per year. We were able to meet this aim for 2022/23, which is reflects an ability to engage in clinical audit and quality.



In 2022 we implemented our monthly “Clinical Audit excellence recognition” intranet page to promote best practice and spotlight the work that teams do to undertake good audit at GOSH. This forms part of the wider work of the Quality team to support and enable team led audit and quality improvement. This features in our bimonthly “Our QI” news bulletin and web portal which gives space to show the excellent work our clinical teams do to review an improve quality.

Attachment Q

Some examples of excellent specialty led clinical audits completed in 2022/23 are highlighted below

Anti-seizure medication (ASM) reduction after starting on the ketogenic diet

The Epilepsy Service completed an audit that has highlighted good practice and also some learning to help improve patient experience and care.

"*This audit has highlighted a number of significant clinical issues which need to be taken in everyday practice. For instance, reduction of the total medication burden can be an additional benefit of the ketogenic diet and should be considered even if the response to the diet was not the expected. Every attempt of medication withdrawal needs to be individualized, balanced against any risks (e.g., in patients with a high pre-existing risk for seizure recurrence) and carefully discussed with patients/carers. It is worth discussing with patients and families what aspects are important apart from seizure frequency and set therapeutic goals at the beginning of every new therapeutic intervention*"

As a result of the audit, the medical management of patients with drug-resistant epilepsy on a ketogenic diet was reviewed within Neurology team, with agreement on a number of principles when approaching those patients.

Credit-Dr Christin Eltze/ Dr Maria Gogou

Palliative Care Team -Antenatal referrals to palliative care

The team have undertaken a service evaluation to understand more about antenatal referrals to the service to help refine the pathway

Key learning

"*Antenatal referrals to the paediatric palliative care team are increasing year on year. A number of patients referred antenatally die before birth or in the first 24 hours of life. There is also a large proportion of patients who survive. This teaches us a lot about the importance of parallel planning in this patient group.*"

What difference will this completed work make to your team and patient care?

"Has helped us to refine the service pathway - thinking about number of follow ups per patient, writing antenatal symptom management plans and bereavement follow up. This will improve the service offered to patients and ensure that the service is equitable between patients. "

Credit-Dr Sophie Bertaud

Plastic Surgery -Audit of pre-operative cancellation amongst surgical patients

The team used clinical audit to identify an opportunity to reduce same day cancellations for avoidable reasons of elective patients. The audit showed that dissemination of the pre-general anaesthetic information sheet, developed as the intervention for this audit, to patients and their parents ahead of their surgeries reduces the on the day cancellations of elective surgery for preventable reasons, namely, non-adherence to preoperative fasting rules.

"Addresses an important problem, clearly demonstrates an important reduction post intervention in same day cancellations for avoidable reasons of elective patients and therefore a positive outcome for patients and the team, MDT and patient involvement "

Attachment Q

It is a great example of an audit done well and was an multi -disciplinary team effort that included co development of an intervention with families.

Credit. Ms Anoopama Ramjeeawon, Ms Patricia Neves, Mr Neil Bulstrode

Attachment Q

Learning from deaths

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

Implementation of the Child Death Review Statutory Guidance

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

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

Deaths in 2021 and case record reviews

Between 1st January 2022 and 31 December 2022, ninety -eight children died at GOSH.

Seventy of those deaths have been reviewed at a CDRM

- Twelve cannot take place until the completion of necessary coroner investigations. This in line with the Child Death Review Statutory Guidance.
- Thirteen are being planned at the time of writing and haven't yet taken place due to challenges in all relevant parties being able to be available to attend the meeting.
- Three are to take place via a local child death review in the borough where the child lived.

Learning from Child death review meetings concluded in 2022

Child Death Review Meetings are the final review meeting in the mortality review process following the completion of all necessary investigations and reviews, and the point at which learning from deaths can be fully and conclusively reported. Therefore, we report below the learning points from concluded Child Death Review Meetings.

Attachment Q

Child death review meetings concluded in 2022.

	Jan – Mar 2022	Apr –Jun 2022	July–Sep 2022	Oct –Dec 2022
N of deaths reviewed at a Child Death Review Meeting	23	23	26	18
N where modifiable factors [2]around GOSH care were identified following the conclusion of a CDRM	0	2	0	0
N of deaths where there were learning points around best practice which could improve quality, the co-ordination of care, or patient and family experience at GOSH	12	9	12	6
N where excellent practice at GOSH was highlighted in the mortality review process[3]	16	19	18	9

Cases where modifiable factors were identified:

- The patient was discharged after a planned admission despite abnormal blood tests and feeling unwell and mother given reassurance. Returned to the local hospital two days later in septic shock. No blood cultures were taken as the abnormal blood results were attributable to other causes. A learning point is that sepsis as a differential should always been considered in this complex cohort of children. An SI has been concluded at the local hospital.

- An SI highlighted a delay in identifying sepsis when the patient initially presented to their local hospital and subsequent delays in administering antibiotics. The SI also included some recommendations for GOSH around the review of supportive care protocols by Haematology/Oncology, which have been actioned.

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

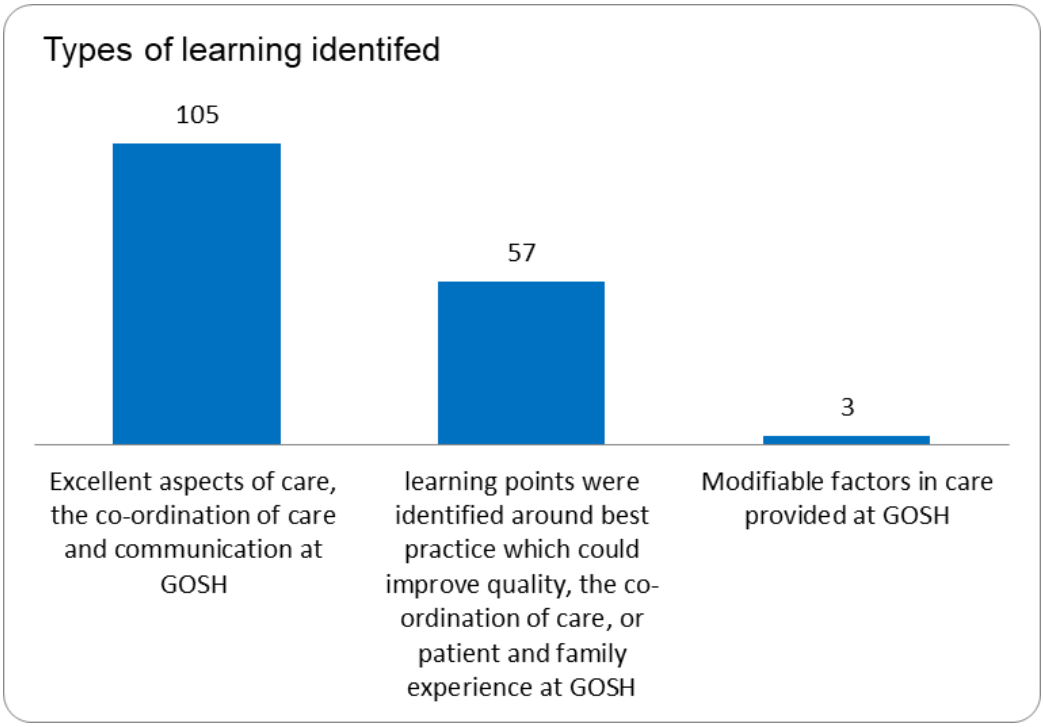
Identification of themes from CDRMs concluded from October 2021 to December 2022

We have conducted a review of learning identified from CDRMs over a longer period of time than quarterly and annual reporting requirements in order to aggregate individual learning points into themes. This is to help identify areas of strength and where we may wish to focus attention and assess whether there may be adequate work streams taking place or are required to address any themes for improvement. It is also helpful to understand the balance of our reporting and that 64% of our learning from CDRMs is about excellence of practice, and to highlight themes where we have noticed excellent practice.
This was reviewed at QSOCC in February 2023 and at Trust Board in March 2023.

One hundred and six CDRMs have been concluded 1st October 2021 – 31st December 2022. It should be noted that each CDRM may identify more than one learning point.

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

Attachment Q



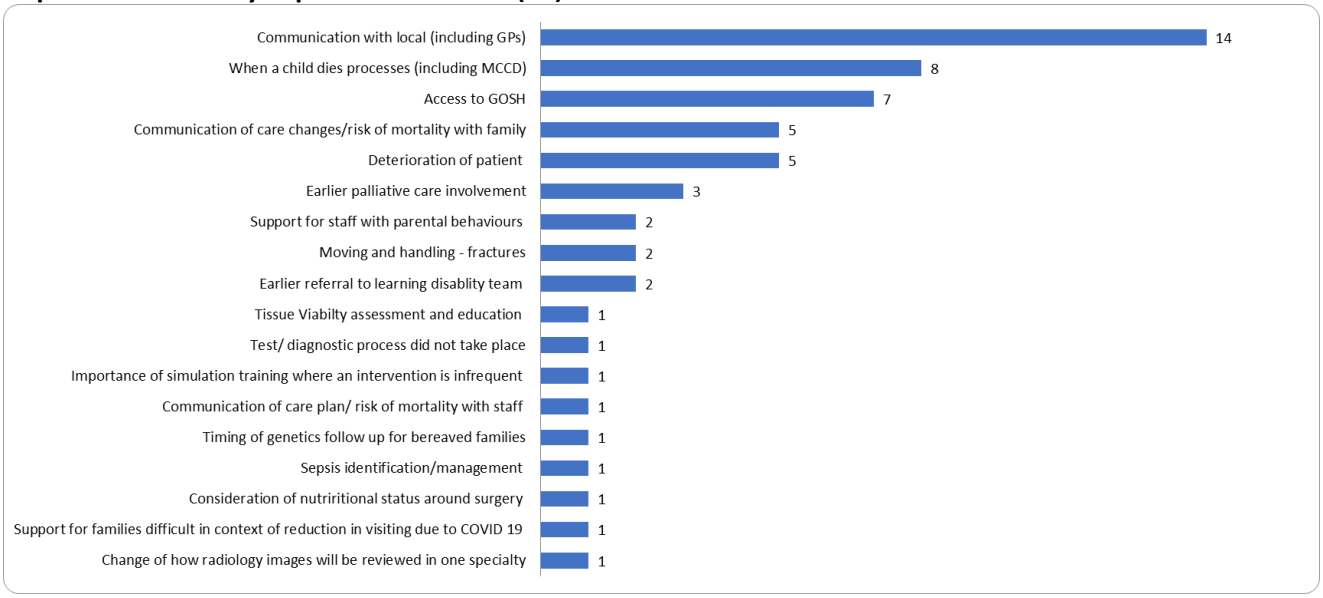
Themes identified from CDRM meetings at GOSH (Oct 2021 to December 2022)

Modifiable factors in care at GOSH (3)

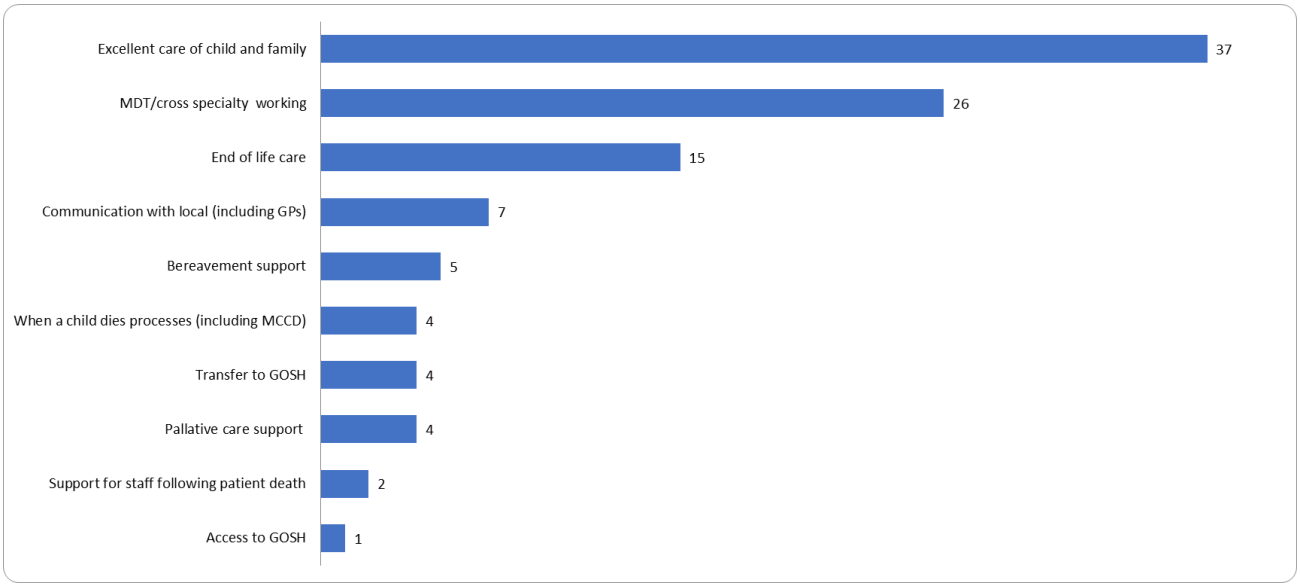
Sepsis identification/management (2)
A Trust wide quality improvement project is in place to support the identification and management of the deteriorating patient.
Management of field safety notice (histoacryl glue) (1)
As a result of the learning from this Serious Incident at GOSH there has been improved control and monitoring of Central Alerting System and national patient safety alerts through clearer policy and periodic comms to support awareness. This has been led by the Safety Surveillance team with collaboration with directorates and staff from many different teams. The incident made recommendations around the recording of lot numbers for implants for embolisation procedures in interventional radiology. Clinical Audit took place in 2022 and 2023 which provided assurance that the recommended practice had been sustained. The positive progress made and learning from the incident and the audit were shared Trust wide through a “Patient Safety and Experience Grand Round” in March 2023.

Attachment Q

Learning points identified around best practice which could improve quality, the co-ordination of care, or patient and family experience at GOSH (57)



Excellent aspects of care, the co-ordination of care and communication at GOSH (105)

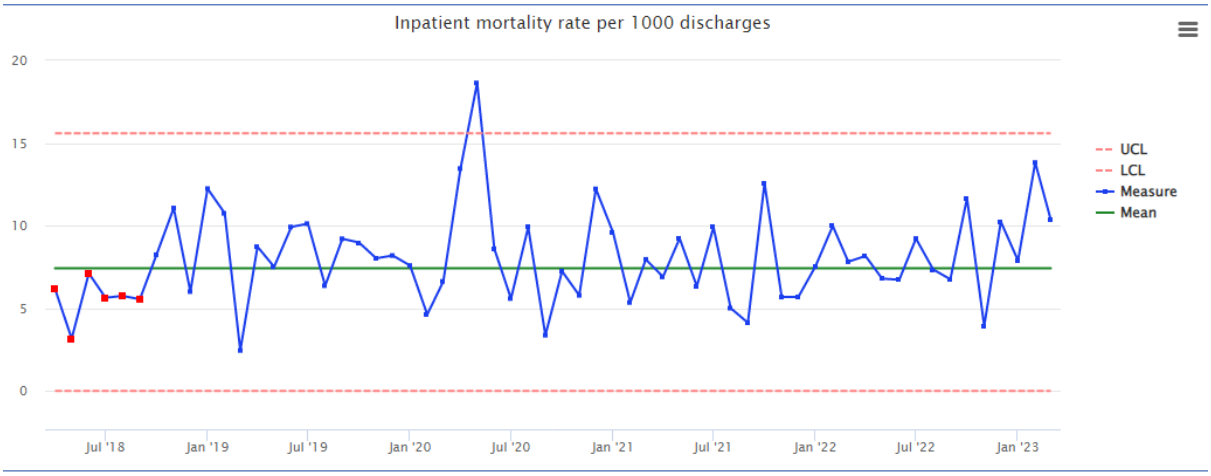


This was reported to QSOCC and there is work in place to address areas where key themes and improvements were identified.

Theme	Workstreams to address this
• Sepsis identification/management • Deterioration of patient	A Trust wide quality improvement project is in place to support the identification and management of the deteriorating patient.
• When a child dies processes	An action plan in response to a learning review is being coordinated by the Head of Patient Experience and has this issue in scope.

Mortality rate

The inpatient mortality rate is within normal variation



Our inpatient mortality rate is useful to understand the frequency of GOSH inpatient deaths compared to activity, and to signal if there is variation that may require exploration. We recognise that it is not risk adjusted data, which considers 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.

- There have been no outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths. This is important as the majority of patient deaths at GOSH are in intensive care areas. Risk adjusted mortality is monitored weekly at the PICU/NICU Morbidity and Mortality meeting
- The most recent PICANet report was published on the 9th of March 2023 and covers the calendar years 2019-21. The report shows GOSH PICU/NICU and CICU risk adjusted mortality as within expected range.

Using Audit to lead improvement

Reducing Parenteral Nutrition prescription and administration errors at GOSH.

Parenteral Nutrition (PN) is a method of administration of essential nutrients to the body through a central vein. Across GOSH, a variation in practice in the prescription and administration of PN was identified, relating to the multiple Datix incidents being reported across the Trust.
The project was initiated in late 2019, with the following aim "All children and young people at GOSH requiring PN receive safe, effective care by 30th March 2023".

Dietetics, led by Kelly Watson, had significant involvement and contribution to the success of this project to date:

- *To address the issues of variation in practice, three guidelines have been written and released for trust-wide use. Specifically, the Monitoring and Assessment Guideline and Prescribing Guideline were co-authored by Pharmacy and Dietetics, highlighting excellent collaboration between the teams.*
- *To ensure the incidents causing patient harm are addressed, two third check calculators were designed and implemented by dietetics to reduce the incidence of prescribing errors.*

Attachment Q

The initial PN assessment is now a joint MDT assessment involving dieticians, fellows and pharmacists, introduced to follow best practice and reduce the inappropriate use of PN. This change was driven by dietetics and will soon be recordable on Epic using a SmartForm for the purpose of future auditing.

"Quality improvement is a team sport, but we really saw great leadership and involvement from the team to reduce PN errors at GOSH"

Participation in clinical research

GOSH, together with the UCL Great Ormond Street Institute of Child Health (GOS ICH), is recognised globally for translational research and innovation. Our Intelligent Research Hospital vision is where every bed is a research bed and research is fully integrated into every aspect of the hospital, to improve outcomes for our patients and the working lives of our staff. We are focused on delivering world-leading research and innovation for patient benefit. The importance of research and innovation at GOSH is demonstrated by its inclusion as a key priority of the Trust's Above and Beyond strategy. A broad portfolio of programmes and projects has been established, alongside the Research Planet Delivery Board, to ensure that we are successful in the delivery of our aim of accelerating translational research and innovation to save and improve lives. Throughout 2022/23, GOSH Children's Charity has been developing its new Research Strategy, consulting with internal stakeholders to ensure alignment across the hospital and GOS ICH, and with external funders to take into account the national research funding landscape.

In 2022/23, we have led cutting edge translational research and innovation to improve and save the lives of children and young people. For example, we treated the first reported patient in the world with base-edited CAR-T cell therapy for her incurable T-cell leukaemia, identified the pathogen causing an epidemic of childhood hepatitis, and began a new clinical trial for an innovative haemophilia treatment.

Research activity

During 2022/23, we have run 933 research projects at GOSH/ICH. Of these, 340 were adopted onto the National Institute for Health and Care Research Clinical Research Network (NIHR CRN) Portfolio, a prestigious network that facilitates research delivery across the NHS (Figure 1). Our extensive research activity continues with the support of our NIHR Clinical Research Facility (CRF) and Biomedical Research Centre (BRC) awards, which were renewed in 2022 for a further 5 years. Our CRF received £4.8m (an increase of 58% on the previous award) and our BRC was awarded £35.3m. The BRC and CRF underpin our entire research infrastructure at GOSH, in collaboration with GOS-ICH and GOSH Children's Charity.

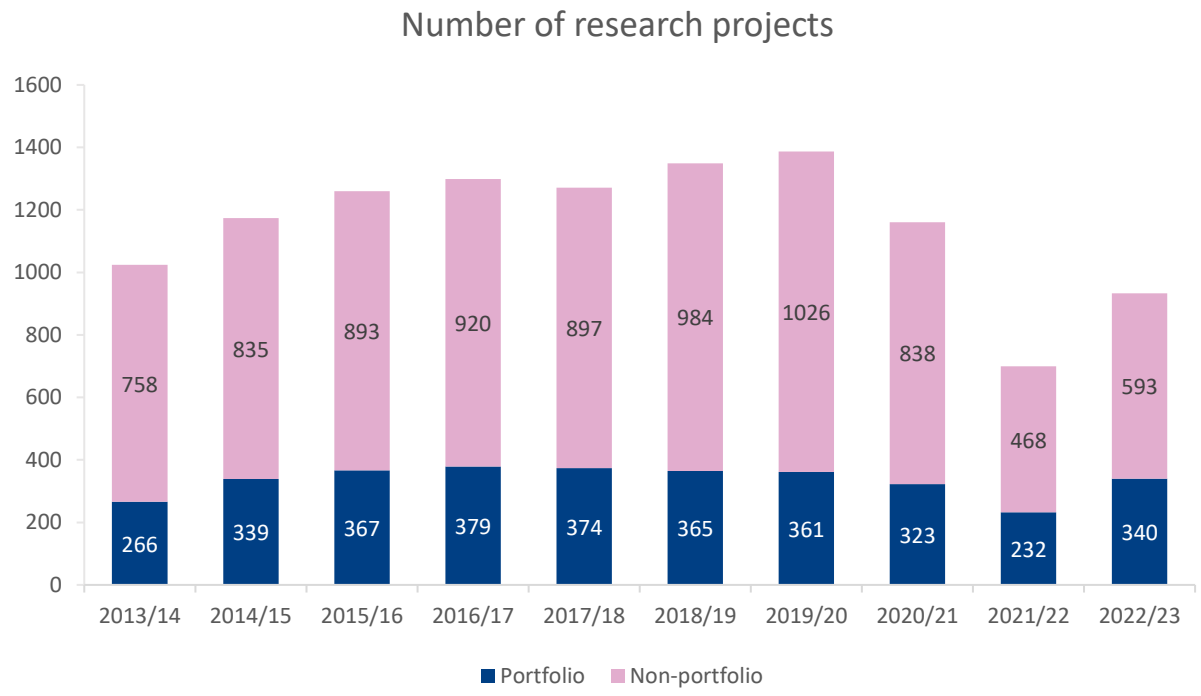


Figure 1: Number of research projects taking place at GOSH/ICH, highlighting the NIHR CRN Portfolio projects.

The number of CRF hosted studies has now returned to pre-pandemic levels, with 54 studies having CRF visits in Q4 of 2022/23. Occupancy of the CRF has increased from a low of 33% during 2021 to 60-70% occupation throughout the latter half of 2022/23. A total of 1359 participant visits took place in the CRF in 2022/23, twice the number of 2020/21 although slightly down on 2019/20. Some of the new ways of working introduced during the pandemic, such as virtual visits and telephone calls have continued as business as usual. There were 2060 telephone visits recorded in 2022/23, compared with 1205 in 2019/20. Overnight visits continue to increase, with 31 overnight stays in 2022/23. The data highlights the continued recovery of clinical research post-pandemic although there remain significant challenges ahead as the NHS tackles an ongoing clinical backlog and the UK looks to address an overall drop in industry engagement in clinical research. However there has been a significant increase in project registrations this year (Figure 2), which could translate into an increased number of active projects in the coming year. Despite the challenges the CRF has set ambitious objectives for future growth and is well placed to acheive these targets as it moves to its new larger location in 2024.

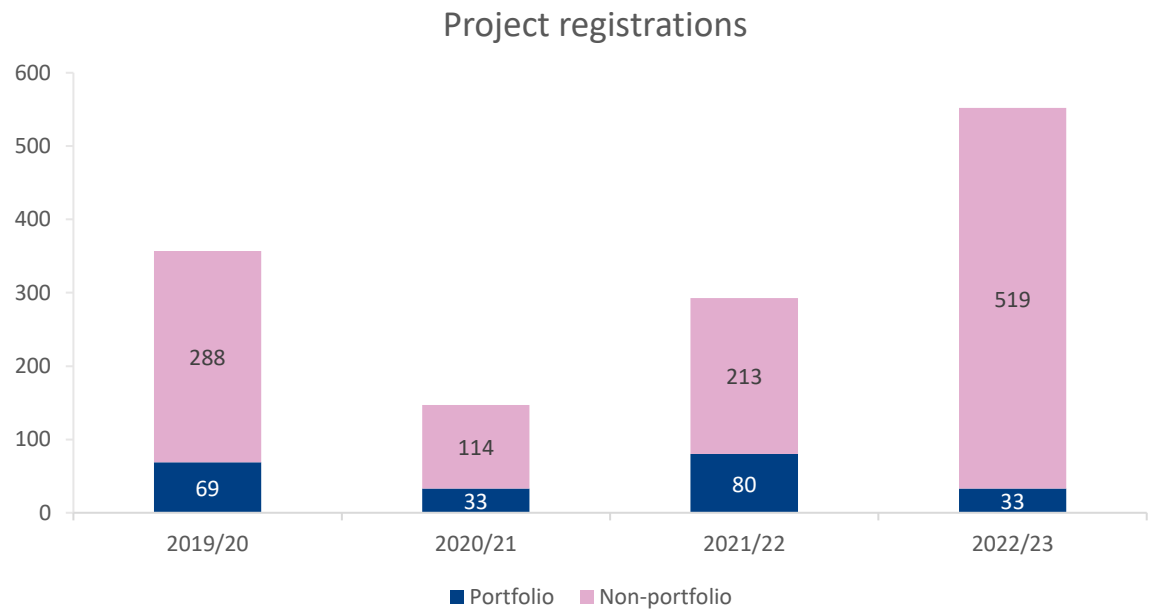


Figure 2: New Project Registrations, highlighting the NIHR CRN Portfolio projects.

In 2022/23, we had 2217 participants in research at GOSH (Figure 3). All research undertaken is approved by the Health Research Authority (HRA), including Research Ethics Committee and Medicines and Healthcare products Regulatory Agency (MHRA) approval as appropriate. Overall recruitment is still lower than figures pre-pandemic. As new registrations increase and the number of open studies returns to levels seen prior to 2020 we would look to see an accompanying increase in recruitment numbers albeit slightly behind the other metrics. As we go through 2023/24 this will be monitored to ensure continued recovery. There will also be scrutiny of the evolution of the portfolio as, in line with our strategic objectives, we look to increase complex, early phase work and have an increased focus on advanced therapy projects. This may result in a more high-risk, high-intenstity portfolio with lower overall recruitment.

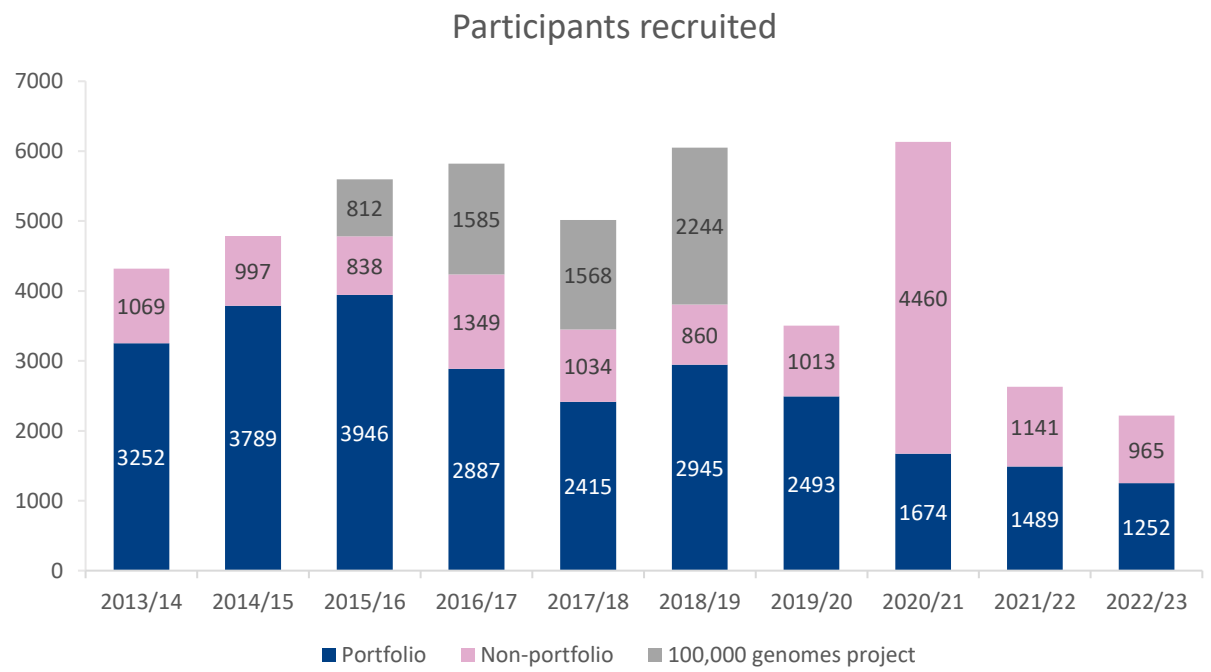


Figure 3: Number of research participants recruited at GOSH/ICH, highlighting the NIHR CRN Portfolio projects and those recruited to the 100,000 genomes project in previous years

Research highlights

In 2022/23 we used our research expertise to bring ground breaking treatments to children and young people. Professor Waseem Qasim led the first trial in the world using base-edited CAR T-cells for T-cell leukaemia, treating GOSH patient Alyssa, then aged 13, who had no further treatment options available to her. Just 28 days following the treatment, she was in remission and went on to receive a second bone marrow transplant to restore her immune system. She continues her recovery at home with her family and has joined the GOSH Young Persons' Advisory Group for research (YPAG). Alyssa returned to GOSH in January to co-host a special BBC Radio 5 live programme, where she was reunited with the clinical staff who cared for her and met laboratory and research staff who made the treatment possible. GOSH often sees the most rare and difficult-to-treat childhood cancers, with many of these patients being on a research study. Alyssa's story sets an example of the high quality care and research we can build on, which will be central in the development of the future Children's Cancer Centre.

In 2022 there was global spike of non A-E hepatitis cases in children, and it was feared they could be related to previous infection with COVID-19. Professor Judy Breuer led a research collaboration between GOSH and UCL GOS ICH to identify the adeno-associate virus (AAV) 2 as the cause of the hepatitis outbreak, ruling out a connection with COVID-19. This finding is of particular significance for the gene therapy community, as many gene therapies are delivered using an AAV. Hepatitis has been a known complication of gene therapy for some time and this could suggest the root cause of this link. More research is now needed to unpick this complex relationship and teams are continuing to work together to turn cutting-edge research findings into patient impact and care.

2022 also saw the start of a new clinical trial for an innovative haemophilia treatment. Researchers from GOSH, Nottingham and Birmingham are testing the treatment in boys under 12 with a rare complication of haemophilia B. The first patient to receive the new drug on the trial was Charlie, 7, who was diagnosed with the disease at birth. Charlie tried several different haemophilia treatments over his first few years before being diagnosed with a rare form of the disease which means he is naturally resistant to the conventional drugs. Current treatment involves injections via a portacath, requiring a lot of maintenance to keep them free from infection and delivery by a trained professional or family member. This complexity often means affected children cannot lead a full active life. The new trial involves a daily injection via a pen

injector, allowing Charlie to do his own injections and take part in school trips, or go away on holiday hassle-free.

The ZCR Gene & Cell Therapy facility has continued to grow as the UK's only academic manufacturing facility for gene and cell therapies within a paediatric hospital. In January 2023, the facility received accreditation from the Medicines and Healthcare products Regulatory Agency (MHRA). Older laboratories in the Octav Botnar and Camelia Botnar wings were also updated and MHRA approved. Combined, these approvals allow the Cell and Gene Therapy service to increase capacity for the manufacture of up to 150 products per year, projected growth of almost 300%. This supports the service's financial sustainability by enabling GOSH to collaborate with a wide range of academic and commercial partners and ultimately enabling more children to benefit from faster bench-to-bedside treatment. Already this year, a new commercial agreement has been confirmed between GOSH and biotechnology company Leucid Bio. The ZCR will provide the quality assurance services required to manufacture their gene therapy product LEU011, a type of CAR T-cell therapy.

Sample Bank

In 2019, we formally launched our GOSH Sample Bank initiative, enabling patients to donate their leftover samples to be used for vital child health research instead of them being thrown away. The samples will allow us to carry out more research to better understand rare conditions and develop new treatments. In 2021/22 we hit 1,000 recruits and aimed to reach a target of 2,000 patients by the end of 2022 (Figure 4). With the CRF often at full capacity, and our delivery team fully stretched, it has been difficult to match the same scale of recruitment in previous years, and we have achieved just over 1400 recruits at the end of 2022/23. However we have taken advantage of Super Saturday events to boost recruitment. The last Super Saturday in November saw 59 patients consented, the highest number of consents in one day.

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

GOSH patient Skye, 15, was diagnosed with a rare form of Primary Pulmonary Hypertension in 2020. Following a lung transplant in 2021, Skye donated her lung tissue to the GOSH Sample Bank in the hope that one day they will help scientists find a cure for other people living with the condition. During her diagnosis, it was discovered that Skye has a rare genetic mutation in a gene called Sox17, that has been connected to the development of PH. It is thought that Skye may be one of only a few people in the world with this mutation. This makes the donation of her lung sample even more invaluable, allowing scientists to study this rare genetic condition.

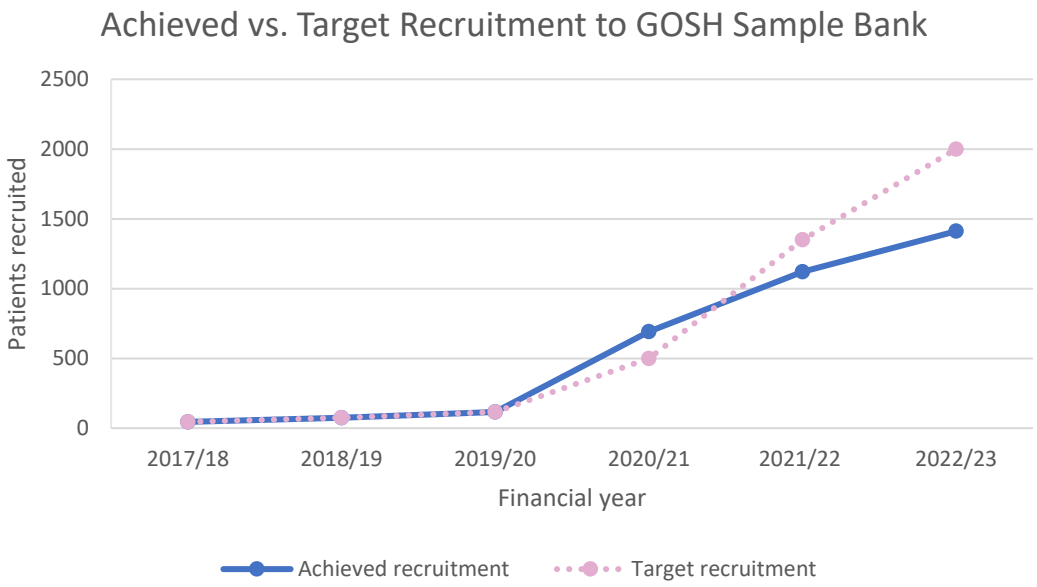


Figure 4: GOSH Sample Bank patient recruitment and targets

In addition, in 2022 GOSH BRC was named as one of six new NIHR BioResource centres, meaning we now receive funding to support this activity. The NIHR BioResource is a national resource that supports public participation in research, recruiting healthy patients and also making it easier to find patients with specific genetic variants. This enables work on specific disease themes, including difficult-to-study rare diseases. There are a total of 18 across the UK, and the Director and Deputy Director of the GOSH BRC are now members of the BioResource national steering committee.

In the last BRC term, GOSH voluntarily recruited participants with a series of rare eye disorders to the Rare Disease BioResource, and we are in the process of setting up the regulatory approvals to recruit to the paediatric Inflammatory Bowel Disease BioResource. We will be recruiting a BioResource Coordinator to be based in the BRC. They will work to increase the range of cohorts we recruit participants from and set up PPIE and dissemination activities relevant to the BioResource.

External Audits of hosted and sponsored clinical trials of investigational medicinal products

In 2022/23 GOSH participated in nine external audits, eight of the studies were hosted trials and one is a GOSH sponsored trial. Observations are categorized as critical, major, or minor. The rating scheme is based upon the observation's potential impact on patient safety, data integrity, or the overall study. All nine of the external audits had no critical findings, however findings were evidenced where a departure from applicable legislative requirements, established Good Clinical Practice (GCP) guidelines or procedural requirements occurred, but was not critical. Typical findings were related to validation documents for Epic, site file management, training, delegation logs, source data and documentation. In all cases there was documented evidence of the Principle Investigator's oversight and involvement in the trial. The observations and conclusions of the audits were based on interviews with key personnel and review of documentation. The protection of trial subjects and data integrity was not found to be a risk in all audit outcomes.

Research income

Research income in 2022/23 was £24.6m and remains lower than in previous years (see Figure 5), we have also seen a decrease in commercial income over the financial year. Despite a drop in income overall, we have ended the year contributing £1.6m to the Trust over and above our core costs.

As we move into 2023/24, we are focusing on growing our research activity, in line with the Department of Health and Social Care's Recovery, Resilience and Growth Programme and to meet ambitious targets for income, continuing to ensure that we provide sufficient infrastructure to support research delivery across the Trust.

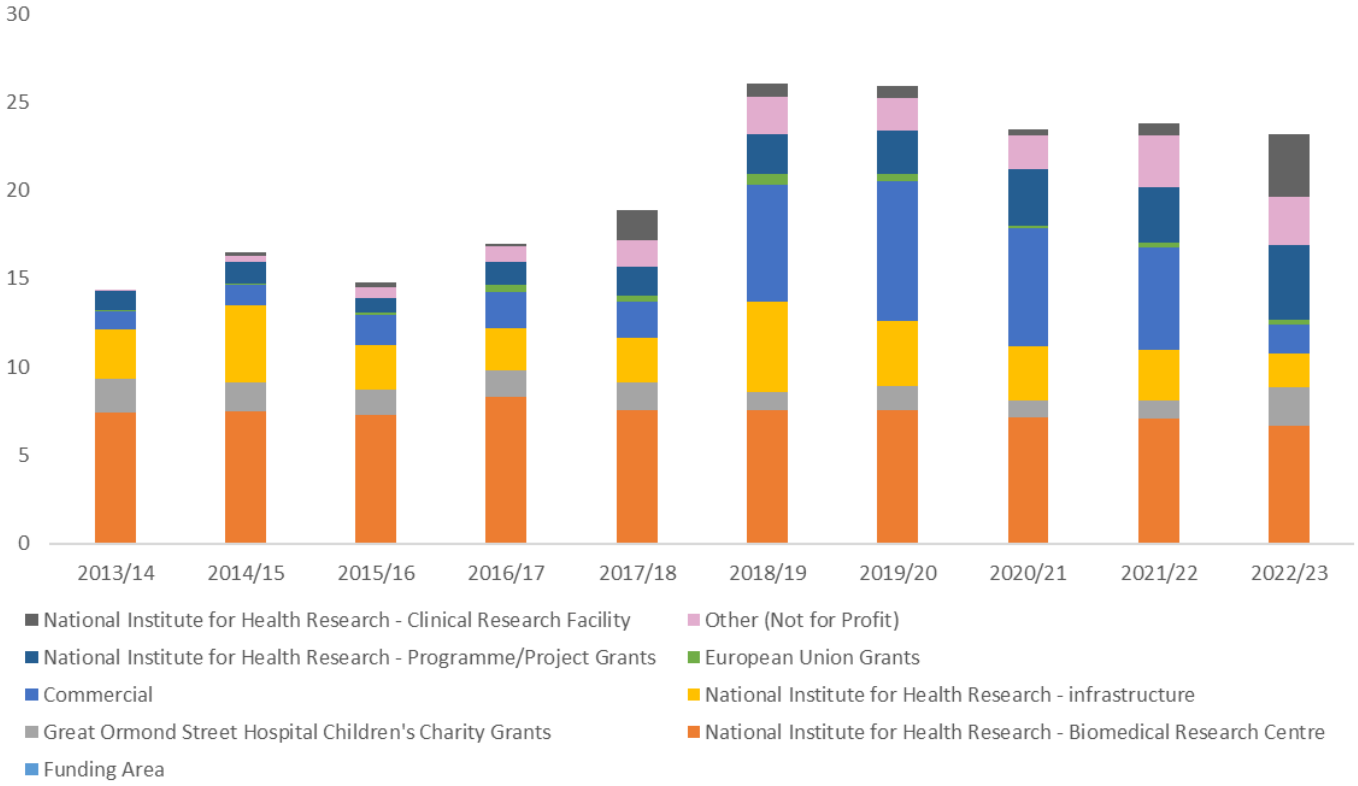


Figure 5: Research income (£m). NB final year end figures not yet validated.

Attachment Q

Innovation

The Data Research, Innovation and Virtual Environments unit (DRIVE) focuses on using data and technology to improve patient care, and the hospital experience for patients and families, as well as staff. Established in 2018, the unit is celebrated its fourth year in 2022. The unit brings together staff with expertise in data and digital technology, and our clinical expertise.

In 2022 the DRIVE roadshow engaged staff with innovation at DRIVE, showing examples of work and how to collaborate with the unit. The Ideas@GOSH process was launched to support staff interested in making improvements for the benefit of patients and families, and connect them with innovation stakeholders throughout the Trust. Always acutely aware that Innovation cannot happen in isolation, in 2022/23 we worked on ongoing projects with several partners including:

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

The DRE provides secure access to patient data recorded for more than 20 years and works alongside the Electronic Patient Record system at GOSH. This allows for data management, visualisation and analysis in research and operational projects, in collaboration with academics, clinicians and partner organisations. The DRE has established project organisational structures and processes aligned with best practice in data science. One current project uses RedCAP to support the largest cohort study of Juvenile Dermatomyositis and related inflammatory conditions in children and young people in the UK. The DRE has also set up a cardiac dashboard to enable the cardiac team to access data more rapidly in informative patient profiles to be discussed in clinical meetings.

GOSH, along with leading children's hospitals in the United States, Canada and Australia form the International Precision Child Health Partnership (IPCHiP). It is the first major collaboration around genomics in child health and aims to accelerate discovery and therapeutic treatment for rare diseases.The first study of the partnership is looking at infantile epilepsy and whether earlier genetic diagnosis improves patient outcomes. The DRE team will design the architecture for, and implementation of, a completely new way to record genomic information so that it can be used to spot vital clues and patterns that can lead to potential new treatments.

In 2022, GOSH and Roche announced a five-year collaborative working agreement to establish a new Clinical Informatics and Innovation Unit at GOSH with four key areas of focus:
1. Improve research capability and clinical decision support systems
2. Increase the use of digital tools to improve how we collect data from research and clinical trials
3. Use anonymised real-world data to improve paediatric personalised healthcare
4. Improve clinical and research data using sensors, devices and wearable technology

During the five-year partnership, Roche will provide funding and second staff to work closely with GOSH DRIVE on projects, led by a steering group of leaders from both organisations. The team will work with other partners such as the public, patients, UK Government bodies and healthcare partners.

Journal publications

In 2022/23 we published 647 papers, 552 of these were with our academic partners. In the five-year period between 2012 and 2016, GOSH and ICH research papers together had the second highest citation impact (1.997) of comparable international paediatric organisations. We have commissioned a further bibliometric analysis of GOSH and its comparators for the period 2018-2022, to evaluate GOSH & ICH's overall research output and citation impact.

Education and Training

Training and education of the next generation of high calibre researchers in paediatric translational research is co-ordinated by the Career Development Academy (CDA) of the GOSH BRC and is monitored by our Research Planet Delivery Board with support from our Centre for Outcomes and Experience Research in Children's Health, Illness and Disability (ORCHID) and GOSH Learning Academy (GLA). Development of research careers remains a priority, and we continue to embed research and learning opportunities throughout careers at GOSH, to attract and retain research leaders. One such example is the GOSH BRC Academic Training Weekend, a residential event which took place in November 2022. The event brought together early career researchers from a wide range of disciplines and specialities, and from across the UK. The event programme was developed to support attendees as they move towards becoming independent researchers by taking them through the different steps along the journey.

Our unique programme of career development schemes for Early Career Researchers, including our Catalyst Fellowships and Wider Health Care Professional internships in partnership with ORCHID, has led to an increase in individuals securing prestigious external fellowships. Twelve Catalyst Fellowships and fourteen Wider Health Care Professional internships have been awarded since the scheme began. The Wider Health Care Professional internships were awarded to a range of professionals, including seven AHPs, one pharmacist, one health care scientist, four nurses, and one psychologist.

Seven individuals were awarded career development awards in 2022/23, including five securing NIHR Clinical & Practitioner Academic Fellowships (PCAFs) and Doctoral Clinical and Practitioner Academic Fellowships (DCAFs). Our Catalyst Fellowships continue to leverage external funding with £5.3M achieved against £881k BRC investment since the scheme began. Post-doctorate, two individuals also received NIHR Development and Skills Enhancement Awards, and Dr Polly Livermore was awarded GOSH's first NIHR Advanced Clinical and Practitioner Academic Fellowship (ACAF) - she is our first nurse to receive a post-doctoral fellowship of any kind.

In March 2022, GOSH's Executive Management Team endorsed a proposal for a Clinical Academic Framework for non-medical staff. The proposal, a collaboration between ORCHID (Centre for outcomes and experience research in Child Health, Illness and Disability), GLA (GOSH Learning Academy), and Research and Innovation, offers staff a structured 12-month programme following completion of doctoral studies, with dedicated time to undertake research activity (including preparing future grant proposals) embedded within their job plan.

We have an established clinical research delivery programme ensuring our clinical researchers provide high quality clinical research care. The Research Advanced Nurse Practitioner leads on advanced practice focussed on supporting the workforce to develop the complex clinical skills required to deliver early-phase translational research. They have established a multidisciplinary programme to enable investigators and research nurses to achieve competence in complex procedures such as intrathecal drug administration resulting in a uniquely skilled workforce allowing us to carry out 14 complex first-in-child studies in 2022/23. The research education team continue to work in collaboration with investigators to identify training needs and develop training packages with particular emphasis on our early phase portfolio pipeline of advanced/gene therapy studies.

Attachment Q

Patient Experience and Engagement

All the examples included here indicate the quality of research at GOSH which has a direct benefit to and involvement of patients, families and the public. Our highly successful Young Persons' Advisory Group for research (YPAG) has seen an increase in attendance and new members over the pandemic and since. We have continued to operate in a virtual format for the last 12 months, this has enabled us to increase our geographical reach. We are moving towards hybrid delivery as part of our wider strategy to deliver patient and public involvement and engagement (PPIE). Our PPIE highlights demonstrating progress against our strategy and impact case studies with examples of where, when and how our young people and families contributed to the development and implementation of the research can be found on the GOSH website, along with more information about GOSH YPAG. Since August 2022 we have supported researchers to engage with the local community and since February 2023 we have returned to delivering in person research engagement events in the hospital.

Our patient and public involvement, experience and participation programme has been held up as an example of good practice repeatedly in our NIHR CRF and BRC annual report feedback. The NIHR GOSH BRC PPIE Steering committee meets monthly, currently supporting the development of the NIHR GOSH BRC/CRF PPIE 2023-2027 Strategy and exploring development of more partnership working with the Paediatric Excellence Initiative, supported by NIHR GOSH BRC funding. The initiative brings GOSH together with Sheffield Children's Hospital, Birmingham Women's and Children's Hospital and Alder Hey Children's Hospital to combine cutting-edge research methods with world-leading clinical trial expertise and accelerate discovery of new treatments for children with rare and complex conditions worldwide. The NIHR GOSH BRC/CRF PPIE 2023-2027 strategy will be submitted to the NIHR PPIE Central Commissioning Facility by June 2023. They will then review the PPIE strategy against the framework on core components and provide feedback to award holders.

Patient experience is at the heart of our clinical research activity. All our patients participate in research voluntarily and we understand the importance of play and play/distraction therapy in ensuring a child's research visit is a pleasant experience. We have a dedicated research Play Specialist who works with the delivery teams to ensure that those patients involved in our early-phase trials have a positive research experience. We are also continually striving to improve our research participant patient experience. Each patient/family who takes part in research within the CRF is asked to complete a feedback form. During 2022/23 the response rate was 34.17% (Trust average 28.20%) with a 99.76% positive experience measure (Trust average 98.24%). Enhanced patient experience has been the focus of plans for the new expanded CRF, with ensuite rooms and built in beds for parents and carers. The patient experience space, including reception, play and waiting area, parents lounge and kitchen, puts patients and their families at the centre of the CRF.

We continue to share our research success stories internally and externally, with a few examples demonstrating our leadership in major breakthroughs that have changed the lives of those with rare and complex diseases world-wide listed on refreshed research webpages: Our commitment to live-changing research | Great Ormond Street Hospital (gosh.nhs.uk). In 2022, we also published our research guide: A Pioneer in Research, outlining our Intelligent Research Hospital ethos and aspirations, and reflecting key themes such as gene therapy, genomics, surgery and intensive care, where we are truly world-leading.

Attachment Q

CQUIN payment framework

What is CQUIN?

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of NHS healthcare providers' income conditional upon improvement. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers, and constitutes 1.25% of the Actual Contract Value between commissioner and provider.

CQUIN schemes have been reinstated for the first time since 2019/20 to help the NHS achieve its recovery objectives with schemes being split into CCG/ICB and Specialised Services. As a specialist provider GOSH was contracted to deliver the Specialised Services, Cerebral Palsy Integrated Pathway (CPIP) Assessment CQUIN. The scheme requires providers is to develop networks to support referral pathways ensuring patients receive a CPIP assessment and that this is entered onto the national database as early intervention can prevent deformity, reduce pain and the need for complex surgery. This scheme applies to all 18 acute paediatric lead centres and should therefore reduce and/or avoid geographical variation in care in line with the commitments of The NHS Long Term Plan.

The Trust has 100% achieved this CQUIN.

Attachment Q

CQC registration

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

Since the height of the global pandemic, the CQC has not carried out any further inspections of the Trust since its 2019 inspection (report published January 2020; services rated 'good' overall and 'outstanding' for the 'caring' and 'effective' domains). Regular engagement meetings with between the Trust and the CQC have continued, to share information and foster an open and transparent relationship.

We have continued to bring actions to completion which arose from that inspection. During 2022 the Trust completed the actions arising from the BDO LLP Well-led independent review, primarily focussing on the Trust Board and senior management team. To support continued focus on the Well-led domain, the Trust has delivered a Board development programme focussed on the CQC's forthcoming single assessment framework for regulation of healthcare providers.

During 2022-23 the Trust amended its Statement of Purpose for the purposes of its CQC Registration. These amendments include the ability to provide care, treatment and support for children and young people detained under the Mental Health Act 1983 and includes the service type in relation to gender dysphoria and/or incongruence. This was approved at the Trust Board on 30 March 2023 and has since been formally submitted to the CQC.

Attachment Q

Data quality

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

Highlights of the work completed in 2022/23 across Information Services, Data Assurance, Information Governance, and Clinical Coding include:

Information Services

- Further development in QlikSense – moving reporting for Genetics, GLH & GLA (Learning Academy) onto the platform & increased analytics apps for Theatres and Beds
- Multiple datasets built in the EPR and HR data warehouses, QlikView and QlikSense to provide the Trust with oversight of various operational areas.
- Standards for both data warehousing and reporting development reviewed and rolled out to wider data teams to align processes.
- Introduction of Staff Development process including Analyst Framework
- Knowledge sharing and best practice collaboration with data teams across the Trust
- Development of National Data Opt Out solution, Was Not Brought (AI) accelerator programme, FFT - collaborative project for theme and sentiment analysis of Friends and Family Test
- New processes embedded for managing team workload to provide updates, assurance, and easier prioritisation.
- New development started for reporting on data from non-EPR systems including GLH (Genetics) and GLA (Learning Academy).
- DHR Connect Project
    - Data Warehouse Environment Access review and standardised
    - Shared configuration updates from Development for RMH
    - Segregation of Data Warehouse environment to remove Marsden Data from custom development and additional segregation for Epic Standard Tables
- Submitted 876 Central and Statutory returns during 2022/23.

Data Assurance

We continue to work to enhance our IG framework and our general approach to IG through:

- Ensuring that we have embedded, throughout the Trust, a ‘data protection by design and default’ approach.
- Maintaining the documentation of processing activities, including the lawful basis for processing personal data.
- Ensuring the appropriate security measures, such as our commitment to meeting the standards of the Data Security and Protection Toolkit (DSPT).

The updated IG Framework aims to support our future strategy to protect data as an asset and provide a balanced and proportionate approach to risk, placing the child first and always.

Risks to data processing are managed in the same way as other Trust risks but are subject to separate evaluation and scrutiny by the Information Governance Steering Group, which meets on a monthly basis, and in turn providing assurance to the Trust’s Audit Committee.

During 2022/23, the Trust compiled its evidence for the DSPT and submitted this by the due date of 30 June 2022. On the basis of this submission the Trust received rating of “standards met”. (In prior years this has only been achieved after a number of follow-up submissions). This annual submission

demonstrates GOSH's commitment to assuring that we are practicing good data security and our personal information is being handled correctly.

This year there have been six serious information governance incidents (classified at a reportable level using the Incident Reporting Tool within the DSPT). Three of these incidents were reported to the Information Commissioner's Office (ICO)/ From these incidents the Trust has worked to improve the processes involved and adapted and extended training.

Secondary Uses Service

As required by NHS Digital, GOSH submitted records during 2022/23 to the Secondary Uses Service (SUS) for inclusion in the National Hospital Episode Statistics. These are included in the latest published data. The table below shows key data quality performance indicators within the records submitted to SUS.

Indicator	Patient group	Trust Score	Average national score
Inclusion of patient's valid NHS Number	Inpatients	92.8%	99.6%
	Outpatients	93.3%	99.8%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.9%	99.7%
	Outpatients	99.8%	99.5%

Notes:

- The table reflects data from year to date 2022-2023 at month 12 SUS inclusion date.
- Nationally published figures include our international private and non-English patients, who are not assigned an NHS number.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

Information governance

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

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

Clinical coding

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

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

have created their own 'coding guide' and this is updated on a regular basis and allows the team to continue to standardise coding across the Trust. Independent training and study sessions remain in place for each member of the clinical coding team. In addition a weekly audit and training meeting has now been established with the senior coding team to identify common themes and address issues that need to be discussed with NHS information Standards for resolution.

The clinical coding team continue to work towards a robust validation programme working with clinical teams across all specialties. The work that has already been undertaken was acknowledge by the auditor during the 2022/2023 DSPT audit.

The recent 2022/2023 audit for clinical coding for the compliance of the Data Security and Protection Toolkit showed results of over 96.0% accuracy for primary diagnostic coding 98.82% for secondary diagnostic coding, and 96.07% for primary procedure coding and 90.8% for secondary procedure coding. The accuracy of clinical coding was rated as exceeding DSPT Standards across all 4 areas.

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

Area audited	**Number of FCEs**	**Primary diagnosis accuracy**	**Secondary diagnosis accuracy**	**Primary procedure accuracy**	**Secondary procedure accuracy**
Data security and protection toolkit	200	96.00%	98.82%	96.07%	90.80%

There were several areas of good practice noted – these included:

- Quality of diagnoses coding is very good
- Quality of Telemetry coding is very good in particular
- Significant improvement in the primary procedure coding from last year
- Endoscopies (Gastro) were coded well Histology results were checked and updated promptly
- Significant reduction in non-relevant codes being used compared to previous years
- Adhesiolysis coding has improved significantly against previous years
- Ear procedures were well coded
- The medical records were all accessible electronically and are available in a timely manner to the coders
- Encoder is in use, which allows coding 5th characters and coders can select source documents and add any relevant notes to the episode coded
- There are currently no vacant posts in the department

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

- Coders not reading through full op notes to extract all information and assign codes to fully reflect the procedures undertaken.
- Inconsistent coding of site and laterality codes with injections, although not governed by National coding standards.
- Trauma and orthopaedic coding would benefit from further training and consultant validation processes.
- Data quality errors in admission and discharge dates of patients
- Consultant not matching the specialty the patient is admitted under
- Documentation issues reported in previous DSPT audits persist – including the patients problem list not always being reviewed, op title being copied over from the pre-op notes as opposed to the actual procedure taken place resulting in incorrect code assignment by the coders.

Attachment Q

Audit findings and errors have been discussed with individual coders and team training and feedback has been provided. Quick fixes have already been identified and actioned.

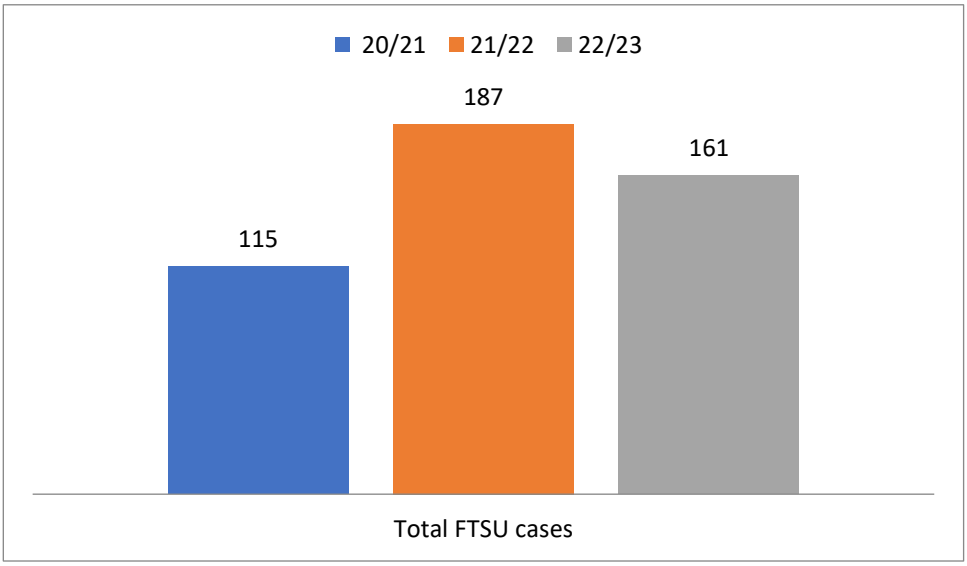
Attachment Q

Promoting safety by giving voice to concerns

Freedom to Speak Up Guardian

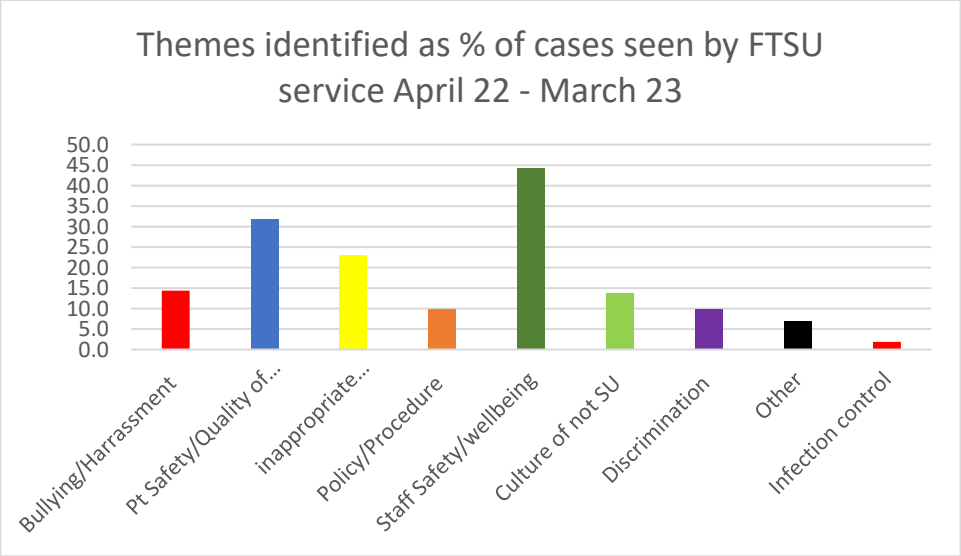
The Freedom to Speak Up service provides confidential and impartial advice to support colleagues in raising concerns about patient safety, quality of care or anything that affects the working lives of staff at the Trust. It is one of several routes of speaking up in the organisation and offers support to staff throughout the process of raising a concern.
In 2022/23 the Freedom to speak up service recorded 161 cases of people speaking up about concerns. This compares to 187 recorded cases in 2021/22..

Number of cases raised with the FTSU service



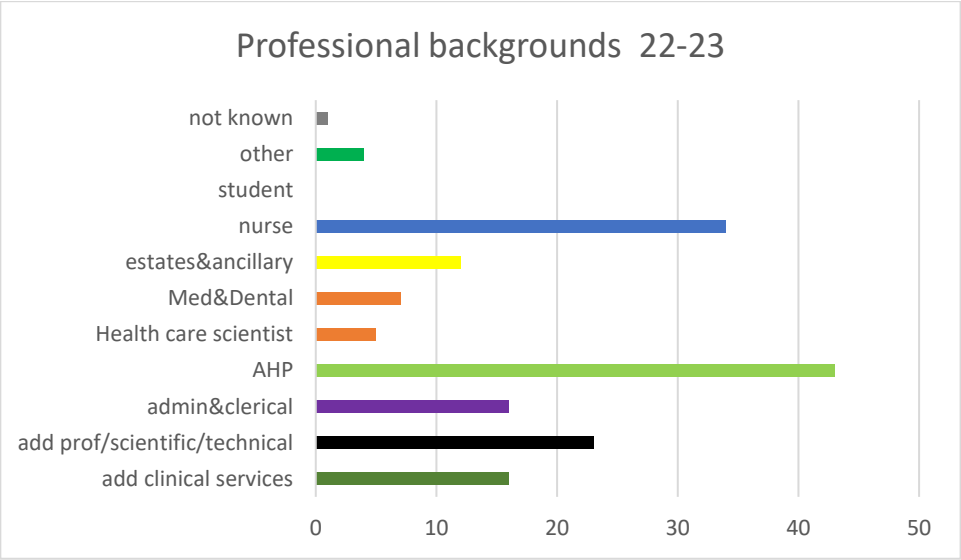
Themes of concerns being raised with the FTSU service 2022/23

Many cases were complex and involve elements relating to several themes. Staff safety/ wellbeing was the most reported issue raised, with 44.4% of people reporting this as an element of their concern. Several concerns led to formal investigations under the appropriate Trust policies.
Patient safety and quality of care was the second highest concern raised (31.9%) followed by cases that had an element of inappropriate behaviour/ attitude (23.1%), bullying/ harassment (14.4%) or reported issues relating to a culture of not speaking up (13.8%).



Attachment Q

Professional backgrounds of people raising concerns with the FTSU service



The FTSU Guardian reports quarterly data to the GOSH Quality, Safety & Experience Assurance Committee, and the People & Education Assurance Committee and externally to the National Guardians Office. This ensures that the work we are doing, including themes around concerns and data is shared both internally and externally through a clear governance structure.
Staff that use the service are asked two feedback questions which relate to their experience of accessing and working with the FTSU Guardian, and whether they would speak up again in the future. All staff who provided feedback described working with the Guardian positively, with many commenting on the speed at which initial discussions were arranged, and the empathetic and supportive advice they received. Some colleagues described not having initially known that the service was available and there continues to be work aiming to increase the profile of the service across the Trust.
91.3% staff who provided feedback to the second question said they would speak up again in the future. Of those who were unsure (6.5%/ N=3) or would not speak up again (2.17%/ N=1), the information shared related not to the FTSUG service itself, but to feeling not being heard by the wider organisation, there not having been significant change/ clear learning, or feeling that they had not received feedback. The FTSU Guardian works to help ensure cases raised via this process receive feedback as to action taken, whilst supporting a wider need for training for those in leadership and line management roles to be able to listen up and follow up.
The staff who reported they would speak up again in future identified that the FTSU service supported them to feel heard, enabled them to work through potential ways forwards, and supported them with this process.

Alongside the FTSU service, the Guardian also co-ordinates the i-speak up platform which was launched in October 2020 and allows people to provide feedback about a colleague's perceived unprofessional behaviour. For the financial year of 2022/23, 11 people raised concerns through this platform (compared to 26 the previous year) with 6 of those concerns leading to peer messenger conversations. The Trust is committed to reviewing the channels available for staff to use to enable them to raise concerns. It is recognised that not all staff groups have equal access to electronic platforms.
The service continues to promote awareness of FTSU pathways and supports the Trust to improve the culture of speaking up. Throughout the year, the Guardian attended a range of team meetings and Trust events to raise awareness of the FTSU service, other ways of speaking up and includes highlighting the NGO national online training modules speaking up (for all workers) and listening up (for managers). The final NGO module 'Following up' (aimed at board level) has also been embedded into the Trust learning platform. In the last quarter of the year there was a transition period with a new Guardian starting in post March 2023 and there is ongoing work to promote this change across the Trust so that staff are aware who to contact and how support can be arranged.

Attachment Q

It is an expectation that all new starters to the Trust complete the speak up training. We believe by making sure that all our new starters have access to information about how to speak up and be heard in the Trust, as well as delivering ongoing training to help increase awareness of the speaking up/ listening up/ following up process, that we improve the care we provide our patients and make GOSH a better place to work.

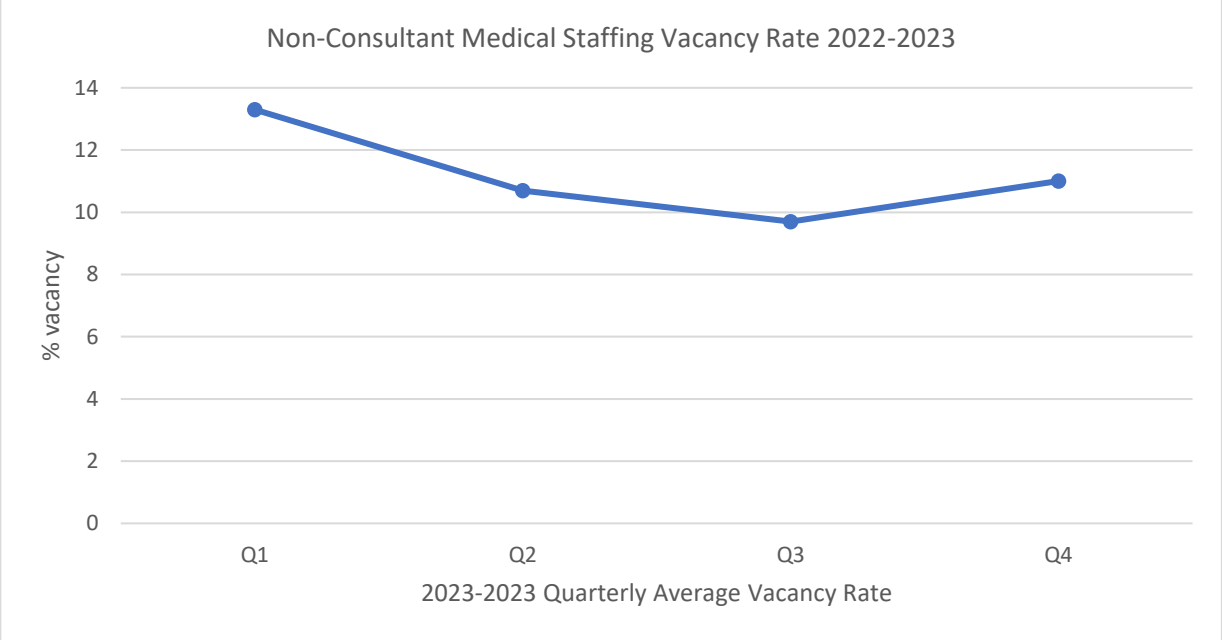
Attachment Q

Reducing rota gaps for NHS doctors and dentists in training

Rota gaps are a constant area of challenge within GOSH which has specific workforce needs as a specialist paediatric hospital. Rota gaps reflect the end point of multiple workforce issues at a national and local level. These issues include:

- short term unplanned absence
- increase in less than full time working (60-80% whole time equivalent) with less opportunity to share posts
- delays in the recruitment process particularly those related to onboarding International Medical Graduates who make up 40% of GOSH's non-consultant workforce
- notification from Health Education England rotational training pathways occurring late, making it impossible to achieve recruitment in to the empty post within the limited time frame
- national reduction in the available European paediatric workforce particularly noticeable since January 2020

Vacancy rates have direct impact on rota gaps. Historically the vacancy rates at GOSH have been lower than the national average in comparable specialist hospitals.



Rota gaps continue to be highlighted as an organisational pressure and are monitored by the Guardian of Safe Working on a quarterly basis. Measure taken to mitigate rota gaps are varied across the organisation and include:

1. Departmental consultant rota leads work alongside band 5 rota coordinators to oversee rota management anticipating potential rota gaps in advance.
2. Every rota is compliant with the 2016 Terms and conditions of service with calculations for annual and study leave factored in.
3. Rota coordinators (RCs) work to maintain a minimum number of doctors known to be required for safe staffing in every specialty. RCs work alongside non-consultant doctors to receive leave requests and notification of absence. The RCs support the consultant rota leads to anticipate vacant posts on resignation, rotation, or end of post.
4. Recruitment dates are open up to 24 months earlier than start date in some circumstances to align with North American and Southern Hemisphere recruitment patterns.
5. The Hospital at Night team now has a generous establishment of medical and surgical doctors which is able to absorb unexpected or unfilled rota gaps without compromising patient and doctor safety.

6. Ongoing support of the exception reporting process to include all Trust grade (none-HEE training doctors) in the exception reporting process has been in place since May 2018. There is now a completely equitable Exception Reporting process available to all non-consultant doctors at GOSH including compensation (remuneration or time off in lieu) and review of work scheduling. Fines levied to departments for any breach on 2016 TCS are in place from November 2022. This supports proactive management of rota groups and is an important safety mechanism.
7. A working group established through the Medical Director's Office is focusing on modernising the clinical workforce through considering the roles of Advanced Clinical Practitioners (ACP). Working collaboratively a combination of ACPs and medics can provide a more robust and sustainable workforce model ensuring safe, skilled patient care.

Attachment Q

Part 2c: Reporting against core indicators

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2022	2021	2020	Most recent results for Trust	Best results Benchmark group	Worst results Benchmark group	National average		
The percentage of staff who would be happy with the standard of care provided by the organisation if a friend or relative needed treatment.	86.3%	89.6%	91.5%	86.3%	92.5%	71.6%	62.9%	The survey is carried out under the auspices of the DHSC, using their analytical processes. GOSH is compared with other acute specialist trust in England. Source: NHS 2022 Staff Survey results	The key actions associated with addressing staff survey findings will be incorporated into the delivery plans that will support the new GOSH People Strategy. Many of the survey questions changed in 2021 to align responses to the NHS People Promise. Alongside these changes there was a focus on emotional resilience and wellbeing. While our results reflected the challenging circumstances in which our staff are working, we have observed a reduction in some of the gains achieved in previous years and brought GOSH closer to the NHS average. Despite this, our People Promise scores, although dipping from last year, have held compared with NCL, the NHS average, London trusts and Children's Hospital Alliance (CHA) being equal to or higher than in the following areas: • We are compassionate and inclusive • We are safe and healthy
Percentage of staff who agreed that care of patients is the organisation's top priority.	84.2%	87.5%	89.1%	84.2%	90.8%	80.4%	74%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from managers in last 12 months.	11.8%	13.3%	13.8%	11.8%	5.7%	14.8%	11.1%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from other colleagues in last 12 months.	22%	20.4%	20.9%	22%	11.1%	24.2%	18.7%		
Percentage of staff who consider the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.	50.6%	74.8%	76.4%	50.6%	67%	46.6%	56%		

									• We are always learning • Staff engagement • Morale Results have been shared with local teams with a view to understanding their staff experience and develop an action plan alongside identified Trust wide priorities with the aim of "Making GOSH a great place to work. "

Indicator	**From local trust data**			**From national sources**				**GOSH considers that this data is as described for the following reasons:**	**GOSH intends to take the following actions to improve this score, and so the quality of its services, by:**
	2022-23	2021-22	2020-21	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Friends and Family Test (FFT) - % of responses (inpatient).	27%	33%	33%	29%	†	†	†	NHSE FFT reporting resumed in January 2021 after the pandemic, however, the report no longer publishes response rates, only a comparison of the experience rating for inpatients and outpatients. GOSH has an internal target response rate of 25%.	GOSH is working on a project with Imperial College London which will use Natural Language Processing to automatically apply sentiment and theme to FFT comments. This will allow us to have more meaningful FFT dashboards at GOSH which frontline teams can use daily to identify and make improvements within the Trust.
FFT - % of respondents who recommend the Trust (inpatient).	98%	98%	98%	98%	100% *data from Feb 2023	66% *data from NHS England Feb 2023	94% *data only available up until Feb 2023		GOSH has an internal target of 95%.
FFT - % of respondents who recommend the Trust (outpatient)	95%	95%	96%	90%	100% *data from Feb 2023	73% *data from NHS England Feb 2023	94% *data only available up until Feb 2023		GOSH has an internal target of 95%.
Number of clostridium difficile (C.difficile) in patients	13	8	13	11	‡	‡	‡	The rates are from PHE Time period: 2022/23	Continuing to test stool samples for the presence of C.difficile, investigate all positive cases,

aged two and over.									implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C.difficile in patients aged 2 and over (number of hospital acquired infections/ 100,000 bed days).	25.1	15.9	27.1	15.9	‡	‡	‡		
Note: C.difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. At GOSH, we test for C.difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported; where a request is made for enteric viruses; and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Healthcare Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report. † Data is released by NHSE and was not available at the time of publishing this report. ‡ Data is released by PHE and was not available at the time of publishing this report.									

Indicator	**From local trust data**			**GOSH considers that this data is as described for the following reasons:**	**GOSH intends to take the following actions to improve this score, and so the quality of its services, by:**
	2022-23	2021-22	2020-21		
Patient safety incidents reported to the National Reporting and Learning System (NRLS):					
Number of patient safety incidents	6015	6132	5915	GOSH uses electronic incident reporting to promote robust reporting and analysis of incidents. A good reporting profile is reflected in high reporting numbers with low levels of harm. Around 10% of incidents reported in 22/23 caused harm.	A combination of local feedback groups (such as Risk Action Groups and Directorate Boards) and education sessions (Grand Rounds and Patient Safety Education sessions) help raise the profile of Safety and the importance of reporting incidents.
Rate of patient safety incidents (number/100 admissions)	13.4	14.6	17.5		
Number and percentage of patient safety incidents resulting in severe harm or death	4 0.07%)	8 (0.13%)	9 (0.2%)		
Four incidents graded major harm (4) or above were reported in 2022/23. Of these, two are SI investigations at GOSH and are currently open for investigation. One incident occurred in a local hospital and is being looked at there. The final incident is due to go for discussion at an IRM shortly to establish whether SI criteria has been met.					

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

There is no nationally established and regulated approach to reporting and categorising patient safety incidents. Different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical

judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a lengthy investigation, which could result in the classification being changed. This complexity makes it difficult to do a formal comparison.

Part 3: Other information

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

Performance against key healthcare targets 2022-2023

Domain	Indicator	National threshold	GOSH performance for 2022/23 by quarter				2022/23 mean	Indicator met?
			Q1	Q2	Q3	Q4 (up to Feb 23)		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	100%	100%	100%	88.46%	96.34%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising: • surgery • anti-cancer drug treatments	94% 98%	100% 100%	100% 100%	100% 100%	88.46% 100%	96.34% 100%	Yes Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	Apr-22 75.27% May-22 76.83% Jun-22 75.31%	Jul-22 73.75% Aug-22 72.25% Sep-22 71.81%	Oct-22 72.42% Nov-22 73.24% Dec-22 70.90%	Jan-23 71.39% Feb-23 69.8% Mar-23 67.29%	Can't have a mean as this is a snaphot	No
Experience	Maximum 6-week wait for diagnostic procedures	99%	Apr-22 84.13% May-22 84.73% Jun-22 82.61%	Jul-22 83.93% Aug-22 84.19% Sep-22 83.53%	Oct-22 88.36% Nov-22 89.12% Dec-22 82.57%	Jan-23 82.64% Feb-23 87.62% Mar-23: 81.88%	Can't have a mean as this is a snaphot	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

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

ADDITIONAL INDICATORS - PERFORMANCE AGAINST LOCAL IMPROVEMENT AIMS

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

Effectiveness	Inpatient mortality rate (per 1,000 discharges)+ *(From data submitted to Hospital Episode Statistics (HES))*		7.21	7.79	8.54	10.60	7.62	
Experience	Discharge summary completion time (within 24 hours)		76.15%	76.52%	72..96%	70.23%	73.98%	

Effectiveness	PICU discharges delayed by 8-24 hours		5	15	35	44	24.75	
Effectiveness	PICU discharges delayed by more than 24 hours		29	36	75	59	49.75	
Effectiveness	Last minute non-clinical hospital cancelled operations and breaches of 28-day standard* - Cancellations - breaches		82 10	104 10	120 13	107 12	103.25 11.25	
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge		2.6%	2.4%	2.4%	2.2%	2.4%	
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge		0.0%	0.0%	1.4%	2.0%	2.7%	
Safety	GOS acquired Central Venous Line related bloodstream infections (per 1,000 line days)		1.5	1.1	1.3	0.8	1.2	

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

Attachment Q

Annex 1: Comments from the Chair of Camden Health and Adult Social Care Scrutiny Committee

Great Ormond Street Quality Report Response 2022/23
Comments from the Chair of the LB Camden Health and Adult Social Care Scrutiny Committee to be added

Attachment Q

Annex 1: Feedback from Members of the Council of Governors

To be added

Attachment Q

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

To be added

Attachment Q

Annex 2: Statements of assurance

The directors are required under the Health Act 2009 and the National Health Service (Quality Reports) Regulations to prepare Quality Reports for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance Detailed Requirements for Quality Reports 2022/23.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to Quality reported to the board over the period April 2022 to March 2023
    - feedback from commissioners dated ?? ??? 2023
    - feedback from governors dated ?? ??? 2023
    - feedback from Non-Executive Directors dated ?? ??? 2023
    - feedback from Chair of Camden Health and Adult Social Care Scrutiny Committee dated ?? ??? 2023
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, report will be published following review at the June '23 Quality, Safety and Experience Assurance Committee (QSEAC) meeting
    - 2020 Children and Young People's Patient Experience Survey published on 9 December 2021
    - the national NHS Staff Survey 2022
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 31 March 2023
    - CQC inspection report dated 22 January 2020
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Reports regulations) as well as the standards to support data quality for the preparation of the *Quality Report*.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

??th ??? 2023
Chief Executive

?? ??? 2023
Chair

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 08 June 2023	
Compliance with the NHS provider licence – self assessment 2022/23 **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment S** ☐ **For approval**
Purpose of report To present the annual self-assessment of compliance with NHS England (NHSE) licence conditions for providers of NHS services.	
Summary of report The NHS provider licence is used by NHS England as a means to regulate providers of NHS services. The licence sets out important conditions that providers must meet to help ensure that the health system works for the benefit of NHS patients. An FT Board is required by NHSE to annually declare compliance or otherwise with a small number of FT licence conditions and one requirement under the Health and Social Care Act. It is good governance to assure the Board that these key conditions under the licence have been met.	
Patient Safety Implications None	
Equality impact implications None	
Financial implications None	
Strategic Risk Providers are normally required to complete an annual self-certification that confirms their continued eligibility to hold an NHS provider licence.	
Action required from the meeting The Board is asked to **consider and agree** the Trust's response to the four conditions, taking into account the views of the governors.	
Consultation carried out with individuals/ groups/ committees In May 2023, the Council of Governors were asked for their views on the attached conditions and evidence cited	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary and Chief Finance Officer	
Who is accountable for the implementation of the proposal / project? The Board is responsible for ensuring continued eligibility to hold an NHS provider licence.	

Compliance with the NHS provider licence 2022/23
Request for governor views on the Trust self-assessment

Overview

The NHS provider licence is used by NHS England as a means to regulate providers of NHS services (NHS Foundation Trusts, like GOSH).

The licence sets out important conditions that providers (GOSH) must meet to help ensure that the health system works for the benefit of NHS patients. These conditions give the regulator the power to:

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

Foundation Trust (FT) Boards are required to annually declare compliance (or otherwise) with a small number of the FT licence conditions, including an annual declaration against one requirement under the Health and Social Care Act. These declarations are published on the GOSH website.

Overview of requirements for declaring compliance with the FT Licence

Licence condition	Deadline and comment
Condition G6(3): Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution.	The deadline for this declaration is **31 May 2023.** The G6 self-certification also needs to be published within one month of sign off by the Board.
Condition CoS7(3): Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service.	The deadline for this declaration is **31 May 2023.**
Condition FT4(8): Providers must certify compliance with required governance standards and objectives	The deadline for this declaration is **30 June 2023.** Trust Board is required to identify risks to achieving the governance standards and any mitigating actions taken to avoid those risks.
Training of Governors (NHSE): NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, as required in s.151(5) of the Health and Social Care Act to ensure that they are equipped with the skills and knowledge they need to undertake their role.	The deadline for this declaration is **30 June 2023**.

Appendix 1 provides a list of evidence against the four requirements outlined above. Within the appendix areas listed in green represent positive assurance and those in purple represent assurance where actions are required/ underway.

The Executive Directors reviewed the evidence cited against the standards at their meeting on **26 April 2023** and proposed the Trust states ***'confirmed'*** compliance against all requirements.

An FT Board is required to consider the views of governors when determining whether the Trust confirms compliance with the above declarations. In May 2023 at an extraordinary meeting, the Council of Governors were asked for their views on the attached conditions and evidence cited. Governors were satisfied with the evidence cited and the Council agreed with the recommendations by the GOSH executive team to confirm compliance with all conditions.

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

The New NHS Provider Licence

A consultation on the NHS Provider Licence took place at the end of 2022 following a need to reflect changes to the statutory and operating environment in the licence and shift of emphasis from economic regulation and competition to system working and collaboration. The new NHS Provider Licence is effective from April 2023 and the changes bring the Licence up to date, reflecting the new legislation and supporting providers to work effectively as part of integrated care systems (ICSs). Compliance against the new NHS Provider Licence will be reported in April 2024 for the 2023/24 reporting period.

Compliance for 2022/23 is required against the original 2013 NHS Provider Licence.

Attachment S

Appendix 1: FT Licence self-certification 2022/23 – four requirements that must be signed off by the Board - SUMMARY

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

Green: Positive assurance
Purple: Assurance provided requiring actions

Yellow highlight: statements approved by EMT

G6 – Systems for compliance with licence conditions and related obligations (scope = past financial year 2022/23): The Licensee shall take all reasonable precautions against the risk of failure to comply with the Conditions of this Licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
The steps that the Licensee must take ….shall include:
(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

The Executive Team recommend *'confirmed'* compliance.
Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors

The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance: The Trust's Assurance and Escalation framework, reviewed in April 2023 sets out how the organisation identifies, monitors, escalates and manages concerns and risks in a timely fashion and at an appropriate level.

Risk Management
The Trust has an established Risk Management Policy that sets out the framework for GOSH to systematically manage its risks and underpins the commitment by the Trust Board to ensuring a robust risk management system is in place. This extends across the organisation from the front-line service through to the Board to promote the reduction of clinical and non-clinical risks associated with healthcare and research and to ensure the business continuity of the Trust. A review of the Risk Management system has been conducted throughout the year with the intention to update the system later in 2023. The Board assurance committees scrutinise the effectiveness of the risk management framework and report to Trust Board. The Audit Committee, an assurance committee of the Board receives an assurance report of compliance with the risk management policy.

ASSURANCE: Although the instances remain historically low, the 2022 Staff Survey showed an increase in the number of staff members who felt confident and supported to report any instances of harassment and violence at work.

Board Assurance Framework (BAF)
The Trust's Board Assurance Framework is used to provide the Board with assurance that there is a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF records the controls in place to manage the key risks and highlights how the control is operating. The BAF includes cross-references to assurance obtained from internal and external audits, and self-assessments of compliance with other regulatory standards. It has been monitored by the Board assurance committees and updated throughout the year.

The Risk Assurance and Compliance Group (RACG) is the executive committee responsible for monitoring progress with the BAF. The Board Assurance Committees also undertake deep dives into each of their assigned BAF risks.

ASSURANCE: In December 2021, KPMG the Trusts Internal Auditors conducted an internal audit into the GOSH BAF (this audit is conducted every two years). The scope of the audit covered how the BAF is prepared and whether there are appropriate governance arrangements in place for monitoring the BAF to obtain assurance that risks are effectively managed. The auditors provided an assurance rating of '*Significant assurance'*(GREEN).

ASSURANCE: In December 2022, the Trust Board held its annual Risk Management Meeting. A check and challenge of current BAF risks was undertaken including conducting a review of several different data sources and mapping the output to our BAF risks for the purposes of checking and challenging the appropriateness of the risks, controls, assurances, and actions cited. At the meeting, Board members also considered the connectivity between BAF risks using the Bow Tie risk management model, and a mapping exercise of BAF risks was completed against another Children's NHS hospital BAF.

Quality Governance
ASSURANCE: The Trust's Internal Auditors, KPMG conducted an Audit on Quality Governance in March 2022. This included reviewing the quality strategy and the ways in which the Trust has set quality objectives and the reporting of quality and safety performance from Board to ward. The Auditors provided an assurance rating of '*Partial assurance with improvements required' (*AMBER - RED). There were five action management actions, two have been completed and a plan has been developed with a timeframe for the remaining three to be completed by June 2023.

ASSURANCE: Whilst there were a number of areas to improve on as a result of the audit there were areas of good practice that were highlighted, and these included:

- A Quality Strategy has been developed and approved during 2020, which provides a methodology to support the implementation and embedding of quality improvement.
- Formal action plans have been developed to support the Trust in delivering these programmes of work set out in the strategy. The action plans set out for each programme the deadline and the officer responsible for delivery.
- The strategy sets out key performance indicators which it will use to assess progress and
- success in delivering the priorities laid out in the strategy.

- Quality and Safety is a standing agenda item for the Board to discuss and monitor at all meetings and they are updated on the Integrated Quality and Performance Report (IQPR) which sets out performance against all key quality metrics.

During the year the Safety Transformation Plan was 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. A singular action plan has been developed to ensure that the Trust has oversight of all relevant actions which are pertinent to patient safety. The actions and communications plan are monitored and overseen by the Safety Transformation Board, which reports through to the Quality, Safety, Outcomes and Compliance Committee on a monthly basis, with a quarterly report into RACG and the QSEAC for assurance.

GOSH has made a 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.

ASSURANCE: Verita undertook an independent review on the effectiveness of the Trusts safety procedures in February 2022; this included whether there are effective processes in place for managing safety risks in red complaints and in claims and inquest. The outcome of the review estimated the Trust are at the 'Reactive' level and suggested a number of improvements which have been included in the Safety Transformation Plan workplan.

ASSURANCE: The Trust internal auditors conducted an audit on Patient Safety Alerts process which was implemented in April 2022 and concluded an overall rating of *'Significant assurance with minor improvement opportunities'* (AMBER GREEN). The rating was driven by the well-designed process for reviewing and actioning patient safety alerts but with improvements required in relation to reporting to the Quality, Safety, Outcomes and Compliance Committee (QSOCC) the audit of action completion.

ASSURANCE: The Trust internal auditors conducted an audit on the harm review process which was approved by the Trust in January 2020 and provides guidance over the completion of harm reviewed for patients waiting longer than 52 weeks. The audit concluded an overall rating of *'Partial assurance with improvements required'* (AMBER-RED) which was not in line with expectations. As a result, the harm review process is being reviewed and there are clear actions and improvements to be completed before there is a re-audit of the process later in the year.

<u>Compliance</u>

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with the CQC registration standards. It is the responsibility of these staff to collate evidence of compliance with the standards.

ASSURANCE: The Trust did not have any CQC enforcement notices during 2022/23.

<u>Information Governance</u>

Our Information Governance (IG) Framework ensures compliance with the principles relating to the processing of personal data as set out by GDPR and the ICO. This is overseen by the Information Governance Steering Group and managed by the Information Governance team. Data Protection Privacy Impact Assessments (DPIA) are undertaken for new projects and policies. All new systems require an appropriate security review by ICT with a focus on any personal data held offsite. A patient and carer privacy notice and research privacy notice is published on the website outlining how the Trust gathers, uses, discloses and manages patient data. A staff privacy notice is published on the GOSH intranet. All documents have been reviewed and updated in early 2023.

ASSURANCE: During 2022/23 there have been six serious information governance incidents (classified at a reportable level using the Incident Reporting Tool within the DSPT). Three of these incidents were reported to the Information Commissioner's Office (ICO) relating to the inappropriate sharing of data with third parties. From these incidents the Trust has worked to improve the processes involved and has adapted and extended training.

<u>Cyber security</u>

In March 2022, NHS England and NHS Digital issued notices to Trusts with advice on improving cyber resilience. The advice laid out recommendations/best practice for NHS organisations to take and evidence as part of the DSPT assessment. The ICT reported the trusts compliance against each of the recommendations to the Executive Management Team and noted areas that were on track to exceed some of the recommendations.

ASSURANCE: A ransomware cyber-attack was made on Advanced Systems, who provide eFinance and eProcurement systems for NHS Trusts. When the Trust became aware of the attack, the Trust suspended access to these systems as a precaution and activated the business continuity plans.

ASSURANCE: The Trust compiled its evidence for the Data Security and Protection Toolkit (DSPT) and submitted this by the due date of 30 June 2022. On the basis of this submission the Trust received a rating of "standards met". (In prior years this has only been achieved after a number of follow-up submissions). This annual submission demonstrates GOSH's commitment to assuring that we are practicing good data security and our personal information is being handled correctly.

ASSURANCE: The Trust's Internal Auditors, conducted an Audit on Data Security and Protection Toolkit in February 2023. This included assessing the overall design and operation of key mandatory data security and protection toolkit controls at the Trust. The findings of the audit provided *Significant assurance* (GREEN). The audit concluded good practice with regards to the DSPT submission through reporting to relevant groups and committees to support the assessment of compliance against toolkit assertions.

Data Partnerships

GOSH's Data Research, Innovation and Virtual Environments (DRIVE) unit, focuses on implementing innovation into paediatric healthcare using data and technology to improve patient outcomes and stakeholder experience.
DRIVE have set up a Data Partnerships Committee that has delegated authority from the Executive Manager Team to advise on the ethical and legal consideration concerning the accessing, sharing and use of personal and special category data at GOSH with external data partners for the purposes of improving the diagnosis, treatment and care of children with rare and complex conditions. The Committee ensures all such commercial and non-commercial partnerships operate under the NHS Information Governance framework, the national regulatory framework including GDPR and the information governance surrounding the access and processing of data.
In June 2021, GOSH went into partnership with the Royal Marsden to share our electronic patient record and combined knowledge and resources to co-design pathways, accelerated by shared research data from both organisations. By sharing skills and expertise across organisations we'll maximise the benefits of the system for staff and patients

ASSURANCE: The Trust's Internal Auditors, conducted an assessment of the key information governance risks associated with Digital Health Record Sharing Partnership between the Royal Marsden NHS Foundation Trust and GOSH. The assessment found no unmitigated IG risks that should prevent the go live but highlighted four risks which were actioned before go-live and three actions to be completed post go-live (by March, April and September 2023) to ensure compliance with UK GDPR regulations.

Infection Control

The Infection Prevention and Control Committee (IPCC) meets monthly and reports to Patient Safety Compliance Outcomes Committee (QSOCC). A continuous advice service is provided by IPC Team / Consultant Microbiologists. The Director of Infection Prevention and Control meets regularly with the Chief Nurse.

ASSURANCE: The Board receives an update on the Infection, Prevention and Control Board Assurance Framework across the year. The Director of Infection, Prevention and Control regularly reports to the Board, including compliance with Infection prevention and Control Board Assurance Framework.

Health and Safety

The Trust is committed to effectively minimising risks, controlling hazards and preventing harm to all. This is done through a proactive programme of risk assessment and audit. There are clear processes for incident reporting, and we encourage a culture in which staff report incidents. The Trust's governance structure ensures statutory compliance is undertaken within legislative requirements. Assurance via the Health and Safety Committee has been provided on a range of subjects such as sharps compliance, Control of Substances Hazardous, Fire Safety, Lone Working, Health and Safety Walkrounds, Redevelopment Projects and Health and Safety mandatory training.

Good progress has been made on estate compliance over the last year, but it remains a risk and is monitored through a risk on the Board Assurance Framework. There are several workstreams that are ongoing, covering areas such as ventilation, fire, management of legionella and these form a significant part of the Above and Beyond Programme for the Space and Place Directorate. The Audit Committee and Quality Safety Experience Assurance Committee continue to receive updates on progress in these areas.

ASSURANCE: The Quality, Safety and Experience Assurance Committee receives a quarterly assurance report on management of health and safety at GOSH.

Safeguarding

The Strategic Safeguarding Committee, chaired by the Chief Nurse, oversees all safeguarding matters across the Trust and reports quarterly into the Quality, Safety, Experience Assurance Committee and provides a Safeguarding Annual Report to the Trust Board. The overarching priorities for the 2022/23 have been to raise the profile of safeguarding across the organisation, so that it is the golden thread that runs across every service. At all levels staff have been encouraged to be professionally curious, seek guidance, risk assess and use the internal and external escalation processes appropriately.

ASSURANCE: In January 2021 a Safeguarding Governance Review was completed by the Head of Special Projects. Joint working across Human Resources, Safeguarding Service, Patient Experience and the Communication Team resulted in all actions being completed during 2021 and the identified areas where relevant, were included as part of the Safeguarding Implementation Plan 2021/22 and contributed to the overarching Safeguarding Strategy 2021-2025. The outcomes in year 1 were met (2021/22) and the Trust is on track to meet year 2 (2022/23).

In December 2022 an Independent Safeguarding Review commenced and was due to be completed in March 2023, however this has been delayed due to a longer than anticipated data gathering exercise. The outcome and recommendations from this will be reported to QSEAC and the Trust Board.

Transforming Pathways

Gender Dysphoria Service: GOSH has been selected along with Evelina Children's Hospital (ECH) and South London and the Maudsley (SLaM) in the South, and Alder Hey and Manchester in the North to establish early adopter services which will include designing the operational and clinical models for the new service based on the Interim Cass Review and subsequent Service Specification. The partnership is working to build processes and assess risk as part of the creation of the Provider Collaborative across the Southern Hub providers.

Performance monitoring

Directorate performance reviews usually take place on a monthly basis and are attended by directorate management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused discussion across a number of key domains: Caring, Safe, Responsive, Well-Led (people, management and culture), Effective, Finance, Productivity. The information presented at the performance reviews include an integrated dashboard which provides a one-page summary of key metrics across the domains, allowing rapid identification of linked risks and issues.

ASSURANCE: The Trust Board receives the latest data on operational performance and quality/ safety matters at every Trust Board meeting via the Integrated Quality and Performance Report. This tracks performance against key indicators, set nationally and internally at GOSH.

Business Continuity

The Emergency Planning Group meets regularly, and reviews implementation and testing of plans and business continuity plans are in place across all directorates/ departments in the Trust. To ensure robust management, clear leadership and accountable decision making during a Major, Critical or business continuity incident, the recognised Gold, Silver, Bronze Command and Control structure is adopted at the Trust. When the command-and-control structure is in place, the Gold Level meetings will ensure they are escalating the necessary information through EMT as and when required. The Audit Committee retains responsibility for seeking assurance of the robustness of the emergency planning framework at GOSH throughout the year. Command and Control continues to be stood up to manage the existing industrial action that the trust continues to be impacted by, in doing this we are reviewing the operational (Bronze) level business continuity plans and ensures there is robust process in place to ensure the hospital remains safe.

ASSURANCE: We remain fully compliant for the NHS EPRR annual assurance core standards and were rated fully compliant against the deep dive. This is check and challenged by NHS England and the NCL ICBS. This is the second year the Trust have remained fully compliant; this assurance is a legal requirement under the CCA 2004. The Trust EPO and AEO (Accountable Emergency Officer) feeds into the Local Health Resilience Partnership which reviews all health care risks at a London level. The Trust EPO also feeds into the Borough resilience forum, which review the Camden specific risks with all EPRR practitioners. This work is led by Camden Police and Camden Council.

Escalation

The Trust has systems and processes in place to support staff and patients in escalating concerns in provision of care or management of systems. These include the complaints process, PALS, Freedom to Speak Up Guardian, Guardian of Safe Working, Raising Concerns Policy, Duty of Candour process, Counter Fraud service etc. The Executive Team actively monitor the responses to duty of candour and hold the directorates to account at performance reviews and via deep dives at Executive Management Team meetings.

Freedom to Speak Up

The Freedom to Speak Up (FTSU) service is part of wider programme of speaking up within the Trust which includes Speak Up for Safety and Speak Up For Values. The service offers independent and confidential support to people so they can speak up and be heard when they feel unable to do so by other routes. The FTSU service is provided by a full-time FTSU Guardian and a small group of FTSU ambassadors. The Guardian works in partnership with the Speak Up programme manager and Associate Medical Director responsible for speaking up. A new FTSU Guardian was appointed in March 2023.

ASSURANCE: The 2022 staff survey results showed that the Trust has seen an improvement in people feeling confident and safe to raise concerns.

Redevelopment of the estate

Together with the GOSH Charity, the Trust has embarked on a strategic infrastructure investment by building a new Children's Cancer Centre (CCC). The programme removes a dated dilapidated building on the GOSH site and replaces it with a new modern fit for purpose building. The vision is to improve outcomes for children through holistic personalised and co-ordinated care. There is a great opportunity for the centre to become a national and global focal point for excellence in paediatric clinical care and research.

A clear governance structure (including risk management framework) has been agreed for the CCC including establishing a Cancer Programme Board with the Director of Space and Place as the Senior Responsible Officer for the programme. The day-to-day delivery of the CCC is the responsibility of the GOSH Programme Delivery Director who reports to the Cancer Programme Board. The Programme Director for the cancer Planet has the responsibility for Cancer Transformation plan/delivery.

ASSURANCE: Camden Council met on the 8 February 2023 and has resolved to grant planning permission for the CCC.

CoS7 – Availability of resources (scope = next financial year 2023/24)

The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
(a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."
OR
(b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".
OR
(c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

The Executive Team recommend (a): **"**After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."
Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors

The Trust sets its budget on an annual basis and actively manages and monitors its financial position and resource levels on a regular basis throughout the year through routine performance reporting to the Board and its Committees. The Executive Team actively monitors the finance position to ensure that the mitigations in place are effective and appropriate.

The NHS introduced a new financial framework in 2022/23 with the formal establishment of Integrated Care Boards. These ICB organisations obtained legal status and commenced their work on 1 July 2022.

The Trust has received NHSE guidance on the new funding arrangements for 2023/24 and has been working with NCL, NHSE and other commissioners to interpret and implement the guidance. The current 2023/24 NHSE and NCL contracts have been triangulated. Due to the pressures facing both GOSH and the wider NHS it was important that the Trust started work on its plans ahead of receiving guidance from NSHE. The Trust therefore started planning for 2023/24 in November 2022 and has been updating the plans as guidance has been released and discussions have been undertaken with NCL ICB.

The Trust has set budgets for 2023/24 and worked closely with Directorates to refine these in line with their activity plans following NHSE guidance.

The private patient income has been reviewed to pull together a recovery plan that looks at patient referrals and the restoration of the pre-covid levels of private activity. NHS income is also being reviewed in line with national guidance, NHSE and NCL. In addition, a better value programme is being pulled together to deliver the efficiencies required by the Trust to cover financial pressures such as inflation. The Trust has attended two-star chamber meetings with NCL where the Trusts has discussed its plans. Each directorate has attended challenge meetings where Trust directors have gone through their proposed budgets to aid in the accurate setting of plans and identification of Better Value.

Research remains strong with the renewal of the Clinical Research Facility award, and the success of the BRC renewal.

The Trust's cash position remains strong entering the 2023/24 financial year and has enough resources available for the next 12 months.

The Trust Audit Committee and Board will review for approval the 2022/23 annual report and accounts (08 June 2023), **[TBC for approval on 8 June 2023]** *on a going concern basis, confirming that the Directors have a reasonable expectation that the organisation has the required resources available for the next 12-month licence (a).*

FT4- NHS foundation trust governance arrangements (scope = next financial year 2023/24). PLEASE NOTE – all four parts need to be confirmed for an overall 'confirmation' The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.
The Executive Team recommend ***'confirmed'*** compliance. *Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors*
The Trust has a range of governance and assurance structures and systems in place including a Trust strategy, scheme of delegation, risk management framework, accountability framework, compliance framework, assurance and escalation framework, policy framework and a financial management framework (see controls and assurances above under licence condition G6). Directors and governors are asked to sign a code of conduct and declare any interests annually for publication on a Register of Interests. Directors complete a self-assessment for the Fit and Proper Person Test (and are reviewed against the criteria annually). The Trust has a FPPT Policy, and an annual report is presented to the Nomination and Remuneration Committee. During 2022/23 all directors were compliant with the FPPT, and no issues were raised. All directors are subject to an annual appraisal. **ASSURANCE**: A self-assessment is prepared annually against the Code of Governance and was reported to the Board in March 2023. The Trust Board considers that from 1 April 2022 to 31 March 2023 it was compliant with the provisions of The NHS foundation trust Code of Governance and will detail its compliance in the annual report. **ASSURANCE**: In March 2023, the Trust Board has received an overview of the changes to the Code of Governance effective from April 2023. The main themes from the new Code were set out alongside GOSH's current compliance and actions to be taken.
FT4- NHS foundation trust governance arrangements (scope = next financial year 2023/24). PLEASE NOTE – all four parts need to be confirmed for an overall 'confirmation' The Licensee shall: (a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; (b) comply with the following paragraphs of this Condition.
The Executive Team recommend ***'confirmed'*** compliance. *Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors*
The Trust has regard to guidance on good corporate governance as issued by NHS England.
FT4- NHS foundation trust governance arrangements (scope = next financial year 2023/24). PLEASE NOTE – all four parts need to be confirmed for an overall 'confirmation' The Licensee shall establish and implement: (a) effective board and committee structures; (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) clear reporting lines and accountabilities throughout its organisation.
The Executive Team recommend ***'confirmed'*** compliance. *Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors*
The Board has a work programme, which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda. The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to committees. There are three Board assurance committees - the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. These committees assess the assurance available to the Board in relation to risk management, review the Trust's non-clinical and clinical and quality risk management processes and review the structures and processes in place to deliver the Trust's vision for a supported and innovative workforce, an excellent learning environment and a culture that aligns with the Trust's strategy and always values. All three committees raise issues that require the attention of the Board. In addition to the three assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these committees report to the Board and the Council of Governors following every committee meeting.

The Trust has terms of reference (last approved by the Trust Board in March 2023) and work plans in place for the Board, Council and assurance committees. The Board committees conduct annual reviews on the delivery of their terms of reference and running of the committees. Findings are reviewed and presented to the committee and where appropriate, changes to the terms of reference and workplans of the committees are made.

The assurance committees receive summary reports from other assurance committees to prevent matters falling between them. These summary reports are also reported at the Board and the Council. At the Council, the chairs of the assurance committees present the summary reports and are held directly to account by the governors at the Council meeting. Governors are also invited to observe assurance committees and Board meetings throughout the year.

The Trust's Assurance and Escalation Framework presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including:

- Performance Management: The Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed.
- The Trust's Risk Management Strategy sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level.
- The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure on-going compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way.
- Policy Framework: This provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust's policy framework is administered by the Policy Approval Group (PAG) and reported through to the Risk Assurance and Compliance Group.
- Committee structure (as detailed above)
- The Risk Assurance and Compliance Group monitors progress with the strategic risks on the Board Assurance Framework.

There are seven directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Management Team meets weekly virtually, and the Senior Leadership Team meets monthly virtually (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operational Board made up of executives and senior operational managers from across the Trust meets fortnightly. The purpose of the Operational Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust and delivery of the operational performance against the Trusts strategic objectives.

The Trust's risk management strategy sets out how risk is systematically managed. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust.

ASSURANCE: The well-Led review in 2021 looked at governance and assurance and recognised that the Board is well-managed, and the quality of board and committee papers is excellent. Looking to the future the report recommended that in order to become a higher performing organisation, the leadership approach is considered by enabling a renewed external strategic focus amongst the executive team and at the same time providing directorates greater autonomy and focussed support to tackle operational issues and take great ownership and accountability. An action plan was developed capturing all 17 recommendations of the review and the Executive Management Team retained overarching responsibility for monitoring delivery of these actions which are now all closed.

The review also suggested reviewing the governance flow of meetings and the Company Secretary undertook a review of the Executive Management Team meeting and Operational board in July 2022. In addition to responding to the findings of the Well Led Report the purpose of the review was:

- to establish a framework that supports organisational alignment,
- provide clarity and clear communication to all staff about accountability; how decisions are made and the expectations of committees when being presented with reports
- take into account changes to the Code of Governance around contribution to the objectives of the NCL ICS and place-based partnerships and to focus on well-being and equality, diversity and inclusion.

The review proposed 25 recommendations for both EMT, and OB combined and were themed around - role and purpose, membership, meting frequency, decision making, agenda setting, quality if papers, subcommittees reporting into EMT/OB. Further work with the Executive team is underway to finalise the review and strategic focus of EMT.

FT4- NHS foundation trust governance arrangements (scope = next financial year 2023/24). PLEASE NOTE – all four parts need to be confirmed for an overall 'confirmation'

The Licensee shall establish and effectively implement systems and/or processes:
(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

The Executive Team recommend *'confirmed'* compliance.
Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors

The Board has agreed standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board.

Each specialty and clinical directorate has an internal monitoring structure so teams regularly review their progress and identify areas where improvements may be required. Each directorate's performance is considered at monthly performance review meetings (see above).

ASSURANCE: In February 2023 an internal audit was conducted on Directorate Governance which provided an assurance rating of *'Significant assurance with minor improvement opportunities'*. This rating was driven by the well-designed governance structure for monitoring performance through directorates. Areas for improvement that were identified have been assigned agreed management actions and timelines for completed by July 2023.

The Finance and Investment Committee reviews the operational, productivity and financial performance and use of resources both at Trust and directorate/ department level.

The Board has a work programme which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda.

The Board assurance committees scrutinise the strategic risks facing the trust on a rotational basis every year, with committee members reviewing the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner.

Key performance indicators are presented on a monthly basis to the Trust Board. The report integrates quality and performance data and includes progress against external targets, internal safety measures, operational efficiency/process measures, well-led and other clinical quality measures such as complaints, incidents and reports from specific quality functions within the Trust such as the Patient Advice and Liaison Service (PALS).

Compliance against health care standards are reported to the Quality, Safety, Outcomes and Compliance Committee (QSOCC) three monthly and then into the Risk Assurance and Compliance Group via the QSOCC summary report. This includes external compliance, CAS alerts, updates from the Good Hospital Group and a separate report for CQC compliance.

ASSURANCE: The external, independent assessors reviewed compliance with NHSI's Well led criteria. (Details provided in above sections).

s.151(5) of the Health and Social Care Act (not a licence condition) **(scope = past financial year 2022/23)**
NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, to ensure that they are equipped with the skills and knowledge they need to undertake their role.

The Executive Team recommend ***'confirmed'*** compliance.
Response to be considered by the board in light of assurance provided here and taking into account the views of the governors

During 2022/23 governors received mandatory training through a handbook that they were required to read and sign. Their completion of the training was then recorded onto our internal online training portal GOLD. This was monitored by the Head of Corporate Governance and governors were reminded and supported to complete the training during the year. For 2023/24, we will be working towards governors having an online profile on the GOSH DEN (Digital Education Network), this is an online educational platform which is part of our GOSH Learning Academy that would enable governors to complete their mandatory training interactively.

Governor development sessions were developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure. Training courses were also delivered by NHSP GovernWell, and several Governors attended external training and events throughout the year and provided reports back to the Trust. Governors also undertook additional training on significant transactions, as they were asked to approve such a transaction during the year. This training was externally facilitated by NHS Providers and followed up with training materials. Additional sessions were also provided internally by the Children's Cancer Centre Team including a joint session with the Non-Executive Directors and a session specifically for new governors who joined in March 2022.

To ensure that newly elected Governors (from March 2023) are provided with the skills and knowledge to fulfil their role, the Corporate Affairs Team and existing Governors co-produced an induction programme, including welcome sessions, externally facilitated session with NHSP and a newly developed interactive governor handbook. Governors will be asked to complete an evaluation of the induction in June 2023 to ensure that the Trust can continuously improve the quality of induction provided.

Ahead of each Council meeting, Governors meet in private with the Lead Governor/ Deputy Lead Governor. The session allows Governors an opportunity to discuss the key issues, network, and prepare for the Council of Governors' meeting. Governors also meet with the Chair in a private session prior to each Council meeting. This gives Governors an opportunity to discuss any issues directly with the Chair and to gather information about the Trust and its activities and processes.

Governors have been given the opportunity to attend a walkrounds, during the year these have included the CCC footprint and public accessible areas.

Governors have the opportunity to observe Board Assurance Committees throughout the year. All future dates are circulated in advance and following the meeting governors have a private session with the NED Chair's to provide their feedback. This supports governors both in their duty to hold NEDs to account for the performance of the Board and also helps to support their knowledge and understanding of what's happening in the Trust.

ASSURANCE: Our 2022 Governors effectiveness survey showed:

- 100% of Governors and NEDs and EDs agreed that Governors knew the difference between the roles of the Council and the Board and 100% of Governors and NEDs and EDs agreed that Governors knew the difference between the roles of a NED and an Executive Director
- 92% of Governors agreed that they had a good understanding of their role and responsibilities with regards to holding the Non-Executive Directors to account and contributing to the development of the Trust Strategy, annual report and accounts.
- 100% of respondents are clear on their role and know the difference between the Council of Governors and the Trust Board.
- 100% of respondents stated they were aware of mandatory training and 84% agreed they received relevant and appropriate induction training that prepared them to undertaken their role.

Governors are invited to join the Membership Engagement Recruitment and Retention Committee; this committee oversees the recruitment and retention of members and most importantly supports maximises engagement opportunities for the members. Through the committee, governors support the Trust to develop and engage with members to get them involved, an example over the last year was the 'Thinking about becoming a governor' workshop held as part of the governor election.

Governors receive a quarterly newsletter from the Corporate Affairs Team containing items for action, Trust news items, key dates and development and training opportunities.

Governors are also given the opportunity and supported to get involved in specific areas of interest. An example of is the Governors Sustainability Working Group which was set up following governors' interests in understanding and being more involved in the Trusts sustainability agenda. Governors will also use this working group going forward to engage with their constituents on the sustainability objective within the Trusts Membership Strategy.

ASSURANCE: The Council of Governors are asked to complete a self-assessment of effectiveness approx. every 18 months. The last assessment was completed in early 2022 and the Council continued to work to deliver the 13 proposed recommendations to improve Council effectiveness and further enhance the training and development needs. Key actions closed during the year included:

- Governors were encouraged to observe one of each Board Assurance Committee during their tenure and ensure there is time for feedback with Non-Executive Directors at the end of each meeting.
- Allow more time at Council meetings by improving the quality of papers and including an additional reading pack for appendices and further supporting information to papers.
- Additional questions were included as part of the governor feedback process to ensure it continue to be developed going forwards.
- An interactive governor handbook was created to include a key information that governors wanted to see.

Attachment T

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
8th June 2023

May IQPR (April 2023 Data)	Paper No: Attachment T
Submitted by: John Quinn COO **Co-Authors** Dr Sanjiv Sharma MD Tracy Luckett Chief Nurse Caroline Anderson Director of HR & OD	☐ For discussion

Purpose of report

To present the Integrated Quality and Performance Report and narrative to the Board to show the Trust level key performance indicators and to provide the Board with assurance that the indicators on patient safety, patient experience, well led, access and efficiency are monitored regularly.

Summary of report

The April strikes unavoidably affected performance and activity; operational teams were again highly prepared which resulted in well supported teams, movement of outpatient appointment to virtual where possible and carefully planned inpatient admissions. 120 admissions and 626 appointments were recorded as rescheduled. Inpatient and Outpatient activity for the strike period was down 40% and 20% respectively, however, recovery has been strong over the past 4 weeks.

The impact on patient experience has been highlighted within FFT ratings particularly for outpatients which remains in the low 90% range, feedback themes have covered waiting times, cancellations and communication.

Performance on high risks appears to have declined but this is largely due to a change in the required frequency of review (now monthly for high risks i.e., rated 15/>). This is expected to improve as these new timescales bed in.

Activity for month 1 is below the internal 2023/24 plan but is above 2019/20 figures by 7.3%. RTT performance and the overall PTL has plateaued, the Trust remains above the national average. DM01 performance reduced by 1% and Cancer metrics were positive meeting all standards. Issue for focus continue to be long waits for access (+104, 78 and 52 weeks) as these remain a challenge in particular specialties. Programmes of work are being put in place to address this and regular updates are being shared externally on progress.

Gram negative bacteraemia's have marginally increased in April, RCAs continue to be undertaken with learning and action plans identified. CV Line infections have reduced but is still being closely monitored.

The Trust Better Value target has been set at £16m and work is underway to identify schemes.

Well-led remains a focus for the Trust. Voluntary turnover for the Trust remains above 14% as per the last four months and is exceeding the target, Nursing voluntary turnover continues to be at 16.5%. Sickness rates have reduced to below 3%, the lowest reported position in the last 12 months.

Patient Safety Implications

The IQPR includes metrics and analysis on Patient Safety.

Attachment T

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 also have implications on revenue.
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

May 2023

Reporting April 2023 data

John Quinn
Chief Operating Officer

Tracy Luckett
Chief Nurse

Sanjiv Sharma
Medical Director

Caroline Anderson
Director of HR & OD

Contents

Executive Overview

The Junior Doctor's strike has had a significant impact on April performance along with air handling issues in two theatres. During the week of the strike the Trust lost 40% of inpatient activity and 20% of outpatient activity. It is also evident in patient experience. The Outpatient experience rating remains low at 91%. Many of the comments being about waiting times, poor communication, delays in care and treatment along with multiple cancellations. These themes are also showing up in complaints.

Open incidents have risen but this is due to a decision to pause closures in Feb/ March. Performance on high risks appears to have declined but this is largely due to a change in the required frequency of review (now monthly for high risks i.e. rated 15/>). This is expected to improve as these new timescales bed in.

Vacancy rates are stable at 7% below the Trust target of 10% but voluntary turnover is still high at 14.4% across the Trust and 16.5% in nursing. Sickness has continued to come down and is now running at 2.7%.

RTT, despite the strikes, has stabilised at 67.7% which 10% above the national average of 58%. Diagnostics is down slightly at 80.1%. All Cancer standards have been met. Long waiters are proving an issues. At a time when NHSE are looking to reduce these, the Trust had nine 104 week waits and 75x 78 week waits. The current forecast is for 78 week waits to reach 102 by the end of June. Various programmes are being put in place to address this including mutual aid from UCLH on dental services.

The Better value target for the Trust has been set at £16m and the detailed programme to deliver this target is now in development, although it also has been delayed because of the immediate need to address the operational challenges related to the strikes.

Integrated Quality & Performance Report, April 2023

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:** Incident numbers remain within expected ranges. Total number of incidents open rose to 1939 this month (from 1836). The PST have begun closing and theming incidents, however there remains work to do to clear the existing backlog created by the decision to pause closures in February and March.
- **Serious Incidents:** One new Serious Incident was declared in April. This was related to an overdose of Morphine. The investigation is ongoing with the report expected in July 2023.
- **Duty of Candour:** All four stage 2 DOCs due in April have been sent, though two of them were sent after the 10 working day target. Of the four stage 3 investigation reports, two have been completed (including one Serious Incident). Two are outstanding. The Patient Safety team supporting the clinical directorates to complete the investigations and send these out as a priority.
- **Risks:** Of the overdue high risks (16 total), 5 were reviewed within the past 30 working days, 5 were reviewed between 30-50 days ago, and 6 were reviewed more than 50 working days ago. The high risks with the longest review periods sit in BBM and S&S. Urgent action is being taken to review and update these risks before the next report. There has also been work to review the highest rated risks (rated 20) with a view to reframing the risks and revisiting the controls, to downgrade ratings where appropriate. Compliance with the risk management policy will be reported to the Audit Committee in June.

Patient Safety - Incidents		May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Last 12 months	RAG			Stat/ Target
New Incidents	Volume	608	577	675	620	600	617	592	498	551	550	589	476		No Threshold			Target
Total Incidents (open at month end)	Volume	1522	1687	1922	2109	2181	2013	1523	1367	1441	1489	1836	1939		No Threshold			Target
New Serious Incidents	Volume	4	1	4	2	1	1	1	1	1	0	2	1		No Threshold			Target
Total SIs (open at month end)	Volume	18	14	15	10	12	3	3	3	3	2	3	4					Target
Overdue SI Actions	Volume	12	25	14	4	18	20	15	16	11	19	9	15		>20	10 - 20	0 - 9	Target
Incidents involving actual harm	%	18%	15%	12%	13%	11%	10%	13%	11%	14%	12%	13%	13%		>25%	15%-25%	<15%	Target
Never Events	Volume	0	0	0	1	0	0	0	0	0	0	0	0		>/=1		0	Stat
Pressure Ulcers (3+)	Volume	1	0	0	0	1	1	1	0	0	0	1	0		>1	=1	=0	Stat
Duty of Candour Cases (new in month)	Volume	7	3	8	7	7	3	4	1	2	7	3	3		No Threshold			Target
Duty of Candour – Stage 2 compliance (case due in month)	%	3/3	3/5	1/3	1/5	3/6	3/5	3/4	1/2	1/2	2/4	3/4	2/4		<75%	75%-90%	>90%	Target
Duty of Candour – Stage 3 compliance (case due in month)*	%	2/6	2/2	1/3	0/0	0/0	2/4	2/5	2/3	1/4	2/3	1 / 1	2/4		<50%	50%-70%	>70%	Target
High Risks (% overdue for review)**	%	32%	5%	5%	40%	9%	4%	5%	35%	19%	26%	48%	59%		>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.

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

Patient Safety - Infection Control & Inpatient Mortality

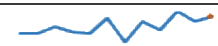
Overview

- YTD CV Line infections have reduced to 1.5/1000 line days. Gram negative bacteraemia's are slightly higher than previous months but root cause analysis with the clinical teams have commenced this month and valuable learning has already been identified with action plans to implement this. There were no C.diff's which met the criteria for this month.
- 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 on the 9th March 2023 and covers the calendar years 2019-21. 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

		May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	2023/24 YTD	Last 12 months	RAG (23/24 threshold)			Stat/ Target
C Difficile cases	In Month	1	2	1	0	1	1	1	3	1	2	0	0	0		>7	N/A	<=7	Stat
C difficile due to lapses (note 2)	Annually															>7	N/A	<=7	Stat
MRSA	In Month	0	0	0	0	0	1	0	0	0	0	0	0	0		>0	N/A	=0	Stat
MSSA	In Month	3	3	2	2	0	1	2	5	1	2	2	1	1		No Threshold			
E.Coli Bacteraemia	In Month	3	2	0	3	2	2	2	2	2	0	1	1	1		>8	N/A	<=8	Stat
Pseudomonas Aeruginosa	In Month	2	1	0	2	2	1	1	0	2	0	0	2	2		>8	N/A	<=8	Stat
Klebsiella spp	In Month	6	3	1	3	0	2	5	3	3	4	3	5	5		>11	N/A	<=11	Stat
CV Line Infections (note 1)	In Month	1.7	1.5	2.4	5.4	2.5	2.4	1.8	2.6	1.7	1.9	2.1	1.5	1.5		>1.6	N/A	<=1.6	T

Inpatient Mortality & Cardiac Arrest

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Last 12 months	RAG	Stat/ Target
Number of In-hospital Deaths	7	7	10	8	7	12	4	9	8	13	11	11		No Threshold	
Inpatient Mortality per 1000/discharges	6.7	6.6	9.0	7.3	6.6	11.6	3.8	10.2	7.8	13.8	10.3	11.8		No Threshold	
Cardiac arrests outside ICU/theatres	0	0	1	1	2	2	0	2	2	2	1	0		No Threshold	
Respiratory arrests outside ICU/theatres	2	3	0	2	2	2	0	1	2	0	1	1		No Threshold	
Inquests currently open	13	13	14	15	10	12	12	9	8	6	8	17		No Threshold	

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Effectiveness

Better Value:

The Trust's Better Value target for 2023/24 is £16m and the detailed programme to deliver this target is now in development, although has been delayed because of the immediate need to address the operational challenges related to recent industrial actions. Schemes valued at approaching £3m have either already been signed off into budgets or will be signed into them imminently, and directorates are developing plans to meet their targets as a matter of urgency, with a range of pay, non-pay and potential additional income related schemes being pursued. A new clinical procurement group is being established with operational leadership and clinical representatives from each directorate, which will be tasked in particular with focusing on product switches and minimising unwarranted variation in product usage. Further work on materials and inventory management will also be pursued with the aim of reducing over-ordering and wastage of expired stock. The first EQIAs have been produced for sign off by the EQIA Panel (Medical Director, Chief Nurse).

Effectiveness	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Last 12 months
Speciality led clinical audits completed (actual YTD)	16	24	32	48	66	80	90	100	110	116	126	4	
Outcome reports published (YTD)	0	0	2	2	3	5	7	7	8	9	13	2	
QI Project completed	0	10	0	1	3	9	2	1	0	1	0	8	
QI Projects started	1	28	7	15	6	2	14	17	14	12	19	14	
NICE guidance currently overdue for review				0	0	0	0	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	£12,822,000	£14,061,472	£16,048,000		
% value of schemes identified compared to their Better Value target	1	83%	80.4%	89.9%	78.0%	82.4%	77.8%	77.6%	77.6%	77.6%	77.60%		
Number of schemes identified	80	97	102	110	119	125	125	125	125	125	125		
Number of schemes fully signed off and EQIA assessed	4	26	45	46	75	118	118	118	118	118	118		
Number of schemes identified but not signed off	76	71	57	64	34	7	7	7	7	7	7		

* Our Quality Hub shows clinical outcomes, clinical audit activity, and QI work that is taking place across the Trust

Patient Experience

Overview

The inpatient FFT met the Trust target for response rate and experience rating. Outpatient FFT responses decreased in April, however there was a very slight increase in the experience rating which was 91%, however this was still below target. The negative theme emerging from outpatients was predominantly about the waiting times. Inpatient concerns were waiting times within day care areas, poor communication, broken equipment and food options.

10 new complaints were received in April, 3 more than April 2022. 1 of these complaints related to a medication administration error and was graded red (high risk) and declared a Serious Incident (SI). We continued to see a theme within our complaints this month regarding delays to care and treatment, such as lengthy waits for surgery, multiple cancellations for surgery and admissions, waiting for test results etc. This will continue to be monitored. There are currently 3 red/ high risk complaints open with one being monitored closely via EMT due to exceptional delays in responding to the family.

There was a significant reduction in Pals contacts (n=154) which is attributed to reduced activity during industrial action. Pals worked closely with Comms regarding information shared with families ahead of the strikes and this seems to have been successful in providing families assurance. Other contacts related to queries and requests for further information relating to patient care. Resolution timeframes (within 48 hours) doubled from 41% in March to 82% in April.

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Last 12 months	RAG		
FFT Experience rating (Inpatient)	98.0%	98.0%	98.0%	99.0%	99.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	99.0%		<90%	90-94%	>=95%
FFT experience rating (Outpatient)	97.0%	97.0%	97.0%	97.0%	97.0%	95.0%	94.0%	93.0%	92.0%	93.0%	90.0%	91.0%		<90%	90-94%	>=95%
FFT - response rate (Inpatient)	35.0%	29.0%	23.0%	28.0%	28.0%	24.0%	24.0%	25.0%	25.0%	28.0%	29.0%	30.0%		<25%	N/A	>=25%
PALS - per 1000 episodes	7.59	9.25	12.37	9.46	10.46	9.74	9.51	9.75	8.58	9.23	10.77	7.55		No Threshold		
Complaints- per 1000 episodes	0.27	0.95	0.38	0.43	0.58	0.36	0.55	0.51	0.47	0.53	0.42	0.49		No Threshold		
Red Complaints -% of total (note 1)	6%	5%	5%	7%	7%	6%	6%	6%	5%	4%	4%	4%		>12%	10-12%	<10%
Re-opened complaints - % reopened (2)	9%	8%	8%	10%	9%	9%	9%	8%	6%	4%	4%	4%		>12%	10-12%	<10%

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

Well Led Headlines: April 2023

Contractual staff in post: Substantive staff in post numbers did not change significantly in April: 5350.2 FTE compared 5351.8 FTE (a decrease of 1.6 FTE since March 2023). Headcount was 5784 vs 5782 (-2 on the previous month).

Unfilled vacancy rate: Vacancy rates for the Trust have remained stable over the last 3 months at circa 7%, and this trend has continued into the new financial year with a rate of 7.1%. The vacancy rate remains below the 10% target, but is 0.9% higher than the same month last year (6.2%). Vacancy rates are highest in Medical Directorate (17.1%), Research and Innovation (40.1%) and Transformation (63.4%).

Turnover (Reported as voluntary turnover over a rolling 12 month period). Voluntary turnover remain static at 14.4% from the previous month which represents a slowing down in the recent trend of increased turnover, however it still exceeds the Trust target (14%). Retention of staff is a pivotal part of of the Trust People Strategy and is a focus of several workstreams across the Trust.

Agency usage: Agency usage for April increased by 0.2% to 1.3% but is within the 2% trust target. The highest spend areas include Space & Place (7.6%), Finance (6.2%) and innovation (4.7%).

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

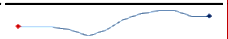
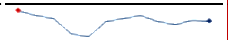
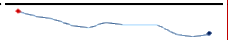
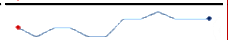
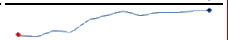
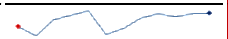
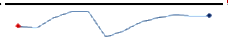
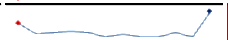
Appraisal/PDR completion: The non-medical appraisal rate has decreased by 1% to 82% for this month, with only two directorates, Genetics (90%) and Finance (96%) meeting / above the Trust target. Consultant appraisal rate was 91% last month, however an updated figure cannot be given until June 2023 due to the transition to a new medical appraisal system.

Sickness absence: April sickness has decreased for the second consecutive month to 2.7%, down 0.2% from April. In order to benchmark GOSH sickness more accurately, and provide a more realistic target the Trust has incorporated the national NHS sickness rate into it's RAG rating (see Well led page for details). The national rate for April was 5.01% and GOSH reported sickness rates were 2.7%. It should be noted that we are currently aware of an under reporting issue due to not all sickness episodes being input by the our payroll provider. This is being addressed with and a plan in place to work with the payroll provider to rectify.

Freedom to Speak Up: The service received 18 contacts in April which is double the number received in March, and the highest monthly rate since August 2022 . The main themes being raised in March related to concerns around staff safety/ wellbeing, patient safety/ quality of care and discrimination. Staff speaking up through the service came from a variety of professional backgrounds.

Well Led

Well Led Metrics Tracking

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Last 12 months	RAG Levels			Stat/Target
Mandatory Training Compliance	93.0%	93.0%	94.0%	93.0%	93.0%	93.0%	94.0%	94.0%	94.0%	94.0%	94.3%	94.0%		<80%	80-90%	>90%	Stat
Stat/Man training – Medical & Dental Staff	86.0%	86.0%	86.0%	85.0%	83.0%	85.0%	88.0%	90.0%	91.0%	91.0%	89.0%	89.0%		<80%	80-90%	>90%	Stat
Appraisal Rate (Non-Consultants)	86.0%	84.0%	83.0%	78.0%	77.0%	82.0%	83.0%	84.0%	82.0%	81.0%	82.6%	82.0%		<80%	80-90%	>90%	Stat
Appraisal Compliance (Consultant)	86.0%	87.0%	85.0%	87.0%	85.0%	85.0%	85.0%	94.0%	95.0%	93.0%	90.7%	90.6%		<80%	80-90%	>90%	Stat
Honorary contract training compliance	74.0%	72.0%	71.0%	69.0%	68.0%	70.0%	69.0%	69.0%	69.0%	66.0%	65.0%	66.0%		<80%	80-90%	>90%	Stat
Safeguarding Children Level 3 Training	94.0%	94.0%	96.0%	95.0%	95.0%	95.0%	95.0%	96.0%	97.0%	96.0%	96.0%	96.0%		<80%	80-90%	>90%	Stat
Safeguarding Adults Level 2 Training	94.0%	93.0%	94.0%	94.0%	93.0%	93.0%	95.0%	95.0%	96.0%	95.0%	95.0%	95.0%		<80%	80-90%	>90%	Stat
Resuscitation Training	77.0%	78.0%	81.0%	81.0%	82.0%	83.0%	87.0%	87.0%	87.0%	87.0%	86.0%	85.0%		<80%	80-90%	>90%	Stat
Sickness Rate see note 3	3.6%	3.6%	3.3%	3.3%	3.6%	3.5%	4.0%	4.5%	3.7%	3.0%	3.3%	2.7%		>5.3%	3-5.3%	<3%	T
Turnover Rate (Voluntary)	12.2%	12.1%	12.6%	12.5%	13.6%	13.9%	14.3%	14.0%	14.2%	14.2%	14.4%	14.4%		>14%	N/A	<14%	T
Vacancy Rate – Trust	6.4%	5.8%	6.8%	7.1%	7.4%	5.9%	6.3%	6.9%	7.2%	7.0%	7.1%	7.1%		>10%	N/A	<10%	T
Vacancy Rate - Nursing	6.2%	6.1%	7.8%	8.8%	9.0%	4.5%	5.6%	7.0%	7.7%	8.3%	8.0%	8.0%		No Threshold			T
Bank Spend	4.2%	5.5%	5.5%	5.5%	5.4%	5.4%	5.4%	5.3%	5.4%	5.4%	5.2%	6.4%		No Threshold			T
Agency Spend	1.2%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.3%		>2%	N/A	<2%	T
Quarterly Staff Survey - I would recommend my organisation as a place to work			62.0%						65.0%			64.0%		No Threshold			T
Quarterly Staff Survey - I would be happy with the standard of care provided by this organisation			87.0%						87.0%			87.0%		No Threshold			T
Quarterly Staff Survey - Overall Staff Engagement (scale 0-10) See note 1			7.0						7.0			6.98		No Threshold			T
Quarterly Staff Survey - Communication between senior management and staff is effective See note 1			41.0%						45.0%			44.0%		No Threshold			T
Number of people contacting the Freedom To Speak Up Service	13	15	20	20	11	15	13	10	7	11	9	18		No Threshold			T
Number of Themes of concerns raised as part of Freedom to Speak Up Service (note 2)	21	24	33	32	15	21	23	15	9	15	17	31		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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Safer Staffing- Nursing only

Vacancy rate: Average registered nurse (RN) vacancy rate remained stable in April at 8% and below trust target (10%). Vacancy percentage rates are high in some individual wards and units due to the small numbers involved. This is currently being mitigated through bank usage and bed closures. Newly Registered Nurse recruitment has now concluded for 2023 with confirmed conditional offers accepted by 107 NRNs for October start date and 45 NRNs for January start date. Bespoke in-person open day recruitment events are scheduled for I&PC in May and BCC in July. We are also working with UCLH to establish a rotational programme to support the recruitment of Haem/Onc nurses.
Voluntary Turnover: Based on a 12 month rolling average, the vol. turnover for April remains above trust target (<14%) at 16.5%. The outline of refreshed retention plan 'STAY' will be presented to PEAC and Trust Board this month.
Sickness absence: Nursing sickness rates are within trust target (<3%) for the first time since the pandemic at 3% in April.
CHPPD: Care Hours per Patient Day is calculated by adding the hours of RNs and HCAs available in a 24-hour period and dividing the total by the number of patients at midnight. CHPPD is a benchmarking metric to provide a picture of care and skill mix. This has remained stable across the trust at 16 in April.
CHPPD Actual vs Plan: The Trust average was 99.2% in April and within acceptable parameters.
Agency spend: Agency usage accounted for 1% of the temporary staffing usage which were Registered Mental Health Nurses (48 shifts) on Squirrel Gastro and Panther ENT. Bank fill rate was at 83% (1951 shifts). Overall temporary staffing shift fill rate was 85% (1999 shifts).
Safe Staffing Incidents: The number of incidents decreased to 6 in April, these are currently being investigated, but no patient harm has been reported as a result of these incidents. The main themes relate to poor skill mix, lack of IV and ECMO competent nursing staff especially on night shifts and 2 HCA bank shift cancellations.

Safer Staffing Metrics	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Last 12 months	Rag Levels		
Vacancy Rate - Nursing	6.20%	6.10%	7.80%	8.80%	9.00%	4.50%	5.60%	7.00%	7.70%	8.2%	8.02%	8.0%		>11	10.1% - 11%	<=10%
Turnover Rate (Voluntary)	14.00%	14.50%	14.90%	15.20%	15.30%	15.80%	16.10%	15.40%	16.10%	16.50%	16.46%	16.50%		>14	N/A	<14%
Sickness Rate see note 3	4.80%	4.20%	3.90%	3.70%	4.00%	4.00%	4.30%	5.50%	3.70%	3.40%	3.38%	3.00%		>3.3%	3-3.3%	<3
Care Hours per Patient Day (CHPPD)	15.7	14.6	16.1	16.8	15	15.5	14.4	15	15.3	15	14.9	16.0			No Threshold	
Care Hours per Patient Day (CHPPD)- Actual vs Plan	-	-	-	-	-	-	-	-	1.037	98.97%	101.93%	99.20%		<85%	85 -90%	>90%
Agency Spend	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.00%	0.00%	1.00%		>2%	N/A	<2%
Safe Staffing Incidents	7	10	3	4	13	13	10	15	3	4	13	6		No Threshold		
Bank Fill Rate	88%	85%	87%	85%	87%	84%	85%	81%	86%	85%	85%	83%		No Threshold		

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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 by bed closures, strikes, key consultant absence and continued volume of inpatient last minute cancellations.

- **RTT** Performance for April 2023 was **67.7%,** 0.4% increase from last month and remains below trajectory. The overall PTL size has plateaued over the last 3 months. None of the directorates met the 92% standard this month. RTT performance has been affected by the Junior Doctor's strikes, inherited breaches, patient and consultant leave, and bed pressures as well as air handling issues in two theatres which led to cancellations and theatre reconfiguration. We do not expect RTT to improve significantly in May due to industrial action taken by Nurses.
- There are nine patients who are waiting above **104 weeks,** an increase from last month, when we reported four. There are 4 ENT patients. Two of these are all complex patients who need to be reviewed by another specialty before treatment can be advised. One of the other ENT patients unfortunately cancelled on the day due, and is now booked in for first available appointment in July. The service is trying to bring this forward. The remaining ENT patient now has a TCI in June. One patient **(Endocrinology)** is an inherited wait received at 154 weeks, and will be seen in May. One patient **(Plastic Surgery)** has a provisional TCI in August and the other patient **(T&O)** has a provisional TCI in October. Two patients are waiting for **Dental** treatment. The Trust is exploring mutual aid with UCLH due to capacity restraints in Dentistry. **78 week waits** have continued to increase (75) and remains above trajectory. **52 week waits** have increased to 379. The long waiters are predominantly in Orthopaedics (78), Plastic surgery (64), Dental (55), ENT (37), Craniofacial (21), Cardiology (20) , Ophthalmology (28), Maxillofacial(11) and Audiological Medicine (10). Revised RTT trajectories and action plans are being produced. Sight & Sound and Body, Bones and Mind directorates are the most challenged.
- At the time of writing the Trust is currently projecting 102 patients, at the end of June 2023, to be waiting 78 week waits or more against the national ambition of zero.
- **DM01** performance for April 2023 was **80.7%**, a decrease of 1.2% from the previous month. The number of 6 week breaches has increased this month to 322, compared to 303 last month. 13 week breaches have seen an increase to 33 up from 25 last month. Trajectories for MRI, CT, Ultrasound, Endoscopy and Sleep Study modalities are being refreshed.
- **Cancer:** It is projected for April that all of the five standards will be met.

Bottlenecks

Consultant availability in particular for Dental, Orthopaedics, Spinal and SNAPS

Junior doctor's and nursing strikes resulted in reduced activity

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 as other providers reduce backlogs. (Where patients arrive from referring hospitals with a significant time already on the clock).

Challenges in diagnostic capacity particularly for MRI 5, MRI sedation, Endoscopy and 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

Revised RTT and Diagnostic trajectories and actions plans being produced

Continued focus on reduction of long wait patients

Additional clinics for Endocrinology from April

Discussion on mutual aid for Dental Services with UCLH

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

Clinical Genetics Consultant joined in April

Assessing additional 4 bed bay be opened on Sky to support throughput.

Day-case project commenced reviewing Nightingale Ward usage

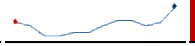
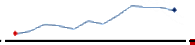
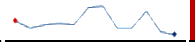
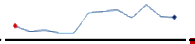
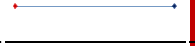
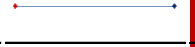
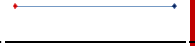
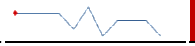
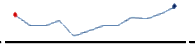
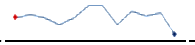
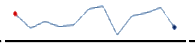
Recruitment of locum Orthopaedic Surgeon

Recruitment process under way for Spinal Surgeon

Responsive

Patient Access Metrics

Access Metrics Tracking

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trajectory	Last 12 months	RAG Levels	Stat/Target
RTT Open Pathway: % waiting within 18 weeks	76.8%	75.3%	73.7%	72.3%	71.8%	72.4%	73.2%	70.9%	71.4%	69.8%	67.3%	67.7%	Below		<92% N/A >=92%	Stat
Waiting greater than 18 weeks - Incomplete Pathways	1,638	1,765	1,900	2,006	2,023	2,012	1,944	2,154	2,169	2,280	2,464	2,415	-		No Threshold	-
Waiting greater than 52 weeks - Incomplete Pathways	160	177	177	196	202	206	219	248	279	311	356	379	Above		>0 N/A =0	Stat
Waiting greater than 78 weeks - Incomplete Pathways	24	24	20	25	30	28	28	45	47	52	58	75	Above		TBC	T
Waiting greater than 104 weeks - Incomplete Pathways	4	3	0	0	1	1	3	5	5	3	4	9	Above		>0 N/A =0	Stat
18 week RTT PTL size	7070	7150	7239	7229	7176	7295	7264	7401	7580	7545	7532	7482	-		No Threshold	-
Diagnostics- % waiting less than 6 weeks	84.7%	82.6%	83.9%	84.1%	83.5%	88.4%	89.2%	82.6%	82.6%	87.6%	81.9%	80.7%	Below		<99% N/A >99%	Stat
Total DM01 PTL size	1,565	1,489	1,506	1,480	1,463	1,714	1,747	1,767	1,663	1,841	1,672	1,668	-		No Threshold	-
Cancer waits: 31 Day: Referral to 1st Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	*100%*	-		<85% N/A >85%	Stat
Cancer waits: 31 Day: Decision to treat to 1st Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	*100%*	-		<96% N/A >96%	Stat
Cancer waits: 31 Day: Subsequent treatment – surgery	100%	100%	100%	100%	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%	94%	92%	93%	*100%*	-		No Threshold	-
Cancelled Operations for Non Clinical Reasons (note 1)	31	28	43	28	33	38	53	27	45	34	28		-		No Threshold	-
Cancelled Operations: 28 day breaches	4	4	4	4	2	5	1	3	3	3	1		-		>0 N/A =0	Stat
Number of patients with a past planned TCI date (note 4)	1,398	1,256	1,261	1,347	1,112	1,193	1,270	1,261	1,390	1,356	1,422	1,542	-		No Threshold	-
NHS Referrals received- External	2,603	2,673	2,607	2,431	2,611	2,901	2,920	2,453	2,754	2,667	2,725	2,176	-		No Threshold	-
NHS Referrals received- Internal	2,023	1,767	1,883	1,789	1,820	2,124	2,198	1,625	1,980	2,039	2,136	1,753	-		No Threshold	-
Total NHS Outpatient Appointment Cancellations (note 2)	6,626	6,816	7,352	7,472	6,910	6,352	6,368	6,449	6,308	6,212	7,456	6,061	-		No Threshold	-
NHS Outpatient Appointment Cancellations by Hospital (note 3)	1,473	1,499	1,569	1,493	1,707	1,441	1,366	1,576	1,514	1,740	2,113	1,584	-		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

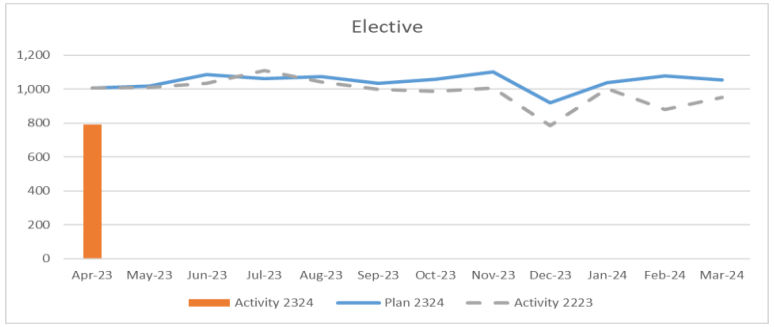
Patient Access - Activity Monitoring at Month 12

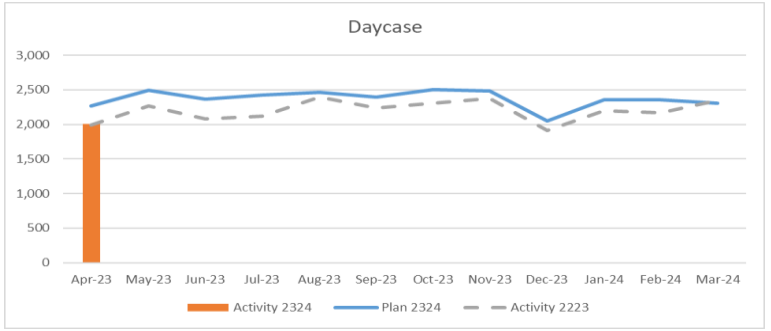
Overview:

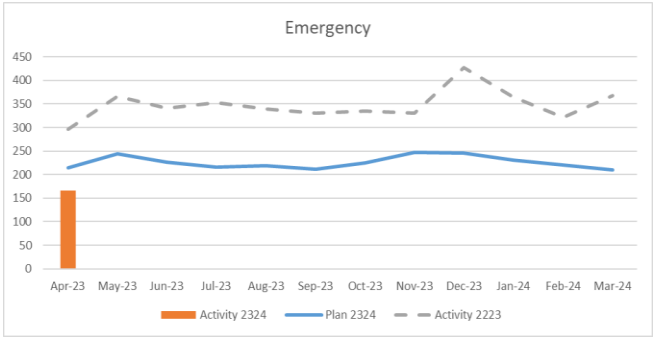
As at M1 of 23/24 all activity was 11% down v plan and 9% down on 2022/23 activity levels. Electives were down against plan at 15% and outpatients 10% down against plan. The Junior Doctor Strikes in mid-March and April was the primary cause of this lower activity level. For the week of the Junior Doctor's strike inpatient activity was down by 40% against plan and outpatients by 20%. This strike and the Nurses strike in early May have also impacted activity before and after the strike weeks.

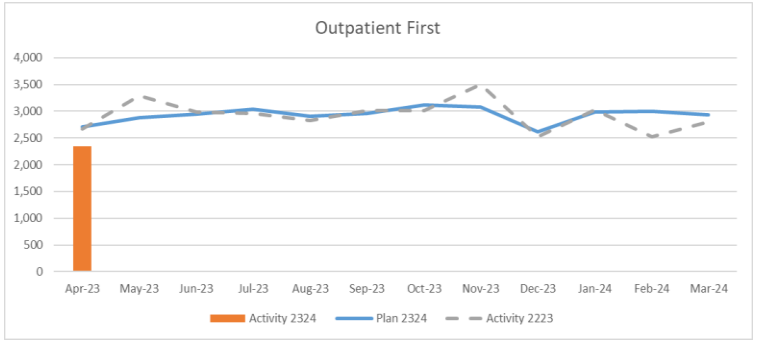
All directorates for M1 23/24 are below plan, Body, Bones and Mind (-0.6%), Core Clinical Services (-8.1%), Blood, Cells and Cancer (-13.7%), Heart and Lung (-22.5%), Brain (-1.6%) and Sight and Sound (-12.4%)

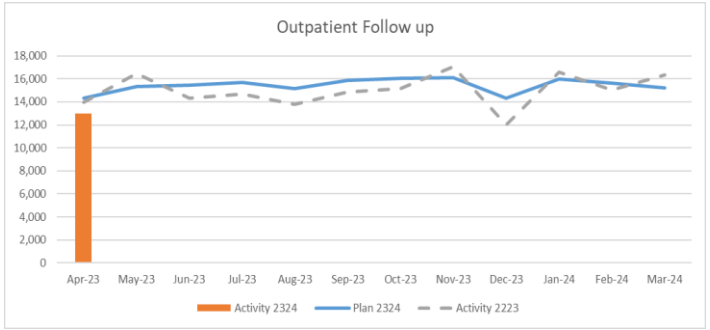
With strikes and bed closures continuing this has impacted the delivery of activity, RTT and DM01 waiting time improvements. Continued focus remains on optimising bed capacity, theatres and reducing long waits.











Overview M1 23-24

POD	Plan 2324	Activity 2324	Activity 2223	% of 22/23	% of Plan
Daycase	2,268	2,002	1,992	100.50%	88.25%
Elective	1,007	790	1,006	78.53%	78.45%
Emergency	215	166	297	55.89%	77.33%
First OPA	2,709	2,343	2,670	87.75%	86.48%
Follow-up OPA	14,304	12,970	13,976	92.80%	90.68%
Grand Total	**20,503**	**18,271**	**19,941**	**91.63%**	**89.11%**

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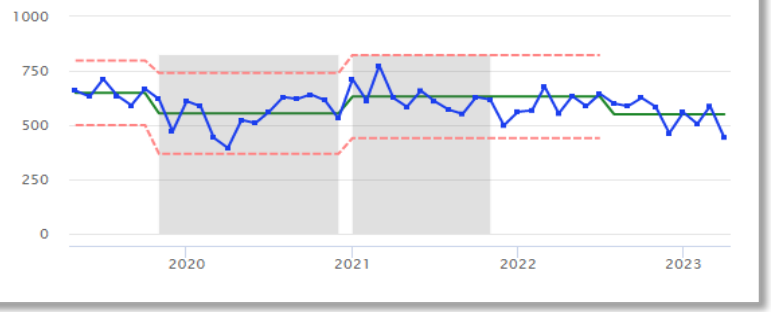
Responsive

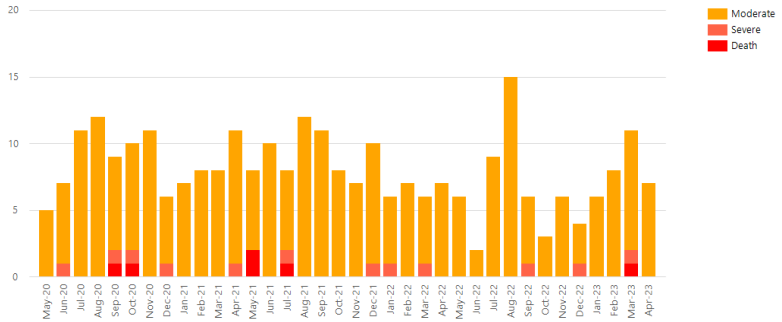
Appendix
Integrated Quality & Performance Report

Appendix 1: Patient Safety (incidents & risks)

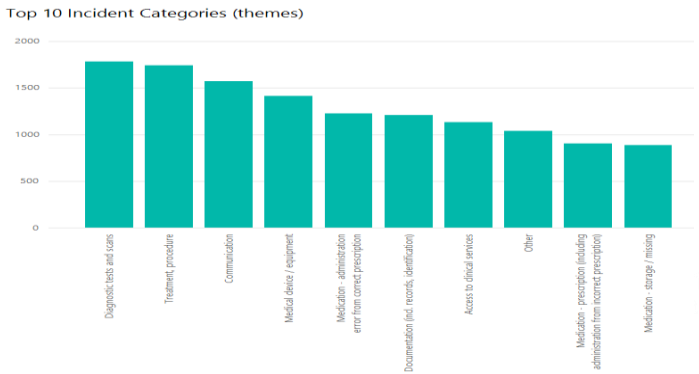
New Incidents



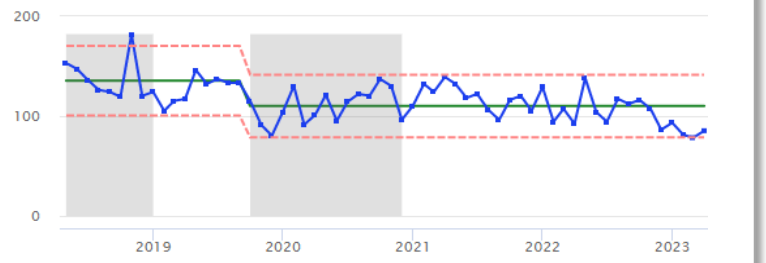
Incidents by Harm



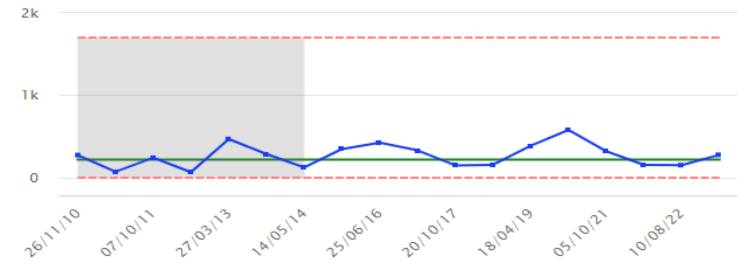
Top 10 Incident Categories (themes)



Medication Incidents



Days Since never events

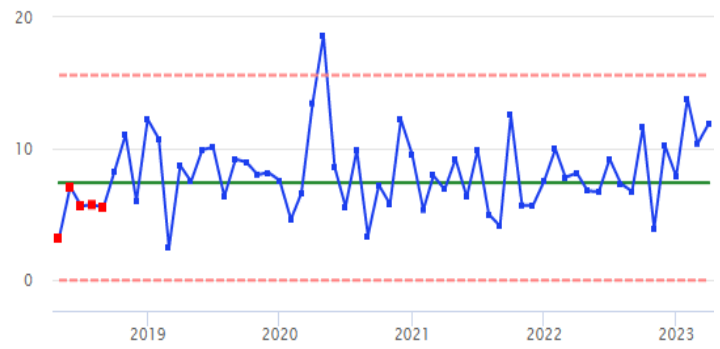


Safe

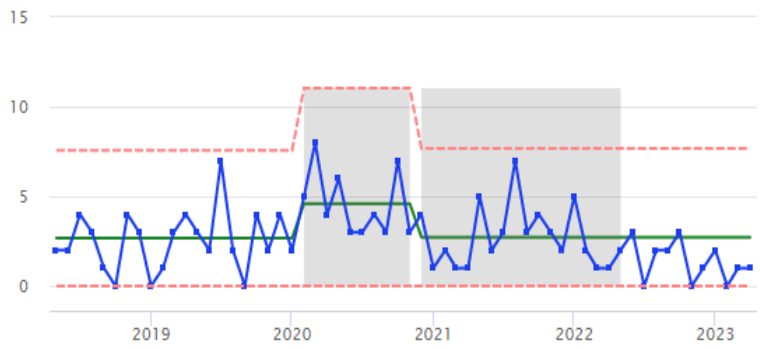
Appendix 2: Patient Safety (Infection & mortality)

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

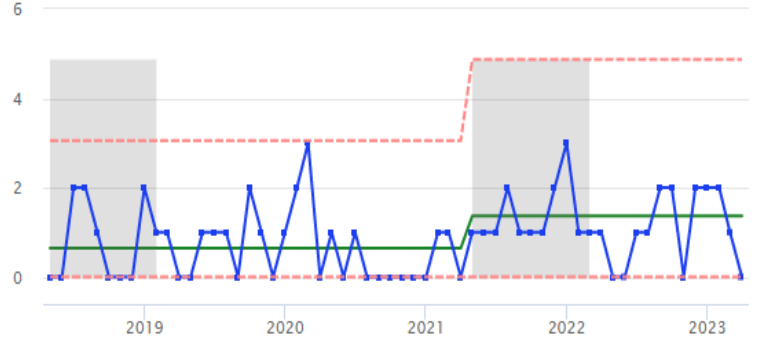
Inpatient Mortality Rate / 1000 Discharges



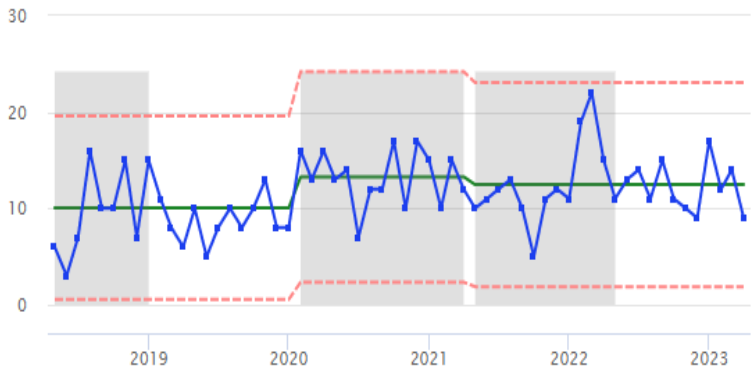
Respiratory Arrests outside ICU



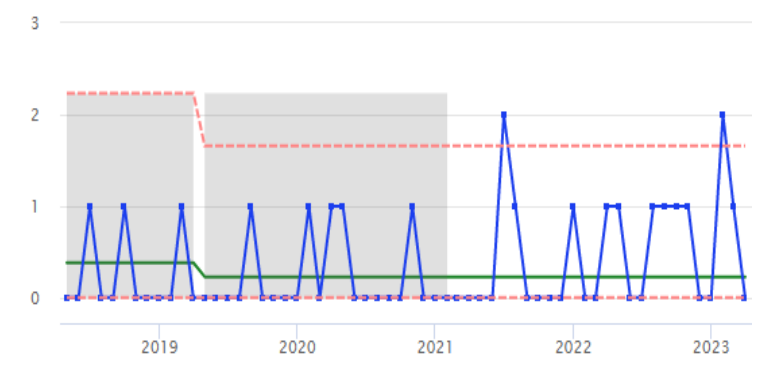
Cardiac Arrests outside ICU



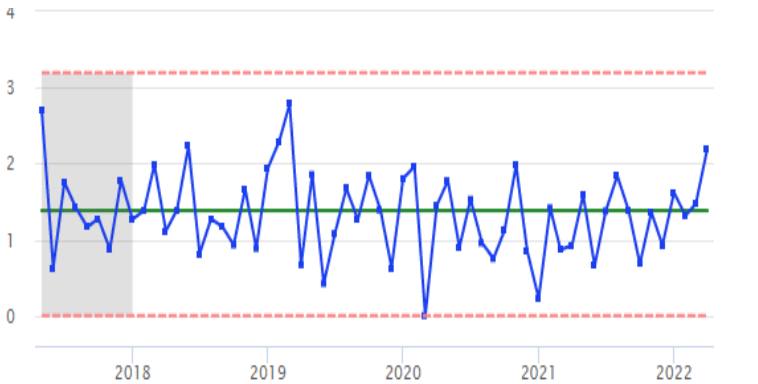
Non 2222 Patients transferred to ICU



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 April was above the Trust target, scoring 99% and all directorates scored 95% or above. However, outpatients scored below the target at 91%. The response rate was higher than in March, with inpatient areas achieving 30%. All directorates scored above the response rate target of 25% with the exception of Core Clinical Services. This was not replicated in outpatient areas. Brain was the only directorate to achieve the outpatient experience target in April, scoring 97%. Blood Cells and Cancer, Heart & Lung, Core Clinical Services and Sight and Sound all scored below the Trust target and Body Bones and Mind received no responses. This will be addressed at the next PFEEC meeting.

Headline:

Inpatient response rate – 30% (increased from March).

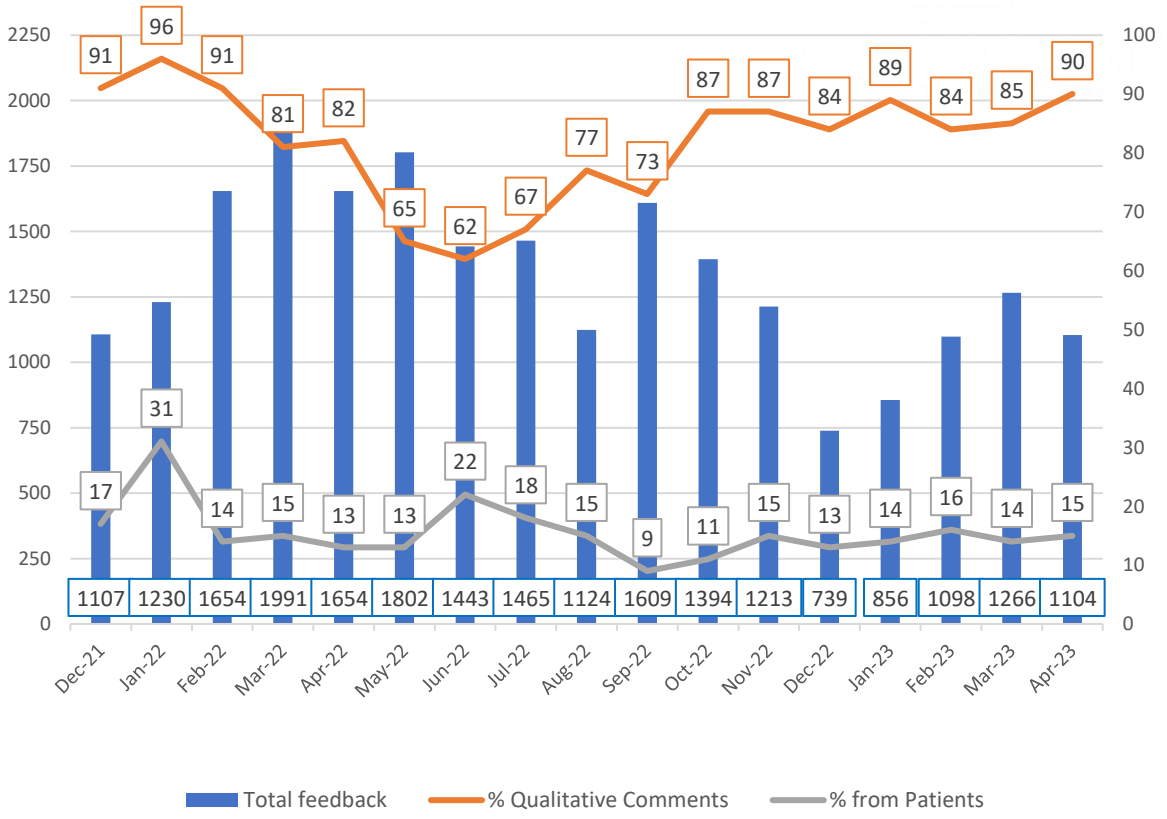
Experience measure for inpatients – 98% (increased from March).

Experience measure for outpatients – 91% (increased from March).

Total comments received – 1104 (Decreased from March).

15% of FFT comments are from patients.

90% of responses had qualitative comments.



Positive Areas:

- Amazing care!
- Lovely warm atmosphere.
- Staff empower patients and their families.
- Cleanliness.
- Staff always smiling!
- Positive environment.
- Play activities
- Artwork.
- Practical advice given to families.
- Improved waiting times in some areas

Areas for Improvement:

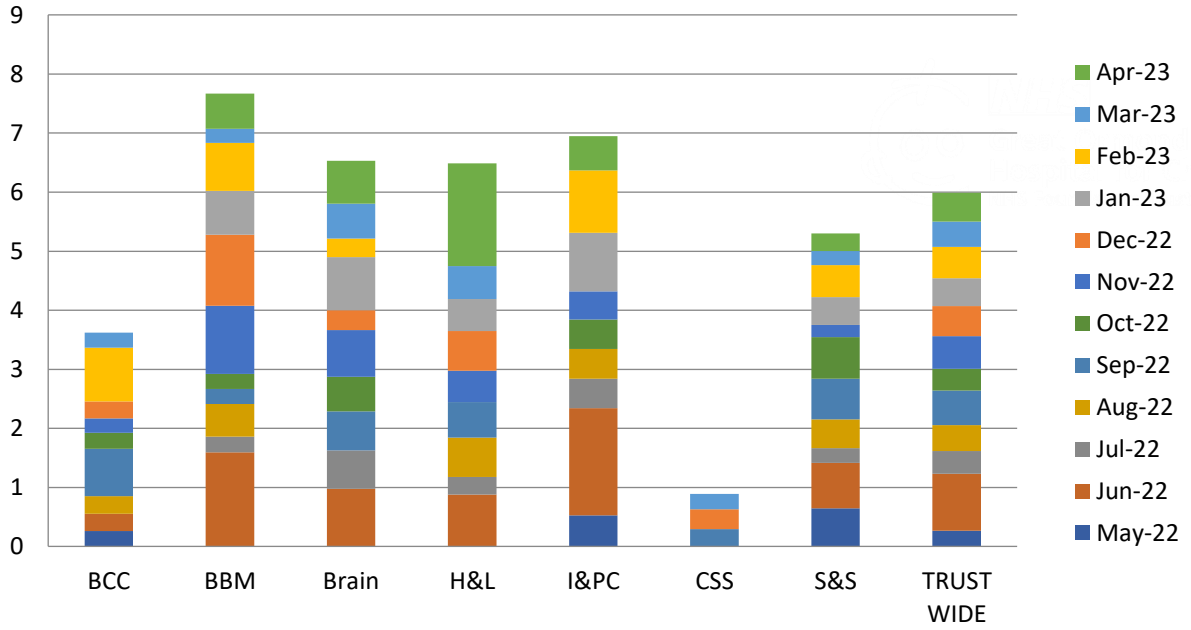
- Communication between medical teams, with parents and prior to procedures.
- Difficult for patients when there is an infection outbreak on a ward and visiting is limited.
- Long waits in outpatients and day care units.
- Broken equipment, TVs and clocks.
- Wi-Fi.
- Food options.

Appendix 3: Complaints

Headline: There were 10 new formal complaints in April which is a slight increase from this time last year and consistent with the increased numbers of complaints raised since June 2022. 1 complaint was graded red (high risk) and declared an SI.

In April families complained about:

- **Treatment, care and decision making** prior to the sad death of their child. Concerns around palliative care, transportation, lack of communication and multiple other aspects of care received.
- **Communication** around changes in clinician and subsequent changes to treatment plan, discussion of risks prior to admission, contradicting advice given by the clinical team.
- **Multiple cancellations and long waits** for surgery, admissions and genetic test results, which caused significant distress and inconvenience. Six complaints raised concerns about **delays to care and treatment** as a result of cancellations and long waits.
- **Follow up /post op care,** including identifying a broken bone prior to discharge and later requiring revision surgery.
- **Inaccurate information** such as the rising costs of private treatment.



Closed complaints since April 2022

152 complaints (including withdrawn and reopened complaints) have been closed since April 2022 with 47 of these requiring extended response times. 57% of draft responses were submitted late to Complaints for review. The average response time this year is 37 days.

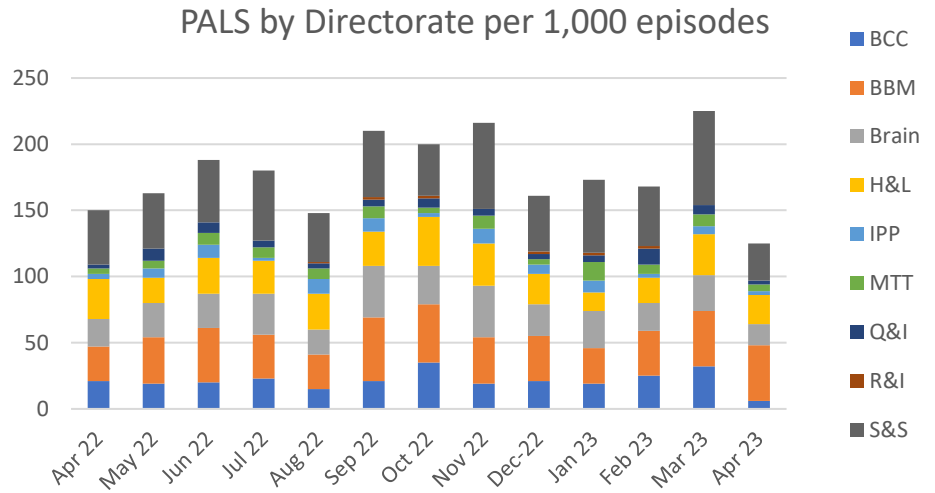
Learning actions/ outcomes from complaints closed in April 2023 included:

Due to an increase in concerns around attitudes and communication, training and education for all secretarial and administrative staff (within the relevant directorate) is being rolled out to ensure that they communicate with our patients and families in a professional manner. This will be reviewed to determine how this can be replicated within other directorates.

Appendix 3: PALS

Headline: Pals received 154 contacts in April 2023 (this is a decrease from March 2023, down by 123 cases). This can be attributed to the strikes and reduction of inpatient and outpatient activity. Contacts primarily related to families seeking information and assistance regarding referral outcomes, clarity on patient's care/ treatment plans, cancellations of OPA/Admissions. Many families continue to contact Pals rather than reaching out to services directly.

3 compliments received in April
1) Lagoon staff commended for their food and polite staff
2) Jennifer Billington and Chameleon ward staff for the tremendous care given
3) Ms Craven in the spinal team for her outstanding work with a complex patient



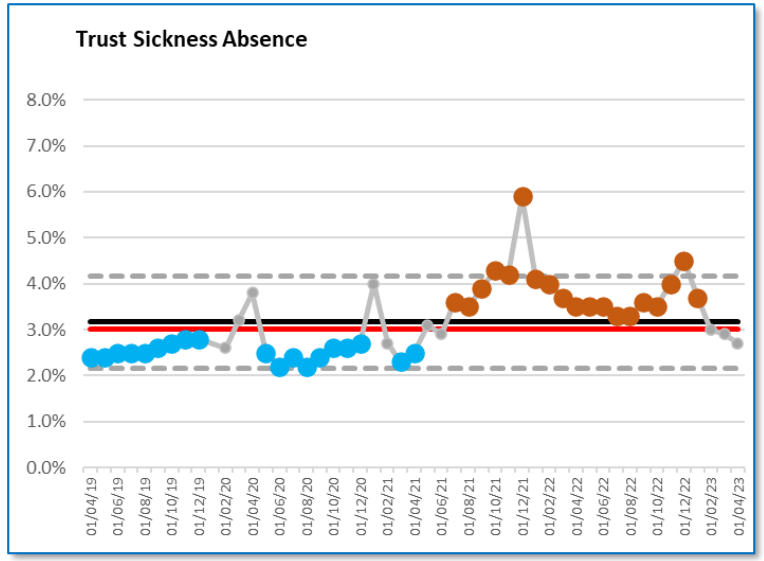
Contacts resolved within 48 hours increased from 41.3% March to 82% in April 2023.

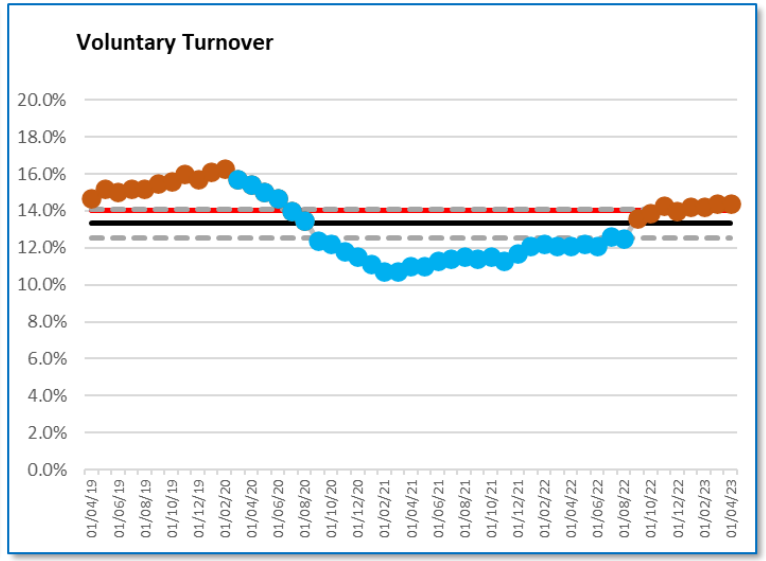
Care Queries: Pals were contacted by 35 families in April: chasing test results, lack of communication from the clinical team, clinical queries regarding patient care and symptoms.

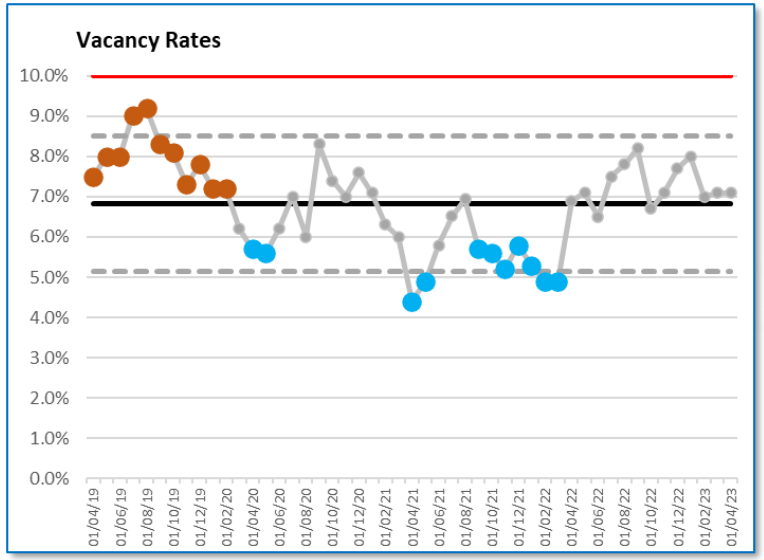
Significant areas of focus: The highest number of Pals contacts were received by SNAPS (increase from 11 in March to 14), Orthopaedics (11 contacts compared to 6 in March) , Gastroenterology (decrease from 11 to 10 in April) and Cardiac Surgery (10 cases in March). Consistent themes related to OPA and admission cancellation due to lack of beds, requests for information regarding test results, referral enquiries and difficulties in speaking to the team. Outcomes primarily related to contacts with families offering further

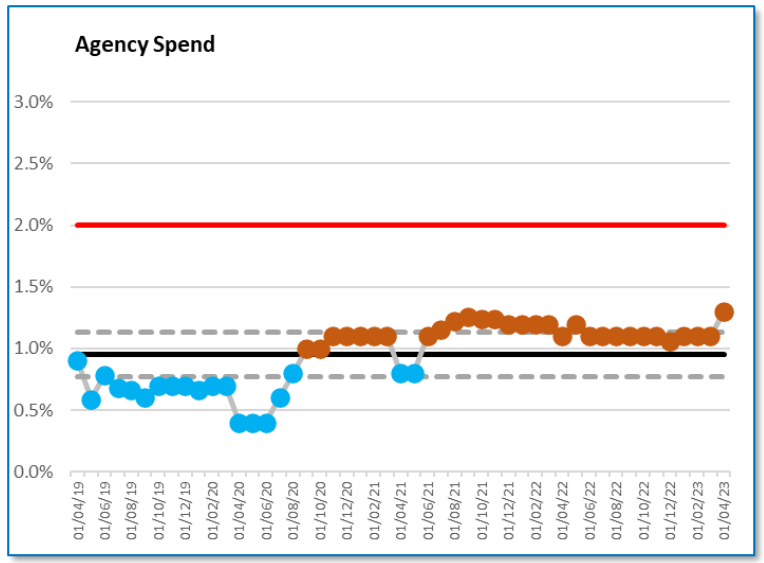
Pals Learning/Service Improvement:
April saw a number of staff strikes within GOSH which we anticipated may cause some distress amongst our families. Pre-empting this, Pals worked closely with the Comms Team to help draft notifications to families advising them of the strikes, how this would affect their child's care and what to do to raise any concerns that they may have. The result was that Pals received no contacts about the strikes. This can be attributed to the fact that families were not only pre-emptively made aware of the strike action, but were also reassured that there were measures in place to respond quickly and appropriately to any concerns and issues should they arise. Pals were happy to support the team with this to ensure that families were provided with as much information as possible and were glad that communication has been so clear and effective.

Appendix 4: Workforce SPC Analysis

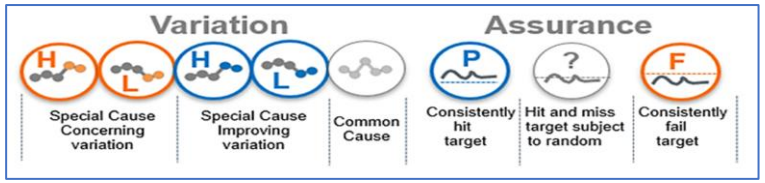






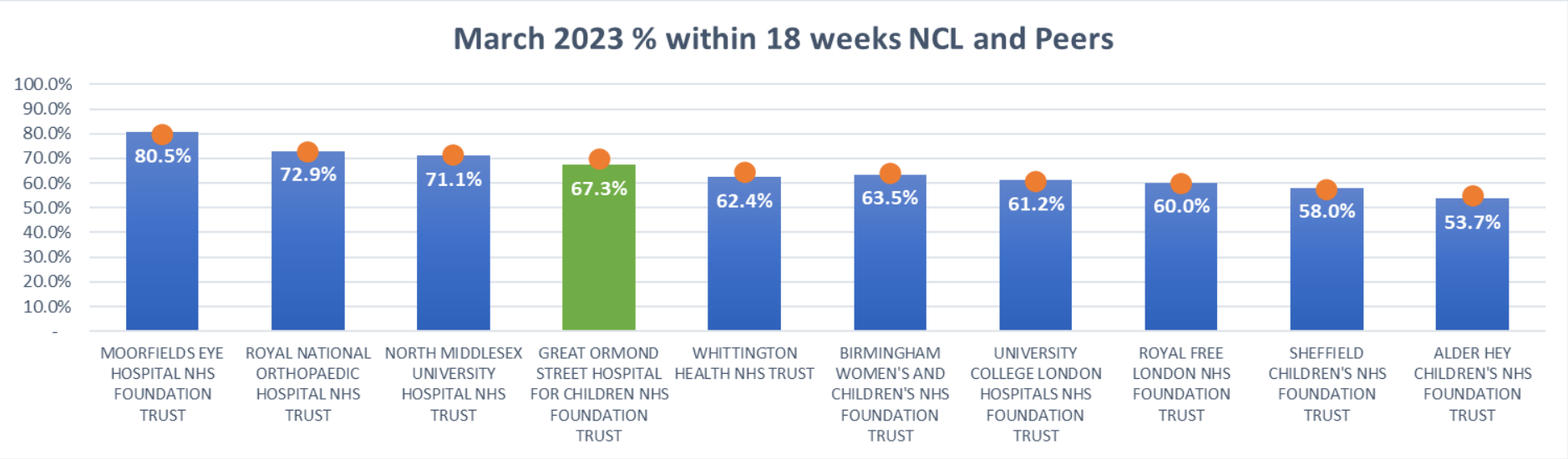


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Trust Sickness Absence	Apr 23	2.7%	3.0%			3.2%	2.2%	4.2%
Voluntary Turnover	Apr 23	14.4%	14.0%			13.3%	12.6%	14.1%
Vacancy Rates	Apr 23	7.1%	10.0%			6.8%	5.2%	8.5%
Agency Spend	Apr 23	1.3%	2.0%			1.0%	0.8%	1.1%



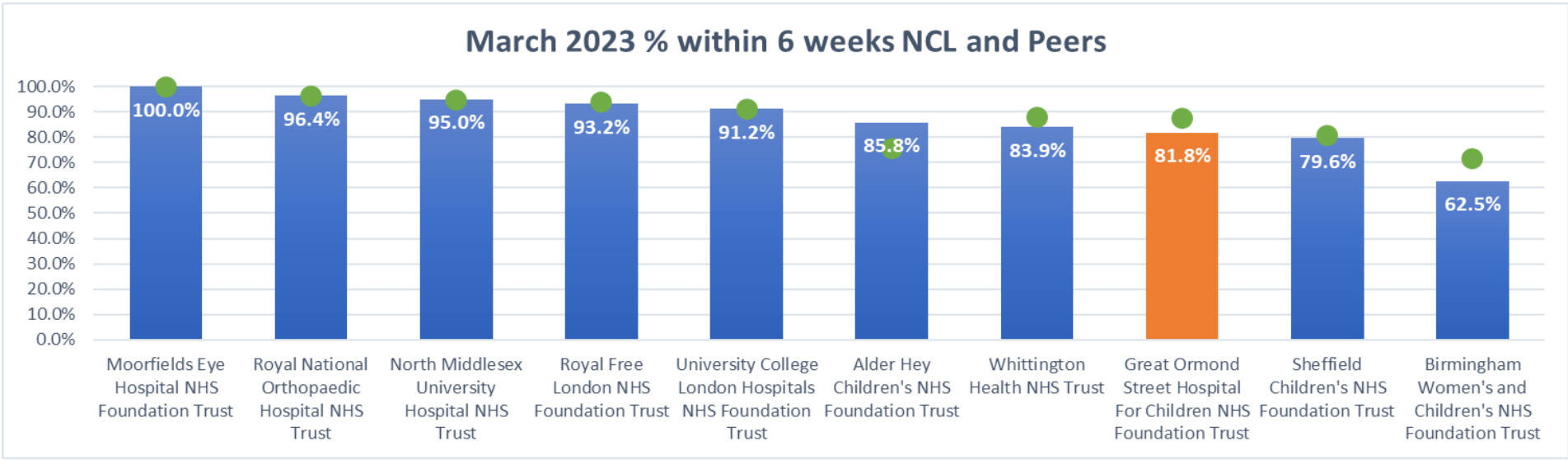
Appendix 5: RTT and DM01 Comparison

Referral to Treatment



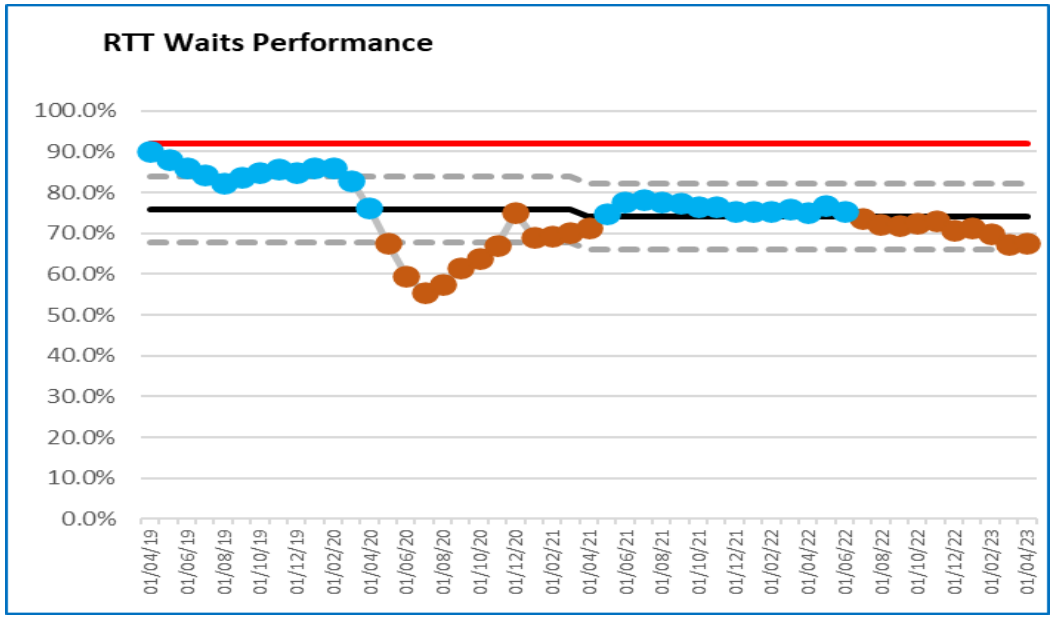
Orange markers indicate February performance. GOSH for the month of March remains in the top four of the selected Peers. However, GOSH is ranked 58th out of 168 providers, this is a drop of 10 places.

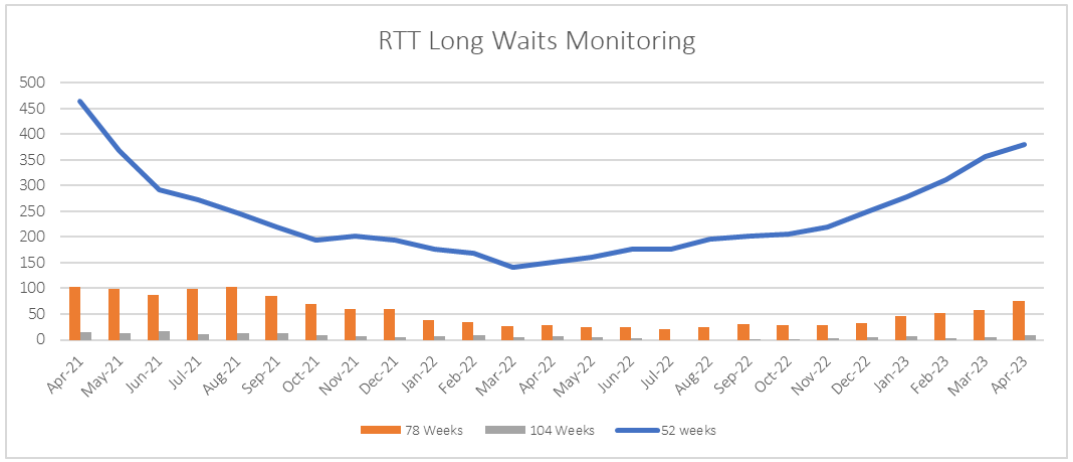
Diagnostics



Green markers indicate February performance. GOSH for the month of March has dropped a place in selected Peers to 3rd bottom. GOSH is ranked 78th out of 154 providers, a drop of 17 places.

Appendix 5: Referral to Treatment times (RTT)





RTT:

67.7% ↑ 0.4%

People waiting less than 18 weeks for treatment from referral.

>52 Weeks:

379 ↑ 23

Patients waiting over 52 weeks

>78 Weeks:

75 ↑ 17

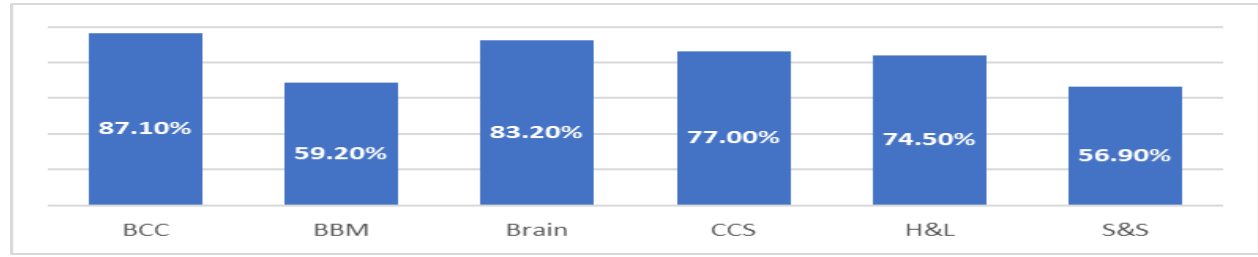
Patients waiting over 78 weeks

>104 Weeks:

9 ↑ 5

Patients waiting over 104 weeks

Directorates



RTT PTL Clinical Prioritisation – past must be seen by date

P2

207 ↓ 1

P3

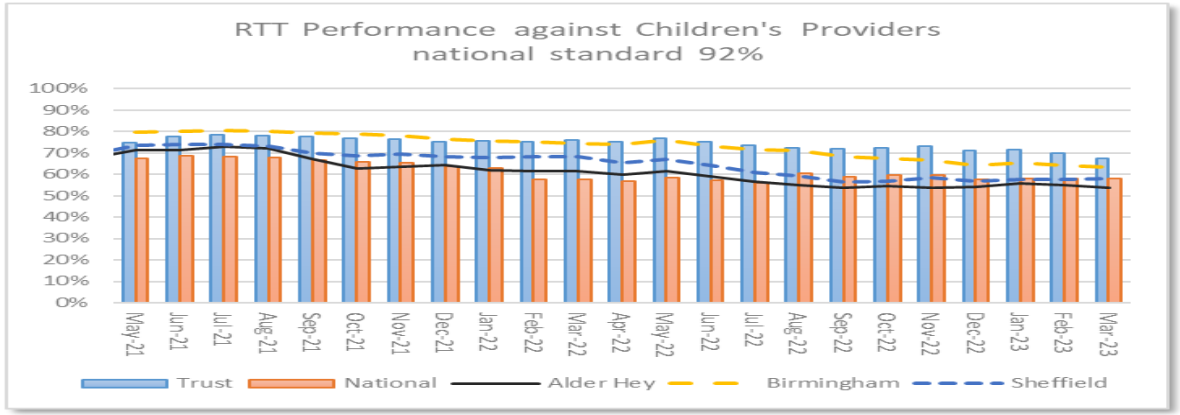
722 ↑ 29

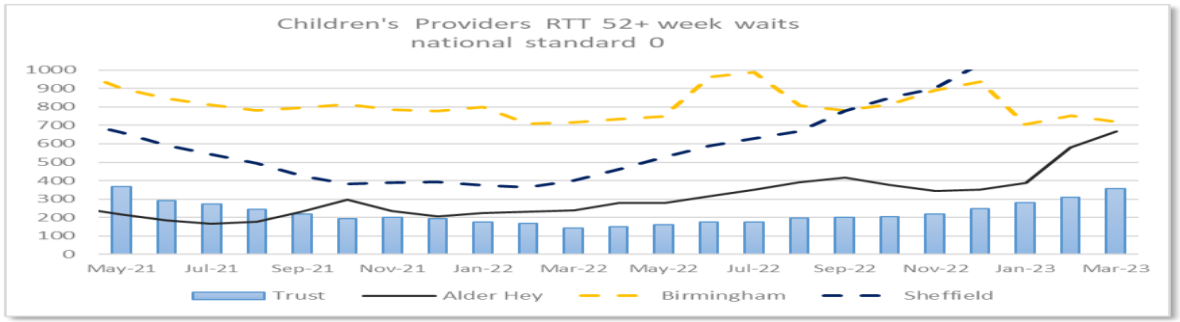
P4

531 ↑ 7

Responsive

Appendix 5: National and NCL RTT Performance –March 2023





Nationally, at the end of March, 58% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks.

GOSH is tracking 9.3% above the national March performance at 67.3% and is inline with comparative children's providers. (RTT Performance for Sheffield Children (58.0%), Birmingham Women's and Children's (63.5%) and Alder Hey (53.7%)).

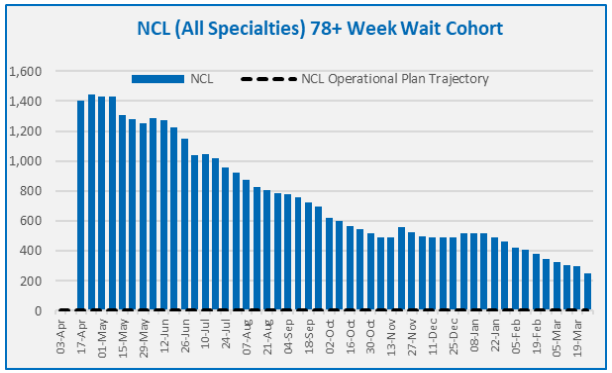
The national position for March 2023 indicates a decrease in patients waiting over 52 weeks at 345,721 patients.

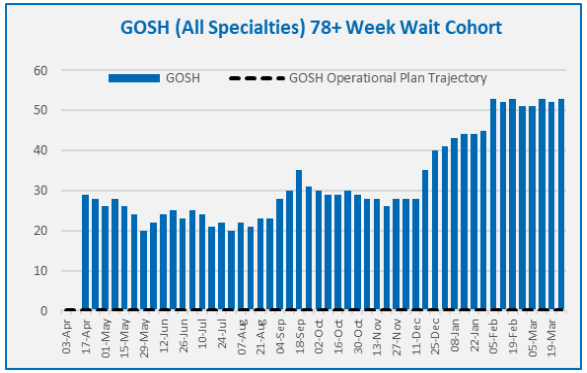
Compared to Alder Hey, Birmingham and Sheffield the number of patients waiting 52 weeks and over for GOSH is lower than all three providers for March. All 4 providers have seen increases in 52 week waits.

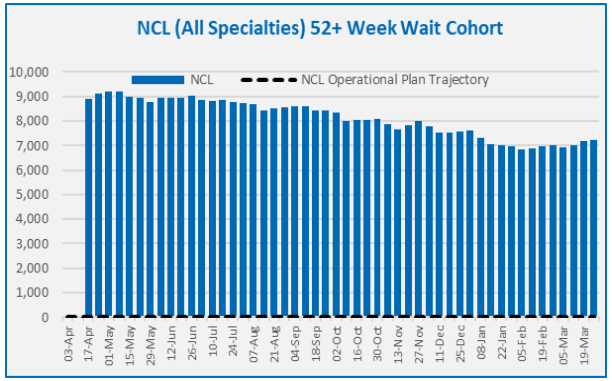
Overall for NCL the 78+ week wait position is above projected plan at 225 patients but has decreased by 1000 since April 2022. GOSH is above trajectory by 57 patients.

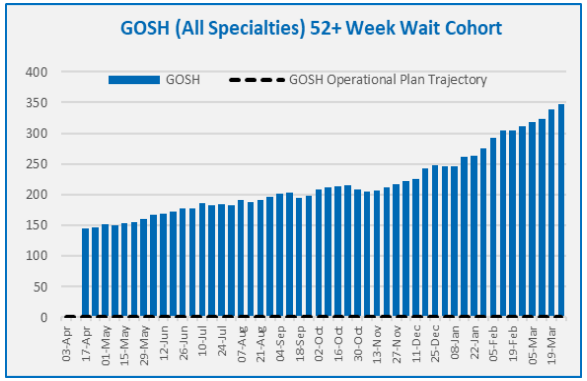
Overall, the number of patients waiting 52 weeks for NCL is reducing. Royal Free and UCLH have the most significant volumes. GOSH is above the agreed trajectory submitted on 30th November 2022.

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



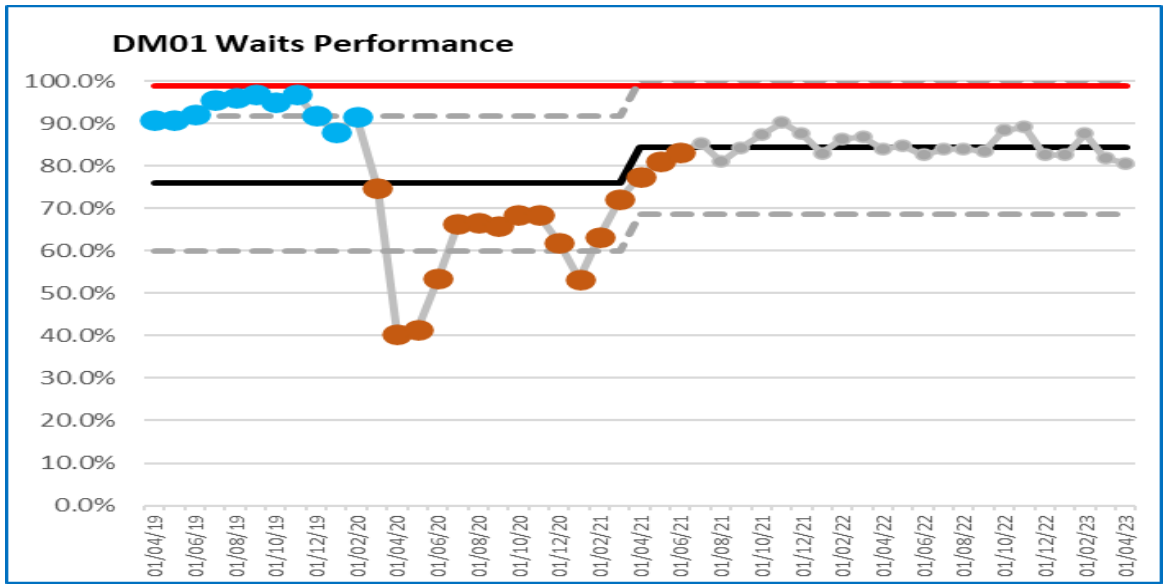


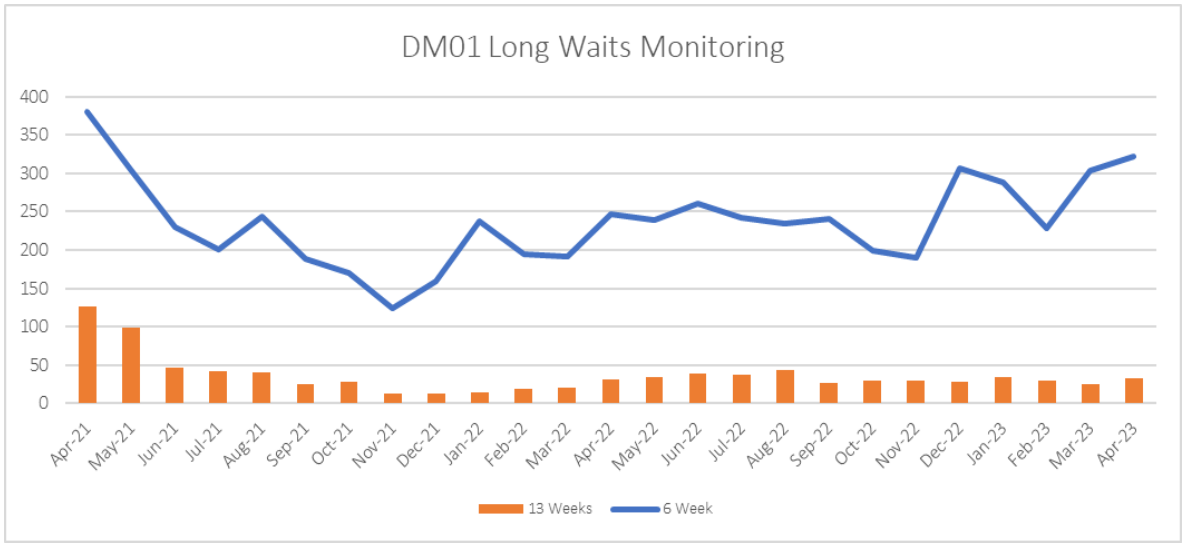




Responsive

Appendix 6: Diagnostic Monitoring Waiting Times (DM01)





DM01:

80.7% ↓ 1.2%

People waiting less than 6 weeks for diagnostic test.

>6 Weeks:

322 ↑ 19

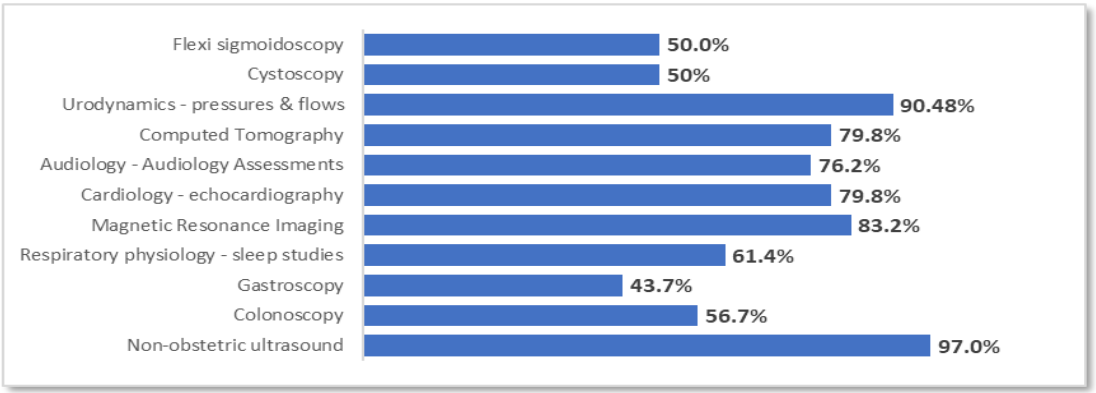
Patients waiting over 6 weeks

>13 Weeks:

33 ↑ 8

Patients waiting over 13 weeks

Modalities not meeting 99% standard



Responsive

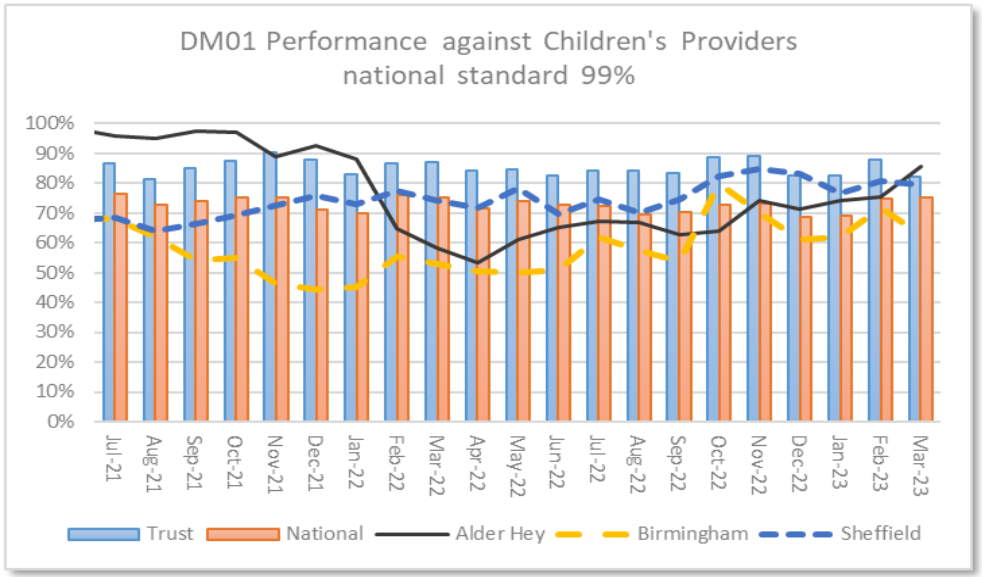
Appendix 6: National Diagnostic Performance and 6 week waits – March 2023

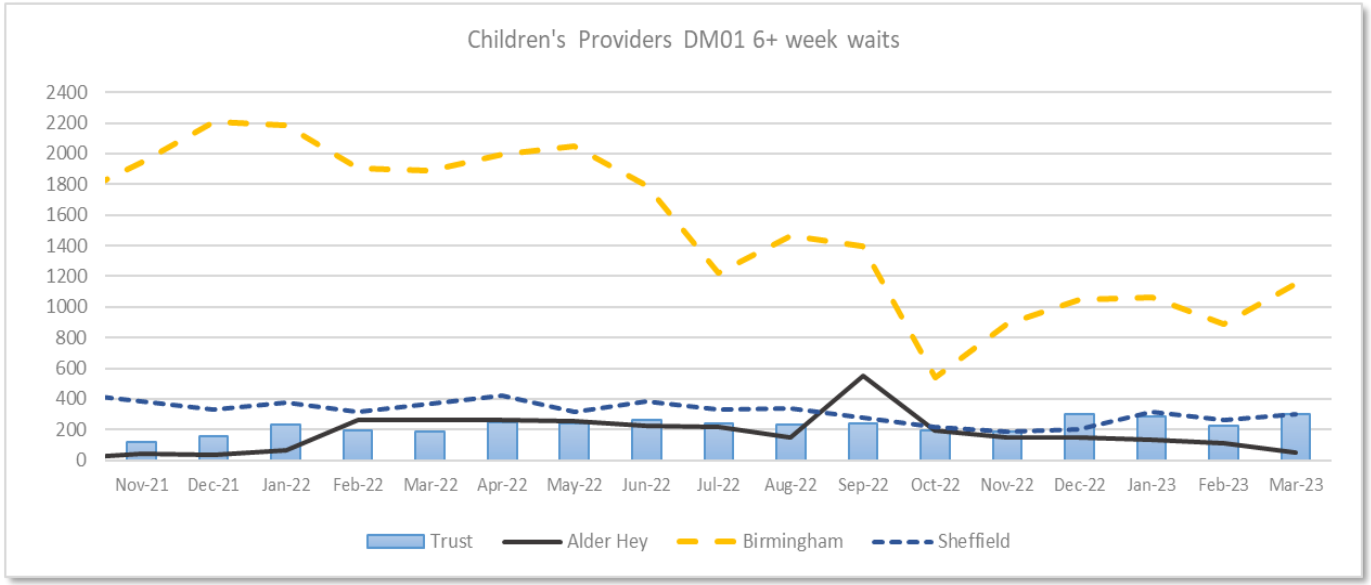
Nationally, at the end of March, 74.9% of patients were waiting under 6 weeks for a DM01 diagnostic test.

GOSH is tracking 6.9% above the national March performance and is inline with comparative children's providers. DM01 Performance for Sheffield Children (79.5%), Birmingham Women's and Children's (62.5%) and Alder Hey (74.9%).

The national position for march 2023 indicates an increase of patients waiting over 6 weeks at 407,167 patients.

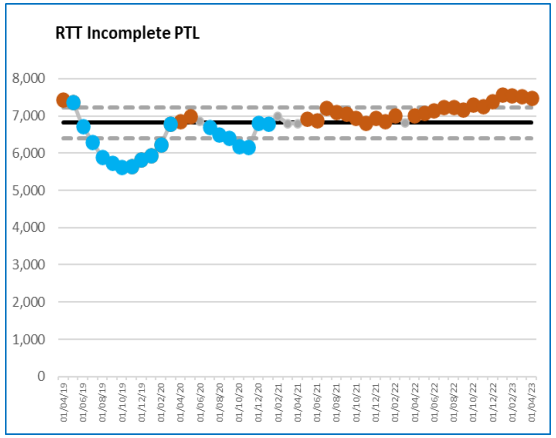
Compared to Birmingham and Sheffield the number of patients waiting 6 weeks and over for GOSH is lower than these providers for March.



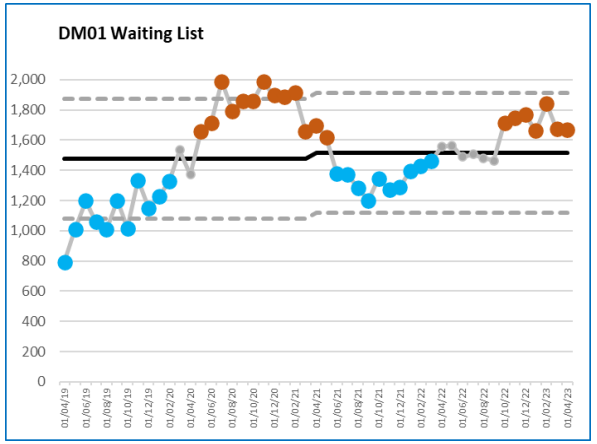


Responsive

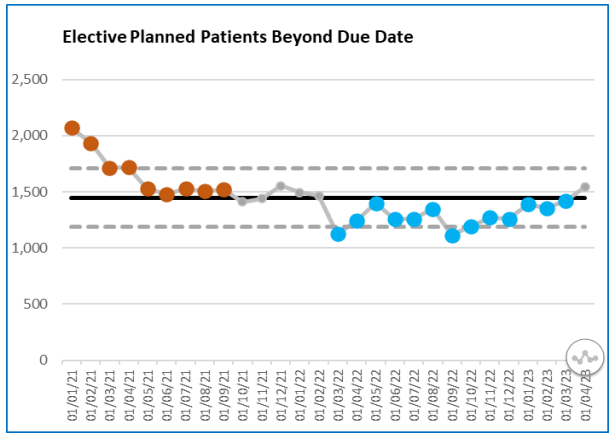
Appendix 7: Patient Access SPC Trends



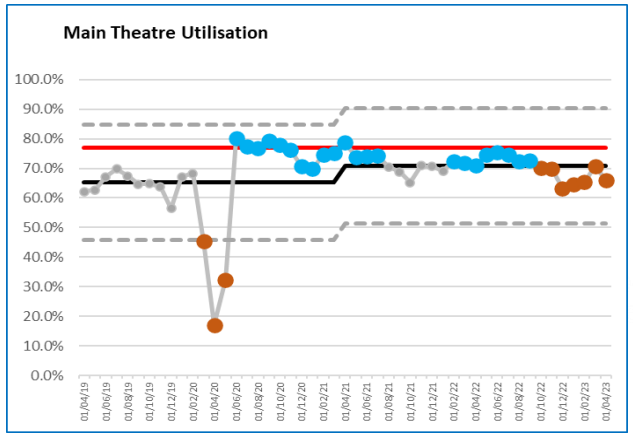
Special cause variation



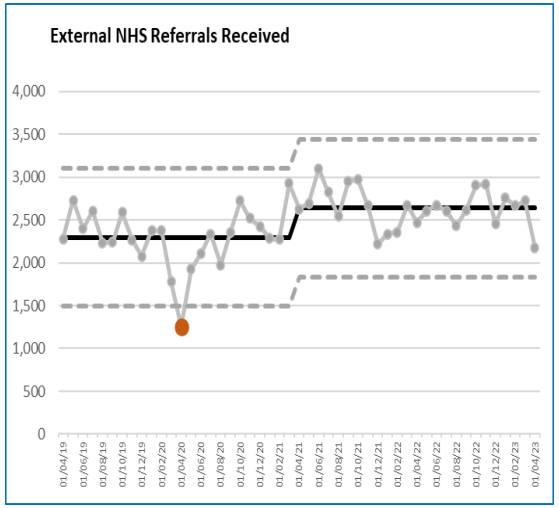
No Significant variation



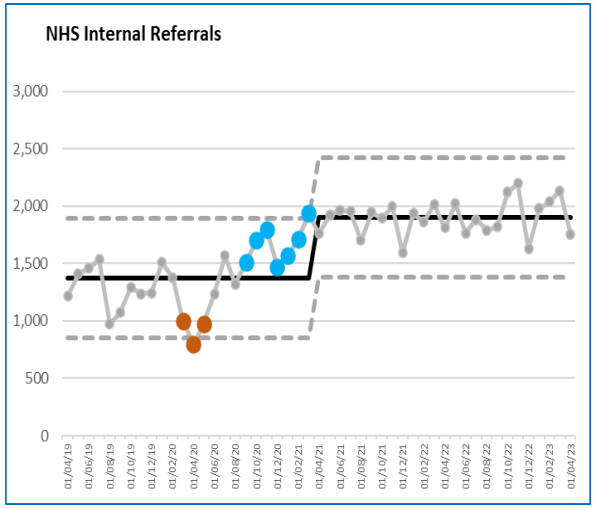
Marginal upward trend, strikes have impacted



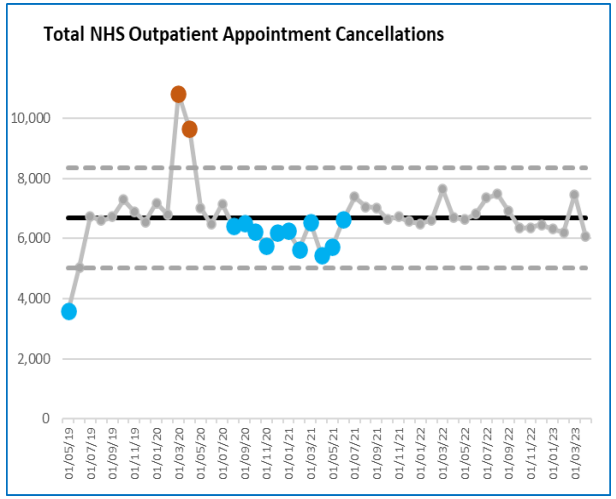
No Significant variation



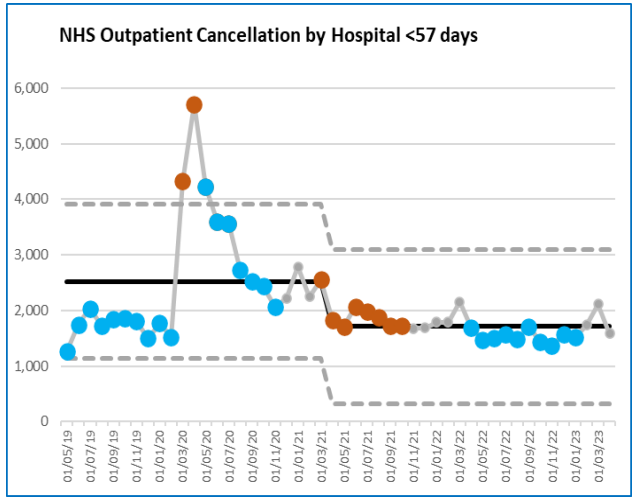
No significant variation, common cause



No significant variation, common cause



No significant variation, common cause



Common cause variation

Responsive

Integrated Quality & Performance Report May 2023 (Reporting April 2023 data)

Attachment W

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
8th June 2023

Month 1 2023/24 Finance Report **Submitted by:** John Beswick Chief Finance Officer	**Paper No: Attachment W** ☐ **For information and noting**

Purpose of report

The table below outlines the trust financial position at Month 1.

	In Month		
	Plan	**Actual**	**Variance**
Income	49.3	47.4	(1.9)
Pay	(31.0)	(30.7)	0.3
Non-Pay	(17.9)	(19.3)	(1.4)
Finance Costs	(2.3)	(1.6)	0.7
Surplus/(Deficit)	**(1.8)**	**(4.2)**	**(2.3)**

The Trust Better Value programme summary:

Better Value programme has a full year 2023/24 target of £32.5m (£16.0m cost related and £16.5m income related) of which £1.7m is in M1 and behind plan (£1.1m Income/margin and £0.6m cost reduction). Delivery to date is £1.1m on income.

Summary of report

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

1. NHS & other clinical income is £1.4m adverse to plan due to genomics funding and reduced activity due to strike action.
2. Private patients' income is £0.3m favourable to plan 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 £0.3m favourable to plan due to vacancies and closer of beds due to strike actions.
4. Non pay costs are £1.4m adverse to plan due to reduction in spend on clinical supplies due to strikes and reduction in pass through costs.
5. The Trust cash balance at the 30th April was £88.0m and £82.2m at month 12 which was an increase of £5.8m from the prior month.
6. Total I&PC debt decreased in month to £27.8m (£29.2m in M12). Overdue debt increased in month to £23.3m (£21.6m in M12).
7. CDEL capital expenditure counting against NCL allocation is £1.1m for April compared to £0.2m plan. This is due to £0.6m of clinical equipment expected for delivery in March, and additional work on the lift replacement programme.
8. Expenditure on the CCC, part of the Charity programme, is £0.3m for April and £2.5m less than plan due to lower enabling works and slightly lower Sisk and professional fees than plan.

9. Strike Action – There is work being undertaken to understand the full impact of the strike action on the Trust finances. The impact relates to reduction in ERF, future backfill for TOIL given to staff, enhanced rates for strike cover, security, catering, and domestics costs with reduction in pay for those on strike. Initial estimates are income of £0.8m, expenditure of £0.4m but this does not yet reflect the full impact of the nursing strikes.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust is £88.0m and £82.2m (M12) which is £5.8m higher than last month.
NHS Debtor Days	NHS debtor days has reduced between March (7 days) and April at 5 days.
I&PC Debtor Days	IP&C debtor days reduced from 204 days in March to 178 days in April.
I&PC Debt	IP&C debt increased from £21.6m in March to £23.3m in April.
Creditor Days	Creditor days has increased from 25 days to 26 days.

Patient Safety Implications
None

Equality impact implications
None

Financial implications
None

Strategic Risk
BAF Risk 1: Financial Sustainability

Action required from the meeting
Trust Board are asked to note the Trust's financial position at month 11, cash flows and finance metrics.

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

Who is responsible for implementing the proposals / project and anticipated timescales?
Chief Finance Officer / Executive Management Team

Who is accountable for the implementation of the proposal / project?
Chief Finance Officer / Executive Management Team

Finance and Workforce Performance Report Month 1 2023/24

Contents

Trust Performance Summary for the 1 months ending 30 Apr 2023

KEY PERFORMANCE DASHBOARD

ACTUAL FINANCIAL PERFORMANCE

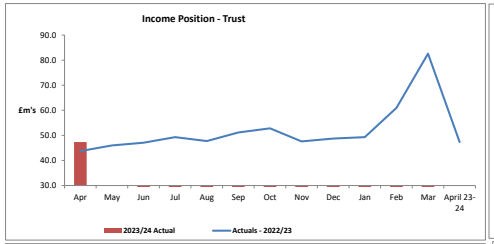
	In month		
	Plan	*Actual*	*RAG*
INCOME	**£49.3m**	**£47.4m**	
PAY	**(£31.0m)**	**(£30.7m)**	
NON-PAY inc. owned depreciation and PDC	**(£20.1m)**	**(£20.9m)**	
Surplus/Deficit excl. donated depreciation	**(£1.8m)**	**(£4.2m)**	

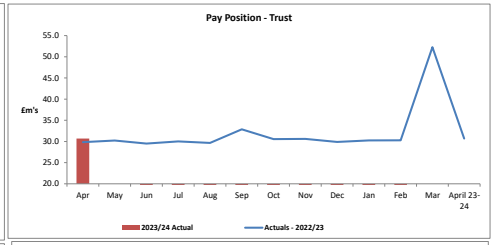
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

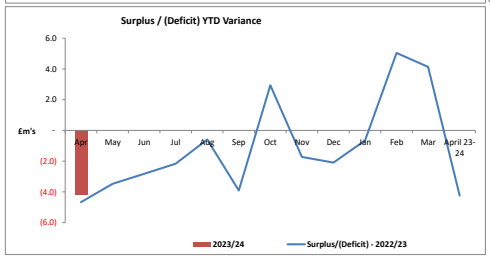
AREAS OF NOTE:

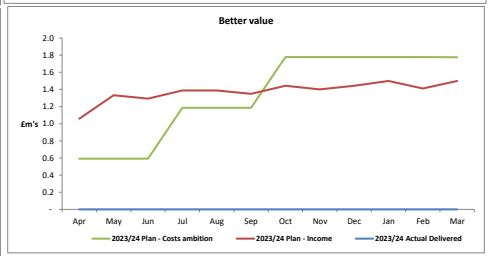
The M1 financial position for the trust is a £4.2m deficit which is £2.3m adverse to plan. This is driven mainly driven by lower then planned NHS income and non clinical income due to industrial action and awaiting finalising on contracts. Furthermore a higher then plan impairment of receivable (£0.9m) and increased passthrough offset with income.

Income is £1.9m adverse to plan mainly due to industrial action and awaiting finalising on contracts. Private patient income is £0.3m favourable to plan as has seen an improvement in activity resulting from increased referrals. Pay is £0.3m favourable YTD due to vacancies. Non pay (including owned depreciation and PDC) is £0.7m adverse YTD largely due to higher impairment provision (0.9m) . The Trust Better value programme is behind plan by £1.7m (£1.1m Income and £0.6m cost reduction).









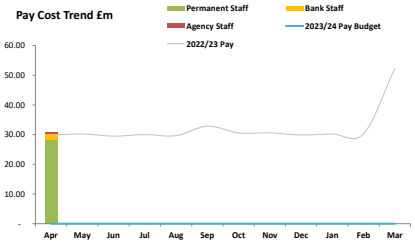
PEOPLE

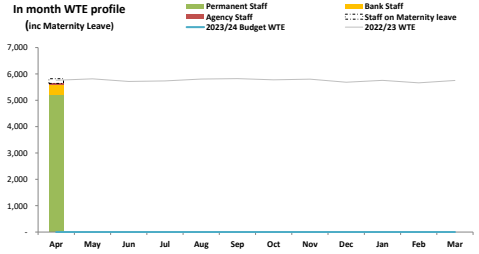
	M12 22/23 Plan	*M1 Actual WTE*	*Variance*
Permanent Staff	5,510.7	5,204.7	306.0
Bank Staff	109.2	391.6	(282.5)
Agency Staff	6.7	44.0	(37.4)
TOTAL	**5,626.5**	**5,640.3**	**(13.8)**

AREAS OF NOTE:

Month 1 WTEs increased in comparison to Month 12, largely within Bank for Nursing due to strike action. Although Substantive staff are below planned levels the use of bank remains high due to continued levels in relation to strikes, Vacancies, Covid isolation and sickness backfill. The Trust has seen continued significant levels of sickness within the domestic team and is working to reduce this and ensure the service continues without interruption.

The 30th April absence rate due to Covid was 0.1% of the permanent workforce which shows a reduced percentage compared to prior month, 0.2% on 30th March.



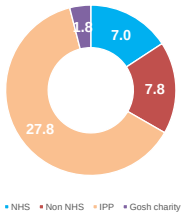


CASH, CAPITAL AND OTHER KPIs

Key metrics	*Mar-23*	*Apr-23*
Cash	**£82.2m**	**£88.0m**
IPP debtor days	**204**	**178**
Creditor days	**25**	**26**
NHS Debtor days	**7**	**5**
BPPC (£)	**91%**	**93%**

Capital Programme	*YTD Plan M1*	*YTD Actual M1*	*Full Year F'cst*
Total Trust-funded	**£0.2m**	**£1.1m**	**£33.6m**
Total PDC	**£0.0m**	**£0.0m**	**£0.3m**
Total IFRS 16	**£0.0m**	**£0.0m**	**£3.8m**
Total Donated	**£2.9m**	**£0.4m**	**£42.0m**
Total Grant-funded	**£0.0m**	**£0.0m**	**£0.0m**
Grand Total	**£3.1m**	**£1.5m**	**£79.7m**

Net receivables breakdown (£m)



AREAS OF NOTE:

1. Cash held by the Trust increased in month from £82.2m to £87.9m.

2. Capital expenditure for the year to end April was £1.5m, £1.6m less than plan. Trust-funded expenditure was £0.9m more than plan and donated £2.5m less than plan.

3. I&PC debtors days decreased in month from 204 to 178. Total I&PC debt (net of cash deposits held) decreased in month to £27.8m (£29.2m in M12). Overdue debt increased in month to £23.3m (£21.6m in M12).

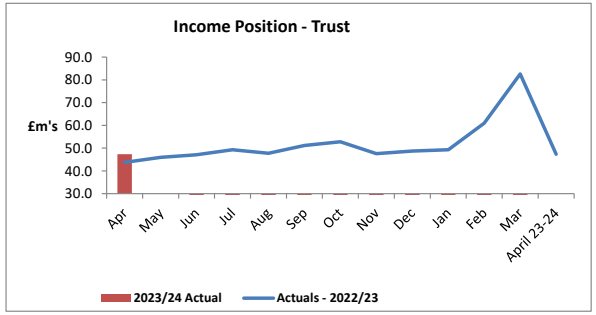
4. Creditor days increased in month from 25 to 26 days.

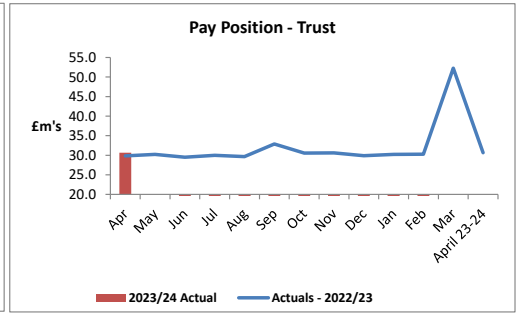
5. NHS debtor days decreased in month from 7 to 5 days.

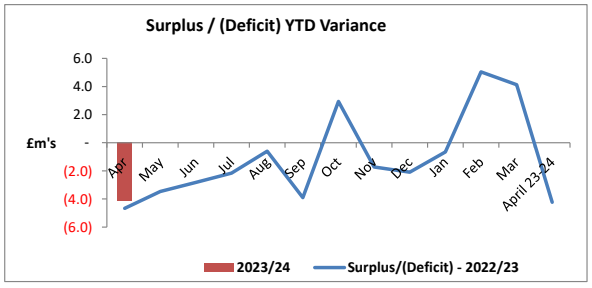
6. In M1, 93% of the total value of creditor invoices were settled within 30 days of receipt; this represented 88% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.

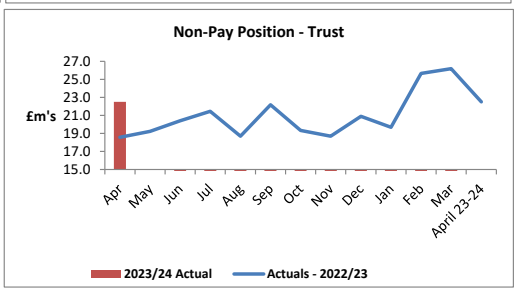
Trust Income and Expenditure Performance Summary for the 1 months ending 30 Apr 2023

2023/24 Annual Plan (£m)	Income & Expenditure	Month 1 Plan (£m)	Month 1 Actual (£m)	Variance (£m)	Variance %	Notes	2022/23 Actual M1 (£m)
483.29	NHS & Other Clinical Revenue	38.25	36.84	(1.41)	(3.70%)	1	35.96
78.00	Private Patient Revenue	5.51	5.79	0.29	5.22%	2	2.76
72.84	Non-Clinical Revenue	5.53	4.73	(0.80)	(14.54%)	3	5.01
634.13	**Total Operating Revenue**	**49.29**	**47.36**	**(1.93)**	**(3.92%)**		**43.74**
(352.42)	Permanent Staff	(29.05)	(28.31)	0.75	2.57%		(27.84)
(3.72)	Agency Staff	(0.31)	(0.41)	(0.10)			(0.34)
(19.42)	Bank Staff	(1.62)	(1.96)	(0.34)	(20.99%)		(1.64)
(375.56)	**Total Employee Expenses**	**(30.98)**	**(30.67)**	**0.31**	**1.00%**	4	**(29.83)**
(102.99)	Drugs and Blood	(7.73)	(7.99)	(0.25)	(3.30%)		(7.33)
(41.33)	Supplies and services - clinical	(3.12)	(3.14)	(0.02)	(0.78%)		(3.12)
(88.01)	Other Expenses	(7.03)	(8.16)	(1.14)	(16.15%)		(6.40)
(232.33)	**Total Non-Pay Expenses**	**(17.88)**	**(19.29)**	**(1.41)**	**(7.91%)**	5	**(16.86)**
(607.89)	**Total Expenses**	**(48.86)**	**(49.96)**	**(1.10)**	(2.26%)		**(46.68)**
26.23	**EBITDA (exc Capital Donations)**	**0.43**	**(2.61)**	**(3.04)**	**(707.56%)**		**(2.95)**
(25.61)	Owned depreciation, Interest and PDC	(2.26)	(1.56)	0.70	30.80%		(1.72)
0.62	**Surplus/Deficit**	**(1.83)**	**(4.17)**	**(2.34)**	**(127.94%)**		**(4.67)**
(24.20)	Donated depreciation	(2.24)	(1.65)	0.59			(1.63)
(23.58)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(4.07)**	**(5.82)**	**(1.75)**	**(127.94%)**		**(6.29)**
0.00	Impairments & Unwinding Of Discount	0.00	0.00	0.00			0.00
41.94	Capital Donations	2.88	0.37	(2.51)			0.47
18.36	**Adjusted Net Result**	**(1.18)**	**(5.45)**	**(4.26)**	**(359.69%)**		**(5.82)**









Summary

- The YTD Trust financial position at Month 1 is a deficit of £4.2m which is £2.3m adverse to plan.
- The deficit is due to a combination of reduced clinical income linked to strikes, awaiting finalisation of higher than planned impairment on receivables.

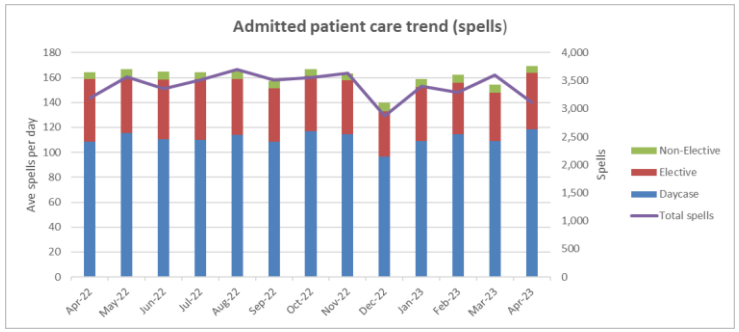
Notes

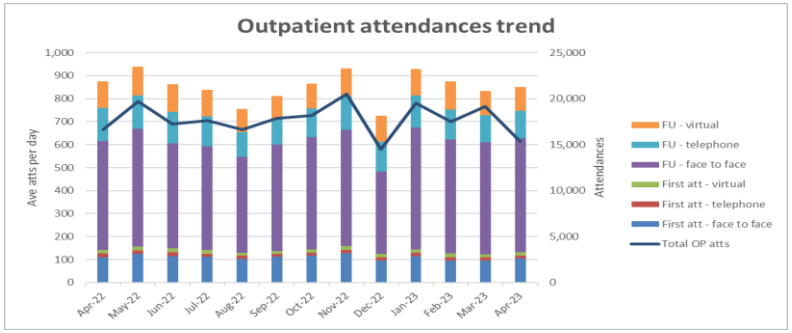
1. NHS clinical income is £1.4m adverse to plan due to reduction in activity due to industrial action and genetics income.
2. Private Patient income is £0.3m favourable to plan YTD which is due to the Trust recovery plan seeing increased levels of activity.
3. Non clinical income is £0.8m adverse to plan YTD. This is mainly driven by reduction in charity and research income and furthermore awaiting finalisation of contracts.
4. Pay costs are £0.3m favourable to plan mainly due vacancies.
5. Non pay is £1.4m adverse to plan largely due higer then planned impairment to receivables (0.9m) and higher levels of passthrough costs (£0.7m) off set with income.

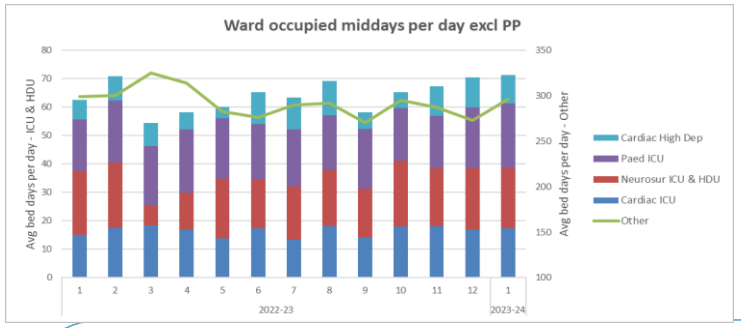
RAG Criteria:
Green Favourable YTD Variance
Amber Adverse YTD Variance (< 5%)
Red Adverse YTD Variance (> 5% or > £0.5m)

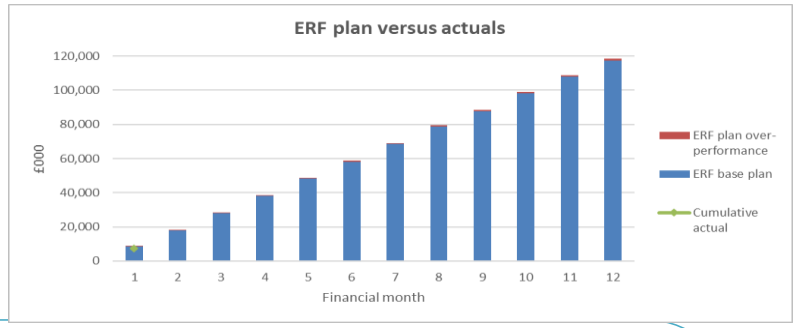
2022/23 Overview of activity trends for the 1 months ending 30 Apr 2023

Great Ormond Street Hospital for Children NHS Foundation Trust







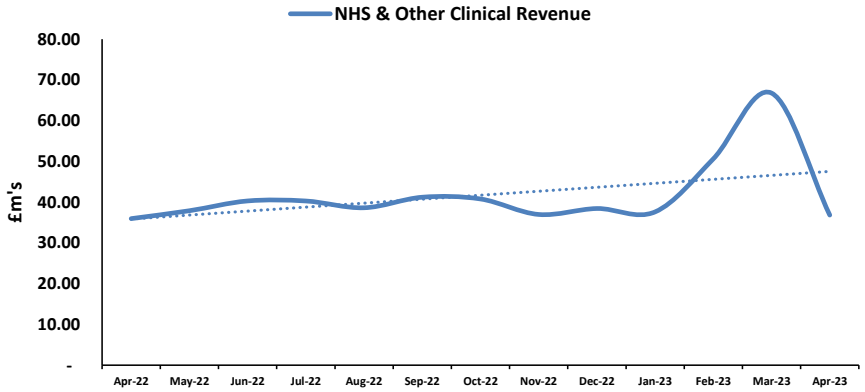


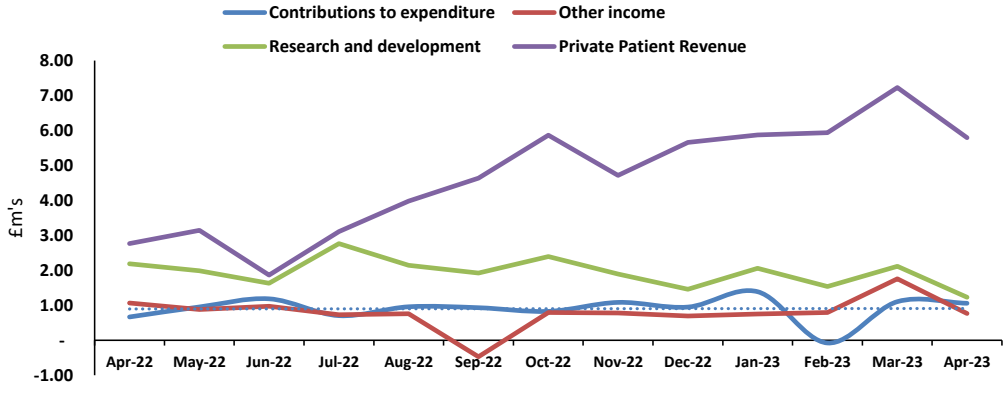
Summary

- Admitted patient care per day in April 2023 is higher than March with daycase increasing by 8.7% and elective increasing by 17% per day. This equates to a 9.5 spell increase for daycase and 6.6 for elective activity per working day for April vs March. NB: because April 2023 only had 18 working days due to containing 5 weekends and two bank holidays, any elective work taking place on non-working days, e.g. Saturday and Easter Renal dialysis daycases, or overnight Sleep Studies discharged on a Saturday etc will disproportionately contribute to performance more so than other months which only have 4 weekends.
- Bed days for April 2023 are showing an increase per working day vs March 2023, this increase is taking place outside of designated ICU&HDU locations.
- Outpatient attendances increased per working day versus March 2023, this increase was within face-to-face attendances, with both face-to-face first and follow-up attendances each increasing by 9 attendances per working day. Face to face % activity levels have stablised since August 2022, at circa 70% face to face and 30% non-face to face. The number of outpatient attendances may increase as activity is finalised.
- Both March 2023 and April 2023 have been impacted by strike action, days during the Junior doctor strikes on 11-15 April saw on average 46 less First appoinments, 13 less OP procedures, 36 less daycases and 25 less elective spells discharged per working day than during non-strike periods in April. These four days resulted in an estimated £796k reduction in ERF income compared to other working days' ERF income in the month.
- The ERF scheme has changed between 2022/23 and 2023/24, the new scheme covers Daycase, Elective, Outpatient First and OP Procedures, activity within these PODs is valued at 100% of the NHS payment scheme and effectively returns those PODs back to a cost and volume arrangement. On the basis of current information, which includes some estimates for uncoded work, M1 performance for ERF is £7,417k versus a plan of £8,452k giving an under-performance of £1,035k against the total plan consisting of ERF target at 113% and planned over-performance.

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

2022/23 Income for the 1 months ending 30 Apr 2023





Summary

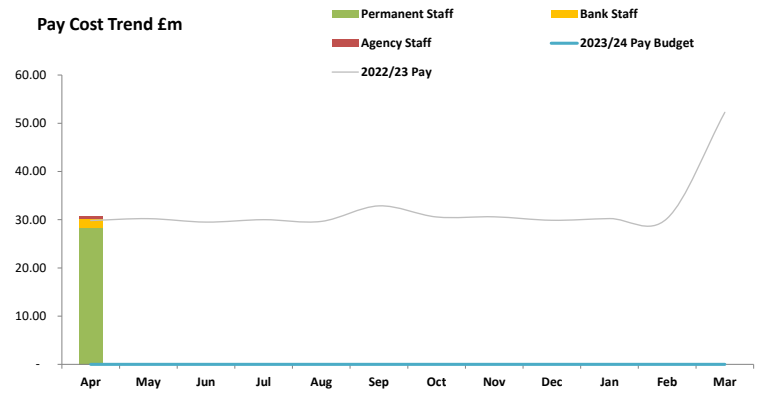
- Income from patient care activities excluding private patients is £1.4m adverse. This is due to significant decrease income for genomics funding and ERF which is offset with increase in passthrough income.
- Non clinical income is £0.8m adverse. Mainly driven by lower research income, Charity income and awaiting finalisation of contracts.
- Private Patient income is £0.3m favourable to plan YTD which is due to the Trust recovery plan seeing increased levels of activity throughout the year.
- GIDS and CICU income under review – additional income has been received in relation to these services however internal work needs to be undertaken to understand costs against this income and an element of the funding for GIDS needs to be transferred to other Trusts.

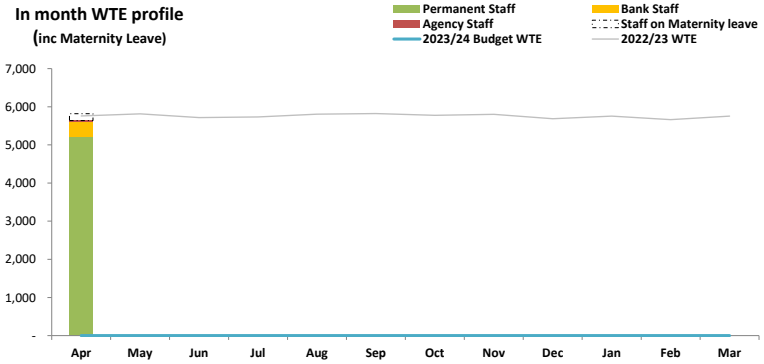
Workforce Summary for the 1 months ending 30 Apr 2023

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

£m including Perm, Bank and Agency	2022/23 actual full year			2023/24 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)	68.2	1,286.7	53.0	5.7	1,313.6	52.1	(0.0)	(0.1)	0.1	G
Consultants	66.7	394.1	169.2	5.7	387.1	176.1	(0.1)	0.1	(0.2)	A
Estates & Ancillary Staff	16.4	445.7	36.8	1.4	463.7	35.6	(0.0)	(0.1)	0.0	G
Healthcare Assist & Supp	12.2	306.9	39.7	1.0	313.1	38.6	0.0	(0.0)	0.0	G
Junior Doctors	33.5	393.0	85.2	2.8	398.4	83.1	0.0	(0.0)	0.1	G
Nursing Staff	100.9	1,616.5	62.4	8.4	1,666.4	60.4	0.0	(0.3)	0.3	G
Other Staff	1.0	17.9	56.2	0.1	16.6	54.6	0.0	0.0	0.0	G
Scientific Therap Tech	67.2	1,072.7	62.7	5.2	1,037.3	59.9	0.4	0.2	0.2	G
Total substantive and bank staff costs	**366.1**	**5,533.4**	**66.2**	**30.2**	**5,596.3**	**64.7**	**0.3**	**(0.3)**	**0.7**	G
Agency	4.1	39.0	104.2	0.4	44.0	111.2	(0.1)	(0.0)	(0.0)	A
Total substantive, bank and agency cost	**370.1**	**5,572.4**	**66.4**	**30.6**	**5,640.3**	**65.0**	**0.3**	**(0.4)**	**0.7**	G
Reserve*	1.1	0.0		0.1	0.0		(0.0)	(0.0)	0.0	G
Additional employer pension contribution by NHSE (M12)	14.6	0.0		14.6	0.0		(13.4)	(13.4)	0.0	R
Total pay cost	**385.8**	**5,572.4**	**69.2**	**45.3**	**5,640.3**	**96.3**	**(13.1)**	**(13.8)**	**0.7**	R
Remove maternity leave cost	(2.5)			(0.2)			(0.0)	0.0	(0.0)	G
Total excluding Maternity Costs	**383.3**	**5,572.4**	**68.8**	**45.1**	**5,640.3**	**95.9**	**(13.1)**	**(13.8)**	**0.7**	R

*Plan reserve includes WTEs relating to the better value programme



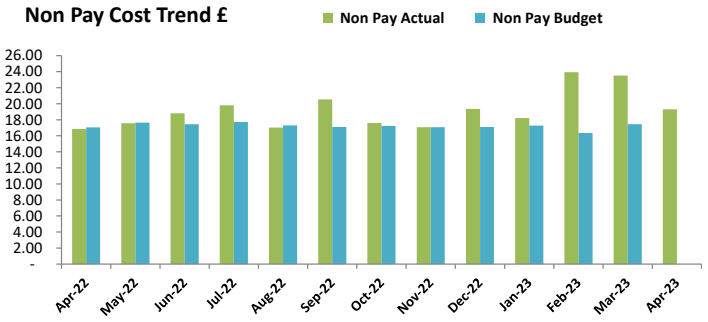


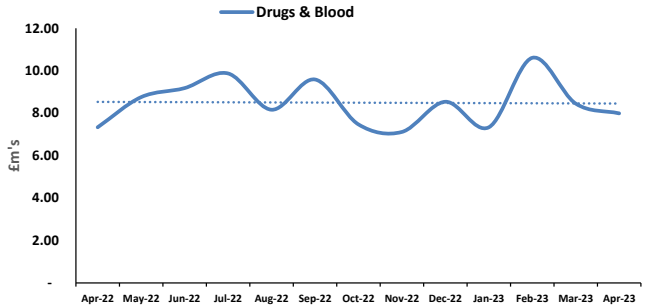
Summary

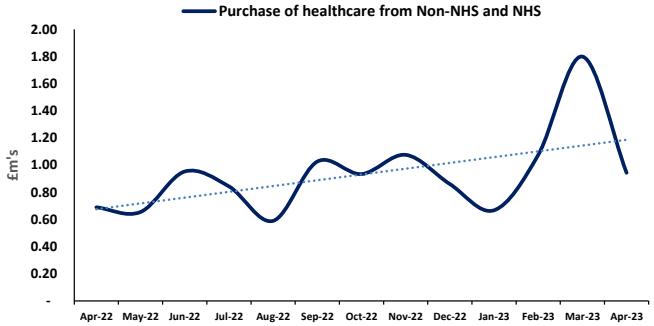
The table compares the actual YTD workforce spend in 2023/24 to the full year workforce spend in 2022/23 prorated to the YTD.

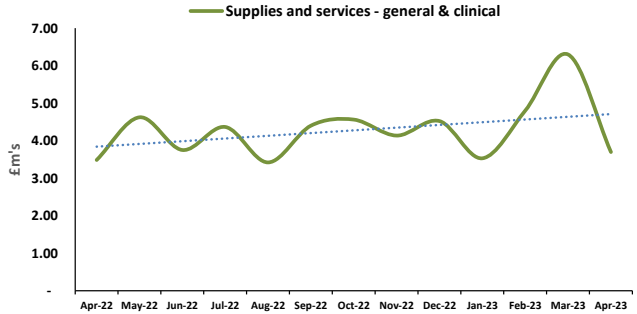
- Pay costs are below the 2023/24 plan by £0.3m and when compared to the 2022/23 extrapolated actual it is £13.1m higher. This increase from 2022/23 is being driven by volume increase (£13.8m) and price reduction (£0.7m). The price variance is driven by the NHS pay award, additonal consolidated pay award and increase in NI payments. The largest element of the volume increase is driven by the full year insourcing of the cleaning service.
- April has seen the number of staff absent from the Trust due to Covid remain at 0.1%.
- The Trust continues to see high levels of maternity leave (178 WTE) which is contributing to the higher than planned levels of temporary staffing across the Trust.
- Estates & Ancillary are £0.1m adverse due to high levels of sickness within the cleaning service. When compared to 2022/23 the key driver of the increase is the level of sickness and the full year insourcing of the service.

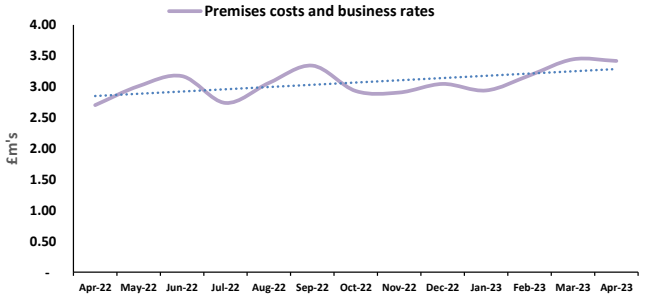
Non-Pay Summary for the 1 months ending 30 Apr 2023











Summary

- Non pay is £1.4m adverse to plan in month mainly due to:
- Drugs and Blood costs are £0.7m adverse to plan due to increase in costs for passthrough drugs offset with income.
- Impairment of receivables is £0.9m adverse to plan due to the increased provision associated with the growth in private activity.

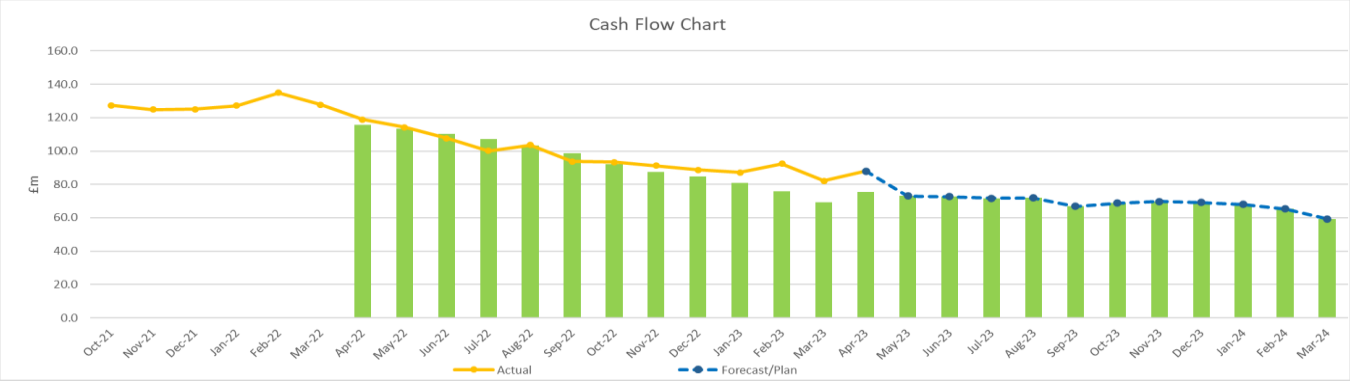
	Statement of Financial Position	YTD Unaudited Actual 31 Mar 23 £m	*YTD Actual 30 Apr 23* *£m*	In month Movement £m
	Non-Current Assets	649.95	648.22	(1.73)
	Current Assets (exc Cash)	106.34	107.42	1.08
	Cash & Cash Equivalents	82.17	87.97	5.80
	Current Liabilities	(123.48)	(134.16)	(10.68)
	Non-Current Liabilities	(27.40)	(27.33)	0.07
	Total Assets Employed	**687.58**	**682.12**	**(5.46)**

31 Mar 2023 Unaudited Accounts £m	Capital Expenditure	YTD plan 30 April 2023 £m	YTD Actual 30 April 2023 £m	YTD Variance £m	Forecast Outturn 31 Mar 2024 £m	RAG YTD variance
6.95	Redevelopment - Donated	2.88	0.34	2.54	39.67	R
3.35	Medical Equipment - Donated	0.00	0.03	(0.03)	2.28	G
-	ICT - Donated	0.00	0.00	0.00	0.00	G
10.30	**Total Donated**	**2.88**	**0.37**	**2.51**	**41.95**	R
-	**Total Grant funded**	**0.00**	**0.00**	**0.00**	**0.00**	G
7.93	Redevelopment & equipment - Trust Funded	0.00	1.06	(1.06)	19.33	R
2.39	Estates & Facilities - Trust Funded	0.02	0.00	0.02	7.36	R
4.65	ICT - Trust Funded	0.19	0.02	0.17	6.88	R
-	Contingency/unallocated	0.00	0.00	0.00	0.00	G
-	Disposals	0.00	0.00	0.00	0.02	G
14.97	**Total Trust Funded**	**0.21**	**1.08**	**(0.87)**	**33.59**	R
-	**Share allocation**	**0.00**	**0.00**	**0.00**	**0.00**	G
0.10	**Total IFRS 16**	**0.00**	**0.00**	**0.00**	**3.83**	G
0.36	**PDC**	**0.00**	**0.00**	**0.00**	**0.33**	G
25.73	**Total Expenditure**	**3.09**	**1.45**	**1.64**	**79.70**	R

	Working Capital	31-Mar-23	30-Apr-23	RAG	KPI
	NHS Debtor Days (YTD)	7.0	5.0	G	< 30.0
	IPP Debtor Days	204.0	178.0	R	< 120.0
	IPP Overdue Debt (£m)	21.6	23.3	R	0.0
	Inventory Days - Non Drugs	87.0	91.0	R	30.0
	Creditor Days	25.0	26.0	G	< 30.0
	BPPC - NHS (YTD) (number)	45.4%	73.1%	R	> 95.0%
	BPPC - NHS (YTD) (£)	78.4%	93.8%	R	> 95.0%
	BPPC - Non-NHS (YTD) (number)	82.0%	88.1%	R	> 95.0%
	BPPC - Non-NHS (YTD) (£)	91.9%	92.5%	A	> 95.0%
	BPPC - Total (YTD) (number)	80.7%	87.7%	R	> 95.0%
	BPPC - Total (YTD) (£)	90.7%	92.7%	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)

	Liquidity Method	31-Mar-23 Actual	Apr-23	RAG	31-Mar-23 Forecast	RAG
	Current Ratio (Current Assets / Current Liabilities)	1.5	1.5	G	1.8	G
	Quick Ratio(Current Assets - Inventories - Prepaid Expenses) / Current Liabilit	1.5	1.4	G	1.6	G
	Cash Ratio(Cash / Current Liabilities)	0.7	0.7	R	0.8	R
	Liquidity days Cash / (Pay+Non pay excl Capital expenditure)	52.6	55.5	A	44.0	A
	Liquidity Days (Payroll)(Cash / Pay)	87.3	90.4	G	73.0	G



Comments:

1. Capital expenditure for the year to the end of April was £1.5m; the Trust-funded expenditure was £1.1m, £0.9m ahead of plan due to £0.6m of equipment expected in March but delayed, and lift refurbishment works delayed from March; the donated expenditure was £0.4m, £2.5m less than plan due to addi tional payments on CCC PCSA being later than planned.
2. Cash held by the Trust increased in month from £82.2m to £87.7m
3. Total Assets employed at M1 decreased by £5.4m in month as a result of the following:
   - Non current assets decreased by £1.7m to £648.2m.
   - Current assets excluding cash totalled £107.4m, increasing by £1.1m in month. This largely relates to Contract receivables no t invoiced (£4.7m higher in month); Inventories (£0.5m higher) and Charity capital receivables (£0.1m higher in month). This is offset against the decrease in Other receiva bles (£0.2m lower in month) and Contract receivables invoiced (£4.0m lower).
   - Cash held by the Trust totalled £87.7m, increasing in month by £5.8m.
   - Current liabilities increased in month by £10.7m to £134.2m. This includes deferred income (£7.9m higher in month); expenditu re accruals (£2.2m higher month); NHS payables (£0.7m higher in month) and Other payables (£1.1m higher in month) This is offset against the decrease in Capital creditors (£1.2m lower in month.
   - Non current liabilities totalled £27.3m This includes lease borrowings of £22.0m.
4. I&PC debtors days decreased in month from 204 to 178. Total I&PC debt (net of cash deposits held) decreased in month to £27.8 m (£29.2m in M12). Overdue debt increased in month to £23.3m (£21.6m in M12).
5. In M1, 93% of the total value of creditor invoices were settled within 30 days of receipt; this represented 88% 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 d ays.
6. By supplier category, the cumulative BPPC for Non NHS invoices (by number) was 88% (82% in M12). This represented 92% of the total value of invoices settled within 30 days (92% in M12). The cumulative BPPC for NHS invoices (by number) was 73% (45% in M12). This represented 94% of the value of invoices settled within 30 days (78% in M12).
7. Creditor days increased in month from 25 to 26 days.

Attachment X

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
8th June 2023

Nursing Workforce Assurance Report **Submitted by: Tracy Luckett, Chief Nurse**	**Paper No: Attachment X** **□ For information and noting**

Purpose of report
The purpose of this paper is to provide the board with the assurance that plans, and processes are in place which align with the National Quality Board (NQB) Standards and Expectations for Safe Staffing (2016 further supplemented in 2018). This report covers reporting period Jan – March 2023 Q4.

Summary of report
To note the information in this report in relation to:

1. The RN vacancy rate is currently 8.02% in March 2023 and remains below trust target (10%).
2. RN voluntary turnover decreased to 16.45% in March 2023 and remains the second lowest in NCL and lower than trust pre-pandemic levels.
3. Sickness rates improved over the last quarter to 3.38 % in March and remains above target (3%)
4. Central recruitment continues with 41 newly registered nurses joining the trust in Q4, with a further 146 NRNs in the pipeline for Oct 23 and Jan 24.
5. A new retention plan is currently being developed and will be launched as part of the Nursing Strategy focusing on 4 'STAY' priorities.
6. There were 26 safe staffing incidents reported in Q4 with the highest occurrence in BCC (11). No direct patient harm occurred, however there were delays to treatment as a result.
7. The reported CHPPD was 15.29 in Jan, 14.99 in Feb and 14.95 in March 2023.
8. Temporary staffing shift requests increased in Q4 to 7990 with an average fill rate of 86%.
9. During Q4 there were 2 open NMC referrals under review, neither of the nurses are currently working within the Trust.
10. Following the recent industrial action taken on the 30 April 2023 and 1st May 2023 by RCN members, a brief update has been provided to confirm that safe staffing was maintained throughout this period.

Patient Safety Implications
Appropriate mitigations are in place to maintain safe staffing levels which has a direct corelation to patient safety.

Equality impact implications
None

Financial implications
All posts involved in the central recruitment campaigns have been incorporated into 22/23 Directorate budgets.

Attachment X

Strategic Risk BAF Risk 2: Workforce Sustainability BAF Risk 12: Inconsistent delivery of safe care
Action required from the meeting None
Consultation carried out with individuals/ groups/ committees EMT
Who is responsible for implementing the proposals / project and anticipated timescales? NA
Who is accountable for the implementation of the proposal / project? NA

1. Introduction

The purpose of this paper is to provide the People and Education Assurance Committee (PEAC) with an overview of the activity in relation to the Nursing Workforce including updates on recruitment, retention and arrangements put in place to protect safe staffing, covering reporting period Jan- March 2023 (Q4).

2. Workforce Data Overview

Nursing workforce data at directorate and ward/unit level is reviewed monthly at the Nursing Workforce Assurance Group (NWAG) meeting to ensure activity is intelligence led and aligned with national and local, strategies and priorities, and to maintain safe staffing through proactive recruitment, retention, and workforce planning.

2.1 Vacancy and Voluntary Turnover The latest RN workforce position based on validated data:

- Trust wide RN vacancy rate remains below trust target (10%) at 8.02% in March. There are pockets of higher vacancy rates on some wards and units (Appendix 1), this is mitigated through bed closures, redeployment of staff and temporary staff usage.
- RN voluntary turnover rose above trust target (14%) to 16.52% in February, before reducing to 16.45% in March 2023. We currently have the second lowest rate amongst our North Central London (NCL) Integrated Care System (ICS) partners and remain lower than our pre-pandemic levels of 17.3% in Nov 2019. To address the increase in voluntary turnover we are working on a trust wide nurse retention plan and with ICS and national initiatives which are outlined in section 4 of the report.

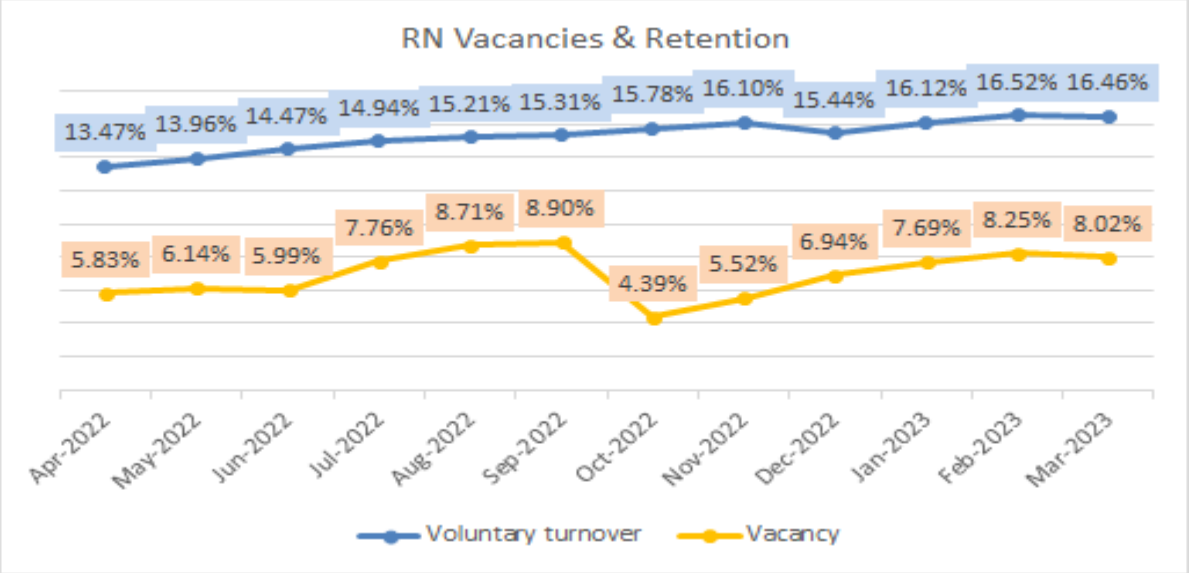


Fig. 1 Registered Nurse (RN) vacancy and voluntary turnover rate (12-month view)

2.2 RN Sickness rates have continued to improve over the last quarter (3.38% March 2023) and just above target (3%).

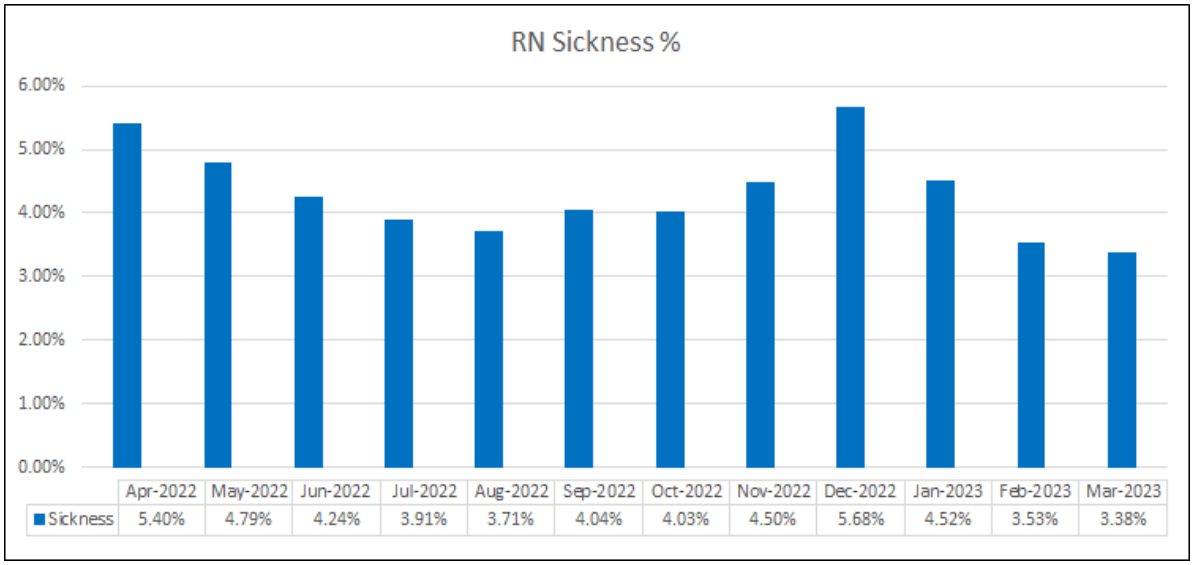


Fig.2 RN sickness rates 12 month rolling

3. Recruitment Activity Overview

Centralised Recruitment Campaigns are staged throughout the year to maintain a constant pipeline of new recruits, mitigating peaks and troughs in voluntary turnover, this is in addition to local recruitment activity. The most recent recruitment activity since the last report comprised of:

3.1 Newly Registered Nurses (NRNs) successfully recruited 29 NRNs in January 2023 and 12 NRNs in April 23 therefore a total of 41 NRNs started at the trust within the last quarter. Following a successful GOSH Nursing Open Day, a further 146 NRNs received conditional offers for our next cohorts due to be welcomed in October 2023 and January 2024.

Month	**Number of successful recruited NRNs**
January 2023	29
April 2023	12
Total	**41**
Pipeline	**Conditional offers sent**
October 2023	105
January 2024	41
Total	**146**

Fig.3 Recruitment Pipeline

3.2 International Nurse Recruitment (INR) our central international nurse recruitment campaign in collaboration with the Capital Nurse Consortium (CNC) concluded in March 2023 as we focus our efforts on local, national, and European nurse recruitment opportunities. Throughout 2022/23 and in partnership with the CNC, 14 nurses were successfully deployed across the organisation into clinical areas. As of March 2023, we have had a 100% retention rate of all onboarded international nurse recruits across all cohorts dating from the first to land in January 2020. Development is underway with the international education team to ensure there is a clear development pathway for all international recruits over and above the existing preceptorship programme.

3.3 Health Care Support Worker (HCSW) Apprenticeships are recruited three times a year and are advertised in collaboration with Camden and Islington council. This is to attract a more local

demographic into our workforce with the aim of improving retention. During Q4, 15 HCSW were successfully recruited (five in January and 10 to commence in May). Following the successful working relationship with the apprenticeship provider Dynamic, a new contract has been negotiated. Recruitment for the September cohort will commence in April 2023.

3.4 Virtual Nurse Recruitment Open Day was successfully delivered in March 2023 with 130 attendees on the day, 75% being newly registered nurses, 7% being experienced and 17% from overseas. This was to be expected given the open day deliberately coincided with the advertisement of our newly registered nurse job opportunity. 58% attendees were from London and the South-East which aligns with our ambition to be more representative of our local population. Interviews took place in early April and 125 candidates were sent conditional offers for a start date in either October 2023 or January 2024. We encouraged all ward areas to ensure their adverts were live concurrently with the open day and all experienced nurses were directed to the individual live adverts.

4. Retention Activity Overview

4.1 Considering rising turnover rates, the NWF and Senior Nursing teams have been working together on the implementation of several initiatives as outlined below. In addition to this we hope to develop and launch a new nursing retention plan to align with the forthcoming new Trust Nursing Strategy which will be announced in the Summer.

The retention plan will focus on the key areas important to our nurses and which are currently having the greatest impact on voluntary turnover. Key themes as to why staff have left include: Promotion/new opportunities, cost of living/relocation, impact of redeployment and ward closures and lack of reward/recognition.

Throughout 2023/24 we will be focusing on our '**STAY**' priorities which will cover areas such as career progression, flexible working models, development opportunities, reward and recognition including benefits, accommodation provision and cost of living support. The priority areas are:

- **S**uccessful careers
- **T**ime for you
- **A**lways learning
- **Y**ou are valued

4.2 Retention Insight Meetings at Ward/Unit Level are being carried out which offer a structured approach to open, honest and helpful dialogue with ward/unit managers regarding specific localised retention issues. Wards are being prioritised and contacted depending on their vacancy rates, voluntary turnover rates and number of leavers in the last year. As of April 2023, 61% of wards have received an insight session, with all outstanding sessions to be prioritised in the first quarter of 2023/24. Interventions are being recommended and soft intelligence is being gathered to help support ongoing recruitment and retention activity in each local area across the trust.

4.3 Retention Masterclasses have now been established as a rolling series open to all nursing managers and team leaders. These virtual, bitesize classes present themes from the National Health Service England (NHSE) retention toolkit and key data points examined at Nursing Workforce Assurance Group (NWAG) which may be applied in an operational capacity. Retention masterclass topics delivered to date include:

- Understanding your staffing data
- Flexible Working
- Effective Rostering
- Getting the most from your 1:1s
- Career Development & Planning
- Staff Engagement
- Staff Reward & Recognition

These rolling masterclasses will continue throughout the summer with increased frequency to ensure optimum attendance can be achieved.

4.4 Drop-in Careers Clinics have been established as a regular service in the Lagoon once a month commencing in January 2023. These career clinics offer the ideal platform for nurses to look for advice and support in developing their clinical, managerial, and professional profile. This forum will help support and guide individuals depending on their strengths and career aspirations whilst providing a safe environment to discuss/agree development needs that both support the delivery of high-quality patient care, as well as driving staff career development and retention. There is an abundance of opportunities within the trust and these career clinics will help centralise all opportunities to ensure all nursing staff have fair and equal access to these. Benefits include:

- A confidential, structured conversation who are dedicated to supporting professional growth.
- Developing self-awareness, increasing confidence and motivation.
- Understanding different career pathways across the trust
- Exploring options for learning and development
- Open Door Policy – on site 5 days a week

4.5 Stay Interviews - based on feedback, it has shown that there are four factors which help to retain staff in our organisation. These are:

- Feeling valued and recognised
- Having a supportive manager
- Career and development opportunities
- Work life balance/flexible working opportunities

A stay conversation provides an opportunity to explore these factors on an individual basis. It isn't part of a staff appraisal but can contribute to it if the individual wishes. A GOSH Nursing stay interview template is in the initial development stages to give nursing line managers a format to have a structured check in with members of their team on a regular basis. The stay interview template will be piloted across individual wards with a history of high voluntary turnover throughout Q2 and Q3. Feedback will be collated, and the final template will be distributed to all to help improve retention rates across all directorates.

5. Safe Staffing Incidents

Safe staffing incident reporting decreased in Q4 compared to Q3 with 26 incidents across all directorates. Many incidents were classified as 'Incident occurred but there was no harm' with 3/26 classified as 'minor'. Key themes from all incidents include planned surgeries being cancelled due to

lack of nurses/beds, sub optimal skill mix for specialist clinical interventions such as: IVs, tracheostomies, and chemotherapy. Due to the high concentration of junior staff in the ward environments, maintaining a strong skill mix and good level of specialist competencies is challenging despite the high level of educational support.

Directorate	Jan 2023	Feb 2023	March 2023	Directorate total
H&L	0	3	3	**6**
BBM	0	0	0	**0**
CCS	2	1	0	**3**
BCC	0	3	8	**11**
I&PC	1	0	1	**2**
S&S	0	2	0	**2**
R&I	0	0	0	**0**
Brain	1	0	1	**2**
Monthly total	**4**	**9**	**13**	**26**

Fig.4 Safe staffing Datix reports per directorate – Quarterly view

6. *Care Hours Per Patient Day (CHPPD)*

CHPPD is the national principal measure of nursing, midwifery, and healthcare support staff deployment in inpatient settings including ICUs. CHPPD is a benchmarking tool with no upper or lower parameters. The reported CHPPD for January 2023 was 15.29, decreasing slightly to 14.99 in February 2023 and 14.95 in March 2023.

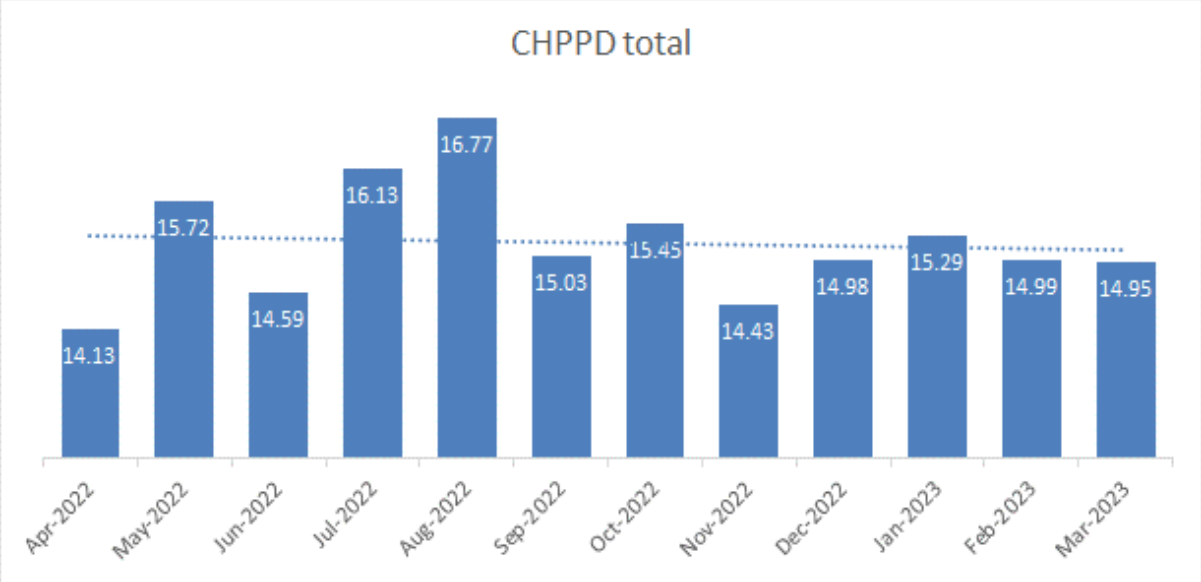


Fig.5 CHPPD 12 month rolling trend

7. Temporary Staffing

Shift requests increased in Q4 (7990) by 1130 compared to Q3 (6860), with an average fill rate increasing from 83.3% in Q3 to 86% in Q4. Request rates were driven by staff sickness, patient acuity, vacancies in some areas and activity levels. 144 shifts were filled by Registered Mental Health agency nurses (RMN), January 39 shifts, February 71 shifts and March 34 shifts. The agency usage was

predominantly required across the Body, Bones and Mind (BBM) and Blood, Cells, and Cancer (BCC) directorates.

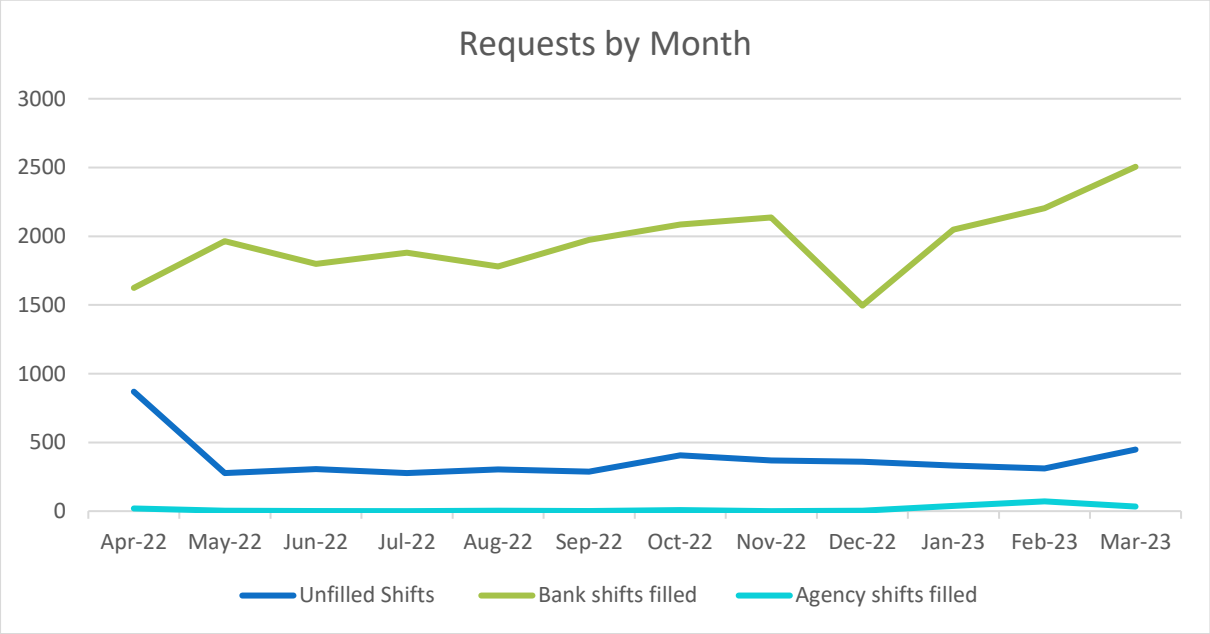


Fig. 6 Nursing & HCA bank requests 12-month overview

8. Professional Nursing Standards

To ensure patient safety, maintain professional discipline and employ nurses who share our trust values and behaviours, we occasionally need to investigate and/or address performance. This is to ensure nurses are offered the right level of support and supervision or in serious cases require a referral to the Nursing and Midwifery Council (NMC) to understand whether they pose a risk to the public, so steps may be taken to promote learning and prevent issues arising. During Q4 there were 2 open NMC referrals under review, neither of the nurses are currently working within the Trust.

9. Industrial Action

Following on from the last update provided to PEAC on industrial action taken by the Royal College of Nursing (RCN) members in Q3, a full report will be provided once debriefing and data has been confirmed following the recent action taken on the 30th April and 1st May. Safe staffing levels were maintained over this period through a combination of meticulous planning, early implementation of a 'command and control' structure and use of temporary staffing with additional support measures in place.

10. Conclusion

In conclusion the workforce metrics demonstrate that although vacancy rates have improved and remain below trust target, voluntary turnover continues to rise. Skill mix and the heighted level of support required for newly qualified nurses (NQNs) coming through is also impacting on nursing capacity. Due to the high concentration of junior staff in the ward environments, maintaining a strong skill mix and good level of specialist competencies is challenging despite the high level of educational input at the trust. The focus for the coming year is to increase recruitment of experienced nurses and improve the retention of our existing specialist nursing workforce through a number of initiatives. This

is a nationally observed trend across the NHS, with a wide range of plans in place at a local, regional, and national level to ensure work is underway to improve the support provided. Positive improvements over the last quarter include reduced sickness rates and a healthy recruitment pipeline in place over the coming year with increasing interest from experienced nurses working elsewhere in the UK and abroad. We will continue to explore new and innovative ways to recruit and retain, address safe staffing concerns, and ensure our nursing colleagues have a voice, to feel recognised and valued.

Appendix 1 – RN workforce data (March 2023)

Workforce March 2023 Staffing								
Directorate	Ward	Budget FTE	Staff in Post FTE	Vacancy %	Vacant FTE	Sickness rates	Vol Turnover %	Maternity %
Blood, Cells & Cancer	Elephant Ward	26.00	26.83	-3.2%	-0.83	2.3%	16.4%	0%
	Fox Ward	31.63	30.33	4.1%	1.30	3.4%	14.5%	3%
	Giraffe Ward	16.00	16.29	-1.8%	-0.29	0.6%	4.1%	12%
	Lion Ward	24.00	20.99	12.6%	3.01	7.0%	26.3%	0%
	Pelican Ward	21.99	17.41	20.8%	4.58	7.9%	22.6%	0%
	Robin Ward	30.75	26.36	14.3%	4.39	3.4%	25.7%	3%
	Safari Ward	13.00	11.06	14.9%	1.94	0.9%	24.8%	9%
Body, Bones & Mind	Chameleon Ward	37.20	29.22	21.5%	7.98	5.5%	8.6%	13%
	Eagle Ward	45.30	39.36	13.1%	5.94	1.4%	26.3%	3%
	Gastro Suite	8.00	10.00	-25.0%	-2.00	4.8%	10.9%	10%
	Mildred Creak Unit	14.70	11.80	19.7%	2.90	2.4%	56.9%	0%
	Squirrel Ward (Gastro)	21.65	18.16	16.1%	3.49	3.9%	6.0%	3%
	Sky Ward	32.00	25.92	19.0%	6.08	7.5%	21.3%	0%
Brain	Kingfisher Ward	14.72	15.64	-6.3%	-0.92	2.5%	5.3%	26%
	Koala Ward	59.81	50.90	14.9%	8.91	5.7%	30.7%	1%
	RANU (Starfish)	5.00	5.23	-4.5%	-0.23	1.6%	19.4%	12%
	Squirrel Ward (Endo & Meta)	16.57	13.30	19.7%	3.27	1.5%	22.7%	5%
Heart & Lung	Bear Ward	58.45	54.71	6.4%	3.74	3.8%	27.5%	1%
	Flamingo Ward (CICU)	132.40	126.21	4.7%	6.19	2.3%	14.9%	2%
	Kangaroo Ward	19.00	21.53	-13.3%	-2.53	10.3%	12.6%	0%
	Leopard Ward	38.87	34.26	11.9%	4.61	2.3%	20.9%	0%
	Neonatal Intensive Care Unit (NICU)	68.00	60.73	10.7%	7.27	2.8%	25.4%	3%
	Paediatric Intensive Care Unit (PICU)	113.60	107.76	5.1%	5.84	4.8%	19.4%	6%
	Walrus Clinical Investigations Centre	7.07	7.61	-7.6%	-0.54	9.3%	13.7%	0%
IPP	Bumblebee Ward	32.20	32.63	-1.3%	-0.43	3.6%	12.3%	3%
	Butterfly Ward	32.20	24.61	23.6%	7.59	6.9%	17.2%	4%
	Hedgehog Ward	16.60	8.60	48.2%	8.00	1.1%	18.4%	0%
Core Clinical Services	Anaesthetic Staff Theatre	49.90	42.11	15.6%	7.79	1.9%	17.6%	0%
	Interventional Radiology Theatres	20.00	16.27	18.6%	3.73	1.2%	7.0%	0%
	Radiology Theatres	9.00	8.00	11.1%	1.00	0.0%	47.1%	13%
	Recovery Theatres	40.74	37.63	7.6%	3.11	4.9%	16.0%	0%
	Scrub Staff Theatre	82.10	77.93	5.1%	4.17	5.3%	20.3%	8%
	Puffin (SDAU) & Woodpecker Ward (PACU)	20.20	20.76	-2.8%	-0.56	1.6%	31.8%	5%
Research & Innovation	R&I Delivery Clinical	0.00	48.48	-	-48.48	3.6%	18.5%	1%
	Clinical Research Network (North Thames)	13.30	0.00	100.0%	13.30	-	-	-
Sight & Sound	Panther Ward	25.45	19.81	22.2%	5.64	3.7%	26.1%	3%
	Panther Ward (Uro)	22.50	19.79	12.1%	2.71	1.8%	18.9%	5%

Attachment Y

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
8th June 2023

Biannual Safe Staffing Establishment Review 2023 **Submitted by: Tracy Luckett, Chief Nurse**	**Paper No: Attachment Y** □ **For information and noting**

Purpose of report
To provide assurance to the Trust Board that arrangements are in place to review the establishments on a biannual basis, to determine if inpatient wards are safely staffed with the right number of nurses with the right skills and at the right time. This is in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018. It also incorporates NHSE's Developing Workforce Safeguards (2018).

Summary of report

- The assurance process is compliant with the Developing Workforce Safeguards guidance (NHSE 2018)
- Evidence in the form of SNCT data demonstrated that patient acuity and complexity has risen in some areas across the trust.
- Skill mix and the heighted level of support required for newly qualified nurses (NQNs) coming through is also impacting on nursing capacity leading to a skills gap and greater demand on the existing nursing workforce.
- Panther and Pelican wards were discussed at length and the panel agreed with the proposals to increase their establishments due to the increasing acuity and skills gap to ensure the correct skill mix and senior supervision is in place to protect safe staffing.
- Where there are areas of high staff unavailability (sickness, vacancies, or maternity leave) mitigation is provided through bed closures and use of temporary staffing.
- 11 new recommendations have been outlined in the report, progress will be monitored via Nursing Workforce Assurance Group.

Patient Safety Implications
Appropriate mitigations are in place to maintain safe staffing levels which has a direct corelation to patient safety.

Equality impact implications
None

Financial implications
Any recommended increase in establishment will need to be incorporated into the 23/24 Directorate budgets.

Strategic Risk
BAF Risk 2: Workforce Sustainability
BAF Risk 12: Inconsistent delivery of safe care

Action required from the meeting
None

Attachment Y

Consultation carried out with individuals/ groups/ committees EMT
Who is responsible for implementing the proposals / project and anticipated timescales? NA
Who is accountable for the implementation of the proposal / project? NA

Purpose

Since April 2019, Trusts are assessed annually for compliance with National Quality Board (NQB) guidance through the Single Oversight Framework (SOF) as described in Developing Workforce Safeguards (NHSI, 2018). Biannual nursing establishment reviews are undertaken every Spring and Autumn, to provide assurance that the Trust is maintaining safe levels and to review progress against the implementation of recommendations since the last report.

Introduction

Great Ormond Street Hospital (GOSH) has a responsibility to ensure a safe and sustainable workforce and all Trusts must demonstrate compliance with the 'triangulated approach' to deciding staffing requirements described by the National Quality Board (NQB) guidance in the recent 'Developing Workforce Safeguards' by NHS Improvement (2018). This combines evidence-based tools, professional judgement, and outcomes to ensure the right staff with the right skills are in the right place at the right time.

The NQB guidance states that providers:

1. must deploy sufficient suitably, competent, skilled, and experienced staff to meet the care and treatment needs safely and effectively
2. must have a systematic approach to determining the number of staff and range of skills required to meet the needs of the people using the service and to keep them safe at all times
3. must use an approach that reflects current legislation and guidance where it is available

In line with NQB recommendations, a strategic biannual staffing review has been conducted, the key elements of which include:

Requirement	**Compliance status**
Using a systematic, evidence-based approach to determine the number and skill mix of staff required	
Using a valid and reliable acuity/dependency tool	
Exercising professional judgement to meet specific local needs	
Benchmarking with peers	
Taking account of national guidelines, bearing in mind they may be based on professional consensus.	
Obtaining feedback from children, young people and families on what is important to them and how well their needs are met. (Further refinement and detailed feedback to be included in future reviews)	

In addition to the above, the NQB's expert reference group's cross-check includes:

- Children and young people's ward managers should use at least two methods for calculating ward workload and staffing requirements.
- Boards should ensure there is no local manipulation of the identified nursing resource from the evidence-based figures in the tool being used, as this may adversely affect the recommended establishment figures and remove the evidence base. Children and young people's acuity/dependency tools should include a weighting for parents/carers, so their impact on the ward team is reflected in ward establishments.
- Most parents or carers will stay in the hospital, making a significant contribution to their child's care and wellbeing. However, they also require support, information and often education and training to enable them to care for their child in partnership with hospital staff. Their personal circumstances and responsibilities such as other siblings, work commitments and the travelling distance to the hospital may prevent them from visiting. The child or young person will then depend more on staff for fundamental care, stimulation, and emotional support.
- Time-out percentages (uplift) should be explicit in all ward staffing calculations. Managers should articulate any reasons for deviation from the 21.6% to 25.3% range emerging from the evidence review. GOSH uplift is 22%.
- Staffing resource aligned to levels of patient acuity/dependency should be realistic and determined on quality assured services.
- Adjustments should be made to workforce plans to accommodate ward geography – for example, single-room design wards.
- Two registered children's nurses should be on duty at all times in an inpatient ward.
- Allocate time within the establishment for regular events such as patient inter-hospital transfers and escort duties for patients requiring procedures and investigations if this is not already factored into the validated acuity/dependency tool.
- Allow time for staff to respond effectively to changes in patient need and other demands for nursing time that occur often but are not necessarily predictable: for example, patient deterioration, admissions, and end-of-life care. Capacity to deal with unplanned events should be built into the ward establishment using professional judgement. This is commonly referred to as 'responsiveness time'.

Methodology for Calculating Nursing Numbers

The Children's & Young People's Safer Nursing Care Tool (C&YP SNCT), has been fully implemented across all inpatient services within the trust with the most recent collection of data gathered over a 4-week period in Jan/Feb. The C&YP SNCT is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013 which has been used successfully in many organisations. It has been developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing in Children's and Young People's in-patient wards. The tool, when used with Nurse Sensitive Indicators (NSIs), is a reliable method against which to deliver evidence-based workforce plans. Day case units and outpatient departments rely on professional judgement as no validated tool currently exists.

Decision support tools, such as those for measuring acuity/dependency, help managers determine safe, sustainable staffing levels and remove reliance on subjective judgements.

Professional consensus suggests no single tool meets every area's needs, so NHSEI recommend combining methods.

To ensure a triangulated evidence-based approach, comprehensive data packs were shared with the Directorate Heads of Nursing and Patient Experience (HoNs), general managers and chiefs of service. The review panel was chaired by the Deputy Chief Nurse and panel members included the HON, Assistant Chief Nurse (Nursing Workforce) and Associate Director of Finance. Senior representation from Human Resources and the Operations Team were also invited but unable to attend. Data packs were shared with all panel members including those unable to attend, and contained:

- Data on the existing budgeted staffing establishment
- Bed base including HDU bed numbers/Telemetry beds
- Safer Nursing Care Tool (SNCT) calculations for guidance based on patient acuity
- Calculations based on national guidance for that specialism e.g., Association for Perioperative Practice (AfPP), Paediatric Intensive Care Standards (PICS),
- Registered/unregistered nursing workforce skill mix proportions
- Variance between data sets and recommended numbers
- Overview of Datix incidents reported since the last review, to identify any themes, trends, or areas of concern.
- Quality metrics
- Patient & family feedback
- Complaints and PALs contacts
- Student placement experience feedback
- Roster management
- Temporary staff usage
- Professional judgement (as determined by HoNs and clinical teams)

Staffing Establishments

The staffing requirement for each ward was reviewed and cross referenced with directorate's own information. It is important to note that the review focuses on the required number and skill mix of registered and unregistered nursing workforce to provide safe staffing care based on the number of open/funded beds and patient acuity. Roles such as Advanced Clinical Practitioners and Clinical Nurse Specialists were not included in this review. Review questions align with the NHS Workforce Safeguards (2019) and Care Quality Commission (CQC) Key Lines of Enquiry.

Review outcomes

Overall, the review found that current establishments are insufficient in some areas to support safe staffing because of rising patient acuity and complexity post pandemic, in addition to increasing activity because of delays and backlogs. High concentration of junior staff in the ward environments, which maintaining a strong skill mix and good level of specialist competencies is challenging despite the high level of educational input. The focus for the coming year is to increase recruitment of experienced nurses, improve the retention of our existing specialist nursing workforce, and improve the support and senior oversight of the

junior workforce through a number of initiatives, which will be outlined in a new retention plan. Establishment review outcomes for individual directorates are outlined as follows:

Sight and Sound (S&S) – The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Panther ENT** The current staffing establishment is safe for the existing number of funded inpatient and HDU beds, however it does not provide adequate resource to address the additional day case activity following the relocation of urodynamics. SNCT does not capture day case activity and this increased requirement is supported by professional judgement. An additional 2 RNs would be required to support the delivery of safe care across the whole inpatient and day-case service.
- **Panther Urology** The current staffing establishment is safe however increasing patient acuity is impacting on activity levels which need to be mitigated through ward team mergers, temporary redeployment of staff or bed closures. This in turn is impacting on staff morale and high voluntary turnover. To maintain constant activity levels and reduce the need for mitigations professional judgement indicates that an additional 2 RNs are required.
- **Outpatients** The current staffing establishment was safe; however, the skill mix is under review due the challenges of delivering services across four sites. The HON and ACN are currently reviewing the workforce configuration to explore the conversion of RN posts to Nursing Associate (NA) posts which will increase workforce numbers and create a career progression pathway for NAs.

Body, Bones and Mind (BBM) – The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Squirrel Gastro** The staffing establishment is safe, which is further supported through the repurposing of inpatient beds to day case activity.
- **Chameleon** The staffing establishment numbers have been corrected since the last review and are deemed safe. However, with increasing pressure to take higher acuity 'step down' PICU patients, the establishment levels will need to be monitored closely. Short term mitigations are in place when there are peaks in patient acuity but are not sustainable long term.
- **Eagle** The current establishment covers both the ward and the dialysis unit. With increasing numbers of patients requiring dialysis often bed usage must be converted from inpatient activity to dialysis use. Backlogs have also impacted on delayed treatment and diagnosis of patients requiring transplant, with this activity increasing post pandemic. The HON is currently reviewing the configuration of this workforce to include Band 4 haemodialysis technicians and to establish an Advanced Clinical Practitioner career pathway/succession plan.
- **Sky Ward** The staffing establishment is safe based on current activity levels.
- **Mildred Creek Unit (MCU)** The staffing establishment is safe based on the current bed base and unit location. However, additional staff need to be recruited in advance of the unit's relocation due to the impact the new environment will have the team's ability to provide safe nursing care. This has been further supported following an external review.

Brain - The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Koala** The current staffing establishments are safe and aligns with national staffing recommendations including telemetry, HDU and SNCT score. The junior skill mix was discussed, and several plans are in place to support this including increased supernumerary time for Newly Registered Nurses (NRNs), additional education support and the introduction of clinical Band 7 posts to improve retention and senior oversight and support.
- **Possum Ward** was closed at the time of the review and scoring exercise.
- **RANU (Alligator)** – The current staffing establishment is safe
- **Squirrel Endo-met** – The current staffing establishments are safe based on the existing bed base. A junior sister is now in post and additional educational support is in the pipeline.
- **Kingfisher** – The current staffing establishment is safe, although day-case activity is increasing and continues to be monitored.

International and Private Care (I&PC) - SNCT scoring is designed for NHS activity rather than private experience and expectations. Professional judgement is therefore applied to reflect additional challenges such as cultural differences, language barriers and service user expectation, which impact on direct and indirect care in this area. Benchmarking with other private paediatric providers will be considered to support triangulation. The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Butterfly** The current staffing establishments are safe based on current activity levels.
- **Bumblebee** The current staffing establishments are safe based on current activity levels.
- **Hedgehog** Since the last review the staffing budget has been agreed and recruitment is currently underway. The first round of SNCT scoring since Hedgehog reopened aligns with the current budgeted establishment but may need to be adjusted once full capacity has been reached to support its isolated position and the private experience.

Blood, Cells and Cancer (BCC) – The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Lion, Giraffe and Elephant** The current staffing establishments are safe once adjusted to include phased posts. Due to the small sizes of these wards, nurses are deployed, and patient acuity distributed to maintain safety with cross cover from ward managers as required. Currently some posts are on pause and need to be phased back into the budget. This needs to be addressed as a matter of urgency to achieve the required establishment and to maintain safe staffing levels.
- **Pelican (inpatient)** and **Pelican (ambulatory)**. To support both inpatient and day case activity, professional judgement indicates that an additional 2 RNs and 2 HCAs are required to support safe staffing. The review panel agree with this recommendation following triangulation with quality metrics and other nurse sensitive indicators.
- **Fox and Robin** The current staffing establishment is safe however it is worth noting the most recent round of SNCT scoring is only indicative as the wards were relocated with a reduced bed base during the exercise.
- **Safari** As a day-case unit the current staffing levels are safe however once the ward is split across two sites and relocated on Cheetah this will require additional nursing resource and a review of establishment needed.

- **Children's Cancer Centre (CCC)** With the planned development of the CCC it's important we start to grow the workforce now with a phased approach over the coming years to ensure we have the right staff with the right skills at the right time. Due to this specialism and the skills required this work needs to commence in 2023/2024

Heart & Lung (H&L) – The Directorate HoN in consultation with the clinical teams confirmed the following:

- **Bear** Since the last review, recommendations have been implemented and the establishment is now deemed safe and correct.
- **Leopard** The current staffing establishments are safe, however his will continue to be monitored due to an increase in patient acuity due to earlier PICU patient 'step downs'
- **Kangaroo** The current staffing establishments are safe. Plans are in place to increase the bed base which will require an increase in the staffing establishment.
- **Intensive Care Units – NICU, Flamingo (CICU), PICU**
  The current establishments are safe based on the funded bed base. The establishments for PICU and CICU are slightly lower than the recommended national critical care guidance (which includes a 25% headroom, compared to the GOSH standard of 22%) and are not determined by SNCT scoring. Additional NHSE funding has been agreed to increase the bed base in CICU which will include additional staffing requirement, this has been incorporated into the 23/24 budgets and will be reflected in the next establishment review.

Core Clinical Services (CCS) – AfPP guidance and professional judgement is used to determine recommended staffing establishments in theatres, SNCT is not applicable. A workforce consultation is currently underway. The Directorate HoN in discussion with the clinical teams confirmed the following:

Interventional Radiology (IR) Based on professional judgement the current establishment is not safe due to the challenges of the physical environment, increasing the risk when working in isolation. To address this plan are in place to conduct a consultation with staff across both the IR and Cath lab teams, to improve transferable skills and resilience.

Scrub The current establishment is safe since the recommendations following the last review were implemented.

Anaesthetics The current establishment is safe since the recommendations following the last review were implemented.

Recovery The current staffing establishment is safe.

Anaesthetic Pre-Operative Assessment (APOA) The current staffing establishment is safe.

Summary

Recommendations from the previous report

1. To achieve improved the triangulation methodology of Nurse Sensitive Indicators with the implementation of the Ward Accreditation scheme – **Pending implementation of Ward Accreditation**

2. CCS to conduct a review of current establishments with an emphasis on ensuring the right people with the right skills are in the right place – **Completed**
3. Discrepancies in budgeted establishments for BBM and O&I to be rectified – **Completed**
4. Consideration of the additional need to support a 'Green pathway' on Eagle Ward – **Completed**
5. Review of roster templates to ensure effective use of nursing resource during peak activity – **Completed**

Recommendations ahead of next review

1. Increase the nursing establishment of the Panther Wards to address increasing acuity, skill mix and retention
2. Review of career pathway options for nursing associate in outpatients
3. Conduct a focused review of the blended nursing workforce and new roles on Eagle ward.
4. Review of the nursing workforce for MCU ahead of any relocation
5. Monitor safe staffing levels on Koala Ward while action plan is being implemented
6. Increase the nursing establishment on Pelican Ward to support safe staffing levels because of increased day case activity and patient acuity
7. Remove phasing of existing posts to the BCC budgets to achieve full established requirements
8. Ahead of the relocated of Safari across two sites to include Cheetah, a review of establishment will be required
9. Consider plans for phasing in of new posts to the BCC establishments to prepare for the future CCC workforce requirements.
10. To review the trust headroom of 22% in line with PICS recommendations and increasing professional, specialist and statutory/mandatory training requirements.
11. Report on the outcome of the consultation on IR and cath lab workforce to improve resilience and skill mix.

Conclusion

The review found that some of the current nursing establishments are insufficient on Panther and Pelican wards, IR theatres and Cath lab, due to rising activity, complexity of patients and challenges with skill mix. These are currently being mitigated and safety maintained through reduced bed base and limiting some activity. All other areas confirmed that their staffing establishments were correct and safe. However, as activity and acuity continue to increase and new services are added, establishments in some areas (MCU and Safari) will need to be reviewed and adjusted accordingly. Progress against the review recommendations will be monitored via NWAG. The assurance process is compliant with Developing Workforce Safeguards guidance (NHSE 2018) and continues to evolve and improve through triangulation of data and intelligence.

Attachment Z

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
8th June 2023

GOSH Staff Survey Results / Action Plan 2022 **Submitted by:** Caroline Anderson, Director of HR&OD	**Paper No: Attachment Z** **For information and noting**

Purpose of report
The report provides an overview of Trustwide actions which are being implemented following the publication of annual staff survey results and outlines next steps for directorate leadership teams to take forward locally within their services.

Summary of report
The paper provides an overview of plans for workforce initiatives created based on the feedback received through the NHS Staff Survey 2022 results which were shared with People & Education Committee and Trust Board in March 2023.

Trustwide actions have been developed relating to four themes – Wellbeing, Equality Diversity & Inclusion, Career Progression and Reward & Recognition. Local directorate leadership teams are working to ensure results and action plans for the directorates are communicated widely amongst teams.

Patient Safety Implications
None

Equality Impact implications
Tracking and monitoring Staff Survey results provides valuable insight against progress towards the trusts strategic objective of Making GOSH a great place to work for all staff, and in particular staff with protected characteristics.

Financial implications
n/a

Strategic Risk

Action required from the meeting
Trust Board is asked to note the content of this report

Consultation carried out with individuals/ groups/ committees

Who is responsible for implementing the proposals / project and anticipated timescales
Senior Leadership Teams, Operational Board, Executive Management Team

Who is accountable for the implementation of the proposal / project
Caroline Anderson, Director of HR & OD

Attachment Z

NHS Staff Survey 2022
Action Plans

Making GOSH a great place to work

1. Introduction

The purpose of this report is to provide an overview of plans for initiatives created based on the feedback received through the NHS Staff Survey 2022 results, which were shared with People & Education Committee and Trust Board in March 2023.

2. National & Local Strategies

The NHS Staff Survey is one of the key tools through which we measure the impact of the activities and initiatives which make up the national and local workforce strategies detailed below. These strategies provide structured, longer term plans to improve the working lives of NHS staff. Any action plans or initiatives put in place in response to survey results must align and contribute to the delivery of these strategies.

The NHS People Plan

The People plan for 2020/21 *'We are the NHS – action for us all'* was published in August 2020 and sets out what the people of the NHS can expect – from their leaders and from each other.

The Plan sets out practical actions that employers and systems should take, as well as the actions that NHS England and NHS Improvement and Health Education England will take over the remainder of 2020/21. It focuses on:

- **Looking after our people** particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically
- **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong
- **New ways of working and delivering care** emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care
- **Growing for the future** particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer.

The NHS People Promise

The promise has been designed to reflect the things that staff tell would most improve their working experience and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are now measured against the seven people promise elements and against 2 of the themes reported in previous years (staff Engagement and Morale). The reporting also includes new sub-scores which feed into the People Promise elements and themes.

Above and beyond strategy

The first priority of the GOSH five year strategy 'Above and Beyond' commits to **making GOSH a great place to work by investing in the wellbeing and development of our people**. It states that as a GOSH community, we must value and respect each other, work together as one team, and put in place the support, education and development opportunities to help us be at our best, every day.

The GOSH People Strategy

In November 2019 we launched the first GOSH People Strategy, with a three-year plan to create an inclusive organisation where all our people are valued for who they are, as well as what they do. Launched in October 2020 our new Diversity and Inclusion Framework (D&I) and Health and Wellbeing Framework (H&WB) provide the foundations to reinforce the commitments set out in our People Strategy, creating the environment and a work programme to ensure they are delivered and, in doing so, help us meet the expectations set out in the NHS People Plan.

3. 2022 Results

The outputs from the survey are shaped around the NHS People Promise and two additional themes (Engagement and Morale). A detailed report of results was presented to Trust Board in March 2023, a copy of which is included at Appendix 3. At a summary level, whilst results for GOSH showed a deterioration across all themes, the trust continues to compare competitively when viewed against the range of peer groups.

Trust	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Great Ormond Street Hospital	7.3	5.7	6.7	6	5.5	6	6.7	7.1	5.7
NCL Average (inc GOSH)	7.2	5.8	6.7	6	5.5	6.2	6.8	6.9	5.7
London Trusts (inc GOSH)	7.2	5.8	6.7	5.9	5.5	6	6.7	6.9	5.7
Acute Specialist Trust (inc GOSH)	7.5	5.9	6.9	6.2	5.6	6.2	6.8	7.2	6
National NHS Average	7.2	5.8	6.7	5.9	5.4	6.1	6.7	6.8	5.7
Children Hospitals Alliance	7.3	5.8	6.8	6	5.5	6.1	6.7	7	5.7

GOSH is better

Same as GOSH

GOSH is lower

- Of note are the NCL scores where GOSH is above average or equal to in 6 areas with the majority of other areas within 0.2 points.
- GOSH is also higher or equal to the NHS average in 7 areas.
- GOSH scores higher than the NHS and NCL average for *We are compassionate and inclusive* with only Acute Specialist Trusts scoring higher.

- Our scores for Engagement are equal to NCL and above all other comparator groups, with the exception of acute specialist trust.
- Our scores for Morale or equal to our comparator groups, with the exception of acute specialist trust.
- We have the highest scores for *We are compassionate and inclusive*, *We are safe and healthy*, *We are always learning*, *Staff Engagement* and *Morale* with the exception of acute specialist trusts.

4. Priority Themes

Following the 2021 staff survey seven priorities were agreed centrally for directorates to implement. This approached raised a number of challenges. Seven priority areas was felt to be too many to focus on, centrally set priorities cannot take into account local needs and nuances and as a result, directorates in many cases may have felt less connected to or ownership over these priorities.

A different approach is recommended this year whereby in 2023/4 we commit to the **four themes.** These themes have been chosen based on the data from the staff survey and their alignment to strategic objectives:

- **Wellbeing** – Despite increased activities and initiatives, this area has seen a drop and will gain in importance due to the cost-of-living crisis. Questions related to this area include a lack of awareness of the Wellbeing Service and Hub, but also in questions concerning exhaustion, overwork and burnout.

- **Equality, Diversity and Inclusion (EDI)** – In most cases non-white members of staff, women, and staff under 50 reported lower scores than the organisation average.

- **Career progression** – This was a relatively low score of 50% and support early career development and retentions activities was also low. This was evidenced in questions concerning access to development, the quality of appraisals and a high number of staff expressing the desire to leave the organisation. There was also some evidence in the free text responses that commented on the lack of available development opportunities and progression within GOSH.

- **Reward and Recognition** – Scores for the *We are recognised and rewarded* people promise score and its constituent questions all experienced a fall. This sense of dissatisfaction with reward and recognition was also reflected in decisions undertake industrial action.

Therefore, the actions being put in place at a Trust level are:

Theme	Actions
Wellbeing	Establishment of a physical space for a staff support hub. This will be a similar model to the PALS office but for staff. A range of staff support service will be delivered from this hub. For example: Wellbeing advice, Trade Unions, Staff Networks, FTSUG, Staff Networks, Payroll, Career Clinics, Citizens Advice
	Greater visibility of the Wellbeing Service: Greater staff engagement to raise awareness of the range of services available through the Wellbeing Hub including 'Ward Walks', posters and leaflets
	Seen & Heard Champions - Trained and supported champions that sit on recruitment panels as integrated members of the panel to support inclusive selection practices.

Theme	Actions
Equality Diversity & Inclusion	Champions will sit on all selection programmes for grades 8a and above where underrepresentation is more acute
	Reverse Mentoring Programme - This involves paring a senior member of staff with a more junior from an underrepresented group to learn from their lived experiences to support more informed and inclusive decision making
	New inclusive leadership workshops threated into new L&M development programmes - Standalone leadership module that focuses on being an inclusive leader.
	Revised leadership programmes which better meet GOSH's leadership development needs and have inclusive leadership principles embedded throughout all modules
Career Progression	Digital Appraisal Portal - New appraisal process with different process for different staff groups allowing for a more tailored process where required. Digital element will enhance data and reporting capabilities including with information regarding learning needs generating automatic annual learning needs analysis (LNA) to directly inform future development offerings.
Reward & Recognition	GOSH Exceptional Member of Staff (GEMS) Recognition Scheme - The GEMS initiative was relaunched in October and consists of a team and individual winner each month. The winners are awarded with certificates, a letter with details of their nomination and physical awards by a member of the executive team. The winners are also announced via the traditional communications channels and at Virtual Big Brief (VBB). The GEMS process will be further developed to ensure all nominees and directorate winners receive recognitions.
	Long Service Awards - celebrating and recognising our long serving members of staff - Ceremony to be held in July 2023
	Annual Staff Awards and Celebration - Annual staff event to celebrate GEMS award winners. Awards ceremony to be held in September 2023

5. Sharing Results and Local Action Plans

Following publication of the national results, and in addition to reporting trust level results and benchmarking, in February 2023 each directorate was provided with a detailed results report. These included a breakdown of Directorate and Department level results for themes and individual questions, along with comparison data from previous years where possible, as well as trend data and NHS Staff Promise data.

Using these reports, HR Business Partners have worked with directorate leadership teams to draft their own, local actions plans which commit to at least one objective per theme to be implemented in a way that has the most impact for their areas. Directorates are encouraged to develop additional objectives that apply just to their directorate or specific teams. A breakdown of local Directorate actions is included at Appendix 1.

To further refine directorate action plans and support the development of team/department actions – updated results reports will be shared with leadership teams in the next week. This will include further analysis of team/department results to provide further emphasis on areas of local teams to focus on. Directorate Leadership teams and HR Business Partners are working to share team/department results with local leaders and encourage them to communicate the results with their teams and commit to team actions, utilizing the template at Appendix 2.

To support ongoing monitoring of staff survey action plans and, more importantly, the overall engagement and stability of local workforce, an updated set of workforce metrics will be included in Directorate performance review packs (quarterly). This will include traditional workforce KPIs, quarterly staff survey results, and other impact measures (such as WRES indicators) aligned to the

GOSH People Strategy. Updated workforce metrics will be implemented from the June PRM onwards and aims to provide a more holistic view of the workforce assurance.

6. GOSH People Strategy Refresh

Our three-year People Strategy was launched in 2019 and is being refreshed in Quarter 1 of 2023/24. The new strategy builds on the work the current strategy but is set within our current organisational context and priorities for the future. The refreshed People Strategy will cover the 3-year period April 2023 to March 2026. The overarching commitment and purpose remains consistent with the current strategy, which states:

Our people are the head, the heart, the hands and the face of Great Ormond Street Hospital (GOSH). They make us who we are and allow us to do extraordinary things.

We value and respect them individually and collectively for who they are, as well as what they do. As a Trust we are committed to ensuring all our people are well led and well managed, but also, supported, developed and empowered to be, and do, their best.

The refreshed strategy will build on the solid foundations established by the previous strategy and will have delivery plans shaped around four pillars:

- **Culture and Engagement**: The work programmes from our Equality, Diversity & Inclusion, and Health & Wellbeing frameworks will continue from the solid progress made over the last two years. New areas of work will include a review of our values and a cultural change programme to embed speaking up and psychological safety

- **Building a Sustainable Workforce**: focusing on recruitment, retention and workforce planning with increased focus on fair and open recruitment, onboarding, careers pathways and progression, and role configuration to support service redesign

- **Skills and Capability**: continuing to build on our well-established education and development offer from the GOSH Learning Academy, new programmes will be developed focusing on system working, financial and digital literacy, and leadership and line management.

- **Process Systems and Infrastructure**: focusing on improving processes around business planning, demand and capacity planning and business development. Upgrading our systems and tools to improve collaborative working and decision making.

The new people strategy and frameworks that underpin it will be supported by robust annual delivery plans that will incorporate the actions and objectives to deliver against the staff survey themes and initiatives. Each of the frameworks will be supported by supported by a set of benchmarked impact metrics, to track progress, a subset of which will be used to with other data sets to track progress and impact over the life of the strategy. A subset will also included in the performance review management processes to track progress at a directorate level.

Attachment Z

Appendix 1

Local Directorate Actions

Directorate	Actions
Blood, Cells & Cancer	**Wellbeing** - Continue with the monthly delivery of a sustainable wellbeing activity rota, Explore with the charity the possibility of exercise bikes on the wards for staff and patient use, Recruit Health and Wellbeing Ambassadors within each team to represent BCC
	EDI - Engage with trust wide initiatives such as Seen and Heard Champions, Reverse Mentoring, Inclusive leadership training programme
	Career Progression - Career Conversations with Staff, Set up an internal BCC rotation programme, Look at external rotations with UCLH, Continue Admin team feedback sessions and look for opportunities for admin staff to develop knowledge and skills
	Reward & Recognition - Continue to feature Praise in all Business Meetings, Continue Directorate Gem Awards
Brain	Directorate nursing recruitment and retention group being started so key stakeholders can feed into plans
	Encouraging admin and nursing teams to apply for new trust management apprenticeships to improve chances of internal promotion
	Brain SLT staff survey sent out to reflect on our management skills and find opportunities for improvement
	Trial of clinical band 7s on Koala Ward to ensure competency and training of junior staff protected.
	New directorate comms strategy including SLT blog to be launched to improve communication
	Work towards early positive expectation setting discussions with families that have the potential to cause conflict
	Re-launch directorate GEMS awards
	Brain Directorate Summer Party to take place in July
Core Clinical Services	**Pharmacy** - Away day with the management team to review staff survey results. Pharmacy manufacturing team working with recruitment and retention, skills mix and introducing trainee/development roles for lower graded roles
	Theatres & Anaesthesia - Band 7 Team Leader development work with a psychologist around management skills + difficult conversations
	Radiology - Radiographer recruitment and retention focus, providing stability across the band 6 workforce, Development opportunities - Working with UCLH on a rotation programme
	Therapies - Dietetics Management + leadership skills for team leads, SLT Speaking up and safety, building on the work carried out last year, OT Continuing introducing a rotation programme for the band 6's to develop skills and experience, Physio Investing in senior leadership. Considering similar management and leadership training programe as dietetics
	Laboratory Medicine - Training for leads to develop and improve quality of PDRs, Pan-labs meetings

Attachment Z

Appendix 1

Local Directorate Actions

Directorate	Actions
International & Private Card	**Wellbeing -** supporting improving resellience, Stay conversations and exit questionnaires, Introduce new flexible working and self rostering
	ED&I - Support the directorate in improving the staff experience in relation to discrimination from patients and families
	Career progression - Quality of the PDR experience, explore/assess the current position - support staff and managers in having a vastly improved experience through improved process, meaningful experience not just a tick box exercise and set some expectations about how to conduct these meetings. Succession PLanning
	Develop a constitution for the directorate
Heart & Lung	Introduce a range of initiative to improve staff experience; • introducing self-rostering across the directorate (all ITU's are already using this practice) • Understanding the needs of the under 29's _regular workshops will be starting in May • Team and individual initiatives celebration • Well-being weeks • Launch conflict resolution simulation training
Sight & Sound	Setting up Directorate Wellbeing Group and promotion of wellbeing and the champions
	Developing retention plans for Admin and Nursing
	Promoting EDI across the Directorate
	Raise awareness of GEMS and PRAISE and identify ways to recognize nomination and positive feedback received across directorate monthly
	Review/develop communication strategy across Directorate (implementing learning that comes out of the Trustwide Comms pilot)
Space & Place	Improvements have been made to PDR compliance, and we have trialled a new appraisal form with Domestic services which has enabled us to have more meaningful conversations and achieve 97% compliance. Plan to review where else this form could be rolled out and to begin to quality check appraisals.
	We scored poorly in several questions related to staff feeling able to improve their knowledge and skills, see career progression at GOSH and develop their potential. We plan to hold listening events to explore these areas more, alongside ensuring we are promoting all internal development opportunities at team meetings/newsletters/through robust PDRs. Considering creating champion roles across the Directorate to go to speak with individuals/teams about their career etc. how they got there
	We acknowledge that there is work to do across the Directorate to foster a culture of inclusivity; no firm plans for this area however as a minimum we plan to approach the staff networks for guidance/ideas and will hold listening events to hear more about staff experience.

Appendix 2 – Team Action Plan template

Staff Survey Action Plans

As Leader you are encouraged to work with colleagues to agree three themes for action:

1. **A celebration theme:** a positive result we can celebrate and learn from.
2. **One quick win:** a goal which can be achieved in 3-6 months
3. **One theme for improvement:** theme to focus improvement effort on with scope for multi-year actions

Decide whether you want to focus on your highest and lowest scoring theme? Or whether you want to have a stakeholder vote? As you choose priorities, stick to your list of items that need attention. Don't bite off more than you can chew—most successful action plans address only 2-3 items at most.

Our natural inclination is to hone in on the lowest-scoring questions however this may not yield the biggest impact staff engagement. Remember to invest time into your **celebration** action.

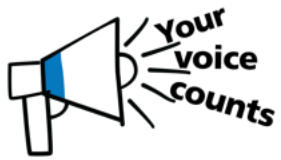
Build on existing initiatives and align your action plans with existing plans or objectives. You can then use the Staff Survey as a metric for measuring success. Agree ownership of actions and make different team members accountable. Agree regular communication and discussion/feedback through existing structures e.g. team meetings.

Survey results are about feelings; action planning is about behaviors. The goal is to identify behaviors that have led to negative feelings and behaviors that will lead to positive feelings. Determine the specific theme you want to improve, celebrate or have a quick win with and consider what specific behaviours/practice you want to: "Continue," "Stop," and "Start."

Sense check your action plans with your team and ask whether they have additional ideas which will make the plans even more effective

Attachment Z

Team Name Staff Survey Actions



We're committed to making **team name** a great team to work in. Based on your feedback in the Staff Survey we're going to do the following…

Action points	Responsible Lead	Date to be in effect
Our celebration theme is:		
Our Team will continue to x in order to x		
Our Team will stop x in order to x		
Our Team will start to x in order to x		
Our quick win is:		
Our Team will continue to x in order to x		
Our Team will stop x in order to x		
Our Team will start to x in order to x		
A theme for improvement:		
Our Team will continue to x in order to x		
Our Team will stop x in order to x		
Our Team will start to x in order to x		

Attachment Z

Appendix 3 – 2022 Results Report

Staff Survey 2022
Board ver.2.4.docx

Attachment 1

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 8th June 2023	
Annual Health and Safety and Fire Safety Report **Submitted by: Chris Ingram** **Fire, Health and Safety Manager**	**Paper No: Attachment 1** **□ For information and noting**

Purpose of report
To present to the Board the Trust performance in health and safety and fire safety and to provide assurance that the Trust has met its statutory duties.

Summary of report
- Introduction
- Health and Safety annual update
- Fire Safety annual update
- Future aims for 2023/ 24

Patient Safety Implications
Health and Safety is more concerned with staff safety but a robust health and safety performance will help our staff to provide look after our patients. Fire safety is important in all areas of the Trust including our clinical areas. A robust set of processes in regard to fire safety will ensure our patients are kept safe.

Equality impact implications
Both health and safety and fire safety processes are in place to ensure that all staff and patients are kept safe. In some circumstances extra mitigations are in place to ensure this. An example of this would be a Personal Emergency Evacuation Plan (PEEP) for staff members or bespoke ward training for our staff looking after patients in the intensive care units.

Financial implications
The safety department does not have a direct budget but there are lots of different streams where finance is required to ensure a safe estate. There is also the implication that if the Trust did not fulfil it's statutory duties we may be prosecuted and fined.

Strategic Risk
BAF Risk 9: Estates Compliance

Action required from the meeting
- Note the contents of the annual report regarding the Trust's performance in Health and Safety and Fire Safety
- Acknowledge the summary of the external (AE's) Fire Safety Report

Consultation carried out with individuals/ groups/ committees
Agreed by Executive Director for Space and Place and Fire, Health and Safety Manager. Presented and reviewed at Health and Safety Committee and Fire Safety Committee. Presented as separate reports.

Attachment 1

Who is responsible for implementing the proposals / project and anticipated timescales? Fire, Health and Safety Manager
Who is accountable for the implementation of the proposal / project? Executive Director for Space and Place

Attachment 1

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Public Trust Board
8th June 2023
Health and Safety and Fire Safety Annual Report – 2022/23

1 Purpose of paper

GOSH Health and Safety and Fire Safety Team support the Trust management and staff to meet their statutory duties in relation to controlling health and safety and fire safety risks. This helps to preclude the chance of harm to patients, visitors, and staff. The team does this by having a robust system of risk assessment, audit, incident review and walkarounds which allows the team to anticipate and alleviate risks before they cause harm. This paper reviews the previous financial year to provide assurance that the Trust meets its statutory requirements.

The Trust has specialised risk assessments in areas such as Fire Safety, Control of Substances Hazardous to Health (COSHH) and Sharps Safety. Impact assessments are also required before each Redevelopment Project. In addition, there are many local risk assessments that are completed as and when are required.

2 Key focus areas for Health and Safety

The following work has been undertaken by the team during the reporting period are summarised in Table 1 below. This work ensures that the Trust meets it statutory duties. This list is not exhaustive.

Table 1- H&S Focus Areas and Headlines

Description of work	Progress and lead	Timescale	Original RAG Rating (21/22)	Current RAG rating (22/23)
Safer Sharps Project – The Safer Sharps Working Group have met monthly in the reporting period. The Clinical Procurement Team are now attending the Health and Safety Committee to provide updates on progress.	Safety devices are now being brought into the Trust with the latest being hypodermic Needles and Butterfly needles. In some areas a dual supply of safety and regular devices are maintained due to clinical need. When a standard device is in place a risk assessment is completed. The improvement in the Safer Sharps Project has contributed to a reduction in sharps incidents by more than 20%. (21/22 – 62 to 22/23 – 50)	Safer Sharps Group meets monthly with an update bi-monthly to the Health and Safety Committee. Update is on the agenda Risk Assessments for all standard sharps are reviewed annually		

Description of work	Progress and lead	Timescale	Original RAG Rating (21/22)	Current RAG rating (22/23)
	Lead: H&S Team and Clinical Procurement Team			
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - Any incident that involves a staff member being away from the Trust for more than 7 days, results in a serious injury or has occupational exposure to a named disease must be reported under RIDDOR.	23 incidents were reported under RIDDOR. This is an increase from 19 in the previous year. 5 of these incidents related to potential exposure to COVID 19. **Lead: Fire, Health and Safety Team**	Incidents must be reported under RIDDOR within 15 days. All incidents reported under RIDDOR are discussed at the Health and Safety Committee.		
Train 90% of staff in Health and Safety and Fire Safety. Health and Safety training is completed through E-Learning and has not been affected by COVID 19.	On the 1st of April 2023 compliance with Health and Safety training was 96% (96% in 2022). **Lead: Fire, Health and Safety Team**	Monitored monthly. Email sent out to all those who are not compliant on the 1st of each month by the Training Department.		
The Trust reports Health and Safety incidents on Datix. The Health and Safety Team review and investigate all Health and Safety incidents an also administer and approve all Security incidents.	876 (875 last year) health and safety incidents were reported from 1/4/22 – 31/3/23. This included 98 (75 last year) patient safety accidents. **Lead: Fire, Health and Safety Team**	The team aims to reply to each H&S incident within 1 working day.		
The Trust has also fulfilled its statutory requirements in several other areas. These include: • Lone Working • COSHH • Policies • Walkarounds	The Health and Safety Team have presented audits, reports and policies at the Health and Safety Committee. This helps the Trust to meet its statutory obligations. Actions are recorded and if required contentious issues are escalated to the Executive Management Team meeting. **Lead: Fire, Health and Safety Team**	The Health and Safety Team meets on a bi-monthly basis and is chaired by the Executive Director for Space and Place.		

3 Work of Health and Safety Committee

The Health and Safety Committee meets bi-monthly and is chaired by the Executive Director for Space and Place. The committee has met 6 times throughout the year and discussed and actioned a wide range of issues. The committee has received regular reports regarding health and safety, fire safety, health and safety incidents, any security issues and the progress of the health and safety walkaround.

The following committees report into the Health and Safety Committee. The Health and Safety Committee receives any issues that need to be escalated and these are added to the action log when required:

- GOSH/ICH Liaison Committee
- CBL Safety Committee
- Space and Place Health and Safety Committee
- Safer Sharps Group
- Fire Safety Committee

4 Impact of COVID 19 on Trust during reporting period

The overall impact of COVID 19 has been reduced from the previous year. There are still some health and safety impacts, however. These are:

- Increased reporting under RIDDOR. This is reflected in the numbers for this reporting period but is likely to reduce next year.
- Increased musco-skeletal injuries due to a lack of ergonomic facilities available when staff are working from home. This has been mitigated by allowing staff to purchase ergonomic equipment for homeworking.

5 Focus for Fire Safety - Table 2- Fire Safety Focus Areas and Headlines

Description of work	Progress and lead	Timescale	Original RAG Rating (21/22)	Current RAG rating (22/23)
Fire Safety mandatory training – Trust standard is to be above 90% compliance. Fire Safety Training is currently at 93% compliance for bi-annual training and 86% for annual training. Overall compliance is at 88%. (21/22 – 87%). There are a variety of different sessions available including: • Fire Response Team Training • Evacuation Chair Training • Fire Warden Training	To increase compliance extra sessions have been arranged for evenings, early morning and the weekends. It has still proved difficult to hit the Trust target, but the team has continued to complete as many sessions as possible. **Lead: Health and Safety and Fire Safety Team**	Monitored and discussed monthly at the Fire Safety Committee		

Description of work	Progress and lead	Timescale	Original RAG Rating (21/22)	Current RAG rating (22/23)
• Tabletop Evacuation Training for clinical staff • Site Specific Training • Live fire simulations				
Fire Risk Assessments – All areas in the Trust must have a suitable fire risk assessment. The Trust completes 229 across the site. This number does not include the extra ones completed for our Accommodation buildings.	For most of the reporting period the Trust was 100% compliant. Due to staff sickness in March and April there was a temporary fall in this number but as of 23rd May 2023 the Trust is at 100%. **Lead: Health and Safety and Fire Safety Team**	Monitored and discussed monthly at the Fire Safety Committee		
Authorised Engineer Report – Completed November 2022 and February 2023 and presented at the Fire Safety Committee in March 2023.	More information below. For full report see Appendix 1. **Leads: Fire Safety Team and Authorised Engineer**	This is an annual requirement in line with HTM 05.		
False Fire Alarm Activations and Fire Incidents. The Trust had 50 fire alarm incidents during this reporting period (92 - 21/22). The GOSH Fire Safety Team are aware that Fire Response Team (FRT) Training frequencies may need to increase due to reduced false alarms giving less opportunity to use these as refresher opportunities. Each incident is reviewed to see if there are lessons to be learnt.	The London Fire Brigade (LFB) attended 6 times in this reporting period. • 2 x lift rescues • 1 x fire incidents – Nursery fire • 2 x false alarm • 1 x smoke issuing in Plant Room due to faulty equipment. No LFB action required.	Incidents are monitored daily through Datix		
Major Fire Incident – 20th April 2022 – Staff Nursery: Laundry machine ignited. 34 children and 17 staff members safely evacuated in 90 seconds **Cause:** Faulty appliance (dryer)	The Nursery staff and Fire Response Team were praised by the London Fire Brigade for their response. The learning from the incident has been inserted into all fire safety training at GOSH. The GOSH Fire Safety Team presented a lessons learned seminar at	Nursery had extra fire drills afterwards and fire risk assessment was reviewed after incident and again on an annual basis.		

Description of work	Progress and lead	Timescale	Original RAG Rating (21/22)	Current RAG rating (22/23)
	first GOSH Learning Patient Safety and Experience Grand Round.			

6 Authorised Engineer (AE) Report for Fire Safety

In October 2022, the Trust employed an Authorised Engineer for Fire Safety (AE). Previously the Trust has not employed someone in this role. Having an independent expert to consult with has proved invaluable particularly regarding the Children's Cancer Centre. In February 2023, the AE issued their annual report to the Trust and this was presented at the March 2023 Fire Safety Committee. The report was completed by reviewing the documentation the Trust holds plus interviews with staff. Interviews were held with the Fire Safety Team, a Clinical Site Practitioner, the Director of Space and Place, a Fire Warden, Estates Manager and the Emergency Planning Officer.

Comments from the report included:

"Overall, we found that the control and management of fire safety at the Hospital to be excellent."

"We believe that the two recommendations made will further enhance the Trust's control of fire safety."

The two recommendations have been discussed at the Fire Safety Committee and will be managed through this forum. The AE's report provides strong assurance for the Trust that fire safety is being managed in a safe and robust manner.

7 Main Aims for 2023/2024

- Maintain Health and Safety training above 90%.
- Respond to all Health and Safety incidents within 1 working day.
- Ensure that our new buildings particularly the Children's Cancer Centre meet high safety standards and are safe for our staff and patients to move into before they are used.
- Incorporate increased numbers of clinical areas into the walkaround process.

8 Recommendation

Trust Board are requested to:-

- Note the contents of the annual report for Health and Safety and Fire Safety
- Acknowledge the summary of the external (AE's) Fire Safety Report.

Attachment 2

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
8th June 2023

Guardian of Safe Working Report Q4 2022/23 **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working; AMD workforce	**Paper No: Attachment 2** **For information and noting**

Purpose of report
This report is the Q4 report of 2022/23 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1st January to 31st March 2023 inclusive.

Summary of report
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:

- 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 plans for industrial action
- Vacancy rates are higher then Q3 2023 and Q4 2022

Patient Safety Implications
- Rota gaps

Equality impact implications
None

Financial implications
- Continuing payment for overtime hours documented through the exception reporting practice – extended to non- training doctors
- Fine levied for breaching 2016 TCS applied to all junior doctors from March 2023

Strategic Risk
BAF Risk 12: Inconsistent delivery of safe care

Action required from the meeting
None

Consultation carried out with individuals/ groups/ committees
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?
Prof Sanjiv Sharma, Chief Medical Officer

Attachment 2

Guardian of Safe Working Hours Report
Q4: 1st January – 31st March 2023

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.

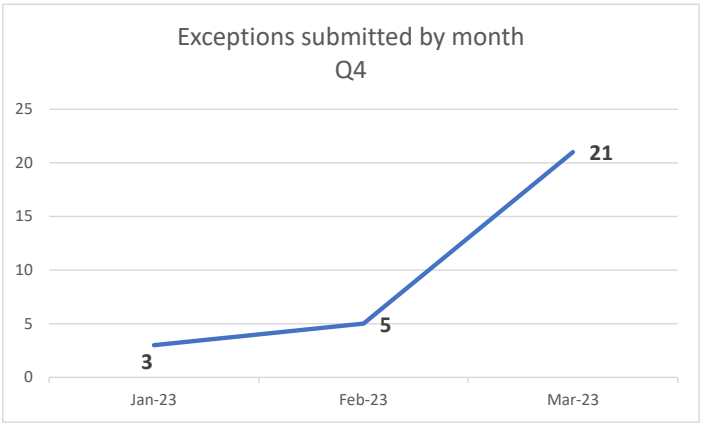
2 Background

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

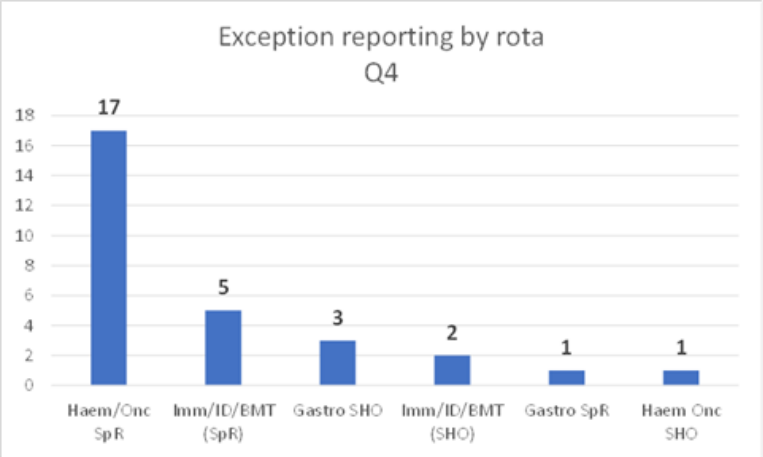
3.2 Average exceptions per month have increased from Q2 (5.3 per month) to 9.67 per month in Q4. It should be noted that the majority (21[72%]) occurred in the final month of the quarter.



3.3 29 ERs submitted in the period January to March 2023

- 26 ER: extra hours worked.
- 2 Pattern
- 1 Service support

- 16 doctors submitted the reports (15 SPR, 1 SHO)
- 7 doctors reported more than once in the period (1 reported 4 times)
- ER reports across 6 rotas



3.4 Exception report outcomes

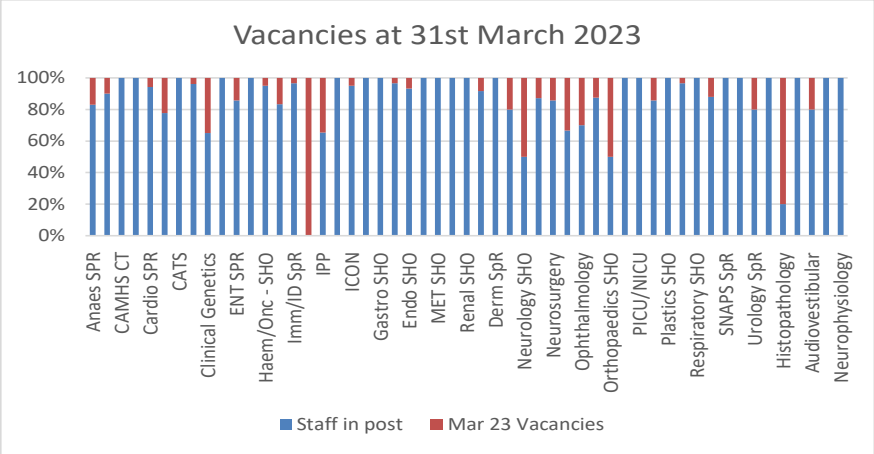
Outcome	Outcome
TOIL	1
Payment	27
No further action	1
Grand Total	29
FINE > 13 hour working breach	1

- *"colleague has been ill - so ended up doing a 12 hours shift alone seeing patients admitted under BMT+ immunology, along with external referrals in these 2 specialties. In normal circumstances 2 registrars are present on the long day- but as the sickness was acute on the day of the shift, it wasn't able to find a locum so I ended up doing the rounds along with the necessary interventions to all the inpatients. Given the patients' load and the lack of adequate staff on that day I ended up working a 13 hrs shift-staying till 9:30 pm without even having lunch"*

- *"Staying overtime to finish documentation (discharge summaries), as not feasible within regular working hours due to high clinical needs on the ward"*

4 Vacancy Rates

4.1 The overall vacancy rate across junior doctor rotas as of 31st March 2023 is 40.8 FTE (11.0%). This is an improvement on the February 2023 figure of 12.3% (45.3 FTE) vacant, but higher than the January 2023 of 9.4% (34.7 FTE). The Quarter 4 figure is also higher than the Q3 rate of 9.8% (36.1 FTE vacant). It is also higher than the Trustwide vacancy rate of 8.1% for March 2023

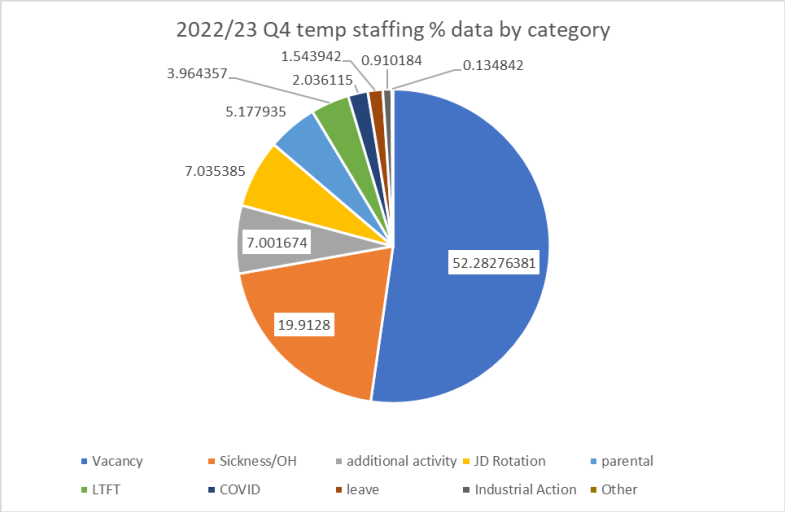


5 Bank and Agency usage

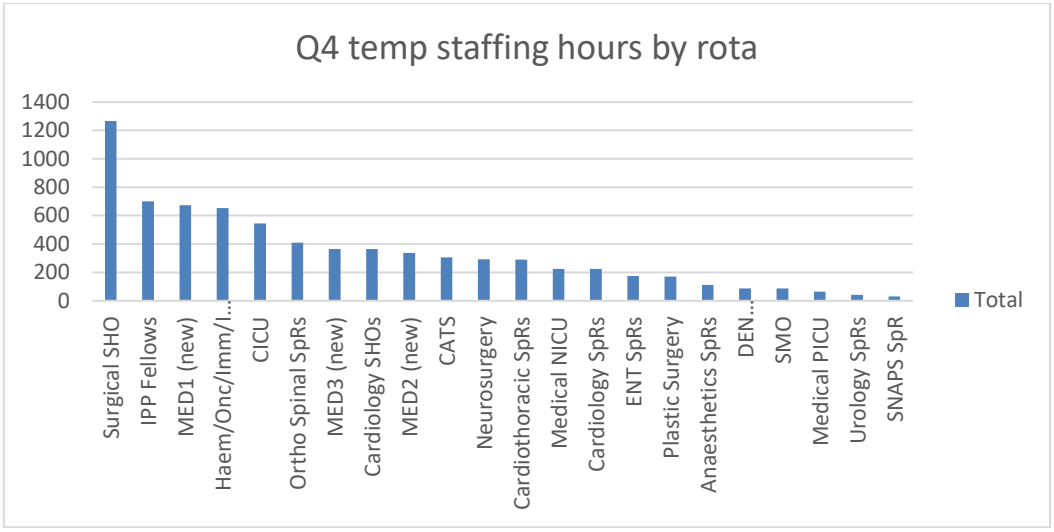
5.1 In the 3 months of Q4, over half (53.9%) of the temporary staffing hours were due to vacancy followed by staff sickness (20.2%). Cover for Less than full time (LTFT) working was next highest at 7.3%

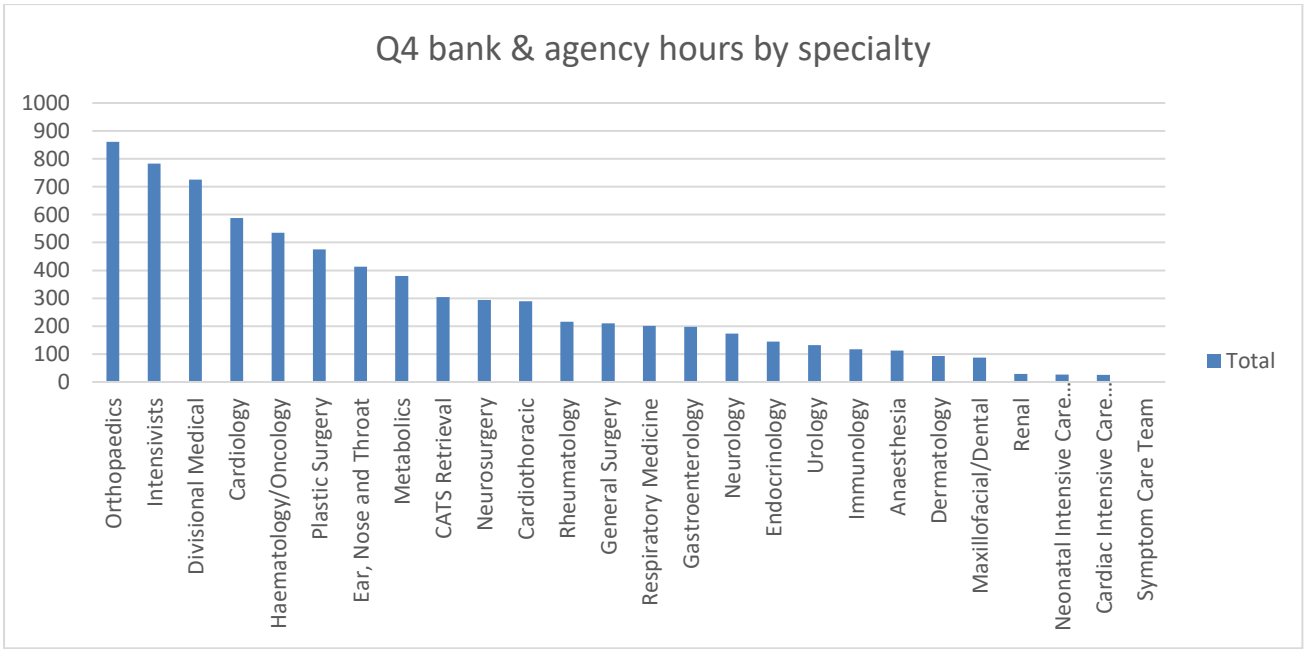
5.2 Sickness increased from 12.4% in Q3.

Attachment 2



5.3 Although data 'by rota' demonstrates the Surgical SHO rota as the most frequent rota using temporary staff with 130 shifts filled, it is the orthopaedic day time SHO bank requirement (an average of 43.3 per month), which drives the cost up, with plastics and ENT SHO daytime requirements adding additional bank hours.





5.4 31 rotas used an average of 10 or less temporary shifts per month.

5.5 When looking at shifts booked in the period, 99.7% of shifts in the period were Bank shifts with 4 Agency shifts booked in the last 3 months.

6 Industrial Action 13 March 07:00 to 16 March 07:00

6.1 157 GOSH Junior Doctors (JDs) took Industrial action during the strike period and held a peaceful picket line.

6.2 There were 120 shifts covered by consultant /SAS grade doctors during March industrial action that totalled 1076.75 hours. JDs only covered 7 shifts at 67.5 total hours. There were no reported safety incidents.

7 Junior Doctors Forum (JDF).

7.1 JDF are working with the Trust and Local Negotiating Committee regarding the ongoing call for industrial action from the Unions. A strike committee is now established.

7.2 JDF meets monthly on a virtual basis. The JDF winter ball held in February was a great success.

8 Summary

8.1 All GOSH rotas are compliant – challenges continue with respect to vacancy management.

8.2 All submitted exception reports are now being reviewed for application of potential fines as per the 2016 TCS from 1st April 2023

8.3 Junior doctors are well engaged and working closely with Trust on plans for industrial action

Attachment 2

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 2

TCS contract includes but is not limited the following amendments:

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

Attachment 2

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
8th June 2023

Guardian of Safe Working Annual Report 2022/23 **Submitted by: Dr Renée McCulloch, GOSW; AMD workforce**	**Paper No: Attachment 2** **For information and noting**

Purpose of report

- Provides assurance to the Board on progress being made to ensure that doctors working hours are safe for the year ending March 2023.

- The Board is asked to report information on rota gaps and the plan for improvement in the Trust's Quality Account and publish the details of Guardian fines in the Trust's annual accounts.

Summary of report

- Compliance with 2016 TCS: Implementation of the New Amendments October 2019
  - All rotas include calculation for safe minimal staffing numbers set by departments.
  - Provision for both study and annual leave allowance is factored into all rotas.
  - Rota coordinators check compliance with all rota changes

- Exception reporting (ER) is available to all Junior Doctors (including Trust Grade Drs) and continues to be the only formal tool to monitor compliance with 2016 contractual obligations of the Trust

- Four fines have been levied. It is likely that this signifies low reporting rates rather than assuring compliance.

- GOSH vacancy rates have increased and range 9.8% and 13.4% over 2022/23, sitting higher than the Trust average.

- Bank rates for non-consultant doctors working unsociable hours have been increased from April 1st 2022

- Medical workforce lead project implemented during COVID under leadership from the Medical Director's Office has ended March 31st 2023. Management is being transitioned to sit within the Operational Team.

Key risks/ challenges

- Timely recruitment and onboarding of doctors
- Maintaining quality and safety oversight previously provided by Medical Workforce Lead role
- Continuing Better Value approach to managing medical staffing

Equality impact implications None
Financial implications • High vacancy rate and related bank costs, particularly if unmonitored • Fines now implemented for all breaches related to regulation/ recommendations provided by the TCS 2016 for Junior Doctors.
Strategic Risk BAF Risk 12: Inconsistent delivery of safe care
Action required from the meeting None
Consultation carried out with individuals/ groups/ committees N/A
Who is responsible for implementing the proposals / project and anticipated timescales?
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma Medical Director

1. Introduction

1.1. The 2016 Terms and Conditions of Service (TCS) for NHS doctors and dentists in training highlight the importance of appropriate working hours and attendance at training and education opportunities for junior doctors. Both issues have a direct effect on the quality and safety of patient care with increasing recognition on the negative effect of rota gaps on junior doctor training and wellbeing.

1.2. Contractually every Trust has a Guardian of Safe Working (GoSW), a senior appointment who ensures that issues of compliance with safe working hours are addressed and provides assurance to the Board of the employing organisation that doctors' working hours are safe.

1.3. The 2016 TCS set firm limits to the number of hours trainee doctors can spend on duty. GOSH works within these limits for all doctors despite differing contractual arrangements across the establishment. The 2016 TCS guides safe working hours with principles that must apply to all.

1.4. Content for this report is gathered through data analysis of rostering, finance and exception reporting software systems, through working alongside the junior doctor's committee and the local negotiating committee and collaborating with operational and human resource departments

2. High level Data* as of 31st March 2023

Number of Trust Doctors		251 (includes Education and Research Fellows)
Number of Training Doctors	132	
Number of vacant unfiled posts		40.8 out of a total of 370 rota slots (11 %)

*Numbers indicate full time equivalent posts on fixed rota establishment

3. Patient Safety

3.1. Due to the high proportion of Trust Grade doctors, it was agreed in October 2022 at the Local Negotiating Committee that exception reports submitted by all doctors (including non-training grade doctors) will be eligible for fines as per 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.

3.2. During 2022/23 there has been ten immediate safety concerns reported directly through the exception reporting ER system. Eight were created in error. Two were associated with surgical SHO unsafe staffing levels and were escalated to operational teams.

3.3. Rest provision contributes to safe patient care by ensuring staff are making safe effective decisions. Residential on call rooms on Level 9 were upgraded and reopened in June 2023

4. Work Schedules

4.1. NHS employers mandate that doctors in training should receive schedules of work

that are safe for patients and safe for doctors and should be finalised and available 8 weeks prior to commencement of the new post. In 2022/23 all work schedules were available and published within the necessary time frames.

5. COVID-19 Response from Medical Workforce Leadership November 2020- March 2023 Stepped Down

5.1. Under the Medical Director's Office, five Medical Workforce Leads (MWLs) were appointed to continue to develop and improve out of hours working under the leadership of the Associate Medical Director (workforce) as part of the COVID management and recovery plan.

5.2. In addition to activation of alternative OOH systems during pandemic surge, MWLs have achieved:

- Daily situational awareness briefing and anticipatory planning for rota gaps
- Absence monitoring and oversight
- Medical workforce redeployment management
- Support to OOH safety and risk process
- A sustainable and flexible 'one team' approach to out of hours working
- Education and training opportunities including simulation course

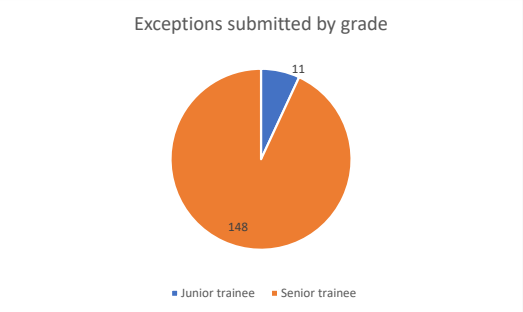
5.3. The OOH transition to the operational team was delayed but is currently underway.

6. Exception Reporting

6.1. Exception reporting (ER) is the mechanism by which doctors are able to report safety concerns in the workplace. Initially this was purely for those on the 2016 TCS contract. However, GOSH enables both Health Education England (HEE) trainees (2016 TCS) and non-training (trust) grade doctors (2002 TCS) to exception report at GOSH in recognition of the principles of safety and equity: doctors should be part of processes that protect the safety of patients and our workforce treated with equity.

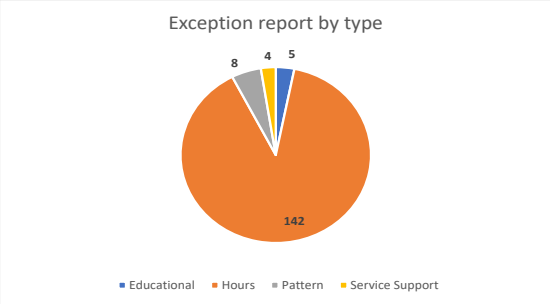
6.2. Since March 2017 all GOSH junior doctors can receive either financial compensation or time off in lieu of additional work performed if either preauthorised or when validated by a clinical manager. From March 2023 all submitted ERs will be eligible for GOSW fines as per the 2016 TCS if breaches occur.

6.3. In 2022/23 GOSH received 159 exception reports (down 1 from 2021/22) submitted by a total of 36 individual doctors. There was an average of 13 reports each month. These numbers while fluctuating from month to month are broadly in line with the long-term average (for example 2019/20 numbers: 149 reports submitted by 31 doctors).

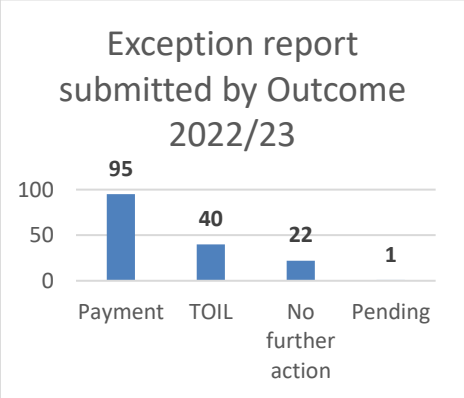


6.4. Presented monthly less than 1% of the junior doctor workforce are submitting ERs. This is a very small proportion of doctors but aligns with the national knowledge and our previous ER surveys in January 2018 and January 2020.

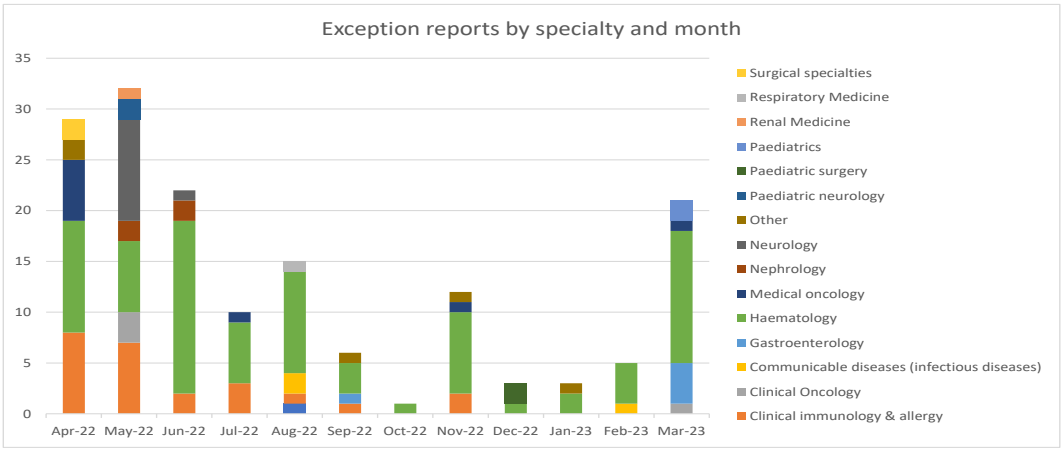
6.5. The vast majority of ERs are related to additional hours work and submitted by senior Trust grade (non-training) doctors.



6.6. Most ERs resulted in financial compensation; TOIL as an outcome has doubled and is often preferred to payment.



6.7. ERs have been presented by multiple specialties. Variation in reporting pattern is seen through the year. Incidence of reporting can be seen in some specialities that have experienced vacancies:



6.7.1. Onboarding delays International Medical Graduates (IMGs) particularly in Haematology and Oncology who have a large establishment relying on IMG recruitment

6.7.2. Immunology and Infectious Disease (ID) (also can be reported through a 'haematology' label as some doctors rotate) also had considerable work volume issues. The Immunology/ ID establishment was increased by 2WTE in March 2022 and was fully established in Autumn 2023.

6.7.3. Bone Marrow Transplant team exception reporting is also noted within haematology and Immunology statistics and is currently under review.

6.8. Doctors still struggle with the reporting process and the closing of exception reports by educational supervisors is often slow. The GoSW often facilitate closure of ERs and does so frequently as many breach response time guidelines. Monitoring of time to closure is planned for 23/24.

7. Fines

7.1. Four fines were levied during 2022/23 (up from only 1 in 2021/22) to date. These included unintended additional bank duties for a surgical SHO and several doctors breaching the thirteen hour maximum shift time. Three fines applied for the doctors on the 2016 TCS and one, the first Trust fellow on 2002 TCS in March 23.

7.2. ER software (Allocate) does not automatically identify breaches and depends on doctors to report breaches (such as frequently not getting 5 hours continuous rest on non-resident on call rotas) which they are often reluctant to do.

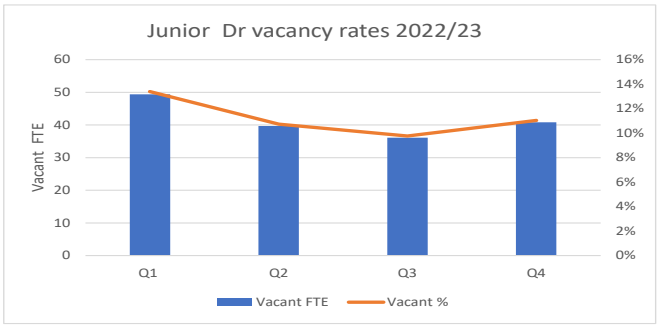
8. Rota Gaps and Vacancy Rates

8.1. Vacancy rates and rota gaps reflect the end point of multiple workforce issues including:

- short term unplanned absence
- delays in recruitment process, particularly timeframes onboarding IMGs
- variations in numbers of trainees sent to the Trust by the deanery
- Increase in doctors working less than full time
- national reduction in the medical paediatric workforce with a reduction in European pipeline

8.2. GOSH vacancy rate has varied between 9.8% and 13.4% over 2022/23 (increased from previous year; range 7-11%). While it is below the national

average, it was above the trust target of 10% for three of the four quarters of 22/23.



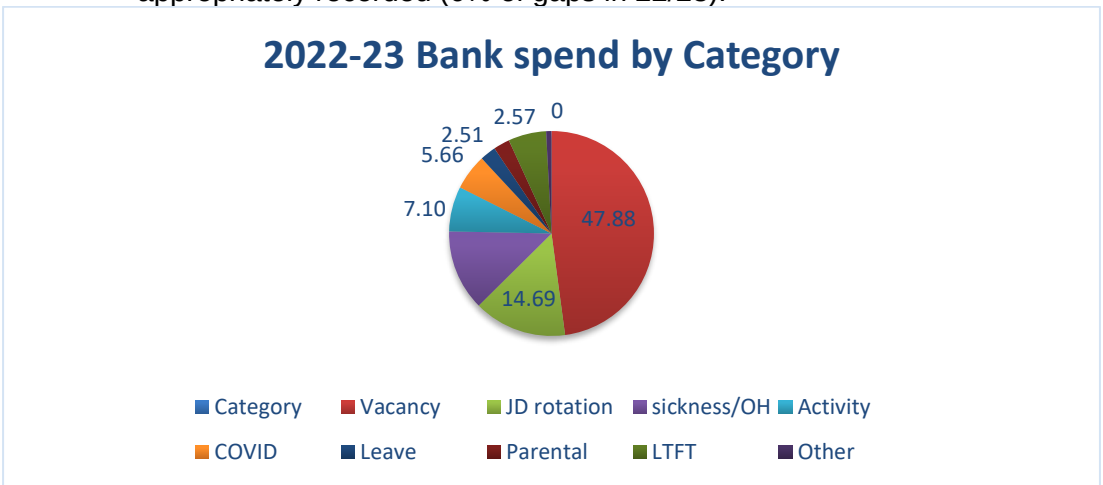
8.3. Rota gaps have been highlighted as an organisational and national pressure. Measures are being taken to mitigate the situation at GOSH include:

- implementation of a standard operation procedure for rota gaps
- establishing minimal numbers of doctors required to safely staff speciality areas
- devising rotas that factor in allowance for annual and study leave
- allocating managerial oversight providing cross organisation rota coordination and support
- supporting increase bank rate for JD unsocial hours from April 2022
- establishing systems that mitigate gaps such as OOH hospital at night 'one team' system
- developing a task: finish group in 23/24 to consider modernising the clinical workforce

8.4. Categorisation of Banks Spend Linked to Rota Gap management

8.4.1.1. Data cleansing (MWL role) has improved categorisation of bank spend on Health Roster. This has informed our understanding and identified targets for improvement.

8.4.1.2. Vacancy remains the most common reason (48% increased from 21/22: 40%) for bookings followed by JD rotation (induction/ delays in onboarding/ early resignation) and non-COVID staff sickness (12.75%). COVID related absence reduced from 21/22: 8% to 22/23: 5.7%. LTFT working is now being appropriately recorded (6% of gaps in 22/23).



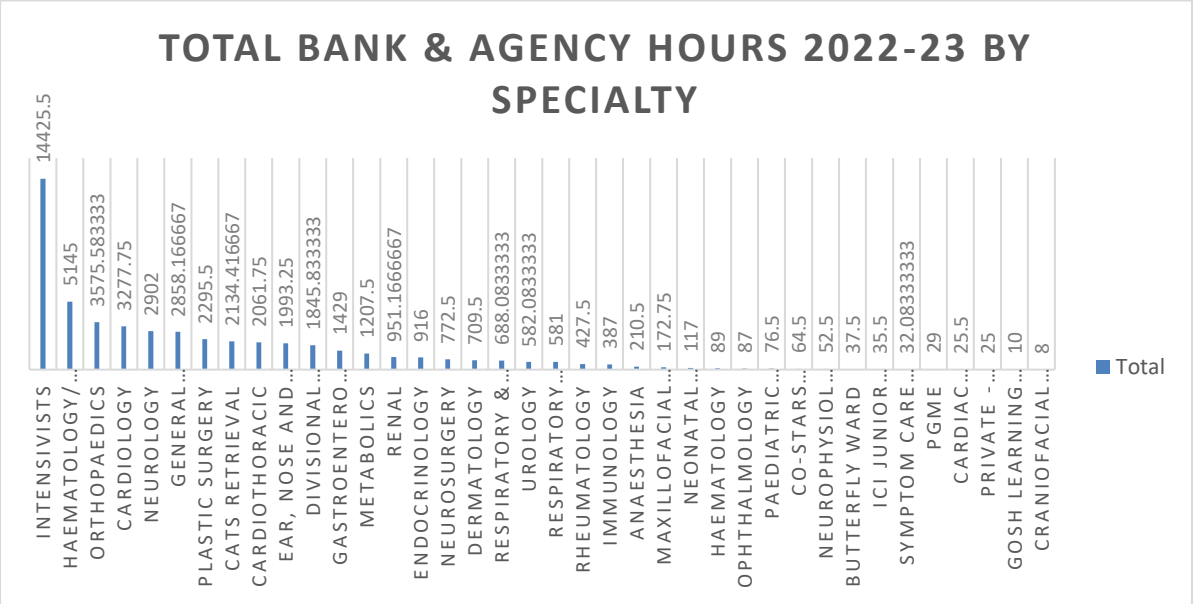
9. Bank Hours

9.1. Bank shifts are primarily filled 'in house' as opposed to locum agencies. Familiarity with GOSH's internal electronic patient record (EPIC) is essential There is significant reliance on internal 'bank' to cover both short- and long-term gaps in rotas across the Trust.

9.1.1. If doctors wish to do work additional shifts, they must be aware of breaching safe working hours; they have responsibility and a duty of care for regulating their own working hours in addition to the organisation. Some organisational oversight is achieved through the rota coordinators who check additional bank shifts for compliance.

9.1.2. It is important to note, that in most cases a large proportion of the hours filled by bank are 'daytime' hours and not out of hours. This suggests that there may not be the numbers required within specialty to maintain safe staffing levels during the day.

9.1.3. The NICU rota required the most additional banks shift support in 22/23. There are 52 'intensivist' doctors across NICU, PICU and CICU 14% of the junior doctor workforce.

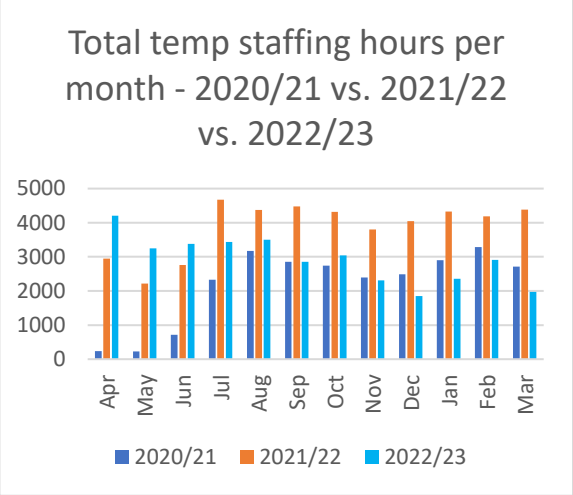


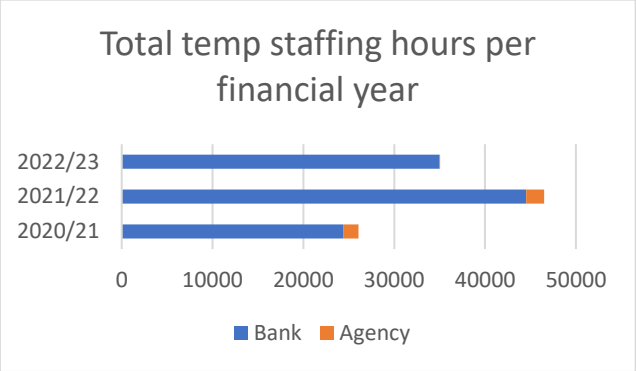
10. Junior Doctor Bank and Agency Spend

10.1. Year to Date bank and agency spend is £2.6M. Note reduction since 2019/20 despite increase in rate in April 2022 and reduction in total bank hours by 24.6% on 21/22

10.2. Rota intervention management (MEGGA to Med 1-3; HaemOnc BMT restructure; H@N 'one team' approach and surgical SHO reconfiguration) has supported safer systems and better value approach.

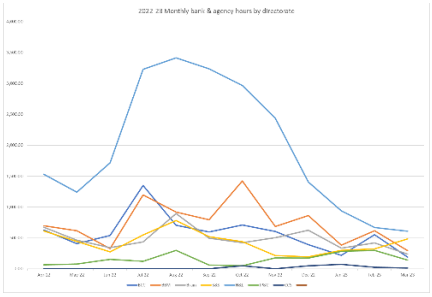
	2019/20	2020/21	2021/22	2022/23
Bank & Agency Spend	£2.79M	£1.62 M	£2.38M	£2.6M





10.3. This data has not been offset by salary savings for vacant posts. Bank costs should be triangulated with salary savings related to vacant posts.

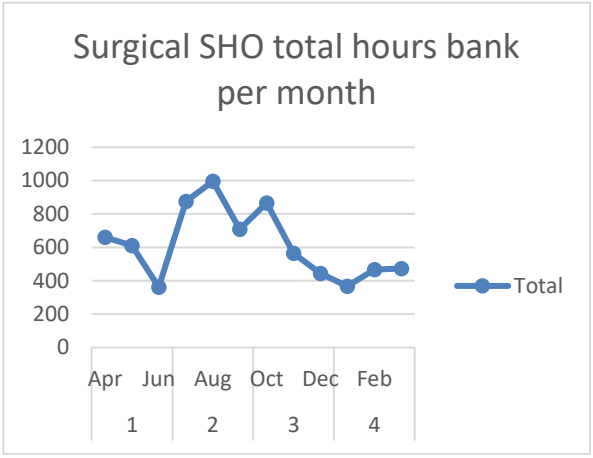
10.4. Heart and lung directorate had the highest bank costs but hosts the intensive care units. Banks spend has been reduced significantly in Q4 22/23.



11. Surgical SHO Rota

11.1. Surgical SHO intervention from September ’22 has improved the safety of the interdependent surgical specialty SHO cover OOH. We have had no exception reports during this time frame, bank spend for OOH work has reduced (please note

this spend below includes daytime speciality vacancy- high in some areas) and SHO doctors report much improved, manageable working structures.



12. Junior Doctors Forum (JDF)

12.1. The JDF continue to run monthly on a virtual forum. Attendance has been variable and recruitment to Junior Doctor Speciality Representative posts requires more focus from directorates.

12.2. General engagement with the junior doctors across the organisation is good. Of particular note is their helpful collaboration and peaceful picket line during the industrial action in March 23.

13. For Board consideration

13.1. Risk related to poor compliance assurance offered by the exception reporting system should continue to be acknowledged.

13.2. Clinical input to rota management and improved data capture of junior medical workforce bank costings has resulted in opportunity to deliver a Better Value culture.

13.3. Focus on improved systems for recruitment and onboarding of doctors in 2023-24 contribute to improve vacancy levels, reduce bank costs, and support safe patient care.

13.4. Most assurance is determined by good clinical leadership, open communication, and sound operational infrastructure to support recruitment, education and training opportunities and rota management.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
8 June 2023

Freedom to Speak Up Service Annual Report **Submitted by:** Kiera Parkes- Freedom to Speak Up Guardian	**Paper No: Attachment 3** ✓ **For information and noting**

Purpose of report

- To provide the committee with an overview of the numbers of cases being raised, themes and support offered by the FTSU service in 2022/23
- To provide an update on the Freedom to Speak Up service for 2022/23 and priorities for 2023/24.
- To highlight any concerns related to our FTSU provision and culture of speaking up

Summary of report

In 2022/23 the service dealt with 161 recorded cases compared to 187 recorded contacts in 2021/22. Unlike the previous two years where bullying/ harassment had been the most raised theme, in 2023/23 staff safety/ wellbeing was the most reported theme with patient safety/ quality of care being the second.
Allied Health Professionals (AHPs) raised the highest number of concerns with the service, with nurses and being the second highest professional group.

The Annual NHS staff survey highlighted some decreases in the speaking up culture within the Trust. There is ongoing work that needs to be done to improve the culture of speaking up in the Trust and ensure that staff feel listened to.

The previous Freedom to Speak Up Guardian who was in post since December 2020 moved to part time work between January and March 2023, with a new full time Guardian taking up the post in March.

The Trust 'Raising Concerns' Policy is currently being updated and should reflect the NHSE policy and guidance for speaking up.

The FTSU service continues to develop new ideas and work in partnership with other key stakeholders to make sure we are improving and providing a high level of service to those needing to speak up, improve access and opportunity and support the Trust to improve the culture of speaking up.

Patient Safety Implications

Patient safety implications are one of the key reasons staff speak up, and the FTSUG role is in place to support this process.

Where a patient safety concern is raised, the Guardian works with and supports the staff member to escalate this or does so on their behalf as appropriate so that there is assurance senior staff have oversight as needed and that actions are in place.

Equality impact implications

None

Financial implications

None

Strategic Risk BAF Risk 12: Inconsistent delivery of safe care BAF Risk 14: Culture
Action required from the meeting To note the report and consider whether the current FTSU service is providing the appropriate level of support for those needing to speak up and that we are contributing to improving the culture of speaking up in the Trust
Consultation carried out with individuals/ groups/ committees FTUS reports into QSEAC and PEAC
Who is responsible for implementing the proposals / project and anticipated timescales? Kiera Parkes- Freedom to Speak Up Guardian
Who is accountable for the implementation of the proposal / project? Sanjiv Sharma, Chief Medical Officer

Attachment 3

Freedom to Speak Up Guardian's Report: May 2023

Introduction

The Freedom to Speak Up (FTSU) service is part of wider programme of speaking up within the Trust and one of several routes to raise concerns. The service offers independent and confidential support to staff members so they can speak up and be heard when they feel unable to do so by other routes. Staff can raise any concerns they may have about the quality and safety of the care we provide or about anything that affects their working lives.

Service Provision, Resource and Governance

The FTSU service is provided by a full-time FTSU Guardian. The Guardian who had been in post since December 2020 moved to part time work between January and March 2023, with a new full time Guardian taking up the post in March. The service is reviewing the FTSU ambassador role which has been less defined at the Trust since the National Guardian's Office (NGO) changed the nature of the role to not being able to carry out case work.

The Guardian works in partnership with the Associate Medical Director responsible for speaking up and a range of colleagues across the Trust to support and improve a culture of speaking up.

The Guardian meets regularly with the Medical Director, Chief Executive and other senior leaders to provide updates, escalate concerns, and provide an overview of themes. The Guardian also meets with the non-executive director (NED) who is responsible for FTSU and for Whistleblowing. The Guardian establishes good working relationship with HR colleagues (meeting regularly with the HR Business Partners for example), and other key stakeholders.

The previously existing relationship between the Guardian and internal communications team has been invaluable in continuing to promote the service, and to help share the message of a change in post holder across the organisation.

The FTSU Guardian provides quarterly data to the National Guardians Office (NGO) and reports to the Quality, Safety & Experience Assurance Committee, and the People & Education Assurance Committee.

The role of the Guardian and support structures

The Guardian provides confidential and independent advice and support to our staff to raise concerns when they feel unable to do so through other routes available to them, or when they feel these have not been successful. Staff can contact the Guardian via email or by phone/ text message, and we are continuing to look at ways of increasing access to the service for all colleagues.

Feedback has highlighted the importance of the service for the wellbeing and empowerment of staff to speak up in future with many staff commenting on the approachability and support of the Guardian once they had made initial contact.

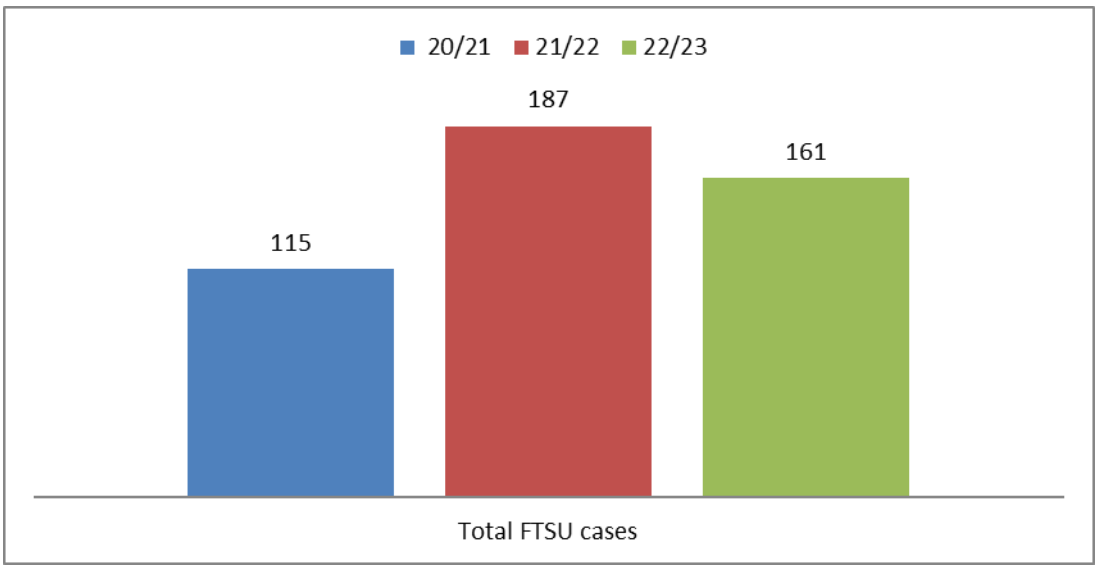
The service also promotes awareness of speaking up pathways and supports the Trust to promote a culture of speaking up and listening up. An important part of the Guardian role is to support managers and leaders in the Trust to listen, act as required, and then feedback to those raising concerns.

The Guardian sits on the Health & Wellbeing Steering Group and the Diversity & Inclusion Steering Group and attends the Staff partnership Forum to support the strategic development of a positive speaking up culture.

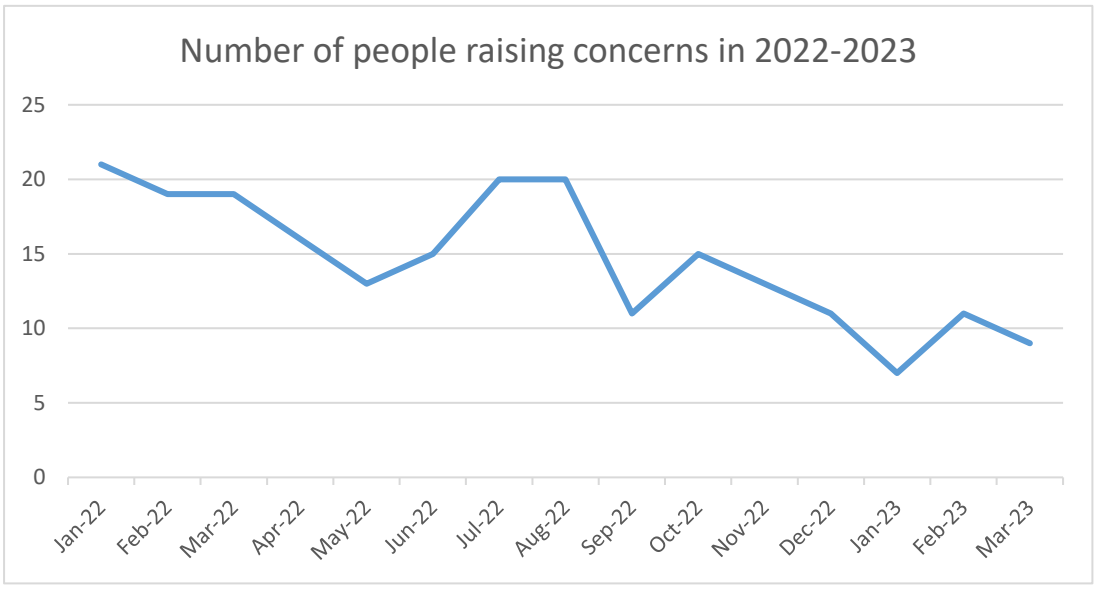
The role of the Guardian is unique in any organisation given the nature of the confidential support they offer and their position of independence. The Guardian meets with the with the Responsible Officer every 2 weeks at minimum, and the new Guardian will receive monthly supervision from an external provider. There is also support available from other Guardians through the regional and national networks established through the National Guardian's Office.

An area of development that requires ongoing review is how we provide a consistent FTSU service throughout periods of annual leave and any other absence of the Guardian.

Total number of FTSU contacts per year



In 202/23 the service dealt with 161 recorded cases compared to 187 recorded contacts in 2021/22. The following graphic shows the monthly contact figures since the start of 2022:



Comparing and benchmarking against other Trusts is complex given how organisations/Guardians identify and report speaking up concerns, what processes are in place other than the FTSUG role to hear concerns and what the culture is like within the organisation around speaking up. Access to the quarterly data submitted to the NGO by other Trusts is in the public forum and at the time of writing this report Q4 and annual data was not yet available. Comparing Q3 data to other children's hospitals Alder Hey and Sheffield Children's could be helpful, although it should be noted that those organisations submit data as a "small" organisation (less than 5000 staff) and GOSH is classed as a "medium" size organisation (5-10,000). GOSH reported 39 cases brought to the FTSUG in Q3 2022/23, Alder Hey reported 16 cases and Sheffield Children's reported 27. For the 2021/22 financial year across the three organisations- GOSH 187, Alder Hey 43 and Sheffield 74.

Further work may be needed to better understand how the speaking up data from other Trusts can influence good practice at GOSH and one area of learning for the coming year is to seek further engagement with the Guardian networks.

Demographics of people raising concerns

We ask colleagues who raise a concern through the FTSU service to provide demographic data that is recorded in an anonymised way to help the organisation see who is using the service and who may be experiencing barriers to speaking up. We invite people to provide as much information as they feel comfortable to and advise them that they do not need to provide any information. Of those that responded this information is detailed below but it should be noted this does not provide information related to all staff who accessed the service or for all demographics:

Gender	• 75 % identified as female • 23% identified as male • 2% identified as non-binary/trans
Ethnicity	• 36% identified as being from an ethnically diverse community • 64% identified as being from a white community
Sexuality	• 79% identified as straight • 11% identified as LGBTQIA+ • 10% information not available
Long Term Health Condition /Disability	• 23% identified as having a long-term health condition or disability
Age	• 5% 18-24 years • 40% 25-34 years • 30% 35-44 years • 16% 45-54 years • 6% 55+ years • 3% unknown

The Trust's Diversity and Inclusion Update (June 2022) showed that as of May 2022 the Trust's BAME staff representation was 36% and that the workforce was 76% female and 24% male. As reported last year, lesbian,

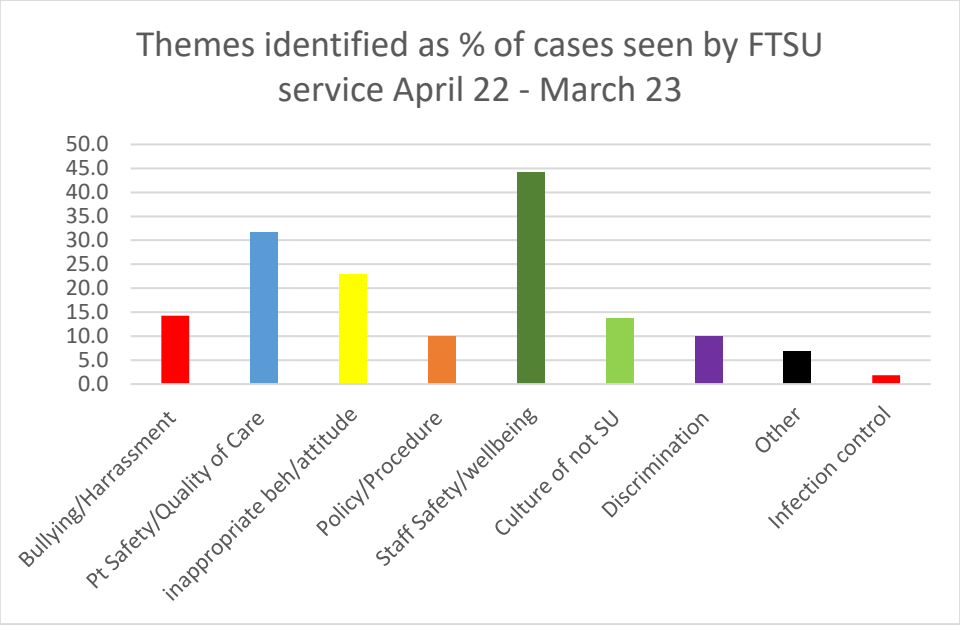
gay and bi-sexual colleagues were represented slightly higher in terms of speaking up data than the workforce data, and the numbers of people identifying with a disability or LTHC was significantly higher than those who identified with a disability in the D&I annual report. The majority of staff contacting the service were aged between 25 and 44, which is reflected in the workforce with 62% of staff in the D&I report stated as 40 or under.

In the coming year we will continue to review this data to help understand which groups may need increased support to access the service as well as looking at how the data is requested.

Themes of concerns raised

Reporting to the National Guardian's Office (NGO), requires us to highlight the number of cases with an **element** of a particular them.

For the purposes of this report, the main NGO set themes plus other consistent themes that have been raised by staff at GOSH have been included. In many cases, more than one theme is identified.



Many cases were complex and involve elements relating to several themes. Staff safety/ wellbeing was the most reported issue raised. In most cases this was related to wellbeing rather than staff safety and in many cases another concern (for example patient safety or bullying) was also impacting the staff member's wellbeing. These included themes of concern related to staffing levels, not being able to take leave or complete mandatory training, the process of formal investigations and relating to speaking up. There were also cases of staff who experience mental health issues and discussed support/ approach from the Trust relating to this.

Patient safety and quality of care was the second highest concern raised followed by cases that had an element of inappropriate behaviour/ attitude (such as micro aggression, use of tone and intimating behaviour, bullying/ harassment or reported issues relating to a culture of not speaking up. Patient safety issues raised included concerns relating to infection control, staffing levels, the impact of difficult relationships with colleagues, team working, safe practice of colleagues and training in relation to procedures for which consent is being taken.

Staff were supported to escalate these concerns themselves or with help from the Guardian who had assurance these were being actioned appropriately.

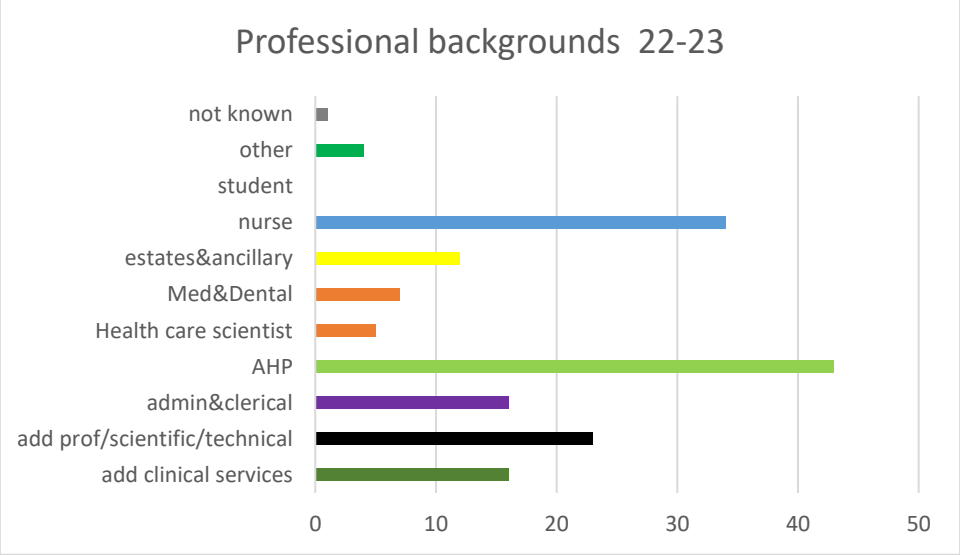
Bullying and Harassment was the highest reported theme in 2020/21 and 2021/22 and there has been a decrease in the number of staff contacting the FTSU service relating to this over the last year. In relation to a culture of not speaking up, these related to not feeling heard when speaking up particularly prior to contacting the FTSU Guardian and several of these related to one service with which there is ongoing work being carried out.

Concerns relating to policy and procedure were about sickness, recruitment and flexible working processes and staff feeling these were not being applied in line with process.

Several concerns were raised relating to experiences of structural/institutional racism within the Trust and unconscious bias from senior managers, many staff did not want to raise these formally but wanted their voices to be heard. This highlights an ongoing problem of how to support people to escalate concerns whilst also actively supporting the institution and individuals to recognise and challenge bias and discrimination when people do not use formal processes. It also highlights the important work the Trust is doing to tackle discrimination and promote equality and equity.

Several contacts with the FTSU service led to formal investigations under the appropriate Trust policies. As seen in the previous year, some of these processes understandably take a long time to reach an outcome or for change to be enacted, which is reflected in some feedback from staff about their experience of speaking up. The Guardian also spoke to some staff over the year who did not want to escalate via formal processes such as Grievance or Dignity at Work policies, which highlights another potential learning point for the organisation along with the experiences of staff who felt they had not or would not be heard when escalating concerns.

Professional backgrounds of people raising concerns



The NGO changed the professional groups for reporting data for 2022/23. The most significant changes were separating administrative and clerical colleagues and estates and ancillary colleagues into distinct groups.

Additional clinical services include those supporting clinical care such as HCA/nursing assistants. Additional professional/scientific/technical services include psychologists, social workers, pharmacists, and other technicians

Colleagues from Allied Health Professionals were the most frequent group to raise concerns with the Guardian, with nurses the second highest group. As discussed in the 2021/22 FTSU report the Guardian had worked with the AHP lead and senior nursing colleagues to promote and support speaking up amongst those professional groups alongside others. In the coming year the service will continue to review ways of working with different staff groups, particularly those who have accessed the service less frequently.

Anonymous cases and confidentiality

All information shared with the Guardian is confidential unless the colleague agrees for it to be shared, or there is significant risk that requires escalation.

Three cases were raised anonymously in 2022/23 compared to 2 in 2021/22 and 8 in 2020/21. Although the majority of colleagues felt able to share their identity with the Guardian, staff often expressed concern about this being shared if the Guardian escalated on their behalf, and there was frequent discussion with staff who were worried how they would be treated if they took matters forward themselves. This indicates that there is still work to be done in the organisation to improve psychological safety and the speaking up/ listening up culture.

Experience of disadvantageous or demeaning treatment (detriment)

This is a complex area to understand given that detriment can be both a real and perceived in experience. The NGO requires Guardians to report detriment if the staff member raising the concern explains this as their experience. If a colleague feels they have been treated this way, the concern should be taken seriously, and the Guardian will support the person to have their voice heard and the additional concern investigated appropriately and proportionally.

One staff member who contacted the FTSUG in 2022/23 reported they had experienced disadvantage or demeaning treatment (detriment) due to speaking up, compared to five people in 2021/22. This colleague was supported by the Guardian and the issue escalated to HR for review.

Feedback about speaking up in the organisation

Everyone who accesses the service is asked to provide feedback on their experience of the FTSU service and of speaking up in the Trust with two questions- 1) Please tell us about your experience of using the FTSU service and 2) Would you speak up again? It is important to note that the second question can be interpreted as speaking up generally (rather than strictly about raising concerns to the FTSUG) and also that not all staff provide feedback as it is optional.

All staff who provided feedback described working with the Guardian positively, with many commenting on the speed at which initial discussions were arranged, and the empathetic and supportive advice they received. Some colleagues described not having initially known that the service was available and there continues to be work aiming to increase the profile of the service across the Trust.

91.3% staff who provided feedback to the second question said they would speak up again in the future. Of those who were unsure (6.5%/ N=3) or would not speak up again (2.17%/ N=1), the information shared related not to the FTSUG service itself, but to feeling not being heard by the wider organisation, there not having been significant change/ clear learning, or feeling that they had not received feedback. The FTSU Guardian works to

help ensure cases raised via this process receive feedback as to action taken, whilst supporting a wider need for training for those in leadership and line management roles to be able to listen up and follow up.

The staff who reported they would speak up again in future identified that the FTSU service supported them to feel heard, enabled them to work through potential ways forwards, and supported them with this process.

There is still a large proportion of staff do not provide feedback, and therefore their experiences of the process are not known. There will be a further exploration of the feedback system to see if there are more successful ways of doing this, for example amending the questions and/ or enabling feedback to be provided anonymously.

i-speak up platform

Alongside the FTSU service, the Guardian also co-ordinates the i-speak up platform which was launched in October 2020 and allows people to anonymously provide feedback about a colleague's perceived unprofessional behaviour. For the financial year of 2022/23, 11 people raised concerns through this platform (compared to 26 the previous year) with 6 of those concerns leading to peer messenger conversations. The Trust is committed to reviewing the channels available for staff to use to enable them to raise concerns and it is recognised that not all staff groups have equal access to electronic platforms.

Speaking up, Listening Up and Following Up training for staff

Since April 2021 the Trust has been providing a package of national and local training around speaking up via GOLD (the Trust's learning platform) and this continues to be part of induction for all new staff. Information about how to contact the FTSU Guardian is included in the materials staff receive on induction, and all new starters are required to complete the NGO "speaking up" training alongside the Trust "speak up for safety" session.

The NGO "listening up" training for line managers which helps them to support staff, and the "Following up" training module for senior leaders are also embedded into GOLD. In the coming year uptake of this learning will be reviewed to help understand needs for further promotion.

The Guardian also delivers bespoke teaching sessions around the speaking up process regularly across the Trust.

Staff survey results

The survey results relating to speak up indicate a decrease in staff confidence in speaking up and the overall process.

- 73.6% of respondents said they would feel secure raising concerns about unsafe clinical practice (**-2.4%** v last year (LY). National average (NA) 75.4%. NA v LY -3.3%).
- 58.8% said they were confident that the organisation would address their concern (**-4.5**% v LY. NA 64.0%. NA v LY -2.9%).
- 65.2% said they would feel safe to speak up about anything that concerns them in the organisation (-1.7% v LY. National average 67.5%. NA v LY -0.9%).
- 51.3% said that if they spoke up about something that concerned them that they were confident the organisation would address their concern (-3.8% v LY. National average 55.3%. NA v LY -3.2%).

Understanding the reasons for staff feeling this way is an important piece of work for the organisation, in order to help improve the psychological safety of staff and support the speaking up culture.

Visibility and partnership working in 2022/23

Throughout the year the Guardian continued to attend a range of team meetings across the Trust to promote a culture of speaking up and provide information about how to speak up and listen up, as well as delivering training to groups across the organisation including International Nurses and other nursing development courses and trainee AHPs. The Guardian has worked to continuously raise the profile of the role, including appearing on the 'Big Brief', updating the intranet pages with video content about the service, infographics, staff feedback and other resources. This is believed to have a positive impact on staff accessing the service and helping to build trust in the Guardian's role.

Working in partnership is key to improving speaking up culture and the Guardian works actively to support the staff forums, this year particularly working with REACH and PRIDE. The Guardian in post for most of the year is part of the White Allies programme, developed by NHS England and Improvement London, The Kings Fund and BRAP. The focus of the work is to support the Trust around race equity and in embedding the equality, diversity, and inclusion agenda.

The Guardian is also part of the London and national networks of Freedom to Speak Up Guardians which are forums to share ideas of best practice and help understand the work that is being done across the country to improve speaking up culture.

Developments/action plan for 2023-24

The new Guardian will continue working with other key stakeholders to improve visibility and access to the FTSU service for everyone working at GOSH. The Guardian is keen to continue attending team/ departmental meetings and teaching days for different professional groups and will continue to support the Band 6 Nurse and International Nurses development pathways amongst others. Information on the intranet has been updated along with further review of these resources, and the Guardian is working with the internal communications team to produce new posters and speaking up leaflets that will be distributed across the hospital.

Alongside the Trust safety transformation programme other initiatives are being considered in order to review how learning from speaking up can be further shared with the organisation whilst maintaining confidentiality, as well as how this learning can be triangulated with other safety intelligence across the organisation (for example as part of the preparation work for the Patient Safety Incident Response Framework).

In order to help continually review and improve the service, methods of requesting and collating demographic data and feedback relating to speaking up from colleagues will be explored, along with consideration of a bespoke database. We will also be exploring ways of improving accessibility to the Guardian including physical space for meeting and anonymous reporting,

The Guardian will work with other key stakeholders across the Trust to support a culture of speaking, listening and following up which is essential based on feedback received and the staff survey results.

In 2022 NHS England published the new Freedom to Speak Up guidance and policy. All NHS organisations and required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Update of the current policy is being led by HR colleagues and the Freedom to Speak Up Guardian will be involved in supporting this. NHSE is asking all Trusts to update the local Freedom to Speak Up policy to reflect the new national policy template; assess the Freedom to Speak Up arrangements against the revised guidance; and create and work to a Freedom to Speak Up improvement plan.

Reviewing the FTSU Ambassador role is also a focus for the beginning part of 2022/23 alongside exploring how the service can work with other staff support roles in the Trust such as the new wellbeing Ambassadors and Champions.

Action Plan/ Priorities for 2023/24

1) To undertake a structured review of the FTSU provision using the NGO gap analysis tool to improve the support structures, processes, and culture of speaking up.
2) To assess the service against the new Trust policy when completed, and create an improvement plan as per NGO/ NHSE request
3) Continue to work closely with the D&I lead and staff networks, and to better use and understand our demographic data to improve our speaking up culture
4) Continue to review ways by which all staff groups can access the service
5) Review the ambassador role and explore how the service can work alongside other support roles, as well as consider how the service can be maintained in periods of Guardian absence

Kiera Parkes, Freedom to Speak Up Guardian

May 2022

Summary of the Audit Committee meeting held on 20th March 2023

Matters arising
An update was provided on the rise in line infections and the metrics in the Integrated Quality and Performance Report which would contribute to the identification of overly high activity levels. The increase in line infections had reduced back down to near usual levels and safe staffing metrics were positive. Activity was at optimal levels of 83-84% and would continue to be monitored. There an been an increase in infection in one service and a number of actions were in place; a paper would be presented to QSEAC.

Trust Board assurance committee updates
The Committee received updates from the following assurance committee meetings:

- Quality, Safety and Experience Assurance Committee –January 2023
- Finance and Investment Committee – February 2022 and March 2022
- People and Education Assurance Committee – January 2023

Board Assurance Framework Update from the Risk Assurance and Compliance Group
The Committee discussed the key risks which would be included in the Annual Governance Statement and agreed that cyber security should be added to the existing agreed list of risks: Financial sustainability; operational performance; medicines management and estates compliance.

The Committee agreed:

- The wording of a risk related to GOSH's operation as part of an integrated care system, subject to a minor amendment
- To remove the strategic positioning risk
- To develop health inequalities as a separate risk
- The proposed wording of the climate emergency risk subject to a minor amendment
- The proposed wording of a risk around the delivery of mental health services
- To downgrade the information governance risk to a trust-wide risk as a result of the controls and assurances in place.

BAF Risk 3: Operational Performance
The Committee noted the challenges of increasing compliance with the metrics set out in the Integrated Quality and Performance Report in the context of industrial action. Discussion took place about the potential impact of a partial move to *payment by results* and the risk around the importance of data quality and institutional memory prior to the introduction of the block contract. There had been a reduction in scores in all areas of the staff survey and benchmarking data showed that GOSH's scores may have reduced more than those of other Trusts. It was possible that this was linked to the increase in activity above 2019 levels. The Committee said that it was important to reach an optimal balance of activity beyond which there were diminishing returns. It was noted that some key metrics on the IQPR were red rated, and opportunities were considered with North Central London ICS and the Children's Alliance to work collectively and allow mutual aid.

Interim update on Root Cause Analysis of Unplanned Power Interruption including Data Centre resilience
An RCA was ongoing related to two unrelated incidents which had occurred simultaneously. The importance of focusing on developing up to date planned preventative maintenance and the Computer

Aided Facility Management (CAFM) system and the Committee noted that the Executive Management Team had approved additional resource to focus on CAFM. It was anticipated that most buildings would be managed by CAFM in three months' time. It was confirmed that no immediate changes to the programme were required in order to maintain patient safety and the 10-year capital plan supported the update of equipment as required.

BAF Risk 7: Cyber Security
Considerable work had been undertaken over the previous two years to implement tools that supported monitoring for abnormal cyber activity and auditing access. An annual cycle of both internal and external penetration testing was in place and positive results had been received from the testing in the previous year in which no critical or high alert items had been identified. A monthly cyber dashboard was provided to the ICT programme board, Information Governance Steering Group and Operational Board and reporting around patching was ranked by NHSE as part of a whole cyber ranking. The ICT team was working closely with directorates, finance and procurement on shadow IT and the importance of devices and systems being subject to a Data Protection Impact Assessment.

Revised Risk Management Policy
Following comments at a previous audit committee, the revisions to the Risk Management Policy had been limited to key updates including an update to the frequency of reviewing high risks in the Trust. The Audit Committee agreed that a monthly update to high risks was appropriate. The Committee emphasised the importance of procuring a new or updated risk management system and requested that an update was provided at the next meeting including a definitive date for procurement and implementation.

Annual overview of Better Value programme for 2022/23 and looking towards 2023/24
The Committee discussed the importance of moving towards a multiyear programme including a smaller number of more transformational schemes over a two-to-three-year period. Discussion took place around the potential to continue to make cost savings and the Committee noted that there was potential, but it was important that staff were engaged with the process. The planning for better value had slipped and focus would be placed on the area in the coming weeks with a high-level plan and specific deliverables for year end 2023/24 in place by mid-April.

Losses and Write offs
The Committee requested that all write offs were appended to the paper going forward.

External Audit 22/23 Progress update
The work on the external audit was broadly in line with plan and the audit partner was comfortable with the progress being made.

Internal Audit Progress Report
Four final reports were received:

- Directorate Governance – Significant assurance with minor improvement opportunities
- Harm Review Process – Partial assurance with improvements required
- Data Security and Protection Toolkit – Significant assurance
- Digital Health Record Information Governance Report – Advisory only, no rating provided.

Three medium priority actions were overdue, two of which had been impacted by the strikes and the due date had been revised to October 2023. It was anticipated that the remaining action would be closed by the end of March 2023. The Committee expressed disappointment at the outcome of the harm review audit, and it was agreed that a the revised process and plan to audit its implementation would be reviewed by the RACG.

The Committee discussed the EPR Go Live of another London Trust with whom GOSH was sharing its platform. It was confirmed that Go Live had gone well and the Committee highlighted the importance of following up the actions post go live.

Counterfraud Update 2022/23
A number of areas of the functional standards tracker remained amber but work was taking place to move towards green in these areas. It was likely that all metrics would become green except for Declarations of Interest in which the Counter Fraud Authority required 100% compliance.

Year-End Update
There had been an update to the index used in the valuation of land and buildings which had led to an increase in the net value of £20.3million. This had not yet been reviewed by the external auditor's property specialist. Consideration was being given to the point at which accelerated depreciation of the frontage building should begin and it was agreed that this was likely to be when the funding agreement had been signed.

- Credit Note Provision (IFRS 9)

The Committee discussed the provisioning methodology which was in place and noted that IFRS9 required an evidence-based judgement to be made. The audit partner noted that there was no history of bad debt or write off except in the case of a failed state and payments made during the pandemic had shown that there was intention to pay.

Annual effectiveness review of the RACG
A desktop review of RACG had taken place and would be presented to QSEAC. It was noted that an independent review of the RACG was carried out via the Well Led Review and the internal audit review of the Board Assurance Framework.

Summary of the Quality, Safety and Experience Assurance Committee meeting held on 29th March 2023

Quality and Safety at GOSH – Chief Medical Officer Report

A Global Ministerial Summit on patient safety hosted by the World Health Organisation had focused on 'implementation' highlighting the number of deaths due to avoidable harm globally each year. Discussion had also taken place on co-production and also quantitative measurement which were also priorities for GOSH.

Strike action continued which was operationally disruptive and the Trust was working to ensure that as much notice as possible was given to patients and families whose appointments were affected.

The Committee discussed the staff survey results which had reduced in all areas. Benchmarking data showed that there had been a slightly greater reduction at GOSH than other Trusts and the committee agreed that it was important to consider the feedback provided and flex the plan around staff wellbeing where necessary.

On the horizon

A review of benchmarking had taken place showing that in some cases benchmarking like-for-like patient safety data is not an effective method of comparison and considering standardised themes and trends would be more helpful.

Audits had taken place of risk action group meetings to score the content and discussion and it had found that meetings were variable between directorates. Work would take place to standardise meetings whilst also supporting teams to discuss areas which were important to them.

Quality and Patient Experience: Chief Nurse Report

There had been an increase in complaints in the context of increased activity and a review had taken place of complaints in one directorate which was receiving more than others and support was being provided to manage the complex complaints. A review was taking place to identify any trends. There had been a reduction in response rates for the Friends and Family Test and this was being monitored. Feedback had been received about a lack of play available for patients at weekends and volunteers would be coming back into the Trust at weekends and activities such as the art cart and weekend club would be resuming. There had been a delay to the start of the external safeguarding review because of the volume of information involved. Reviewers would now come on site in April 2023. A peer review of the Trust's learning disability service had been undertaken by another paediatric Trust and the team was awaiting receipt of the report. There had been an increase in pressure ulcers and a deep dive had taken place. Ulcers had now reduced to previous levels and contributing factors had been around patient acuity and patients on continuous positive airway pressure (CPAP) and extracorporeal membrane oxygenation (ECMO).

Update from the Risk Assurance and Compliance Group on the Board Assurance Framework

The RACG continued to work through the actions agreed at the Board Risk Management Meeting in December 2022. A mental health risk had been approved and the Audit Committee had reviewed the proposed wording at its March 2023 meeting and recommended it to the Trust Board. The Committee highlighted the importance of considering mental health services at GOSH in the round as opposed to inpatient provision only and agreed to recommend the proposed wording of the risk to the Trust Board for approval.

Draft QSEAC Annual Report 2022/23

The Committee noted the draft annual report and agreed to provide any comments outside the

meeting. The volume of work undertaken by the committee was noted and the committee highlighted the importance of ensuring that the work undertaken was in line with the Executive Team's priorities.

High Dependency Care (HDU) Options Appraisal Project

An overview was provided of the project to develop and review options for HDU provision at GOSH focusing on the safest model. The Committee noted that definitions of HDU care were not standardised throughout the Trust and data quality was key to accurately identify the volume of HDU activity. Patient experience was an important component of the project and discussion was taking place with the Young People's Forum as well as being scored as part of the model.

Update on Better Value Programme

The largest number of equality and quality impact assessments had been signed off and discussion had taken place at the Finance and Investment Committee about the number of small schemes which had been identified. A dashboard of indicators was being developed and the committee noted that there was no indication of an adverse impact of Better Value on quality and safety. The committee emphasised the importance of considering health inequalities as part of the equality impact assessment process.

Internal Audit Progress Report (Quality focused reports)

One quality focused report had been completed since the last meeting on the Harm Review Process and a rating of *partial assurance* had been provided. It had been found that a process had been agreed centrally in the Trust but had not been embedded and was therefore being applied inconsistently across directorates. The matter would be discussed at RACG to provide clarity around roles and responsibilities and ensure that an audit process was in place. The committee expressed disappointment at the outcome of the review and said that it was important that it acted as a catalyst to drive improvement.

Freedom to Speak Up Guardian Update

The new Freedom to Speak Up Guardian gave an overview of her observations in the role. She said that some staff had been hesitant to report datix incidents due to a concern about a potential negative impact. The committee reiterated the importance of accelerating the work on psychological safety and ensuring a feedback loop was in place to ensure that staff were clear about the action that had been taken as a result of their reporting.

Health and Safety Update

The Committee welcomed the continued improvement around safer sharps and a report around fire safety which had provided a rating of 'excellent'.

Escalations to Board and deep dives for next meeting#

It was agreed that the following matters would be escalated to the Trust Board:

- Internal audit on the harm review process
- HDU options appraisal project
- Positive external report on fire safety
- RACG update – recommendation of the wording for the mental health risk.

Governor feedback

Governors and NEDs discussed the increase in pressure ulcers which had previously been identified and the appointment of a 0.5WTE tissue viability nurse and the replacement of mattresses. Governors also highlighted the importance of considering staffing levels throughout the organisation in terms of best practice.

Attachment: 6

Summary of the People and Education Assurance Committee held on 23 May 2023

Focus of Meeting

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

Board Assurance Committees

The Committee noted the summaries from the Audit Committee and Quality, Safety and Experience Committee held in March 2023 and the Finance and Investment Committee held in February, March and May 2023.

Workforce Metrics Update

The Committee was updated on the six key workforce metrics, of which three achieved or exceeded their target in March 2023 (vacancy, agency spend and statutory and mandatory training). Turnover rates for March 2023 increased to 14.4% and have been above target for four of the last six months. Although turnover reduced during the pandemic, reducing to a low of 10.7% in March 2021, since then it has returned to the longer-term average of near or above the target for the Trust. The Committee was informed that there would be a deep dive into turnover presented at the next meeting. Sickness absence remains above the Trust target at 3.3% but this remains considerably lower than the NHS national average. PDR is within 10% of achieving the Trust's target of 90% and an improvement on the 12-month average. The Committee wase advised that HR Business Partners are engaging with directorates to address the areas below target and that a project to improve the PDR process is underway.

Nursing Workforce Assurance Report

The Committee heard how the registered nurse vacancy rate remained below the Trust target at 8.02% and that the voluntary turnover had decreased to 16.45%, meaning the Trust had the second lowest turnover in NCL and it was lower than pre-pandemic levels. Sickness levels had improved and were 3.38% in March, above the Trust target but at these are starting to stabilise. The Trust was pleased to welcome 41 newly registered nurses in quarter 4 with a further 146 in the pipeline for October 2023 and January 2024. The Committee discussed retention and reflected on issues raised by staff which impact their decisions to stay at GOSH, such as accommodation and travel costs. The Committee was informed that these are being considered as part of a retention plan being developed and launched as part of the new Nursing Strategy. As requested, the nursing workforce report included the data for each ward, so the Committee was able to see segregated data across the Trust.

Biannual Safe Staffing Establishment Review

The Committee was provided with assurance that the arrangements are in place to review the safe staffing establishment and that the process is compliant with the Development Workforce Safeguards guidance (NHSE 2018). Overall, the review found that current establishments are insufficient in some areas to support safe staffing because of rising patient acuity and complexity post pandemic, in addition to increasing activity because of delays and backlogs. Additional senior positions have already been put into place where insufficient establishments were identified, and work continues to look at the skill mix on wards to make sure experienced staff are available. The focus for the coming year is to increase recruitment of experienced nurses, improve the retention of existing specialist nursing workforce and improve the support and senior oversight of the junior workforce through a number of initiatives, which will be outlined in a new retention plan as part of the Nursing Strategy.

Internal Audit Update

The Trust's Internal Auditors provided an update on the progress made with implementing the recommendations from their review of Above and Beyond: People Planet. The audit provided significant

assurance with minor improvements and the recommendations are being considered as part of the People Strategy refresh and are expected to be implemented by October 2023.

Overview of the refreshed People Strategy
The Committee was presented with an update on the refresh of the People Strategy and updated on the developing programmes of work based on the four elements - culture and engagement, building a sustainable workforce, developing skills and capability and processes, systems and infrastructure. The committee noted the ambitious programme and discussed how this would be communicated and embedded within the organisation.

GOSH Learning Academy (GLA) Update
The Committee heard how the overall status for the GLA programme remains on track. Implementation of the recommendations from the midpoint review have commenced as Phase 2 of the GLA programme of work commences. Progress to date has included recruitment into succession planning roles of Co - Director and Deputy Director of Education, appointment of a Chair for the new External Advisory Board, and approval of Phase 2 budget and financial forecasting model as the GLA transition to sustainability. Recognising the depth, breadth, and scale of the GLA programme, Phase 2 sees the implementation of a new, improved governance and reporting structure for the GLA to ensure robust monitoring of impact, deliverables and outputs, whilst providing assurance on financial sustainability, risk, and performance metrics. The new structure was approved at the GLA Executive Oversight and Assurance Committee in April 2023. The Committee congratulated the GLA on its progress and achievements to date.

Internal Communications, Engagement and Cascade
The Committee received a presentation on the achievements against the internal communications and engagement objectives of the People Strategy 2019-22 and heard about the programmes being supported in the refreshed People Strategy. Members discussed the cascade of information within the organisation and work undertaken to improve the flow of information. The new process is being piloted with a number of areas and the feedback will be considered before implementing Trustwide.

Employer Value Proposition (EVP)
The Committee was presented with GOSH's EVP that has been developed with the support of an external advisor (on a pro bono basis) to support the People Strategy. The EVP describes the many benefits or working in an organisation and is aimed at attracting top talent and retaining current employees. The new EVP, *Always striving for better*, has been designed with three pillars which are examples of how GOSH employees always strive to do better. The Committee discussed the strapline, *Together, we do amazing,* and in particular concerns arising from using a grammatically incorrect statement, especially in an institution which involved education. The Committee was told of the consultation process involved in its development. The Committee then heard how the new EVP will be rolled out across the organisation and was presented with examples of the new materials in development.

Staff Survey Results and Action Plans
The committee agreed in the interests of time to have this discussion at a later board development session that is dedicated to culture.

Staff Voice: Brain Directorate and Research and Innovation Directorate
The Committee welcomed Alison Taberner-Stokes, Head of Nursing, Zoe Hallett, General Manager and Robert Robinson, Deputy Chief of Service from the Brain Directorate and Jenny Rivers, Director from the Research and Innovation Directorate. Each directorate representative talked about actions they are taking to support staff within their directorates. They recognised that their plans were drawn from a number of feedback and information sources throughout the year and not just the staff survey results. The Committee heard how the Brain directorate is focusing on building the talent within its workforce

and recognising the achievements of staff. They felt upskilling staff and boosting morale through improved communication is having a positive impact across the directorate. The business continuity structures implemented during the pandemic helped to cascade information and so some of this has continued through regular team and leadership huddles with the idea of also creating a directorate blog in the future. Whilst a smaller directorate, research and innovation found they were focusing on similar themes. After the pandemic they continued a weekly meeting, now every other week, to help support the flow of communication. There are challenges around accountability for middle level leadership and the expectation that as senior managers they have a role to play in the cascade of information. The directorate held a leadership day where, using the Disney creative model, they picked out themes to focus on and most of these were shown to be in the directorate's control to improve. Leaders have gone away to consider these in their areas and will come back together later in the year to share their progress. The response rate to the annual staff survey in research and innovation was a lot lower than other areas so work is underway to try and understand the reasons for this.

Freedom to Speak Up update and Annual Report 2022/23
The Committee welcomed Kiera Parkes, the new FTSU Guardian to her first PEAC. The update focused on the annual report and the committee was informed that the service dealt with 161 recorded cases, compared to 187 the year before. Many cases were complex and involve elements relating to several themes. Staff safety/wellbeing was the most reported issue raised. In most cases this was related to wellbeing rather than staff safety and in many cases another concern was also impacting the staff member's wellbeing. Patient safety and quality of care was the second highest concern raised followed by cases that had an element of inappropriate behaviour/ attitude. There were three cases where staff wanted to protect their identity this indicates that there is still work to be done in the organisation to improve psychological safety and the speaking up/ listening up culture. Developments and actions plans in 2023/24 will focus on communication both internally and with key stakeholders to improve visibility and access to the FTSU service for everyone working at GOSH.

Staff Focused Whistleblowing Concerns
The Committee was informed there were no new concerns during the reporting period (January 2023 – May 2023).

Update on the Board Assurance Framework (BAF)
The Risk Assurance and Compliance Group (RACG) had reviewed half of all BAF risks, and the Committee was updated on the three BAF risks over which PEAC has oversight, namely workforce sustainability, culture and the GOSH learning academy. The Committee was content with the proposal from RACG to increase the net score for workforce sustainability due to the continuation of the recent trend of increased turnover exceeding the Trusts target. Following the recent revision to the risk statement for BAF Risk 14 – Culture and following the discussion at RACG, the Committee were content with the proposed risk score and risk appetite. The Committee was also content with reducing the risk score of BAF Risk 16 – GLA following the successful awarding of the full GOSHCC grant and commercial income achievement. The committee agreed to move its deep dive discussion to the board development session focused on culture.

PEAC Annual Report
The Committee was presented with a report of its activities through 2022/23 for inclusion in the GOSH annual report and asked to feedback any comments to the Deputy Company Secretary.

END

Attachment 7

Finance and Investment Committee update

Since the last report to Trust Board on 30th March 2023 there have been one meetings of FIC as follows:

Date Meeting type	Summary of meeting purpose
12May 2023 Scheduled meeting	A standard agenda: Finance report, Performance report, Capital Projects update as well as an update on Trust procurement, Sustainability and a first review of the Board Assurance Framework (BAF) risks allocated to the Committee.

This report summarises the key developments and discussions arising from the 12 May 2023 meeting. For a copy of the minutes please contact Paul Balson, Head of Corporate Governance (Paul.Balson@gosh.nhs.uk).

2023/24 annual plan update

Discussions between NHS England and partner NHS organisations in North Central London regarding the 23/24-year end position were ongoing. GOSH had been asked to provide an additional £600k of savings against the current submitted "breakeven" plan. The basis of the 2023/24 plan assumed no further industrial action. The Committee requested further information before approving the final position.
The Committee discussed the challenges arising from the year-end position setting process, the risks it posed to Trust culture and system wide implications.

Finance report Month 12 (March data)

The Committee reviewed the unaudited year end position. Key points raised included:

The Trust ended the year £600K favourable to plan (a £10.0m control total deficit actual against a planned £10.6m).

The year end position was positively affected by robust activity performance for I&PC.

The Better Value programme had delivered £16.1m of savings across all Directorates

The Committee thanked the wider organisation and especially the finance and operational teams for the better than planned year end 2022/23 position.

Performance report Month 12 (March data)

The Performance Team had developed a weekly Bed occupancy report to ensure the Trust will be able to balance both reducing the NHS backlog and increasing I&PC income.
The Trust were looking into changing the Trust's model of care to efficiently provide capacity for urgent case and the likely impact of further strike action on activity.
The Committee reviewed the overall 'long waits' position as well as several directorates' action plans and improvement trajectories. It was noted that a number of specialties were achieving their constitutional targets.

Sustainability

The Committee reviewed the Trusts baseline assessment of its carbon creation and noted that 93% of the total came from energy usage. The Committee reiterated the Trust's commitment to the climate emergency and endorsed in principle (pending a future business case) the large-scale change of switching the Trust from gas fired combined heat & power to electric; as well as the smaller scale changes (e.g., energy efficient lightbulbs) required to achieve its targets.

The Non-Executive Directors felt that staff engagement in sustainability initiatives was very positive.

Procurement update

The Committee received its annual update on procurement savings and developments.
The current macro environment is driving price increases for the Trust (where medical consumables typically increased in price by 10-15%) and other some operational issues between the inhouse and Guy's and St Thomas' NHS Foundation Trust shared service elements of the service had presented challenges for the team.
Work was underway to improve the way product safety alerts are implemented and find efficiencies in estates purchasing processes.
The Committee requested that the Chief Finance Officer and Interim Director of Space and Place consider methods for securing the most optimised energy terms moving forward and that future reports include a dedicated section on Environmental, Social and Governance (ESG) considerations.

Children's Cancer Centre

The Committee received an overview of key milestones to date, the immediate risks and mitigations as well as the ongoing engagement work. The Committee also noted the progress made on tracking the project's risk profile as milestones were achieved and metrics for measuring 'CCC construction disruption'.

Major projects

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

Annual report

The Committee approved its annual report for inclusion in the annual report and accounts.

Board Assurance Framework

The Committee agreed the following actions for the BAF risks allocated to it:

BAF Risk 1 Financial Sustainability

- No change to the current risk score given the challenges in the system.

New BAF risk: I&PC activity

- The Committee agreed to *split out* a new risk from BAF Risk 1: *The risk that the financial sustainability of the Trust is significantly impeded by a failure to deliver IP&C and commercial contribution targets*. The controls, assurances, gaps and scores would be populated for the next meeting of the FIC.

BAF Risk 15: Children's Cancer Centre

- The Committee agreed to take responsibility for reviewing the risk.

Feedback from Governor observers

Two Governors (Public London and Parent London) observed the May meeting. They provided post-meeting feedback to the Chair and other Non-Executive Directors as follows:

The meeting was well Chaired and covered alot of topics.

The Council of Governors would appreciate an update on several of the topics - the Corporate Affairs Team would look at ways to facilitate this.

The Procurement report was well received and Governors were assured that NEDS had probed management on considerations around the impact of changes to law and EU standards on medical equipment.

The sustainability agenda has progressed - Governors and NEDs would be vigilant for 'Green washing'

The Council will request a session to increase understanding on how the Trust will be able to increase I&PC activity without any detriment to NHS patients

End

Attachment 8

Great Ormond Street Hospital for Children
NHS Foundation Trust

Summary of the Council of Governors' Meeting held on 20th April 2023

Finance Report (March 2023 data)

The financial year had concluded, and the Trust's unaudited year-end figures showed that GOSH had met its agreed outturn of £10.6million deficit following considerable work had been required to mitigate a risk around an additional £20million deficit.

Understanding the breath of research at GOSH

Governors received a presentation on research at GOSH and noted that focus was being placed on making the research vision more visible to patients and families. A new clinical research facility would be opened towards the end of the year which would increase capacity. Discussion took place around the ethics process related to research and noted that a robust governance structure was in place as well as a number of research ethics committees. The GOSH Charity had recently reviewed its multiyear cash flow including funding provided for research and medical equipment and had been satisfied that it could continue to provide this support on a multiyear basis.

Use of data at GOSH

The innovation directorate was focused on three key areas: digital, medical devices and drug discovery and had been particularly successful around cell and gene therapy and drug discovery. In some areas GOSH required the support of commercial organisations to use data to move forward with diagnosis, treatment and care and a Data Partnerships Committee had been established with delegated authority from the executive management team to consider the ethical and legal considerations of this work. Due diligence took place on each potential partner organisation and each relationship was considered for approval by the Trust Board. Going forward, technology would become available whereby external organisations could be given access to appropriate data on a trusted platform which would continue to be owned by GOSH.

Update from the Young People's Forum (YPF)

The YPF had been working with the patient safety team and had recently made a video in which YPF members discussed what patient safety means to patients. This had been shown at the GOSH patient safety and human factors conference. Members' views focused on the importance of learning when things went wrong. Forum members had also worked with the Chief Nurse on the Nursing Strategy and supported the GOSH Learning Academy to develop a teaching module on paediatrics for prospective advanced healthcare practitioners.

Reports from Board Assurance Committees

The Council received updates from the following assurance committee meetings:

- Quality, Safety and Experience Assurance Committee (March 2023)
- Audit Committee (March 2023)
- Finance and Investment Committee (March 2023)

Chief Executive Report including Integrated Quality and Performance Report (February 2023 data)

The Children's Cancer Centre had been granted full planning permission by the London Borough of

Camden Planning Committee having met the conditions required following the approval of conditional planning permission in February 2023. As part of the development work, the hospital's front entrance would be moving to Guilford Street and communication would take place to minimise the impact on patients, families and staff. The impact of staff strikes had been extremely challenging and there had been a significant reduction in activity. There would also be a considerable impact as a result of the planned nursing strike over the May Day Bank Holiday for which no derogations had been agreed.

Discussion took place about the go live of the Royal Marsden NHS Foundation Trust's EPR system which was being shared with GOSH. It was confirmed that learning had been identified from the process and an audit programme was being implemented from which additional learning would be drawn.

Governors requested updates on waiting lists and the development of the Gender Development Service at a future meeting.

Process for the Lead Governor and Deputy Lead Governor Election

The Council noted the timetable for the Lead and Deputy Lead Governor elections and approved the nominations process.

Draft Council of Governors' section in GOSH Annual Report 2022/23

The Council approved the draft Council of Governors' section in the annual report and noted that focus was being placed on ensuring that the report was engaging for children and young people with explanations provided for complex or technical language.

Membership of Council Committees and working groups

The membership of Council Committees and working groups was refreshed annually to ensure that Governors had the opportunity to get involved in different aspects of the Council's work. The Council noted the details about self-nomination to the committees and groups would be circulated in the Governor newsletter.

Governance Update

The Council election had been completed since the previous meeting and newly elected governors had taken part in an induction programme run by the Trust and NHS Providers. A Council effectiveness review would be conducted and any recommendations presented to Governors.

Update from the Membership Engagement Recruitment and Retention Committee (MERRC)

A membership data cleanse had taken place as part of the election process and had led to a reduction of 100 members. The MERRC had set ambitious recruitment targets going forward and membership engagement sessions were being held in the Lagoon supported by Governor volunteers.

Attachment 8

Great Ormond Street Hospital for Children
NHS Foundation Trust

Summary of the Extraordinary Council of Governors' Meeting held on 18th May 2023

Appointment of the GOSH Trust Chair

An executive search firm had been appointed following a tender to support the Chair recruitment. The Council of Governors' Nominations and Remuneration Committee had shortlisted five candidates with a range of backgrounds for interview. Candidates had been given tours of the hospital and met with four stakeholder panels, the chairs of which provided feedback and used to inform the interviews. The interview panel had comprised of four Governors from the Council of Governors' Nominations and Remuneration Committee, the Deputy Chair and the Chair of the North Central London Integrated Care Board and they had unanimously agreed that Ellen Schroder was the preferred candidate. This view was supported by the Trust Board.

The Council approved the appointment of Ellen Schroder as Chair of the Trust Board and Council of Governors (subject to employment checks) noting that in the first instance she would be appointed as an associate Non-Executive Director.

Compliance with the NHS provider licence – self assessment

Foundation Trusts were required to declare annually compliance or otherwise with a small number of Foundation Trust licence conditions as well as one requirement of the Health and Social Care Act. The Executive Management Team had reviewed the evidence for each condition and had proposed that the Trust was compliant with each. The Board would review the self-assessment and was required to give regard to the views of the Council of Governors.

The Council reviewed the evidence provided and agreed with the Executive Team's proposal that GOSH was compliant with the Foundation Trust licence conditions and requirement of the Health and Social Care Act.

Attachment 9

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
8 June 2023

Register of Seals **Submitted by: Anna Ferrant, Company Secretary**	**Paper No: Attachment 9** **□ For approval**

Purpose of report
Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised.

Summary of report

Date	Description	Signed by
06/04/2023	Deed of Indemnity between (1) Great Ormond Street Hospital for Children NHS Foundation Trust and (2) Great Ormond Street Hospital Children's Charity in relation to Great Ormond Street Children's Hospital Frontage Building, Great Ormond Street London, WC1N 3JH (x2 copies; one for each organisation)	MS, JQ
06/04/2023	Agreement between (1) Great Ormond Street Hospital for Children NHS Foundation Trust and (2) Great Ormond Street Hospital Children's Charity and (3) The Mayor and Burgesses of the London Borough of Camden relating to the land known as Great Ormond Street Children's Hospital Frontage Building, Great Ormond Street London, WC1N 3JH pursuant to Section 106 of Town and Country Planning Act 1990 (amended); s278 of the highways Act 1980; Section 16 of the Greater London Council (General Powers) Act 1974; Section 111 of the Local Government Act 1972; and Section 1(1) of the Localism Act 2011 (x3 copies; one for each organisation)	MS, JQ

Patient Safety Implications
None

Equality impact implications
None

Financial implications
None

Strategic Risk
None

Action required from the meeting
To endorse the application of the common seal and executive signatures.

Consultation carried out with individuals/ groups/ committees
N/A

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

Who is accountable for the implementation of the proposal / project?
Anna Ferrant, Company Secretary oversees the register of seals