Meeting of the Trust Board
Thursday 6 July 2023

Dear Members

There will be a public meeting of the Trust Board on Thursday 6th July 2023 at 2:00pm.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**2:00pm**
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 8 June 2023**	Chair	**I**	
3.	**Matters Arising/ Action Checklist**	Chair	**J**	
4.	**Chief Executive Update**	Acting Chief Executive	**K**	**2:05pm**
	PERFORMANCE			
5.	**Integrated Quality and Performance Report: May 2023 data**	Chief Operating Officer/ Chief Medical Officer/ Chief Nurse/	**M**	**2:15pm**
6.	**Finance Report: May 2023 data**	Chief Finance Officer	**N**	**2:30pm**
	STRATEGY AND PLANNING			
7.	**Update on the Nursing Strategy 2023-2026: Safe in our hands**	Chief Nurse and Deputy Chief Nurse	**O**	**2:40pm**
8.	**Approval of the Revised People Strategy**	Director of HR and OD	**P**	**2:55pm**
9.	**Transformation Update**	Chief Operating Officer	**Q**	**3:10pm**
	ASSURANCE			
10.	**Learning from Deaths Report Q4 2022/23**	Chief Medical Officer	**R**	**3:20pm**
11.	**Annual Reports** • **Annual Director of Infection, Prevention and Control Report 2022/23** • **Annual Safeguarding Report 2022/23** • **Responsible Officer Annual Report 2022/23** • **Annual Sustainability report 2022/23**	DIPC/ Chief Nurse Head of Safeguarding/ Chief Nurse Responsible Officer/ Chief Medical Officer Interim Director of Space and Place	**S** **T** **U** **V**	**3:30pm**
12.	**Board Assurance Committee reports** • **Quality, Safety and Experience Assurance Committee – June 2023 meeting** • **Audit Committee Assurance Committee**	Chair of QSEAC	**W**	**3:50pm**

	Update – June 2023 meeting Including BAF Update and recommendations **There has been no meeting of the People and Education Assurance Committee or the Finance and Investment Committee since the last Board meeting*	Chair of Audit Committee	**X**	
	GOVERNANCE			
13.	**Register of Seals**	Company Secretary	**Y**	**4:00pm**
14.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			
15.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 18 October 2023.			

DRAFT Minutes of the meeting of Trust Board on
8th June 2023

Present

Sir Michael Rake	Chair
Amanda Ellingworth	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
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Luke Murphy*	Deputy Head of Patient Experience
Sylvia Chegra	Associate Director Patient and Family and Site Services
Joshua*	GOSH patient
Kristel*	Joshua's mother
Katya Herman*	Music Therapist
Jatinder Olk*	Head of Quality
Chris Ingram*	Fire, Health and Safety Manager
Renee McCulloch*	Associate Medical Director for Workforce and Guardian of Safe Working
Kiera Parkes*	Guardian of Safe Working
Jacqueline Gordon	Governor (observer)

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

17	**Apologies for absence**
17.1	Apologies for absence were received from Jason Dawson, Interim Director of Space and Place. Sylvia Chegra, Associate Director Patient and Family and Site Services was in attendance in his stead.
18	**Declarations of Interest**
18.1	No declarations of interest were received.
19	**Minutes of Meeting held on 30 March 2023**

19.1	The Board **approved** the minutes of the previous meeting.
20	**Matters Arising/ Action Checklist**
20.1	Actions taken since the previous meeting were noted.
21	**Patient Story**
21.1	Joshua, a GOSH patient and Kristel, Joshua's mother joined the Board to discuss their experiences of using music therapy at GOSH during admissions to the hospital. Joshua said that most of his negative experiences in the hospital had been associated with being admitted to a different ward where staff did not know him as well. He said that when he was in hospital, he missed college and seeing his friends and this additional layer of challenge was difficult. Kristel said that Joshua did not have a formal diagnosis, and this was challenging when being admitted to wards which primarily treated patients with specific diagnoses. She said that two of her children were GOSH patients and on one occasion were admitted at the same time. This had been very difficult to manage and receiving respite when her children were receiving music or play therapy had been extremely important.
21.2	Joshua said that music therapy had been extremely important for lifting his mood and he felt that it was a period of light during a difficult time. He said that at his first admission he had been very anxious and stressed and the new environment had been challenging and this had been helped by music therapy.
21.3	Katya Herman, Music Therapist said that she worked across the hospital with patients of all ages both to improve their experience of being in hospital and also for therapeutic purposes such as singing with respiratory patients. Joshua had started to play the saxophone, and this was helpful as a physiotherapy exercise which had helped with breath control and stronger breathing by strengthening his diaphragm. Matthew Shaw, Chief Executive said other centres were doing innovative work around the use of music and there was more that GOSH could do in this regard.
21.4	Katya said that she saw patients on a referral basis but there was not sufficient capacity to see all patients. Patients with a learning disability, regular or long admissions and those with anxiety about procedures were prioritised as well as younger patients whose parents were not able to stay with them as much.
21.5	Tracy Luckett said that an excellent annual report had been produced by the music therapy service and discussion was taking place about additional support that could be provided in this area.
22	**Chief Executive Update**
22.1	Matthew Shaw thanked staff and management teams for their hard work to prepare for, and recover from, periods of strike action which had been challenging and was a distraction from the Trust's ongoing objectives. The Trust's waiting list benchmarked well, but there were a number of long waiting patients which was not acceptable and focus was being placed on reducing this number. Sir Michael Rake said that the Board was extremely supportive of the Executive Team's work in this regard and the focus on minimising disruption to patients.

23	**Quality Report 2022/23**
23.1	Jatinder Olk, Head of Quality said that the priorities set out in the report were developed by the Quality Review Group which was composed of a wide group of stakeholders in a variety of different roles. The priorities represented their key areas for improvement and there had been excellent engagement across the Trust.
23.2	Matthew Shaw highlighted that over half of services now had publicly available outcomes which was the most of hospitals internationally. This was beneficial to patients and families and for international referrals and it was important to continue to focus on this for other specialties.
24	**GOSH Foundation Trust Annual Financial Accounts 2022/23 and Annual Report 2022/23**
24.1	John Beswick, Chief Finance Officer said that the Audit Committee had met in the morning prior to Trust Board and reviewed the accounts. The Trust's external audit partner had reported that their work was not yet concluded however the work on significant risks had been finalised and no material issues had been identified. It was anticipated that the accounts would be signed in the next few days.
24.2	The Audit Committee had discussed the approach to bad debt provisioning and the judgement involved in the calculation made. The external auditor had felt that the provisioning level was too high as a result of an overly prudent policy however it remained within a materially acceptable range and the Audit Committee and management team was satisfied that an appropriate policy was in place. Two other areas of provisioning had been discussed: the potential financial implications of an ongoing legal case and an amount payable from the Integrated Care System (ICS) however neither had been material, either individually or as whole. Learning had been identified around the adoption of IFRS16.
24.3	Gautam Dalal, Audit Committee Chair said that no matters had been raised by Internal Audit or Counter Fraud which required the attention of the Board. The committee had also reviewed the Internal Audit plan for 2023/24 and discussed the importance of reviewing the Children's Cancer Centre programme and development of a new service. A debrief on year-end processes would take place at the next Audit Committee meeting.
24.4	Subject to the completion of the external audit the Trust Board **approved** the following documents: • GOSH Foundation Trust Annual Financial Accounts 2022/23 • Annual Report 2022/23 • Annual Governance Statement • Assurance Committee Annual Reports • Draft Head of Internal Audit Opinion • Draft Letter of Representation
24.5	The Board **agreed** to delegate authority to the Audit Committee in the event that any changes were required to the above documents.
24.6	The Board thanked the teams involved for their work to prepare the year end

	documents.
25	**Compliance with the NHS provider licence – self assessment 2022/23**
25.1	Anna Ferrant, Company Secretary said that the Executive Team had reviewed the evidence set out against four conditions of the Foundation Trust Licence and one requirement under the Health and Social Care Act and had proposed that the Trust was compliant with the conditions. The self-assessment had been presented to the Council of Governors at its May 2023 extraordinary meeting and the Council had been satisfied with the evidence provided and the proposal that the Trust was compliant with all conditions.
25.2	The Board **agreed** the Trust's response to the four conditions of the Foundation Trust licence.
26	**Integrated Quality and Performance Report – Month 1 2023/24**
26.1	John Quinn, Chief Operating Officer said that the periods of industrial actions had had a substantial impact on operational performance and senior management capacity. Not withstanding the Trust's good RTT performance, there were a number of long waiting patients and focus was being placed on reducing these. In some specialties such as dental, mutual aid had been sought from other organisations. GOSH's performance against cancer targets remained good.
26.2	Sanjiv Sharma said that focus was being placed on the timely closure of incident reviews. Changes had been made to the Risk Management Policy and these were being embedded in directorate areas.
26.3	Tracy Luckett said that the Trust continued to perform well in Friends and Family Test feedback both in terms of the response rate and the experience reported. There had been a deterioration reported in terms of experience, but this had recovered in month 1. Feedback was being received about the impact of waits and cancellations and this was being monitored by the Executive Team.
26.4	Caroline Anderson, Director of HR and OD said that focus was being placed on honorary contract holders and verifying their current training status with substantive organisations. This work was ongoing.
27	**Month 1 2023/24 Finance Report and update on GOSH 2023/24 Budget**
27.1	John Beswick said that there was an adverse variance to plan in month 1 as a result of the reduction in Elective Recovery Funding due to the staff strikes. Discussion was taking place with NHS England about the way in which this funding would be recovered. Contribution from Better Value had also been delayed as management attention was focused on industrial action.
27.2	**Action:** Matthew Shaw said that John Beswick had been asked by the London region to develop a methodology for calculating losses as a result of strikes. Chris Kennedy, Non-Executive Director said that the delay to Better Value would lead to a loss of early year savings which would result in a full year variance. He said that it was important that this was also represented in the calculation.
27.3	Amanda Ellingworth, Non-Executive Director asked whether GOSH was managing the strikes efficiently in comparison to other organisations and John

	Beswick said that GOSH was disproportionately impacted as all cohorts of staff who were eligible to strike were doing so at GOSH.
27.4	Suzanne Ellis, Non-Executive Director highlighted that there had been a reduction in genomics funding and John Beswick said that this was a timing issue. He said that the contract had not been signed and had therefore not been recognised.
28	**Nursing Workforce Assurance Report**
28.1	Tracy Luckett said that the nursing vacancy rate was currently 8.2% which was positive however turnover was increasing, and work was taking place to develop ways to reduce this. Chris Kennedy said that it was important to capture data on staff who were leaving the nursing profession as opposed to leaving GOSH and that this must be escalated to the Government. Tracy Luckett said that the Nursing Board had agreed to take forward the 'stay' retention framework. Discussion with staff had shown that key drivers of turnover were cost of living and travel to a central London site. The Trust was doing what it could to influence around travel and consideration would be given to how both the local and national system could be influenced. Caroline Anderson said that GOSH had an unusually young workforce and this also led to a higher turnover. She said that a combination of solutions would be required.
28.2	**Action:** Sir Michael Rake emphasised the importance of supporting staff with travel where this was a barrier to working at GOSH and it was agreed that this would be explored.
28.3	Suzanne Ellis highlighted that some wards had extremely high turnover in excess of 40% and said that it was important to move forward with support in these areas. Tracy Luckett said that the nursing workforce team was working with those wards and focus was being placed on wellbeing.
28.4	<u>Nursing Establishment Review</u>
28.5	Tracy Luckett said that the review had taken place and had identified areas in which the establishment itself required further consideration and areas in which focus would be placed on the skills mix of nursing colleagues.
29	**GOSH Staff Survey Results / Action Plan 2022**
29.1	Caroline Anderson said that four key themes for focus had been identified from the 2022 staff survey results: wellbeing, education, progression and reward and recognition. She said that relationships with line managers was key and listening events would be taking place throughout the Trust, however these had been delayed by strikes. Teams had developed their action plans, and these were being managed as part of Directorate Performance Reviews.
29.2	Amanda Ellingworth asked for a steer on the timeframe required for the Trust's actions to have a real impact. She expressed some concern about making substantial changes to the action plan as opposed to ensuring that existing ongoing action taken was comprehensive and managed through to conclusion. Caroline Anderson said that the improvement made in previous years' staff survey results had been maintained and it was important to now ensure that teams took ownership of the programmes of work.

29.3	Suzanne Ellis asked how the Trust could encourage high performance team culture and Amanda Ellingworth asked how focus could be placed on the teams which required the most support. Caroline Anderson said that teamwork at GOSH was strong and recognition was important in this regard. She added that quarterly metrics would be available which would identify where particular teams required support.
30	**Annual Reports**
30.1	Annual Health and Safety and Fire Report 2022/23
30.2	Chris Ingram, Fire, Health and Safety Manager said that positive progress had been made in 2022/23 particular with respect to the safer sharps project as a result of additional capacity in clinical procurement. There had been an increase in RIDDORs in line with the increase in the number of staff onsite and this would continue to be monitored by the Health and Safety Committee.
30.3	The Trust had employed an Authorised Engineer for Fire Safety (AE) and this independent expertise had been important particularly around the Children's Cancer Centre. The AE had provided a very positive annual report which included two recommendations, the implementation of which was being discussed at the Fire Safety Committee. Chris Ingram said that there had been a reduction in the number of false fire alarms resulting in the London Fire Brigade coming to site. This was positive but had led to a natural reduction in familiarity of the LFB with the GOSH site. A Memorandum of Understanding was in place to ensure that they were on site quarterly however scheduling the visits was proving challenging. The Board emphasised the importance of ensuring that the MOU was adhered to.
30.4	**Action:** Chris Ingram said that unfortunately the Fire Officer post was vacant and was proving challenging to fill as a result of the strong external market for fire officers where salaries were not in line with Agenda for Changing banding for the role. Matthew Shaw emphasised the importance of the Fire Officer role and said that consideration would be given to the way in which one could be successfully recruited.
30.5	Suzanne Ellis noted that there was no specific budget for Health and Safety and asked whether sufficient support was provided by other areas. Chris Ingram confirmed that it was and that he was able to escalate any issues as they arose. The Board welcomed the progress made.
30.6	Guardian of Safe Working Report Q4 2022/23 and Annual Report 2022/23
30.7	**Action:** Renee McCulloch, Associate Medical Director for Workforce and Guardian for Safe Working said that minimum staff numbers on rotas had been set for each specialty which was a new way of working for doctors and calculations of annual leave and study leave had been included. Vacancy rates had been higher in 2022/23 and this had been attributed to workforce issues nationally and also issues with recruiting doctors from Europe. Delays were also being experienced in terms of international colleagues joining the Trust. Sir Michael Rake asked whether the NHS was connected with the Home Office in order to support international recruitment and Sanjiv Sharma said that a number of national bodies were involved in the process to support junior doctors working at GOSH and feedback had been about the rate at which applications could be processed. The Trust was also working with the Children's Hospital Alliance to

	raise the issue which disproportionately impacted specialist organisations. It was agreed that this would be raised with the Trust's local MP. Renee McCulloch said that the Trust had connected with the General Medical Council and proposed a role as a pilot organisation as GOSH had a large number of international medical graduates. It was agreed that the matter would also be raised with the Shadow Secretary of State for Health and Social Care.
30.8	Caroline Anderson asked for a steer on the morale of Junior Doctors and Renee McCulloch said that the group was very aware of the disruption during periods of industrial action and was focused on patient safety.
30.9	**Action:** Chris Kennedy said that considerable work was taking place around the use of artificial intelligence in rota design and he agreed to discuss this with the Chief Clinical Information Office outside the meeting.
30.10	<u>Freedom to Speak Up Guardian Annual Report 2022/23</u>
30.11	Kiera Parkes, Freedom to Speak Up (FTSU) Guardian said that there had been a small reduction in cases raised in 2022/23 and the time made available had been used as an opportunity to promote the service and engage with staff. It had been challenge to collate robust demographic data to identify groups which may face barriers to contacting the service and work was taking place with the staff networks to identify any additional support required.
30.12	There was good awareness throughout the Trust of ways in which concerns could be raised however Kiera Parkes emphasised the importance of continuing to demonstrate that the Trust was a listening organisation and concerns were welcomed.
30.13	The National Guardian's Office would be releasing data for 2022/23 which would enable benchmarking to take place and a staff survey subscore for FTSU had been developed and the data related to this would be reviewed.
30.14	Sir Michael Rake said that the ability to raise concerns in a safe environment was a key component of culture and said that an understanding of the barriers to staff raising concerns was key. He said that this was a critical area which would support the Trust's cultural aims.
31	**Board Assurance Committee reports**
31.1	<u>Audit Committee update – March 2023 meeting and June 2023 (verbal)</u>
31.2	Gautam Dalal said that alongside discussion of the year end documents at the meeting prior to Trust Board, the committee had undertaken deep dives into data quality. He said that he and Suzanne Ellis had visited the ICT team and gained a good understanding of the priorities and progress being made.
31.3	<u>Quality, Safety and Experience Assurance Committee update – March 2023 meeting</u>
31.4	Amanda Ellingworth, Chair of the QSEAC said that the committee had received an internal audit report on the harm review process which had provided a rating of partial assurance. The Executive Management Team was focused on improving the process and ensuring it was embedded in clinical teams and this would be re-audited. A mental health risk was being added to the Board Assurance

	Framework and a presentation had been received on the options appraisal for the provision of High Dependency care across the Trust.
31.5	<u>People and Education Assurance Committee – May 2023 meeting</u>
31.6	Kathryn Ludlow, Chair of PEAC said that turnover across the hospital was increasing and a deep dive would be received on this at the next meeting. Good progress was being made by the GOSH Learning Academy which had moved into its next phase of work and was recruiting to key posts. Presentations had also been received from directorates on their action in response to staff survey results.
31.7	<u>Finance and Investment Committee – March 2023 and May 2023 meetings</u>
31.8	Suzanne Ellis, Chair of FIC said that many of the matters discussed at the previous meetings had also been covered by the Board. The committee discussed sustainability and the carbon baseline, and a good discussion had taken place. A business case was being developed which would provide the options for moving forward. There was good staff engagement in this area.
31.9	An update on procurement had been received and the committee had asked that sustainability was considered going forward. Suzanne Ellis said that it was important that consideration was given to Environment, Social and Corporate Governance (ESG) matters in all activity undertaken at GOSH.
32	**Council of Governors' Update – April 2023 and May 2023**
32.1	Sir Michael Rake said that the Council of Governors had approved the appointment of the new Chair and had welcomed a presentation on research from Russell Viner. Presentations would be provided at a future meeting about the International and Private Care and its importance in supporting NHS services and the complexities of developing new services.
33	**Any other business**
33.1	There were no other items of business.

Attachment J

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 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	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/ Mark Coker	July 2023	Referred to QSEAC in June 2023
27.2	08/06/23	Matthew Shaw said that John Beswick had been asked by the London region to develop a methodology for calculating losses as a result of strikes. Chris Kennedy, Non-Executive Director said that the delay to Better Value would lead to a loss of early year savings which would result in a full year variance. He said that it was important that this was also represented in the calculation.	JQ/ JB	October 2023	Not yet due
28.2	08/06/23	Sir Michael Rake emphasised the importance of supporting staff with travel where this was a barrier to working at GOSH and it was agreed that this would be explored.	MS, CA	July 2023	Verbal Update
30.4	08/06/23	Chris Ingram said that unfortunately the Fire Officer post was vacant and was proving challenging to fill as a result of the strong external market for fire officers where salaries were not in line with Agenda for Change banding for the role. Matthew Shaw emphasised the importance of the Fire Officer role and said that consideration would be given to the way in which one could be successfully recruited.	MS, CA, JD	July 2023	A candidate has been appointed and is subject to pre-employment checks.
30.7	08/06/23	Renee McCulloch, Associate Medical Director for Workforce and Guardian for Safe Working said that minimum staff numbers on rotas had	MS, SS	End July 2023	Not yet due

Attachment J

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		been set for each specialty which was a new way of working for doctors and calculations of annual leave and study leave had been included. Vacancy rates had been higher in 2022/23 and this had been attributed to workforce issues nationally and also issues with recruiting doctors from Europe. Delays were also being experienced in terms of international colleagues joining the Trust. Sir Michael Rake asked whether the NHS was connected with the Home Office in order to support international recruitment and Sanjiv Sharma said that a number of national bodies were involved in the process to support junior doctors working at GOSH and feedback had been about the rate at which applications could be processed. The Trust was also working with the Children's Hospital Alliance to raise the issue which disproportionately impacted specialist organisations. It was agreed that this would be raised with the Trust's local MP. Renee McCulloch said that the Trust had connected with the General Medical Council and proposed a role as a pilot organisation as GOSH had a large number of international medical graduates. It was agreed that the matter would also be raised with the Shadow Secretary of State for Health and Social Care.			
30.9	08/06/23	Chris Kennedy said that considerable work was taking place around the use of artificial intelligence in rota design and he agreed to discuss this with the Chief Clinical Information Officer outside the meeting.	CK, SSr	July 2023	In progress: Meeting to be arranged

Attachment K

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 6 July 2023	
Chief Executive's Report **Submitted by: Matthew Shaw, Chief Executive**	**Paper No: Attachment K** **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, including: • Maximising our capacity- tackling waits and expediting access to specialist care for children and young people, including work with out system partners • Making the most of our resources - Delivering on our financial commitments, working towards sustainability and driving income to support delivery of our strategy to advance care for CYP with complex health needs • Transformation to improve our systems, processes and capabilities- projects and programmes in support of our quadruple aim to improve access, quality and value and to 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	

GOSH receives over £3.5m for research and innovation and a visit from the Secretary of State for Health and Social Care

GOSH has been awarded over £3.5m by the National Institute of Health and Care Research (NIHR) for research and innovation equipment as part of a wider £96m award to 93 NHS (& NIHR grant recipients) organisations across England.
This will allow us to purchase state-of-the-art microscopes, a liquid nitrogen generator, a genomic sequencer and a specialised 3D-printer that can print medicines as well as basic equipment such as trolleys, computers and data storage. As the Board will be aware, many of our research platforms are running at full capacity with long waiting times due to a lack of equipment availability. This additional investment will facilitate faster translation of our research into the clinic, and allow us to help more patients.

The Health and Social Care Secretary, Steve Barclay MP, visited GOSH as part of the media announcement and met a patient family involved in a research trial, as well as staff from across the hospital. We are very grateful to all our colleagues who helped us to make the best of this opportunity to showcase the essential role of research to patient care, as well as discuss the wider challenges staff and families are currently facing in relation to industrial action and cost of living.

We were also able to raise the wider systemic challenges around waiting times for children and young people at GOSH and across England, and the need for more centralised focus and support to improve access to paediatric specialist care. We will follow up on our conversations with the minister's team.

Appointment of Dr Kiki Syrad as Director of Research and Innovation

We were delighted to be able to announce last month that our longstanding colleague and collaborator Kiki Syrad, the current Director of Impact and Charitable Programmes at Great Ormond Street Children's Charity, has been appointed to this substantive role and will start in October.

Kiki has held senior leadership positions in the charity sector for more than 15 years and at the charity she has led on the development of two five-year research strategies for GOSH, which led on to £120m of investment in research across the UK. Prior to her current role, she was Head of Research and Funding at Breast Cancer Now. Kiki did her PhD at Melbourne University, Australia, focusing on cancer therapies. As a researcher, she was part of the Angiogenesis group at the Weatherall Institute of Molecular Medicine in Oxford, working on a potential therapeutic cancer target and identifying novel cancer markers.

When Kiki joins in October, she will take over from Dr Jenny Rivers, our Acting Director of Research and Innovation. Jenny leaves GOSH to take up the role of Director of Research and Development at Barts Health.

Congratulations to Jenny on her appointment. Jenny has made a huge difference to the directorate in the five years she has been with us and we look forward to continuing to work with her through our work with UCL Partners, which both GOSH and Barts Health are a part of.

Impact of industrial action

The BMA has announced that junior doctors will be taking part in strike action at GOSH for five days from 7am on Thursday 13 July until 7am on Tuesday 18 July.

Consultants are also planning to strike two days afterwards for two days from Thursday 20 July.
This will cause further disruption to our staff, patients and families and take a further toll on our waiting times position, morale and resilience. We have stood up our command and control structure to support planning and will provide an update on any developments at the Board meeting.

Every strike affects our ability to see patients and requires that we 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.

As we have previously said, we completely respect the right of staff to take part in lawful industrial action, and we are grateful to have had an opportunity to explain the impact of ongoing pay disputes during the ministerial visit last week.

Nursing & People strategies

We are delighted to be bringing the Board our first ever nursing strategy today, and to be able to share with you some of the feedback from our ongoing staff engagement sessions.

We want to say a huge ‘thank you’ and ‘well done’ to Tracy Luckett, Darren Darby and the whole nursing leadership team for a clear and compelling vision for nursing at GOSH, which links beautifully to our wider People and Above and Beyond strategies, supports our ambitions for Quality and Safety and provides us with a clear and practical set of deliverables and metrics.

It is also fantastic that we are bringing forward our refreshed People Strategy for this meeting. We had a very helpful session as a Board on culture at GOSH last week. It was great to reflect on how far we have come since 2019 on delivering against our first and most important strategic priority – making GOSH a great place to work.

Despite all of the tumultuous changes that we have navigated over the past 4 years so, and the fact that many of the critical issues that affect staff satisfaction our outside of our control – I’m really proud of the work we’ve done together. From developing and supporting our staff networks, to expanding opportunities for staff engagement, to transforming our education offer and providing practical support to help mitigate the cost of living crisis… and so much more.

As we discussed, we still have much to do to embed the People strategy and to make sure all our staff feel as supported as they possibly can be to tackle the huge challenges ahead – from finding savings and driving efficiencies, to delivering record levels of activity and transforming services. Not to mention navigating the ongoing challenges of Industrial Action and a major decant programme to make way for our new Cancer Centre.

The cultural challenge we now face goes far beyond providing practical and functional support for staff – it is about developing our GOSH Mindset so that we can build the skills and resilience we all need to navigate these huge challenges – while still feeling able to be supportive, kind and compassionate - to our patients, our colleagues and, perhaps most importantly, to ourselves.

Attachment M

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6th July 2023

June IQPR (May 2023 Data)	**Paper No: Attachment M**
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
Overall Trust indicators are positive with 15 out of the 23 RAG indicators green and 7 red. Patient access domain remains the challenged domain with the others showing stronger performance.

Disruption from industrial action in April improved during the month and services got back to normal working and focus has been on returning to normal.

Activity recovery from the Junior Doctor's strike has been strong and when compared to 19/20 activity overall is at 115%. However, with impending strikes activity levels are being closely monitored. Activity for month 2 was -5.5% down v plan and 8% down on 2022/23 activity levels.

Patient experience has been affected by industrial action however in May outpatient experience for the month of May is above the national 95% standard, this is the first time in 6 months. A significant focus has been on increasing feedback from patients and families which has resulted in an additional 600 forms received, an increase of 292% from April. Feedback themes have covered short notice cancellations and delays in care, treatment, and medication administration.

Duty of candour stages for all due cases in May were met, which is a significant improvement. Performance on high risks has improved with only a small number not being reviewed within schedule, these have all been followed up.

RTT and DM01 performance has marginally increased. 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.

CV Line infections remain stable, and this is being closely monitored. One C-diff case was reported in May and is a Trust assigned case.

The Trust's Better Value target for 2023/24 is £32.5m, of which £16.5m is an additional contribution from IPC. A detailed programme to deliver the remaining £16m is in development.

Well-led remains a focus for the Trust. Vacancy rates for the Trust has increased to 10% after being stable for several months. This may be as a result of the new budgets being released and is being investigated. Voluntary turnover remains within the same range as the previous 4 months at above 14%

for the Trust and 16% in Nursing. Sickness has stabilised at 2.8% for the last 2 months for the Trust, however Nursing sickness is at 3.4% which is similar to the last 4 months.
Patient Safety Implications The IQPR includes metrics and analysis on Patient Safety.
Equality impact implications There are no specific metric on equality, but the report includes metrics on Access, Freedom to speak up and Patient experience.
Financial implications The IQPR only includes metrics on Better Value and no other specific metrics on Finance, but access and activity performance will 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

June 2023

Reporting May 2023 data

John Quinn
Chief Operating Officer

Tracy Luckett
Chief Nurse

Sanjiv Sharma
Medical Director

Caroline Anderson
Director of HR & OD

Contents

Executive Overview

Activity recovery from the Junior Doctor's strike has been strong and when compared to 19/20 activity overall is at 115%. However, with impending strikes activity levels are being closely monitored. The Outpatient experience rating for the first time in six months is above the national target at 97%, with the volume of feedback increasing by 292%. Patients comments remain being about short notice cancellations and waiting time delays in care, medication administration and treatment along. These themes are also showing up in complaints.

Duty of candour cases for both stages we completed within the expected timeframes, this is a significant improvement. While open incidents remain higher than previous levels this is mainly due to the volume requiring closure within the patient safety team which is being addressed in June 2023. Performance on high risks has improved with only a small number not being reviewed within schedule, these have all been followed up.

Vacancy rates for the Trust has increased to 10% after being fairly stable for several months. This may be as a result of the new budgets released and is being investigated. Voluntary turnover remains within the same range as the previous 4 months at above 14% and 16% in nursing. Trust sickness has stabilised at 2.8%.

RTT, despite the strikes, has marginally increased to 68.4% which is 11% above the national average of 57%. Diagnostics has improved to 83.7% and 6 week waits have reduced. All Cancer standards have been met. Long waiters are continue to be an issue. At a time when NHSE are looking to reduce these, the Trust had eleven 104 week waits and 89 x 78 week waits. The current forecast is for 78 week waits to reach 94 by the end of June. Various programmes are being put in place to address this including mutual aid from UCLH on dental services, RNOH for Orthopaedics and additional theatre lists.

The Trust's Better Value target for 2023/24 is £32.5m, of which £16.5m is an additional contribution from IPC. A detailed programme to deliver the remaining £16m is in development.

Integrated Quality & Performance Report, May 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 continue to be consistent with expectations. Total number of open incidents has risen slightly, though in reality this mainly reflects incidents with Patient Safety for closure. In response to this increase, over 200 incidents have been closed in the first week of June.
- **Serious Incidents:** One new SI was declared in May. This was related to a drug overdose in the International and Private Care directorate. The incident is being looked at alongside another overdose-related SI declared in April to identify any common learning. It is not thought the two incidents are related. The final report is due for completion on 26 July 2023.
- **Duty of Candour:** The duty of candour position has improved since last month with 100% of both stage 2 and stage 3 DOC being completed within their expected timescale.
- **Risks:** The high risk position has also improved with only 4 high risks (15%) missing their review schedule. These risks originated in Research & Innovation, Space & Place, Heart & Lung and the Medical Director's Office. All have been followed up with risk owners for updates. Overall, only 6% of risks were overdue their review schedule.

Patient Safety - Incidents

		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Last 12 months	RAG			Stat/ Target
New Incidents	Volume	577	675	620	600	617	592	498	551	550	589	476	528		No Threshold			Target
Total Incidents (open at month end)	Volume	1687	1922	2109	2181	2013	1523	1367	1441	1489	1836	1939	2187		No Threshold			Target
New Serious Incidents	Volume	1	4	2	1	1	1	1	1	0	2	1	1		No Threshold			Target
Total SIs (open at month end)	Volume	14	15	10	12	3	3	3	3	2	3	4	4					Target
Overdue SI Actions	Volume	25	14	4	18	20	15	16	11	19	9	15	12		>20	10 - 20	0 - 9	Target
Incidents involving actual harm	%	15%	12%	13%	11%	10%	13%	11%	14%	12%	13%	13%	11%		>25%	15%-25%	<15%	Target
Never Events	Volume	0	0	1	0	0	0	0	0	0	0	0	0		>/=1		0	Stat
Pressure Ulcers (3+)	Volume	0	0	0	1	1	1	0	0	0	1	0	0		>1	=1	=0	Stat
Duty of Candour Cases (new in month)	Volume	3	8	7	7	3	4	1	2	7	3	3	6		No Threshold			Target
Duty of Candour – Stage 2 compliance (case due in month)	%	3/5	1/3	1/5	3/6	3/5	3/4	1/2	1/2	2/4	3/4	2/4	3/3		<75%	75%-90%	>90%	Target
Duty of Candour – Stage 3 compliance (case due in month)*	%	2/2	1/3	0/0	0/0	2/4	2/5	2/3	1/4	2/3	1 / 1	2/4	3/3		<50%	50%-70%	>70%	Target
High Risks (% overdue for review)**	%	5%	5%	40%	9%	4%	5%	35%	19%	26%	48%	59%	15%		>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

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Overview

- YTD CV Line infections remain stable. Gram negative bacteraemia's (klebsiella spp in particular) are slightly lower than the previous month and root cause analysis continues on healthcare acquired Gram negative bloodstream infections. There was one C.diff case which met the definition for reporting. There were no staphylococcus bloodstream infections
- 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

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

Inpatient Mortality & Cardiac Arrest

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Last 12 months	RAG	Stat/ Target
Number of In-hospital Deaths	7	10	8	7	12	4	9	8	13	11	11	8		No Threshold	
Inpatient Mortality per 1000/discharges	6.6	9.0	7.3	6.6	11.6	3.8	10.2	7.8	13.8	10.3	11.8	7.8		No Threshold	
Cardiac arrests outside ICU/theatres	0	1	1	2	2	0	2	2	2	1	0	3		No Threshold	
Respiratory arrests outside ICU/theatres	3	0	2	2	2	0	1	2	0	1	1	5		No Threshold	
Inquests currently open	13	14	15	10	12	12	9	8	6	8	17	15		No Threshold	

Return to Contents Page

Effectiveness

Better Value:

The Trust's Better Value target for 2023/24 is £32.5m, of which £16.5m is an additional contribution from IPC. A detailed programme to deliver the remaining £16m is in development, although has been delayed because of the immediate need to address the operational challenges related to recent industrial actions. Schemes valued at over £6m are considered to be lower risk and highly likely to deliver in full; many of these have either already signed off into budgets or will be signed into them imminently. Directorates are developing plans to meet the remainder of their targets as a matter of urgency, and this work is being supplemented by a range of cross organisational schemes in areas such as clinical procurement, pharmacy and laboratory test optimisation, contract reviews, inventory management and waste control.

Effectiveness	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Last 12 months
Speciality led clinical audits completed (actual YTD)	24	32	48	66	80	90	100	110	116	126	4	4	
Outcome reports published (YTD)	0	2	2	3	5	7	7	8	9	13	2	2	
QI Project completed	10	0	1	3	9	2	1	0	1	0	8	8	
QI Projects started	28	7	15	6	2	14	17	14	12	19	14	18	
NICE guidance currently overdue for review			0	0	0	0	0	0	0	0	0	0	
Better Value YTD Actual		3706440	£4,633,985	£6,010,393	£8,681,000	£9,848,000	£11,152,000	£12,822,000	£14,061,472	£16,048,000		£754,000	
% value of schemes identified compared to their Better Value target	83%	80%	89.9%	78.0%	82.4%	77.8%	77.6%	77.6%	77.6%	77.6%			
Number of schemes identified	97	102	110	119	125	125	125	125	125	125			
Number of schemes fully signed off and EQIA assessed	26	45	46	75	118	118	118	118	118	118			
Number of schemes identified but not signed off	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.
Our QI - is space to recognise the good work that teams around the Trust do to improve quality , and an opportunity to see the positive outcomes of Quality work at GOSH.

Patient Experience

Overview

The Inpatient FFT met the Trust target for response rate and experience rating, although both were marginally lower than in April. The outpatient experience score was above the Trust target after falling below the target for the previous 6 months. The volume of outpatient feedback increased dramatically from 215 to 842 (292% increase). Negative comments in outpatients were predominantly focussed on waiting times. There were also comments about letters and text messages regarding appointments directing patients and families to the incorrect location.

9 new complaints were received in May, which is an increase of 2 compared to May 2022 and reflects the trend of increased complaint numbers received. We continued to receive complaints this month regarding delays to care and treatment, such as short notice cancellations for surgery and admissions, waits for administration of medications following admission and delays with an appointment on the ward etc. This will continue to be monitored. There are currently 3 red/ high risk complaints open with one being recently declared a red complaint and serious incident and one being paused whilst awaiting information from the family which is deemed imperative to the investigation.

Pals contacts rose to 246 in May (an increase of 92 from April). Contacts primarily related to families seeking information and assistance regarding referral outcomes, clarity on patient's care/ treatment plans, cancellations of OPA/Admissions.

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Last 12 months	RAG		
FFT Experience rating (Inpatient)	98.0%	98.0%	99.0%	99.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	99.0%	98.0%		<90%	90-94%	>=95%
FFT experience rating (Outpatient)	97.0%	97.0%	97.0%	97.0%	95.0%	94.0%	93.0%	92.0%	93.0%	90.0%	91.0%	97.0%		<90%	90-94%	>=95%
FFT - response rate (Inpatient)	29.0%	23.0%	28.0%	28.0%	24.0%	24.0%	25.0%	25.0%	28.0%	29.0%	30.0%	27.0%		<25%	N/A	>=25%
PALS - per 1000 episodes	9.25	12.37	9.46	10.46	9.74	9.51	9.75	8.58	9.23	10.77	7.55	10.14		No Threshold		
Complaints- per 1000 episodes	0.95	0.38	0.43	0.58	0.36	0.55	0.51	0.47	0.53	0.42	0.49	0.37		No Threshold		
Red Complaints -% of total (note 1)	5%	5%	7%	7%	6%	6%	6%	5%	4%	4%	4%	4%		>12%	10-12%	<10%
Re-opened complaints - % reopened (2)	8%	8%	10%	9%	9%	9%	8%	6%	4%	4%	4%	4%		>12%	10-12%	<10%

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

Well Led Headlines: May 2023

Contractual staff in post: Substantive staff in post numbers in May were 5370.9FTE an increase of 19.58 FTE since April 2023 . Headcount was 5808 (+26 on the previous month).

Unfilled vacancy rate: The new budgets how now been released from finance which show May 23 vacancy rates for the Trust have increased to 10% after being fairly stable for several months. This may be as a result of the new budgets released by finance. The vacancy rates are highest in International and Private Care (23.5%), Research and Innovation (48.6%) and Transformation (67.7%).

Turnover: is reported as voluntary turnover over a rolling 12 month period. Voluntary turnover decreased marginally to 14.2% down 0.11% from the previous month however, is within the same range as the previous 4 months.

Agency usage: Agency usage for May increased slightly to 1.4% from 1.33% the previous month but remains within the 2% trust target. Corporate areas such as Finance (7%), Medical Directorate (7.9%), and Space & Place (5.9%), the highest spending directorates.

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

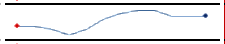
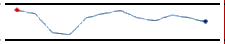
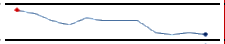
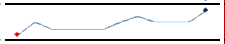
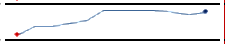
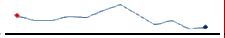
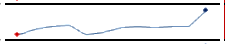
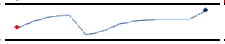
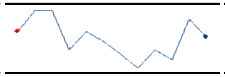
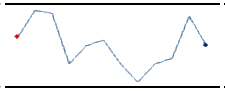
Appraisal/PDR completion: The non-medical appraisal rate has decreased by 1% to 81% in May, with only Finance (94%) performing above the Trust target. Consultant appraisal rate is remains at 91% this month.

Sickness absence: May sickness is 2.8%, and within trust target. 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 May was 4.44%.

Freedom to Speak Up: The service received 14 contacts in May which was a slight decrease from the previous month (18). The main themes being raised in May related to concerns around policy/ procedure, staff wellbeing, and bullying and harassment. Those raising concerns came from a range of professional backgrounds.

Well Led

Well Led Metrics Tracking

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Last 12 months	RAG Levels			Stat/Target
Mandatory Training Compliance	93.0%	94.0%	93.0%	93.0%	93.0%	94.0%	94.0%	94.0%	94.0%	94.3%	94.0%	93.9%		<80%	80-90%	>90%	Stat
Stat/Man training – Medical & Dental Staff	86.0%	86.0%	85.0%	83.0%	85.0%	88.0%	90.0%	91.0%	91.0%	89.0%	89.0%	89.0%		<80%	80-90%	>90%	Stat
Appraisal Rate (Non-Consultants)	84.0%	83.0%	78.0%	77.0%	82.0%	83.0%	84.0%	82.0%	81.0%	82.6%	82.0%	80.7%		<80%	80-90%	>90%	Stat
Appraisal Compliance (Consultant)	87.0%	85.0%	87.0%	85.0%	85.0%	85.0%	94.0%	95.0%	93.0%	90.7%	90.6%	91.0%		<80%	80-90%	>90%	Stat
Honorary contract training compliance	72.0%	71.0%	69.0%	68.0%	70.0%	69.0%	69.0%	69.0%	66.0%	65.0%	66.0%	65.0%		<80%	80-90%	>90%	Stat
Safeguarding Children Level 3 Training	94.0%	96.0%	95.0%	95.0%	95.0%	95.0%	96.0%	97.0%	96.0%	96.0%	96.0%	98.0%		<80%	80-90%	>90%	Stat
Safeguarding Adults Level 2 Training	93.0%	94.0%	94.0%	93.0%	93.0%	95.0%	95.0%	96.0%	95.0%	95.0%	95.0%	95.0%		<80%	80-90%	>90%	Stat
Resuscitation Training	78.0%	81.0%	81.0%	82.0%	83.0%	87.0%	87.0%	87.0%	87.0%	86.0%	85.0%	86.0%		<80%	80-90%	>90%	Stat
Sickness Rate see note 3	3.6%	3.3%	3.3%	3.6%	3.5%	4.0%	4.5%	3.7%	3.0%	3.3%	2.7%	2.8%		>5.3%	3-5.3%	<3%	T
Turnover Rate (Voluntary)	12.1%	12.6%	12.5%	13.6%	13.9%	14.3%	14.0%	14.2%	14.2%	14.4%	14.4%	14.2%		>14%	N/A	<14%	T
Vacancy Rate – Trust	5.8%	6.8%	7.1%	7.4%	5.9%	6.3%	6.9%	7.2%	7.0%	7.1%	7.1%	9.8%		>10%	N/A	<10%	T
Vacancy Rate - Nursing	6.1%	7.8%	8.8%	9.0%	4.5%	5.6%	7.0%	7.7%	8.3%	8.0%	8.0%	10.2%		No Threshold			T
Bank Spend	5.5%	5.5%	5.5%	5.4%	5.4%	5.4%	5.3%	5.4%	5.4%	5.2%	6.4%	5.8%		No Threshold			T
Agency Spend	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.3%	1.4%		>2%	N/A	<2%	T
Quarterly Staff Survey - I would recommend my organisation as a place to work		62%						65.0%			64%			No Threshold			T
Quarterly Staff Survey - I would be happy with the standard of care provided by this organisation		87%						87.0%			87%			No Threshold			T
Quarterly Staff Survey - Overall Staff Engagement (scale 0-10) See note 1		7.0						7.0			7.0			No Threshold			T
Quarterly Staff Survey - Communication between senior management and staff is effective See note 1		41.0%						45.0%			44%			No Threshold			T
Number of people contacting the Freedom To Speak Up Service	15	20	20	11	15	13	10	7	11	9	18	14		No Threshold			T
Number of Themes of concerns raised as part of Freedom to Speak Up Service (note 2)	24	33	32	15	21	23	15	9	15	17	31	21		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

Return to Contents Page

Safer Staffing- Nursing only

Vacancy rate: Average registered nurse (RN) vacancy rate increased to 10% in May due to the increase in budgeted establishments in the new financial year and not an increase in leavers, which is further evidenced through a small reduction in turnover. Central and local recruitment campaigns continue across all directorates with bespoke in-person open day recruitment events scheduled for BCC in July and H&L in September.

Voluntary Turnover: Based on a 12 month rolling average, the vol. turnover for May remains above trust target (<14%) but reduced from last month to 16.16%. The refreshed Retention Plan 'STAY' was presented to Nursing Board and will be launched later this month.

Sickness absence: Nursing sickness rates increased to 3.42% in May and above Trust target (3%).

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 15.8 in May.

CHPPD Actual vs Plan: The Trust average was 97.55% in May and within acceptable parameters.

Agency spend: There were only 2 agency nurse shifts booked in May which equates to less than 1% of the temporary staff usage. Bank fill rate was at 84% (1980 shifts).

Safe Staffing Incidents: There were 7 safe staffing incidents reported in May, these are currently being investigated. Two incidents resulted in patient procedures being cancelled due to lack of CICU beds. The main themes relate to short term staff sickness, Clinical Site Practitioner (CSP) support and skill mix.

Safer Staffing Metrics	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Last 12 months	RAG Levels			Stat/Target
Vacancy Rate - Nursing	6.1%	7.8%	8.8%	9.0%	4.5%	5.6%	7.0%	7.7%	8.2%	8.0%	8.0%	10.0%		>11%	10.1% - 11%	<= 10%	T
Turnover Rate (Voluntary)	14.5%	14.9%	15.2%	15.3%	15.8%	16.1%	15.4%	16.1%	16.5%	16.5%	16.5%	16.2%		>14%	N/A	<14%	T
Sickness Rate see note 3	4.2%	3.9%	3.7%	4.0%	4.0%	4.3%	5.5%	3.7%	3.4%	3.4%	3.0%	3.4%		>3.3%	3-3.3%	<3%	T
Care Hours per Patient Day (CHPPD)	14.6	16.1	16.8	15.0	15.5	14.4	15.0	15.3	15.0	14.9	16.0	15.9		No Threshold			T
Care Hours per Patient Day (CHPPD)- Actual vs Plan								104%	99%	101.9%	99.2%	97.6%		<80%	80-90%	>90%	T
Agency Spend	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%	0.0%	1.0%	0.1%		>2%	N/A	<2%	T
Safe Staffing incidents	10	3	4	13	13	10	15	3	6	13	6	7		No Threshold			T
Bank fill rate	85%	87%	85%	87%	84%	85%	81%	86%	70%	85%	83%	84%		No Threshold			T

Return to Contents Page

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 inpatient last minute cancellations.

- **RTT** Performance for May 2023 was **68.4%,** 0.7% increase from last month and remains below trajectory. The overall PTL size has increases by **508** patients compared to last month, this is mainly due to Clinical Genetics referrals. None of the directorates met the 92% standard this month. RTT performance has been affected by the national strikes, inherited breaches, patient and consultant leave, and bed pressures. We do not expect RTT to improve significantly in June due to industrial action taken by Junior Doctors.
- There are 11 patients who are waiting above **104 weeks,** an increase from last month, when we reported nine. There are two **ENT** patients. One of these is a complex patient who needs to be reviewed by another specialty before treatment can be advised. The other ENT patient 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. One **Endocrinology** patient is an inherited wait received at 154 weeks, and was treated in June. There are two **Plastic Surgery** patients, one is a complex patient and needs a TCI to be coordinated around three surgeons' availability and post op care. The other patient has a TCI in August. One of the two **Orthopaedic** patients was treated in June, and the other patient has a provisional TCI in August. One **Audiology** patient unfortunately cancelled their appointment in June, and is now rebooked for July. Three patients are waiting for **Dental** treatment. These patients will be seen in a virtual clinic by UCLH dentists in June and next steps will then be established. **78 week waits** have continued to increase (89) and remains above trajectory. **52 week waits** have increased to 483. The long waiters are predominantly in Orthopaedics (95), Dental (79), Plastic surgery (70), ENT (42), Ophthalmology (26), Craniofacial (17), Cardiology (15), Audiological Medicine (14), Spinal Surgery (13) Dermatology (11) and SNAPS (11). 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 **94** patients, at the end of June 2023, to be waiting 78 week waits or more against the national ambition of zero.
- **DM01** performance for May 2023 was **83.7%**, an increase of 3.0% from the previous month. The number of 6 week breaches has decreased this month to 273, compared to 322 last month. 13 week breaches have seen an increase to 45 up from 33 last month. Trajectories for MRI, CT, Ultrasound, Endoscopy and Sleep Study modalities are being refreshed.
- **Cancer:** It is projected for May 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

Mutual aid for Dental Services with UCLH starting in June 2023

Meetings with RNOH regarding Orthopaedic support

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

Assessing additional 4 bed bay to 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

Recruitment of Dental consultant working 5 PAs at GOSH

Responsive

Patient Access Metrics

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Access Metrics Tracking

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Trajectory	Last 12 months	RAG Levels			Stat/Target
RTT Open Pathway: % waiting within 18 weeks	75.3%	73.7%	72.3%	71.8%	72.4%	73.2%	70.9%	71.4%	69.8%	67.3%	67.7%	68.4%	Below		<92%	N/A	>=92%	Stat
Waiting greater than 18 weeks - Incomplete Pathways	1,765	1,900	2,006	2,023	2,012	1,944	2,154	2,169	2,280	2,464	2,415	2,526	-		No Threshold			-
Waiting greater than 52 weeks - Incomplete Pathways	177	177	196	202	206	219	248	279	311	356	379	438	Above		>0	N/A	=0	Stat
Waiting greater than 78 weeks - Incomplete Pathways	24	20	25	30	28	28	45	47	52	58	75	89	Above		TBC			T
Waiting greater than 104 weeks - Incomplete Pathways	3	0	0	1	1	3	5	5	3	4	9	11	Above		>0	N/A	=0	Stat
18 week RTT PTL size	7150	7239	7229	7176	7295	7264	7401	7580	7545	7532	7482	7990	-		No Threshold			-
Diagnostics- % waiting less than 6 weeks	82.6%	83.9%	84.1%	83.5%	88.4%	89.2%	82.6%	82.6%	87.6%	81.9%	80.7%	83.7%	Below		<99%	N/A	>99%	Stat
Total DM01 PTL size	1,489	1,506	1,480	1,463	1,714	1,747	1,767	1,663	1,841	1,672	1,668	1,673	-		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%	94%	92%	93%	100%	*100%*	-		No Threshold			-
Cancelled Operations for Non Clinical Reasons (note 1)	28	43	28	33	38	53	27	45	34	28	21		-		No Threshold			-
Cancelled Operations: 28 day breaches	4	4	4	2	5	1	3	3	3	1	1		-		>0	N/A	=0	Stat
Number of patients with a past planned TCI date (note 4)	1,256	1,261	1,347	1,112	1,193	1,270	1,261	1,390	1,356	1,422	1,542	1,552	-		No Threshold			-
NHS Referrals received- External	2,673	2,607	2,431	2,611	2,901	2,920	2,453	2,754	2,667	2,725	2,176	2,843	-		No Threshold			-
NHS Referrals received- Internal	1,767	1,883	1,789	1,820	2,124	2,198	1,625	1,980	2,039	2,136	1,753	2,067	-		No Threshold			-
Total NHS Outpatient Appointment Cancellations (note 2)	6,816	7,352	7,472	6,910	6,352	6,368	6,449	6,308	6,212	7,456	6,061	6,500	-		No Threshold			-
NHS Outpatient Appointment Cancellations by Hospital (note 3)	1,499	1,569	1,493	1,707	1,441	1,366	1,576	1,514	1,740	2,113	1,584	1,498	-		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

Responsive

Patient Access - Activity Monitoring at Month 2

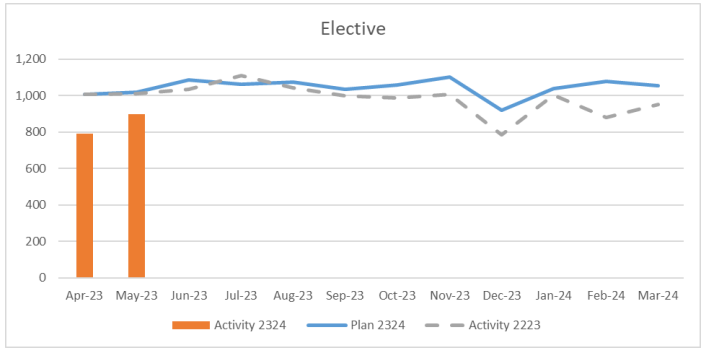
Overview:

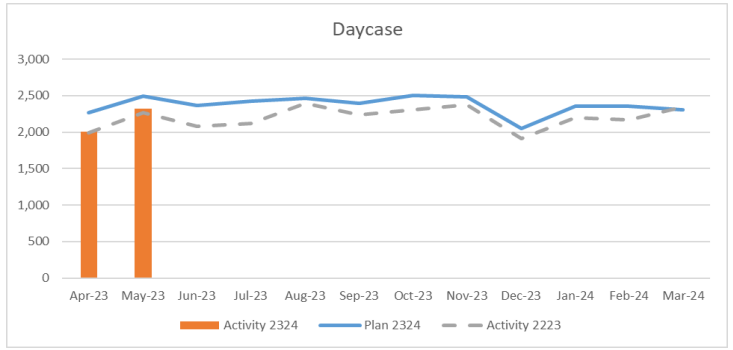
As at M2 of 23/24 all activity was -5.5% down v plan and 8% down on 2022/23 activity levels. However, when comparing to 19/20 activity overall is 15.6% above, if follow-ups ae excluded activity is 102% above 19/20.

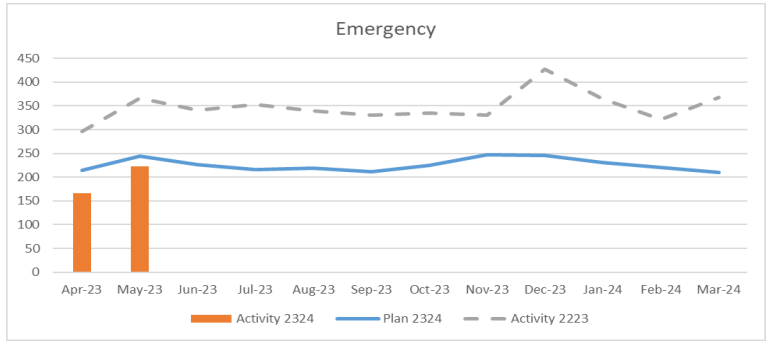
Electives continue to be less than plan at -17% and outpatients 4% down against plan. Recovery from the Junior Doctor Strikes has been strong but with future impending strikes activity levels are being closely monitored.

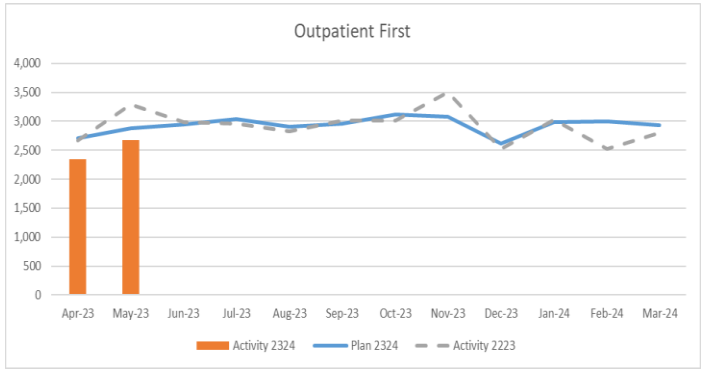
As at M2 23/24, Body, Bones and Mind was the only directorate above plan.

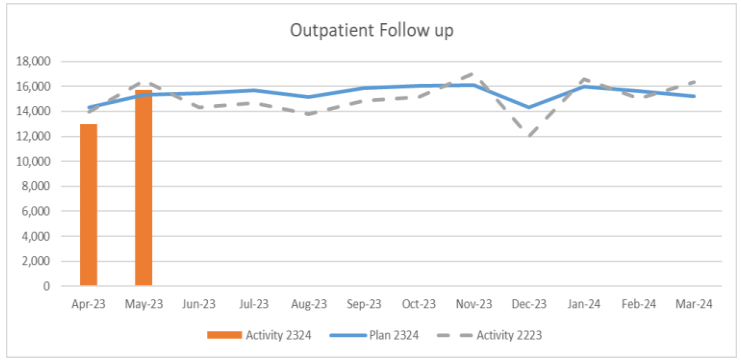
With strikes and bed closures continuing this has impacted the delivery of activity, RTT and DM01 waiting time improvements. Continued focus remains on optimising bed capacity, theatres and reducing long waits.











Overview YTD M2 23-24

POD	Plan 2324	Activity 2324	Activity 2223	% of 22/23	% of Plan
Daycase	4,761	4,326	4,262	101.50%	90.86%
Elective	2,028	1,687	2,016	83.68%	83.19%
Emergency	459	388	663	58.52%	84.62%
First OPA	5,585	5,013	5,960	84.11%	89.76%
Follow-up OPA	29,636	28,717	30,447	94.32%	96.90%
Grand Total	**42,468**	**40,131**	**43,348**	**92.58%**	**94.50%**

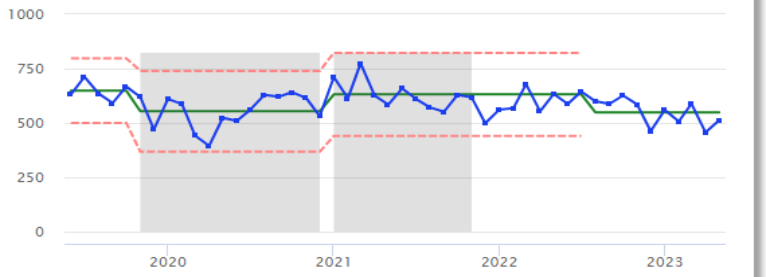
Return to Contents Page

Responsive

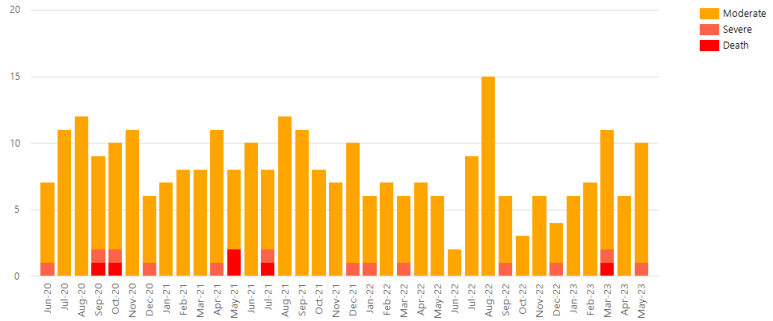
Appendix
Integrated Quality & Performance Report

Appendix 1: Patient Safety (incidents & risks)

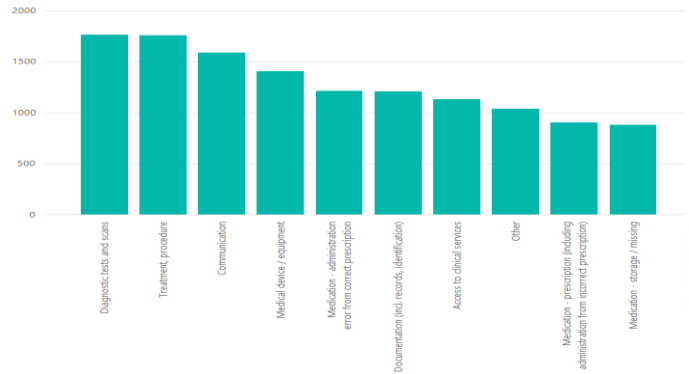
New Incidents



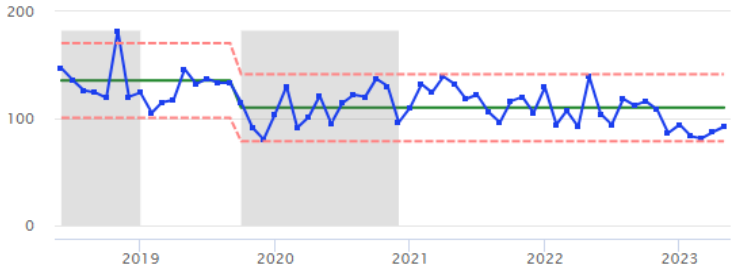
Incidents by Harm



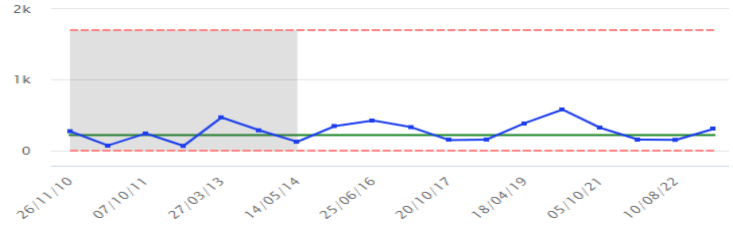
Top 10 Incident Categories (assigned at the point of incident reporting)



Medication Incidents



Days Since never events

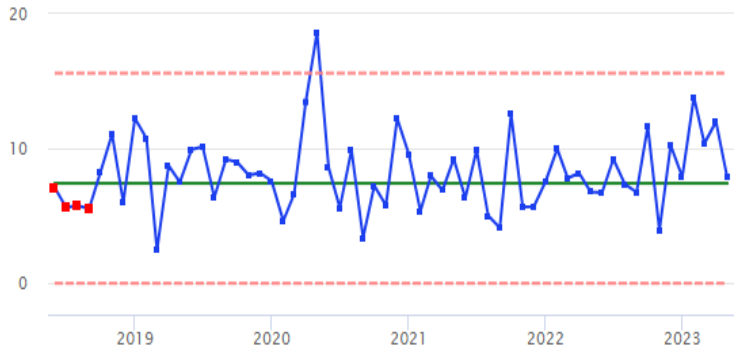


Safe

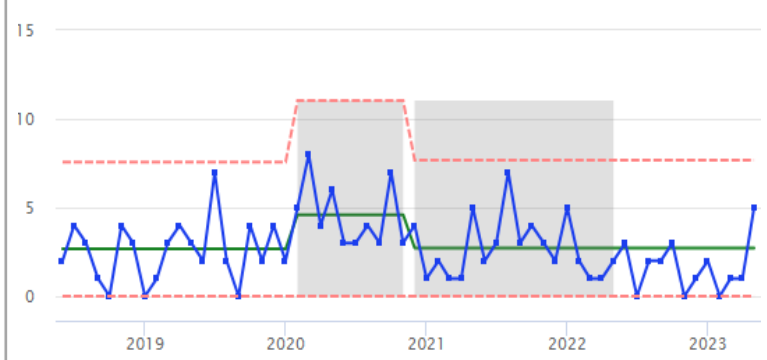
Appendix 2: Patient Safety (Infection & mortality)

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

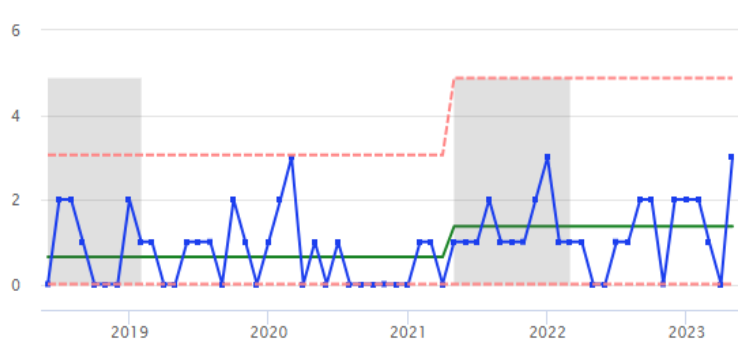
Inpatient Mortality Rate / 1000 Discharges



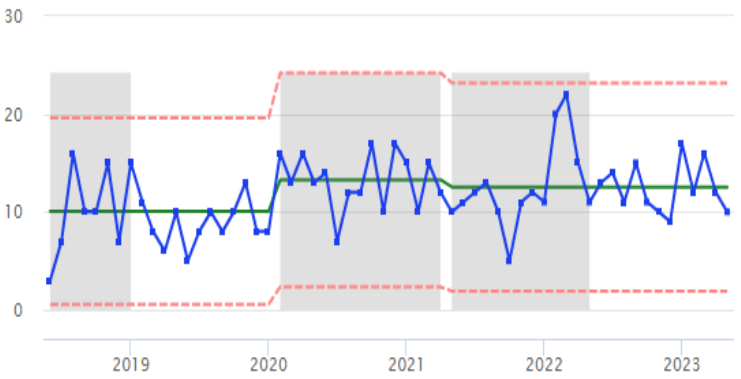
Respiratory Arrests outside ICU



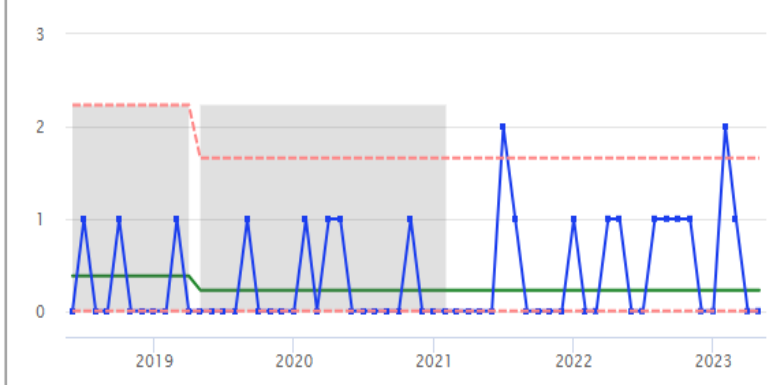
Cardiac Arrests outside ICU



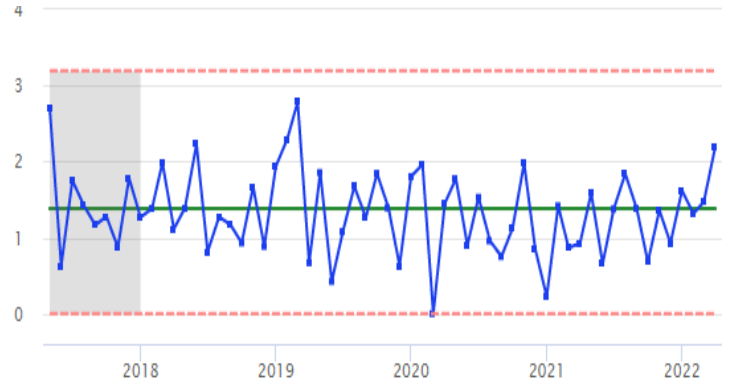
Non 2222 Patients transferred to ICU



Cat 3+ Hospital Acquired Pressure Ulcers



CV Line Infection / 1,000 line days



Appendix 3: Friends and Family

Overview:

The inpatient experience score for May was above the Trust target, scoring 98% and all directorates achieved the Trust target of 95% Trust or above. Outpatients also achieved the Trust target in May for experience after dropping below target for the previous 6 months. Three directorates, Blood Cells and Cancer, Body Bones and Mind, and Core Clinical Services did not reach the target of 95%. However, outpatients managed to significantly increase the volume of feedback since the recent FFT audit was carried out. The outpatient volume has increased by an impressive 292%.

For inpatients, the response rate was slightly lower than the previous month at 27% but still above the Trust target. Overall the total responses increased by 57% on the previous month. All directorates scored above the response rate target of 25% with the exception of Blood Cells and Cancer, Core Clinical Services and Sight and Sound.

Headline:

Inpatient response rate – 27% (decreased from April).

Experience measure for inpatients – 98% (decreased from April).

Experience measure for outpatients – 97% (increased from April).

Total comments received – **1718** (increased from April).

12% of FFT comments are from patients.

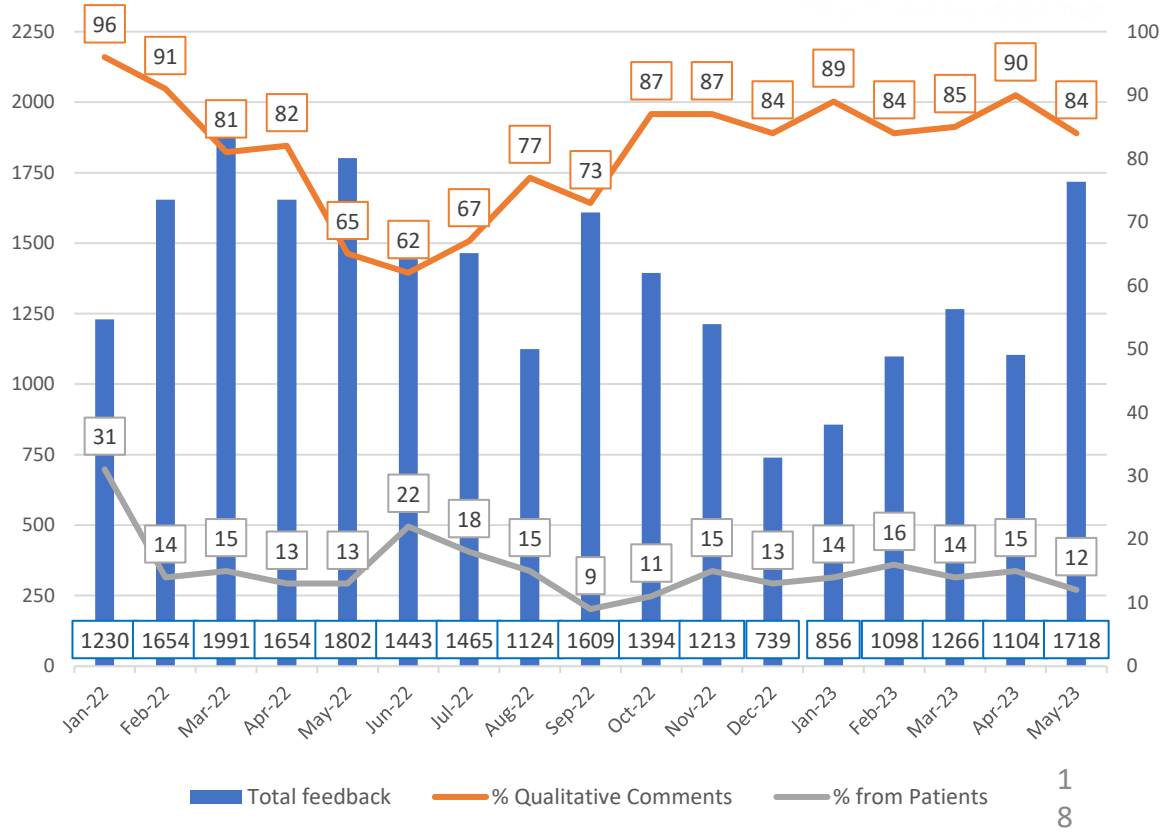
84% of responses had qualitative comments.

Positive Areas:

- Reception staff friendly.
- Staff explanations about health conditions and procedures.
- Exceptional care.
- More toys are now available.
- Hospital atmosphere.
- Parents feel that their child is in safe hands.
- Cleanliness.
- Staff are welcoming.
- Staff professionalism.

Areas for Improvement:

- Broken lifts in Hippo and Zebra- concerns about this recurrent issue and delays caused (n=14)
- Long waits in OP (n=8) and day case areas (n=29)
- Outpatient letters and texts guiding families to the wrong place for their appointment. (n=6)



Appendix 3: Complaints

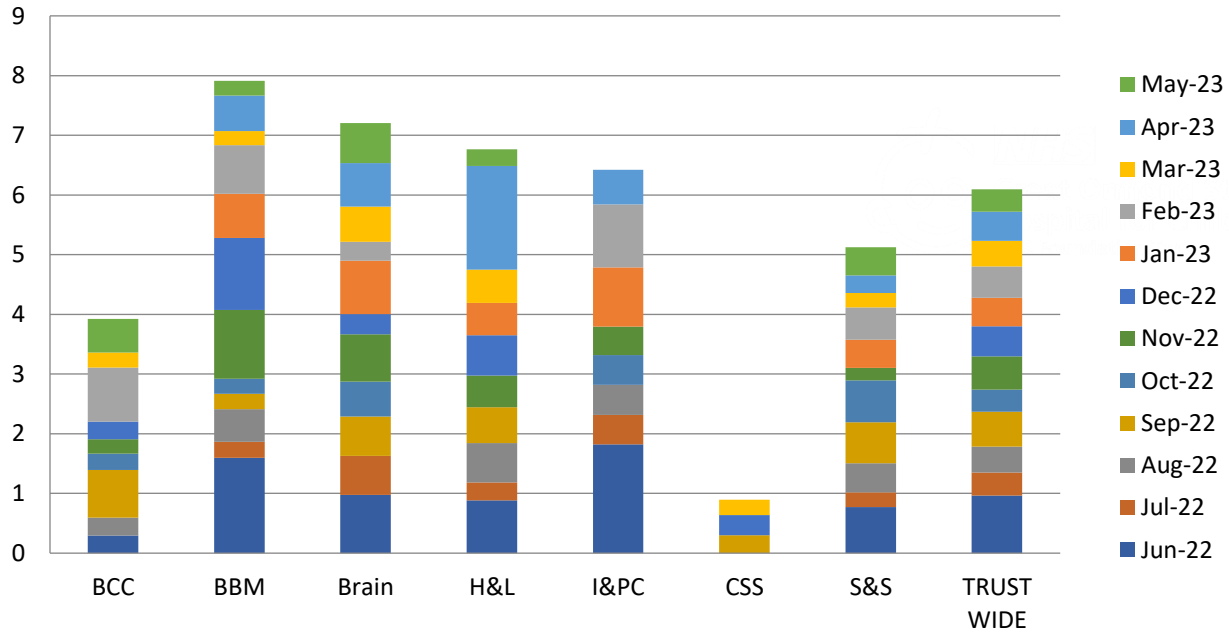
Headline: There were 9 new formal complaints in May which is a slight increase from this time last year and consistent with the increased numbers of complaints raised since June 2022.

In May families complained about:

- **A data breach** where a safeguarding referral was shared with an ex-partner
- **Care provided by staff on the ward,** including NG tube insertion
- **A lengthy delay** and wait for an appointment that was scheduled on the ward
- **Multiple discussions around DNAR** at the end of life. The family felt this was inappropriate and their wishes were not respected.
- **Cancellation of procedure at the last minute** and **lack of advice** given at discharge following a long period when the child remained nil by mouth.
- **The correct treatment not being given**, and concerns that there was a delay in giving IV medication when admitted, as well as not receiving the appropriate training to administer.
- **Child being brought to GOSH by father, without mother's permission or knowledge** and queries around whether the diagnosis is incorrect as it was reliant on information from father.
- Multiple aspects of the an admission and the **care received on the ward**, including **delayed admission**, **behaviour, rudeness and lack of interest from staff** and little parental involvement in the decision making as well as a lack of play input and **poor contradictory communication.**

Closed complaints since April 2023

22 complaints (including withdrawn and reopened complaints) have been closed since April 2023 with 8 of these requiring extended response times. 50% of these draft responses were submitted late to Complaints for review.



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

Due to feedback around the support for patients with learning disabilities the following actions have been shared and/or agreed. We have just set up a new role in the hospital, Lead Practice Educator for Learning Disabilities, and we are now undertaking a more extensive programme of staff education across the Trust, related to Learning Disability/Autism. This includes the particular importance of appropriate planning for children with additional needs and ensuring reasonable adjustments are put in place, including appropriate communication support and resources.

Appendix 3: PALS

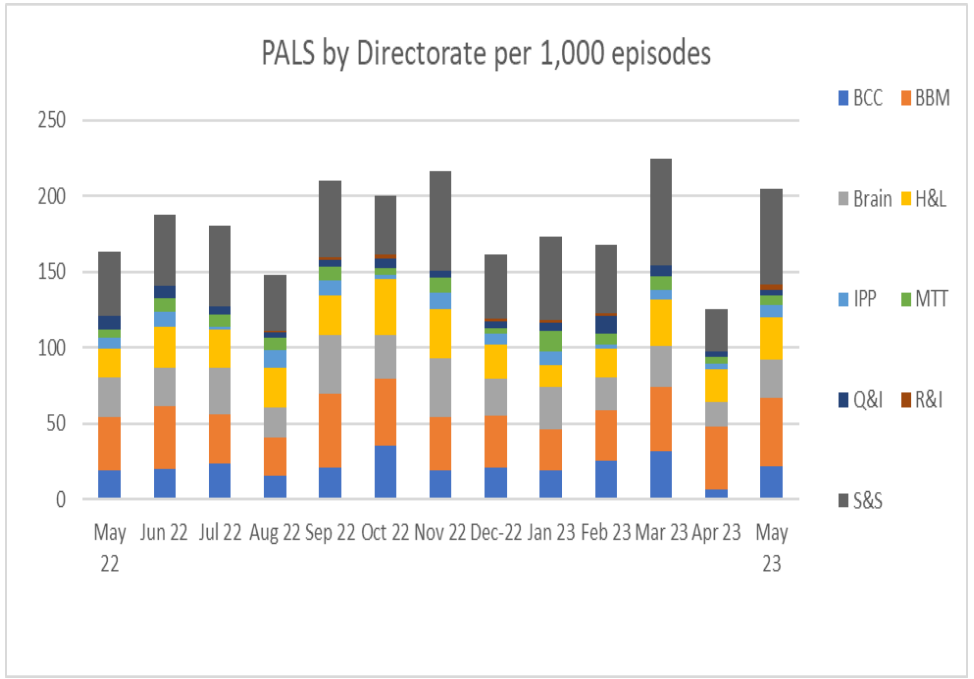
Headline: Pals received 246 contacts in May (this is a increase of 92 cases April (154 contacts). Contacts primarily related to families seeking information and assistance regarding referral outcomes, clarity on patient's care/ treatment plans, cancellations of OPA/Admissions.

Contacts resolved within 48 hours increased from 82% in April to 85% in May.

Care Queries: Pals were contacted by 77 families in May: Contacts included lack of communication from the clinical team with families wanting clarification on treatment plans, clinical queries regarding patient care and symptoms, families chasing test results

Significant areas of focus: The highest number of Pals contacts were received by SNAPS (increase from 14 in April to 21 in May), Cardiology (20 contacts in May compared to 6 in April) and Dermatology (12 cases in May compared to 5 in April)

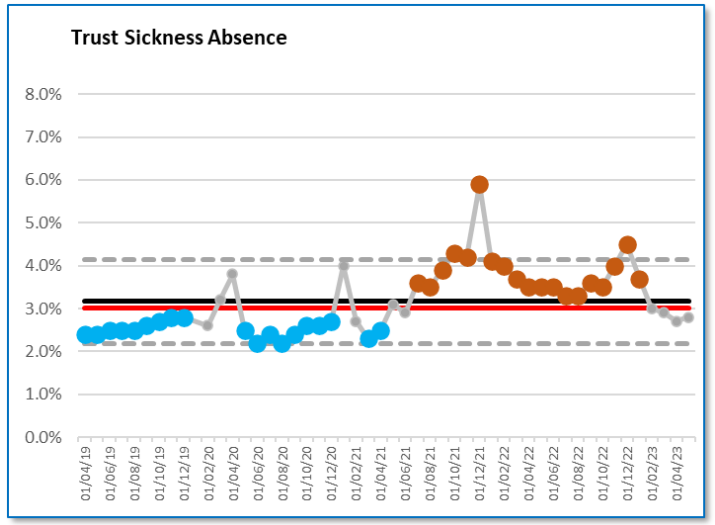
Consistent themes related to OPA and admission cancellation/ scheduling due to lack of beds, requests for information regarding test results, referral enquiries and difficulties in speaking to the team.

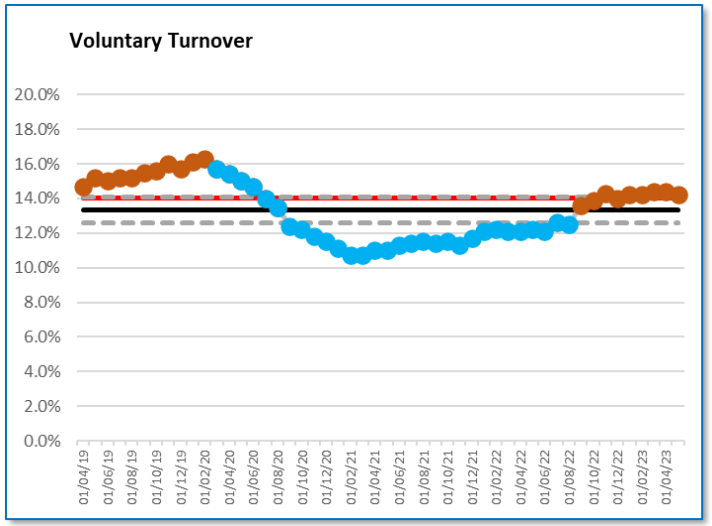


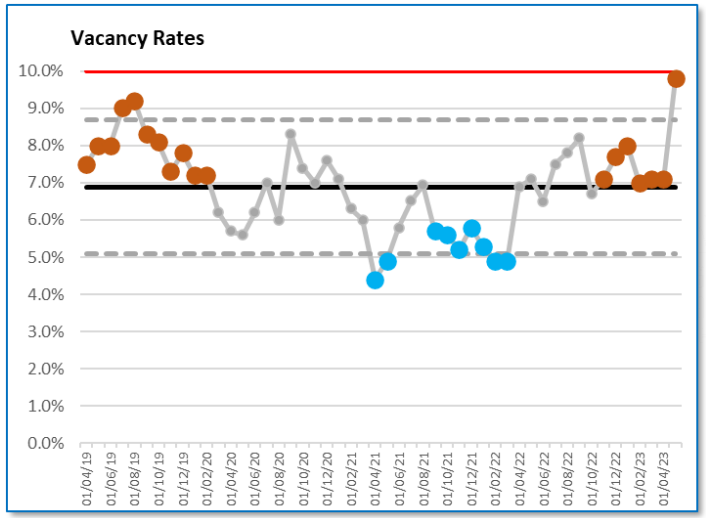
Pals Learning/Service Improvement:

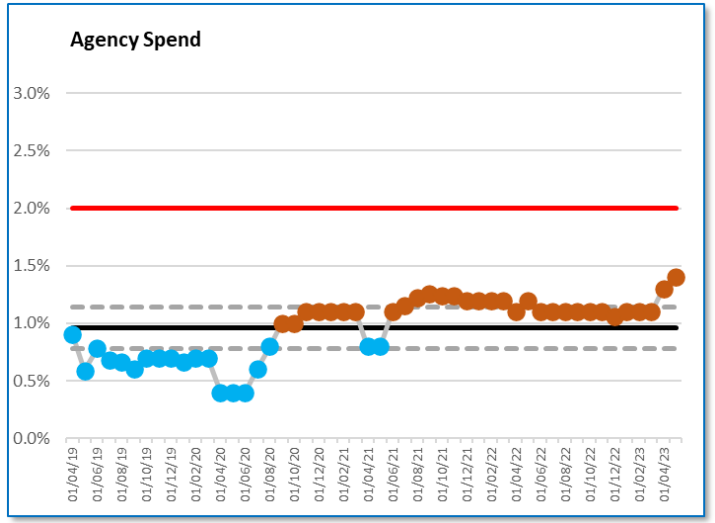
Pals have been contacted by external Hospitals asking for the Patient safety team's nhs.net account to alert them about incidents that have occurred. At present the team do not have a general nhs.net account, but now due to the amount of contact from Pals requesting this they have agreed to set up a Patient safety nhs.net inbox.

Appendix 4: Workforce SPC Analysis

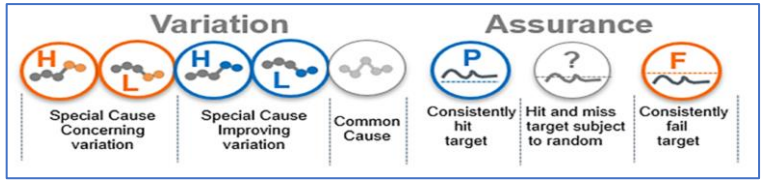








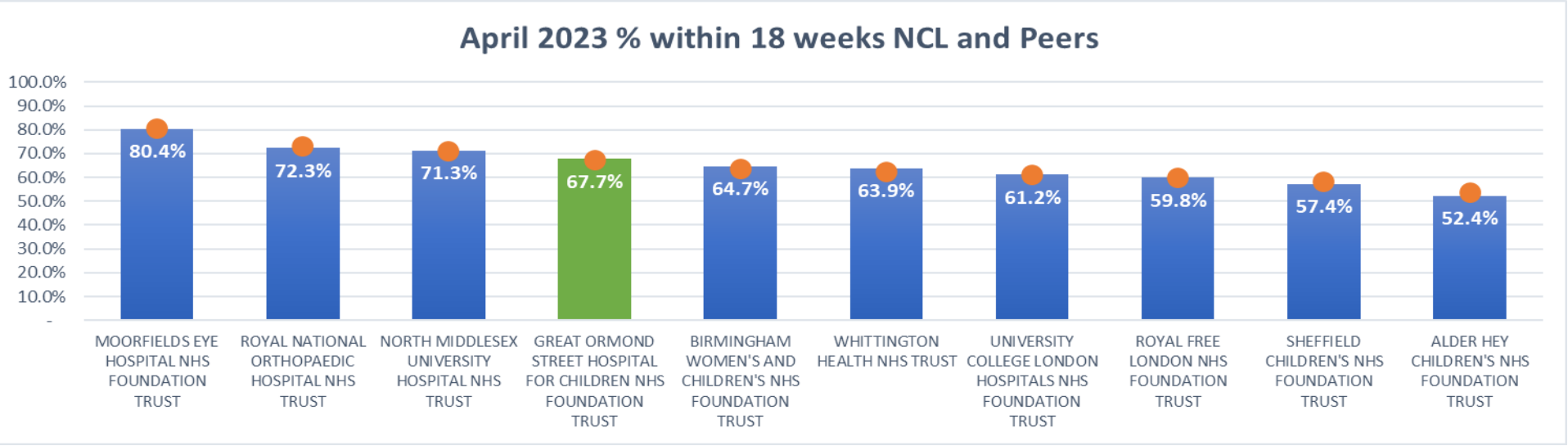
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Trust Sickness Absence	May 23	2.8%	3.0%			3.2%	2.2%	4.1%
Voluntary Turnover	May 23	14.2%	14.0%			13.3%	12.6%	14.1%
Vacancy Rates	May 23	9.8%	10.0%			6.9%	5.1%	8.7%
Agency Spend	May 23	1.4%	2.0%			1.0%	0.8%	1.1%



Well Led

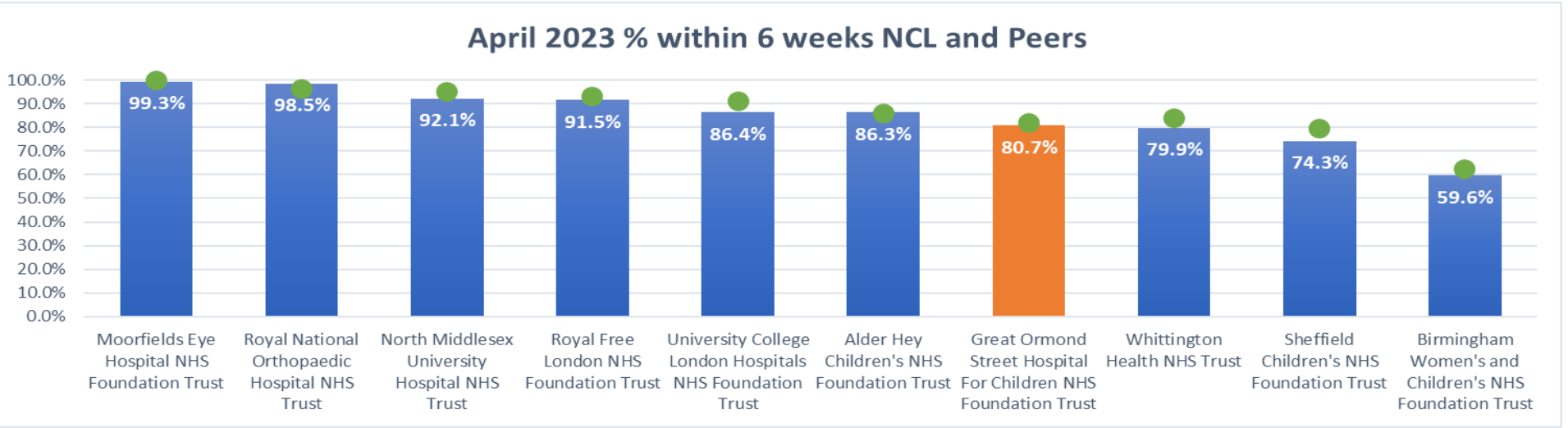
Appendix 5: RTT and DM01 Comparison

Referral to Treatment



Orange markers indicate March performance. GOSH for the month of April remains in the top four of the selected Peers. However, GOSH is ranked 50th out of 167 providers, this is an increase of 8 places.

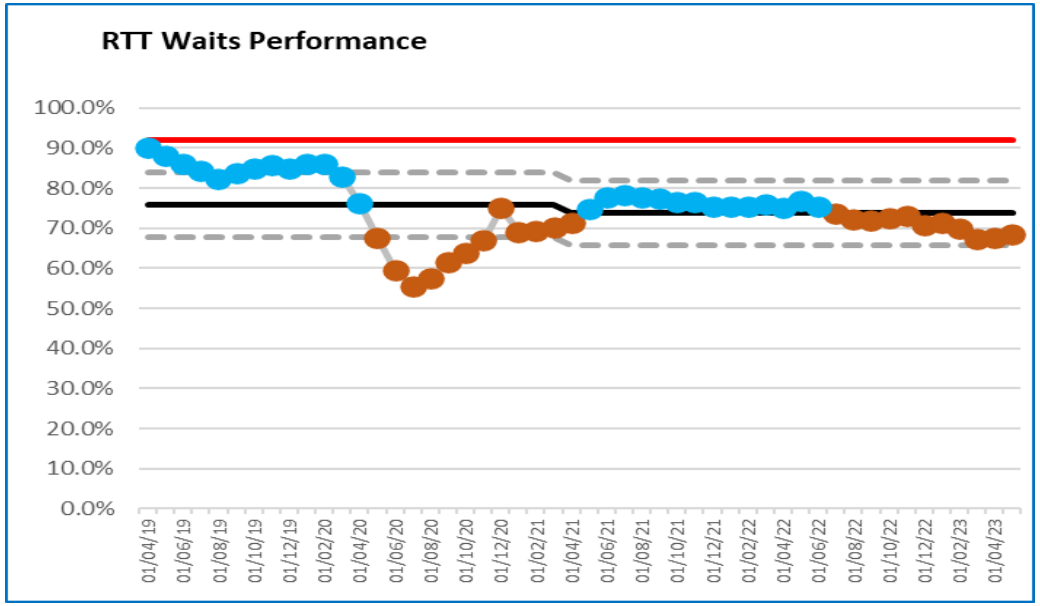
Diagnostics

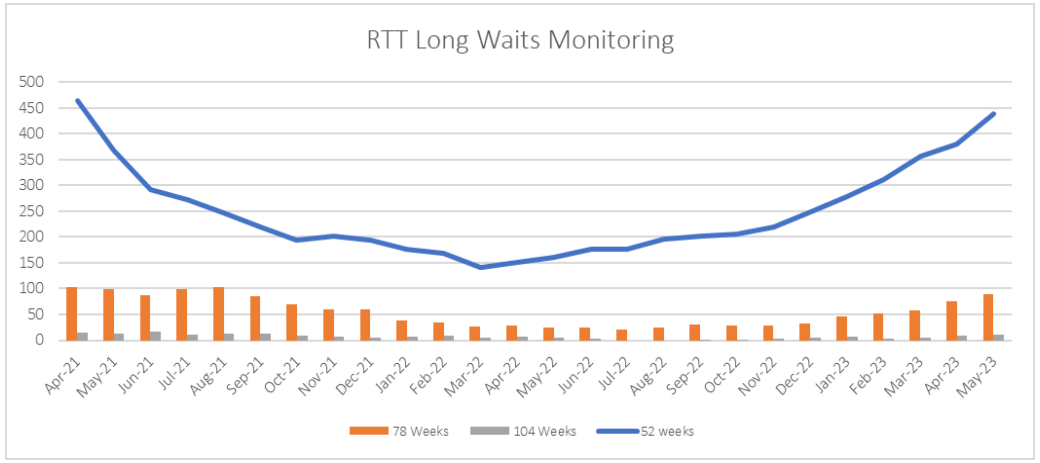


Green markers indicate March performance. GOSH for the month of April is 4th bottom place amongst selected Peers. GOSH is ranked 70th out of 154 providers, an increase of 8 places.

Responsive

Appendix 5: Referral to Treatment times (RTT)





RTT:

68.4% ↑ 0.7%

People waiting less than 18 weeks for treatment from referral.

>52 Weeks:

438 ↑ 59

Patients waiting over 52 weeks

>78 Weeks:

89 ↑ 14

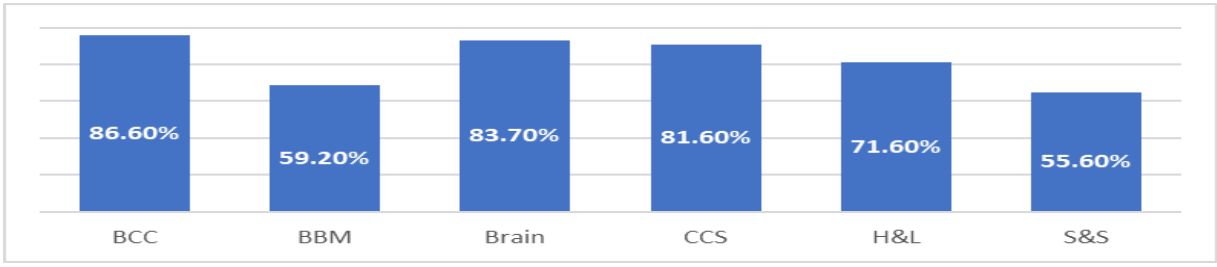
Patients waiting over 78 weeks

>104 Weeks:

11 ↑ 2

Patients waiting over 104 weeks

Directorates



RTT PTL Clinical Prioritisation – past must be seen by date

P2

178 ↓ 29

P3

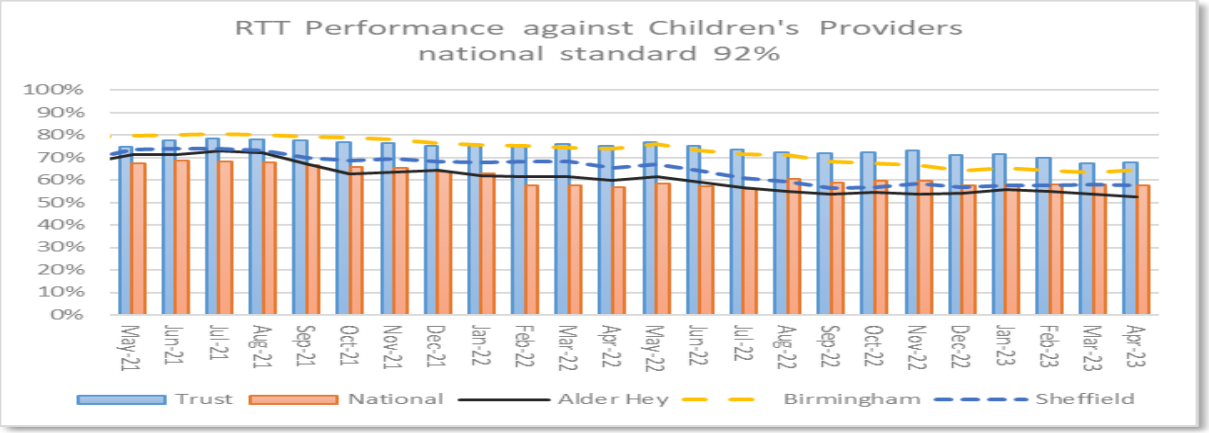
666 ↓ 56

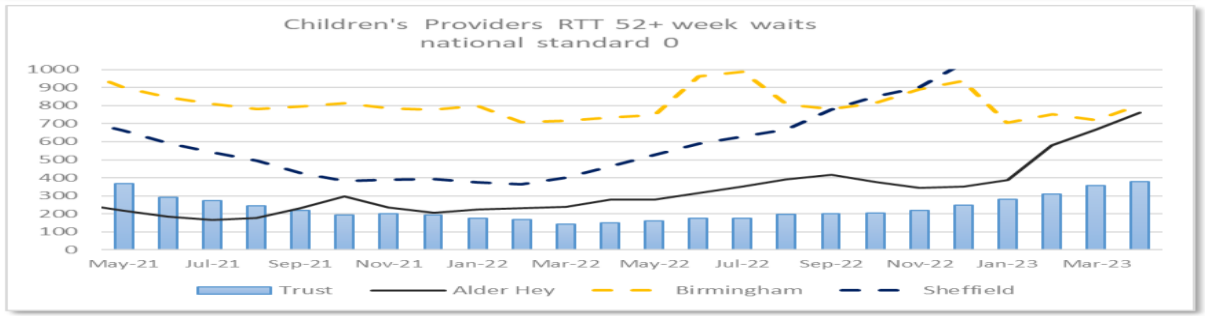
P4

551 ↑ 20

Responsive

Appendix 5: National and NCL RTT Performance –April 2023





Nationally, at the end of April, 57% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks.

GOSH is tracking 10% above the national April performance at 57.6% and is inline with comparative children's providers. (RTT Performance for Sheffield Children (57.4%), Birmingham Women's and Children's (64.7%) and Alder Hey (52.4%)).

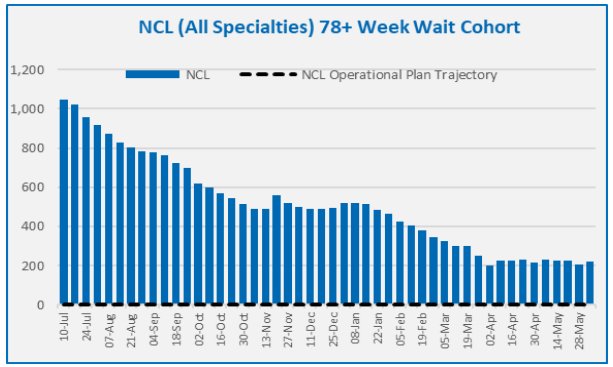
The national position for April 2023 indicates an increase in patients waiting over 52 weeks at 357,881 patients.

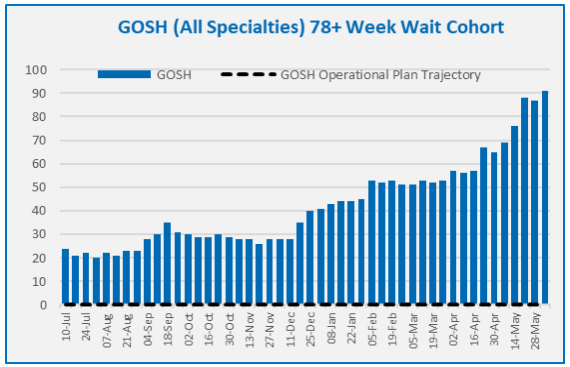
Compared to Alder Hey, Birmingham and Sheffield the number of patients waiting 52 weeks and over for GOSH is lower than all three providers for April. All 4 providers have seen increases in 52 week waits.

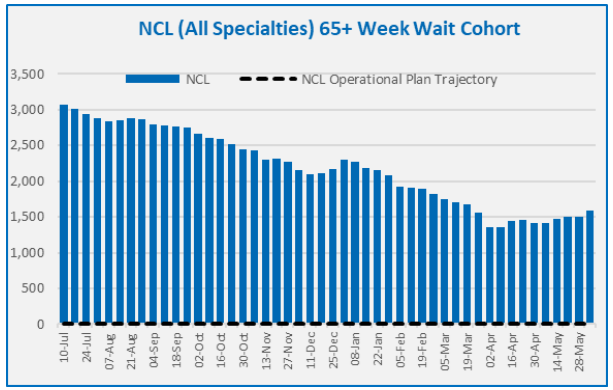
Overall for NCL the 78+ week wait position is above projected plan at 210 patients but has decreased by 1000 since April 2022. GOSH is above trajectory by 91 patients.

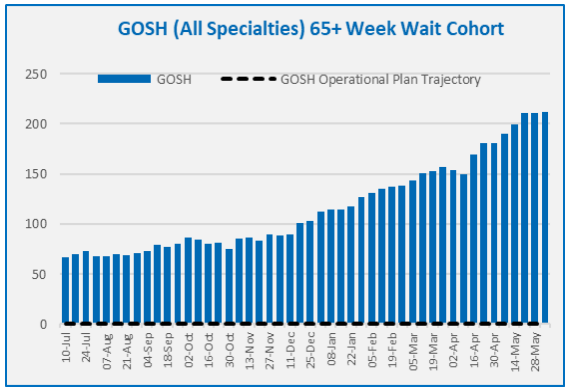
Monitoring of the 65 week wait national ambition of zero patients at March 2024 NCL providers are performing well against the required removal rate.

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



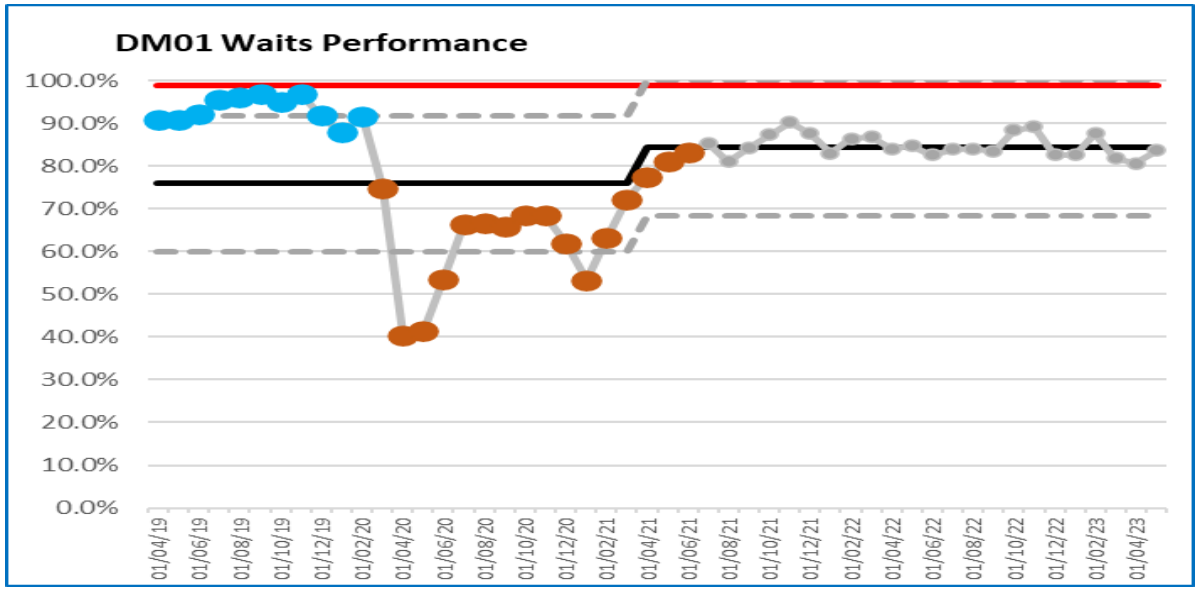


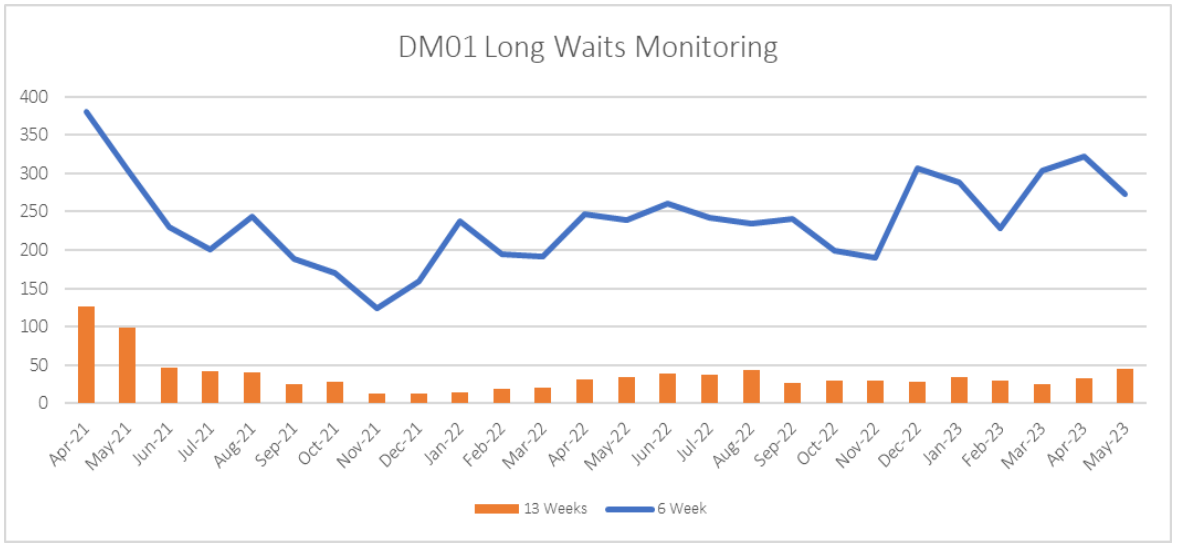




Responsive

Appendix 6: Diagnostic Monitoring Waiting Times (DM01)





DM01:

83.6% ↑ 3.0%

People waiting less than 6 weeks for diagnostic test.

>6 Weeks:

273 ↓ 49

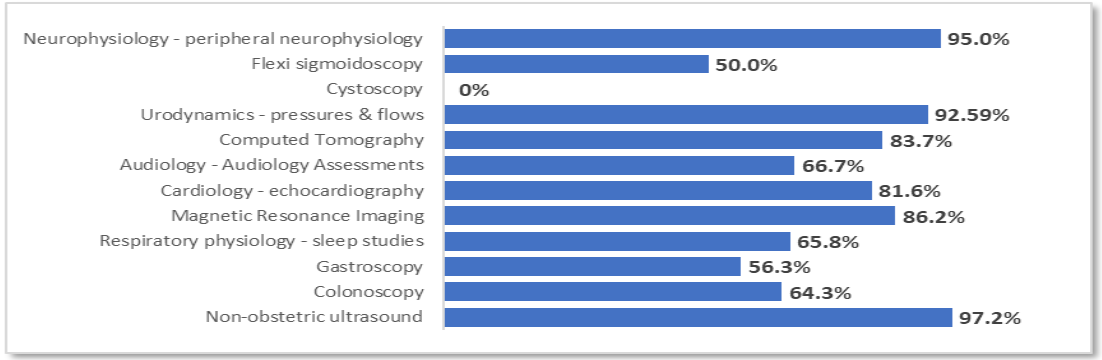
Patients waiting over 6 weeks

>13 Weeks:

45 ↑ 12

Patients waiting over 13 weeks

Modalities not meeting 99% standard



Responsive

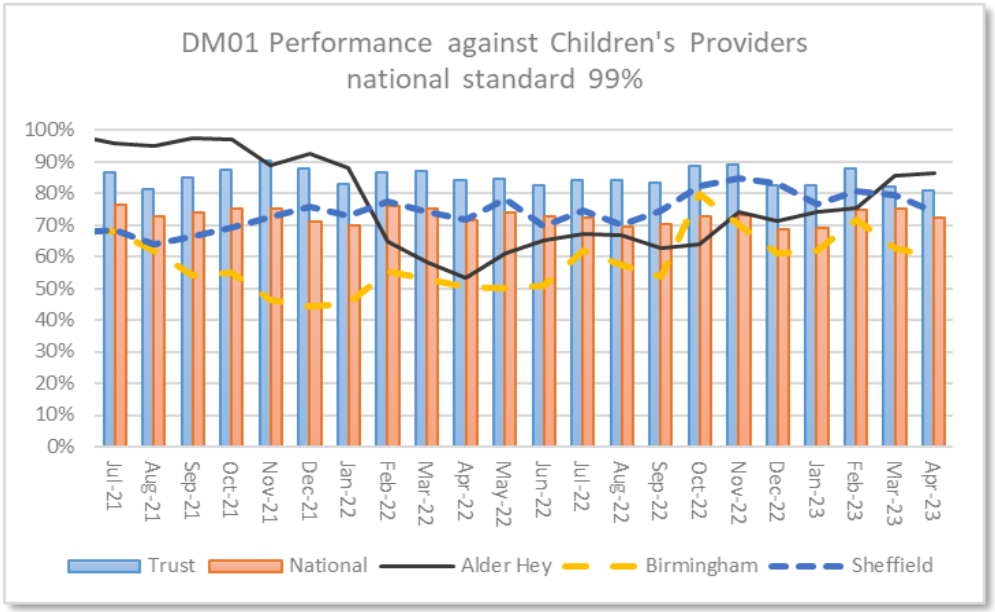
Appendix 6: National Diagnostic Performance and 6 week waits – April 2023

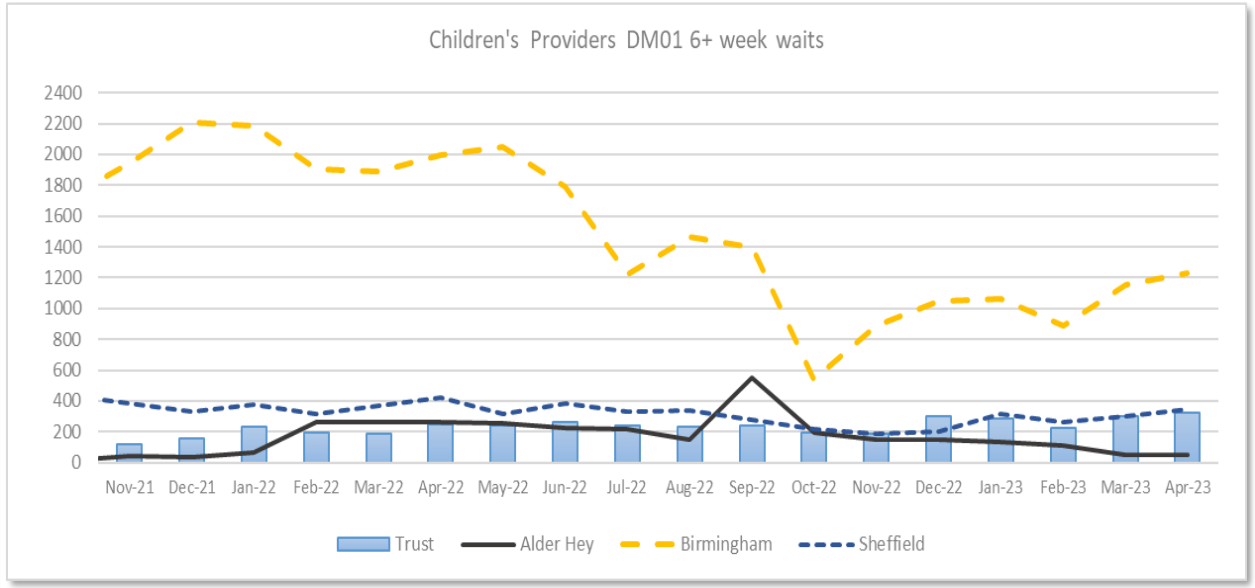
Nationally, at the end of April, 72.4% of patients were waiting under 6 weeks for a DM01 diagnostic test.

GOSH is tracking 8.2% above the national April performance and is inline with comparative children's providers. DM01 Performance for Sheffield Children (74.2%), Birmingham Women's and Children's (59.6%) and Alder Hey (86.3%).

The national position for April 2023 indicates an increase of patients waiting over 6 weeks at 430,804 patients.

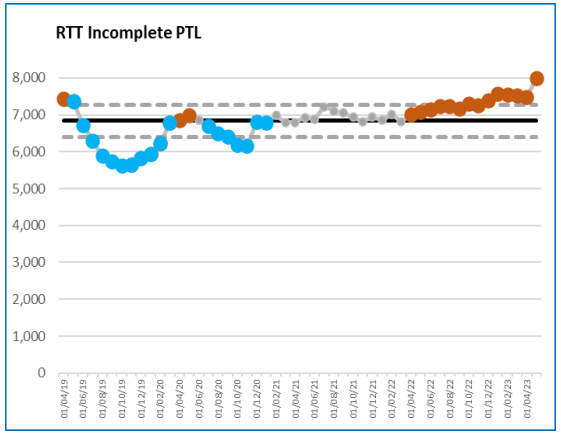
Compared to Birmingham and Sheffield the number of patients waiting 6 weeks and over for GOSH is lower than these providers for April.



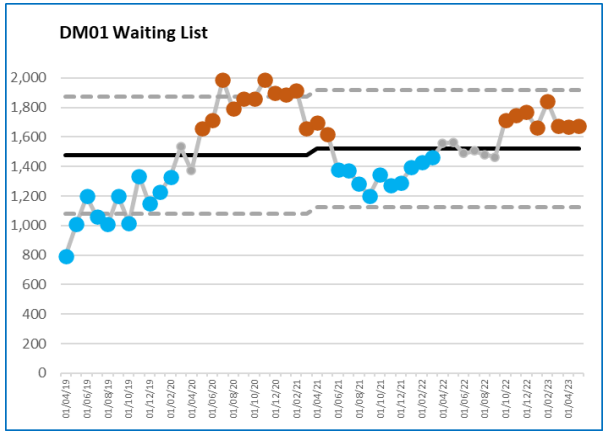


Responsive

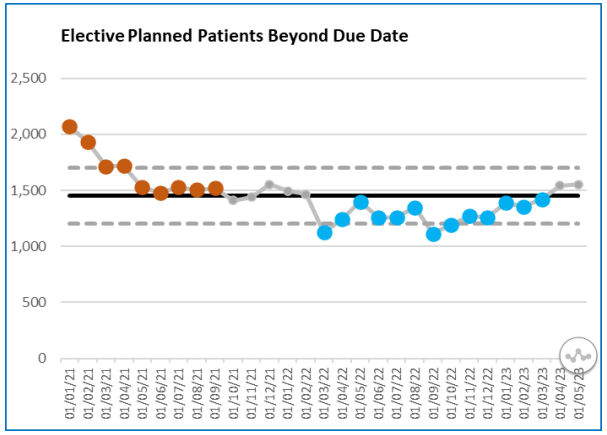
Appendix 7: Patient Access SPC Trends



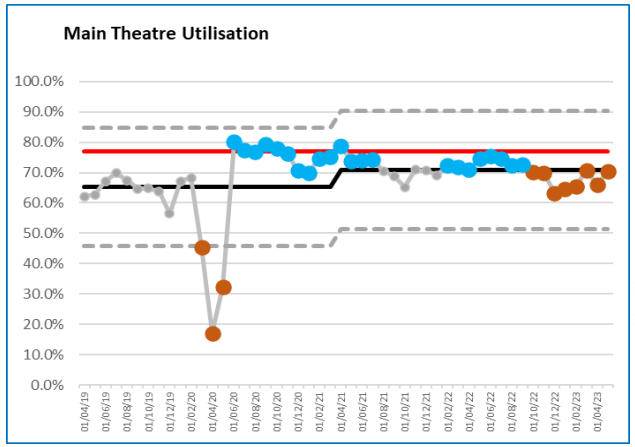
Special cause variation



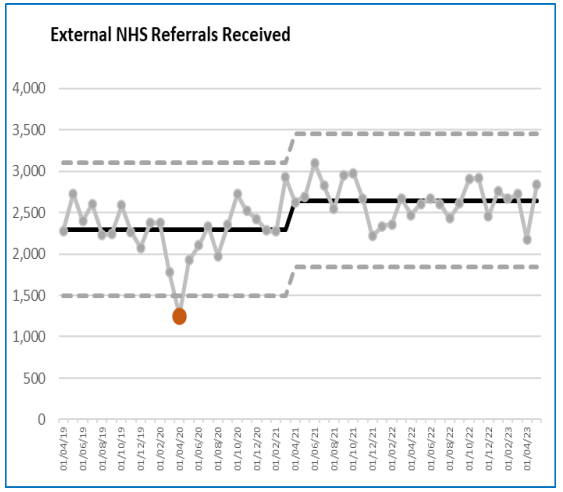
No Significant variation



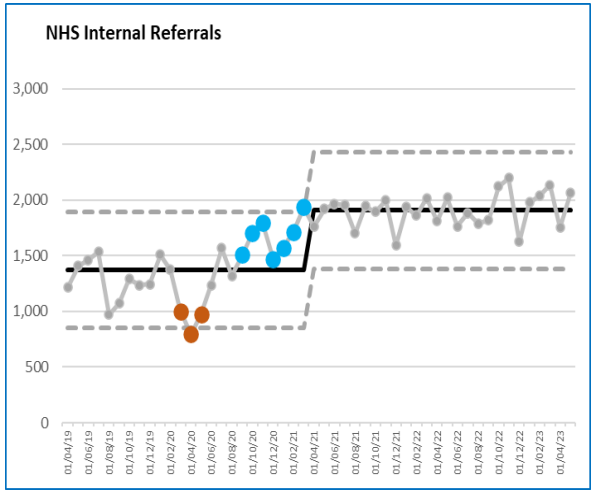
Marginal upward trend, strikes have impacted



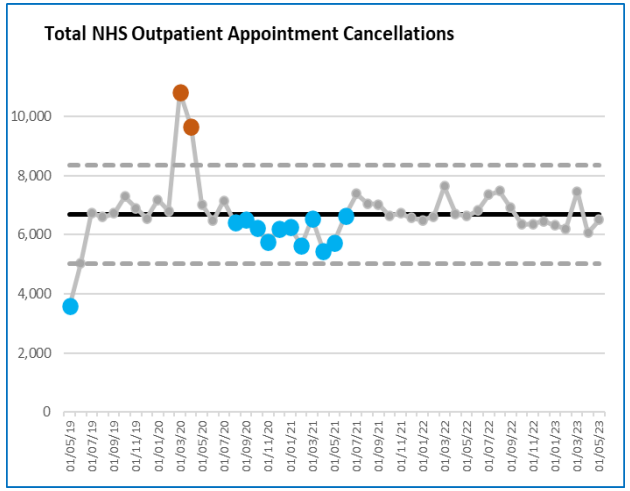
No Significant variation



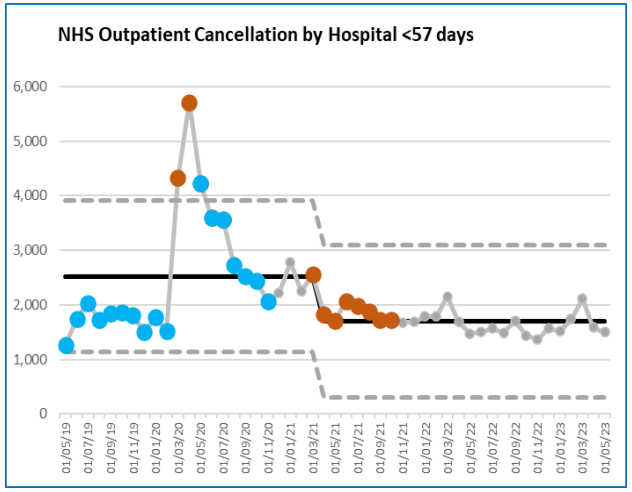
No significant variation, common cause



No significant variation, common cause



No significant variation, common cause



Common cause variation

Responsive

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

Attachment N

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6th July 2023

Month 2 2023/24 Finance Report **Submitted by:** John Beswick Chief Finance Officer	**Paper No: Attachment N** ☐ **For information and noting**

Purpose of report

The Trust is reporting a £4.4m deficit YTD position at Month 2; a £2m adverse position overall to plan and materially impacted by the unbudgeted impacts of Industrial Action by Nurses and Junior Doctors (£1.6m).

The table below outlines the trust financial position at Month 2

	In Month			Year to Date		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	51.4	52.7	1.3	100.7	100.0	(0.7)
Pay	(31.0)	(31.9)	(1.0)	(61.9)	(62.6)	(0.7)
Non-Pay	(20.6)	(20.5)	0.1	(40.3)	(41.0)	(0.7)
Finance Costs	(0.4)	(0.5)	(0.1)	(0.9)	(0.8)	0.1
Surplus/(Deficit)	**(0.6)**	**(0.3)**	**0.3**	**(2.4)**	**(4.4)**	**(2.0)**

The Trust Better Value programme summary:

Better Value programme has a full year 2023/24 target of £32.5m (£16m cost related and £16.5m income related).

At M2 £3.1m has been delivered YTD out of £3.6m YTD Target.

Summary of report

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

1. Strike Action – The trust has had both junior doctor and nursing strikes in April/ May resulting in 6 days of strike action. This has seen an impact in lost ERF Income (£1.0m) and additional Pay costs (£0.6)
2. NHS & other clinical income is £0.6m favourable to plan due to increased pass-through drugs for CART activity and additional pay award funding however offset with underperformance in Research (£1.0m) and Charity (£0.5m) Income.
3. Private patients' income is £0.3m favourable to plan due to increased levels of activity. International private patient income saw an improvement since last month strike impact.
4. Pay costs are £0.7m adverse due to pay award (£1.1m) and increase in Bank and Agency costs due to strike actions (£0.6m).
5. Non pay costs and Finance Costs are £0.6m adverse to plan, due to increased pass-through costs and higher impairment of receivable for private patients.
6. The Trust cash balance at the 31st May was £86.0m; a decrease of £2.0m from the prior month.
7. Total I&PC debt increased in month to £28.4m (£27.8m in M1). Overdue debt decreased in month to £24.8m (£23.3m in M1).
8. Capital expenditure against ICB allocated CDEL at M2 is £1.8m, £1.1m more than plan, mainly due to timing of medical equipment delivery.

9. Charity-funded and grant-funded expenditure is £3.0m, £3.2m less than plan due to rescheduled building programme.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust is £86.0m; £2.0 lower than last month.
NHS Debtor Days	NHS debtor days is unchanged at 5 days in April and May.
I&PC Debtor Days	IP&C debtor days reduced from 178 days in April to 173 days in May.
I&PC Overdue Debt	IP&C debt increased from £23.3m in April to £24.8m in May.
Creditor Days	Creditor days has increased from 26 days to 38 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 2, 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 2 2023/24

Contents

Trust Performance Summary for the 2 months ending 31 May 2023

KEY PERFORMANCE DASHBOARD

ACTUAL FINANCIAL PERFORMANCE

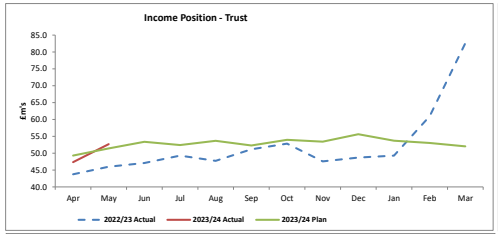
	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	**£51.4m**	**£52.7m**		**£100.7m**	**£100.0m**	
PAY	**(£31.0m)**	**(£31.9m)**		**(£62.0m)**	**(£62.6m)**	
NON-PAY inc. owned depreciation and PDC	**(£21.0m)**	**(£20.9m)**		**(£41.1m)**	**(£41.9m)**	
Surplus/Deficit excl. donated depreciation	**(£0.6m)**	**(£0.2m)**		**(£2.4m)**	**(£4.4m)**	

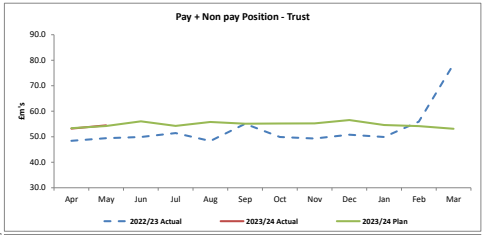
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

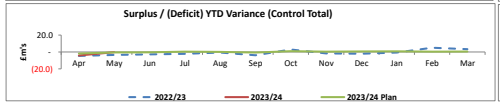
AREAS OF NOTE:

The YTD financial position for the trust is a £4.4m deficit which is £2.0m adverse to plan. This is driven mainly by the low levels of the Trust Better Value programme delivery, lower Research income then planned, increased impairment and impact of Strike action.

5.00







PEOPLE

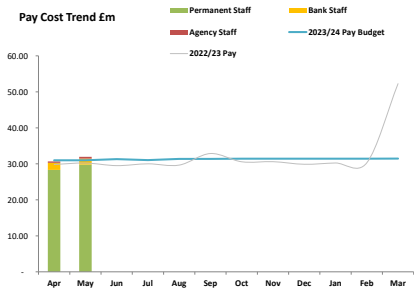
6

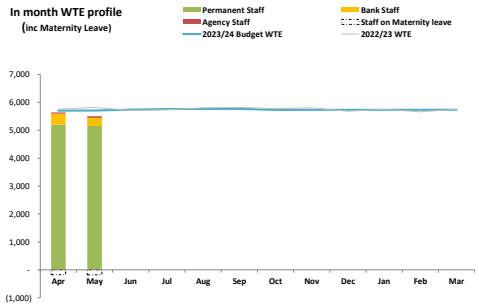
7

	M2 Plan WTE	M2 Actual WTE	Variance
Permanent Staff	5,353.2	5,154.9	198.3
Bank Staff	316.1	290.6	25.4
Agency Staff	38.8	56.7	(17.9)
TOTAL	**5,708.1**	**5,502.2**	**205.8**

AREAS OF NOTE:

Month 2 WTEs decreased in comparison to Month 1, largely within Agency related to strike action. Although Substantive staff are below planned levels the use of bank remains high due to continued (but reducing) levels in relation to Vacancies, The Trust has seen significant levels of sickness within the domestic team and is working to reduce this and ensure the service continues without interruption.



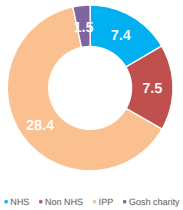


CASH, CAPITAL AND OTHER KPIs

Key metrics	Apr-23	May-23
Cash	**£88.0m**	**£86.1m**
IPP debtor days	**178**	**173**
Creditor days	**26**	**38**
NHS Debtor days	**5**	**5**
BPPC (£)	**93%**	**93%**

Capital Programme	YTD Plan M2	YTD Actual M2	Full Year F'cst
Total Trust-funded	**£0.7m**	**£1.8m**	**£33.6m**
Total PDC	**£0.0m**	**£0.0m**	**£0.3m**
Total IFRS 16	**£0.0m**	**£0.0m**	**£3.8m**
Total Donated	**£6.3m**	**£3.0m**	**£42.0m**
Total Grant-funded	**£0.0m**	**£0.0m**	**£0.0m**
Grand Total	**£7.0m**	**£4.8m**	**£79.7m**

Net receivables breakdown (£m)



AREAS OF NOTE:

1. Cash held by the Trust decreased in month from £88.0m to £86.1m.

2. Capital expenditure for the year to end May was £4.8m, £2.2m less than plan. Trust-funded expenditure was £1.1m more than plan and donated £3.3m less than plan.

3. I&PC debtors days decreased in month from 178 to 173 days. Total I&PC debt (net of cash deposits held) increased in month to £28.4m (£27.8m in M01). Overdue debt increased in month to £24.8m (£23.3m in M01).

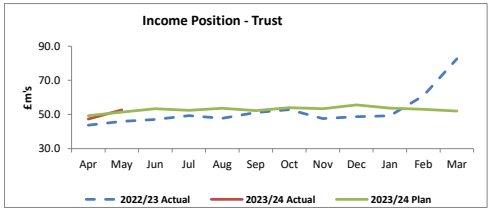
4. Creditor days increased in month from 26 to 38 days. This largely relates to invoices for the period prior to 31 March 2023. At the time of this update, some of these invoices were already paid and it is expected that creditor days will decrease over the next month.

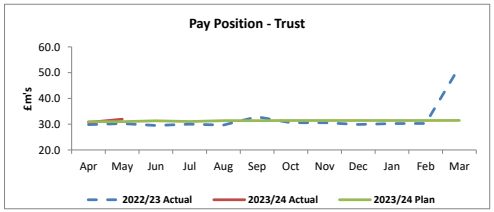
5. NHS debtor days remained the same as the previous month at 5 days.

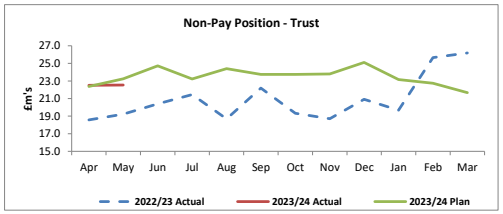
6. In M02, 93% of the total value of creditor invoices were settled within 30 days of receipt; this represented 85% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.

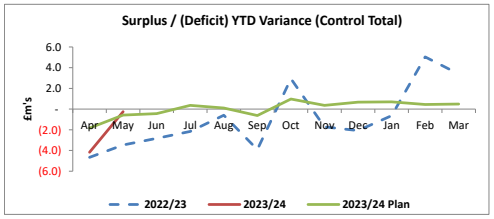
Trust Income and Expenditure Performance Summary for the 2 months ending 31 May 2023

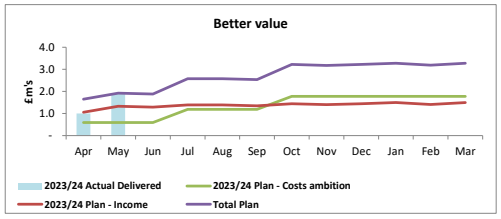
2023/24												2022/23	CY vs PY
Annual Plan	Income & Expenditure	Month 2				Year to Date				Rating	Notes	Actual	Variance
		Plan	Actual	Variance		Plan	Actual	Variance				M2	
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	Variance		(£m)	(£m) %
483.29	NHS & Other Clinical Revenue	39.41	41.42	2.01	5.10%	77.66	78.25	0.59	0.77%	G	1	73.87	4.39 5.60%
78.00	Private Patient Revenue	6.37	6.37	0.01	0.12%	11.87	12.17	0.30	2.49%	G	2	5.91	6.26 51.45%
72.84	Non-Clinical Revenue	5.62	4.89	(0.73)	(13.02%)	11.15	9.61	(1.54)	(13.77%)	R	3	9.94	(0.33) (3.40%)
634.12	**Total Operating Revenue**	**51.39**	**52.68**	**1.29**	**2.50%**	**100.68**	**100.03**	**(0.65)**	**(0.64%)**	R		**89.72**	**10.32 10.32%**
(352.61)	Permanent Staff	(29.05)	(29.80)	(0.75)	(2.57%)	(58.11)	(58.11)	(0.00)	(0.00%)	G		(55.90)	(2.21) (3.80%)
(3.72)	Agency Staff	(0.31)	(0.47)	(0.16)	(51.50%)	(0.62)	(0.88)	(0.26)	(41.52%)	R		(0.71)	(0.17) (18.86%)
(19.42)	Bank Staff	(1.62)	(1.67)	(0.05)	(3.07%)	(3.24)	(3.63)	(0.39)	(12.03%)	R		(3.44)	(0.19) (5.21%)
(102.99)	Drugs and Blood	(8.18)	(8.68)	(0.50)	(6.10%)	(15.92)	(16.67)	(0.75)	400.00%	R		(16.09)	(0.58) (3.48%)
(41.62)	Supplies and services - clinical	(3.50)	(3.50)	0.00	0.09%	(6.64)	(6.64)	0.00	500.00%	G		(7.21)	0.57 8.56%
(87.54)	Other Expenses	(7.05)	(6.64)	0.41	5.82%	(14.06)	(14.80)	(0.74)	600.00%	R		(11.13)	(3.67) (24.79%)
(232.14)	**Total Non-Pay Expenses**	**(18.74)**	**(18.82)**	**(0.09)**	**(0.46%)**	**(36.62)**	**(38.11)**	**(1.50)**	**700.00%**	R	5	**(34.43)**	**(3.68) (9.66%)**
(607.89)	**Total Expenses**	**(49.72)**	**(50.76)**	**(1.04)**	(2.10%)	**(98.58)**	**(100.72)**	**(2.14)**	800.00%	R		**(94.48)**	**(6.25)** (6.20%)
26.23	**EBITDA (exc Capital Donations)**	**1.68**	**1.92**	**0.24**	**14.45%**	**2.10**	**(0.69)**	**(2.79)**	**900.00%**	R		**(4.76)**	**4.07 591.46%**
(25.64)	Owned depreciation, Interest and PDC	(2.26)	(2.08)	0.18	7.80%	(4.52)	(3.74)	0.78	17.24%			(3.38)	(0.36) (9.63%)
0.60	**Surplus/Deficit**	**(0.58)**	**(0.16)**	**0.42**	**71.76%**	**(2.42)**	**(4.43)**	**(2.01)**	**(83.13%)**			**(8.14)**	**3.71 83.80%**
(24.18)	Donated depreciation	(2.25)	(1.54)	0.71		(4.49)	(3.19)	1.29				(3.11)	(0.08) (0.03)
(23.58)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(2.83)**	**(1.71)**	**1.12**	**71.76%**	**(6.90)**	**(7.62)**	**(0.72)**	**(83.13%)**			**(11.25)**	**3.63 47.60%**
0.00	Impairments & Unwinding Of Discount	0.00	(0.09)	(0.09)		0.00	0.00	0.00				0.00	0.00
41.94	Capital Donations	3.39	2.66	(0.73)		6.27	3.04	(3.24)				1.42	1.61 0.53
18.36	**Adjusted Net Result**	**0.56**	**0.86**	**0.31**	**54.91%**	**(0.63)**	**(4.59)**	**(3.95)**	**(625.72%)**			**(9.83)**	**5.24 114.28%**











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

Summary

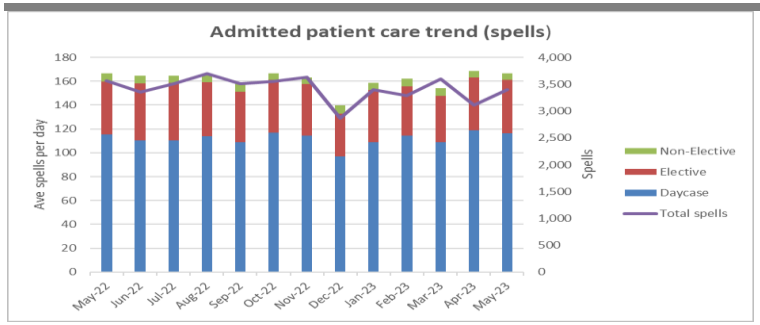
- The YTD Trust financial position at Month 2 is a deficit of £4.4m which is £2.0m adverse to plan.
- The deficit is due to lost income and additional costs associated with the strikes, and lower then planned Non clinical Income. The position includes both income and expenditure for the NHS Pay award.

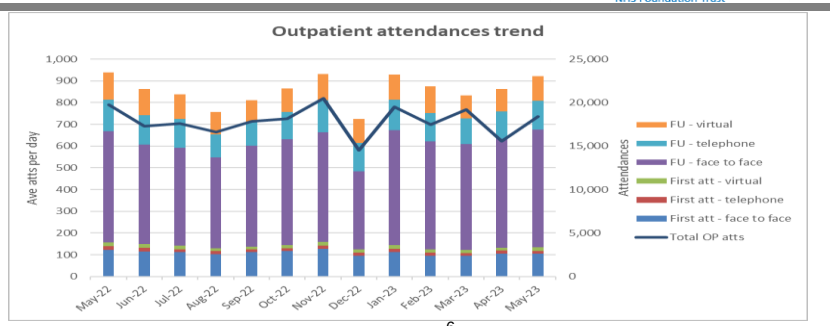
Notes

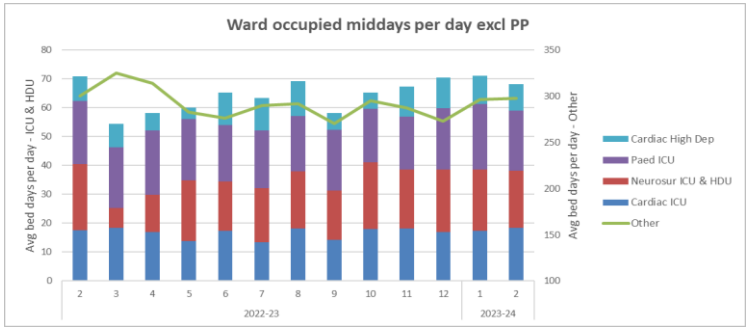
1. NHS clinical income is £0.6m favourable to plan YTD due to increased income for passthrough drugs and activity (£0.6m), additional pay award funding (£1.0m) and lost ERF due to reduced activity during the YTD strikes (£1.0m).
2. Private Patient income is £0.3m favourable to plan YTD which is due to seeing increased levels of referrals/ activity. M1 plan was reduced for the strike impact and so Month 2 has seen a recovery.
3. Non clinical income is £1.5m adverse to plan YTD. This is mainly driven by lower then planned Research & Development income expected following milestone achievement in Q2 and income from the charity.
4. Pay costs are £0.7m adverse to plan YTD mainly due to high levels of bank and agency usage linked to the additional costs incurred due to the strikes (£0.6m), the additional pay award (£1.1m) and reduced research spend.
5. Non pay is £1.5m adverse to plan YTD largely due to increase in Passthrough costs (£0.8m) offset with income and increased impairment of receivables associated with increased levels of private income (£0.7m).
6. Depreciation is lower than plan due to submission of the Children's Cancer centre investment plan to NHSE in May and the corresponding accelerated depreciation of assets starting in month 2 instead of month 1.

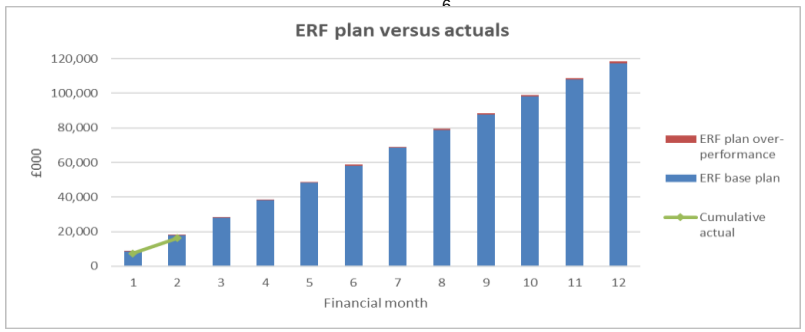
2022/23 Overview of activity trends for the 2 months ending 31 May 2023

Great Ormond Street Hospital for Children NHS Foundation Trust







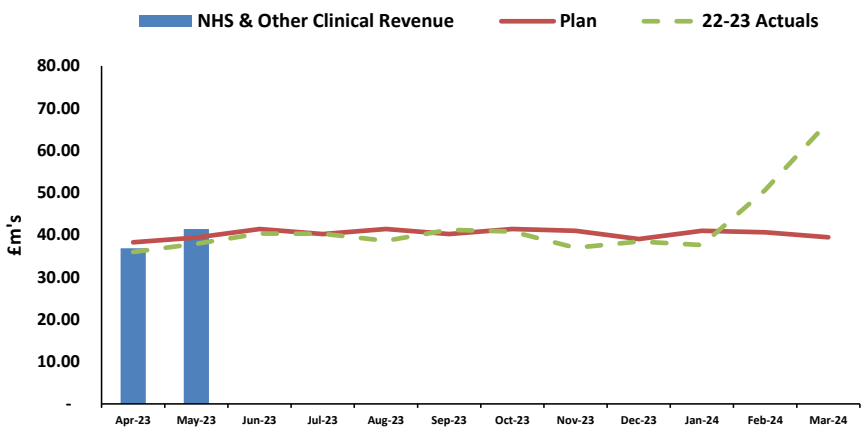


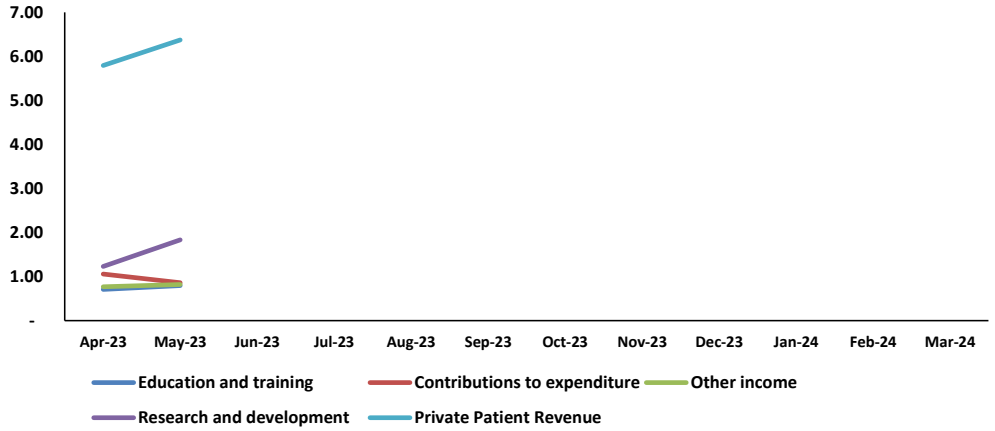
Summary

- Admitted patient care per day in May 2023 is lower than April with daycase decreasing by 2.1% and elective and non -elective increasing by 1.2% and 1.3% respectively per day. This equates to a 2.5 spell decrease for daycase and increases of 0.5 for elective and 0.1 for non -elective per working day for May versus April.
- Bed days for May 2023 are largely static versus April with a small decrease per working day versus April 2023 in line with ac tivity.
- Outpatient attendances increased by 6.7% per working day versus April 2023, with the largest increase being for face -to-face follow-up attendances where there has been an additional 39.7 attendances per working day. Face to face % activity levels have stablised since August 2022, at circa 70% fa ce to face and 30% non-face to face. The number of outpatient attendances may increase as activity is finalised.
- The ERF scheme has changed between 2022/23 and 2023/24, the new scheme covers Daycase, Elective, Outpatient First and OP Proc edures, 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 c urrent information, which includes some estimates for uncoded work, M2 performance for ERF is £16,261k versus a plan of £17,995k giving an under -performance of £1,734k against the total plan consisting of ERF target at 113% and planned over-performance. This is an improvement against the month 1 performance as month 2 has not been impacted by strike activity however it is expected that performance will be lower again in June owing to the Junior Doctor strikes.

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

2022/23 Income for the 2 months ending 31 May 2023





Summary

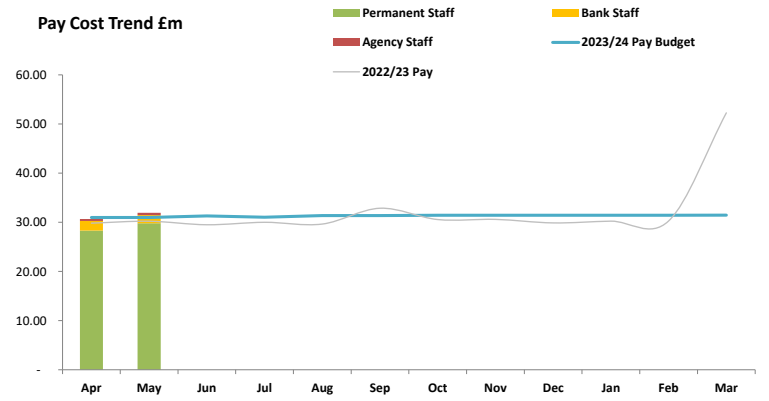
- Income from patient care activities excluding private patients is £0.6m favourable to plan YTD. This is due to increased income for pass through drugs and pay award funding offset by lost ERF associated with the Trust strikes.
- Non clinical income is £1.5m adverse to plan YTD. Mainly driven by lower then planned Research & Development income expected following milestone achievement in Q2 and income from the charity.
- Private Patient income is £0.3m favourable to plan YTD. This is due to the increased activity levels of referrals/ activity. Private patient income has increased from prior month which was impacted due to strikes.

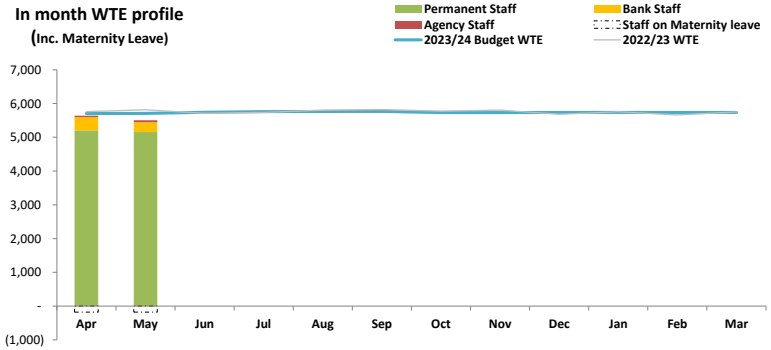
Workforce Summary for the 2 months ending 31 May 2023

*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	11.6	1,274.1	54.9	(0.3)	0.1	(0.4)	A
Consultants	66.7	394.1	169.2	11.2	383.7	174.9	(0.1)	0.3	(0.4)	A
Estates & Ancillary Staff	16.4	445.7	36.8	2.9	477.2	36.5	(0.2)	(0.2)	0.0	A
Healthcare Assist & Supp	12.2	306.9	39.7	2.2	325.6	39.6	(0.1)	(0.1)	0.0	A
Junior Doctors	33.5	393.0	85.2	5.7	389.5	88.0	(0.1)	0.0	(0.2)	A
Nursing Staff	100.9	1,616.5	62.4	16.9	1,611.2	62.8	(0.1)	0.1	(0.1)	A
Other Staff	1.0	17.9	56.2	0.2	16.4	57.3	0.0	0.0	(0.0)	G
Scientific Therap Tech	67.2	1,072.7	62.7	10.9	1,034.6	63.0	0.3	0.4	(0.1)	G
Total substantive and bank staff costs	**366.1**	**5,533.4**	**66.2**	**61.5**	**5,512.4**	**66.9**	**(0.5)**	**0.2**	**(0.7)**	A
Agency	4.1	39.0	104.2	0.9	50.4	104.5	(0.2)	(0.2)	(0.0)	A
Total substantive, bank and agency cost	**370.1**	**5,572.4**	**66.4**	**62.4**	**5,562.8**	**67.3**	**(0.7)**	**0.0**	**(0.7)**	R
Reserve*	1.1	0.0		0.2	8.5		(0.1)	(0.1)	0.0	A
Additional employer pension contribution by NHSE (M12)	14.6	0.0		0.0	0.0		0.0	0.0	0.0	G
Total pay cost	**385.8**	**5,572.4**	**69.2**	**62.6**	**5,571.3**	**67.4**	**(0.7)**	**(0.0)**	**(0.7)**	R
Remove maternity leave cost	(2.5)			(0.3)			(0.1)	0.0	(0.1)	A
Total excluding Maternity Costs	**383.3**	**5,572.4**	**68.8**	**62.3**	**5,571.3**	**67.1**	**(0.9)**	**(0.0)**	**(0.8)**	R

*Plan reserve includes WTEs relating to the better value programme



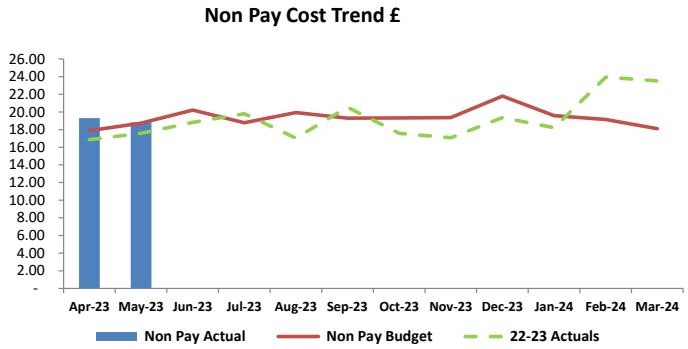


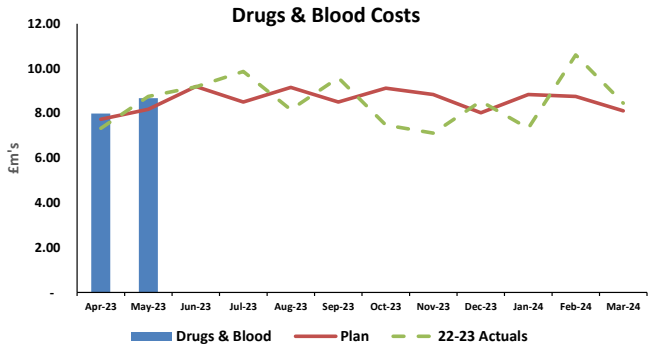
Summary

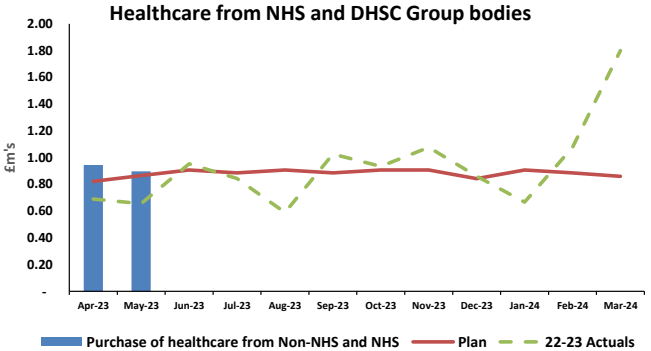
The table compares the actual YTD workforce spend in 2023/24 to the full year workforce spend in 2022/23 prorated to the YTD.

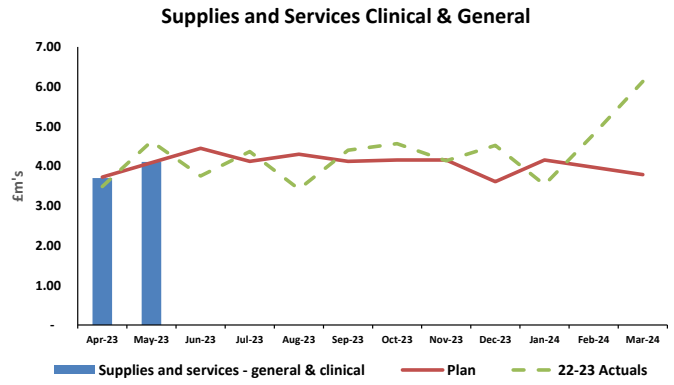
- Pay costs are above the 2023/24 plan YTD by £0.7m and when compared to the 2022/23 extrapolated actual it is £0.9m higher. This increase from 2022/23 is being driven by price increases (£0.8m). The price variance is driven by the NHS pay award.
- The Trust continues to see high levels of maternity leave (178 WTE) which is contributing to the higher than planned levels of temporary staffing across the Trust.
- Consultants & Junior Doctors are £0.5m favourable YTD to plan due to increased costs from teh strikes being partly offset by vacancies.
- Estates & Ancillary are £0.3m adverse YTD to plan due to high levels of sickness within the cleaning service. When compared to 2022/23 the key driver of the increase is the increased staffing required to deliver the required levels of cleaning.
- Scientific Therapeutic and Technical Staff are £0.1m favourable to plan YTD due to vacancies within Pharmacy for MRHA licence staff.

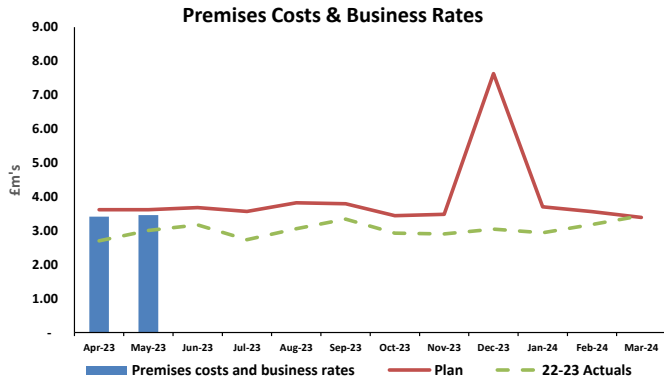
Non-Pay Summary for the 2 months ending 31 May 2023

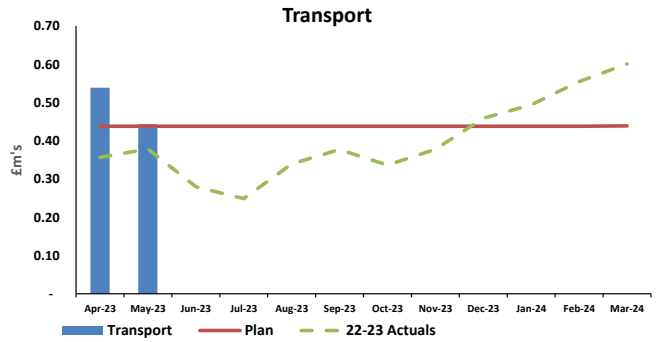








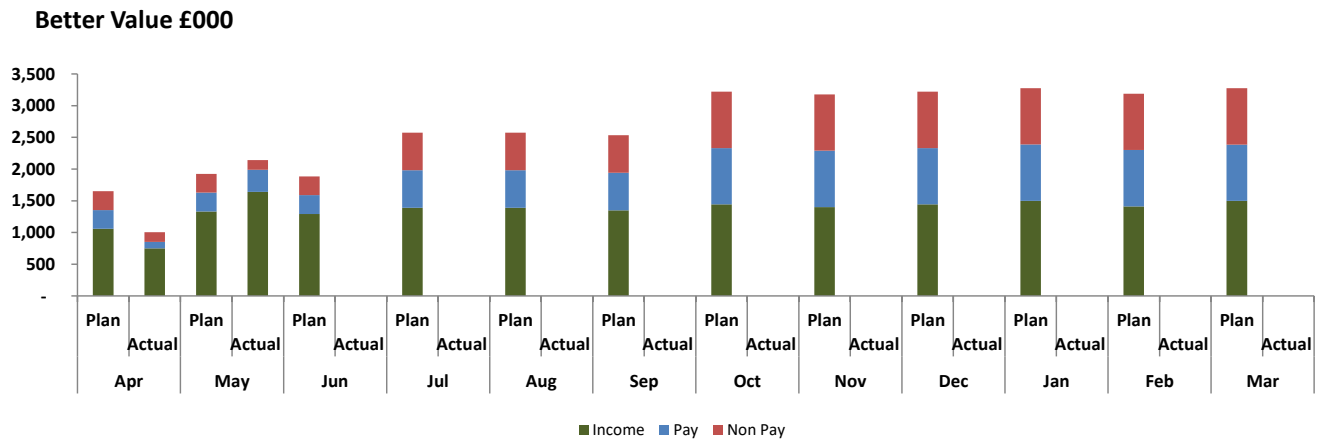




Summary

- Non pay is £1.5m adverse to YTD.
- Impairment of receivables is £0.8m adverse to plan YTD due to the increased provision from the growth in private activity and timing of payments.
- Drugs and Blood costs are £0.8m adverse to plan YTD due to a number of high cost CAR-T issues YTD and additonal costs of passthrough drugs.
- Premises costs are £0.4m favourable to plan YTD due to reduced computer software purchase
- Service from NHS organisation costs are £0.1m adverse to plan YTD due to increased send away tests and tissue typing for organ transplant.
- Transport costs are £0.1m adverse to plan YTD mainly due to higher then planned travel costs.

Better Value and COVID costs for the 2 months ending 31 May 2023



Better Value:

- The Trust is continuing to develop it's better value programme for 2023/24 and continues to hold weekly Directorate / PMO meetings to finalise the schemes and develop new ones.
  - At Month 2 £3.1m of the £3.6m plan has been delivered.
  - Month 2 plan was for £3.4m of recurrent savings, Trust has delivered £2.9m.
  - Month 2 plan was for £0.1 of non recurrent savings, Trust has delivered £0.2m.

Cash, Capital and Statement of Financial Position Summary for the 2 months ending 31 May 2023

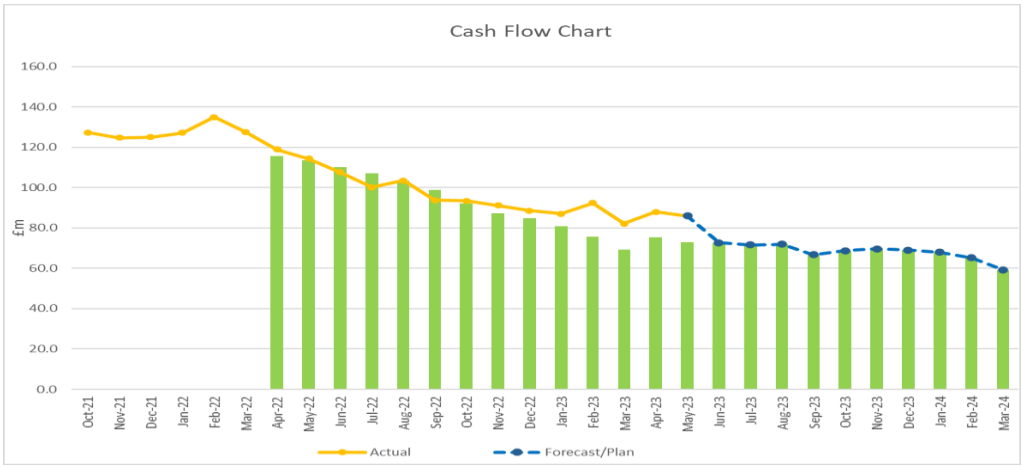
Audited Actual 31 Mar 23 £m	Statement of Financial Position	YTD Actual 30 Apr 23 £m	*YTD Actual 31 May 23 £m*	In month Movement £m
649.95	Non-Current Assets	648.22	648.31	0.09
106.34	Current Assets (exc Cash)	107.20	114.13	6.93
82.17	Cash & Cash Equivalents	87.97	86.05	(1.92)
(124.23)	Current Liabilities	(134.68)	(138.96)	(4.28)
(33.04)	Non-Current Liabilities	(32.98)	(32.94)	0.04
681.19	**Total Assets Employed**	**675.73**	**676.59**	**0.86**

31 Mar 2023 Audited Accounts £m	Capital Expenditure	YTD plan 31 May 2023 £m	YTD Actual 31 May 2023 £m	YTD Variance £m	Forecast Outturn 31 Mar 2024 £m	RAG YTD variance
6.95	Redevelopment - Donated	6.27	2.79	3.48	39.67	R
3.35	Medical Equipment - Donated	0.00	0.25	(0.25)	2.28	G
-	ICT - Donated	0.00	0.00	0.00	0.00	G
10.30	**Total Donated**	**6.27**	**3.04**	**3.23**	**41.95**	R
-	**Total Grant funded**	**0.00**	**0.00**	**0.00**	**0.00**	G
4.76	Redevelopment - Trust Funded	0.04	0.06	(0.02)	11.67	R
3.17	Medical Equipment - Trust Funded	0.25	0.80	(0.55)	7.68	R
2.39	Estates & Facilities - Trust Funded	0.04	0.42	(0.38)	7.36	R
4.65	ICT - Trust Funded	0.40	0.51	(0.11)	6.88	R
-	Contingency/unallocated	0.00	0.00	0.00	0.00	G
14.97	**Total Trust Funded**	**0.73**	**1.79**	**(1.06)**	**33.59**	R
-	**Share allocation**	**0.00**	**0.00**	**0.00**	**0.00**	G
0.13	**Total IFRS 16**	**0.00**	**0.00**	**0.00**	**3.83**	G
0.36	**PDC**	**0.00**	**0.00**	**0.00**	**0.33**	G
25.76	**Total Expenditure**	**7.00**	**4.83**	**2.17**	**79.70**	R

31-Mar-23	Working Capital	30-Apr-23	31-May-23	RAG	KPI
7.0	NHS Debtor Days (YTD)	5.0	5.0	G	< 30.0
204.0	IPP Debtor Days	178.0	173.0	R	< 120.0
21.6	IPP Overdue Debt (£m)	23.3	24.9	R	0.0
87.0	Inventory Days - Non Drugs	91.0	88.0	R	30.0
25.0	Creditor Days	26.0	38.0	A	< 30.0
45.4%	BPPC - NHS (YTD) (number)	73.1%	66.1%	R	> 95.0%
78.4%	BPPC - NHS (YTD) (£)	93.8%	90.0%	A	> 95.0%
82.0%	BPPC - Non-NHS (YTD) (number)	88.1%	85.9%	R	> 95.0%
91.9%	BPPC - Non-NHS (YTD) (£)	92.5%	93.1%	A	> 95.0%
80.7%	BPPC - Total (YTD) (number)	87.7%	85.4%	R	> 95.0%
90.7%	BPPC - Total (YTD) (£)	92.7%	92.9%	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)

31-Mar-23 Actual	Liquidity Method	Apr-23	May-23	RAG
1.5	Current Ratio (Current Assets / Current Liabilities)	1.4	1.4	G
1.4	Quick Ratio(Current Assets - Inventories - Prepaid Expenses) / Current Liabili	1.4	1.4	G
0.7	Cash Ratio(Cash / Current Liabilities)	0.7	0.6	R
52.6	Liquidity days Cash / (Pay+Non pay excl Capital expenditure)	55.5	55.2	A
87.3	Liquidity Days (Payroll)(Cash / Pay)	90.4	90.8	G



Comments:

1. Capital expenditure for the year to the end of May was £4.8m; the Trust-funded expenditure was £1.8m, £1.1m ahead of plan due to £0.8m of equipment expected in March but delayed, and £0.4m lift refurbishment equiment which was stored offsite by the contractor and not recognised in 2022/23 expenditure; the donated expenditure was £3.0m, £3.2m less than plan due to additional payments on CCC PCSA being later than planned and non-critical slippage on decant and enabling.
2. Cash held by the Trust decreased in month from £87.9m to £86.0m
3. Total Assets employed at M02 decreased by £0.9m in month as a result of the following:

- Non current assets increased by £0.1m to £648.3m.
- Current assets excluding cash totalled £114.1m, increasing by £6.9m in month. This largely relates to Contract receivables not invoiced (£6.2m higher in month) and Charity capital receivables (£2.3m higher in month). This is offset against the decrease in Other receivables (£1.2m lower in month) and Inventories (£0.4m lower)
- Cash held by the Trust totalled £86.0m, decreasing in month by £1.9m.
- Current liabilities increased in month by £4.3m to £139.0m. This includes Capital creditors (£0.6m higher in month); expenditure accruals (£1.0m higher month); NHS payables (£0.9m higher in month) and Other payables (£2.5m higher in month) This is offset against the decrease in deferred Income (£0.7m lower in month).
- Non current liabilities totalled £32.9m This includes lease borrowings of £27.7m.

4. I&PC debtors days decreased in month from 178 to 173 days. Total I&PC debt (net of cash deposits held) increased in month to £28.4m (£27.8m in M01). Overdue debt increased in month to £24.8m (£23.3m in M01).
5. In M02, 93% of the total value of creditor invoices were settled within 30 days of receipt; this represented 85% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.
6. By supplier category, the cumulative BPPC for Non NHS invoices (by number) was 86% (88% in M01). This represented 93% of the total value of invoices settled within 30 days (92% in M01). The cumulative BPPC for NHS invoices (by number) was 66% (73% in M02). This represented 90% of the value of invoices settled within 30 days (94% in M02).
7. Creditor days increased in month from 26 to 38 days. This largely relates to invoices for the period prior to 31 March 2023. At the time of this update, some of these invoices were already paid and it is expected that creditor days will decrease over the next month.

Attachment O

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6th July 2023

Nursing Strategy – Safe in Our Hands to achieve joy at work **Submitted by:** Darren Darby – Deputy Chief Nurse on behalf of Tracy Luckett – Chief Nurse	**Paper No: Attachment O** □ **For discussion**

Purpose of report

To introduce the strategic direction for nursing for 2023-2026, 'Safe in Our Hands, to achieve joy at work' supporting the Trust in achieving the aims and objectives of our 'Above and Beyond' strategy.

Summary of report

The GOSH Nursing Strategy is underpinned by four pillars:

1. Skilled & Inquisitive workforce: We will continue to develop a skilled inquisitive workforce, creating strong foundations to provide exceptional care. We will optimise nursing opportunities to innovate and engage with research to promote person-centred practice and improving outcomes.

2. Amplified voices: The nursing voice will be amplified through creating a shared governance and collective leadership model. We will raise the voice of children by working in collaboration with partners and by delivering quality healthcare for all through equitable excellent experience and optimal outcomes.

3. Friendly: We will strive to become a 'nurse friendly' place to work through recognition and respect improving joy in work.

4. Extraordinary leaders and careers: Extraordinary leaders enable extraordinary nurses to have extraordinary careers. We will ensure all leaders are developed to have skill and knowledge to deliver compassionate leadership.

Patient Safety Implications
None

Equality impact implications
None

Financial implications
Nothing to be approved at this time – To note as part of the accreditation programme there is likely financial implications

Strategic Risk
BAF Risk 2: Workforce sustainability

Action required from the meeting
To provide the Board with a briefing on the proposed Nursing Stratrgy- prior to formal launch in Autumn 2023

Consultation carried out with individuals/ groups/ committees
EMT, Ops Board, Nursing Board, Matron Group, Clinical Nursing Teams,

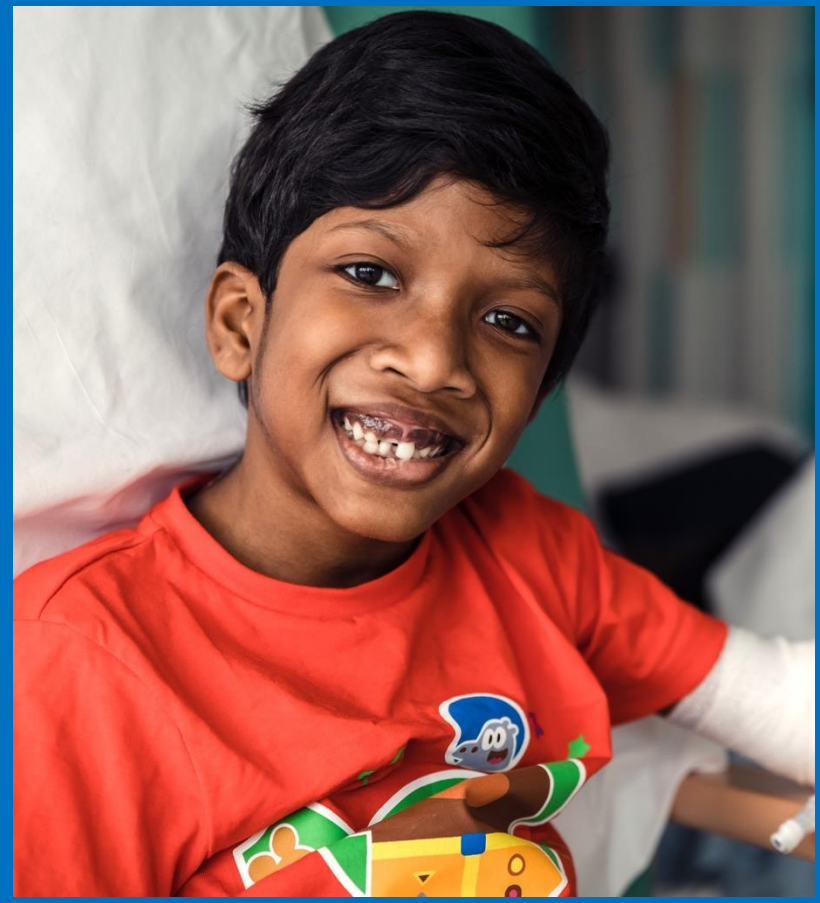
Attachment O

Who is responsible for implementing the proposals / project and anticipated timescales? Darren Darby – Deputy Chief Nurse
Who is accountable for the implementation of the proposal / project? Tracy Luckett – Chief Nurse

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

UCL
GREAT ORMOND STREET INSTITUTE OF CHILD HEALTH

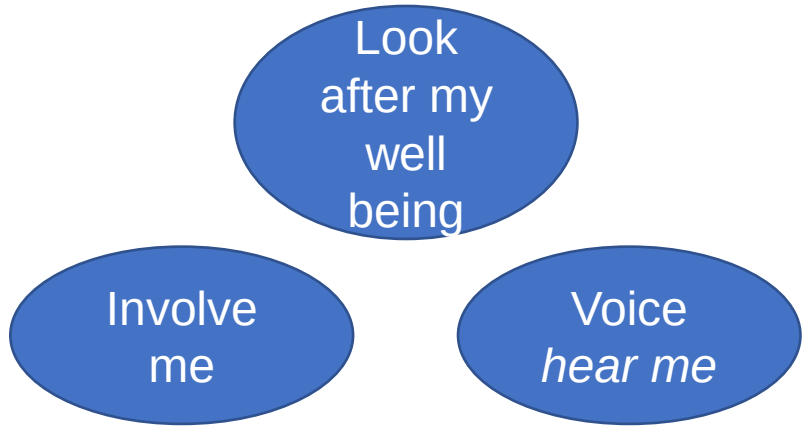
Creating a Nursing Strategy
The journey so far….



GOSH Trust Board 6th July 2023

Important points to consider

- Why a strategy and why now ?
- Stakeholder involvement
- What we are hearing…
- What's next



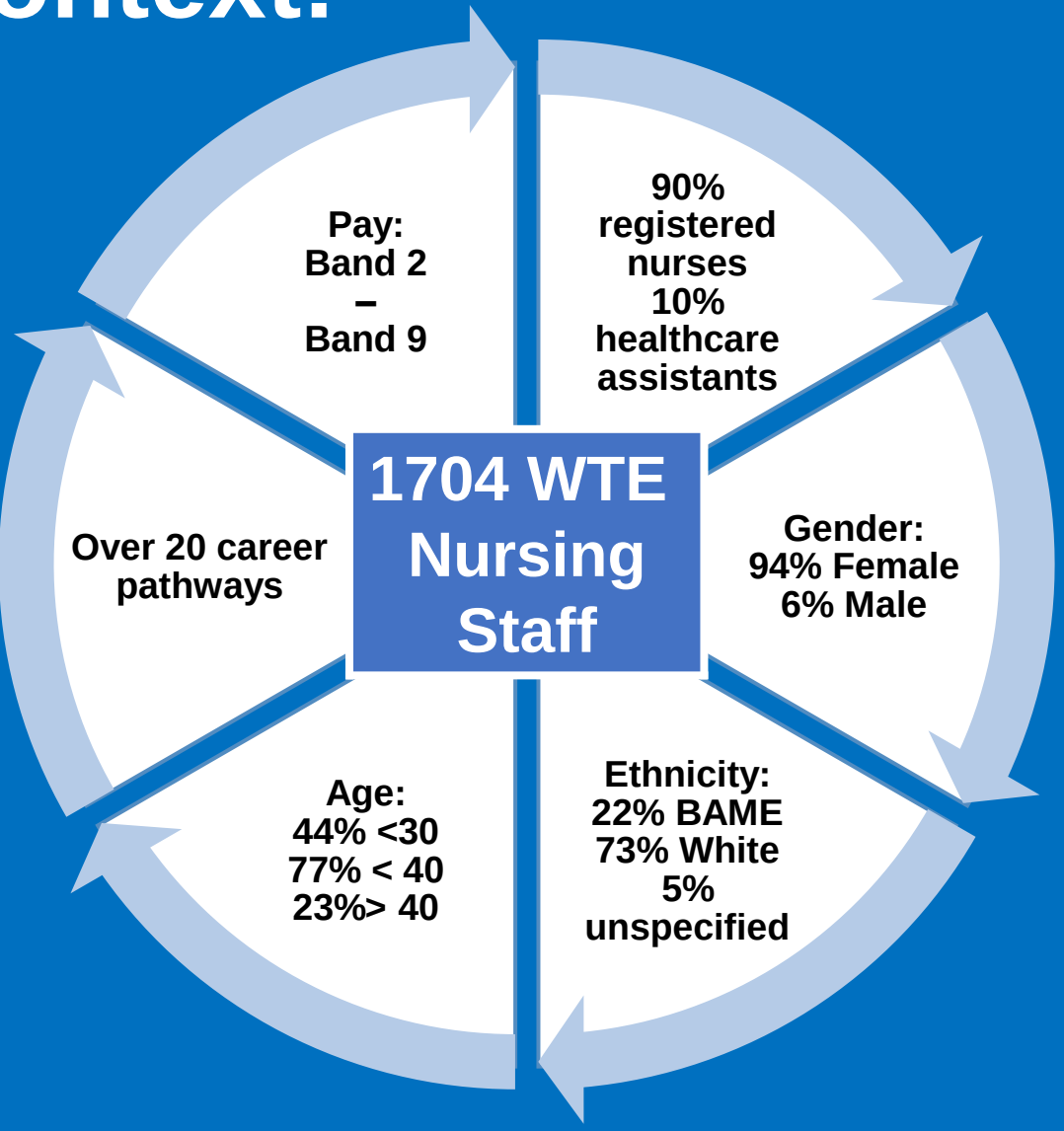
NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

GOSH Nursing Strategy 2023-26

Safe in our hands

– to achieve joy at work

Context:



Care Quality Commission

Royal College of Nursing
The voice of nursing

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Sydney

Philadelphia

Toronto

Most International Children's Hospitals have a nursing strategy & accreditation

Boston

Seattle

Great Ormond Street Hospital for Children
NHS Foundation Trust

Capturing our vision for nursing – away day September

Improve communication: Silo working, improve meeting structure, infrastructure

Improve Inclusion: Nursing profession, All employees, Pt & Families

Celebrating Nursing

Changing the narrative & feedback – never events/always events

Reporting of nursing strategic plan (up & down)

Become the first nurse friendly children's hospital in the UK

Holistic Care – education, training to develop nurses to deliver pt centred care

Bring both expertise & profession to the table

Nursing strategic Ops Plan – Prioritise, deliver, measure impact

Engagement with staff on clinical floor

Silo working – work in partnership with local hospitals to deliver care/education

Sharing knowledge/learning together/integrating teams

Staff networks – nurses network/social engagement

Team working – SLT for nursing – team away days

Vision: SAFE in our hands - to achieve joy at work

Great Ormond Street Hospital for Children NHS Foundation Trust

S We will continue to develop a **skilled** inquisitive workforce

A The nursing voice will be **amplified**

F We will strive to become a 'nurse **friendly**' place to work through recognition and respect improving joy in work

E **Extraordinary** leaders enable extraordinary nurses to have extraordinary careers

Priority 1

SKILLED

We will continue to develop a **skilled** inquisitive workforce, creating strong foundations to provide exceptional care. We will optimise nursing opportunities to innovate and engage with research to promote person-centred practice and improving outcomes.

Aim	What will this look like?	How will we measure progress / achievement
Develop a skilled workforce, creating strong foundations to provide exceptional care.	• We will develop a skilled, inquisitive workforce by ensuring all staff have equal access to education, training and development to enable delivery of individualised person-centred care, improving patient experience and outcomes • With GOSH Learning Academy (GLA), we will deliver specialist paediatric education & training programmes to support nurses in their journey from novice to expert practice across all specialty areas. • We will expand our nursing academic offer within the GLA supporting nursing practice from foundation to enhanced specialist, advanced practice and consultancy. • We will embrace innovation, digital technology and virtual reality in education and simulation enhancing our learning experience. • All staff and educators delivering training will be supported through the GLA, ensuring they have access to resources. • We will work in partnership with our Children & Young People to co-design education to ensure our staff have the skills, knowledge & competence to deliver personalised care.	• We will be viewed as a learning organisation, evidenced in our staff survey and staff feedback • Increased access to courses across all specialities • Annual training needs analysis across nursing • We will embed the Kirpatrick model of evaluation to assess skills, confidence and impact on practice of the education and training delivered • Improved patient and family feedback • We will monitor the impact, effectiveness and delivery of our nurse education programme through the GLA governance framework

Priority 2

Inquisitive

We will continue to develop a **skilled** inquisitive workforce, creating strong foundations to provide exceptional care. We will optimise nursing opportunities to innovate and engage with research to promote person-centred practice and improving outcomes.

Aim	What will this look like?	How will we measure progress / achievement
Develop a skilled inquisitive workforce, optimising nursing opportunities to innovate and engage with research.	• **Embed Research Hospital Strategy throughout nursing** • Provide local and national leadership on clinical research and outcomes & experience research that inspires our nurses and harnesses their research potential • Support, develop & nurture our nursing teams to have time to care, using research and evidence-based practice to advance practice • Align nurse research with patient need • Bridge the gap between research and clinical care through research hospital transition initiative by improving our process to enable staff to comfortably become involved in research delivery whilst remaining embedded in a clinical service • Releasing nurses research potential • Build the best research system • Developing future nurse leaders of research • Digitally enabled nurse led research	• Undertake NIHR SORT assessment (Self-Assessment organisational readiness tool) • Implement CNO Nursing research strategy by year April 2024 • Nursing publications, conference presentations and award submissions annually – annual plan tracker • Champion ward accreditation – pathway to excellence • Expansion of internship programmes to support clinical academic careers • Establish post-doctoral nursing roles within clinical directorates • Adoption in clinical services of Research toolkit developed from NHSE Matrons handbook • Research champions embedded in directorates

Priority 3

AMPLIFY

The nursing voice will be **amplified** through creating a shared governance and collective leadership model. We will advocate for children by working in collaboration with partners and by delivering quality healthcare for all through equitable excellent experience and optimal outcomes.

Aim	What will this look like?	How will we measure progress / achievement
Amplifying the voice of the nursing profession and committed to ensuring the voices of children, young people, families/carers is equitable	• Through collective leadership, nurses will have a strong collaborative voice, and opportunity to contribute to what matters for nursing, whatever their band or role • Pride in the profession and recognition of the contribution of nursing • A shared nursing governance model where collectively, nurses will debate what is important and what needs to change • Partnership of leaders and staff in which decisions regarding practice are made by the people who will be carrying out the work to advocate the voice of children and ensuring nursing excellence	• Participation in the #TeamCNO Collective Leadership programme • Successful application to join the ANCC pathway to excellence programme Within 2 years • Gain ANCC Pathway to Excellence accreditation within 5 years • Annual Nursing conference to share innovation and good practice, to inspire nurses

Priority 4

FRIENDLY

We will strive to become a ‘nurse **friendly**’ place to work through recognition and respect improving joy in work

Aim	What will this look like?	How will we measure progress / achievement
A ‘nurse friendly’ place to work through recognition and respect improving joy in work	• Establish a nursing council • Capture local and trust initiatives to share nursing success and recognition to design a trust wide standardised GOSH nursing recognition/reward scheme • Capture and share the impact of GOSH nursing – internally and externally • Improvement of psychological safety, committing to a reduction in poor behaviours toward nursing staff • Scope the implementation of IHI Framework for Improving Joy at work	• Attendance numbers, floor to board voices re trust wide decisions • Routinely survey nurses to find out ‘what matters to me’ • Socialisation and recognition of nursing success. • Recognition as a great place to work – person centred practice • Understanding the impact of nursing to wider work eg guidance, policies etc • Reduction in datix reporting, reduction in need for freedom to speak up • Celebration and networking events

Priority 5
EXTRAORDINARY LEADERS

Extraordinary leaders enable extraordinary nurses to have extraordinary careers. We will ensure all leaders are developed to have skill and knowledge to deliver compassionate leadership.

Aim	What will this look like?	How will we measure progress / achievement
Extraordinary leaders	• Increased access to nursing leadership and management development programmes. • Our programmes will support nurses throughout their career pathway from undergraduate to senior nurse. • Our nursing leaders will be compassionate and confident in their leadership ability and feel empowered to make decisions within their scope of practice to positively influence their services and the wider Trust, while fulfilling the organisation's values. • Our nurse leaders will be self-aware, recognising their impact on others, while empowering and nurturing their colleagues to be their best. • Embrace collaborative working and promote collective leadership so that nurses are empowered to lead in all areas, at all levels.	• Undertake a cultural assessment across our senior leaders. • Delivery of bespoke nursing leadership development programmes, with 80% of nurses attending a programme applicable for their role. • Ensure that all band 6 given the opportunity to attend the Band 6 Development Programme within 12 months of commencing their role. • All nurses will be able to identify how they contribute to the trust's priorities through appraisals and revalidation. • All nurses will be able to identify where they are in their leadership journey utilising the nursing leadership development pathway & our GOSH leadership & management framework • Ensure that our leadership training aligns with our compassionate leadership culture and nursing vision at GOSH

Priority 6 EXTRAORDINARY CAREERS

Extraordinary leaders enable extraordinary nurses to have Extraordinary careers. We will ensure all leaders are developed to have skill and knowledge to deliver compassionate leadership.

Aim	What will this look like?	How will we measure progress / achievement
Extraordinary careers	• Clearly defined career pathways from HCSW through to senior nursing leadership roles in all areas • Improved recruitment and retention of nurses which reflect the diversity and ethnicity of our patient and local population • Establish a pipeline of 'home grown' nurses with the expansion of the Apprenticeship program • To be the employer of choice for our host nursing students, to commence and continue their careers with us • Opportunities to work at ICS, regional, national and international level reflective of GOSH's reach across paediatric nursing to develop new clinical specialist roles, rotations and secondment opportunities to improve the lives of children everywhere	• Vacancy levels to remain below Trust target 10% • Voluntary turnover to remain below Trust target 14% • Year on year improvement of the diversity and ethnicity of our nursing workforce across all bandings, with particular emphasis on diverse leadership role • Introduce a talent management programme • Year-on-year expansion of apprenticeship numbers • >90% of our host student to choose GOSH as their employer of choice • Introduce e-job planning for all autonomous roles

How will the GOSH Nursing Strategy 2023-26 support other Trust strategies?

Great Ormond Street Hospital for Children NHS Foundation Trust

GOSH Nursing Strategy priorities (2023-26)	GOSH Learning Academy Strategy (2019-22)	GOSH People Strategy (2019-22)	GOSH Safety Strategy (2020-25)	GOSH Above and Beyond (2020-25)
Priority 1: We will continue to develop a skilled inquisitive workforce, creating strong foundations to provide exceptional care.	Apprenticeships and Undergraduate Training	Developing skills and capability *Ensuring the that the Trust continues to meet its core responsibilities as a teaching, training and research hospital, as well as building new skills and capability to meet the new challenges and changing priorities*	Priority 2: Getting the basics right *Meeting all regulatory, compliance and governance requirements within specified timescales*	Priority 1: Make GOSH a great place to work by investing in the wellbeing and development of our people
Priority 2: We will optimise nursing opportunities to innovate and engage with research to promote person-centred practice and improving outcomes.				
Priority 3: We will amplify the nursing voice through creating a shared governance and collective leadership model.	Talent Management	Culture, engagement, health and wellbeing *Ensuring all our staff feel well led and well managed, but also valued, developed, supported and empowered to be and do their best.*	Priority 3: Providing our patients and staff with the necessary skills and opportunities to improve patient safety	Priority 2: Deliver a Future Hospital Programme to transform outdated pathways and processes
Priority 4: We will strive to become a 'nurse friendly' place to work through recognition and respect improving joy at work.				
Priority 5: We will ensure all leaders are developed to have skill and knowledge to deliver compassionate leadership	Improving patient care	Capacity and workforce planning *Resourcing, retention and strategic workforce planning*	Priority 6: Ensuring the appropriate analysis of, and timely response to clinical outcome metrics, trends and vulnerabilities	Priority 5: Accelerate translational research and innovation to improve and save lives
Priority 6: We will ensure all leaders are developed to have skills and knowledge to deliver compassionate leadership.				

Questions and feedback

Your queries and feedback are pivotal to the successful implementation of the GOSH Nursing Strategy, Safe in ou Hands.

Please scan the QR code to ask any questions and provide feedback.

Attachment P

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6 July 2023

Approval of the Revised People Strategy **Submitted by: Caroline Anderson, Director of HR and OD**	**Paper No: Attachment P** **□ For approval**

Purpose of report

To present the GOSH People Strategy 2023 – 2026 for approval.

Summary of report

In 2019 we published our first People Strategy. This updated version builds on the legacy and work of the original, but sets it within our current context, which post Covid has become more complex and challenging. As with the original, the purpose of this People Strategy is to bring together all of the people management issues and related activities to provide visibility, but also to ensure that they are aligned, coordinated and focused on delivering the current and future priorities of the Trust, alongside our commitment to our people.

The new strategy continues to form the basis of the work to deliver the commitments of the Above and Beyond Strategy, specifically Planet 1, 'Making GOSH a great place to work'.

Significant work has been delivered since its publication and together with the underpinning Diversity and Inclusion and Health and Wellbeing frameworks, (Seen and Heard, and Mind, Body and Spirit), the strategy has provided a strong foundation to support staff through the unprecedented challenges of the pandemic and post Covid recovery.

Those internal challenges have been matched by a fast moving external context which means we now operate in a more complex and uncertain environment, with increased controls and scrutiny driven by system changes and a challenging financial and economic context.

As a consequence, the refreshed People Strategy provides both a response to our ongoing challenges around recruitment, retention, leadership, performance and engagement, as well as the development of corporate infrastructure and skills to deliver our priorities and build a sustainable and resilient organisation for the future. Recognising this change will impact on service configurations, skills and capabilities, structures and the way we work.

In response to the above, and the national and local context in which we must now operate, the People Strategy has been built around four key themes:

1. **Culture and engagement** - including health and wellbeing and EDI, ensuring all our staff feel well led and well managed, but also valued, developed, and empowered to be and do their best.

2. **Building a sustainable workforce** - to include capacity, strategic workforce and succession planning and resourcing and retention.

3. **Developing skills and capability** - ensuring that the Trust continues to meet its

core responsibilities as a teaching, training and research hospital, as well as building skills and capability to meet the new challenges and changing priorities for the future.

4. **Processes systems and infrastructure** - modernising and updating the corporate and HR infrastructure, including, staff planning and deployment systems sustainable business support processes, collaborative working tools and HR policies and processes.

Patient Safety Implications
To be determined

Equality impact implications
There will be equality impacts as a consequence of this strategy which will be determined through the development and implementation of individual programmes of work

Financial implications
To be determined

Strategic Risk
BAF risk 2: Workforce Sustainability
BAF risk 14: Culture

Action required from the meeting
The Board is asked to consider and APPROVE the strategy for implementation.

Consultation carried out with individuals/ groups/ committees

- PEAC
- Staff Partnership Forum
- People Planet Programme Board
- LNC
- Staff Networks
- Nursing Board

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

Who is accountable for the implementation of the proposal / project?
Director of HR and OD

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

People Strategy

2023–2026

Making GOSH a great place to work

Contents

Foreword by Matthew Shaw

Everything we do at Great Ormond Street is as a result of the dedication and skill of our people.

Our first People Strategy launched in 2019 set the framework for looking after our people and supporting Planet 1 of our Above and Beyond Strategy – 'Making GOSH a great place to work'.

This revised strategy is an evolution - many of the core elements remain - building on the progress made and taking into account that the context has changed.

There have many significant moments and shifts in our cultural and economic landscape over the last three years. The horrific murder of George Floyd in the United States brought the Black Lives Matter movement to global prominence. The Coronavirus pandemic had a deep and sustained impact on our workforce and the wider NHS. More recently, we have been experiencing a cost of living crisis and periods of industrial actions across multiple sectors, including ours.

It is against this backdrop that the People Strategy has never felt more important.

We cannot hope to attract and retain our staff if we do not pay deliberate attention to how we listen and support them. We need to look after them so they can look after the children and young people that need our care.

We also need to tailor our approach to our workforce. We have a very young workforce, often at the earlier stages of their career. Over the last few years it's really struck me that what I see as important and what they would see as important in a place to work may be very different. The importance of flexible working and a better life balance seems heightened, and we need to really consider how we can operate fairly with a workforce with different perspectives.

We remain a community that can only be successful through effective teamwork. The children and young people we see are complex and require support from multiple specialties. This means people can't work in isolation and we need to continually challenge ourselves how we work better across teams with the child at the centre.

We also have to acknowledge that we are a somewhat hierarchical organisation. This should not impede our staff's ability to speak up and be heard and leaders have a responsibility to their teams not just the organisation. As a senior leadership team we have the responsibility to ensure

the right training and development opportunities are available at every level of the organisation.

Our Seen and Heard framework set out how we intended to be a more diverse and inclusive organisation. We have made some progress but there is a long way to go before diversity reflects all layers and bands and until all people fair and equitable opportunities whatever their backgrounds and protected characteristics

One very important way in which we hear from our staff is our annual staff survey. It's maybe the feedback I look at most. As we launch this revised strategy, after a couple of years of sustained improvements, we have seen decreases in staff satisfaction. This is really disappointing. We need to be ever more determined to improve.

Culture change takes time. It is a team sport. I am clear as CEO that I have the responsibility to put a framework in place but it is everyone's role to play their part in upholding the values. We need to ensure everyone understands that doing your job is not just about achieving task but how you make people feel while you're getting the job done.

If we get this right and have the right infrastructure in place, GOSH really will be a great place to work.

Introduction and Purpose

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 work.

In 2019 we published our first People Strategy. This updated version builds on the legacy and work of the original, but sets it within our current context, which post Covid has become more complex and challenging. As with the original, the purpose of this People Strategy is to bring together all of the people management issues and related activities to provide visibility, but also to ensure that they are aligned, coordinated and focused on delivering the current and future priorities of the Trust, alongside our commitment to our people.

The new strategy continues to form the basis of the work to deliver the commitments of the Above and Beyond Strategy, specifically Planet 1, 'Making GOSH a great place to work'. Significant work has been delivered since its publication and together with the underpinning Diversity and Inclusion and Health and Wellbeing frameworks, (Seen and Heard, and Mind, Body and Spirit), the strategy has provided a strong foundation to support staff through the unprecedented challenges of the pandemic and post Covid recovery.

Those internal challenges have been matched by a fast-moving external context which means we now operate in a more complex and uncertain environment, with increased controls and scrutiny driven by system changes and a challenging financial and economic context.

As a consequence, the refreshed People Strategy provides both a response to our ongoing challenges around recruitment, retention, leadership, performance and engagement, as well as the development of corporate infrastructure and skills to deliver our priorities and build a sustainable and resilient organisation for the future. Recognising this change will impact on service configurations, skills and capabilities, structures and the way we work.

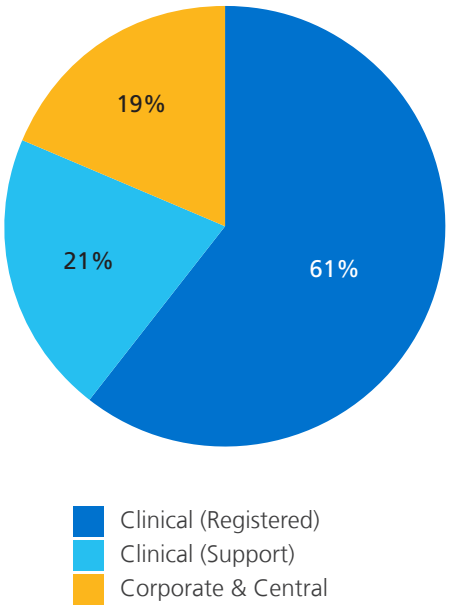
It is essential that the Trust and our staff are well positioned to successfully navigate this new operational context and prepare for the future. In recognition of the criticality of organisational culture in this process, the refreshed strategy also introduces a new Culture and Engagement framework to reinforce the work of our existing frameworks.

GOSH was established in 1852 and was the first hospital in England to provide in-patient beds specifically for children. Today, GOSH is a tertiary and quaternary paediatric hospital that provides specialised and highly specialised services to children and young people (CYP) with rare and complex conditions. It is the largest paediatric center in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. There are 63 different clinical specialties at GOSH and around half of patients come from outside London. GOSH is also renowned internationally. Delivery of the People Strategy will be overseen by the People Planet Programme Board, with assurance being provided by the People and Education Assurance Committee. The first year of the new strategy will focus on consolidating the work of the previous strategy and addressing the most acute and urgent workforce issues, arising from our changing context, including investment in the building blocks to create a positive working environment for all. This will include joining up and extending staff support arrangements; continued focus on EDI; and the creation of an environment where all our staff feel valued, trusted and listened to. This work will be extended in year two to deliver a more strategic approach to addressing some of the longer-term systemic workforce issues. These include the development of clear career and training paths for all roles, building skills for the future and becoming an employer of choice. In year three it is expected that there will be a need to review and refresh the People Strategy against the progress and delivery of the overarching GOSH Strategy, to ensure that it remains aligned and mutually reinforcing but also to prepare for the new roles, multidisciplinary team working and the integrated care systems which will define the healthcare workforce into the future.

Our people in numbers – April 2023

- The Trust has 5,800 staff (an increase of 19% since the last People Strategy was launched)
- Following the insourcing of our domestic services in 2021, the highest growth staff group was in Estates which has increased by 165%
- 58% of our staff are in Bands two to six
- 61% of our workforce is in a registered profession
- The average age of our staff is 39, and we have a younger workforce than the NHS average
- 55% of our workforce is under 40 (NHS average 42%), with 20% over 50 (NHS 33%)
- 13.5% of our staff are from the EU/EEA which, while a slight reduction since 2019, (14.5%) has remained broadly stable

Our GOSH staff



- The percentage of staff from ethnically diverse backgrounds has increased to 37% (from 29% in 2019). This remains lower than the NHS London average (48%) but is a marker of progress and will continue to be focus going forward.
- Ethnic diversity in Nursing has increased to 22% but remains lower than the Trust average, while Allied Health Professionals is the lowest overall in the Trust at 16%. The service with the highest level of ethnic diversity is in Estates and Facilities, at 68% followed by additional clinical services at 45% and admin and clerical at 44%. The medical workforce is 41%
- 75% of our staff are female, which is similar to the NHS average
- We have seen an increase in staff declaring a disability (4% up from 2% in 2019). From our staff survey results where 17% of respondents said they had a long-lasting condition or illness, we know we should continue to work on improving our declaration rates to properly understand the wellbeing needs of our people.
- Although they remain lower than NHS averages, we have seen an increase in our sickness rates over the last few years, with a 2022 average reported rate of 3.8%. This compares to a NHS rate of 5.5%
- Turnover rates in the Trust have changed over the last three years, primarily due to the impact of Covid, peaking at 16.3% in February 2020, before falling to well below the 14% target to 10.7% in March 2021. Since then, turnover has increased to 14.3%, equivalent to pre-pandemic levels
- Turnover rates are highest amongst Band 5 nurses (24.1%), Band 4 administrative staff (19.9% - which has reduced by 5.1%) and Band 3 clinical support roles (17.7%), while medical turnover rates (excluding junior doctors) is lowest at 2.2%
- Temporary staffing usage of Agency remains well controlled at the Trust at 1.1% of the total Trust pay bill, while Bank usage is reported as 5.2%
- The previous 3 years have seen a year-on-year increase in staff satisfaction rates which have benchmarked well against our peers. However, we saw a reduction in the 2022 scores, which although not unexpected given the current national and organisational context and is in line with our benchmarked peer groups (excluding acute specialist trusts) but will require action to address

National and local drivers for change

The NHS 10-year Long-Term Plan was published in 2019 and sets out a vision and ambition for healthcare in England, based on a new service model which includes: more focused action on prevention and health inequalities; improved quality of care and health outcomes across all major health conditions; and the harnessing of technology to transform and support the establishment of integrated Care systems. Underpinning that vision is a commitment to invest in the NHS workforce which is captured in the NHS People Plan published in 2020. Since both documents were published, the healthcare landscape has been transformed by the individual and cumulative impact of a range of unprecedented events and circumstances, which have left a legacy that has shifted the role and priorities of the healthcare sector and its organisations, including here at GOSH.

These include the **coronavirus pandemic**. The impact of Covid on both the organisation and the workforce has been significant. The standing down of elective work has created a significant NHS backlog. While we have made good progress in recovering activity relative to our peers, it is still significant and reducing it remains a government priority, which will impact on staff. In terms of GOSH, the pandemic acted as a springboard in some areas, rapidly accelerating the scale and pace of change. Staff showed commitment, energy and creativity, supporting the Trust and NCL partners, changing ways of working and supporting recovery. But it has also left a negative legacy of increased sickness (including long Covid); lower morale and resilience; and for some, anxiety and burnout. So, while the pandemic has acted as a catalyst for the increased focus on staff communication and engagement, EDI and health well-being, maintaining that support and focus will be essential to delivering our long-term workforce goals in what has become an increasingly complex environment.

NHS Systems change

In July 2022, Integrated Care Systems (ICSs) were established as legal entities across England, as part of a remodelling of the way Health and Care is organised, and resulted in GOSH becoming part the North Central London ICS, which is overseen by Integrated Care Board (ICB). This is in response to a shift in demand for health in recent years and the requirement for services to collaborate and focus on local populations; to reduce fragmentation of care and health inequalities; and improve patient experience and safety. While we understand the importance of partnerships and collaboration, having a long history of working with a range of partners inside and outside healthcare, working in a governance system that prioritises local healthcare is at odds with our role as a national provider of specialist paediatric care. As part of this reshaping, NHS commissioning of specialised services will be devolved from NHS England to ICBs. As a specialist, tertiary and quaternary care hospital, how we will logistically manage and be held accountable for multiple contracts with ICSs is unclear. However, it will require us to reset our narrative and position as a local, regional, national and international provider and seek resolution to the systemic recruitment and retention issues in the current system, if we are to attract and retain the people we need to deliver our commitments and ambitions for the future.

Both of the above issues have contributed to a changing

Financial and Economic Context. Historically, GOSH has relied on international/private care (IPC) income and charitable donations to balance its budget and underwrite NHS care. Both of these sources of funding were hit by the pandemic and while IPC income is recovering it is still below pre-pandemic levels, but with ambitions to grow. The restructure of the NHS means the allocation of specialist funding will be devolved from NHSE to local ICSs and won't necessarily be ringfenced for specialist services. As a specialist hospital, this is expected to impact approximately 70% of specialist funding based on 2020-2021 figures, which considering the volatility of spending on specialist care, will make securing contracts with multiple ICSs challenging. Strategic plans for the Trust going forward will have to operate within this changing financial context of increased external controls and scrutiny. Extending and consolidating our income sources will be essential to building financial resilience and sustainability. The situation has been further exacerbated by the UK macro-economic environment which has contributed to increased operating costs.

The NHS People plan

In 2020, NHS England published the NHS People Plan, which set out a commitment to the NHS workforce and 10 people based actions to support transformation across the whole NHS. This was based on: inclusion and belonging; health and well-being; improving leadership capability; new ways of working and delivering care; and growing for the future.

As part of NCL ICS, GOSH will support the delivery of these 10 people priorities which will be assessed through the CQC inspection framework and measured through the annual NHS staff survey which was updated in 2021 to reflect the NHS people promise. In 2023 the North Central London ICS published its people strategy which focuses on 3 workforce priorities (recruitment, development and transformation).

The commitments and actions from both plans align strongly with our own people strategy however, the impact of the last three years and the current turbulent and changeable external landscape will make delivery challenging. The current economic environment including the cost of living crisis is impacting significantly on staff emotional and financial wellbeing and is in part, driving an employee relations context which is unprecedented in the NHS, adding pressure on an already less resilient workforce.

Being proactive with our emotional and financial support for staff, and working collaboratively with their representatives and advocates, while balancing our core commitment to delivering safe care, will be essential to successfully navigating this situation. In 2023 the North Central London ICS published its strategy which focuses on 3 workforce priorities (recruitment, development and transformation).

Our Trust context and priorities

GOSH is a complex organisation. It has developed over time as a consequence of the complexity of our work, the workforce we employ and the children we care for, as well as the choices and decisions made in the development of individual services.

We recognise the growing complexity of our patient demographic - the children we care for often have rare and/or multiple conditions with significant morbidity and a high burden of illness. Patients and families often require the support of several specialities and need access and input from our teams on a regular basis. A significant amount of our work is enabling and facilitating other healthcare providers to safely care for our patients closer to home.

As an organisation, GOSH has grown organically with our service configurations and ways of working often reflecting developments in patient care and the roles to support them, as well as the research and clinical outcomes pioneered here. As a consequence, while multidisciplinary team working is a well embedded concept and is crucial to the success of the organisation, GOSH can best be described as a collection of highly specialised services which often sit within or alongside each other.

The absence of the integrated pathways and service delivery models has resulted in silo working within and between some teams, reducing the opportunity for more efficient ways of working. Although there have been improvements over the last 3 years, for example the introduction of a single Anaesthetic Pre assessment (AOPA) and the introduction of our integrated patient record system (EPIC) there is still much work to do to improve processes and integrate services to work more efficiently.

The complexity, range and uniqueness of the services we offer is reflected in our workforce. We employ a higher number and broader range of senior specialist clinical roles including Consultants, Advanced Clinical Practitioners, Allied Health Professionals and Health Care Scientists, which alongside national and local shortages across key roles, including nursing and single specialty consultants, add additional pressure to our recruitment and retention requirements.

The 2019 People Strategy identified a number of key strategic challenges and necessary building blocks which at the time were exacerbating our workforce challenges. Key among these was the absence of an organisation-wide strategy and a corporate narrative, both of which are essential building blocks for focused delivery and effective staff engagement. In 2020, GOSH published its new **overarching strategy, Above and Beyond.**

Above and Beyond reaffirms our core purpose - to advance care for children and young with complex health needs so they can fulfil their potential, through **Care, Research, Education and Digital Innovation**, and reiterated our ongoing commitment to put '*Children and young people first, always*'.

Crucially, the Above and Beyond strategy introduced and consolidated six priority work programmes to be delivered over the life of the strategy, these were to:

1. Make GOSH a great place to work by investing in the wellbeing of our people.
2. Deliver a Future Hospital programme to transform outdated pathways and processes.
3. Establish the Gosh Learning Academy (GLA) as the first-choice provider of outstanding paediatric training.
4. Improve and speed up access to urgent care and virtual services.
5. Accelerate Translational Research and Innovation to truly become a Research Hospital.
6. Create a Children's Cancer Centre to offer holistic personalised and coordinated care.

Since its publication two additional GOSH wide strategies have been published. **The Safety Strategy** in 2020 and more recently the **Clinical Strategy** published in February 2023. The Safety Strategy reiterated our commitment to patient safety as part of our core purpose to ensure that all our patients and their families receive high quality and safe care and is delivered through two ambitious programmes, one focusing on Safety transformation and the other on Safety Culture. Together, the Above and Beyond Strategy and the Safety Strategy provided an important counterbalance to the demands of the pandemic, which could have become all-consuming and potentially overwhelming. The organisational foundations provided by these overarching strategies and the programmes they initiated, ensured that solid and in some cases accelerated progress was made across, People, The Gosh Learning Academy, Research, the Cancer Centre and Patient Safety.

Finance and transformation

The 2019/20 also saw a marked change in our financial position. Historically, the Trust has been relatively well funded principally due to International Private Patient (IPP) practice, which has subsidised the financial deficit in NHS work and the GOSH Charity which funds over and above what the NHS is able to. Both saw a sharp decline as a result of the pandemic. In addition, tariff income has reduced across London, and

for specialist providers in particular. Alongside an increase in fixed cost and inflation, this has resulted in a budget deficit for the first time. As a result, the Trust is having to bridge this financial gap through a significant 'Better Value' programme focusing on quality, improvement and efficiency.

Responding to the workforce challenges

The overarching Above and Beyond Strategy, alongside the other GOSH-wide strategies, including the People, Safety and Clinical Strategies and transformation and innovation programmes, will provide the organisational framework to maintain focus on delivering the priorities and ambitions of the Trust, alongside managing the challenges set out above.

That strategic framework had been translated into a range of programmes which individually and collectively will change the way we work, how the workforce is organised, and the roles, skills and capabilities that will be required. They will include multi-year programmes such as the redesign and delivery of the cancer services and the building of the Cancer Centre, the Safety Transformation Programme, and transformation and optimisation programmes such as HDU, day cases and discharge planning.

In addition, on an annual basis there will continue to be in-service and directorate change programmes and a continued focus on building financial resilience and sustainability.

Supporting these programmes will be a range of system and infrastructure projects which will act as facilitators to the workforce and organisational changes required. In 2023/24, these include the work of the GOSH Learning Academy, clinical workforce reforms and improvements to business processes, systems and tools, including ongoing investment in HR Policy and infrastructure.

In response to the above, and the national and local context in which we must now operate, the People Strategy has been built around four key themes:

1. **Culture and engagement** - including health and wellbeing and EDI, ensuring all our staff feel well led and well managed, but also valued, developed, and empowered to be and do their best.
2. **Building a sustainable workforce** – to include capacity, strategic workforce and succession planning and resourcing and retention.
3. **Developing skills and capability** - ensuring that the Trust continues to meet its core responsibilities as a teaching, training and research hospital, as well as building skills and capability to meet the new challenges and changing priorities for the future.
4. **Processes systems and infrastructure** - modernising and updating the corporate and HR infrastructure, including, staff planning and deployment systems sustainable business support processes, collaborative working tools and HR policies and processes.

Culture and engagement

Context and key issues

Culture is the most significant contributor to the success or otherwise of an organisation. As with all organisations, our culture is driven by the work we do and the context in which we do it, but also by a range of other complex organisational issues which have developed over time. Creating a positive organisational culture where all staff can thrive and achieve takes time and continued focus and investment. While we have seen improvements in our culture as measured by the staff survey and other metrics, it was from a low base and there is still much work to do.

Issues which continue to impact on our culture at GOSH include the following:

Taking care of our staff (Mind, Body and Spirit)

Working with seriously ill children and their families, many of whom have complex conditions and uncertain futures, is physically and emotionally difficult. It places huge demands on our staff day in and day out and the context in which that work is delivered, including increasing patient acuity, has become even more challenging. Our response to the pandemic provided a catalyst for increased focus and with the support of the GOSH Charity we have been able to invest in extending our well-being initiatives. The publication of our Health and Wellbeing Framework, Mind Body and Spirit, the introduction of the well-being hub and the extension of initiatives to support financial well-being have been important additions to our offer. While there are now a wide range of support arrangements in place, there is still a lack of confidence by managers to both hold well-being conversations and facilitate access to resources and support as well as a general lack of awareness on the part of staff on what is available. Consolidating our offer, raising awareness and skills to facilitate access and ensuring our offer remains relevant and valued by staff will remain areas of commitment and focus.

Seen and Heard (Equality, Diversity and Inclusion)

The publication of the Seen and Heard Framework in 2020 was a response to some of the workforce challenges identified in the first People Strategy. These included an ethnically diverse representation rate significantly below the London average; the absence of employee voice; staff survey results which raised concerns about harassment and bullying; and a lack of progress and opportunity for staff from non-white backgrounds and for staff with disabilities and long-term conditions. The contribution of the newly established staff networks has been essential to the creation of a more inclusive work environment, but while there has been some progress there is still much to do. EDI will remain a focus for the Trust going forward, with continued focus on creating an inclusive workplace, recruitment and progression and amplification of the employee voice.

Upholding our values and standards of behaviour

GOSH has a rich history and heritage, which alongside its unique range of paediatric disciplines and its reputation for research and clinical excellence, attracts some of the most talented practitioners in healthcare. The complex and often unique nature of our patients results in the creation of transitionary multidisciplinary teams built around the needs of the child. At its best, matrix working is highly effective, but carries with it inherent risks as it cuts across the traditional concepts of line management and team structures. It therefore requires active management of team dynamics. A failure to do so creates challenges in working practice and relationships, which if left unchecked can lead to a breakdown in individual relationships and/or dysfunctional team working. It has become apparent that the GOSH values, which have served us well, no longer reflect the organisation we aspire to be and some are actively counterproductive. Although there has been improvement in this area, the Trust would benefit from a process and programme to reinforce the behaviour and values we expect from all staff.

Valuing and celebrating teamwork and collective contribution

The principle of 'The child first and always' is deeply engrained in the organisation and guides the way we work. However, it hasn't always been matched by an equally clear and unequivocal statement of commitment to our people. We do not always acknowledge the roles of all our people, individually and collectively, and the importance of teamwork and collective contribution to the functioning of the hospital. In recent years, the opportunity to celebrate the people who work here and the amazing work they do has been restricted by the pandemic. This has created a vacuum but also an imbalance in the characteristics which drive and define organisational culture, i.e., respect, belonging, acknowledgement and trust. It will be important that we refocus and celebrate the contribution and achievement of our staff and the work they do together.

Developing innovation, improvement and optimisation capability and confidence

As organisation who has pioneered medical and surgical advances over a number of years, we have been at the forefront of many innovations, changes and improvements to care. Historically, these changes have been in the context of relative financial stability. Changes in the organisation are inevitable, some are welcome and some less so. As we navigate the continual changes to healthcare structures and respond to ever increasing demands for our services, how our people approach, develop resilience to and deliver change will be important.

Developing a culture where all of our people, teams and individuals, have a day to day role in innovation, improvements and optimisation of their workplace, supporting the patient care they deliver, will play a key part in their development and investment, as well as having benefits to the Trust.

Develop engagement capability

Since the first People Strategy was published, we have invested in some key infrastructure to help drive engagement. We have a new intranet platform which has vastly improved staff members' ability to find key information and engage with each other. We have enhanced our ability to hold large scale hybrid events which facilitate meaningful two-way engagement between staff and leadership. We have also developed the organisation's first Employee Value Proposition (EVP). This activity has contributed to consistently high scores in the engagement domain of the staff survey.

Our challenge now is to ensure our corporate tools are working as hard as they can to facilitate engagement and their content strategies are aligned with our EVP, which must now be rolled out. To support this objective, we will be launching an app version of our intranet.

We also need to build the capability of our leaders to conduct meaningful two-way engagement through the introduction of a management cascade and a monthly 'Core Brief', which will provide key messages for the month. The past few years have been turbulent for the NHS. Our organisation needs to be able to describe how we will stay true to strategy and what we will prioritise in this fluid and changing context. To this end, we will be developing a corporate narrative to provide better consistency to the way our leadership team describe the opportunities and challenges that lie ahead.

Our senior leadership team is instrumental in shaping our culture. We also need to contribute to redefining an approach to engaging and bringing together our group of senior leaders. This needs clear definition of objectives and an appropriate rhythm for activity.

Commitments and actions:

Shifting organisational culture requires continued focus on and investment in the promotion of those characteristics which contribute to a positive working environment. This involves creating an open supportive and inclusive workplace, as well as dealing with the negative characteristics which detract from it.

In response to the above we will:

- Create a new Culture and Engagement framework which sets out our commitment to establishing a culture which supports our ambitions to make GOSH a great place to work for all staff.

- Refresh our Health and Wellbeing and EDI frameworks to align them both to the new People Strategy and our organisational context.
- Develop delivery plans to be reviewed annually with a set of impact metrics to assess and track progress.
- Review, consolidate and relaunch our well-being offer for staff to support them individually and collectively at difficult times ensuring that they are clear, accessible and mutually reinforcing.
- Extend reach and access to include a physical onsite staff well-being and support hub.
- Deliver and embed the Safety Culture programme to establish a culture which promotes transparency and supports the right and responsibility for all staff to speak up for safety, for themselves and for others.
- Continue to work with cross-organisational and directorate staff forums to inform and co-design our response to staff engagement and support initiatives
- Create and publish a Trust-wide response to the staff survey supported by local plans.
- Design and rollout a programme of culture workshops to inform and co-design the articulation of our desired culture going forward to support the alignment of the ambitions of the People and Safety strategies and integration of the Safety Culture transformation programme.
- Undertake a Trust wide process to review our Values and behavioural frameworks to more accurately reflect the organisation we aspire to be and the culture we want to create.
- Invest in understanding and supporting effective matrix and complex team working, including setting expectations and standards of behaviour, supported by conflict resolution and mediation service.
- Refresh of our approach to recognition and celebration to reinforce what we value, including collective contribution and teamwork.
- Optimise the Our GOSH intranet to promote two-way dialogue.
- Create an annual corporate narrative and introduce a monthly cascade and core brief to support meaningful two-way engagement.
- Establish a network of corporate leaders to strengthen corporate leadership and working, supported by a governance infrastructure and an expectation statement which sets out corporate accountability and ownership to sit alongside their service responsibilities.
- Create a respectful, constructive and mutually beneficial relationship with the staff partners and union representatives and ensure full involvement in and shaping of GOSH People Strategy and appropriate programme.

Building a sustainable workforce

Context and key issues

In many ways, our workforce of circa 6000 is typical of many Trusts in that it is predominately female (76%) and weighted in favour of clinical roles (61% are clinically registered practitioners, 21% are clinical support staff and 19% of staff are in corporate and central support roles). However these statistics mask a range of issues which have grown over time and have delivered both benefits as well as challenges and are further complicated by the specialist nature of the work done here.

Our workforce characteristics include having both a young workforce and low representation of staff from diverse ethnic backgrounds relative to other parts of the NHS, together with low tenure in some key roles, including nursing and support roles. There are a range of issues to address relating to: recruitment pipelines and processes; career and training paths; our employer brand and the experience and capability as result of low tenure. All of these issues have been exacerbated by a cost of living crisis which has created significant pressures for many. There are also implications for communications and engagement. With a workforce which is young, mobile, digitally savvy and not necessarily committed to a future career at GOSH, it is essential that we are able to provide an employment offer which is attractive in the first place, and follow that up with a working environment and career opportunities that encourage people to stay.

The impact of age and tenure

While bringing vibrancy and new ways of thinking, having a young workforce inevitably requires higher levels of supervision and support, especially for younger workers living away from home for the first time or being new to the UK or London. With 53% of our workforce under 40 and an absence until recently in line management development, that support has often been provided by a cohort of first time or less experienced and confident supervisors and managers.

Recruitment and retention of nursing staff

Our Nursing colleagues are at the heart of the organisation making up our largest staff group, with over 1700 wte, and uniquely span across all AFC bands. The GOSH Nursing 2023-2026 strategy, 'Safe in our Hands' supports the priorities in this People strategy. It aims to create a supportive workplace for our nurses to achieve their best careers, delivering the care they want to deliver in a hospital where they are proud to work.

The nursing strategy is based upon four key principles; to continue to develop a skilled inquisitive workforce, amplify the nursing voice, striving to become a nurse friendly hospital, celebrating our successes and our profession as we support nurses to have extraordinary careers. As part of the Nursing strategy and post pandemic our approach to recruitment has changed, to focus on local recruitment to increase diversity and widening our reach and targeting experienced registered nurses with transferable skills here in the UK and internationally which brings a richness of new ideas and knowledge to our workforce. One of the priorities of the of the strategy is to retain our nurses through several new and bold initiatives with our STAY retention campaign - 'Successful careers', 'Time for you', 'Always learning' and 'You are valued' incorporating career progression, flexible working models, development opportunities, reward and recognition including benefits, accommodation provision and cost of living support.

Turnover in administration and support roles

While we have seen a 5% reduction in the turnover of admin staff in the last 2 years, bucking the trend of the post-covid increase and supported by the move to standardised job descriptions linked to training paths. We still turnover 19% of our admin and support roles each year. There is more we could do to encourage progression, internal promotion, secondment and shadowing. In addition, there is more work to do to understand the detail and drivers behind some of the other workforce statistics including succession planning and career paths for Allied Health Practitioners (AHP) and Health Scientists. The health workforce of the future is expected to be more integrated with multidisciplinary teams. This will have a significant impact on recruitment as well as training and education.

Building a diverse workforce

While we have seen an increase of 8% in representation of staff from ethnically diverse backgrounds since the original strategy was published, it remains below that of other London Trusts. Historically, our employer brand had evolved organically, informed by the strong external brand of the hospital and the GOSH Charity brand, with the latter in particular having a different purpose and role. The Trust launched its own logo in 2019 which is well embedded and work began on developing a separate employer brand and employee value proposition (EVP) to promote GOSH as an open and inclusive employer of choice, with a wide range of careers, roles, training, education opportunities and people. While that work was delayed and then reset following the pandemic, it is now complete and will be a key enabler to our plans to open up recruitment.

Building and maintaining a specialist workforce

As well as being clinically excellent, our clinical colleagues are researchers, teachers and trainers, involved in management of medical services and representing their specialities as national and international leaders. We recognise how health care systems are changing and want to be at the forefront of this by developing an extended workforce and modernising how our clinical teams deliver care.

Specific, unique clinical expertise is found within GOSH and we acknowledge how our clinicians work at the forefront of their specialties and how they innovate and lead in their areas. Opportunities for progression within highly specialist fields has become extremely challenging within the current NHS system despite the demand for highly specialised paediatric services increasing. We will need to be more creative in the way we nurture and deliver advanced clinical practice and grow talent, particularly in specialties unique to GOSH.

Succession planning and talent management

This is an area that requires more structured focus and attention. There are a range of issues to address, driven in part by the number and range of specialities provided by the hospital and the vulnerability of some teams, often exacerbated by national skill shortages. Short-term planning, often driven by financial constraints, has resulted in structures in some teams and services which fail to provide development and progression opportunities. Succession planning and talent management are dependent on effective workforce planning and the use of effective appraisal and development processes.

Commitments and actions

In response to the above we will:

- Launch and embed our repositioned employer brand and employee value proposition (EVP) to promote GOSH as an open and inclusive employer of choice.
- Develop an overarching recruitment and resourcing strategy with sub strategies to support key roles.
- Debias our recruitment policies and processes to deliver open and transparent process which are also efficient and effective.
- Build and maintain a strategic workforce planning model which is integrated into financial and activity planning work streams and the business planning cycle to support recruitment planning.
- Support directorates to build and maintain annual workforce plans focused on their workforce priorities and recruitment hotspots and support them to establish success.
- Establish an administration recruitment and retention work stream focused on building career and training paths and promoting opportunities which encourage people to stay and build a career at GOSH.
- Implement the Nursing Strategy and imbed the STAY nursing recruitment and retention programme
- Open up and promote internal recruitment opportunities through secondments, work shadowing and promotion opportunities.
- Implement the Modernising the Clinical Workforce programme to support workforce planning, integrated working and succession planning across and within linked professions supported by job planning.
- Plan for the future workforce through the extension of the advanced clinical practice programme and the use of clinical leaders roles (proleptics) for services unique to GOSH.

Developing skills and capability

Context and key issues

Launched in 2019, the GOSH Learning Academy (GLA) has established itself as one of the leading providers of paediatric education, training, and development nationally and internationally. Importantly, the GLA has a continued focus on supporting our people throughout their career at GOSH across all professions and staff groups.

Recognising our current challenges, the GLA has invested in building confidence, competence and capability through various routes such as apprenticeships and by offering a broad range of generic and specialist courses. However, while there are clear career development pathways for clinical staff, this needs to be strengthened across all staff groups to improve succession planning and equal opportunities for development while increasing staff retention.

In support of the refreshed People Strategy there will be a continued focus on building capability and capacity in a range of skills and disciplines, including but not limited to: leadership, line-management, transformation, service redesign, programme and project management, financial and service planning and analytics.

Aligned with the GLA, the refreshed People Strategy will focus on the development of core and generic skills for the wider workforce outside of clinical disciplines.

Supporting development and progression

In the past we have invested less in our non-clinical workforce and our learning and development offer to them has been limited. GOSH provides an excellent environment for our people to have interesting and varied careers, supported by education, training and development opportunities. In partnership with the GLA, we need to invest in our people working across all clinical professional groups such as Allied Health and Healthcare Science, as well as the whole range of administrative support and managerial roles that are so vital to ensuring our hospital functions every day. During the Covid pandemic years, there was a focus on clinical education and development and as a consequence, we have underinvested in our corporate services including our people working in human resources, finance, ICT, digital facilities, and estates. We need to rapidly provide clear career paths for people working in all services to support their professional and technical development to meet the changes that the refreshed organisational strategy will require.

Providing equal access to all staff

We recognise that education and learning underpin patient safety outcomes and experience. Despite the significant investment in education, training and development provided in large part by the opportunities afforded by the GLA, the benefits are not felt evenly across the Trust. Our generic workforce development offer has increased significantly over the last three years but remains undeveloped in some areas and needs further integration and promotion to ensure the benefits are accessed and felt across the whole organisation. Recognising the need for boundaries within areas of clinical education, we will ensure wherever possible that we have a multi-professional approach, where appropriate, and ensure these opportunities are well communicated to all teams. Additionally, we will provide career coaching for colleagues that are unsure of how to take the next steps in their development and enable managers to have information to support career conversations at their fingertips.

Supporting and growing distributed leadership

In October 2018, a new organisational structure for the clinical directorates was implemented, based on a distributed leadership model which introduced new roles, responsibilities, processes and ways of working. While providing real potential to improve service delivery and management of staff, the development of the new structures and working arrangements were interrupted by the pandemic resulting in the need to move to command and control structures which remained in place for two years. This significantly reduced the opportunity to mature and grow the skills and working arrangements necessary to work and manage in a distributed leadership model and the new and different skills now required to operate in our changing organisational context. The situation was further exacerbated by changes in in the senior leadership.

Developing compassionate, competent and inclusive leadership

We previously provided pockets of leadership development largely delivered as part of clinical training paths. The adoption of a GOSH leadership framework provides an opportunity to establish clarity and expectations of all leaders in their roles as corporate, service and systems leaders as well as line managers. The strategy formed part of a broader leadership framework and was used to develop leadership programmes for aspiring leaders, developing leaders and established leaders. All levels of the leadership development programme will focus on self-leadership, team leadership, system leadership as well as corporate leadership for senior roles. To this end, we will make best use of our apprenticeship levy to provide access to leadership

development programmes. Going forward, the leadership framework, its standards and expectations, will feed into roles, structures, recruitment as well as performance and assurance frameworks.

Improving line management

Our relationship with our immediate line manager is essential to providing a supportive work environment. We recognise that previous underinvestment in this area, together with our age profile means that not all managers feel competent or confident in their ability to make sound people management decisions. In extreme cases this has led to requirements for mediation and team interventions to remedy positions of conflict or ineffective team working. We will continue to focus on people who have a line management responsibility to develop their capability to ensure good judgement and decision making. We will also offer support to managers in developing their coaching skills and approach, team development, and empowering and engaging their teams. In addition, we will increase the capability across the organisation to engage with and lead service redesign, increase financial capability and acumen, embed the use of quality improvement methodology, and improve project and programme management.

Digital, data and technology

Digital technology is both an enabling and transformative function at GOSH that provides the foundations for integrated clinical systems (such as the Epic EPR), the Digital Research Environment (DRE) and medical devices. To best exploit digital technology and foster a culture of innovation, a digitally confident and enabled workforce is required. There are currently varying levels of digital literacy across the various staff groups. We need to develop plans to ensure that we support all staff to best make use of digital technology investments. A digital literacy assessment will be undertaken to assess our current position across the Trust and identify the gaps in knowledge and skills, so that a package of support and training can be constructed to ensure that GOSH is able to fully capitalise on the transformation opportunities provided by digital/technological innovation.

Commitments and actions:

To realise the ambitions set out in the GOSH Strategy, alongside the commitments to our people arising from the new People Strategy, will require investment in building capability and capacity in a range of skills and disciplines .

In order to meet the changing requirements of the organisation we will:

- Provide a learning and development framework that is easily accessible for all staff across all roles and disciplines.
- Develop career pathways for all roles linked to learning opportunities and apprenticeships.
- Provide a multi-professional leadership development programme for aspiring, developing and established leaders.
- Develop and implement a development programme to support and harness the potential of the Corporate Leadership Network
- Embed leadership behaviours into appraisal and talent processes.
- Review and modernise our approach to personal development reviews (PDRs) to provide meaningful opportunities to improve performance and capability alongside development.
- Increase the capability of managers to provide a supportive work environment.
- Provide a structured approach to accessing coaching, mentoring and mediation.
- Develop a programme of development to increase capability and confidence for service redesign, change management, digital technology, and project management.
- Develop the future digital workforce required through the design and implementation of a core digital skillset to be incorporated into the Trust's standard job descriptions.
- Retain and develop the best technology talent for GOSH through a digital apprentice programme, along a comprehensive training and development programme to ensure that our technology staff are well trained and developed.

Corporate processes, systems, and infrastructure

Key issues

The development of the original People Strategy brought into sharp focus the previous absence of investment in people related issues across the Trust and this is reflected in the quality of corporate infrastructure and our corporate services generally. All organisations need efficient and effective infrastructure (policies, structure, systems, and processes) in order to function efficiently, manage effectively and grow sustainably.

This underinvestment is reflected in:

A framework of HR polices which have grown over time

Although we have made some progress, our HR policy framework still lacks coherence. They still focus on process as opposed to outcome and are seen by staff and their representatives as overly punitive and negative in both tone and language. The HR policy framework needs to provide a backdrop to adequately support constructive employee relations. This is exacerbated by lack of experience and skills on the part of line managers and the level and quality of support provided to them, resulting in prolonged processes with often unsatisfactory outcomes for all parties. There is a need to continue with the process of repositioning our approach to policy design and its application which facilitates healthy workplace relationships and promotes informal resolution, before initiating formal processes.

Use and configuration of our workforce deployment and support systems are underdeveloped

The systems and processes we use to engage and support our managers and staff have improved over the last 3 years with the roll-out of Healthroster, improvements to the NHS Employee Staff Record system (ESR) and the introduction of GEARS to manage and facilitate staff changes, although they all require further optimisation. Other staff tools and systems such as job planning, appraisals and the learning management system (GOLD) are scheduled for replacement or upgrade in 2023/24. The Trust will also be moving to a new payroll provider and oversight will transfer to the HR and OD function to improve responsibility and integrate processes. Together, these actions will improve our ability to not only deploy our workforce effectively, but also to analyse and understand our workforce issues, their drivers and solutions.

Resourcing and recruitment processes

The applicant tracking system (TRAC) was introduced in 2019 and while it has improved some processes, like other workforce sytems, it needs further work to maximize its potential. The Trust has historically had a lower vacancy rate than the national average but requires regular recruitment due to higher than average turnover. Processes for recruiting staff have been transactional and aligned to individual recruitment episodes rather than to a wider recruitment and attraction strategies. This has often led to duplication and delays to recruitment which in turn can impact the delivery of services.

Business processes and systems

In many ways, GOSH is an extraordinary place to work with excellence and innovation reflected in our clinical, education and research achievements. While there have been investment and improvements in some of our corporate and supports services, there remains much to do particularly around planning and financial management. The processes which support annual business planning demand and capacity planning, and business development, financial planning and procurement are often difficult to navigate.

Maximising our ICT systems and infrastructure

In 2019, Digital Technology at GOSH required improvement across several areas including cyber security, an ageing device estate, access to service support and software and communication systems. Considerable work has been undertaken in the last 18 months to provide robust technology foundations with a focus on fundamental processes, improving standards and compliance while enhancing our security and a refresh our existing hardware/software platforms. This work culminated in the development of the 2023-2026 GOSH Technology strategy. Under the banner of enhancing Trust operations, a key strategic objective is to provide our staff with access to smarter systems. We recognise the difficulty of understanding the diverse ways that GOSH staff have to communicate with one another and bringing these together on a single unified communications platform where users can video chat, exchange text messages, receive telephone calls, receive alerts, share and collaborate on documents. Nonetheless, this is an important element of our vision for providing smarter and more joined up systems and builds upon the investment that the Trust has already made in the Microsoft Teams platform.

Keeping our patients, staff, and corporate data safe and secure is fundamental in all that we do. We will continue to support our staff in being cyber resilient and aware. Training and awareness campaigns will be used to ensure that learning and best practice are shared with GOSH staff to help them best identify and navigate potential cyber threats.

Supporting Flexible and Hybrid working

Since the pandemic, the world of work has moved to more agile ways of working which affect clinical and non clinical roles equally, but differently in terms of when, where and how their patterns of work are organised. While we have established hybrid working in principal, there is a need to review and consolidate those arrangements in order to ensure that the benefits are optimised and to support the requirements resulting from the new cancer centre.

Delivering service improvements, efficiency and change

Over recent years, the Trust has adopted a number of different tools and projects to deliver quality, safety and efficiency improvements – these have resulted in some excellent local examples of change but in many cases these have not become widely embedded across the Trust and often fall away when not actively managed by individuals within local teams. There is an urgent requirement to develop change management capability, infrastructure and a culture of transformation across the Trust. This is alongside an enabling organisational structure which will support and empower our staff to identify, design and adopt new practice and successfully deliver the changes required at both a strategic and local level.

It is crucial to the successful delivery of any change that the people implications are understood and planned for at the outset, including interdependencies and the cumulative impact, in order that inherent risks can be managed and mitigated.

Commitments and actions

In order to support the organisation through the changes, we need to build new capabilities and stronger corporate support functions with roles that allow them to operate as strategic support functions, working in partnership with the CEO, directors, senior leaders, staff and their representatives, to safely prepare the organisation and deliver the transformation and change required alongside transactional services which are efficient and effective.

In order to meet the changing requirements of the organisation we will:

- Establish a policy framework which promotes and supports modern employee relations and puts people before processes.
- Upgrade our HR and staff deployment systems to ensure that we are supporting managers and staff effectively and embed robust analytics to identify areas for improvement.
- Review and upgrade recruitment processes, onboarding and induction
- Refocus both the work and structure of the HR function to reflect its new enhanced role and provide a foundation for future investment in capability building and career development.
- As part of the Better Value programme, review and improve core business processes to support effective and sustainable working.
- Replace and upgrade our office administration software to provide improved functionality, support collaborative working and communication tools.
- Implement a flexible and hybrid working programme to included principles and toolsets to support team decision making.
- Establish appropriate capability and structures to deliver and champion the transformation agenda and to oversee the successful design, implementation, integration and delivery of transformation programmes informed by our strategic objectives.
- Develop a transformation portfolio to provide support for and oversight of projects and programmes delivering change across the organisation, ensuring we have the capability and capacity to deliver and embed a culture of transformation.

Measuring the Impact of the People Strategy

The commitments set out in this three year strategy will be embedded into three frameworks: our EDI framework (Seen and Heard), our Health and Wellbeing framework (Mind, Body and Spirit) and a new framework to cover Culture and Engagement. Each of the frameworks with have an annual delivery plan and a set of benchmarked impact metrics to track progress. The individual impact trackers will be used along with other data sets to provide an overarching set of metrics to track progress and impact over the life of the strategy and will include workforce, delivery and experiential data drawn from the staff survey and other data sets.

The metrics used to track progress and impact of the strategy, will also provide a view of the emotional and physical health of the organisation and its workforce and will include the following:

- Organisational engagement and morale scores as measured by the staff survey
- Advocacy (percentage of staff recommending GOSH as a place to work)
- Staff survey and pulse survey response rates
- Effective leadership and line management
- Psychological safety and confidence to speak up (we have a voice that counts)
- Recognition and celebration
- Listening and learning
- Effective communication
- Efficiency and efficacy of our workforce
- Workforce demographics (percentage of staff from diverse backgrounds)
- Workforce data (turnover, vacancy, sickness, appraisal rates and stat/man training)

There will be a set of metrics for each of the frameworks and a subset will be included in the directorate performance review management processes (PRMs) to be reviewed along alongside the Directorate workforce and staff survey action plan.

Summary

Great Ormond Street Hospital is a challenging, complex and inspiring place to work. Each and every day our people come together to support each other to deliver excellent patient care, often working to help our patients and their families navigate through demanding processes and difficult decisions. Creating a working environment where all our people are valued for who they are as well as what they do and where they enjoy their work and coming into work, is everybody's job and is in everybody's interests.

Currently, our organisational culture is primarily defined by our regulatory framework as it is with all hospitals, but also and uniquely, by our reputation, our research and clinical outcomes, our undeniable commitment to our patients and a strong value-based commitment by individuals to their work, and pride in what the organisation stands for and delivers.

However, these positive characteristics are being undermined by poor basic infrastructure and a failure to clearly articulate a commitment to our people, including in some instances setting and upholding standards of behaviour.

Through this People Strategy we will:

- Continue to Invest in the development, diversity and inclusion and welfare of our whole workforce.
- Create opportunities for career development and advancement across all disciplines and professions.
- Develop the competence and skills to meet existing requirements alongside capability for the future, including service transformation.
- Raise our leadership and line management capability, developing compassionate and inclusive leaders, who are trusted for their motivation as well as their competence.
- Reposition our employee brand as an open and inclusive employer of choice, to attract and retain talent.
- Invest in our corporate systems and infrastructure to provide more efficient ways of working and help managers to support and deploy staff effectively and work and grow sustainably.
- Grow communication and engagement capability across and through the organisation.
- Review our values so they reflect the organisation we aspire to be and embed them in all that we are and all that we do.

As a Trust we will work together with all our people and their representatives, to create a working environment, job roles, training and development, opportunities, support and culture that our people want and deserve. We will create an organisation which actively promotes and values teamwork and collaboration, where all our staff are well led and well managed and where everybody irrespective of their role, feels valued, heard, supported, safe and connected.

Attachment Q

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6 July 2023

Transformation update **Submitted by: John Quinn, COO**	**Paper No: Attachment Q** **□ For information and noting**

Purpose of report
To update the Board on work recently undertaken with operational directorates to prioritise the Trust's change and transformation activity.

Summary of report
This paper describes a wide portfolio of existing projects being undertaken within the Trust which range from research, innovation and transformation at one end of the continuum, to optimisation and business as usual activities at the other. It explains work that has been undertaken with operational directorates to focus increasingly on a smaller number of high impact projects which will receive central support from the transformation team, with some other projects either reaching their natural end or being suitable for handover to local teams for ongoing implementation.

Patient Safety Implications
There are no direct patient safety implications from the work described in this paper although successful delivery of transformation activity will support the delivery of safe, effective and high-quality patient care.

Equality impact implications
There are no direct equality impacts from the work described in this paper although as the Trust develops its approaches to issues including ambulatory care and aspects of flow, this has the potential to improve access and equality of access to services.

Financial implications
Priority projects described in this paper, starting initially with day cases, should support more efficient use of the Trust's existing capacity, with potential for future growth if that enables additional activity to be undertaken.

Strategic Risk
Company Secretary to complete

Action required from the meeting
The Board is asked to receive the report for information and note that oversight of these activities will be undertaken by the Future Hospital and Access to Care Board, which reports to the Above and Beyond Executive Oversight Committee.

Consultation carried out with individuals/ groups/ committees
Ongoing engagement of operational management teams.

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

Who is accountable for the implementation of the proposal / project?
Chief Operating Officer

Transformation Update
July 2023

Purpose

This paper provides the Board with an update on work recently undertaken with operational directorates to prioritise the Trust's change and transformation activity, in support of delivering our future hospital and improving access to our services (Planets 2 and 4 of the *Above and Beyond* strategy).

Recommendation

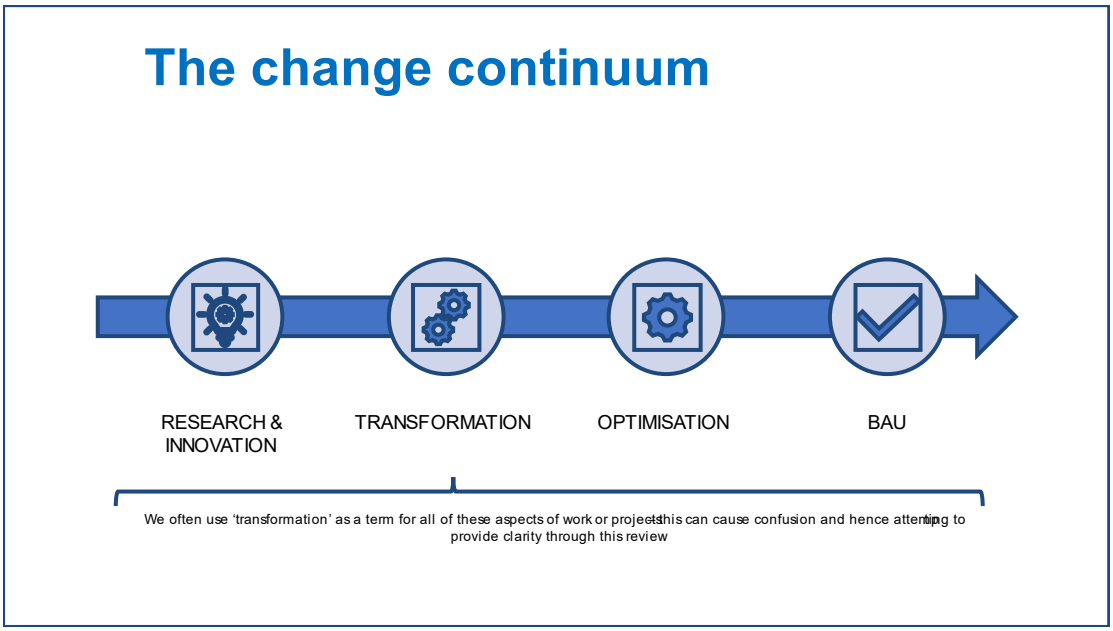
The Board is asked to receive the report for information and note that oversight of these activities will be undertaken by the Future Hospital and Access to Care Board, which reports to the Above and Beyond Executive Oversight Committee.

Rationale

At its February Strategy workshop, the Board received an update on the work of the Transformation team and agreed their work should be focused increasingly on a small number of high impact priorities that matter both to patients and staff. The aim was to make the most of our innovation, research and transformation expertise to deliver *Above and Beyond* and the *Clinical Strategy.* This would require a move away from a very substantial existing portfolio of smaller projects which had not delivered significant scalable benefit.

Since that workshop the Executive have held three dedicated meetings and several other discussions with the leadership teams of the operational directorates, initially focussing on clarifying where current activities sat on the "change continuum" (see figure 1 below) and then moving on to identify a smaller number of priority programmes for focus over the coming year.

Figure 1 – the Change Continuum



The starting point is one of a significant range of projects under each of these headings including, for example:

Table 1 – current deliverables and projects

Research & Innovation	• Virtual ward • Remote monitoring • Clinical Intelligence Unit • Data for Operations use • Future Hospital ward • Gene Therapies
Transformation	• HDU/Level 1 & 2 project • Remote shared care • General paediatrics • No child should wait (including increased activity within existing capacity, one stop shop and reduction of multiple GAs)
Optimisation	• EPR • Patient Safety Programme • QI projects • Flow (theatre productivity, bed utilisation, day case strategy, transition) • Local optimisation initiatives (e.g., Pharmacy MHRA) • IPC optimisation (flow, capacity & demand, billing)
BAU	• Decant and enabling programme and space moves • Trust site masterplan • Yearly planning and Better Value • People Strategy implementation and OD

In addition, the Trust has embarked upon, or plans work in, a range of other high priority business development projects and responses to the external environment/requests for support including:

- The Children's Cancer Centre and associated transformation programme
- Developments in foetal surgery
- Urgent care model sector support for children aged under 3
- Development of neurorehabilitation pathways with RNOH
- Cardiac service optimisation work
- GIDS in response to new national commissioning requirements
- New paediatric pain rehabilitation (research) programme
- Pharmacy transformation
- Gastroenterology sector support

The Transformation team has also been working on a wide range of further initiatives such as

- the development of a new haematological oncology electronic dashboard to substantially reduce administrative burden
- development of new haematological oncology discharge videos
- building care pathways for the new Macroglossia service into the Epic EPR system
- specification of a new Epic beds dashboard to support the work of the bed management team
- development of the new Decision Making and Consent Policy and;
- contribution to national work led by Alder Hey on a new Was Not Brought In AI indicator.

Feedback from directorates at the aforementioned sessions and discussions was that they strongly supported the proposal to prioritise a much smaller number of high impact priority areas. They felt that there were a number of basic, access and flow related areas where further optimisation was needed, and which could potentially produce significant patient benefit. These were in addition to recognising the continued importance of work to develop, value, recruit and retain our workforce – work which will be led under the umbrella of the refreshed People Strategy.

Following these discussions, it was agreed that the central transformation and PMO team resource would be increasingly focused upon the following range of projects which are elevated for central resourcing:

Table 2 – priority projects for central Transformation/PMO support

Future Hospital and Access to Care initiatives	• Day case optimisation (immediate priority) • Improving discharge (to follow over next 6 months) • Vision for Level 3 (procedures floor) • High Dependency Level 1 and 2 care • Developing Ambulatory Care (link with CCC programme)
Other projects	• Better Value • Paediatric Pain Management Research Programme • Pharmacy / MHRA • CCC decant programme • Above and Beyond portfolio oversight

A range of other projects led by the team are near their natural conclusion and work is now being undertaken to identify lessons learned. Others will be passed to directorates to implement as part of their own local business optimisation plans. In addition, the Trust will be continuing to progress the range of business development projects described above.

Next steps

The Future Hospital and Access to Care Board is revising its governance and approach to focus on the five initiatives noted in table 2 above. Each of these projects is now developing a detailed set of objectives and key results for the next six months, with a review proposed after three months and six month intervals.

Recommendation

The Board is asked to receive the report for information and note that oversight of these activities will be undertaken by the Future Hospital and Access to Care Board, which reports to the Above and Beyond Executive Oversight Committee.

Attachment R

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 6 July 2023	
Learning from Deaths report- Child Death Review Meetings – Q4 2022/23 **Submitted by:** Dr Sanjiv Sharma , Chief Medical Officer Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews Andrew Pearson, Clinical Audit Manager	**Paper No: Attachment R** For information and noting

Purpose of report

To provide Trust Board with oversight of learning from deaths identified through mortality reviews, this includes positive practice, but also where there were modifiable factors.

Meets the requirement of the National Quality Board to report learning from deaths to a public board meeting. Child Death Review Meetings (CDRM) are statutory following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019.

Summary of report

To highlight learning from child death review meetings (CDRMs) concluded between the 1st January and 31st March 2023 at GOSH.

Twenty-five child death review meetings (CDRMs) took place at GOSH in this timeframe. The reviews highlighted:

• There was one death where there were potential modifiable factors identified by the CDRM in the experience of care provided at GOSH and with the local hospital. The case has been re-referred to the coroner and final learning will be shared in a future Learning from Deaths report once that process has concluded.

• Additional learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience at GOSH in seventeen cases. In two cases the local teams advised they were not aware of changes in a child's condition, which has been raised as a theme in previous reports.

• Excellent aspects of care, the co-ordination of care and communication at GOSH were highlighted by the CDRMs in sixteen cases.

• This report also highlights that outside of this reporting period the CDRM/Mortality Review Group have identified modifiable/potential modifiable factors around the administration of Premiloc prior to admission to GOSH for four babies who died at GOSH in January and February 2023

Patient Safety Implications

Four GOSH NICU deaths occurred between the 6th January 2023 and 24th February 2023 where the transferring centre was UCLH have been reviewed by the CDRM or MRG noted on 18th May 2023.

• In all four deaths the CDRM/Mortality Review Group have identified modifiable/potential modifiable factors around the administration of premiloc prior to admission to GOSH.

• Administration of Premiloc (hydrocortisone steroids) to these babies may have been associated with the subsequent perforations. A series of incidents of perforations have been flagged to the UCLH Neonatal unit who are reviewing their data and have stopped the administration of Premiloc in response to feedback from NICU at GOSH. The RCT (Lancet) demonstrated anincrease in sepsis in babies of 24-25 weeks gestation, but no association with perforations and other neonatal units have used Premiloc without any

recognised association to NEC/perforations. UCLH NICU is liaising with other units in order to clarify the situation. Notably other risk factors for perforation makes it difficult to determine an association. • This has been raised with the Medical Director and the AMD for Safety, to ensure that appropriate information from GOSH can been shared to inform and support any UCLH review of these cases. The AMD for Safety and Interim Head of Patient Safety are in contact with the Safety team at UCLH.
Equality impact implications None identified
Financial implications None
Action required from the meeting There are no recommendations or actions for the Board to consider
Consultation carried out with individuals/ groups/ committees The report has been reviewed by the June 2023 QSOCC
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews
Who is accountable for the implementation of the proposal / project? Medical Director

Learning from deaths report –learning from Child Death Review Meetings Q4 2022/23

Aim of this report

To highlight learning from child death review meetings (CDRMs) concluded between the 1st January and 31st March 2023 at GOSH.

Summary

Child Death Review Meetings (CDRMs) are the final meeting to confirm actions and learning in the mortality review process following the completion of all necessary investigations and reviews.

Twenty-five child death review meetings (CDRMs) took place at GOSH in this timeframe.

The reviews highlighted:

- There was one death where there were potential modifiable factors[1] identified by the CDRM in the experience of care provided at GOSH and with the local hospital. The case has been re-referred to the coroner and final learning will be shared in a future Learning from Deaths report once that process has concluded.
- Additional learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience at GOSH in **seventeen** cases. In two cases the local teams advised they were not aware of changes in a child's condition, which has been raised as a theme in previous reports.
- Excellent aspects of care, the co-ordination of care and communication at GOSH were highlighted by the CDRMs in **sixteen** cases.
- This report also highlights that outside of this reporting period the CDRM/Mortality Review Group have identified modifiable/potential modifiable factors around the administration of Premiloc prior to admission to GOSH for babies who died at GOSH in January and February 2023.

Aggregation of learning themes from CDRMs

This report highlights learning from CDRMs concluded in Q4. In our Q3 report we conducted a review of learning identified from CDRMs over a longer period in order to be more able to aggregate and identify themes. That took place to identify areas of strength, and where we may wish to focus attention and assess whether there may be adequate workstreams taking place or are required.

This was reported to QSOCC (March 2023), Trust Board and in the GOSH 2022/23 quality report. 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.

[1] 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. (National Guidance on Learning from Death, NHS England, 2017)

The most frequently occurring learning point in that analysis was around communication with local hospitals. We will update that aggregation every six months to ensure that wider themes can be identified outside of a small quarterly reporting period.

Further information follows this summary.

Contents

13th June 2023
Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews
Andrew Pearson, Clinical Audit Manager

Cases where modifiable factors were identified following the conclusion of the CDRM

Potential modifiable factors identified at GOSH/local Q4 2022/23

Month death	Location of learning	Learning /Actions taken
January 2022	GOSH/local	The value of having all the professionals at the CDRM highlighted the value of an earlier multi-professionals meeting with the right individuals in order to ensure all of the information was available. The case has been re-referred to the coroner and final learning will be shared in a future Learning from Deaths report once that process has concluded.

Modifiable factors identified outside of GOSH Q4 2022/23

Month death	Location of learning	Learning /Actions taken
October 2022	Local/GOSH child death notification process to local	**Modifiable factor** Discussion regarding whether the flu vaccine might have prevented the outcome raises the importance of vaccination and the potential impact of several factors: access to services, timing of vaccine availability and the Covid pandemic as potentially important factors in vaccine uptake. **Learning for GOSH** Local team fed back that the notification of child's death via telephone to SHO (on her day off) and to Consultant via email was not felt to be appropriate given the presentation in this case was not expected to be associated with a poor outcome. This has highlighted the need for local teams to be updated of the Child's clinical status (i.e. potentially poor prognosis) during the inpatient stay. An email notification is being considered.
February 2023	Local	It has been suggested that the administration of Premiloc (hydrocortisone steroids) to this baby may have been associated with the subsequent perforations. A series of incidents of perforations has been flagged to the Neonatal unit who are reviewing their data and have temporarily stopped the administration of Premiloc in response to feedback from GOSH. The RCT (Lancet) demonstrated an increase in sepsis in babies of 24-25 weeks gestation, but no association with perforations, and other neonatal units have used Premiloc without any recognised association to NEC/perforations. The NICU is liaising with other units in order to clarify the situation.

<u>Premiloc administration in babies prior to arrival at GOSH</u>

The above case is indicative of a theme which has been noted in subsequent reviews outside of this reporting period.

Four GOSH NICU deaths occurred between the 6th January 2023 and 24th February 2023 where the transferring centre was UCLH have been reviewed by the CDRM or MRG noted on 18th May 2023.

- In all four deaths the CDRM/Mortality Review Group have identified modifiable/potential modifiable factors around the administration of premiloc prior to admission to GOSH.
- Administration of Premiloc (hydrocortisone steroids) to these babies may have been associated with the subsequent perforations. A series of incidents of perforations have been flagged to the UCLH Neonatal unit who are reviewing their data and have temporarily stopped the administration of Premiloc in response to feedback from NICU at GOSH. The RCT (Lancet) demonstrated an

increase in sepsis in babies of 24-25 weeks gestation, but no association with perforations and other neonatal units have used Premiloc without any recognised association to NEC/perforations. UCLH NICU is liaising with other units in order to clarify the situation. Notably other risk factors for perforation makes it difficult to determine an association.

- This has been raised with the Medical Director and the AMD for Safety, to ensure that appropriate information from GOSH can been shared to inform and support any UCLH review of these cases.

Learning points identified Q4 2022/23

Additional learning points around best practice which could improve quality, the co-ordination of care, or patient and family experience at GOSH.

Location of learning	Month of death	Learning /Actions taken
PICU, Neurology, IR, Anaesthetics	February 2022	1. VGAM is a rare condition and direct clinical experience is concentrated to relatively few clinicians. The majority of cases in the UK are managed at the Trust. Neonates with VGAM are at risk of rapid deterioration in the first few days of life. These patients should be managed on PICU until a decision is made regarding embolisation. There should be clear management guidelines both for PICU and for post-PICU care, including criteria for discharge form PICU, escalation of care and re-admission to PICU. The procedure to be followed after the death of a child in theatre (including documentation), needs to be clarified, with roles and responsibilities outlined in the Trust 'When a Child Dies' guideline. The investigation identified that the difference between verifying a death (the process of identifying that a person has died) and certifying (completing a medical certificate of cause of death) is not clear to all staff and the definitions should therefore be included in the guideline. Verification of death should be completed by medical staff and clearly documented in the notes in a place visible to other staff involved in the patient's care. Genetic investigations for genetic mutation (very rarely associated with VGAM) does not appear to have been sent and has been identified as an additional learning point.
Rheumatology, PICU, Haematology	May 2022	This case highlighted the importance of early involvement of haematology in this cohort of children, especially those with neurological symptoms and this has already been considered. Patients are now discussed in a regular joint meeting with haematology.
Oncology	July 2022	1. There will always be some families that prefer to receive end of life care in hospital, and this is not necessarily a failing in provision of community services. 2. Local teaching already in place to address the issues around writing MCCD and paperwork after death. Also, the introduction of Medical Examiners (statutory from April 2023) will address many of these problems.
Radiology	July 2022	Initial X-rays demonstrated evidence of perforation identified by Consultant radiologist, suggests that earlier consultant review of X-rays may be helpful in guiding management, although 'delay' was not felt to have contributed to the outcome as time was needed to stabilise the baby prior to laparotomy.
GOSH/CATS/NTS	August 2022	Coordination of a conference call / MDT meeting between local and GOSH professionals prior to transfer of these complex children was identified as a learning point to ensure that parental

		and local team expectations regarding the treatment goals (and limitations) at GOSH. In terms of practicalities the CATS/NTS teams have previously been identified as very helpful in coordinating these conference calls, however it is less clear for ward transfers who might be responsible for coordinating this approach. Potential for a role within GOSH (modelled on APOA).
PICU/Immunology	September 2022	1. Challenging to differentiate between thymic and bone marrow disorder which are associated with different treatment strategies. This assay is currently being trialled to run in-house at GOSH which will prevent logistical delays with sending samples to Paris (at the time of this case).
NICU	September 2022	Families who undergo FETO procedures are well supported during this part of the process (including accommodation provided by GOSH charity during this phase of care). However, the ongoing support for this group of children who are known to have a high risk of mortality and prolonged inpatient stay after birth was identified as requiring a better package of ongoing support. This was exemplified in this case by the death (although anticipated) occurring out of hours e.g. at the weekend when there is a lack of Family Liaison Team to help to coordinate care after a child dies (eg supporting registering the death). This was identified as a learning point and will be fed back to the FETO group. The Trust is already aware of the need for a 7-day service of Family Liaison Team from other reviews.
PICU	August 2022	The importance of previous death due to meningitis as a potential flag for immunodeficiency (albeit rare with only 50 cases of this type worldwide) should be considered as a learning point (as clinicians were falsely reassured by low CRP, and lack of signs of sepsis). The family were concerned that the presentation was exactly what they had seen in the sibling who died, and the importance of parental concern is another learning point. Consider whether use of an interpreter in a family where English is not parent's first language might have elicited this history. This might have identified the rationale for their anxiety more accurately and raised a flag linking the current presentation to the previous death and earlier antibiotic administration.
Cardiology	October 2022	1. The diagnosis is associated with a high risk of mortality both intraoperatively and if coronary abnormalities are identified (as was the case for this child), and therefore there was a potential role for parallel planning (even as early as antenatally) which might not have been useful in terms of symptom care, but might have helped the family to understand the high risk and enabled choices in place of care after death for example. 2. Antenatal counselling from fetal team was reviewed and there is no mention of the potential for death as an outcome, which will be fed back to the team for this cohort of children as a learning point. 3. CICU team met the family after child was transferred to CICU after death (planned post op CICU bed post procedure). It was felt that ideally meeting the family prior to the procedure might have improved the family's experience and alerted the CICU nursing team to the high risk of mortality associated with the procedure - to be fed back to band 7 team via CICU matron. 4. Feedback from the family highlighted the importance of having both parents involved in the consent process, especially for procedures with such a high risk of intra-op mortality, while acknowledging that families have other responsibilities in terms of

		work and childcare. It is already an established practice to try to avoid consent immediately before a procedure, however in this case the procedure was urgent.
PICU	December 2022	Parent requested clarification [at CDRM] on the discussions that took place (by phone) and this demonstrates the importance of having these discussions face to face (whenever practically possible to do so).
CICU	October 2022	1. Family requested a recording of the heartbeat from a previous echo and an ECG trace. Perhaps this might be considered as part of memory making for other families as a learning point to share with the family liaison and palliative care teams. 2. GP feedback that they weren't aware of the child's deterioration following surgery until they received notification of the child's death**.** This is a recurring theme at CDRMs.
CICU	September 2022	History of biphasic stridor from birth was not identified as significant. This case has been flagged at the South Thames ENT network meeting as a teaching case, to raise awareness of the significance of biphasic stridor as a red flag clinical sign, as a learning point. Recognition of the difficulties in managing chylothoraces. There is currently a working group at GOSH to try to create a guideline for management of these cases (involving medical, dieticians and surgical colleagues). Palliative care feedback that this couple had already recognised that the baby might not survive, but there continued to be surgical options explored by the clinical teams - this has been feedback to the [CICU] team
BMT	October 2022	1. The teams involved have reflected on the challenges in getting to know a patient under a new team/hospital and the potential for missing subtle signs of relapse/toxicity (due to not knowing the child so well). This case demonstrated the importance of excellent communication with the POSCU where the child is well known. 2. The importance of supporting GOSH nursing staff around these very sad outcomes is a key learning point in this case. In order to provide these novel treatments GOSH needs to support and retain the young nursing workforce who have to look after these children and their families undergoing very challenging novel treatments and at end of life.
Haematology/BMT	October 2022	The BMT team have reflected on the use of chemotherapy, used for children who require BMT after failed CAR-T and have adjusted these regimes in view of the high early complications seen in this cohort of children as a learning point. Due to the political situation this family evacuated and flew to the UK to receive treatment at GOSH as part of a Red Cross plan. There were several challenges which will be feedback to the GOSH CEO who was involved in the planning for bringing this group of children to the UK. It was felt at CDRM that this is really important to feedback to the Red Cross, so that the emotional cost and appreciation of cultural differences and logistics are fully catered for in any further operations of this nature.
Neurosurgery, PICU	October 2022	1 Local team raised queries about the use of hypertonic saline, and this has identified that outreach training from transport team [PANDR] might be a useful teaching opportunity using this case as an example. 2. Difficulty in transferring images to neurosurgeons may have contributed to a delay in transfer (which might have been inappropriate in another case where time critical

		transfer may have changed the outcome), highlighting the importance of not delaying transfer to PICU without awaiting neurosurgical review of images. 3. Family feedback that discussions about potential organ donation took place at the wrong time (too soon) and indicated they might have considered donation if this had been broached at another time. This will be feedback to the PICU team that ideally approaches by SNOD teams are associated with more families agreeing to donation. 4.The Keyworker was not in the original JAR meeting and this was identified as a learning point (the Keyworker is already identified in the Form A notification from GOSH).
PICU	December 2022	Not known to palliative care until final admission. Foster parent had previously been declined hospice respite (as did not meet the criteria). Potential for earlier palliative care referral was identified as a possible learning point in view of gradual decline over previous 12 months and might have provided additional support for the family, although the end of life events were unpredictable, therefore acknowledging this is always more obvious in hindsight.

Learning from excellence at GOSH - positive practices, care, and communication highlighted through the CDRM reviews. Q4 2022/23

Specialties	Month of death	Summary
PICU, Neurology, IR, Anaesthetics	February 2022	Excellent MDT working between local and UCLH / GOSH when antenatal diagnosis was made, enabling in utero transfer within days to enable delivery and postnatal transfer in line with [VGAM] pathway.
Rheumatology, PICU, Haematology	May 2022	Good MDT teamworking with regular echos. This cohort of children are regularly discussed in an international consortium.
Cross Trust (Oncology primary team)	July 2022	This case was an excellent example of multi-professional working across teams, specialities, and trust. This included the anaesthetic team at local [Hillingdon], excellent support from the local [nursing team] and from the GOSH palliative care team. The local CN team were credited for running a 7-day service and being very willing and capable of providing the complex symptom care this child required. A multidisciplinary meeting was held which even included the palliative care pharmacists. Once the decision was made to transfer the child to GOSH the child was moved within only a few hours. Family was supported to remain at GOSH and received hospice-style care (play/palliative care etc). This feedback had been feedback to the individuals involved.
Internal and external teams(NICU admission)	August 2022	Family feedback that they were overwhelmed by the care and attention that they had received from the NHS and wanted to thank all the teams involved. The family have raised funds and would like the donations to go to NICU babies and staff.

NICU	September 2022	NICU nurses went above and beyond (including going across to UCLH after shift to pick up equipment for the family).
PICU	August 2022	Good teamwork and appropriate escalation out of hours with neurosurgical team support and PICU consultant. Parents updated and wishes respected at time of deterioration. ECMO explored. Investigations sent peri-mortem as per immunology, including skin biopsy, have identified immunodeficiency as explanation for the invasive infection in this child [and deceased sibling] identified because the child was brought to GOSH where testing for these rare conditions is more readily available.
PICU/ID/Neurology	October 2022	Excellent multidisciplinary teamworking between PICU/ID/Neurology teams enabling this child to receive approval for treatment via DTC within 24 hours of presentation.
Cardiology/anaesthesia	October 2022	Very challenging anaesthetic case and procedure was undertaken enabling the diagnosis to be defined.
Neurosurgery/PICU	December 2022	Excellent communication between the teams across three different hospitals. Consultant Neurosurgeon was credited for being extremely helpful in coordinating this child's care. Parent's feedback that the support on PICU was excellent and that the team held her hand throughout, and particularly credited the nurse who was with them at the time of their child's death. Father feedback that the GOSH team were so supportive and professional in enabling them to minimise his suffering and maintain dignity at the end of life. Child was transferred to hospice after death and the hospice continue to support the family.
NICU	February 2023	Baby's deterioration was rapid and there was support offered to the family by our NICU team and family liaison nurses.
Cardiology	October 2022	Family very much wanted to go ahead with the surgery, their reflections to the team post end of life were the same and they felt the team had done everything. They have expressed gratitude to the single ventricle team and CNS contacts for their time with their child.
NICU/Renal/Immunology	November 2022	Excellent MDT teamworking.
CICU	September 2022	ENT Consultant proactively attended the Tracheal team meeting at GOSH in order to expedite the transfer across.
Haematology/BMT	October 2022	Death was well managed with symptom care and avoided PICU admission. The BMT CNS was in regular contact with the CCN team and provided regular updates. Young Lives were credited for providing excellent support around repatriation of the body [to XXXXX] under difficult circumstance. The GOSH catering department provided [XXXXXXXXXX] food and the GOSH charity provided clothing for this group of families who were evacuated to the UK.

PICU	October 2022	Parents feedback that they felt well supported by everyone in PICU and have greatly appreciated the keyworker follow up support.
PICU	December 2022	Good package of care from GOSH, local Hospital and community services. A fairly recent work up provided reassurance that there was no clear underlying treatable cause, and therefore the final admission, although not anticipated, was managed very calmly with the child's care needs clearly identified. Family provided sincere thanks to all the professionals in their support, especially the medical, nursing and family liaison team, and Chaplain. One particular nurse was identified by parent as having a clear vocation for nursing and this will be feedback to her.

The mortality review process at GOSH

Mortality reviews take place through two processes at GOSH:

1.Mortality Review Group (MRG)

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

2.Child Death Review Meetings (CDRM)

These are in place at GOSH following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019. Child Death Review Meetings are "a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death." They include clinicians or professionals from external providers. CDRM meetings should be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews.

Completion of child death review meetings

Twenty-five CDRMs took place at GOSH between the 1st January and 31st March 2023.

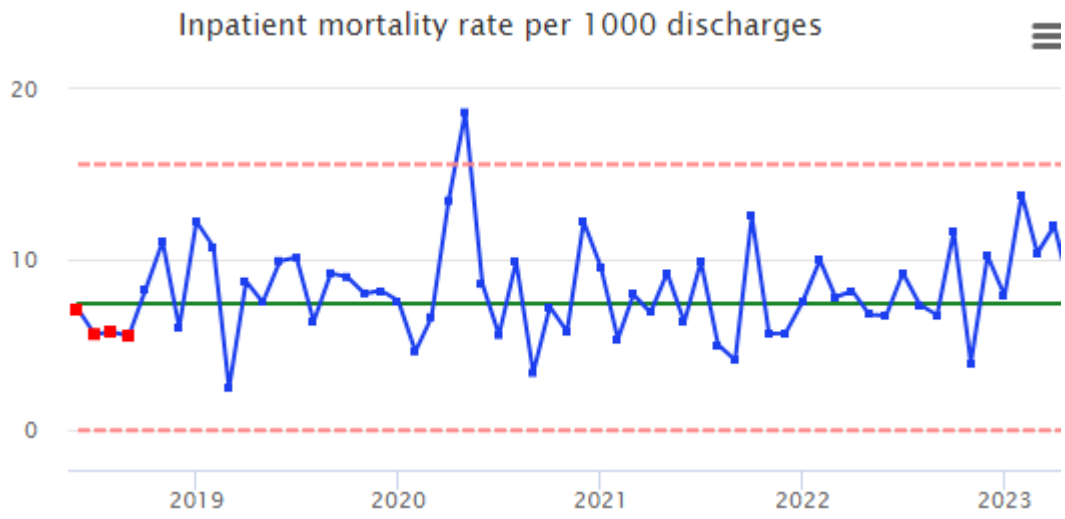
CDRM meetings should be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews.

At the time of writing:
Thirty-nine CDRMs have not been completed within 12 weeks of the child's death:

- Fifteen cannot take place until the completion of necessary coroner/external investigations. This in line with the Child Death Review Statutory Guidance.
- Twenty-four are being scheduled at the time of writing due to challenges in consultant capacity and work required to arrange and attend the meetings.

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/ICU 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/CICU Morbidity and Mortality meetings.

The most recent national PICANet report was published on 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.

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6th July 2023

Infection Prevention Control Annual Report **Submitted by: Helen Dunn, DIPC**	**Paper No: Attachment S** ☐ **For information and noting**

Purpose of report
The report describes the work of the Infection Prevention & Control (IPC) team and associated committees including the Infection Prevention Control Committee (IPCC). Governance structures are detailed within the report and described briefly within the executive summary. Key achievements and ongoing challenges are highlighted with mitigations described if required.

Summary of report
The annual report covers the achievements and risks identified by the Infection Prevention Control team as well as the work of the team and associated teams and departments who regularly report through the Infection Prevention Control Committee (IPCC).
Key achievements and challenges are identified with mitigations provided. Mandatory surveillance data and performance against thresholds is provided alongside learning from root cause analysis (RCA).
Screening surveillance data for MRSA, gram negatives and highly resistant organisms (CPE) is provided and of note CPE colonisation both community and healthcare associated is markedly increased this year.
Brief summaries of the workstreams reporting into the IPCC are provided in both the annual report and the executive summary with full reports being seen from these departments and groups at the IPCC.
A workplan for the coming year is also provided in the annual report.

The full report is provided on Diligent under additional reading for information.

Patient Safety Implications
Reduced air changes in bedrooms in some clinical buildings - fallow times have been increased to mitigate risk but a long-term solution is required.

Increased line infection rate within the year- likely cause identified and mitigations in place include the change in management of department supplying equipment and ongoing monitoring of the national supply chain.

Increase in number of highly resistant organisms (CPE) with more healthcare- associated cases noted, particularly within IP&C. Action plan in place to increase screening, isolation and associated cleaning for patients from overseas.

Equality impact implications
None

Financial implications
None

Strategic Risk
BAF Risk 12: Inconsistent delivery of safe services

Action required from the meeting

Attachment S

For the committee to discuss and note prior to uploading to website as this is a public report
Consultation carried out with individuals/ groups/ committees Presented at the Infection Prevention Control Committee (IPCC) Presented at QSEAC Reviewed by the Chief Nurse
Who is responsible for implementing the proposals / project and anticipated timescales? Work plan to be completed by the Infection Control team and monitored at the IPCC
Who is accountable for the implementation of the proposal / project? Chief Nurse/ DIPC

Executive Summary of the

Infection Prevention and Control Annual Report 2022/2023

1. Purpose

Great Ormond Street Hospital for Children NHS Trust recognises the obligation placed upon it by the Health and Social Care Act Code of Practice of the prevention and control of infections (2015) and related guidance. The report describes the work of the Infection Prevention & Control (IPC) team and associated committees including the Infection Prevention Control Committee (IPCC). Governance structures are detailed within the report and described briefly within the executive summary. Key achievements and ongoing challenges are highlighted with mitigations described if required.

2. Infection Prevention and Control Staffing

The Infection Control Team continues to be established using a multi-disciplinary team approach. There is a Director of Infection Prevention Control (DIPC) in place. There continues to be additional executive support with the Chief Nurse taking on the role as Executive Lead for IPC.

2.1 Governance

The Infection Prevention and Control Committee (IPCC)

The IPCC meets every month (except Aug & Dec). The committee's function is to receive and provide assurance around IPC as well as escalating any significant risks which are identified. Any risks linked to IPC are reviewed in the meeting and escalations made as appropriate. Details of the committees that report into the IPCC are listed within the main body of the report but includes quarterly reports from Space & Place on ventilation and water management. The committee reports to Quality Safety and Outcome Committee (QSOC) and the Trust Board regularly.

Themes of work from the IPCC and challenges identified

Key achievements:

The team provided support and input with the design for the Children's Cancer Centre (CCC) including decant and enabling works: the team have continued to support the design of CCC and the associated enabling works.

Management of COVID-19 & face to face audit days: The response to COVID-19 continued this year with guidance being updated and communicated across the organisation. In addition, all other essential work was maintained, and audit days returned to in person with teaching and facilitation provided for links.

Review and RCA of Gram-negative bacteraemias: Early within the year it was observed that we had more Gram-negative bacteraemia's than in previous years. As a result, the IPC team proactively completed RCAs which allowed themes to be identified and explored for causes

and has led to the introduction of RCAs for all healthcare associated Gram negative bacteraemia's with the multi-disciplinary team this year.

Relaunch of the IPC pages on the hospital intranet: an extensive project was undertaken to rebuild the IPC resources on the new hospital intranet.

Business case completed and approved for microbiological plating following ventilation verification: to improve flow and bed availability an inhouse team to complete microbiological plating was proposed. The case was created and approved and is in the final stages of being set up.

Areas of focus, interventions to mitigate risks and areas of improvement

Risk	Actions/Mitigation
Ventilation- Three trust wide risks are currently in place surrounding both the specialist and the standard ventilation provided in clinical areas. 1. Relates the verification of the specialist ventilation (Positive Pressure ventilation lobby) and theatre areas, which were behind schedule. There was also no AP in post. 2. Chilled beams had not been inspected and cleaned as per the Health Technical Memorandum (HTM) guidance. 3. Newly commissioned standard bedrooms in the trust were not commissioned to 6 air changes despite this being in the design	1. An AP is now in post and the PPVL schedule is running 90% on plan with a schedule in place which is overseen at decant and the ventilation monitoring meeting. 2. A decant program has been undertaken which has included cleaning of chilled beams and a Computer Aided Facilities Management (CAFM) system has been introduced to monitor and record this work going forward. An SOP is also in progress to support this moving forward. 3. Fallow times within these areas have been increased to reflect the reduced air changes and the IPC team have requested they are checked as part of the chilled beam cleaning in decant.
Estates- It has been identified that there is a lack of assurance around management of risk and documentation within estates.	Significant change in the senior team has been undertaken to address this and change the culture of working. The introduction of a CAFM system and manager and the appointment of AP's has assisted but it is anticipated and acknowledged that this progress will need to be monitored closely moving forward.
Increased line infections- 2.3/1000 line days (128 episodes). (Rate 1.3 last year, 66 episodes). Line infection rates this year rose throughout the trust peaking in August 22.	It was identified that from Easter until the Summer supply of the wipes used to clean the end of needle free connectors (on the end of central lines) were in limited supply. It was very likely this led to an increase in line infections. Work was undertaken with pharmacy and materials management as well as the clinical teams to monitor this nationally and improve how this consumable was ordered in the trust. Prior to September 22 this was ordered by the wards and supplied by pharmacy, it is now supplied, and stock is managed by materials management.
Surgical site surveillance- It has been identified the system used to record (RL Datix) spinal surveillance, other general surgery and cardiac cannot be optimised to	Work is underway with the IT team, performance team and data manager within IPC to specify a system that meets the needs of the trust.

the desired standard. The system has several issues which means that data cannot reliably be captured in a standardised way presenting a risk to data recording and analysis.	For continuity- Spinal surveillance continues and we have commenced cardiac surveillance now that a trained individual is in post. Patients who meet the criteria for infection are actively identified and Root Cause analysis (RCA) completed to identify learning or any gaps in the surgical care bundle.

3. Organisms Subject to Mandatory Reporting

Organism	**Threshold set for 22/23**	**Number reported 20/21 *(HAI)***	**Number reported 22/23 (HAI)**
MRSA	No threshold	1 (1)	1 (1)
MSSA	No Threshold	19 (13)	25 (11)
E-coli	<8	8 (5)	20 (16)
Pseudomonas aeruginosa	<8	14 (8)	10 (7)
Klebsiella sp	<12	16 (11)	35 (27)
Cdiff	<8	8 (5)	13 (11)

The trust attributable MRSA bloodstream infection was avoidable. Admission screening highlighted the child was colonised with MRSA but they were given sub-optimal antibiotics during their surgery. Learning actions have been undertaken by the clinical teams. MSSA RCA demonstrates that a significant portion of these children were colonised with MSSA prior to line insertion. An SOP has been created and is in the process of being rolled out to enable all children having an elective line inserted to have a pre-operative wash with chlorhexidine.

All Gram-negative bacteraemia's were above the desired thresholds except pseudomonas aeruginosa. This does reflect a national increase in the numbers of these organisms. RCA continue to attempt to analyse and identify learning. Our themes demonstrated that a large proportion of these children are enterally fed and gut translocation seems to be a common likely cause of bloodstream infection. Again, this highlights the importance of stool screening to ensure appropriate antimicrobials are considered.

4. Surveillance of MRSA and Multiple 'Resistant' Gram Negative Organism Including Screening

Whilst numbers of standard Gram-negative resistant organisms have remained around the same level there has been an increase in healthcare-associated MRSA colonisations. No clear source for this increase was identified and there were no reported outbreaks, but we have placed a large emphasis on admission and repeat screening for long stay patients.

There has been a significant increase in the overall number of carbapenamase resistant organisms with almost half of these being healthcare-associated. The majority but not all these cases have occurred within International & Private Care. Additional screening and control measures have been identified and will be implemented in the year 23/24 to help control transmission and detection but this may have a cost and impact to flow to the trust.

5. Investigation of Infection Prevention and Control Incidents and Outbreaks

No major outbreaks were reported within the year but there have been ongoing detections of healthcare associated CPE within International & Private Care.

There was one Serious Incident related to IPC which was related to the loss of ventilation within theatres.

6. Management of Respiratory and Enteric Viruses

Numbers for respiratory viruses remained stable but more were attributed as healthcare-associated infections, including COVID-19. This is likely to be associated with the relaxing of social distancing and change in community testing as many of our families leave the trust for various reasons and patients also receive visitors. There was also an increase in enteric viral infections. Whilst there were more healthcare-associated infections noted there were no significant outbreaks that led to ward or bed closures. Again, this increase is likely to be due to increased social interaction within the community.

Respiratory viral infections detected:	**Total**	**Community onset**	**Hospital onset**
Total in 2020/21	626	491	102
Total in 2021/22	1567	1458	254
Total in 2022/23	1686	1297	389
Enteric viral infections detected:			
Total in 2020/21	131	71	60
Total in 2021/22	234	127	107
Total in 2022/23	314	147	167

7. Audit and Compliance to Policy

Hand hygiene data has remained stable ranging between 73-100%. Bare below the elbows remained above 92%. Areas of improvement are still identified and included within local and trust wide action plans and then monitored at the directorate infection control committees.

Care bundle compliance has remained below the desired level. Work has been undertaken to centralise and standardise the IV guidelines and any issues with education and adherence to these guidelines, but this has taken longer than anticipated. Work continues with the Epic team to optimise documentation of invasive devices.

Surgical site surveillance takes place across three directorates within the Trust. Surveillance programmes underway for the year 22/23 included spinal surveillance, cardiac surgery, and neurosurgical procedures. It has been identified this year that the system used to record (RL Datix) spinal surveillance, other general surgery and cardiac cannot be optimised to the desired standard. The system has several issues which means that data cannot reliably be captured in a standardised way presenting a risk to data analysis. This was added to the risk register and work is underway to design and build an appropriate system to support and develop this function further. This has not stopped the continued surveillance of spinal surgery which we report to the UKHSA and the commencement of cardiac surveillance in this financial year.

8. Central Line Surveillance

2.3/1000 line days (128 episodes). (Rate 1.3 last year, 66 episodes). Line infection rates this year rose throughout the trust peaking in August 22. It was identified that from Easter until the Summer supply of the wipes used to clean the end of needle free connectors (on the end of central lines) were in limited supply. This led to an increase in line infections. Work was undertaken with pharmacy and materials management as well as the clinical teams to monitor this nationally and improve how this consumable was ordered in the trust. Prior to September 22 this was ordered by the wards and supplied by pharmacy, it is now supplied, and stock is managed by materials management. Further concerns have been raised throughout the year around the supply of stock including central lines and parafilm (which is used the cover the ends). This highlights the fragility of the national supply chain which we are reliant on for stock.

9. Wider Infection Prevention and Control Service

Estates- The estates team has undergone a period of significant turbulence with changes in senior management and work is still underway to ensure that assurance and appropriate documentation is provided to the required standard. Nevertheless, positive changes have been seen and there are now authorised persons (AP's) in place for water and ventilation and a great deal of work has been undertaken on the specialist ventilation annual program. A decant program has been undertaken which has included cleaning of chilled beams and a Computer Aided Facilities Management (CAFM) system has been introduced to monitor and record this work going forward.

The management of the cooling towers were raised as an area of concern earlier in the year by the authorised engineer (AE). This has been addressed with an action plan and greater oversight and assurance.

Facilities (including linen & decontamination)- The decontamination contract which is held with BMI circle was in year, so work was undertaken to work with a new supplier. This will be awarded to the Royal Free Hospital with the contract commencing on 31st July 2023. There are no concerns to raise with the current supplier. The decontamination of endoscopes is carried out inhouse and we continue to run the medical equipment decontamination unit (MEDU).

The linen contract was re-tendered in 2022 and the contract awarded to Elis for three years. A robust monitoring system is in place for the contract,

The Domestic team introduced the National Cleaning Standards 2021 in August 2022. Overall monitoring of monthly cleaning audits is satisfactory, but it is noted that the trust scored below the desired standard during the PLACE audits which were re-introduced this year. A working group is in place to address these findings and feeds back to the IPCC regularly.

Antimicrobial Stewardship- The team continue to review policy as required and monthly fungal MDT are in place with an appropriate policy to support. CQUIN reporting for the year was focussed on adult infection and resistance. Consumption data is part of the standard contract and consumption reduction is only for watch and reserve antibiotics. We have a 4.5% reduction target from 2018 baseline to March 2023 and 6.5% by March 24. The AMS team, work with the digital research environment (DRE) toc automate some audit functionality.

Sepsis- The DIPC was appointed the interim lead for sepsis and the working group has been established meeting regularly and reporting to the IPCC and linking with the deteriorating child group. Workstreams focus on guidance updates, audit of compliance with the sepsis 6 bundle,

bundle optimisation and education. The auditing and reporting of the bundle compliance was not available within Epic until February 2023. An initial audit into bundle compliance was undertaken where areas of good practice and areas for bundle optimisation were identified. These will form part of clinical education and feedback on areas of good practice into bundle usage. This will be alongside work with the lead practice educator for patient safety on the recognition and management of sepsis for all clinical staff. This education will be constructed in the summer of 2023 ready for launch in September 2023.

Occupational Health- Influenza uptake decreased to 52% (57.6% in 21/22) but this was the highest vaccination rate in NCL and the fourth highest within London. There were 56 attendances for exposure to bloodborne viruses a decrease of 15%. Most of the incidents occur during disposal although re-sheathing was also identified as a theme this year.

10. Board Assurance Framework (BAF)

The IPC team has maintained a responsive service as part of the pandemic, regularly reviewing guidance related to COVID-19 and other respiratory guidance and ensuring that risks are identified and mitigated.

There were 41 hospital acquired COVID-19 cases in the last year compared with 24 the previous year. Guidance from NHSE/I was changed to recommend cases were only investigated if harm was caused. We continued to monitor our cases and look for sources were possible. We continued to find parents and visitors a common source. We attribute the increase in numbers due to a lack of awareness by families as testing was stepped down in the community and social distancing ended. We worked with clinical teams to update guidance as required and as asymptomatic testing ended in Sep 2022 in line with national guidance, we focused our education on symptom recognition and testing. Staff continued to universally mask in clinical areas, but this requirement was removed from staff only and public areas in June 2022.

FIT testing continues to be provided and is now an established service with records of staff tested available. Both qualitative and quantitative testing is undertaken. This is a requirement under Health & Safety legislation and despite regular reminders some staff who need respiratory protection have not been released to be tested.

Compliance with isolation audits have generally remained above 70%. Overall, there was good compliance with most areas within the isolation audit. Areas of good practice included staff awareness and knowledge of their patient's infection status and isolation requirements as well as patient/family awareness of the rationale for isolation. Compliance with PPE was also good. Areas identified as requiring improvement included a lack of posters displayed on doors of isolated patients, the majority of the posters missing were the respiratory viral pathway posters which have since been retired from use. Compliance with admission screening was also a recurrent theme and highlighted by teams as an area for improvement.

The largest area of risk currently identified without a long-term resolution plan in place is the identification that not all standard bedrooms in the trust were not commissioned to 6 air changes when they were opened despite them being designed to 6 air changes. Mitigations in place to control this risk include extended fallow times in these areas.

Infection Prevention and Control Annual Report 2022/2023

Contents

1. Purpose

1.1 The Director of Infection Prevention and Control (DIPC) Annual Report reports on infection prevention and control activities within Great Ormond Street Hospital NHS Foundation Trust for April 2022 to March 2023. The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability.

1.2 A zero-tolerance approach continues to be taken by the Trust towards all avoidable Healthcare associated infections (HCAIs).

1.3 The Infection Prevention Control Committee (IPCC) reports to Quality Safety Outcomes Committee (QSOC) formally Patient Safety Outcomes Committee (PSOC) which reports to the Quality Safety Executive Audit Committee (QSEAC) which is a sub section of the Board.

1.4 The DIPC presents the annual report to the Board and attends quarterly to provide a regular update.

Infection Prevention and Control Staffing

1.5 Director of Infection Prevention and Control (DIPC):

Helen Dunn, Consultant Nurse IPC since May 2020- present

Executive lead for IPC:

The Chief Nurse is the Executive lead for IPC; supported for medical issues by the Deputy medical director. The DIPC meets bi-weekly with the Chief Nurse to discuss any issues related to IPC. A highlight report of all acute significant IPC issues is presented weekly to the Safety Team.

1.6 The Infection Prevention and Control Team (IPCT) during 2022/23

Nursing and clinical scientist establishment:

- Consultant Nurse IPC & DIPC - Helen Dunn
- Deputy Lead Nurse in IP&C - Barbara Brekle
- Lead Practice Educator IP&C- Clare Paul (maternity cover for Kate Harkus)
- IPC Nurse – Helen Saraqi
- IPC Nurse- Kate Rennie- commenced April 22
- IPC Nurse- Anna-Lena Waldner- left in Nov 22
- Principal Clinical Scientist in IPC & Infection Control Doctor (ICD)- Dr Elaine Cloutman-Green

Medical Staff:

- Dr John Hartley - Consultant Microbiologist, part time
- Dr Garth Dixon - Consultant Microbiologist: 1PA for IPC
- Dr James Soothill - Consultant Microbiologist:1 PA for IPC

- Dr James Hatcher – Consultant Microbiologist Lead Clinician for the Department of Microbiology, Virology and Infection Control: 1 PA IPC
- Dr Surjo De- Consultant Microbiologist: 1 PA IPC
- Professor Judy Breuer – Consultant Virologist (advisory)

Working with:

- The Infectious Diseases Consultant Team

Antimicrobial stewardship (AMS) -
One WTE pharmacist
Paediatric infectious disease consultant AMS time – Chair of AMS committee
Antimicrobial Policy Group Chair - consultant microbiologist 1 PA (IPC time)
Consultants in microbiology and Paediatric Infectious Diseases (PID) contribute.

Administrative support
Angela McGee Administrator IPC Team & Microbiology and Virology – 1 WTE

IPC Data management
Timothy Best This is a permanent role with support provided across the laboratory but with a focus on IPC activity and data. This year has seen the successful recruitment for a bioinformatician to support the laboratory and IPC with investigations.

1.7 Development of IPC Team
In recognition of the ever-growing demands for IPC services a band 6 role which was fixed term during the pandemic was made substantive this year. A member of the team is currently on a Masters Pathway in IPC supported by a bursary from GOSH charity.

1.8 Quality Improvement Team
Continues to provide invaluable central support for audit and surveillance data display.

1.9 Directorate Responsibility
Under the terms of the Trust IPC Strategy set out previously each Directorate developed a local Directorate group / structure to drive local planning and implementation of IPC actions.

1.10 The Directorate system started in Aug 2019.The trust now functions under 9 directorates:

- Body, Bones & Mind
- Brain
- Research & Innovation
- Blood, Cells & Cancer
- International & Private Care (I&PC) formerly International Private Patients (I&PC)
- Sight & Sound
- Operations & Images
- Heart & Lung
- Medicines, Tests and Therapies

1.11 Governance and reporting

The Infection Prevention and Control Committee (IPCC).

The Terms of Reference were updated in May 2022.

This committee is chaired by the DIPC and meets monthly 10 times a year. Regular reports are submitted to QSOC (formally PSOC) & Trust Board.

Membership by role:

- Consultant Nurse Infection Control & Director of Infection Prevention and Control – the Chair
- Executive lead for infection control – the Chief Nurse
- Medical Director team (TBC)
- IPC Team
- Infection Control Doctor
- Consultant Microbiologist(s)
- Paediatric ID consultant
- Director of Estates & Facilities (or Head of Estates and Head of Facilities as representatives)
- Head of Staff Health & Wellbeing (or representative)
- Representation from each clinical directorate (role not specified)
- Pharmacy/AMS
- Member of Risk team
- Representation from Academic Paediatric Infectious Diseases, ICH
- UK Health Security Agency (UKHSA)
- Additional members may be invited to attend the IPCC as appropriate.

In order to fulfil its requirements, the committee will receive a status report from:

Report	From: (Committee/Group/Individual)	Frequency
IPC Report	IPC Team	Monthly
Estates and Facilities	Director of Estates and Facilities (including ventilation, water, decontamination & domestic services)	Quarterly
Occupational Health	Head of Staff Health & Wellbeing	Quarterly
Directorates	Directorate representation	Quarterly (each directorate)
Built Environment	Deputy Director Redevelopment	As required
UKHSA	UK HAS representative	Monthly, verbal
Genetically Modified Organisms Safety Committee	DIPC	Quarterly
Water Safety Group	DIPC/Director of Estates and Facilities	Quarterly
AMS Committee	Pharmacy/AMS lead	Quarterly
Sepsis Group	Sepsis Lead	Quarterly

Administrative support: provided by IPC Administrator

1.12 Achievements and areas of focus

Key IPC achievements:

The team provided support and input with the design for the Children's Cancer Centre (CCC) including decant and enabling works: the team have continued to support the design of CCC and the associated enabling works.

Management of COVID-19 & face to face audit days: The response to COVID-19 continued this year with guidance being updated and communicated across the organisation. In addition, all other essential work was maintained, and audit days returned to in person with teaching and facilitation provided for links.

Review and RCA of Gram-negative bacteraemias: Early within the year it was observed that we had more Gram-negative bacteraemias than in previous years. As a result, the IPC team proactively completed RCAs which allowed themes to be identified and explored for causes and has led to the introduction of RCAs for all healthcare associated Gram-negative bacteraemias with the multi-disciplinary team this year.

Relaunch of the IPC pages on the hospital intranet: an extensive project was undertaken to rebuild the IPC resources on the new hospital intranet.

Business case completed and approved for microbiological plating following ventilation verification: to improve flow and bed availability an inhouse team to complete microbiological plating was proposed. The case was created and approved and is in the final stages of being set up.

Areas of focus, interventions to mitigate risks and areas of improvement:

Risk	Actions/Mitigation
Ventilation: three trust wide risks are currently in place surrounding both the specialist and the standard ventilation provided in clinical areas. 1. Relates the verification of the specialist ventilation (positive pressure ventilation lobby) and theatre areas, which were behind schedule. There was also no AP in post. 2. Chilled beams had not been inspected and cleaned as per the Health Technical Memorandum (HTM) guidance. 3. Newly commissioned standard bedrooms in the trust were not commissioned to 6 air changes despite this being in the design	1. An AP is now in post and the PPVL schedule is running 90% on plan with a schedule in place which is overseen at decant and the ventilation monitoring meeting. 2. A decant program has been undertaken which has included cleaning of chilled beams and a Computer Aided Facilities Management (CAFM) system has been introduced to monitor and record this work going forward. An SOP is also in progress to support this moving forward. 3. Fallow times within these areas have been increased to reflect the reduced air changes and the IPC team have requested they are checked as part of the chilled beam cleaning in decant.
Estates: it has been identified that there is a lack of assurance around	Significant change in the senior team has been undertaken to address this and change the culture of working. The

management of risk and documentation within estates.	introduction of a CAFM system and manager and the appointment of AP's has assisted but it is anticipated and acknowledged that this progress will need to be monitored closely moving forward.
Increased line infections- 2.3/1000 line days (128 episodes). (Rate 1.3 last year, 66 episodes). Line infection rates this year rose throughout the trust peaking in August 22.	It was identified that from Easter until the summer supply of the wipes used to clean the end of needle-free connectors (on the end of central lines) were in limited supply. It was very likely this led to an increase in line infections. Work was undertaken with pharmacy and materials management as well as the clinical teams to monitor this nationally and improve how this consumable was ordered in the trust. Prior to September 22 this was ordered by the wards and supplied by pharmacy, it is now supplied, and stock is managed by materials management.
Surgical site surveillance: it has been identified the system used to record (RL Datix) spinal surveillance, other general surgery and cardiac cannot be optimised to the desired standard. The system has several issues which means that data cannot reliably be captured in a standardised way presenting a risk to data recording and analysis.	Work is underway with the IT team, performance team and data manager within IPC to specify a system that meets the needs of the trust. For continuity- spinal surveillance continues and we have commenced cardiac surveillance now that a trained individual is in post. Patients who meet the criteria for infection are actively identified and root cause analysis (RCA) completed to identify learning or any gaps in the surgical care bundle.

1.13 There was no KPMG Infection Control Audit internal audit in 2022-23, the last one took place in 2021-22

2. Organisms Subject to Mandatory Reporting

2.1 The following organisms are subject to mandatory reporting. These are MRSA & MSSA bloodstream infections, *Clostridioides difficile* and Gram-negative blood stream infections (*Escherichia coli, Klebsiella species, Pseudomonas aeruginosa*).

2.2 The table below shows the trends over previous years.

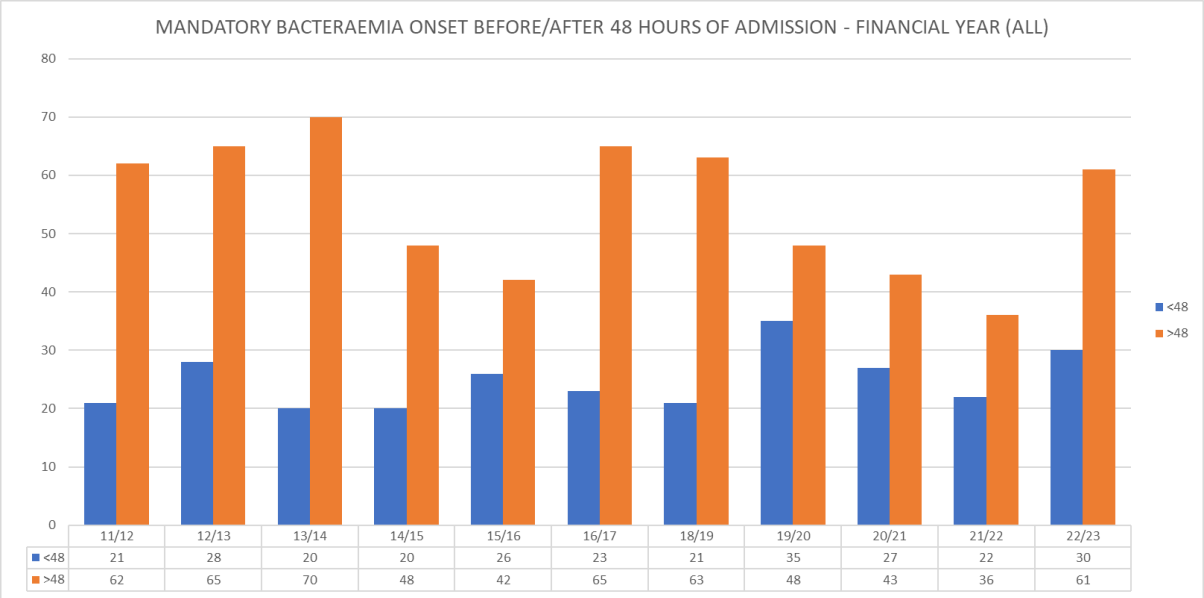
2.3

	E. coli		Klebsiella		MRSA		MSSA		P. aeruginosa	
Year	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI
19/20	3	7	13	15	1	0	9	13	10	9
20/21	5	14	4	10	1	1	12	9	6	9
21/22	3	5	5	11	0	1	6	13	5	8

22/23	4	16	8	27	0	1	14	11	3	7
Grand Total	**15**	**42**	**30**	**63**	**2**	**3**	**41**	**46**	**24**	**33**

2.4 The table below displays the thresholds which were set for the year 2022/23 and the trust achievements. Further evaluation of this data is carried out below.

Organism	Threshold set for 22/23	Actual number (HAI)
MRSA	No threshold	1 (1)
MSSA	No Threshold	25 (11)
E-coli	<8	20 (16)
Pseudomonas aeruginosa	<8	10 (7)
Klebsiella sp	<12	35 (27)



	11/12	12/13	13/14	14/15	15/16	16/17	18/19	19/20	20/21	21/22	22/23
<48	21	28	20	20	26	23	21	35	27	22	30
>48	62	65	70	48	42	65	63	48	43	36	61

2.5 The bar chart demonstrates the overall rise of total reportable bacteraemias. This figure was significantly reduced during the pandemic and care and analysis must be undertaken to look at the root causes for this rise and interpreting this data.

Meticillin-resistant Staphylococcus aureus (MRSA Bacteraemia)

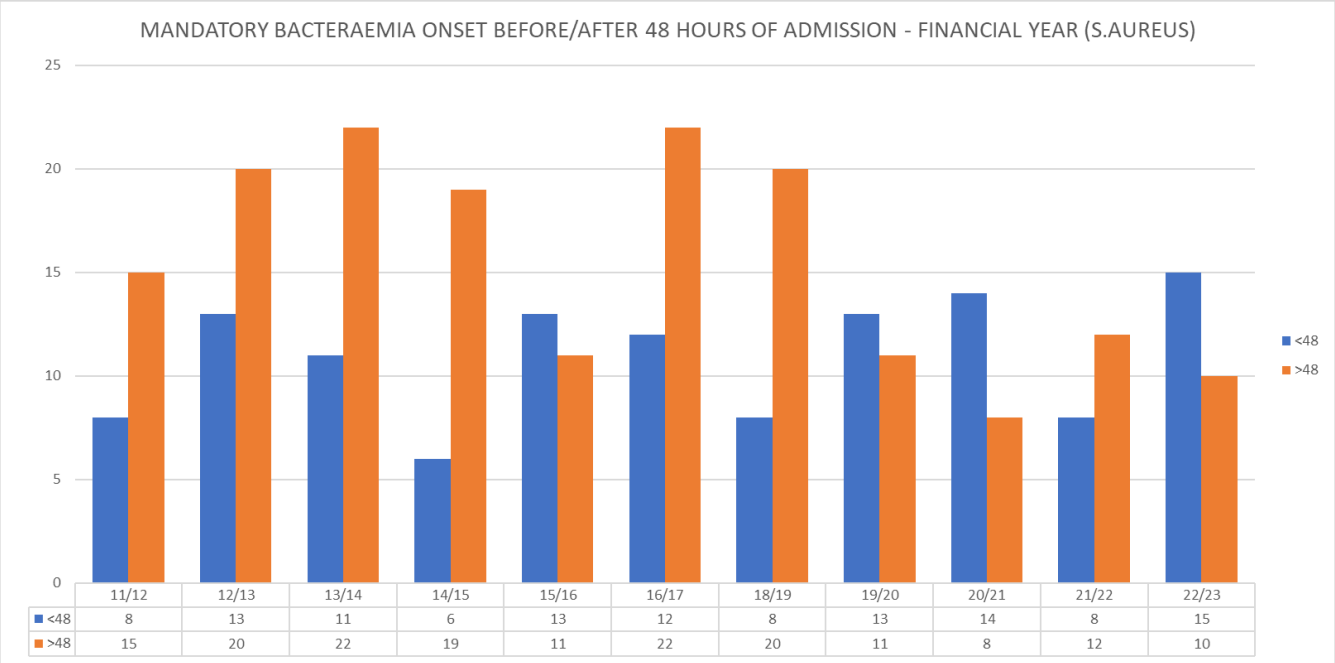
2.6 In 2022/23 financial year 1 child had an MRSA bacteraemia. This was Trust attributable. A full RCA was conducted into the case. Despite admission screening identifying MRSA this was missed by the surgical team and anaesthetic team resulting in the child receiving sub-optimal prophylactic antibiotics for their elective surgery. Decolonisation or suppression treatment (pre-op washing) was also not considered by the surgical or ward team. Learning actions were undertaken and there has been confirmation from the teams that these actions have been completed.

Meticillin- sensitive Staphylococcus aureus (MSSA Bacteraemia) (Hospital onset)

2.7 In 2022/23 financial year 25 children had an MSSA bacteraemia, 11 were Trust attributable. Whilst this is a rise in total numbers of MSSA there was a slight decrease in those attributable to the Trust. This continues the downward trend in total S.aureus bacteraemias.

Root cause analysis of all S. aureus bacteraemias (MRSA and MSSA)

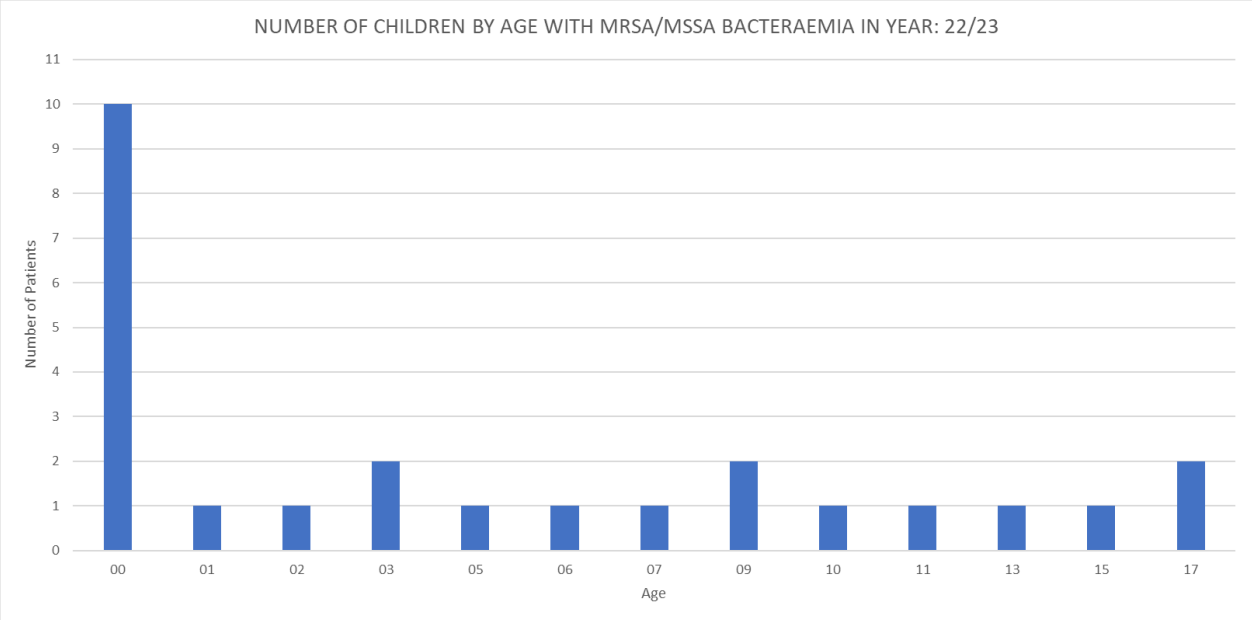
All S. aureus bacteraemias are reviewed by IPC team and full or mini-RCAs requested for all S. aureus bacteraemias developing after 48 hours of admission and not incubating before admission and those occurring in prior GOSH patients.



	11/12	12/13	13/14	14/15	15/16	16/17	18/19	19/20	20/21	21/22	22/23
<48	8	13	11	6	13	12	8	13	14	8	15
>48	15	20	22	19	11	22	20	11	8	12	10

2.8 Seventeen RCAs were requested for completion by clinical teams. Sixteen out of seventeen were completed for the year which was an improvement on the previous year. One was not completed for the year.
Thematic analysis demonstrates that a significant portion of the children were already colonised with MSSA. Pre-operative washing was documented, but the agent used was not always regularly specified in the RCA. Other themes identified included the lack of documentation of line care and delays in cultures being taken as temperatures put down to other causes.
An SOP has been created to ensure all children having elective central lines inserted have a pre-op wash with 4% chlorhexidine bodywash. Ongoing work continues around documentation of line care.

2.9 Previous years data showed the highest proportion of children with MRSA/MSSA bacteraemia coming from <1 year olds. Whilst this is still true there is a much more even distribution over the age groups for this financial year.



Clostridioides difficile

2.10 In line with previous agreement with NHS England, while we test extensively for toxigenic C. difficile colonisation and infection, we continue to report all children aged 2 and over who have C. difficile toxin in the faeces and diarrhoea with no other cause, or other possible cause but treated. The table below shows testing and reporting over the past five years.

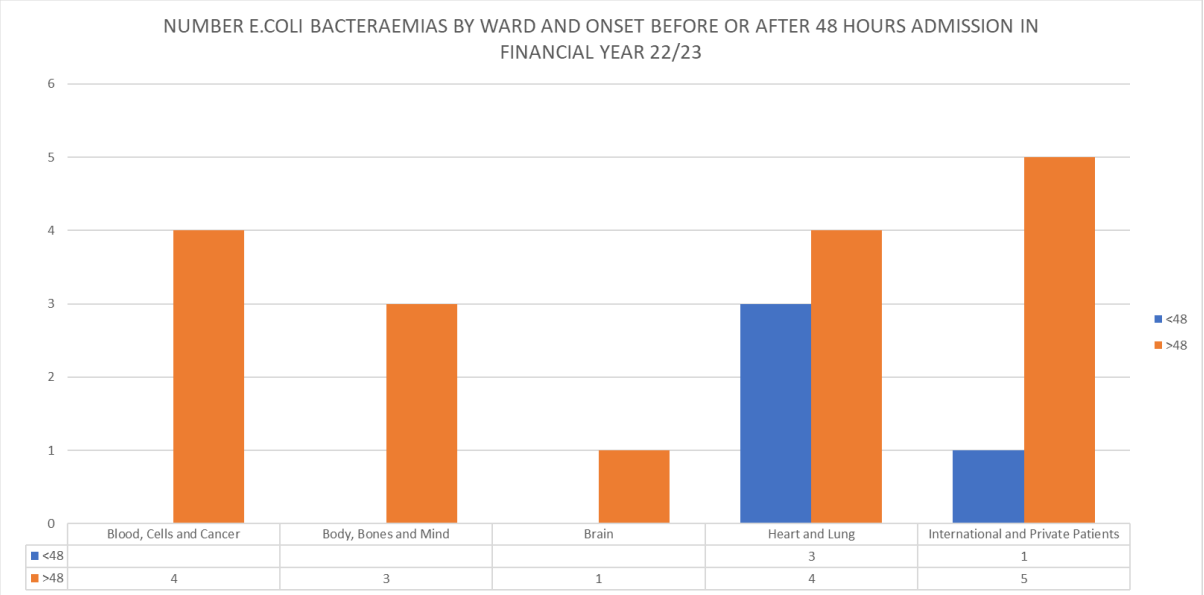
	18/19	19/20	20/21	21/22	22/23
C. difficile 1st toxin new detections ALL ages and any duration of admission	57	47	48	47	59
CDI notified on HCAI website (total numbers)	7	7	13	8	13
Number 'trust apportioned cases' (aged above 2 years old and in for > 3 days when tested and reported as possible CDI on HCAI site)	7	2	10	5	11
Objective (number below which we aim to keep apportioned cases.	14	5	5	7	8
Possible lapse in care	0	0	0	0	0

2.11 Analysis of every case is undertaken to assess the likelihood of true disease, and any avoidable risk factors or lapses in control measures.

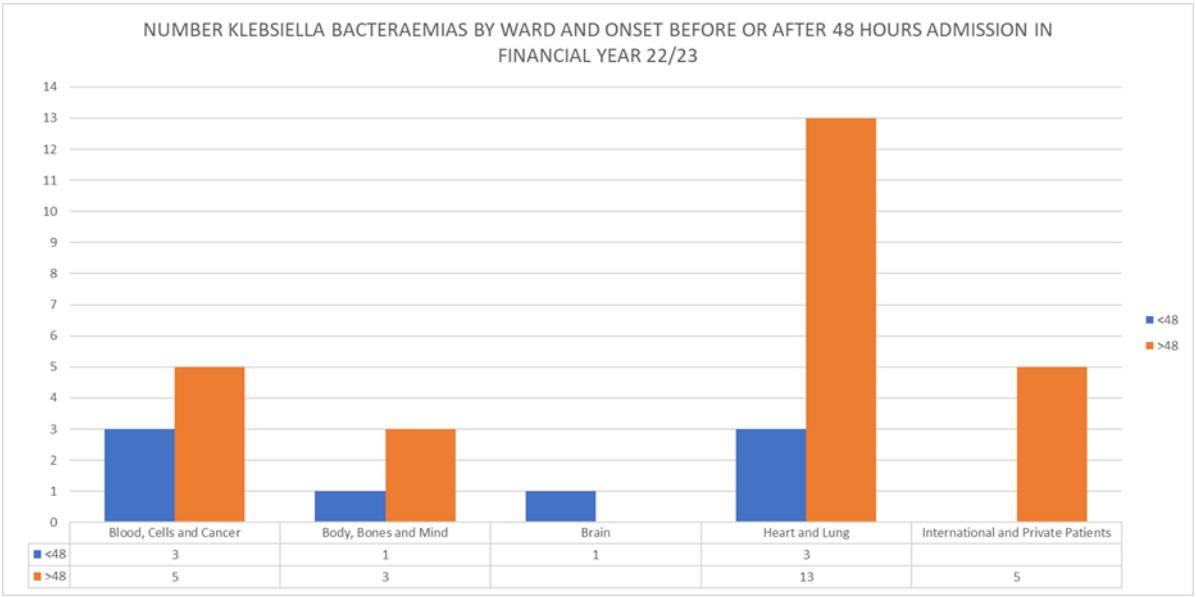
The number of cases reported in 22/23 rose slightly. There were two cases of disease; one case of pseudomembranous colitis which was transferred and treated immediately but testing was not undertaken until day 4 of admission. The second case was queried as a case of CDAD and treated. There were also three cases of <2 year old patients being treated for C.diff but not reported. There was a higher than usual number of healthcare associated detections within BCC were gene and toxin were detected but treatment was not required. This could have been a result of enteric virus outbreaks in this area and co-incidental C.diff being detected. Further investigation into this is ongoing with the specimens sent for further typing and analysis.

2.12 E.coli & Klebsiella sp bacteraemia

The number of children with E.coli bacteraemia reported rose in 22/23 to 20 with 16 of these being hospital acquired. This is a threefold increase on the previous reported year.



The number of Klebsiella sp. bacteraemia increased from 16 to 35 in the year 2022/23, with 27 of these being attributable to the Trust. This demonstrates another significant increase on the previous year.



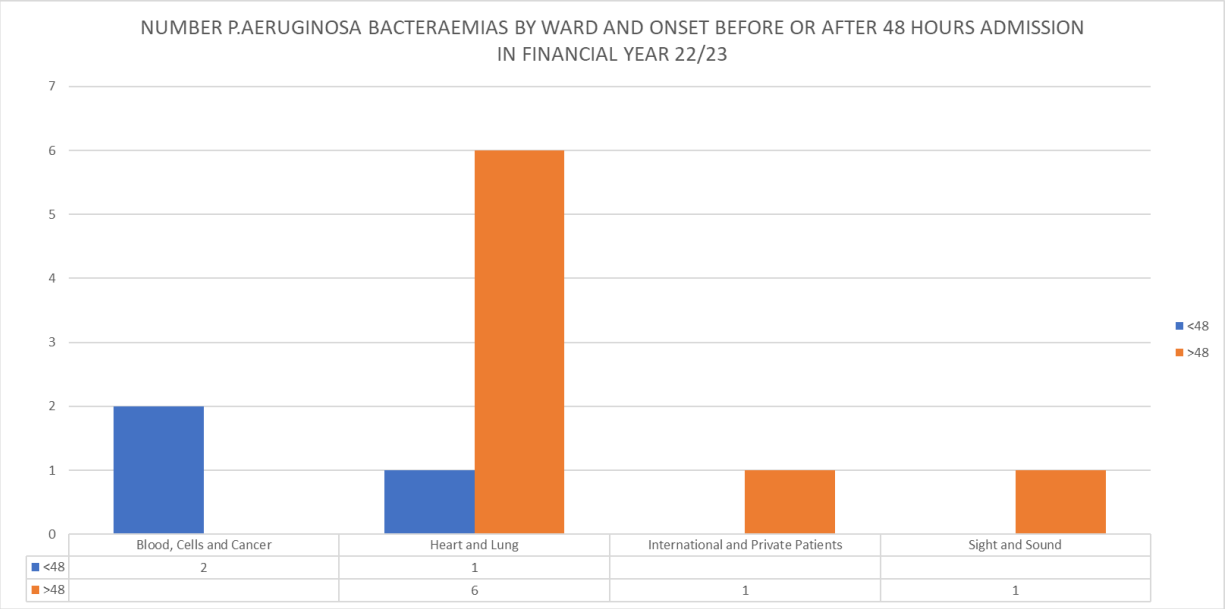
2.13 The distribution of E.coli and Klebsiella sp bacteraemias has changed in the year 22/23. More healthcare associated bacteraemias occur in I&PC than any other directorate although numbers are still high within the Heart and Lung Directorate for both organisms. Thematic analysis shows that colonisation with the organism causing the bloodstream infection is common indicating that gut is an important source. Other commonalities including enteral feeding and immunosuppression. Most of these infections also appear to be in children under the age of one although infection occurs across all age groups in smaller numbers. During

23/24 full root cause analysis will be carried out with the clinical teams to identify further themes and learning.

2.14 Pseudomonas aeruginosa bacteraemia

The number of Pseudomonas aeruginosa bacteraemias decreased to 10 in the year 2022/23, with 7 of these being attributable to the Trust. This demonstrates a small decrease.

It is observed that the majority of the cases occurred in the Heart & Lung DIrectorate. No clear trends were identified and patient-based Pseudomonas surveillance is in place within the intensive care areas and cardiac ward. No patient clusters of Pseudomonas aeruginosa have been identified.



Mandatory Surveillance of Glycopeptide Resistant Enterococcal bacteraemia (GRE) 2022/23

2.15 The number of children experiencing VRE (Vancomycin-resistant Enterococcus) bacteraemias remains largely unchanged. The numbers, although higher than in recent years, broadly maintain consistency around the overall mean and are reflective of slightly higher numbers of colonised inpatients.

Year	Samples	Patients
12/13	5	5
14/15	2	2

15/16	2	2
16/17	2	2
17/18	6	3
18/19	14	4
19/20	8	5
20/21	8	3
21/22	4	4
22/23	7	7

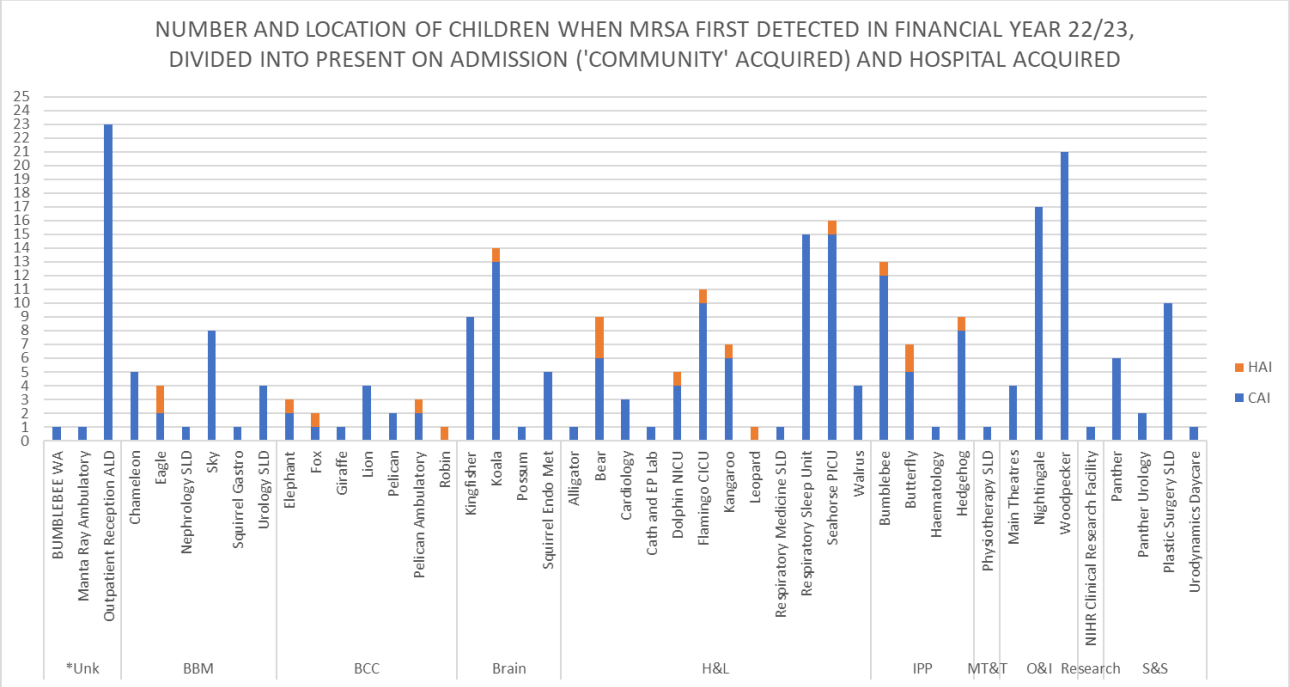
3. Screening for MRSA and Multiple 'Resistant' Gram Negative Organisms

MRSA colonisation by financial year:

3.1 All patients are screened on admission or prior to admission at Great Ormond Street Hospital. Details of newly detected MRSA carriage is shown in the table below.

	CAI	HAI	N/C	UNK	Grand Total
13/14	151	15	2	0	168
14/15	151	8	0	1	160
15/16	166	23	2	2	193
16/17	209	16	3	4	232
17/18	198	9	3	3	213
18/19	207	24	2	3	236
19/20	205	17	0	5	227
20/21	154	10	0	1	165
21/22	196	5	0	0	201
22/23	213	16	0	0	229
Grand Total	**1850**	**143**	**12**	**19**	**2024**

3.2 The table below shows the ward location of where both community and hospital first detections were isolated.



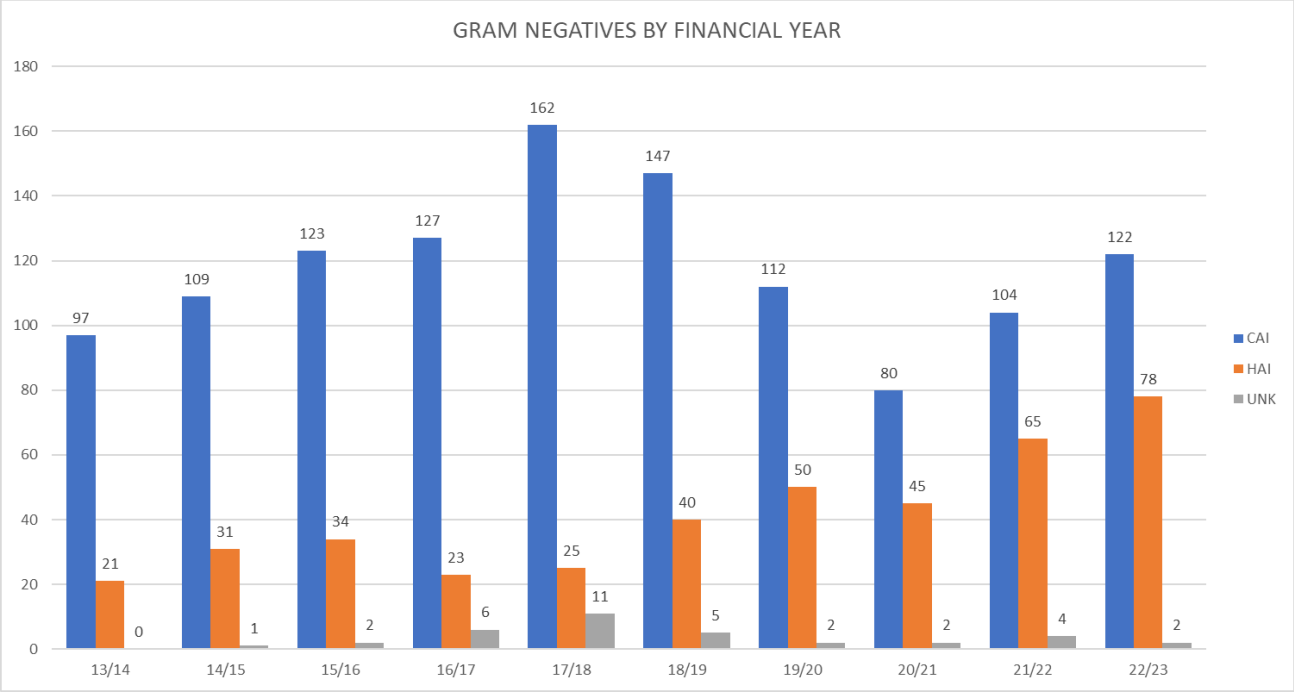
3.3 We aim to investigate every apparent GOSH acquired case. Long term colonised patients are always present and represent ongoing risk.

3.4 In previous years there has been a disproportionately high rate of carriage in the I&PC directorate, but this year we see detections across the organisation.

3.5 Seventeen HAI cases were detected in the year 2021/22 up from five in the year 2020/21. These were all investigated by the IPC team and no source was identified. There were no outbreaks of MRSA reported this year.

<u>Multiple resistant 'gram negative' organisms, including transmissible carbapenemase producing organisms</u>

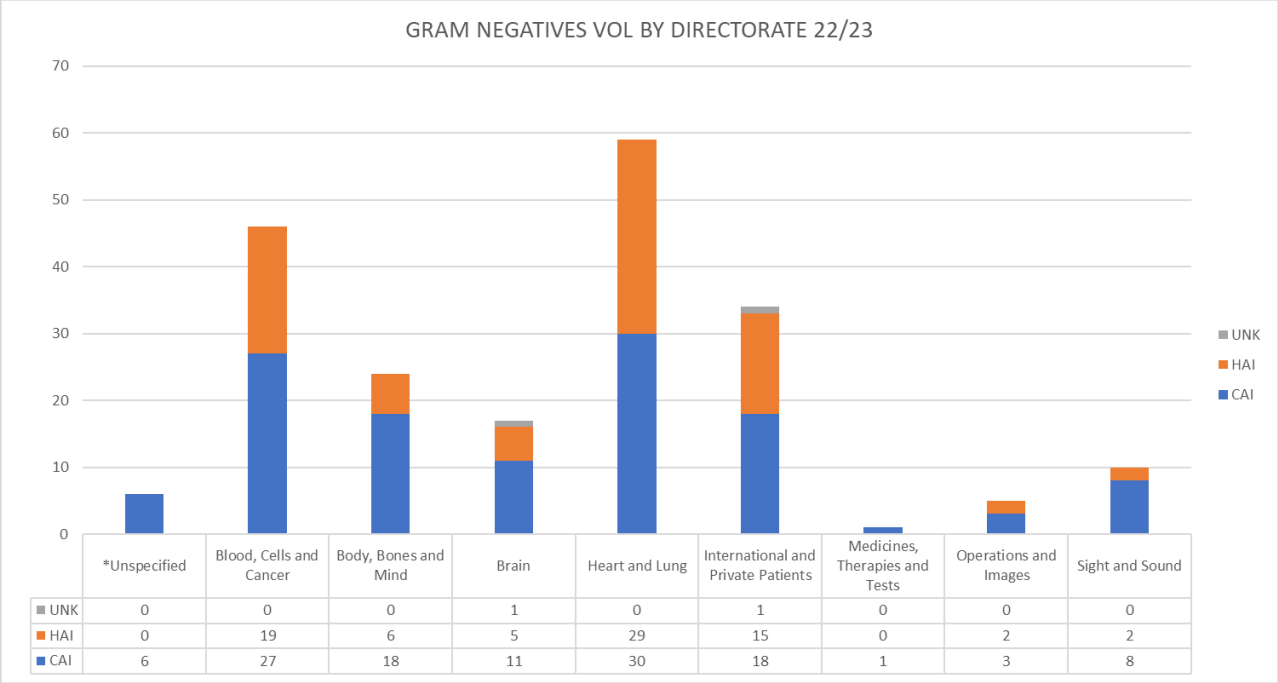
3.6 All patients should have a stool sample sent for screening for resistant Gram-negative organisms on admission. The chart below shows the number of children with newly detected colonisation with multidrug resistant Gram-negative organisms (as defined in GOSH admission screening policy) by financial year**.**



CAI = those colonised on admission
HAI = those acquiring colonisation in hospital

3.7 The overall numbers of both community and healthcare acquired standard Gram-negative organisms continue to increase year on year following the pandemic but healthcare associated numbers are at a much higher level than we have seen in previous years and are continuing to grow. The high level is due to the continuing national and international increase in antimicrobial resistant organisms, but was also due to cross infection. In addition, stool screening compliance figures are not as high as we would like them to be, meaning children may be allocated as HAI when they arrived with the resistant organism or there may be cases of cross-infection which go unnoticed due to transmission-based precautions not being implemented.

3.8 The chart below shows the location of children when first detected as colonised with multidrug resistant Gram-negative organisms in financial year 2022-23. This year we investigated 37 of the 78 cases of HAI Gram-negatives, but routine typing of these organisms does not take place therefore identifying sources can be more complex. This is made even more difficult if not every child admitted has a stool sample sent as cases of unknown risk may then be present. The prompt screening of patients on admission and every 30 days would reduce the risk of children acquiring Gram-negative organisms within GOSH.



	*Unspecified	Blood, Cells and Cancer	Body, Bones and Mind	Brain	Heart and Lung	International and Private Patients	Medicines, Therapies and Tests	Operations and Images	Sight and Sound
UNK	0	0	0	1	0	1	0	0	0
HAI	0	19	6	5	29	15	0	2	2
CAI	6	27	18	11	30	18	1	3	8

3.9 Potential acquisitions occur throughout the year and not all isolates can be investigated through detailed typing, so complete analysis of source is not possible. Where the initial epidemiological analysis strongly suggests cross infection further typing is undertaken if an outbreak is suspected.

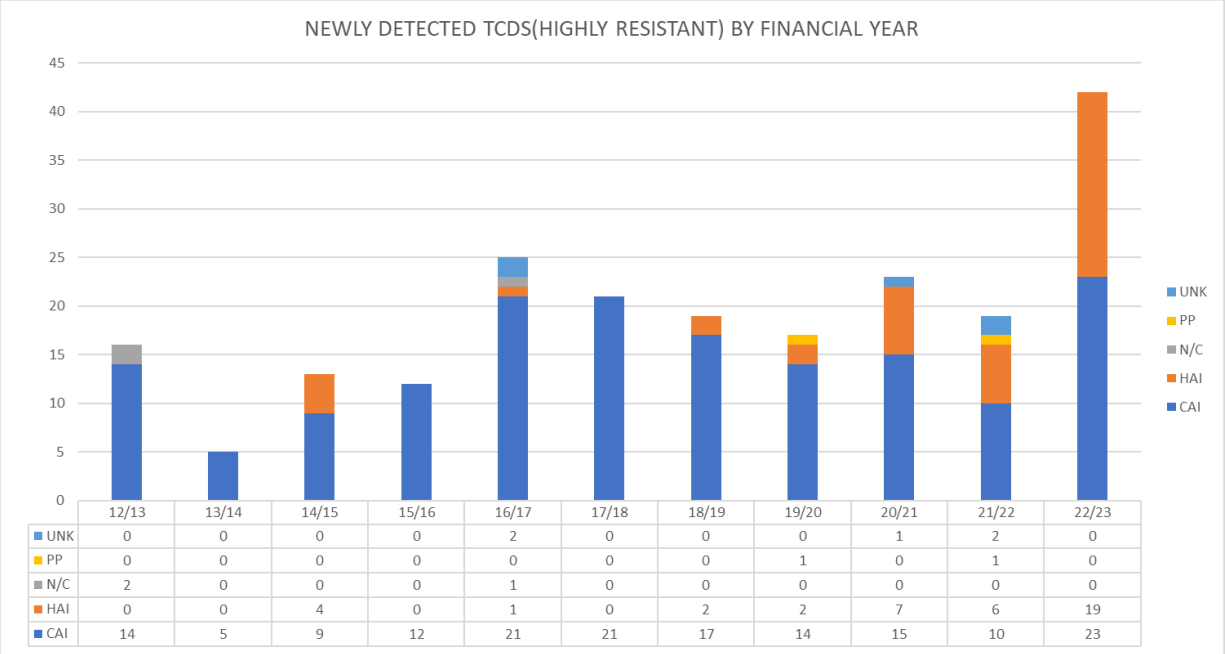
3.10 The organisation is stretched in its ability to apply controls mechanisms without adverse impact on other aspects of care provision; however, we feel it is essential to continue to do so.

Carbapenemase resistant Gram-negative organisms

3.11 The transmissible carbapenemase resistance determinants (TCDs; blaNDM, KPC, oxa48, VIM and IMI especially) represents the most serious threat to treatment yet. Organisms carrying this mechanism may become truly untreatable. They are becoming more prevalent in various countries and regions within UK and have been responsible for major outbreaks. We routinely screen for carriage and implement strict control mechanisms when found. Overall rates in 2022/23 have soared from fifteen in 21/22 to forty-three in 22/23. Nearly half of these organisms are healthcare associated suggesting the organisation has reached its limit in the control of these organisms and additional measures and controls need to be implemented.

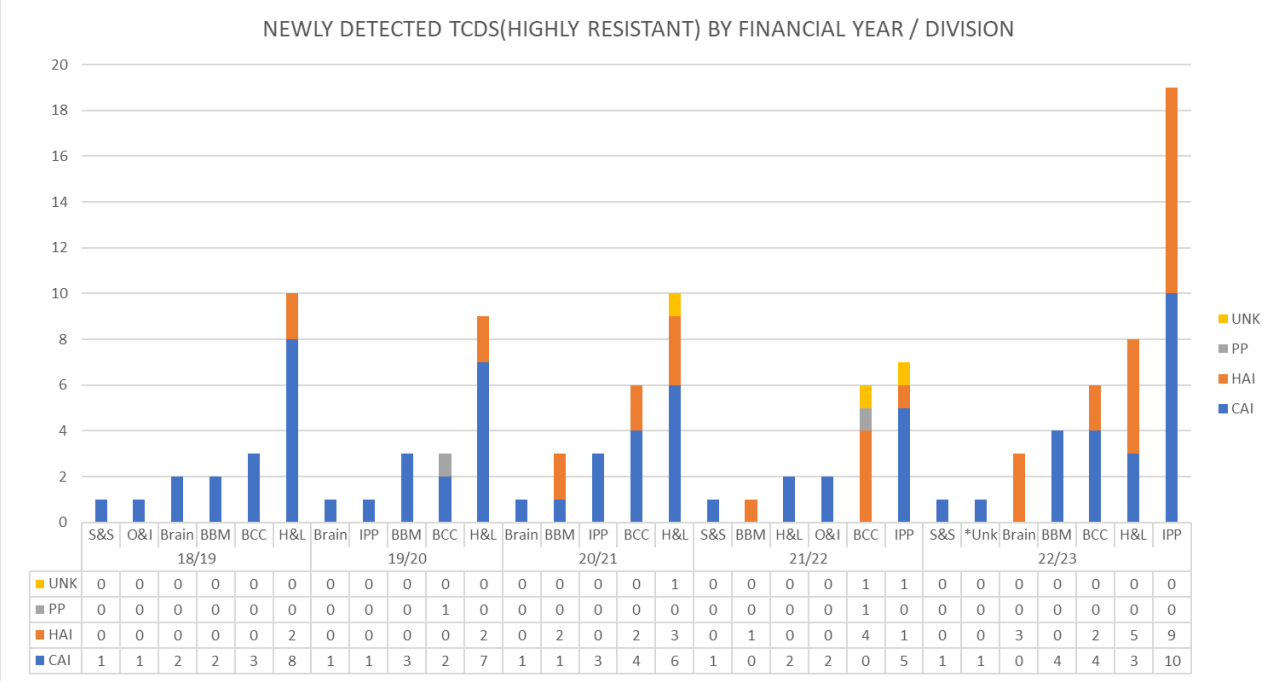
3.12 Organisms are detected during routine screening and clinical samples. There were 19 unique healthcare associated mechanisms of carbapenemase resistance determinants detected in 17 patients. 2 patients were found to have acquired more than one resistance mechanism.

3.13 Bar chart showing the number of children newly detected as colonised with significant **transmissible carbapenemase carrying organisms**



	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
UNK	0	0	0	0	2	0	0	0	1	2	0
PP	0	0	0	0	0	0	0	1	0	1	0
N/C	2	0	0	0	1	0	0	0	0	0	0
HAI	0	0	4	0	1	0	2	2	7	6	19
CAI	14	5	9	12	21	21	17	14	15	10	23

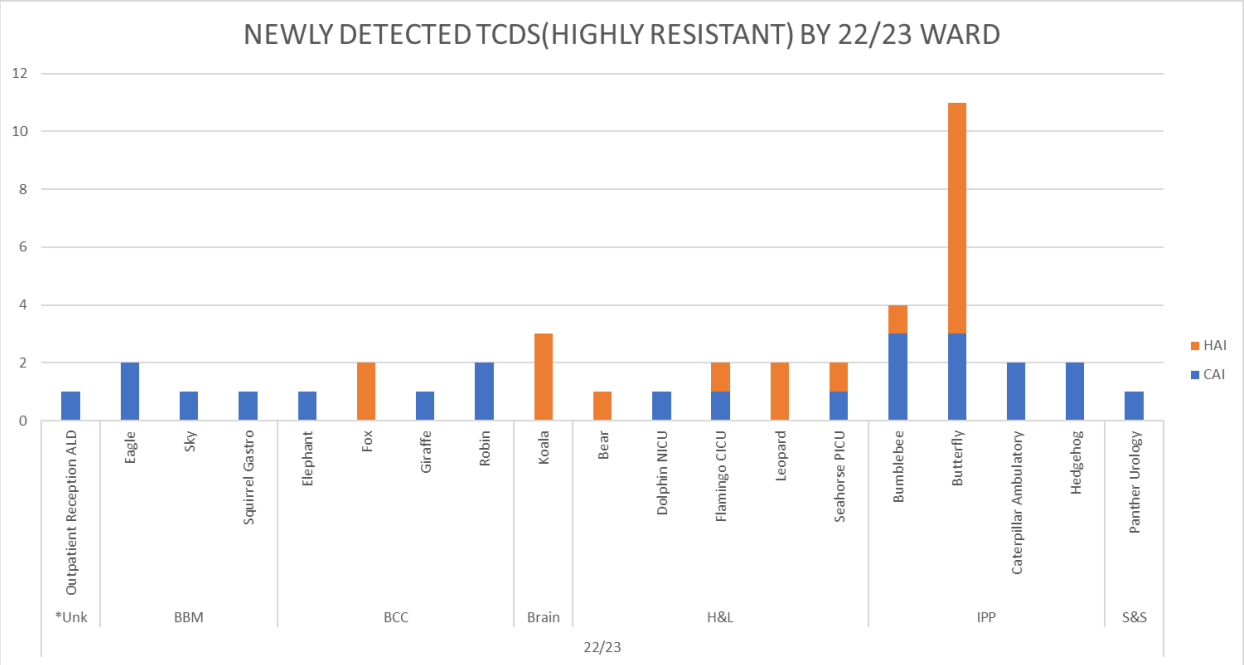
3.14 Just over half the cases are detected on admission. Lack of compliance with stool screening means that there may be cases which we do not know about which are a risk to the trust. Work is ongoing within the trust to increase compliance with stool screening and the IPC team review screening compliance and follow up with wards on a regular basis (usually weekly). Where suspected clusters are identifed then typing is requested although this is limited in its capacity both nationally and at Trust level. To date this typing has not shown any TCDs of the same mechanism to be related but this does not rule out cross-transmission.



	18/19						19/20					20/21					21/22						22/23						
	S&S	O&I	Brain	BBM	BCC	H&L	Brain	IPP	BBM	BCC	H&L	Brain	BBM	IPP	BCC	H&L	S&S	BBM	H&L	O&I	BCC	IPP	S&S	*Unk	Brain	BBM	BCC	H&L	IPP
UNK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
HAI	0	0	0	0	0	2	0	0	0	0	2	0	2	0	2	3	0	1	0	0	4	1	0	0	3	0	2	5	9
CAI	1	1	2	2	3	8	1	1	3	2	7	1	1	3	4	6	1	0	2	2	0	5	1	1	0	4	4	3	10

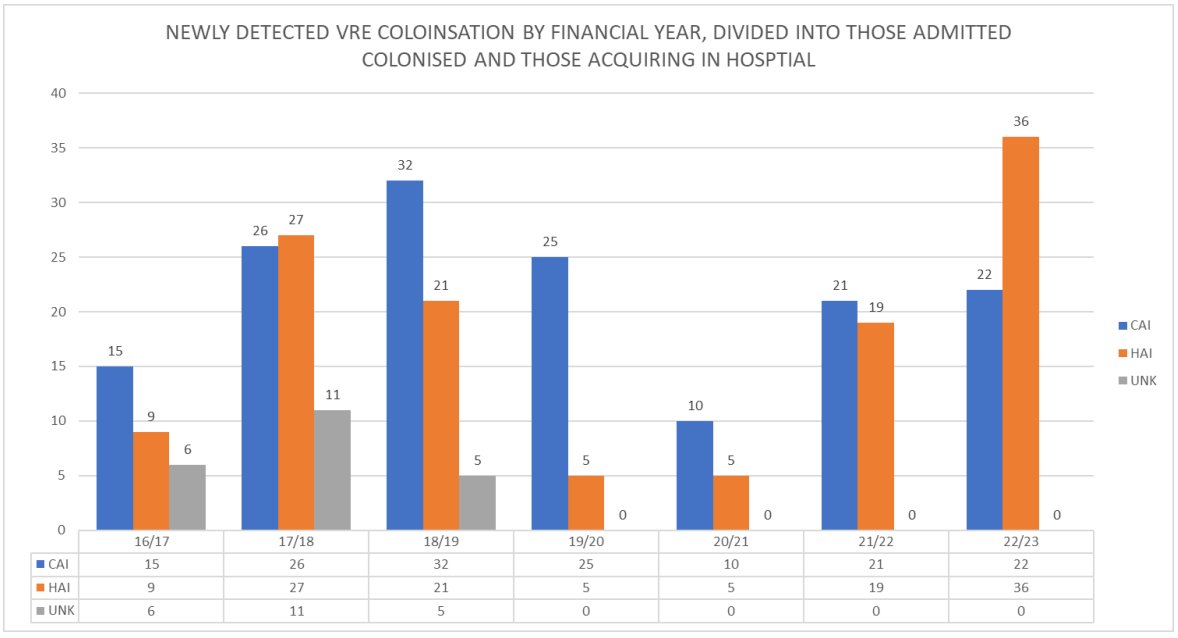
3.15 Within the year we managed several local outbreaks within the I&PC directorate. These were sporadic and associated with three main mechanisms: NDM, KPC and OXA-48,

therefore a major outbreak was not declared at the time. The data demonstrate that the majority of cases of carbapenemase resistance determinants are found both on admission or as acquired organisms within the I&PC directorate suggesting that the current control mechanisms in place are not sufficient in preventing the risk of acquisition of these organisms.



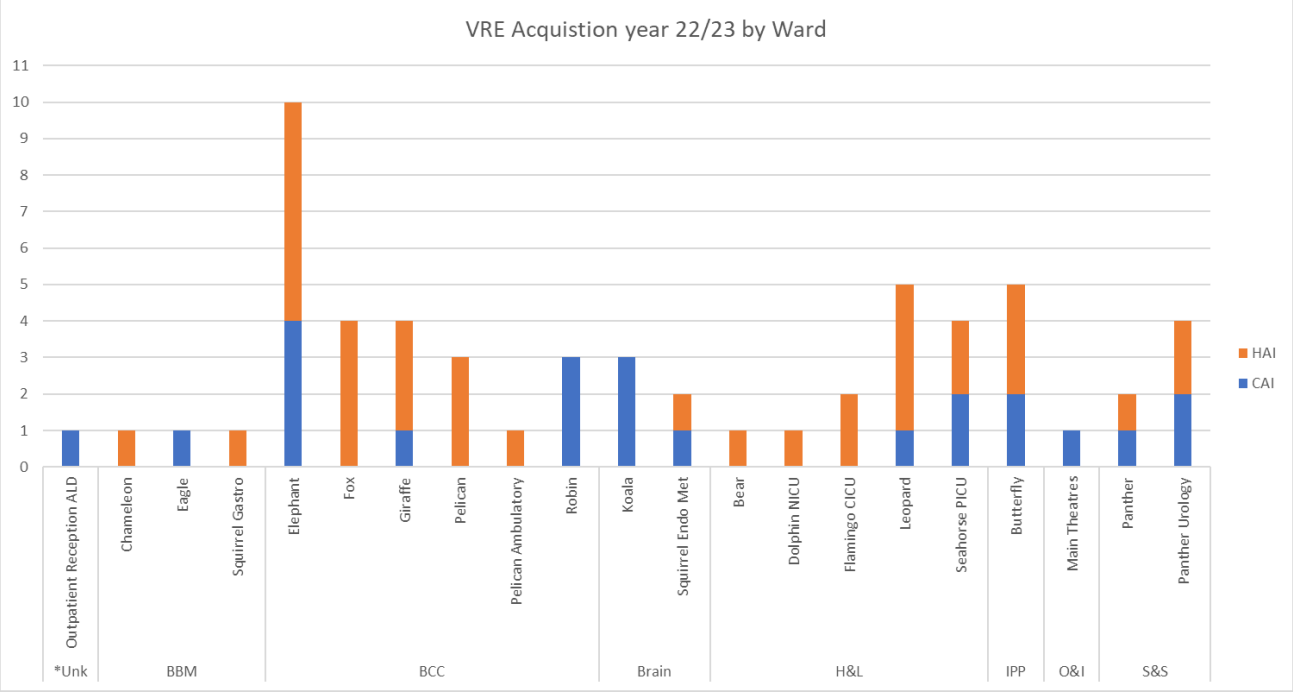
Vancomycin resistant enterococci (VRE)

3.16 VRE colonisation, community and hospital acquired, is shown below. Children may be found in most clinical services.



3.17 As a result of the increase in cross transmission detected in 2017-18, we have increased terminal cleaning after room occupancy and, combined with actions on general cleaning, we hoped to reduce transmission. A small but sustained reduction was seen in hospital acquired cases. This reduction has not been sustained and this year there has been another rise in healthcare associated infections suggesting that current control measures were not sufficient. Fortunately, nearly all these detections are colonisations rather than infections. We continue to monitor this through the IPCC.

3.18 The graph below shows community and hospital acquisitions for 22/23. Most of the healthcare associated cases continue to occur within the BCC directorate, but acquisition occurs across the organisation.



Screening compliance for multiple 'resistant' Gram-negative organisms

3.19 Routine admission faecal surveillance is performed to allow:

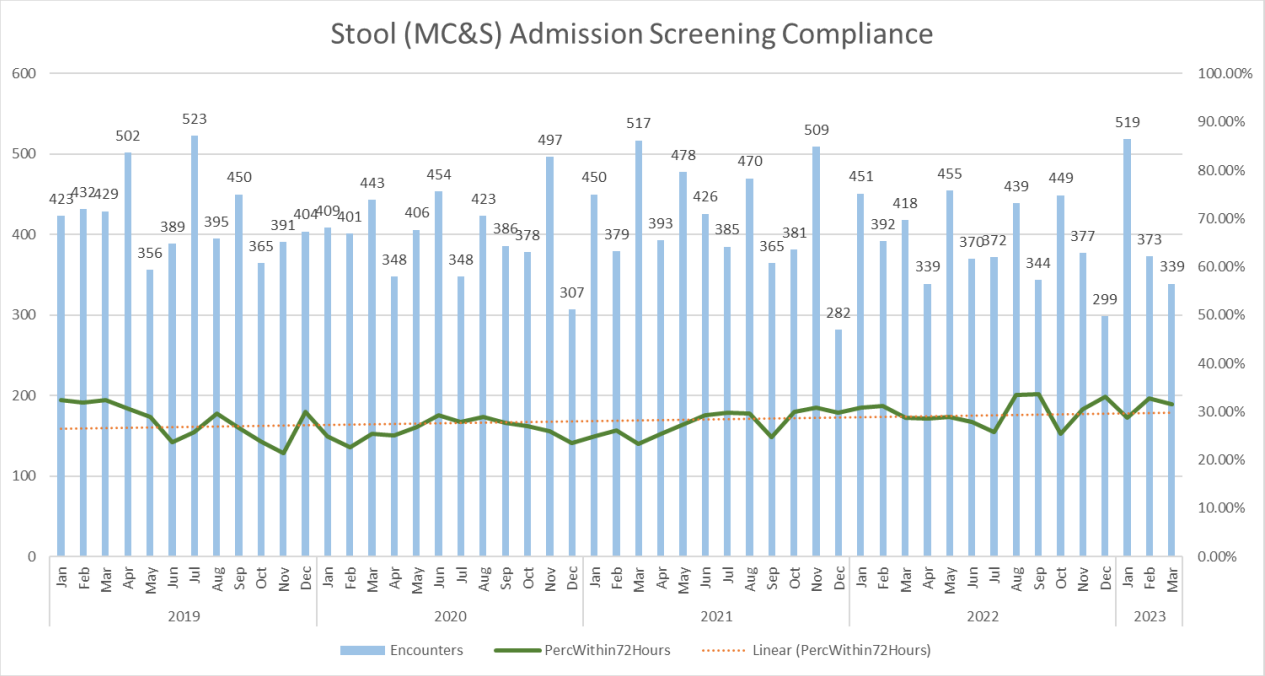
- instigation of isolation procedures in patients who are colonised with multiple antibiotic resistant organisms , including transmissible carbapenemase resistance ('ALERT' organisms as defined in the 'Microbiological screening of patients on admission' guideline) and
- to guide individual antibiotic choice of empirical treatment of serious sepsis.

We also detect colonised or infected children during processing of clinical samples and as part of routine stool screening on admission and after 30 days as an inpatient.

3.20 Screening/testing shows a maintained number of colonised children detected on admission and an increase in those acquired in hospital.

3.21 Reporting definitions have been generated and approved at the IPCC during the year 2020/21 for stool screening. Any child who is admitted for greater than 72hrs who has not had a stool sample will show as non-compliant with the screening programme.

3.22 Work has previously been undertaken to introduce screening alerts on Epic and in 22/23 further work was undertaken to make these alerts live for rescreening at 30 days in the coming year. The IPC team also regularly review any outstanding screens and highlight to wards on a regular basis to improve compliance.

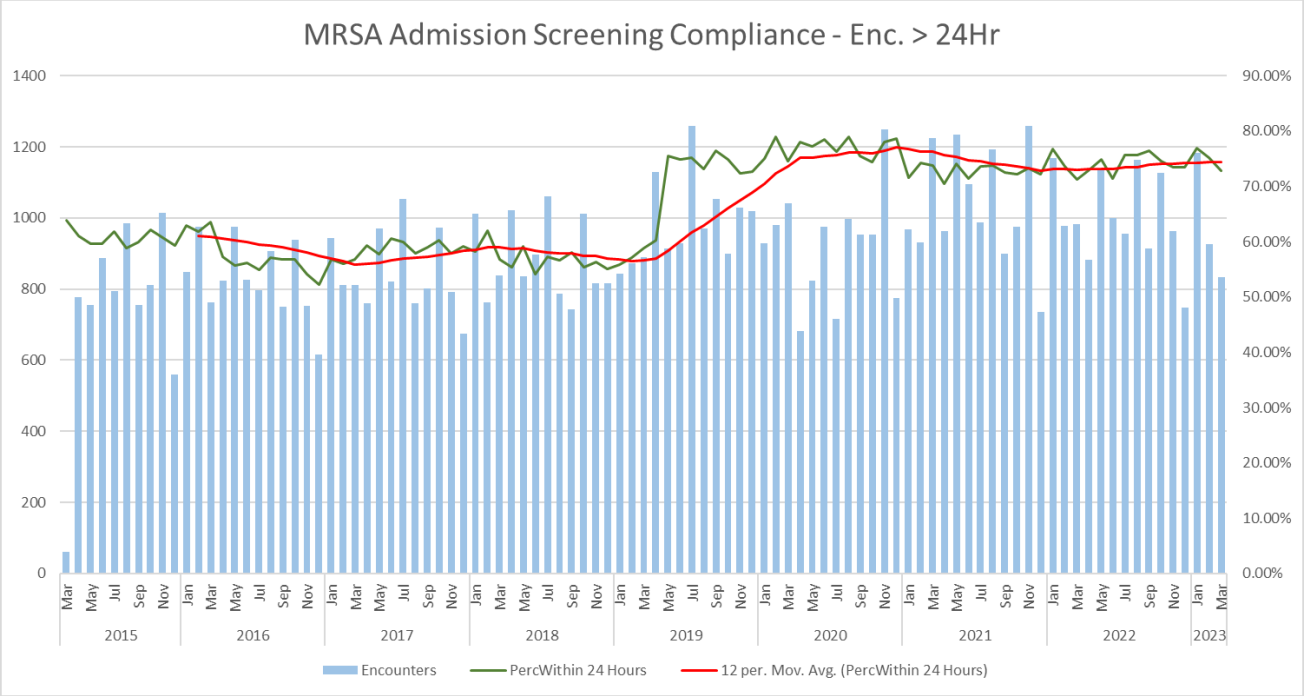


Screening compliance for MRSA

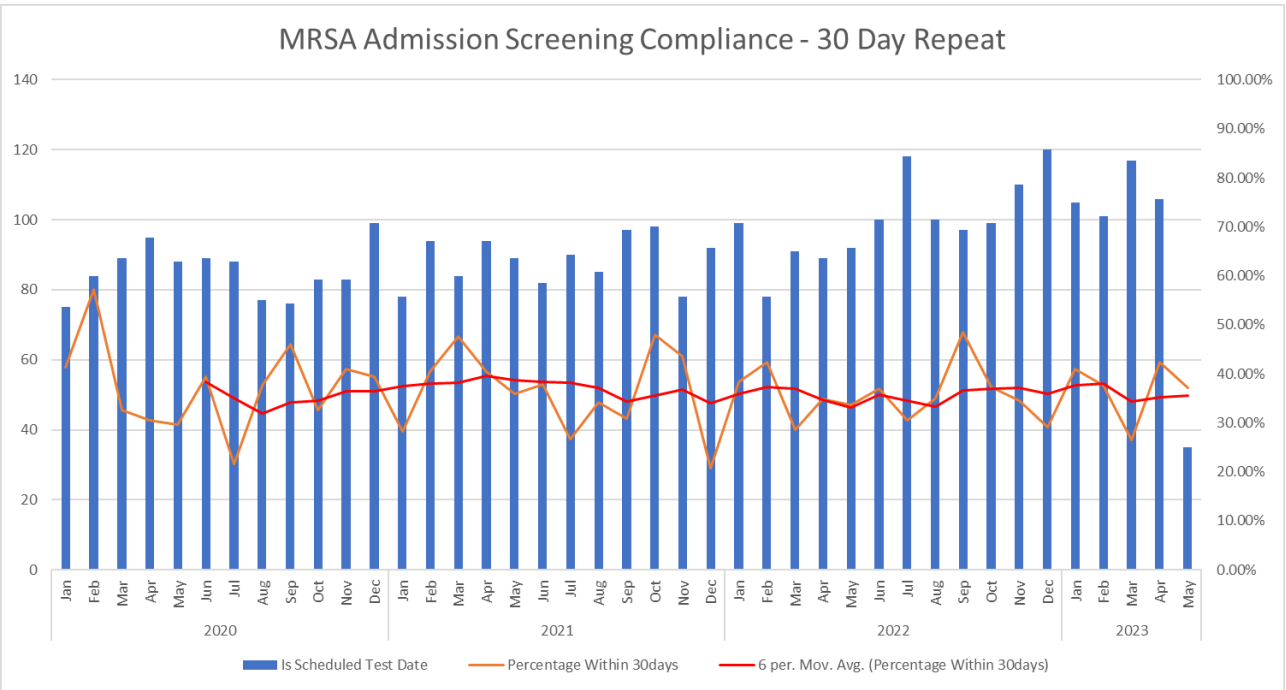
3.23 The Trust MRSA screening policy is universal admission screening (in the 30 days prior to admission (or sooner if admitted elsewhere in those 30 days) or within 24 hours of admission). We aim to achieve > 80% for all admissions, and near to 100% for the ICUs (except some situations it is not appropriate, so > 95% target).

3.24 Wards are provided continuous feedback on completion of screening through the Infection Control Screening Compliance Report located on the Nursing Care Quality Dashboard (which wards monitor daily). In addition, patient alerts and flags are now also present on Epic to highlight to staff if admission screens are missing. Reports are also available within Epic to highlight outstanding screens. The IPC team also regularly review any outstanding screens and highlight to wards on a regular basis to improve compliance.

3.25 The graph below shows compliance with MRSA screening over time. Compliance with screening has improved since the introduction of Epic and has remained stable.



3.26 The graph below highlights the reduced compliance with the 30-day repeat rescreening for long stay patients.



4. Investigation of Infection prevention and control incidents and outbreaks

4.1 Serious Incidents: There was one SI related to IPC in 22/23 – loss of ventilation in Theatres 14 & 15.

4.2 Major outbreaks: There were no outbreaks meeting the definition of a major outbreak in 22/23. However, there have been ongoing detections of healthcare- acquired CPE across International & Private Care.

4.3 The IPC team was involved in the response to the UKHSA Health Protection Briefing Note 2022/058 Mycobacterium Chelonae Contaminated Heart Valves Briefing Note 058.

The IPC team also participated in an external learning review conducted by NICHE on behalf of NHSE.

4.4 There were also no wards closed or on restricted admission due to enteric and respiratory viruses.

5. Management of Respiratory and Enteric Viral Infections

Surveillance of Respiratory virus infection

5.1 Respiratory viruses are common in children and often asymptomatic or only causing mild infection. However, in children with immunodeficiency or other severe illness, normally mild infections may be serious, with even the simplest 'common cold' leading to death. We are aware that children acquire infections while in hospital, with multiple sources among patients, visitors and siblings, staff and other adults. The prevention of cross infection requires good compliance with standard and transmission-based infection prevention procedures, including assessment of risk and low threshold for testing, including in asymptomatic immunocompromised children who shed high loads for long periods.

5.2 First detections are called hospital acquired if the symptoms onset in hospital or if the first test was after 48 hours; some detections will have been incubating. Some children have 2 or 3 viruses so the total number of positive patients is less than the number of viruses.

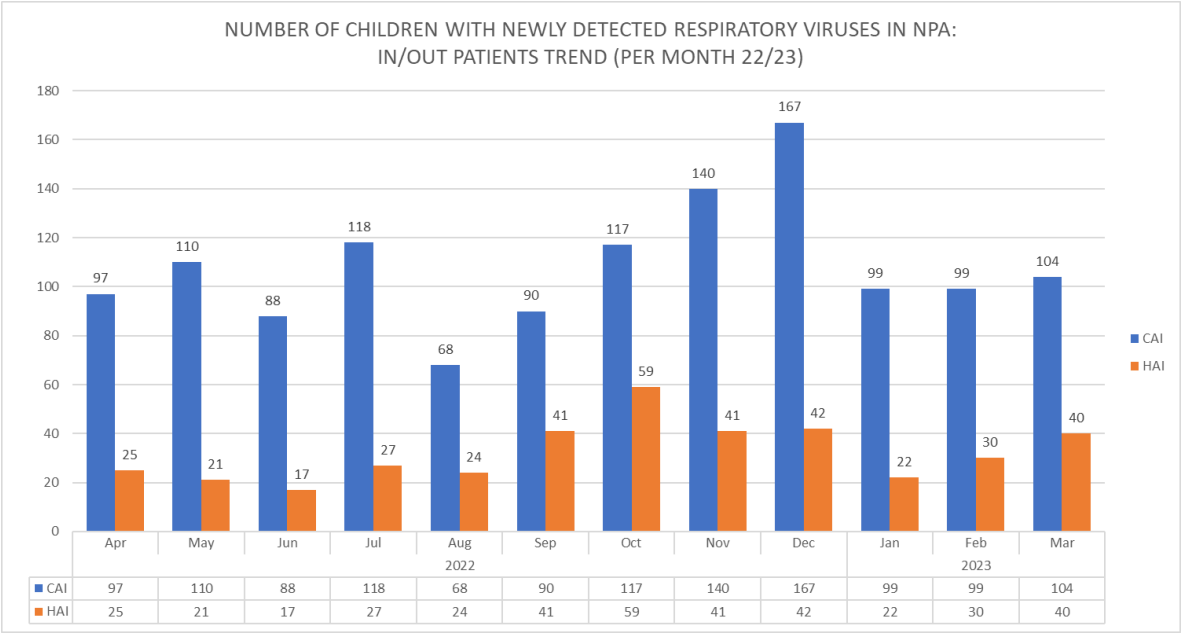
5.3 Comparison of previous years is shown in the table below. The number of positive tests overall remains around the same as the previous year with slightly more children acquiring respiratory viruses while in hospital. Influenza, SARS-CoV2 and Rhinovirus account for the majority of healthcare acquired infections, suggesting risk is still present.

5.4 Adenovirus infection increased slightly but this was largely detected at admission and healthcare associated numbers remained around the same as the previous year.

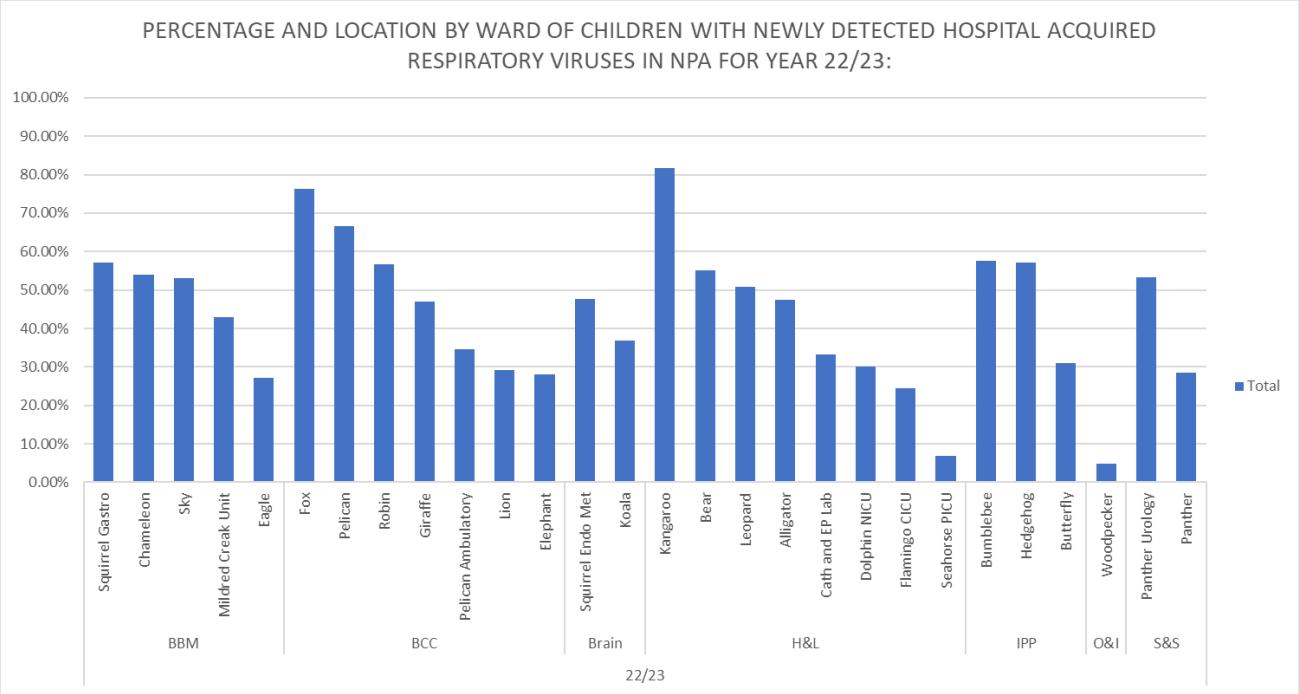
	19/20		20/21		21/22		22/23	
Org	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI
Adenovirus	106	61	60	38	62	21	105	28
Bocavirus	28	11	20	4	82	25	45	12
Bordetella Pertussis	3	0	0	0	0	0	0	0
Coronavirus 229E	2	4	1	0	7	1	1	1
Coronavirus HKU1	6	3	5	1	8	1	15	3
Coronavirus NL63	14	2	6	0	32	8	1	1
Coronavirus OC43	5	9	1	0	23	3	13	0
Enterovirus	1	0	0	1	3	1	0	0

hMPV	37	6	0	0	49	4	42	6
Influenza A	32	6	2	0	8	2	67	10
Influenza A H1N1	6	2	0	0	0	0	0	0
Influenza A H3	6	0	0	0	3	0	7	0
Influenza B	10	0	0	0	2	0	17	6
Legionella pneumophilia	1	0	0	0	0	0	0	0
Mycoplasma pneumoniae	0	0	1	0	0	0	0	0
Parainfluenza 1	23	6	0	1	0	0	31	9
Parainfluenza 2	13	15	3	0	3	2	15	3
Parainfluenza 3	30	12	5	0	70	14	55	11
Parainfluenza 4	8	5	5	1	26	5	10	0
Rhinovirus	193	120	188	33	589	127	558	241
RSV A	61	54	4	5	21	3	34	9
RSV A/B	9	0	0	0	72	5	66	2
RSV B	14	3	0	1	22	8	20	4
SARS-CoV-2	6	1	190	17	376	24	195	43
Grand Total	**614**	**320**	**491**	**102**	**1458**	**254**	**1297**	**389**

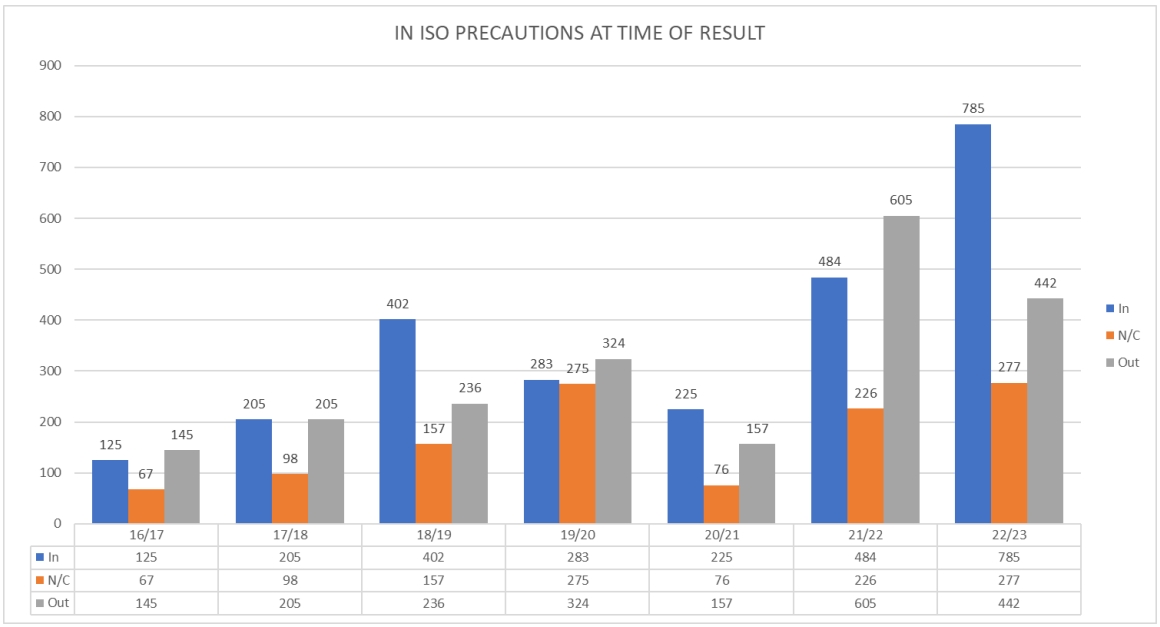
5.5 The charts below demonstrates that respiratory viruses transmit throughout the year. The traditional winter peak has returned but there remain a large number of respiratory viruses which are detected throughout the year emphasising the importance of a robust screening programme on admission and daily symptom check throughout the patient stay.



5.6 The chart below demonstrates that hospital acquired respiratory viruses occur across the trust so intervention is needed in all areas to prevent transmission.



5.7 Data collected demonstrates that staff awareness about putting children in isolation precautions at the time the samples are sent has improved dramatically but does not occur everytime.



Surveillance of Viral Gastro-enteritis

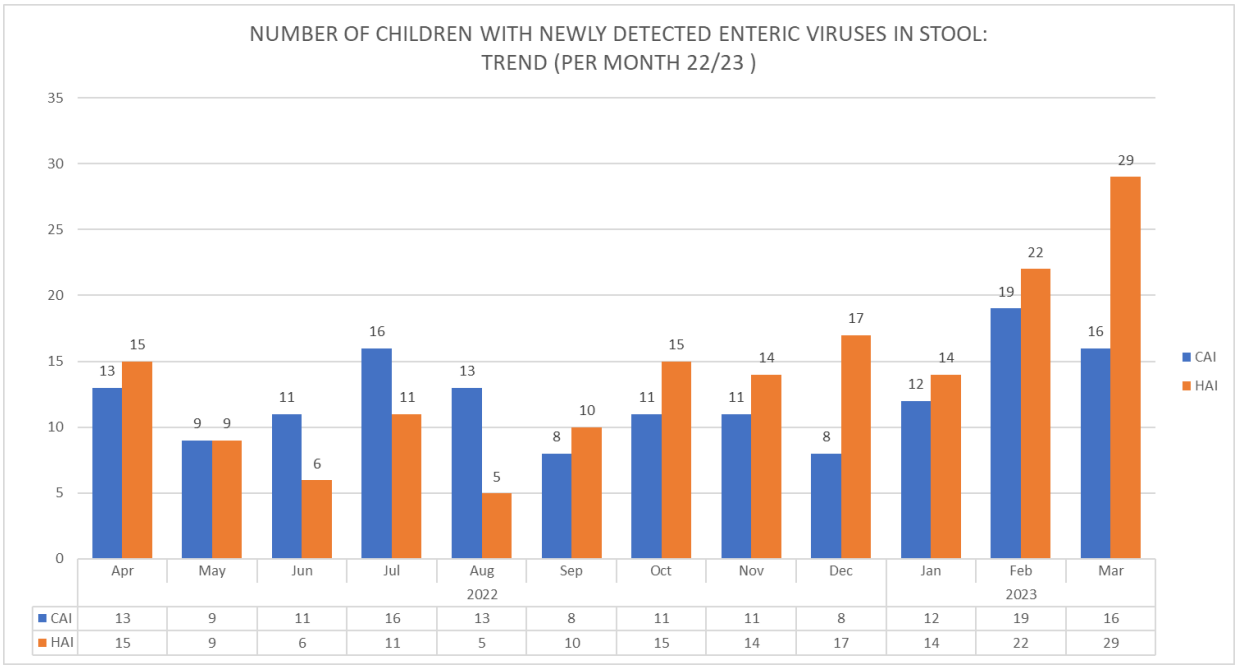
5.8 GOSH Trust outbreak control policy includes isolation of children with suspected viral gastro-enteritis with emphasis on recognition and early intervention.

5.9 As in respiratory infections, children, parents and staff frequently enter the Trust incubating these common infections and act as sources for localised outbreaks. Control of these explosive outbreaks may require closure or restriction of admission to units, along with additional environmental cleaning, as attack rates are high and secondary cases occur. Detailed investigation of these outbreaks and numbers of reported patients, staff or visitors affected are kept by the IPC team and the decision to close wards is based on risk assessment and epidemiological data.

5.10 As shown in the table below the number detected in 2022/23 has increased to 147 (from 127 in 2021/22), with 167 (up from 107) recorded as hospital acquisitions. There was a significant increase in healthcare associated Norovirus and Astrovirus detections linked with localised detections and outbreaks in clinical area.

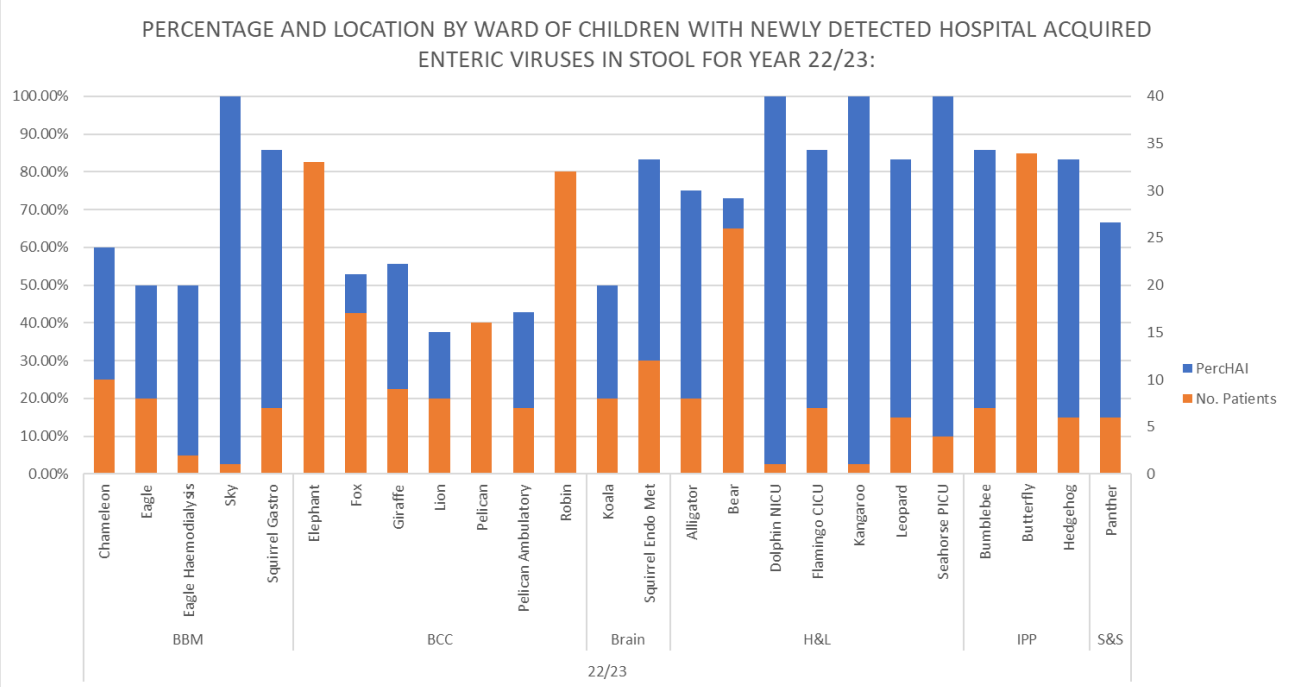
	19/20		20/21		21/22		22/23	
Org	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI
Adenovirus	81	84	38	42	68	49	65	68
Astrovirus	15	8	0	0	6	9	19	18
Norovirus G1	10	4	3	0	2	0	5	1
Norovirus G2	40	28	4	1	29	22	33	49
Rotavirus	13	6	8	3	10	4	6	10
Sapovirus	33	28	18	14	12	23	19	21
Grand Total	**192**	**158**	**71**	**60**	**127**	**107**	**147**	**167**

5.11 Enteric viruses remain present throughout the year with more cases during the late winter months. As with respiratory viruses detections occur throughout the year.

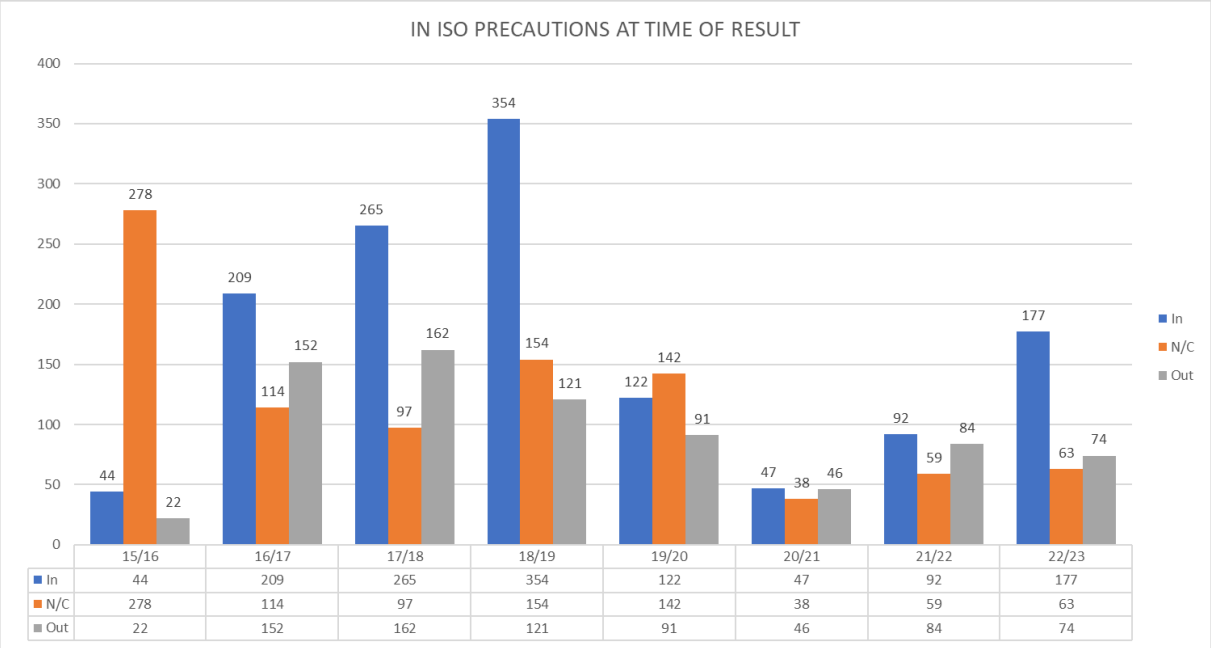


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2022									2023		
CAI	13	9	11	16	13	8	11	11	8	12	19	16
HAI	15	9	6	11	5	10	15	14	17	14	22	29

5.12 The graph below demonstrates as with respiratory viruses despite the smaller numbers of enteric viruses, hospital acquired cases occur across the organisation meaning that improvement is required in all areas to detect symptoms and prevent transmission.



5.13 The table below shows that the proportion of patients in the correct transmission-based precautions at the time of a result being available has improved. The IPC team has worked hard this past year to focus on daily symptom-based assessment focusing on both respiratory and enteric virus symptom recognition.



	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
In	44	209	265	354	122	47	92	177
N/C	278	114	97	154	142	38	59	63
Out	22	152	162	121	91	46	84	74

6. Audit and Compliance to Policy

6.1 The infection control trust-wide audit plan is well embedded in the Trust's overall audit programme and registered with the audit department. This plan is based on the internal and external infection control strategy which includes elements of High Impact Interventions from the "Saving Lives" programme. These care bundles were reviewed and updated in 2022/23. Care bundle audits are completed for the associated devices

- Peripheral line care bundle (insertion and maintenance)
- Urinary catheter care bundle (insertion and maintenance)
- Renal dialysis care bundle audited

6.2 Hand hygiene audits are also carried out looking at compliance with 'Bare below the elbows' and the '6 moments of hand hygiene' adapted from the '5 moments' used by the World Health Organisation (WHO).

6.3 Isolation precautions continue to be audited as part of the quarterly audit days.

6.4 The infection control link personnel in the clinical areas take responsibility, with guidance from the IPCT, for performing planned audits. All data is displayed, by the QI Team, on continuous dashboards, although this required modification with the audit process change and switch to Epic.

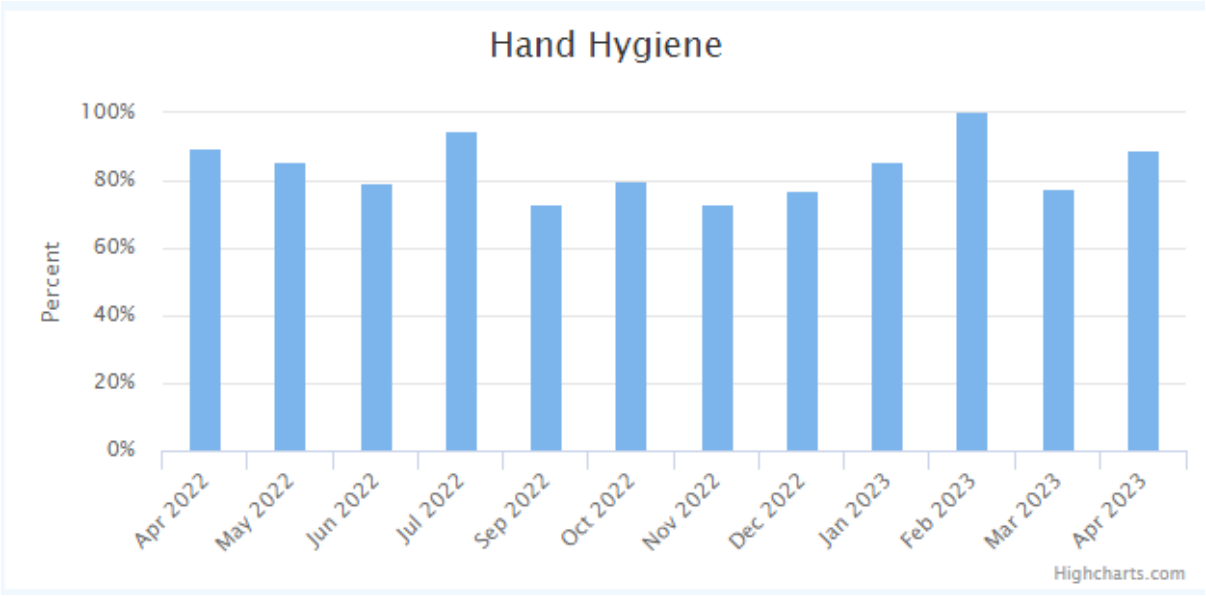
6.5 The infection control trust-wide audit plan undertook a major change in focus and direction in October 2018. In previous years and until the change, hand hygiene (including bare below the elbows) and high impact intervention audits were carried out monthly. Results from both these audits were in the mid to high 90 percentiles and had remained at this rate for many years.

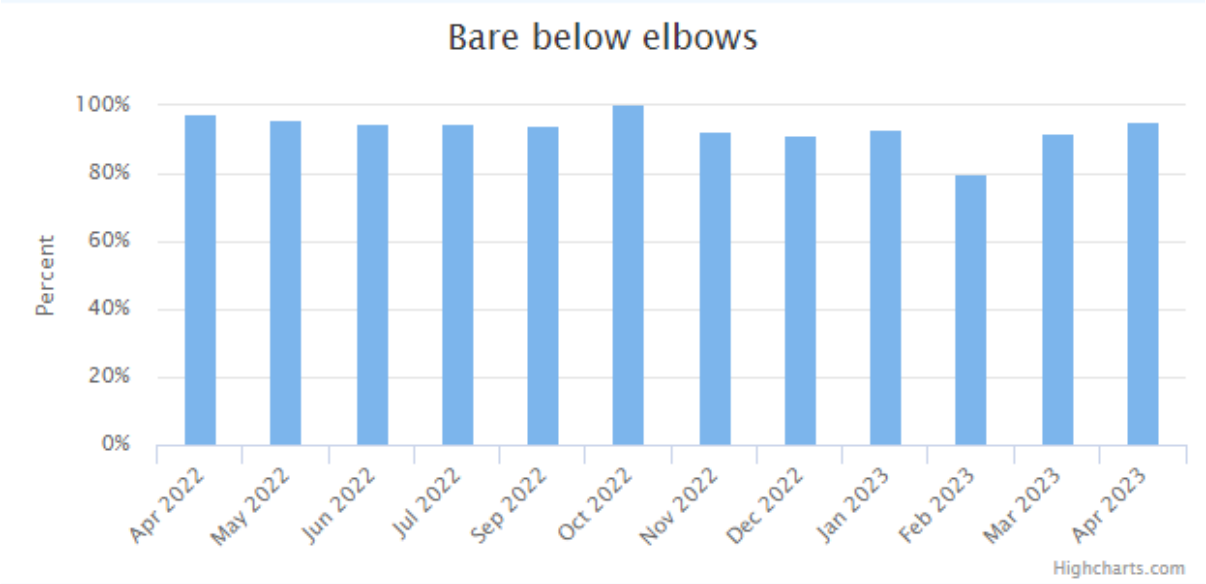
6.6 In October 2018 with approval from the IPCC and the Trust board we moved to quarterly audit days where hand hygiene audits and updated high impact intervention audits would be carried out using point prevalence methods rather than a minimum number of audits per month. In addition to completing the audits and collecting qualitative data as well as quantitative data we implemented the use of action plans to be completed each quarter on the findings from the audit days.

Hand Hygiene Results

6.7 The graph below shows the percentage rates of hand hygiene compliance for the year. Rates have generally remained stable at over 80% when looking at trust wide compliance with ranges from 73% - 100%.

Bare below the elbow's compliance remained above 92% throughout the year at the time of the quarterly audit days. There was a small audit carried out by one department in February 2023 that scored 80% but this was not part of the quarterly audit days.

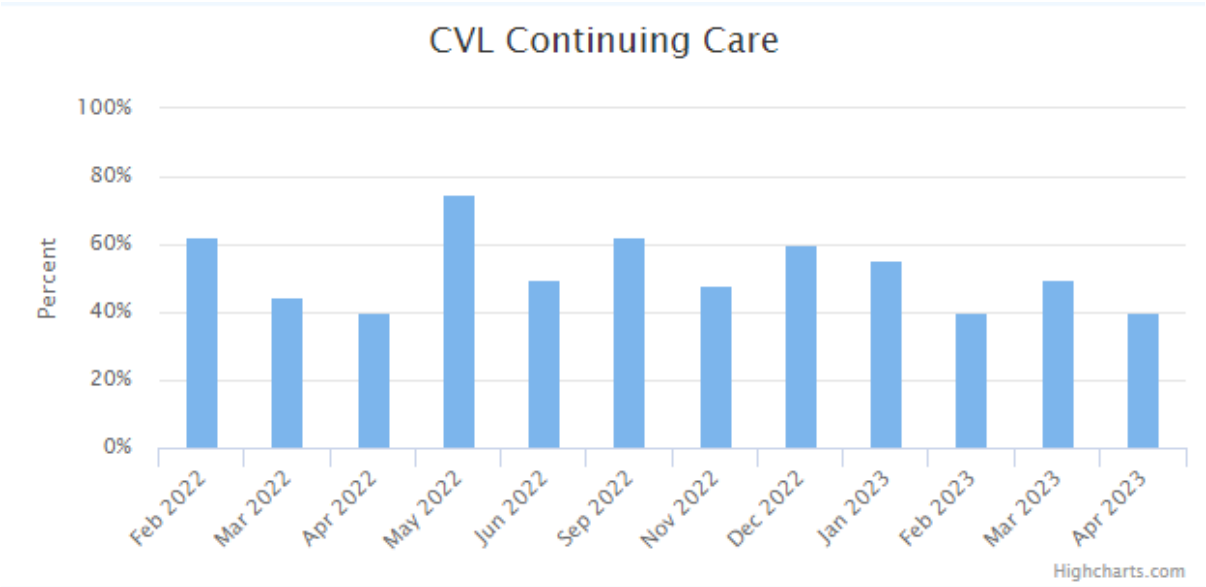




6.8 Action plans are live within the IPC dashboards and compliance is monitored through the directorate IPC meetings and the quarterly audit days.

Central Venous Line Ongoing Care

6.9 The graph and table below show the percentage compliance and numerical values for the past year(s).



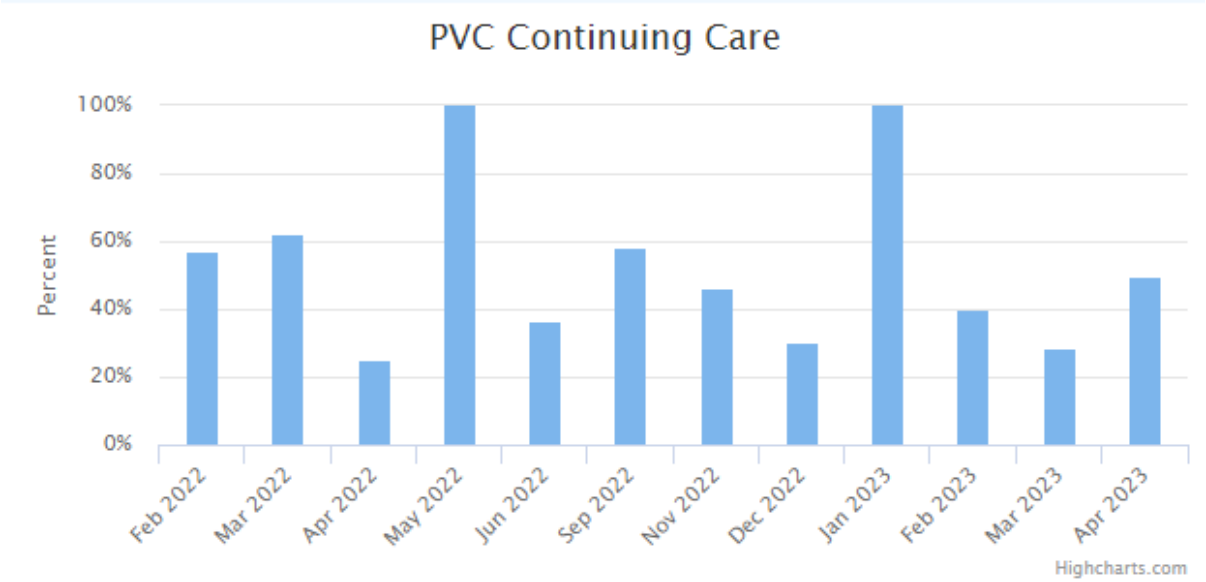
CVL Continuing Care

Period	Observed	Compliant	Percent
Feb 2022	8	5	63%
Mar 2022	106	47	44%
Apr 2022	5	2	40%
May 2022	40	30	75%
Jun 2022	74	37	50%
Sep 2022	111	69	62%
Nov 2022	54	26	48%
Dec 2022	65	39	60%
Jan 2023	9	5	56%
Feb 2023	5	2	40%
Mar 2023	76	38	50%

6.10 Care bundle compliance remains sub-optimal. There have been previous issues around the recording of information in the Electronic Patient Record (EPR) which have been addressed and continue to be reviewed. Capital Nurse has been implemented as a piece of education around Intravenous care, but more work is required around standardising relevant clinical guidelines to set the standard required for staff and act as a clinical resource.

Peripheral Cannula Ongoing Care

6.11 The graph and table below show compliance with the PVC continuing care bundle. Compliance has been variable across the course of the year. Further work is needed around the recording of flushes when cannulas are not used for 8hrs and around the recording of line care within Epic.

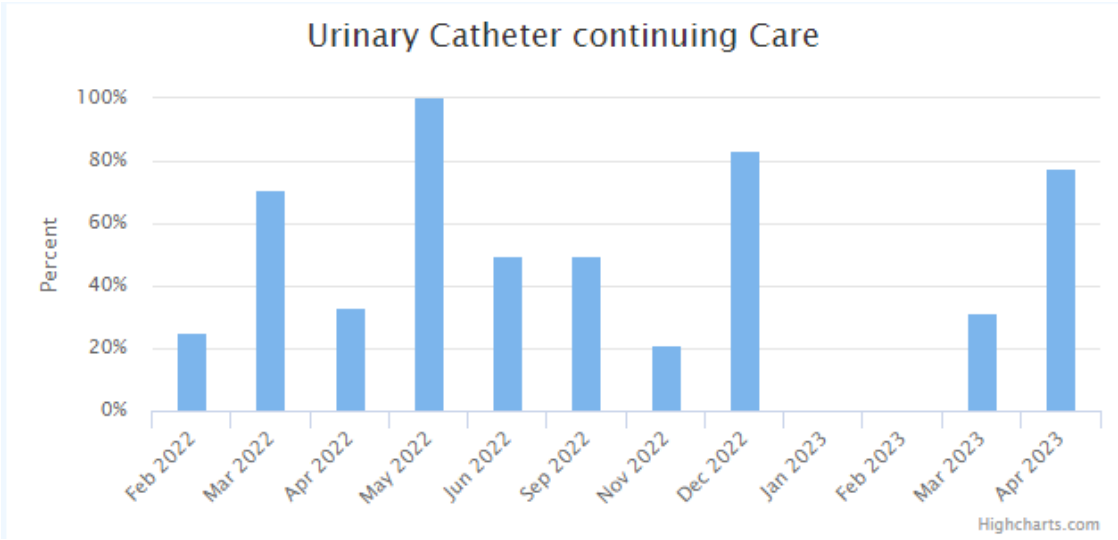


PVC Continuing Care

Period	Observed	Compliant	Percent
Feb 2022	7	4	57%
Mar 2022	48	30	63%
Apr 2022	4	1	25%
May 2022	30	32	107%
Jun 2022	52	19	37%
Sep 2022	62	36	58%
Nov 2022	41	19	46%
Dec 2022	23	7	30%
Jan 2023	1	1	100%
Feb 2023	5	2	40%
Mar 2023	52	15	29%

Urinary Catheter Ongoing Care

6.12 The graph and table below show compliance with the urinary catheter continuing care bundle. There is a high variance in compliance rates due to the small numbers of catheters, making education difficult to roll out in this area. There are also difficulties in recording elements of the care bundle as they are recorded in different places within Epic. Work to address this within Epic was undertaken in 2022/23 and is planned to be launched 2023/24.



Period	Observed	Compliant	Percent
Feb 2022	4	1	25%
Mar 2022	17	12	71%
Apr 2022	3	1	33%
May 2022	14	14	100%
Jun 2022	10	5	50%
Sep 2022	16	8	50%
Nov 2022	14	3	21%
Dec 2022	6	5	83%
Jan 2023	2	0	0%
Feb 2023	0	0	
Mar 2023	19	6	32%

Ventilator associated pneumonia (VAP) / Ventilator associated events (VAE).

6.13 VAP reduction plans are in place throughout the ICUs for the reduction of risk of ventilator associated events, but the ICUs do not undertake any systematic surveillance. In the past a review of surveillance had demonstrated rates were comparable to other paediatric units (usually in the US). These are uncommon events compared to adult ITUs, and generally required a lot of input from ITU staff in terms of data gathering, decision making about cases, etc. Therefore, a decision was made not to carry out formal surveillance unless we had more of the classical VAP/HAP in long term ventilated patients, and further intervention was needed.

Surgical site surveillance

6.14 Surgical site surveillance takes place across three directorates within the Trust. Surveillance programmes underway for the year 22/23 included spinal surveillance, cardiac surgery and neurosurgical procedures. It has been identified this year that the system used to record (RL Datix) spinal surveillance, other general surgery and cardiac cannot be optimised to the desired standard. The system has several issues which means that data cannot reliably be captured in a standardised way presenting a risk to data analysis. This was added to the risk register and work is underway to design and build an appropriate system to support and develop this function further. This has not stopped the continued surveillance of spinal surgery which we report to the UKHSA and the commencement of cardiac surveillance in this financial year.

6.15 Neurosurgical surveillance- figures

A total of **1199** neurosurgical procedures were performed within this period.

The overall number of adverse events was **166** with an adverse event rate of **13.8%** (166/1199)

The overall number of Infections was **20** and therefore infections make up **12%** of the adverse events (25/166)

The overall Infection rate for neurosurgical procedures (25/1199) during this time was **1.7%.**

The overall breakdown for surgical site infections (SSIs) is as follows:

Grade	**Superficial Incisional (SI)**	**Deep Incisional (DI)**	**Organ Space (Not GOSH Shunt)**	**CSF (Shunt)**
Total	**7**	**4**	**2**	**7**

There have been no specific clusters of infections.

Shunt Infections

A total of **180** shunt procedures was performed.

The overall shunt infection rate was **7** providing an Infection rate of **3.9%** (7/180).

The **NEW** shunt insertion infection rates was: **5%** (3/60)

The **REVISION** shunt infection rates were: **4.5%** (4/120)

6.16 Neurosurgical surveillance- narrative

Regular meetings take place quarterly to review infections as part of audit activity with the Brain directorate. As part of these meetings an in-depth analysis and review of any infection and associated learning is explored with the clinical team, microbiology consultant and the IPC team.

Changes in practice this year have occurred because of learning based on RCA. The changes focused on ensuring antibiotics are given in a timely manner prior to surgery and on ensuring the patients temperature is optimised and patients do not go to theatre cold.

6.17 Cardiac surgical site surveillance- figures

Surgical site surveillance within cardiac surgery recommenced in late 2022 with the new surveillance officer undertaking a wide range of training. As a result there is limited data for the year 22/23.

Data from April 2023 showed that 36 surgical cases were completed of which 27 received surveillance. To date no infections have been identified within this group.

6.18 Cardiac surgical site surveillance- narrative

MRSA pre-operative screening is good with 100% compliance. There was also good compliance with antibiotic prophylaxis.
In the year 23/24 surgical site surveillance within cardiac will be collected in the same standardised way that it is performed within spinal surgery with better data, output and appropriate root cause analysis (RCA) for any infection meeting the definition. The surgical site surveillance officer will be supported in this development by the surgical site surveillance lead for spines and the IPC team.

6.19 Spinal surgery- figures

SSI numbers stable – only x1 *new onset* SSI case in 2022 for a total of 148 operations.

2022 Jan-Dec combined SSI rate risk 0.7% (within national range).

2022 sample size reduced post COVID-19: 148/year – previous 3 years pre COVID-19: +/- 200/year

6.20 Spinal surgery- narrative

Overall key SSI risk factors stable when compared to previous quarters;

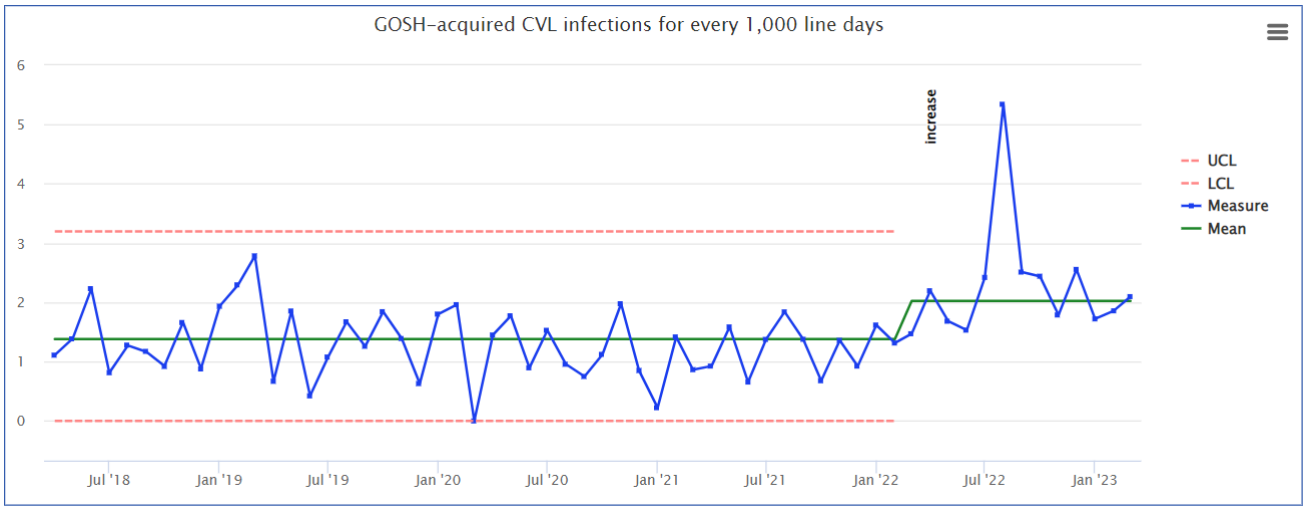
- No significant pattern changes of a series of data points over time for:
    - Timely antibiotics pre KTS (100%); ✓
    - Pre-op wash at ward level (100%); ✓
    - Timely pre-op MRSA screening (100%); ✓
    - Normothermia intra-op (65%). ✓ Historical range before pre-warming started: 30%.

Moving forward the team plan to continue the current spinal surveillance programme and assist the Infection & Prevention Control team to build an inhouse SSI system and associated dashboards as well as expanding the surveillance to include additional surgical specialities.

7. GOSACVCRB (GOS acquired CVC related bacteraemias ('Line infections')*

7.1 GOSH has been monitoring central line infection rates for several years, using a specific in-house definition which dates back to pre- 'Matching Michigan'. Most recent year's data is shown below in table and SPC graph format and demonstrates a small reduction year on year.

Period	GOSACVCRB_No	DaysRecorded	Rate	Rate_YtD
Year 15/16	75	51976	1.4	1.4
Year 16/17	87	52679	1.7	1.7
Year 17/18	82	50661	1.6	1.6
Year 18/19	82	52303	1.6	1.6
Year 19/20	73	54936	1.3	1.3
Year 20/21	63	53044	1.2	1.2
Year 21/22	66	52396	1.3	1.3
Year 22/23	128	55240	2.3	2.3



Ward location of children with a surveillance definition of a GOSACVCRB:

7.2 Data in the table below splits the rate and numerical count of the line infections by ward. It also includes the number of line days collected by that ward which is now automated from the Electronic Patient Record (EPR).

Directorate	Ward	GOSACVCRB	Total LineDays 22/23	Rate 22/23
Blood, Cells and Cancer	ELEPHANT	6	3606	1.7
Blood, Cells and Cancer	FOX	7	2889	2.4
Blood, Cells and Cancer	GIRAFFE	7	2191	3.2
Blood, Cells and Cancer	LION	1	1242	0.8
Blood, Cells and Cancer	PELICAN	4	1887	2.1
Blood, Cells and Cancer	PELICAN AMB	6	1236	4.9

Blood, Cells and Cancer	ROBIN	6	2890	2.1
Blood, Cells and Cancer	SAFARI DC	0	25	0.0
Body, Bones and Mind	CHAMELEON	3	2414	1.2
Body, Bones and Mind	EAGLE	2	1507	1.3
Body, Bones and Mind	EAGLE HAEMOD	0	102	0.0
Body, Bones and Mind	GIU	0	3	0.0
Body, Bones and Mind	SKY	0	930	0.0
Body, Bones and Mind	SQGASTRO	2	2257	0.9
Brain	KINGFISHER	0	103	0.0
Brain	KOALA	5	1762	2.8
Brain	SQENDOMET	1	1418	0.7
Heart and Lung	ALLIGATOR	3	521	5.8
Heart and Lung	BEAR	16	4159	3.8
Heart and Lung	CATS	0	21	0.0
Heart and Lung	CICU	14	7244	1.9
Heart and Lung	CMRI	0	1	0.0
Heart and Lung	KANGAROO	2	693	2.9
Heart and Lung	LEOPARD	3	2385	1.3
Heart and Lung	NICU	11	2655	4.1
Heart and Lung	PICU	15	3575	4.2
Heart and Lung	RSU	0	93	0.0
International and Private Patients	BUMBLEBEE	6	1606	3.7
International and Private Patients	BUTTERFLY	5	3931	1.3
International and Private Patients	CATER AMB	0	26	0.0
International and Private Patients	HEDGEHOG	2	293	6.8
Operations and Images	IR	0	2	0.0
Operations and Images	THEATRES	0	164	0.0
Operations and Images	WOODPECKER	0	1	0.0
Research and Innovation	CRF	0	24	0.0
Sight and Sound	PANTHER	0	505	0.0
Sight and Sound	PANTHERURO	1	877	1.1
Sight and Sound	URODY	0	1	0.0

Organisms associated with GOSACVCRB

7.3 GOSH central line surveillance programme is important because it monitors over time the infection rates of those with central lines across the trust, not just in ICUs as some national programmes do.

7.4 In 2022/23 128 episodes have been called GOSACVCRB (compared with 66 in 2021/22). This was a significant increase on previous years. There was a significant issue in the summer of 2022 around the supply of 2% chlorhexidine 70% alcohol wipes for the needle free connectors which accounted for some of this rise. There were also further challenges in the supply chain around the supply of parafilm and central venous catheters which occurred at various points in the year.

7.5 The table below shows the breakdown of species cluster. The top 3 species clusters identified were Gram-positive cocci of which coagulase negative staph were the most species identified. Gram-negative resistant (GNR) had a significant increase with Klebsiella pneumoniae increasing from the 6 in 20/21 to 22 in 22/23. Enterococcus faecalis numbers remained around the same. Of note there was a significant decrease in the GOSH CVCRB related to Staphylococcus aureus compared to the previous year which was an outlier with 15 cases identified.

Org	17/18	18/19	19/20	20/21	21/22	22/23
ANO2	**1**	**0**	**2**	**0**	**1**	**1**
Bacteroides sp.	1	0	0	0	0	0
Brevibacterium sp.	0	0	1	0	0	0
Clostridium perfringens	0	0	1	0	0	0
Clostridium sp.	0	0	0	0	1	0
Cutibacterium acnes	0	0	0	0	0	1
FUNGI	**4**	**10**	**7**	**3**	**2**	**7**
Candida albicans	3	6	1	0	0	2
Candida krusei	1	0	0	0	0	1
Candida parapsilosis	0	3	4	3	2	2
Candida sp.	0	0	2	0	0	2
Fungus (undefined)	0	1	0	0	0	0
GNC	**2**	**0**	**0**	**0**	**0**	**0**
Moraxella catarrhalis	1	0	0	0	0	0
Neisseria sp.	1	0	0	0	0	0
GNR	**14**	**15**	**26**	**17**	**11**	**41**
Enterobacter cloacae	3	2	7	0	1	2
Enterobacter sp.	1	1	3	2	4	5
Escherichia coli	5	7	5	3	0	12
Klebsiella oxytoca	0	2	7	4	0	0
Klebsiella pneumoniae	5	3	4	8	6	22
GPR	**1**	**4**	**4**	**1**	**0**	**5**
Bacillus cereus	0	1	2	0	0	0
Bacillus sp.	1	1	0	0	0	2
Corynebacterium sp.	0	0	1	0	0	1
Lactobacillus sp.	0	0	1	1	0	2
Microbacterium sp.	0	2	0	0	0	0
MYCO	**0**	**0**	**0**	**0**	**1**	**2**
Mycobacteria sp.	0	0	0	0	1	0
Mycobacterium abscessus	0	0	0	0	0	1
Mycobacterium chelonae	0	0	0	0	0	1
PSEUDO	**6**	**7**	**7**	**14**	**9**	**9**
Achromobacter sp.	0	0	0	1	2	0
Burkholderia cepacia complex	0	0	0	1	0	0
Pseudomonas aeruginosa	4	4	3	5	3	5
Pseudomonas sp.	0	0	1	1	2	1
Stenotrophomonas maltophilia	2	3	3	6	2	3
STAPH	**48**	**36**	**59**	**45**	**67**	**106**
Staphylococcus aureus	6	5	6	2	15	4
Staphylococcus capitis	1	3	4	4	0	9
Staphylococcus epidermidis	29	22	37	33	48	68
Staphylococcus haemolyticus	3	2	7	4	4	12
Staphylococcus hominis	9	4	5	2	0	13
STREP	**17**	**19**	**18**	**18**	**14**	**17**
Enterococcus faecalis	6	4	5	5	12	6
Enterococcus faecium	5	8	7	4	0	10
Enterococcus sp.	0	1	2	5	0	0
Streptococcus sp.	0	1	0	2	0	0
viridans group Streptococci	6	5	4	2	2	1
Grand Total	**93**	**91**	**123**	**98**	**105**	**188**

Other bacteraemia and sensitivity data.

7.6 Blood culture surveillance is complicated due to mixed cultures and difficulty defined clinical episodes. In the year 22/23 there were:

12,539 separate blood culture sets sent (11,620 in 21/22)
866 were positive (681 in 21/22)

7.7 Removing repeat isolates (same species within 14 days of initial) there were

496 new clinical episodes with (419 in 21/22)

7.8 Regular surveillance has been undertaken of crude bacteraemia episodes defined by any positive blood culture in a child.

GOSH CVC infection reduction programme.

7.9 The programme to reduce GOS acquired CVC related bacteraemias (GOSACVCRB; 'line infections') has used an improvement process based on the universal or focussed introduction of care components combined with continuous process and outcome audit. Initially the 'Saving Lives' standard care bundle was implemented across the entire trust and significant reduction in line infection rate was seen year on year. However, this did not reach zero.

7.10 The main control is implementation of the standard care bundle, which, despite continuous attention has not reached 100%.
Review of additional interventions was also undertaken, and it was decided to introduce Parafilm® and Biopatch® in most areas of the organisation.

7.11 Compliance with good line care has remained lower than the required standard. Work has continued with Epic to improve the ability to document within the patient record and a programme of education will be rolled out once this is finalised to ensure all staff are carrying out line care to the correct standard and documenting this care appropriately.

8 Wider Infection Prevention and Control Service

8.1 The services below all submitted full annual reports to the IPCC. Key achievements and areas of risk are identified and brought to attention within this annual report for review by the board.

Estates & Facilities (including Decontamination)

8.2 Estates
The estates team have experienced a period of positive change that has included improved accountability for its IPC related functions such as ventilation and water quality. While it is fair to say that the team have not reached a point that could be considered as totally satisfactory, a platform now exists that is both stable and improving as we move to a point of excellence within the estate's transformation programme.

In particular, the work undertaken around integrating the estates engineering and operational teams into a single space has improved communications ensuring that IPC related issues such as air flow, room pressure and changes water systems infrastructure condition, have become a shared conversation within subsequent ownership, within the team.

The CAFM (Computer Aided Facilities Management) system is fast becoming a tool for tracking compliance with the PPVL, ventilation and chilled beam scheduling being fully integrated into this automated system.

The cooling tower management has been a long-standing issue and a recent award of a contract to WCS has been made against a scope of works that falls short of the Trusts requirements. However, the contractor has been invited into the Trust and has been extended for a period of 6 months against an enlarged scope that not only covers the correct level of activity but also includes a degree of training.

The management of water quality results has been far from satisfactory with the system parameters within the Compass™ reporting software being completely out of tolerance. As a result, the estates water quality team will shortly make representations to the water quality committee to accept a revised schedule of tolerances that will safely reduce the current 10,000 non-conformances to reasonable workable number that will allow the team to take control of the real issues.

8.3 Facilities

Decontamination 2022-23

8.4 The trust holds a contract with BMI/Circle Health for the provision of sterile services for the reprocessing of surgical instruments and endoscope decontamination business continuity agreement.

The contract has been in place since April 2021 and was terminated by BMI/Circle at the beginning of December (2023), due to increasing demand within their own hospitals limiting available capacity for external contracts. The termination date for the contract is July 31st, 2023. The mobilisation project group was set up in February to engage with the new provider, Royal Free Hospital, and support the transition of the contract.

The service holds the required accreditation for delivering the service – ISO 13485 and is audited annually by the Notified Body (appointed by the MHRA) as well as the trust AE(D) who undertakes an annual audit of the service.

There is in a place several meetings in place to allow for the service to be monitored and for clinical engagement with the team providing the service. These include:

- Clinical user group meeting
- Decontamination Contract Review Meeting
- Surgical Infection Control Committee
- Trust Decontamination Committee

The Facilities team who oversees the contract worked closely with the clinical teams in monitoring the KPIs for the service which has seen an error rate of below the industry standard (2%) as well as looking to identify trends from the reported defects (NCRs) which are a record of non-conformances recorded by both the service provider and the service user.

The trust continues to monitor protein levels on instruments post wash in line with the guidance and has a documented process for managing the sampling criteria and monitoring results. The decontamination and clinical teams are working on several projects including the introduction of a protein detection system post instrument wash to help support the introduction on the

current NICE guidance as well as an annual instrument count to monitor the instrument trays and supplementaries that are currently in the system.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Trays	**2800**	**3495**	**3031**	**3385**	**2851**	**3280**	**3347**	**3131**	**2446**	**3104**	**2739**	**2988**
Total Supps	**1963**	**2354**	**2091**	**2308**	**2365**	**2215**	**2980**	**2277**	**1842**	**2248**	**2114**	**2295**
Error Rate %	**0.73**	**0.88**	**0.86**	**0.94**	**1.07**	**0.97**	**0.80**	**0.68**	**0.53**	**1.05**	**0.61**	**0.62**

Whilst Sterile Services is provided by an outsourced provider, there are two main services that are provided by in-house teams – Flexible Endoscope Decontamination and Medical Equipment Decontamination. Both services are provided by dedicated staff in recently refurbished units – EDU & MEDU which are monitored by the external AE(D).

As part of the monitoring for the inhouse service the following areas are managed and reported on in line with HTM and the relevant standards:

- Water Quality
- Validation of equipment – washer disinfector (MEDU), endoscope washer disinfectors (EDU), scope storage cabinets (EDU), Vac a Scope storage system (EDU), Environmental audits/testing (EDU/MEDU)

Activity for the services are shown below and are in line with previous years, to note MEDU has a dedicated fogging room which was commissioned in April 22 and all compatible equipment from BCC and ICUs now undergo hydrogen peroxide decontamination when processed via MEDU:

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
EDU	322	341	302	373	346	332	322	353	273	342	310	357
MEDU - Manual	874	739	1189	757	402	614	867	662	561	607	596	675
MEDU - Automated	3179	4649	12771	4941	4481	3797	4481	3797	4159	3218	2878	1779

Domestic Services

8.5 The trust has a domestic service that is provided by an in-house team and in line with the relevant standards and guidance documents.

The National Standards of Cleanliness 2021 were introduced in August 2022 and the team have implemented the following in recognition of the new requirements:

- Star rating poster that indicates the rating given from the most recent audit. The new standards convert the percentage audit score achieved into a star rating for the overall score achieved. These posters display this star rating and are displayed in the facilities noticeboard/s for each area

- 'Audim' which is the electronic audit tool was changed to reflect the new standards and the addition of one further element. There are now technically 50 elements which was implemented to allow for both the audits to be recorded in line with the new standards as well as providing the star rating after each audit

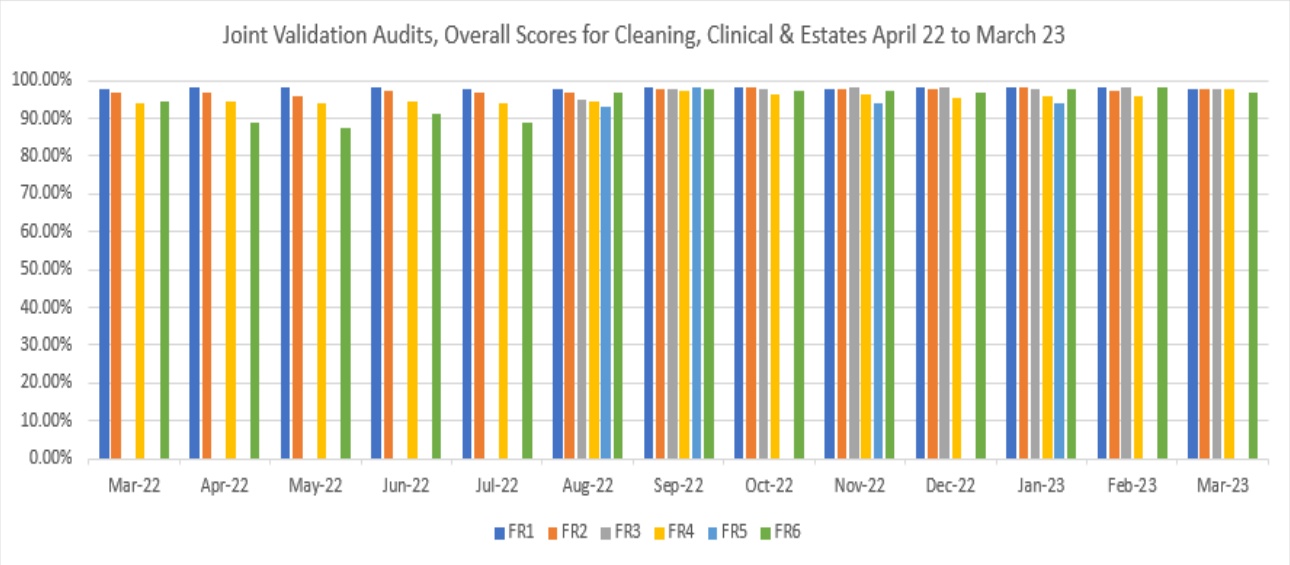
- SLAs now include information about the NCS 21. This includes the new responsibility matrix and the patient associated ward equipment cleaning matrix.

The Facilities team continue to monitor the number of cleans undertaken in the hospital (table below) which has continued to see the number of Level 2 plus cleans rise compared to 21/22:

Requested Clean	April to July 2021	August 2021 to March 2022	April 2022 – March 2023
Level 1	1	6	
Level 2	4921	16008	12587
Level 2 plus	76	218	669
Level 3	213	518	679
Level 4	168	491	645

The service carries out audits in line with the standards, with the results reported on at the monthly Domestic Services Review meeting which is attended by both facilities, clinical and Infection Prevention and Control colleagues. During the review of the information, rectifications are discussed and trends reviewed.

The audit scores for 2022/23 are tabled below:



Linen & Laundry

8.6 The Trust works in partnership with Elis who are contracted to provide a linen and laundry service. The contract was tendered in 2022 which saw the Elis awarded the service for a further 3 years.

The contract has a robust monitoring process which includes audits of areas where linen is stored and quality checks (monthly), site visits (annually) and monthly contract meetings where the service that has been delivered and contractual KPIs are monitored.

Below is the table for the total number of items delivered and rejects which is reviewed on a monthly basis to ensure that it is both in line with industry standards as well as looking to identify trends and action rectifications:

	April	May	June	July	August	September	October	November	December	January	February	March
Used hired linen	127000	150000	128920	121190	136000	128350	140000	144000	130270	136090	123000	146830
Rejects	1120	1006	924	1073	779	1096	1084	1245	1292	1044	1083	1319

Antimicrobial Stewardship

8.7 The terms of reference for the AMS committee and membership are in line with NICE guidance on antimicrobial stewardship and the 'Start Smart then Focus' initiative. Our team continue to collaborate nationally via UK-PAS and our yearly START meeting. The Lead Antimicrobial Pharmacist returned from maternity leave in March 2023.

8.8 The AMS committee meets quarterly via a virtual platform. There continues to be 4 main work streams identified (Policy, Resistance reporting, Education and Audit).

8.9 Policy

The antibiotic policy group continue to meet monthly to ensure review and updating of all Trust guidelines pertaining to antimicrobials.

8.10 Prescribing audits

CQUIN reporting for the year was focussed on adult infection and resistance. Consumption data is part of the standard contract and consumption reduction is only for watch and reserve antibiotics. We have a 4.5% reduction target from 2018 baseline to March 2023 and 6.5% by March 24. The AMS team, work with the digital research environment (DRE) toc automate some audit functionality.

8.11 Resistance reporting

Individualised micro-susceptibility charts continue to be widely used in the trust; these are regularly reviewed in the AMS rounds. A Trust-wide antibiogram has been developed which also continues to allow live data and important pre-emptive switches in antibiotic policy.

8.12 Education and Research

The START meeting continues to be held annually. The AMS team continue to share their work through publications and poster presentations at conferences. The team continue to be involved in local and national public engagement events highlighting the importance of AMS.

Sepsis

8.13 In December 2022 the DIPC was appointed as the interim sepsis lead. Since then, the Sepsis steering group has reformed initially meeting monthly and then bi-monthly reporting into the IPCC.

8.14 Workstreams focus on guidance updates, audit of compliance with the sepsis 6 bundle, bundle optimisation and education. The auditing and reporting of the bundle compliance was not available within Epic until February 2023. An initial audit into bundle compliance was undertaken where areas of good practice and areas for bundle optimisation were identified. These will form part of clinical education and feedback on areas of good practice into bundle usage. This will be alongside work with the lead practice educator for patient safety on the recognition and management of sepsis for all clinical staff. This education will be constructed in the summer of 2023 ready for launch in September 2023.

Occupational Health

8.15 **Occupational Health new starters**

The Occupational Health (OH) Service is an in-house service. All applicants on receipt of a conditional job offer are assessed by occupational health prior to commencement to ensure that they fulfil the requirements around immunisation status for healthcare workers as per the Green Book.

Staff Immunisations

In line with the Green Book guidance, we screen all new starters to assess immunity to measles and chicken pox.

A total of 394 occupational vaccinations were administered (excluding Influenza and COVID-19 which are not occupational vaccinations) during 2022/23.

Influenza Vaccine

The Flu Planning group co-ordinated an active vaccination programme for all staff. Flu vaccinations were offered centrally within the hospital for 9 weeks running alongside the Covid Boosters. Staff were able to book appointments to be given both the Covid booster and flu vaccination together or book just to receive either vaccine separately. After the nine-week programme flu vaccines were available from OH.

Final flu uptake figures for Healthcare Workers 2022/23 was 52%. Whilst this was a drop compared to recent years it was acknowledged that across the NHS staff remained vaccine weary. GOSH had the highest uptake amongst HCWs within NCL and were fourth highest across all London Trusts. We were for a second year congratulated by the NHSE Immunisation Commissioning Manager and asked to share how we achieved good uptake.

Year	Percentage uptake of flu vaccinations for HCWs	Percentage increase/decrease
2015/16	48%	-
2016/17	62%	14% increase
2017/18	61%	1% decrease
2018/19	61%	0 change
2019/20	59%	1% decrease
2020/21	71.6%	12.6% increase
2021/22	57.5%	14.1% decrease
2022/23	52%	9.5% decrease

Exposure to blood borne viruses

During 2022/23 there were 56 attendances at OH following needlestick injuries. It is pleasing to see a 15% decrease in needlestick injury exposures compared to last year, this reflects the work that has taken place to ensure safer sharps are available within the Trust.

On exploring the data recurring themes remain unchanged.

Most incidents occur during disposal – the themes are that sharps are initially discarded onto a tray post procedure and then an individual sustains an injury when picking up and discarding into the sharps box. We have seen several of these types of injuries involving butterfly needles. With the introduction of safe butterfly needles, we will hopefully see a reduction in these types of injuries. We continue to see occasional injuries caused by re-sheathing, which is not in line with Trust guidance, additional preventable injuries have been due to accessing a sharps box that was too full with a needle protruding out and incidents where staff were passed a sharp from a colleague and sustained an injury during the process.

The Safe Sharps working group continues to monitor the use of sharps within the Trust in line with the HSE Safe Sharps directive, recommending the use of safe alternatives where practicable to implement a safer alternative for paediatric use.

Skin Surveillance:

Dermatitis is an occupational hazard for health care workers. As such we review and advise all staff who have any skin reactions. Generally, the work related skin reactions we see are linked to frequent handwashing and wearing of gloves. The wearing of gloves is classified as wet work.

Overall attendances at OH with skin issues continue to reduce year on year with 13 new attendees 2022/23 compared with 35 in 2021/22 and 95 new attendees 2020/21. Much of the advice provided 2020/21 was associated with skin issues associated with mask wearing rather than hand issues associated with wet work.

9. Board assurance Framework (BAF)

9.1 Effective infection, prevention and control has been fundamental in our efforts to respond to the COVID-19 pandemic and return to normal activity levels as we emerge from the pandemic. The purpose of the BAF is to provide assurance that Infection Prevention and Control (IPC) Measures have been reviewed considering changes in national guidance to support management of Covid-19, other respiratory viruses and measures beyond these aspects of IPC.

The Assurance Framework was first published on 4th May 2020. The framework was updated in Sep 2022 to reflect the ten criteria used within the Health & Social Care Act (2019) and support the introduction of the National Infection Prevention Control Manual (NIPCM).

Use of the framework is not compulsory, however its use as a source of internal assurance will support the organisation to maintain quality standards.

9.2 Board Assurance Framework (BAF)

The BAF is a live document and has been presented regularly to the trust board and executive management team since it was published in May 2020. Based on our self-assessment against the Assurance Framework, we identified a programme of work to support further implementation and improvement in our ways of working. This is ongoing and iterative based on updates on the BAF and the NICPM as published by NHS England.

The largest area of risk currently identified is the around the lack of assurance around the identification that not all standard bedrooms in the trust were commissioned to 6 air changes when they were opened despite them being designed to 6 air changes. Mitigations in place to control this risk include extended fallow times in these areas. This was last reviewed in April 23.

9.3 COVID-19 response

There were 41 hospital acquired COVID-19 cases in the last year compared with 24 the previous year. Guidance from NHSE/I was changed to recommend cases were only investigated if harm was caused. We continued to monitor our cases and look for sources were possible. We continued to find parents and visitors a common source. We attribute the increase in numbers due to a lack of awareness by families as testing was stepped down in the community and social distancing ended. We worked with clinical teams to update guidance as required and as asymptomatic testing ended in Sep 2022 in line with national guidance, we focused our education on symptom recognition and testing. Staff continued to universally mask in clinical areas, but this requirement was removed from staff only and public areas in June 2022.

9.4 Isolation audits

Compliance with isolation precautions for patients is audited as part of the quarterly audit days. It assesses patient, family and staff awareness of isolation, the use of care plans and information leaflets, the availability, use, risk assessment and disposal of PPE, and the cleaning of equipment and the environment.

Compliance with isolation audits have generally remained above 70%. Overall, there was good compliance with most areas within the isolation audit.

Areas of good practice included staff awareness and knowledge of their patient's infection status and isolation requirements as well as patient/family awareness of the rationale for isolation. Compliance with PPE was also good.

Areas identified as requiring improvement included a lack of posters displayed on doors of isolated patients, the majority of the posters missing were the respiratory viral pathway posters which have since been retired from use. Compliance with admission screening was also a recurrent theme and highlighted by teams as an area for improvement.

9.5 Fit Testing

Fit testing is recognised as a key element of protection for staff. This is all recorded on a central database. The key challenges which we have faced are around consistency in the brand/make of FFP3 masks supplied centrally, particularly where this has meant we need to re-fit-test all relevant staff. There has also been a higher failure rate in some of the masks provided through the central system. A dedicated fit testing is in place providing fit testing to the organisation. The BAF recommends that staff are fit tested to more than one mask, this has been challenging due to staff not wanting to attend multiple times for mask fitting. It is also recommended that staff who fail fit testing have this documented within their occupational health record. Currently this is not held within that record but is held by line managers.

9.6 Care Quality Commission (CQC)

There was no on-site visit from the CQC this year.

10. Recommendation

The Trust Board is asked to receive this report and note the content.

Part B - Programme of work

New projects:

Programme of Work of new project	Lead	Time frame	Progress to date	Complete/ Action required	Hygiene code
Implementation of in-house plating service	IPC Team/Space & Place	Sep 23	Business case approved- awaiting equipment	No	1, 2, 8
Surveillance- creation of a trust wide surveillance oversight group which will monitor all aspects of the surgical pathway	IPC Team	Commence ASAP	Business case for system	Yes	1, 6
IPC input into Children's Cancer Centre, including the	DIPC/ICD	Ongoing	Input ongoing	No	1, 6, 7, 9

decant and enabling					
Decontamination contract (new contract due to go live) and NICE implementation around protein testing	ICD	Started April 23	Ongoing	No	1, 6, 8, 9
Review the electronic filing system to ensure the system is clearly labelled and data is robustly stored	IPC PA	Ongoing	Commenced and ongoing	Yes	1
Surveillance- All required data reported to PHE. RCA's currently taking place for HCAI Staphylococcus aureus & Gram-negative infections with clinical teams	IPC team/ Divisions	Commence April 23	This has started and input from clinical teams is good	No	1,3,5,8
Planning and delivery of bitesize teaching for practice educators at ward level on subjects related to IPC (MRSA, CPE etc)	IPC team	Start Summer 23	Not commenced yet	No	1, 4, 5
Review of mandatory IPC education level 1 & 2	IPC Educator	Commenced 22/23	Underway and review awaiting before planning go live	No	1, 3, 4, 5

Programme of work: Ongoing

Programme of ongoing Work	Lead	Time frame	Progress to date	Action required	Hygiene code
IPC continuous Quality Improvement Programme- Implementation of IPC link nurse programme to support a hand hygiene and care bundle quality improvement programme with action plans driving improvement	IPC Team	On-going	Undertaken quarterly	No	1, 6, 9, 10
Audits- conduct regular audits with the facilities and clinical users to assess the environment and standard of cleaning & be involved with the PLACE process	IPC Team/Facilities	Ongoing	Undertaken quarterly	Yes	1, 2
Audits- carry out IPC best practice audits which include environmental elements within inpatient wards	IPC Team/Ward teams	Ongoing	Annually	Yes	1, 2, 4, 7, 9, 10
Audit- the team/IPC Links will audit compliance against policies in place across the trust should be monitored through audit. Examples of this include the isolation audit.	IPC team	Completed as part of IPC Link audit days	Undertaken at least annually	No	1, 7
Training- The IPC team will monitor and feedback training compliance	IPC Team	On-going	Feedback monthly at IPCC	No	6

with level 1 & 2 training					
Information dissemination- The team will update/create patient/staff infection leaflets pertinent to infection prevention control	IPC team	On-going	Updated bi-annually	Yes- ensure up to date	3
Information dissemination- the team will review and update policy and guidelines to ensure they reflect new evidence and best practice	IPC team	On-going	Updated as required	Yes- ensure up to date	1, 5, 6, 9
Surveillance- The team will continue to report and collect information on mandatory surveillance categories required by PHE. Where the infections are healthcare associated a root cause analysis +/- RCA review meeting will take place.	IPC Team	On-going	Updated in and submitted to PHE **Thresholds for 22/23:** C.diff <7 E.coli <8 Pseudomonas aeruginosa <8 Klebsiella sp <11	No	1, 5, 9
Work with the EPR teams to ensure the successful development and rollout of EPIC and RL solutions	IPC team/ EPR	Ongoing	Regular twice monthly meeting	No- ongoing	1, 2, 4, 9
Water & ventilation oversight- the team will ensure that the Space & Place Team co-ordinate the testing and management of	IPC team	On-going	Monthly monitoring meeting and quarterly water safety group	No	1, 8, 9

these environments through engagement and support at the Water & Ventilation Safety Groups.					
Divisional IPC support- the team will provide infection control support to the divisions at divisional infection control meeting and on a day to day basis. In order to facilitate this the team will each lead on certain divisions.	IPC Team	On-going.	Monthly meetings	No	1
The team will continue to manage the fit testing service which sits within Core Clinical Services	IPC Team	On-going	Compliance reported to the IPCC.	No	10
Maintenance of hospital intranet- IPC webpages	IPC Team	Ongoing	Ongoing	No	4, 6, 9
Support Higher Education and external learning activities related to IPC	IPC Team	Ongoing	Ongoing	No	1, 4, 9

Attachment T

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6th July 2023

Safeguarding Children Annual Report 2022-2023 **Submitted by:** Michelle Nightingale, Nurse Consultant Safeguarding/ Named Nurse	**Paper No: Attachment T** ☐ For information and noting

Purpose of report
To present an annual review of the safeguarding arrangements and activities during 2022-23.

Summary of report
The purpose of this report is to provide assurance to the Board that the safeguarding arrangements to protect our patients and staff, are safe, robust and fit for purpose.

During 2022/23, the Safeguarding Service has continued to evolve and develop to meet the increasing needs of the population it serves.

The remit has been to develop a four-year Safeguarding Strategy, which responds to both the local and national agendas, identifying gaps, challenges, best practice and raising the profile of safeguarding across the Trust. The draft Strategy will be completed following the recommendations from the Independent Safeguarding Review by the Ineqe Safeguarding Group

Independent Safeguarding Review
In Q3/4 (2022/23) the Independent Safeguarding Review commenced. The Ineqe Safeguarding Group was commissioned to review the current arrangements, making recommendations to ensure safe and responsive systems and processes are robust, but are also embedded in practice across all areas of the organisation.

The Report will be shared with the Trust in late September 2023, following the completion of extensive focus groups, individual interviews and a 360º tabletop exercise.

Summary of Achievements
- Launched the new Safeguarding Training Programme in April 2022.
- Launched new Safeguarding Children Policy
- Recruited 72 Safeguarding Champions from across the Trust
- Extensive programme of activities, as part of the corporate strategy in conjunction with Hestia's Everyone's Business Programme to respond to Domestic Abuse (DA).
- Launched the delivery of standardised Safeguarding Supervision to staff across the Trust

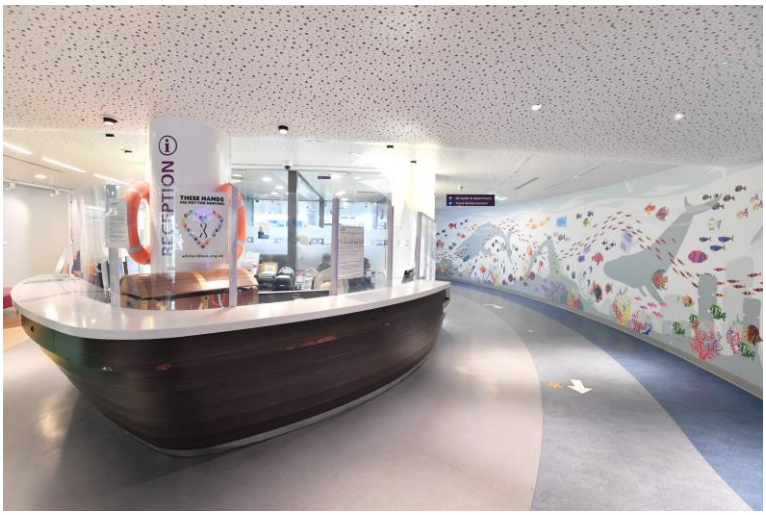
Summary of Key Priorities for 2023-24
1. **Further progression of the training and development programme**

2. **Specific Projects including**
    a. Gender Identity Development Service (GIDS) Safeguarding planning and implementation
    b. Link Health Visitor & Midwife Pathway to support healthy child pathway in ICUs
    c. Review of Adult (over 18yrs) commissioned services in GOSH in line with the Care Act and Working together to Safeguard Children
    d. Completion of the Suspected Abuse Protocol led by the Named Doctor for Safeguarding.
    e. Inclusion of future metrics as part of Safety Surveillance and Health Inequalities

Patient Safety Implications
MCA/DoLs applications – Mitigations in place to reduce the risks of delayed applications to the Court of Protection, which could result in a breach of the court leading to a fine to the organisations.

Attachment T

Equality impact implications Please see attached Briefing (saved under additional reading on Diligent) sent to all clinical teams during Q4 2022-23, to ensure they understand their duty of care in assessing capacity to consent.
Financial implications Potential for fine from the Court of Protection.
Strategic Risk BAF Risk 12: Inconsistent delivery of safe services
Action required from the meeting For information and noting
Consultation carried out with individuals/ groups/ committees Consultation with relevant teams
Who is responsible for implementing the proposals / project and anticipated timescales? Named Nurse
Who is accountable for the implementation of the proposal / project? Chief Nurse



ANNUAL REPORT 2022 - 2023

SAFEGUARDING CHILDREN, YOUNG PEOPLE & ADULTS

Michelle Nightingale
Nurse Consultant
Safeguarding/Named Nurse

Contents

1. Introduction

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

'…Safeguarding is firmly embedded within the core duties and statutory responsibilities of all organisations across the health system.

Fundamentally, it remains the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently, and conscientiously applied; the wellbeing of those children and adults is at the heart of what we do……Organisations need to co-operate and work together within new demographic footprints to seek common solutions to the changing context of safeguarding and developing structural landscape needed to deliver the NHS Long Term Plan.' (Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework. NHS England V3, 21 July 2022)

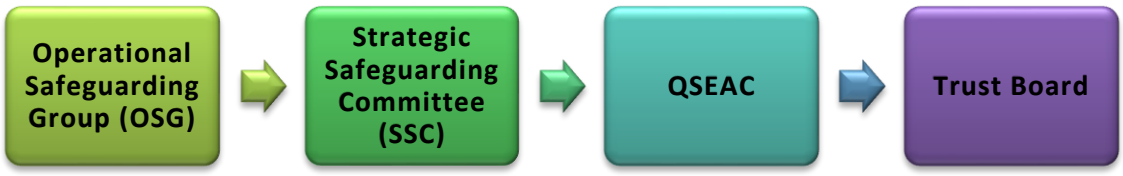
Governance Structure

The Trust's safeguarding governance structure is in line with NHS England's Safeguarding Accountability & Assurance Framework (2022). At Board level, the Chief Nurse is the Executive Lead for Safeguarding Children, Adults at Risk and Prevent, and the Deputy Medical Director holds the Safeguarding Portfolio; there is a Non-Executive Director with the safeguarding portfolio. The Chief Nurse is a standing member of the Camden Safeguarding Adults Board (SAB) and Camden's Safeguarding Children's Partnership Executive Board (LSCP).

The Board reviews safeguarding arrangements via quarterly reports to the Quality, Safety and Experience Assurance Committee (QSEAC); the Trust Board will receive a Safeguarding Annual Report at the end of Quarter 4.

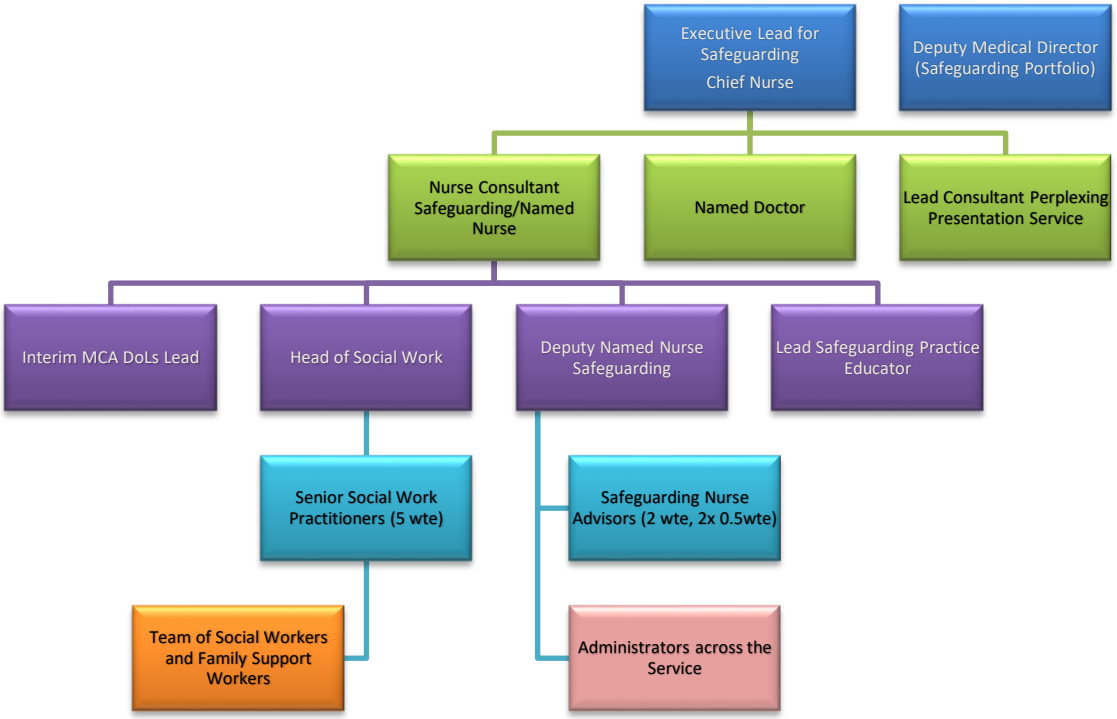
The Chief Nurse receives assurance quarterly via the Strategic Safeguarding Committee, which is also attended by the Designated Professionals from North Central London Integrated Care Board (ICB). The Reports are also submitted to the Care Quality Review Group (CQRG), for overall assurance to NHS England.

The Named Professionals lead the quarterly multi-disciplinary Operational Safeguarding Group (OSG), which reports to the Strategic Safeguarding Committee.



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

2. Safeguarding Service Structure



During 2022/23, the Safeguarding Service has continued to evolve and develop to meet the increasing needs of the population it serves.

The remit has been to develop a four-year Safeguarding Strategy, which responds to both the local and national agendas, identifying gaps, challenges, best practice and raising the profile of safeguarding across the Trust. The draft Strategy will be completed following the recommendations from the Independent Safeguarding Review by the Ineqe Safeguarding Group (*see p15*).

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

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

External	Internal
▪ London Safeguarding Children Procedures Editorial Board ▪ NHS England & Improvement London Named Safeguarding Professionals Forum ▪ Camden Safeguarding Adults Board ▪ Camden Safeguarding Children Partnership and its subgroups	▪ Ethics Committee ▪ Nursing Board ▪ Mortality Review Group Meeting ▪ Records Management ▪ Risk & Quality Meetings ▪ Aggregated Analysis Group (risks, complaints, claims and safety) ▪ Reducing Restrictive Practice Working Party ▪ Break the Glass Working Group ▪ Intimate Images Working Group ▪ Missing Child ▪ Discharge Processes

3. Performance and achievements

During 2022/23:

- The Team attended 305 virtual external child protection related meetings to represent or support staff.
- Launched the new Safeguarding Children Policy
- Launched the new Safeguarding Training Programme in April 2022.
- Recruited **72** Safeguarding Champions from across the Trust
- As part of the corporate strategy in conjunction with Hestia's Everyone's Business Programme to respond to Domestic Abuse (DA), we have:
    - Recruited **23** DA Champions from across the Trust
    - Trained HR Business Partners in responding to DA amongst colleagues
    - Launched the 2nd GOSH participation in the United Nations' 16 Days of Activism in November 2022.
    - Created a Guidance to support staff to manage disclosures of DA.
    - Launched Blue Sky app onto all Trust phones and devices. Bright Sky app | Hestia
    - In Q2 of 2023/24 an Independent Domestic and Sexual Violence Advocate (IDSVA): through our partners at Camden's Safety Net will contribute to our on-going work by providing a day's support to staff, patients and their families.
- Contributing member of the Health Inequalities Committee
- Contributing member on GOSH's Digital Health Inequalities Working Group
- Trained Social Workers and Nurse Advisors in standardised Safeguarding Supervision for delivery across the Trust.
- Contributed to the AI Predictor Tool for Was Not Brought (WNB)
- Distributed the first Safeguarding Newsletter in Spring 2023
- Welcomed the first Chief Nurse Fellow to work with the Safeguarding Service.

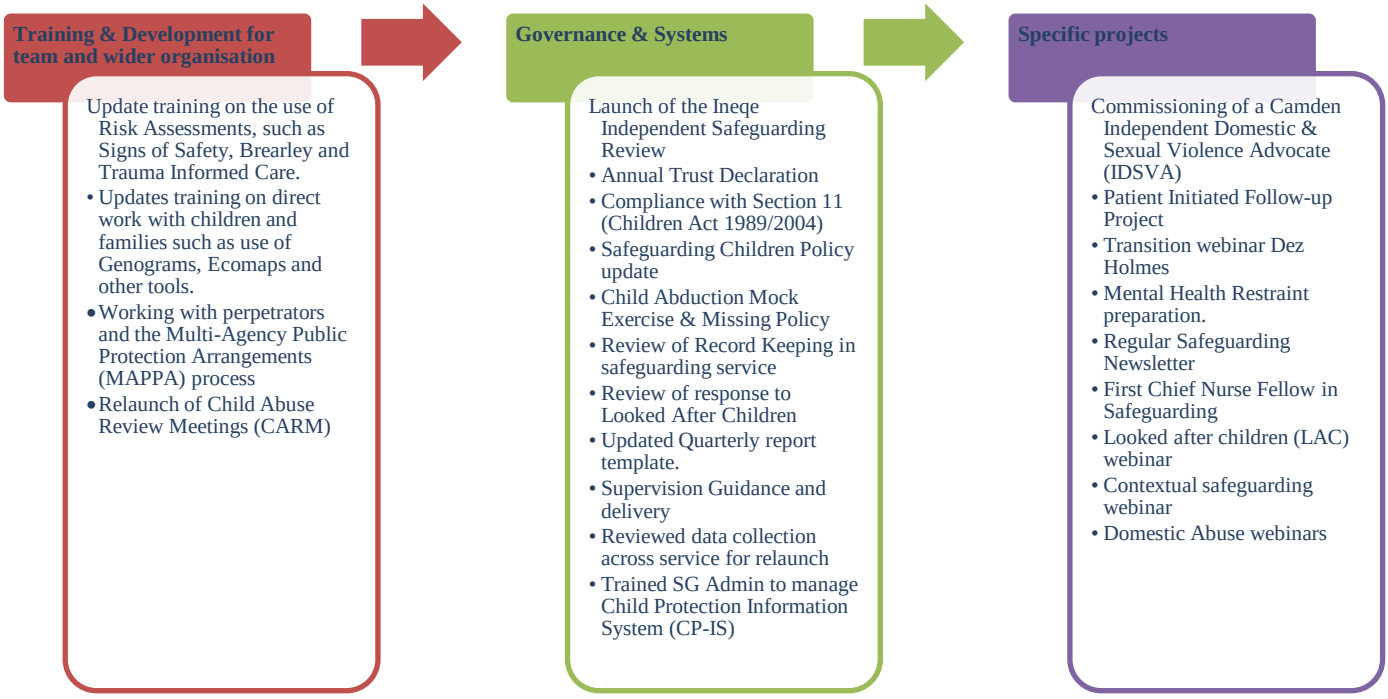
4. Service Delivery

The Royal College of Paediatric & Child Health reported in 2022 that *'…. the influence of poverty on children's health and wellbeing is undeniable. Children living in poverty are more likely to have poorer health outcomes including low birth weight, poor physical health, and mental health problems. The health impacts of growing up in poverty are significant and follow children across their life.*

The current cost of living crisis will only exacerbate this by pushing more families into poverty. It is essential that health inequalities driven by poverty are addressed to improve child health outcomes, as well as reduce costs to the NHS in the long term.' (RCPCH 2022)

This statement reflects the increasing complexities and challenges of GOSH patients and their families present with, within the context of managing a child or children with acute or chronic medical needs. In response the Service continues to meet or plan the draft Safeguarding Strategy Year 2 (2022/23) outcomes, including:

Year Two 2022/23



4.1. Partnership Working

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

Safeguarding Interventions

The Social Workers, Family Support Officers and Safeguarding Nurse/Professional Advisors are working cohesively under the one Safeguarding Service umbrella.

Challenges in Q4: for the Duty office referrals the challenge is that staff continue to have to make two referrals (one to social work and one to safeguarding) for the same child. Additionally, the team are unable to respond directly to the referral to request further information or liaise with the referrer. Plans are in place with the EPIC Optimisation Team to move to one referral for Q3 of 2023-2024. This will support the wider service in responding to the increase in referrals and resource capacity across the service.

Alongside the work moving toward a single referral, we have reviewed our data collection across the safeguarding and social work teams to bring this together as one service to prevent duplication and gather accurate and meaningful data. The aim is for this to be ready in line with the referral changes for Q3 2023-2024.

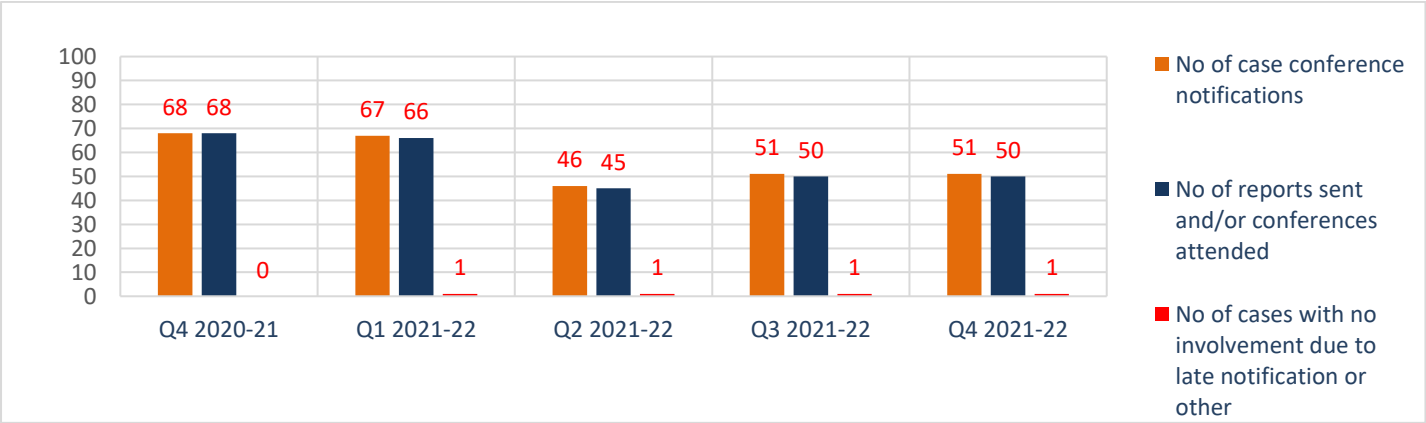
4.1. Children subject to a Child Protection Plan (CPP)

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

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

During Q2 2022-23, we launched the implementation of new FYI flags on the EPIC system to better collate the above data, as not all children referred to safeguarding for serious injuries are subject to a CPP or LAC. During 2023-24 we will develop an audit tool for these for regular review and update.

Figures below provide data of CP Conference notifications and attendance.

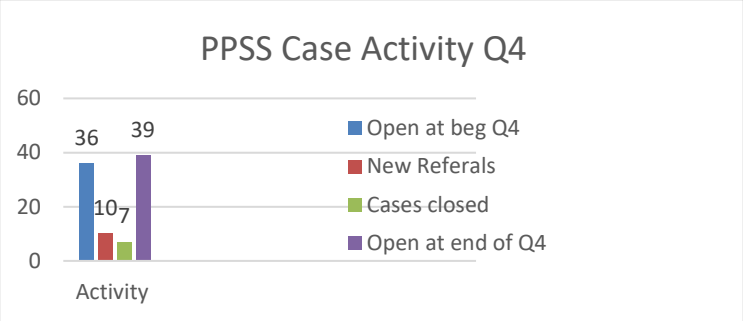


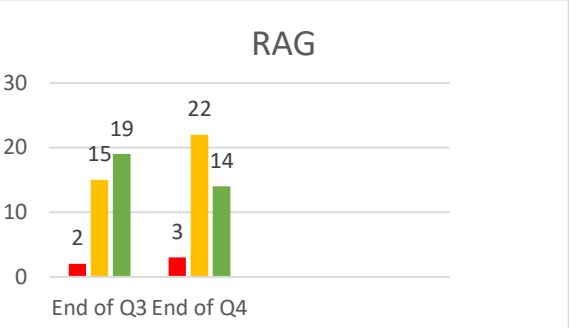
*Please note, where it states, *'no involvement'*, these are conferences where the Safeguarding Service has not been invited to the conference by the local authority or received the invitation after the conference has occurred. Nevertheless, information will still be prepared and shared post conference.

4.2 Perplexing Presentation Support Service (PPSS)

- Over the final quarter of 22-23 the referrals into the service remain consistent, **with 10 new cases in total**.
- Within quarter 4 the team have only been able to **close 7 cases** where clarity was gained and concerns were resolved, or the case was discharged, and information appropriately handed over to local health teams. This is a consistent reduction in cases being closed and reflects the nursing support for this service reducing.
- At the end of quarter 4 the service has **39 active cases** where clarity is required with regard to health. For a consecutive month this is the highest number of active cases the service has had open at one time and again reflects the lack of resource this service currently has to be able to track and review these cases.

- **Mitigations:** A Business Options paper has been submitted to support the continuation of this service, with a proposal for a dedicated team.





Cases are risk rated (RAG)

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

The Perplexing Presentation Support Service (PPSS) has enabled a tracking system of cases throughout the period of times when presentation remains unclear. When clarity has been obtained or the child discharged with information shared the case can be closed to the service. By holding a caseload where cases progress and contemporaneous records are kept on the child's record, we are able to effectively recall historic information if it should be required.

PPSS Case study

This was the case for one of our re-opened cases in Q4. It had previously been known to the Safeguarding Service prior to the PPSS launch and formed part of the initial case load in 2021.

Background:
Child known to GOSH cardiac team since birth due to requiring significant neonatal cardiac surgery.

Presenting concerns:
Initially raised maternal anxieties relating to feeding, health, and behaviour, all of which had not been observed by the clinical team. The clinical team were supported by PPSS to risk assess the case and to clarify what the child's needs were. This assessment could then be used to "de-medicalise" and to focus on her health, development and lived experience, to allow her to lead as "normal" a life as possible; whilst streamlining care and aiming to reassure the family. Maternal anxieties reduced as did medical-seeking behaviour, so case closed to PPSS, but continued to be seen clinically.

2nd Referral:
During Q4 the case was re-referred to PPSS by external health teams, due to increasing concerns. Professionals' meetings were held and an agreed health consensus formulated. Despite the complex medical history, the purpose of PPSS in this case was to get a clear consensus of what her needs and difficulties are and identify any discrepancies between what had been reported by parents, and objectively known/observed by professionals.

Outcome:
The collaborative working has prevented an unnecessary gastric procedure and has allowed this child to participate in schooling and activities in the same way that her peers do. The primary aim was to reduce parental anxieties to enable the child to positively progress her health and wellbeing. However, in this case this could not be achieved and following a professionals' meeting under FII guidance it was agreed this had met the threshold for significant harm and a referral was made to Children's Social Care.

Learning:
There were additional difficulties with internal teams not working collaborative to share factual clinical information, rather, there was an over reliance on parental reports of information.

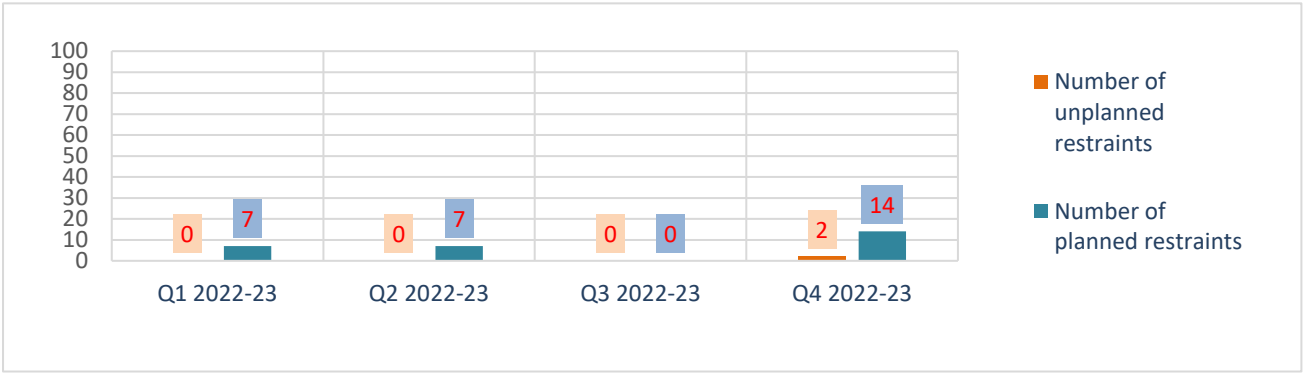
The oversight of PPSS provided a safety net to identify gaps in communication and to join this up between teams.

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

Joint working continues with PAMHS, within the Body, Bones and Mind Directorate. The Safeguarding Service attend MDT, multi-agency meetings, psycho-social meetings. In 2023, in response to identified complexity and caseloads in the Mildred Creek Unit, we introduced safeguarding supervision and have three clinical staff who volunteered to be Safeguarding Champions.

All reporting via Mental Health Services Data Set Restrictive Interventions Reporting continues as per requirements. The Trust follows the Therapeutic Holding and Restraint Policy (2020).

The figures below demonstrate episodes in the Mildred Creak Unit for adolescents.



5. Training

The new training programme has now been running for one year since April 2022. The Key Performance Indicator (KPI) minimum compliance for mandatory safeguarding training at all Levels is **90%.**

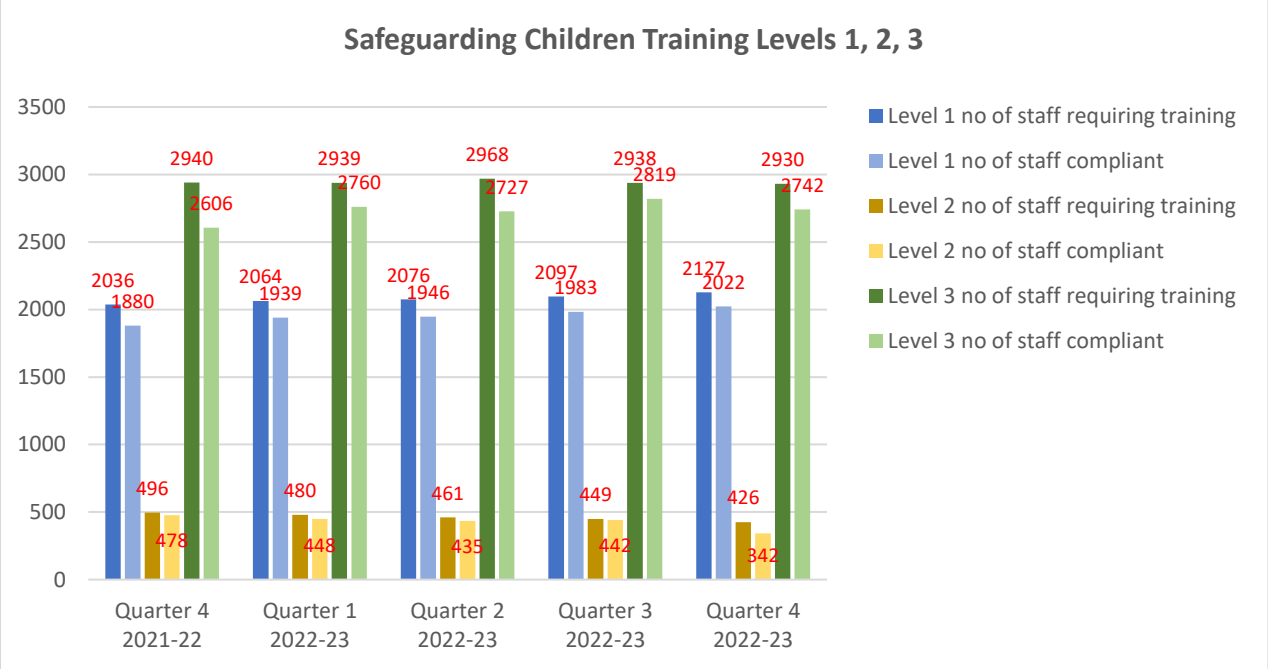
The Intercollegiate Document 2019[1] (ID) lists several competences at all levels. Each level has accompanying compliance 'hours' over the 3 years, so for example, staff competency at **Level 3** equates to a minimum of 12 – 16 hours of 50% e-learning and *'50% of indicative education, training and learning time will be of a participatory nature, interactive and involve the multi-professional team wherever possible[1].'*

Level 2 is a minimum of compliance hours of 4 hours over 3 years:

> In Q4, the option for e-learning refresher training for Level 2 staff was removed, and all level 2 staff must now attend a 3-hour session which is delivered either face to face or virtually.

Level 3 is a minimum attendance 6 hours face to face or virtual study day once every three years.

In addition, Level 3 staff need to attend 4 to 8 hours of blended learning over a three-year period. Blended learning opportunities offered through the DEN include live sessions of the Child Abuse Review Meetings, Safeguarding Champions training sessions, reflective learning records (which include safeguarding supervision) and Camden Safeguarding Children Partnership training.

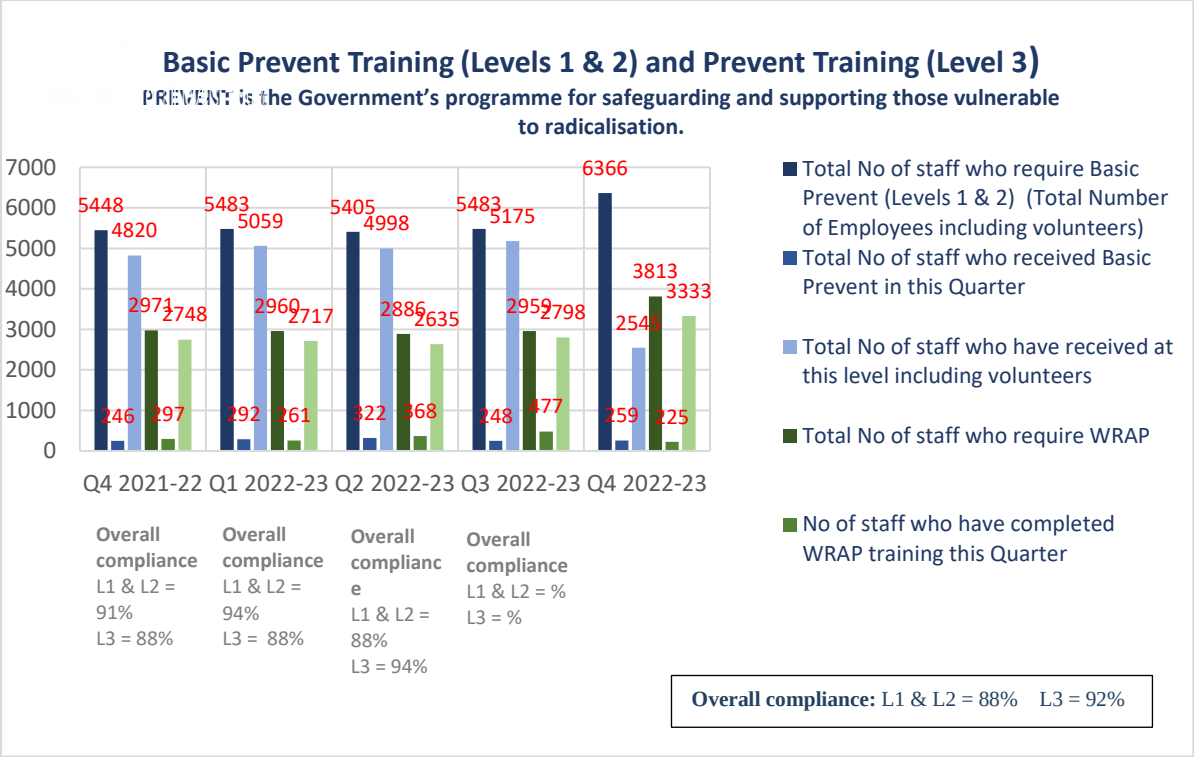


Prevent training

The Trust are required to report cases on a quarterly basis to NHS Digital for both Female Genital Mutilation (FGM) and PREVENT

FGM training forms part of Levels 1, 2 and 3 Safeguarding mandatory training programmes. Further planning is in place to work with colleagues in NCL for GOSH to deliver a specialist webinar and additional training on FGM.

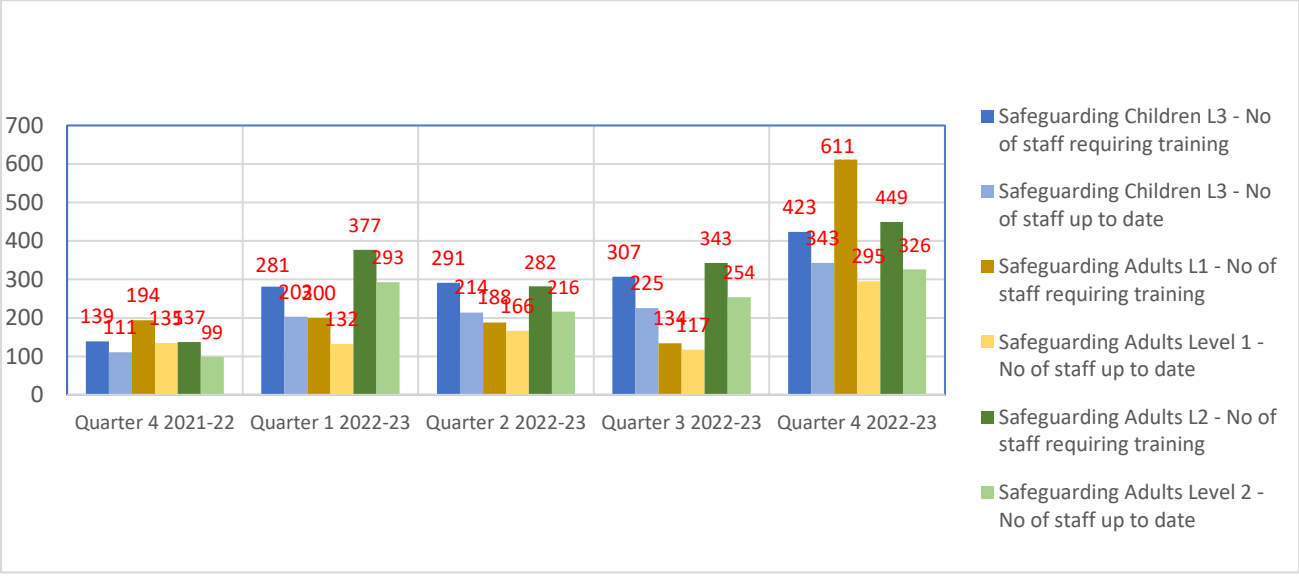
There have been **nil returns** in both categories in 2022-23.



Honorary Contracts

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

HR and Learning & Development (L&D) continue to review the process of monitoring and cleansing the data to identify those who are non-compliant. The Honorary Contract policy is under review by HR.



Staff holding honorary contracts are currently at 81% compliance for Level 3 Safeguarding Children training. For Safeguarding Adults Level 1 there is 94% compliance, and Level 2 95% compliance.

6. Safeguarding Supervision

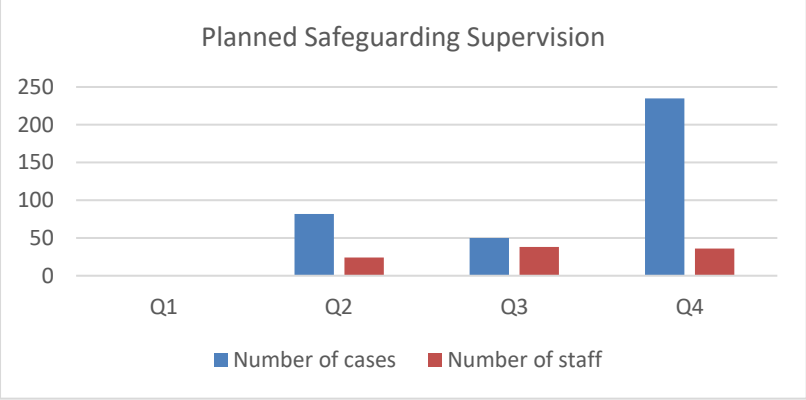
The CQC's Key Lines of Enquiry (KLOE) under **Effective** asks **in E3: How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?**

Compliance to supervision states in E3.4 *'What are the arrangements for supporting and managing staff to deliver effective care and treatment? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation).'*

So that safeguarding supervision is made available to all staff and to ensure compliance with the KLOE (outlined above), we have developed safeguarding supervision guidance. Initially safeguarding supervision will be aimed specifically at staff who are band 7 and above, although all patient-facing staff are welcome to attend. Group supervision will be offered to clinical teams, wards, areas and it is likely to be multi-disciplinary. Different specialities can also request group supervision (for example AHPs, SLT, safeguarding champions). Ad hoc and one to one safeguarding supervision is also offered.

What we have done so far

- Between January and March 2023, the safeguarding service contacted all heads of directorates, heads of nursing, ward managers, matrons, practice educators and safeguarding champions to promote the new safeguarding supervision offer. This was followed up by individual members of the Safeguarding Service who have been allocated to facilitate supervision across the Trust.
- The supervision offer is aimed at patient facing staff Band 7 and above although there is flexibility and capacity allowing supervision is offered to a wider group. Feedback from some teams is that supervision with a multi-disciplinary group comprising consultants, therapists, and nursing staff can be the most enriching.
- Before supervision takes place, staff should review the safeguarding supervision agreement and a filmed presentation about safeguarding supervision on LMS GOLD. So far 39 staff have completed this preparatory stage, and those who haven't are encouraged to do so following their supervision session.
- Facilitators use recognised supervision models in their sessions – for example the Brearley assessment tool; the Gibbs Reflective Model and the Signs of Safety approach.
- EPIC records how many staff receive safeguarding supervision and how many patients are discussed. This reporting function was only made available from February. Two sessions were reported on EPIC in February and March reaching a total of 29 staff. Supervision which does not address specific patients is recorded on a separate spreadsheet.



The data covers the number of planned supervision sessions which include the new safeguarding supervision offer; sessions delivered by the Named professionals; cases discussed in the Perplexing Presentation Service and the Complex Gastro.

7. Serious Incidents & Patient Safety

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

GOSH with its tertiary nature means that any registered child may be subject to a child abuse or neglect, resulting in serious harm or death. In 2018, Under *Working Together to Safeguard Children* 2018, Serious Case Reviews (SCRs) have been replaced by Child Safeguarding Practice Reviews. The guidance and criteria for carrying out reviews has also changed. Some cases were commenced under the previous version of SCRs prior to changes, so have been concluded under that model.

When a child dies or is seriously harmed in circumstances where abuse or neglect are known or suspected (i.e. is a serious child safeguarding case), Local Safeguarding Children Partnerships/Boards are required to consider if a Child Safeguarding Practice Review (CSPR) is appropriate to consider the involvement of organisations and professionals with the child and family. In order to do this, a rapid review must be carried out within 15 days of the notification of the serious child safeguarding case to the National Child Safeguarding Practice Review Panel

GOSH may also be involved in local Learning Reviews, which there is multi-agency learning, but has not met the threshold for a CSPR. Learning from recent SCRs/Adult Reviews or CSPRs where GOSH has been involved was shared at a Trust-wide lunchtime seminar.

Serious Case Reviews (SCRs):	**2 cases open:** These cases are yet to be published. The delay continues due to on-going police investigations or criminal proceedings.
Child Safeguarding Practice Reviews (CSPRs):	○ 2 cases are awaiting author sign-off and publication ○ 2 cases have been published. Recommendations and learning will be disseminated accordingly.
Local Learning Reviews:	2 open cases ○ 1 case has been concluded but the report was never published. The confidential report has been shared with GOSH for the purposes of learning. ○ Actions from second case to be reviewed for any updates.
Adult Learning Review:	1 completed adult learning review, which has been published.

Figure show common themes and learning from those cases published recently

7.2. People in a Position of Trust

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

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

7.2.1 Internal Allegations against Staff or Volunteers (ASV).

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

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

Total cases for 2022/23 to end of Q4 = 7

7.2.2. The Disclosure and Barring Service (DBS)

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

Reviews of Positive Declarations by Nurse Consultant for Safeguarding in 2022/23: **Total = 9**

7.2.3. Persons Who Pose a Risk

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

This includes participation in meetings of cases of those who pose a risk, safeguarding and safe and respectful behaviour.

7.3 Safeguarding Patient Safety & Complaints reporting 2022 -23

7.3.1 Datix safeguarding incident reports

Total No.	Minor Harm	No Harm
59	6	53

7.3.2 Complaints reports involving safeguarding

Total No.	Lead Investigator	Contributing
6	2	4

8. Mental Capacity Act & Deprivation of Liberty Safeguards (MCA/DoLs)

Planning NHS Readiness for the Liberty Protection Safeguards (LPS):

- The Trust now has 3 members of staff with the Best Interest Assessor qualification.

- LPS will not now be implemented as expected in April 2024 – there is no longer a date for this. Updates are expected after the next parliamentary vote.

- GOSH has been following the NHSEI readiness crib sheet released in December 2021. This will continue. It highlights a checklist regarding the:
    - LPS workforce
    - LPS data
    - Delayed / deferred DoLs

Joint working with Safeguarding, Learning Disability and Legal Teams

- The numbers of DoLS applications made during 2022 -23 remains steady and reflects the constant flow of 16 – 17-year-olds into the Trust requiring assessments.

- There has been increased training and communications to clinical teams, to guide and support in completing the standard forms and referrals for MCA/DoLs on Epic. This also includes the use of alert flags and working with families and carers to understand the care and preferred needs of the young people, to ensure it is documented on Epic.

- A Standard Operating Procedure (SOP) is being drafted to support staff further in identifying young people pre-admission, who may require an assessment, to ensure appropriate planning for admission such as information leaflet to parents prior to the child turning 16 years old, about MCA/DoLs, placing an alert flag on Epic, commencing the assessment process prior to admission and ensuring the multi-disciplinary teams including theatres are made aware of the young person's needs and additional needs where appropriate.

- Safeguarding, Learning Disability and the Legal Team also continue to provide training and communications to stakeholders to enable applications to be made prior to admission, where we are aware.

9. Audits

Planned Audits

During Q1 2023-24 the following will be audited:

1. **Mental Capacity Act & Deprivation of Liberty Safeguards (MCA/DoLs)**
    - Aim -to understand whether key principles of the Mental Capacity Act are demonstrated when patients 16+have not consented for themselves
    - Inclusions – patients who have had had operating procedures and have not consented for themselves. *Awaiting outcome*

2. **Chaperone Pilot in Outpatients**
    - Outcomes of the Pilot which commenced in April 2022
    - Review of current position and ongoing work

3. **NICE Guidelines on Looked After Children (LAC)**
    - To review if the Trust are meeting the needs of these vulnerable children.
    - Preliminary data from this audit has been collected in Q4.
    - Initial findings indicate a higher rate of WNB for LAC. Of these 5 key areas have been highlighted where the WNB is occurring on >20% of OPA.
    - Further work is planned to carry out a review of a random sample to interrogate for further information.
    - The aim of the work is to identify areas of development to address health inequalities within this patient group.

4. **Secure Address on Epic**
    - This is an annual audit to ensure effectiveness.

5. **Safeguarding Concerns Flags on Epic**
    - A review will be completed to ensure the flags can be reviewed and revised as information changes to reflect the child's current status or circumstances.

External Audits

In Q1 the Safeguarding Team were asked to participate in the Camden LSCP Multi-agency audit *on 'Safeguarding children and young people with disabilities and with an Education Health Care Plan (EHCP)'.* Five cases were known to GOSH and information was returned as per our involvement in their care.

Representative from the Safeguarding Team was asked to attend the moderation meetings with Camden for two cases in which we had considerable involvement. Following completion of the series of case meetings, Camden will be producing a full report analysing key messages, actions to be undertaken and outline future plans to develop practice. We will await Camden's report and take appropriate action as per their response.

Independent Safeguarding Review

In Q3/4 (2022/23) the Independent Safeguarding Review commenced. The Ineqe Safeguarding Group was commissioned to review the current arrangements, making recommendations to ensure safe and responsive systems and processes are robust, but are also embedded in practice across all areas of the organisation.

The Report will be shared with the Trust in late September 2023, following the completion of extensive focus groups, individual interviews and a 360º tabletop exercise.

10. Key Priorities 2023/24

Key Priorities

Overall, the Safeguarding Strategy will be informed by the recommendations from the Independent Safeguarding Review, but below are the aims for Year 3 2023/24

1. **Training & Development**
   - GOSH Safeguarding Conference
   - Makaton training for safeguarding service
   - Psycho-social review/PAMHS - Tier 1 or 2 adolescent depression training
   - Harmful Practices training
   - Increase in webinar programme
   - Annual training on direct work with children and families such as use of Genograms, Ecomaps and other tools
   - Perplexing Presentation Support Service - income generated referral mechanism
   - Business planning for Safeguarding module with link university

2. **Specific Projects**
   a. Link Health Visitor & Midwife Pathway for ICUs
   b. Gender Identity Development Service (GIDS)
   c. Pilot of Urology Adolescent Pre/post Assessment clinic with sexual health nurse and youth worker
   d. Involvement in the NCL Start Well Programme
   e. Review of Adult (over 18yrs) commissioned services in GOSH in line with the Care Act and Working together to Safeguard Children.
   f. Completion of the Suspected Abuse Protocol led by the Named Doctor for Safeguarding.

3. **Future Metrics as part of Safety Surveillance and Health Inequalities**
   a. Child Deaths – including quarterly data by age group and Rapid Review attendances
   b. Subject Access Requests (SARs)
   c. Legal requests
   d. Local Risk Management Systems (new SI reporting)

11. References

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

Quick Briefing on the Mental Capacity Act for 16- and 17-year-old children

Background

The Mental Capacity Act 2005 (MCA) (https://www.legislation.gov.uk/ukpga/2005/9/contents *and code of practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice)* provides the legal framework for acting and making decisions on behalf of individuals over the age of 16 who lack the mental capacity to make particular decisions for themselves because of a disturbance or impairment in the functioning of their mind or brain (whether temporary or permanent). It empowers young people to make decisions for themselves whenever possible and protects those who lack capacity by providing a legal framework that places individuals at the very heart of the decision-making process.

Why it Matters

It is important that professionals, families & carers understand there is a legal framework surrounding decision making for young people. The MCA is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. The aim is to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

Information

Five statutory principles that underpin the Act are as follows:

1. The Act's starting point is to assume that anyone aged 16 or over has capacity to make decisions for themselves.
2. All practicable steps should be taken to support the person to make their own decisions.
3. Unwise decisions do not mean the person lacks capacity.
4. Acts done on behalf of someone who lacks capacity must be in their best interests. When considering best interests, it is important to check the person's previously expressed wishes, feelings, beliefs and to consult with all interests' parties i.e., family/ carers.
5. Before an act is done or a decision is made, it must be considered whether it can be achieved in a way that is less restrictive of the person's rights or freedoms of action

What to do

If you work with young people 16 and over, you have a legal duty to have regard to the MCA Code of Practice. We must do all we can to maximise capacity for our young people to enable them to make decisions where possible.

If capacity is in doubt the 2-stage test of capacity must be carried out as set out by the MCA.

GOSH Staff <u>must</u> consider the following:

- Where care consequent to medical treatment amounts to a deprivation of liberty, an application must be made to the Court of Protection for authorisation as soon as possible. Failure to do so may amount to a breach of the young person's human rights and may lead to a legal claim and fines.
- Those cases will involve young people over the age of 16 where the following types of care may be required on admission:
  1. Checks more than hourly which he cannot object to.
  2. Someone always being in the room (including parents).
  3. Any level of restraint (including clinical holding).
  4. Sedation.
  5. Medication being forcibly given.
  6. Not being able to leave the ward without supervision.
  7. Locks on ward doors.
  8. Raised bedrails to prevent the young person from leaving the bed.
  9. A patient being placed in a chair and being unable to move from the chair without assistance.

Such cases should be raised with the safeguarding and/or legal team as soon as an ***admission is booked***.

For all cases where the admission is of a young person over the age of 16 with a learning disability please check if they have a ***reasonable adjustment flag*** on EPIC detailing necessary adjustments in care and contact the learning disability team as soon as possible.

Legal Team: gosh.solicitors@gosh.nhs.uk

Safeguarding: Safeguarding@gosh.nhs.uk

Learning Disability: Learning.Disability@gosh.nhs.uk

Briefings created by Michelle Nightingale, Nurse Consultant Safeguarding/Named Nurse 2023. With thanks to Kyle Squire, Trust Barrister and Kate Oulton, Nurse Consultant, Learning Disability.

Benchmarked and adapted from Lorraine Lawson and Penny Cumine 2021

Attachment U

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 6 July 2023	
Responsible Officer's Report **Submitted by: Dr Philip Cunnington, Associate Medical Director and Responsible Officer**	**Paper No: Attachment U** ☐ **For information and noting**

Purpose of report
To provide the Board with assurance that the statutory functions of the Designated Body and Responsible Officer are being appropriately discharged.

Summary of report
Should cover a short overview of areas for Board to focus on:

- Appraisal compliance is slightly down on last year
- Expect this to improve with greater use of REV6 (GMC) forms
- New appraisal system now in place, has taken a lot of resource to get to this stage but should be less burdensome for doctors to complete appraisal
- Expect compliance to exceed 90% for 2023/4

Patient Safety Implications
None

Equality impact implications
None

Financial implications
None

Strategic Risk
BAF Risk 12: Inconsistent delivery of safe services

Action required from the meeting
Annex A to be reviewed and signed off by Board for submitting to NHSE

Consultation carried out with individuals/ groups/ committees
Not Applicable

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

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

Annual Responsible Officer's Board Report

2023

1. Purpose of the Paper

The purpose of this paper is to inform Board members of Medical Appraisal and Revalidation arrangements within GOSH, to provide assurance that the Responsible Officer and the Designated Body are discharging their statutory responsibility, and to highlight current and future issues with action plans to mitigate potential risks.

This report describes the progress against last year's action plans, issues during the reporting year, and sets out actions on further developing the quality of appraisals and support.

2. Summary

All doctors are required to participate in an annual appraisal process, which reflects their complete scope of work. For those doctors in training posts this happens through the Annual Review of Competency Progression (ARCP) process. These annual processes help doctors satisfy the requirements for revalidation, which occurs every five years. For doctors arriving at our organisation who may be new to the National Health Service, this is a new process to get to grips with, as is the role of the GMC as the health regulator.

A Board Report Template has been circulated and this is in Annex A, which requires signing by the Chief Executive and returning to NHS England.

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) had 706 doctors connected to it as a Designated Body on 31st March 2023. This is an increase of 31 on the previous year. Annually we are still seeing a steady increase in connections of approximately 30 doctors each year – we believe this is due to two main reasons:

1) More doctors using honorary contract status when they leave/retire and, if they are not employed elsewhere, are entitled to connect to GOSH;
2) While we are not obliged to be the designated body for Bank doctors it was agreed at the Medical Appraisal and Revalidation Committee that where a doctor is providing regular service, and has done so within the preceding three months, they may connect to us and we will provide access to appraisal and revalidation support, and software.

This will increase again early 2024 when Physician Associates come under GMC Regulation.

2.1 Medical Appraisal

Category	2022/23 Appraisal Status	No.	%
1	Completed Appraisal	538	76.2%
2	Approved Incomplete or Missed Appraisal	92	13.0%
3	Unapproved Incomplete or Missed Appraisal	76	10.8%

Categories 1 and 2 give a compliance rate of 89.2% overall, a downturn on last year. However, of the 79 in category 3, 6 have since completed their appraisal –after the 31st March 2023 cut-off date.

There were 92 doctors classed as having an Approved Incomplete or Missed Appraisal (AOA Category 2) and the reasons are shown below:

- 78 joined the Trust from abroad and had been employed for less than 12 months on 31st March 2023 and were therefore not yet due an appraisal;
- 5 had an agreed postponement due to long term sick leave or compassionate leave;
- 7 had an agreed postponement due to maternity leave;
- 1 had an agreed postponement due to being on Sabbatical;
- 1 had an agreed postponement due to being under a local process.

Of the 76 listed in Category 3:

- 6 appraisals have since been completed with a meeting date after 31st March 2023;
- 16 doctors have since left the Trust;
- 54 remain overdue however due to the change in appraisal software provider have not been able to complete their appraisal. The majority should be completed by end July 2023. Following discussion with our GMC ELA, we will be using the REV6 process (request to remind the doctor to engage sufficiently in the processes related to revalidation) earlier than we have previously. Doctors who have not completed their overdue appraisals by the end of July 2023 will be considered by the Medical Appraisal and Revalidation Committee for referral to the GMC for this process.

NHS England released guidance for restarting appraisals advising that the focus for appraisal should be supportive and reflective conversations, with less emphasis on written documentation during 2020. The appraisal input form on the PReP (Premier IT e-Portfolio Revalidation Management Software) was amended to incorporate the new guidance including a “Health and Wellbeing” section. This more supportive approach has been well received according to feedback collected by the appraisal office.

Directorate Breakdown of Appraisals due 1 April 2022 – 31 March 2023

	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	IPC	Core Clinical Services	Sight & Sound	Corp	Total
Cat 1	**103**	**65**	**90**	**108**	**10**	**111**	**47**	**4**	**538**
Cat 2	**9**	**14**	**14**	**35**	**2**	**9**	**9**	**0**	**92**
Cat 3	**8**	**12**	**11**	**31**	**0**	**3**	**8**	**3**	**76**
Total	**120**	**91**	**115**	**174**	**12**	**123**	**64**	**7**	**706**
Compliance % (Cat 1&2)	**93.3%**	**86.8%**	**90.4%**	**82.2%**	**100%**	**97.6%**	**87.5%**	**57.1%**	**89.2%**

The appraisal rate for each directorate is monitored at Directorate Performance Reviews, and individual appraisal compliance is uploaded monthly to QlikView.

2.2 Appraisers

The Trust had 163 trained appraisers on 31st March 2023.

Using the new system now have the ability to limit allocation, review resource per specialty etc and these new reports will be used in the coming year to assess whether further appraisers are required.

An appraisers forum was held early in the year and a further forum is planned with the new system coming on line to support our appraisers in using the software.

Appraiser refresher training will also be arranged for later in the year, particularly with the changes in Good Medical Practice expected.

2.3 Revalidation

Between 1st April 2022 and 31st March 2023, 140 doctors for whom GOSH is the Designated Body were due to have Revalidation Recommendations made to the GMC, of which 81 were revalidated, 58 were deferred due to insufficient evidence and 1 was referred to the GMC for non-engagement. Of the 58 deferred, the reason for the majority of those deferrals was for Patient Feedback – this remains the biggest issue following COVID measures nationally.

5 of those deferred are “chain deferrals” and have been deferred more than once. Most of these are due to a lack of appraisal history so we have been supporting them with regular engagement for appraisals.

The one doctor who was referred to the GMC for non-engagement has now successfully completed their appraisal and revalidation.

2.4 Quality Assurance

On our old system, appraisers are scored by their appraisees, this is done anonymously at the end of their appraisal following acceptance of their Appraisal Output Form. To maintain anonymity a report was produced for the appraiser once they had completed a minimum of three appraisals. The report was attached to their portfolio for reflection in their own appraisal. The report covered nine different aspects of appraisal and also included areas for free typed comments.

Using the L2P system an email is sent to the appraisee at the end of their appraisal asking them to complete an Appraisal Feedback Questionnaire. Again admin can release those reports to the individual appraiser for inclusion in their own appraisal, but to maintain anonymity this will be done when a minimum of three appraisals have been completed.

2.5 Responding to Concerns and Remediation

In the past year there have been no completed Maintaining High Professional Standards (MHPS) investigation reports, and there are three ongoing MHPS investigations. In addition, one formal grievance procedure has been concluded.

In the past year we have had eight doctors either currently working, or who have worked at the Trust, either undergoing fitness to practise investigations by the General Medical Council or working in the Trust following the conclusion of an investigation.

Of those currently still working in the Trust:

- One has had their fitness to practise investigation completed and is working with undertakings on their practice with a workplace supervisor and is fully compliant with them.

- One has had their fitness to practise investigation completed and has received a warning regarding their conduct which will remain publicly available for two years.

- One is undergoing a fitness to practise investigation with regards to their professional conduct but has no restrictions on their clinical practice.

- One has had their fitness to practise investigation completed and has received a six-month suspension to their licence to practice.

- One has had their provisional investigation closed following a decision that no further investigation was warranted.

- The remaining three doctors no longer work in the Trust:

One doctor has had their formal hearing at the Medical Practitioner Tribunal Service (MPTS) concluded. This related to concerns raised whilst employed by the Trust. The tribunal decided that their fitness to practise was not impaired. The Tribunal determined to issue a warning.

One doctor has been subject to a fitness to practise investigation related to concerns when at another Trust. This is still on-going, but they have now left and are now employed at another Trust.

One doctor has been referred to the GMC following concerns regarding their clinical capability and has had their honorary contract terminated. We are contributing to the on-going investigation.

Designated Body Annual Board Report

Section 1 – General:

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Continue supporting the new Responsible Officer Comments: RO was fully trained and continues to attend update meetings with GMC. Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Recommendation from Miad EQA to consider part-time support for Revalidation and Appraisal Manager to ensure continuity of support for the RO and mitigate risk, and succession planning. Comments: No further action taken on this. Action for next year: Carry forward to this year.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue monitoring connections and maintaining accurate records. Comments: In addition to the leavers and starter reports from workforce, we regularly review bank doctors' connections/shifts to ensure they are appropriately connected. Action for next year: A review of honorary contract connections should be held this year to ensure that their contracts are still valid and that connection is still appropriate.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Monitor national changes with a view to updating the local policy as and when required. Comments: A review of the current policy has been submitted; however we further expect changes when the update to Good Medical Practice is published. In addition, Physician Associates are due to fall under GMC regulation early 2024 and will need including in the policy. Action for next year: Monitor national changes with a view to updating the local policy as and when required.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Submit action plan to Medical Appraisal and Revalidation Committee and work through the recommendations of the report. Comments: Some actions are covered within the appraisee and appraiser checklists on the new appraisal software, remaining actions to be reviewed and actioned this year Action for next year: Work through the remaining actions of the EQA

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To continue to support the ongoing work as needed. Comments: Short term placements are provided with access to conduct appraisals when required, irrespective of time within the Trust, and their appraisal due date is set to one year after their previous appraisal. Action for next year: Continue this support and professional development.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Look to extending the wellbeing training and continue supporting all doctors to hold reflective appraisals. Conclude tender process for electronic system. Comments: It was decided not to go to tender, and rather we had a preferred supplier for both appraisal and job planning software. The appraisal element is now live, and an appraisal checklist on the new system encourages doctors to cover their whole practice, consider complaints etc. A monthly report is also sent to Workforce detailing who is overdue appraisal, who is compliant etc – this is uploaded to QlikView to allow the departments to review their compliance rates. Action for next year: Monitor appraisals to ensure the new system is effective, and where necessary advise appraisees on how to further develop their appraisals.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue reducing the number that exceed their appraisal due date through education. Comments: Following advice from our GMC ELA we have been less averse to using the REV6 form after all attempts to engage a doctor in the appraisal process have failed. Where reasons for appraisals not being completed were agreed by the RO they have been recorded as Special Circumstances on our previous appraisal system and a deferral period agreed. Action for next year: This information needs to be transferred to our new appraisal system so we will be working on this over the next few months. Additionally, we will continue to use REV6 where a doctor fails to engage.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Monitor national changes and review the policy when appropriate. Comments: The Appraisal policy was amended recently and submitted, mainly consisting of changes regarding appraisal software supplier. Changes to Good Medical Practice and bringing Physician Associates under GMC regulation will be incorporated once further detail has been released. Action for next year: Update policy when details of changes have been announced.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Maintain number of appraisers depending on the number of appraisers who step down from the role, or who leave the Trust. Comments: A New Appraiser Training session was held in April 2022 providing the Trust with 16 new appraisers. Our new appraisal system provides reporting facilities to review number of appraisers, appraisers within a specialty, forecast by specialty, and we have now limited the number of appraisals one doctor can do to 8. This should prevent some doctors being overburdened and spread the appraisal load to those who often complete less. Authorisation is needed from the Appraisal Team where an appraiser wants to exceed that number. Action for next year: Monitor the effectiveness of the restrictions, and review whether we have sufficient trained appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: Increase number of appraisers receiving refresher and wellbeing training. Restart Appraiser Forum meetings for information sharing. Comments: Appraiser forums have restarted, and better attended than before the pandemic, possibly due to being online and easier to attend. Further forums are scheduled. Refresher training now that the new system is live is required – this will be looked into before the end of the year. Action for next year: Refresher training and New Appraiser training courses (if needed) to be booked.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Implement changes suggested by External Quality Assurance. Comments: Due to the work involved in procuring a new software system and having all relevant information up to date and transferred, the recommendations have been delayed. These are to be reviewed and/or completed this year. Quality assurance for the new software will need to be delayed until a sufficient settling in period has passed. Action for next year: Review EQA recommendations.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Great Ormond Street Hospital for Children NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	**706**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**538**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**168**
Total number of agreed exceptions	**92**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Continue bringing revalidations up to date. Comments: Monthly Medical Appraisal and Revalidation meetings are held to confirm those decisions due in the month(s) ahead and recommendations submitted by the RO after the meeting. Action for next year: Continue process

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Maintain current process. Comments: In advance of the revalidation recommendation, if deferral or non-engagement is likely the Medical Revalidation Manager advises the doctor in good time to allow corrective action to be taken or simply to make the doctor aware (if there is no time for correcting issue). At the time of the recommendation online the RO emails the doctor confirming the recommendation made, if positive the RO reflects on their evidence/commitment etc, and if deferral is required RO explains the reasons why and provides a timeline to complete any outstanding issues. Action for next year: Continue process.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Liaise with other centres regarding sharing best practice, and review cases for both consistency and timeliness. Comments: The RO has met with a number of centres to explore the structure and composition of decision-making groups dealing with conduct and capability issues. Whilst our group is similar, we have revealed a shortfall in training and capability within the directorates to embed a consistent approach for all staff. We have been unable to review cases across all the professions at GOSH to ensure consistency of threshold for interventions, and to review each case with respect to how policies were followed, especially with respect to timeliness.

Action for next year: Explore a joined-up approach between the regulatory role within the Medical Director's office and the operational side to identify and scope the need for training in dealing with concerns, and to review cases for both consistency and timeliness.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Develop in-house expertise for exploring concerns, review governance structure of Medical Employee Relations Meeting, Appraisal revalidation Committee and liaised with Quality and Safety so that data from incidents and outcomes is available.

Comments: There is still a gap in in-house capability for exploring new concerns which will remain a priority. There has been good collaboration with Quality and Safety to ensure data is shared either in response to a request from the RO, or if a pattern emerges within Quality and Safety that needs further exploration.

Action for next year: Continue to raise the need for developing in-house expertise for exploring concerns drawing both regulatory and operational sides into the planning and development. Review proposals to require peer review of notes and practice of all doctors once per revalidation cycle.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Review structure and composition of Medical Employee Relations Meeting and ensure Action Log of cases reviewed includes clear detail of policies followed and timelines.

Comments: An up-to-date action log is now maintained and has been extremely useful in tracking actions and clear application of the relevant policy. However, ensuring timeliness has proved difficult due to the nature of the work and the lack of supporting capability within the organisation and the need for reliance on external case investigators. Advice is sought from NHSR as required. Attendance has remained variable due to demands placed on others and reminders are sent to ensure appropriate representation. Variance of our policy compared with the National MHPS process requires review.

Action for next year: continue to ensure clear timelines and adherence to policy. Support deputy director of HR and OD in reviewing the policy which is overdue.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent

governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Action from last year: Continue to review the data to ensure transparency and fairness. Comments: Over the last year of those cases discussed at Medical Employee Relations meetings 16 were male and 12 were female, 24 concerned conduct/behaviour and 4 concerned clinical capability. Three cases have moved to formal MHPS investigations, the others have been managed informally. Action for next year: Continue to review the data.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: continue review of processes to ensure robust SOPs for on-boarding staff. Comments: The new SOP appears to be working well and information has been shared well between the IPP directorate and the RO. The MPIT form allows transfer and receipt of information, as do local RO networks and relationships with local private hospitals which have again proved useful when addressing mutual problems during the last year where significant concerns have been shared. Action for next year: continue review of processes and working collaboratively with other organisations.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Review sample of cases at Medical ER 'M and M' and continue to collect demographics. Comments: Unfortunately Medical ER 'M and M' review has not taken place. All concerns are discussed at Medical Employee Relations meeting to ensure consistency of decision making and we are aware of the demographic details of employees to monitor for bias.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action for next year: conduct Medical ER 'M and M' and continue to monitor the demographic data, although numbers are small.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue robust checks and sharing of information between Trusts.

Comments: No further update provided from HR

Action for next year: Continue as above and update Board 2024

Section 6 – Summary of comments, and overall conclusion

It has been another extremely busy year within the Appraisal and Revalidation department.

Much of the focus over the last year has been on procuring and implementing the new appraisal software system. Last minute issues surrounding contractual and IT issues severely hampered our ability to maintain our high compliance rates, and exposed us to potential organisational risk. This was mitigated by a huge amount of work by colleagues across the Trust. We are optimistic that the new system will help reflect the Medical Director's Office goal of continuing to make appraisal a process squarely focussed on individual development and wellbeing.

We are looking to be involved in developing appraisals for those in leadership positions, providing expert training from the Faculty of Medical Leadership and Management. This should ensure that we recognise the development needs of those in leadership roles and that it is reflected/recognised within their development plans.

Over the coming year we will be reviewing the impact of the new system and seeking feedback from all stakeholders. The results will be included in the report next year along with any action plan if required.

Section 7 – Statement of Compliance:

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[Chief executive]

Official name of designated body: Great Ormond Street Hospital for Children NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Attachment V

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6th July 2023

Annual Report of Sustainability at GOSH and Climate & Health Emergency **Submitted by:** Jason Dawson – Interim Director of Space and Place	**Paper No: Attachment V** ☐ **For information and noting**

Purpose of report
This annual report has been produced to provide an update on Sustainability at GOSH and the progress with the Climate & Health Emergency (CHE).

Summary of report
Great Ormond Street Children's Hospital (GOSH) declared a Climate and Health Emergency in March 2021. The World Health Organisation (WHO) identifies Climate Change as 'the single biggest health threat facing humanity' and notes that 'health professionals worldwide are already responding to the health harms caused by this unfolding crisis'.

As a leading global healthcare provider, GOSH's own targets are more ambitious than those for the NHS as whole. **The trust aims to be net zero for the carbon emissions linked to operations it controls by 2030 and for all emissions by 2040**.

The Annual Report provides an update on the following: -

- Progress made to date
- Carbon Baselining and KPI's
- Sustainability Programmes of Work including Green Champions
- Gosh Energy Usage and Carbon Emissions
- Approach to decarbonisation of the GOSH Estate including roadmap to 2030
- Programme governance and resources

Patient Safety Implications
None

Equality impact implications
None

Financial implications
The financial implications to implement planned energy efficiency and decarbonisation of the GOSH estate will be considered within separate business cases

Strategic Risk
BAF Risk 10: Climate Emergency

Action required from the meeting
The Trust Board are requested to: -

- Note the progress that has been made in relation to the Climate Health Emergency and the next steps as outlined above.
- Note the options for decarbonisation of the GOSH estate and expect a business case to be presented that will fully outline resource requirements

Attachment V

Consultation carried out with individuals/ groups/ committees The contents of this annual report have been developed by the Sustainability Programme Board and previously shared with the Finance and Investment Committee
Who is responsible for implementing the proposals / project and anticipated timescales? Associate Director of Estates
Who is accountable for the implementation of the proposal / project? Interim Director of Space and Place

GOSH Climate and Health Emergency declaration
Protecting our planet for our patients

Annual Report to the Board of Directors

July 2023

Sustainability at GOSH and Climate & Health Emergency

1 Purpose of Paper

Great Ormond Street Children's Hospital (GOSH) declared a Climate and Health Emergency in March 2021. The trust aims to be net zero for the carbon emissions linked to operations it controls by 2030 and for all emissions by 2040.

This annual report has been produced to provide an update on Sustainability at GOSH and the progress with the Climate & Health Emergency (CHE).

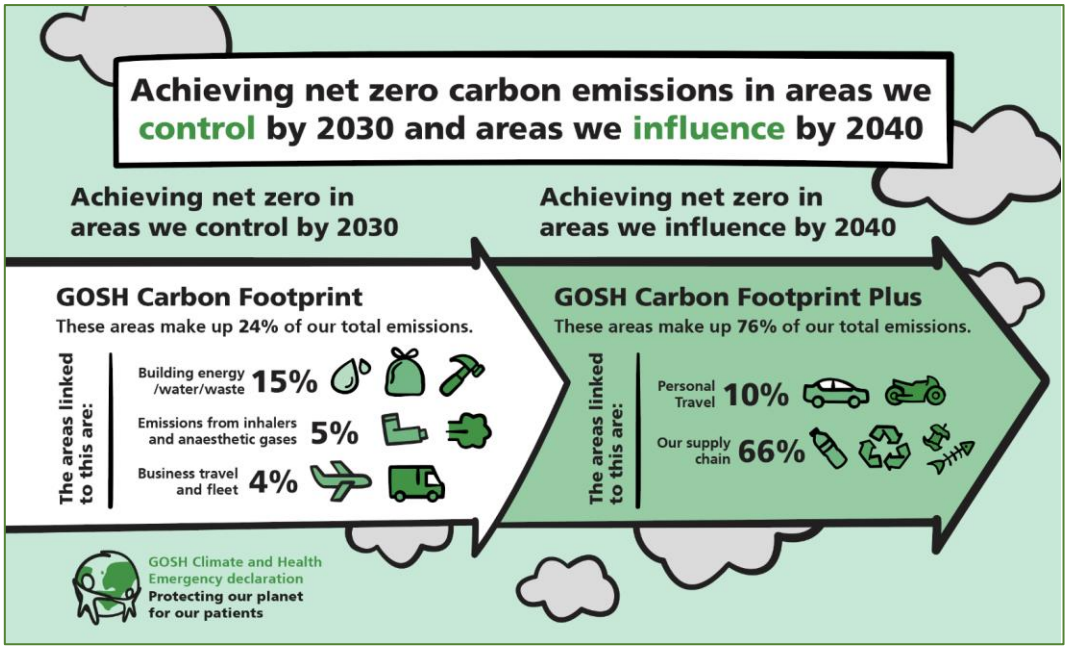
2 Climate Health Emergency

Great Ormond Street Children's Hospital (GOSH) declared a Climate and Health Emergency in March 2021. The World Health Organisation (WHO) identifies Climate Change as 'the single biggest health threat facing humanity' and notes that 'health professionals worldwide are already responding to the health harms caused by this unfolding crisis'[1].

The UK has set a legally binding target under the Climate Change Act 2008 to reduce its emissions to Net Zero by 2050 and the NHS is committed to achieving net zero emissions for its carbon footprint by 2040 and for all emissions (carbon footprint plus) by 2045.

As a leading global healthcare provider, GOSH's own targets are more ambitious than those for the NHS as whole. **The trust aims to be net zero for the carbon emissions linked to operations it controls by 2030 and for all emissions by 2040**.

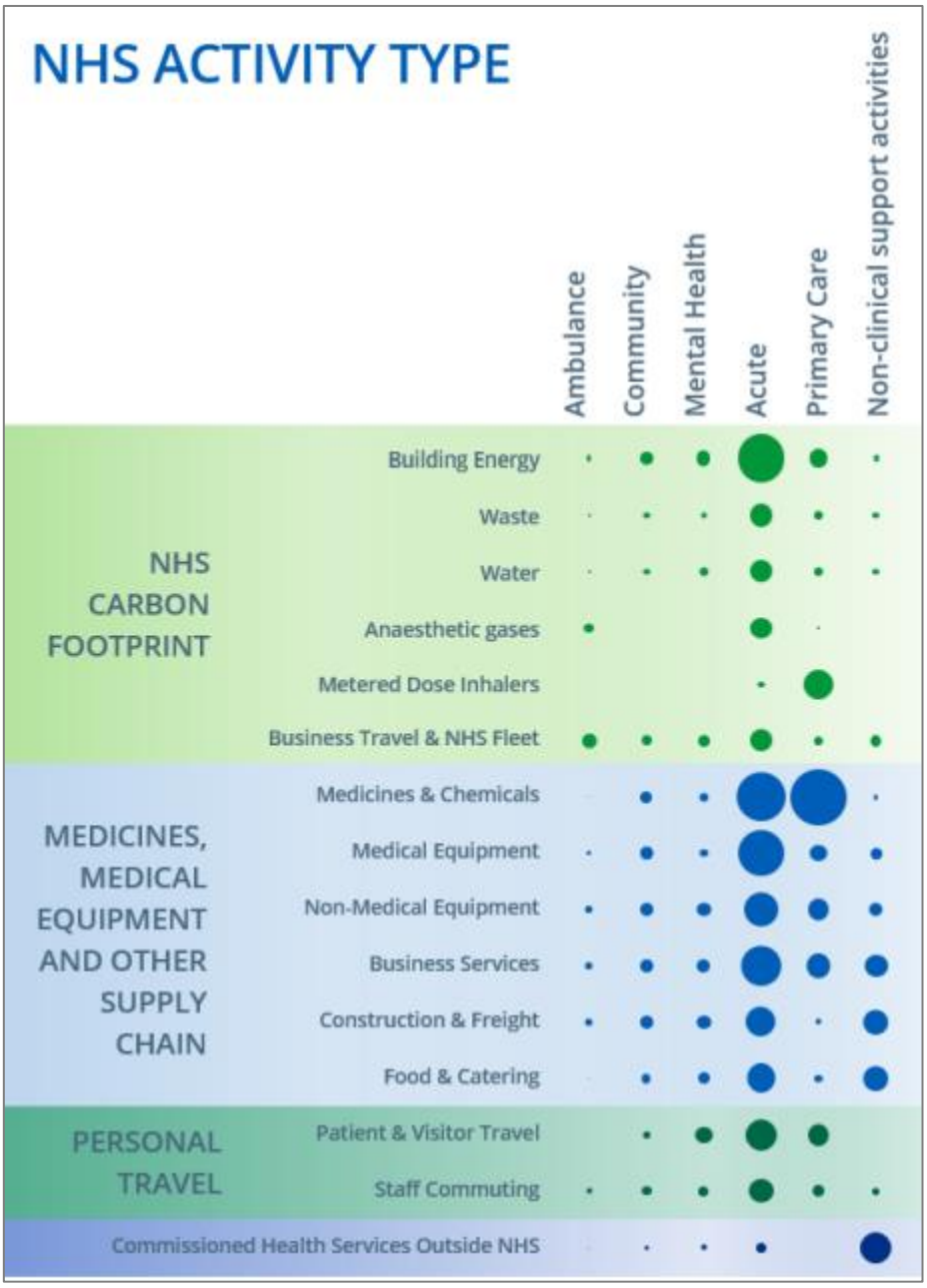
Figure 1- Climate Health Emergency



[1] https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health

Around 4% of national carbon emissions are linked to NHS operations[2] and within acute hospitals the emissions associated with energy use for heating, cooling and power are the largest source of emissions within the NHS Carbon Footprint and are one of the priority areas that must be addressed if GOSH's decarbonisation commitments are to be met (see Figure 2).

Figure 2 - Relative contribution of different activities / sources to the NHS Carbon Footprint and Footprint Plus



[2] Delivering a 'Net Zero' National Health Service – *NHS England – July 2022.*

3 Summary of Progress

There has been significant progress since our declaration of a Climate Health Emergency summarised as follows: -

3.1 CO2 baselining

Work was completed in 2022 to establish a baseline carbon measure for the hospital site. Measured against the 2030 target GOSH's tCO2 equivalent baseline for the year 2020/21 is **16,108 tCO2e**.

3.2 Green Champions and Sustainability Programme of Works (POWs)

Ten sustainability Programmes of Work have been identified by Green Champions and they are currently delivering over 40 sustainability projects

Examples include: -

- an EPIC build that incorporates postcode specific air quality data and accompanying educational resources into the patient record (Digital Transformation);
- Establishing a medicines sustainability group that has taken a lead role across NCL on tackling medicines waste.
    - The group have created and chair an official sustainability group linked to the Medicines Optimisation Board and have conducted an innovative (& replicable) internal carbon foot printing exercise around paracetamol use.
- The GLA Sustainable Education group is building an exciting programme of staff education linked to all ten Programme areas on the GOSH DEN,
- the Food and Nutrition group has reduced formula milk waste significantly and is currently conducting carbon baselining on all non-patient food ahead of implementing a series of changes.

3.3 Review of GOSH Energy Use and Pathway to Net Zero by 2030

A costed pathway to Net Zero by 2030 has been established clearly breaking down the 'Deep Decarbonisation' journey we'll take to meet our target for emissions sources mainly linked to estate energy use.

Exciting work is also underway to address emissions sources related to our 2040 target, with a supplier engagement framework being devised to deliver to our partners.

3.4 Addressing environmental determinants of health

Addressing environmental determinants of health that link to the Climate Emergency is also progressing well, with the first phase of the GOSHCC funded 'healthy hospital street transformation' due for completion in July. This will result in a choice of detailed/costed concept designs for the transformation of GOS that will be used as a funding tool to progress this exciting work.

4 CO2 equivalent baseline and KPIs

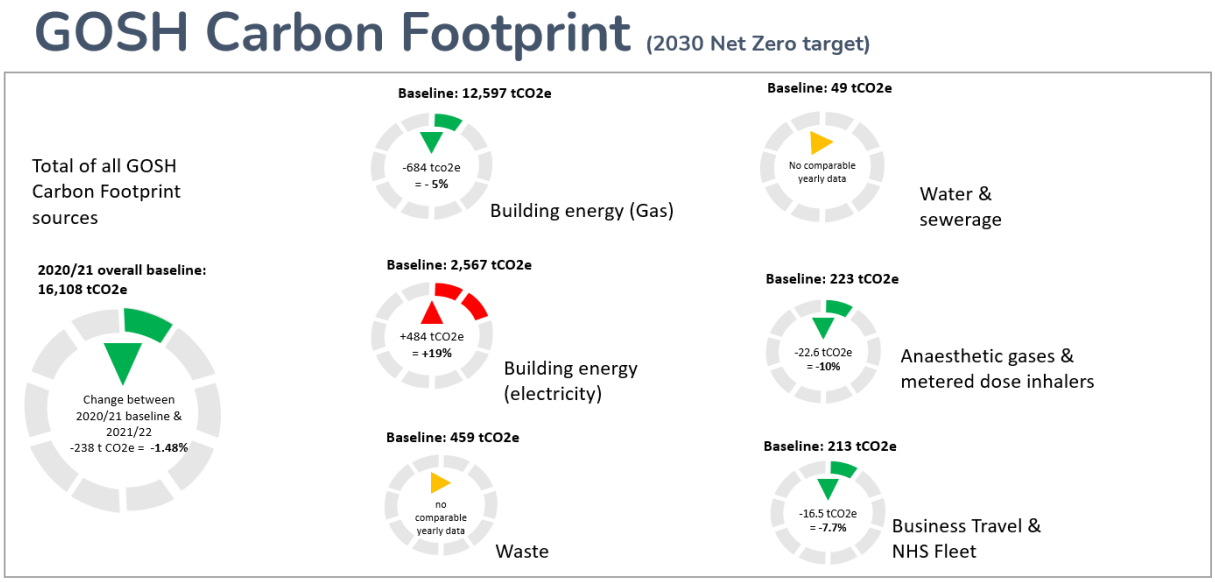
Our current tCO2 equivalent baseline is for the year 2020/21. The baseline tCO2e for GOSH is as follows: -

- 2030 GOSH Footprint 16,108 tCO2e
- 2040 GOSH Footprint PLUS 53,330 tCO2e

4.1 Gosh Footprint KPI's – 2030

A set of Key Performance Indicators and dials have been established to track the GOSH carbon footprint against the 2020/21 baseline.

Figure 3 - GOSH Carbon Footprint dials - 2030 target



The KPI dials for the 2030 GOSH Footprint KPI dials show an overall reduction of 1.48% reduction in CO2e across 2 years with the main variations as follows: -

- Gas use was down by -5% due to maintenance and the rebuilding of the CHP engine
- Electricity usage was up by +19% to off-set the reduction in Gas consumption within the CHPs
- The CO2e impact of anaesthetic gas use was down -10% due to the team's work reducing Desflurane use,
- Fleet impact was down -7.7% due to the increased use of electric vehicles by our Non-Emergency Patient transport service

5 Sustainability Programmes of Work (POWs) and our Green Champions Community

Our staff 'Green Champions' are a group of over ninety volunteer staff who support the ten Programme of Work (POW) areas, working in an additional capacity to their substantive roles to help deliver the areas outlined by the Greener NHS.

They include active staff working groups who meet bi-monthly and work to improve processes in sustainable medicines, travel, digital transformation, food and nutrition, education, and sustainable care. Working groups for procurement/finance, Space and Place, climate adaptation/resilience and 'our people' are still in formative stages and we are working with the teams to understand how they can feed efficiently into this work.

Programme of Work	Example of success (2022/2023)
Procurement & Circular Economy	**This year:** Sustainable procurement team training delivered and a programme of learning available on the GOSH Digital Education network **Next year:** Supply Chain engagement programme and wider in-house sustainable procurement training
Travel & Transport	**This year:** New staff travel survey created & completed. Bicycle access programme used by ~30 staff. Range of active travel resources made available to staff through intranet **Next year:** Maintain excellent cycling infrastructure and retain cycle friendly employer status. Increase electric ambulance fleet
Food & Nutrition	**This year:** Save Every Drop campaign has focussed on reducing wasted milk and formula on wards **Next year:** Full CO2e baselining of food purchased within our Lagoon restaurant
Our People	**This year:** Allied Health Professional leadership students created training materials covering areas including sustainable travel, medicines waste and air pollution. Wider climate emergency and air quality training made available to all staff **Next Year:** Training programme for all 10 sustainability 'Programme of Work' areas available on GOSH DEN. Specification for NHS wide sustainability apprenticeship created and shared
Sustainable Care	**This year:** Funding won to provide patients with sustainable sanitary items, allowing for more independence and providing a sustainable option and reduce waste. **Next Year:** Pilot project exchanging a disposable for reusable item within a ward
Medicines Sustainability	**This year:** Joined the Sustainable Medicines partnership, completed a paracetamol review and trailed a paper saving project linking dispensary-based patient information leaflets to QR codes. Assumed lead trust role within NCL ICB on sustainable medicines **Next Year:** Continue delivering leading projects within GOSH and NCL on medicines packaging and education, patient supply, and waste.
Digital Transformation	**This year:** Postcode level No2 and PM2.5 data imported and made visible to staff on each patient record in relation to WHO guidelines. Resources and guidance available to staff along with patient template letters leading. Working with the new Digital Fellow to create the GOSHPods Goes Green podcast series **Next Year:** Postcode air pollution data project moves to staff education phase and GOSHPods Goes Green expands
Space & Place	**This year:** Zero Carbon Estate Pathways report outlines our current energy use baseline and reduction scenarios to 2030. All Facilities meetings include a sustainability focus. **Next Year:** Report response outlining next steps towards a net zero estate by 2030 receives organisational sign off.
Public Realm:	**This year:** Funding awarded for a healthy street transformation design to be carried out in collaboration with the local community & the London Borough of Camden **Next year:** Healthy Street design completed, and funding/delivery plans underway
Adaptation:	**This year:** Initial discussions around trust climate adaptation and resilience plan underway with NCL and London Borough of Camden **Next Year:** Complete and embed trust climate adaptation and resilience plan

6 GOSH Energy Usage and carbon emissions

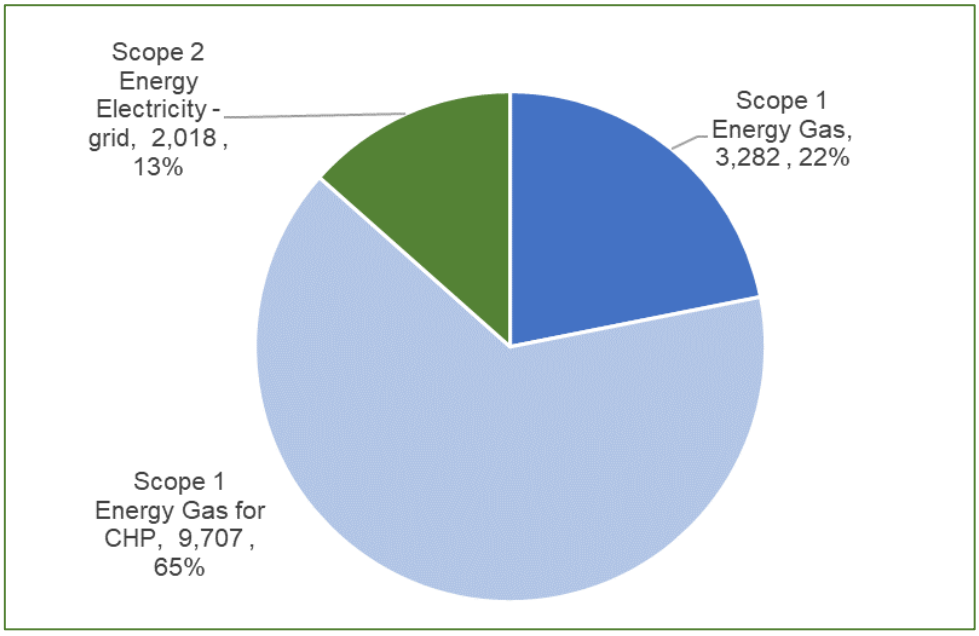
In 2022/23, energy use on the GOSH estate was responsible for emissions of approximately 15,000 tCO2e which accounts for over 94% of its 2030 carbon footprint.

Figure 4 shows the breakdown of these emissions illustrating the importance of gas use for boilers and CHP units which comprise around 87% of total energy related emissions.

Scope 1 direct emissions relate to GOSH's carbon emissions linked to energy use in its estates and includes those associated with providing heating, cooling and power to hospital and charity buildings including gas used for heating and to generate power for use in the hospital.

Scope 2 indirect emissions relates to electricity supplied from the national grid (scope 2 emissions).

Figure 4 - Breakdown of carbon emissions by scope in 2022/23 (tCO2e)



6.1 Comparison with NHS benchmark data

Figure 5 and Figure 6 show GOSH hospital energy consumption and carbon emissions as reported to the Estates Return information Collection platform for 2021/22 and compares the emissions of the main hospital building with other specialist acute hospital sites.

This analysis shows that the main GOSH hospital building has the second highest overall energy use per m^2 and the highest energy related carbon emissions. Other buildings across the GOSH estate (eg Barclay Building, Italian Hospital and Zayed Clinical Research) are between 2 and 5 times more energy efficient than the main hospital site[3].

[3] This is likely to reflect their lower level of operational activities and also in many cases their age and relatively higher level of operational control in comparison to the main hospital.

Figure 5 - Energy consumption at GOSH in comparison to other acute specialist hospital

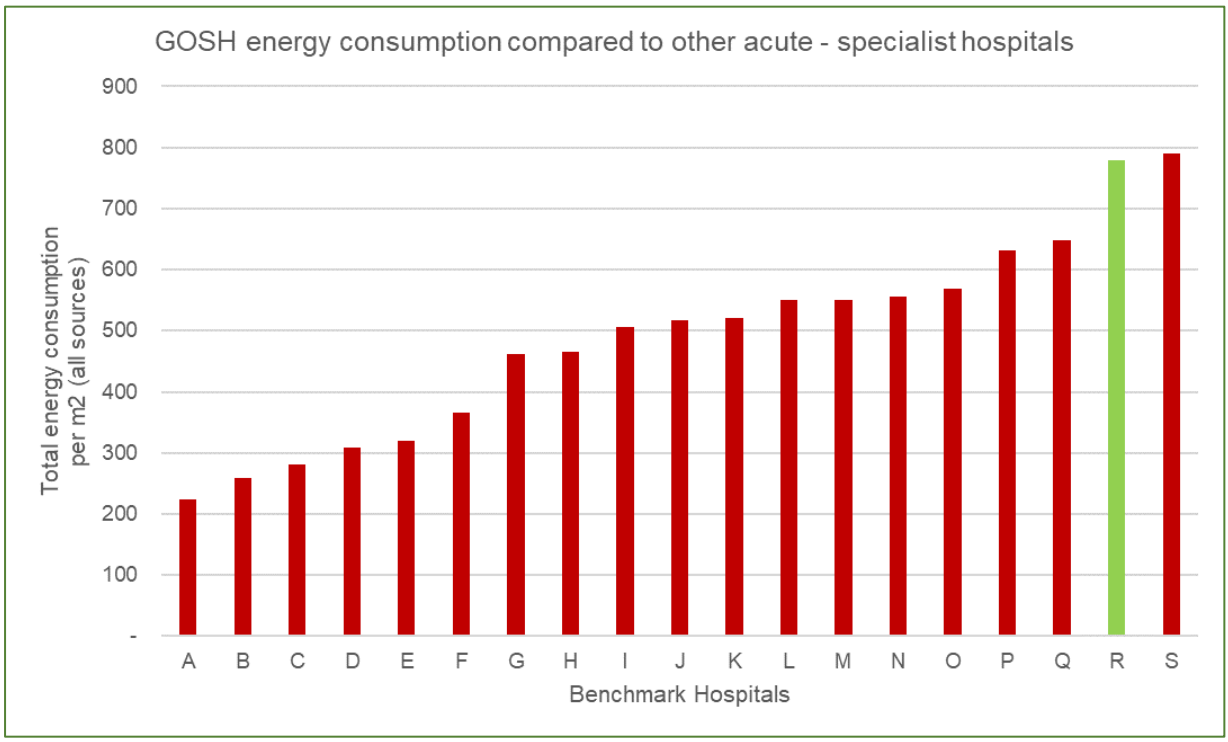
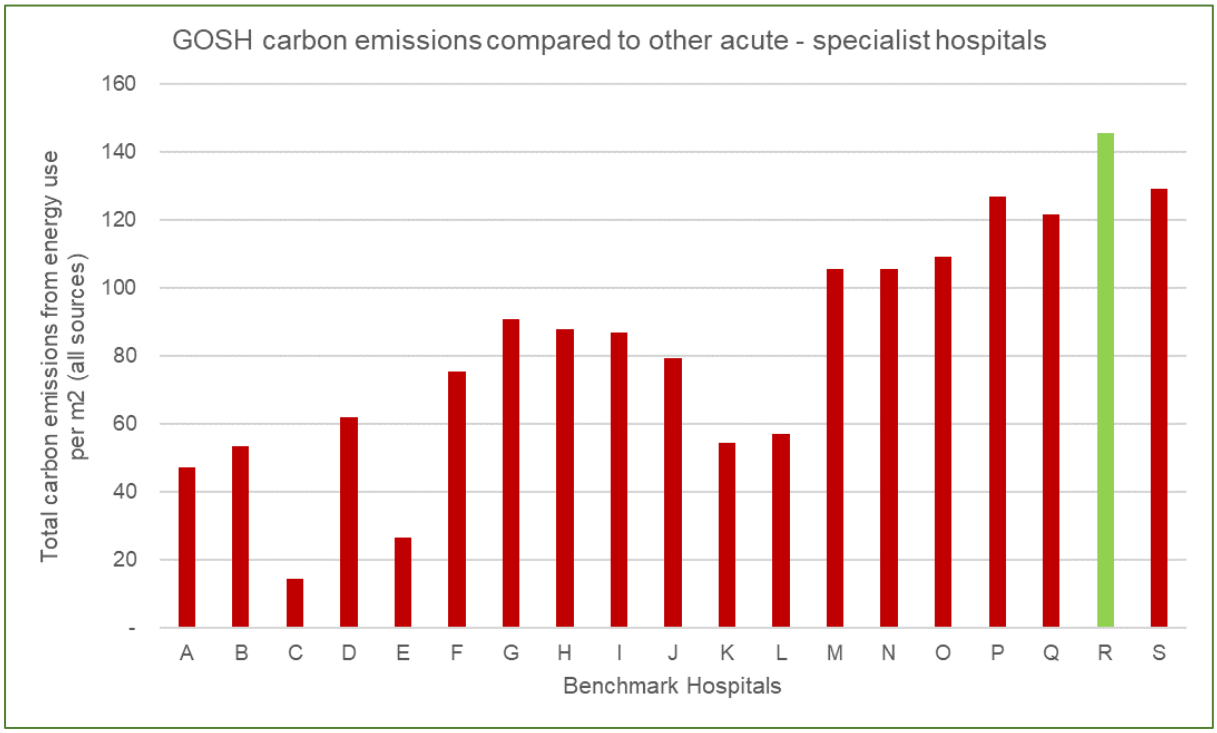


Figure 6 - Carbon emissions at GOSH in comparison to other acute specialist hospital

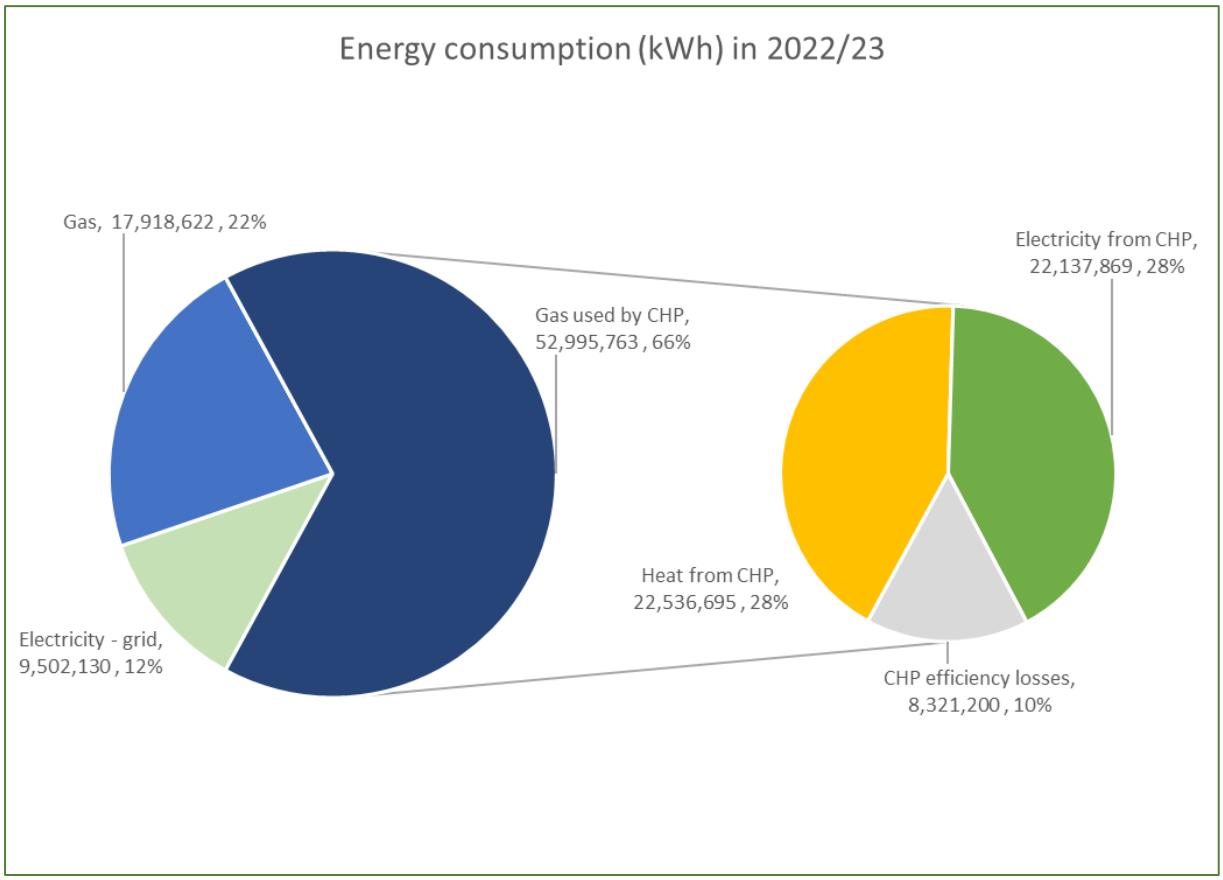


6.2 GOSH Energy Consumption in 2022/23

Figure 7 shows total energy consumption by source and type in 2021/22 in kWh. Around 56% of annual energy consumption is supplied via the two CHP units in either the form of power or heat. This illustrates the dominance of this energy source to GOSH operations and when combined with gas used directly for heat generation (without power) gas consumption currently comprises around 88% of total energy use.

This dominance of gas consumption in the GOSH energy mix is critically important because there is little / no forecast reduction in the carbon intensity of this fuel in contrast to grid electricity consumption with is projected to reduce in carbon intensity steadily in the future with a carbon intensity in 2030 of only around a quarter of that of natural gas.

Figure 7 - GOSH Energy Consumption in 2022/23



6.3 Projection of 'business as usual emissions'

Analysis of future emissions from the estate shows that without significant intervention GOSH's zero carbon commitments will not be met. While there is some emission saving from the decarbonisation of grid electricity this has a small impact overall on emissions with emission reduction by 2030 of only 7% from 2022/23 levels and by 2050 emissions will have only fallen by 11%.

6.4 Impact of the new Children's Cancer Centre

The construction of a new Children's Cancer Centre (CCC) comprises c.18,119m^2 of new space the main hospital estate on the site of the existing 5,806m^2 Frontage Building. The CCC will provide new state of the art facilities and increase in the size of the estate by more than 12,000m^2. The new building will be heated and cooled electrically using heat pump systems and will draw on heat from the main hospital energy centre for domestic hot water supply.

Despite the significant increase in overall footprint of the main hospital (by nearly 13% to 109,000m^2), the cumulative impact of the addition of the CCC is around 1% in terms of total emissions to 2030. This is because the higher electricity consumption of the new building is balanced by the removal of the smaller but less efficient and largely gas heated Frontage Building.

6.5 Planned Efficiency Programme

Capital resource has been identified within the Space and Place 10-year Capital plan and will contribute towards achieving our 2030 Net Zero target.

- **Building Management System (BMS) upgrade programme:** Budget has been allocated over the next 3 years fund the first phase of the BMS upgrade to current operating protocols and installation of submeters in priority areas between 2023 and 2025, This will also include review of set points and zoning within the various hospital spaces to reduce energy wastage.

  It is anticipated that this will reduce our CO2e from operational energy by between ~5 and ~10% over this time. This work must be completed ahead of replacing fossil fuel burning onsite through removal of the CHP units towards 2030. Further proposals around BMS will be brought forward from Space & Place. This contributes to our 2030 Net Zero Target under the Deep Decarbonisation scenario.

- **LED lighting programme**: budget has been allocated across the next 3 years to continue the lighting replacement programme such that all lighting that is not LED (c.30% of the estate) is replaced by 2025.
- **Installation of heat recovery systems** and upgrade of air handling units to reduce heat loss and ventilation energy use in 2026.

7 Summary of approach to decarbonisation

Currently the main hospital building has:

- Poor levels of energy control due to antiquated building management systems[4].
- Low levels of energy efficiency.
- A high reliance on fossil fuel (gas).

The estate decarbonisation strategy must address each of these factors sequentially, i.e., to gather a far better understanding and control over energy use across the estate which will deliver efficiencies and better inform the estates team about where to target for further operational efficiencies. Once energy use in the current estate is better understood and available 'no regrets' measures have been implemented (e.g., LED lighting upgrades, variable speed pumps and fans, etc) then consideration should be given to decarbonising heating and cooling.

In parallel, measures to improve energy efficiency should be implemented wherever work is being done across the estate including other buildings which although far more efficient than the main hospital, can still be made more efficient and can reduce their reliance on fossil fuels.

A key opportunity likely to arise periodically across the non-main hospital estate is the replacement of end-of-life gas boilers. A GOSH policy that requires the use of heat pumps to be a consideration wherever such work is being planned would ensure that valuable decarbonisation opportunities are not missed. This is particularly important for heating plant with a typically lifespan of +15 years, as failure to act would either lock in a significant additional period of fossil fuel use or require plant to be removed part way through its lifespan with associated wastage of investment and of the embodied carbon in the plant materials.

Removal and replacement of the gas CHP units in the energy centre is a major undertaking and should be a core component of a future GOSH Masterplan and Estates Strategy. The strategy will need to explicitly plan for and support the move to low carbon heating and cooling, including through the following measures:

- Providing necessary space for a new energy centre or connection into local decarbonised heat networks should this prove to be possible.
- Incorporating allowances for necessary controls and metering to optimise energy use and reduce average costs by enabling effective demand response measures.
- Incorporating opportunities to reduce demand through energy efficiency measures as part of estate replacement / improvement works.
- Ensuring that new facilities maximise potential for renewable energy generation where this does not conflict with operational or amenity value.
- Minimising the amount of estate required through operational efficiencies delivered through digital service delivery and optimisation of building utilisation.

[4] Updates to sitewide data protocols have resulted in the loss of connectivity of data collection and control units across the main hospital site making control of energy use and internal conditions challenging and inefficient.

7.1 Carbon reduction scenarios

A carbon pathways model has been developed to understand GOSH's current estate related carbon emissions and to consider how these will change in the future under a range of different scenarios.

Future carbon emissions associated with GOSH's estate activities are projected through to 2050 for 4 alternate scenarios in addition to a 'business as usual' scenario based on continuation of current levels of activity and consumption. The scenarios are described below:

7.1.1 Scenario 1 -Business as usual (BAU)

Assumes continuation of current levels of activity and associated consumption of energy, clinical gases, transportation, etc

7.1.2 Scenario 2 - BAU + Children's Cancer Centre

In this scenario the new planned Children's Cancer Centre is added to the estates data in place of the current frontage building from 2026.

7.1.3 Scenario 3 - Planned Efficiency Programme

This scenario BAU plus for operational efficiencies to reduce wasted energy and adoption of more energy efficient technologies such as LED lighting and a renewed BMS

7.1.4 Scenario 4 - Deep decarbonisation

This scenario incorporates all the measures described for scenario 1 but then includes the replacement of the gas boilers and CHP units and absorption chillers in the energy centre with electric heat pump-based systems.

It is expected that the switch to electrified heating would come as part of the next iteration of the GOSH estate strategy. For example, as part of works to the Nurses Home building or other older parts of the existing estate. It is expected that external space of around 500m2 would need to be secured to enable an air source heat pump-based solution. With plant room and roof space limited, careful consideration will need to be given to location of new equipment to ensure continued operation until the site is ready to switch off existing plant.

7.1.5 Scenario 5 - Jump to Deep decarbonisation

This scenario presents an alternative approach that illustrates the challenges of trying to remove gas from the GOSH site without undertaking necessary steps to reduce demand. In practice, this approach would not be practical due to operational and technical constraints however it illustrates the critical role that demand reduction through improved systems and controls play in the decarbonisation process.

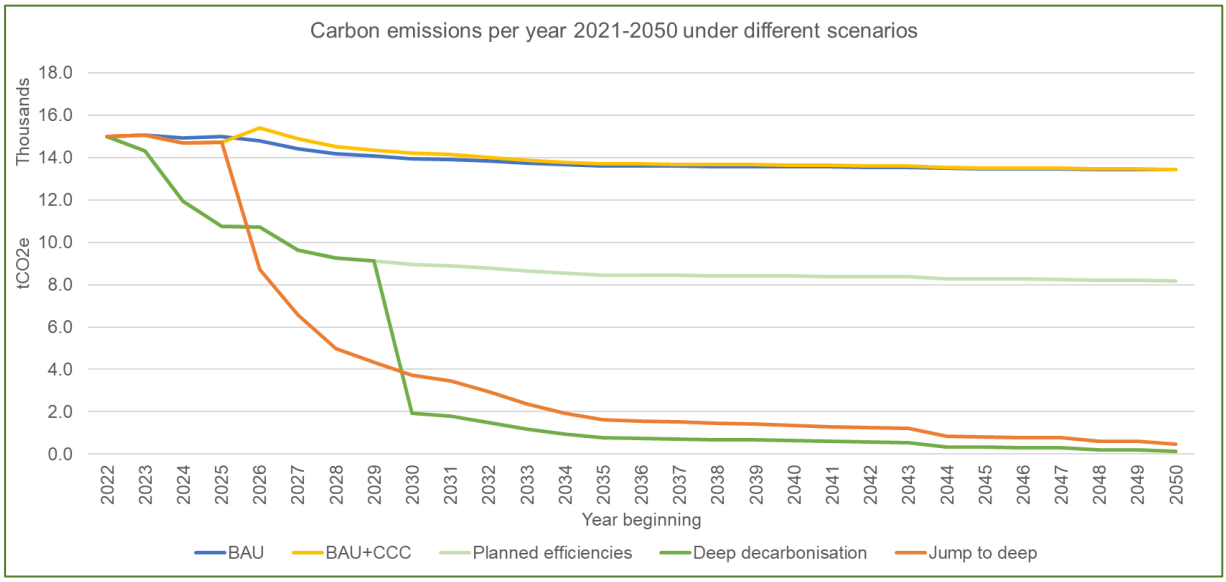
7.2 Impact on operational carbon of each scenario

Of the various options available to decarbonise the estate the only option that delivers significant cost savings and an improved health care environment whilst remaining affordable is the Deep Decarbonisation scenario. This entails a programme of energy efficiency measures culminating in the replacement of the existing gas heating and CHP system with full electric heating. This scenario delivers a c.87% reduction in estate emissions by 2030 compared to 2022/23.

Other scenarios would either fail to deliver the necessary carbon savings or would impose unaffordable and inequitable costs related to the high levels of associated electricity consumption.

Figure 8 shows the impact of the decarbonisation pathways on annual operational carbon emissions linked to the GOSH estate.

Figure 8 - Operational carbon emissions under different scenarios



In the period 2022-2030 both the Planned Efficiencies and Deep Decarbonisation strategies make significant progressive carbon savings. After this period the savings from the Planned Efficiencies scenario are exhausted and the residual carbon intensive gas consumption means that even by 2050 emissions are in the order of 8,000 tonnes CO2e per year, a saving of around 33% but still far short of GOSH's commitment.

By contrast, the Deep Decarbonisation scenario delivers further significant carbon reductions with the removal of gas systems in 2030 delivering over 87% savings by 2030/31 and with emission continuing to decline thereafter to 2050.

The Jump to Deep scenario delivers no additional carbon saving until the gas systems are removed in 2026 and then shows a rapid reduction in emissions following the switch to a lower carbon energy source and then from ongoing decarbonisation of grid electricity. However, under this scenario the significantly higher volume of energy consumption means that carbon savings only briefly dip below the Deep Decarbonisation scenario in 2029 and thereafter emissions are higher resulting nearly 10,000 tonnes of additional CO2e emissions by 2050.

7.3 Indicative Capital Expenditure

The projected capital expenditure required to reach a ~87% reduction is broken down into the following phases:

		Investment	
Year	Action/s	CAPEX Cost £million)	CAPEX Cost £/tCO2 saved
2022/23	Current position	0	0
2023/24	BMS, metering, energy management and rolling efficiency measures (e.g., LED upgrades)	**£11.4m**	£2,655
2024/25			
2025/26			
2026/27	Heat recovery and ventilation upgrades	**£5.5m**	£10,629
2027/28	Design / planning	**£1m**	n/a
2028/29			
2029/30	Removal of CHP and install of electrified energy centre	**£10m**	£1,296
2030/31			
2030/31	PPA/Offsets	**tbc**	tbc
Total		**£27.9m**	

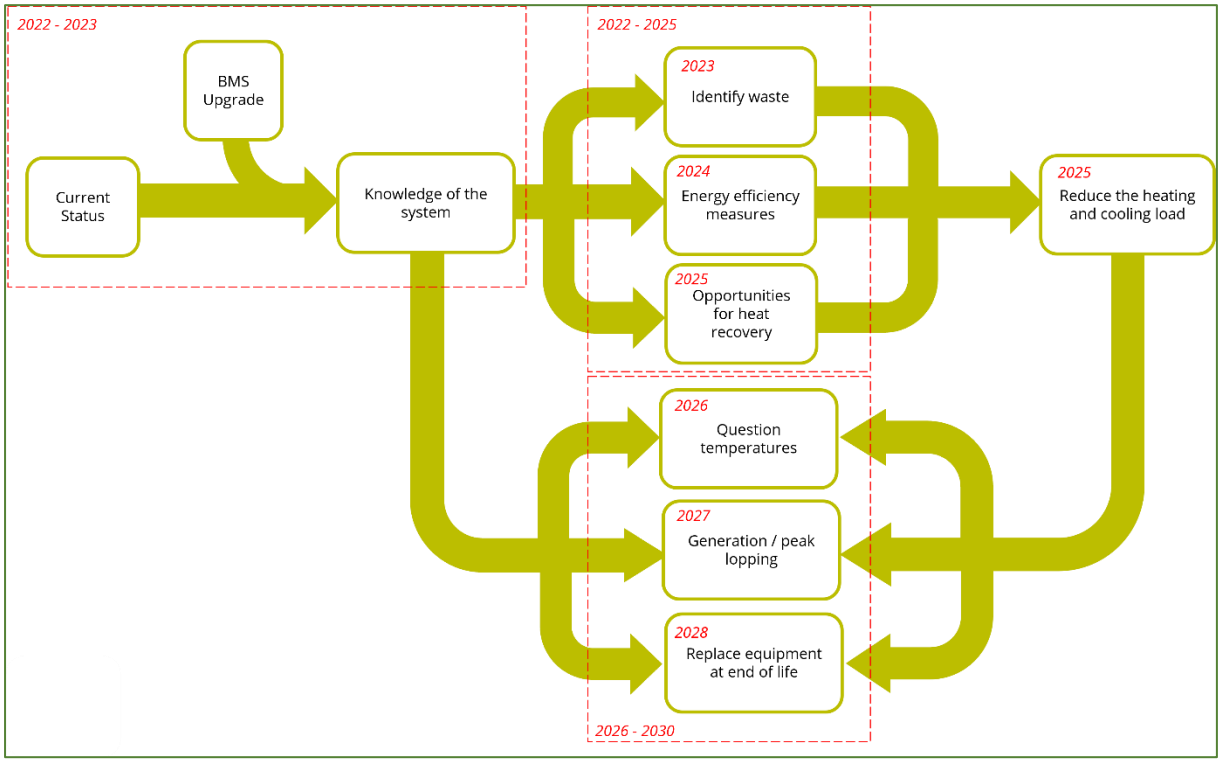
It should be noted that these costs are indictive only and only include the asset replacement. The indicative costs do not account for any additional space or estate that may be necessary. These costs will be developed further, and once greater certainty is established future business cases will be presented to appropriate committees for further consideration.

7.4 Outline Roadmap to 2030

The following high-level programme of works (see Figure 9) is based on a logical sequence of measures for a complex estate, rather than a specific design. As more information becomes available on energy usage in different spaces and on demand profiles for heating and cooling the nature and priorities for investment should be revisited.

The programme progress from the implementation of a BMS upgrade currently in its early stages, through to the 2030 target and removing the CHP, thus eliminating combustion on-site.

Figure 9 - Proposed Roadmap through to 2030

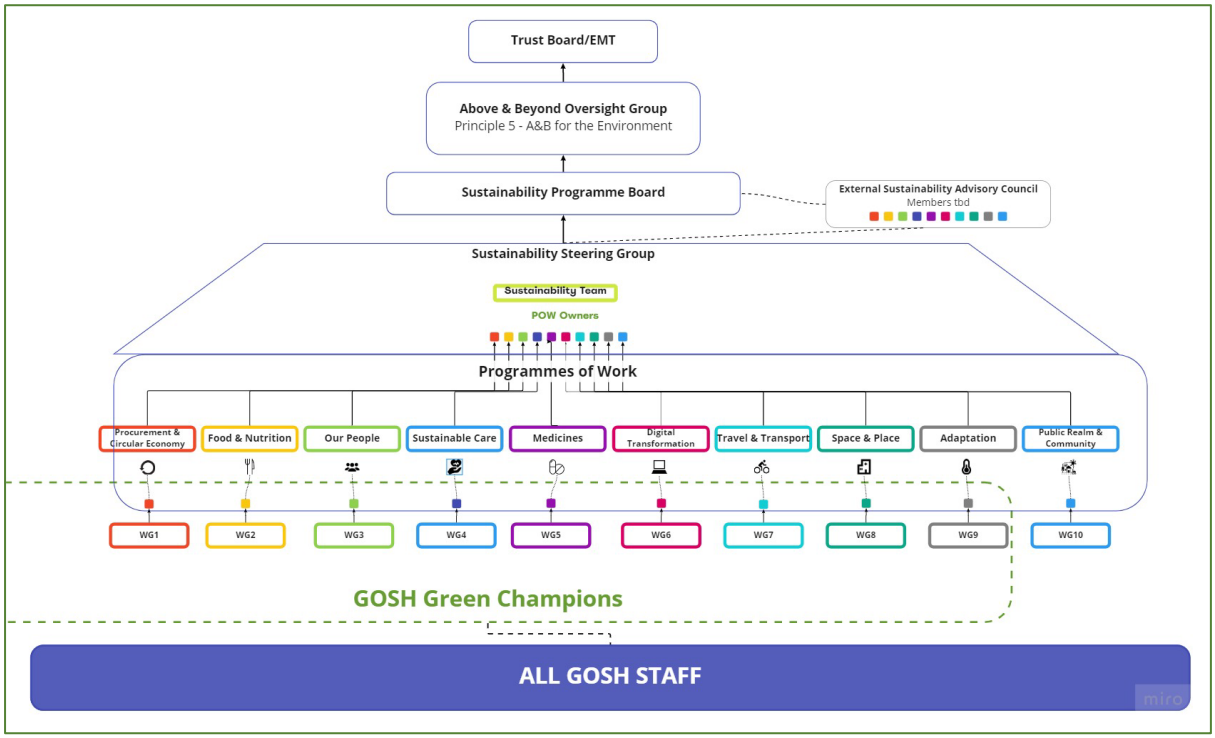


8 Programme Governance

The governance arrangements and resources requirements to deliver to on the Trusts Climate Health Emergency have developed over the last 2 years and we now have an opportunity to re-assess the leadership and project team that will be needed. Further work is currently being undertaken to assess the resource and leadership requirements that will be necessary.

Figure 10 represents the Sustainability Programme Structure and the links between GOSH Staff, the Green Champions and Programmes of Work, and the Executive and Non-Executive Leadership.

Figure 10 - Sustainability Programme Structure



8.1 Sustainability Programme Board

A bi-monthly summary of programme progress is reported to the Sustainability Programme Board through a regular slot on the agenda. The focus of the Board is to present key strategic papers to its members for discussion and input.

The Board is chaired by the Executive Director of Space and Place and includes the Trust Board NED lead for sustainability, the COO as well as representation from the YPF, GOSH Charity, Communications, Finance and Sustainability teams.

The Board provides oversight, input, and backing to a range of strategic papers ahead of them progressing to wider GOSH Governance including EMT. As outlined, the SPB and its remit has evolved over the last year and is currently being reassessed including the allocation of a limited budget to support the Green Champions.

8.2 Steering Group

It has been identified that there is a gap between the ten Programme of Work groups and the Sustainability Programme Board which requires input from a senior level sustainability steering group

(SSG) containing executive sponsors. We are currently working to agree its membership and will have it in place ahead of the August SPB. Agreement on the membership and scope of the roles is required to take this forward and discussion around this is underway.

8.3 Project Team

The GOSH Sustainability Team consists of 2 FTE & 1 PTE staff led by the Head of Sustainability and supported by the Sustainability Project Manager. The Project Lead for Placemaking is a part time role, focussing on health links to our local environment and public realm. The team coordinates and delivers upon all local sustainability project activity, overarching strategic activity, compliance, partnerships, and innovation within GOSH in relation to the Climate Health Emergency (CHE).

8.4 Review of resource and leadership requirements

As outlined above there is a need to re-assess the leadership and resource requirement to enable GOSH to deliver on its Climate Health Emergency. The Director of Space and Place is currently undertaking a review of these resource requirements not only including the project team but also the support capacity with Green Champions who are currently volunteering their time on top of very bust workloads.

9 Priorities for 2023/24

- Completion and presentation of the new Sustainability Strategy and Action Plan, along with costings/resourcing requirements
- Continue to deliver planned energy efficiencies utilising funding contained within the 10-year estates capital programme including switch to LEDs etc.
- Implementation of a site wide energy metering strategy to enable monitoring of energy usage
- Completion of the feasibility study for the replacement of the Building Management System including the delivery of phase 1 of the new installation
- Development of business case for the decarbonisation of the GOSH estate including dialogue with the charity
- Re-assessment of the sustainability structure and governance will be carried out in the June SPB
- Develop a programme of staff engagement and promotion of the Programmes of Work including profiling of Green Champions

10 Recommendations

The Board of Directors are requested to: -

- Note the content of the annual report including the progress that has been made in relation to the Climate Health Emergency and the next steps as outlined above.
- Note the options for decarbonisation of the GOSH estate and expect a business case to be presented that will fully outline resource requirements

Attachment W

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Quality, Safety and Experience Assurance Committee held on 28th June 2023

Matters arising

- Trust Board action 140.2: Wi-Fi connectivity across the hospital

A new Wi-Fi network had been rolled out in the hospital in late 2022 which could accommodate a large number of users and the Trust offered a generous bandwidth to each user which was considerably higher than that provided by other Trusts. PALS contacts related to Wi-Fi had significantly reduced and education would take place with ward staff about how best to use it. Focus would also be placed on communications to ensure that patients, families and staff knew what to expect from, and how to access, the Wi-Fi at GOSH.

- QSEAC action 33.9: Range of staffing experience required to monitor patients in IP&C and when outliers across the hospital

The model of staffing on I&PC wards had changed throughout the pandemic and nursing staff had been upskilled. In general, there was a pipeline for international and private care patients which enabled staff to work with practice educators in cases where additional knowledge was required. The team had identified pathways to formalise the way in which complex patients were admitted and work was taking place to improve recruitment including potential ways to recognise the different model of working in I&PC.

Quality and Safety at GOSH – Chief Medical Officer Report

To date, there had been no patient safety incidents which were attributable to strike action however harm reviews would continue to take place for long waiting patients whose care may have been delayed by industrial action. It was noted that Consultants had balloted to strike, and this would also impact the waiting list.

An international panel had undertaken a follow up review of the gastroenterology service and had provided very positive verbal feedback. Recommendations would be made in the report to support the further development of the service. An external review had also taken place of the ethics service and the informal feedback had been positive; the team is awaiting the formal draft report.

Focus was being placed on moving towards implementing the Patient Safety Incident Response Framework and good progress was being made to appoint Patient Safety Partners and Patient Safety Specialists. GOSH was now the hospital with the highest number of services producing publicly available outcomes internationally. The NEDs welcomed this news.

Discussion took place around medication errors, the causes of which were multifactorial. It was agreed it was important to use the systems in place already such as Epic to create a series of checks which would prevent errors in the future and work was underway.

Quality and Patient Experience: Chief Nurse Report

- Patient Experience and Engagement Annual Review 2022/23

There had been a 75% increase in formal complaints which was in line with other organisations however the complexity of the complaint cases was significant. A review of the complaints management process would be undertaken by internal audit.

The play team had focused on recording data to support demonstrating the impact of the service on patients and their care however it was challenging to benchmark in the service as other Trusts did not collect the same level of data.

- Annual Director of Infection, Prevention and Control Report 2022/23

All gram negative bacteraemia had been above the threshold in 2022/23 and similar challenges were also being experienced by other Trusts. All cases had been reviewed and Root Cause Analyses of all cases would be taking place going forward. Challenges remained around ventilation particularly in standard rooms however it was confirmed that the required mitigations were in place and patients were safe. The Committee noted that some of the Trust's existing ventilation required replacing and an options appraisal would be provided to the committee on potential next steps later in the year.

There had been national supply issues with some infection control related consumables. The pharmacy service had now assumed management of stock, and this had been helpful.

Discussion took place around the national increase in antibiotic resistance and a working group had been established and additional screening and control measures identified which would be implemented in 2023/24. It was likely that enhanced cleaning would also be required going forward.

- Annual Safeguarding Report 2022/23

The review panel for the independent safeguarding review had undertaken a first round of meetings with staff and a second round would take place later in the year. Positive feedback had been received from the first group of meetings. Work was taking place with the legal team and learning disability team to ensure that staff had the correct information to mitigate the risk of breaches of the requirements around Deprivation of Liberties. Focus was being placed on ensuring staff took part in level 3 safeguarding training.

The Committee discussed the proportion of GOSH patients who had experience of being looked after and the implications for health inequalities. It was confirmed that the safeguarding team was linked into the health inequalities working group to help inform the implications for patients attending appointments and receiving a safe discharge.

Update on provision of Dental Services at GOSH
Virtual clinics had begun with the support of mutual aid and a good number of appointments had been made available at weekends. Clinics that had taken place over last two weeks had not identified any patients who had come to harm as a result of their waiting time. A dentist had been appointed to the service and support for their development had been agreed by the Trust providing mutual aid. The Committee welcomed progress that was being made in the service.

Update on Space and Place quality and safety matters
Over 98% of all Positive Pressure Ventilation Lobby (PPVL) rooms had been reverified and were now operational and a forward plan was in place to continue the cycle of cleaning. The Trust's cooling towers were being maintained in line with plan and the water quality had been confirmed at good. The committee noted that there had been some positive cases of legionella and it was confirmed that this number was low and was being well managed with ongoing flushing and local disinfection to mitigate the risk. It was noted that key posts in the Space and Place team were interim, and plans were in place to undertake a formal recruitment process.

Health and Safety Update
Good improvement continued to be made in safer sharps and there was good clinical engagement in place. A 20% reduction in incidents had been identified. There were challenges around cooling areas of the hospital in hot weather and mobile air conditioning had been rolled out; it was confirmed that comfort cooling would be in place in the Children's Cancer Centre. The committee discussed the impact of heat on paediatric health, and it was confirmed that no patterns had been identified in this regard.

Learning Disability Service Peer Review
A five-year learning disability strategy was in place which focused on equity and families feeling equally valued. A system was in place to flag patients with a learning disability or autism, and this highlighted to staff that consideration of reasonable adjustments was required. Consideration was required of capacity to remove and add flags for patients on Epic. A peer review of the service had been undertaken by another paediatric Trust which had commended the GOSH team for its passion and interest and the Trust's ambitious strategy but said that further consideration of its operational implementation was required.

Paediatric Critical Care Level 1 and 2 – what next?
A preferred option had been identified for the provision of critical care levels 1 and 2 going forward which would represent a very substantial change to the organisation and a pilot in a small number of wards would take place prior to roll out. An ambitious plan was in place for the next year and the project board was considering next steps including building a primarily clinical team to take the programme forward.

Internal Audit Annual Plan 2023/24 and Internal audit Progress Report (Quality focused reports)
The Committee reviewed the internal audit plan for 2023/24 and requested that discussions took place around an early view of the next year's plan at the Board Risk Management Meeting in December 2023. Scoping had begun for the complaints review which would be presented at the next meeting. One quality focused recommendation was overdue which was in progress.

Freedom to Speak Up Guardian Update
Discussion took place around the themes of cases raised and the committee noted that amongst almost all cases issues around civility between colleagues. It was highlighted that staff in many areas were under considerable pressure and it was important that the Executive Team was able to balance the level of pressure in the organisation.

Update from the Risk Assurance and Compliance Group (RACG) on the Board Assurance Framework
RACG had discussed the current status of the medicines management BAF risk and agreed that the score would remain the same and be reassessed in 6 months' time. The Committee agreed that further work was required on the risk statement for the mental health risk and agreed the wording of a new BAF risk for health inequalities.

- BAF Deep dive - BAF Risk 3: Operational Performance

Manufacturing had been a key risk and the Trust had taken the decision to pause the parenteral nutrition unit which was now possible due to improved relationships with external suppliers. In the two weeks following the team had been able to decrease the overdue actions by 50%. Internal and external working relationships had been improved by the team and two key roles would be joining the service in the coming weeks to support improvements. The Committee discussed the supply chain for medications and noted that there were a large number of lines which were not in full supply. The team worked hard to pre-empt clinical switches and contributed data to a national programme which managed shortages on behalf of providers.

- BAF Deep dive - BAF Risk 11: Medicines Management

Although it was challenging to meet access targets, the Trust benchmarked well against others in terms of Referral to Treatment delivery. Industrial action had impacted this progress and there was a clear change in the metric noted following each period of strikes. The Trust had a number of long waiting patients, and a plan was in place to reduce this. Improvements were being made in the Trust's approach to strikes and fewer patients required cancellations as learning was collected from each period of action.

Update from the People and Education Assurance Committee (May 2023)
The Committee discussed the nursing workforce assurance paper and review of the nursing workforce establishment.

Attachment W

Governor feedback

Governors welcomed the work to publish outcomes in a large proportion of specialties. Discussion took place about the work that would take place to develop 'heat' maps from the quality data which was collected which would inform areas for further review. Governors highlighted the importance of ensuring that the consideration of sustainability was built into all areas of the Trust's work including quality improvement projects.

Attachment: X

Summary of the Audit Committee meeting held on 8th June 2023

The Committee noted summaries of the following assurance committee meetings:

- Quality, Safety and Experience Assurance Committee – March 2023
- People and Education Assurance Committee –May 2023
- Finance and Investment Committee –March and May 2023

Internal Audit Progress Report

There were three overdue internal audit recommendations, and it was agreed that they would be discussed at Risk Assurance and Compliance Group. The Committee emphasised the importance of commitment and accountability in closing recommendations in line with a reasonable due date and it was agreed that when deadlines were agreed evidence would be required that they could be met. A report on diagnostics had provided an assurance rating of *significant assurance with minor improvement opportunities*. Discussion took place around the number of order and receipt points in the Trust which was felt by the internal auditors to be high, and it was agreed that work would take place to ensure that there was assurance around the documentation of controls and processes.

The Committee reviewed the internal audit plan for 2023/24 and noted that although all areas were not covered each year, consideration was given to where particular audits interrelated with a number of areas. The plan was approved.

Chief Financial Officer's review of the Annual Financial Accounts 2022/23, including the Going Concern assessment

Key management judgements were around the valuation of land and buildings and some significant impairments had materialised as a result. The methodology for debt provisioning had been agreed but continued to be discussed with the external auditors.

Status report to the Audit Committee on the 2022/23 audit

Audit work continued however no material issues had arisen so far and this was also the case in terms of the Value for Money audit. The Committee noted the considerable increase in the work that was required from the Trust and the auditors to complete an audit, and this had impacted on the timeframes on which the Trust had been able to deliver some elements. The timetable had been ambitious and GOSH remained ahead of other organisations in the auditor's portfolio. An amber rating had been provided around the implementation of IFRS 16 and a control recommendation had been made. No material issues had been identified in terms of management judgements made in relation to management override of controls, capital expenditure or property valuation. In line with previous years the auditor felt that the Trust's provisioning for International and Private Care debt was prudent but within a materially acceptable range.

The Committee agreed to recommend the annual accounts 2022/23 to the Board for approval.

GOSH Draft Annual Report 2022/23

Subject to some minor amendments the committee agreed to recommend the annual report 2022/23 to the Board for approval.

Board Assurance Framework Update following the Risk Assurance and Compliance Group (RACG)

For approval by the Trust Board: The Committee received an update on the BAF and agreed to recommend the following to the Trust Board for approval:

- **New BAF Risk: International and Private Care (IP&C)**
  With international and private work increasing since the Pandemic due to air corridors opening and increased commercial activity, the Audit Committee and Finance and Investment Committee agree that it

is appropriate to propose decoupling the risk of not achieving the IP&C and commercial delivery plans from the financial sustainability BAF risk and establishing it as a separate BAF risk. The risk statement for the new standalone risk around the delivery of International and Private Care is:

The risk that the financial sustainability of the Trust is significantly impeded by a failure to deliver IP&C and commercial contribution targets.

- **New BAF Risk: Climate Emergency**
  This is a new risk statement agreed by the Trust Board in March 2023. The controls, assurances, any gaps, and proposed risk scores are recommended for approval by the Trust Board:
  - Gross risk score: 5 Likelihood x 4 Consequence = 20
  - Net risk score: 4 Likelihood x 4 Consequence = 16
  - Risk appetite: Cautious
  - Assurance committee: Audit Committee.

- **New Risk Content: Integrated Care System**
  This is a new risk statement agreed by the Trust Board in March 2023. The controls, assurances and any gaps are recommended by the Audit Committee for approval by the Trust Board including the following proposed risk scores:
  - Gross risk score: 4 Likelihood x 4 Consequence = 16
  - Net risk score: 3 Likelihood x 4 Consequence = 12
  - Risk appetite: Cautious.
  - Assurance committee: Audit Committee

- **Revised BAF risk net score: Estate Compliance**
  Over the past 6 months, a considerable amount of work has been conducted around estates management and compliance. On this basis the Audit Committee recommends that the net risk score is reduced as follows:
  - Net risk score: from 5 Likelihood x 4 Consequence = 20
    to
  - Net risk score: from 4 Likelihood x 4 Consequence = 16

- **Revised BAF risk net score: Workforce Sustainability**
  Although several workstreams across the Trust continue to focus on and mitigate the impact of higher than target voluntary turnover and nursing staff turnover, the Audit Committee support a recommendation to increase the net score for this risk from:
  - Net risk score: from 2 Likelihood x 4 Consequence = 8
    to
  - Net risk score: from 3 Likelihood x 4 Consequence = 12

- **Revised BAF risk net score: GOSH Learning Academy**
  Following the successful awarding of the full GOSHCC grant investment, the Audit Committee and People and Education Assurance Committee support a recommendation to reduce the net risk score for this risk from:
  - Net risk score: from 3 Likelihood x 3 Consequence = 9
    to
  - Net risk score: from 2 Likelihood x 3 Consequence = 6
  - It is suggested that the risk appetite (*Minimal*) is moved downwards to *Cautious* noting the type of activity involved and the extent to which delivery of the GLA is carefully planned and inherent risk is able to be managed.

Attachment: X

Board Assurance Framework Deep Dives: BAF Risk 5: Unreliable data

In light of the technology strategy and proposed clinical informatics unit the Trust's data strategy would be reviewed. Good team structures were in place in the data quality and data assurance teams and data was well validated and support was being provided around data literacy and enabling colleagues to become more proactive in interrogating data. Focus was being placed on ensuring that data was available to users and there was an appetite in the Trust for this to be widened. GOSH was connecting with other organisations through the national Clinical Information Officer group, the Children's Hospital Alliance and the user community for the Trust's data analytics tool. Further work was required to ensure that Epic was being used to its full potential and around staff education.

Compliance with Trust Risk Management Policy

Focus was being placed on stubborn risks for which there had been no change in risk scores and a risk meeting was being established which would include representation from clinical directorates and corporate teams. The team continued to work towards implementation of the Patient Safety Incident Response Framework (PSIRF) ensuring that GOSH was compliant with the nationally mandated deadline. Following this focus would be placed on procuring an overarching risk management system which would support a number of areas. In response to the internal audit of the harm review process the revised process had been reviewed by the Executive Management Team and would form part of Directorate Performance Review Meetings.

Preparedness: Update on Emergency Planning/ Business Continuity Annual Report 2022/23: (BAF Risk 8: Business Continuity)

Gold command training had taken place internally with a revised scope focusing on the support which would be received from the Integrated Care System (ICS). The ICS had come to GOSH to support the training. Learning from the live testing of plans over the previous year had identified the need to add additional action plans around staff shortages, weather and transport.

Procurement Waivers

The Committee noted the procurement waivers and the focus that was being made in improving rigour in the process.

Losses and Write offs

The Committee noted the losses and ex-gratia payments.

Local Counter Fraud Specialist (LCFS) Annual Report 2022/23

The Trust's functional standard self-assessment would be submitted with an overall green rating which was comprised of 11 green rated standards and one amber related to declarations of interest. GOSH was not an outlier in this respect and the Trust had a policy and processes in place for capturing and raising the profile of the process.

The Committee approved the counter fraud workplan for 2023/24.

Review of Non-Audit work conducted by the External Auditors

The Committee noted that no non-audit work had been undertaken by the external auditors.

Assurance of compliance with the Bribery Act 2011
The update was noted.

Compliance with Data Protection Act 2018

The committee discussed the information governance actions around GOSH's Epic system being shared with another London Trust and it was noted that focus was being placed on analysing audit data from the 'break glass' process.

Raising Concerns in the Workplace Update

Attachment: X

No new cases had been raised since the last meeting. The Raising Concerns in the Workplace (Whistleblowing) Policy was in the process of being reviewed in order to bring together the various routes for raising concerns in the Trust. The Committee emphasised the importance of concerns being triaged and allocated to the correct process and that issues could be escalated where necessary.

Revised Assurance and Escalation Framework

The Committee approved the revised assurance and escalation framework.

Governor feedback

Feedback was received from one Governor who observed the meeting and welcomed the robust discussions and broad conversations which had taken place as well as the positive culture in the meeting. Discussion took place around the sustainability BAF risk which was a key matter for Governors, and it was agreed that consideration would be given to the environmental impact of the write off of medications in future reports.

4Great Ormond Street Hospital for Children NHS Foundation Trust: Board Assurance Framework (June 2023)

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
					L x C	T	L x C	T							
1	Financial Sustainability	**Principle 4: Financial Strength**		Failure to continue to be financially sustainable	5 x 5	**25**	4 x 5	**20**	**Cautious**	1-2 years	Chief Finance Officer	**John Beswick, Chief Finance Officer**	17/04/2023	Audit Committee	March 2023
2	Workforce Sustainability	**Principle 3: Safety and quality**	**Priority 1: Make GOSH a great place to work**	Failure to attract, support and develop a sustainable and highly skilled workforce.	4 x 4	**16**	3 x 4	**12**	**Cautious**	1-2 years	Director of HR and OD	**Sarah Ottaway, Associate Director of HR and OD/ Caroline Anderson Director of HR and OD**	12/04/2023	People and Education Assurance Committee	May 2023
3	Operational Performance	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme / Priority 3: Improve and speed up access to urgent care and virtual services**	Failure of our systems and processes to deliver efficient and effective care that meets patient/carer expectations and supports retention of NHS statutory requirements and the FT licence.	4 x 5	**20**	3 x 5	**15**	**Minimal**	1 year	Chief Operating Officer	**Anne Laythe, John Quinn, Rebecca Stevens/ Richard Brown**	21/06/2023	Audit Committee/ QSEAC	March 2023 June 2023 (QSEAC)
4	Integrated Care System	**All Strategy Principles**	**All priorities**	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.	4 x 4	**16**	3 x 4	**12**	**Cautious**	5-10 years	Chief Executive	**Matthew Shaw/ Anna Ferrant**	13/04/2023	Audit Committee	For October 2023
5	Unreliable Data	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Failure to establish an effective data management framework:	4 x 4	**16**	4 x 3	**12**	**Minimal**	1-2 years	Chief Operating Officer	**Richard Brown, Chief Data Officer**	14/04/2023	Audit Committee	November 2022 June 2023
6	Research infrastructure	**Principle 3: Safety and quality/ Principle 4: Financial Strength**	**Priority 5: Accelerate translational research and innovation to save an improve lives**	The risk that the Trust is unable to accelerate and grow research and innovation to achieve its full Research Hospital vision due to not having the necessary research infrastructure.	3 x 5	**15**	2x 4	**8**	**Minimal**	1-2 years	Director, Research & Innovation	**Jenny Rivers, Dep Dir, R&I**	13/04/2023	Audit Committee	January 2023
7	Cyber Security	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	The risk that the technical infrastructure at the Trust (devices, services, networks etc.) is compromised via electronic means.	5 x 5	**25**	3 x 5	**15**	**Averse**	1-2 years	Chief Operating Officer	**Mark Coker, Director of ICT/ John Quinn, COO**	03/04/2023	Audit Committee	November 2022 March 2023
8	Business Continuity For review by RACG in July 2023	**Principle 3: Safety and quality/ Principle 5: Protecting the Environment**	**Priority 2: Deliver a Future Hospital Programme**	Business continuity management plans are insufficiently robust and understood to support delivery of services and critical functions.	4 x 5	**20**	4 x 3	**12**	**Averse**	1 year	Chief Operating Officer	**Rachel Millen, Emergency Planning Officer/ John Quinn, Chief Operating Officer**	11/04/2023	Audit Committee	March 2023
9	Estates Compliance	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Inadequate maintenance of the estate affects the safety of the environment in which care is delivered by staff to patients and carers.	5 x 4	**20**	4 x 4	**16**	**Averse**	1 year	Director of Space ad Place	**Jason Dawson, Interim Director of Space and Place**	21/ 06/2023	Audit Committee/ QSEAC	Jan 2023 (QSEAC) June 2023 (QSEAC)
10	Climate Emergency	**Principle 5: Protecting the Environment**	**All priorities**	The Trust fails to deliver against its commitment to deliver a net zero carbon footprint, which is fundamental to deliver the Trust's Climate and Health	5 x 4	**15**	4 x 4	**16**	**Minimal**	1-5 years	Interim Director of Space and Place	**Jason Dawson, Interim Director of Space and Place/**	14/04/2023	Audit Committee	June 2023

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
					L x C	T	L x C	T							
				Emergency declaration (by 2040 for the emissions the Trust controls and influences).								**Charles Hanford, Programme Director**			
11	Medicines Management	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.	5 x 5	**25**	4 x 5	**20**	**Averse**	1-2 years	Chief Operating Officer	**Jane Ballinger, Chief Pharmacist/ Nick Towndrow, GM/ John Quinn, Chief Operating Officer**	23/06/2023	Quality, Safety and Experience Assurance Committee	June 2023
12	Inconsistent delivery of safe care	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	BAF Risk 12: Risk of (severe/serious) patient harm arising from a failure to follow safety standards, foster a culture of openness and transparency, and use data to support improvement • Patients are not consistently cared for within a comprehensive safety system which ensures they are protected from avoidable harm through compliance with regulatory standard • The organisation does not consistently focus on openness, transparency and learning when things go wrong, or use the opportunity to learn from when things go well. • The organisation does not use its own safety performance data as a tool to guide improvement, interventions or actions, training and learning	4 x 4	**16**	3 x 4	**12**	**Averse**	1-2 years	Medical Director	**Sanjiv Sharma, Medical Director/ Claire Harrison**	20/06/2023	Quality, Safety and Experience Assurance Committee	Reports on quality of services at every Board and QSEAC
13	Mental Health Strategy NEW RISK For review at RACG in July 2023	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	A lack of strategic focus on the delivery of mental health services at GOSH contributes to inequitable access to safe, effective care for children and young people with psychological needs.	4 x 4	16	3 x 4	12	Averse	1 -2 years	Chief Nurse	**Tracy Luckett, Chief Nurse/ Helen Griffiths, Consultant Psychologist BBM**	11/06/2023	Quality, Safety and Experience Assurance Committee	New risk
14	Culture Risk scores to be reviewed again at RACG in July 2023	**Principle 2: Values led culture**	**Priority 1: Make GOSH a great place to work**	There is a risk that GOSH fails to develop a culture where our people are well led, well managed, supported, developed, and empowered to be their best.	4 x 4	**16**	3 x 4	**12**	**Averse**	1-5 years	Chief Executive	**Caroline Anderson Director of HR and OD**	12/04/2023	Trust Board/ People and Education Assurance Committee	May 2023
15	Cancer Centre	**All Strategy Principles**	**Priority 6: Create a Children's Cancer Centre to offer holistic, personalised and coordinated care**	Failure to build a new cancer centre and failure to deliver holistic, personalised and coordinated care. This risk incorporates risks currently reflected on the CCC risk register as follows: • Transformational programme does not deliver holistic, personalised, and coordinated care • Delay in Full Business Case approval from NHSE/I • The project not achieving Planning Permission • Fundraising target not achieved	4 x 4	**16**	3 x 4	**12**	**Averse**	1-5 years	Director of Space and Place	**Jason Dawson, Director of Space and Place/ Gary Beacham, Children's Cancer Centre Delivery Director/Daniel Wood Children's Cancer Planet Director**	06/04/2023	Finance and Investment Committee	March 2023

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
					L x C	T	L x C	T							
				• Changes in clinical brief required to maintain Works Cost Limit or additional funds required to fund an increase over and above budget (including inflation pressures) • Risk of time elapsing and the building remaining relevant and fit for purpose											
16	GOSH Learning Academy	**Principle 2: Values led culture / Principle 3: Safety and quality**	**Priority 1: Make GOSH a great place to work/ Priority 3: Develop the GOSH Learning Academy**	Risk of the GOSH Learning Academy not establishing a financially sustainable framework, impacting on its ability to deliver the outstanding education, training and development required to enhance recruitment and retention at GOSH and drive improvements in paediatric healthcare.	**4 x 3**	**12**	**2 x 3**	**6**	**Cautious**	1-2 years	Chief Nurse	**Tracy Luckett, Chief Nurse/ Lynn Shields, Director of Education**	14/04/2023	People and Education Assurance Committee	For September 2023

Attachment Y

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
6th July 2023

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment Y** □ **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
8 June 2023	Deed of Indemnity relating to the development at Great Ormond Street Hospital, Great Ormond Street, London, WC1N 3JH. Between GOSG FT and GOSH CC.	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