Meeting of the Trust Board
Wednesday 7 February 2024

Dear Members

There will be a public meeting of the Trust Board on Wednesday 7 February 2024 at 2:00pm in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.

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 30 November 2023**	Chair	**M**	
3.	**Matters Arising/ Action Checklist**	Chair	**N**	
4.	**Patient Story**	Chief Nurse	**O**	**2:10pm**
5.	**Learning from Deaths report- Child Death Review Meetings – Q2 2023/24**	Chief Medical Officer	**P**	**2:30pm**
6.	**Directorate Presentation – Body, Bones and Mind (BBM)**	BBM Senior Leadership Team	**Q**	**2:40pm**
7.	**Feedback from Non-Executive Director walkrounds**	Chair and NEDs	**Verbal**	**3:00pm**
	PERFORMANCE			
8.	**Chief Executive Update**	Chief Executive	**R**	**3:10pm**
9.	**Integrated Quality and Performance Report (Month 9 2023/24) December 2023 data**	Chief Medical Officer/ Chief Nurse/ Chief Operating Officer	**S**	**3:20pm**
10.	**Finance Report (Month 9 2023/24) December 2023 data**	Chief Finance Officer	**T**	**3:35pm**
	ASSURANCE			
11.	**Safe Nurse Staffing Report November 2023**	Chief Nurse	**U**	**3:45pm**
12.	**Staff Story – Impact of Industrial Action on Junior Doctors**	Chief Medical Officer	**Verbal**	**3:55pm**
13.	**Update from Guardian of Safe Working Q2 & Q3 2023/24**	Guardian of Safe Working	**W**	**4:15pm**

	STRATEGY AND PLANNING			
14.	**Progress Update on Annual Planning 2024/25**	Chief Operating Officer/ Chief Finance Officer	**Verbal**	**4:25pm**
15.	**Patient Safety Incident Response Framework**	Chief Medical Officer	**X**	**4:35pm**
	RISK AND GOVERNANCE			
16.	**Board Assurance Committee reports** • **Quality, Safety and Experience Assurance Committee – November 2023 and February 2024 (Verbal)** • **Audit Committee January 2024 including updates to the Board Assurance Framework (for approval)** • **Finance and Investment Committee Update – December 2023** • **People and Education Assurance Committee Update – November 2023 and February 2024 (Verbal)**	 Chair of QSEAC Chair of Audit Committee Chair of the Finance and Investment Committee Chair of the People and Education Assurance Committee	 **Y** **Z** **1** **3**	**4:45pm**
17.	**Register of Seals**	Company Secretary	**2**	**5:00pm**
18.	**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.)			
19.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 9 May 2024.			

DRAFT Minutes of the meeting of Trust Board on 30 November 2023

Present

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

In attendance

Cymbeline Moore	Director of Communications
Jason Dawson	Director of Space and Place
Dr Kiki Syrad	Director of Research and Innovation
Anna Ferrant	Company Secretary
Jennifer McCole	Director of Transformation
Victoria Goddard	Trust Board Administrator (minutes)
2 members of staff	
1 members of the public	

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

99	**Apologies for absence**
99.1	No apologies for absence have been received.
100	**Declarations of Interest**
100.1	No declarations of interest were received.
101	**Minutes of Meeting held on 18 October 2023**
101.2	The Board **approved** the minutes of the previous meeting.
102	**Matters Arising/ Action Checklist**
102.1	Minute 30.7 – Sanjiv Sharma, Chief Medical Officer said that recruitment of junior doctors was a key issue for GOSH as a large proportion of the Trust's junior doctor workforce was international. It was a complex area and the hospital continued to work with the GMC and Royal Colleges.

103	**Chief Executive Update**
103.1	Matthew Shaw, Chief Executive thanked colleagues in the hospital for their continued hard work to maintain high levels of activity and acknowledged the staffing issues and pressure in some areas of the organisation. He emphasised the importance of ensuring that beds remained open as far as possible to treat the backlog of patients. Some patients had waited a long time and Matthew Shaw said that it was important improve the Trust's position in terms of these long waiting patients.
103.2	Some key visitors had been welcomed to the Trust including the Shadow Secretary of State for Health and Social Care and the Children's Commissioner for England and this had provided an opportunity to highlight the support required for the paediatric agenda.
103.3	Gautam Dalal, Non-Executive Director asked about an influenza outbreak which had been reported in China and asked whether action was required. Matthew Shaw said that this had been discussed at the QSEAC meeting with the Director of Infection Prevention and Control and the IP&C team were well sighted in this matter which was being discussed at the Infection Prevention and Control Committee.
104	**Integrated Quality and Performance Report (Month 6 2023/24) September 2023 data**
104.1	John Quinn, Chief Operating Officer said that the metrics in the IQPR reflected the ongoing strike action that had been taking place during the reporting period. Long waiting patients remained a focus and a plan was in place to improve the position by March 2024. These trajectories were being discussed with NHS England and would be revised as required.
104.2	Friends and Family Test data remained strong however the number of open incidents was rising and this was being managed. Sanjiv Sharma confirmed that there had been an improvement in data around Duty of Candour and this was now rated green.
104.3	Tracy Luckett, Chief Nurse said that key areas of focus was nurse staffing and infection control metrics. Work was taking place to improve central venous line infection rates and consideration was also being given to the way in which data was presented and separating community and hospital acquired infections in the data.
104.4	Ellen Schroder, Chair said it was clear that access metrics were red rated and highlighted the importance of ensuring that clinicians had good visibility of their waiting list. Discussion took place around the point at which referrals were received and John Quinn said that whilst some referrals to GOSH had already experienced long waits, it was important to focus on areas on which the Trust did have influence such as ensuring that patients who had already been referred did not move into the category of long waiting patients.
104.5	Suzanne Ellis, Non-Executive Director highlighted that the number of cancelled operations was red rated and had increased and there had also been an increase in bed closures. She asked how this would be improved and John Quinn said that an action plan was in place around bed closures, and this had already had an

	impact. He said that whilst bed closures were extremely regrettable there were situations where the Trust was not able to provide safe staffing and difficult decisions around bed closures and patient cancellations were required. The action plan was managed by Heads of Nursing and General Managers and was reviewed weekly at the Operational Management Group meeting. John Quinn added that this had a significant impact on patient experience and complaints as well as activity and this had been reported to QSEAC.
104.6	Amanda Ellingworth said that although the Trust focused on recruitment and retention on an ongoing basis there continued to be key areas where there were challenges with staffing which impacted on bed closures. She asked for a steer on the level of confidence that the Trust would be able to reduce these challenges. Tracy Luckett said that although GOSH performed well against its peers, there continued to be vacancies and short-term sickness. She added that work was taking place around the decision making for bed closures and discussion about managing these risks were required through performance review meetings. Amanda Ellingworth asked if the activity level and bed capacity which had been projected was reasonable and Tracy Luckett said that the aim was to overrecruit to the nursing workforce to ensure that short term sickness levels were not detrimental to activity.
104.7	Ellen Schroder said that she had attended a meeting of Chairs with NHS England and a key focus had been on productivity, particularly in terms of the 19% increase in staffing in the NHS compared 2019/20. Matthew Shaw said that the London region had produced a graph of the growth in staffing against activity levels which had shown that GOSH's increase in staffing had been broadly in line with the increase in activity.
104.8	Caroline Anderson, Director of HR and OD said that there had been significant challenges in recent months which had impacted statutory and mandatory training performance for the Trust and particularly for honorary contract holders. The HR and OD team had been focused on the upgrade of the online training system and a change to the payroll service provider. Appraisal rates had also been impacted by the changes to the online training system and were now an area of focus.
105	**Finance Report (Month 7 2023/24) October 2023 data**
105.1	John Beswick, Chief Finance Officer said that there was a year-to-date deficit of £11.6million against plan primarily driven by additional costs and performance shortfall as a result of strike action. International and Private Care income growth had been substantial, but lower than planned.
105.2	NHS England had written to Integrated Care Boards (ICB) confirming that £800million of funding had been applied to mitigate costs because of industrial action and consequently Trusts had been required to submit new planned financial outturns in November 2023. North Central London ICB would be submitting a balanced plan; however, it was anticipated that GOSH's best outturn would be £6million deficit.
105.3	Ellen Schroder asked what proportion of the Better Value programme had been RAG rated green and John Beswick said that all parts of the programme related to revenue were rated green and the Trust continued to forecast that it would achieve all planned growth. Of the £16million cost related target approximately £10million had been developed. Each directorate had been working separately on

	schemes and focus was now being placed on cross cutting responses to matters such as access.
106	**Safe Nurse Staffing Report**
106.1	Tracy Luckett said that the nursing vacancy rate had reduced to 9% after 90 new nurses started in post. The 'STAY' retention strategy had been launched which included the development of KPIs to evidence directorates' commitment to achieving the retention set out in the plan and a Trust wide recruitment and retention meeting had been established. A proposal to over recruit against target was being developed as well as to begin international recruitment. Work was required around wellbeing, and ambassadorial roles for overseas nurses were being explored. The People and Education Assurance Committee had requested a more robust recruitment and retention plan be presented at the February 2024 meeting.
106.2	**Action:** Chris Kennedy asked for further information on the data that was available about why nurses left GOSH. Tracy Luckett confirmed that this data was being reviewed and would be included in the workforce assurance report going forward. The results of exit interviews in October had shown that colleagues were leaving London due to the cost of living and anecdotally causes were around accommodation and the very high activity levels leading to issues with work / life balance.
106.3	Gautam Dalal asked how long nurses remained at GOSH and Tracy Luckett said that band 5 nurses stayed for 2.5 years on average and band 6 for 4.5 years on average. She said that work was required to highlight the education that was available to newly qualified nurses and encourage retention. She added that the last international nurse recruitment campaign had been in 2020 and data showed that GOSH's retention was the best in North Central London in this group.
107	**Update on Annual Planning 2024/25**
107.1	John Quinn said that the Trust was working on its activity planning to ensure that this was in line with the Children's Cancer Centre business case which would add 2% activity. A town hall was taking place in the week following the Board meeting to share plans with the organisation and a series of challenge sessions would also be taking place at an earlier point in the year than in previous planning cycles.
107.2	John Beswick said that a multiyear plan had been developed as part of the Children's Cancer Centre business case and this would be built upon. Plans were being developed with the assumption that there would be no further periods of strike action.
107.3	**Action:** Ellen Schroder noted that the Trust's activity target for 2024/25 would be 114% and asked for a steer on activity levels for the current year. John Quinn said that activity was likely to end at between 107%-109% of 2019/20 activity. Gautam Dalal asked what proportion of capacity this comprised, and it was confirmed that work was taking place on demand and capacity with DRIVE and this would be reported to the Board. John Quinn said that it was anticipated that 114% activity was achievable however meetings would be taking place with directorates to discuss capacity and the findings would be shared with the Board. Matthew Shaw said that the hospital was extremely busy, and it was likely that

	investment would be required to generate capacity in the hospital prior to the completion of the Children's Cancer Centre.
107.4	Chris Kennedy highlighted that GOSH was part of an Integrated Care System (ICS) which was projecting a balanced outturn, and this had previously been challenging to achieve. John Beswick said that a meeting of ICS CFOs would be taking place on 1st December 2023 to discuss this matter.
108	**Transformation Update**
108.1	Jennifer McCole, Director of Transformation said that the role of the transformation team was to coordinate the transformation work taking place in the organisation and to support understanding its impact. In March to May 2023 an overview of the transformation projects in the Trust was undertaken. It was agreed that as the impact had not been sufficiently high, focus would be placed on the following key areas which were likely to have the greatest impact.
108.2	<u>Day Case Improvement</u>
108.3	The aim of the programme was to avoid overnight stays which would be impactful for those patients, totalling approximately four or five a day, and also to those patients who did require an overnight stay and would have more readily available access to beds. Colleagues had been seconded to undertake this project which had enabled the team to review admission criteria and capacity.
108.4	<u>Paediatric Critical Care Level 1 and 2 (HDU)</u>
108.5	Jennifer McCole said that this project was a more complex change which involved developing a new model of care that was predicted to impact up to 20% of beds in the organisation and was likely to lead to the largest high dependency unit nationally. A clinical team had been appointed and a business case would be developed within 6 months including revenue and capital implications.
108.6	<u>Ambulatory care</u>
108.7	Ambulatory care was a key component in offering holistic, personalised and coordinated care and would be piloted in cancer services in the first instance.
108.8	<u>Pharmacy Manufacturing Improvement</u>
108.9	Priorities in the coming weeks included the development of options to meet the inpatient demand for Total Parenteral Nutrition (TPN) and the go live of an education and training programme.
108.10	<u>Pain Rehabilitation Programme</u>
108.11	The Transformation Team was providing project management support to establish a new Paediatric Pain Rehabilitation Programme (PPRP). Discussion was taking place with the DRIVE and quality teams around working together closely to make a change.
108.12	Colleagues had been seconded to transformation projects which had supported the development of their skills for integrating into their home teams. Clear communications around the reasons for projects being initiated and potentially ended was being prioritised.

108.13	Suzanne Ellis said that developing an integrated change narrative would be important to ensure that projects were not discrete pieces of work and asked whether a transformation strategy was in place. She added that it was important to ensure that relevant data was collected to identify impact. Jennifer McCole said that a key enabler was broadening attendance at the Future Hospitals and Access to Care Board and ensuring that projects were taking place in a coordinated way.
108.14	Ellen Schroder highlighted the importance of sustainability as an overarching theme of transformation and added that it was important that initial projects were successful in order to build confidence in the organisation. Jennifer McCole said that projects were being sequenced based on organisational priorities identified by the clinical directorates led by the Chief Executive and the Chief Operating Officer. Gautam Dalal highlighted that the clinical intelligence unit would support the identification of areas for improvement and Matthew Shaw said that the availability of beds was the Trust's primary issue which could support improved utilisation and the day case project would make improvements in this area.
108.15	**Action:** Gautam Dalal requested a cascade diagram to depict the cumulative progress that would be made as a result of the transformation programme.
108.16	Russell Viner, Non-Executive Director highlighted that Trusts had been asked to make a 30% reduction in outpatient appointments. He asked whether sufficient consideration was being given to this area. He said that in the future it was likely that patients would only require an inpatient stay for high dependency care and asked whether a strategy was in place which would answer these longer-term questions. Matthew Shaw said that outpatients was an important area and while there were opportunities to be more efficient in terms of appointments, GOSH's patients were complex and were treated throughout their childhoods and the cycle of their illness. John Quinn agreed that it was important to consider the future of healthcare due to its links to the strategy and masterplan and this was being discussed with DRIVE.
108.17	Amanda Ellingworth said that it was important to incorporate health inequalities in all transformation programmes and Ellen Schroder agreed, adding that it was likely that different action would be required for patients and families who were subject to different inequalities. Chris Kennedy said that health inequalities as a standalone issue would benefit from the focus and change management skills which were part of the transformation programme. Tracy Luckett said that health inequalities was an overarching project which was linked to all programmes of work. John Beswick said that it was important to ensure that a project was identified which would lead to improvements for patients, families, staff and was also drove efficiencies.

109	**Diversity and Inclusion Annual Report**
109.1	Caroline Anderson said that the Diversity and Inclusion Annual Report had been discussed at the PEAC meeting and some amendments would be made to the report around clarity of language. Amanda Ellingworth said that the Committee had welcomed the progress made as the start of a journey and requested that the Trust was more ambitious in this regard.
109.2	There had been improvements in seven of nine Workforce Race Equality Standards (WRES) including an increase in the representation of global majority colleagues. There had also been an improvement in the gender pay gap which was a consequence of work over several years.
109.3	The number of staff who had declared a disability was approximately 4% and this was under reported in comparison to the staff survey which was an indicator of staff feeling comfortable to report. Ellen Schroder welcomed the improvement in the gender pay gap and noted that there had also been an improvement in the gender gap around clinical excellence awards.
109.4	**Action:** Ellen Schroder expressed some surprise at the lack of global majority representation in the nursing and allied health professional workforce. She said that although improvements had been made, more must be done in this regard. Caroline Anderson said the Trust had been focusing on local recruitment and this had already begun to have an impact. The Trust's apprenticeship programme was also successful in recruiting colleagues from diverse backgrounds. Cymbeline Moore, Director of Communications said that although some progress had been made, the perception of GOSH was that it was not an inclusive organisation and it was important that the Trust challenged itself in this regard. Ellen Schroder requested that the Board undertake antiracism training at the earliest opportunity.
109.5	**Action:** The Board noted that an error had been made in table 3.10 in which two column headings had been reversed and it was agreed that this would be corrected.
109.6	**Action:** Chris Kennedy asked how far the insourcing of staff accounted for the improvement in the balance between global majority and white colleagues and it was agreed that this breakdown would be provided. Amanda Ellingworth said that focus at PEAC should be placed on comparing lower and higher banded staff and the data around promotion, grievance and disciplinary action.
110	**Key Governance Documents**
110.1	<u>Schedule of Matters for the Trust Board</u>
110.2	Anna Ferrant, Company Secretary said that the document, which was required under the Code of Governance, set out the powers reserved for the Trust Board. It also reflected the work of the Board Assurance Committees, the Council of Governors, and working in an integrated care landscape and with external partners such as the GOSH Charity. The document had been updated and reformatted.
110.3	Suzanne Ellis highlighted the new matter related to the work of the GOSH Charity and approval of naming rights. She asked whether this had been agreed with the

	Charity and Matthew Shaw confirmed that this had been worked through in detail as part of the Memorandum of Understanding between the hospital and charity.
110.4	The Board **approved** the revised Schedule of Matters reserved for the Trust Board.
110.5	<u>Standing Financial Instructions and Scheme of Delegation</u>
110.6	John Beswick said that the document had been reviewed by the Audit Committee. The Trust was in a period in which there was a need to maintain financial control however it was important to balance this with ensuring that levels of responsibility were appropriate to allow individuals to take action where necessary.
110.7	**Action:** It was agreed that John Beswick would ascertain whether the Trust had the authority to set the financial limit at which the Board was required to approve contracts at £5.5million.
110.8	**Action:** John Beswick said that the term 'commercial contract' would be updated to 'procurement contract'.
110.9	Subject to the above change and confirmation of the financial limit for Trust Board approval of contracts, the Board **approved** the amendments to the Standing Financial Instructions and Scheme of Delegation.
110.10	**Action:** Matthew Shaw said contracts above a certain threshold should be shared with the Finance and Investment Committee.
111	**Update on Board Assurance Framework and revised Trust Risk Appetite Statement**
111.1	Anna Ferrant said that the updates had been discussed by the Audit Committee were recommended for approval by the Board:
111.2	<u>BAF risk 8: Business Continuity</u>
111.3	The Audit Committee had considered a revised BAF risk statement and proposed this was redrafted from a strategic and future risk management perspective and was not context specific.
111.4	The Board **noted** the update.
111.5	<u>BAF risk 11: Medicines Management</u>
111.6	The Audit Committee and QSEAC had agreed that considerable work had taken place around medicines management and following a deep dive the committees had both agreed that a reduction in the net risk score from 20 to 15 was appropriate.
111.7	The Board **approved** the change to the net risk score.
111.8	<u>BAF risk 13: Mental Health Strategy</u>
111.9	The controls, assurances, gaps and scores of the risk had been reviewed by the QSEAC and Audit Committee and were recommended for approval.

111.10	The Board **approved** the risk.
111.11	<u>BAF risk 17: International and Private Care and Commercial</u>
111.12	The Board had previously agreed that this risk would become standalone rather than being incorporated into the financial sustainability risk as it had been previously. The Finance and Investment Committee and Audit Committee had agreed the controls, assurances and scores for the risk and they were **approved** by the Board.
111.13	<u>BAF risk 18: Health Inequalities</u>
111.14	The QSEAC and Audit Committee had agreed the risk statement, controls, assurances and scores. The Board noted the importance of health inequalities and discussed how far the risk was within GOSH's control. Russell Viner said that many of the changes made in the future such as increasing digitalisation was likely to increase inequalities and Tracy Luckett said that health inequalities were a key part of discussions in many operational and clinical meetings. She said that although the breadth of the subject was considerable there were a number of areas which were within GOSH's control.
111.15	The Board **approved** the risk statement, controls, assurances and scores.
111.16	Anna Ferrant said that the Trust's risk appetite statement had been updated and would continue to be a live document which would be used as a framework for reviewing the BAF through assurance committees.
111.17	The Board **approved** the revised risk appetite statement.
112	**Board Assurance Committee reports**
112.1	<u>Audit Committee October 2023</u>
112.2	Gautam Dalal, Chair of the Audit Committee said that the meeting had primarily focused on reviewing BAF risks and undertaken BAF risk deep dives. A tender process for audit arrangements was also ongoing and this had been discussed.
112.3	The Board noted the challenges that some Trusts had experienced in receiving bids for audit tenders and Gautam Dalal said that an alternative solution had been discussed with the current auditor in the event that no external audit bids were received.
112.4	<u>Finance and Investment Committee Update – November 2023</u>
112.5	Suzanne Ellis, Chair of the Finance and Investment Committee said that the Committee had discussed the advanced works proposal for the Children's Cancer Centre and the financial forecast for the second half of 2023/24.
112.6	<u>People and Education Assurance Committee Update – November 2023</u>
112.7	Kathryn Ludlow, Chair of the PEAC said that the committee had reviewed the workforce metrics and noted that sickness absence was above the Trust's target. There had been a reduction in the appraisal rate, and this was an area of focus. A new framework for cultural engagement had been developed and this had been reviewed by the committee. A staff story had been received from the Chaplaincy

	team and the committee noted the excellent service they provided to patients, families and staff.
112.7	There had been 22 contacts made with the Freedom to Speak Up Guardian in the quarter which was in line with the previous quarter.
112.8	<u>Quality, Safety and Experience Assurance Committee – November 2023</u>
112.9	Amanda Ellingworth said that the committee had discussed long waiting patients as well as the quality focus in transformation and an update had been received on progress made with the action plan arising from an external review. There had been 15 quality related cases raised to the Freedom to Speak Up Guardian and the committee had highlighted the importance of triangulating 'weak signals' to identify potentially emerging issues.
112.10	A report had been published from Sands & Tommy's Policy Unit which had high level learning which was relevant to all Trusts and in response discussion would be taking place around QSEAC agendas to ensure that the committee had the capacity to discuss key matters.
113	**Council of Governors' Update**
113.1	Anna Ferrant said that the Council had discussed and approved governance matters related to Non-Executive Director recruitment, appointment, tenure and remuneration and a report had been received from the Young People's Forum who had provided feedback around the importance of the GOSH main entrance to patients and families. They had also discussed the ward naming policy and its application to the Children's Cancer Centre.
114	**Register of Seals**
114.1	The Board **endorsed** the use of the company seal.
115	**Any Other Business**
115.1	There were no items of other business.

Attachment N

TRUST BOARD – PUBLIC ACTION CHECKLIST
February 2024

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
106.2	30/11/23	Chris Kennedy asked for further information on the data that was available about why nurses left GOSH. Tracy Luckett confirmed that this data was being reviewed and would be included in the workforce assurance report going forward. The results of exit interviews in October had shown that colleagues were leaving London due to the cost of living and anecdotally causes were around accommodation and the very high activity levels leading to issues with work / life balance.	TL	February 2024 and ongoing	Actioned and included in future workforce assurance reports to PEAC
107.3	30/11/23	Ellen Schroder noted that the Trust's activity target for 2024/25 would be 114% and asked for a steer on activity levels for the current year. John Quinn said that activity was likely to end at between 107%-109% of 2019/20 activity. Gautam Dalal asked what proportion of capacity this comprised, and it was confirmed that work was taking place on demand and capacity with DRIVE and this would be reported to the Board. John Quinn said that it was anticipated that 114% activity was achievable however meetings would be taking place with directorates to discuss capacity and the findings would be shared with the Board. Matthew Shaw said that the hospital was extremely busy, and it was likely that investment would be required to generate capacity in the hospital prior to the completion of the Children's Cancer Centre.	JQ	February 2024	Update on annual planning on the Trust Board public agenda
108.15	30/11/23	Gautam Dalal requested a cascade diagram to depict the cumulative progress that would be made as a result of the transformation programme.	Jennifer McCole	May 2024	Not yet due
109.4	30/11/23	Ellen Schroder requested that the Board undertake antiracism training at the earliest opportunity.	CA	February 2024	Plans being developed for Board training in April 2024 at a Board Development session
109.5	30/11/23	Seen and Heard Report: The Board noted that an error had been made in table 3.10 in which two column headings had been reversed and it was agreed that this would be corrected.	CA	December 2023	In progress
109.6	30/11/23	Chris Kennedy asked how far the insourcing of staff accounted for the improvement in the balance between global majority and white colleagues and it was agreed that this breakdown would be provided. Amanda Ellingworth said	CA	January 2024	Action passed to PEAC

Attachment N

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		that focus at PEAC should be placed on comparing lower and higher banded staff and the data around promotion, grievance and disciplinary action.			
110.7 110.8	30/11/23	<u>SFIs and Scheme of Delegation</u> It was agreed that John Beswick would ascertain whether the Trust had the authority to set the financial limit at which the Board was required to approve contracts at £5.5million. John Beswick said that the term 'commercial contract' would be updated to 'procurement contract'.	JB	February 2024	The Chief Finance Officer confirmed the following with Audit Committee NED members (via email) in January 2024: • It is a matter for individual Trusts to set this financial limit of £5.5 million. • Section 7.2 referred to 'Commercial contracts' and this has been amended to 'Procurement contracts'. On this basis, Audit Committee members approved the updated Scheme of Delegation and Standing Financial Instructions.

Attachment O

Trust Board 7 February 2024	
Patient Story - Experience of support for families with a young baby **Submitted by** Tracy Luckett, Chief Nurse **Prepared by** Claire Williams and Luke Murphy, Patient Experience	**Paper No: Attachment O** □ **For information and noting**

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

Summary
Ethan, aged 4 ½ months, was admitted to GOSH in December 2023 and is under Gastroenterology. Currently on Squirrel ward, Ethan's mother will attend Trust board in person to share her experiences of being in hospital with a young baby, the support provided including from Play and areas we can improve on.

Patient Safety Implications
N/a

Equality impact and experience implications
N/a

Action required from the meeting
For information

Strategic risk implications
BAF Risk 12: Inconsistent delivery of safe care

Financial implications
Not Applicable

Implications for legal/ regulatory compliance
- The Health and Social Care Act 2010
- The NHS Constitution for England 2012 (last updated in October 2015)
- The NHS Operating Framework 2012/13
- The NHS Outcomes Framework 2012/13

Consultation carried out with individuals/ groups/ committees
N/a

Who is responsible for implementing the proposals / project and anticipated timescales?
Head of Patient Experience

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

Attachment P

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7th February 2024

Learning from deaths report –learning from Child Death Review Meetings. Q2 2023/24 **Submitted by:** Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews Andrew Pearson, Clinical Audit Manager	**Paper No: Attachment P** 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
This report focuses on learning from eleven child death review meetings (CDRMs) which took place at GOSH between 1st July and 30th September 2023.

The reviews highlighted:
- In no cases were modifiable factors identified by the CDRM in the care provided at GOSH. In no cases were modifiable factors identified by the CDRM where there is learning outside of GOSH.
- 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 seven cases.
- Excellent aspects of care, the co-ordination of care and communication at GOSH were highlighted by the CDRMs in nine cases.

This report highlights learning from CDRMs concluded in Q2. In addition to that we conduct a six-monthly thematic review of learning identified from CDRMs over a longer period to better aggregate and identify wider themes, and that updated analysis will be included in the next report.

CDRM meetings should ideally be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews. It should be noted that this timeframe is guidance and not a statutory requirement. At the time of writing forty-seven CDRMs have not been completed within 12 weeks of the child's death. There are challenges in clinical staffs' capacity and work required to arrange and attend the meetings. There has been impact of industrial action on capacity for clinical staff to attend meetings. All GOSH CDRMs are chaired by the Medical Lead for Child Death Reviews, and there can be constraints in available time in the role to chair multiple meetings. A plan has been agreed with the Chief Medical Officer to resource additional capacity for chairing CDRM meetings and supporting the Mortality Review Group. This additional resource is expected to be available from April 2024. There has been a recent increase in clinical volunteers to attend the Mortality Review Group which should help advance CDRM planning.

Action required from the meeting
There are no recommendations for the Board to consider.

Attachment P

Patient Safety Implications None identified.
Equality impact implications No health inequalities have been identified in this report.
Financial implications None
Strategic Risk BAF Risk 12: Inconsistent delivery of safe care
Consultation carried out with individuals/ groups/ committees The report has been reviewed by the January 2024 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? Chief Medical Officer

Learning from deaths report –learning from Child Death Review Meetings. Q2 2023/24

Aim of this report

To highlight learning from child death review meetings (CDRMs) concluded between 1st July and 30th September 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. This report focuses on learning from **eleven** child death review meetings (CDRMs) which took place at GOSH between 1st July and 30th September 2023.

The reviews highlighted:

- In **no** cases were modifiable factors[1] identified by the CDRM in the care provided at GOSH. In **no** cases were modifiable factors identified by the CDRM where there is learning outside of GOSH.
- 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 **seven** cases.
- Excellent aspects of care, the co-ordination of care and communication at GOSH were highlighted by the CDRMs in **nine** cases.

This report highlights learning from CDRMs concluded in Q2. In addition to that we conduct a six-monthly thematic review of learning identified from CDRMs over a longer period to better aggregate and identify wider themes, and that updated analysis will be included in the next report.

CDRM meetings should ideally be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews. It should be noted that this timeframe is guidance and not a statutory requirement. At the time of writing forty-seven CDRMs have not been completed within 12 weeks of the child's death. There are challenges in clinical staffs' capacity and work required to arrange and attend the meetings. There has been impact of industrial action on capacity for clinical staff to attend meetings. All GOSH CDRMs are chaired by the Medical Lead for Child Death Reviews, and there can be constraints in available time in the role to chair multiple meetings. A plan has been agreed with the Chief Medical Officer to resource additional capacity for chairing CDRM meetings and supporting the Mortality Review Group.

Contents

Further information follows this summary.

9th January 2024

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

[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)

Learning points identified

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

Month of death	Specialties	Summary
January 2022	CICU	Learning identified in a root cause analysis report in 2022. MDT meetings are crucial tools for managing the care of complex multi-specialty patients. **Recommendations from RCA report:** Where a discussion is required between two teams, neither of which are the lead specialty, this should take place directly between those teams without involving the lead speciality as a “middleman” to avoid miscommunication. All decisions should then be communicated with the lead speciality team. Where a patient’s main problem or concern significantly changes over the course of an admission, consideration should be given as to whether the admitting specialty should remain as lead in their care. This decision should be made in an MDT environment. Ensure that the investigation and timeline is shared with the Deteriorating Patient Steering Group, for their consideration and incorporation into their ongoing workstreams. Ensure that the findings in the final report are fed into the on-going themed work the Trust is undertaking to address issues relating to documentation, including clarity of recommendations and accuracy of documentation. The coroner raised concern regarding the PEWS scoring which cannot be adjusted within the records system to a variation in relevant baseline for some children, therefore it will be necessary to address how the decision-making works for patients with known unusual baselines and this has been fed into the Trust wide deteriorating patient project. The coroner recommended that GOSH ensure there is appropriate and understandable disclosure of observation records. This arose from a detailed discussion of the 'observations', which do not appear in the medical records in a tabular format, in the same way they do on the 'live' version of EPIC, and the family had been unable to locate the relevant observations and PEWS scores from the medical records produced from EPIC (which ran to about 8000 pages). There is no obvious solution to this and has been explored with electronic notes provider (Epic). **The learning from the root cause investigation was reviewed at the Deteriorating Patient QI Project Steering Group in 2022 to inform the workstreams of that project**
January 2023	CICU	GP fed back that they were not updated throughout the child's admission and did not receive a discharge summary of the events or social issues which made it much more challenging to provide ongoing support to the mother. This was identified as a learning point in terms of the importance of the local teams being able to support the wider family (regardless of the discharge location) especially after death.
February 2023	PICU	1. Parents found the delay in transfer from local to GOSH (5 days) very difficult. Patient was stable in local hospital and there are limited beds at

		GOSH that require prioritisation for children who are unstable and require urgent treatment. This is a recurring theme. 2. Referral made to palliative care by PICU was declined. Patient already known to the team for oncology outreach/esc. Following a conversation with the oncology team they also feel the referral is not appropriate at the moment for palliative care as they expected child to recover from the acute episode. 3. Previous social care issues were not known to several members of the MDT at the CDRM (local hospital, CCN, GOSH etc) Unfortunately the social care team were not at the CDRM however the CDR Specialist nurse will arrange a separate meeting with relevant teams to ensure coordinated support is being provided to mother.
February 2023	Neuroradiology/ neurology/neuro surgery/PICU)	1. The teams involved have reflected on the multidisciplinary decision to proceed with lumbar puncture (Neuroradiology/neurology/neurosurgery/PICU) in a child with fixed and dilated pupils which demonstrated high opening pressures. 2. All unexpected deaths should be subject to a Joint Agency response meeting to enable an immediate review of the care provided especially if child presented previously to other health care providers in the days/weeks prior to the final admission
January 2023	PICU	1. Parents fed back that communication in the final days at end of life around the anticipated timing of death lacked compassion. The child acutely desaturated and appeared to be dying but stabilised for another few days. This has been identified as a learning point in terms of communicating the uncertainty about end of life to families to prevent this distress for other families in the future.
February 2023	CICU	1. Referred to and seen by GOSH palliative care team. Was not referred antenatally which was identified as a learning point. 2. Communication with local teams - It would appear that the Health Visitor had not been informed of baby's admission or (life limiting) condition. Health visitor called mother to arrange New Birth visit.
February 2023	PICU	1. National Learning Issues around parental understanding / communication. Suggestion that there should be multidisciplinary clinics for the parents of children with multi complexities. This would provide consistent messages to families from all professionals. Some areas already have CP clinics however this service would benefit many other children with complex clinical requirements. 2. Parents identified that having Trisomy 21 listed under 'Problem List' in clinical correspondence was not appropriate. The team to whom this was fed back have already changed their practice to list 'Current Issues' in place of 'Problem List' in response to this feedback.

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

Month of death	Specialties	Summary
August 2022	ECMO/Palliative Care	Good communication, very good support from family liaison teams (for example providing extra accommodation for the family) ECMO nurses led the redirection of care. Palliative care were involved in supporting the family with transfer to hospice after death. Family fed back that they were extremely grateful that their child was given every opportunity
January 2023	Metabolic	Very positive feedback for Metabolic Consultant who was exceptional in communication around the prognosis with this family. This has already been fed back to the individual via the PRAISE system.
December 2022	PICU	Child was a successful organ donor and parents have reported in national media highlighting that all children can be organ donors and how much they valued this opportunity.
January 2023	CICU	Father was very grateful for the care provided and wanted to return to personally thank the nurses who were there at the time of the child's death. This has also been fed back to the nursing team involved in the child's care.
February 2023	Lion Ward/PICU/Oncology /CVAT team	*Feedback from parents: "Happily we have a caring and attentive GP, who was aware of my ongoing concerns. At her 8 week check he carried out much more extensive checks than are usually carried out at this appointment. From the moment we stumbled into Great Ormond Street Hospital in a blind panic with a tiny baby, to the moment I was rolled out in a wheelchair without her, we had the most exceptional, considerate, high quality, all-round loving care I could possibly imagine. We felt utterly confident in her treatment protocol and in every aspect of [name']s care on both Lion Ward and PICU. I think of GOSH as the place where incredible, knowledgeable, kind people held our hands through the most horrific time of our lives. They treated our child promptly and responsively, they loved her and cared for her and got to know her in a way that went far beyond anything I could ever have expected or imagined. They reassured and supported my husband and I in ways I never expected or imagined*. "Individuals listed and thanked from Oncology/PICU/CVAT teams
February 2023	PICU	Rapid diagnosis and investigations on arrival to GOSH, SNOD referral and organ donation, positive verbal feedback from family who have also gone on to fundraise for GOSH
January 2023	Respiratory/PICU/Psychology	Psychology helped to support daily updates from PICU and facilitated visits from the Leopard team to the child on PICU from the lead Respiratory speciality consultant to the long-term ward nursing team at the end of life which prevented hearsay and was an example of excellent practice that could be helpful to other speciality teams across the Trust.
February 2023	CICU	Extensive conversations with family, spiritual care team, and primary care team. End of life care very well managed.

February 2023	PICU	All the relevant teams worked hard to ensure coordinated care for this child (including seeking second opinions, arranging timely investigations) and in all aspects of working with this family across the multidisciplinary team to accommodate their concern and questions both during life and in the follow up provided after death.

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 meeting 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

Eleven CDRMs took place at GOSH between the 1st of July and 30th September2023.
CDRM meetings should be held within 12 weeks of the child’s death, following the completion of all necessary investigations and reviews. It should be noted that this timeframe is guidance and not a statutory requirement. The Child Death Review Statutory and Operational Guidance states “*The meeting should take place as soon as is practically possible, ideally within three months, although serious incident investigations and the length of time it takes to receive the final post-mortem report will often cause delay”*

At the time of writing forty-six CDRMs have not been completed within 12 weeks of the child’s death:

- **Thirteen** cannot take place until the completion of necessary coroner/external investigations.
- **Thirty-three** are being scheduled at the time of writing due to challenges in clinical staffs’ capacity and work required to arrange and attend the meetings. There has been impact of industrial action on capacity for clinical staff to attend meetings. All GOSH CDRMs are chaired by the Medical Lead for Child Death Reviews, and there can be constraints in available time in the role to chair multiple meetings.

There are challenges in clinical staffs’ capacity and work required to arrange and attend the meetings. There has been impact of industrial action on capacity for clinical staff to attend meetings. All GOSH CDRMs are chaired by the Medical Lead for Child Death Reviews, and there can be constraints in available time in the role to chair multiple meetings. A plan has been agreed with the Chief Medical Officer to resource additional capacity for chairing CDRM meetings and supporting the Mortality Review Group

We are aware of a small number of cases for patients who died outside of GOSH which have been closed by the Child Death Overview Panel without a CDRM being concluded. We intend to meet guidance and best practice principles to identify learning by continuing to hold CDRMs

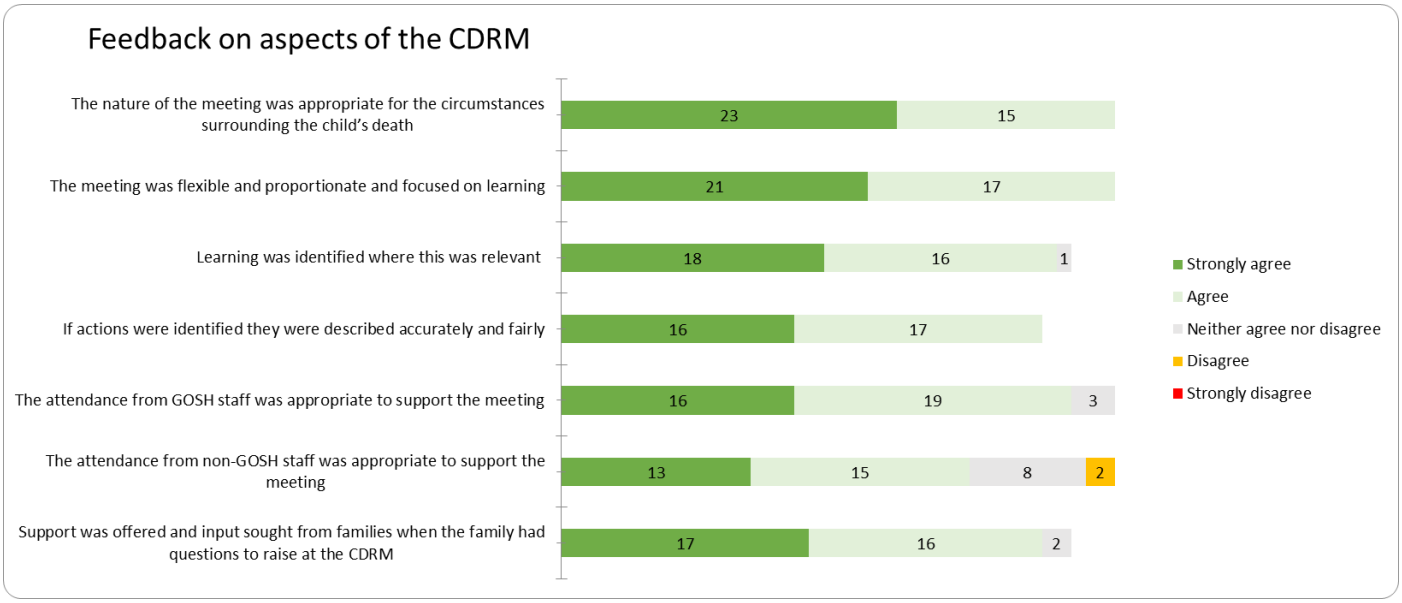
Feedback on CDRMs

Audit is underway to review the CDRMs as part of an action plan in response to external learning review recommendations which apply to the child death review process at GOSH.

Audit to evaluate the views of all CDRM attendees commenced in September 2023 and is embedded into the CDRM process to allow continual feedback. This helps to gain feedback from CDRM attendees to assess the quality of engagement of GOSH in line with aims and principles of the CDRM as per national guidance.

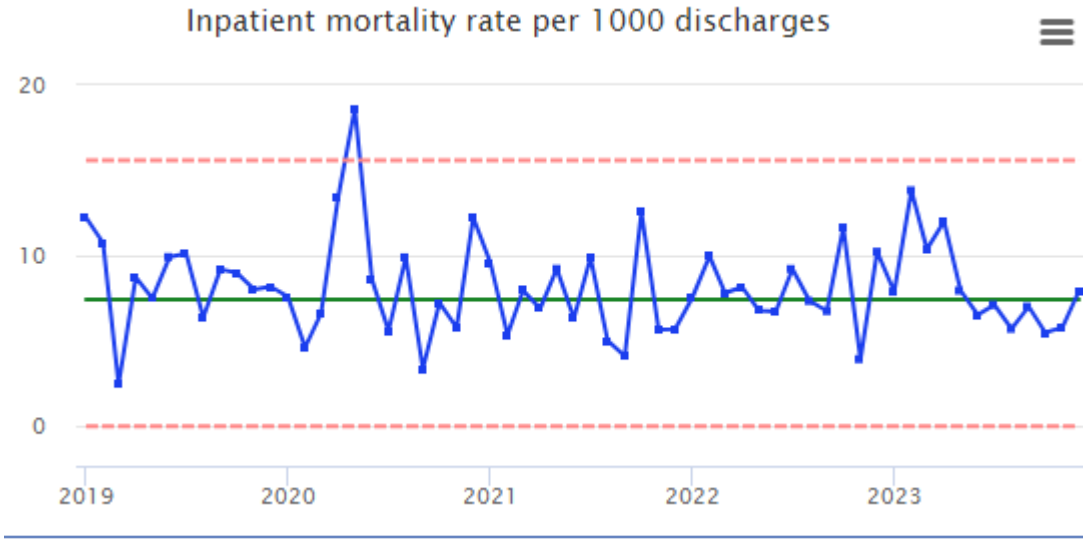
This enhances our governance as it allows feedback on the effectiveness of the CDRM to be reviewed by the Medical Lead for Child Death Review in real time, including suggestions for improvements and reflections and feedback on what worked well.

Feedback has been received from 38 CDRM attendees since September 2023.Key metrics are positive and are summarised below.



Mortality rate

The inpatient mortality rate is within normal variation and there are no signals of concerns in our risk adjusted ICU mortality data.

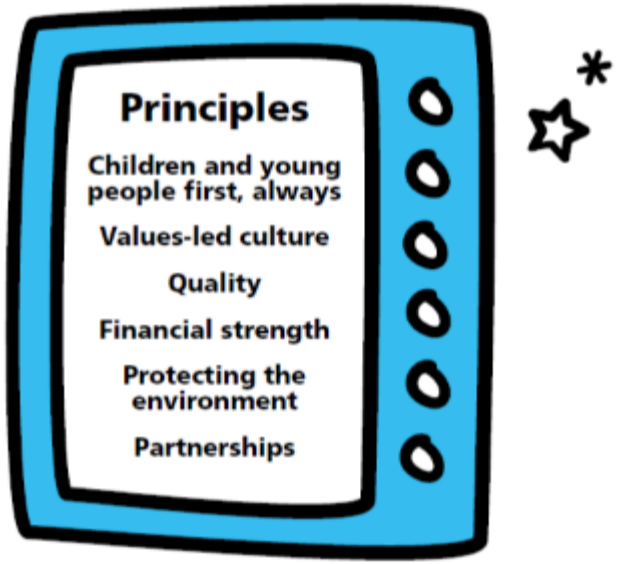


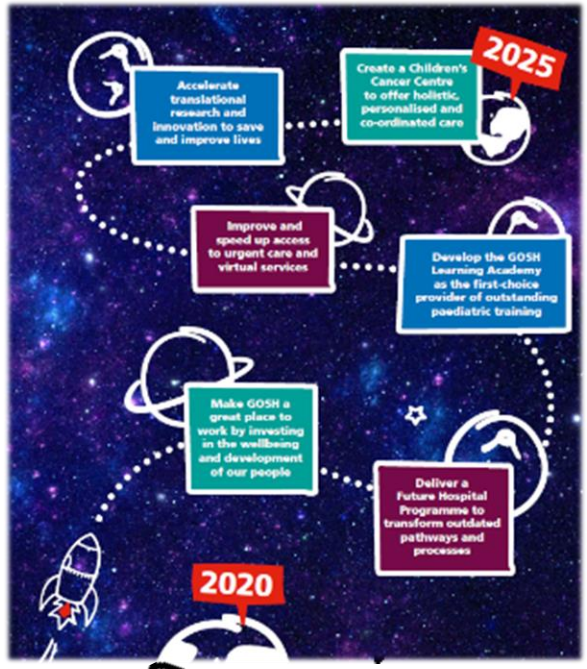
We monitor our hospital mortality rate and check for any trends and changes in real time, and this is reported every month in our Integrated Quality and Performance Report (IQPR). Importantly we also look at risk adjusted data, which considers how unwell the patient was on admission and the likelihood of death as a potential outcome.

There have been no outliers detected in our real time risk adjusted monitoring of ICU deaths. This is important as the majority of patient deaths at GOSH are in intensive care areas. Risk adjusted mortality is monitored at the PICU/NICU/CICU Morbidity and Mortality meetings.

The gold standard for measuring paediatric mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANet). 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

BODY BONES AND MIND DIRECTORATE REVIEW





Trust Board
February 2024

Sian Pincott - Chief of Service

Nick Towndrow - General Manager

Carly Vassar - Head of Nursing and Patient Experience and Deputy Chief of Service

Team Organogram

Chief of Service

Sian Pincott

Head of Nursing and DCOS

Carly Vassar

General Manager

Nick Towndrow

Gastroenterology

Specialty Lead: Osvaldo Borelli

Service Manager: Sacha Lee- Chiti

General Paediatrics

Specialty Lead: Imke Meyer-Parsons

Service Manager: Joseph Stevens

SNAPS

Specialty Lead: Simon Blackburn

Service Manager: Joseph Stevens

Spinal and Orthopaedics

Specialty Lead: Vacant

Service Manager: Tamika Rennie

Renal

Specialty Lead: Matko Marlais

Service Manager: Tamika Rennie

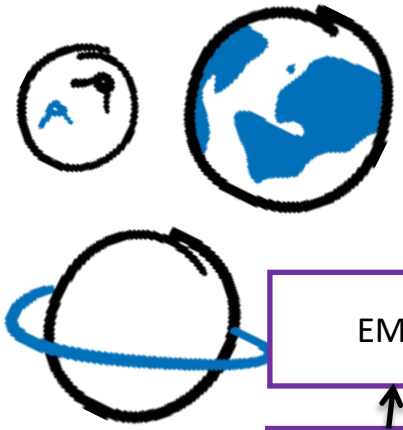
PAMHS

Specialtyy Lead: Simon Wilkinson and Helen Griffiths

Service Manager: Sacha Lee Chiti

Deputy General Manager Toni Lawrence

Matron Team Claire Waller, Nadia Gooden and John Forrester



BRAIN

Key to meeting purpose:
Performance
Communication
Green mtg – external
Purple mtg – internal

Not yet in place

EMT

Ops Board (Fortnightly)

BBM Directorate Performance Meeting
Monthly

BBM Board Meeting
Chair: Sian Pincott
Monthly P C

External meeting, representing GOSH

Directorate Huddle
Chair: Sian Pincott
Weekly Friday C P

Directorate Quality & Safety Committee Meeting
Chair: Carly Vassar
Alternate Months P C

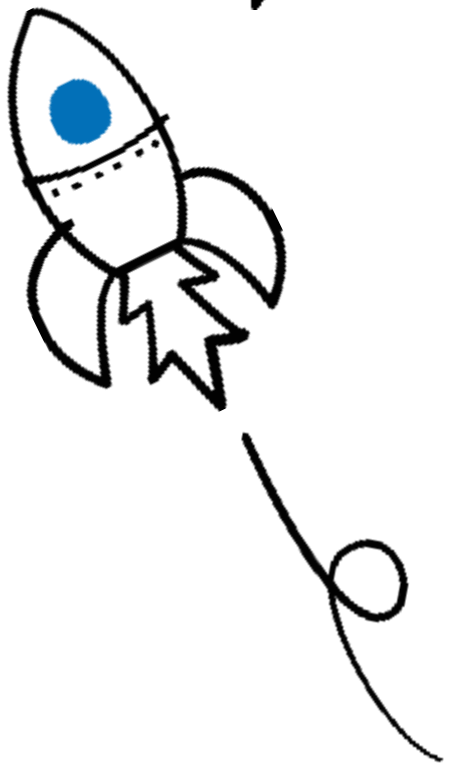
Specialty RAGs and business meetings

Budget meetings

Mental Health Oversight Committee

Performance meeting

Local team meetings
- Ward meetings
- Consultants' meetings
- Trainee meetings



Directorate Profile

Our Budget:

- Annual Budget 22/23: £29.8m

Our Space

- **Eagle** – Acute Renal Ward
- **Eagle Dialysis** – Dialysis Unit
- **Squirrel Gastroenterology**– Gastroenterology Ward
- **Gastro Investigation Unit** – Endoscopy theatre and gastroenterology Investigation Unit.
- **Sky** – Spinal and Orthopaedic Ward with HDU.
- **Chameleon** – SNAPS Ward with Neonatal HDU
- **MCU** – Tier 4 Non secure CAMHS inpatient unit
- **Panda Day care** – Feeding and Eating Disorders Unit

Our Highly Specialised Services:

- Paediatric Intestinal Pseudo-obstruction (PIPO) Service
- Intestinal Transplantation (with King's College Hospital)
- Haematopoietic Stem Cell Transplantation for severe immune-mediated gastrointestinal inflammatory disease

Our Staff

Staff Group	WTE
Additional Clinical Services	65.7
Add Prof Scientific and Technic	53.0
Administrative and Clerical	53.8
Allied Health Professionals	0.0
Estates and Ancillary	5.5
Healthcare Scientists	0.0
Medical and Dental	89.8
Nursing and Midwifery Registered	207.5
Grand Total	**477.4**

Our Specialties

- Spinal
- Orthopaedics
- Gastroenterology
- PAMHS – previously separated as CAMHs and Psychology
- Nephrology
- Specialist and Neonatal Paediatric Surgery
- CEW – Complications of excess weight
- General Paediatrics- including Safeguarding

Top three successes

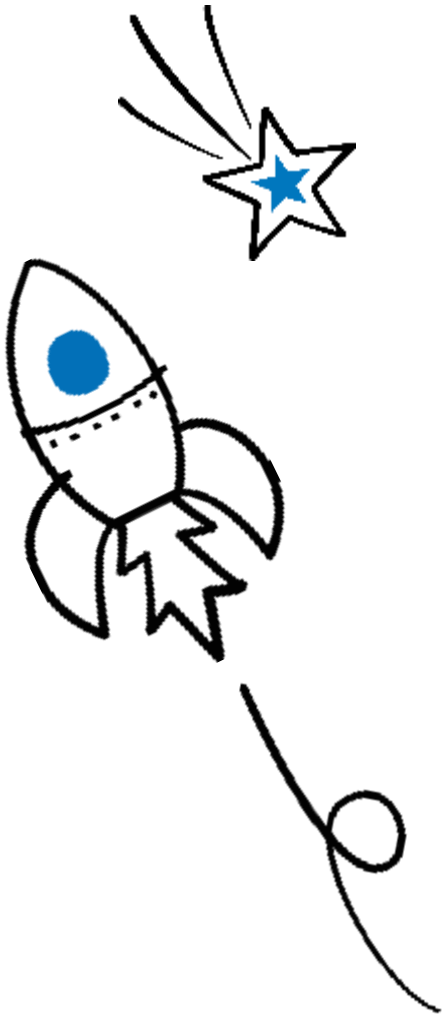
- First ever Conjoined twins MDT clinic
- Planning and move to new mental health inpatient and outpatient space
- The UK's first kidney transplant without requiring immunosuppression: Girl receives UK's first rejection-free kidney from mum - BBC News

Top three challenges

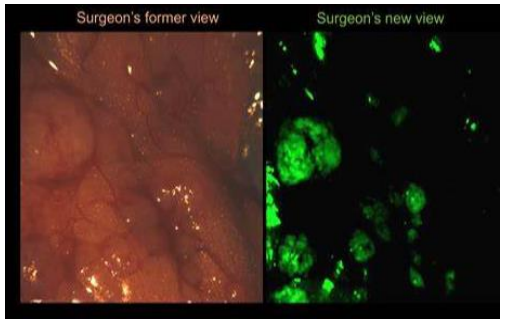
- Staffing Retention and recruitment – significantly in highly specialist areas
- Managing elective and emergency activity against a backdrop of industrial action; balancing effectively our capacity with service demands
- Transfer of Royal Free Hospital specialist gastroenterology services to GOSH

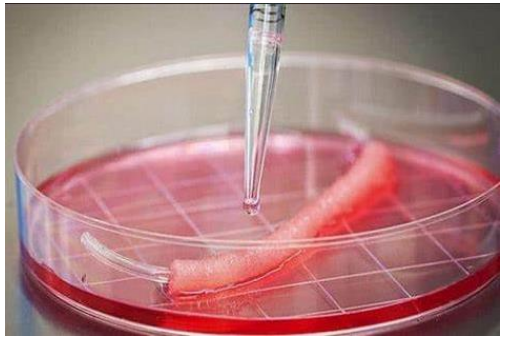
Top three priorities

- Safe implementation of the Mental Health Act
- Delivery of recommendations for orthopeadic and gastroenterology reviews.
- To develop research relationships externally to enhance our portfolio, and attract additional resource and funding



Research and Innovation



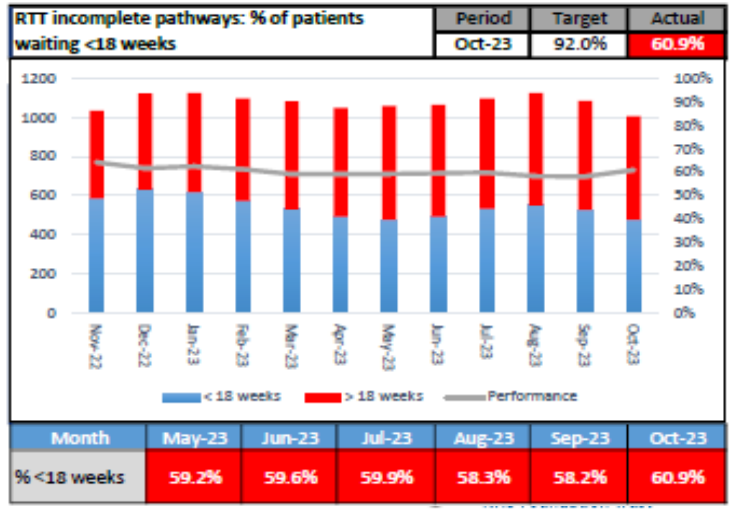


- Renal team at GOSH undertook the UK's first kidney transplant without requiring immunosuppression: Girl receives UK's first rejection-free kidney from mum - BBC News
- Three members of GOSH Nephrology team were part of successful £10million collaborative research grant from LifeArc (due to commence in 2024)
- More than 300 academic publications from the GOSH Nephrology clinical team in the last 5 years
- GOSH nephrology team has led several national and international clinical trials over the last year (https://www.kidney-international.org/article/S0085-2538(23)00760-3/fulltext)
- Fluorescence guided surgery: we are pioneers in the UK for indocyanine green fluorescence for perfusion, lymphatic drainage and biliary tree anatomy; developing targeted FGS for paediatric solid tumours.
- We are also developing novel devices for high-definition intraoperative imaging with photoacoustics and high-frequency US. Innovative photodynamic adjuvant intraoperative treatments for residual cancer (near-infrared photoimmunotherapy)
- Oesophageal tissue engineering nearing translation to the clinical environment for long gap oesophageal atresia
- Diaphragmatic pacemaker for hypoventilation – First in UK inserted this year
- Contributions to fetal surgery at UCH, and minimal access fetal surgery in Belgium in partnership with colleagues in both institutions

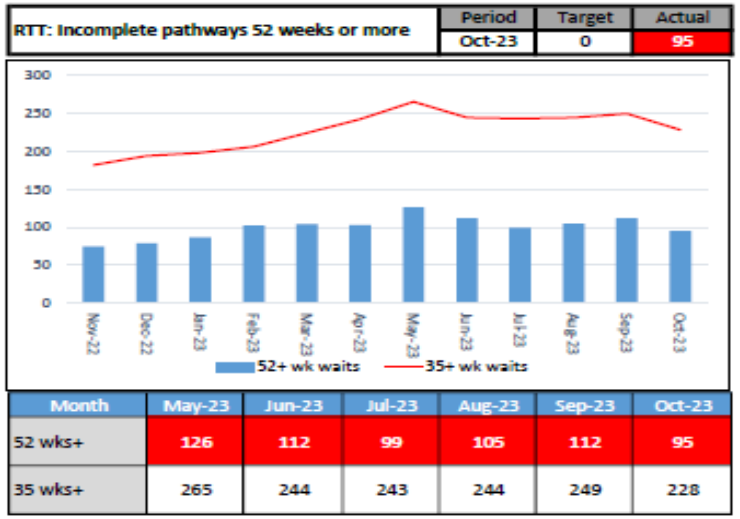
Principle 1: Children and young people first, always

Restoring elective activity and clinical prioritisation

RTT incomplete pathways:
% of patients waiting < 18 weeks = 60.9% October 2023



Month	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
% <18 weeks	59.2%	59.6%	59.9%	58.3%	58.2%	60.9%



Month	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
52 wks+	126	112	99	105	112	95
35 wks+	265	244	243	244	249	228

Situation:

- Impact of industrial action and bed capacity on patient flow and activity
- Ongoing impact of Covid backlog in ortho/spines on waiting times
- Resultant poorer patient experience, increase in clinical incident reporting and complaints

Actions being taken:

- Focus on improving pathway administration & validation
- Prioritisation of the most clinically urgent cases and longest waiters
- Additional resource and support to match patient acuity
- Retention drives in nursing across all wards in BBM

Challenges:

- Limited capacity for both emergency and elective activity; prioritisation of emergency work leading to deterioration of RTT position
- Acuity of patients in general surgery requiring additional nursing numbers
- Cancellation of elective activity during industrial action, compounding pressures
- Bed Capacity - estate
- Consultant succession planning

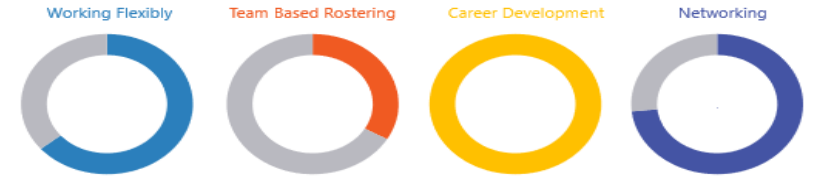
Principle 2: A values-led culture

What are the top three issues for workforce?

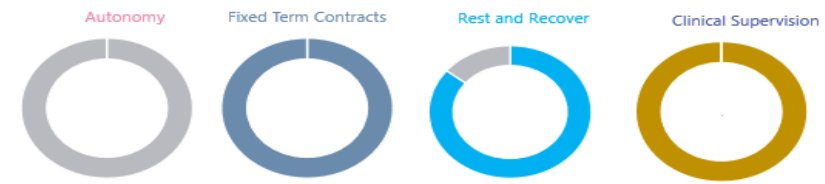
- Recruitment and retention of directorate ward nursing workforce – including retention dashboard
- Developing a strategy across specialties in the directorate to optimise care starting with apprentice programme for renal technicians
- Review of clinical workforce models, first Medical Physician Associate role to be commenced in nephrology

Retention Plan Quarterly Update | Body, Bones and Mind

	Number of nursing staff on a flexible working arrangement outside of team based rostering (number)	Number of wards or units with Team based rostering arrangements (number)	Number of nursing staff accessing a career development opportunity (internal) (number)	Number of staff involved at an ICS, regional, national or international level (external) (number)
Starting number	32	1	60	11
Current number	32	1	60	11
Target number	50	3	60	15
Percentage of target reached	64%	33%	100%	73%



	Number of nursing staff in autonomous roles using e-job planning (number)	Number of nursing staff on fixed term contracts (target 0) (number)	Number of wards/units with good quality rest and relaxation areas (number)	Number of protected hours contributed to clinical supervision (number)
Starting number			6	150
Current number			6	150
Target number			7	150
Percentage of target reached	0%	100%	86%	100%

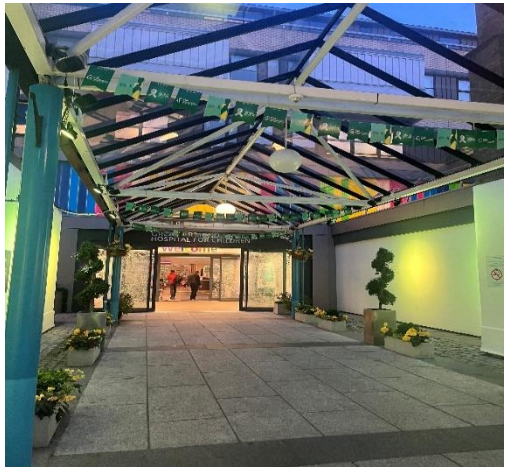


Key Actions

- Listening events- planned for junior doctors, to extend remit
- Directorate communication and engagement strategy
- Wellbeing support
- Embedding good process and support from day 1- new starters

Principle 2: A values-led culture

GEMS Team Winner April 2023: Chameleon Ward



Celebrating Mental Health Day 2023

Directorate	Ward name	No of discharges from EPIC (Participants)	Response Rate December 2023	December 2023 Calculated Directorate Response Rate	% Would Recommend	December 2023 Rating of Experience
Body Bones & Mind	Chameleon	17	59%	43%	100%	98%
	Eagle Ward	38	18%		100%	
	Gastro Endoscopy Suite	15	20%		100%	
	Mildred Creak Unit	-	-		-	
	Sky	72	53%		97%	
	Squirrel	13	62%		100%	

GEMS Individual Winner January 2023: Caroline Gainsbury, Discharge Liaison CNS, Chameleon Ward

Principle 3: Quality

Compliance

DATIX incidents

- DATIX incident reporting remains consistent: c60/month, overdue incidence remain slightly increased however all are reviewed within one working day by a member of the directorate leadership team.

Serious Incidents

- Six SI in 2023 - 1 PAMHS, 5 SNAPS

BCMA scanning compliance

- BCMA medication scanning remains a challenge. Patient scanning has been compliant for over 12 months.

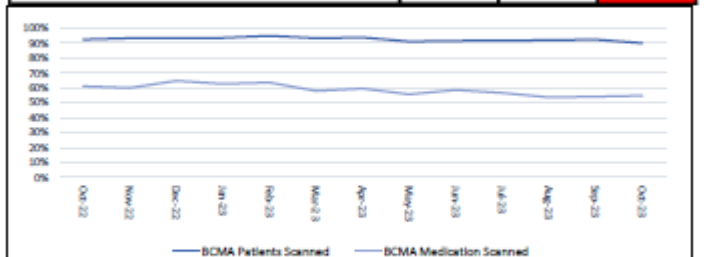
Arrests outside of ICU

- Deep dive into unplanned ICU admission and 2222 calls with agreed actions for resource support in general surgery

Incidents reported on DATIX	Oct-23	YTD
Incidents reported in month	68	475
Incidents open at month end	128	
Overdue incidents at month end: Total	61	

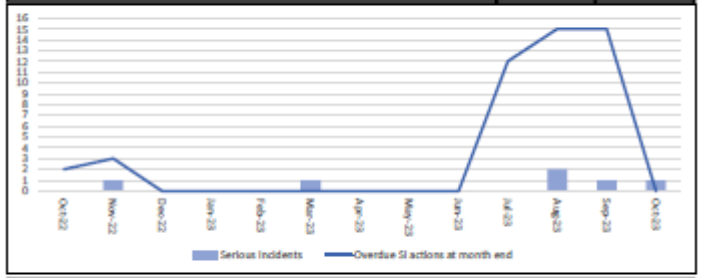
Month	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Incidents	77	65	66	42	56	52	55	80	80	74	66	68
Open	124	121	140	93	81	106	126	92	115	97	101	128
Overdue: Total	62	63	92	31	38	42	77	15	28	40	27	61

	Period	Target	Rate
BCMA Patient Scanning	Oct-23	90%	90%
BCMA Medication Scanning	Oct-23	70%	55%



Month	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Patients	93%	94%	94%	95%	93%	94%	91%	92%	92%	92%	93%	90%
Medication	60%	65%	63%	64%	58%	60%	56%	59%	57%	54%	54%	55%

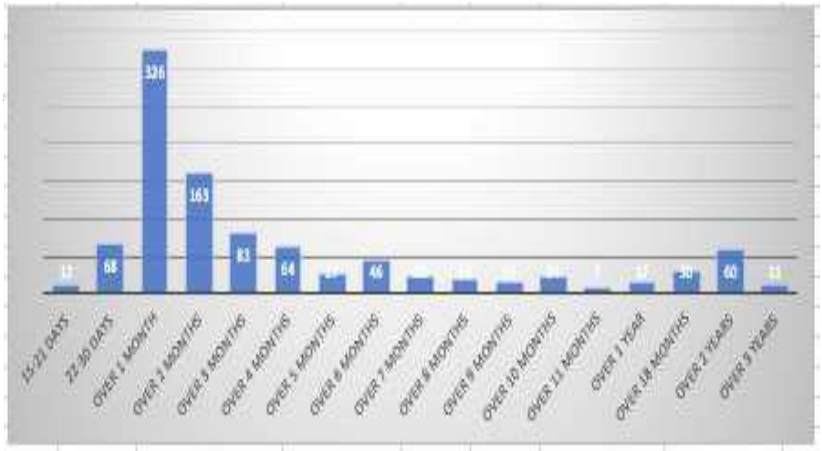
	Period	Actual
Serious Patient-Safety Incidents	Oct-23	1
	YTD	4
Overdue SI Actions at Month End	Oct-23	0



Month	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Incidents	1	0	0	0	1	0	0	0	0	2	1	1
Overdue actions	3	0	0	0	0	0	0	0	12	15	15	0

Principle 3: Quality

Compliance



Directorate	Not Sent	Sent	Total	% Not Sent
CAMHS	10	18	28	35.71%
Gastroenterology	14	8284	8298	0.17%
General Paediatrics	1	480	481	0.21%
Nephrology	2	2274	2276	0.09%
Orthopaedics	7	2102	2109	0.33%
SNAPS	4	5644	5648	0.07%
Spinal Surgery		874	874	0.00%
Grand Total	**38**	**19676**	**19714**	0.19%

Clinic letter backlog

- **Improving.** Significantly reduced number of clinic letters older than 4 months.
- Focus on remaining areas of non-compliance.
- Turnaround times currently averaging 8 days, this has remained quite static over last 12 months.
- On-going work to improve data quality and ensure letters not required are marked as such.

Discharge summary backlog

- **Improving.** Increased focus on process and data accuracy has led to an improvement in backlog of discharge summaries. Backlog mostly driven by attendances that did not require a summary but was not marked as such.

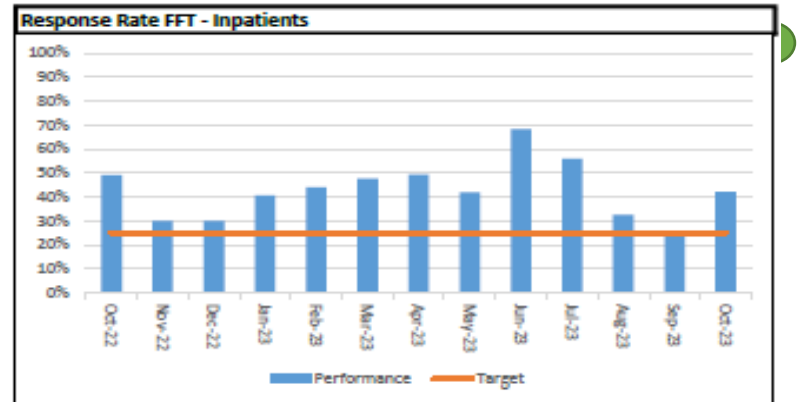
BBM Performance meeting established to drive improvement on clinical documentation, clinic outcomes, work queue management and PTL validation in line with MBI recommendations

Friends and Family Test (FFT)

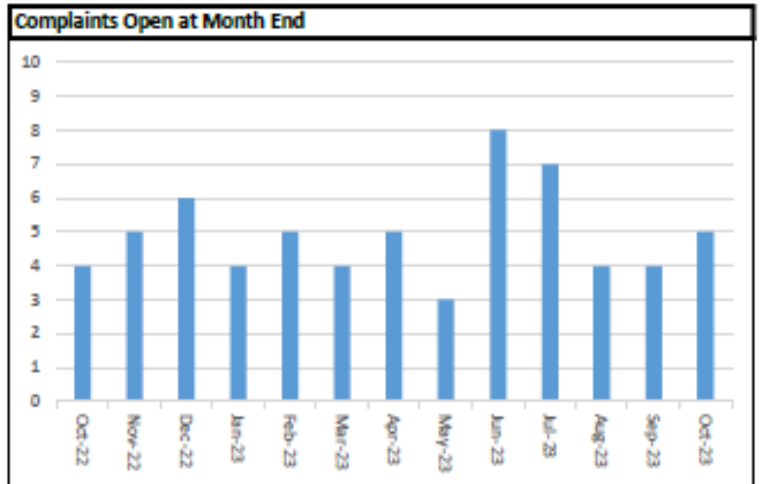
- Inpatient response rate has consistently met target for last 2 years with well-established systems for collection and ward champions.
- Have maintained a high proportion of positive inpatient responses over last 12 months.

Complaints

- Complaint rate continues to be high
- Themes include cancellation, complex child protection, clarity of clinical concerns. Also have pattern of repeated complainants -7 of these complaints are from 2 parents.
- Nature of number of complaints are complex and challenging, additional training being arranged



Period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Rate	42%	68%	56%	33%	25%	42%
No. resp.	94	146	123	70	52	89
No. elig.	224	214	220	214	211	211



Period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
No.	3	8	7	4	4	5

Principle 4: Financial strength

	Full Year NHSE Plan 22/23 (£m)	Full Year Actuals 22/23 (£m)	M9 YTD Plan 23/24 (£m)	M9 YTD Actuals 23/24 (£m)	Full Year NHSE Plan 23/24 (£m)
Non-Nhs Clinical Income	1.78	0.72	2.26	1.45	3.02
Non Clinical Income	0.43	0.50	0.40	0.40	0.53
Pay	(30.64)	(32.41)	(23.66)	(25.91)	(31.55)
Non Pay Costs	(1.32)	(1.81)	(1.33)	(1.62)	(1.78)
Grand Total	**(29.75)**	**(33.00)**	**(22.33)**	**(25.68)**	**(29.78)**

Efficiency & Savings-Better Value 23/24

- Better Value Target of £1.131K
- Target partially identified (£297K identified)

Schemes delivering include:
- Non recurrent nursing vacancy
- Review of contracts in non-pay
- New outreach work

Schemes in development include:
- New NHS commissioned work

2023/24 Position

Income:

- International and Private income not hitting plan due to bed pressures
- Research income overperforming YTD

Pay:

- Increased pay costs due to AfC pay uplift (above expected pay rise budgeted for)
- Temporary staffing costs driven by vacancies and industrial action

Non pay:

- Negative variance due to unidentified better value. Underspent on non-pay YTD.

Principle 6: Partnerships

New and established relationships

- Collaborative research and clinical activity in Fetal surgery at UCLH and minimal access fetal surgery in Belgium
- Improving research networks- awaiting imminent start of first resident research Professor in gastroenterology, from Shaare Zedek Medical Center, Jerusalem, February 2024
- Senior roles within multiple professional organisations: Prof Deborah Eastwood, President of the British Orthopaedic Association; Dr Keith Lindley, President of the British Society of Paediatric Gastroenterology, Hepatology and Nutrition; Prof Paolo Di Coppi, President of the European Paediatric Surgeons Association etc

Network relationships

- North Thames paediatric network- Gastroenterology chair Dr Borrelli
- International networks- eg Gastroenterology: USA, Canada, Netherlands, France, Australia, Belgium, Italy
- NCL Mental Health Champions
- RNOH and Evelina- consultants working cross sites- potential development of regional spinal network for allocation and prioritisation of activity
- Appointment of a joint locum consultant in gastroenterology to Royal Free Hospital and GOSH December 2023

Attachment R

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 7 February 2024	
Chief Executive's Report **Submitted by: Matthew Shaw, Chief Executive**	**Paper No: Attachment R** **For information and noting**
Purpose of report Update on key operational and strategic issues.	
Summary of report An overview of key developments relating to our most pressing strategic and operational challenges, namely: • Supporting our people • Developing and transforming our services • Expediting activity and access to care for children's and young people & working with system partners • Financial sustainability and advocating for a fair settlement for children and young people with complex health needs	
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	

1. Hospital performance

Continued strike action is still impacting patient access and activity levels. Long-waiters are a focus in support of NHSE expectations on long-waiter reduction but are proving difficult to clear. Mutual aid is in progress for key affected specialties and we are making progress, but will need to maintain our focus on these patients going forward.

Despite the lost time due to industrial action, RTT remains relatively stable (at 67.5%) and within the top third in the country. Activity levels are close to plan and our year-to-date data (April 23 -Dec 23) shows we are at 13.5% above 2019/20 activity levels.

2. Strategic refresh, trust values update and masterplan

As we approach the 2025 horizon of the "Above and Beyond" strategy refresh, we are thinking carefully about alignment of our strategic endeavours and planning for the next iteration.

Scoping for this critical project is already underway, with an exciting preliminary focus on culture as a foundational element. The GOSH values refresh will serve as a crucial starting point, driving alignment and guiding principles for the wider strategy refresh.

In parallel with the values programme, we will be developing our site masterplan, supporting clinical and corporate teams to collaborate and agree an approach to support delivery of our clinical strategy and optimize physical space for maximum efficiency and productivity.

A robust business strategy will need to be at the heart of the refresh process, and this will commence with a detailed piece of insight work that will assess our current position, including where we have delivered strategic alignment and where we are struggling with it. We envision this as a collaborative project, uniting teams across disciplines to collaboratively chart our future course. It's a significant undertaking, demanding the involvement of multiple teams, professions, and key stakeholders – from patients and families to commissioners and referrers.

We will be developing this foundational work over the coming weeks and will aim to present our proposed approach at the April board meeting.

3. Measles cases rising across England

We are concerned about reports of the rising levels of measles cases across the country and the impacts this has been having on children’s health services elsewhere in the UK. Low vaccination rates post-Covid, the highly infectious nature of the disease, the complication/mortality rate and limited capacity across peadiatric intensive care services means that monitoring this situation carefully across the NHS is essential.

I was reassured that public health teams in London have a robust plan in place to monitor and respond to the anticipated increase in cases. Naturally, the GOSH community will need to be ready to provide whatever support is needed to help deal with any increase in demand.

4. Space and place update

We signed the advanced works agreement for the Children's Cancer Centre in December 2023 and completed the key phase of office decant. The frontage building is now being decommissioned and will be closed in February. The main entrance will be closing on 19th February 2024 with works now being concluded for our new relocated entrance on Guilford Street. The hospital teams have done a fantastic job navigating this huge change programme, and since September 2023 we have moved over 1,400 staff and over 30 outpatient clinic spaces – on schedule and without cancelling a single patient.

We successfully rehoused all of the outpatient clinics that were previously located in the Frontage Building. We moved services occupying over 30 outpatient clinic spaces, including new bases for APOA (Southwood), Neurodisability and Orthopaedics (Cheetah), Haematological Oncology (RLHIM), Staff FIT testing (OBW) and numerous other displaced clinics to maximise the utilisation of the space available following closure of the Frontage building.

We are delighted with the new facilities for Paediatric and Adolescent Mental Health (PAMHs) and the Clinical Research Facility (CRF). Some pictures are provided below to demonstrate the quality of these new areas. The PAHMs service moved into their new facility in January and the CRF are planned to move in mid-February. We'd be happy to approach the clinical teams to request a visit for board members to these new spaces at a mutually convenient time.

Photos by Melanie Issaka. Artwork by Giles Round commissioned by GOSH Arts.

Industrial action

We should expect and will plan for further disruption over the coming year caused by industrial action as our national NHS workforce crisis continues.

The board will be aware that BMA members have narrowly rejected the pay deal offered – at 51 to 49%, based on a 65% turnout.

The BMA junior doctors committee have announced they are re-balloting members for another six months of action. The ballot will run to 20th March and a 'yes' vote will extend the mandate for strike action to September 2024. For the first time junior doctors in England will also be asked to approve Action Short of a Strike (ASOS) as part of the mandate for action.

Meanwhile, nursing strikes continue in Northern Ireland; the RCN is actively campaigning against changes to legislation to protect the freedom of nurses to strike; and with ongoing dissatisfaction on the pay deal there is every reason to believe that they will receive a mandate for further action.

Naturally, employee wellbeing and retention must be a key area of focus for us going forwards – both within the trust and in our interactions with the wider system.

Start Well – public consultation on proposed changes to children's surgical services in North London

North Central London Integrated Care Board and NHS England (London) Specialised Commissioning are consulting on proposed changes to maternity, neonatal, and children's surgical services in North Central London. It is open until 17th March and the information is available at: Start Well: Proposed changes to maternity, neonatal, and children's surgical services - North Central London Integrated Care System (nclhealthandcare.org.uk)

We are supporting the consultation team by hosting a range of events for GOSH staff members – both general drop-ins and sessions targeted at staff in relevant areas of expertise – and will develop an analysis of the range of views expressed for submission ahead of the consultation deadline.

Ends

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 7 February 2024	
January 2024 IQPR (December 2023 Data) **Submitted by:** John Quinn, Chief Operating Officer **Co-Authors** Dr Sanjiv Sharma, Chief Medical Officer Tracy Luckett Chief Nurse Caroline Anderson Director of HR & OD	**Paper No: Attachment S** □ **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
Strike action is still impacting patient access and activity levels. Long-waiters are proving difficult to clear, with slowly rising numbers against a backdrop of an NHSE expectation of long-waiter reduction. Focus remains on these patients and mutual aid is in progress for key affected specialties. Despite the lost time due to industrial action, the RTT rate remains relatively stable (at 66.8%) and above national averages and activity levels are close to plan and above last year and 2019/20. However, inpatient activity (more impacted by strikes) is lower.

Patient safety and experience remain good with FFT experience ratings still above target. However, the response rate dropped below the Trust target at 21%. Cancellations remain a common theme.

Incident numbers in December were slightly down, which is typical of the month with the reduced activity around Christmas. Total number of open incidents has also reduced as the Patient Safety Team acted to clear backlogs, though there remain a significant number of overdue incidents with the directorates. Compliance for high risks overdue for a review declined this month, but this is expected to improve in January.

Freedom to speak up numbers have been up for the last two months with a variety of themes. It is encouraging that staff feel able to speak up to the FTSU Guardian which helps ensure they feel heard and receive feedback.

Both Trust and nursing sickness rates remain above the Trust target. Consultant appraisal rate has decreased to 86% this month. Mandatory training compliance and Trust turnover rate remain stable. Nursing vacancy rate has increased to 10.4% this month compared to 9.3% last month.

The Trust's Better Value target for 2023/24 is £32.5m, of which £16.5m is an additional contribution from I&PC. A detailed programme to deliver the remaining £16m is underway. Directorates have identified over £10m worth of Better Value savings thus far.

Patient Safety Implications
The IQPR includes metrics and analysis on Patient Safety.

Equality impact implications

There are no specific metrics 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

Attachment S

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality & Performance Report

January 2024

Reporting December 2023 data

John Quinn
Chief Operating Officer

Tracy Luckett
Chief Nurse

Sanjiv Sharma
Medical Director

Caroline Anderson
Director of HR & OD

Contents

Executive Overview

Strike action is still impacting patient access and activity levels. Long-waiters are proving difficult to clear, with slowly rising numbers against a backdrop of an NHSE expectation of long-waiter reduction. Focus remains on these patients and mutual aid is in progress for key affected specialties. Despite the lost time due to industrial action, the RTT rate remains relatively stable (at 66.8%) and above national averages and activity levels are close to plan and above last year and 2019/20. However, inpatient activity (more impacted by strikes) is lower.

Patient safety and experience remain good with FFT experience ratings still above target. However, the response rate dropped below the Trust target at 21%. Cancellations remain a common theme, and it is hoped that a standard operating procedure will support better communication of cancellations.

Incident numbers in December were slightly down, which is typical of the month with the reduced activity around Christmas. Total number of open incidents has also reduced as the Patient Safety Team acted to clear backlogs, though there remain a significant number of overdue incidents with the directorates. Compliance for high risks overdue for a review declined this month, but this is expected to improve in January.

Freedom to speak up numbers have been up for the last two months with a variety of themes. It is encouraging that staff feel able to speak up to the FTSU Guardian which helps ensure they feel heard and receive feedback.

Both Trust and nursing sickness rates remain above the Trust target. Consultant appraisal rate has decreased to 86% this month. Mandatory training compliance and Trust turnover rate remain stable. Nursing vacancy rate has increased to 10.4% this month compared to 9.3% last month.

The Trust's Better Value target for 2023/24 is £32.5m, of which £16.5m is an additional contribution from I&PC. A detailed programme to deliver the remaining £16m is underway. Directorates have identified over £10m worth of Better Value savings thus far. Schemes valued at over £10m are largely considered to be lower risk and highly likely to deliver in full. All identified schemes were reviewed in December to ascertain which schemes are likely to deliver this financial year. Despite the overall number of identified schemes decreasing, the value of several schemes that remain has increased. It has been agreed with directorates that the paperwork for outstanding schemes should be delivered by the end of January 2024.

Integrated Quality & Performance Report, December 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		→
Nursing T/O & vacancy		↗

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 in December were slightly down, which is typical of the month with the reduced activity around Christmas. Total number of open incidents has also reduced as the Patient Safety Team acted to clear backlogs, though there remain a significant number of overdue incidents with the directorates (1259 as of 18/01/24)
- **Serious Incidents:** Two new serious incidents were declared in December. One was related to a power failure which impacted main theatres, with one patient having their procedure abandoned. This is being reviewed externally. The second incident was a never event in main theatre with a retained swab, though the swab was removed without additional surgery being required as the patient had been left open at the end of the procedure (no harm).
- **Duty of Candour:** DOC figures improved this month with compliance across stage 2 and no stage 3 due in month.
- **Risks:** High risk compliance dropped; this is typical of December when many RAGs are cancelled in the second half of the month. This is expected to improve in January. Overall compliance remains good.
- **Overdue SI Actions:** SI actions are being actively monitored and reviewed. SI closure meant new actions were added and timescales are being reviewed for these.

Patient Safety - Incidents		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Last 12 months	RAG			Stat/ Target
New Incidents	Volume	551	550	589	476	528	627	589	657	521	645	628	521		No Threshold			Target
Total Incidents (open at month end)	Volume	1441	1489	1836	1939	2187	1950	2100	2382	2438	2247	2572	1914		No Threshold			Target
New Serious Incidents	Volume	1	0	2	1	1	1	1	3	1	3	1	2		No Threshold			Target
Total SIs (open at month end)	Volume	3	2	3	4	4	5	3	6	5	8	7	6					Target
Overdue SI Actions	Volume	11	19	9	15	12	5	18	24	9	8	7	3		>20	10 - 20	0 - 9	Target
Incidents involving actual harm	%	14%	12%	13%	13%	11%	13%	13%	11%	10%	9%	13%	12%		>25%	15%-25%	<15%	Target
Never Events	Volume	0	0	0	0	0	0	0	0	0	0	0	1		>/=1		0	Stat
Pressure Ulcers (3+)	Volume	0	0	1	0	0	0	0	1	0	0	0	1		>1	=1	=0	Stat
Duty of Candour Cases (new in month)	Volume	2	7	3	3	6	4	5	7	2	5	6	2		No Threshold			Target
Duty of Candour – Stage 2 compliance (case due in month)	%	1/2	2/4	3/4	2/4	3/3	0/2	3/3	4/7	3/4	2/2	3/6	1/1		<75%	75%-90%	>90%	Target
Duty of Candour – Stage 3 compliance (case due in month)*	%	1/4	2/3	1 / 1	2/4	3/3	0/1	3/4	5/5	1/1	4/5	1/4	0/0		<50%	50%-70%	>70%	Target
High Risks (% overdue for review)**	%	19%	26%	48%	59%	15%	4%	11%	38%	31%	15%	11%	50%		>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

- 2 cases of C.Diff were reported this month. One was a continuing outpatient infection from the month before.
- One community acquired MRSA BSI, positive on admission.
- Pseudomonas aeruginosa BSI continue to be elevated compared to previous years with no clear cause identified at this time.
- Central line infections increased slightly this month with line days decreasing slightly making the YTD line infection rate 2.3/1000 line days.
- 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. (See note 1) .

Infection Control

		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	2023/24 YTD	Last 12 months	RAG (23/24 threshold)			Stat/ Target
Total C Difficile cases	In Month	1	2	0	0	1	0	0	0	1	1	3	2	10					Stat
C difficile Trust Assigned	Annually				0	1	0			1	1	1	0	6		>7	N/A	<=7	Stat
MRSA	In Month	0	0	0	0	0	0	1	0	1	0	0	1	2		>0	N/A	=0	Stat
MSSA	In Month	1	2	2	1	0	1	1	2	0	2	1	3	11		No Threshold			
E.Coli Bacteraemia	In Month	2	0	1	1	2	2	1	3	0	0	2	2	13		>8	N/A	<=8	Stat
Pseudomonas Aeruginosa	In Month	2	0	0	2	2	2	0	1	3	4	1	4	19		>8	N/A	<=8	Stat
Total Klebsiella spp	In Month	3	4	3	5	2	1	5	2	4	4	3	4	29					Stat
Klebsiella spp Trust Assigned	Annually				2	1	1	5	2	3	3	3	4	24		>11	N/A	<=11	Stat
CV Line Infections (note 1)	In Month	1.7	1.9	2.1	1.5	1.7	1.4	3.3	2.3	2.9	3.3	1.8	2.6	2.3		>1.6	N/A	<=1.6	T

Inpatient Mortality & Cardiac Arrest

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Last 12 months	RAG	Stat/ Target
Number of In-hospital Deaths	8	13	11	11	8	7	7	6	7	5	6	7		No Threshold	
Inpatient Mortality per 1000/discharges	7.8	13.8	10.3	11.8	7.8	6.5	7.0	5.6	6.9	5.4	5.7	7.9		No Threshold	
Cardiac arrests outside ICU/theatres	2	2	1	0	3	3	1	0	1	3	2	0		No Threshold	
Respiratory arrests outside ICU/theatres	2	0	1	1	5	5	3	4	4	4	4	5		No Threshold	
Inquests currently open	8	6	8	17	15	17	20	18	14	15	15	17		No Threshold	

Note1: 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

Effectiveness

Better Value:

The Trust's Better Value target for 2023/24 is £32.5m, of which £16.5m is an additional contribution from I&PC. A detailed programme to deliver the remaining £16m is underway. Directorates have identified over £10m worth of Better Value savings thus far. Schemes valued at over £10m are largely considered to be lower risk and highly likely to deliver in full. All identified schemes were reviewed in December to ascertain which schemes are likely to deliver this financial year. Despite the overall number of identified schemes decreasing, the value of several schemes that remain has increased. It has been agreed with directorates that the paperwork for outstanding schemes should be delivered by the end of January 2024. The PMO and Finance BPs continue to work with directorates to encourage and monitor the delivery of outstanding schemes. 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, printing and mail, patient transport and accommodation – these being supported by the establishment of dedicated task and finish groups.

Effectiveness	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Last 12 months
Speciality led clinical audits completed (actual YTD)	110	116	126	4	4	15	19	24	30	50	60	66	
Outcome reports published (YTD)	8	9	13	2	2	4	4	5	5	5	6	7	
QI Project completed	0	1	0	8	8	1	5	10	1	1	4	0	
QI Projects started	14	12	19	14	18	11	14	5	15	19	17	5	
NICE guidance currently overdue for review	0	0	0	0	0	0	0	0	0	0	0	2	
Better Value YTD Actual	£12,822,000	£14,061,472	£16,048,000	£253,000	£753,000	£649, 000	£851,000	£2,247,000	£2,926,000	£3,704,000	£4,215,000	£7,032,000	
% value of schemes identified compared to their Better Value target	78%	77.6%	77.6%					63.70%	63.70%	63.70%	63.70%	75.90%	
Number of schemes identified	125	125	125	50	58	78	88	109	122	122	122	91	
Number of schemes fully signed off and EQIA assessed	118	118	118					22	22	37	45	53	
Number of schemes identified but not signed off	7	7	7					100	100	86	78	38	

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: In December 2023 feedback continued to highlight concerns about cancelled appointments and procedures with families seeking rescheduled dates. It is hoped that a standard operating procedure will support better communication of cancellations. There were reductions in both Pals contacts (which fell to 174) and FFT comments (which decreased by 1589) both reflecting seasonal trends, industrial action and reduced activity within the hospital.

In addition to queries regarding cancellations, families contacted Pals seeking clarification of their children's care plans and advising of changes in their condition and seeking assistance in contacting their clinical teams and other departments in the hospital. 79% of contacts in December were resolved within 48 hours or less.

FFT experience ratings were met but the response rate dropped below the Trust target at 21% for the first time since November 2022. Families continue to comment on the broken lifts in RHLIM, the lack of parking for wheelchair vehicles and the shortage of dropped kerbs and pedestrian crossings on Great Ormond Street. Positive comments were predominantly about the care patients and families received and the wonderful staff. Staff were praised for being friendly, kind, and compassionate.

9 formal complaints were received in December. This is a reduction from November (n=13) and an overall reduction in complaints received between April and December 2022 (n=102) and the same period in 2023 (85). The number of red complaints has also fallen with 3 received since April 2023 in comparison with 6 in 2022. 64% of complaints have been closed within the original timeframes agreed with complainants. 48% of draft responses have been submitted late to the Complaints team for review.

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Last 12 months	RAG		
FFT Experience rating (Inpatient)	98.0%	98.0%	98.0%	99.0%	98.0%	99.0%	99.0%	98.0%	99.0%	99.0%	99.0%	99.0%		<90%	90-94%	>=95%
FFT experience rating (Outpatient)	92.0%	93.0%	90.0%	91.0%	97.0%	95.0%	95.0%	96.0%	95.0%	96.0%	95.0%	95.0%		<90%	90-94%	>=95%
FFT - response rate (Inpatient)	25.0%	28.0%	29.0%	30.0%	27.0%	35.0%	31.0%	26.0%	26.0%	32.0%	31.0%	21.0%		<25%	N/A	>=25%
PALS - per 1000 episodes	8.58	9.23	10.77	7.55	10.14	11.07	7.11	7.25	7.16	9.43	9.83	8.37		No Threshold		
Complaints- per 1000 episodes	0.47	0.53	0.42	0.49	0.37	0.31	0.45	0.38	0.37	0.27	0.48	0.43		No Threshold		
Red Complaints -% of total (note 1)	5%	4%	4%	4%	4%	5%	5%	4%	3%	3%	3%	3%		>12%	10-12%	<10%
Re-opened complaints - % reopened (2)	6%	4%	4%	4%	4%	5%	4%	3%	2%	2%	3%	2%		>12%	10-12%	<10%

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

Return to Contents Page

Well Led Headlines: November 2023

Contractual staff in post: Substantive staff in post numbers in December was 5503.2 FTE compared to 5520.9 FTE November , which is an increase of 17.7 FTE. The headcount was 5960 (-25 on the previous month).

Unfilled vacancy rate: December 2023 vacancy rates for the Trust have increased to 7.6% (from 7.2% in November). The vacancy rates are highest in International and Private Care (20.7%), Research and Innovation (45.6%) and Transformation (62.6%).

Turnover: is reported as voluntary turnover over a rolling 12 month period. Voluntary turnover remains stable at 12%.

Agency usage: Agency usage for December remained static for the second month in a row at 1.3%, this remains within the 2% Trust target. Corporate areas such as Finance (14.6%), Medical Directorate (10%), are the highest spending directorates.

Statutory & Mandatory training compliance: The December training rate for the Trust remain stable at 94%, up 1% from the previous month with all directorates meeting the target. During Quarter 4, our HR team are implementing the changes to the Honorary contract policy that was agreed in 2023. This will drive improvements to the honorary training rates going forward into 2024/25.

Appraisal/PDR completion: The non-medical appraisal rate for December rose 2% to 81%, Research and innovation (92%) is the only Directorate within target, however International (85%) and ICT (87%) are within 5% of the target. Medical appraisal rate was 86% for December.

Sickness absence: December sickness was over the Trust target at 3.9%, a 0.1% increase from the previous month. In order to benchmark GOSH sickness more accurately, and provide a more realistic target, the Trust has incorporated the national NHS sickness rate into its RAG rating (see Well led page for details). The national rate for December was 5.34%. Which has also increased from the previous month. Indicating a national trend.

Freedom to Speak Up: There were 8 new contacts to the FTSU Guardian in December which is a decrease from previous months. Staff safety and wellbeing was the highest theme seen, followed by patient safety/ quality of care and speaking up culture. Those speaking up came from a range of professional groups.

Well Led

Well Led Metrics Tracking

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Last 12 months	RAG Levels			Stat/Target
Mandatory Training Compliance	94.0%	94.0%	94.3%	94.0%	93.9%	93.7%	94.0%	93.0%	92.0%	93.1%	93.5%	94.3%		<80%	80-90%	>90%	Stat
Stat/Man training – Medical & Dental Staff	91.0%	91.0%	89.0%	89.0%	89.0%	90.0%	90.0%	88.0%	86.0%	87.0%	87.0%	88.0%		<80%	80-90%	>90%	Stat
Appraisal Rate (Non-Consultants)	82.0%	81.0%	82.6%	82.0%	80.7%	82.8%	84.0%	84.0%	81.0%	79.8%	79.0%	81.1%		<80%	80-90%	>90%	Stat
Appraisal Compliance (Consultant)	95.0%	93.0%	90.7%	90.6%	91.0%	90.6%	91.0%	95.0%	95.0%	95.0%	95.0%	86.0%		<80%	80-90%	>90%	Stat
Honorary contract training compliance	69.0%	66.0%	65.0%	66.0%	65.0%	71.0%	71.0%	72.0%	72.0%	70.0%	69.0%	70.0%		<80%	80-90%	>90%	Stat
Safeguarding Children Level 3 Training	97.0%	96.0%	96.0%	96.0%	98.0%	99.0%	99.0%	98.0%	93.0%	96.0%	95.0%	96.0%		<80%	80-90%	>90%	Stat
Safeguarding Adults Level 2 Training	96.0%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	95.0%	92.0%	93.0%	93.0%	94.0%		<80%	80-90%	>90%	Stat
Resuscitation Training	87.0%	87.0%	86.0%	85.0%	86.0%	86.0%	87.0%	87.0%	86.0%	84.0%	82.0%	83.0%		<80%	80-90%	>90%	Stat
Sickness Rate see note 3	3.7%	3.0%	3.3%	2.7%	2.8%	3.0%	3.1%	3.1%	3.7%	3.7%	3.8%	3.9%		>5.3%	3-5.3%	<3%	T
Turnover Rate (Voluntary)	14.2%	14.2%	14.4%	14.4%	14.2%	14.0%	13.8%	13.7%	13.1%	12.4%	12.0%	12.0%		>14%	N/A	<14%	T
Vacancy Rate – Trust	7.2%	7.0%	7.1%	7.1%	9.8%	9.5%	10.0%	10.5%	9.4%	7.5%	7.2%	7.5%		>10%	N/A	<10%	T
Vacancy Rate - Nursing	7.7%	8.3%	8.0%	8.0%	10.2%	11.2%	12.6%	14.8%	14.1%	9.1%	9.3%	10.4%		No Threshold			T
Bank Spend	5.4%	5.4%	5.2%	6.4%	5.8%	5.6%	5.8%	5.8%	5.8%	5.9%	5.8%	5.8%		No Threshold			T
Agency Spend	1.1%	1.1%	1.1%	1.3%	1.4%	1.4%	1.3%	1.2%	1.2%	1.2%	1.3%	1.3%		>2%	N/A	<2%	T
Quarterly Staff Survey - I would recommend my organisation as a place to work	65.0%			64.0%			60.0%							No Threshold			T
Quarterly Staff Survey - I would be happy with the standard of care provided by this organisation	87.0%			87.0%			86.0%							No Threshold			T
Quarterly Staff Survey - Overall Staff Engagement (scale 0-10) See note 1	7.0			7.0			6.8							No Threshold			T
Quarterly Staff Survey - Communication between senior management and staff is effective See note 1	45.0%			44.0%			39.0%							No Threshold			T
Number of people contacting the Freedom To Speak Up Service	7	11	9	18	14	11	8	10	22	21	16	8		No Threshold			T
Number of Themes of concerns raised as part of Freedom to Speak Up Service (note 2)	9	15	17	31	21	17	10	12	32	30	22	17		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

Directorate KPI performance December 2023

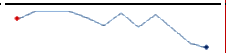
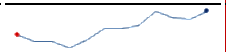
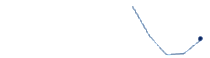
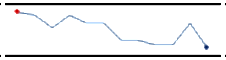
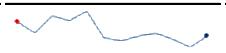
NHS Great Ormond Street Hospital for Children NHS Foundation Trust

	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Core Clinical Services	Genetics	Heart & Lung	Sight & Sound	International	Clinical Operations	Corporate Affairs	ICT	Space and Place	Finance	Human Resources & Organisational Development	Medical Directorate	Nursing & Patient Experience	Research & Innovation	Transformation	Innovation
Voluntary Turnover	14%	12.0%	13.2%	13.1%	13.9%	13.5%	15.9%	11.8%	10.5%	17.5%	9.4%	19.8%	2.3%	4.6%	9.3%	23.1%	11.3%	8.7%	12.7%	7.0%	15.6%
Sickness (1m)	3% - National Average (5.34%)	3.9%	3.2%	4.0%	4.0%	3.5%	3.1%	4.3%	5.7%	4.9%	4.1%	0.9%	2.5%	5.9%	0.6%	0.9%	0.4%	2.9%	2.0%	1.8%	3.5%
Vacancy	10%	7.6%	4.5%	1.6%	2.2%	2.8%	-7.7%	5.6%	6.9%	20.7%	11.5%	7.0%	0.7%	12.0%	6.9%	0.9%	3.8%	9.4%	45.6%	62.6%	-3.6%
Agency YTD	2%	1.3%	0.0%	0.2%	0.2%	2.2%	0.0%	0.2%	0.0%	3.5%	2.4%	0.4%	-1.2%	3.5%	14.6%	3.5%	10.0%	0.9%	0.0%	0.0%	2.9%
PDR	90%	81%	78%	82%	78%	84%	79%	83%	82%	85%	71%	72%	87%	74%	71%	81%	85%	85%	92%	70%	84%
Stat/Mand Training	90%	94%	92%	93%	94%	95%	99%	92%	94%	95%	95%	97%	99%	95%	99%	94%	98%	96%	98%	98%	96%

Key: Achieving Plan Within 5% of Plan Not achieving Plan

Safer Staffing- Nursing only

Vacancy rate: Average registered nurse (RN) vacancy rate maintained below Trust target but has had a slight peak at 10.4%. Central recruitment campaigns continue, next cohort of 24 NRN for April 2024. Plans have commenced to initiate a new international recruitment campaign to the Philippines in the New Year in collaboration with Capital Nurse Consortium.
Voluntary Turnover: Based on a 12 month rolling average, the vol. turnover for December remains above trust target (<14%) with a slight improvement to 14.8.%. We continue to drive forward the retention actions in an effort to retain our skilled and experienced nurses, and this will be monitored through the new Nursing Delivery Committee and targeted monthly recruitment and retention meetings.
Sickness absence: Nursing sickness rates decreased in December 5% and remain above trust target (3%).
CHPPD: CHPPD is a benchmarking metric to provide a picture of care, it does not reflect true skill mix or patient acuity. CHPPD only reflects the staffing levels based on open and occupied beds. This decreased to 13.7 and will be continued to be monitored.
CHPPD Actual vs Plan: The Trust average was 93% in December above the target of 90%. With the introduction Winter Bonus Scheme there has been an improvement of planned vs actual as people are planning shifts ahead of time as well as filling them. This will be revied at the end of March
Temporary staffing spend: There was 1% agency use in December, attributable to RMN shifts. Bank fill rates were 61% in December and below target. Recruitment to bank and new incentives for temporary staff are currently being with our provider of temporary staffing Acacium, there should be improvements noticeable with changes made in the next couple of months.
Safe Staffing Incidents: There was a decrease in safe staffing incidents reported in Decemberer to 4, these are currently being investigated. Panther ENT 1, Fox-1, Lion-1, Koala1- Mian themes and trends are similar to previous months skill mix/competencies especially in relation to high patient acuity and staffing levels particularly out of hours, sickness and bank cancelations.
Bed closures: The metrics above do not capture the mitigation put in place and only reflect the open bed base and not the full bed base. Bed closures and reduced activity are used to maintain safe staffing levels for inpatients however this impacts on patient experience, delayed treatment and patient outcomes. The total number of beds closed in December increased to 564 in total wards merge to establish a more efficient staffing model during the festive period.

Safer Staffing Metrics	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Last 12 months	RAG Levels			Stat/Target
Vacancy Rate - Nursing	7.7%	8.2%	8.0%	8.0%	10.0%	11.2%	12.6%	14.8%	14.1%	9.1%	9.3%	10.4%		>11%	10.1% - 11%	<= 10%	T
Turnover Rate (Voluntary)	16.1%	16.5%	16.5%	16.5%	16.2%	15.8%	16.4%	15.8%	16.3%	15.7%	15.0%	14.8%		>14%	N/A	<14%	T
Sickness Rate see note 3	3.7%	3.4%	3.4%	3.0%	3.4%	4.0%	4.0%	4.2%	5.0%	4.6%	4.5%	5.0%		>5.3%	3-5.3%	<3%	T
Care Hours per Patient Day (CHPPD)	15.3	15.0	14.9	16.0	15.9	16.5	16.2	16.8	16.8	14.4	14.5	13.7		No Threshold			T
Care Hours per Patient Day (CHPPD)- Actual vs Plan	104%	99%	102%	99%	98%	95%	97%	103%	94%	88.2%	88.8%	93.0%		<80%	80-90%	>90%	T
Agency Spend	0.0%	3.0%	0.0%	1.0%	0.1%	0.3%	1.3%	1.2%	0.0%	1.2%	1.3%	1.0%		>2%	N/A	<2%	T
Safe Staffing incidents	3	6	13	6	7	3	6	6	12	10	7	4		No Threshold			T
Bank fill rate	70%	69%	66%	69%	67%	67%	63%	63%	62%	62%	67%	61%		No Threshold			T
Total monthly Bed closures	722	600	802	744	865	545	512	558	598	527	434	564		No Threshold			T

Well Led

Directorate performance for Safer Staffing – Nursing Only December 23

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Core Clinical Services	Heart & Lung	Sight & Sound	International	Research & Innovation
Voluntary Turnover	< 14%	14.8%	14.5%	12%	17.9%	17.6%	13.6%	16.9%	24.8%	12.1%
Sickness (1m)	< 3%	5%	4%	6.1%	4.8%	4.7%	5.5%	5.3%	4.5%	1.1%
Vacancy	< 10%	10.4%	2.4%	11.3%	11.7%	7.1%	9.6%	5.5%	25.8%	25.7%
Agency YTD	< 2%	1%	0%	0%	0%	2%	0%	0%	4%	0%
PDR	> 90%	86%	79%	88%	80%	88%	87%	94%	90%	90%
Stat/Mand Training	> 90%	94%	92%	95%	96%	94%	93%	94%	94%	96%
CHPPD	NA	13.7	13.9	11.8	10.7	N/A	15.2	14.7	14.4	N/A
CHPPD Actual vs Planned	> 90%	93.3%	91.2%	88.1%	100.6%	N/A	86.4%	120.5%	108.8%	N/A
Incidents	NA	4	2	0	1	0	0	1	0	0

Key: Achieving Plan Within 5% of Plan Not achieving Plan

Patient Access Metrics

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

Access Metrics Tracking

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trajectory	Last 12 months	RAG Levels			Stat/Target
RTT Open Pathway: % waiting within 18 weeks	71.4%	69.8%	67.3%	67.7%	68.4%	66.5%	67.2%	66.8%	66.7%	68.6%	67.5%	66.8%	Below		<92%	N/A	>=92%	Stat
Waiting greater than 18 weeks - Incomplete Pathways	2,169	2,280	2,464	2,415	2,526	2,584	2,625	2,709	2,662	2,562	2,648	2,646	-		No Threshold			-
Waiting greater than 52 weeks - Incomplete Pathways	279	311	356	379	438	420	423	431	438	424	408	385	Above		>0	N/A	=0	Stat
Waiting greater than 78 weeks - Incomplete Pathways	47	52	58	75	89	79	91	91	104	96	116	123	Below		TBC			T
Waiting greater than 104 weeks - Incomplete Pathways	5	3	4	9	11	10	13	15	16	10	14	13	Below		>0	N/A	=0	Stat
18 week RTT PTL size	7580	7545	7532	7482	7990	7706	7996	8148	8005	8149	8148	7976	-		No Threshold			-
Diagnostics- % waiting less than 6 weeks	82.6%	87.6%	81.9%	80.7%	83.7%	83.9%	82.3%	77.7%	80.0%	82.2%	83.6%	79.7%	Below		<99%	N/A	>99%	Stat
Total DM01 PTL size	1,663	1,841	1,672	1,668	1,673	1,637	1,765	1,606	1,668	1,789	1,709	1,741	-		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	94%	92%	93%	100%	100%	100%	100%	100%	100%	100%	100%	*100%*	-		No Threshold			-
Cancelled Operations for Non Clinical Reasons (note 1)	45	34	28	21	23	30	22	30	42	46	56	39	-		No Threshold			-
Cancelled Operations: 28 day breaches	3	3	1	1	2	4	5	3	7	2	12	13	-		>0	N/A	=0	Stat
Number of patients with a past planned TCI date (note 4)	1,390	1,356	1,422	1,542	1,552	1,625	1,570	1,592	1,763	1,759	1,886	2,085	-		No Threshold			-
NHS Referrals received- External	2,754	2,667	2,725	2,176	2,843	2,804	2,682	2,525	2,540	2,874	2,847	2,391	-		No Threshold			-
NHS Referrals received- Internal	1,980	2,039	2,136	1,753	2,067	2,024	1,980	1,849	1,810	1,954	2,150	1,766	-		No Threshold			-
Total NHS Outpatient Appointment Cancellations (note 2)	6,308	6,212	7,456	6,061	6,500	6,760	7,158	7,585	6,690	6,751	6,240	5,644	-		No Threshold			-
NHS Outpatient Appointment Cancellations by Hospital (note 3)	1,514	1,740	2,113	1,584	1,498	1,548	1,962	1,642	1,541	1,672	1,220	1,232	-		No Threshold			-
Outpatient Clinic utilisation																		-

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 Metrics (cont.)

Great Ormond Street Hospital for Children NHS Foundation Trust

Access Metrics Tracking	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trajectory	Last 12 months	RAG Levels	Stat/Target
RTT Priority 2 patients	692	742	746	729	725	787	807	717	683	698	745	750	-		No Threshold	
RTT Priority 2 patients beyond fail safe date	159	168	208	207	178	206	239	220	178	181	170	210	-		No Threshold	
Diagnostics- waiting greater than 6 weeks	289	228	303	322	273	264	312	359	334	319	280	354	-		No Threshold	-
Diagnostics- waiting greater than 13 weeks	34	30	25	33	45	32	33	54	70	55	49	46	-		No Threshold	-
Main Theatre Utilisation (NHS Only)	64.7%	65.4%	70.7%	66.1%	70.4%	70.9%	67.4%	66.7%	70.4%	64.5%	67.9%	N/A	-		<77% N/A >77%	T
Main Theatres Late Start Minutes	8,998	6,697	7,423	5,212	6,862	7,115	7,454	7,451	8,097	8,813	10,182	N/A			No Threshold	
Main Theatres Overrun	3,586	3,126	4,645	2,675	4,487	5,178	3,959	3,801	4,054	3,625	6,590	N/A			No Threshold	
Bed Occupancy (All Wards NHS & PP)	84.3%	84.2%	84.9%	80.2%	81.2%	82.6%	78.9%	78.2%	82.5%	79.2%	87.1%	79.5%			<80% 80-84% =>85%	T
Bed Occupancy (NHS Wards Only)	85.7%	84.4%	85.1%	80.4%	81.9%	83.7%	79.9%	78.5%	78.2%	80.2%	87.8%	81.1%			<80% 80-84% =>85%	T
Bed Closures (All Wards NHS & PP)	722	600	802	744	865	545	512	558	598	527	530	564			No Threshold	
Bed Closures (NHS Wards Only)	496	322	479	367	523	181	194	256	261	265	328	331			No Threshold	
PICU / NICU Refused Admissions	10	2	15	2	2	1	4	5	4	9	11	20			No Threshold	
Cardiac CATS Refused Admissions	3	1	4	3	3	3	1	0	2	2	2	2			No Threshold	
PICU Readmissions within 48 hours	0	3	2	2	3	1	3	1	2	3	3	3			No Threshold	
CICU Readmissions within 48 hours	1	0	2	0	1	0	0	1	2	0	3	1			No Threshold	
NHS Discharge Summaries within 24 hours	72.8%	68.0%	69.8%	70.8%	76.3%	82.0%	79.4%	76.8%	74.6%	78.5%	76.9%	82.1%			<100% N/A 100%	T
Number of NHS Discharge Summaries not sent (ytd)	1247	1404	1668	1356	1505	432	424	590	255	181	155	78			No Threshold	
NHS Clinic Letters sent within 7 days	56.1%	55.6%	55.3%	52.8%	59.1%	55.9%	61.8%	57.1%	55.1%	56.6%	52.1%	51.5%			<100% N/A 100%	T
Number of NHS Clinic Letters not sent (ytd)	5218	5354	6102	6157	6158	6040	5610	5301	5468	5401	6172	5915			No Threshold	

Responsive

Patient Access - Activity Monitoring at Month 9

Overview:

For M9 of 23/24 all activity was 10% below on plan but 3.06% above 2022/23 activity levels. However, when comparing to 19/20 activity overall is 19.8% above. YTD activity is 1.98% down against plan but 1.06% above 2022/23 and 13.5% above 2019/20. It should be noted though that inpatient activity is down.

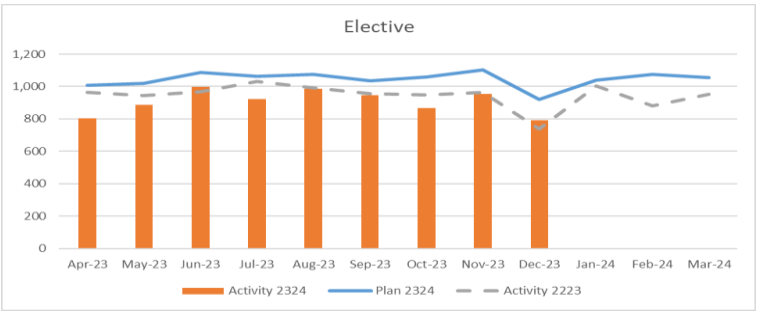
Electives continue to be less than plan at -12.9 % and day cases are 0.4% below plan. Undoubtedly, this is due to the impact of recent Junior Doctors and Consultant strikes and with future impending strikes activity levels are being closely monitored. To end of month 9, 27 days have been strike affected out of 187 working days (14.4%). Typically activity levels on strike days drop to 60% of normal activity. Making this adjustment the Trust would be 4.7% up against plan without the strikes.

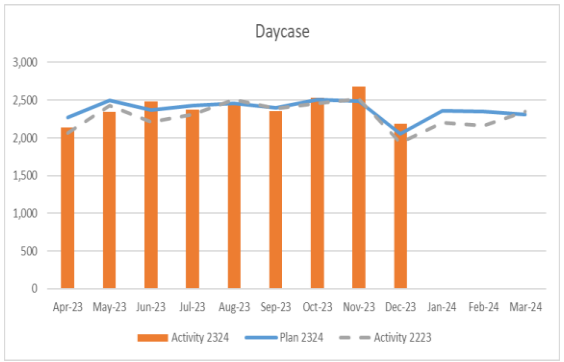
For M9 23/24, all directorates were below plan.

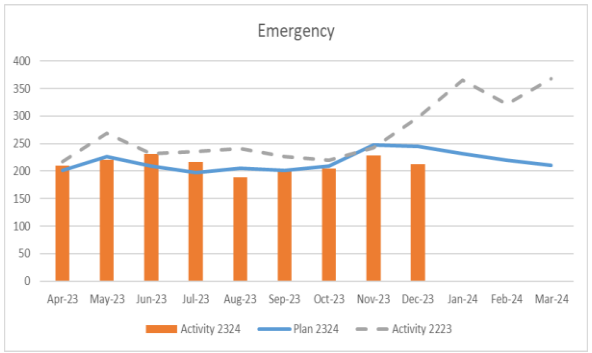
With strikes and bed closures continuing this has impacted the delivery of activity, RTT and DM01 waiting time improvements. Continued focus remains on optimising bed capacity, theatres and reducing long waits.

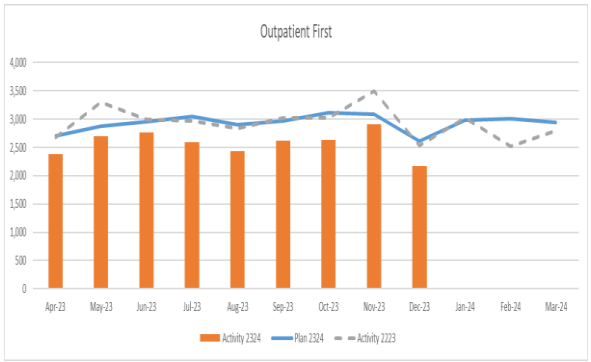
Overview YTD M9 23-24

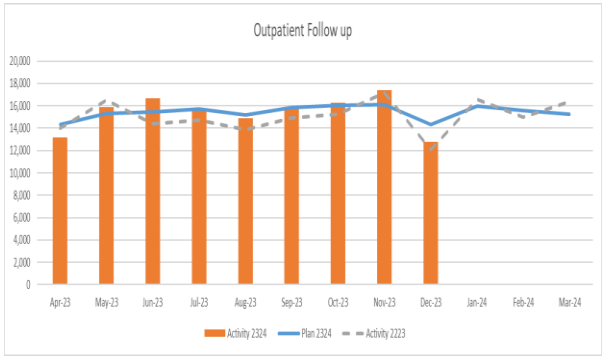
POD	Plan 2324	Activity 2324	Activity 2223	% of 22/23	% of Plan
Daycase	21,462	21,564	20,819	103.58%	100.47%
Elective	9,367	8,157	8,510	95.85%	87.08%
Emergency	1,943	1,911	2,180	87.66%	98.35%
First OPA	26,252	23,196	26,836	86.44%	88.36%
Follow-up OPA	138,273	138,569	133,024	104.17%	100.21%
Grand Total	**197,297**	**193,397**	**191,369**	**101.06%**	**98.02%**











Return to Contents Page

Responsive

Patient Access - Waiting Times Overview

Overview

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

- **RTT** Performance for December 2023 was **66.8%,** 0.7% decrease from last month and remains below trajectory. The overall PTL size has reduced in comparison to last month (7976 vs 8148).None of the directorates met the 92% standard this month. RTT performance has been affected by the national strikes, inherited breaches, patient and staff sickness, and bed pressures. We do not expect RTT to improve significantly in January due to the impact of industrial action taken by Junior Doctors in late December and early January.
- There are 13 patients who are waiting above **104 weeks,** a slight decrease from last month, when we reported 14 and we are below the trajectory provided to NHSE. Four patients are waiting for **Dental** treatment, all have an outpatient appointment booked in January and February. Two **Orthopaedic** patients have TCIs in January. One **Gastroenterology** patient is complex with learning disabilities and autism. One **SNAPS** patient was referred for further diagnostics at their Pre-OP appointment. One **Plastic Surgery** patient needs a tonsillectomy first before their treatment, and this is scheduled in February, whilst another patient needs a review by Orthopaedics before a TCI can be scheduled. One **joint Plastics Surgery** and **Ophthalmology** patient has a TCI in February. Two patients (**Orthodontics** and **Endocrinology**) were referred to us at **182** and **98** weeks wait respectively from other Trusts.. The Orthodontics patient is awaiting a TCI once treatment plan from the local Trust has been confirmed and the Endocrinology patient has now been treated and discharged.
- **78 week waits** have increased this month to 123 and is below the trajectory submitted. Focus continues on reducing long wait patients with weekly oversight at executive level.
- At the time of writing the Trust is currently projecting **134** patients, at the end of January 2024, to be waiting 78 week waits or more and is just above the trajectory submitted.
- **52 week waits** have decreased to 385. The long waiters are predominantly in Dental (110), Plastic surgery (46), Orthopaedics (45), ENT (30), Ophthalmology (16), SNAPS (14), Spinal Surgery (13), Dermatology (13), Cardiology (12) and Urology (11). Sight & Sound and Body, Bones and Mind directorates are the most challenged.
- **DM01** performance for November 2023 was **79.7%**, a decrease of 3.9% from the previous month. The number of 6 week breaches has increased this month to 354, compared to 280 last month. 13 week breaches have decreased to 46 from 49 last month. The Trust is performing above the backlog forecasted in the trajectories for MRI, CT and Ultrasound but is performing better than trajectory for Endoscopy.
- **Cancer:** It is projected for December that all of the five standards will be met.

Bottlenecks

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

Junior doctor's and consultant 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.

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

Unexpected theatre maintenance

Actions

Revised RTT and Diagnostic trajectories and actions plans have been produced

Continued focus on reduction of long wait patients

Exploring Mutual aid with the Evelina for Dental & Plastic Surgery

Dental consultant started in July at GOSH working 5 PAs, with an additional consultant working 8 Pas now recruited (Start date TBC). The Trust is exploring advertising for an additional consultant.

Meetings with RNOH regarding Orthopaedic support

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

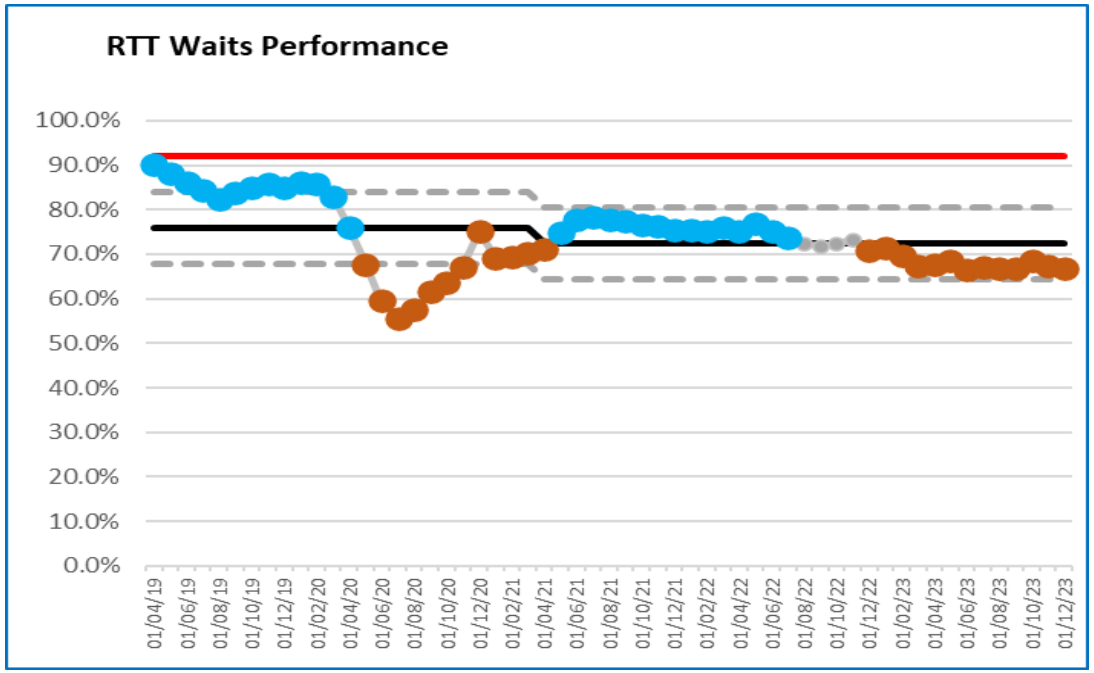
Day-case project commenced reviewing Nightingale Ward usage

Recruitment of locum Orthopaedic Surgeon

Recruitment process under way for Spinal Surgeon

Responsive

Referral to Treatment times (RTT)



RTT:

66.8% ↓ 0.7%

People waiting less than 18 weeks for treatment from referral.

>52 Weeks:

385 ↓ 23

Patients waiting over 52 weeks

>78 Weeks:

123 ↑ 7

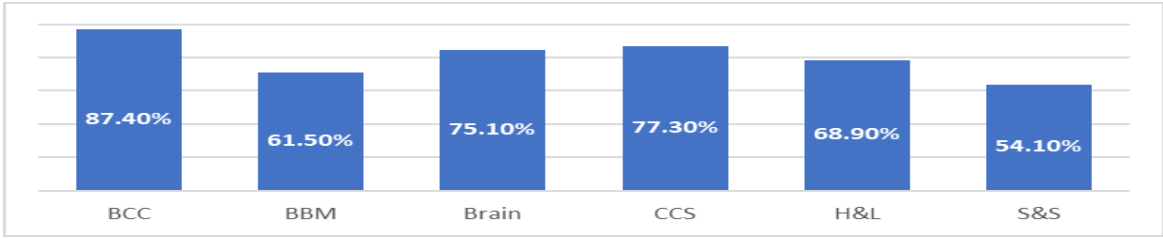
Patients waiting over 78 weeks

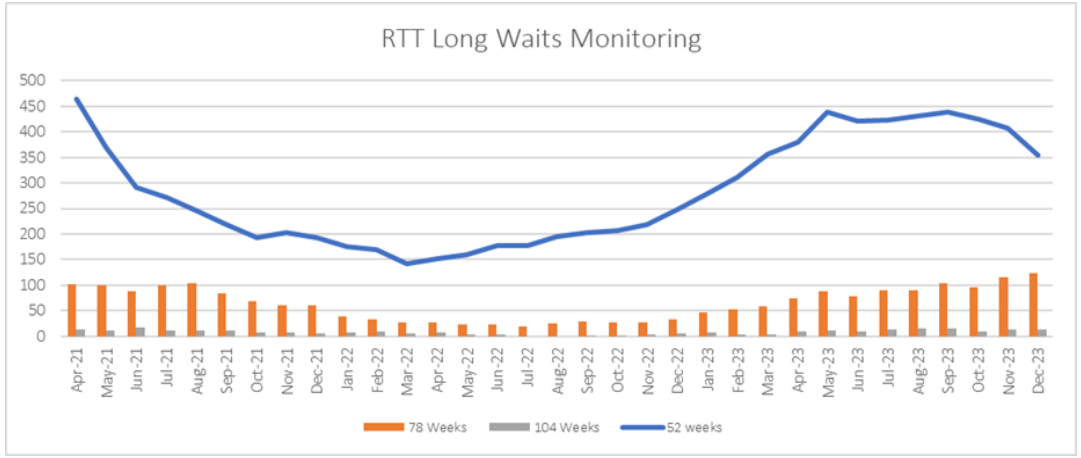
>104 Weeks:

13 ↓ 1

Patients waiting over 104 weeks

Directorates





RTT PTL Clinical Prioritisation – past must be seen by date

P2

170 ↑ 12

P3

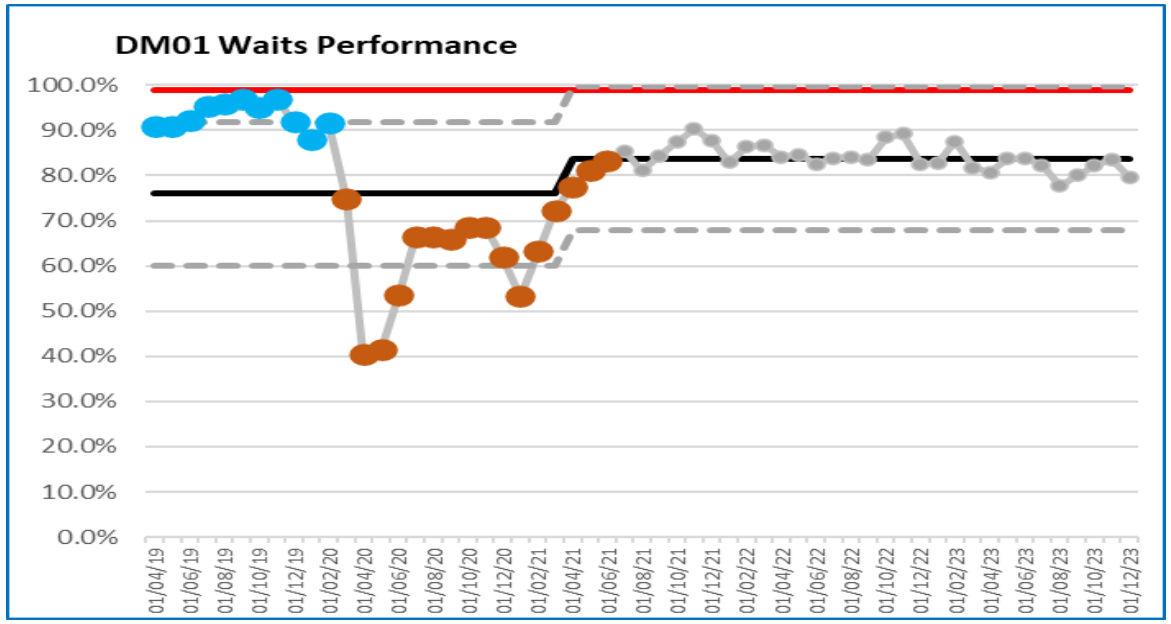
577 ↑ 47

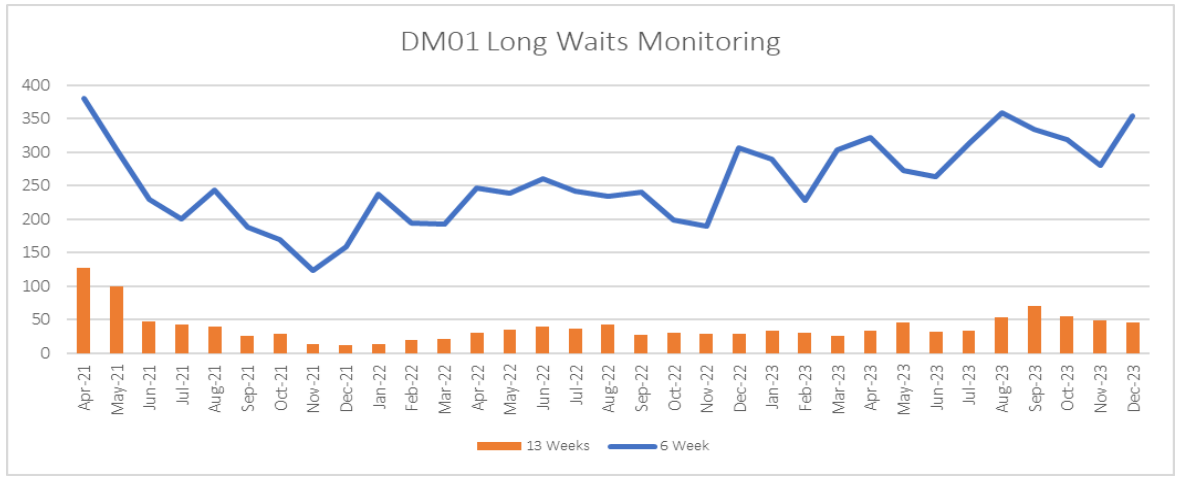
P4

568 ↓ 9

Responsive

Diagnostic Monitoring Waiting Times (DM01)





DM01:

79.7% ↓ 2.2%

People waiting less than 6 weeks for diagnostic test.

>6 Weeks:

354 ↑ *74*

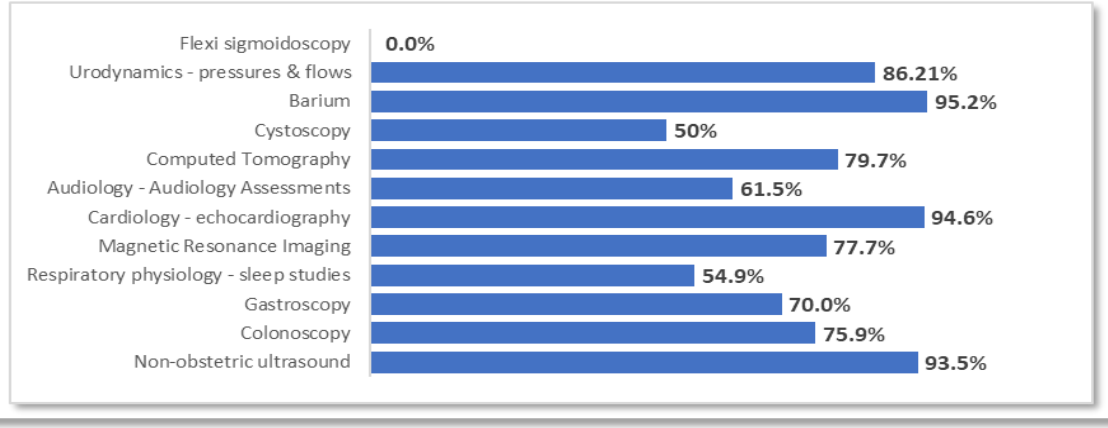
Patients waiting over 6 weeks

>13 Weeks:

46 ↓ 3

Patients waiting over 13 weeks

Modalities not meeting 99% standard



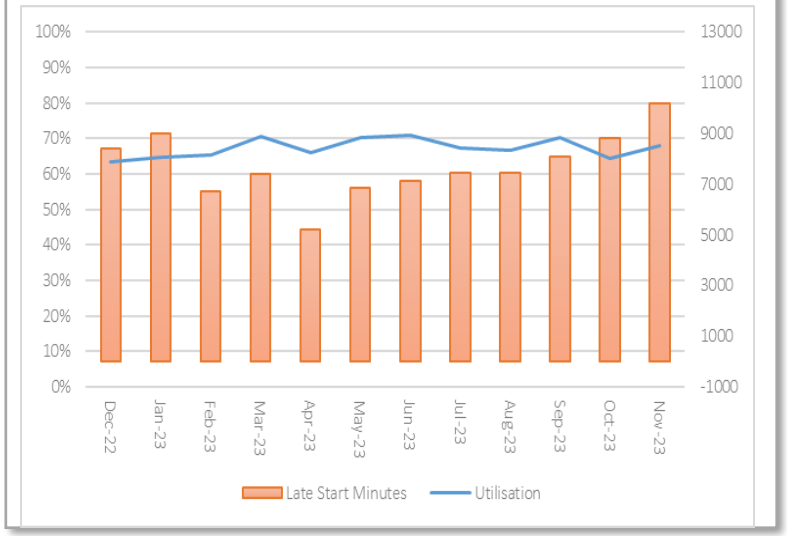
Responsive

Productivity and Efficiency

Main Theatres (NHS)

Theatres Utilisation: 67.4% ↑

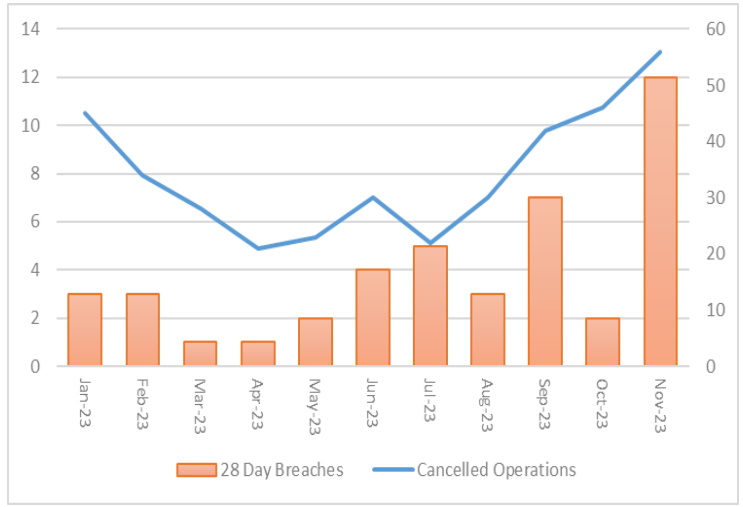
Late Start Minutes 10,182 ↑



Last Minute Non-Clinical Cancelled Operations

Number Cancelled 39 ↓

28 Day Breaches 13 ↑



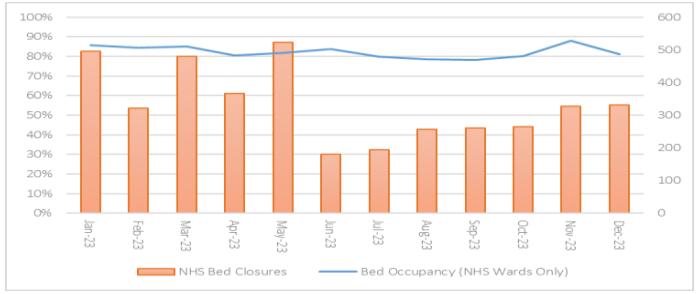
Bed Occupancy and Closures

Occupancy all IP Wards 79.49% ↓

Bed Closures all IP Wards 564 ↑

Occupancy NHS IP Wards 81.1% ↓

Bed Closures NHS IP Wards 331 ↑



December data is not available at the time of writing due to data quality issues which we are working to resolve. November 2023 has seen Theatre Utilisation increase by 3.3% from October, this has been seen within all directorates apart from Heart & Lung and Blood, Cells & Cancer. Late start minutes also increased in November, where a reason was captured the main driver was due to an overrun. A theatres productivity action plan has been produced covering improved booking process, further embedding of 6-4-2, demand and capacity analysis, reducing late starts, and introduction of reutilisation tracker for sessions handed back.

NHS Bed Occupancy decreased in November. All directorates saw an decrease in bed occupancy. NHS Bed closures have increased slightly in November 2023 mainly due to Brain.

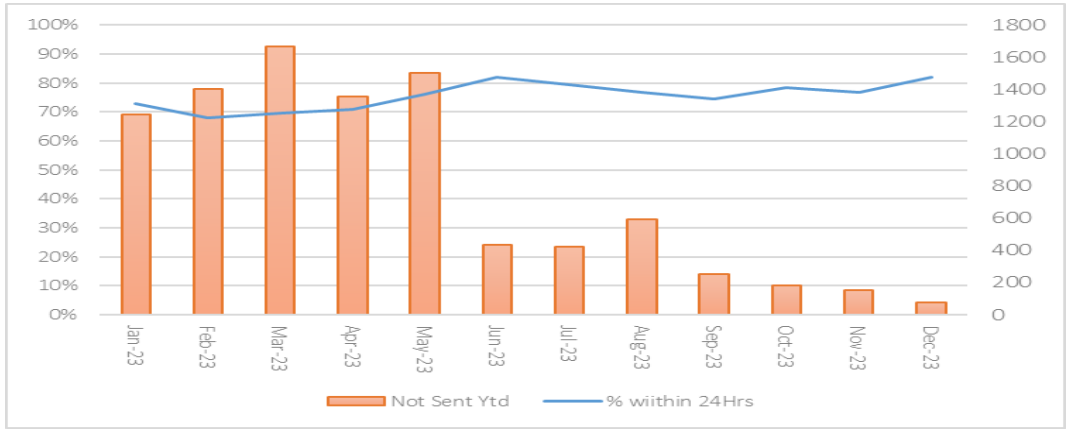
Last minute cancellations have decreased this month compared to last month. Main reasons for these were mainly due to ward and ICU bed unavailability, urgent cases taking priority across and Clinician unavailability across Heart & Lung, Body, Bones & Mind and Sight & Sound directorates.

Patient Communication

NHS Patient Discharge Summaries

Sent within 24hrs: 82.1% ↑

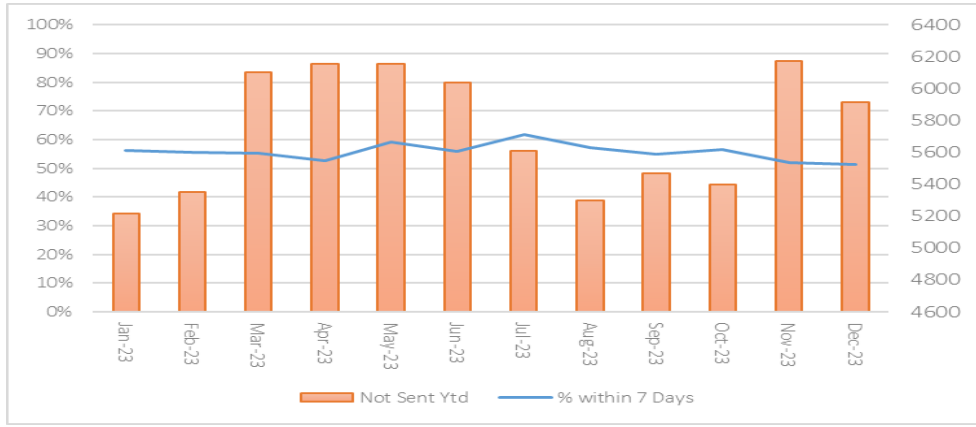
Number not sent ytd 78 ↓



NHS Clinic Letters

Sent within 7 days 51.5% ↓

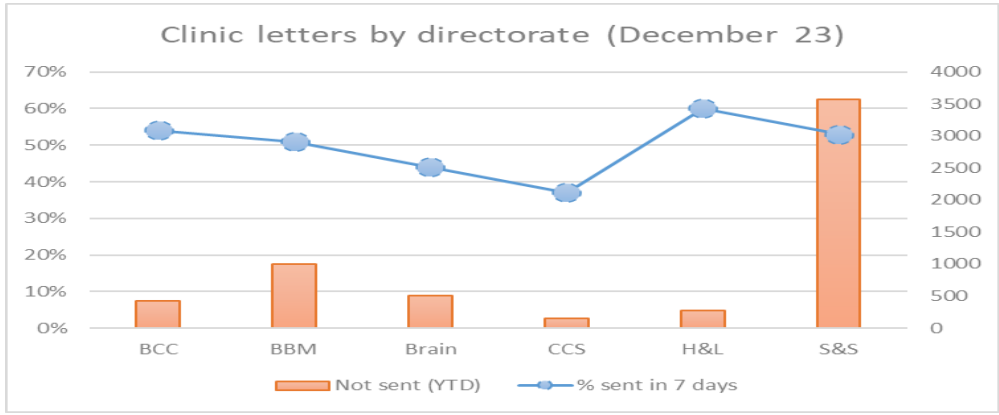
Number not sent ytd 5915 ↓



These remain a challenge for a number of the directorates, these standards are being monitored through the weekly Access and Directorate meetings. Focus also continues at consultant meetings and directorate boards to improve performance. Via the Access Meeting directorates had been requested to clear any discharge summaries and clinic letters one year or older by end of October.

With regards to Discharge Summaries there is small number outstanding 10 months or older and these are being addressed. Significant improvement has been seen within the number of outstanding discharge summaries with a reduction of over 1000. This is mainly due to the work undertaken by Core Clinical Services, Brain and Sight & Sound.

Clinic letters not sent have reduced slightly and this is a reflection of the work undertaken to reduce backlogs. Core Clinical Services has seen significant reductions, although this is offset by the increases in Sight and Sound and Body, Bones and Mind. Sight and Sound have the largest backlog overall for clinical letters, particularly driven by Plastic Surgery, Audiology and Ophthalmology.



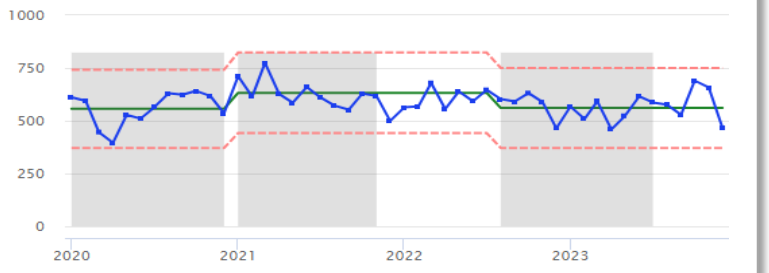
Responsive

Appendix
Integrated Quality & Performance Report

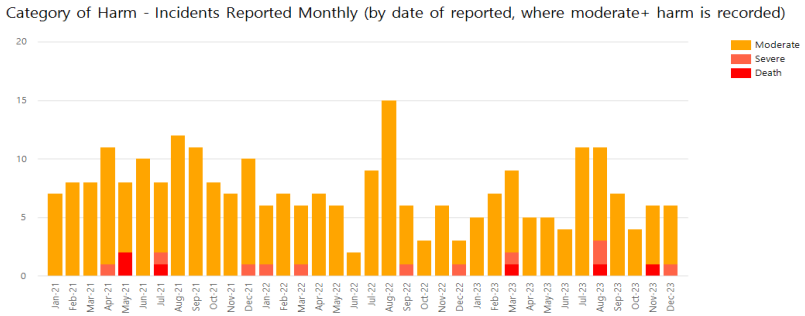
Return to Contents Page

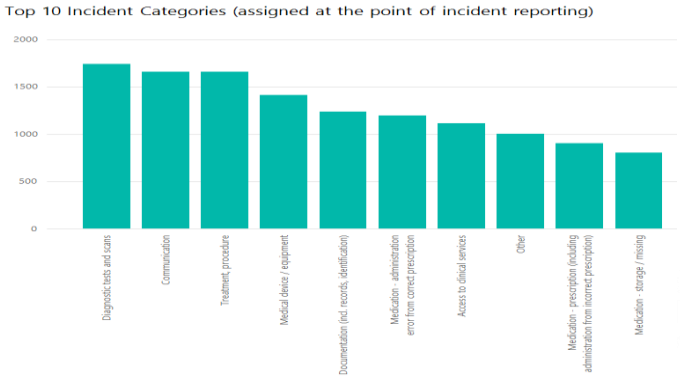
Appendix 1: Patient Safety (incidents & risks)

New Incidents

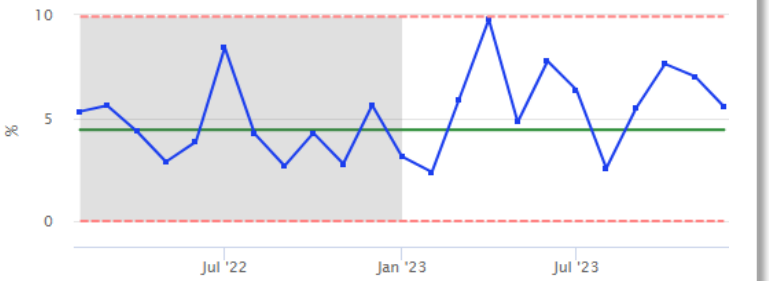


Incidents by Harm

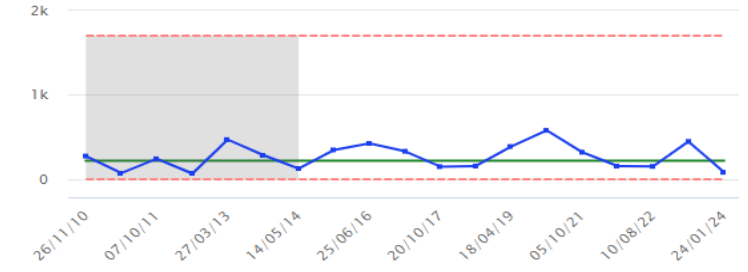




Medication Incidents



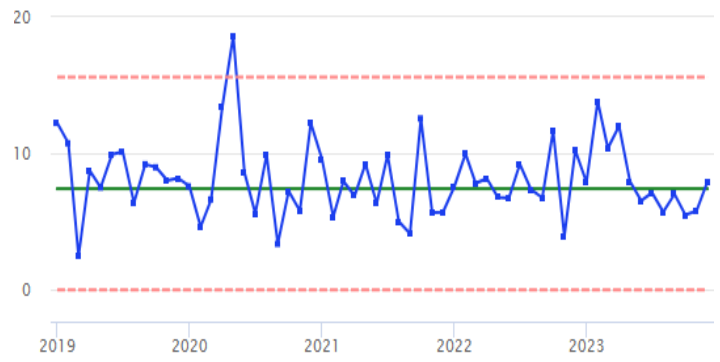
Days Since never events



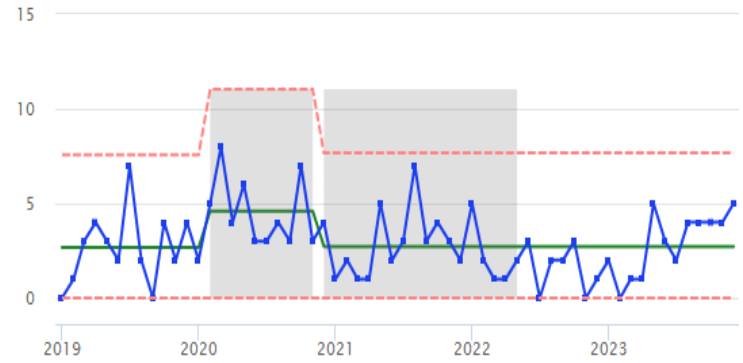
Appendix 2: Patient Safety (Infection & mortality)

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

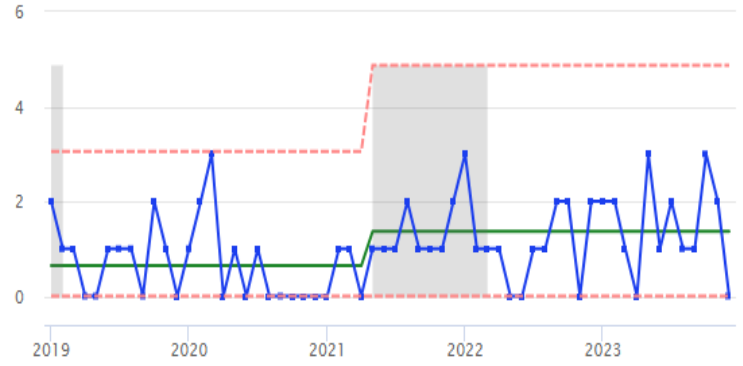
Inpatient Mortality Rate / 1000 Discharges



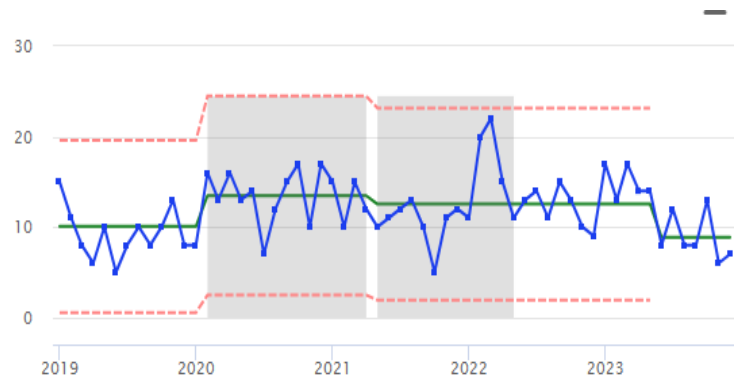
Respiratory Arrests outside ICU



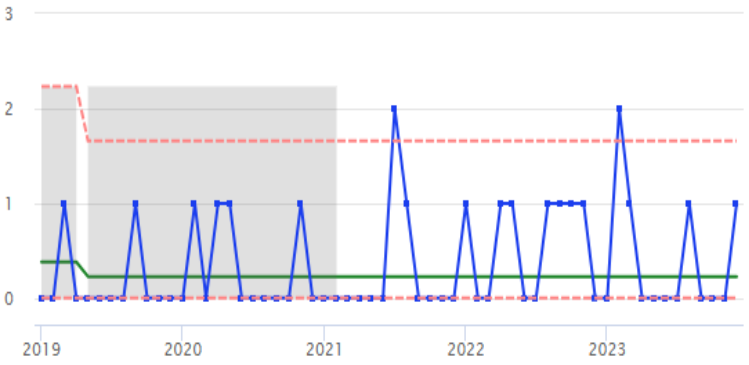
Cardiac Arrests outside ICU



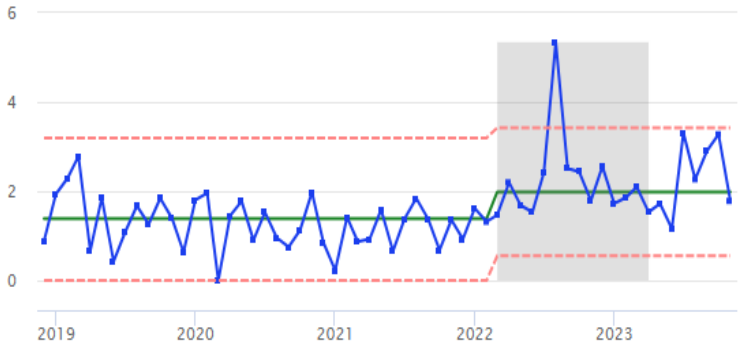
Non 2222 Patients transferred to ICU



Cat 3+ Hospital Acquired Pressure Ulcers



CV Line Infection / 1,000 line days



Safe

Appendix 3: Friends and Family Test

Overview:

The inpatient experience score for December was above the Trust target, scoring 99% for the fourth consecutive month. All directorates achieved the Trust target of 95% or above for experience. International Private Care, Core Clinical Services, Research and Innovation, and Sight and Sound all scored 100%. The overall Trust response rate was 21% which was 10% lower than the previous month. However, it is not unusual for there to be a reduction in the amount of feedback during December. In addition, activity levels fell due to the industrial action. Most directorates achieved a 25% response rate or above, except for Blood Cells and Cancer (although this is still affected by the abnormally high discharge numbers from Pelican Ambulatory n=455), Brain, and Core Clinical services. Outpatients achieved the Trust target for experience for the eighth consecutive month, achieving 95% in December.

Headline:

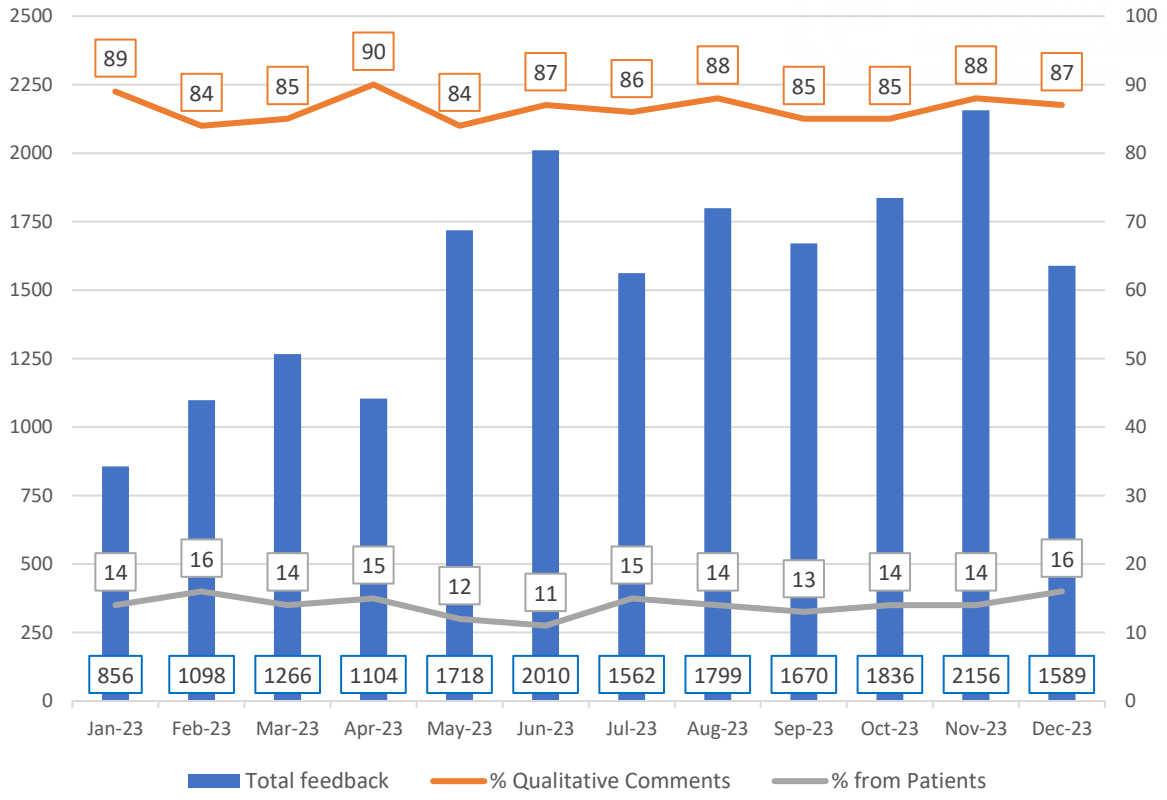
- Inpatient response rate – 21% (decreased from November).
- Experience measure for inpatients – 99% (same as November).
- Experience measure for outpatients – 95% (same as November).
- Total comments received – 1589 (decreased from November).
- 16% of FFT comments are from patients.
- 87% of responses had qualitative comments.

Positive Areas:

- Kind, compassionate staff.
- Impeccable cleanliness.
- Quick and efficient diagnoses.
- Facilities in the hospital.
- Wonderful volunteers!
- Welcoming atmosphere.
- Therapy dogs.
- Patient entertainment.
- Christmas gifts.
- Play team.
- Staff are inclusive of parent needs.

Areas for Improvement:

- Communication.
- Information to be provided about additional investigations prior to arrival.
- Signage and accessibility.
- Appointment reminders sending patients and families to the wrong location.
- Lifts in the Royal London Hospital for Integrated Medicine.
- Parking/unloading areas for wheelchair vehicles and more dropped pavements.
- More preparation for patients moving wards.
- Food and drink facilities in outpatients.



Caring

Appendix 3: Complaints

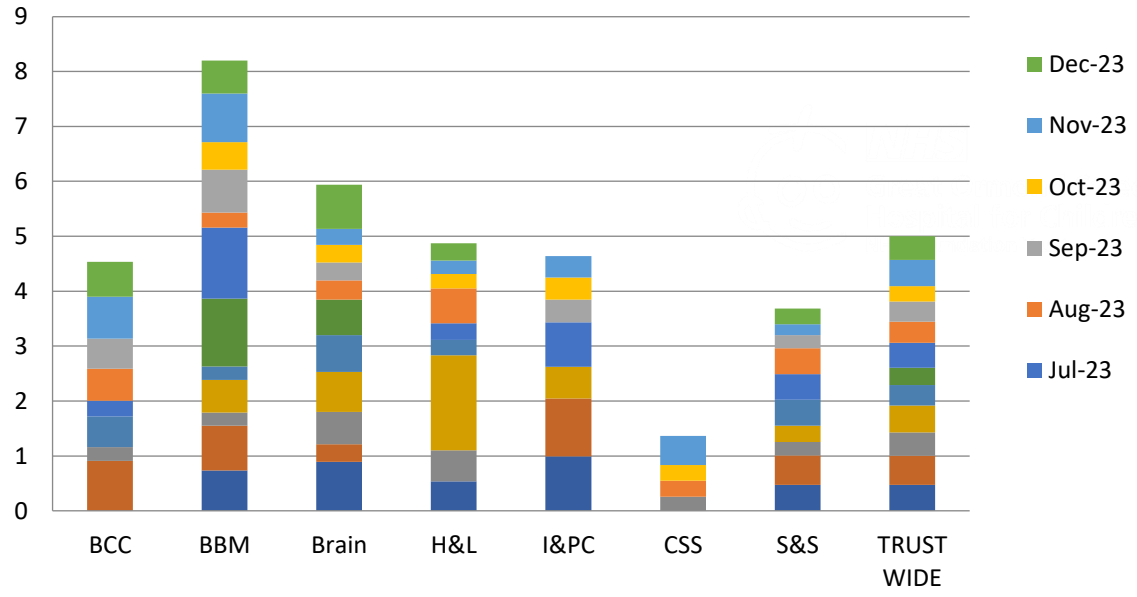
Headline: 9 formal complaints were received in December, a decrease from the number of complaints received last month in November (13) but the same number of complaints received in last December (9).

<u>In December families raised complaints regarding:</u>

- The manner and behaviour of a staff member in relation to questions asked and the upset caused by this.
- The care and treatment received prior to a patient's death (raised in 2 complaints). Concerns include delays in commencing TPN and the impact of this, poor communication between teams at GOSH and with the parents, as well as the lack of action taken around clinical deterioration.
- Delayed transport resulting in the late arrival to an appointment, and then again for the return journey, other concerns around the tone and staff manner and rudeness.
- Issues with administration of vitamin D, differing clinical opinions from doctors and a breakdown in relationships.
- A second opinion, poor communication and discharge from GOSH.
- Cancellation of a procedure due to the lack of beds.
- Needs of the patient not being met, lost samples and a lumbar puncture procedure that could not be completed due to the list being full following administration of general anaesthetic.
- The care and treatment plan and the subsequent request for a further review by another clinician at GOSH.

<u>Closed complaints since April 2023</u>

95 complaints (including withdrawn and reopened complaints) have been closed since April 2023 with 36% of these requiring extended response times. 48% of these draft responses were submitted late to the Complaints Team for review.



Learning actions/ outcomes from a complaint closed in December 2023:

In response to a complaint about a cancelled procedure due to missing equipment, and communication around this, the following action and learning has taken place:

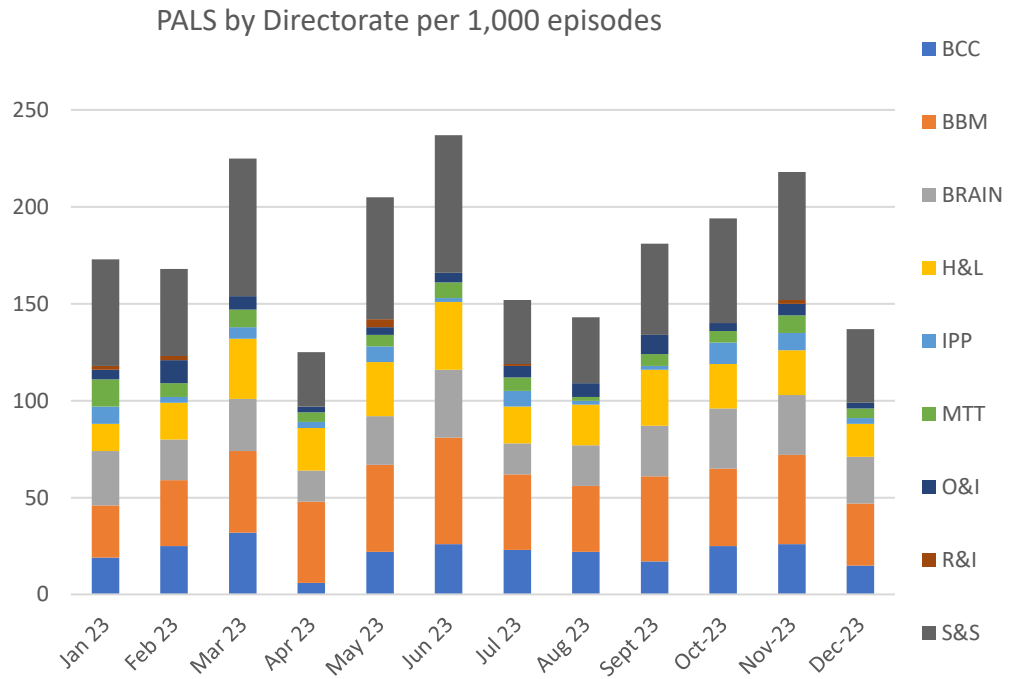
- The development of a training session for theatre clinical staff to understand the impact of behaviours on others, effective communication techniques and understanding our patients' expectations and experiences.
- Development of a standard operating procedure (SOP) for procedure cancellations to improve the communication across all teams, and that it is clear who will inform the family and to ensure their concerns and questions are addressed.

Appendix 3: PALS

Headline: Pals received 174 contacts in December (269 contacts in November). The reduction of cases can be attributed to the industrial action and reduced patient activity over the holiday period. Contacts this month related to families seeking assistance with the referral process and treatment options, requests from companies to visit and donate toys for Christmas, help with requesting medical records, cancellations of outpatient appointments (OPA) and admissions (n=30). Families also chased OPA/Admission dates as a result of long waits and clarification on treatment plans from clinical teams.

Contacts resolved within 48 hours stayed the same at 79% in December

Compliment (n=1 received in December 2023)
Plastic surgery team, anaesthetist and the ward.
Following on from my previous correspondence I just wanted to say he had his surgery today and it could not have gone more smoothly. Every member of staff we encountered was absolutely incredible. Our nurse went above and beyond, the surgeon and the anaesthetist all made him feel incredibly safe and the whole experience was seamless.



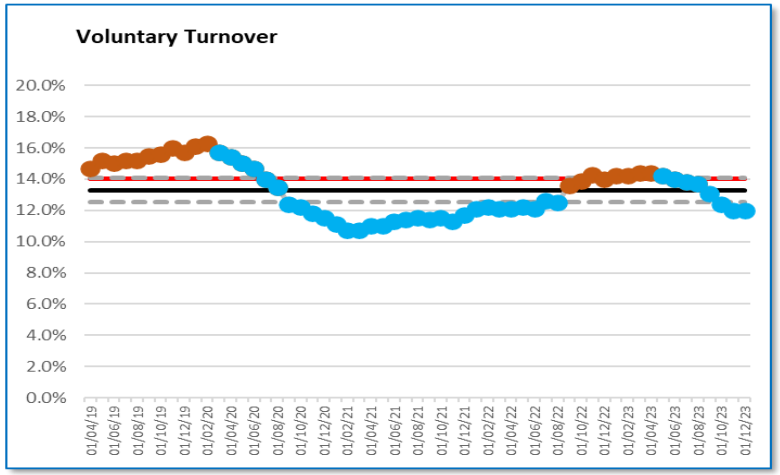
Care Queries: Pals were contacted by 40 families in December: Reasons for contacts were families wanting to share health updates and to discuss them with their medical teams, inpatients chasing contact from medical teams.

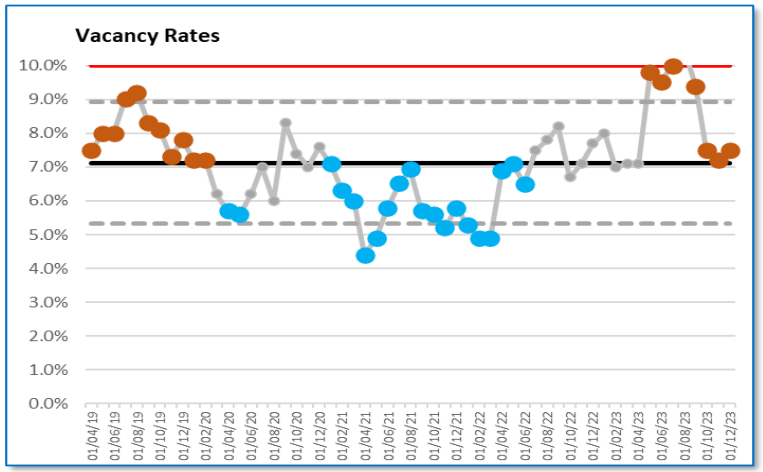
Significant areas of focus: The highest number of contacts related to SNAPS 14, Ophthalmology 11 (16 in November and Cardiology 9, (13 in November). Consistent themes across specialities were awaiting surgery dates, chasing clinic letters, reimbursement for cancelled surgery/ OPA, communication issues with secretaries, chasing test results, appointment enquiries and care queries.

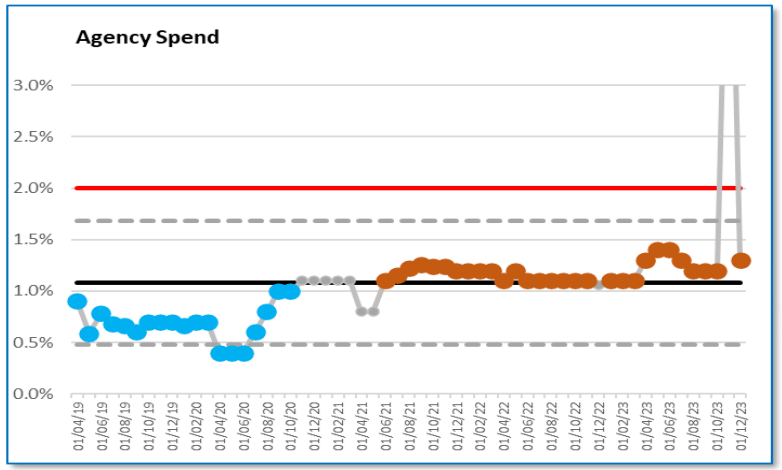
Pals Learning/Service Improvement:

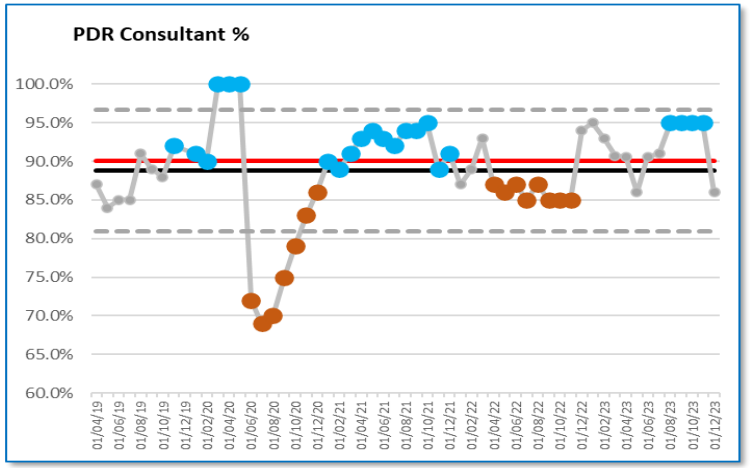
A contact from a parent who is also a wheelchair user highlighted issues regarding the accessibility of some of our accommodation/ facilities, and the importance of understanding the requirements of families using the accommodation. PALS shared this with the accommodation manager who was able to arrange alternative accommodation. This situation is being monitored closely to consider any changes to the accommodation and communication about the facilities.

Appendix 4: Workforce SPC Analysis

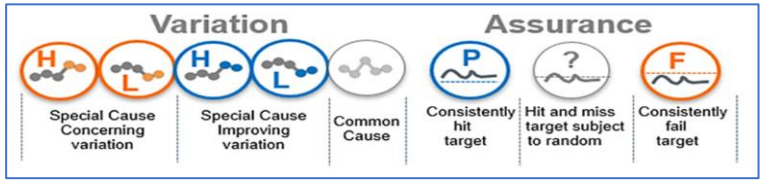








KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Trust Sickness Absence	Dec 23	3.9%	3.0%			3.2%	2.3%	4.1%
Voluntary Turnover	Dec 23	12.0%	14.0%	L		13.3%	12.5%	14.1%
Vacancy Rates	Dec 23	7.5%	10.0%	H	P	7.1%	5.3%	8.9%
Agency Spend	Dec 23	1.3%	2.0%	H	P	1.1%	0.5%	1.7%



Appendix 5: Specialty RTT Performance

Blood, Cells and Cancer

Specialty	Performance Mar-20	Oct-23	Nov-23	Dec-23	Trajectory Status	Tracking
Bone Marrow Transplant	100.0%	50.0%	100.0%		Not Required	
Dermatology	88.7%	90.5%	88.1%	86.2%	Awaiting Sign-off	
Heamatology	100.0%	100.0%	100.0%	100.0%	Not Required	
Haemophilia	100.0%	100.0%	95.5%	96.4%	Not Required	
Immunology	95.9%	93.8%	88.2%	82.7%	Not Required	
Infectious Diseases	100.0%	100.0%	100.0%	100.0%	Not Required	
Oncology	100.0%	91.7%	94.4%	85.7%	Not Required	
Palliative Care	100.0%	100.0%	100.0%	100.0%	Not Required	
Rheumatology	92.7%	95.1%	96.4%	90.4%	Not Required	

Body, Bones and Mind

Specialty	Performance Mar-20	Oct-23	Nov-23	Dec-23	Trajectory Status	Tracking
CAMHS	92.1%	54.5%	57.0%	57.5%	Not Required	
Gastroenterology	75.0%	74.5%	69.8%	69.1%	To be agreed	
General Paediatrics	68.2%	92.2%	72.7%	68.1%	Not Required	
Nephrology	90.5%	86.7%	90.4%	87.5%	Not Required	
Orthopaedics	69.6%	43.7%	46.5%	47.9%	Signed Off	Below
SNAPS	75.4%	70.4%	66.0%	64.1%	Signed Off	Below
Spinal Surgery	73.0%	49.7%	53.4%	61.8%	Signed Off	Below

Brain

Specialty	Performance Mar-20	Oct-23	Nov-23	Dec-23	Trajectory Status	Tracking
Bardet Biedl			100%	100%	Not Required	
Clinical Neurophysiology	100.0%				Not Required	
Endocrinology	91.9%	73%	68%	74%	Signed Off	Below
Epilepsy	98.0%	91.2%	100.0%	100.0%	Not Required	
Metabolic Medicine	93.8%	80.6%	76.3%	75.7%	Signed Off	Below
Neurodisability	80.1%	76.5%	83.3%	84.7%	Signed Off	Below
Neurology	89.4%	92.5%	90.7%	87.1%	Signed Off	Below
Neuromuscular	80.7%	78.4%	71.4%	61.1%	Signed Off	Below
Neurosurgery	80.1%	66.3%	60.2%	58.7%	Signed Off	Below

Core Clinical Services

Specialty	Performance Mar-20	Oct-23	Nov-23	Dec-23	Trajectory Status	Tracking
Clinical Genetics	93.4%	78.9%	79.8%	78.3%	Signed Off	Below
Interventional Radiology	92.2%	56.3%	46.7%	52.2%	Not Required	
Pain Management	79.5%	76.9%	71.1%	64.9%	Not Required	
Speech & Language Therapy	74.1%	67.9%	65.7%	64.6%	Not Required	

Heart and Lung

Specialty	Performance Mar-20	Oct-23	Nov-23	Dec-23	Trajectory Status	Tracking
Cardiac Surgery	88.5%	53.2%	60.0%	57.3%	Signed Off	Below
Cardiology	67.1%	69.7%	68.5%	69.4%	Signed Off	Below
Cardiothoracic Transplantation	100.0%	100.0%	100.0%	100.0%	Not Required	
Pulmonary Hypertension	75.0%	50.0%	75.0%	100.0%	Not Required	
Respiratory Medicine	89.2%	78.0%	84.3%	80.4%	To be agreed	

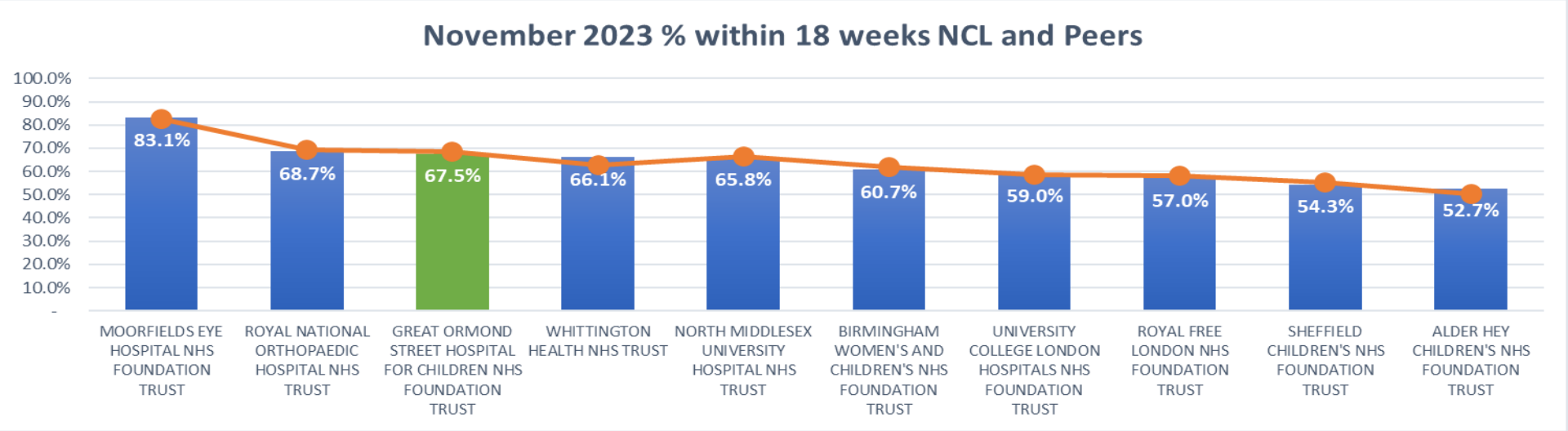
Sight and Sound

Specialty	Performance Mar-20	Oct-23	Nov-23	Dec-23	Trajectory Status	Tracking
Audiology	88.5%	51.0%	42.1%	47.9%	Signed Off	Below
Cleft	78.5%	64.9%	75.6%	75.0%	Signed Off	Below
Cochlear	87.0%	84.2%	91.3%	72.0%	Signed Off	Below
Craniofacial	70.6%	61.4%	57.7%	59.3%	Signed Off	Below
Dental	25.8%	28.3%	27.5%	28.9%	Signed Off	Below
ENT	88.3%	68.5%	66.4%	61.8%	Signed Off	Below
Maxillofacial	82.3%	51.7%	52.0%	58.0%	Signed Off	Below
Ophthalmology	88.0%	68.2%	66.4%	64.5%	Signed Off	Below
Orthodontics	44.8%	41.7%	52.6%	43.8%	To be agreed	
Plastic Surgery	62.9%	43.3%	39.9%	40.9%	Signed Off	Below
Urology	75.4%	67.3%	69.4%	65.9%	Signed Off	Below

Responsive

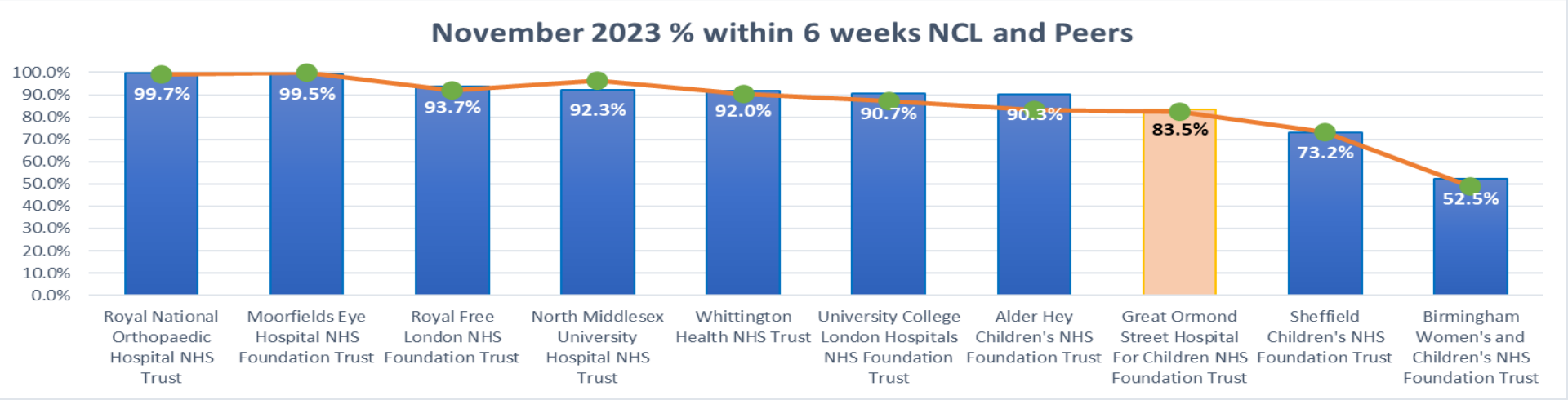
Appendix 5: RTT and DM01 Comparison

Referral to Treatment



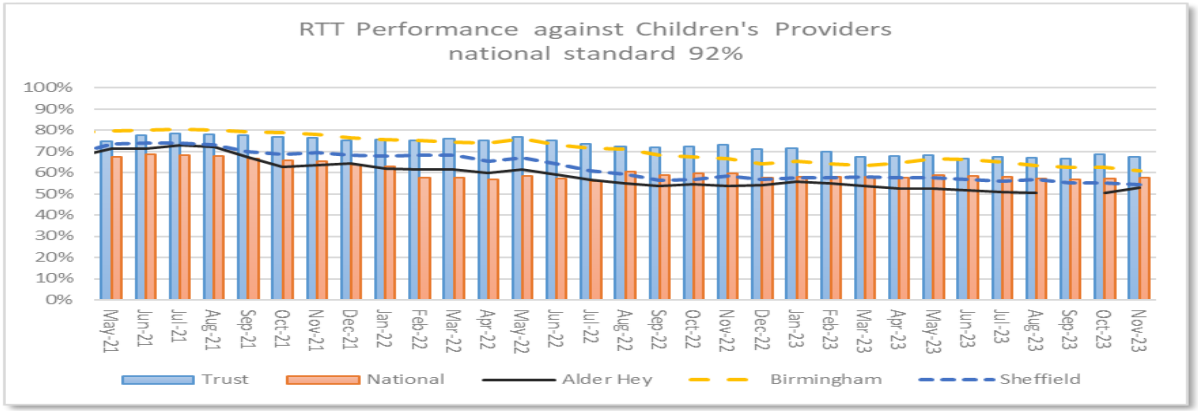
Orange markers indicate October's performance. GOSH for the month of November is at third place amongst the selected Peers. GOSH is ranked 40h out of 167 providers, this is a decrease of 3 places compared to October.

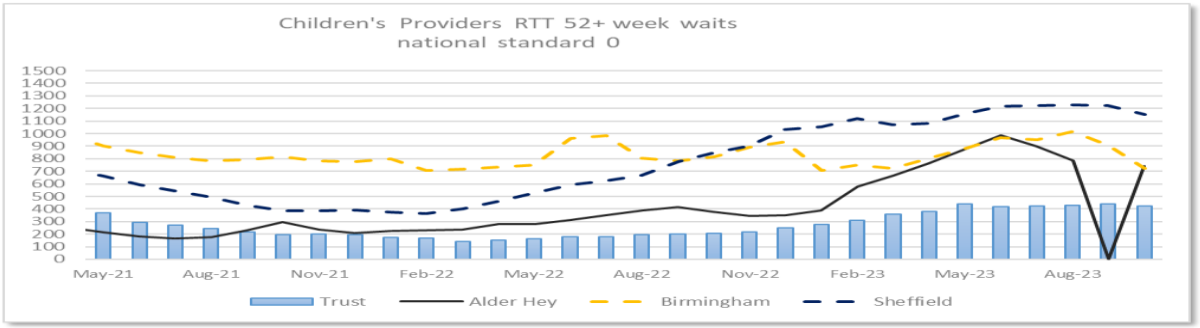
Diagnostics



Green markers indicate October performance. GOSH for the month of November is in the 3rd bottom place, amongst selected Peers. GOSH is ranked 72 out of 154 providers, an decrease of two places from September.

Appendix 5: National and NCL RTT Performance –November 2023





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

GOSH is tracking 10% above the national November performance at 67.5% and is in line with comparative children's providers. (RTT Performance for Sheffield Children (54.3%), Birmingham Women's and Children's (60.7%) and Alder Hey (52.7%))

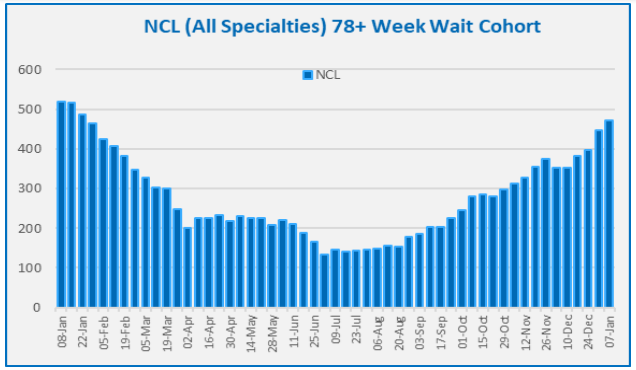
The national position for November 2023 indicates a decrease in patients waiting over 52 weeks at 345,535 patients.

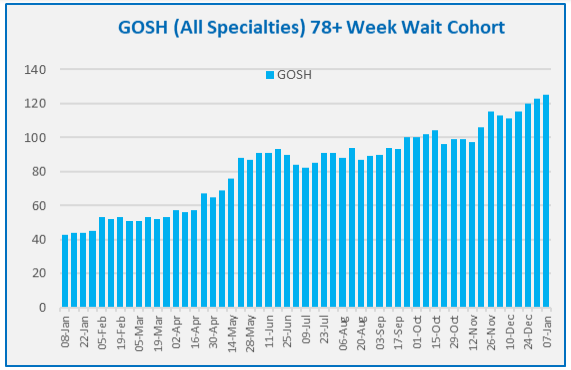
Compared to Birmingham and Sheffield the number of patients waiting 52 weeks and over for GOSH is lower than both providers for November.

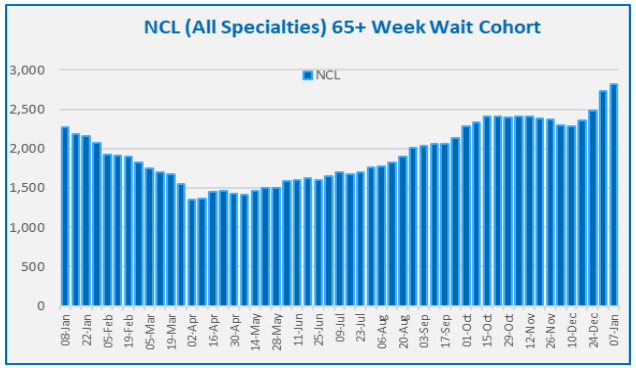
Overall for NCL the 78+ week wait position is at 472 patients, this has been increasing over the last few weeks. GOSH has the second largest volume of 78+ week wait patients in NCL, with Royal Free having the largest volume.

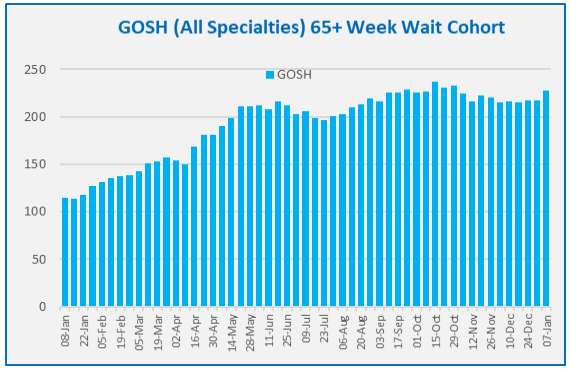
Monitoring of the 65 week wait national ambition of zero patients at March 2025, most of the NCL providers have seen an increase in the last few weeks.

NCL are in a strong position regionally with reducing long waits. However, risk remains with inter provider transfers of patients above 52 weeks as well as the impact of Junior Doctor and Consultant strikes.









Responsive

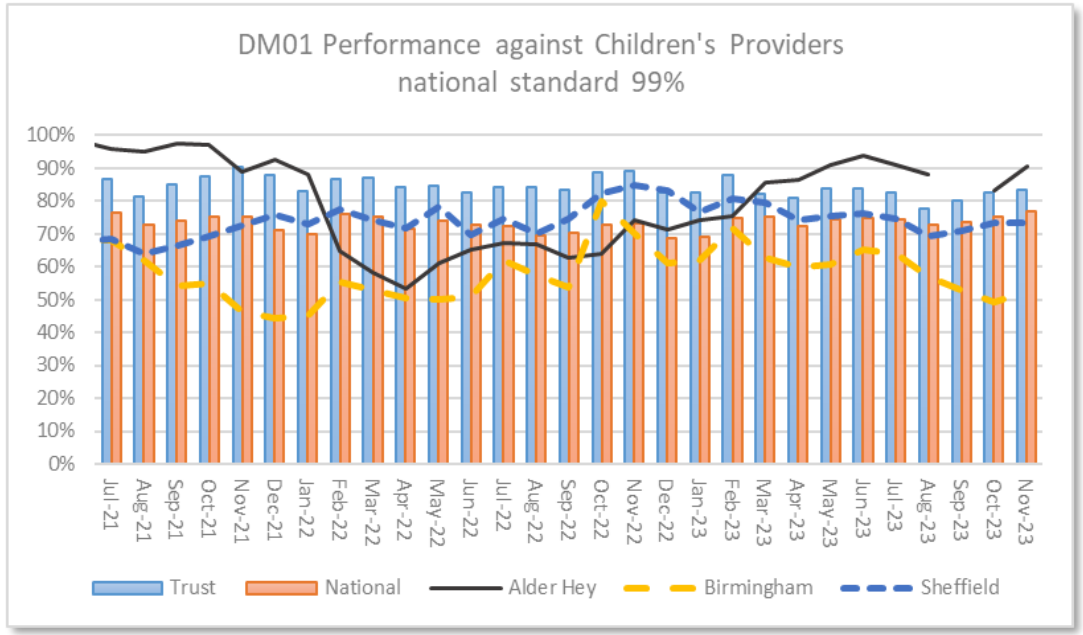
Appendix 5: National Diagnostic Performance and 6 week waits – November 2023

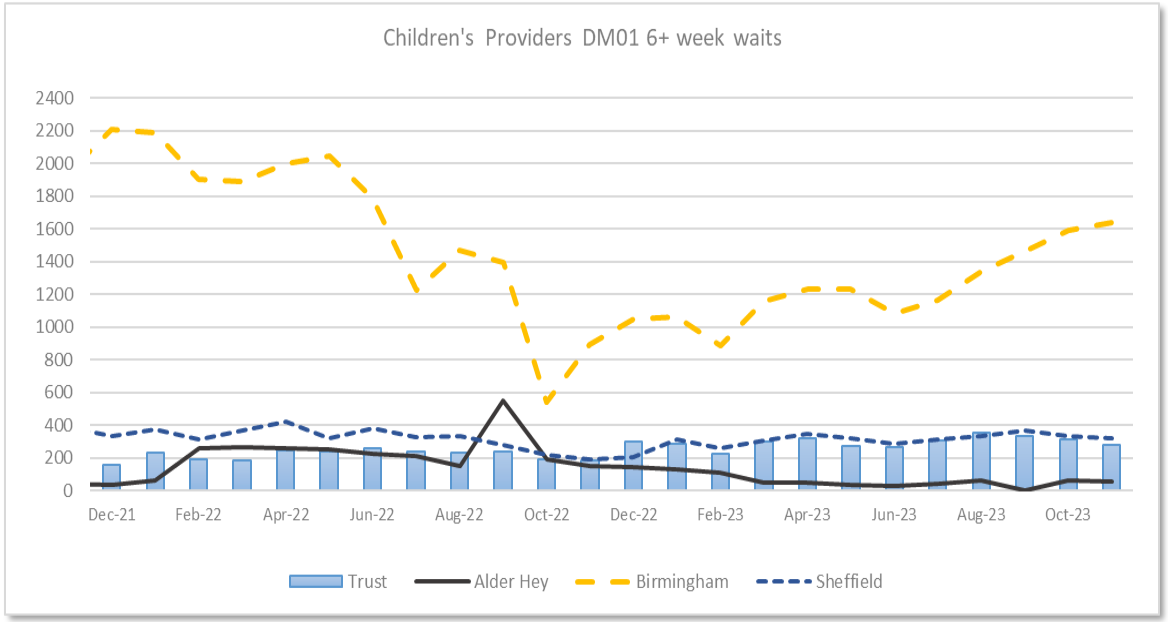
Nationally, at the end of October, 76.7% of patients were waiting under 6 weeks for a DM01 diagnostic test.

GOSH is tracking 6.8% above the national November performance and is in line with comparative children's providers. DM01 Performance for Sheffield Children (73.2%), Birmingham Women's and Children's (52.5%) and Alder Hey (90.3%).

The national position for November 2023 indicates a decrease of patients waiting over 6 weeks at 375, 151 patients.

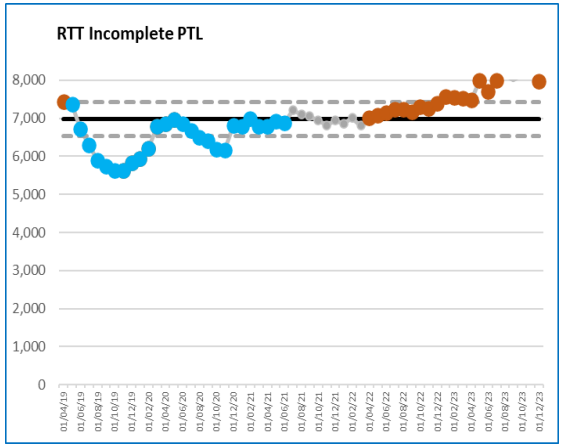
Compared to Birmingham and Sheffield, the number of patients waiting 6 weeks and over for GOSH is lower for November.



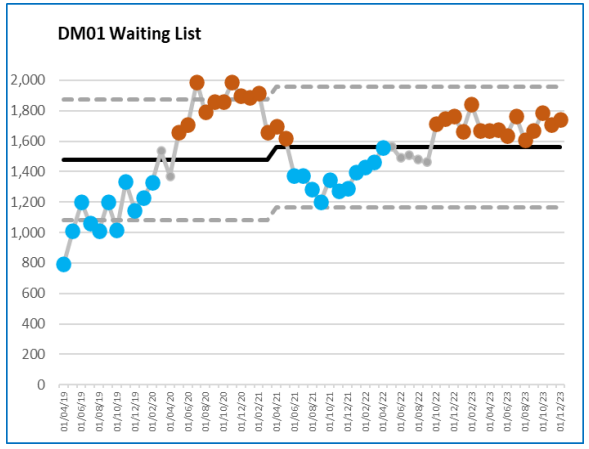


Responsive

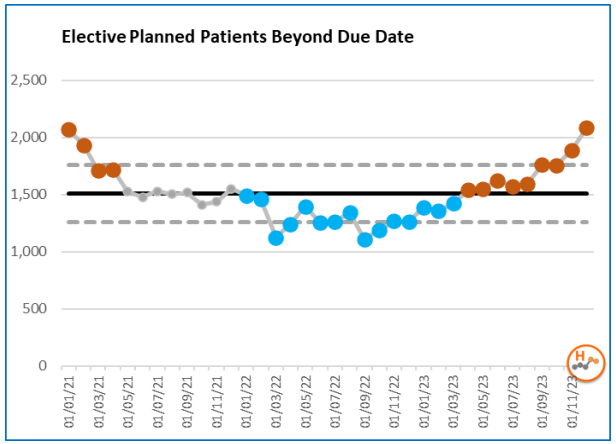
Appendix 5: Patient Access SPC Trends



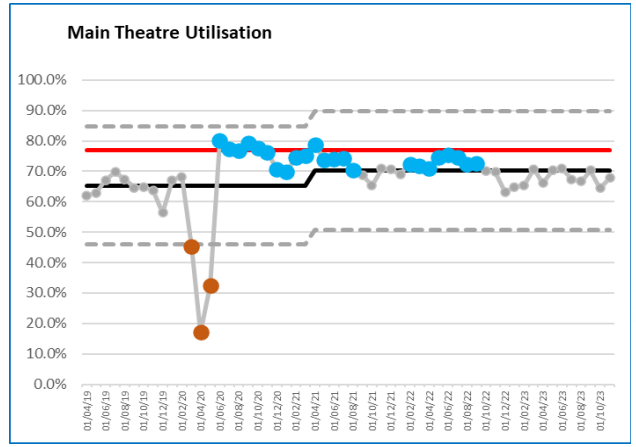
Special cause variation



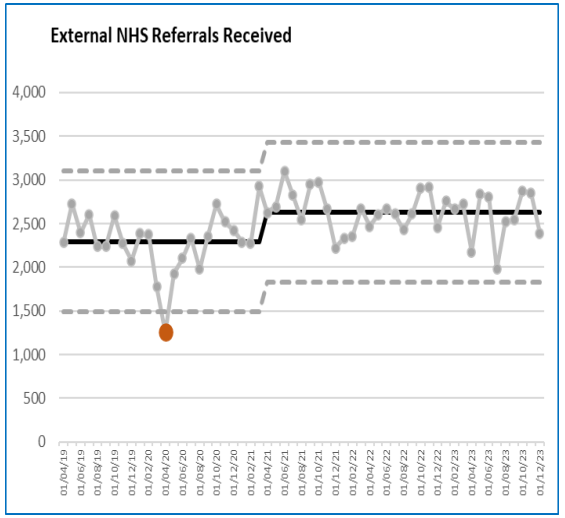
No Significant variation



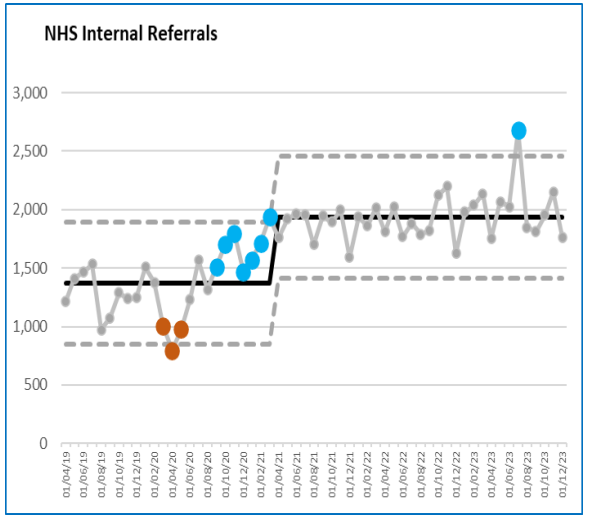
Marginal upward trend, strikes have impacted



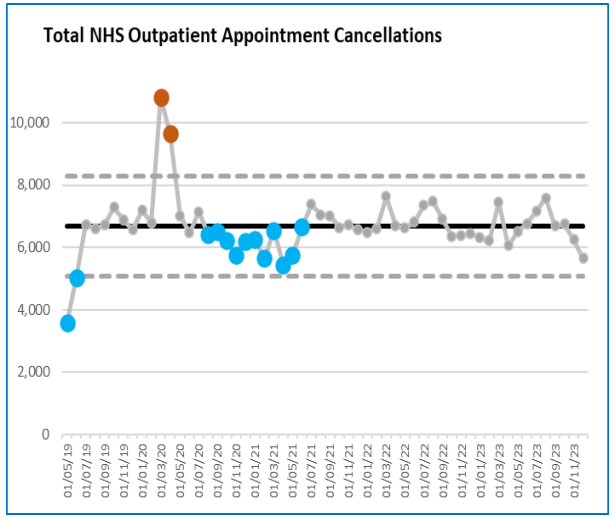
No Significant variation



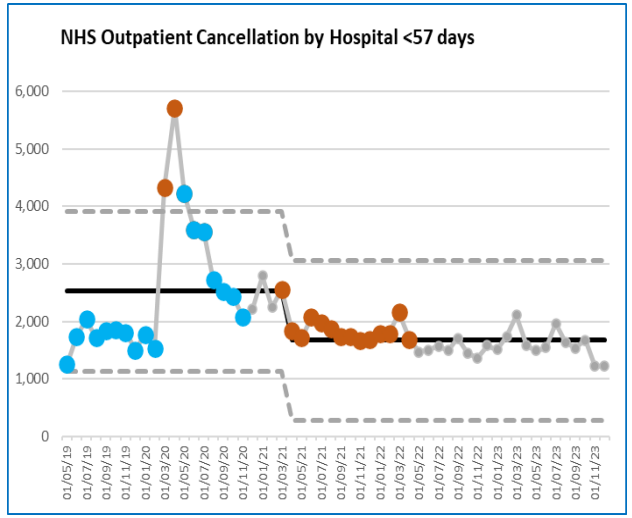
No significant variation, common cause



No significant variation, common cause



No significant variation, common cause



Common cause variation

Responsive

Integrated Quality & Performance Report January 2024 (Reporting December 2023 data)

Attachment T

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7th February 2024

Month 9 2023/24 Finance Report **Submitted by:** John Beswick, Chief Finance Officer	**Paper No: Attachment T** ☐ **For information and noting**

Purpose of report

The Trust is reporting a £10.3m deficit YTD position at month 9; a £9.3m adverse position to plan and materially impacted by:

- Strikes £5.6m adverse to plan.
- Other ERF/performance shortfall £3.2m adverse to plan
- Private patients overperformance £0.3m favourable YTD
- Pay award impact £1.7m adverse to plan.
- ERF 4% target adjustment improving the position by £3.1m
- Additional NCL funding £3.6m
- Higher than planned provision for bad debt £3.7m

The table below outlines the Trust financial performance at Month 9:

	In Month			Year to Date		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	55.6	55.2	(0.4)	475.4	483.0	7.6
Pay	(31.4)	(32.5)	(1.1)	(281.4)	(288.9)	(7.5)
Non-Pay	(23.0)	(23.8)	(0.8)	(191.0)	(201.1)	(10.0)
Finance Costs	(0.5)	(0.4)	0.1	(4.0)	(3.3)	0.7
Surplus/(Deficit)	**0.7**	(1.5)	(2.2)	**(1.0)**	**(10.3)**	**(9.3)**

The Trust Better Value programme summary:

- The Better Value programme has a full year FY23/24 target of £32.5m (£16.0m cost related and £16.5m income related).
- At month 9, £17.7m has been delivered YTD out of £22.8m YTD Target, including the private patient BV target.

Summary of report

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

1. Strike Action – The Trust has had strikes across multiple staff groups April-Dec resulting in 33 days of strike action. This has seen an impact in lost ERF income (£5.0m), which was improved due to strike adjustments (£3.1m) and additional pay costs (£0.6m).
2. The total estimated ERF year to date performance is £5.0m adverse to plan and therefore there is an under-performance of £3.2m that is not explained by strikes. It should be noted that the estimated value is subject to change as activity is coded. Further analysis of ERF under-performance is being undertaken.

3. NHS & other clinical income is £11.6m favourable to plan due to funding from NHSE in relation to strike action (£3.6m), increased pass-through drugs for CAR-T activity, and additional pay award funding. This is partly offset with underperformance in the ERF plan.
4. Private patient income is £0.3m ahead of plan YTD with an over performance in month of £0.2m. This is a reduction on the £2.0m overperformance for month 8.
5. Pay costs are £7.5m adverse due to the pay award (£8.0m), partially offset with income and increase in Bank and Agency costs due to strike actions. This is partially offset with high levels of vacancies and non-recurrent benefits.
6. Non pay costs and Finance Costs are £9.4m adverse to plan, due to increased pass-through costs, clinical supplies, increased bad debt provision and offset by accelerated depreciation linked to CCC starting in month 2 instead of month 1.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust is £71.6m and was £66.2m in month 8 which is £5.4m higher than last month.
NHS Debtor Days	NHS debtor days remains the same as the previous month (3 days).
I&PC Debtor Days	IP&C debtor days increased from 194 days in November to 227 days in December.
I&PC Overdue Debt	IP&C overdue debt increased from £33.8m in November to £35.3m in December
Creditor Days	Creditor days remains the same as the previous month at 34 days.

1. The Trust cash balance at the 31st December was £71.6m and £66.2m at month 8 which was an increase of £5.4m from prior month.
2. Total I&PC debt (net of cash deposits held) increased in month to £47.2m (£39.9m in month 8). Overdue debt increased in month to £35.3m (£33.8m in month 8).
3. Capital expenditure for the year to end of December was £24.2m, £30.0m less than plan Trust-funded expenditure was £9.0m less than plan and donated/grant-funded £17.5m less than plan. Right of use (leased) asset expenditure is £3.6m less than plan. The Trust has agreed a FOT with NCL ICB for Trust funded expenditure of £23.6m, £6.6m less than the plan.

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 9, cash flows and finance metrics.

Attachment T

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 9 2023/24

Contents

Trust Performance Summary for the 9 months ending 31 Dec 2023

KEY PERFORMANCE DASHBOARD

ACTUAL FINANCIAL PERFORMANCE

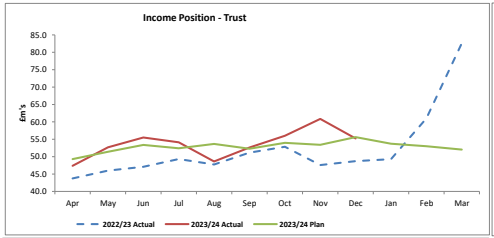
	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	£55.6m	£55.2m		£475.4m	£483.0m	
PAY	(£31.4m)	(£32.5m)		(£281.4m)	(£288.9m)	
NON-PAY inc. owned depreciation and PDC	(£23.5m)	(£24.2m)		(£195.0m)	(£204.4m)	
Surplus/Deficit excl. donated depreciation	£0.7m	(£1.5m)		(£1.0m)	(£10.3m)	

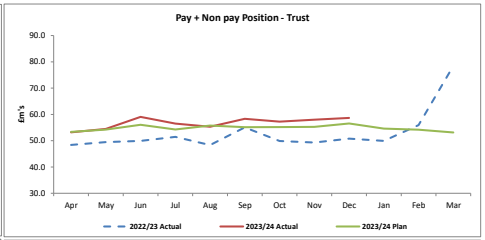
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

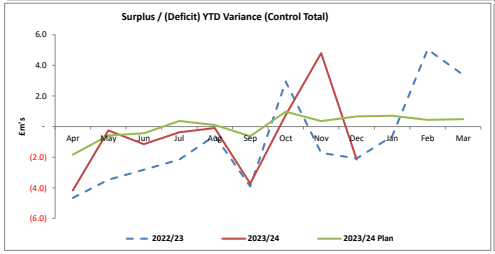
AREAS OF NOTE:

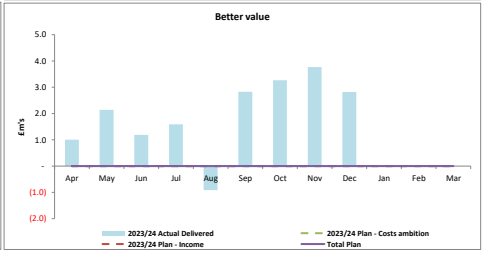
The YTD financial position for the trust is a £10.3m deficit which is £9.3 m adverse to plan. This is driven mainly by the costs of strikes and their impact on Trust ERF income, lower levels of the Trust Better Value programme delivery and lower Research income than planned,

Income is £7.6m favourable YTD mainly due to increased levels of passthrough drugs income, additional NHS funding and additional pay award funding for 23/24, this is partially offset by reduced ERF (£4.3m). Non clinical income is behind plan due to contracts with other organisations remaining unsigned and research income being below plan which is expected to improve in later months. Pay is £7.5m adverse to plan YTD mainly due to high levels of bank and agency usage linked to the additional costs incurred due to the strikes and additional pay award (partly offset by income). Non pay (including owned depreciation and PDC) is £9.6m adverse YTD mainly due to high levels of drugs , increased clinical supplies and increased energy bills. The Trust Better value programme is behind plan by £5.1m which has partly been caused by the time taken in first half of the year in dealing with the strikes.







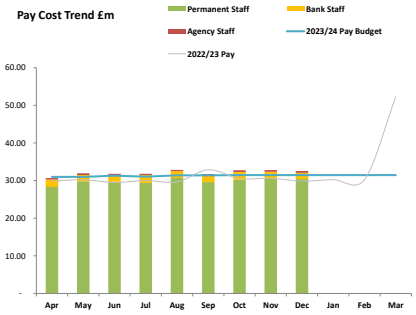


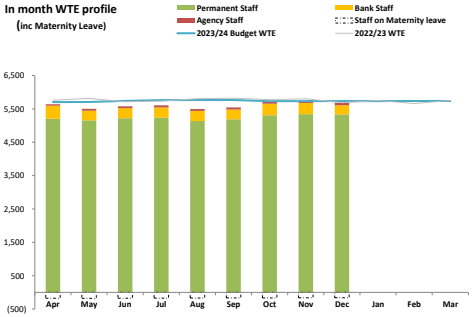
PEOPLE

	M9 Plan WTE	M9 Actual WTE	Variance
Permanent Staff	5,386.7	5,335.1	51.6
Bank Staff	310.3	274.6	35.7
Agency Staff	38.0	67.2	(29.1)
TOTAL	**5,735.1**	**5,676.9**	**58.2**

AREAS OF NOTE:

Month 9 WTEs decreased in comparison to Month 8, largely within Substantive due to leavers. Although Substantive staff are below planned levels the use of agency remains high due to continued (but reducing) levels in relation to vacancies, strikes while Bank has reduced significantly due to recruitment of newly qualified nurses. The Trust has seen reduced levels of sickness within the domestic team which is reflected in lower Bank use and ongoing work around moving bank staff into substantive to ensure the service continues without interruption.



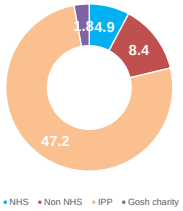


CASH, CAPITAL AND OTHER KPIs

Key metrics	Nov-23	Dec-23
Cash	£66.2m	£71.6m
IPP debtor days	194	227
Creditor days	34	34
NHS Debtor days	3	3
BPPC (£)	89%	88%

Capital Programme	YTD Plan M9	YTD Actual M9	Full Year F'cst
Total Trust-funded	£18.7m	£9.7m	£23.6m
Total PDC	£0.0m	£0.2m	£0.3m
Total IFRS 16	£3.8m	£0.2m	£0.8m
Total Donated and grant	£31.6m	£14.1m	£21.9m
Grand Total	£54.2m	£24.2m	£46.6m

Net receivables breakdown (£m)



AREAS OF NOTE:

1. Cash held by the Trust increased in month from £66.2m to £71.6m.

2. Capital expenditure for the year to end December was £24.2m, £30.0m less than plan. Trust-funded expenditure was £9.0m less than plan and donated/grant-funded £17.5m less than plan. Right of use (leased) asset expenditure is £3.6m less than plan. The Trust has agreed a FOT with NCL ICB for Trust funded expenditure of £23.6m, £6.6m less than the plan after removal of top-slicing.

3. I&PC debtors days increased in month from 194 to 227 days. Total I&PC debt (net of cash deposits held) increased in month to £47.2m (£39.9m in M08). Overdue debt increased in month to £35.3m (£33.8m in M08).

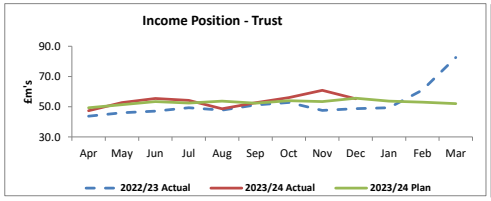
4. Creditor days remained the same as the previous month at 34 days.

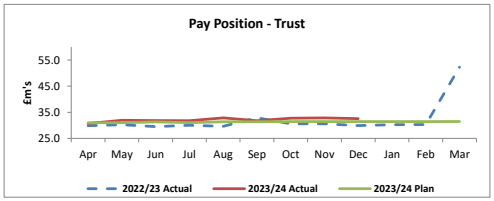
5. NHS debtor days remained the same as the previous month at 3 days.

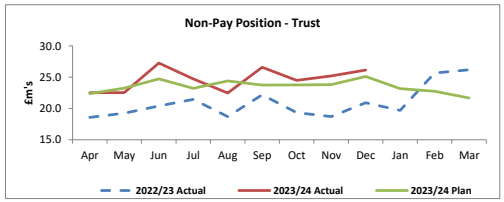
6. In M09, 88% of the total value of creditor invoices were settled within 30 days of receipt; this represented 83% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.

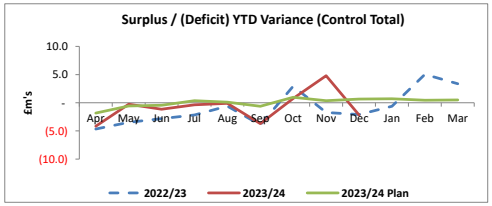
Trust Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2023

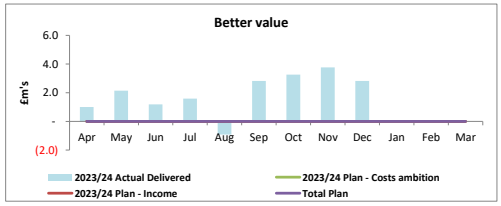
2023/24											2022/23	CY vs PY	
Annual Plan	Income & Expenditure	Month 9				Year to Date				Rating	Actual	Variance	
		Plan	Actual	Variance		Plan	Actual	Variance			M9		
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	Variance	(£m)	(£m)	%
483.29	NHS & Other Clinical Revenue	39.05	41.88	2.83	7.26%	362.26	373.82	11.56	3.19%	G	350.54	23.29	6.23%
78.00	Private Patient Revenue	6.71	6.87	0.16	2.36%	57.61	57.91	0.30	0.52%	G	35.75	22.16	38.27%
72.84	Non-Clinical Revenue	9.85	6.46	(3.39)	(34.43%)	55.52	51.26	(4.26)	(7.68%)	R	47.81	3.45	6.72%
634.12	**Total Operating Revenue**	**55.62**	**55.22**	**(0.40)**	**(0.72%)**	**475.39**	**482.99**	**7.60**	**1.60%**	G	**434.10**	**48.89**	**10.12%**
(352.61)	Permanent Staff	(29.51)	(30.40)	(0.89)	(3.02%)	(264.06)	(268.57)	(4.51)	(1.71%)	R	(255.61)	(12.96)	(4.82%)
(3.72)	Agency Staff	(0.31)	(0.47)	(0.16)	(51.30%)	(2.79)	(3.69)	(0.90)	(32.32%)	R	(2.90)	(0.79)	(21.40%)
(19.42)	Bank Staff	(1.62)	(1.66)	(0.05)	(2.84%)	(14.56)	(16.63)	(2.07)	(14.21%)	R	(14.58)	(2.05)	(12.33%)
(375.75)	**Total Employee Expenses**	**(31.44)**	**(32.54)**	**(1.10)**	**(3.49%)**	**(281.41)**	**(288.89)**	**(7.48)**	**(2.66%)**	R	**(273.10)**	**(15.80)**	**(5.47%)**
(102.99)	Drugs and Blood	(8.03)	(10.41)	(2.39)	(29.76%)	(77.28)	(81.10)	(3.82)	(4.95%)	R	(76.01)	(5.09)	(6.28%)
(41.62)	Supplies and services - clinical	(3.02)	(3.24)	(0.22)	(7.22%)	(31.46)	(35.97)	(4.51)	(14.34%)	R	(32.75)	(3.22)	(8.95%)
(87.54)	Other Expenses	(10.74)	(8.47)	2.27	21.15%	(66.57)	(69.53)	(2.96)	(4.44%)	R	(55.88)	(13.65)	(19.63%)
(232.14)	**Total Non-Pay Expenses**	**(21.79)**	**(22.13)**	**(0.34)**	**(1.54%)**	**(175.31)**	**(186.60)**	**(11.29)**	(6.44%)	R	**(164.64)**	**(21.96)**	**(11.77%)**
(607.89)	**Total Expenses**	**(53.24)**	**(54.67)**	**(1.43)**	(2.69%)	**(456.72)**	**(475.49)**	**(18.77)**	(4.11%)	R	**(437.73)**	**(37.76)**	(7.94%)
26.23	**EBITDA (exc Capital Donations)**	**2.38**	**0.55**	**(1.83)**	**(76.90%)**	**18.68**	**7.50**	**(11.18)**	**(59.86%)**	R	**(3.64)**	**11.14**	**148.54%**
(25.64)	Owned depreciation, Interest and PDC	(1.72)	(2.04)	(0.33)	(19.16%)	(19.71)	(17.80)	1.90	9.65%		(14.88)	(2.93)	(16.45%)
0.60	**Surplus/Deficit**	**0.66**	**(1.49)**	**(2.16)**	**(324.76%)**	**(1.03)**	**(10.31)**	**(9.28)**	**(902.48%)**		**(18.51)**	**8.21**	**79.66%**
(24.18)	Donated depreciation	(1.60)	(1.96)	(0.37)		(19.37)	(17.51)	1.86			(14.69)	(2.82)	(0.16)
(23.58)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(0.93)**	**(3.46)**	**(2.53)**	**(324.76%)**	**(20.40)**	**(27.82)**	**(7.42)**	**(902.48%)**		**(33.21)**	**5.39**	**19.39%**
0.00	Impairments & Unwinding Of Discount	0.00	0.00	0.00		0.00	0.00	0.00			0.00	0.00	
41.94	Capital Donations	3.60	0.19	(3.41)		31.60	13.37	(18.23)			7.83	5.54	0.41
18.36	**Adjusted Net Result**	**2.67**	**(3.27)**	**(5.94)**	**(222.45%)**	**11.20**	**(14.45)**	**(25.65)**	**(229.05%)**		**(25.38)**	**10.94**	**75.68%**











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

Summary

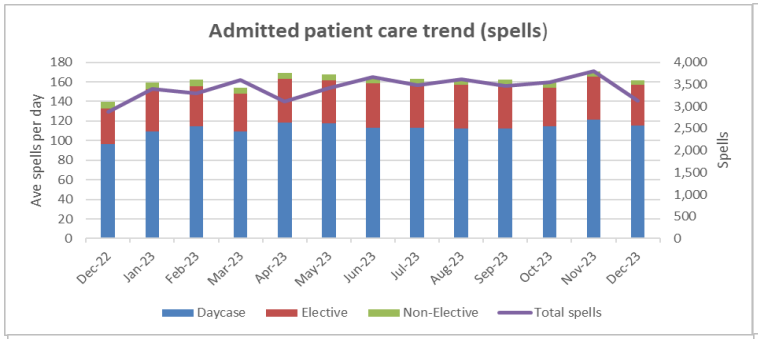
- The YTD Trust financial position at month 9 is a deficit of £10.3m which is £9.3m adverse to plan.
- The Trust deficit is due to lost income and additional costs associated with the strikes and lower than planned non clinical income.

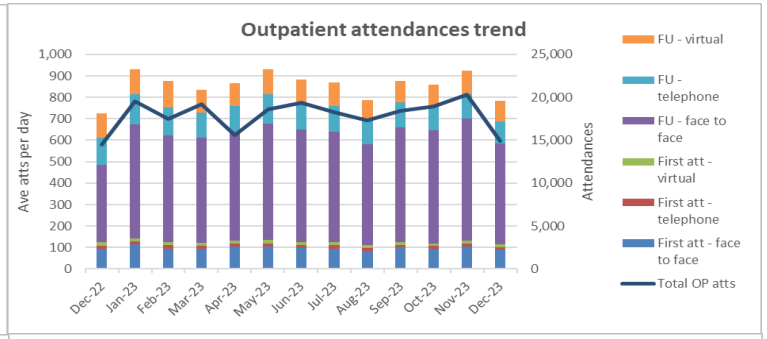
Notes

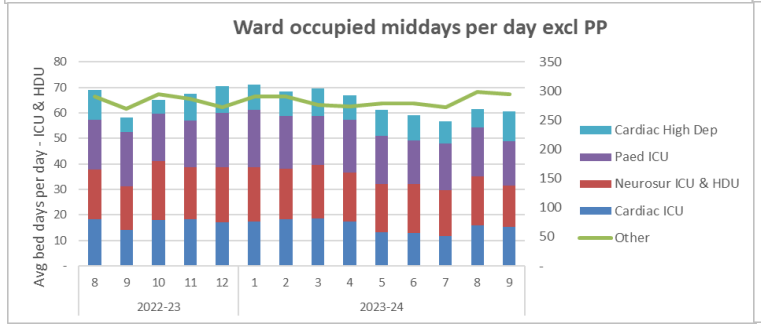
- NHS clinical income is £11.6m favourable to plan YTD due to increased income for passthrough drugs and activity (£3.7m) and additional pay award funding (£6.3m) offset with reduced ERF linked mainly to strikes.
- Private Patient income improved in month overperforming by £0.2m meaning it is above plan YTD by £0.3m. This is due to increased ICU bed days. I&PC is working towards delivering £78.5m by the year end.
- Non clinical income is £4.3m adverse to plan YTD. This is mainly driven by lower than planned Research and Charitable income caused by timing of milestone delivery and finalisation of contracts. .
- Pay costs are £7.5m adverse to plan YTD mainly due to in year pay awards (£8.0m), high levels of bank and agency usage linked to the additional costs incurred due to the strikes (£0.6m) offset with vacancies.
- Non pay is £11.3m adverse to plan YTD related to an increase in passthrough costs (£2.7m, offset by income) and increased clinical supplies costs (£4.5m).
- 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.

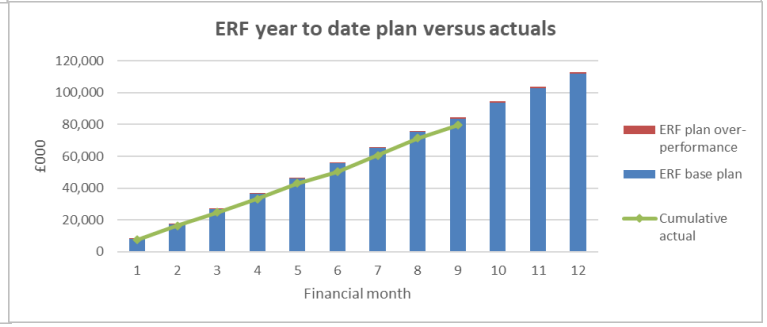
2022/23 Overview of activity trends for the 9 months ending 31 Dec 2023

Great Ormond Street Hospital for Children NHS Foundation Trust









Summary

- Admitted patient care per day in December is lower than November for day case by 6.4 spells and elective activity decreased by 1.97 spells per day (4.5% decrease). Non-elective of 0.66 spells per day (12.1% decrease). December activity has slightly decreased per working day in comparison to November. December activity has decreased versus April (7.5 spells per working day); this is largely driven by decrease day case (3.46 spells) and lower elective cases (3.08 spells).

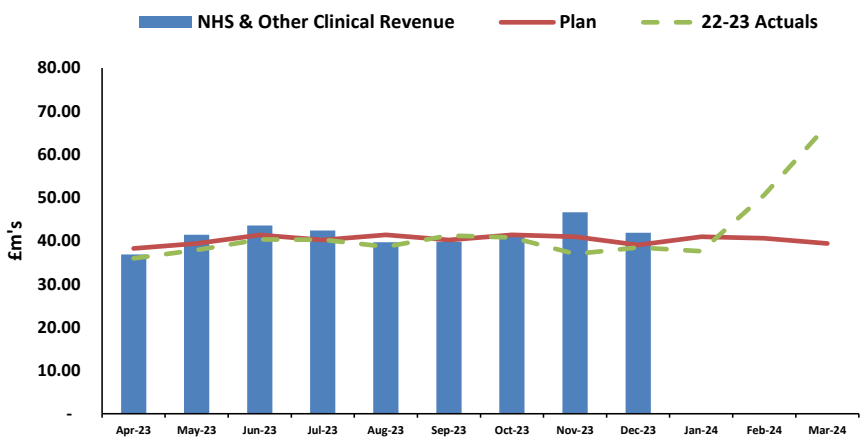
- Bed days for December have reduced by 1.21% reflecting the activity trend and NHS critical care days are 0.88 per working day lower than November with this being offset by other bed days (3.47 per working day). It should be noted that critical care days for private activity was 0.03 per working day higher than November.

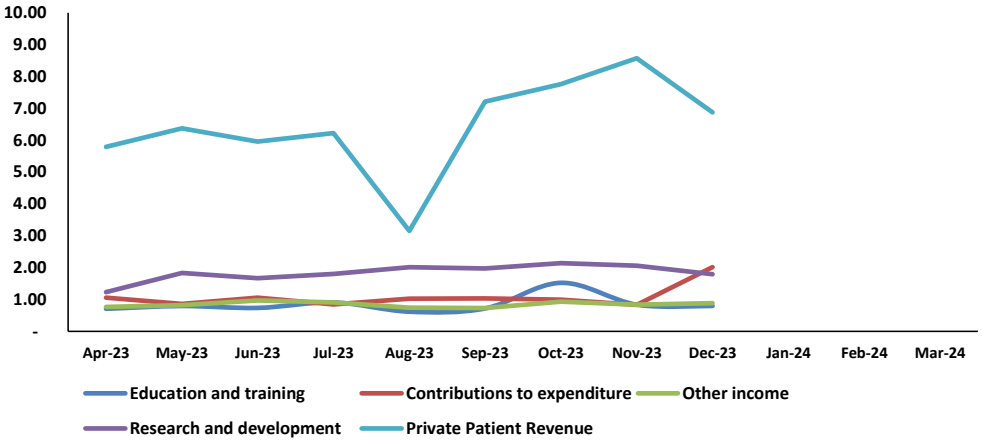
- Outpatient attendances decreased across the board versus November with first attendances decreasing by 18.2 attendances per day and follow ups reduced by 122.04 attendances per day . The number of outpatient attendances may increase as activity is finalised and have been impacted by strikes and Christmas reduced activity.

- On the basis of current ERF information, which includes some estimates for uncoded work, Month 9 performance has an under-performance of £5,1m against the total plan, a deterioration of £0.4m versus November due to lower activity in December. The estimated impact of strikes within the year to date performance is £1.8m giving a variance as a result of under-performance versus the target of £2.5m of which £0.7m relates to the stretch target.

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

2022/23 Income for the 9 months ending 31 Dec 2023





Summary

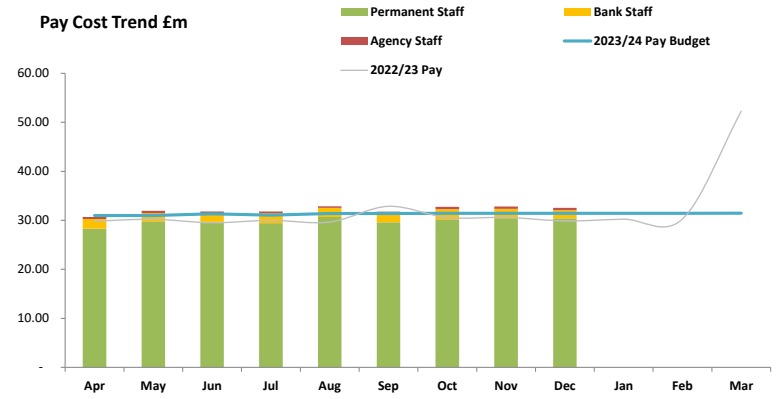
- Income from patient care activities excluding private patients is £8.7m favourable to plan YTD. This is due to increased income for pass through drugs, pay award funding and NHS additional funding of £3.6m offset with ERF reduction.
- Non clinical income is £0.9m adverse to plan YTD. This is mainly driven by lower than planned charity income and research income linked to delays in milestone delivery and the finalisation of contracts.
- Private Patient income overperformed YTD by £0.3m. This is due to increased ICU activity and additional charges for bed days. The Trust continues to work on securing future referrals in order to deliver £78.5m by the year end.

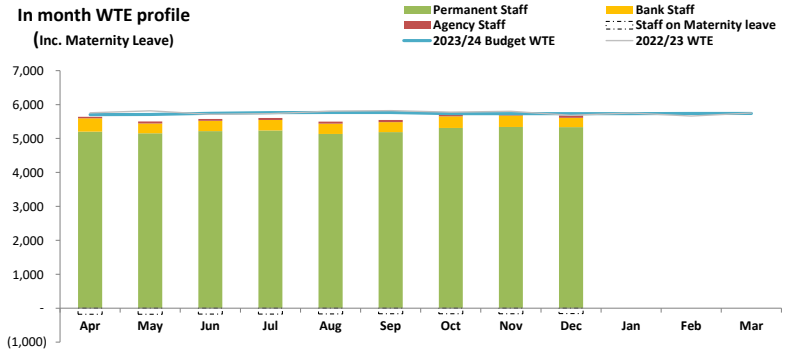
Workforce Summary for the 9 months ending 31 Dec 2023

*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	54.6	1,317.0	55.2	(3.4)	(1.2)	(2.2)	R
Consultants	66.7	394.1	169.2	53.3	395.3	179.6	(3.2)	(0.2)	(3.1)	R
Estates & Ancillary Staff	16.4	445.7	36.8	12.8	455.4	37.5	(0.5)	(0.3)	(0.2)	A
Healthcare Assist & Supp	12.2	306.9	39.7	9.6	323.3	39.8	(0.5)	(0.5)	(0.0)	A
Junior Doctors	33.5	393.0	85.2	27.0	393.3	91.5	(1.9)	(0.0)	(1.9)	R
Nursing Staff	100.9	1,616.5	62.4	75.9	1,595.7	63.5	(0.3)	1.0	(1.3)	A
Other Staff	1.0	17.9	56.2	0.7	17.0	54.2	0.1	0.0	0.0	G
Scientific Therap Tech	67.2	1,072.7	62.7	50.3	1,056.0	63.5	0.1	0.8	(0.7)	G
Total substantive and bank staff costs	**366.1**	**5,533.4**	**66.2**	**284.2**	**5,553.0**	**68.2**	**(9.6)**	**(1.0)**	**(8.6)**	R
Agency	4.1	39.0	104.2	3.7	57.8	85.1	(0.6)	(1.5)	0.8	R
Total substantive, bank and agency cost	**370.1**	**5,572.4**	**66.4**	**287.9**	**5,610.8**	**68.4**	**(10.3)**	**(2.4)**	**(7.8)**	R
Reserve*	1.1	0.0		1.0	0.0		(0.2)	(0.2)	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**	**288.9**	**5,610.8**	**68.7**	**(10.5)**	**(2.6)**	**(7.8)**	R
Remove maternity leave cost	(2.5)			(1.6)			(0.3)	0.0	(0.3)	A
Total excluding Maternity Costs	**383.3**	**5,572.4**	**68.8**	**287.3**	**5,610.8**	**68.3**	**(10.7)**	**(2.6)**	**(8.1)**	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 £7.5m and when compared to the 2022/23 extrapolated average it is £10.5m higher. This increase from 2022/23 is being driven mainly by price increases (£7.8m). The price variance is driven by the NHS pay award.

The Trust continues to see high but decreasing levels of maternity leave (158WTE) which is contributing to the higher than planned levels of temporary staffing across the Trust.

Consultants & Junior Doctors are £2.0m adverse YTD to plan due to increased costs from the strikes and medical pay award.

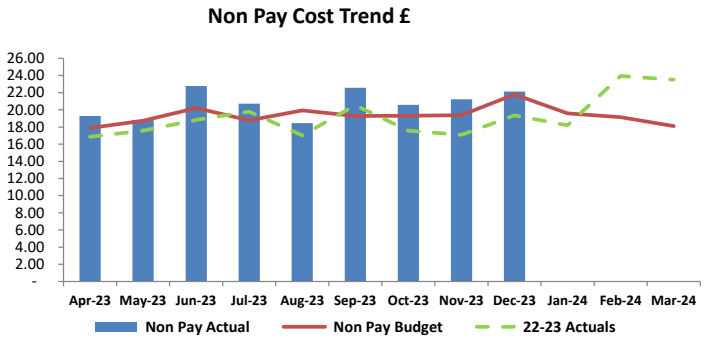
Estates & Ancillary are £0.5m adverse YTD to plan due to high levels of sickness within the cleaning service. When compared to 2022/23 the key driver of the increase additional staffing required to deliver the required levels of cleaning.

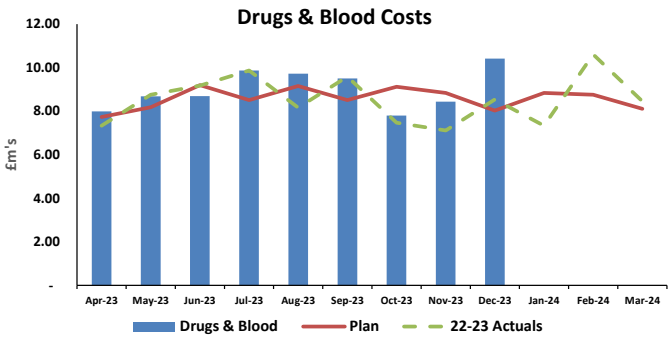
Scientific Therapeutic and Technical Staff are £1.3m adverse to plan YTD due to an increase in bank usage in order to deliver the services required while vacancies are recruited into.

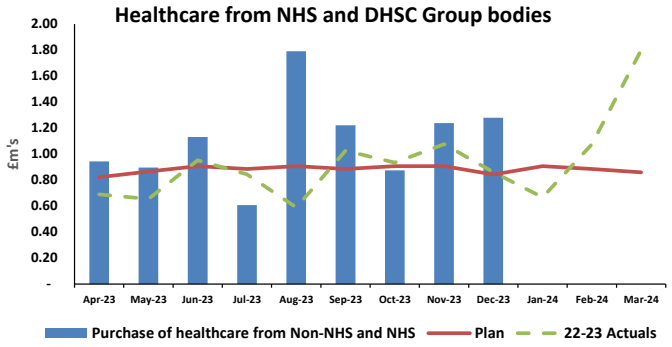
Nursing are £0.5m favourable to plan YTD due to vacancies which were not covered by Bank and Agency

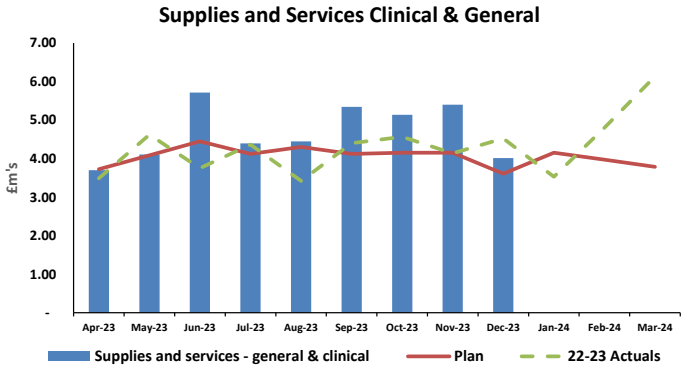
Agency costs YTD increased due to the increased number of staff associated with managing the Trust during the continued strikes while the price variance has fallen.

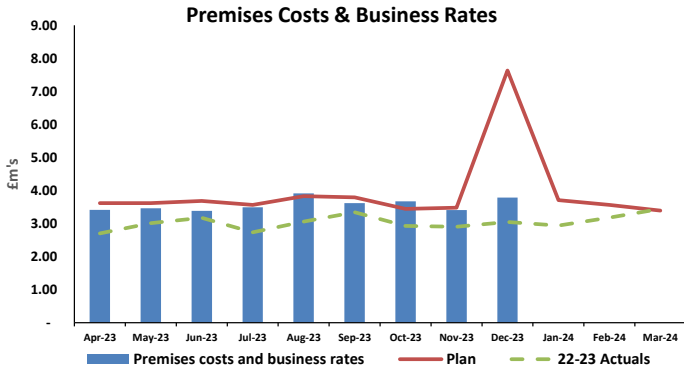
Non-Pay Summary for the 9 months ending 31 Dec 2023

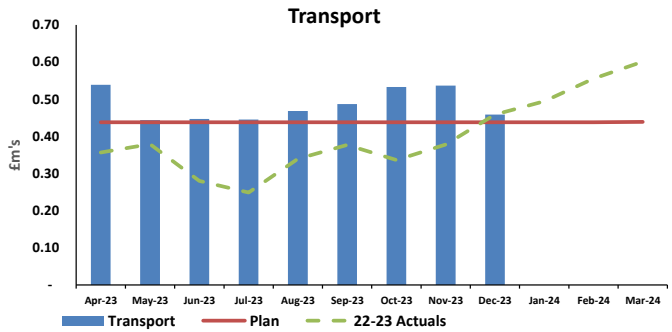








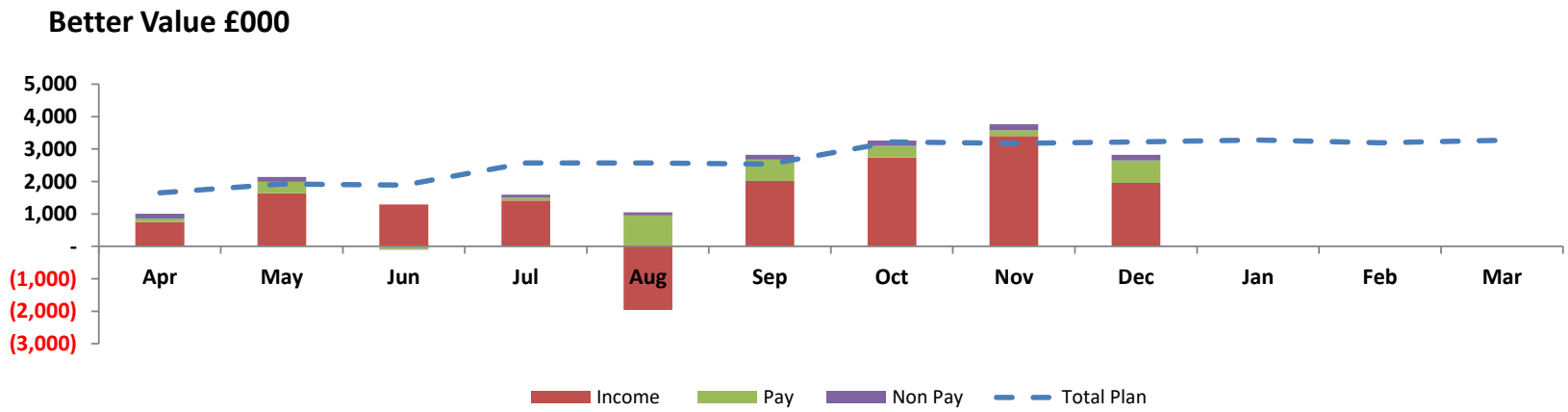


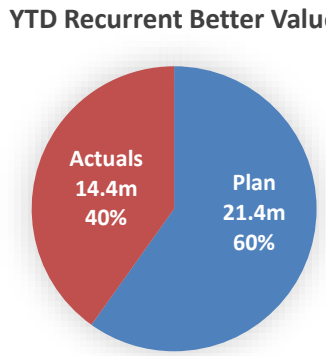


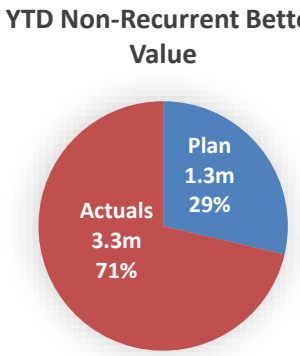
Summary

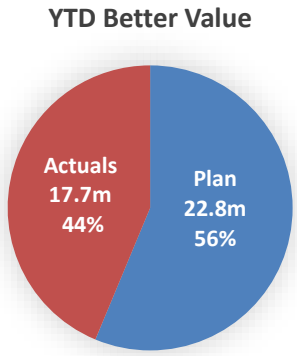
- Non pay is £11.3m adverse to plan YTD.
- Passthrough drugs and blood costs are £3.8m adverse to plan YTD due to a number of high cost cases including a number of CAR-T issues this year which are offset by income
- Clinical supplies are £4.5m adverse to plan YTD due to increase in interpreters fees, reagents, surgical instruments and contract service of equipment associated with the activity levels.
- Healthcare from Non NHS Bodies is £1.4m adverse to plan YTD due to increased send away tests, tissue typing for organ transplant and safeguarding review
- Premises costs are £4.2m favourable to plan YTD due to demolition of the Frontage building not yet having occurred so neither the costs or charitable costs have yet occurred.
- Impairment of receivables is £3.0m adverse to plan YTD due to the increased provision related to the growth in private activity from 2022/23 and timing of payments.

Better Value for the 9 months ending 31 Dec 2023









Better Value:

- The Trust is continuing to work on its Better Value programme to develop new schemes for 2023/24 and advance those already identified. The Trust has put into place fortnightly meetings with a focus on on quickly progressing the Better Value programme and improving the Trust financial position.

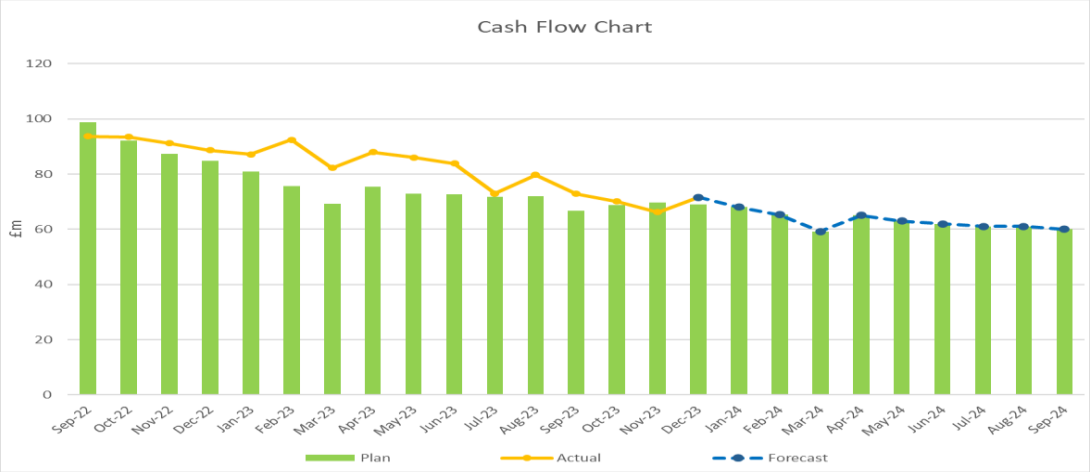
Audited Actual 31 Mar 23 £m	Statement of Financial Position	YTD Actual 30 Nov 23 £m	YTD Actual 31 Dec 23 £m	In month Movement £m
649.95	Non-Current Assets	641.59	641.59	-
106.34	Current Assets (exc Cash)	129.96	127.27	(2.69)
82.17	Cash & Cash Equivalents	66.22	71.58	5.36
(124.23)	Current Liabilities	(135.58)	(140.80)	(5.22)
(33.04)	Non-Current Liabilities	(32.20)	(32.20)	-
681.19	**Total Assets Employed**	**669.99**	**667.44**	**(2.55)**

31 Mar 2023 Audited Accounts £m	Capital Expenditure	YTD plan 31 December 2023 £m	YTD Actual 31 December 2023 £m	YTD Variance £m	Forecast Outturn 31 Mar 2024 £m	RAG YTD variance
6.95	Redevelopment - Donated	30.22	12.39	17.83	18.90	R
3.35	Medical Equipment - Donated and grant funded	1.38	1.69	(0.31)	3.00	A
10.30	**Total Donated and grant funded**	**31.60**	**14.08**	**17.52**	**21.90**	R
4.76	Redevelopment - Trust Funded	6.63	4.28	2.35	8.02	A
3.17	Medical Equipment - Trust Funded	2.00	1.05	0.95	6.03	R
2.39	Estates & Facilities - Trust Funded	4.19	1.39	2.80	3.23	R
4.65	ICT - Trust Funded	5.90	2.98	2.92	6.30	R
14.97	**Total Trust Funded**	**18.72**	**9.70**	**9.02**	**23.58**	R
0.13	**Total IFRS 16**	**3.83**	**0.23**	**3.60**	**0.75**	R
0.36	**PDC**	**0.00**	**0.17**	**(0.17)**	**0.33**	R
25.76	**Total Expenditure**	**54.15**	**24.18**	**29.97**	**46.56**	R

31-Mar-23	Working Capital	30-Nov-23	31-Dec-23	RAG	KPI
7.0	NHS Debtor Days (YTD)	3.0	3.0	G	< 30.0
204.0	IPP Debtor Days	194.0	227.0	R	< 120.0
21.6	IPP Overdue Debt (£m)	33.8	35.3	R	0.0
87.0	Inventory Days - Non Drugs	83.0	83.0	R	30.0
25.0	Creditor Days	34.0	34.0	A	< 30.0
45.4%	BPPC - NHS (YTD) (number)	51.2%	53.2%	R	> 95.0%
78.4%	BPPC - NHS (YTD) (£)	69.4%	68.9%	R	> 95.0%
82.0%	BPPC - Non-NHS (YTD) (number)	83.4%	83.6%	R	> 95.0%
91.9%	BPPC - Non-NHS (YTD) (£)	90.6%	90.4%	A	> 95.0%
80.7%	BPPC - Total (YTD) (number)	82.4%	82.7%	R	> 95.0%
90.7%	BPPC - Total (YTD) (£)	88.6%	88.5%	R	> 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	Nov-23	Dec-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 Liabilit	1.4	1.4	G
0.7	Cash Ratio(Cash / Current Liabilities)	0.5	0.5	R
52.6	Liquidity days Cash / (Pay+Non pay excl Capital expenditure)	36.9	39.9	A
87.3	Liquidity Days (Payroll)(Cash / Pay)	63.5	68.6	G



Comments:

1. Capital expenditure for the year to the end of December was £24.2m; the Trust-funded expenditure was £9.7m, which is £9.0m less than plan due to slippage on Estates programmes, some of which is expected to be recovered in Q4. Although some recovery of the Trust-funded slippage is expected in by the end of March 2024, other projects are expected to underspend. A monthly forecast is prepared to quantify the underspend and identify options for potential substitute expenditure. The Trust has agreed a FOT with NCL ICB for Trust funded expenditure of £23.6m, £6.6m less than plan after removal of top-slicing. The donated expenditure was £14.1m, £17.5m less than plan due to enabling works slippage and delayed start on the CCC main contract. Right of use (leased) asset expenditure is £3.6m less than plan due to stopping the proposal to lease space in 40 Bernard St. This will be partially offset but the newly approved leases of office space for CCC decant, which will cost £0.7m.
2. Cash held by the Trust increased in month from £66.2m to £71.6m.
3. Total Assets employed at month 9 decreased by £2.5m in month as a result of the following:
- Non current assets remained the same as the previous month at £641.6m.
- Current assets excluding cash totalled £127.3m, decreasing by £2.7m in month. This largely relates to Contract receivables invoiced (£8.7m higher in month) and other receivables (£0.1m higher in month). This is offset against the decrease in Capital receivables (£6.0m lower in month); contract receivables not yet invoiced (£4.9m lower in month) and inventories (£0.6m lower in month).
- Cash held by the Trust totalled £71.6m, increasing in month by £5.4m.
- Current liabilities increased in month by £5.2m to £140.80m. This includes Capital creditors (£1.0m higher in month); expenditure accruals (£0.5m higher in month); other payables (£3.3m higher in month) and deferred Income (£0.7m higher in month). This is offset against the decrease in NHS payables (£0.3m lower in month).
4. Non current liabilities totalled £32.2m This includes lease borrowings of £27.2m.
5. I&PC debtors days increased in month from 194 to 227 days. Total I&PC debt (net of cash deposits held) increased in month to£47.2m (£39.9m in month 8). Overdue debt increased in month to £35.3m (£33.8m in month 8).
6. In month 9, 88% of the total value of creditor invoices were settled within 30 days of receipt; this represented 83% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.
7. By supplier category, the cumulative BPPC for Non NHS invoices (by number) was 84% (83% in month 8). This represented 90% ofthe total value of invoices settled within 30 days (91% in month 8). The cumulative BPPC for NHS invoices (by number) was 53% (51% in M08). This represented 69% of the value of invoices settledwithin 30 days (69% in month 8).
8. Creditor days remained the same as the previous month at 34 days.

Attachment U

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7th February 2024

Nursing Workforce Report Quarter 3 October 2023-December 2023 **Submitted by:** Claudia Gomes, Assistant Chief Nurse **Presented by** Tracy Luckett, Chief Nurse	**Paper No: Attachment U** □ **For information and noting**

Purpose of report
This paper aims to provide the Trust Board with oversight of the activity in relation to Nursing Workforce including updates on recruitment, retention and actions taken to ensure safe staffing since the last report.

Summary of report

1. The RN vacancy rate was 14.11% in September 2023 and dropped to 9.11% in October 2023 due to the newly registered nurses intake, therefore it is now under the trust target of 10%.
2. RN voluntary turnover has decreased slightly from September 2023, and is sitting on 14.82% in December 2023 which is just above trust target of 14%.
3. Sickness rates are averaging on 4.86% in Q3, there was a slight improvement in December 2023 at 4.86% in comparison to 5.86% December 2022.
4. Central recruitment continues, intake in October 2023 of 92 NRN, January 2024, 39 NRN commenced, and the trust aims to recruit 24 in April 2024.
5. Q3 reported twenty-one safe staffing incidents, all classified as no harm with one minor harm under investigation. Key themes are staff shortages and training and competencies. Senior cover across 7 days is being managed by the Heads of Nursing, as well as exploring roles such as Clinical Nurse Specialists working clinically to cover weekends and offer support.
6. Temporary staffing shift requests have decreased from Q2 to 10,299 with an average fill rate of 62.66%, new dashboards are being developed to better understand the data and address concerns as trust fill rate should be 95%
7. International recruitment to recommence via Capital Nurse Consortium, and meetings have commenced. Planned and staggered intake to commence in June 2024, pending business case sign off.
8. Retention dashboards have been created to include “Stay” initiatives, Q4 will focus on imbedding these and reporting through Nursing Delivery Committee, and measure impact into and through the next year.
9. Trust will be participating in the Retention People Promise Exemplar Improvement Programme run by NHSE, this means dedicated people promise resource to support retention initiatives.
10. Exit interview data will be shared with Heads of Nursing going forward to triangulate information from stay questionnaires for example.

Action required from the meeting
To note the information in this report in relation to safe staffing.

Attachment U

Patient Safety Implications Covered in paper summary
Equality impact implications None
Financial implications All posts involved in the central recruitment campaigns have been incorporated into Directorate Budgets
Strategic Risk BAF Risk 2: Workforce Sustainability BAF Risk 12: Inconsistent delivery of safe services
Consultation carried out with individuals/ groups/ committees Report was noted at EMT and PEAC prior to Trust Board
Who is responsible for implementing the proposals / project and anticipated timescales? NA
Who is accountable for the implementation of the proposal / project? Tracy Luckett Chief Nurse

1. Introduction

The purpose of this paper is to provide the People and Education Assurance Committee (PEAC) with an overview of the activity in relation to the Nursing Workforce, including updates on recruitment, retention, and safe staffing arrangements for the reporting period October – December 2023 (Q3).

2. Workforce Data Overview

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

2.1 Vacancy and Voluntary Turnover

The latest registered nurse (RN) workforce position based on validated data:
As anticipated the RN vacancy rate in October dropped significantly to 9.1%, remaining steady throughout November at 9.3%. This drop in vacancies is largely attributable to the October NRN cohort (n=92) joining the organisation. A slight increase was observed in December taking the vacancy rate up to 10.4% which correlates with the annual trend of an uptick in leavers at the end of the year prior to Christmas. Although RN voluntary turnover remains just slightly above trust target (14%), Q3 has seen a steady reduction from 15.72% in October to 14.82% in December.

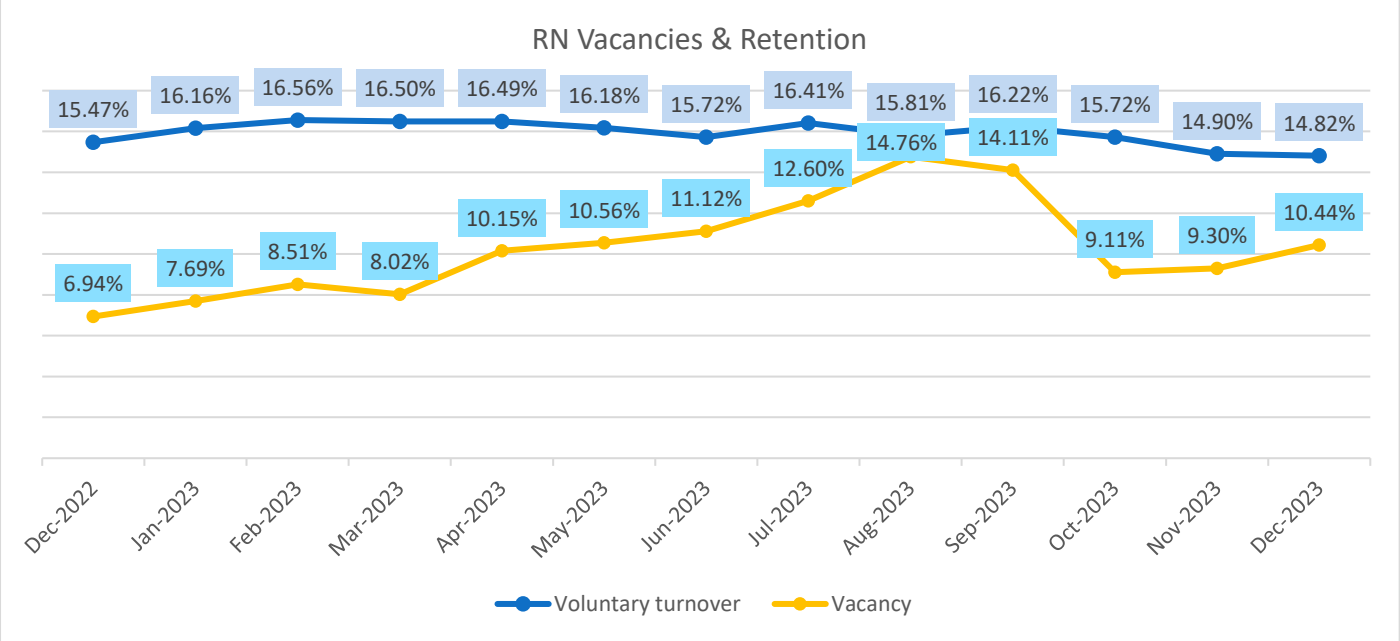
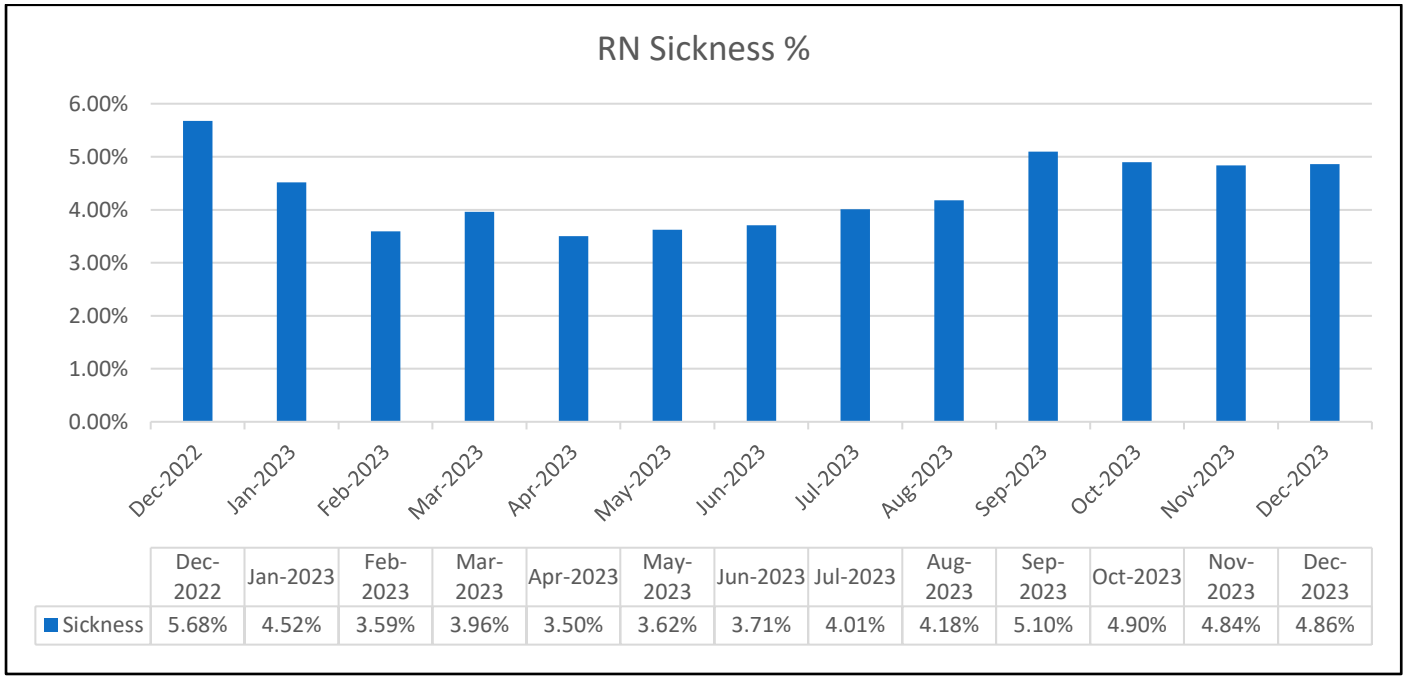


Fig. 1 Trust Registered Nurse (RN) vacancy and voluntary turnover rate (12-month view)



	Dec-2022	Jan-2023	Feb-2023	Mar-2023	Apr-2023	May-2023	Jun-2023	Jul-2023	Aug-2023	Sep-2023	Oct-2023	Nov-2023	Dec-2023
Sickness	5.68%	4.52%	3.59%	3.96%	3.50%	3.62%	3.71%	4.01%	4.18%	5.10%	4.90%	4.84%	4.86%

Fig. 2 RN sickness rates 12 month rolling period.

2.2 RN Sickness rates remained relatively stable across Q3 averaging 4.86% against the Trust target of 3% largely accountable to anticipated winter illness.

2.3 Safe Staffing Incidents
Reporting levels remained similar to the previous quarter with a total of 21 Datix reports citing staffing related incidents across seven of the eight clinical directorates (except I&PC). All except one incident were categorised as 'incident occurred but there was no harm'. One incident was classified in severity as 'minor', however this case remains open and under investigation. Two over-riding themes dominated the reports' sub-categorisation:

- Staff shortage – nursing accounted for 81%
- Training / competencies inadequate accounted for 19%

Key themes include challenges with skill mix and competency levels and identification of sub-optimal staffing levels especially on night and weekend shifts. This reporting timeframe also correlates with the emergence of our newly registered nurses from their induction and supernumerary periods. Despite a high degree of support being tailored to this staff group as they commence their careers via local and central education, and have buddy, and preceptor support, it is recognised that this transition period can cause a temporary skills gap in the workforce. All incidents are reviewed by Heads of Nursing and mitigation measures put in place where possible to prevent recurrence. These include additional educational support to address gaps in skill mix and competency levels, greater senior nursing representation across a 7-day service and exploring additional support mechanisms including Clinical Nurse Specialist (CNS) and Allied Health Professionals (AHP) on ward areas.

Directorate	Oct 2023	Nov 2023	Dec 2023	Directorate total
H&L	3	0	0	3
BBM	1	2	0	3
CCS	1	1	0	2
BCC	1	0	2	3
I&PC	0	0	0	0
S&S	3	3	1	7
R&I	0	1	0	1
Brain	1	0	1	2
Monthly total	**10**	**7**	**4**	**21**

Fig. 3 Safe staffing Datix reports per directorate – Quarterly view.

Actions to address these incidents:

Recruitment and retention meeting

- Key stakeholdres involvement to drive operational, recruitment and retention initiatives

Development of retention Dashboards

- Train to retrain masterclasses
- Stay conversation
- Drop in Career Clinics
- flexible working agreements
- Self rostering

Senior nurses 7 days a week

- Heads of Nursing reviewing Rosters to ensure senior representation 7 days a week
- Bank pay at appropriate Banding to insentivice senior nurses covering weekends and nights
- Winter Bonus Scheme to support shifts to be covered ahead of time and ensure safe staffing on every ward

People Promise Exemplar Programme

- Extra resource to support retention initiatives for the Trust

Staffing SOP

- Development of Standard Operating Procedure, Nursing Staffing Escalation ward and departmental staffing levels

2.4 Care Hours Per Patient Day (CHPPD)
The Trust level CHPPD for October to December ranged between 14.36 and 15.34. More detailed ward level data is available in appendix 1. CHPPD includes total staff time spent on direct patient care but also on activities such as preparing medicines, updating patient records, and sharing patient care information with other staff and departments. It covers both temporary and permanent care staff but excludes student nurses and staff working across more than one ward. CHPPD relates only to inpatient hospital wards where patients stay overnight. In isolation, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective, or responsive. It should therefore be considered alongside other indicators of quality and safety.

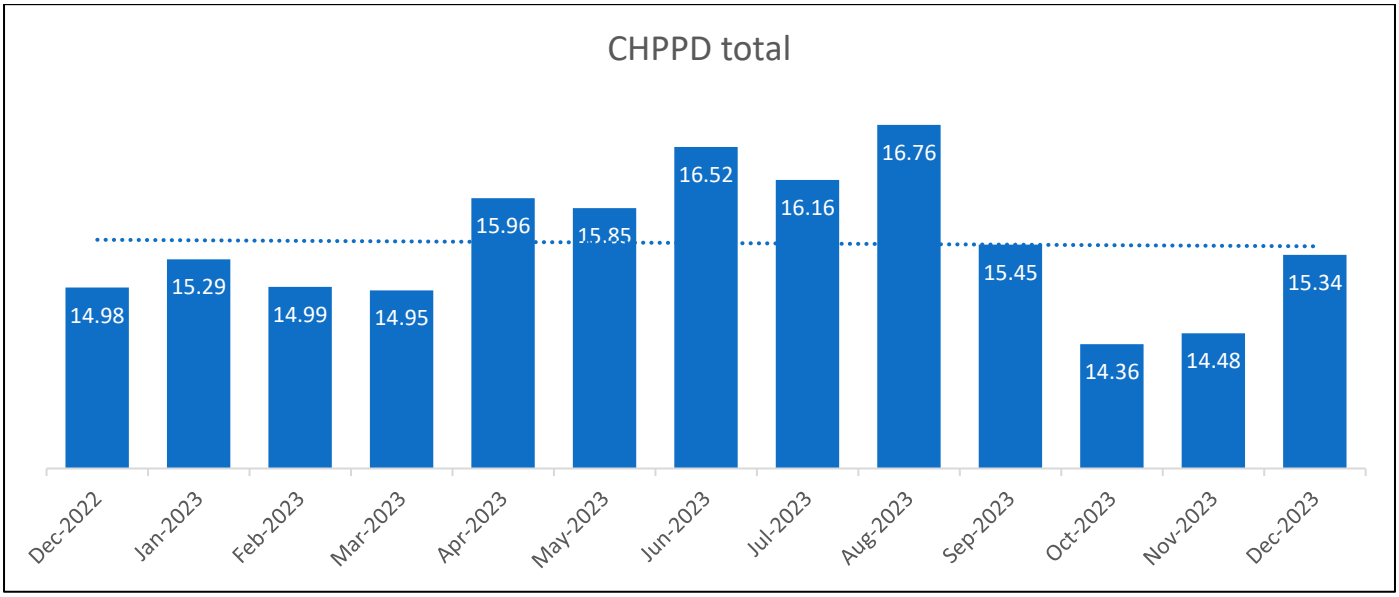


Fig. 4 CHPPD 12 month rolling trend.

3.Temporary Staffing

Temporary staffing is managed on behalf of GOSH by Acacium (previously known as Bank Partners) and part of a wider North Central London framework. The bank shift fill rate target is 95%.
During Q3 the temporary staffing activity was:

October 2023 – 3,597 shifts were requested of which 2,222 were filled (62% fill rate)
November 2023 – 3,738 shifts were requested of which 2,440 were filled (65% fill rate)
December 2023 – 2,964 shifts were requested of which 1,800 were filled (61% fill rate)

Initiatives to improve fill rate continue including bank recruitment events and introduction of new technology to streamline booking process and communication. Monthly meetings with HR, Workforce and Acacium to review performance new dashboards being developed and better communication between stakeholders to monitor compliance.

4. Recruitment Activity Overview

4.1 Centralised Recruitment Campaigns are deliberately staggered throughout the year to maintain pipeline, mitigating peaks and troughs in voluntary turnover.

4.2 Newly Registered Nurses (NRNs)

We welcomed 92 NRNs into the October 2023 cohort of new nurses at GOSH. The final attrition rate for this cohort stands at 22% which is a pleasing 8% improvement on the historical average of 30% usually witnessed with NRN cohorts. We anticipate this lowered attrition rate is attributable to the programme of virtual directorate meet and greets held throughout Q2. These forums gave NRNs an opportunity to meet their new line managers and team members, as well as being offered informal visits to familiarise themselves with their new clinical environments and be invited to any team summer activities. The aim was to offer the incoming team members a much greater sense of belonging and to positively influence their decision to commit to GOSH as their employer of choice. A similar programme of meet and greet events occurred held Q3 to capture the January 2024 NRNs and hopefully positively impacted this cohort's attrition in the same way.

Central recruitment intakes		**Commenced in post or in pipeline**
October 2023		92 commenced
January 2024		39 commenced
April 2024		24 in pipeline

Fig. 5 No. of NRNs commenced in post and in pipeline.

The next nurse recruitment open day is planned for March 2024 to target experienced nurses and those NRNs planning to join us in October 2024/January 2025.

In discussions with the new matron for Learning and Disability (L&D) it has been agreed going forward the L&D team will support any area who wishes to recruit LD nurses. To ensure LD nurses are supported effectively, the following has been recommended to all clinical areas:

Core clinical competency targets are lengthened- this will be agreed across the floor and standardised for all LD NQNs however value your input.

Those recruited must demonstrate that they have had significant clinical ward experience in their final year and can demonstrate this in their application. Previously, those not having this has meant we have had to support LD NQNs to achieve this, and basic nursing skills such as observations and medication administration.

Staff in the areas that recruit are aware of their different nursing background and what this consists of so that the staff supporting on the wards can set realistic expectations rather than the same of those with a paediatrics background.

4.3 International Nurse Recruitment (INR)

The ad-hoc pipeline of Internationally educated nurses (IENs) continues to be managed via NWF. Throughout Q3, we welcomed seven IENs across five clinical directorates (H&L, CCS, BBM, Brain and I&PC). We are re-engaging with the Capital Nurse Consortium with a view to commencing INR in earnest from January 2024. Throughout December, we held introductory meetings with three agencies to outline our specific skills and experience criteria for the IENs we are seeking. These three agencies will facilitate recruitment specifically from the Philippines, India, and rest of the world. Virtual, monthly interview slots are in place with

each agency from January 2024 onwards. Continuous work is also ongoing with our agency from Europe that is sourcing European nurses to ensure a steady pipeline in this area too.

4.4 Health Care Support Worker (HCSW) Apprenticeships

Eleven HCSW candidates are on track to join GOSH in January to commence their apprenticeship pathway. These Eleven apprentices came via the local Camden and Islington advertising route as well as the wider NHS Jobs advert. An introductory meeting was held with Nursing Workforce (NWF) and the Clinical

Apprenticeship Education Team in December with Generation, a charity who offer a free bootcamp style programme to prepare London based candidates interested in their first role in health care. We aim to engage with this charity initiative to attract a high calibre of local candidates who are well prepared for the apprenticeship opportunity for our September 2024 cohort which aligns with their planned programme timetable.

5. Retention Initiatives – Nursing STAY Retention Plan 2023-25

5.1 "Train to Retain"

Retention masterclasses continue to be delivered to nursing managers and team leaders on a rolling basis since their inception in September 2022. These virtual, bitesize classes present
themes from the National Health Service England (NHSE) retention toolkit and key data points examined at Nursing Workforce Assurance Group (NWAG) which are aimed at creating a retention toolkit for managers to use in their individual areas when and where appropriate. Attendance levels fluctuate despite a variety of day/time offerings throughout the calendar and HoNs have been asked to encourage attendance amongst their teams. It has been encouraged that all new Junior Sisters that commenced in their role in January 2024 should have the opportunity to attend all retention modules. All attendance is monitored and has been decided to aid reward and recognition, for any manager that completes all nine masterclasses will receive a certificate of achievement and a praise form will be submitted.

5.2 Directorate Retention

Dashboards have been created following the recent launch of the Nursing Strategy. with sixteen key performance indicators to evidence their commitment to achieve the retention "stay" incentives outlined in the plan. Every directorate has established targets for each indicator and the data is being collated with an aim to identify areas for improvement. These dashboards will be submitted quarterly and presented at the Nursing Delivery Committee. Q3 data has been collated with a compliance rating of 76%. Key areas for improvement include flexible working agreements to be accurately recorded, team-based rostering to be offered if appropriate and the encouragement of managers to attend the bi-monthly retention masterclasses. Further information is described below with a more detailed update of each area that requires improvement.

5.3 Flexible working Agreements

Work has begun to evidence the trust retention initiatives, one of these is the trust commitment to supporting flexible working. To capture this data correctly, all flexible working agreements must be embedded into Healthroster. In December 2023, rostering managers were asked to collate the list of nursing staff that have a flexible working agreement and for the rostering team to support them by ensuring they are uploaded onto Health Roster efficiently. This task will be complete by Q4 and all flexible working agreements across nursing areas will be accurately recorded which will help support our ability to report effective retention incentives the trust.

5.4 Career Clinics

The aim of these monthly slots is to provide staff members with insights into potential career pathways at GOSH and to signpost them to appropriate resources within the Trust to pursue and fulfil their potential. Throughout quarter 3, all monthly slots were fully booked with additional sessions created if necessary for individuals who were not able to attend at the designated date and time.

5.5. Team Based Rostering

Self-rostering is a team approach and therefore is referred to as team-based rostering and has been found to improve staff retention by offering more control over the scheduling of individuals working lives. Certain parameters must be set by agreeing in advance the levels of staff and skill mix required hour-by-hour throughout the working day and ensuring levels of staffing is adequate to ensure the service is met. Following guidance and implementation from the rostering team and the nursing workforce team seven ward units are fully rolled out with team-based rostering with a further two expected to be using this by the end of Q4. The rostering team monitor the performance of team-based rostering regularly and in consultation with directorate.

Heads of Nursing may decide to discontinue this if the following occurs:

- Safe staffing levels are not maintained.
- Skill mix is not maintained.
- Staff are not being treated in a fair and equitable way.
- Reliance on temporary staffing increases

Matrons and ward/unit managers are responsible for ensuring rosters are safe, fair, and equitable. Heads of Nursing are responsible for overall oversight for safe staffing and ensuring the ward areas are utilising the system appropriately to positive impact nursing retention. All KPI's for rosters are monitored monthly at Nursing Workforce Assurance Group.

5.5 Internal Transfers

Enable nursing staff (Bands 3-6) to traverse the myriad different clinical specialities within GOSH to develop new and existing skills with the objective of retaining their skills and experience within the Trust and valuing them as one team members. In Q3 (October- December 2023) there were twenty internal transfers either requested or completed. Body Bones and Mind, Heart and Lung and International & Private Care had the highest number of nursing staff that transferred out. Heart and Lung and Core Clinical Services had the highest number of nursing staff that transferred in.

5.6 Stay Conversations

Full roll out was completed in Q3 as planned across all clinical nursing areas. Training sessions have been created in January to support the implementation the 'Stay and Grow' conversation. To capture themes and steer our priorities the results of these conversation's will be submitted quarterly (Q4) and will be presented at the Nursing Delivery Committee meeting.

5.7 Retention people promise exemplar improvement programme.

The Trust will be participating in the second cohort of this programme run my NHS England and this will allow for extra resource to focus on retention initiatives.

6. Professional Nursing Standards

To ensure patient safety, maintain professional discipline and employ nurses who share our trust values and behaviours, we occasionally need to investigate and/or address performance. This is to ensure nurses are offered the right level of support and supervision or in serious cases require a referral to the Nursing and Midwifery Council (NMC) to understand whether they pose a risk to the public, so steps may be taken to promote learning and prevent issues arising. During Q3 there were two open NMC referrals on existing employees, one with restrictions in place and one without, both are under investigation by the NMC. In addition to this there are three open investigations in relation to ex-employees who were either dismissed or resigned these investigations are ongoing. Two new referrals to the NMC have been made in Q3 both are at vetting stage at the moment.

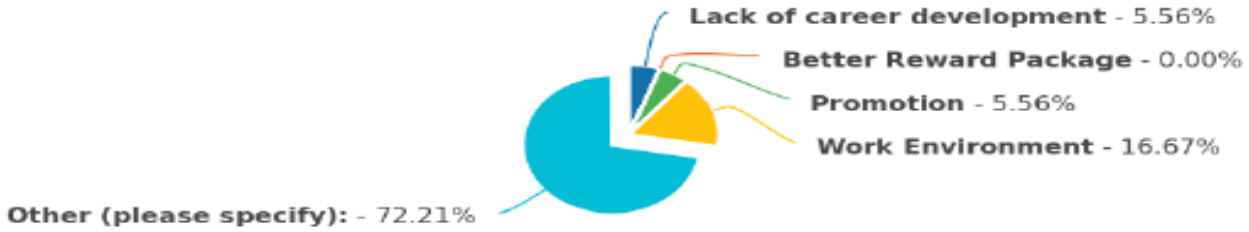
7. Exit Interview Summary of Nursing Staff from Oct 2023 to 19th Jan 2023

Main themes included in 'other' reasons below:

- 1 Travelling distance.
- 5 Relocation
- 1 Bereavement
- 1 Death in family needing to support.
- 1 Secondment ending
- 1Changing career path
- 1 Bullying and harassment
- 1 Going back to university.
- 1 Line management

7.1 Exit Interview main reason for leaving

1. What is your main reason for leaving?



	Answer Choices	Response Percent	Response Total
1	Lack of career development	5.56%	1
2	Better Reward Package	0.00%	0
3	Promotion	5.56%	1
4	Travel Cost	0.00%	0
5	Work Environment	16.67%	3
6	Other (please specify):	72.22%	13

8. Conclusion

As stated in previous Quarter we have seen a decrease of RN vacancy rates due to the intake of newly qualified nurses in October, a slight spike again in December but with the recruitment and retention initiatives it is expected that this will stabilise in the next quarter and going forward.

Nursing Workforce Assurance Report Q3 2023/24

Big focus on retention initiatives during this period with an overall good adherence to them across all directorates. The main focus over the next quarter is to embed these initiatives and then evaluate their impact. in the next upcoming months.

Workshops held by the Nursing Workforce team are having a positive impact and ward managers are feeding back that this is supporting them.
Gosh has enrolled in the undertaking of the Retention People Promise Exemplar Improvement Programme and this should support the retention of great staff with new ideas and ways of working. Nurses continue to be impacted by the “London factor” in respect of the cost-of-living crisis and despite the financial advice and support being offered through the GOSH health and wellbeing service, work will continue to look at further options available to us to support retention.

To strengthen this process recruitment and retention workstream has also been stood up to actively address issues such as accommodation for example.

Safe staffing continues to be mitigated through bed closures and redeployment of staff however there has been a slow decrease of the number of closed beds as the solutions bring brought from the Heads of Nursing and Ops teams meeting have been implemented. Winter bonus scheme has had an initial positive impact on the filling of bank shifts this is a trend that is expected to be continued during the winter and reviewed in March.

Exit interview data is to be shared with Heads of Nursing going forward to ensure triangulation of information occurs as well as actions taken on feedback received.

Claudia Gomes
Assistant Chief Nurse.

Appendix 1 – RN workforce data (December 2023)

Workforce December 2023									
			Staffing						
Directorate	Ward	CHPPD	Budget FTE	Staff in Post FTE	Vacancy %	Vacant FTE	Temp Staffing %	Sickness rates	Vol Turnover %
Blood, Cells & Cancer	Elephant Ward	11.81	26.00	22.98	11.6%	3.02	3%	2.3%	23.8%
	Fox Ward	16.22	31.63	31.21	1.3%	0.42	4%	3.7%	10.4%
	Giraffe Ward	12.26	16.00	12.79	20.1%	3.21	3%	6.1%	18.6%
	Lion Ward	19.71	24.00	22.83	4.9%	1.17	7%	7.2%	12.4%
	Pelican Ward	13.06	21.99	16.93	23.0%	5.06	13%	9.6%	26.4%
	Robin Ward	10.50	30.75	28.07	8.7%	2.68	4%	1.7%	20.3%
	Safari Ward	-	13.00	15.79	-21.4%	-2.79	5%	4.5%	19.3%
Body, Bones & Mind	Chameleon Ward	11.19	37.20	29.76	20.0%	7.44	17%	9.3%	12.7%
	Eagle Ward	14.95	45.30	42.46	6.3%	2.84	2%	3.6%	7.4%
	Gastro Suite	-	8.00	8.76	-9.5%	-0.76	11%	0.7%	0.0%
	Mildred Creak Unit	12.76	14.70	11.40	22.4%	3.30	16%	7.9%	42.5%
	Squirrel Ward (Gastro)	11.36	21.65	18.46	14.7%	3.19	18%	16.2%	5.8%
	Sky Ward	9.39	32.00	24.84	22.4%	7.16	14%	6.4%	23.4%
Brain	Kingfisher Ward	25.33	14.62	14.33	2.0%	0.29	6%	5.0%	0.0%
	Koala Ward	3.70	59.81	42.90	28.3%	16.91	13%	5.4%	42.1%
	RANU (Starfish)	-	5.00	4.23	15.5%	0.77	4%	1.9%	19.4%
	Squirrel Ward (Endo & Meta)	20.76	17.00	18.37	-8.1%	-1.37	11%	10.0%	0.0%
Heart & Lung	Bear Ward	10.66	63.45	57.09	10.0%	6.36	12%	4.1%	11.3%
	Flamingo Ward (CICU)	28.37	134.78	118.47	12.1%	16.31	11%	5.9%	13.5%
	Kangaroo Ward	16.59	19.00	16.45	13.4%	2.55	4%	9.0%	10.4%
	Leopard Ward	16.59	38.87	36.44	6.2%	2.43	13%	3.6%	19.3%
	Neonatal Intensive Care Unit (NICU)	15.20	67.74	52.21	22.9%	15.53	6%	10.9%	24.5%
	Paediatric Intensive Care Unit (PICU)	6.54	113.60	103.65	8.8%	9.95	7%	5.0%	14.0%
	Walrus Clinical Investigations Centre	-	7.69	8.23	-7.0%	-0.54	1%	8.9%	0.0%
IPP	Bumblebee Ward	13.79	37.40	29.67	20.7%	7.73	12%	2.8%	25.9%
	Butterfly Ward	15.10	37.40	25.43	32.0%	11.97	23%	8.0%	29.3%
	Hedgehog Ward	14.58	16.60	8.75	47.3%	7.85	38%	4.1%	46.5%
Core Clinical Services	Anaesthetic Staff Theatre	-	48.90	43.47	11.1%	5.43	8%	3.8%	6.9%
	Interventional Radiology Theatres	-	20.00	15.51	22.4%	4.49	0%	3.1%	24.5%
	Radiology Theatres	-	9.00	7.00	22.2%	2.00	9%	0.0%	22.2%
	Recovery Theatres	-	40.74	41.13	-1.0%	-0.39	11%	7.2%	26.9%
	Scrub Staff Theatre	-	83.90	72.47	13.6%	11.43	14%	7.3%	15.6%
	Puffin (SDAU) & Woodpecker Ward (PACU)	-	20.20	22.84	-13.1%	-2.64	9%	4.4%	17.5%
Research & Innovation	R&I Delivery Clinical	-	0.00	51.17	-	-51.17	100%	1.1%	12.1%
	Clinical Research Network (North Thames)	-	16.19	0.00	100.0%	16.19	0%	-	-
	Somers Clinical Research Facility	-	0.00	0.00	0.0%	0.00	0.00	0.00	0.00
Sight & Sound	Panther Ward	16.12	25.45	24.32	4.4%	1.13	14%	9.8%	27.9%
	Panther Ward (Uro)	13.26	22.50	15.47	31.2%	7.03	22%	7.9%	21.8%
Clinical Operations	Clinical Site Practitioners	-	15.30	13.81	9.7%	1.49	7%	7.2%	11.9%

Attachment W

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 7 February 2024	
Guardian of Safe Working report Q2 and Q3 2023/24 **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment W**
Aims / summary This report is the Q2 & Q3 report of 2023/24 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1st July to 31st December 2023 inclusive.	
Action required from the meeting • To note the impact of industrial action from the verbal update delivered by the junior doctors. • To note the main usage of bank relates to unfilled posts	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working (GOSW) supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications • Continuing payment for overtime hours documented through the exception reporting practice – extended to non- training doctors	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working, Associate Medical Director: Workforce Mr Simon Blackburn Deputy Medical Director for Medical & Dental Education	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Medical Director	

Attachment W

Guardian of Safe Working Hours Report
Q2 & Q3: 1st July – 31st December 2023

1 Purpose

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

2 Background

See Appendix 1

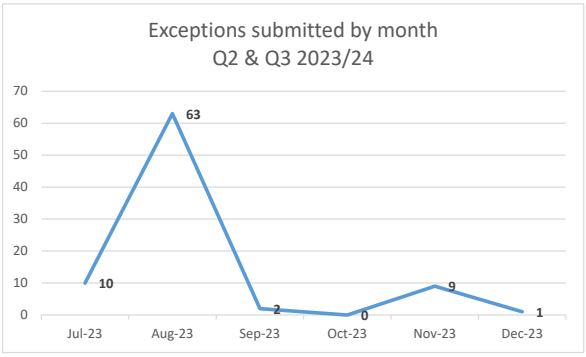
3 High level Data total of 364 doctor posts in the Establishment

Number of Trust Doctor WTE as of 31 Dec 2023 = 244.85

Number of Training Doctor WTE as of 31 Dec 2023 = 123.55

4 Exception Reporting: High Level Data

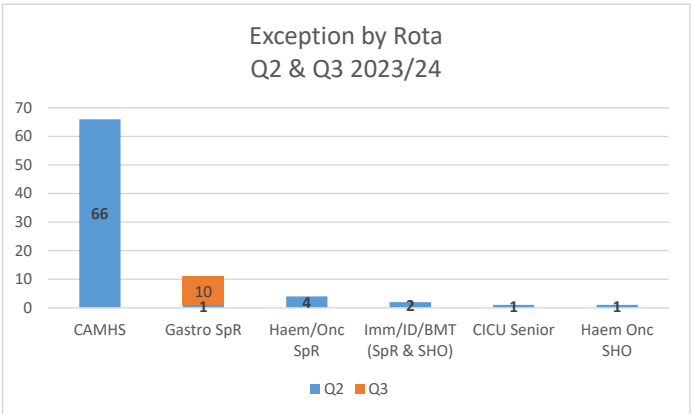
4.1 Average exceptions per month across the 2 quarters were 14.2 per month, with the vast majority occurring in Quarter 2 (75). It should be noted that the majority (63 [74%]) occurred in one month of Quarter 2 due to a specific issue within one area.



4.2 85 ERs submitted in the period July to December 2023

- 82 ER: extra hours worked.
- 2 Pattern
- 1 Education
- 10 doctors submitted the reports (8 SPR, 2 SHO)
- 5 doctors reported more than once in the period (1 reported 43 times)

4.3 ER reports submitted across 6 rotas



4.4 Exception Report Outcomes

Outcome	Outcome
Payment	83
Organisation changes	1
No action	1
Grand Total	85

- *"I was asked to come in early as no ANP or specialty doctor today but was assured I'd be able to leave early to make the hour back. I was not able to leave early*
- *"only Junior Doctor scheduled to work ... There were a lot of patients with high complexity, and a patient deteriorated, so I had to stay back to finish my work."*
- *"lack of 1:1 clinical supervision throughout the month. This amounts to at least 4h of missed supervision. …missed supervision in the gap between the outgoing and incoming ward consultants. Total = 7h".*

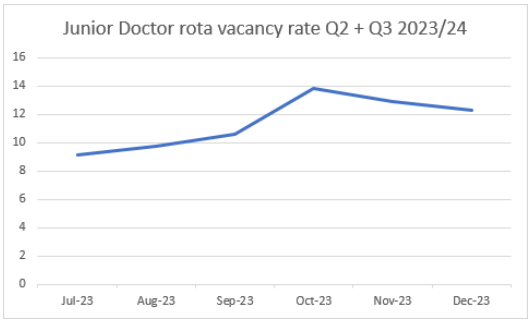
4.5 Exception Reporting Related Actions:

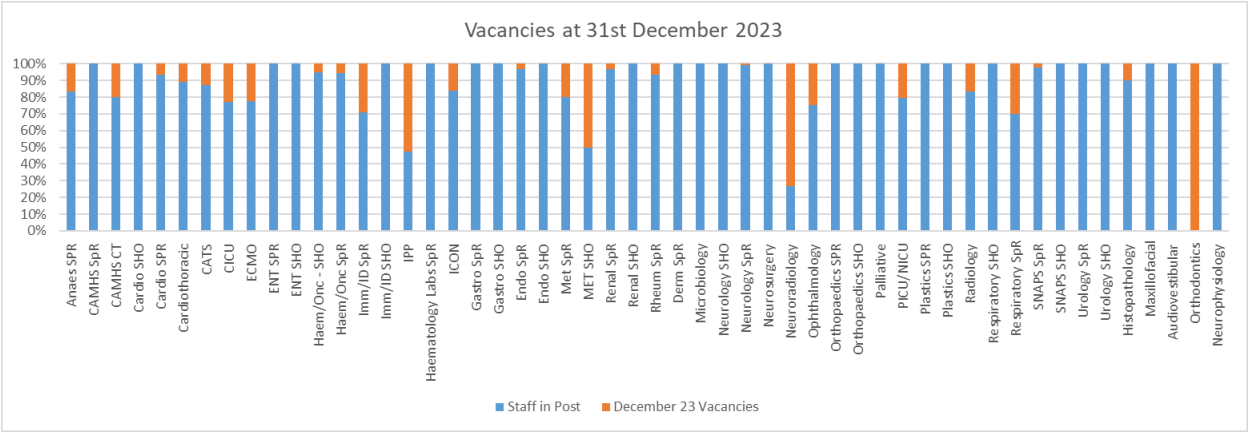
4.5.1 CAHMs: meetings with service lead, educational leads and junior doctors on multiple occasions; TPD and Director of Medical education involved; review by deanery expected.

4.5.2 IPC – working with consultants to improve work flow and distribution

5 Vacancy Rates

The overall vacancy rate across junior doctor rotas as of 31st December 2023 is 44.8 FTE (12.3%). This is an increase from the closing figure for Q2 (September 2023 38.9 FTE, 10.6%) and higher than the December 2022 Q3 rate of 9.8% (36.1 FTE vacant). It is also higher than the **Trustwide vacancy rate of 7.6%** for December 2023

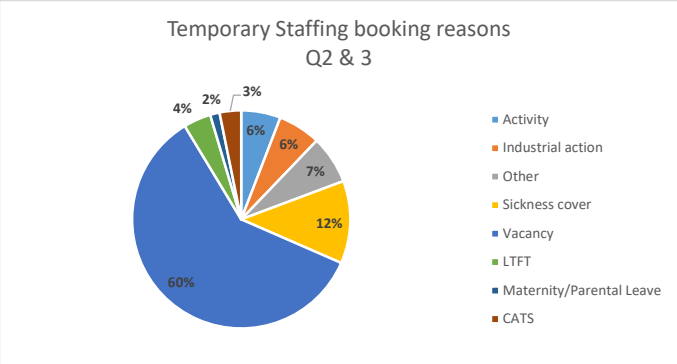




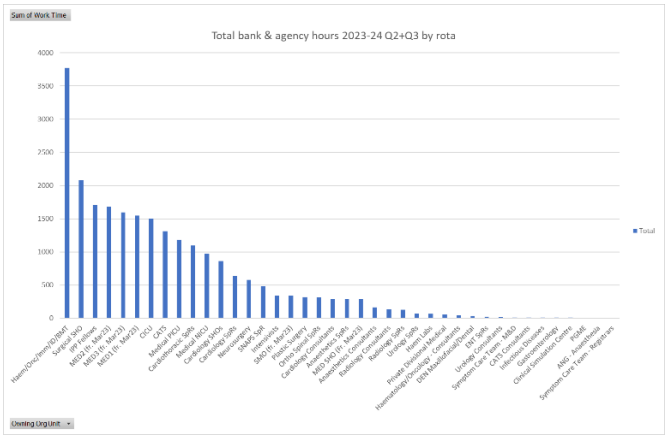
Attachment W

6 Bank and Agency usage

6.1 In the 6 months of Q2 and 3 (July to December 2023), over half (60%) of the temporary staffing hours were due to Vacancy, followed by cover during sickness (12.3%) and cover during industrial action (6.3%). There were 20 no of days of Industrial action over this period.



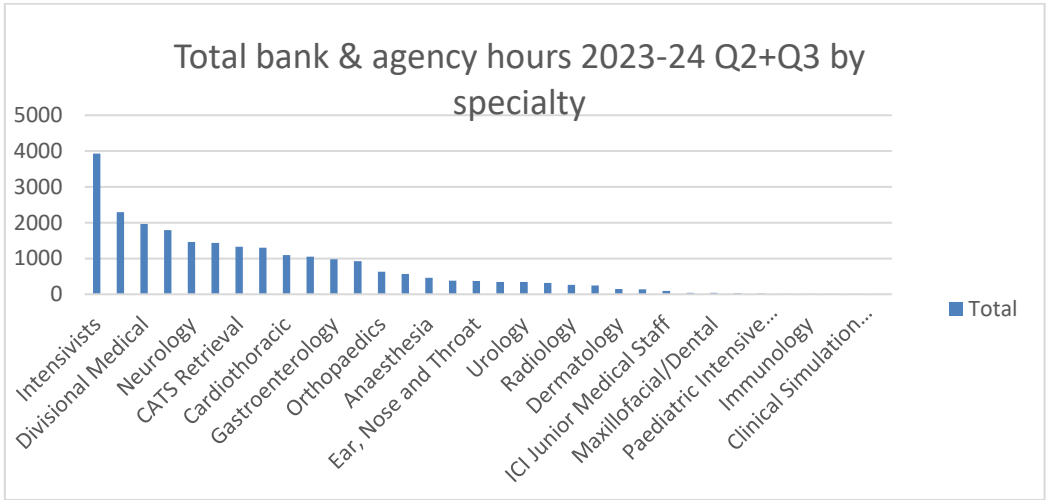
6.2 The Haem/Onc/Imm/ID/BMT rota was the most frequent rota using temporary staff with 388 shifts filled (an average of 64.7 per month), followed by the Surgery SHO rota with 210 (35 average) and IPP Fellows (203 shift (33.8 average). 27 of the 36 rotas used an average of 10 or less temporary shifts per month.



6.3 When looking at shifts booked in the period, there was no Agency usage booked in the last 6 months.

6.4 The intensive care units required the most bank hours and were significantly (approximately 30-40%) under recruited over this period.

6.5



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

7.1 Rotas are compliant however most challenge remains with recruitment and onboarding process.

8 Rota Gap Mitigation

8.1 Currently reconfiguring the Haem Onc rota and reducing the establishment to an achievable number for recruitment purposes

8.2 Task: Finish group to improve efficiency of recruitment and onboarding of junior doctors will be commenced in March/ April 2024

9 Junior Doctors Forum (JDF).

9.1 JDF members will present verbally to the Board on their experience of Industrial action

9.2 JDF are currently recruiting new representatives. Morale is generally low within the group.

9.3 The annual JDF ball will be held on Feb 9th 2024

10 New Guardian of Safe Working Hours, Dr Edward Gaynor, Paediatric gastroenterologist has been appointed. Dr Gaynor will report to the Deputy Medical Director for Workforce, Careers and Wellbeing

11 Summary

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

11.2 Some rotas are being reconfigured to adapt to recruitment challenges.

11.3 A task-finish group led by the Medical Director's Office will work alongside medical HR to improve the workforce planning and recruitment of Trust doctors including the large number of international medical graduates employed at GOSH

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

Attachment W

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

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

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

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

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

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

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

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

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

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

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

Attachment W

TCS contract includes but is not limited the following amendments:

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

Attachment X

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 7th February 2024	
Patient Safety Incident Response Framework – Plan and Policy **Submitted by:** Sanjiv Sharma, Chief Medical Officer	**Paper No: Attachment X** - **For approval**

Purpose of report

These two documents – the Patient Safety Incident Response Plan and Patient Safety Incident Response Policy set out the process and governance arrangements for the new Patient Safety Incident Response Framework (PSIRF).

Implementation of PSIRF is a nationally mandated requirement as part of the NHS' National Patient Safety Strategy and has been included as part of the 2024 NHS Standard Contract.

The PSIRF replaces the existing Serious Incident Framework and provides individual trusts greater autonomy in relation to the types of safety events (incidents) the Trust investigates, and the methodology used to do so. This means all Trusts across England and Wales will instigate a different approach to incidents which could include an after-action review (AAR), thematic analysis or an investigation where the focus will be on the identification of system-based learning rather than specifically on causality. The exceptions to this are in relation to a Never Event and some nationally mandated areas which are still under discussion with NHS England – these will automatically trigger a full investigation.

In preparation for the design of these two documents, the Trust undertook a review of all complaints, incidents, risks, child death reviews and other patient safety data over a three-year period from 2020 to 2023 to understand the themes during that time frame.

Summary of report

The six current key patient priority areas are as per the below, and these will be reviewed in 18 months' time to ensure that they are still the correct areas of focus.

1. Admissions, Discharges and Transfers
2. Medication
3. Communication
4. Access to Clinical Services
5. Responding to Deteriorating Patients
6. Invasive Procedure Problems

The selection of those which trigger an investigation will be selected based on a set criteria, which includes the actual/potential impact or harm; likelihood of recurrence; and the potential for learning. The attached plan sets out the process in which we will implement the Patient Safety Incident Response Framework in the Trust, including how we will respond to safety events, and the associated sign off process. The policy and sets out how Great Ormond Street Hospital for Children NHS Foundation Trust (hereafter referred to as GOSH) will approach the development and maintenance of effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

Patient Safety Implications

The implementation of the PSIRF will ensure that the Trust is able to identify learning from safety

events and identify areas of improvement across the Trust. It allows the Trust to be more flexible in decision making, ensure that events are investigated for the right reasons which are discussed with the families in question.
Equality impact implications None
Financial implications None
Action required from the meeting: The Trust Board is requested to approve the Plan and Policy in relation to the Patient Safety Incident Response Framework which has been endorsed by the Quality, Safety and Experience Assurance Committee on 1st February 2024.
Consultation carried out with individuals/ groups/ committees: The plan and policy have had extensive consultation from both internal and external stakeholders and has recently been approved at the Executive Management Team. Prior to this, the documents have been discussed at the Quality, Safety, Outcomes and Compliance Committee and across various staff groups at all levels of the Trust, and was formally endorsed by the Quality, Safety and Experience Assurance Committee.
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Patient Safety and Associate Medical Director for Patient Safety and Resuscitation
Who is accountable for the implementation of the proposal / project? Chief Medical Officer

Patient Safety Incident Response Plan

Great Ormond Street Hospital for Children
NHS Foundation Trust

2024 - 2025

Patient safety incident response plan

Effective date:

Estimated refresh date: 8th June 2025

	Name	Title	Signature	Date
Author	Shona Little Daniel Mortara	Head of Patient Safety Project Manager – MDO		
Reviewer				
Authoriser	Dr Sanjiv Sharma	Medical Director		

Version	Date	Summary of Version
1.0	May 2023	National template filled in with GOSH specific information by Daniel Mortara
1.1	September 2023	Thematic analysis data added to document by Shona Little
1.2	October 2023	Document wide changes made by Shona Little
1.3	October 2023	Document wide changes made by Shona Little after discussion with DCOSs and HONs
1.4	November 2023	Document wide editing done by Daniel Mortara
1.5	December 2023	Addition of diagrams by Daniel Mortara
1.6	December 2023	Changes to diagrams made by Daniel Mortara and Shona Little
1.7	December 2023	Minor changes by Andrew Pearson
1.8	January 2024	Document wide content changes made by Nikki Fountain.
1.9	January 2024	Minor content edits made by Kiera Parkes, definitions table added and addition of content to trust priority diagram by Daniel Mortara.
1.10	January 2024	Comments added from Patient Safety Team, Chief of Service and Deputy Chief of Service. Comments also added from Patient Safety Partners. Change to CCS [under directorate picture]. NHS England – Specialised Commissioning Comments Included and Director for Co-Production comments included.
1.11	January 2024	Access to clinical services wording changes following comments from John Beswick, CFO at Executive Management Team meeting.

DRAFT

The PSIRP should be read alongside the Patient Safety Incident Response Framework (PSIRF) guidance[1] and GOSH's Patient Safety Incident Response Policy.

Term	Definition
PSIRF	Patient Safety Incident Response Framework. This is a national framework applicable to all NHS commissioned care. To ensure equity and consistency on how GOSH respond to safety events, this framework will apply to all care delivered by GOSH. Building on data collated and learning from best practice across the wider healthcare system, PSIRF is designed to enable a risk-based approach to responding to patient safety events, prioritising support for those affected, effectively analysing events, and sustainably reducing future risk, improve safety culture and work towards minimising avoidable harm.

[1] NHS England » Patient Safety Incident Response Framework

Patient Safety Event	A patient safety event, which GOSH will use as an alternative to incident. This is an event or circumstance which causes or could have caused harm to a patient.
PSIRP	Patient Safety Incident Response Plan. GOSH has set out a plan determining how we will undertake PSIRF locally, including our list of local priorities. These have been developed through a co-production approach with subject matter experts and supported by analysis of local data.
PSII	Patient Safety Incident Investigation. PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple PSII and other learning responses into a similar incident type. Recommendations and improvement plans are then designed to effectively address those system factors and deliver safer care for people who use our services.
AAR	After-Action Review. A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from a wider group of those affected to identify opportunities to improve and increase to occasions where success occurs.
Safety Huddle	Safety huddles are **short multidisciplinary briefings** designed to give healthcare staff, clinical and non-clinical and opportunities understand what is going on with each patient and anticipate future risks to improve patient safety and care.
SERG	Safety Events Review Group. A weekly forum where events meeting the local priorities, events of concern and emerging themes are discussed to identify suitable learning responses. This forum will review PSII reports and provide assurance for executive sign off.
OLAF	Organisational Learning and Assurance Forum A monthly forum where learning response coordination will be reviewed to monitor safety actions; develop organisational safety actions and inform quality improvement work to be taken to the Quality Review Group.

DRAFT

	This forum will be responsible for reviewing all learning response outcomes, identifying how learning will be shared across GOSH and monitoring that learning is embedded and improvements in care.
QSOCC	Quality, Safety, Outcomes and Compliance Committee. QSOCC is a subgroup/committee of the Executive Management Team and is chaired by the Chief Medical Officer or Chief Nursing Officer. It has delegated authority from the Executive Management Team to oversee and monitor all aspects of patient safety and quality and to ensure that the Trust continues to be a learning organisation. The purpose of QSOCC is to monitor and identify quality, safety, outcomes and compliance metrics through the oversight and triangulation of data, insight, and informal signals.
RAG	Risk Action Group A forum where each directorate has a RAG. Some areas may have sub-directorate RAG meetings which report into the directorate board meetings or quality and safety meetings. The purpose of the RAG is to identify and assess risks in the clinical area. The forum also reviews near misses/no harm/low harm events to identify themes and trends to take a proactive approach to improvement and work to manage risks before events happen.

DRAFT

Introduction

Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex and dynamic healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

When things go wrong, patients and families are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety events also incur costs through lost time, additional treatment, and litigation. Overall, the majority of events are caused by system design issues, and not by individuals.

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety events for the purpose of learning and improving patient safety. It is recognised that there will need to be a shift towards systems-based approaches to a learning culture to allow GOSH to effectively respond to and learn from events, with the purpose of reducing the risk of avoidable harm as low as reasonably possible.

The Serious Incident Framework (SIF) outlines a suggested list of events which require a full investigation, with external oversight and approval. The introduction of PSIRF provides GOSH with more autonomy and flexibility in our approach to patient safety events.

Patient safety events can be defined as

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

Compassionate engagement is a key fundamental of PSIRF. Clear communication with those affected by patient safety events to determine the focus of any review is vital to ensure that the voice of the patient, families/carers, and staff is at the heart of any response and learning. Documentation of clear communication and engagement is vital.

It should be acknowledged that PSIRF is a new framework for the identification and response to patient safety events, however the aims and ethos have been adopted within healthcare for some time. The implementation process will take time to progress and embed and will require regular review to ensure that GOSH can demonstrate positive assurance in improvements and safety. Enhancing data quality and agility will need to be at the heart of the implementation process to ensure continuous progression.

Effective introduction and ongoing development of PSIRF will be achieved through identifying key themes, patterns, and trends from the data, identifying opportunities for learning and ensuring there are organisational improvement plans in place, over the medium and long term. These will be reviewed, by internal and external agencies, to provide assurance that GOSH can demonstrate effective learning, supported by sustainable improvements in the quality and safety of services and improved care for people who use our services.

The application of System Engineering Initiative for Patient Safety (SEIPS) methodology, to identify the safety actions that need to be considered, is new within the trust. As such, it is recognised that those leading on learning responses may benefit from support from either a

more experienced practitioner, or a trained peer who has the same level of experience, as a "buddy". It is possible that this expertise/support may be sought from an external source (e.g., another healthcare provider learning response lead from within North Central London Integrated Care Board (NCL ICB) or GOSH may be requested to provide "buddy" support.

The GOSH profile, however, must be flexible in its approach to risk and learning, and therefore, where there is either significant risk, opportunities for significant new learning, or opportunities to explore systems and processes for the purpose of learning, the Trust will remain flexible and consider specific individual circumstances and/or emerging themes alongside the implementation of this plan. Events for escalation to a PSII will not be graded by severity of harm, but rather the opportunity to understand what happened and the opportunity for learning and improving care.

A Patient Safety Incident Response Plan (PSIRP) is required for all services provided under the NHS Standard contract. This applies to all services provided by GOSH.

This PSIRP sets out how GOSH will respond to patient safety events reported by staff, patients, families, and carers to allow for continuous improvement of the quality and safety of the care we provide. The PSIRP will be reviewed bi-annually following the initial review to be carried out in June 2025

> *The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them.*
>
> Aiden Fowler, National Director of Patient Safety NHS England

DRAFT

Aims

PSIRF has four main aims upon which this plan is based, and the table below sets out how these aims will be achieved through specific objectives.

Patient Safety Incident Response Framework

Compassionate engagement and involvement of those affected by patient safety incidents

- Act on feedback from patients, families, carers and staff about current problems with patient safety incident responses.
- Involve patients, families, carers and staff in patient safety learning responses for better understanding of issues & causal factors.

Application of a range of system based approaches to learning from patient safety incidents

- Identify learning from incidents and areas to improve to allow us to reach our aim of reducing all avoidable harm to zero by 2025; further developing systems of care to continually improve their quality and efficacy.
- Develop clear pathways from learning to Quality Improvement

Supportive oversight focussed on strengthening response system functioning

- Establish a local assurance group, including our commissioners, to uphold efficacy of PSIIs and alternative responses to patient safety incidents which promotes ownership, rigour and expertise and promote organisational learning.
- Develop a climate which supports a just culture (3)

Considered and proportionate responses to patient safety incidents

- Make more effective use of staff resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to develop and implement improvements more effectively.

To meet the requirements for the National Standards for Patient Safety Responses, we will

- Develop a body of expertise within the Patient Safety Team, and the wider organisation, to conduct learning responses which ensure compassionate engagement and involvement for all affected.
- Undertake system-based approaches which support directorate, cross-directorate, and organisational learning, which has a positive impact on providing safer care for patients and families.
- Ensure patients, families/carers and staff affected by patient safety events are compassionately engaged with at the earliest opportunity and are involved, as much as they wish to be, in the review and learning processes to allow for change which reflects the needs of people who use our services.
- Assign an appropriately trained member of the Executive Team to oversee delivery of the PSII standards and support the approval of all PSIIs.
- The Organisational Learning and Assurance Forum, will oversee, manage and provide assurance all learning responses and local improvement across GOSH, sharing and embedding learning.
- Use Quality Improvement (QI) methodology and improvement science approaches to develop learning and implement improvements in care.

Our Services

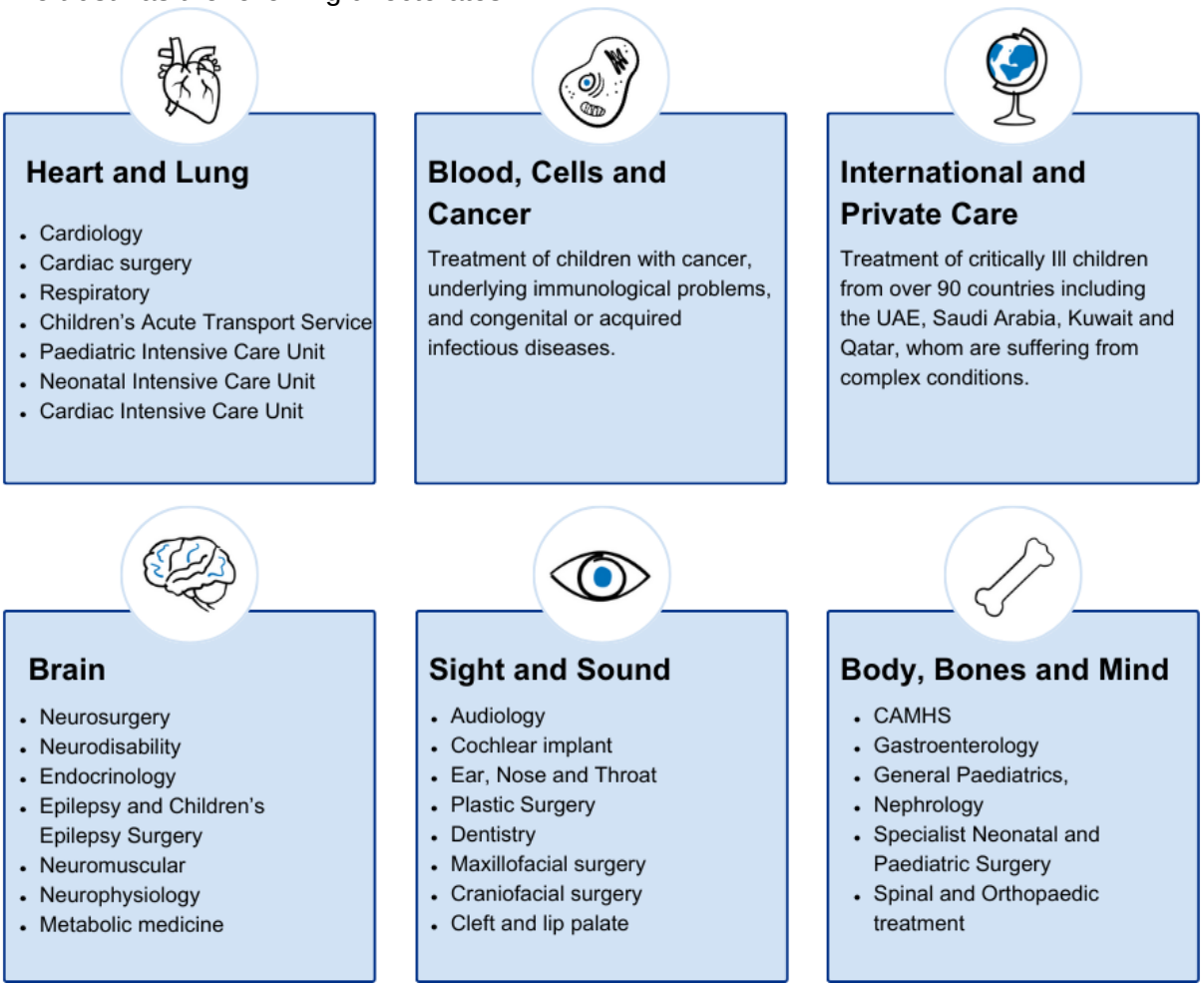
Great Ormond Street Hospital (GOSH) is an international centre of excellence in child healthcare. Since its foundation in 1852, the trust has been dedicated to children's healthcare and to finding new and better ways to treat childhood illnesses.

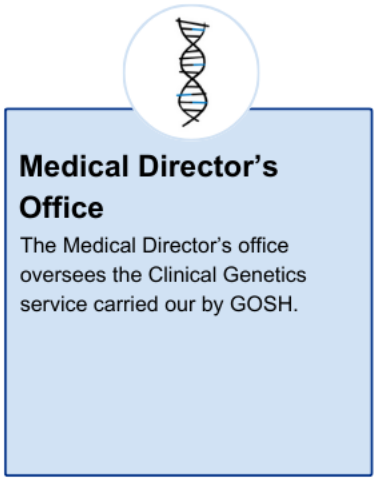
GOSH receives around 242,694 outpatient visits and 42,112 inpatient visits per year, and approximately 750 children and young people per day[2].

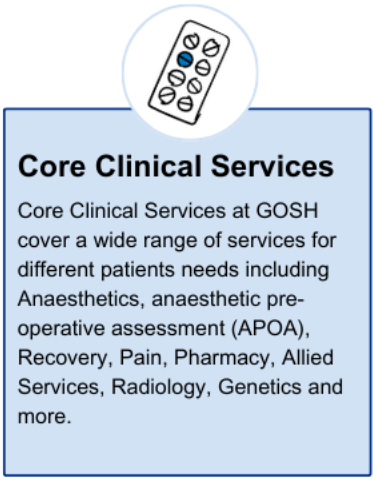
There are over 60 clinical specialities across the Trust and GOSH is the largest paediatric centre in the UK for:

- Paediatric Intensive Care.
- Cardiac Surgery.
- Neurosurgery.
- Paediatric cancer services.
- Nephrology and renal transplants.
- Tracheal Surgery.
- Children treated from overseas and privately within our International and Private Care (I&PC) wing.
- Research and Innovation.
- Tier 4 inpatient CAMHS mental health care.

The trust has the following directorates:







Safety Improvement Profile

GOSH has strengthened existing governance processes and will continue to review existing processes to ensure that they meet the PSIRF standards and to deliver the key aims of PSIRF. Patient safety is a key purpose and it essential there is effective learning from incidents.

Incident themes and trends will be reviewed at directorate Risk Action Groups (RAGs). The purpose of this forum is to review all safety events, with an emphasis on incidents across the directorate, or sub-directorate, to identify patterns. This allows for local learning and improvement to take place with the aim of minimising events and preventing avoidable harm. Patterns and events of concern can be escalated to the SERG for review by members of the senior leadership team.

The Safety Events Review Group (SERG) will continue to review incidents which:

1. Meet the national or Trust priorities.
2. Where there are identified patient safety themes.
3. Emerging themes which impact on patient safety.
4. Provide a forum for review and sign off of PSIIs.

Learning from events, PSII and learning responses will be undertaken in the Organisational Learning and Assurance Forum (OLAF) where there will be consideration for directorate, organisational and system-wide learning. PSII safety actions, themes from learning responses and local learning initiatives will be reviewed by this forum with recommendations for sharing learning and assurance that learning is being embedded.

OLAF will work collaboratively with the Quality Review Group (QRG) to identify and commission specific quality improvement projects to address learning from events. The QRG will ensure that clinical and corporate directorates provide robust assurance on quality improvement, in accordance with the Trust Quality Strategy.

Findings from individual PSII and other PSIRF learning responses will be collated and compared to identify themes in modifiable factors upon which quality improvement initiatives can be developed to support organisational learning.

The trust will apply the principles of patient safety science and improvement methodology to identify:

- What improvements are recommended and prioritisation of quality improvements.
- Plans for implementation and involving stakeholders.
- Measuring the impact of the changes or identifying alternative changes where the desired impact is not achieved.
- Engage QI teams to ensure services have the resource to embed and sustain improvement.
- Hospital-wide Safety Transformation Programme.

The trust has the following safety improvement plans underway:

- Deteriorating patients Working Group
- Complex Patient Working Group
- Medicines Safety Committee
- Total Parenteral Nutrition (TPN) Improvement Group

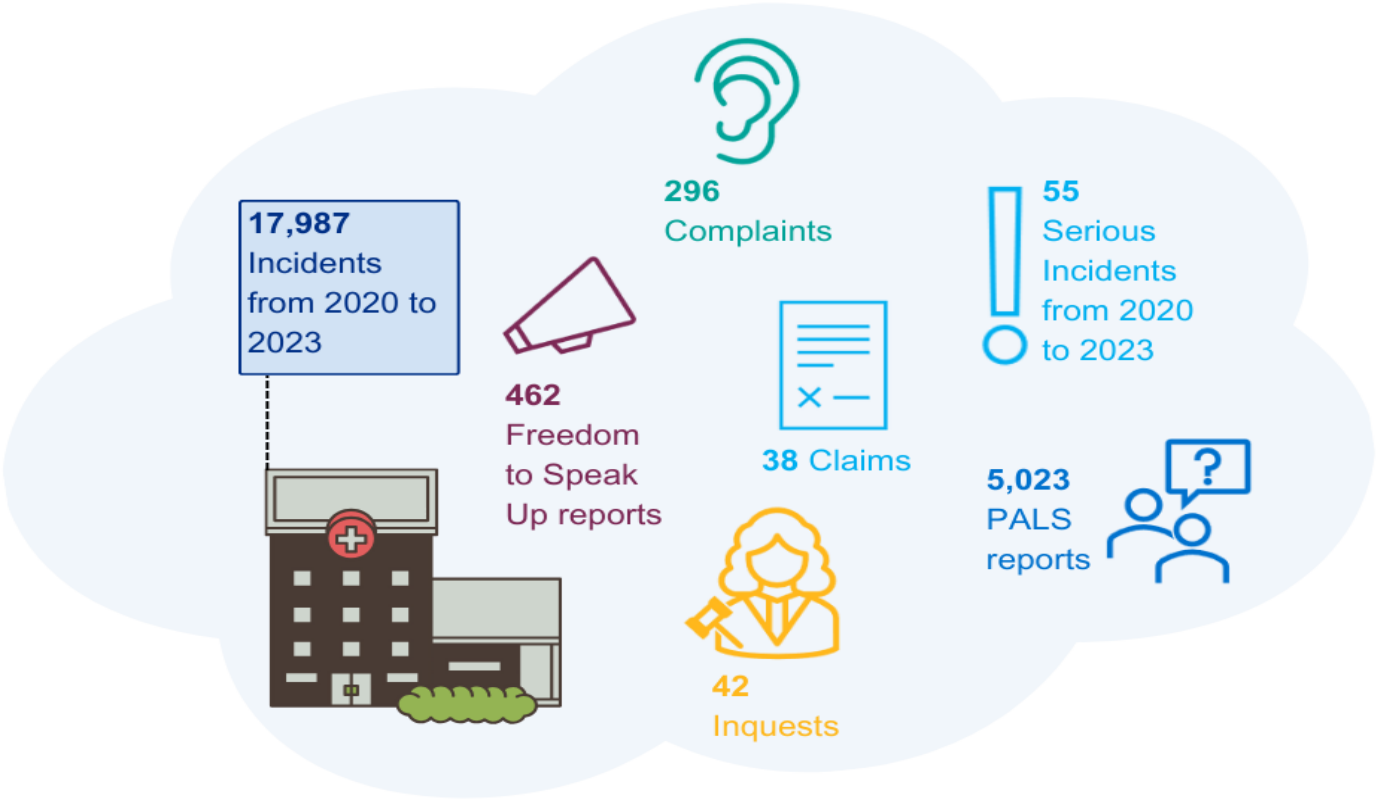
Clinical effectiveness processes such as clinical audits, Horizon Scanning and Learning from Death data will continue to be monitored to ensure any new patient safety trends and risks are identified and acted upon in a timely manner. This data will also be used to inform the Trust's patient safety event risk profile.
All forums listed above will report to the Quality, Safety, Outcomes and Compliance Committee (QSOCC).

Identifying the Trust Safety Incident Profile

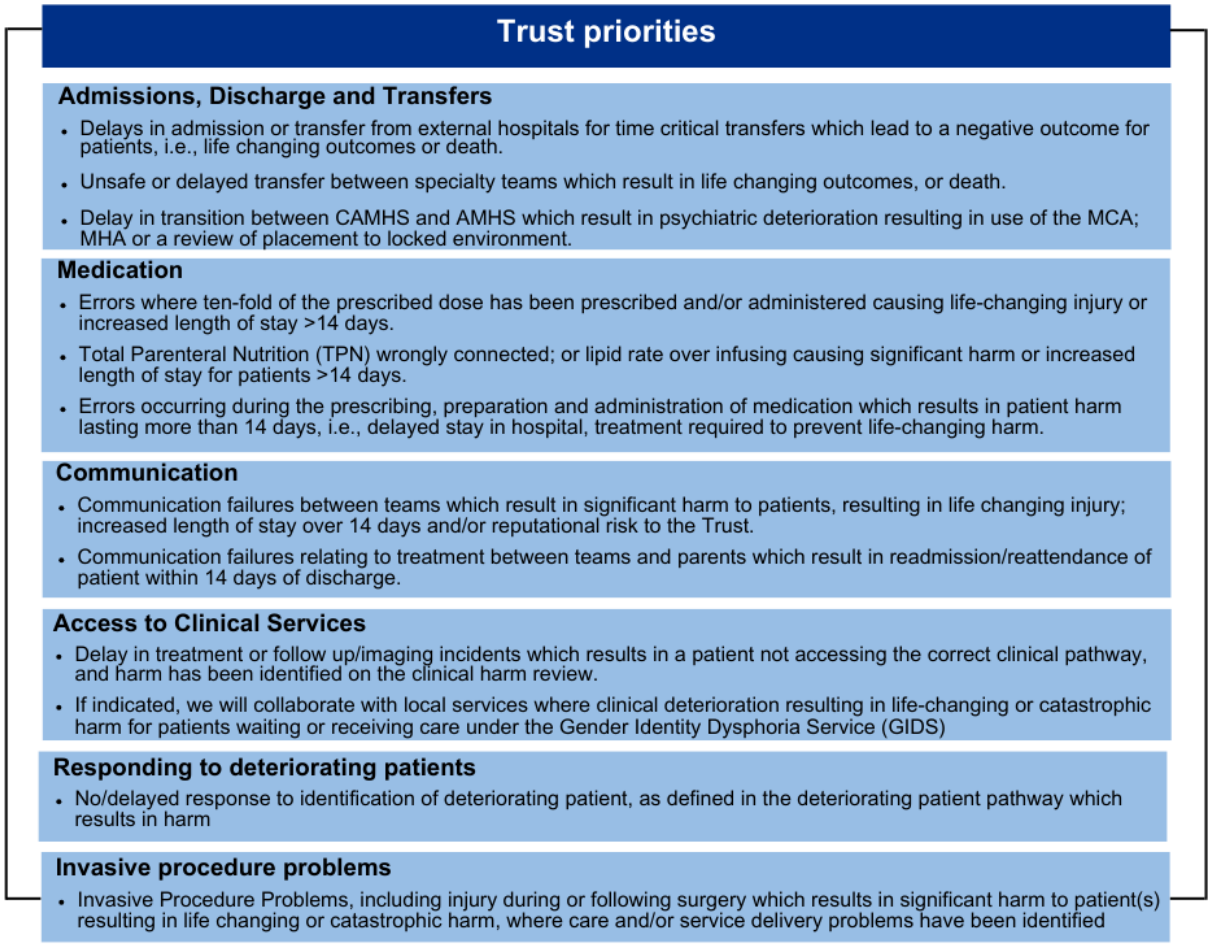
The Trust completed a thematic analysis approach to determine our patient safety priorities. Thematic analysis is a method of identifying, analysing, and reporting patterns (themes) within data.

The data sources used to define the trust profile are outlined below. The analysis of data was undertaken by subject matter experts for each area to provide expert knowledge of trends and priorities and inform how the trust will respond to events. The review period was between 01 April 2020 to 31 March 2023 to ensure that the data was reflective of pre- and post-COVID data. This included careful consideration of safety improvement opportunities and plans/interventions already in place.

To determine the focus and priorities for PSII, engagement sessions to agree and finalise the Trust priorities were undertaken. This plan has also been reviewed by our Patient Safety Partners (PSPs).



We have determined **six patient safety priorities** that will be the focus for the next 18 months. These patient safety priorities have been developed from a review of the data listed above, and where the specified level of harm, or negative impact has occurred, will be subject to a Patient Safety Incident Investigation (PSII) using system-based methodology. Root Cause Analysis (RCA) methodology is not recommended for safety investigations.



For events which do not meet the threshold for a PSII as outlined in the six priorities, an alternative, proportionate learning response will be identified and undertaken, involving staff, patients, families/carers, and where identified, a patient's wider support network.

PSII, and other learning responses, are completed for the purpose of learning to and gain an understanding of system contributors about events. This will allow for improvements to be made to systems to make care safer for people who use services.

The selection of patient safety incidents investigations will be selected based on:

- Actual and/or potential impact of the incident outcome on harm to people, service quality, reputation of the Trust etc.
- Likelihood of recurrence
- High potential for new learning regarding:
    - Incident causing factors
    - Improving system efficiency and effectiveness
    - Opportunities to greatly influence wider system improvement.

How we will Respond to Safety Events

A full outline of national defined priorities which require referral for review by another agency or requiring a PSII can be found in the Patient Safety Incident Response Policy and Appendix A.

The table outlined below will guide how we will respond to the identified priorities and local investigations, including the governance arrangements to ensure we have meaningful learning which can be implemented across the Trust with the aim of reducing avoidable harm.

Timescales for Patient Safety Incident Investigations

PSII should ordinarily be completed within 3 months of their start date. The expected date of completion, including executive member sign off should be agreed at the commissioning of the investigation; patient and/or family and/or carer involvement, unless expressed otherwise, should be involved in determining completion dates. Once a date has been agreed with all involved, all efforts should be made to ensure completion of PSIIs are undertaken within this timeframe.

A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Where the processes of external bodies delay access to information for longer than six months, a PSII can be completed and subsequently reviewed when the information becomes available; a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

Duty of Candour

Once an incident has been identified that meets the Statutory Duty of Candour threshold, which the trust outlines are moderate harm and above, then the legal duties as outlined in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 will be carried out in full.
Duty of Candour is regulated by the Care Quality Commission (CQC).

A culture of openness is crucial to improving the safety of patients, families, and staff; thus improving the quality of healthcare. Duty of candour involves apologising and explaining what happened to patients who have been harmed as a result of their care or treatment.

An overview of duty of candour can be outlined in 3 steps:

1. **Conversation**: Apologise in person as soon as we become aware that something has gone wrong.
2. **Candour Letter**: Send a letter with a summary of the conversation and outline plans as to how GOSH will respond to this patient safety event (within 10 working days).
3. **Completion**: Arrange for the learning from the response and if there are areas where GOSH will work to improve care and systems will be shared with those affected once this response has been completed.

Learning Responses Which Support Engagement and Learning

All patient safety events will have a learning response, however, often engagement and learning are best achieved through a proportionate learning response.

Many patient safety events will not require PSII but may benefit from a different type of response to gain further insight or address queries from the patient, family, carers, or staff. A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

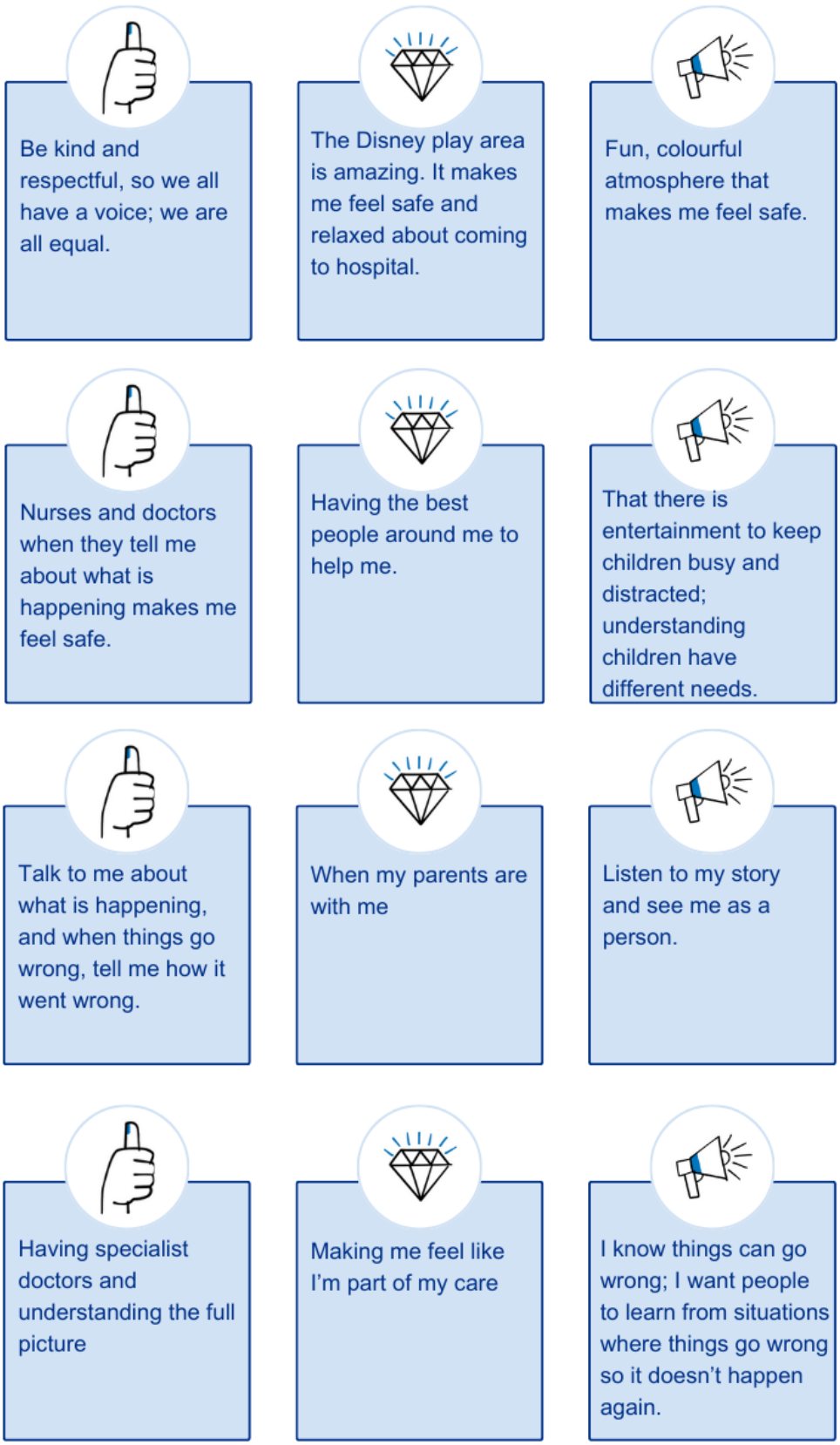
Different response techniques can be adopted, depending on the intended aim, and required outcome to identify learning.

GOSH will use the following response methods:

Learning Response Method	Objective
Immediate safety actions	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. damage to equipment or the environment.
'Being open' conversations	To provide the opportunity for a verbal discussion with the affected patient, family, or carer about the incident (what happened) and to respond to any concerns.
Case record/note review	To determine whether there were any problems with the care provided to a patient by a particular service.
Safety huddle	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk • share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm.
Incident timeline	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
After-action review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses, and areas for improvement. This usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved, and it captures learning, which can then be shared locally, organisationally and system wide.

Engaging and Involving those Affected by Patient Safety Events

As part of World Patient Safety Day 2023, we engaged patients, families/carers, and staff about what makes them feel safe.



The Patient Safety Incident Response Framework (PSIRF) recognises that learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. A Restorative Just and Learning Culture is essential when reviewing or investigating incidents, and there is a need to ensure psychological safety to encourage openness and transparency to support colleagues reflect upon processes and actions taken during care delivery to allow for learning and improvement and facilitate closure for those affected.

GOSH recognises the significant impact patient safety events can have on patients, their families and carers, and our staff.

Getting the right level of involvement from those affected and listening to the voice of people is crucial in developing systems for meaningful learning.

At GOSH, we are in the process of developing an engagement framework for those affected by patient safety events which will focus on the areas below:

- Developing a baseline for engagement, listening to the voice of those affected
- Better use impact statements to allow us to better support those affected by safety events
- Involve those affected by safety events in learning responses and Quality Improvement
- Learn from stories of those affected to allow us to develop to the needs of individuals
- Develop innovative approaches to engaging children in patient safety

GOSH offer support for staff affected by patient safety events through the following channels:

- Access to Employee Assistance and Wellbeing services (Care First).
- Debrief services via PEERS
- Trauma Risk Management Services (TRiM)

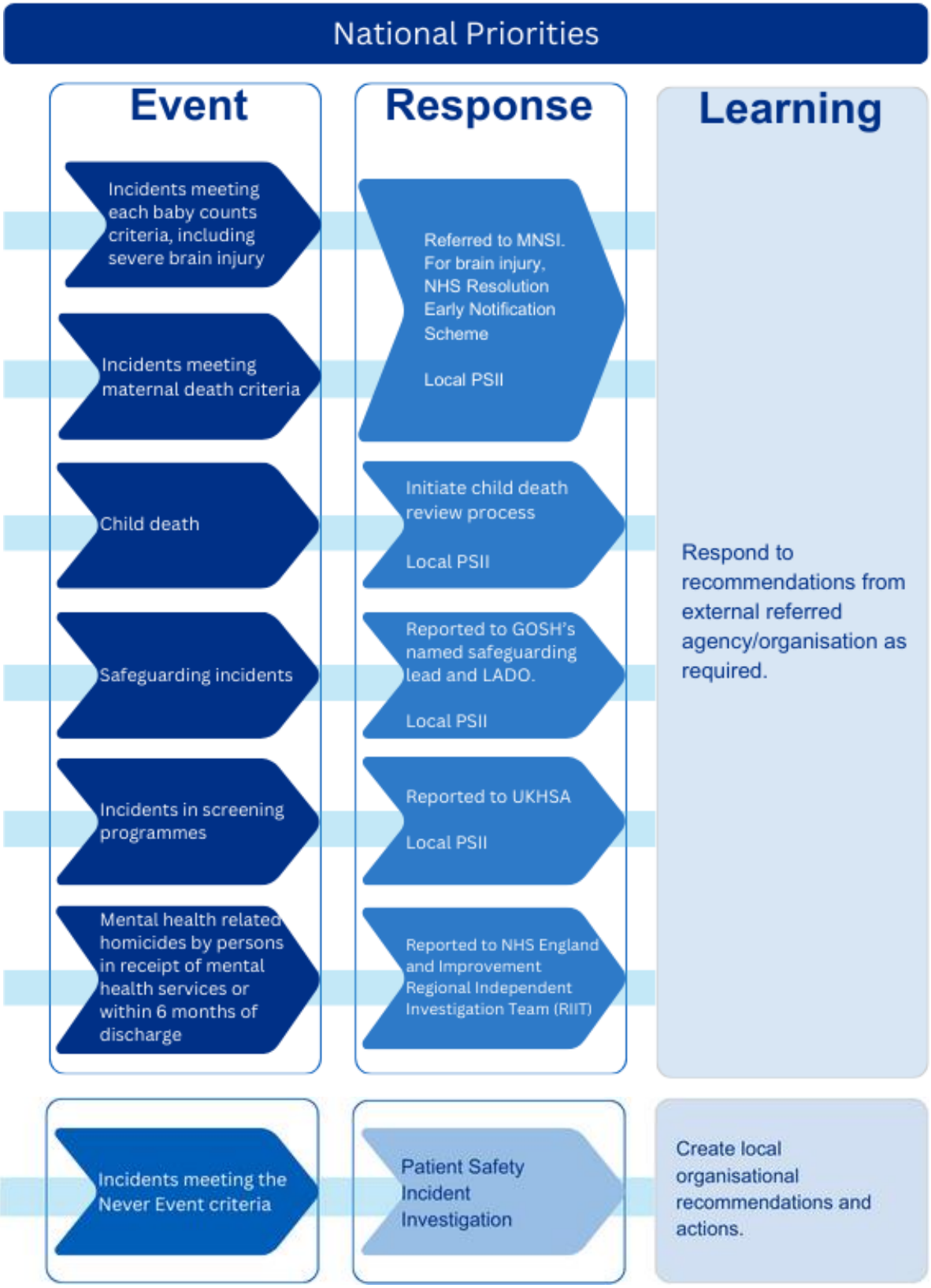
Safeguarding incidents:

Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation.

Incidents in screening programmes

For further information see incidents in screening programme.

Appendix A


National Priorities
Event
Response
Learning
Incidents meeting each baby counts criteria, including severe brain injury
Incidents meeting maternal death criteria
Child death
Safeguarding incidents
Incidents in screening programmes
Mental health related homicides by persons in receipt of mental health services or within 6 months of discharge
Referred to MNSI. For brain injury, NHS Resolution Early Notification Scheme
Local PSII
Initiate child death review process
Local PSII
Reported to GOSH's named safeguarding lead and LADO.
Local PSII
Reported to UKHSA
Local PSII
Reported to NHS England and Improvement Regional Independent Investigation Team (RIIT)
Respond to recommendations from external referred agency/organisation as required.
Incidents meeting the Never Event criteria
Patient Safety Incident Investigation
Create local organisational recommendations and actions.

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street
London WC1N 3JH
020 7405 9200
gosh.nhs.uk

Thank you to every member of staff involved in the production.

Thank you to the Patient Safety Partners for their support and review of this document.

The Patient Safety Incident Response Plan is available to view at gosh.nhs.uk.

Head of Patient Safety
Great Ormond Street Hospital
Great Ormond Street
London
WC1N 3JH

PLEASE NOTE: Printed copies of this policy may not be the current version. Please refer to All Trust policies on OurGOSH for the current, approved version.

Great Ormond Street Hospital for Children NHS Foundation Trust

Policy

Patient Safety Incident Response Policy

Key Points
• This policy sets out the process, roles, and responsibilities for managing, reviewing, and determining proportionate learning responses, including the reporting of Patient Safety Incident Investigations (PSII) across all services provided by GOSH. • The term "patient safety review" is used in this document (as opposed to investigation) to ensure that the focus is on systems and processes, learning from events to improve safety, and promote compassionate engagement for all affected by safety events.

Version:	2
Lead Author:	Head of Patient Safety
Executive Lead:	Chief Medical Officer
Date Approved by Policy Approval Group/Responsible Committee	01 February 2024
Policy Category:	Clinical Management
Review Date:	August 2025
Target Audience:	All GOSH Employees

Version	Date	Summary of version
1.0	May 2023	National template filled in with GOSH Specific information by Daniel Mortara
1.3	January 2024	Wording changes and addition of definitions by Kiera Parkes and Daniel Mortara
1.4	January 2024	Document-wide structural changes by Nikki Fountain
1.5	January 2024	Document updated with Patient Safety Team comments, NHS England comments, Patient Safety Partner comments and Director for Co-Production comments.

		Comments received from Chief of Service and Deputy Chief of Service.
2	Feb 24	Formally approved at the Quality, Safety and Experience Assurance Committee (QSEAC)

Document Control	
Previous Version Information:	
Previous Title:	Serious Incident Management Policy
Previous Approval Date:	Not Applicable
Relevant to CQC requirements:	Yes Safe, Effective, Responsive, Caring and Well-Led
Relevant to Data Security and Protection Toolkit	Yes
Relevant to Good Clinical Practice (GCP) requirements	Yes
Other External Assessments	Yes If yes, please state which**:** Care Quality Commission, Learning from Patient Safety Events (LfPSE), StEIS, Patient Safety Incident Response Framework (PSIRF), National Patient Safety Strategy, Involving Patients in Patient Safety (IPiPS)
Consultation:	
Individual(s) Consulted:	Executive Medical Director Associate Medical Director for Safety and Resuscitation Chief Nurse Director for Safety Surveillance Freedom to Speak Up Guardian
Department(s) Consulted:	All Clinical Directorate Senior Leadership Teams Patient Safety Team Quality Team Patient Experience & Engagement/Complaints Leadership Team Non-Clinical Department Leads
Committee / Group(s) Consulted:	Safety Transformation Board Deputy Chief of Service Head of Nursing Quality, Safety and Outcomes Compliance Committee (QSOCC) Executive Management Team
Amendments Made:	This is a new policy to support the introduction of the Patient Safety Incident Response Framework

	(PSIRF) and guide decision making and response to patient safety events.
Keywords:	Patient Safety; PSIRF; Safety Event, Incident, PSII

Related Trust Documents:

Patient Safety Incident Response Plan
Being Open and Duty of Candour Policy
Information Governance Policy
Complaints Policy
Safeguarding Children and Young People Policy
Safe and Respectful Behaviour Policy
Learning from Deaths Policy
Raising a Matter of Concern Policy (Soon to be replaced by the FTSU policy)
Infection Prevention and Control Assurance Framework and Operational Policy

Contents

1 Introduction

1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out how Great Ormond Street Hospital for Children NHS Foundation Trust (hereafter referred to as GOSH) will approach the development and maintenance of effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

1.2 This policy should be read in conjunction with our current Patient Safety Incident Response Plan, which is a separate document that sets out our plan for learning from patient safety events and safety improvement.

1.3 PSIRF advocates a co-ordinated systems-based and data-driven response to patient safety events. It embeds patient safety responses within a wider system of learning, improvement and prompts a significant cultural shift towards systematic patient safety management.

1.4 This policy supports development and maintenance of an effective patient safety event response system that integrates the four key aims of PSIRF which align to GOSH values:

- Compassionate engagement and involvement of those affected by patient safety events.
- Application of a range of system-based approaches to learning from patient safety events.
- Considered and proportionate responses to patient safety events and safety issues.
- Supportive oversight focussed on strengthening response system-functioning and improvement.

2 Definitions

2.1 The glossary below defines commonly used terms within this document and the Patient Safety Incident Response Plan (PSIRP).

Term	Definition
PSIRF	Patient Safety Incident Response Framework. This is a national framework applicable to all NHS commissioned care. To ensure equity and consistency on how GOSH respond to safety events, this framework will apply to all care delivered by GOSH. Building on data collated and learning from best practice across the wider healthcare system, PSIRF is designed to enable a risk-based approach to responding to patient safety events, prioritising support for those affected, effectively analysing events, and sustainably

	reducing future risk, improve safety culture and work towards minimising avoidable harm.
PSIRP	Patient Safety Incident Response Plan. GOSH has set out a plan determining how we will undertake PSIRF locally, including our list of local priorities. These have been developed through a co-production approach with subject matter experts and supported by analysis of local data.
PSII	Patient Safety Incident Investigation. PSIIs are conducted to identify underlying system factors that contributed to an event. These findings are then used to identify effective, sustainable improvements by combining learning across multiple PSII and other learning responses into a similar event type. Recommendations and improvement plans are then designed to effectively address those system factors and deliver safer care for people who use our services.
AAR	After-Action Review. A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from a wider group of those affected to identify opportunities to improve and increase to occasions where success occurs.
Never Event	Patient safety events that are considered to be preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
Safety Huddle	Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and/or non-clinical opportunities to discuss and understand what is going on with each patient and anticipate future risks to improve patient safety and care.
NPSS	National Patient Safety Syllabus. This outlines the NHS England approach to patient safety emphasising a proactive approach to identifying risks to safe care while also including systems thinking and human factors.
SERG	Patient Safety Events Review Group. A weekly forum where events meeting the local priorities, patient safety events of concern and emerging themes are discussed to identify suitable learning responses.
OLAF	Organisational Learning and Assurance Forum A monthly forum where learning response coordination will be reviewed to monitor safety actions; develop organisational safety

	actions and inform quality improvement work to be taken to the Quality Review Group. This forum will be responsible for reviewing all learning response outcomes, identifying how learning will be shared across GOSH and monitoring that learning is embedded and improvements in care.
QRG	Quality Review Group This is a monthly forum where the Quality Improvement Team, with representatives from safety and directorates meet to discuss the improvement initiatives across GOSH based on incident trends.
QSOCC	Quality, Safety, Outcomes and Compliance Committee. QSOCC is a subgroup/committee of the Executive Management Team and is chaired by the Chief Medical Officer or Chief Nursing Officer. It has delegated authority from the Executive Management Team to oversee and monitor all aspects of patient safety and quality and to ensure that the Trust continues to be a learning organisation. The purpose of QSOCC is to monitor and identify quality, safety, outcomes and compliance metrics through the oversight and triangulation of data, insight, and informal signals.
Near Miss	Patient safety events that did not cause harm but had the potential to cause harm. The events were avoided.
Patient Safety Event	A patient safety event, which GOSH will use as an alternative to incident. This is an event or circumstance which causes or could have caused harm to a patient.
LFPSE	Learning from Patient Safety Events is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare.
DATIX	Our local risk management system. This system designed to collect and manage data on patient safety events, as well as data on risks, complaints, claims). The purpose of collecting such data is to identify learning and implement improvement. The ultimate goal is to make healthcare safer for patients and staff through shared learning and continuous systems improvement.
Safety Actions	A plan that outlines the process of keeping a person or a group of people safe from harm. A safety action is used to prioritise safety improvements.

PSP	Patient Safety Partner. A new role developed by NHS England to help improve patient safety across healthcare in the UK.

3. Scope

3.1 Patient safety incident responses under this policy follow a systems-based approach. This recognises that safety is provided by interactions between components, not from a single root cause. Responses do not focus on the actions or inactions of people, or "human error" as the cause of an incident.

3.2 GOSH understands that that safety outcomes and work processes are influenced by work-systems that include people, tasks, tools and technologies, organisation of work, environmental factors, and external factors.

3.3 Reviews undertaken under this policy have no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

3.4 Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose.

3.5 The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

3.6 Information from a patient safety response process should be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3.7 This policy applies to the following staff groups:

- All GOSH employed staff - where the individual is directly employed by GOSH either on a fixed term or permanent contract.
- Board Members – Member of the Trust Board. Specifically the Chair, Non-Executive Directors, and Executive Directors
- Governors – Member of the Council of Governors
- Contractors – individuals on-site at GOSH, who are employed by an external contracting company including consultancy work.
- Agency staff – individuals on-site at GOSH who are employed via an agency on the NHS Agency Framework.
- Honorary contract holder – individuals engaged via a GOSH Honorary contract.
- Bank staff – individuals with a GOSH bank contract.
- Volunteers - individuals employed via the GOSH volunteer programme.
- Students - students on placement within the Trust as part of their educational programme
- Observers – those over the age of 18 and wish to observe a department within GOSH

- Young visitors programme – those on placements in the different clinical areas of GOSH who are between 16-17 years of age
- Work experience candidates – students who are gaining work experience within the Trust
- Foundation Year 1 & Foundation Year 2 Placements – those training to be doctors at Foundation Year 1 and 2 level, who wish to experience a Paediatric Hospital environment to help inform future career decisions
- Research Placements – those holding an Honorary research contract or letter of access issued by the research governance team (R&D office) or an honorary contract if they are undertaking both research and clinical work issued by GOSH HR.
- Clinical trial monitors - those visiting for purposes of conducting visits relevant to a clinical trial.

4. Aims and Objectives

4.1 The aim of this policy is to support GOSH colleagues in delivering PSIRF, ensuring that the 4 aims of PSIRF are achieved, PSIRF standards are met, and there is a reduction in avoidable harm through quality and improvement initiatives for people who use our services and deliver GOSH services.

4.2 To achieve this aim, the following policy objectives must be realised:

4.2.1 A decision-making framework for patient safety events is utilised and learning responses are undertaken using system-based methodology. A response to events and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, GOSH can explore patient safety events relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

4.2.2 Ensure that there is meaningful and compassionate engagement, involvement, and support for all affected by patient safety events.

4.2.3 Ensure that all staff are receive training, commensurate to their role in relation to patient safety, to provide an expert workforce and develop a positive safety culture.

4.2.4 GOSH will develop a safety culture strategy which will support the aims of PSIRF and improve care delivery across services. GOSH uses the principles of just and learning culture in safety reviews. A just and learning culture is one which balances fairness, learning and accountability, by making colleagues feel confident to speak up when things go wrong, rather than fearing blame. This allows GOSH to learn using a compassionate approach that assumes good intention and understands the impact of systems and environments and why decisions were taken at the time.

4.2.5 The five elements which GOSH to creating a just and learning culture in GOSH are:

- GOSH has clear values and all employees know what is expected of them.

- GOSH systems are designed to prevent or minimise error.
- GOSH offers robust training, and colleagues speak up when mistakes happen.
- Colleagues understand the important role of the GOSH Freedom to Speak Up Guardian (FTSUG) in escalating concerns and safety issues.
- Robust responses are undertaken so learning is identified and shared, colleagues are held to account and not blamed.
- There is a culture that encourages reporting of events, risks and near misses to promote learning.

5. Duties and Responsibilities

5.1 The Trust describes the roles and responsibilities in relation to its response to patient safety events, including investigator responsibilities and upholding national standards relating to patient safety events.

5.2 Trust Board

The Trust Board is responsible and accountable to ensure that that this policy is being implemented, that lessons are being learnt, and areas where concerns have been raised are improving. This will be achieved via the Quality, Safety, Outcomes and Compliance Committee (QSOCC). In the case where concerns arise relating to embedding learning and actions, the Trust Board, through the Quality, Safety and Experience Assurance Committee, will seek assurance that these concerns are acted upon.

5.3 Chief Medical Officer & Chief Nurse

The Chief Medical Officer has Board responsibility for patient safety and is the organisational lead for ensuring that there are adequate arrangements in place for PSII reviews and monitoring. In addition, they ensure that there is adequate assurance to demonstrate learning is being identified, shared and changes to practice because of PSIIs and reviews are implemented across the Trust.

The Chief Medical Officer and Chief Nurse will be responsible for the oversight of the implementation of this policy and the PSIRP. The Chief Medical Officer and Chief Nurse will be responsible for providing executive sign-off for PSII and oversight that improvements and learning are being embedded within the organisation.

5.4 Head of Patient Safety

The Head of Patient Safety (HoPs) will be responsible for developing and overseeing systems and processes to support the implementation of the plan. In addition, the HoPS will be responsible for providing assurance regarding the implementation of the plan, compliance with the Engaging Families framework and learning response coordination. The HoPS will be responsible for ensuring that the priorities remain applicable to the Trust, and processes for emerging themes are captured and allow for identification and learning from emerging themes. They will

work with executive lead to address identified weaknesses/areas for improvement in the Trust's response to patient safety events including gaps in resource including skills and training.

The HoPS will provide support and guidance to the Senior Directorate and Directorate Safety Partners; and will act as an escalation point for Directorate leads when there are barriers to the implementation of PSIRF.

The HoPS will act as a link with external partners, such as NCL ICB, NHE England London Region and other safety forums, for the purpose of providing oversight; escalations in relation to cross-system events and external reviews.

5.5 The Patient Safety Team

- Ensures that patient safety reviews/learning responses are undertaken for all events that require a response (as directed by the Trust's PSIRP). Develops and maintains local risk management systems and relevant event reporting systems to support the recording and sharing of patient safety information.
- Prepare the SERG report with the Directorate support and co-ordinate with SERG secretariat to support with presenting to this forum.
- Engage and involve those affected by patient safety events, completing the patient/family engagement checklist and ensure continued engagement with those involved as the learning responses progresses. For staff, there will be no engagement checklist, but expectations will set and documented on the investigation record at the point of engagement to ensure staff are involved and supported through the learning response process.
- Provide support/signposting for those affected by patient safety events such patients, families and staff.
- Lead on PSII, with support from Directorates and Subject Matter Experts.
- Proactively manage alternative learning responses and safety actions in collaboration with Directorate leads, with support from the Head of Patient Safety.
- Oversee the After-Action Review (AAR) Faculty, and forums in relation to alternative learning responses.
- Undertake, monthly and quarterly thematic analyses in relation to near misses/low/no harm events to identify areas for learning. This will be a new area of work.
- Provide advice on Human Factors principles and system-based methodology.
- Support identification of key learning points for sharing and formulation of SMART safety actions.
- Support review of Directorate and Trust-wide risks, considering learning from learning responses/PSII.

5.6 Associate Medical Director (AMD) for Safety and Resuscitation

- Ensure robust review and challenge regarding PSIRF and patient safety at SERG
- Arrange external reviews as required.

- Act as an escalation point to the Chief Medical Officer and Chief Nurse when there are barriers to progressing learning responses and learning across GOSH.
- Ensure that learning is identified and embedded through the Organisational Learning and Assurance Forum (OLAF).

5.7 Deputy Chiefs of Service (DCOS)/Heads of Nursing (HoN)/General Managers (GM)/Chief of Service (CoS)

- Support the Senior Directorate/Directorate Safety Partners in preparing reports for SERG.
- Ensure immediate actions arising from SERG are implemented in collaboration with the patient safety team.
- Provide a directorate overview and support with identifying subject matter experts to support with PSII.
- Proactively manage alternative learning responses in collaboration with the patient safety team.
- Engage in learning responses, ensuring that these are completed within timeframes, and shared via the OLAF to support directorate, organisational and cross-system learning and improvement.
- Ensure those affected by patient safety events are proactively supported during responses, including an initial debrief of the event.
- Act as an escalation point where there are identified barriers to undertaking learning responses and reviews at a directorate level.
- Contribute to local and organisational action plans to identify and embed learning by supporting and completing actions.
- Provide assurance that a systems-based methodology has been used to undertake PSII, themes from learning responses are monitored and local safety actions are progressing.
- In collaboration with identified patient safety team representative, ensure all actions have been agreed by action owners taking into consideration organisational actions; and where audit is involved, this has been discussed and agreed prior to submission
- Liaise with Patient Safety Team for advice and queries regarding methodology, articulation of findings, formulation of recommendations, or identification of organisational actions/escalation of risk on completion of PSII and alternative learning responses.

5.8 Safety Surveillance Team

- Support with system-wide learning through horizon scanning and safety intelligence.
- Support systems and processes for safety and continuous quality improvement, working with safety, quality, experience, and legal teams

- Horizon scan to identify key external drivers for GOSH, translating those into meaningful messages and actions
- Support excellence in managing Trust wide risk in line with best practice in risk management
- Support the wider patient safety education workstream
- Safety Alerts

5.9 Quality Improvement Team

- Support with the identification and prioritisation of improvement initiatives at an organisational level.
- Review suggestions for QI projects from the Organisational Learning and Assurance Forum.
- Monitor assurance and progress of individual quality assurance projects relating to priority areas.
- Support with identification of emerging themes, through data, audit and outcomes.

5.10 Patient Experience & Engagement Team/Complaints Team

- Contribute to the development, implementation, and review of the patient/family/carer engagement framework in relation to patient safety events to ensure collaboration across experience and safety.
- Support the patient safety team with patient and family/carer involvement and input during the review process where this relates to high-risk complaints which fall within the scope of the PSIRP.
- Provide quality assurance checks on the high-risk complaint aspects of learning responses prior to review by the Head of Patient Safety.

5.11 Matrons/Ward Managers/Team Leader/ Heads of Service

- Support and encourage staff to report events on the GOSH incident reporting system
- Identify learning when reviewing and closing events, identifying themes for learning which will support improvement and risk management across services.
- Support the Organisational Learning and Assurance Forum (OLAF) in identifying themes and learning, supporting local, organisational and systemwide learning, action planning and quality improvement; sharing across staff groups and services to support improvement.

5.12 Chief Finance Officer/Director of Space and Place/Director of Transformation

Support attendance at OLAF to consider support required to embed learning and drive improvement from a differing experience.

5.13 Head of Education for Patient Safety

The Head of Education for Patient Safety will review all patient safety related training requirements against the agreed training plan. They will work closely with the patient safety team to deliver patient safety training across GOSH; working to identify if there are any training gaps and sourcing training to address any areas for development.

6 Patient Safety Incident Response Planning

6.1 GOSH will undertake a proportionate approach to its response to patient safety events to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety reviews and our existing safety improvement workstreams.

6.2 The PSIRP is based on a thorough analysis of themes and trends from patient safety data and intelligence over a period of time as agreed by the GOSH board. This policy should be read in conjunction with the PSIRP.

6.3 The seven priorities identified in the PSIRP will be regularly reviewed against safety, quality and governance reports and surveillance to ensure they are responsive to unforeseen and emerging risks.

6.4 The GOSH plan must remain flexible in its approach to risk and learning, and therefore, GOSH will consider specific individual circumstances and/or emerging events/themes alongside the implementation of this plan.

6.5 A review exercise will be undertaken after an initial 18 months, and then every three years or more frequently if appropriate. The review period will be agreed with the North Central London Integrated Care Board (ICB) and NHS England Specialised Commissioning.

6.6 This review will include a review of our learning response capacity, mapping of our services, an organisational wide review of safety data (e.g., PSII reports, improvement progress, complaints, claims, risks and risk management, staff survey results, patient/family/carer/staff feedback where they have been affected by a patient safety event, event data and inequalities data) and wider stakeholder engagement.

6.7 The new PSIRP will be available on the external GOSH website, replacing previous versions.

7 Responding to Patient Safety Events

7.1 Staff must continue to feel supported and be able to report any events, and/or concerns in relation to patient safety. The reporter will record the level of harm they believe to have been experienced by those affected. There is still a requirement to report events regardless of whether they are events that feature on the national PSIRF priorities list or within our local priorities in our PSIRP.

7.2 The patient safety team, and directorate leadership teams will continue to promote, support, and encourage colleagues and partners to report near misses, with a shift to a focus of thematic analysis and themes which provide the greatest opportunity for learning and improving safety.

7.3 Patient Safety team will support staff to review patient safety events and ensure that they are responded to proportionately and in a timely manner.

7.4 The Patient Safety Team will undertake a triage of events to support directorates with identification of an appropriate learning response and identification events requiring urgent escalation to SERG or for an exceptional meeting to be held. The team will direct enquiries to the relevant colleagues to ensure each event will be appropriately managed, support with early identification of learning; and support plans for engagement, information sharing and learning.

7.5 It is recognised that most events may only require a local review within the service; some events, where it is felt the opportunity for learning and improvement is significant or where themes are identified, will be brought by a representative from the directorate and/or the (senior) directorate safety partner to the Safety Events Response Group (SERG) for a discussion and decision making as to how best to manage the event in accordance with the PSIRP.

7.6 Event reports will be reviewed by the patient safety team to ensure an appropriate learning response during daily triage and at closure of the event. This is to ensure that the correct theme has been identified to support thematic analysis, and to ensure appropriate a learning response is included, and feedback has been given to the reporter.

6.8 Events which appear to meet requirements for reporting externally to national bodies such as Maternity and Newborn Safety Investigations (MNSI) Programme hosted by the CQC, Medicines and Healthcare Products Regulatory Agency (MHRA); NHS Resolution (NHSR); NHS England Regional Independent Investigation Team (RIIT).

6.9 Directorate leadership teams will ensure that any events which may require cross-system or partnership engagement (where reviews are undertaken which may involve services outside of GOSH) are identified and shared with the patient safety team, who will support and lead on ensuring that partnership colleagues are fully engaged in reviews and share learning as required. The North Central London Integrated Care Board (ICB) and NHS England Specialised Commissioning will support a collaborative approach with arrangements if required.

6.10 It is recognised that this new approach will represent a culture shift for the organisation which needs to provide support and guidance, utilising the principles of good change management. Those with a responsibility for safety will ensure regular communication and involvement through our communication framework and our wider organisational governance structures.

8 Patient Safety Incident Response Decision Making

8.1 Reporting of events will continue in line with existing GOSH policy and guidance.

8.2 The principles of proportionality and a focus on events that provide the greatest opportunity for learning are central to decision making under PSIRP. This will provide a wider range of options for further investigation as outlined in the PSIRP.

8.3 The Patient Safety Team will provide directorate safety support in relation to the following areas:

- Identification and escalation of any events that have or may have caused significant harm or death.
- Identification of any events requiring external reporting or scrutiny.

- Identification of any other events of concern, such as near-misses, non-patient safety events that could lead to potential harm or significant failures in established safety procedures.
- Identification of themes, trends, or clusters of events within a specific service.
- Identification of themes, trends, or clusters of specific event types.
- Identification of any events relating to local risks and issues.

8.4 Appendix A outlines the decision-making process for responding to patient safety events.

8.5 There will be a weekly Safety Events Response Group (SERG). This meeting will review patient safety events and escalation from directorates to ensure an appropriate level of response has been allocated and to identify those events that appear to meet the need for further exploration due to the possibility of meeting the criteria for an alternative learning response or PSII.

8.6 A monthly assurance report on progress, themes, and emerging trends outside of normal variation identified through the SERG will be discussed in the Quality, Safety, Outcomes and Compliance Committee (QSOCC). Safety Actions and Learning Responses will be included in the Organisational Learning and Assurance Forum (OLAF).

8.7 The information will be reviewed regularly against the identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by QSOCC if required.

8.8 Issues of declared and major incident or which require GOSH to stand up the Business Continuity Plan will be escalated to the ICB as soon as possible by the Head of Patient Safety in agreement with the Executive Medical Director.

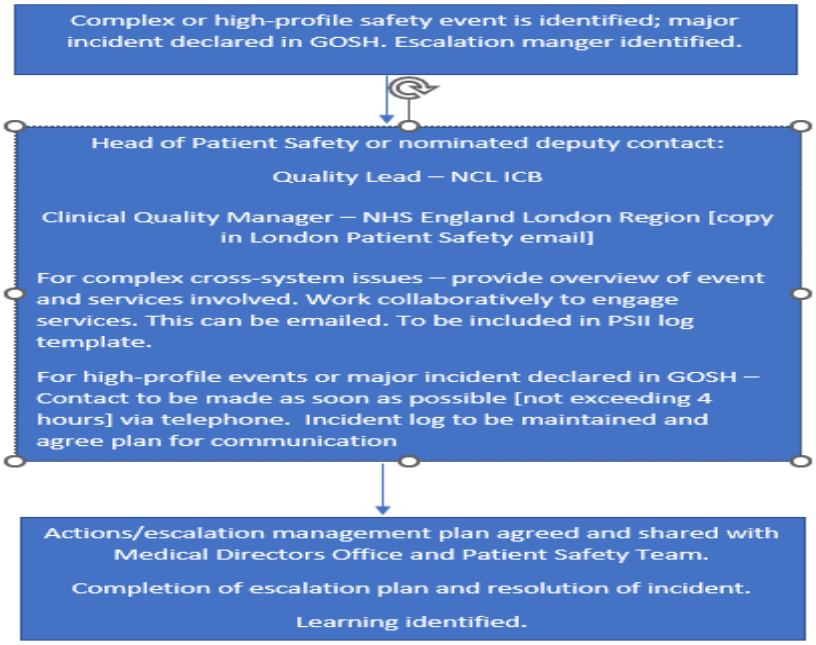
8.9 It should be acknowledged that GOSH provides services for patients across multiple ICBs and regions. As such, it is important that escalation and reporting mechanisms are in place across boundaries and responsibility and accountability are understood.

9 Responding to cross-system events/issues

9.1 The Patient Safety Team will assist in the coordination of these events identified to other providers directly, via contact with Patient Safety Specialists or agreed reporting processes with other providers.

9.2 If a complex cross-system issue is identified, we will refer to North Central London ICB and NHS England London Region Specialised Commissioning to assist with the co-ordination. We will anticipate both agencies will provide support and advice in identifying a suitable reviewer, should this circumstance arise.

9.3 The process below outlines the responsibilities in relation to escalation:



10 Timeframes for Learning Responses

10.1 The impact extended timescales can have on those involved and the risk of delaying findings may compound harm for those affected by patient safety events.

10.2 Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

10.3 Timeframe for completion will be agreed with those affected (such as patients, families/carers', and staff), as part of setting the terms of reference. It needs to be recognised that there are times when patients, families/carers and staff may not be able to be involved in the safety event review process or learning response; this may be due to accessing treatment, emotional distress, or other factors. Colleagues leading on learning responses should ensure that there is communication with those affected to allow them to re-engage in the process and continue to be involved.

10.4 Staff leading on learning responses will maintain the involvement log for those affected by patient safety events.

10.5 If there is a disagreement agreeing a timeframe for learning responses which cannot be resolved, this will be escalated to the Head of Patient Safety. Please refer to section 16 for more information on engaging and involving those affected by patient safety events.

10.6 Where a PSII is indicated, this will be started as soon as practically possible following the identification and completed within three months.

10.7 In the event that during the course of the review it is identified that another partner organisation should be engaged, the timeframe set for completion of the PSII should be reviewed to reflect this. Where a joint review is being undertaken, the PSII process should not exceed six months in duration.

10.8 Responses exceeding agreed timeframes set with those affected will be reviewed by the Head of Patient Safety and Deputy Chief of Service/Head of Nursing to understand why the timeframe has been exceeded and if it possible to mitigate any delays.

10.9 Where external bodies (or those affected by patient safety events) cannot provide information to enable completion within the timeframe, the Senior Directorate Safety Partner or Directorate Safety Partner will review all information to complete the response to the best of their ability. Consideration will be given as to whether new information would indicate the need for further review once this is received. The decision for further review will be made by the Safety Events Response Group (SERG).

10.10 There may be an exceptional circumstance where a longer timeframe for completion of a learning response is required. In this case, all extended timeframes will be agreed between those affected, including patients, families, and staff and the learning response lead.

10.11 One of the most important factors in ensuring timeliness of a learning response is thorough, complete, and accurate event reporting when the circumstances are fresh in the mind of the event reporter and the wider team. These principles are set out in the Incident Reporting and Management Policy but must be reinforced through PSIRF.

10.12 Our plan provides more detail on the types of learning response considered most appropriate to the circumstance of the event. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guide only:

- Initial safety event review – as soon as possible, within 5 working days of reporting.
- Debrief/Huddle – as soon as is safe to complete once an incident has happened.
- After Action Review – within 20 working days of the initial report.
- Thematic Review – within 4 months depending on complexity.

11. Safety Action Development and Safety Improvement Plans

11.1 GOSH will use the principles outlined in the NHS England Safety Action Development Guide (2022) to develop safety actions.

11.2 Safety actions will be monitored via the Organisational Learning and Assurance Forum (OLAF) using an integrated approach of reducing risk and limiting the potential for future harm.

Commented [JP1]: As above regarding this new forum

11.3 OLAF is a monthly forum where learning response coordination will be reviewed to monitor safety actions; develop organisational safety actions and inform quality improvement work to be taken to the Quality Review Group.

11.4 This forum will be responsible for reviewing all learning response outcomes, identifying how learning will be shared across GOSH and monitoring that learning is embedded and improvements in care.

11.5 All safety actions must be developed with and agreed by staff/forums that will be responsible for implementing the change.

11.6 Safety actions developed through learning responses must incorporate means of monitoring completion and sustained effectiveness.

11.7 Safety actions should:

- Follow SMART (Specific, Measurable, Achievable, Realistic and Time-Bound) principles and have designated owners to monitor and measure successful implementation and sustained development in practice.
- Be concise, consisting of a small number of action points that have been prioritised based on impact.
- Agree areas for improvement, outlining where improvement is needed, with consideration for organisational and cross-system learning.
- Define safety measures to demonstrate if actions are influencing what is intended.
- Allow GOSH and staff to focus resource on those actions that are likely to result in sustained beneficial change.
- Actions reminding staff of policies/procedures/guidelines should not be included.
- Actions for sharing reports in various forms should not be included.

11.8 Safety actions will form the Safety Improvement Plan.

11.9 A Quality Improvement (QI) approach is crucial in learning and improvement following a patient safety learning response.

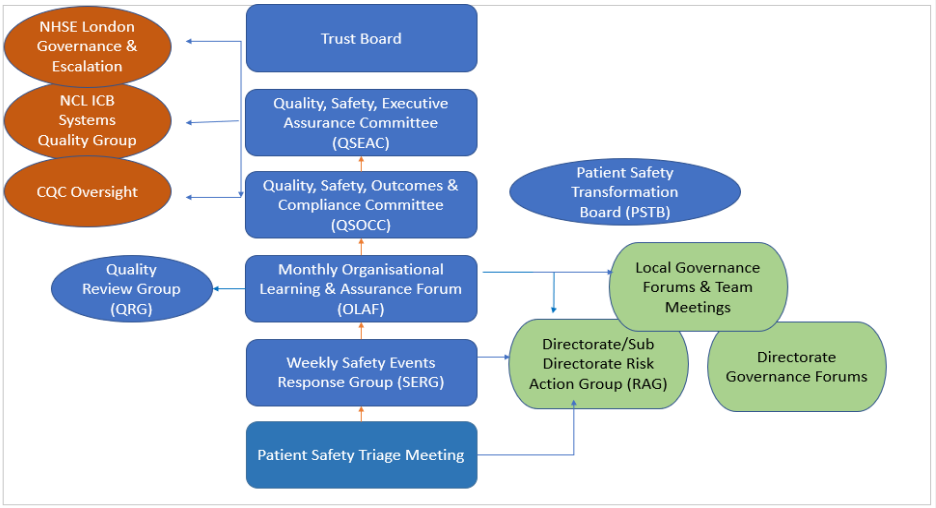
11.10 The focus of the OLAF will not be providing overall assurance on safety plan completion but an emphasis on measuring and monitoring outcomes. Key metrics will be reported to QSOCC monthly.

12. Oversight Roles and Responsibilities

12.1 Our oversight will be:

- Focused on enabling learning and improvement.
- Collaborative and compassionate.
- Supportive of creating psychologically safe opportunities for learning and improvement.
- Open and transparent.
- Systems and data focused.

12.2 The below diagrams outline the oversight responsibilities in relation to patient safety event decision making, and oversight of safety improvements plans. This is turn will inform ongoing review of the PSIRP, and outcomes reviewed against trust priorities and risks to inform organisational transformation:



12.3 North Central London ICB, NHS England Specialised Commissioning as our commissioner, and our regulator the Care Quality Commission (CQC) have specific responsibilities under PSIRF.

12.4 This links with the National Quality Board standards which include:

- A shared single vision of quality
- An overview of quality governance in an Integrate Care System.

12.5 We will share our oversight and monitoring reports with our ICB colleagues to provide assurance on the effectiveness of our PSIRP. We will work closely to develop our process and improvement measures collectively as we embed and learn utilising our new response tools and standards.

12.6 We will support ICB/NHSE led assurance visits.

12.7 The CQC will closely monitor and test the strength of our application of the PSIRF and associated patient safety event response standards as part of its assessment approaches. We will work closely with the CQC to ensure timely notification of high profile and complex events, as well as providing all statutory notifications as required by the Health and Social Care Act (2008) and set out in CQC's guidance on statutory notifications.

12.8 It is important that under PSIRF there is a shift from monitoring of process, timescales, and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients. It should be noted that similarly, the ICB's role will focus on the oversight of PSIRF plans/priorities and monitoring progress with

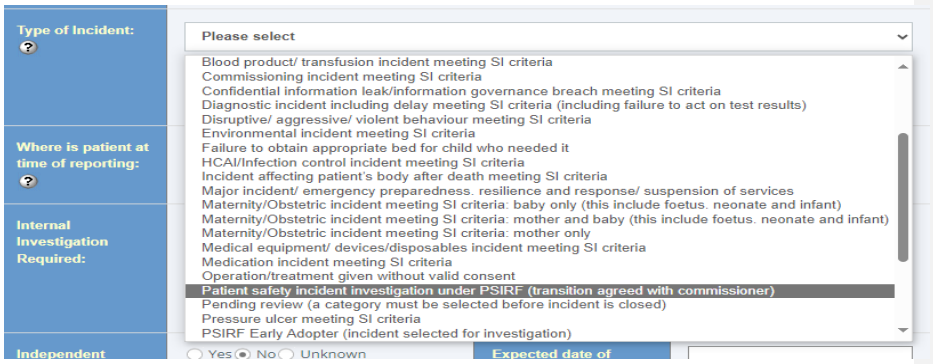
improvements. There will no longer be a requirement to “declare” a serious incident and have individual patient safety responses “signed off” by commissioners.

12.9 The ICB will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety. The metrics, measures (objective and subjective) and evidence required will be agreed in discussion with the ICB.

13. Undertaking a Patient Safety Incident Investigation (PSII)

13.1 Once it has been agreed at SERG that a safety event should proceed to a PSII, this will be reported on StEIS. The patient safety team will continue to report the incident on StEIS until advised further.

13.2 Colleagues will log into the StEIS system as normal to add an incident and complete the necessary fields. Under Type of Incident, the PST colleague will select “Patient Safety Incident Investigation under PSIRF”.



13.3 The PSII will be led by the patient safety team. The allocated staff members will liaise with the services affected to outline the support and subject matter experts from the directorates.

13.4 The (senior) directorate safety partner will engage with those affected by the safety event including the patient, families/carers and staff affected. They will outline the safety review process.

13.5 All affected will be involved in developing the terms of reference, the scope of the review and agree a timescale for completion. People will also be supported to engage in the review process, asking questions and have the opportunity to provide information for review.

13.6 Frequency for contact will be agreed for all involved in the review process and recorded on the log. Please see Appendix B.

13.7 The report writing process will be undertaken by the (senior) directorate safety partners. Upon completion on the national template (please refer to Appendix C), this will be shared with subject matter experts and Deputy Chiefs of Service for assurance that the system-based methodology has been undertaken and that all learning has been identified.

13.8 The above team, involving those affected by the patient safety event if they wish to be involved, should be involved in determining safety actions as outlined in section 11 of this policy. All action owners must be aware and agree to be responsible for safety actions.

13.9 As above, the team will be involved in identifying the level of involvement those affected by safety events wish to be in improvement activities.

14. Training requirements

14.1 The Trust has implemented a comprehensive patient safety training package, complying with the NHS Health Education England Patient Safety Training syllabus, to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events.

14.2 The table below lists the training requirements as outlined in the National Patient Safety Strategy:

Training Course	Applicable to	Outline
Level One: Essentials for Patient Safety	All staff	1. Listening to patients and raising concerns 2. The systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work 3. Avoiding inappropriate blame when things don't go well 4. Creating a just culture that prioritises safety and is open to learning about risk and safety
Level 2: Access to Practice	Clinical and Non-Clinical Staff at AfC Band 6 or above who have the potential to support or lead patient safety event responses.	Introduction to systems thinking and risk expertise (how we can identify and manage risk to keep patients' safe). Human Factors (the science of work and working together in safely designed systems) and safety culture (the significance of a true learning culture, free of inappropriate blame). This includes an assessment, which on completion staff will receive a certificate and have access to the sector specific sessions covering

		Mental Health, Maternity care, Acute care etc.
Level 3 & 4	Patient Safety Specialists	Certificate in Patient Safety and Human Factors.

14.3 GOSH colleagues with a responsibility for patient safety and quality have undertaken the recommended NHS syllabus training.

14.4 Any GOSH PSII will be led by a member of staff who has received a minimum of two days formal training and skills development. Training will include learning from patient safety events and gaining experience of patient safety responses. Records of such training will be maintained by the GOSH learning Academy. Learning response leads must also have completed level one and level two of the National Patient Safety Syllabus (NPSS).

14.5 Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Deputy Chief of Service (DCOS) with support from the Patient Safety team.

14.6 The patient safety team will oversee the After-Action Review (AAR) faculty which will provide guidance and support to services which wish to undertake AARs to identify learning following an event.

14.7 GOSH expect that staff leading learning response reviews are able to:

- Apply human factors and system thinking to principles to gather qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate highly complex matters in difficult situations.

14.8 Those with an oversight role on our Trust Board and Senior Leadership Team must have completed the Level 1 and Level 2 of the National Patient Safety Syllabus.

14.9 GOSH expect that staff in oversight roles are able to:

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement.
- Apply human factors and systems-thinking principles.
- Obtain (e.g. through conversations) and assess both qualitative and quantitative information from a wide range of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
- Recognise when safety actions following a patient safety incident response do not take a system-based approach.
- Summarise and present complex information in clear and logical manners and in report form.

15. Addressing Health Inequalities

15.1 GOSH recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

15.2 GOSH, as a public authority, is committed to delivering on it's statutory obligations under the Equality Act (2010) and will use data intelligently to assess for disproportionate patient safety risks to patients from across the range of protected characteristics.

We will also address apparent health inequalities as part of our safety improvement work. We understand that our services provide care to significant numbers of the Core20PLUS5 population cohort identified by NHS England and Improvement (2021). In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our plan and this policy. We consider this as an integral part of the future development process.

15.3 GOSH will identify themes related to learning disabilities/Autism (or other groups linked to Core20 Plus5) as there is evidence that there are greater safety concerns for these populations

15.4 Engagement of patient, families and staff following a patient safety event is critical to review of patient safety events and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety event response.

15.5 GOSH works within the national Learning Disability Improvement Standards that include the following in relation to patients with learning disabilities, autism or both:

- Trusts tell people if their care has raised safety concerns and what will be done to prevent recurrences
- Trusts must demonstrate that they learn from complaints, investigations, and mortality reviews, and that they engage with and involve people, families, and carers throughout these processes.

15.6 We strive to improve the service we provide for our local community, nationally and internationally, and provide better working environments, free of discrimination.

16. Engaging and Involving Patients, Families/Carers and Staff following a Patient Safety Event

16.1 It needs to be acknowledged that it can be a distressing time for patients and staff following an incident. The PSIRF recognises that learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety event response system that prioritises compassionate engagement and involvement of those affected by patient safety events (including patients, families, and staff). This involves working with those affected by patient safety events to understand and answer any questions they have in relation to the event and signpost them to support as required.

16.2 Engaging those affected by patient safety events is crucial to the work of patient safety. It is important that all staff involving families in this process are familiar with the Guide to "Engaging and involving patients, families and staff following a patient safety incident" and the "Learn Together" resources.

16.3 We are firmly committed to continuously improving the care and services we provide. We want to learn from any safety event where care does not go as planned, or expected by our patients, their families, or carers to prevent recurrence.

16.4 We recognise and acknowledge the significant impact patient safety events can have on patients, their families, and carers.

16.5 Getting involvement right with patients and families in how we respond to events is essential, particularly to support improving the services we provide. Part of this involves our key principles of always learning and being helpful whenever there is a concern about care not being as planned or expected or when a mistake has been made.

16.6 As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an event.

16.7 As part of our new policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Duty of Candour Policy.

16.8 In addition, the Trust has a Patient Advice and Liaison Service (PALS). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions. PALS can help and support with the following:

- Advice and information
- Comments and suggestions
- Compliments and thanks
- Informal complaints
- Advice about how to make a formal complaint

17. Patient Safety Partners (PSPs)

17.1 The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS in the UK.

17.2 PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

17.3 This role across the NHS will evolve over time, acting as a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

17.4 PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved, this may include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is our priority. As the role evolves, we may ask PSPs to participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the patient safety team to ensure PSPs have the essential tools and advice they need.

17.5 The PSPs will be supported in their honorary role by the Safety Surveillance Manager for the Trust who will provide expectations and guidance for the role. PSPs will have regular scheduled reviews and regular one-to-one sessions with our Safety Surveillance Manager and training needs will be agreed together based on the experience and knowledge of each PSP.

17.6 The PSP placements are on an honorary basis and will be reviewed after one year to ensure we keep the role aligned to the patient safety agenda as this develops.

18. Monitoring arrangements

18.1 This section must explain how the policy will be monitored, reviewed and updated. An example is provided below.

Policy element to be monitored	Lead	Audit Tool	Frequency	Reporting arrangements (Committee or group)	Response required on any issues/recommendations identified
PSIRF Process	Head of Patient Safety	Audit Outcomes Review	6 weekly	QSOCC	Assurance of implementation of PSIRF; review of resources required to implement change, overview and review of local priorities; identification and remedy of emerging themes.

19. Equality Impact Assessment

Prompting questions are included in the template below to help guide your completion of the Equality Impact Assessment.

Equality Analysis Form – Patient Safety Incident Response Policy

Title of Document:	Patient Safety Incident Response Policy
Completed By:	Head of Patient Safety
Date Completed:	
Summary of Stakeholder Feedback:	

Potential Equality Impacts and Issues Identified

Protected Group	Potential Issues Identified	Actions to Mitigate / Opportunities to Promote
Age	• Which age groups will the policy affect? • Could it disadvantage one age group over another? • Have you considered different age groups in your communication/ consultation plan?	Training materials will include information on supporting children and young people to be involved in the review and ensuring that they have the correct support available to them to do so.
Disability - including Learning Disability and hidden disabilities e.g. mental, physical or neurological conditions that are not obvious and can lead to misunderstandings, false perceptions, and judgments.	• Is the location covered by the policy accessible? • Have you considered people with disabilities (including learning disabilities in your communication/consultation plan? • Do you have alternative ways for people with disabilities to contact a service? • How will people who cannot read or write, or who have learning difficulties be able to use the service? • Does the area where the service is held contain suitable equipment, such as hearing induction loops?	*Patient Safety Team will support interpretation and implementation for staff.* Mental Capacity Act Lead and Safeguarding team are appropriately signposted within the policy to provide support. Ensuring that interpreters (e.g. BSL) are available and that letters/supporting information can be available in different formats (e.g., large font, Easy Read) *Staff will be provided with additional*

	• Will reasonable adjustments be required within the scope of the policy for staff with disabilities?	*support as required during meetings.* *Staff are signposted to wellbeing support channels and are supported by the Lead Reviewer and Directorate Senior Team.*
Gender Re-Assignment	• Are facilities such as toilets and bathrooms segregated on gender grounds? • Are staff trained to be able to work with people undergoing or have undergone gender re-assignment?	Not Applicable
Marriage or Civil Partnership	• Are equal rights given to people who are in a Civil Partnership as they would be to a married couple? • Is parental responsibility an issue with this policy?	Not Applicable
Pregnancy and Maternity	• Could pregnant women or mothers of young babies be affected by the policy?	Yes
Race	• Does the policy disadvantage one racial or ethnic group over another? • Does the service acknowledge differences in health belief? • Is the service flexible with regard to acceptable schedules of treatment? • How will people who do not speak English as a first language be able to use the service? • For a HR policy – do specific provisions need to be made during the operation of the policy for those staff who do not have English as their first language?	Ensuring that interpreters are available, and that letters/supporting information can be available in different formats and languages as required. Appropriate signposting in policy and letters. Ensuring that assessments are done to understand the family needs.
Religion or Belief	• Could the policy advantage one religion or belief over another?	Ensuring that support is available from appropriate people, e.g.,

	• Do staff understand belief systems and practices of the population? • When do religious festivals occur and what behaviour is expected from followers? • Will eating habits or proscribed foods impact on treatment? • For a HR policy - Will a member of staff's beliefs affect how they access the provisions of the policy? What is needed to ensure that all staff are able to access the provisions of the policy equally? • For a HR policy- Are staff with different beliefs and faiths likely to need specific provisions made within the scope of the policy?	religious leader or family or friend.
Sex	• Does the family set up, such as who is the primary carer, make any difference to how they will use the service? • Do gender roles within the family or society as a whole impact on service use? • For a HR Policy e.g. Parental leave - Could males find it harder to access the provisions of the policy? If so what can be done to ensure all staff can access the provisions equally?	Not Applicable
Sexual Orientation	• Does a person's sexual orientation influence how they might use a service?	

20. References

19.1 Revised Never Events Policy and Framework. NHS England 2021. https://www.england.nhs.uk/patient-safety/revised-never-events-policy-and-framework/

19.2 Health and Safety Policy. GOSH intranet.

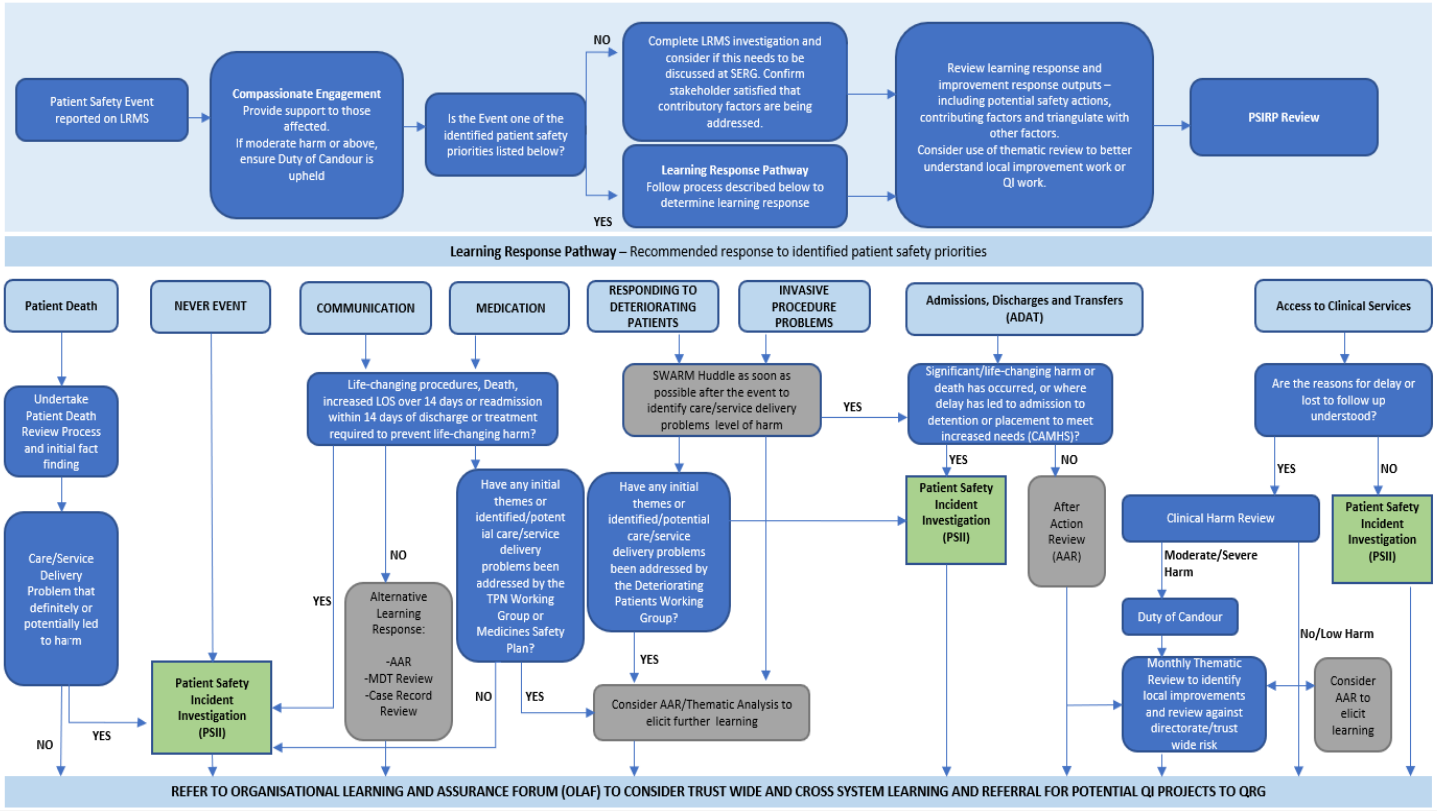
19.3 Patient Safety Incident Response Framework. NHS England 2020. https://www.england.nhs.uk/patient-safety/incident-response-framework/

19.4 A Just Culture. NHS England https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

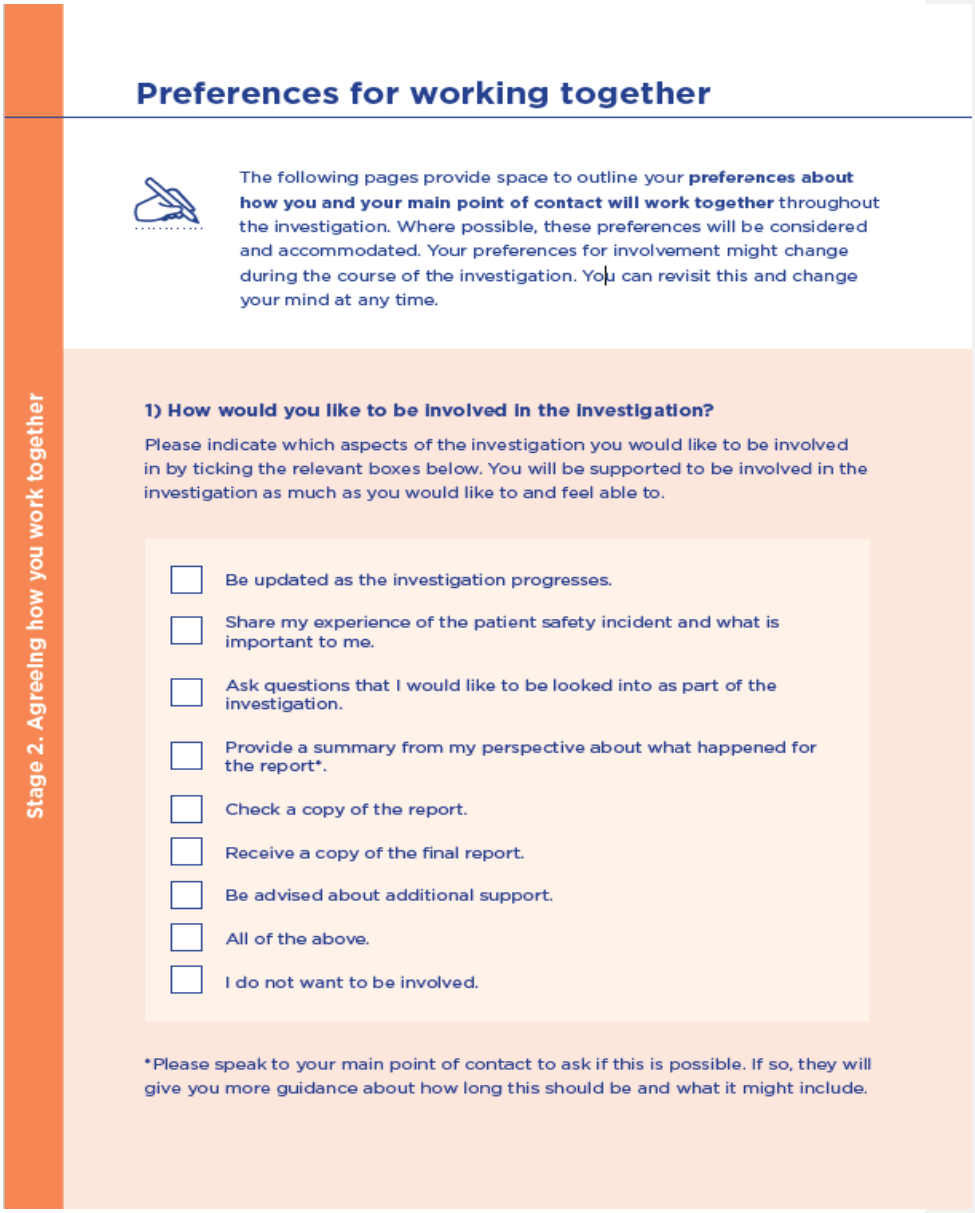
19.5 GOSH Being Open and the Duty of Candour Policy. GOSH intranet.

19.6 GOSH Complaints Policy. GOSH intranet. http://goshweb.pangosh.nhs.uk/clinical_and_research/CGST/Documents/Complaints%20Policy.pdf

Appendix A – Local Priorities Decision Making Algorithm



Appendix B – Involvement Resources for those affected by Patient Safety Events



Stage 2. Agreeing how you work together

Preferences for working together

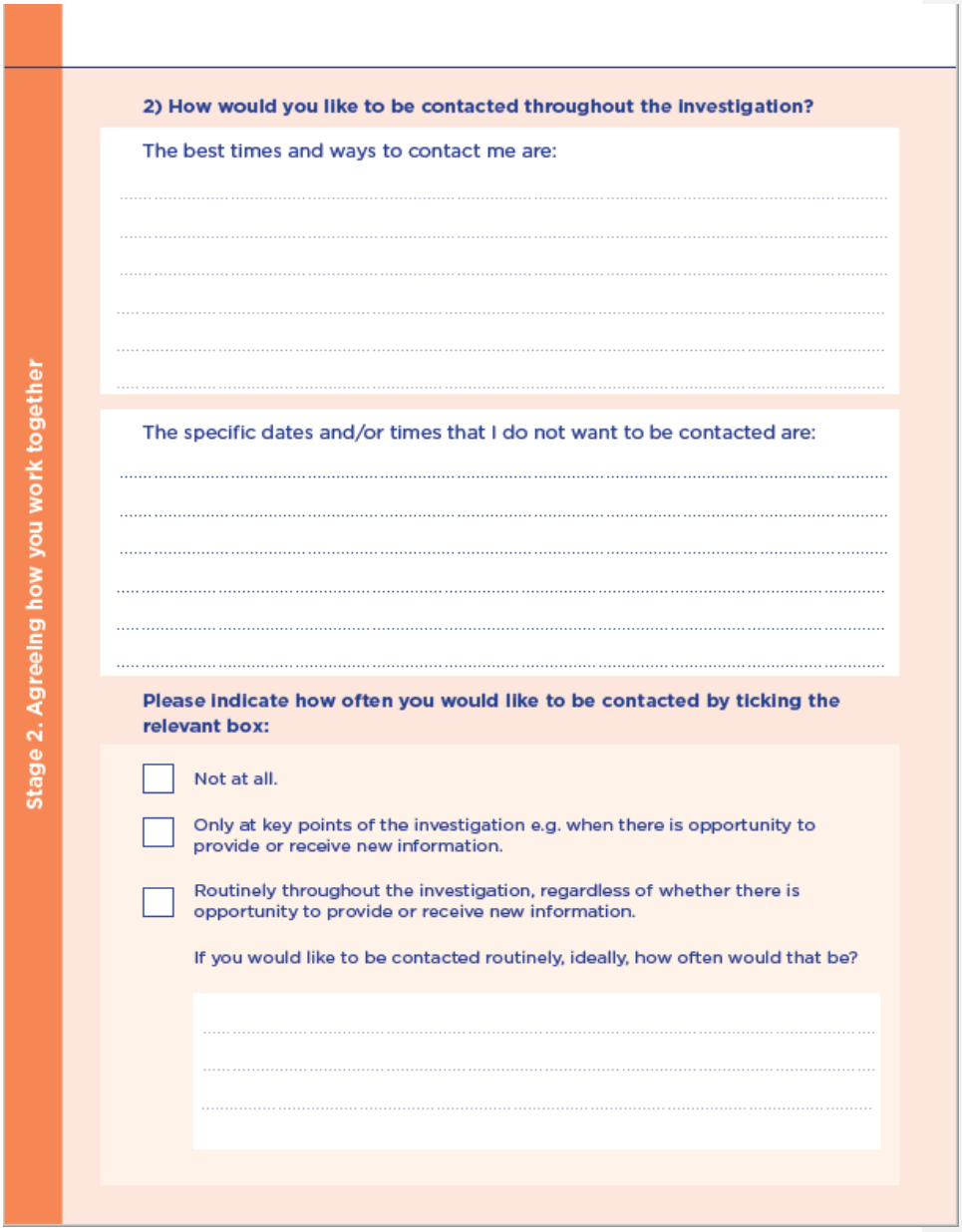
The following pages provide space to outline your **preferences about how you and your main point of contact will work together** throughout the investigation. Where possible, these preferences will be considered and accommodated. Your preferences for involvement might change during the course of the investigation. You can revisit this and change your mind at any time.

1) How would you like to be involved in the investigation?

Please indicate which aspects of the investigation you would like to be involved in by ticking the relevant boxes below. You will be supported to be involved in the investigation as much as you would like to and feel able to.

- ☐ Be updated as the investigation progresses.
- ☐ Share my experience of the patient safety incident and what is important to me.
- ☐ Ask questions that I would like to be looked into as part of the investigation.
- ☐ Provide a summary from my perspective about what happened for the report*.
- ☐ Check a copy of the report.
- ☐ Receive a copy of the final report.
- ☐ Be advised about additional support.
- ☐ All of the above.
- ☐ I do not want to be involved.

*Please speak to your main point of contact to ask if this is possible. If so, they will give you more guidance about how long this should be and what it might include.



PSII file name: **Use local naming convention. Always include the version number and/or document status**

Stage 2. Agreeing how you work together

3) What questions do you have?

4) What additional support might you need?

5) How would you, or the patient, like to be referred to within written communication such as the report? Please note, sometimes reports are anonymised.

6) Are there any other things that you would like your main point of contact to know?

What to do once you have completed these pages

You can show your main point of contact what you have written here or you can keep it private, but use it to guide your conversation. Your contact will try and meet your needs wherever possible.

PSII file name: **Use local naming convention. Always include the version number and/or document status**

Patient safety incident investigation (PSII) report

On completion of your final report, please ensure you have deleted all the blue information boxes and green text.

Notes on the PSII template

This national template is designed to improve the recording and standardisation of PSII reports and facilitate national collection of findings for learning purposes. This format will continue to be evaluated and developed by the National Patient Safety Team.

General writing tips

A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:

- use clear and simple everyday English whenever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short.

PSII file name: **Use local naming convention. Always include the version number and/or document status**

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

3 Distribution list

List who will receive the final draft and the final report (eg patients/relatives/staff involved¸ board). Remove names prior to distribution.

Name	Position

4 About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

5 A note of acknowledgement

Notes on writing a note of acknowledgement

In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc) who gave time and shared their thoughts.

You could consider referring to the patient by name or as 'the patient' according to their wishes.

Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements.

6 Executive summary

Notes on writing the executive summary

To be completed **after the main report has been written.**

6.1 Incident overview

Notes on writing the incident overview for the executive summary

Add a brief, plain English description of the incident here.

6.2 Summary of key findings

Notes on writing the summary of key findings for the executive summary

Add a brief overview of the main findings here (potentially in bullet point form).

6.3 Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.

Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.

Refer to the Safety action development guide for further details on how to write safety actions.

NB: The term 'lesson learned' is no longer recommended for use in PSIIs.

7 Contents

To update this contents table, click on the body of the table; select ‘update field’; and then ‘update page numbers only’; and then click ‘ok’.

8 Background and context

Notes on writing about background and context

The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.

It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

9 Description of the patient safety incident

Notes on writing a description of the event

The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.

Think about how best to structure the information – eg by day or by contact with different services on the care pathway.

It should be written in neutral language, eg ‘XX asked YY’ not ‘YY did not listen to XX’. Avoid language such as ‘failure’, ‘delay’ and ‘lapse’ that can prompt blame.

If the patient or family/carer has agreed, you could personalise the title of this section to ‘[NAME]’s story/experience’.

10 Investigation approach

10.1 Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:			

10.2 Summary of investigation process

Notes on writing about the investigation process

If useful, you should include a short paragraph outlining the investigation process:

- how the incident was reported (eg via trust reporting system)
- how agreement was reached to investigate (eg review of patient safety incident response plan, panel review, including titles of panel members)
- what happened when the investigation was complete (eg final report approved by whom)?
- how actions will be monitored.

10.3 Terms or reference

Notes on writing about scope

In this section you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:

- the aspects of care to be covered by the investigation
- questions raised by the those affected that will be addressed by the investigation

If those affected by the patient safety incident (patients, families, carers and staff) agree, they should be involved in setting the terms of reference as described in the Engaging and involving patients, families and staff after a patient safety incident guidance.

A template is available in the learning response toolkit to help develop terms of reference.

10.4 **Information gathering**

Notes on writing about information gathering

The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:

- investigation framework and any analysis methods used. Remember to keep jargon to a minimum (eg the investigation considered how factors such as the environment, equipment, tasks and policies influenced the decisions and actions of staff)
- interviews with key participants (including the patient/family/carer)
- observations of work as done
- documentation reviews, eg medical records, staff rosters, guidelines, SOPs
- any other methods.

Recorded reflections, eg those used for learning portfolios, revalidation or continuing professional development purposes, are **not suitable** sources of evidence for a systems-focused PSII.

Statements are not recommended. Interviews and other information gathering approaches are preferred.

11 Findings

Notes on writing your findings

The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.

You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.

Do not re-tell the story in the description of the patient safety incident. This section is about the 'how' the incident happened, not the 'what' and 'when'.

Start with an introductory paragraph that describes the purpose of the section and structure you are going to use.

For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.

You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

- by the themes you have identified during the investigation – in which case put your strongest theme first
- following the framework or the analytical method you used
- in chronological order corresponding to the care pathway described in the reference event, eg community care, ambulance service, acute care (taking care not to repeat the story of the reference event)
- in order of the main decision points during the incident.

Use clear, direct language, eg 'The investigation found…'

If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).

Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.

Areas for improvement that describe broader systems issues related to the wider organisation context are best addressed in a safety improvement plan. You should describe what the next stages are with regards to developing a safety improvement plan that will include meaningful actions for system improvement.

12 Summary of findings, areas for improvement and safety actions

Notes on writing the final summary

The purpose of this section is to bring together the main findings of the investigation.

Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).

If no actions are identified the safety action summary table is not required. Instead you should describe how the areas for improvement will be addressed (eg refer to other ongoing improvement work, development of a safety improvement plan)

12.1 **Safety action summary table**

Area for improvement: [eg *review of test results*]								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***	**Planned review date** ***(eg annually)***
1.								
2.								
…								

Area for Improvement: [eg *nurse-to-nurse handover*]								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***	**Planned review date** ***(eg annually)***
1.								

…								

13 Appendices

Notes on appendices

Include any necessary additional details such as explanatory text, tables, diagrams, etc (Delete this section if there are none).

14 References

Notes on references

Include references to national and local policy/procedure/guidance, and other data sources as required.

14.1

Attachment Y

Great Ormond Street Hospital for Children
NHS Foundation Trust

Summary of the Quality, Safety and Experience Assurance Committee meeting held on 28 November 2023

Quality and Safety at GOSH – Chief Medical Officer Report

The Committee reviewed a report published by Sands & Tommy's Policy Unit which, although not directly applicable to GOSH, had learnings that could be considered in the round, particularly around prioritising the agenda for discussion at QSEAC meetings. An update was given on key projects which were taking place at GOSH and the preferred option for the provision of high dependency care at GOSH which was likely to impact up to 20% of inpatient beds in the Trust.

Discussion took place around clinical outcomes, and it was agreed that work would take place in the medium term to focus on outcomes for healthcare professionals other than doctors which were not as frequently collected or reported. It was noted that work was taking place in DRIVE to develop an intelligent system which would support the identification of specific data such as outcomes by consultant.

Work continued to take place to identify themes from incident data and it was noted that GOSH's top 5 incidents changed on a monthly basis. Categorisation of incidents would improve once Learning from Patient Safety Events (LfPSE) had been implemented. The Committee discussed reporting at GOSH and the importance of considering this in terms of the trend of reporting.

Quality and Patient Experience: Chief Nurse Report

Infection Prevention and Control

As a result of the introduction of additional screening, good progress was being made in reducing the incidence of Carbepenamase Producing Enterobacteriaceae (CPE) and Candida remained an organism of focus due to its treatment resistant nature. The Infection Control team continued to work in partnership with the Estates and Facilities team and the Committee noted that there had been considerable staff turnover in some areas which was impacting the consistency around projects and approaches.

Patient Experience

The theme around all forms of feedback had been cancellations and some families had also been unhappy about the short notice at which cancellations had been communicated and the practical and emotional impact of this. The Committee noted that during the periods of industrial action a decision had been made to avoid cancelling patients until later in order to see as many patients as possible and acknowledged that this had affected patients and family experience of the hospital. Complaints were also related to bed closures and focus was being placed on bed management and an action plan was being developed. An external organisation expert in managing waiting lists was reviewing the way in which GOSH booked patients and had identified some nuances between long waiting and the management of complex patients' bookings.

Safeguarding

A single referral mechanism and data collection via Epic had been introduced for Safeguarding and Social Work and which had supported the aim of streamlining service provision. A 'break the glass' process was in place on Epic to safeguard this data. There were challenges around the perplexing presentation service and a business case to provide additional support was being considered by the Operations Board in December

2023. The Committee reviewed future reporting metrics which were planned for the service and emphasised the importance of ensuring that they were quality based rather than activity based.

Health and Safety Update

There had been an improvement in the RAG rating of health and safety walkrounds which had moved to a green rating and a large amount of waste had been removed from key areas. A new Fire Officer had joined the team who was very experienced.

Safety Transformation Update

The work that had taken place on the safety transformation programme in the last 16 months had led to the Trust moving from a 'reactive' to 'active' rating on the patient safety maturity index. The action plan had been reviewed and three priorities identified for the next twelve month's work. The Committee noted that there were only a very small group of Trusts seeking to work in this way and said that it would be important to undertake research in this area.

Update on actions following NHS England commissioned External Learning Review

There had been 18 recommendations made in report of which 59% had been completed and 23% would be completed in three months. The Committee noted that a large number of the issues raised in this case had arisen as a result of the lack of guidance and support which would have been provided by the palliative care team and it was agreed that data would be reviewed by the Committee on the proportion of patients who accessed the service to understand who was using the service.

Freedom of Information Act Annual Update 2022/23

In the last five weeks a large proportion of the backlog of open FOI requests had been closed and it was anticipated that the backlog would be largely cleared by the new year. A very small team was managing a large number of requests and the Committee noted the challenge around ensuring that information was provided by teams in a timely manner. The requests varied considerably in complexity and a KPMG review of the FOI process had shown that GOSH received a larger number of requests that other organisations of its size.

Internal Audit Update of quality related reports

There were two internal audits with a quality focus on the 2023/24 audit plan and the fieldwork had been completed for the review of complaints. There were two overdue actions arising from previous reports, one of which, a high priority action, had now been closed.

Update on quality related Freedom to Speak Up cases

There had been 53 contacts in the reporting period which was an increase over the quieter summer period. The Committee highlighted the importance of triangulating the data particularly as the data set was very small.

BAF Deep dive

<u>BAF Risk 19: Transformation</u>

The areas of transformation which were prioritised were driven by the Trust's strategy and transformation was run through the future hospitals board which provided a governance structure for oversight by the Executive Team and Trust Board. KPIs would be implemented for the programme and there was continued monitoring for unintended consequences.

Surgical outliers (SNAPs)

The matter had been escalated from the Risk Assurance and Compliance Group as, due to the capacity of the SNAPs service, the majority of patients were outliers on different wards, and some had required readmission to critical care. This issue was partly linked to bed closures however there remained a mismatch between demand and capacity and initially eight additional beds had been identified which

would be opened incrementally as staffing became available. It was confirmed that appropriate policies were in place to ensure that outlying patients were clinical well managed however it was noted that in general it was beneficial for patients to be in the location associated with their home specialty.

The Committee noted an update from the September meeting of the People and Education Assurance Committee.

Update from the Risk Assurance and Compliance Group on the Board Assurance Framework
The Committee agreed to recommend the proposed controls, assurances, and actions as well as gross and net risk scores for the Transformation BAF risk to the Board for approval.

The Committee agreed that the CYP Gender Services risk remained an operational risk and would be added to the trust-wide risk register.

QSEAC self-assessment questions 2023/24
The Committee approved the self-assessment questions and noted that in addition to those who attended the QSEAC as a member, attendee or presenter, those Executive and Non-Executive Directors who did not attend QSEAC would also been asked whether they felt assured by the work of the committee.

QSEAC Workplan 2023/24
The Committee emphasised the importance of considering the report from Sands and Tommy's Policy Unit which was clear about the impact of a large number of agenda items with a lack of time for interrogation and discussion. It was agreed that two deep dives would take place at each QSEAC meeting and that additional time would be allocated to support discussion.

Escalations to Board and deep dives for next meeting
The Committee agreed that the following matters would be escalated to the Trust Board:

- Waiting lists and long waiting patients
- Safety transformation programme update
- Update on actions following NHS England commissioned External Learning Review
- Freedom to Speak Up Guardian Report

Governor feedback
Governors welcomed the diverse range of topics which had been discussed.

Attachment Z

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Audit Committee meeting held on 24th January 2024

Trust Board assurance committee updates

The Committee noted updates from the following assurance committee meetings:

- Quality, Safety and Experience Assurance Committee –October 2023
- People and Education Assurance Committee – November 2023
- Finance and Investment Committee – November and December 2023

Board Assurance Framework (BAF) Update (from the Risk Assurance and Compliance Group)

The summary BAF is presented to the Trust Board for review (see Appendix 1 – full BAF in the reading room)

The Audit Committee considered the BAF risks at the January meeting and agreed the following recommendations to the Trust Board:

Business Continuity BAF risk

The Business Continuity BAF risk has been redrafted following comments at the October 2023 Audit Committee meeting about the risk needing to be broader rather than positioned within a time specific context. The Audit Committee recommend a revised risk statement for the Business Continuity BAF risk:

FOR APPROVAL:

The trust is unable to deliver normal services and critical functions caused by unexpected events; external challenges (global/ social/ political/ technological/ environmental) and/ or inadequate business continuity planning. Impact: An adverse effect on the trust's operational performance and continuity of delivery of safe, effective care.

Children's Cancer Centre BAF risk

The RACG had reviewed and updated aspects of the risk statement to reflect assurances provided by the Gateway Review and Camden Council Planning approvals. It was noted that this was a interim risk statement whilst the risk profile of the CCC programme was under review. The Audit Committee reviewed the proposed revised risk statement and emphasised the importance of ensuring that the focus of the risk was on delivery of a modern cancer service which was supported by the development of the cancer centre building. It was also agreed to add reference to the risk around demand for the service not being realised/ changing over time. Audit Committee members reviewed the risk statement outside of the Committee meeting and recommend this for approval by the Trust Board (new text in green):

FOR APPROVAL:

Failure to deliver a modern Cancer Service at GOSH supported by development of a new Children's Cancer Centre that provides holistic, personalised and coordinated care.

This risk incorporates the following:

- *Transformational programme is not delivered to plan and on time and does not:*
  - *deliver holistic, personalised, and coordinated care.*

  - *meet expectations for an enhanced patient experience.*
  - *Deliver agreed sustainability targets.*
- *GOSH Charity Fundraising target not achieved/ Trust financial position worsens (BAF Risk 1: Financial Sustainability)*
- *Decant of the site is delayed with a subsequent delay to works commencing.*
- *Risk of redevelopment timetable slipping with associated operational and financial impact.*
- *Risk that the demand and capacity modelling is not realised and/or changes over time.*
- *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.*

The Committee discussed the proposed Trust wide risk about the development of a gender service and it was suggested that the risk would be split into short, medium and long term aspects of the service. The Committee agreed the status of the risk as a Trust wide risk.

Board Assurance Framework Deep Dives

- BAF Risk 10: Climate Emergency

The Trust continued to work towards meeting the commitments set out in the climate emergency declaration and the key area for consideration was combined heat and power which would involve consideration of funding and space. This would be incorporated into the master planning process and the 10-year financial plan. Good engagement was being experienced from colleagues and Governors who had requested that all topics of discussion included a sustainability element. Discussion took place on the building of the cancer centre and it was noted that as well as the efficiency of the building itself, assurances had also been received about the efficiency of the construction programme.

- BAF Risk 17: International and Private Care

The Committee discussed the wider purpose of providing International and Private Care services and the philosophy of GOSH as an international paediatric hospital but emphasised the importance of ensuring that appropriate focus could always be provided to NHS patients, some of whom were on long waiting lists.

EPIC Benefits realisation

The use of Epic as an enabler to support transformation was noted as was the importance of bringing together transformation objectives in areas across the Trust. The Committee highlighted the importance of benefits such as the way Epic supported clinicians to provide better care or make improvements in areas such as clinic letter turnaround. A 'Thrive' programme was beginning which would focus on the Trust's use of Epic to optimise and modernise healthcare.

Write offs

There had been a reduction in the number of waivers being received and the Committee discussed the processes for managing stock in pharmacy following the write off costs associated with one item with a short life. It was noted that substantial work had taken place in this area as part of the Epic programme and improvements had been made.

External Audit 2023/24 Progress update

The scope of the 2023/24 audit would be consistent with that of the previous year and a new area of significant risk had been identified which was the recognition of NHS revenue. In the event that this was agreed prior to

year-end the matter would be downgraded to an area of focus. There had been some changes to reporting deadlines and the Value for Money audit which had been brought into line with the audit opinion and it had been agreed that work would take place to conclude in April 2024. New disclosures were required around sustainability, and this was primarily focused on the Trust's governance arrangements.

Internal Audit Progress Report (November 2023 – January 2024)

Two reports had been received: a review of Intellectual Property and Human Tissue Authority which provided a rating of *partial assurance with improvements required*; and complaints management which provided a rating of *significant assurance with minor improvement opportunities*. It was agreed that discussion would take place at the Risk Assurance and Compliance Group on the gaps which had been identified by the review of the management of human tissue.

Three actions from previous reports were overdue and revised deadlines had been provided and the auditors were confident of completion.

Local Counterfraud Progress Report

The Committee expressed some concern about the timeliness with which investigations were taking place and emphasised the impact on individuals and teams of ongoing investigations and delays. It was agreed that further information would be provided at future meetings about the actions which were taking place to progress cases.

Year End Update

A new process had been introduced whereby management judgements would be discussed and quantified at the Audit Committee in March 2024. The finance team continued to work with the external auditors on the approach to the audit and it was not anticipated that there would be any changes to accounting policies, however there had been a number of strategic developments in the Trust throughout the year.

Audit Committee Effectiveness Survey Questions

The Committee approved the proposed questions for the annual Audit Committee effectiveness survey.

Procurement Waivers

Focus was being placed on ensuring that appropriate documentation was in place for waivers and ensuring that standard procurement processes were followed wherever possible.

Governor feedback

Governors welcomed the continued focus on sustainability and discussion took place around cyber risks. It was noted that the external auditors would report on the Trust's internal controls in relation to cyber as part of the year end audit. Discussion took place around the focus that was being placed on staff exit interviews.

Great Ormond Street Hospital for Children NHS Foundation Trust: Board Assurance Framework (1 February 2024)

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**	09/01/2024	Finance and Investment Committee	March 2023 October 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**	08/01/2024	People and Education Assurance Committee	June 2023 Board workshop February 2024
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 Layther, John Quinn, Rebecca Stevens/ Richard Brown**	16/11/2023	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**	05/01/2024	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	**Zuman Hussein, Chief Data Officer**	16/11/2023	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	**Kiki Syrad, Director of R&I/ Lorraine Hodson**	03/01/2024	Audit Committee	January 2023 At October 2023 Trust Board
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**	14/12/2023	Audit Committee	March 2023 October 2023
8	Business Continuity Revised BAF risk statement subject to approval at February 2024 Trust Board	**Principle 3: Safety and quality/ Principle 5: Protecting the Environment**	**Priority 2: Deliver a Future Hospital Programme**	PROPOSED RISK STATEMENT: The trust is unable to deliver normal services and critical functions caused by unexpected events; external challenges (global/ social/ political/ technological/ environmental) and/ or inadequate business continuity planning. Impact: An adverse effect on the trust's operational performance and continuity of delivery of safe, effective care.	TBC	**TBC**	TBC	**TBC**	**TBC**		Chief Operating Officer	**Rachel Millen, Emergency Planning Officer/ John Quinn, Chief Operating Officer**	Risk statement under review	Audit Committee	March 2023 Risk under revision

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							
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 and Place	**Jason Dawson, Interim Director of Space and Place**	08/01/2024	Audit Committee/ QSEAC	Jan 2023 (QSEAC) June 2023 (QSEAC) May 2024 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 Emergency declaration (by 2040 for the emissions the Trust controls and influences).	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/ Nick Martin**	04/01/2024	Audit Committee	June 2023 January 2024
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**	3 x 5	**15**	**Averse**	1-2 years	Chief Operating Officer	**Jane Ballinger, Chief Pharmacist/ Nick Towndrow, GM/ John Quinn, Chief Operating Officer**	03/01/2024	Quality, Safety and Experience Assurance Committee	June 2023 September 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**	17/11/2023	Quality, Safety and Experience Assurance Committee	Reports on quality of services at every Board and QSEAC
13	Mental Health Strategy	**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**	16/11/2023	Quality, Safety and Experience Assurance Committee	New risk September 2023 May 2024
14	Culture	**Principle 2: Values led culture**	**Priority 1: Make GOSH a great place to work**	There is a risk that GOSH fails to develop a culture where our people feel well led, well managed and are 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**	08/01/2024	Trust Board/ People and Education Assurance Committee	May 2023 June 2023 (Board session)
15	Cancer Centre Revised interim BAF risk statement under review following January 2024 AC	**All Strategy Principles**	**Priority 6: Create a Children's Cancer Centre to offer holistic, personalised and coordinated care**	PROPOSED RISK STATEMENT: *Failure to deliver a modern Cancer Service at GOSH supported by development of a new Children's Cancer Centre that provides holistic, personalised and coordinated care.* *This risk incorporates the following:* • *Transformational programme is not delivered to plan and on time and does not:* ○ *deliver holistic, personalised, and coordinated care.* ○ *meet expectations for an enhanced patient experience.* ○ *Deliver agreed sustainability targets.*	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**	04/01/2024 Risk statement under review	Finance and Investment Committee	March 2023 September 2023 November 2023 TB

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							
				• *GOSH Charity Fundraising target not achieved/ Trust financial position worsens (BAF Risk 1: Financial Sustainability)* • *Decant of the site is delayed with a subsequent delay to works commencing.* • *Risk of redevelopment timetable slipping with associated operational and financial impact.* • *Risk that the demand and capacity modelling is not realised and/or changes over time.* • *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**	29/12/2023	People and Education Assurance Committee	September 2023
17	IP&C and Commercial	**Principle 4: Financial Strength**		The risk that the financial sustainability of the Trust is significantly impeded by a failure to deliver IP&C and commercial contribution targets.	**4 x 4**	**16**	**3 x 4**	**12**	**Cautious**	1-2 years	Chief Operating Officer/ Chief Finance Officer	**John Quinn/ John Beswick/ Chris Rockenbach**	05/01/2024	Finance and Investment Committee	NEW risk September 2023
18	Health Inequalities	**Principle 3: Safety and quality**	**All priorities**	The Trust's strategies, systems, processes, policies and service delivery exacerbate health inequalities of our patients (differences in the care people receive and the opportunities they have to lead healthy lives (Kings Fund – June 2022)), impacting negatively on their physical and mental health status, their access to care and services and the quality and experience of the care provided.	**4 x 4**	**16**	**3 x 4**	**12**	**Minimal**	1-2 years	Chief Nurse	**Tracy Luckett, Chief Nurse/**	16/11/2023	Quality, Safety and Experience Assurance Committee	November 2023
19	Transformation	**All Strategy Principles**	**All priorities**	Failure to establish an environment (capability, culture, resources, systems and processes) to transform services thereby hampering delivery of improvements in patient safety and experience, service design and productivity and efficiency.	**4 x 4**	**16**	**3 x 4**	**12**	**Cautious**		Chief Operating Officer	**John Quinn, COO/ Jennifer McCole, Director of Transformation**	20/11/2023	Finance and Investment Committee/ Quality, Safety and Experience Assurance Committee	November 2023 QSEAC

GOSH BAF Risks – Gross Scores February 2024

Likelihood		Consequences				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain				9. Estates Compliance; 10. Climate Emergency	7. Cyber Security; 1. Financial Sustainability; 11. Medicines Management
	4 Likely			16. GOSH Learning Academy	5. Unreliable data; 17. IP&C; 12. Inconsistent delivery of safe; 18. HIE; 4. Integrated Care System; 19. Transformation; 15. Cancer Centre; 14: Culture; 2. Workforce Sustainability TBC; 13. MH Strategy	3. Operational Performance; 8. Business Continuity
	3. Possible					6. Research Infrastructure and resourcing
	2. Unlikely					
	1.Rare					

GOSH BAF Risks – Net Scores February 2024

Likelihood		Consequences				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain					
	4 Likely			5. Unreliable data; 8. Business Continuity	9. Estates Compliance; 10. Climate Emergency	1. Financial Sustainability
	3. Possible				14: Culture; 17. IP&C; 2. Workforce Sustainability TBC; 19. Transformation; 13. MH Strategy; 18. HIE; 12. Inconsistent delivery of safe; 15. Cancer Centre; 4. Integrated Care System	11. Medicines Management; 3. Operational Performance; 7. Cyber Security
	2. Unlikely			16. GOSH Learning Academy	6. Research Infrastructure and resourcing TBC	
	1.Rare					

QSEAC & Audit Committee; QSEAC; Audit Committee; Trust Board; People and Education Assurance Committee; Finance and Investment Committee; FIC & QSEAC

Finance and Investment Committee update

Since the last report to the Audit Committee there have been three Finance and Investment Committee (FIC) meetings:

Date & meeting type	Summary of meeting purpose
Friday 17 November 2023	An extraordinary confidential meeting was arranged to consider approval of the Children's Cancer Centre 'Advanced Works' proposal for which the Trust Board had delegated authority to the Finance and Investment Committee.
Monday 20 November 2023	An extraordinary confidential meeting was arranged to consider approval of a forecast outturn for the 2023/24 financial year. The outturn was requested by NHSE/I and all Non-Executive Directors (including the Chair) were invited to this meeting. The Chair delegated responsibility for this approval to the Finance and Investment Committee. Also for approval, was a self-certification assurance on outpatient recovery return.
Friday 1 December 2023	A scheduled meeting with a standard agenda: Finance report, Performance report and Capital Projects update.

This report summarises the key developments and discussions arising from these meetings. Where possible, minutes of these meetings are available from Paul Balson, Head of Corporate Governance (Paul.Balson@gosh.nhs.uk).

Children's Cancer Centre (CCC) advanced works proposal - Friday 17 November 2023

Advanced works on the CCC were proposed to maintain programme activity whilst the other organisational governance and approvals processes are completed ahead of main construction. The Committee sought assurance that the advanced works satisfied the following criteria:

- Social value – it was the right thing to do for patients and families.
- They offered the Trust value for money.
- The stated costs were accurate, affordable and not a risk to the Trust's short- and long-term financial sustainability.
- The robustness of the construction partner's finances.
- The works could be delivered on time.
- The award of funds for advance works would have no bearing on the award of the main construction contract.
- The sum quoted was a maximum sum for the works that would not be exceeded.

- That a full risk assessment of the planned patient pathways, business continuity, fire arrangements, infection control practices and other key areas would be required before any physical works could commence.

Following discussion and assurance, the Committee approved the release of funds for commencement of advance CCC works.

Trust forecast outturn for financial year 2023/24 - Monday 20 November 2023

The Deputy Chief Finance Officer presented the rationale for the underlying assumptions of the worst, best and likely case forecast outturns. The Committee discussed the Trust's options as well as the recent and future financial challenges faced by the NCL ICS and other London ICCs.

The Committee approved the likely scenario for the 2023/24 financial year for submission.

At the 1 December 2023 meeting, the Chief Finance Officer provided an updated position.

Self-certification assurance on outpatient recovery - Monday 20 November 2023

The Committee approved the Trust submission of a series of assurances requested from NHS England in regard the protection and expansion of elective capacity with focus on outpatient recovery.

Finance updates on the wider environment – 1 December 2023

Committee members discussed the following external financial issues and the potential implications for GOSH:

- The financial impact of industrial action on partner Trusts in the Children's Alliance and how they compared to GOSH.
- Plans for how the Trust could improve its levels of research income.
- Trust preparations for the 2024/25 financial year.
- Trust plans to decarbonise the Estate.

Finance Month 7 report – 1 December 2023

The Trust position at Month 7 was a £13.6m deficit year to date. This was £11.6m adverse overall to plan.	Strike action had impacted performance by £5.5m.	International and Private Care income was £1.9m lower than planned

Performance Month 6 report – 1 December 2023

The Committee discussed 'long waits', the 'Harm Review' process undertaken to assess the impact long wait has on patients and requested that the Trust Board receive a demographic review of long waiters.

The Committee requested a review of how long waiters received from other Trusts are coded and how it related to income.

Children's Cancer Centre Update – 1 December 2023

The Committee was informed that the CCC team were working up a detailed process map inclusive of risk workshops, processes for ensuring value for money and measuring disruption during decants and construction.

Major projects update – 1 December 2023

The Committee noted the updates and requested that future iterations of the report include how the projects fit in within their wider programmes of work.

End

Great Ormond Street Hospital for Children NHS Foundation Trust

Key Points from the People and Education Assurance Committee (PEAC) held on 29 November 2023

Workforce Metrics

- In October 2023 targets were achieved for four of the six key workforce metrics (vacancy, voluntary turnover, agency spend and statutory and mandatory training).
- Turnover rates have continued to reduce in recent months and were 12.4% for October 2023. This is the lowest rate since July 2022. The voluntary turnover rate has been reducing for eight consecutive months
- The vacancy rate was 7.5% which is 1.9% reduction on the previous month which is as result of the new joiners increasing headcount.
- Sickness was at 3.7% which is above the Trust's local target of 3 but below the NHS average of 4.8%.
- PDR rates were at 79% against the Trust target of 90%. The October rate for PDR of 80% is a decrease on the 12-month average. HR Business Partners are engaging with Directorates to address areas below target. A project to improve the PDR process is underway and it is included in the recently launched updated GOLD system.

Nursing Workforce Assurance Report

- The registered nurse vacancy rate increased in September 2023 to 14.11% which is above the Trust target of 10% and higher than last year and the pre-pandemic level. It is anticipated that this will drop to 8.8% (unvalidated) following the intake of newly registered nurses being reflected in the numbers.
- Voluntary turnover of registered nurses remained stable at 16.3% in September 2023 but remains above the Trust target of 14%. Retaining nursing staff continues to be a challenge. The most common reasons for leaving are Relocation and Promotion (both 19.3%) followed by work life balance (12.7%) and Education and training (5.7%).
- There is a high turnover of newly qualified nurses with some dropping out during training. There are a number of retention initiatives in place, such as the STAY plan, retention insight meetings, masterclasses and drop in clinics all of which are regularly promoted.

People Strategy Update

- The refreshed People Strategy was approved by the Trust Board in July 2023 and will be supported by three frameworks. Two existing frameworks, Seen and Heard (D&I) and Mind, Body and Spirit (H&WB) are currently being refreshed in consultation with staff through their representatives and advocates including the networks. The Trust will add a third framework to cover the commitments relating to culture and engagement to provide focus and support delivery.
- Work in some areas of the new Culture and Engagement Framework is already underway, such as reward and recognition but others, such as reviewing the Trust's values, will commence shortly.

Seen and Heard Annual Report

- Key achievements over the last 12 months include:
  - BAME representation in the workforce has been increased by 2% to 37%.
  - An increase in BAME staff at bands 8A-C by 8.3%.
  - A reduction in the relative likelihood of white candidates being appointed from a ratio of 2.05 to 1.82.
  - A reduction of BAME staff reporting experiencing harassment from 17.7% to 16.4%.
  - 3.7% of staff have declared a disability on the NHS Electronic Staff Record (ESR). This is an increase from 3.1% in 2022.
  - 68.3% of Disabled staff felt that their employer had made adequate adjustments. A year-on-year increase from previous years.

- In the coming year, the activities and initiatives for the team will be:
  - Opening up external recruitment, promoting GOSH as a creative, diverse and include employer of choice.
  - Creating internal career paths and opportunities for progression and ensure fair and transparent access to jobs, training and education.
  - Creating a more inclusive work culture for all to build understanding, connectivity, and support value-based people management practice.
  - Creating channels and safe spaces which amplify the employee voice, ensuring that we listen, hear and take action as a consequence.

Staff Voice: Chaplaincy and Spiritual Care

- Reverend Dorothy Moore Brooks has been at the Trust for 20 of the last 22 years and most recently been appointed Acting Lead Chaplain and Head of Spiritual Care.
- In her early days at the Trust, Rev Brooks had been lucky to meet the late Queen Elizabeth and in subsequent years has been encouraged to stay due to the amazing people she has worked with. As Chaplain, Rev Brooks felt privileged to journey the highs and lows with many patients and their families for days, months and sometimes years.
- On average, the Chaplaincy Service supports 40 staff, patients and families a day, with the service running 24/7, 365 days a year. Providing the service out of hours is particularly important. Rev Brooks felt blessed to have such an amazing skilled team of Chaplain Volunteers, including the Rabbi, who is contracted to 1 day a week but works tirelessly when the community is in need. Whilst it is an honour to run and be part of the service, Rev Brooks noted how hard it can be for the team who can go from supporting a birthday party to an end of life ritual but regardless always strive to provide present, professional and sustainable care. The team do a lot of work supporting events and festivals which facilitates the opportunity to engage in hope, community and peace.

Annual Report on relations with staff partners and union representatives

- The past 12 months have seen a complex and challenging environment across the NHS, dominated by unprecedented strike action, with a wide range of Trade Unions securing mandates for action as a result of disputes with the government over pay and conditions.
- The Trust has been affected to a greater extent than other hospitals as not only has the Trust been impacted by strike mandates secured on a national basis by the BMA Junior Doctors committee and BMA Consultants committee, but also by local (Trust specific) mandates secured by the Royal College of Nursing, UNISON, the Chartered Society of Physiotherapy, and Society of

Radiographers. Whilst challenging at times, the Trust's approach has been respected and appreciated by Trade Union colleagues, with the RCN Regional Oversight Committee singling out GOSH and commenting on the Trust's exemplar approach and an example of positive partnership working.

Freedom to Speak Up Service Update: July 2023 – September 2023 (Q2)

- Forty people raised a concern with the FTSU service during the second quarter. Patient safety/ quality of care and staff safety/ wellbeing was reported as the most prominent theme, with nursing staff raising the most contacts with the service. Funding has been secured for a dedicated Wellbeing Officer to support staff and keep communication flowing so those raising concerns are clear on the steps being taken and feel psychologically safe.
- There is ongoing work to ensure the FTSU Guardian profile is raised throughout the hospital; and the Guardian is working with teams to meet with staff in harder to reach areas, such as Space and Place. In addition, drop-in sessions have been held twice a week in the Sight and Sound building and meetings in the staff wellbeing hub, The Hive.
- There have been no anonymous contacts raised in the quarter and there have been no notifications of people feeling they have suffered a detriment as a result of speaking up**.** The FTSU Guardian is developing a survey to circulate in the New Year, asking staff if they have felt unable to speak up and what stopped them from doing so, as well as seeking feedback from those who have gone through the process.

Staff Focused Whistleblowing Concerns

- No new cases had been raised since the last meeting.

Update on the Board Assurance Framework (BAF)

- All risks were updated by risk owners in August 2023 and have been reviewed by the Risk Assurance and Compliance Group and Audit Committee in October 2023. No changes have been proposed to the gross or net risk scores at this time.

People and Education Assurance Committee Terms of Reference

- The terms of reference had been updated to reflect the new People Strategy themes and workstreams.

Attachment 2

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
7 February 2024

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 2** ☐ **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
20 December 2023	Children's Cancer Centre Advanced Works Letter of Instruction.	JQ, MS

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