

Meeting of the Trust Board Thursday 29 January 2026

Dear Members

There will be a public meeting of the Trust Board on Thursday 29 January 2026 at 1:30pm in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.

AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment	Timing
1.	Apologies for absence	Chair	Verbal	1:30pm
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	Minutes of Meeting held on 20 November 2025	Chair	L	
3.	Matters Arising/ Action Checklist	Chair	M	
	<u>SAFETY</u>			
4.	Patient Recall Findings within the Lower limb Lengthening and reconstruction service, part of the orthopaedic surgery department	Chief Executive/ Chief Medical Officer	N	1:40pm
	<u>PERFORMANCE</u>			
5.	Chief Executive Update	Chief Executive	O	2:30pm
6.	Integrated Quality and Performance Report (Month 9 2025/26) December 2025 data	Acting Chief Medical Officer/ Chief Nurse/ Chief Operating Officer	P	2:45pm
7.	Finance Report (Month 9 2025/26) December 2025 data	Chief Finance Officer	Q	3:00pm
	<u>ASSURANCE</u>			
8.	Nursing Workforce Assurance Report Q3 2025/26	Chief Nurse	R	3:15pm
9.	Learning from Deaths Report Q2 2025/26	Acting Chief Medical Officer	S	3:25pm
	<u>RISK AND GOVERNANCE</u>			
10.	Board Assurance Committee reports: Quality Safety and Experience Assurance Committee – January 2026 Audit Committee – January 2026 Finance and Performance Committee Update – December 2025	Chair of QSEAC Chair Audit Committee Chair of the Finance and	T U V	3:40pm

	• People and Education Assurance Committee – November 2025	Performance Committee Chair of PEAC	X	
11.	Update from the Council of Governors – November 2025	Chair	W	4:00pm
12.	Any Other Business (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			4:10pm
13.	Next meeting The next public Trust Board meeting will be held on Wednesday 18 March 2026 .			



**Great Ormond Street
Hospital for Children**
NHS Foundation Trust

**DRAFT Minutes of the meeting of Trust Board on
20 November 2025**

Present

Ellen Schroder
Suzanne Ellis
Kathryn Ludlow
Matthew Shaw
Caroline Anderson
Tracy Lockett
Dena Marshall
Margaret Monckton*
Dr Sophia Varadkar

Chair
Non-Executive Director
Non-Executive Director
Chief Executive
Director of HR and OD
Chief Nurse
Chief Operating Officer
Chief Finance Officer
Acting Chief Medical Officer

In attendance

Amanda Rajkumar
Jason Dawson
Cymbeline Moore
Dr Kiki Syrad
Anna Ferrant
Victoria Goddard
Ebaadah*
Soumia*
Kate Oulton*

Jon Schick*
Fareeha Usman*
Dr Phil Cunningham*

Dr Ed Gaynor*
Dr Tolu Abifarin*
Lynn Shields*
Simon Blackburn*
Steven Whyte*
Cathy Roberts*

Associate Non-Executive Director
Interim Director of Space and Place
Director of Strategy and Engagement
Director of Research and Innovation
Company Secretary
Trust Board Administrator (minutes)
Sibling of a GOSH patient
Parent of a GOSH patient
Consultant Nurse for Co-Production and Senior
Research Fellow
Acting Planning Director
Head of Equality, Diversity and Inclusion
Deputy Medical Director and Responsible
Officer
Guardian of Safe Working
Chair of the Resident Doctors' Forum
Director of Education
Co-Director of Education
Deputy Director of Education
Associate Director of Education for Clinical and
Professional Groups

One member of the public

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

122	Patient Story
122.1	The Board received feedback from a family currently staying at GOSH who reported that sibling support had been invaluable during their stay and welcomed the recognition of the daunting and traumatic experience that an inpatient stay could be for all members of the family including siblings. Soumia, whose seven-month-old daughter Emaanah was an inpatient at GOSH said that the family had been able to attend the recent fireworks event which had provided a sense of normality and an opportunity to reflect on previous family traditions, away from the hospital environment. She added that, ordinarily, they spent most of their time within a hospital room where Ebaadah,

122.2	Emaanah's brother was required to be quiet, and the event allowed him to relax and enjoy himself. It also enabled them to meet other families which fostered a sense of community. The event space itself had been easily assessable to GOSH families. Ebaadah said he sometimes felt that the focus was very much on his sister and Soumia said that this reinforced the need for inclusive support. Sibling play workers on NICU had been valuable to the family's experience however they were very busy and there was limited availability. Soumia said that Ebaadah was able to have one-to-one time with play workers which helped maintain routine and structure for siblings.
122.3	Action: Discussion took place around access to the GOSH school and the Board agreed that school provision for siblings would be discussed. Soumia explained that they were currently home-schooling and trying to fit this into their daily structure, which was challenging. Kate Oulton, Consultant Nurse for Co-Production and Senior Research Fellow informed the Board that a bid had been submitted to the charity for the Everyday Impact Fund to support patient experience initiatives.
122.4	Matthew Shaw, Chief Executive asked about the family's experience of accommodation and Soumia welcomed the access to accommodation which had been essential for keeping the family together, as they were not from London. She added that without this support, their stay would not have been possible.
122.5	Kate Oulton shared plans to establish a sibling society and noted that working with young people like Ebaadah marked the beginning of co-production efforts.
123	Apologies for absence
123.1	Apologies for absence were received from Gautam Dalal, Non-Executive Director; Adrian Joseph, Non-Executive Director; Helen Cross, Non-Executive Director and Camilla Kingdon, Non-Executive Director.
124	Declarations of Interest
124.1	No declarations of interest were received.
125	Minutes of Meeting held on 24 September 2025
125.1	The Board approved the minutes of the previous meeting.
126	Matters Arising/ Action Checklist
126.1	Action 100.8: Ellen Schroder, Chair said that focus had moved on and was now more about how productivity was being measured. She said that it was important to ensure that GOSH's methodology was in line with that of NHS England and was appropriate for discussion with the integrated care board. Ellen Schroder reiterated the importance of understanding the Trust's cost base and workforce data. Suzanne Ellis, Non-Executive Director said that the transparency of GOSH's data in these areas had improved significantly over the previous six months.
127	Strategy 2025-2030
127.1	Cymbeline Moore thanked the Board for its support and for attending the launch of the new Trust Strategy, <i>Together We Power Care</i> , which took place on 22 October 2025. Engagement around the launch had been excellent, with approximately 1,200 people

	involved across multiple events. The Young People's Manifesto, launched alongside the strategy, had been particularly well received and a clinician had already requested to use the manifesto in team meetings to better understand what patients and families wanted from the organisation
127.2	Work was now underway to develop a delivery plan, ensuring that key initiatives in innovation and transformation were aligned with the strategy. This included establishing workstreams that reflected the operating context and exploring models of care, such as how GOSH would work in relation to neighbourhood health. Work was taking place to define how progress would be reported to the Board and collaboration with HR was ongoing to embed strategic intent into PDRs. A "strategy on a page" was being developed to help colleagues interpret the strategy within their roles and responsibilities.
127.3	Executive visibility and engagement across the organisation was key and Cymbeline Moore confirmed that a schedule was being developed to support values-based engagement and stakeholder involvement. Focus was now on sustaining momentum and ensuring that implementation began in a phased way from April 2026, aligned with the medium-term financial plan.
128	Update on Annual Planning 2026/27
128.1	Jon Schick, Acting Planning Director said that this year's approach placed greater emphasis on medium-term planning rather than a single-year focus, aligning with the NHS 10-Year Plan and its priority areas. The national timetable was ambitious, with initial submissions required by December 2025, which was significantly earlier than in previous years. This provided an important opportunity for GOSH to translate its recently refreshed strategy into tangible actions.
128.2	Key priorities within the national framework included continued improvement in waiting times, a move towards a digital-by-default model, and delivery against commitments such as the 150-day clinical trial set-up target. The Board also noted the requirement to learn from staff feedback, including findings from the staff survey, and to progress initiatives on anti-racism and sexual safety.
128.3	Financially, the focus would shift to individual organisations rather than systems, with plans to phase out national deficit support funding and achieve a break-even position by 2028/29. There was also an expectation of 2% annual productivity improvement and a move towards removing block contracts. Whilst this may present opportunities for GOSH, it was also important to ensure that funding for specialist paediatric services was protected.
128.4	Work had already begun to develop activity plans and performance trajectories, ensuring capacity was aligned to deliver the required standards. This would inform the income plan. The capital programme and the development of the Better Value programme were being prioritised, and a set of cross-cutting initiatives were being progressed to support delivery. The next step for the Board would be to review and approve the first cut numerical plan, including activity, workforce, and finance, by early December, with engagement through the Finance and Performance Committee on 8 December. This would be followed by a Board development session on 14 December to ensure alignment and oversight ahead of submission to NHS England by 17 December 2025. Whilst timelines were pressurised, having a plan in place by year end would enable focus to move to delivery.

128.5	Ellen Schroder asked whether the expectation was for Trusts to achieve break-even by 2028/29 and Jon Schick confirmed that the aim was to reduce reliance on deficit funding and move towards financial sustainability. Suzanne Ellis asked how the move to digital-by-default was being factored into planning and Matthew Shaw said that this would be addressed in the CEO report.
128.6	The Board noted the update and approved the proposed process and timelines for submission of the first cut integrated plan, including engagement through the Finance and Performance Committee and Board development session.
129	Revised Statement of Purpose
129.1	Matthew Shaw said that the document was required by the CQC and had been updated to reflect the new location of the gender service.
129.2	The Board approved the revised statement of purpose.
130	Chief Executive Update
130.1	Matthew Shaw thanked colleagues for their hard work and acknowledged the significant organisational pressures. Key strategic work was underway, including the successful launch of the new organisational strategy, <i>Together We Power Care</i> , and the anti-racism statement, which reinforce the Trust's values. Education and engagement activities were ongoing, and the refreshed values and behaviour framework would be in place by the new financial year following substantial staff involvement.
130.2	A recent internal audit had benchmarked digital and AI capabilities across 22 NHS Trusts and had shown that GOSH was significantly ahead of its peers.
130.3	The second phase of the London Care Record had been implemented at GOSH which was important for enabling continuity of care across London. The Epic Thrive programme continued to enhance the usability of the electronic patient record system which involved personalised training. Uptake of the Thrive programme had increased significantly following the introduction of Tortus training. Tortus was now being rolled out to more clinicians following a successful evaluation period.
130.4	GOSH was ranked number one in London for vaccine administration. Tracy Lockett, Chief Finance Officer highlighted the importance of this work, particularly given the anticipated impact of flu this winter, and said that there was also out of hours vaccine provision.
131	Integrated Quality and Performance Report (Month 6 2025/26) September 2025 data
131.1	Dena Marshall provided an update on performance, noting that Referral to Treatment (RTT) performance for September was 70.1%, which has remained broadly stable throughout the year. This was largely due to the continued validation of the Patient Tracking List (PTL) which ensured accuracy. She highlighted the national expectation to significantly reduce the number of patients waiting over 65 weeks by the end of December. The Trust was currently ahead of plan and on track to approach its target of 27 patients, although this would be challenging and would require discussion on resource reallocation in the coming weeks. Dena Marshall also reported a substantial reduction in 52-week waits during October, down to 229 patients, and confirmed that diagnostic performance (DM01) continued to improve, reaching 81% in October, with

	good progress being maintained.
131.2	Activity levels were 2% above the same period in the previous year but remained 2% below plan. Day-case activity was 6% below plan. There had been a positive shift from elective inpatient procedures to day-case treatment, which was beneficial to patients. It was noted that there had been a downturn in referrals in some specialties and Dena Marshall said that it would be important to understand whether this is a temporary fluctuation or indicative of longer-term changes in demand and workforce requirements.
131.3	Discussion took place around the requirement to maintain 52 week waits at below 1% of the PTL and Dena Marshall said that it was important to demonstrate steady progress in this area. Ellen Schroder asked when waiting list performance was likely to return to pre-COVID levels, and Matthew Shaw said that whilst this remained the long-term goal, substantial work was still required.
131.4	Sophia Varadkar, Acting Chief Medical Officer noted that Quality Support Visits, introduced six months ago, were now embedded within the quality and safety process, aligning well with other programmes and providing valuable intelligence. Thematic analysis of findings was underway and would be reported through RACG and the IQPR to future Board meetings. Sophia Varadkar outlined changes to the safety team structure, which now operated under three pillars: patient safety, compliance, and risk, each led by a senior partner. A Duty Safety Partner role had been launched to ensure urgent issues could be addressed promptly, providing real-time guidance and cover during periods of leave. Key safety metrics remained strong, with WHO Surgical Safety Checklist compliance at 99%, and an increase in harm reviews for patients on waiting lists. Policies continued to be updated, and the revised Duty of Candour policy had been approved.
131.5	Action: Ellen Schroder asked about the introduction of the Duty Safety Partner role and asked how frequently emergency situations arose. Sophia Varadkar clarified that while such issues were rare, teams often required immediate guidance, and the new role ensured continuity of support. The Chair asked that data on the number of approaches be monitored to assess the impact of the initiative
131.6	Tracy Lockett, Chief Nurse reported that Friends and Family Test (FFT) scores remained strong, with positive experiences for both inpatients and outpatients. While complaints had increased year-to-date, a recent deep dive found no concerning themes. Benchmarking against other NHS organisations continued.
131.7	Infection prevention and control indicators had reached threshold levels, consistent with national trends and reflecting the complexity of patients treated at GOSH. A deep dive had been undertaken at RACG, and assurance was provided by the Director of Infection Prevention and Control that this was being monitored. NHS England would be invited to conduct a peer review, and the Trust had also written to NHSE regarding the appropriateness of thresholds given the complexity of GOSH's patient cohort.
131.8	Caroline Anderson, Director of HR and OD said that workforce spend reduction remained a key focus, with reductions in substantive, agency, and bank costs being achieved. Workforce data remained strong, with low vacancy and turnover rates and high compliance with statutory and mandatory training. However, sickness absence and Freedom to Speak Up contacts had increased, reflecting the impact of organisational change.
131.9	Suzanne Ellis, Non-Executive Director asked whether safeguarding considerations

	were embedded in the complaints process, and Tracy Lockett confirmed that safeguarding was fully integrated and monitored.
132	Finance Report (Month 6 2025/26) September 2025 data
132.1	Margaret Monckton, Chief Finance Officer reported that the Trust was currently £6.7 million behind plan and £1 million behind the recovery plan. The key drivers of this position included a £1 million shortfall on International and Private Care (I&PC) income, costs associated with the Mutually Agreed Resignation Scheme (MARS), and a £1 million catch-up on drug expenditure following stock reconciliation.
132.2	Pay expenditure continued to exceed plan, with substantive staffing costs being the main driver despite bank and agency spend being below plan. However, when MARS costs were excluded, the underlying pay trend showed improvement. Whole Time Equivalent (WTE) staffing had reduced to below 6,000, reflecting the impact of workforce controls and MARS implementation. Year-to-date, £11.8 million of Better Value savings had been delivered, although this was below plan.
132.3	Ellen Schroder queried the reported £13.3 million increase in income against budget and asked whether this represented a genuine improvement or a distortion. Margaret Monckton confirmed that approximately £10 million of this related to a high-cost gene therapy drug, which would be presented separately to avoid misinterpretation in future reports.
132.4	Action: Matthew Shaw said that the Trust was very likely to report a deficit for the year 2025/26 and Suzanne Ellis emphasised the importance of reviewing the financial forecast and the Medium-Term Financial Plan (MTFP) at the next meeting. She asked that the I&PC plan was reviewed to ensure it remained reasonable given the challenges of the future year.
133	Nursing Workforce Assurance Report Q2 2025/26
133.1	Tracy Lockett confirmed that vacancy rates remained low, although there had been a slight increase during the quarter. Recruitment continued for posts agreed through pipeline meetings, and a full review of the pipeline would take place in January 2026. Detailed work was ongoing to ensure that staff working at GOSH were supported and developed, with retention initiatives continuing to be a priority.
133.2	There had been an increase in sickness absence across the organisation, which was being closely monitored. The report highlighted that sickness rates for registered nurses peaked at 5.3% in September, the highest level in the past 12 months, with mental health and respiratory illness being the main reasons for long-term absence. Short-term absence has also seen a shift, with anxiety becoming a leading cause in August. Targeted wellbeing support and monitoring would continue to stabilise sickness levels.
133.3	Ellen Schroder asked whether significant costs had been removed from nursing recruitment and retention programmes and Tracy Lockett confirmed that while absolute figures were not available at this stage, work was underway to review graduate recruitment numbers and reduce associated costs. She added that general education costs were also being reviewed, and there was a focus on ensuring that practice educators and facilitators spent more time working on wards with clinical teams.
134	Board Assurance Framework Update

134.1	Anna Ferrant, Company Secretary confirmed that all risks had been tested and scrutinised, with two risks reviewed by the Audit Committee (AC) and recommended for Board approval.
134.2	The first recommendation concerned BAF Risk 10: Climate Emergency. The Audit Committee had acknowledged the positive external assurance received from the CQC, which rated the Trust's governance and approach to environmental sustainability as 'Good'. Following this review, the Audit Committee recommended that the net risk score be reduced to 3L x 4C = 12, reflecting the progress made. The Board approved the reduction in the net risk score for the Climate Emergency risk to 12. Suzanne Ellis highlighted the importance of Climate Emergency to the Council of Governors and confirmed that the Audit Committee had given this matter the appropriate focus.
134.3	The second recommendation related to BAF Risk 12: Inconsistent Delivery of Safe Care. Anna Ferrant explained that significant work has been undertaken to review this risk, which was now based on key areas of evidence. The Audit Committee and QSEAC had reviewed a proposed revised risk statement and recommended it for Board approval. The Board reviewed and approved the proposed risk statement.
135	Next Steps on our Anti-Racism Journey
135.1	Caroline Anderson updated the Board on the launch of the Trust's Anti-Racism Statement, which took place on 3 November 2025. Matthew Shaw read the statement aloud and shared an accompanying video with the Board. Caroline Anderson expressed thanks to Fareeha Usman, Head of Equality, Diversity and Inclusion and the REACH Network for their leadership and commitment to driving and championing this work, noting that this represented a significant milestone for GOSH.
135.2	Fareeha Usman reflected that the statement was a product of the organisation's collective journey and emphasised the importance of continuing to embed anti-racism principles across all areas of the Trust. Next steps included maintaining REACH's role as co-owner of the initiative and ensuring that the work remained visible and impactful. She thanked the Board for its visible leadership, stressing that this was essential to demonstrate that anti-racism was fully embedded within the organisation's culture.
135.3	Ellen Schroder commended the success of the launch and highlighted the need to sustain momentum and measure progress over time. She added that monitoring uptake of anti-racism training and other engagement activities would be an important indicator of impact. The Board agreed that ongoing measurement and reporting would be critical to ensure accountability and continuous improvement.
136	Annual Reports
136.1	<u>Responsible Officer Annual Report 2024/25</u>
136.2	Phil Cunningham, Deputy Medical Director and Responsible Officer reported that all but one of the high-level recommendations from the Higher-Level Responsible Officer visit had been implemented, and with additional resource now in place, the team was able to continue to monitor the quality of appraisals to ensure compliance and improvement.
136.3	A masterclass had recently been delivered by a law firm on managing concerns, and the next session would focus on expectations and support for clinical leads. Following this training, 46 leaders would be trained from across directorates and would work to

	share areas of good practice and strengthen local leadership capability.
136.4	Monitoring demographics of those involved in appraisal and remediation processes remained important and while the Trust had a higher proportion of women involved compared to other organisations, other aspects of diversity were broadly in line with sector benchmarks. The Board noted the significant learning achieved over the past year and expressed appreciation to the Head of Employee Relations and Freedom to Speak Up Guardian for their contributions.
136.5	Matthew Shaw thanked the responsible office for his leadership, acknowledging the complexity and challenges of the role and commending the excellent work undertaken during a difficult year. Phil Cunnington highlighted the benefits and challenges of the expertise and geographical diversity within the workforce and stressed the need to provide greater support for locum doctors and to share this experience more widely across the NHS. He added that the organisation now had a better understanding of what it meant to support staff and suggested reframing the approach to managing concerns as a duty of care.
136.6	<u>Diversity and Inclusion Annual Report 2024/25</u>
136.7	Caroline Anderson presented the Diversity and Inclusion Annual Report 2024–2025, noting that a revised approach had been taken to presenting the information, ensuring that it connected with wider system priorities and integrated key frameworks such as the Anti-Racism Action Plan, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and the Seen and Heard framework.
136.8	Fareeha Usman highlighted key achievements, including the representation of staff from Black and Minority Ethnic (BME) backgrounds, which now stood at 40% of the workforce, continuing a positive upward trend. There had also been an improvement in the proportion of colleagues declaring a disability, rising from 4.6% to 6.5%, and the median gender pay gap had reduced to 4.9%, compared to 6.4% last year. However, it was noted that disparities persisted in recruitment and disciplinary processes, and work continued to address these issues. There had been positive progress in the delivery of the Anti-Racism Action Plan and the success of initiatives such as the RISE Sponsorship Programme, which supported career progression for staff from a global majority background, and the expansion of Seen and Heard Champions to recruitment panels. Apprenticeships were highlighted as a key positive, with over 460 apprentices now in post, representing more than 7% of the workforce.
136.9	The Board discussed the importance of addressing underreporting of disability. Ellen Schroder observed that the current figures likely underestimated the true prevalence, as many conditions were not visible. Caroline Anderson said that there had been an improvement, supported by the ENABLED Network, which was now well established. Tracy Lockett raised the need to consider neurodiversity, noting that complaints reviewed by the Freedom to Speak Up Guardian indicated this was a recurring theme. Ellen Schroder emphasised the need to ensure neurodiverse colleagues were not overlooked due to narrow definitions of diversity.
137	Guardian of Safe Working Report Q1 2025/26
137.1	Edward Gaynor, Guardian of Safe Working reported that Resident Doctor (RD) staffing had improved significantly in the previous quarter, with vacancy rates reducing to 5.4–5.8%, compared to previous periods. Recruitment had strengthened in several

	previously challenging areas. However, there remained a significant locum spend, primarily driven by sickness absence and rota gaps. Engagement with the Resident Doctors' Forum (RDF) had improved, supported by the appointment of a new Chair and two deputy chairs, which enabled the Chair to take a more strategic role. The RDF continued to provide a vital platform for raising issues and influencing improvements in working conditions.
137.2	Exception reporting remained very low, with only two reports in Q2, both from the same specialty which represented less than 1% of the Trust's 400 Resident Doctors. Focus groups were held in areas with low reporting to better understand barriers. A review of rotas was underway following the two reports from the same area, and fines were applied in line with contractual requirements. National changes to exception reporting, originally scheduled for September 2025, had been delayed until February 2026, and implementation planning was in progress.
137.3	The Board discussed the 10-Point Plan to Improve Resident Doctors' Working Lives, which aimed to address long-standing issues such as payroll accuracy, rota transparency, and access to rest facilities. GOSH scored 63% in its initial baseline assessment and had developed an action plan to improve performance. Early progress included improvements in HR processes and rest areas. Audits had been undertaken of new starters and good improvements had been noted for these resident doctors around rotas and 100% compliance had been achieved for NHS England doctors' contracts, a significant improvement. The plan would be localised to reflect GOSH priorities and embedded within the Quality and Safety Improvement Programme (QSIP) as a continuous, long-term project. The Chair of the RDF had been appointed as the peer lead for improving RD lives and would work alongside the Acting Chief Medical Officer to ensure delivery.
137.4	Tolu Abifarin, RDF Chair highlighted key issues for Resident Doctors at GOSH, particularly the need for greater transparency and equity between NHS trainees and locally employed doctors, who often worked at the same level but under different contractual terms. Matthew Shaw said that he had attended an RDF meeting and the group had welcomed Board and executive attendance to hear concerns directly and invited members to attend future sessions. He said that he was keen to develop initiatives to give Resident Doctors managerial experience, including shadowing and buddying opportunities, as well as involvement in digital innovation projects such as DRIVE. These initiatives would provide valuable insight into hospital operations and enhance career development.
137.5	The Board also discussed representation within the RDF and Tolu Abifarin said that although there was representation from most specialties' discussion was taking place around broadening engagement in all specialties, particularly those who may feel isolated.
137.6	Caroline Anderson confirmed that HR had introduced a point of contact for Resident Doctors, which had worked well for NHS-employed doctors, but highlighted challenges in obtaining information for locally employed staff before they joined GOSH. It had been agreed that PEAC would review options for harmonising contracts between NHS trainees and locally employed doctors and report back in February 2026.
137.7	Action: Ellen Schroder said that it was important to focus on the areas from the 10-point plan which were within the Trust's control and asked that the Board was kept

	updated on progress.
138	GOSH Learning Academy Annual Report 2024/25
138.1	Lynn Shields, Director of Education presented several key highlights from the report, including the donation of the apprenticeship levy to external organisations to support their apprenticeship programmes, demonstrating GOSH's commitment to widening access to healthcare careers. Tracy Lockett reported that a healthcare support worker from GOSH had won a prestigious award, reflecting the Academy's success in helping staff feel confident and equipped with the skills they required. The simulation and postgraduate education teams were invited to lead a workshop at the Association for Medical Education Conference in Basel, and the Medical Undergraduate Team received an award for excellence from UCL Medical School. In addition, the Virtual Reality project developed in collaboration with UCL had been featured on the BBC's <i>Operation Ouch</i> , showcasing GOSH's leadership in digital innovation.
138.2	The Learning Academy also supported service managers to complete leadership modules and facilitated access to training and education for their teams. Tracy Lockett emphasised that the Academy provided both general education and specialist programmes, including pioneering initiatives such as the UK's first paediatric advanced practice curriculum, which required leadership and collaboration.
138.3	Board members commended the achievements outlined in the report. Ellen Schroder said that the Learning Academy was hugely successful, delivering significant impact.
138.4	The Board approved the GOSH Learning Academy Annual Report 2024–2025.
139	Board Assurance Committee reports:
139.1	<u>Finance and Performance Committee Update – October 2025</u>
139.2	Suzanne Ellis, Chair of the FPC said that there had been a number of meetings in quick succession. The October 2025 meeting had covered many items which had been on the Board agenda including the Trust's financial position, an opportunity in the pharmacy service, the children's cancer centre, the medium term financial plan and the Trust's operational performance
139.3	<u>Quality, Safety and Experience Assurance Committee – September and November 2025</u>
139.4	Kathryn Ludlow, QSEAC member noted that complaints had risen over the past quarter, as highlighted in both the September and November 2025 meetings. While the relative increase was large, absolute numbers remained relatively small however, the Committee had agreed that the trend should be monitored closely. Alongside this, strong positive feedback continued to be received from patients through the Friends and Family Test, demonstrating that overall experience remained positive.
139.5	The Committee had discussed progress on the Paediatric Critical Care (PCC) Level 1 and 2 programme, which remained a key focus. Sophia Varadkar confirmed that although initial progress had slowed, this time had been used to review previous work and strengthen the programme's foundations. Plans were now in place to relaunch the initiative. A mobile High Dependency Unit (HDU) would be established for a small number of shifts per week once a specialty lead had been appointed.

139.6	An update had been provided on the Mental Health Framework, emphasising the importance of achieving parity of esteem between physical and mental health which included emotional wellbeing. A health and safety update had been received, and the committee had noted the focus on the environment in the Sight and Sound building.
139.7	The Board received an update on the Bioethics Service, which had been in place for 25 years but now requires a strategic refresh. A task and finish group had been established to review governance, succession planning, and opportunities to develop the service into a national offering.
139.8	Finally, the Board noted a deep dive on health inequalities, which highlighted significant work to understand social determinants of health and reduce variability in the “was not brought” metric across specialties.
139.9	<u>Audit Committee – October 2025</u>
139.10	Matthew Shaw, Audit Committee attendee said that there had been a change in the way that internal audit measured the outstanding recommendations which had led to a significant increase in the number. Work to close these actions continued to be monitored at RACG. There had been a considerable improvement in progress with counter fraud actions and the firm was working to review and move forward with, or close cases, at an appropriate speed.
139.11	<u>People, Education and Assurance Committee Update – September and November 2025 (Verbal)</u>
139.12	Kathryn Ludlow, Chair of PEAC said that a deep dive had been undertaken on culture. A number of other items on the agenda had already been discussed by the Board.
140	Update from the Council of Governors
140,1	Anna Ferrant said that an extraordinary Council meeting had been convened to consider the appointment of Amanda Rajkumar as a Non-Executive Director. Governors had approved the appointment.
141	Appointment of Deputy Chair and Senior Independent Director
141.1	Anna Ferrant said that Kathryn Ludlow currently held the roles of Deputy Chair and Senior Independent Director and would be stepping down from the Board on 30 November 2025. It was proposed that these roles would be taken on by Camilla Kingdon from 1 December 2025. The Board approved the proposal to appoint Camilla Kingdon as Senior Independent Director. The Board agreed to recommend the proposal to appoint Camilla Kingdon as Deputy Chair to the Council of Governors for approval.
142	Any other business
142.1	There were no other items of business.

TRUST BOARD – PUBLIC ACTION CHECKLIST
January 2026

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
96.6 96.8	24/09/25	Matthew Shaw suggested that the Trust should consult with colleagues from other Children’s Hospital Alliance Trusts to understand how they shared information from CDRMs. He also emphasised the importance of creating a “safe space” for clinical teams to come together, often with differing views, to learn from these events. It was agreed that this topic should be brought back to the Board for further discussion and clarity. It was agreed that the question of whether parents were given direct sight of the CDRM form would be raised with the Head of Bereavement.	SV	January 2026	On agenda
97.3	24/09/25	<u>Patient Experience</u> Ellen Schroder queried whether the outcome of the bid to the GOSH Charity would be reflected in the next Annual Report. Claire Williams said that if successful, the bid would result in increased staffing and resources, which would support accelerate progress and would be expected to feature in future reporting. Ellen Schroder requested that the Board be provided with a summary of the bid, including what was requested, what was received, and the anticipated impact.	TL	January 2026	The health inequalities bid to GOSH Charity has been submitted and is waiting to be reviewed as part of a wider review of bid submissions. The Lead for Health Inequalities is working with the GOSH strategy team to map health inequalities initiatives across the new Trust strategy and this aligned with the content of the bid submission.
122.3	20/11/25	<u>Patient story</u> Discussion took place around access to the GOSH school and the Board agreed that school provision for siblings would be discussed. Soumia explained that they were currently home-schooling and trying to fit this into their daily structure, which was challenging. Kate Oulton, Consultant Nurse for Co-Production and Senior Research Fellow informed the Board that a bid had been submitted to the charity for the Everyday Impact Fund to support patient experience initiatives.	TL	January 2026	Examples of patient experience initiatives funded by the Charity are detailed below.

Attachment M

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
131.5	20/11/25	Ellen Schroder asked about the introduction of the Duty Safety Partner role and asked how frequently emergency situations arose. Sophia Varadkar clarified that while such issues were rare, teams often required immediate guidance, and the new role ensured continuity of support. The Chair asked that data on the number of approaches be monitored to assess the impact of the initiative.	SV	Ongoing	The Duty Safety Partner role has been in place since November 2025. The six directorate safety partners (DSPs) take it in turns to be the duty DSP for one week in six. Duties undertaken as part of the role include: -Taking first steps to assess and action all Datix reports categorised as moderate harm or above -Responding to safety incidents or concerns raised via other GOSH teams (e.g. legal, safeguarding, complaints) or external agencies -Support any safety actions arising from the weekly Safety Events Review Group meeting that require immediate attention The level of activity is variable but initial feedback from the team and stakeholders has been favourable, reflecting greater responsiveness and a clearer pathway when patient safety help or advice is required. This will be monitored and reported via the Chief Medical Officer report into QSEAC going forward.
132.4	20/11/25	Matthew Shaw said that the Trust was very likely to report a deficit for the year 2025/26 and Suzanne Ellis emphasised the importance of reviewing the financial forecast and the Medium-Term Financial Plan (MTFP) at the next meeting. She asked that the I&PC plan was reviewed to ensure it remained reasonable given the challenges of the future year.	DM	January 2026	Noted and action ongoing

Attachment M

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
137.7	20/11/25	Ellen Schroder said that it was important to focus on the areas from the resident doctors' 10-point plan which were within the Trust's control and asked that the Board was kept updated on progress.	SV	Ongoing	To be reported via PEAC

Patient Experience Initiatives: Fireworks display

The Everyday Impact Fund was used to create an inclusive fireworks experience for GOSH families, particularly those with complex needs who couldn't attend the annual Coram's Fields fireworks display in person. The funding supported a partnership with Coram's Fields to bring an accessible fireworks show to the hospital through live-streaming to every bedside, a dedicated fireworks party in the Lagoon, and tailored fireworks menus and snacks. This helped ensure that all children and young people – including inpatients, outpatients and those joining in the specialised Coram's 'Accessible Zone' – could safely enjoy a festive celebration designed around their needs.

Patient Experience Initiatives: GOSH Voice Café (starting April 2026)

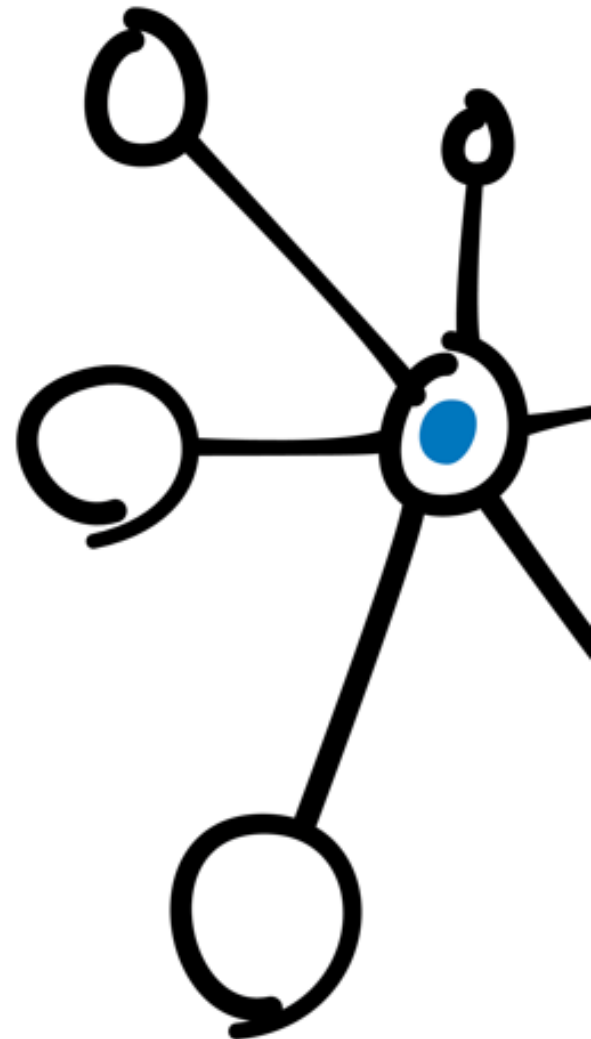
GOSH Voice Café is a monthly drop-in space for parents and carers at GOSH, designed to offer a safe, inclusive environment for peer-to-peer support, reflection, and creative coproduction. The café gives families a chance to step away from the ward, enjoy tea, coffee and mindful activities, and contribute their views in a setting created specifically for them. It also serves as a platform for creative coproduction projects in partnership with groups like GOSH Arts—for example, co-designing wallpaper or fabric for parent/carer rooms in the new Children's Cancer Centre. The café aims to support wellbeing, reduce isolation, build community, and ensure parents' and carers' voices are meaningfully included in shaping hospital services.

GOSH Voice Café is kindly funded through the GOSH Charity.

Our first official café will begin in April, focused on hospital catering.

Patient Recall Findings within the Lower Limb Lengthening and Reconstruction Service, part of the Orthopaedic Surgery Department

Published January 2026



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Foreword

On behalf of the Trust Board, we want to first offer our sincerest apologies to all our patients and their families who have been affected by the care provided by an Orthopaedic Surgeon at our hospital between 2017 and 2022.

We have heard extensively from patients and their families about the impact this care has had on them, and we know that we have broken the trust that so many families place in us. We have also heard of the guilt that many families are carrying that they did not spot that something was wrong, or that they feel they should have spoken up. The harm their children have come to have happened in our hospital and is no one's fault but ours.

This report sets out what we found in our review of patient care in full. It is important that we are open and honest about what has happened, what we have learnt and what we are doing as a consequence.

The independent patient review process was extensive, and we recognise how difficult this may have been for patients and families. We are very grateful to the families who took their time to give us feedback during the review, which helped us change and improve elements of the process.

Each review was shared in its entirety with patients and their family. We know that these reviews could never capture the totality of their experiences and may have felt limited and blunt. We are sorry for the distress and worry that has been caused by both the review process and the reports themselves.

We have a duty to ensure all our services are safe and to learn from when things go wrong to make all our care better and safer. As a result of this review, the Orthopaedic Team has put in place a range of measures to improve the quality of care provided. This has particularly focused on how a patient's care plan is decided from the outset to ensure that the care to be delivered is the best course of action for that patient.

We have identified learnings that we need to take across the hospital. This has led to a particular focus on standardising the way patient care is discussed, agreed and documented. We have also invested in support for our clinical leaders, including the introduction of a new, speciality lead training programme.

We know that the culture of teams and services plays a key part in how concerns are raised promptly. We want to acknowledge and thank our staff who spoke up with their concerns which led to us commissioning the Royal College of Surgeons of England (RCS) Review. Raising concerns about a colleague takes courage and we value the trust that our staff placed in us by doing so. But we know that there is more we can do - and are doing - across the hospital to ensure that our staff, patients and families feel able to do this at the earliest opportunity, and that concerns are acted on. We hope that the changes we have made and continue to make as a result of their experience will help prevent future patients and families going through what happened to them.

We would like to thank the Orthopaedic Team for the care they have continued to provide to patients through this process, and for the changes they have made to the way they work to make their service better and safer.

We would also like to thank the independent experts for their support in this process and for their commitment to completing their reviews impartially.

To our patients and families, we would like to again offer profound apologies. We know that nothing can make up for the experiences that you have had, nor can we fully understand the

impact this has had on your lives. We have an unwavering commitment to learn and change so we are able to provide the safe, high-quality care that all our families expect of us and deserve.

Ellen Schroder, Chair

Matthew Shaw, Chief Executive

Executive Summary

This summary explains why we carried out a major review of patients treated by an Orthopaedic Surgeon, what was found, and what the hospital is doing to improve care.

Why the Review Happened

Following concerns raised about Mr Yaser Jabbar's clinical practice in June 2022, the Trust commissioned the Royal College of Surgeons (RCS) to review both his work and the broader Orthopaedic Service. The RCS recommended a detailed review of approximately 200 of Mr Jabbar's patients. To ensure thoroughness, the Trust expanded this to include all patients he had seen, initiating a full recall of 721 individuals in February 2024.

How the Review Was Completed

A group of senior children's Orthopaedic Surgeons from outside GOSH independently assessed each patient's records, including clinic notes, scans and operation details. Where information was missing or unclear, they requested further documentation or arranged to see the patient in person. Families were kept updated and, when reviews were complete these were shared. For those who had a grading of harm they could choose how they wanted to receive the outcome: by letter, phone, video call or in person.

What the Review Found

Most children were not harmed by the care they received. However, the independent experts found that 98 patients (12.4%) experienced some level of harm, and 94 of these cases were linked to specifically the care provided by Mr Jabbar. Harm gradings ranged from mild, such as an unnecessary general anaesthetic, to severe gradings for situations like delayed diagnosis of complications or surgery that did not achieve the intended outcome.

In some cases, the patient records were incomplete, making it impossible to reach a clear conclusion. A very small number of children came to harm for reasons not related to Mr Jabbar, such as administrative delays or issues involving other clinicians.

What was Wrong with the Care

Across the seven areas of care reviewed by the independent experts, they found inconsistencies in the approach taken across all areas. There were higher numbers of patients graded as coming to harm who were part of a surgical pathway. This didn't necessarily mean that all those who came to harm, did so as a result of the surgery itself, but could include any part of their clinical pathway.

In addition, the review found several recurring problems. Some patient records were unclear or incomplete. Consent discussions were not always fully recorded. In some cases, assessments were brief or key information was missing. Decisions about surgery were not always well documented, and alternative treatment options were sometimes not explained clearly. Occasionally, complications were not recognised or acted on quickly enough. These issues affected families' understanding, confidence and, in some cases, their child's recovery.

How Families Felt

Many families told us they experienced distress, worry and frustration during both their child's treatment and during the review.

When reflecting on how their child was cared for at the time, some felt their concerns had been dismissed, or that they did not have enough information to make decisions. Parents also spoke about feeling guilty, even though none of this was their fault.

Feedback from families helped improve the review process itself including the introduction of a dedicated Complex Case Manager to support families and improving how results were shared.

What GOSH has Done to Improve Care

We have taken a range of steps to ensure children receive safer, more consistent care. Within the Orthopaedic Service this includes improving how new patients are assessed and followed up and introducing clearer processes for planning and reviewing all cases. All patients are now discussed in multi-disciplinary team meetings both before and after surgery. Particularly complex cases are also discussed with clinical colleagues from the Royal National Orthopaedic Hospital.

Changes are also being made across the whole hospital to strengthen patient safety. These include standardising the way patients are reviewed before and after treatment and how discussions are held when there is an unexpected outcome. We are also ensuring all our services have ways they can measure outcomes and compare themselves with outcomes from other centres. Effective teamwork is being fostered through the development of a leadership programme for the lead of every clinical specialty. We are also working to ensure families are supported in raising concerns.

Support for Families

GOSH is deeply sorry for what the children and their families affected by this review have experienced and the lasting impact this may have. Support continues to be available, including psychological help, the Patient Advice and Liaison Service (PALS), and external organisations such as Action against Medical Accidents (AvMA).

Chapter 1: Introduction and Context

In this chapter we explain what we have intended this report to be, why the review was commissioned, and information about the surgeon and the Orthopaedic Service.

What This Report Is

This report is first and foremost for patients and families who have been impacted by the review into the care provided by Mr Jabbar. Information has been included which we believe will be of most use and relevance to them, and we have tried to set it out in a way that provides clarity on what has been a lengthy and complex process.

We appreciate that this report contains lots of information, we will ensure that versions in other languages and formats will be available. We have also provided a brief introduction to the start of each chapter to help explain what will be contained within the chapter.

This report gives the final numbers of patients reviewed, provides the figures in relation to the patients who have been deemed to have come to harm, and summarises the themes identified in relation to the areas of care assessed.

Senior members of the hospital offered to meet with any patient and/or their family impacted by this review and held more than 100 conversations of this nature. This report contains feedback from patients and their families that was shared during these conversations and what we can learn from them.

We have also highlighted where changes were made to the recall process or the support provided throughout the review as a result of the feedback received from our patients and their families. We can assure all patients and families that there are no identifiable comments included within this report.

We have sought to learn from the process and findings of the patient recall and the review of the Orthopaedic Service and identify those learnings that could be applied more broadly across the hospital. The wider learnings and actions taken are described in Chapter 4.

We are committed to sharing our findings, what we have learnt, and how it can be applied broadly to improve care for all.

Where terminology may be difficult to understand, we have provided a glossary of the terms used in the report which can be found in Chapter 6.

Patient Recall

Following concerns raised by a colleague we asked the Royal College of Surgeons (RCS) to review the practice of Mr Jabbar. The RCS recommended that we review approximately 200 of Mr Jabbar's patients. We extended our review to all of the patients seen by Mr Jabbar to ensure a thorough assessment of whether any harm could have occurred to any of his patients at any stage of their care journey.

In February 2024 we announced the patient recall, initially for 721 patients, and we committed to sharing the findings with patients and their families once we had completed the process. All patient reviews were completed by October 2025.

The RCS were also asked to review the practice of another Orthopaedic Surgeon who volunteered their cases, and the wider Orthopaedic Service – more information on all elements

of their review, findings, and actions can be found in Chapter 4. Of note, the practice of the other Orthopaedic Surgeon reviewed was found to be of a good standard.

The Surgeon - Mr Jabbar

Background

Mr Jabbar, a Consultant Orthopaedic Surgeon, started working as a Consultant in 2014. He was British and trained at a medical school in the United Kingdom.

He joined GOSH in 2017 following a competitive recruitment process, with no concerns raised regarding his clinical practice or behaviour. Prior to joining GOSH, Mr Jabbar worked at a London Teaching Hospital as a Consultant Surgeon in Paediatric Orthopaedics and Limb Reconstruction.

As one of the Consultant Orthopaedic Surgeons within the Limb Lengthening and Reconstruction (LLR) Service, Mr Jabbar's scope of practice included treating patients with a range of orthopaedic conditions. Some of these treatments involved the use of circular frames, metal plates, bone grafts, implants, and castings as appropriate. In addition, Mr Jabbar worked with Interventional Radiology to treat children whose blood vessels did not form properly at birth (vascular anomalies).

Concerns into His Practice

Following concerns raised in June 2022, we asked the RCS to review Mr Jabbar's practice. We also initiated an investigation in line with the hospital's Maintaining Higher Professional Standards (MHPS) policy. Whilst this investigation was underway and following discussions with the General Medical Council (GMC), restrictions were placed on Mr Jabbar's clinical practice and additional support was provided by another experienced Surgeon. Mr Jabbar took an unpaid sabbatical in September 2022 and formally resigned from GOSH in June 2023. A full timeline can be found in Appendix A.

When concerns were raised in 2022, we looked back at Mr Jabbar's work since starting at GOSH in 2017. In that time, there had been seven complaints raised and one Serious Incident (SI). One complaint related to his communication style, another relating to the care provided and the remainder relating to delays for treatment due to him being absent from the hospital. None of these complaints, in isolation or combined, provided any broader concerns that needed additional oversight or investigation, above and beyond the responses provided to the individual families.

The Serious Incident in 2021 was thoroughly investigated, with a second opinion sought from an external Orthopaedic Consultant. Both the Trust's internal investigation and the external review, highlighted specific actions which needed to be addressed by Mr Jabbar in relation to the family and patient in question, but it did not identify any wider concerns which needed a broader investigation. This SI was closed through the Trust's governance processes and was ratified by NHS England; it did not trigger any further exploration of any possible issue with Mr Jabbar's practice.

We maintained contact with Mr Jabbar throughout the RCS review process and advised him at the request of the RCS that he should be restricted from undertaking all clinical work. We also shared this with the GMC as part of our regular updates with the regulator. On receipt of the RCS Service Report in October 2023, we shared it with Mr Jabbar in November 2023 and submitted a referral to the GMC for their review. Mr Jabbar voluntarily relinquished his license to practice with the GMC in January 2024.

Orthopaedic Service

The Orthopaedic Service at GOSH consists of a range of clinical professionals, including Consultant Orthopaedic Surgeons, Resident Doctors, Nurses, Clinical Nurse Specialists, Physiotherapists, Occupational Therapists, Orthotists, Psychologists, and Play Specialists. These clinicians work in partnership with the Administration Teams, and work alongside several other specialist teams to deliver holistic care to patients and their families. Mr Jabbar worked in the Orthopaedic sub speciality of Limb Lengthening and Reconstruction (LLR).

The LLR is a highly specialist service within the wider Orthopaedics and Spinal Department at GOSH. It assesses and treats some of the most rare and complex conditions affecting the arms and/or legs, many of which have no established standard approaches either nationally or internationally. Because these conditions can be so complex, clinical practice often varies between individual specialists, and treatment plans must be tailored to each child's unique presentation. The surgery associated with these conditions carries complication rates between 35 and 85%.

Patients are usually referred from other paediatric centres but can be referred from other departments within GOSH. Therefore, it is common for the Orthopaedic Team to work in conjunction with other teams across the hospital. As GOSH does not have an Accident and Emergency Department, and we are not part of any trauma network, much of our work is conducted on an 'elective' basis. This means that most of the clinical work is planned and not performed on an emergency basis. Patients are seen in dedicated limb reconstruction outpatient clinics and complex cases are discussed at multi-disciplinary team (MDT) meetings. The Orthopaedic Service provides an on-call advice service to other hospitals nationally, where clinicians can phone for advice on rare and complex patients.

During 2024/25, a total of 80 operations were performed within the LLR Service, and 823 outpatient appointments took place.

Chapter 2: Patient Recall - Methodology

Here we provide an overview of how the patient recall was established, managed, and the level of oversight in place. We discuss how the numbers of patients were determined, and the definitions used to categorise the levels of harm.

Governance and Oversight

In April 2024 we stood up the Orthopaedic Service Improvement Programme Board (OSIP Board) to oversee the actions required from the RCS review and provide leadership to the work. This was chaired by the Chief Medical Officer (CMO), with representation from NHS England and other members of the Trust.

The OSIP Board met fortnightly and were presented with updates on the number of patient reviews completed, the levels of harm found, and any reparative actions necessary. The OSIP Board reported to the Executive Management Team, chaired by the Chief Executive, after each meeting and provided assurance reports to the Trust Board and the Quality, Safety and Experience Assurance Committee (QSEAC), a sub-committee of the Trust Board, for oversight.

Once the concerns were raised in June 2022, these were communicated with the Care Quality Commission (CQC) and NHS England - both of which have supported us through the recall process and decision making where required. On receipt of the report from the RCS in October 2023, we shared the report with the CQC and our Commissioners at both NHS England (London Region) and North Central London Integrated Care Board (NCL ICB) and have ensured that regular updates on progress have been shared with them.

Identifying Patients to be Reviewed

When the decision was made to review Mr Jabbar's patients, we determined that it was essential to include all patients who had clinical contact with him, rather than approximately 200 patients suggested by the RCS in their report. This approach was to ensure a thorough assessment of whether any harm could have occurred at any stage of a patient's care journey.

GOSH has an electronic patient record system (known as Epic) and this, along with historical data sources, were searched to identify patients with any reference to Mr Jabbar in their record. A total of 851 patients were found, and two Senior Clinicians reviewed all records to determine the level to which Mr Jabbar was involved in their care. At this point, 130 patients were discounted from the review process as there was no clear evidence, on the initial review, of clinical contact with Mr Jabbar or his team, leaving 721 patients to be reviewed.

We grouped the 721 patients into four categories according to clinical priority, to ensure the patients who we were most concerned about were reviewed first. These categories were:

- Category 1: Serious Incidents (SIs), complaints, amputations, significant concerns on initial review, concerns raised by healthcare professionals, plates/nails used in their surgery.
- Category 2: All external metalwork, other complications not discussed as part of the consent process, unclear treatment plan.

- Category 3: Complications discussed as part of the consent process.
- Category 4: All other patients.

In February 2024 we wrote to all patients whose care was to be reviewed to explain the review process to them. Following this, two patients who were not initially flagged for review contacted our Patient Advice Liaison Service (PALS) and confirmed that they had clinical contact with Mr Jabbar. These patients were immediately added to the review cohort, increasing the total to 723.

Working with Other Hospitals

Mr Jabbar worked both for the NHS and privately at other London hospitals, and therefore some of our patients have been treated by him both at GOSH and elsewhere. It was important for these patients that the entirety of their care – regardless of where they received it – was reviewed.

We identified 75 patients who were seen at GOSH and at least one other hospital, and it was agreed that the hospital where the most significant intervention occurred would lead the review into that patient's care. These hospitals are Chelsea and Westminster NHS Foundation Trust, Cromwell Hospital, The Portland Hospital, and St John and St Elizabeth Hospital. To support this work, we convened a small working group with key members of each of the relevant organisations, which also had representation from NHS England, NCL ICB and was co-chaired by the Medical Director from the CQC.

All hospitals where patients had been seen by Mr Jabbar worked together to share relevant medical records. From the 75 patients identified, 38 had their most significant intervention at GOSH and we manage their clinical review. The remaining 37 patients had their review managed by a different hospital. Of note, six of these 37 patients had already been reviewed by GOSH by the time this work was done and therefore feature in our reporting numbers, the other 31 patients are not included within our total numbers.

Adding Additional Patients to the Review

To ensure the patient recall process was as comprehensive as possible, in April 2025 we conducted a further review of the medical records of all the patients who had been initially excluded. This allowed us to better understand their interactions with Mr Jabbar and determine whether their care should be formally reviewed.

From the remaining 128 patient records, 97 were subsequently added to the review and two new categories were added. These were to be reviewed following completion of categories 1-4.

- Category 5a: Initially assessed as having no contact, but further searches found minimal involvement and limited records.
- Category 5b: Private patients with minimal involvement and no or very limited records held by GOSH.

For the remaining 31 patients, no evidence of clinical contact with Mr Jabbar was found. These patients were notified by letter of this decision and advised to contact PALS if they believed this was incorrect. To date, we have received no evidence to the contrary. For context, a Consultant's name can appear in records for reasons unrelated to direct care, such as triaging referrals, cancelled appointments, or clinic scheduling changes. A full summary of patient numbers can be found in Appendix B.

The Patient Recall Review Team

We initially recruited three independent, experienced Consultant Paediatric Orthopaedic Surgeons in the UK with specialist expertise in Limb Reconstruction to conduct the patient reviews. Of note, this is a highly specialised area of medicine with a limited number of experts nationwide.

The reviewers completed these patient reviews alongside their existing NHS duties, and we projected an 18-month timeline from May 2024, when the first reviews began. To ensure we could meet this timeline, between July and October 2024 we recruited an additional five reviewers to support the patient recall. We also approached some international experts, but due to differences in surgical technique and clinical approach, we chose to remain with those whose clinical practice aligned with UK standards.

Reviewers met collectively at monthly peer review meetings to discuss particularly complex cases and also took one out of every five cases they had reviewed to this meeting, to ensure a consistent approach to their assessments.

Reviewing Patient Care

The reviewers assessed the medical records and imaging available within our electronic patient record for each patient. If a reviewer could not complete an assessment based on available records but from the information available, and believed there could be a potential harm grading, they were able to invite the patient for a consultation and/or request additional imaging. In some cases, additional records were also requested from other centres when there was evidence a patient had been treated elsewhere.

For each patient, they completed a standardised report template which covered a number of areas. Experts used national guidelines to determine care, such as GMC “Good Clinical Practice” (published August 2023, updated December 2024). Where specific guidelines were not available during the reviewed timeline, the reviewers used their knowledge of acceptable practice to form an opinion. The areas reviewed were:

- Record keeping and documentation.
- Assessment, including history, examination, and diagnosis.
- Investigations and imaging.
- Consent process.
- Decision-making and case selection.
- Surgical skill and technique.
- Identification, management, and ownership of complications.

For each of the areas outlined above the reviewers were asked to determine whether the care provided was:

- Acceptable.
- Room for improvement.
- Unacceptable.
- Unable to determine.
- Not Applicable.

In addition, they were asked to comment on:

- General conclusions and summary of care.
- Evidence of physical harm.
- Recommendations for future care.

Recommendations in the Individual Patient Reviews and Closure of these

For each patient, the reviewers provided recommendations about whether any further care was required, including any additional interventions, or whether there was no further involvement needed.

For some patients, follow up appointments and/or referrals to other services were arranged. In addition, all patient reviews were added to their electronic patient record so their clinical team could see the review outcome and any recommendations. A patient's review status was marked as closed when all outstanding actions were completed.

Assessing and Defining Harm

According to NHS England's Policy guidance on recording patient safety events and levels of harm, a patient safety incident is defined as "something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm". When such an event occurs, it is assessed to determine whether it resulted in harm and, if so, the level of harm, which can range from no harm to severe harm or death.

Harm may arise from a wide set of factors, such as mistakes in medication or clinical technique, as well as broader system issues like workload pressures, administrative failures, or delays in access to care.

NHS England emphasises that the process for determining harm must be objective and based on the best available information at the time, recognising that judgements are required when deciding whether an incident has occurred and what level of harm, if any, resulted from it. In the context of paediatric limb reconstruction, where staged or repeated surgery is often a necessary and planned part of treatment due to growth and development, further planned procedures are not considered harmful events.

As previously mentioned, Paediatric Orthopaedic Surgery, and particularly Limb Reconstruction a highly complex area of surgery, with many known complications some of which may be unavoidable. The challenge when assessing harm is being able to establish whether the complication was a result of poor care or was an expected complication for the type of care being provided.

We recognise that some patients and families may feel that the harm gradings do not fully capture the complexity or impact of their experiences, and we sincerely apologise for any distress this may have caused. However, it was essential that we followed a nationally recognised and standardised harm-assessment process to ensure consistency, fairness, and reliability in reporting.

To ensure that patients' and families' experiences were meaningfully represented, we have also included anonymised reflections that express the wider impact on their lives.

Levels of Harm

Physical and psychological harm were graded using NHS England's framework (August 2023, updated October 2024). The table below defines the levels in use within the framework. Additional information about the levels of harm can be found in Appendix C.

Examples taken from NHS Guidance of what the levels can mean:

- **Low / Mild Harm:** Unnecessary general anaesthetic and therefore additional recovery and observation time.
- **Moderate Harm:** Missed opportunity for timely intervention (e.g. a surgery was delayed significantly) which resulted in a more invasive surgical technique being required and extended the length of treatment.
- **Severe Harm:** Post-operative fracture due to poorly placed metal work. This would necessitate further surgery and a significantly extended recovery time.

For the patient recall, we introduced an additional grading of 'unable to determine.' This new grading was only assigned to those reviews where there was not enough information available to the reviewers to allow them to make an informed decision.

Psychological Harm

We recognise that other types of harm such as psychological harm are intertwined with any attribution of physical harm – especially in the cases of children, young people, and their families. Absence from school, or from not being able to play, can impact the wellbeing of our patients and those around them. This is a highly complex area to assess and quantify and can only be done meaningfully with a trained psychologist or other suitably trained professional.

We initially set out wanting to assess both physical and psychological harm, recognising that the two are very closely related. The reviewers were Orthopaedic Surgeons, not mental health professionals, and as such were not themselves in a position to assess or diagnose psychological harm. We recognise it is also very difficult to assess psychological harm purely from a review of medical notes and documentation.

We received feedback directly from patients and families that the assessment of psychological harm did not accurately reflect their experiences, and the subsequent gradings being applied were causing distress – we took the step to stop assessing for psychological harm. Therefore, from January 2025, psychological harm was graded as 'Unable to Determine' and only if records indicated there had been past Mental Health Team involvement was this referenced in their summary.

We recognise that whilst the approach for assessing psychological harm was well intentioned, it was limited and did not capture the full psychological impact as experienced by patients and families.

Other Factors Contributing to Harm

Patients rarely see one single clinician during their treatment journey, and this is especially true of patients with complex orthopaedic conditions. Whilst the review focused on care provided by Mr Jabbar, the reviewers looked at the complete treatment journey each patient received, which therefore often included other clinicians. In a small number of cases, they identified some concerns unrelated to Mr Jabbar's care, some of which resulted in harm.

This included substandard care by other Surgeons and poor administrative processes which resulted in some patients waiting unacceptably long times for appointments. In all these cases,

these issues were investigated appropriately, discussions took place with the patients, families, and clinicians, and remedial plans were put in place if required.

Sharing Outcomes with Patients and Families

Once the review outcomes were received, these were discussed at a weekly meeting attended by a range of clinicians and included those involved in the recall workstream. These meetings ensured findings were addressed, care plans implemented where needed, and actions monitored.

No Harm Identified

When no harm was identified, unless the review findings required discussion, a cover letter was sent to the patient and their family with a copy of the full review report.

Patients were invited to contact PALS if they had any questions or wanted to discuss their review, and these were facilitated by the appropriate team.

Harm Identified

We recognised that for many patients and families receiving a review outcome that indicated harm had been found would be very distressing. Therefore, before sending the review report, we contacted all patients and families asking them how they would like to receive this. Patients could request the report in writing, over the phone, in a videocall, or at an in-person meeting. They could also request to receive the report prior to or following a discussion with us.

When harm was identified, we apologised and were open and transparent with our patients and their families about the grading, and what had contributed to this.

Supporting Families Through the Review Process

Our intention throughout the review process has always been to be open and honest with patients and families. We provided regular written updates to patients and families who were waiting for their review to take place to let them know how the review was progressing, and to share any other updates with them.

We recognised the review was not only a clinical process but that it carried significant emotional burden for families. Many parents described feelings of isolation, uncertainty, and distress during this period. The review highlighted the need for families to be heard, supported, and guided through complex conversations about their child's care and the implications of the findings.

We ensured that support was available via phone and email, using translation services if required, providing families a direct route for queries and emotional support. Parents were supported in navigating difficult conversations with their children and were signposted to appropriate psychological services.

We offered informal discussions with either the Chief of Service and the Head of Patient Experience and Engagement, or with the Managing Director and Clinical Director from International and Private Care.

We held these conversations as it was important for patients and families to receive an apology from us and to be able to express their thoughts. A summary of the meeting was shared afterwards. For some patients and their families, we held additional meetings with them,

so they were able to process and further understand the findings of their review and raise any additional queries they may have had.

For those patients and families who had specific Orthopaedic related questions, and were still a patient of GOSH, we arranged for them to meet with a senior Orthopaedic Consultant Surgeon who was able to address any questions they had in more detail and provide a greater level of clarity where needed.

In addition, we offered for patients and families to speak with other senior members of the hospital, who were not part of the review process, for them to share their experiences.

Consistent Communication

How and how often we communicate with families and patients in these situations needed careful consideration, with some wanting regular in-depth updates, whilst others wanted as little as possible. We tried to ensure that we respected those wishes where possible and provided quarterly update letters to patients awaiting their review to try to balance the needs of all patients and families.

Responding to Feedback

We are grateful to the patients and families who shared their feedback about the review process with us. This enabled us to make changes to certain processes and the way in which we communicated with them.

The changes made included no longer rating psychological harm and introducing a method by which patients and families who came to harm could choose how they received the outcome of their review. We also introduced the role of Complex Case Manager, which is described in more detail below.

Patients and families also shared with us some of the frustrations they had with the review process. These included the time taken for their reviews to be completed, and whether they could request a re-review of their notes or provide additional, anecdotal information to be considered by the independent experts.

Based on the notes and images that were available we chose to undertake a desk top review in order to ensure that we provided the same level of review to each patient and their family. We recognise that this approach may have had limitations, however it was driven by our commitment to be consistent and fair with all patients and families.

The provision of face-to-face clinic appointments for all families would have resulted in significant additional time being added to the recall timeline. In light of existing concerns about the timeline and our awareness that the review process itself was a source of some distress to the families involved, we determined this was not an acceptable approach. We also felt that it would be unfair if we began re-reviewing patients' part-way through the recall, and that this could have a negative impact on those whose reviews had previously been completed.

Recurring themes we heard from patients and families included a feeling of guilt, loss of trust in GOSH, and the level of emotional impact that the review was having on them. We are truly sorry that patients and families have felt this way and also for the additional burden this review has created.

We also acknowledge the concerns patients and families have expressed about being unsure how to raise issues with us, that they felt dismissed when they sought to raise concerns with Mr Jabbar, and the worry that they may be seen as a troublemaker which could adversely affect their child's care.

Complex Case Manager

In response to family feedback, in March 2025 we established a dedicated Complex Case Manager who was able to provide holistic support and advice to patients and families where required. This role was able to connect patients and families to psychological support.

This role was established in response to feedback from patients and families who described the review as “clunky” and explaining that they felt isolated with no clear route for raising concerns. This role provided a space for patients and families to express frustration, fears, and concerns about their wellbeing and their child or young person’s future. Feedback from parents said that they valued the reliability of promised call-backs, which helped begin to rebuild trust.

Once established, patients and families repeatedly expressed that this role was “crucial” and “vital,” with some stating they would not have pursued further information without it. We acknowledge that this role should have been in place from the start of the review and are grateful to those who highlighted this need.

Psychological Support

Psychological support was provided in response to feedback received from those impacted by the review. In addition to the Complex Case Manager, we acknowledge that this should have been available from the outset. Psychological input at an earlier stage, in hindsight, would have been beneficial, especially in relation to the decisions taken regarding the assessment of psychological harm.

A range of options for psychological support were available, depending on the need of patients and families. Some did not require a full psychological assessment, instead needing a space to speak and feel heard.

If patients or families required formal psychological support, the Clinical Psychology Team worked to prioritise those affected by the review. If they were still patients at GOSH, they received psychological support in the same way as other patients do. Patients and families told us that these interventions helped them feel comfortable continuing with their care at GOSH.

If they were no longer patients of GOSH, we made alternative arrangements to find a method of support which worked best for them. It was important for this range of options to be available, and patients and families told us this was important in differentiating what support they needed and enabled us to determine how best to provide it.

Chapter 3: Findings

This section details the findings of the patient recall programme. It is presented in two sections:

Section One: This sets out the number of patients who have come to harm, along with the level of harm that was caused.

Section Two: A summary of the areas of care arising from analysis of the findings of the independent experts.

Section One: Patient Harm Gradings

As discussed in Chapter 2, we have used the definitions of harm as defined by NHS England.

We understand that this report may be distressing to some of our patients and their families and for that we apologise. We also recognise that for many patients and families the grading of harm has felt unrepresentative of their experiences.

Where a rating of 'Unable to Determine' has been given this is because there was insufficient information available for the independent experts to be able to make an informed opinion on a potential grading of harm. Where the harm outcome was recorded as 'Unable to Determine' these have been listed as a separate finding below and have not been amalgamated into one of the other categories.

Total Harm Numbers

The independent experts carried out clinical case reviews for all 789 of Mr Jabbar's patients and found a total of 98 patients (12.4%) had come to harm.

Table 1: Total number of cases of harm found.

Harm Ratings	Total Patients (789)
No Harm	638
Mild Harm	20
Moderate Harm	40
Severe Harm	38
Unable to Determine	53
Percentage of Harm	12.4%

For four of the 98 patients who came to harm, although Mr Jabbar had clinical involvement with these patients, the independent experts found that this harm was not attributable to Mr Jabbar. For three of these patients, the harm caused was attributed to another Surgeon, who no longer works at GOSH. The other patient came to harm due to being lost to follow up, which means that they did not receive a timely clinical follow up.

The three patients whose harm was caused whilst under the care of another Surgeon had their care peer-reviewed by an external Consultant Orthopaedic Surgeon and then shared with the Surgeon directly. In addition, the concerns were discussed with the patients and families involved and with the GMC. The GMC advised that the cases did not meet the threshold for

referral and advised that local support was required, which was provided by GOSH and their current employer.

Total Harm Numbers directly attributable to Mr Jabbar

The patient reviews found 94 (11.9%) patients had come to harm that was attributable to Mr Jabbar. Of these 94 patient cases, there were six patients where the harm was not attributed to solely Mr Jabbar, and there were additional aspects of their care which contributed to the overall harm rating applied. This included missed opportunities for on-going screening through treatment and lack of communication between services to address radiological findings for example.

Table 2: Total number of cases of harm found, attributable to Mr Jabbar

Harm Ratings	Total Patients (789)
No Harm	642
Mild Harm	19
Moderate Harm	39
Severe Harm	36
Unable to Determine	53
Percentage of Harm	11.9%

Harm Ratings - Surgical and Non-Surgical Intervention

Out of the 789 patients, 42.2% (333) were part of a surgical pathway. The table below shows the levels of harm identified across those who were part of a surgical pathway, compared to those who were not part of a surgical pathway.

Although these harm levels are presented by non-surgical and surgical patients, the harm may not have been attributed by the surgery itself. The harm could be a result of decision-making, lack of timely intervention, ineffective identification, and management of complications. We highlight some of the themes from each of the areas of care graded later in this chapter.

Table 3: Harm found in surgical and non-surgical patients attributed to Mr Jabbar

	Surgical	Non-Surgical
Number of Patients	333	456
No Harm	235	407
Mild Harm	18	1
Moderate Harm	38	1
Severe Harm	35	1
Unable to Determine Harm	7	46
Percentage of Harm	27.3%	0.7%

Section Two: Summary of Areas of Care

As part of their review process, we asked the independent experts to assess the care provided against seven key areas of patient care:

- General conclusions and summary of care.
- Record keeping and documentation.
- Assessment, including history, examination, and diagnosis.
- Investigations and imaging.
- Consent process.
- Decision-making and case selection.
- Surgical skill and technique.
- Identification, management and ownership of complications.

Each area of care was graded as either not applicable, unable to determine (if notes did not contain the information), acceptable, room for improvement, or unacceptable.

There were 371 patients (47%) whose care across all seven areas was graded as either acceptable or non-applicable, and for these patients there was no harm identified. We know from the data, that the attribution of harm was the lowest in those patients where decision-making and case selection, along with assessment, including history taking, examination, and diagnosis were both graded as acceptable.

As the number of areas of care rated as unacceptable, or room for improvement increased, the percentage of harm increased. All the areas of care are heavily interlinked, and it is therefore not possible to identify a particular cause or area of care which resulted in harm. However, the data analysis does highlight which areas, when marked as unacceptable or requires improvement, resulted in a higher number of patients coming to harm.

When looking at the group of patients who were part of a surgical pathway (333 patients), two areas of care, surgical skill and technique, and the identification, management and ownership of complications had a high number rated as unacceptable. These areas were rated unacceptable in 17.7% (n = 59) and 15.6% (n = 52) of patients respectively. In the remaining five areas of care, the numbers that were deemed unacceptable were much lower at between 6.1 and 9.3%.

Analysis of the independent expert case reports into Mr Jabbar's practice identified that Mr Jabbar was highly inconsistent in his approach to clinical care with recurrent deficiencies in documentation, assessment, and surgical decision-making. The reports have been analysed, and the following themes have been identified. We would like to assure you that these do not allow for the identification of any patient or family.

A summary of the findings of the different areas of care is detailed below. These document:

- An explanation of standard practice expected in the UK.
- Where Mr Jabbar's practice was assessed by the independent experts as meeting this standard.
- Where Mr Jabbar's practice was assessed by the independent experts as not meeting this standard.
- Implications for patients including, where available, feedback from patients and families.

There is inevitable overlap in the themes described in these categories. Concerns related to record keeping and documentation are reflected across all areas of care summarised below.

Consent

What is standard practice in the UK?

Children and young people should be involved in decisions about their care as much as they can, and their opinions should be respected. Consent must be real and valid. This means it should be given freely by someone who has the right and ability to decide. For children and young people, clinicians need to check if they are mature enough to understand and agree to the treatment themselves. If the child or young people cannot do this, consent must come from a parent or someone with legal authority, and doctors must always act in the patient's best interests.

Information should be clear, accurate, and explained in a way the child and young person can understand. Clinicians should make sure both the patient and their parents or families have enough time and support to make a decision, and they should check that everyone understands before moving forward. If the treatment plan changes or new options are suggested, consent must be reviewed and recorded at that time. Records should show what was discussed, including risks, benefits, alternatives, and if an advocate or interpreter was involved.

What were the findings of the review in relation to consent processes undertaken by Mr Jabbar?

Standard practice: The reviewers found satisfactory documentation of risks and benefits in many cases. This included MDT involvement in assessing proposed clinical treatment. Clear communication with patients and families of procedural plans was evident, involving interpreters where necessary. In many cases, opportunities for patients and families to reflect was evident from the medical records. Interventional radiology and combined procedure consents were generally well-detailed.

Sub-standard practice: Key issues were highlighted, such as missing, incomplete, or illegible consent forms, overuse of generic language, and insufficient documentation of alternative treatment options. There were instances where the procedure undertaken differed from what was originally consented to, with no proper record for the rationale for changes. A lack of documented consent around material risks, possible complications and alternative treatments was identified. Further risks were presented by administrative inconsistencies, such as altered dates and conflicting records, while limited Consultant oversight and inadequate recording of capacity and parent authority in complex cases highlighted the need for improved governance and record-keeping.

What are the implications for patients?

When consent forms are missing, incomplete, or hard to read, there is no reliable record of what was agreed. This undermines informed consent and can lead to children and young people having procedures they or their parents did not fully understand or approve. Using vague, generic wording and failing to note other treatment options means families may miss the chance to make choices that suit their child or young person's needs.

Errors like altered dates, conflicting records, and poor documentation of important risks weaken trust in the consent process.

Of those patients treated by Mr Jabbar, the independent experts identified that some patients were subject to inadequate risk counselling.

Many families said they were not given clear explanations about treatment options, risks, or why certain decisions were made. They were often confused about the purpose of procedures, expected results, and alternatives. Several families reported raising concerns directly with Mr Jabbar, but they felt these were usually dismissed.

History Taking, Examination, Diagnosis and Investigation

What is standard practice in the UK?

When taking a patient's medical history, it should be detailed and suited to their age and stage of development. This means looking beyond symptoms to include psychological, social, cultural, and family factors. Doctors should listen to the child or young person's views and concerns and avoid making assumptions about what matters to them. They should also consider any safeguarding issues or signs that the child or young person may be vulnerable.

Any tests or investigations should only be carried out if there is evidence to support them, they have been explained clearly, and the associated risks are discussed. Doctors should make sure tests do not conflict with other treatments and that results are shared quickly and accurately.

A diagnosis should come from a full assessment of the child or young person's condition, combining clinical findings, test results, and the child or young person's personal circumstances. Doctors should be open about what they know and what they are unsure of and help families make informed decisions about next steps. If a condition is complex or rare, the child or young person should be referred to a specialist without delay.

Records must be clear, accurate, and up to date. They should document the history, examination findings, test results, reasoning behind the diagnosis, and what was discussed with the child or young person and their family.

What were the findings of the review in relation to Mr Jabbar's clinical practice (History taking, examination, diagnosis and investigation)?

Standard practice: Many cases featured a thorough record of the patient history, examination, and diagnosis, supported by appropriate imaging and MDT involvement, which enabled accurate identification of key conditions and effective follow-up. Holistic approaches were evident in some cases, with psychosocial factors and allied health professional input helping to provide a comprehensive clinical picture, and remote consultations were sometimes used to maintain care continuity during the pandemic.

Some patients had thorough or adequate MDT documentation in place, with structured operative and inpatient notes with the patient's history, examination, investigations, and plans clearly documented. In some cases, there was acceptable clinic documentation to allow the reviewer to understand the decisions made. The information provided by the Allied Health Professionals (including Physiotherapy Teams and Orthotists) was detailed and well-constructed.

In many cases, the records showed appropriate selection and use of imaging modalities, such as X-rays, CT, MRI, and ultrasound, tailored to the clinical scenario and pathology, as well as the incorporation of pre and postoperative imaging. Imaging decisions were frequently supported by MDT input, with age-appropriate considerations and efforts to minimise radiation exposure in paediatric patients.

Sub-standard practice: Some records were brief or incomplete, and lacked essential details such as deformity measurements and neurovascular status, while preoperative planning and imaging reviews were sometimes missing. Consultation and involvement of additional specialists or specialty clinics was lacking in complex cases. There were instances of limited Consultant oversight, and insufficient documentation of planned corrections.

A lack of notes, or absence of essential details were consistently identified as a concern - this included operating notes, consent forms, planning notes, radiological and clinical measurements, risk benefit discussions, and rationale for deviations from agreed plans.

Concerns identified the absence of essential imaging before major procedures, and limited saving of intraoperative imaging. There was also a lack of documented clinical reviews of imaging in relation to deformity planning and measurements. Issues were identified with reliance on outdated images, poor record-keeping and interpretation, limited use of functional (weightbearing) or comparative views, which hindered diagnostic accuracy and safe clinical decision-making.

What are the implications for patients?

If a patient's medical history is not taken properly or adapted to their age, important details can be missed. Factors such as emotional wellbeing, family circumstances, and social factors often affect health, and ignoring them can lead to wrong or incomplete diagnoses. This means the patient might get treatment that is not right for them.

A diagnosis should come from a full picture of the patient's health, but when records are unclear or incomplete, it is hard to show why decisions were made or confirm they are in the patient's best interests.

Of those patients treated by Mr Jabbar, where harm was identified, patients were subject to:

- Instances where surgery proceeded without documented comprehensive assessment, imaging review, or quantification of deformity.
- Wrong diagnoses and treatment decisions were sometimes made by looking only at scan or X-ray results, without properly considering how the patient actually felt or how their condition affected their daily life and abilities.
- Not properly comparing the images taken during surgery with the plan made before the operation and what the operation was meant to achieve.
- Poor recording of neurovascular assessments.

Case Selection, Decision-Making and Surgical Skill and Technique

What is standard practice in the UK?

Before recommending surgery, doctors must make sure it is truly needed and, in the patient's best interests. This decision should come from a full assessment of the child or young person's condition, needs, and circumstances, based on their medical history, examination, and test results. It should follow recognised guidelines and evidence and consider how effective the treatment is likely to be. Alternatives to surgery, including less invasive options, should always be discussed openly with the child or young person and their parents or families.

If surgery is recommended, the reasons must be clear and written down, including the expected benefits, possible risks, and any uncertainties. Decisions about complex or high-risk cases should involve input from different specialists and oversight from a senior consultant. Records should be kept up to date and show how decisions were made, so the process is transparent and can be reviewed if needed.

Doctors should never assume what matters most to the child, young person or family - they should involve them in every step of decision-making. If there are disagreements, these should be handled sensitively and in line with professional guidance. Above all, decisions must put safety first, be fair, and ensure continuity of care, while meeting professional and legal standards.

Doctors should only do work they are trained and competent to do, and they must keep their knowledge and skills up to date. They should provide care to a high standard, using proven and appropriate techniques for the child or young person's needs. If they choose a different approach from the usual method, they must have a good reason for it and record that reason clearly, with proper oversight. Throughout, the focus should be on keeping the child or young person safe, and ensuring care is consistent. Records must be accurate and easy to read, and all actions must follow legal and professional rules.

What were the findings of the review in relation to Mr Jabbar's clinical practice (case selection, decision-making, and surgical skill and technique)?

Standard practice: Decision-making and case selection demonstrated several strengths, including the use of appropriate conservative management, staged observation, and MDT input for complex deformities, as well as shared decision-making that acknowledged family preferences and functional goals. There was evidence of reasoned selection of surgical techniques aligned to patient needs, timely acceptance of non-intervention for stable conditions, appropriate referrals, and integration of psychological readiness and rehabilitation planning.

The review of surgical skill and technique revealed numerous strengths, including the frequent use of established procedures and constructs, thorough operation notes, and effective intraoperative imaging, which collectively contributed to successful outcomes in many cases. There were also examples of complex cases benefiting from dual Consultant involvement and teamwork, and technically sound limb reconstruction procedures.

Sub-standard practice: Inconsistent planning, undocumented day-of-surgery changes, insufficient MDT discussion and Consultant oversight in high-risk cases, and a tendency to prioritise radiographic findings over clinical symptoms.

Additional concerns related to limited documentation for complex decision making, with an unjustified preference for certain surgical techniques including unconventional or unrecognised procedures, or the omission of documented discussion of established treatment options.

There were instances of premature removal of fixation devices, the combination of procedures without clear rationale, inadequate counselling on fracture risk, and an over-reliance on junior staff.

There were some serious problems found, including poor planning before surgery, not making the area stable enough, unclear or incomplete notes, and putting implants in the wrong place. Other issues were making cuts in the bone at the wrong level or using the wrong method, making decisions that didn't match what was seen in the scans during surgery, problems with how frames and pins were used, and not involving the wider team when dealing with infections.

What are the implications for patients?

If surgery is not clearly needed or in the patient's best interests, it can lead to unnecessary procedures that put the patient at risk. When doctors do not take a full history, examine the patient properly, or review test results carefully, they may misdiagnose the problem and

choose the wrong treatment. Choosing an unusual method without a clear reason or proper oversight adds unnecessary risk, especially if the approach isn't proven.

When decisions are based on personal preference instead of a thorough assessment and recognised guidelines, patients and families may not be told about safer or alternative options. Poor communication and incomplete records make it hard to understand why decisions were made.

Of those patients treated by Mr Jabbar, where harm was identified, patients were subject to:

- Inappropriate or poorly documented surgical strategies, such as a singular correction, rather than a progressive incremental correction and inadequate surgical fixation.
- Insufficient safety netting advice (providing patients with clear information about when to seek further medical help if their condition does not improve or new worrying symptoms appear) in follow-up.

Identification, Management and Ownership of Complications

What is standard practice in the UK?

Doctors must spot complications quickly and act straight away to keep the patient safe. This means checking the patient promptly, raising concerns when needed, and using treatments that are evidence based and risk assessed. They should explain clearly to the patient and their family what has happened, what will be done, and what the likely outcome is. If something goes wrong, doctors must be open and honest, report the problem, and make sure it is properly investigated so lessons can be learned.

Taking responsibility is essential. Doctors should not shift blame but own the decisions and care provided. They need to work closely with colleagues, call in specialists when necessary, and make sure the child or young person's care continues smoothly. Records must be clear, accurate, and written at the time, showing what happened, what was done, and what was discussed with the patient and family.

What were the findings of the review in relation to Mr Jabbar's clinical practice (identification, management and ownership of complications).

Standard practice: There were examples of prompt recognition and effective management of complications, including timely surgical intervention, multidisciplinary escalation, and appropriate antibiotic use. In some cases, clear communication with families and robust follow-up supported patient safety and functional recovery.

Sub-standard practice: Delayed or missed identification of serious complications, limited Consultant oversight and onward referral, and inadequate documentation of discussion of adverse events with other team members. There was evidence of inconsistent postoperative reviews and a lack of action despite concerning findings. There were instances when patients appeared to have a complication of surgery, yet their symptoms were misattributed to an alternative diagnosis.

Issues with recognising and addressing complications, as well as insufficient intraoperative safeguarding of neurovascular structures and inadequate preparation of the bone for fusion surgeries, further highlighted areas needing improvement.

What are the implications for patients?

If problems after surgery are not spotted quickly and dealt with appropriately, the patient could come to harm. Their condition might get worse, recovery could take longer, or the situation could even become life-threatening. Delays in raising concerns or using unrecognised treatments can lead to care that is unsafe or ineffective. When doctors don't explain clearly what went wrong and what will happen next, patients and families are left worried and confused, which damages trust and makes it hard to make decisions together.

Of those patients treated by Mr Jabbar, where harm was identified, patients were subject to:

- Delayed recognition or management of complications such as compartment syndrome, infection, non-union, malalignment, and neurovascular injury with limited onward specialist referral and inconsistent consultant oversight.
- Incomplete documentation around complications and infected implants.

Chapter 4: Wider Learnings and Actions

In this chapter we describe the findings of the review into the Orthopaedic Service and the actions we have taken as a result to improve the service and services across the hospital. We have reflected on what has happened and asked ourselves what more we can do to make our services safe and therefore have also set out the additional actions we are taking.

Improving the Orthopaedic Service

The Royal College of Surgeons Review

As described earlier in this Report, as well as reviewing the care provided by Mr Jabbar, we asked the RCS to review the Orthopaedic and LLR Services through their invited review service. Whilst conducting the initial investigation we found evidence that indicated broader concerns about ineffective teamworking in the LLR service. As such, an invited review from the RCS was considered the most appropriate way to explore these concerns and to identify any areas of improvement impartially.

The RCS produced two reports: one into the service; and the other into the practice of the two Surgeons. As is described earlier, they raised serious concerns about the practice of Mr Jabbar which led to our patient recall process. The practice of the other Surgeon was found to be of a good standard.

We received the report into the service – the Service Review - on 31 October 2023. It highlighted areas of good practice and areas of concern that had the potential to impact on patient safety and care.

The areas of concern included:

- Team working, communication, behaviours, inclusivity, culture, and the effectiveness of MDT working.
- Identification, management, and discussion of complication rates.
- Effectiveness of existing clinical governance practices.
- Management of patient referrals, follow ups and waiting lists.

The RCS did not ask or recommend for the practice of any other member of the team to be reviewed.

The report highlighted the many committed staff who worked hard every day to deliver the best care possible to their patients. The reviewers also said that despite the challenge and constraints they found, they were impressed by the quality and standard of care being provided by staff, and their passion and commitment towards providing excellent support and communication to patients and their families, as well as to each other.

Royal College of Surgeons Report Recommendations

The RCS made a total of 122 recommendations for the hospital to consider. We accepted all the recommendations, and we established the Orthopaedic Service Improvement Board in April 2024 to oversee the actions required to address the recommendations.

A comprehensive action plan was developed to address the recommendations, with the recommendations grouped into the following themes:

- Trust wide / corporate actions.
- Team working, unity and communication.
- Clinical record keeping.
- Outpatient processes.
- MDT processes.
- M&M processes.
- Patient recall.

All the RCS recommendations have been fully addressed, and in response to our update provided on 9 October 2025, the RCS stated that considerable progress has been made, with a good foundation in place in order for the Orthopaedic Service to move forward. Given the work that has taken place and the programme of work which remains in progress, they have concluded their active follow-up of this review. This conclusion is based on the hospital seeing through the remaining actions.

Orthopaedic Service Improvement Programme – Areas of Focus

Ensuring the Orthopaedic Team had the right resources and support

Supporting the Orthopaedic Team and rebuilding as a collective was key to enabling improvements and changes in practice. We recognised that the review findings were challenging for them and had impacted relationships within the team and with the Senior Leadership Team (SLT).

To support this work, we appointed an Interim Speciality Lead who had extensive experience in clinical leadership. Regular meetings between clinical and senior operational leaders were established to improve communication, identify issues early, and solve problems collectively. Key areas of improvements in practice are detailed in the section below.

We have recruited two new Consultant Surgeons; one specialises in Paediatric Limb Reconstruction and the other has a specialist interest in neuromuscular conditions. These two appointments addressed the vacancy left by Mr Jabbar and increased the workforce by an additional surgeon as recommended by the RCS.

New Referral and Follow-up Patient Processes

A standard process is now in place which governs the way the Orthopaedic Service accepts new patients, manages its waiting lists, and how it schedules appointments. Since the Review, the time taken for new referrals waiting to be seen has improved, and there are fewer patients waiting for appointments.

A “Consultant of the week” system has been introduced so that one specific Consultant is responsible each week for reviewing incoming referrals. Clear referral acceptance and rejection criteria and guidance have been agreed to ensure referrals to this highly specialised service are appropriate. When the service cannot accept a referral, advice is sent to the referring team.

Improving Multi-Disciplinary Team and Mortality and Morbidity (M&Ms) processes

When complex specialist care and treatment is being planned and considered, it is important that a range of professionals are involved in discussions around care. Two ways this can routinely take place are through effective MDT and M&M meetings.

MDTs, otherwise known as peer-support meetings, are meetings where a number of different surgeons, together with other professionals, input into the plans for complex care before and during delivery to ensure the best possible outcomes. These discussions are also a way to identify and discuss differences in clinical practice which may lead to concerns being raised.

M&Ms are meetings that allow clinical staff to reflect upon and discuss complications, unexpected events and adverse outcomes.

The RCS Service Review highlighted a need to improve the processes around the MDT and M&M meetings within the Orthopaedic Service. To address this, clear terms of reference were introduced for each meeting which define the purpose, membership, and expectations for behaviours in these meetings. A standardised process for preparing, presenting, and documenting cases at both meetings has also been added into the electronic patient record system.

The improved MDT process now ensures that all planned orthopaedic operations are discussed in a formal fortnightly meeting before surgery to agree that the surgical approach is appropriate, and again after surgery to review its outcomes. These meetings involve the Orthopaedic Consultants, a Radiology Consultant and a number of Allied Health Professionals (including Specialist Nurses and Theatre Nursing staff).

Surgeons from GOSH also now meet fortnightly with Orthopaedic Surgeons and other clinicians from the Royal National Orthopaedic Hospital (RNOH). This face-to-face meeting provides an opportunity for combined case discussions, with early identification of challenges, and for sharing experience and knowledge to suggest where adjustments to surgical plans may be beneficial.

These discussions help to ensure the best possible surgical plan is devised for the patient. For the GOSH Consultants, the focus is to discuss complex limb reconstruction cases that may be outside the sphere of expertise of the other surgeons in the Orthopaedic department at GOSH. This would include all patients for whom circular external fixator frames are being considered, in keeping with a recommendation for the RCS Review.

Records of these joint meetings show comprehensive and supportive discussions. Patients and families in these complex cases, where management is particularly difficult, are informed in advance that their case will be discussed in these meetings and are then kept informed of the outcomes of discussions. Patients and families have reported their appreciation of this process.

The pre-existing M&M meetings continue as a separate process to the MDT meetings. Patients whose care does not go to plan are identified by the Orthopaedic Team and discussed in detail at this monthly meeting. These discussions help identify factors (including surgical, medical, nursing, or administrative) that may have influenced undesirable outcomes and highlight potential improvements.

Developing Outcome Measures

There are currently no internationally agreed outcome measures for paediatric patients with lower limb reconstruction needs, and very few units in the UK are collecting such data. The team of clinical staff that work to care for orthopaedic patients, and in particular the Physiotherapy team, have reviewed the specific outcome measures for children and young

people with limb differences that are available internationally and have agreed on a system that they feel is most appropriate to guide and assess treatment for our patients at GOSH. This work is being presented at national conferences in the UK in 2026.

The team have also agreed outcome scores for conditions that affect the foot and ankle and for neuromuscular conditions that require orthopaedic surgery.

Understanding and Improving Team Culture

Those staff from the Orthopaedic Service and teams that support them, who had been interviewed as part of the RCS review, took part in follow-up interviews led by our Human Resources (HR) team. The follow-up interviews took place in February 2025 and were to understand whether the improvement work had resulted in the Orthopaedic Service feeling different to work in, specifically related to teamwork and behaviours.

The results showed improvements in the team culture, with staff reporting positive changes. They also identified future priorities, including the recruitment of a Specialty Lead from within the service. This Specialty Lead is now in place.

Improving Wider Services at the Hospital

Our patient safety statement was approved by the GOSH Board in February 2023, which cements our commitment to listen, learn, and lead to ensure that we deliver high-quality and safe care to our patients and families.

As part of this commitment when we have concerns about any individual member of staff or service, we will not hesitate to undertake a review to ensure that the care we provide is of a high standard. Where it is not, we have a duty to learn from what we have found and to ask ourselves if there are wider learnings and actions we must take in other areas of the hospital.

Actions arising from the Review

In addition to the actions detailed above to improve the Orthopaedic Service and the care it provides, the RCS made a number of 'corporate recommendations' for the hospital to take forward.

These included:

- The hospital making dedicated efforts to build stronger links with RNOH.
- Improving the way complaints are responded to.
- Ensuring there are formalised, robust and transparent ways for staff to raise concerns.
- Improving staff induction and training to better integrate incoming staff.

Taking these in turn:

Building stronger links with RNOH

As detailed above we now have a fortnightly MDT meeting involving members of staff from both clinical teams. A monthly Partnership Board meeting takes place between GOSH and the RNOH, which include members of the Executive and Senior Leadership Teams of both Trusts. This oversees the exploration of opportunities to collaborate across the full range of orthopaedic clinical and clinical support activities, including transition from children and young people's services to adult services. Both organisations are working together within the region

to identify how to improve outcomes, access, patient experience, quality and clinical efficiency of children and young people's Musculoskeletal services across North Central London.

Improving the way complaints are responded to

Complaints training was delivered to the Directorate Leadership Team which oversees a range of services including orthopaedics in January 2024. The complaints training covered:

- Understanding what a formal complaint is and how they are managed.
- Guidance on how to conduct a thorough investigation into a formal complaint.
- Increased awareness of the tools to support an investigation of a complaint.
- How to write a formal complaint response.
- Guidance on appropriate tone.
- Apologies when writing a response.

Ensuring there are formalised, robust and transparent ways for staff to raise concerns

We know that a keyway of being alerted to potential issues with care is by all staff speaking up. As explained earlier we were alerted to potential issues with Mr Jabbar's practice after a colleague raised concerns and we are grateful for the staff member who did this.

The ways in which staff can raise a concern are detailed in our Freedom to Speak Up Policy and we undertake a continuous programme of education to ensure our staff are aware of all the routes - internally and externally – they can use.

Our Freedom to Speak Up Guardian (FTSUG) service is an important way staff can speak up although we know that speaking up happens across the hospital in many other ways too. In the last year we have doubled the FTSUG Service's resource which has allowed us to be more proactive in developing a Speak Up culture. Work has included going out to target hard to reach areas and areas where there has been low reporting. We also ask all staff to complete the National Guardian's Office Speak Up and Listen Up training.

The latest data on FTSUG cases shows that we are in the highest quartile nationally for the proportion of staff speaking up. While we know some barriers still exist to speaking up, we have already seen examples where members of staff have spoken up where something has not felt quite right with outcomes and we have then been able to review services with the clinical teams to ensure the care is of the standard we, and our patients and their families, expect.

Improving staff induction and training to better integrate incoming staff

We have reviewed and updated our induction programmes for all Consultants with an increased focus on job planning and team responsibilities and accountabilities. A peer support group for Consultants who have under five years' service has also been set up. We are also currently training the first cohort of mentors to support a mentorship scheme for new Consultant colleagues.

Actions arising from our reflections on what has happened

Whilst the RCS report focused specifically on the Orthopaedic Service, there were lessons and recommendations within it that have broader implications and opportunities for GOSH.

GOSH has therefore developed a hospital-wide Quality and Safety Improvement Programme (QSIP). This builds on an existing programme of patient safety transformation.

This programme is overseen by the Executive Management Team and has been co-created with the Senior Clinical Leadership Teams to deliver the changes identified by the RCS as well as findings from the recent Surgical and Well Led inspections by the CQC in 2025. GOSH recognises that it cannot operate in isolation, and there have been several significant national publications recently which alter the way NHS Trusts view quality, safety, and patient experience. These publications will be considered within the QSIP to ensure that GOSH continues to learn from others.

The QSIP is structured across several phases. Our current phase which runs to March 2026 includes the following priority areas:

- Strengthening meeting governance in relation to MDT meetings and M&M meetings across all of our specialities.
- Training and development programme for Speciality Leads to ensure they have the necessary skills and expertise to lead their speciality.
- Supporting the smooth running of the speciality through service level planning; an annual agreement that defines the duties, responsibilities, and objectives for all Medical Consultants.

Progress Against Trust Wide Actions

MDT and M&M Meeting Governance

We are undertaking a large piece of work to standardise MDTs across the hospital. We started by reviewing national and international guidelines and good practice to agree a definition and generic Terms of Reference.

We are now working with all our specialties to ensure that they have up-to-date terms of reference and a nominated chair for every MDT meeting. We are also focussing on how the meetings are run to ensure consistency and quality of our documentation, and to raise the profile of all voices within an MDT. To support this, we are working with all chairs to focus on skills such as managing conflict, behaviours, consistent documentation, actions, and identifying themes.

As with MDTs, we are undertaking a large piece of work to standardise M&M meetings. We have reviewed national and international guidelines and good practice and are agreeing a definition and generic Terms of Reference. We have set up a Task and Finish Group to look at M&M documentation to agree a standard process and how we gather cross organisational themes.

Reviewing Outcome Measures for Our Services

Many of our services have nationally agreed outcome measures which are reported and allow us to compare our clinical outcomes with others and therefore identify any variances.

However, we know in some services like LLR there are no nationally agreed outcome measures. We are doing a comprehensive piece of work to identify the services where there are no nationally agreed outcome measures and are now working with our teams and national and international peers to discuss what measures we could use.

We have also developed a proposal to set up an outcomes workstream through the Children's Hospital Alliance (CHA). This is being actively discussed with the CHA and would see us work with other children's hospitals and services across the UK to establish a clinically meaningful approach to benchmarking outcomes for low-volume, high-complexity paediatric services.

Investing in our clinical leaders

Effective leadership is key to a high functioning team and delivering safe care. For each of our clinical specialties we have a Specialty Lead. We are co-creating a leadership programme with these leads. It has already delivered two managing doctors masterclasses to over 40 senior members of staff, and a one-year development course is planned to start in April 2026. The course will support learning within three domains described below:

1. Self-Leadership and Leading Teams

This is about leaders understanding themselves first — their strengths, weaknesses, and values — so they can lead others effectively. It also covers how to motivate and support teams, helping everyone work well together.

2. Organisational Leadership and Management

This focuses on running a department or service within the NHS. It is about planning, managing resources, and making sure things get done efficiently while keeping patients, families, and staff at the heart of decisions.

3. System Leadership

This is about looking beyond the leader's team or organisation and thinking about the bigger picture — how different parts of the NHS and social care work together. It is about collaboration across boundaries to improve care for the whole community.

We anticipate that our leads will develop a community of practice, learning and sharing with each other, exchanging ideas, solving problems together, and supporting each other to keep improving.

Supporting Patients to Raise Concerns

We work hard to ensure our staff are able to respond directly to concerns raised by patients and families, and/or to signpost feedback pathways as and when issues arise during the course of a child or young person's care. We appreciate that patients and families may have issues they feel have not been addressed and therefore support them to raise concerns through a number of other routes.

A keyway we aim to listen and resolve concerns is through our PALS team – often the first port of call for patients and families. In addition to this, patients and families are able to share any feedback (including any concerns or issues) through the Friends and Family Test feedback processes (via paper cards or electronically). Staff from Patient Experience review feedback received to ensure that it is being managed through the appropriate process and that that it is followed up appropriately. Information about ways to raise any issues and/or share feedback are promoted through the hospital including but not limited to posters, information on bedside entertainment systems, via MyGOSH (the electronic health record app) and patient information.

Of note, we robustly monitor PALS contacts and triangulate with other data sources such as complaints and other feedback to identify any themes/areas that we need to look into.

Martha's Rule

Martha's Rule was introduced into the NHS following the tragic events which led to the death of Martha Mills following a bicycle accident. It provides a way for patients, families, and staff to raise concerns they may have about themselves or a patient and receive a second opinion.

The concerns are addressed by the Clinical Site Practitioners, who are advanced nurses who provide care for unwell children, support staff and families and oversee emergency admissions

and staffing out of hours. They provide an opportunity for those concerned to discuss any worries or deterioration with someone impartial.

GOSH acted as a pilot site for the roll out of Martha's Rule and it is now in place across our hospital. Although this is in place, and has been utilised by families, we know we need to improve the visibility of the programme for families and make it clearer exactly how they seek advice.

Chapter 5: Next Steps

Support to Patients and Families

We are deeply sorry to all the children, young people, and their families who have come to harm or have been impacted by these events. We also recognise that the findings within this report will be difficult for some patients and their families to read and we are very sorry for any distress that this causes.

Psychological support remains available for any patients and their families impacted. If you feel you would benefit from this, please contact the Patient Advice and Liaison Service (PALS) on 020 7829 7862 or by emailing pals@gosh.nhs.uk. In addition, if you have any general questions or need to discuss any of the elements in this report, please also contact our PALS team.

The NHS has a list of charities and organisations who may be able to provide support, and these can be found at www.gosh.nhs.uk/orthopaedic-review. Alternatively, you can also seek support from your General Practitioner (GP), and you can also find helpful advice and support from AvMA, a charity for patient safety and justice (www.avma.org.uk).

We appreciate families may wish to discuss their own concerns directly with the Police and can do so via normal routes including calling 101 or visiting their nearest station. For more information visit <https://www.police.uk/pu/contact-us/>.

Working with Other Organisations

We have been working closely with our Local Authority Designated Officer (LADO) to keep them informed of our work. The LADO is a safeguarding professional who is responsible for overseeing concerns, allegations, or incidents involving individuals working with children and young people.

They work with multiple organisations including social care, the Police, and employers to manage allegations and take any steps necessary. Informing them of our work to recall patients for review is a standard part of our 'Working Together to Safeguard Children' guidance.

NHS England Independent Patient Safety Investigation

After receiving the RCS report, GOSH began to explore commissioning an investigation, led by an independent party, to understand whether there were any missed opportunities to prevent the harm that occurred prior to concerns being raised. This was widely supported within the hospital, and oversight was to sit with the Non-Executive Directors on the Trust Board.

After sharing plans with NHS England, it was agreed that NHS England London region would commission an independent patient safety investigation to review the responsiveness of GOSH when potential harm was identified within the complex clinical pathway for the limb lengthening service.

The investigation will focus on governance and organisational culture at GOSH and aims to:

- Promote openness and transparency about what occurred and the factors involved.
- Identify opportunities for improvement to reduce the likelihood of similar events in the future.

- Provide actionable recommendations to strengthen the delivery of health services across relevant organisations.

This review is intended to complement the RCS assessments by concentrating on systems and processes rather than individual cases or clinical harm.

It is something that the hospital welcomes and we will work with the appointed company to ensure that we are able learn from these events and ensure that steps are taking to reduce the risk of a similar incident taking place in the future.

Chapter 6: Glossary

Term	Definition
Acute correction	Correction of a deformity in a single surgery, rather than correcting the deformity across multiple surgeries.
Amputations	Surgery to remove part of a limb.
Bone grafts	Small pieces of bone (from your child or a donor or synthetically made) used to fill gaps or support bone healing.
Casting	A hard protective shell (plaster or fibreglass) that holds a limb in place while it heals.
Circular frames	A circular frame in orthopaedic surgery is a medical device used on the outside (external) of the leg or arm to provide stability and the allow surgeons to make small adjustments of bone positioning during healing.
Clinical Nurse Specialists	Senior Nurses with expertise in the specific speciality who provide expert care, manage cases, advocate and support patients and their families through their health care journey
Clinical priority	How urgently care or surgery is needed, based on safety and benefit for the child.
Compartment Syndrome	A rare emergency where pressure builds in a limb and threatens blood and nerve supply—needs urgent care.
Conservative management	Treating a medical condition using the least invasive, non-surgical methods
Consultant Paediatric Orthopaedic Surgeon	A Senior Children's Bone and Joint Surgeon who leads surgical care and decision-making.
Deformity	Where a part of the body has not developed in the usual way or does not have the usual shape.
Deformity planning	Careful measurement and imaging used to plan the safest, most effective way to straighten or correct a deformity.
Duty of Candour	A legal duty for NHS organisations to be open and honest when care may have caused harm, including an apology and explanation.
Epic	Epic is a supplier of electronic patient record systems. All patient notes, investigations and theatre records are within Epic patient records. *GOSH went live on the Epic system in 2019.
External metalwork	Any metal device on the outside of the limb, such as frames or pins attached through the skin.
Fixation	Holding broken or cut bones steady using plates, screws, pins, or nails so they can heal.

Fracture	A broken bone.
General anaesthetic	Medicine that sends the patient to sleep so they feel no pain during an operation.
General Medical Council	A public body that regulates Doctors, Physician Associates, and Anaesthetic Associates in the United Kingdom.
Holistic approaches	Looking at the medical, physical, emotional, and social aspects when planning care.
Implants	Medical devices like screws, plates, rods, or nails placed in the body to support bones.
Inadequate fusion preparation	Not preparing bone or joint surfaces well enough before fusion, which can reduce the chance of solid healing.
Insufficient stabilisation	The bone wasn't held firmly enough by the metalwork, risking poor healing or movement.
Interventional Radiology	A medical specialty which uses image-guidance to perform surgery through small incisions.
Intra-operative imaging	Taking medical images during a surgery, in real time, to help the surgical team see what's happening inside the body as they operate
Intra-operative safeguarding of neurovascular structures	Protecting nerves and blood vessels during surgery so they aren't stretched, trapped, or injured.
Invasive surgical technique	A procedure that involves cuts into the body or insertion of instruments to carry out treatment.
Lengthening nails	Telescopic metal rods placed inside the cavity of a bone that slowly lengthen it over time.
Limb lengthening	Medical treatment that helps make a leg or arm bone longer by using the body's natural ability to grow new bone
Limb reconstruction	Specialist surgery and support to rebuild or correct a limb's bones and soft tissues.
Malalignment	A bone or joint that is not in the correct position.
Metal plates	Metal strips screwed to bone to keep it stable while it heals.
Metalwork	The screws, plates, rods, or wires used during surgery to hold bones steady.
Methodology	The agreed way the review or study is carried out—including what is checked and how decisions are made.
Misdiagnoses	When the original diagnosis turns out to be wrong.
Morbidity and Mortality Meeting	A regular safety and learning meeting where the team reviews complications and outcomes to improve care.
Multidisciplinary Team Meeting	A planned discussion where all the professionals involved in a child's care agree the best plan together.

Neuromuscular conditions	Medical conditions that affect the way your nerves and muscles work together.
Neurovascular assessments	Physical checks of blood flow and nerve function in a limb (colour, warmth, pulses, movement, and sensation), usually comparing the affected limb to the other.
Neurovascular status	The current blood supply and nerve function in a limb.
NHS England	The national organisation that oversees how the NHS runs in England.
Non-union	A broken bone that has not healed.
Nurses	Registered professionals who provide day-to-day care, monitoring and support for children and families.
Occupational Therapists	Specialists who help children do everyday activities (dressing, school, play) using exercises, equipment, or adaptations.
Orthotists	Clinicians who design and fit braces, splints or insoles to support limbs, improve alignment or function.
Osteotomy levels	The exact place(s) in a bone where it will be cut to change shape or alignment.
Outcome measures	Simple scores or tests used to track how well treatment is working (for example: pain, movement, daily function).
Peer review	Peer review is a process where medical experts check each other's work to make sure it is accurate.
Physiotherapists	Movement and exercise specialists who help children build strength, improve mobility, reduce pain, and recover.
Pin-site infection	Redness or infection around a pin that goes from a frame into the skin; usually minor and treatable.
Play Specialists	Staff who use play to prepare, distract, and comfort children before, during and after procedures.
Post-operative fracture	A break in a bone that happens after surgery.
Prevalence	How common something is - e.g., how many children out of 100 have a condition.
Psychological support	Help from mental-health professionals to cope with feelings, stress or trauma linked to illness or treatment.
Psychologists	Professionals who help children and families with emotions, coping strategies and behaviour.
Psychosocial factors	Family, school, emotional and social influences that affect a child's health and recovery.
Radiographic findings	What X-rays or scans show.
Recall Pathway Workstreams	The strands of work that handle reviewing care and tracking progress for the orthopaedic review.

Reparative Pathway Workstreams	The strands of work that handle further treatment when reviews find care needs to be amended.
Resident Doctor	A fully qualified Medical Doctor who is still undergoing postgraduate training. They have finished medical school but are not yet a consultant or GP. They work in hospitals (or sometimes GP practices) while continuing their training and gaining experience.
Risk counselling	A discussion between a clinician and a patient to inform the patient about the potential risks and benefits of their care.
Safety and Quality Strategies	The hospital's plans to improve safety and the quality of care over time.
Safety Transformation Programme	A hospital-wide improvement programme to strengthen patient safety systems and culture.
Safety-netting advice	Clear guidance on warning signs to watch for and when to seek help after you go home, usually given during the discharge process
Senior Responsible Officer	The executive leader accountable for an improvement programme's delivery and oversight.
Staged Observations	Refers to a medical approach where a patient is monitored and reassessed at set intervals.
Suboptimal implant positioning	The screws, plates or intermedullary nails are not in the best place, which can affect alignment or healing.
Terms of reference	A written document that sets a meeting's purpose, membership and how it works.
The Royal College of Surgeons of England	An independent professional body and registered charity that promotes and advances standards of surgical care for patients and regulates surgery and dentistry in England and Wales.

Appendix A – High-Level Timeline

Date	Event
June 2017	Mr Jabbar joins GOSH
6 May 2021	Serious Incident Investigation concludes
15 June 2022	Concerns raised to Chief of Service
11 July 2022	Initial approach to Royal College of Surgeons
August 2022	Clinical practice restricted to non-complex surgery
September 2022	Review formally commissioned with the Royal College of Surgeons
1 October 2022	Mr Jabbar starts unpaid sabbatical
February, April and May 2023	Royal College of Surgeons visits GOSH
12 June 2023	Mr Jabbar formally resigns from GOSH
31 October 2023	Royal College of Surgeons Service Review Report received
29 May 2024	First patient review completed
24 October 2025	Patient recall concludes

Appendix B - Patient Recall – Breakdown of Figures

Identifying patients for review

Table 5: breakdown of patients identified for review.

Patient group	Number	Cumulative
Patients with Mr Jabbar's name included in their medical records	851	851
Patients initially excluded from review cohort because there was little evidence to suggest significant contact with Mr Jabbar	(130)	721
Patients added to the review cohort following family contact with PALS	2	723
Patients added to the review cohort following re-evaluation of medical records	97	820
Patients removed from GOSH's cohort as it was determined the most significant area of their care was delivered by another hospital	(37)	783
Patients who were determined to have the most significant aspect of their care delivered by another hospital, BUT their review had already been done by GOSH	6	789
Total patient review cohort led by GOSH		789

Table 6: patients by clinical prioritisation category

Category	Total patients by categories
1	149
2	117
3	15
4	411
5a	60
5b	37
Total	789

Appendix C – Harm Definitions

NHS England has established guidelines on how to assess clinical harm and the gradings that are applied. Full information can be found at: [NHS England » Policy guidance on recording patient safety events and levels of harm](#)

For the purposes of the GOSH review of patient care, only physical harm was assessed. This is because the independent experts were Orthopaedic Surgeons, not mental health professionals, and as such were not themselves in a position to assess or diagnose psychological harm.

Table 7: Gradings of harm as per NHS England guidelines

Level of Harm	Physical Harm
No Harm	Any patient safety event that had the potential to cause harm but was prevented, resulting in no harm, or any patient safety incident that occurred, but no harm was sustained by the patient. No physical harm has been sustained.
Low/Mild	Low physical harm is when all of the following apply: - Minimal harm occurred – patient(s) required extra observation or minor treatment. - Did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit. - Did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication. - Did not or is unlikely to affect patient's independence. - Did not or is unlikely to affect the success of treatment for existing health conditions.
Moderate	Moderate physical harm is when at least one of the following apply: - Has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment and did not need immediate life-saving intervention. - Has limited or is likely to limit the patient's independence, but for less than 6 months. - Has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.
Severe	Severe harm is when at least one of the following apply: - Permanent harm/permanent alteration of the physiology - Needed immediate life-saving clinical intervention.

	• Is likely to have reduced the patient's life expectancy. • Needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment. • Has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability of their existing health conditions. • Has limited or is likely to limit the patient's independence for 6 months or more.
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Trust Board 29 January 2026	
Chief Executive's update Submitted by: Matthew Shaw, Chief Executive	Paper No: Attachment O ☐ For approval ☐ 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 Note delegated authority is requested for the integrated plan and accompanying Board assurance statements to be discussed and agreed by the Finance and Performance Committee.	
Strategic Risk BAF Risk 1: Financial Sustainability BAF Risk 3: Operational Performance	
Action required from the meeting Delegate authority to the Finance And Performance Committee (as above)	
Consultation carried out with individuals/ groups/ committees Not applicable – routine business	
Who is responsible for implementing the proposals / project and anticipated timescales? Executive Team	
Who is accountable for the implementation of the proposal / project? CEO	

Financial position

The Trust is working to finalise its integrated planning statement to NHS England, with a 12th February 2026 national submission deadline.

This multi-year plan will cover the actions required to build on recent progress in operational performance including further improvement to referral to treatment times, and actions to return the Trust to ongoing sustainable financial balance. It will include plans for the contribution from NHS, International & Private and other commercial activities, and detail the productivity and efficiency initiatives planned to support successful delivery.

Action for the Trust Board: As the plan will be submitted before the next meeting of the Trust Board, delegated authority is requested for the plan and accompanying Board assurance statements to be discussed and agreed by the Finance and Performance Committee.

Staff vaccinations

The Winter Vaccination Programme has continued to perform strongly through to January, ensuring ongoing protection for patients, families, and staff, while providing strong learning to inform future vaccination campaigns.

To date, over 3,400 members of staff have been vaccinated, equating to 57% uptake among frontline staff. The Trust remains number one in London for frontline staff flu vaccination uptake, sustaining this position over several weeks.

The programme was extended beyond December into January in response to the ongoing severity of flu this season and continued staff demand. Uptake has remained steady with repeated vaccine re-orders required, indicating sustained engagement rather than late-stage decline.

Alongside the walk-in service, proactive roving approaches and targeted night-shift delivery have supported uptake, taking vaccination directly to staff, including non-clinical and less visible service areas. This approach enabled engagement with staff groups who do not routinely access clinic-based services, including staff who had not previously been vaccinated.

Acknowledging the work GOSH staff are leading

Over the past few months, GOSH has featured prominently in positive national and sector media outlets, testament to the incredible achievements of our staff. Notably, groundbreaking work on the world-first base-edited T-cell gene therapy for previously incurable T-cell leukaemia, developed in collaboration with UCL, has been widely covered and showcases how our cutting-edge science is changing lives through translating research into real clinical impact.

We were extremely grateful to our partners at Arsenal, who arranged for the men's and women's first teams to visit in December, bringing festive cheer to patients, families and staff and generating uplifting coverage and social media engagement. We were also pleased to contribute to coverage of the £13.7m NIHR investment into brain tumour research, through a consortium for which Professor Darren Hargrave, Clinical Professor in paediatric neuro-oncology at GOSH and ICH will be co-lead. This underlines our central role in pioneering studies that could transform treatment options for young patients.

Collectively, these stories and many others not only demonstrate the collaborative impact of our staff and partners on patient outcomes and experience but also reflect the skill of our communications team in ensuring their achievements are widely heard and celebrated across media platforms.

Ends

Trust Board
29 January 2026

January IQPR (December 2025 Data)

Paper No: Attachment P

Submitted by:

Matthew Shaw, Chief Executive

☐ **For discussion**

Co-Authors

Dena Marshall, Chief Operating Officer
Dr Sophia Varadkar, Acting Chief Medical Officer
Tracy Luckett, Chief Nurse
Caroline Anderson Director of HR & OD

Purpose of report

Overall performance remains stable across most metrics. **National Outcomes Framework (NOF)** indicators have been highlighted, with the latest published data included. For Q2 2025/26, the Trust received an average score of 2.04 and remains in segment 3 due to the financial position. Q3 data is pending, but improvement is anticipated in the Access to Services domain following a reduction in long waits.

Access:

RTT performance continues to improve, reaching 69.9% in December. Only 193 patients (2.4% of PTL) were waiting over 52 weeks—the lowest level this year. There were 48 patients waiting over 65 weeks, slightly above projections due to unavoidable cancellations, with similar numbers expected in January.

DM01 performance dipped marginally but remains strong, with 13-week waits unchanged. The new MRI scanner goes live in January 2026, supporting greater throughput in February. Audiology diagnostic breaches reduced, supported by ABR sedation pathways and targeted initiatives. The Trust continues to benchmark favourably against peers for RTT and Diagnostics.

Overall **activity** remains below plan due to reduced elective and day-case admissions, lower specialty demand, greater emergency case complexity, and a shift to more day-case procedures. Planning for 2026/27 is underway, with directorates preparing second-round submissions for NHSE.

Patient Safety:

Central line infection rates remain below threshold, with no **Trust-assigned MRSA** or **C. diff** cases also reported.

Duty of Candour compliance met all required timelines.

VTE assessment compliance fell following improvement in the previous month; work continues to resolve a data integrity issue. **Medication safety incidents** continue to decline, nearing historical levels.

No **PSIs** were reported for the second consecutive month. Overall, patient safety indicators remain stable and within statistical control limits.

Patient Experience:

FFT scores remain strong with consistent positive feedback. Year-to-date **complaints** exceed last year, mainly relating to cancellations, communication, and treatment plans—issues also reflected in **PALS** contacts. PALS continues to work closely with clinical teams to support effective communication channels. Numerous compliments regarding staff performance were also received.

Well led: The Trust recognises the organisational impact of ongoing change, shown by increased contact with the FTSU Guardian, higher sickness levels, lower PDR rates, and more requests for HR and OD support. Sickness absence remains high across staff groups, with 40% attributed to cold/flu or anxiety/stress, though still below national averages. Appraisal completion rates remain below 85% and require additional focus. FTE and overall contractual headcount continue to reduce as organisational changes progress.
Patient Safety Implications None
Equality impact implications None
Financial implications None
Strategic Risk BAF Risk 3: Operational Performance
Action required from the meeting N/A
Consultation carried out with individuals/ groups/ committees EMT huddle
Who is responsible for implementing the proposals / project and anticipated timescales? N/A
Who is accountable for the implementation of the proposal / project? N/A

Integrated Quality & Performance Report January 2026

Reporting December 2025 data



**Dena
Marshall**

Chief
Operating
Officer

**Tracy
Luckett**

Chief Nurse

**Sophia
Varadkar**

Acting Chief
Medical
Officer

**Caroline
Anderson**

Director of HR
& OD

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IQPR Headlines, January 2026— reporting December's data

(1 of 2)

Chief Medical Officer Overview

Statutory Compliance: All statutory responses remain within required thresholds. Duty of Candour cases and Patient Safety Incident Investigations are progressing to plan and within agreed timescales. While December saw a slight increase in low-harm incidents and a reduction in moderate-harm incidents, these remain within expected monthly variation.

Venous Thromboembolism (VTE) Assessments: Compliance briefly improved in November but was not sustained into December. There is a noted discrepancy between VTE compliance recorded in EPIC and the figures reported by the data team. Work is underway to investigate and resolve this data integrity issue.

Medication Safety: Medication-related incident levels continue to trend downward toward historic baseline levels. Although no single cause for the earlier increase has been identified, targeted interventions led by Medicines Safety Pharmacists—supported by insights from Quality Support Visits—have been implemented in clinical areas. Ongoing monitoring continues via the IQPR Patient Safety KPIs.

Sophia Varadkar

Patient Safety

- No new PSIs were declared in December.
- All Duty of Candour completed on time
- Slight decrease in Clinical Harm Review completion

Chief Nurse Overview

We continue to see sustained improvement in central line–associated infection rates, with no MRSA bloodstream infections recorded since October 2025.

Inpatient experience remains strong, with FFT scores holding at 98%, meeting the Trust target. Outpatient satisfaction also improved to 95%. As expected during the Christmas period, the inpatient response rate dipped.

PALS contacts reduced to 185, aligned with seasonal trends, with 65% resolved within 48 hours. Complaints saw a modest rise to 14 in December, primarily related to cancellations, communication, and aspects of treatment.

Registered Nursing vacancies increased slightly to 3.4%, though this will improve with 12 new starters commencing in January 2026. Turnover remains stable at 8.3%, and sickness absence has reduced to 4.6%. Safer staffing incidents remain steady at 18 per month.

Tracy Luckett

Patient Experience

- FFT inpatient response rate target was not met this month (24%)
- Both Inpatient and Outpatient experience targets were met
- Slight increase in complaints from the previous month
- All other indicators remain stable

Infection, Prevention & Control

- Central line infection rates have sustained improvement
- Three cases of C.difficile reported this month
- There were no MRSA bloodstream infections this month

IQPR Headlines, January 2026— reporting December's data

(1 of 2)

Director of Human Resources & Organisational Development Overview

Workforce spend continues to be a key focus of the Trust's financial sustainability efforts, Organisational restructures within corporate directorates are being concluded, alongside workforce reviews aligned to professional staff groups within Clinical Directorates.

Review of workforce data and the impact of the workforce controls is undertaken weekly by Executive Management Team (EMT) and/or the Financial sustainability and shows a steady reduction in total workforce numbers currently tracking at 3.3% which is currently on track to match the projected year end run rate.

We acknowledge the impact of change to an organisation, which is reflected in increased contact with FTSU Guardian, sickness levels, reduction in PDR rates and requests for advice and support from HR & OD Teams and Managers it is also reflected in the outcome from staff survey which was received in December and is currently embargoed.

As we move through the next quarter we will continue to focus and prioritise organisational culture and provide opportunities for engagement with staff. This includes the promotion of our anti-racism statement following its launch on 3rd November and the refresh the Trust's values and behavioural framework, which moves from launch of the project into the development phase with staff focus groups running during December and January. Recruitment of the new CEO and launch of a second Mutually Agreed Resignation Scheme (MARS) in early January will add additional uncertainty.

Tracking these impacts, to identify additional support for teams and individuals will form part of the quarterly workforce report, which will be considered by EMT & People and Education Assurance Committee (PEAC).

Caroline Anderson

Well Led

- Slight decrease in headcount this month (-16.9 WTE)
- Voluntary turnover has decreased slightly to 7.1% from 7.2%
- Trust vacancy rate has decreased slightly (2.3%)
- Most other indicators are stable

Chief Operating Officer Overview

The Quarter 3 National Operating Framework (NOF) metrics have not yet been released. We anticipate that the Access to Services domain will show improvement for Q3, as reductions in long wait times are expected to positively influence the NOF outcomes.

There has been continued progress in RTT performance, with ongoing reductions in long waits. These results reflect the sustained commitment and hard work of the directorates. Long waiting times have reached their lowest level this financial year. December performance stands at 69.9%, with 193 patients waiting 52 weeks, representing 2.4% of the PTL.

Efforts to address 65-week waits resulted in 48 patients reported at month end. Although this figure did not align with initial projections, over half of these cases were attributed to factors beyond the Trust's control. This presents challenges for January, given a significant number of cancellations were due to illness, requiring up to six weeks before patients can be rescheduled. It is anticipated that January's 65-week waits will remain comparable to those in December.

DM01 performance declined slightly but remains strong, while 13-week waits were consistent with the previous month, reflecting continuous focus on this patient group. The new MRI scanner is scheduled to become operational in January 2026, following a necessary testing phase, and is expected to enhance throughput during February 2026. Audiology diagnostic breaches decreased in December, supported by improvements and progress in the ABR sedation pathway and waiting list initiatives.

December theatre utilisation was consistent with previous months. However, there was a 13% increase in completed cases and a 5% rise in utilisation in December 2025 compared to December 2024. Targeted efforts to optimise theatre planning during the Christmas period involved both operational and clinical teams.

Currently, overall, Trust activity remains below plan, primarily due to reduced volumes in elective and day-case admissions. This is attributed to lower demand in certain specialties, higher complexity among emergency cases, and a trend towards increased day-case procedures. Planning for the 2026/27 period is in progress, with directorates actively engaged and the second iteration of plans scheduled for submission to NHSE in February.

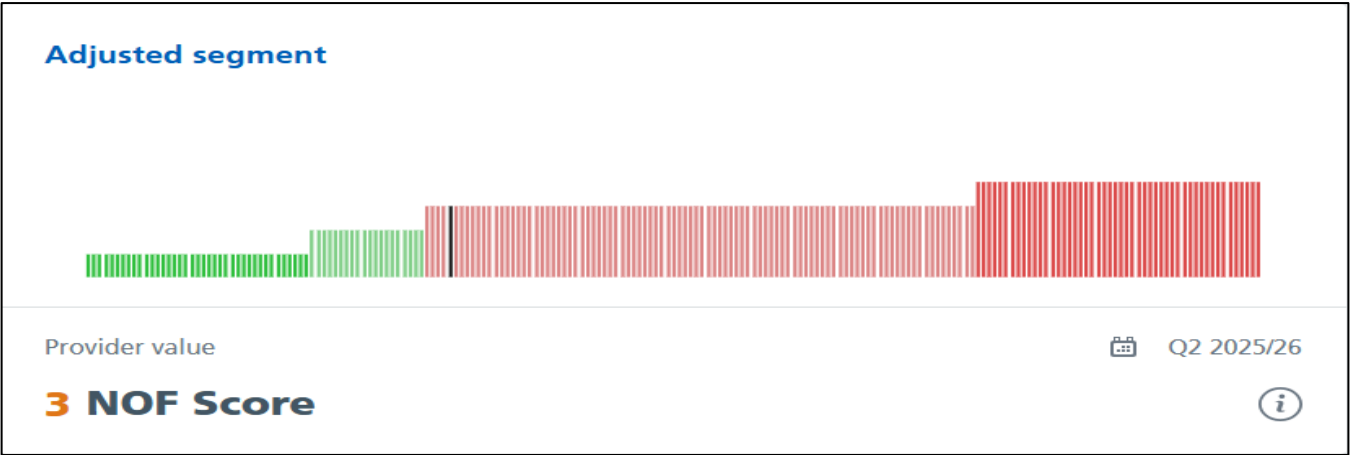
Dena Marshall

Access and Effectiveness

- RTT performance increased to 69.9% but below our operational plan trajectory. The number of patients waiting 52+ weeks continued to decrease and are now 193 (down 12).
- Diagnostics performance and long waits continues improve with a reduction of patients waiting over 6 and 13 weeks.
- Overall activity is 1% below plan, mainly due to day-case and elective inpatient activity, which are 4.2% and 7.3% below plan, respectively
- Other indicators are stable

National Oversight Framework: Updated position

Domain	Metric	Initial NOF Score Q1 25/26	Updated NOF Score Q1 25/26	Q2 NOF Score 25/26	Movement
Access to Services		2.2	2.28	2.53	0.25
Access to Services	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score	1.5	1.37	1.44	0.07
Access to Services	Difference between planned and actual 18 week performance score	3.0	2.39	2.80	0.41
Access to Services	Percentage of patients waiting over 52 weeks for elective treatment score	3.2	3.09	3.35	0.26
Effectiveness and experience of care		1.0	1.00	1.00	0.00
Effectiveness and experience of care	Average number of days from discharge ready date to actual discharge date (including zero days) score	1.0	1.00	1.00	0.00
Patient safety		2.4	2.89	2.92	0.03
Patient safety	NHS Staff Survey - raising concerns sub-score score	2.1	2.11	2.11	0.00
Patient safety	Number of MRSA cases	3.2	3.01	3.21	0.20
Patient safety	Rate of C-Difficile infections score	3.9	3.98	3.98	0.00
Patient safety	Rate of E-Coli infections score	1.0	4.00	4.00	0.00
People and workforce		1.2	1.19	1.25	0.06
People and workforce	Sickness absence rate score	1.1	1.07	1.18	0.11
People and workforce	NHS staff survey engagement theme sub-score score	1.3	1.32	1.32	0.00
Finance and productivity		2.0	2.11	2.52	0.41
Finance and productivity	Combined finance score		3.00	3.00	0.00
Finance and productivity	Planned surplus/deficit score	1.0	1.00	1.00	0.00
Finance and productivity	Variance year-to-date to financial plan score		4.00	4.00	0.00
Finance and productivity	Implied productivity level score	3.1	1.23	2.04	0.81



This score provides a single average value that reflects a provider’s performance across all scored metrics, spanning all applicable domains. It is designed to give NHS providers, systems, and regional teams a high-level view of overall delivery.

The score ranges from 1.00 (best) to 4.00 (lowest). It is based on the individual metric scores and is intended for peer comparison. It should be used alongside the domain scores and individual metric results to provide a more complete understanding of relative performance.

Our average metric score has increased from 1.9 to 2.01 during Q2 2025/26. However, due to our challenged financial position a financial override has been applied to our segment score, moving us from segment 2 to segment 3.

The table summarises how our NOF metrics have moved since the last publication. Of the 14 metrics listed, none have improved scores since Q1, eight have maintained scores and six have worsening scores. Worsening scores are related to our RTT, 52 WW position, staff sickness rate and implied productivity. It is worth noting that our 52 WW position has been improving during Q3. We expect the next update towards the end of Q4.

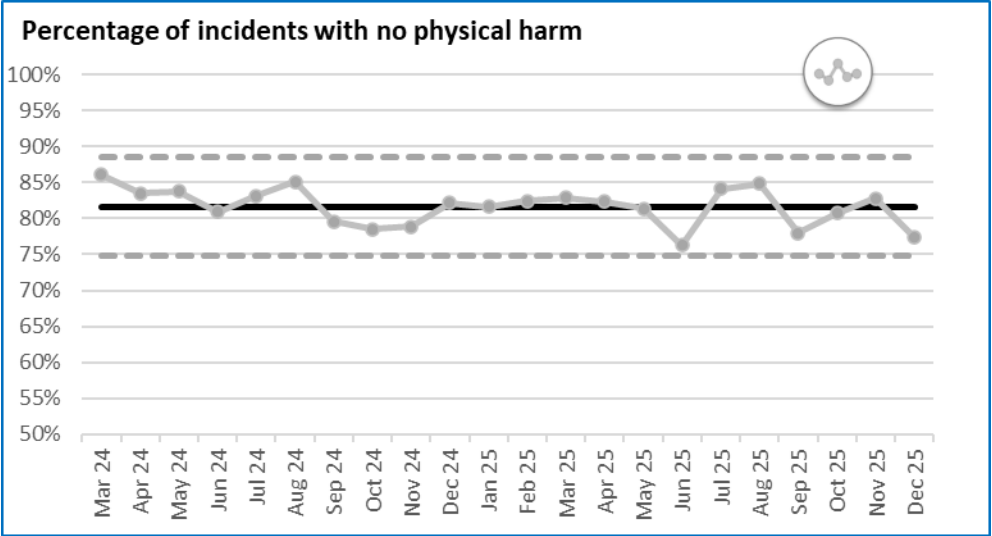
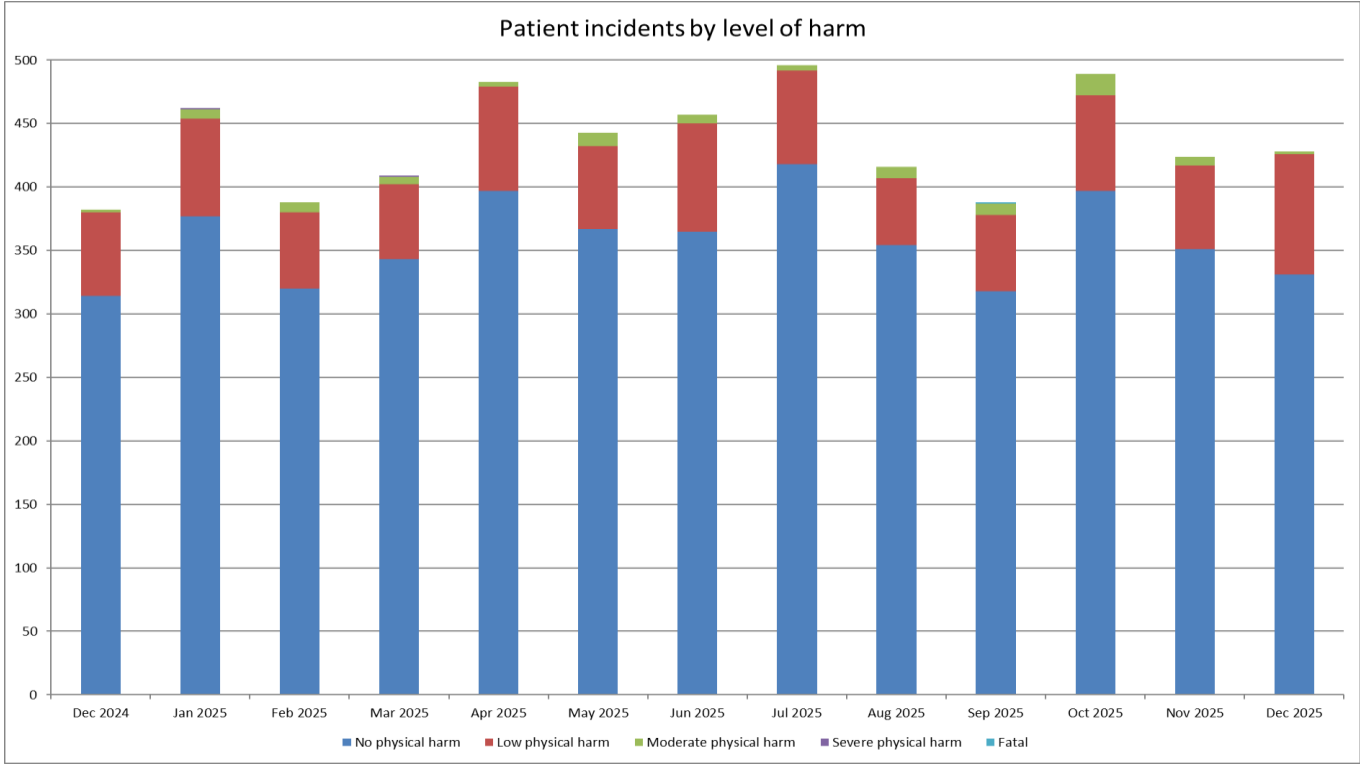
Overview

- **Patient Safety Incident Investigations:** No new PSIs were declared in December.
- **Duty of Candour:** Seven stage 2 letters were due in December and have been. Six stage 3 investigations were due in December, and all were completed within the timescale.
- **Targeted Activity:** Review of Incident Policy and PSIRF Priorities underway. Work also underway to reconfigure DoC, AAR and PSI sections of Datix to ensure more accessible data
- **Targeted Interventions and rise in moderate harm reporting:** Completion of Clinical Harm reviews saw a decrease this month. Focussed work within directorates is on going to ensure completion of harm reviews.

Patient Safety	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Last 12 months	SPC Trend	RAG		Stat/Target	
New PSIs	0	0	1	0	0	1	0	0	1	1	0	0			No Threshold		Target	
Near misses (Patient related)	149	156	151	170	129	158	163	143	123	142	115	117			No Threshold			
VTE assessment	20%	25%	30%	27%	14%	32%	16%	21%	19%	22%	43%	24%			95%			
2222 Calls	19	22	15	9	10	17	20	20	11	14	14	21			No Threshold			
Never Events	0	0	0	0	0	0	0	0	0	0	0	0			>/=1		0	Stat
Pressure Ulcers (3+)	0	2	1	0	1	1	0	0	0	0	0	0			>1	=1	=0	Stat
Duty of Candour Cases (new in month)	3	5	7	1	7	3	3	1	3	2	8	2			No Threshold		Target	
Duty of Candour – Stage 2 compliance (case due in month)	5/7	4/5	6/7	1/1	3/4	3/3	4/4	1/1	3/3	2/2	12/13	7/7			<75%	75%-90%	>90%	Target
Duty of Candour – Stage 3 compliance (case due in month)	0/0	1/2	2/2	0/0	3/5	3/5	0/2	2/2	1/3	3/4	2/2	6/6			<50%	50%-70%	>70%	Target
Freedom to Speak up contacts	15	12	21	19	12	22	21	9	9	27	16	9			No threshold			

Targeted Interventions	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Trend	SPC Trend	RAG		Stat/Target
Stool Screening Compliance	38.0%	35.0%	36.0%	37.0%	36.0%	43.0%	40.0%	42.0%	40.0%	40.0%	41.0%	37.0%					
ID Band Compliance	83.9%	84.8%	84.4%	84.4%	83.5%	85.8%	84.9%	84.2%	85.5%	87.9%	88.9%	87.4%					
WHO Checklist Compliance	99.5%	99.6%	99.2%	99.3%	99.2%	99.5%	99.8%	98.6%	99.0%	99.1%	98.8%	99.3%					
Clinical harm review process compliance- 65+ wks admitted pathways only	45.8%	44.5%	62.2%	77.5%	84.5%	82.5%	78.9%	79.4%	84.3%	84.5%	82.4%	80.3%					

Patient incidents



Statistically, the proportion of incidents without physical harm has remained stable, showing no significant deviations within statistical control limits.

After a rise in moderate physical harm incidents in October, linked to the earlier reported completion of the Dental Clinical Harm Review, the figures have since reduced back to prior levels.

	No physical harm	Low physical harm	Moderate physical harm	Severe physical harm	Fatal	Total
Apr 2025	397	82	4	0	0	483
May 2025	367	65	11	0	0	443
Jun 2025	365	85	7	0	0	457
Jul 2025	418	74	4	0	0	496
Aug 2025	354	53	9	0	0	416
Sep 2025	318	60	9	0	1	388
Oct 2025	397	75	17	0	0	489
Nov 2025	351	66	7	0	0	424
Dec 2025	331	95	2	0	0	428

Patient Safety – Infection Control

Overview

- Central line infection rates have sustained the improvement shown in November with six bloodstream infections attributed to line usage. Half of the identified organisms were skin organisms, representing the importance of skin colonisation as a risk in our population.
- Three cases of C. difficile were reported. The organism was identified within 3 days of admission. One child under 2 was also treated for C.Diff and is not included in the numbers below.
- No MRSA bloodstream infections were recorded, and other Gram-negative bloodstream infections remained within expected levels of variance.

Infection Control		Target Set	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025/26 YTD	Last 12 months	SPC Trend	RAG (25/26 threshold)			Stat/Target	NOF
Total C Difficile cases	In Month		4	1	2	2	4	0	0	3	3	2	1	3	18						Stat	NOF
C difficile Trust Assigned	Annually		2	0	1	2	4	0	0	2	1	1	1	0	11			>6	N/A	<=6	Stat	NOF
Total MRSA cases	In Month		0	1	1	0	0	1	0	0	1	3	0	0	5			>0	N/A	=0	Stat	NOF
MRSA Trust Assigned	In Month		0	1	1	0	0	1	0	0	1	3	0	0	5			>0	N/A	=0	Stat	NOF
Total MSSA cases	In Month		5	1	0	4	5	2	3	3	1	1	2	2	23			No Threshold				
MSSA Trust Assigned	In Month		5	1	0	3	5	1	3	2	1	1	1	0	17			No Threshold				
Total E.Coli Bacteraemia cases	In Month		3	2	1	1	1	2	3	4	2	0	1	1	15			>5	N/A	<=5	Stat	NOF
E.Coli Bacteraemia Trust Assigned	In Month		2	1	1	0	1	2	3	4	1	0	1	1	13			>5	N/A	<=5	Stat	NOF
Total Pseudomonas Aeruginosa	In Month		0	1	3	0	0	3	4	1	1	1	0	0	10			>8	N/A	<=8	Stat	
Pseudomonas Aeruginos Trust assigned	In Month		0	1	3	0	0	3	3	0	1	0	0	0	6			>8	N/A	<=8	Stat	
Total Klebsiella spp	In Month		3	7	2	1	2	5	3	1	2	5	3	3	25			No Threshold				
Klebsiella spp Trust Assigned	Annually		2	3	2	1	2	4	3	1	2	4	3	3	23			>27	N/A	<=27	Stat	
CV Line Infections	In Month		2.2	2.5	1.3	1.1	2.2	2.1	1.6	3.3	2.3	1.7	1.1	1.3	1.87			>1.6	N/A	<=1.6	T	

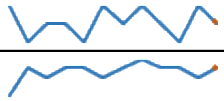
Overview:

The Friends and Family Test (FFT) inpatient experience rating for December remained high at 98%, successfully meeting the Trust’s target. The outpatient experience rating also increased to 95% so also met the Trust target. The inpatient response rate reduced to increased to 24% this month, which is not unusual during the festive period, as there were 323 less discharges in December. Feedback numbers overall remains high across all areas with more than 1400 submissions, with 77% of feedback containing a qualitative comment and 17% of feedback was provided by patients.

The number of complaints reported in December was 14, representing a small increase from November 2025 (n=13). Of these, one could not be investigated due to a lack of information to aid the investigation and lapse in time since the events. Heart and Lung complaints by patient activity increased significantly from November to December but on review the rate of complaints per 1,000 patient episodes (0.54) is aligned to the average over the last 12 months (0.57). Overall, the rise in complaints across the hospital continues with complaints from April 2025 to December 2025 43% higher than the same period in 2024 (n= 126 in comparison to 88)

Both the number of PALs contacts (n=185) and the 48-hour resolution rate (65%) fell again in December reflecting annual trends. Families contacted PALs requesting information about surgeries, appointments, care plans and reimbursements for cancelled appointments. PALs continue to work with wards and outpatient areas to promote ways in which patients and families can raise any concerns or issues.

Patient Experience

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Last 12 months	SPC Trend	RAG		
FFT Experience rating (Inpatient)	99.0%	97.0%	98.0%	98.0%	97.0%	99.0%	98.0%	99.0%	98.0%	97.0%	99.0%	98.0%		—	<90%	90-94%	≥95%
FFT experience rating (Outpatient)	92.0%	95.0%	94.0%	95.0%	95.0%	94.0%	95.0%	96.0%	95.0%	95.0%	94.0%	95.0%		—	<90%	90-94%	≥95%
FFT - response rate (Inpatient)	36.0%	28.0%	27.0%	29.0%	31.0%	27.0%	27.0%	24.0%	32.0%	24.0%	28.0%	24.0%		—	<25%	N/A	≥25%
PALS - per 1000 episodes	7.37	8.26	8.98	8.45	8.86	10.31	6.85	7.59	8.74	7.00	6.77	7.84		—	No Threshold		
Complaints- per 1000 episodes	0.30	0.38	0.38	0.35	0.57	0.44	0.54	0.67	0.39	0.55	0.47	0.45		—	No Threshold		
Red Complaints -% of total	9%	8%	8%	8%	7%	7%	5%	6%	6%	5%	5%	5%		—	>12%	10-12%	<10%

Headline - 14 formal complaints were received in December 2025, a small increase on last month (13). One of these complaints could not be investigated due to a lack of information to aid the investigation and lapse in time since the events. YTD 126 complaints have been received, compared to 88 during the same period last year.

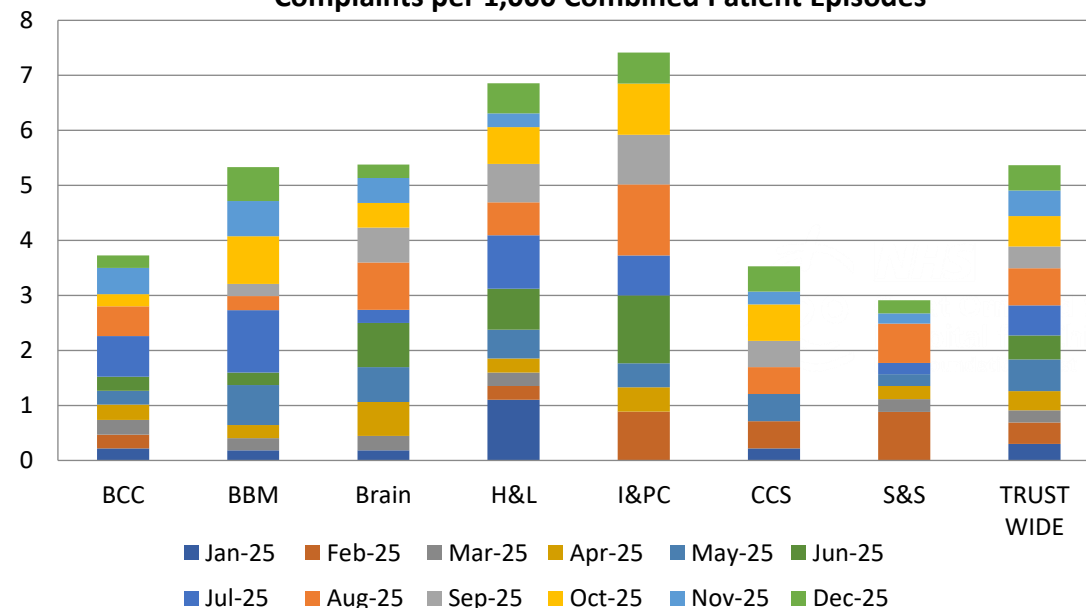
The complaints investigated in December related to concerns about:

- Care and treatment including but not limited to:
 - Management of catheters
 - Aspects of care prior to patient's death and questions about whether this could have been prevented with earlier diagnosis and treatment.
 - Post-operative complications.
 - Complications during an infusion on the ward, causing the patient's arm to swell, leaving the patient fearful to return to GOSH.
 - A misfiling of patient's diagnosis, resulting in the patient undergoing a procedure that was not recommended.
 - Incorrect diagnosis and missed opportunities.
- Communication including:
 - Miscommunication on whether a funding agreement had been approved. Family also raised concerns about the behaviour of the doctor they saw.
 - Parent feels judged by the GOSH medical team and having to justify the need for a general anaesthetic for their child.
 - Accuracy of correspondence from GOSH and amendments requested.
 - Lack of information around hospital events and activities for patients
- Cancellations of a Cardiology appointment.

Closed Complaints Since April 2025:

112 complaints have been closed since April 2025. Of these complaints, 47% of draft responses were received early or on time, a decrease from 52% last month. 77% of investigations were completed within the initially agreed timescale, an increase from 72% last month.

Complaints per 1,000 Combined Patient Episodes



Learning actions from a complaint:

Following a complaint regarding a last minute non-urgent surgical procedure, the following actions have been taken:

A change of practice for very complex patients requiring routine surgery. These patients will not be placed on a last-minute surgical list to allow for:

- Referral to the Specialist Gastrostomy Clinical Nurse Specialist Team to ensure patients can be counselled well in advance of the procedure.
- Additional time to co-ordinate with the Interventional Radiology Team and plan in collaboration around each team's availability.
- Improved and consistent communication between teams regarding the surgical and post-operative care.

Friends and Family Test

Overview: The Friends and Family Test (FFT) inpatient experience rating for December remained high at 98% and the outpatient experience score was 95%, so both met the Trust target. The inpatient response also decreased to 24% which is not unusual over the festive period and correlated with the reduction in discharges numbers. The overall number of feedback responses remains high at 1400 submissions. 77% of submissions contained qualitative comments and 17% were from patients.

Positive comments were predominantly about staff under the Patient Experience Framework theme of **respect for patient centred values**. There were numerous comments about the incredible staff who work across the Trust and how the care is outstanding.

Negative comments were varied again in December; there were comments about the long waits in x-ray and in outpatients and for treatment to start within day case areas. The predominant negative themes were **Access to Care, Co-ordination and Integration of Care and Physical Comfort**. There were comments about confusing appointment letters and notifications, poor communication about delays to appointments and confusing wayfinding. There were also comments about long waits between outpatient and imaging appointments and appointments that could have been swapped to a virtual appointment for families travelling long distances. In addition, there were comments about some outpatient areas not being welcoming.

Positive Areas:

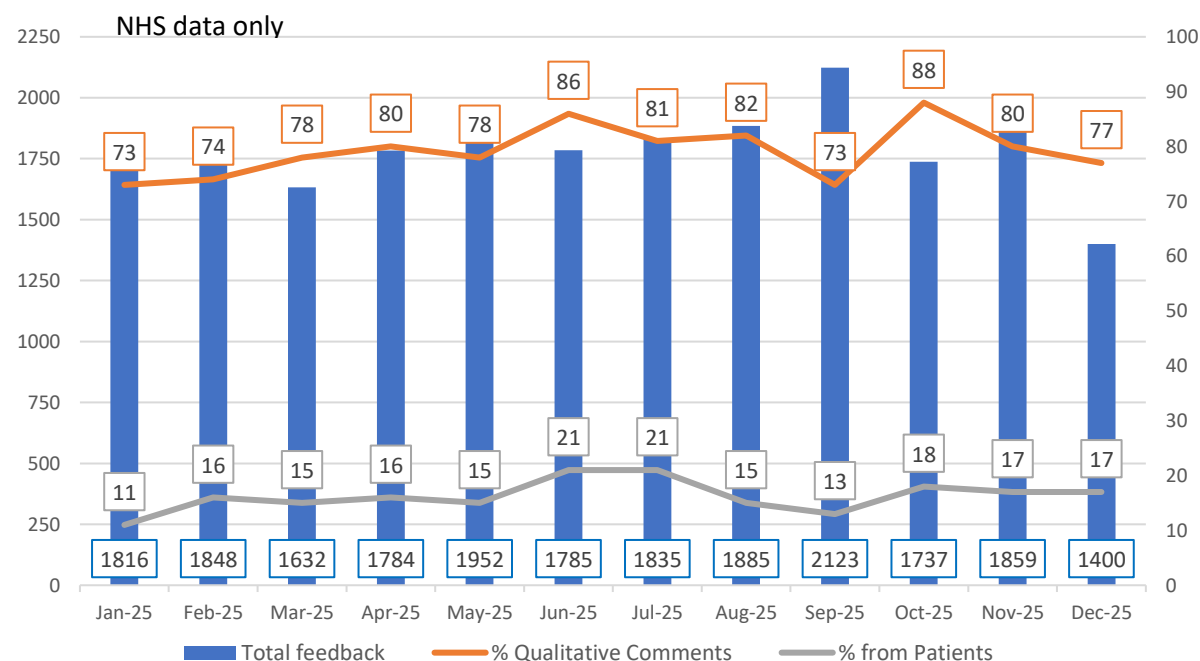
- Friendly kind caring and helpful staff across all roles.
- Staff go above and beyond.
- The Patient Hotel.
- Child friendly staff.
- Compassionate staff.
- Volunteers.
- Play Team.
- Christmas parties and decorations.

Areas for Improvement:

- Long waits for appointments.
- Poor communication about delayed appointments.
- Appointments booked for a different time to the stated time on the letter.
- More appointments could be virtual.
- Food.
- Outpatients- lack of food & drink, and poor welcome.

All positive feedback is shared with the staff named in comments. All negative comments are shared with the relevant area for comment and response to the patient / family if details are available. All comments are available on the dashboards which can be accessed here: [FFT Dashboards](#).

“The surgical team at GOSH saved our baby's life acting with urgency and empathy. All the staff here have shown exceptional care and support for our baby and for us as parents. The little touches and thoughtfulness have made a huge different to our experience and we leave feeling that we are more confident parents.”



Patient Advice and Liaison Service (PALs)

Headlines: PALs contacts decreased to 185 (200 in November) reflecting annual trends. Families contacted PALs requesting information about surgeries, appointments, care plans and reimbursements for cancelled appointments.

65% of contacts were resolved within 48 hours, compared to 71% last month. This variance is attributed to higher levels of annual leave during the holiday period.

Care Queries: Pals received 55 contacts from families seeking information about outpatient appointments and upcoming surgeries. They also raised queries about second opinions, medical plans, coordination of clinical care, outstanding test results and cancelled admissions. At directorate level, Sight & Sound received the highest number of contacts under this category (n=12) with Specialist Neonatal and Paediatric Surgery (SNAP) receiving the highest by specialty (n=7).

Contacts at directorate level: Overall **S&S** received the highest contacts this month (n=34) in comparison to 46 in November. The highest numbers by speciality were **Cardiology** (n=13) and **Ophthalmology** (n=11).

Other contacts related to **travel reimbursement, staff attitude, referral enquiries, transport requests, inpatient concerns admission, prescription and clinical enquires, outpatient appointments and Admission cancellations, and difficulties in obtaining test results and contacting clinical teams.**

PALs promotional materials:

PALs continue to work on promoting feedback routes for patients and families.

The poster shown on the right is displayed around the hospital and shared with wards and outpatient areas to inform families how to raise concerns and provide an escalation path from Charge Nurse/ Matron to PALs and if necessary, complaints.

This is beneficial as concerns raised with the team directly in the first instance can, in most cases, resolve issue there and then. It is also reassuring for the families to be aware of additional support available to them via PALS/Complaints should the team be unable to provide a resolution to concerns, or if they feel unable to raise these concerns themselves.

PALs have found that clearly displaying a number of these posters in key areas on the wards help to resolve issues and concerns quickly and supports the view that GOSH is a helpful and open organisation.

Do you have a problem that we can help with?

Option 1

Ask to talk to the Outpatients Manager or Ward Matron

or

For free, confidential advice and support contact the Patient Advice and Liaison Service
Tel: 020 7829 7862

Email: Pals@gosh.nhs.uk

or

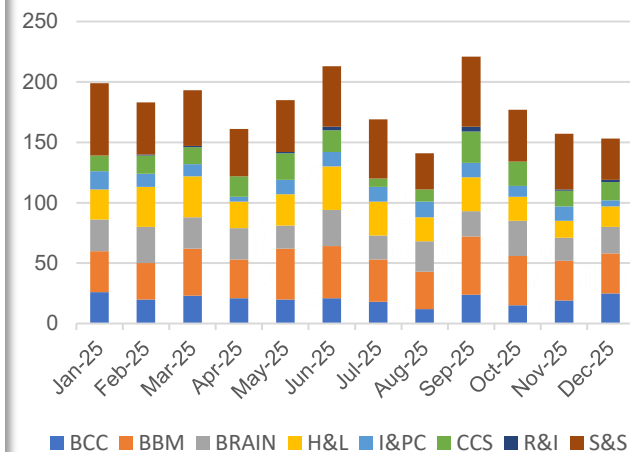
Option 3

To make a formal complaint contact the Complaints Department
Tel: 020 7829 8501
Email: Complaints@gosh.nhs.uk

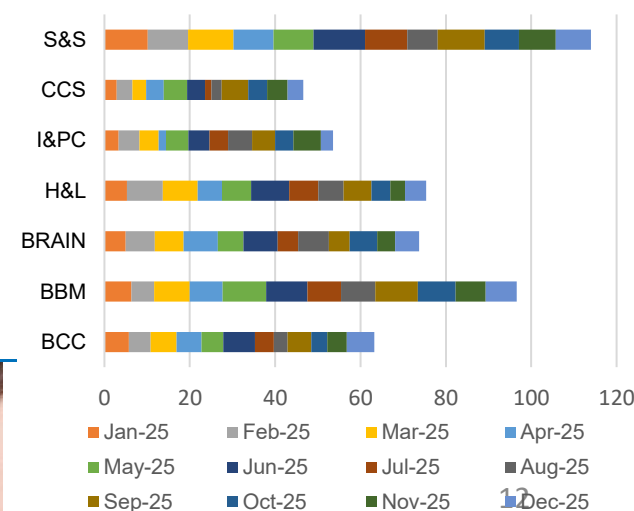
We take your problems seriously



Pals contacts by directorate



Pals contacts per 1,000 episodes



Patient Access - Waiting Times Overview

Overview

Waiting times across the two of the three primary national focus areas remain a significant challenge. Cancer metrics continue to meet the national requirements.

Referral To Treatment (RTT): Referral To Treatment (RTT): Performance for December 2025 stood to 69.9%, representing a marginal improvement of 0.5% compared to the previous month. The overall Patient Tracking List (PTL) has increased to 8,053 from 7,976, bringing it in line with figures observed over the past six months and reflecting seasonality. None of the directorates achieved the 92% standard this month. RTT performance continues to be impacted by patient and staff sickness, patient choice, theatre capacity constraints, and ongoing bed pressures.

At the close of December, the Trust had one patient waiting over **104 weeks**, who needs further investigations before treatment can commence.

78-week waits have reduced to 11, a decrease of seven compared to last month, with seven patients scheduled for their next contact in January and February. Efforts to reduce long-waiting patients remain a priority, with weekly executive oversight in place.

65-week waits decreased by four compared to last month and we did not achieve the December target of 27. However, circa 50% of breaches were mainly due reasons out of the control of the Trust which fell into to last minute patient and clinical cancellations, and awaiting results from other providers.

52-week waits while being marginally above trajectory waits have decreased to 193, marking the lowest recorded this financial year and reflecting all directorate sustained focus. This represents 2.4% of the PTL. The majority of long-waiting patients are in **Audiological Medicine (54), Plastic Surgery (42), Dental (30) and Orthopaedics (13)**. The Sight and Sound and Body, Bones and Mind directorates continue to experience the greatest challenges.

Diagnostic Waiting Times (DM01) For December 2025, performance decreased by 2.6% to 79.2%, from November but an increase of 15.2% since January 2025. The greatest challenges regarding diagnostic long waits persist in Cardiac MRI, Non-Obstetric Ultrasound, and Audiology, with targeted action plans currently being implemented. There has been a slight increase in 13-week waits this month, to 98 from 95 in October. However, since January 2025 13-week waits have decreased by 80%.

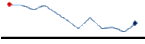
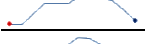
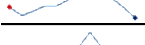
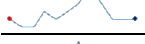
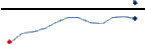
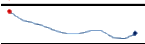
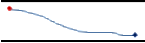
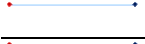
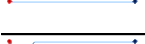
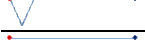
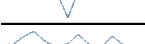
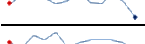
Cancer: It is projected that all five standards will be met for December.

Challenges and actions taken:

Capacity	
Key challenges are largely within Audiology, Dental and Orthodontics.	Additional GA ABR and ENT lists to support diagnostic testing and testing with a therapeutic procedure. Deliver ABR sedation pathway to increase capacity Explore ad-hoc WLI balance clinics and outsourcing to private providers Dental consultant recruitment in process but likely to be in place post April 2026 Orthodontic therapist recruited with a planned start date in March 2026
Staff and Patient sickness	
Bed closures due to combination of patient acuity and staff sickness Unexpected theatre maintenance and closures	Day-case Nightingale Ward project continuing Inpatient bed closures closely monitored Collaborative working with Space and Place on maintenance closures
Inherited waits	
Inherited waits above 52 weeks as other providers reduce backlogs (Where patient arrive from referring hospitals with a significant time already on the clock).	Continued focus and prioritisation on reduction of long wait patients.

Patient Access Metrics

Access Metrics Tracking

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Trajectory	Last 12 months	SPC Trend	Dec 25 target	March 26 target	Stat/Target	NOF
RTT Open Pathway: % waiting within 18 weeks	68.1%	68.8%	68.4%	68.4%	69.9%	69.8%	70.6%	69.2%	70.1%	69.2%	69.5%	69.97%	Below			72.4%	74.1%	Stat	NOF
Waiting greater than 18 weeks - Incomplete Pathways	2,580	2,584	2,530	2,577	2,515	2,443	2,376	2,466	2,375	2,387	2,339	2,418	-					-	
Waiting greater than 52 weeks - Incomplete Pathways	186	192	211	237	234	232	248	246	246	229	205	193	Above			175	84	Stat	NOF
Percentage of PTL 52+ weeks	2.3%	2.3%	2.6%	2.9%	2.9%	2.9%	3.1%	3.1%	3.1%	3.0%	2.7%	2.4%	Above			2.1%	1.0%	Stat	NOF
Waiting greater than 65 weeks - Incomplete Pathways	60	63	65	66	69	72	84	80	73	69	52	48	Above			31	0	T	
Waiting greater than 78 weeks - Incomplete Pathways	18	13	16	19	19	23	24	28	23	24	18	11	Above			0	0	T	
Waiting greater than 104 weeks - Incomplete Pathways	1	0	0	2	1	2	3	5	3	1	1	1	Above			0	0	Stat	
Percentage of patients waiting for a first attendance who have been waiting less than 18 weeks	70.5%	71.9%	76.4%	77.7%	78.0%	77.8%	79.7%	78.5%	78.4%	78.2%	77.6%	76.6%	Above			76.6%	78.0%		
Diagnostics- % waiting less than 6 weeks	64.0%	69.8%	71.3%	72.8%	77.5%	79.9%	80.7%	77.6%	76.4%	80.5%	81.7%	79.2%	Above			73.82%	76.01%	Stat	
Diagnostics- waiting greater than 6 weeks	934	780	709	664	551	501	499	559	548	442	401	513	-					-	
Diagnostics- waiting greater than 13 weeks	484	441	413	354	282	214	175	152	144	151	93	98	-					-	
Cancer waits: 31 Day: Referral to 1st Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Above			85%	85%	Stat	NOF
Cancer waits: 31 Day: Decision to treat to 1st Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Above			96%	96%	Stat	
Cancer waits: 31 Day: Subsequent treatment – surgery	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Above			94%	94%	Stat	
Cancer waits: 31 Day: Subsequent treatment - drugs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Above			98%	98%	Stat	
Cancer waits: 62 Day: Consultant Upgrade	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	-					-	
Cancelled Operations for Non Clinical Reasons	20	32	41	27	19	23	36	21	19	33	22		-					-	
Cancelled Operations: 28 day breaches	4	3	6	5	7	3	4	5	5	5	4		-			0	0	Stat	

Patient Access - Activity Monitoring at Month 9

Overview:

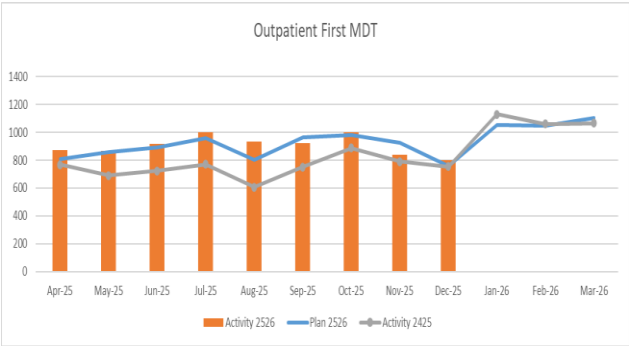
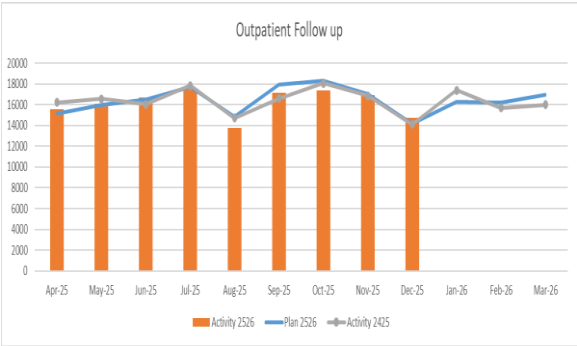
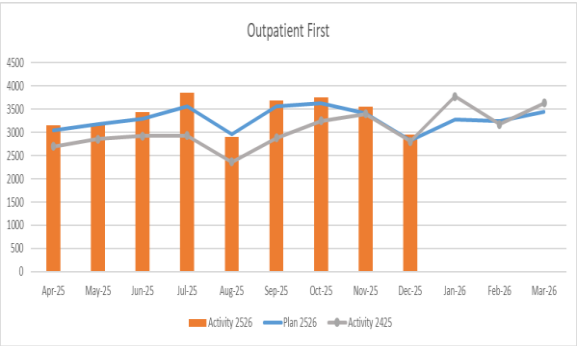
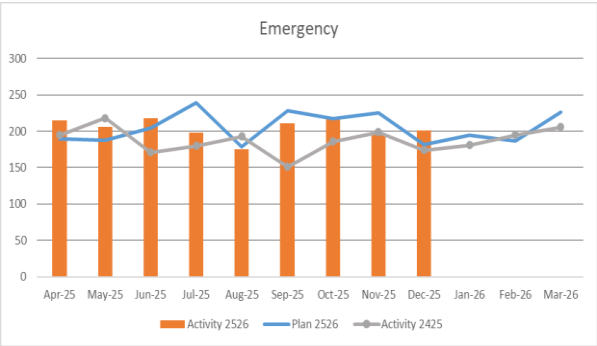
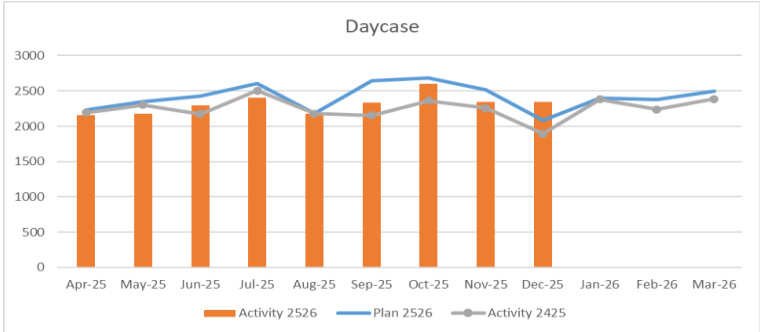
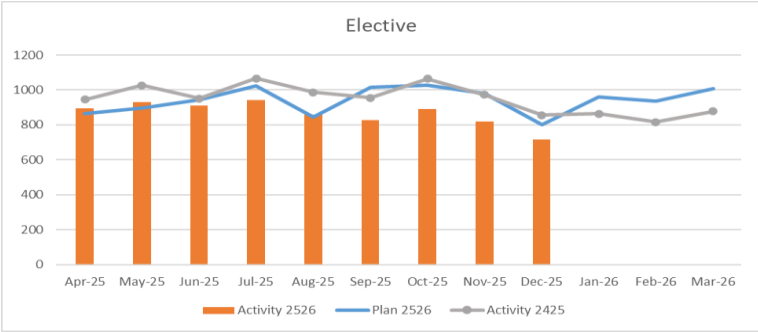
Overall, Trust activity is 1.0% below the plan. For ERF points of delivery, activity is 0.5% under plan, primarily due to reductions in day-case and elective inpatient activity, which are 4.2% and 7.3% below plan, respectively.

The decrease in day-case activity is largely attributable to four specialties—Oncology, Pain Management, Haematology, and Nephrology—which collectively account for 1186 fewer encounters. The shortfall in elective inpatient activity is principally related to ENT, Respiratory Medicine and Epilepsy. Preliminary analysis suggests that several factors are affecting elective activity, including reduced demand in Oncology and Haematology, the presence of complex emergency cases limiting access for elective admissions, and a strategic shift towards day-case procedures in ENT and Ophthalmology.

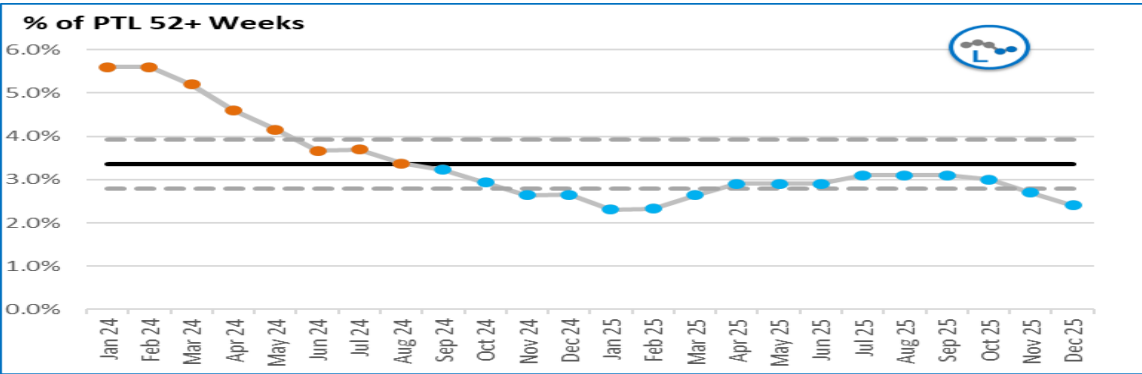
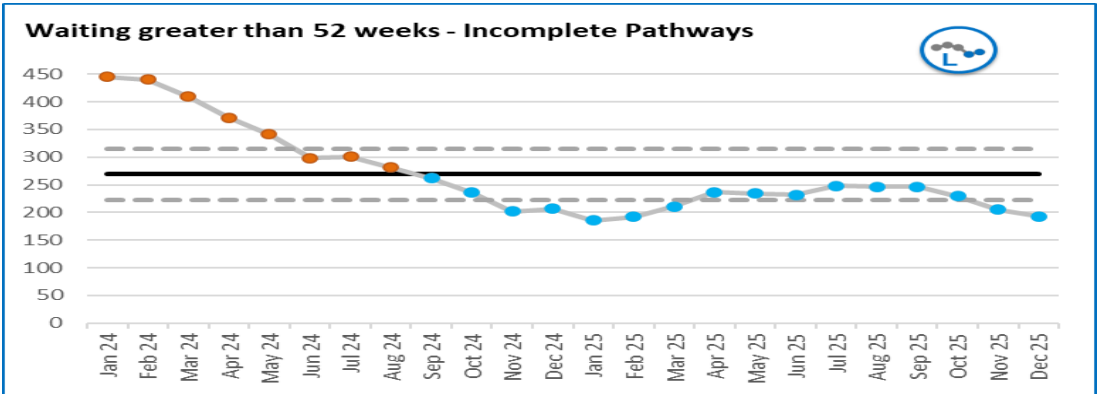
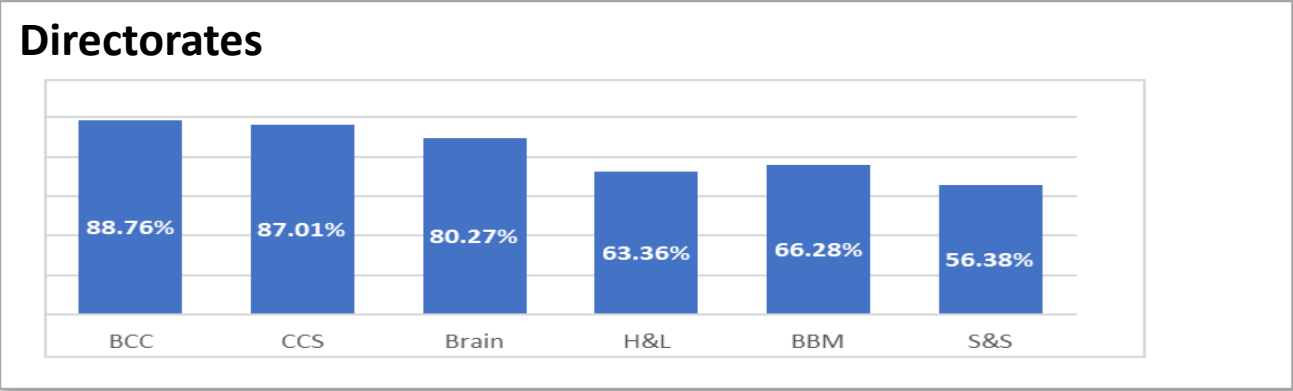
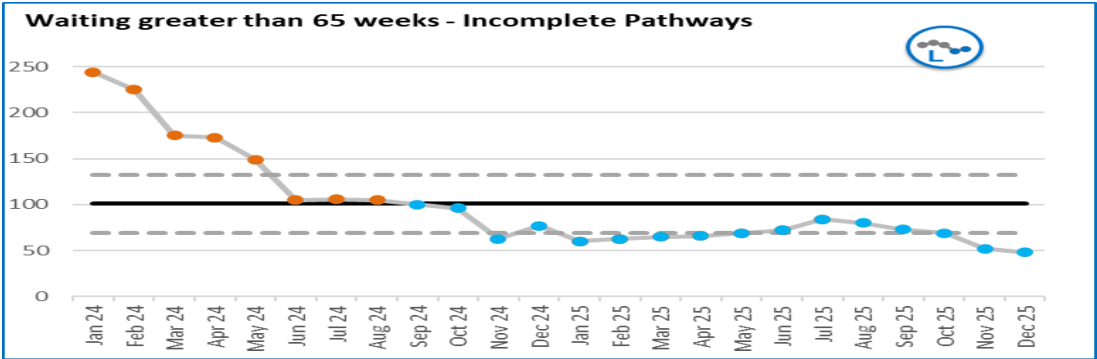
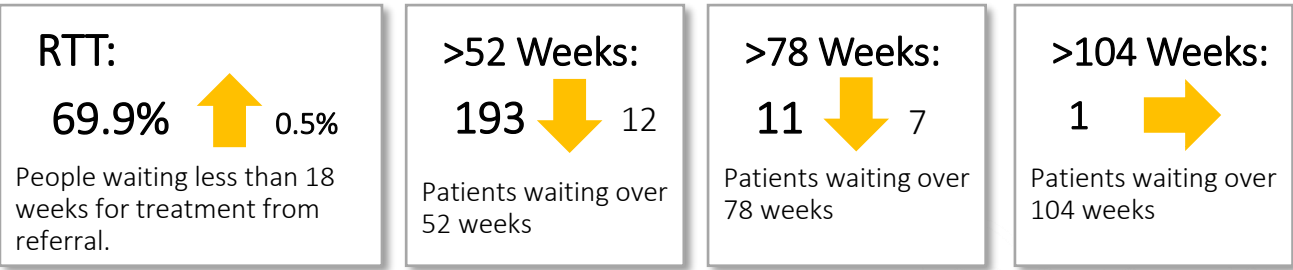
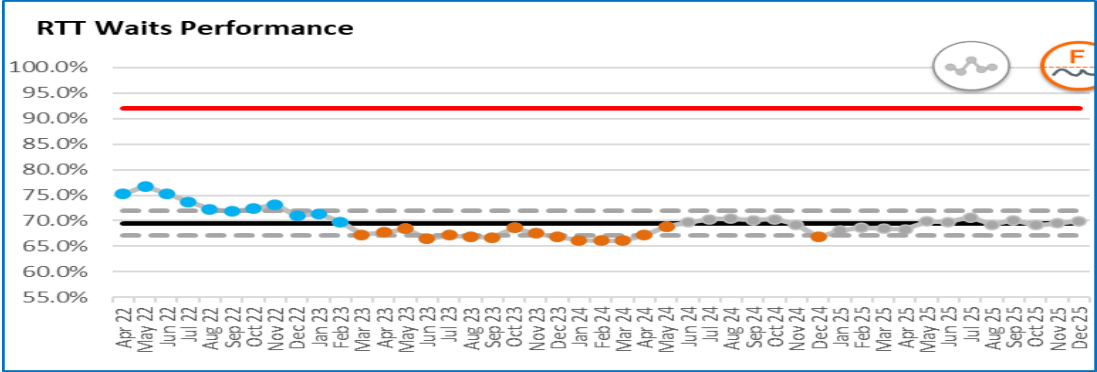
Conversely, first outpatient attendances have increased by 3.3% above plan, with significant growth observed in Respiratory Medicine, Clinical Genetics, and Endocrinology. Monitoring of First Outpatient MDT activity is ongoing; as at Month 9, activity is 2.5% above plan.

Overview M9 25-26

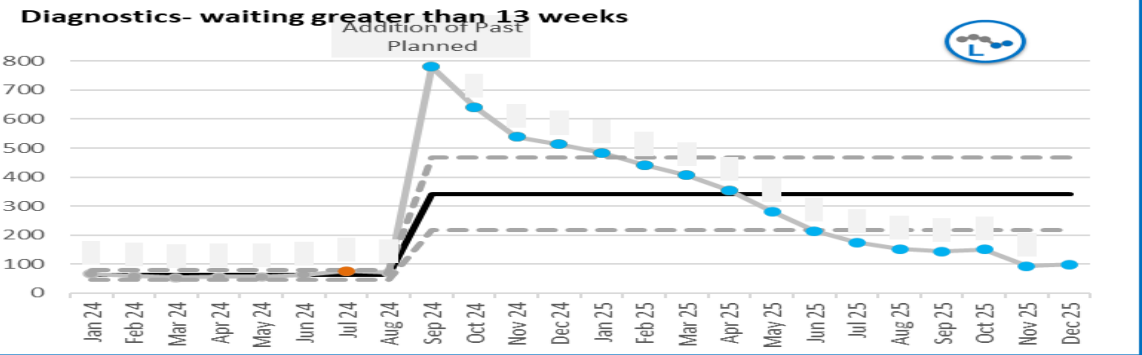
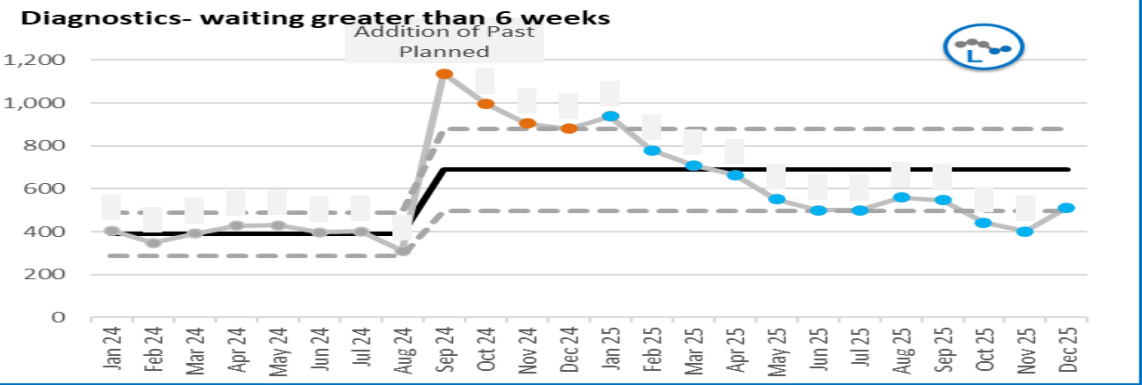
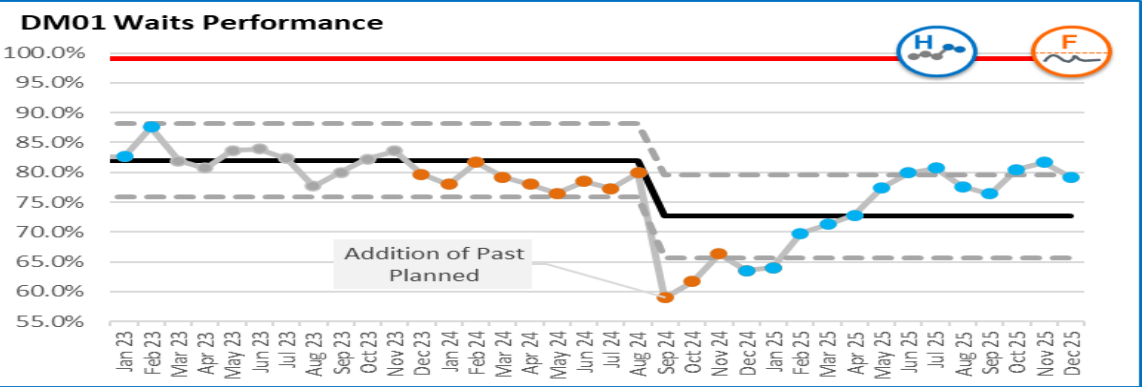
POD	Plan 25/26	Activity 25/26	Activity 24/25	% of 24/25	% of Plan
Daycase	21,729	20,827	20,025	104.00%	95.85%
Elective	8,402	7,789	8,831	88.20%	92.70%
Emergency	1,853	1,841	1,667	110.44%	99.35%
First OPA	29,454	30,427	26,108	116.54%	103.30%
Follow-up OPA	147,683	145,813	146,937	99.24%	98.73%
Frist OPA MDT	7,955	8,157	6,745	120.93%	102.54%
Grand Total	217,076	214,854	210,313	102.16%	98.98%



Referral to Treatment times (RTT)



Diagnostic Monitoring Waiting Times (DM01)

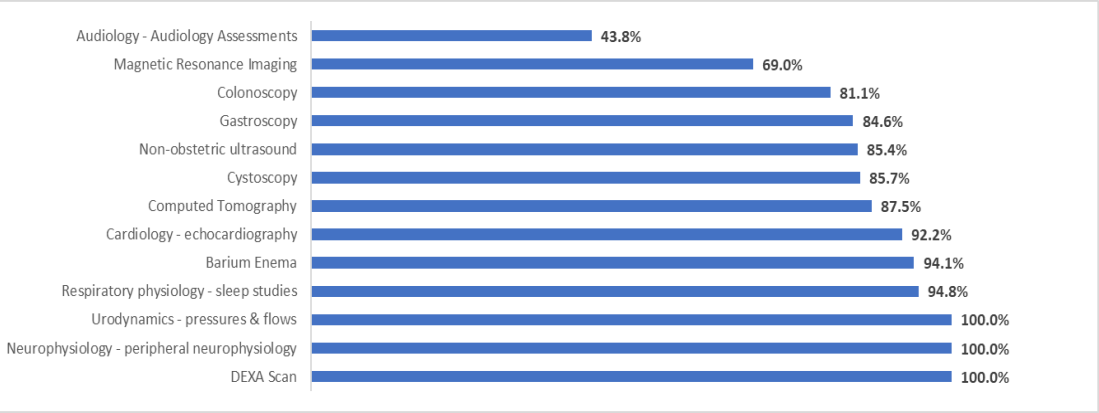


DM01:
79.2% ↓ 2.6%
People waiting less than 6 weeks
for diagnostic test.

>6 Weeks:
513 ↑ 112
Patients waiting over
6 weeks

>13 Weeks:
98 ↑ 5
Patients waiting over
13 weeks

December 2025 Performance by modality



Well Led Headlines: December 2025

Contractual staff in post: Substantive staff in post numbers in the current month are 5933 down from 5949.9 in the previous month (decrease of 16.9 FTE). Headcount is 6441 down from 6459 (decrease of 18)

Unfilled vacancy rate: Current month vacancy rates for the Trust has decreased by 0.7 % to 2.3%, the vacancy rates are highest in Medical Directorate (17.3%) and Research & Innovation (17.4%)

Turnover: is reported as voluntary turnover over a rolling 12-month period. Voluntary turnover has decreased slightly to 7.1% from 7.2% and is within the Trust KPI.

Agency usage: Agency usage is 0.2%, this remains within the 2% Trust target. The highest spending directorate is Human Resources (1.9%)

Statutory & Mandatory training compliance: Training rate for the Trust remained stable at 94% all directorates are meeting the target. NT Genomic Medicine service (99%), and International (98%) , achieved the highest rates

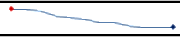
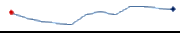
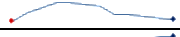
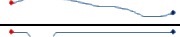
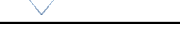
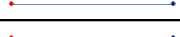
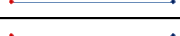
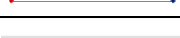
Appraisal/Personal Development Review (PDR) completion: The non-medical appraisal rate increased by 1% to 83%, the consultant's rate is 78%

Sickness absence: Sickness is over the trust target at 4.3% for the second consecutive month. 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 this month was 5.71%.

Freedom to Speak Up Guardians: There were 9 new substantive cases to the Freedom to Speak Up Guardians in December (compared to 27 in October and 16 in November). It is noted that December is often a month where we see a lower than usual number of new cases reported. The highest themes raised in substantive contacts again related to staff safety/ wellbeing and inappropriate behaviours/ attitudes, and staff contacting the FTSUGs came from a variety of professional backgrounds. Our Freedom to Speak Up Ambassadors reported 3 contacts relating to inappropriate behaviours/ attitudes and staff safety/ wellbeing (the ambassador role is to promote speaking up and signpost to different speaking up routes).

Well Led

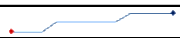
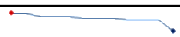
Workforce

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Last 12 months	SPC Alert	RAG Levels	Stat/Target	NOF
Turnover Rate (Voluntary)	9.3%	9.2%	9.0%	8.4%	8.3%	8.1%	7.7%	7.8%	7.3%	7.2%	7.2%	7.1%		↓	>15.4% >14-15.4% <14%	T	
Vacancy Rate – Trust	2.8%	1.5%	0.9%	0.2%	0.0%	1.7%	2.1%	2.8%	2.7%	3.9%	3.0%	2.3%		↑	>11% >10-11% <10%	T	
Sickness Rate	4.1%	3.8%	3.6%	3.5%	3.4%	4.0%	4.2%	4.0%	4.5%	4.5%	4.4%	4.3%			>5.3% 3-5.3% <3%	T	NOF
Substantive staff in post (WTE)	5919	5989	6028	6069	6080	6066	6040	5982	5977	5961	5949	5933			No threshold		
Stability Index	87.1%	86.3%	86.2%	86.0%	86.0%	86.3%	86.2%	87.5%	88.3%	89.9%	90.5%	90.7%			No threshold		
Appraisal Rate (Non-Consultants)	86.0%	88.0%	88.0%	88.0%	87.0%	86.0%	85.0%	85.0%	84.0%	82.0%	82.0%	83.0%		—	<80% 80-90% >90%	Stat	
Mandatory Training Compliance	94.0%	94.0%	93.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%			<80% 80-90% >90%	Stat	
Staff Pulse Survey - Employee Engagement															No threshold		NOF
Staff Pulse Survey - Involvement															No threshold		
Staff Survey - Motivation															No threshold		

Culture & Engagement

	Q4 24/25			Q1 25/26			Q2 25/26			Q3 25/26			Q3 25/26	Last 12 months	SPC Alert	RAG Levels
Advocacy score (staff recommending GOSH as a place to work)	73%															No threshold
Exit Survey - intention to return to GOSH	88.46%	85.71%	92.00%	88.00%	90.00%	70.00%	82.00%	74.00%	67.00%	71.00%	82.00%	69.00%				No threshold

Equality, Diversity & Inclusion

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25			
% Staff from diverse backgrounds (BME) - all staff	39.0%	39.0%	39.0%	40.0%	40.0%	40.0%	40.0%	40.0%	41.0%	41.0%	41.0%	41.0%			No threshold
% Staff from diverse backgrounds (BME) - senior leaders (8c+)	20.0%	20.0%	20.0%	21.0%	20.0%	21.0%	22.0%	22.0%	22.0%	22.0%	23.0%	21.0%			No threshold
% Staff from diverse backgrounds (BME) - Trust board	14.3%														
Relative likelihood of White / BME Candidates being appointed from shortlisting across all posts	2.03%														
Gender Pay Gap (Ave.)	16.9%			13.3%			11.3%			10.7%					

- Trust vacancy rate excludes cost centres GLA2 and GLA3

Safer Staffing- Nursing only

Vacancy rate: Registered nurse (RN) vacancy rate this month is 3.4% which has increased since November.

Voluntary Turnover: Based on a 12-month rolling average, the voluntary turnover for December remains below the Trust target (<14%) at 8.3%. Targeted retention initiatives to retain a skilled and experienced nursing workforce and continue to be monitored through the Nursing Workforce Assurance Group and Recruitment and Retention meetings.

Sickness absence: Nursing sickness rate has reduced to 4.6%. The top reported reasons are due to coughs and colds and anxiety/stress/depression.

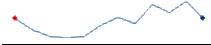
Care Hours per Patient Day (CHPPD) is a benchmarking metric and does not reflect true skill mix or patient acuity. CHPPD reflects the staffing levels based on open and occupied beds. This remained static in December at 16.

CHPPD Actual vs Plan: The Trust average was 94.5% and continues above the target of 90%.

Temporary staffing spend: Monthly Bank spend for December was 202k and the fill rate dropped slightly to 80%. Ongoing work to review bank usage and implement strategies that will contribute to the required financial and pay spend reductions, while ensuring the continued delivery of safe, high-quality care for patients and their families.

Safe Staffing Incidents: There were a total of 18 safe staffing incidents reported during December. All incidences were managed in line with Trust processes, and no patient harm was recorded. Incidents continue to be reviewed to identify themes and inform ongoing workforce and staffing mitigations.

Bed closures: The metrics 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. The total number of beds closed in December was 442 representing an increase compared with November.

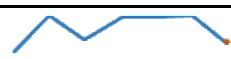
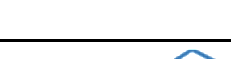
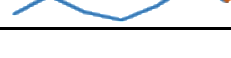
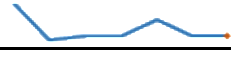
Safer Staffing Metrics	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Last 12 months	RAG Levels			Stat/Target
Vacancy Rate - Nursing	1.50%	0.70%	-0.10%	-1.10%	-1.70%	0.10%	0.00%	1.60%	1.60%	4.50%	1.90%	3.40%		>11%	10.1% - 11%	<= 10%	T
Turnover Rate (Voluntary)	11.3%	11.1%	10.7%	9.8%	9.8%	9.7%	8.7%	9.2%	8.3%	7.9%	8.4%	8.3%		>14%	N/A	<14%	T
Sickness Rate	4.6%	4.1%	3.8%	3.7%	3.8%	4.3%	4.7%	4.4%	5.3%	4.9%	5.5%	4.6%		>5.3%	3-5.3%	<3%	T
Care Hours per Patient Day (CHPPD)	16.0	15.4	15.5	16.4	16.4	16.0	16.2	16.9	16.0	16.2	15.6	16.0		No Threshold			T
Care Hours per Patient Day (CHPPD)- Actual vs Plan	93.30%	94.50%	93.90%	99.80%	99.80%	95.40%	97.30%	101.20%	95.40%	99.00%	96.70%	94.50%		<80%	80-90%	>90%	T
Agency Spend	1.3%	0.06%	0.10%	-0.50%	1.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		>2%	N/A	<2%	T
Safe Staffing incidents	9	9	11	8	9	12	14	18	5	22	19	18		No Threshold			T
Bank fill rate	70%	71%	75%	79%	81%	84%	77%	78%	79%	84%	86%	80%		No Threshold			T
Total Bank Spend £	459,282	502,286	534,093	249,694	383,115	334,004	316,574	334,818	376,267	212,844	180,601	206,733		No Threshold			T
Total monthly Bed closures	421	403	408	386	313	504	370	532	529	312	375	442		No Threshold			T



Research & Innovation Overview

The hospital and ICH have an ambition to become an intelligent research hospital and sustainable infrastructure support is essential to achieving this. It is therefore our highest BAF risk and will be monitored through two key indicators: 1) recruitment to time and target for our trials, which ensures we can apply for 100% of future BRC and CRF funding; and 2) monitoring our research income, especially for R&I infrastructure support.

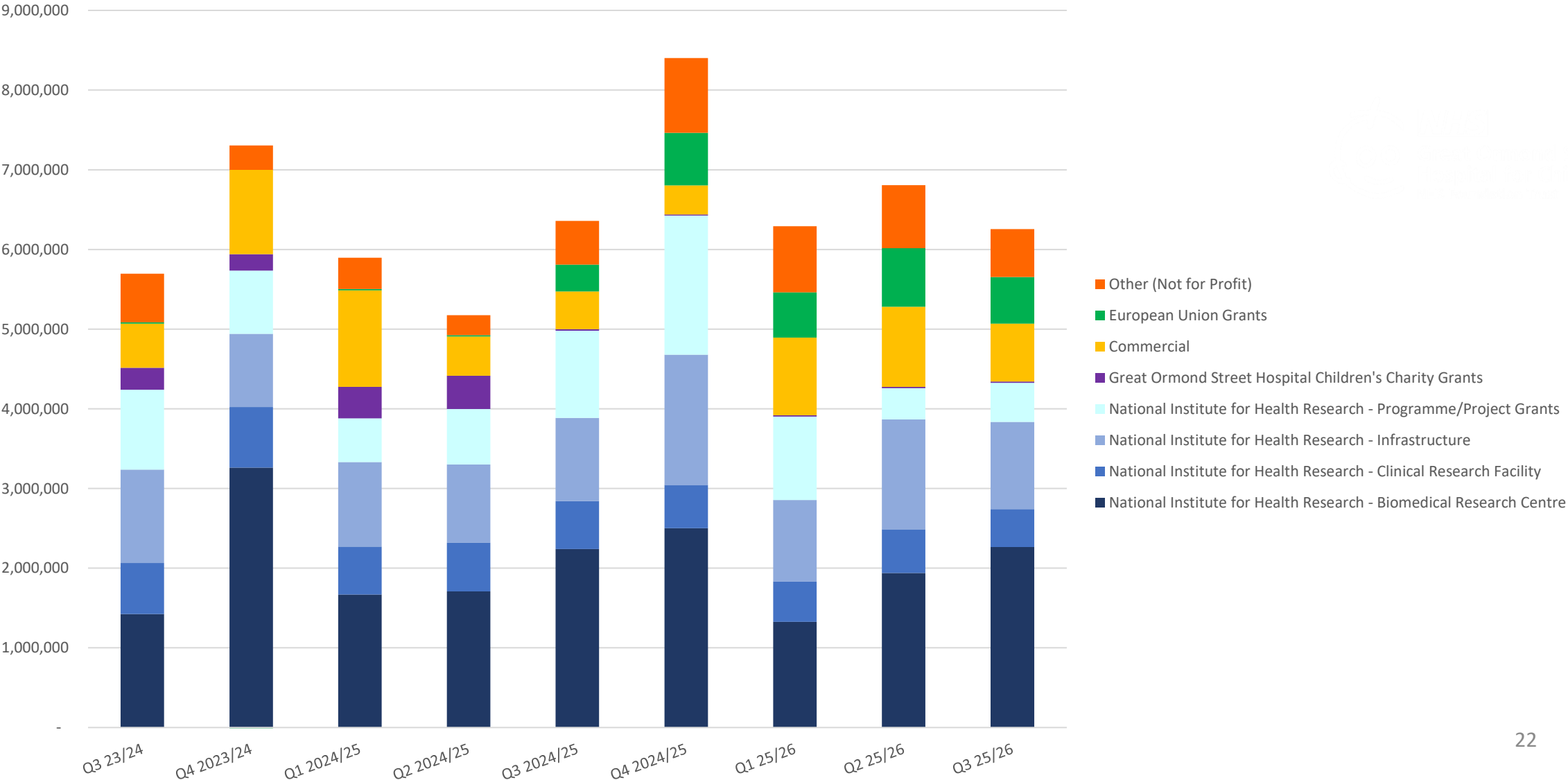
Kiki Syrad

	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Last 8 Quarters	RAG
CTIMP recruitment	35	48	39	47	47	48	38	41		No Threshold
No of active CTIMPS	136	144	142	151	145	141	140	157*		No Threshold
Recruitment to Time and Target		91%	91%	93%	91%	93%	93%	95%		<80% >=80%
R&I Income (m)	£5.70	£7.29	£5.90	£5.17	£6.36	£8.40	£6.81	£6.25		No Threshold
	23/24	24/25				Q1 25/26	Q2 25/26	Q3 25/26		
Leveraged Income (m)	£54.40	£55.97				£52.38				No Threshold
Partnerships	311	217	226	224	267	224	224	†		No Threshold

*Active CTIMP figures may be higher due to the recent data migration in R&I. Data validation is still in progress so numbers will be reviewed when this is completed.

†Reporting on grant funding is not possible via the new system (yet), we are currently working though what the new reporting process will be.

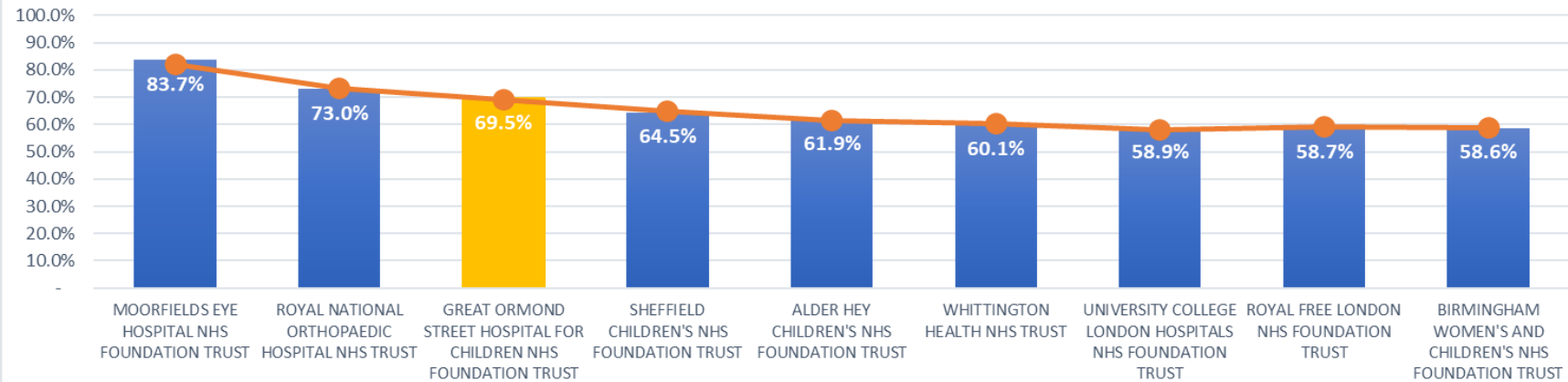
R&I Income



Appendix 1: Regional / National Comparisons

Referral to Treatment

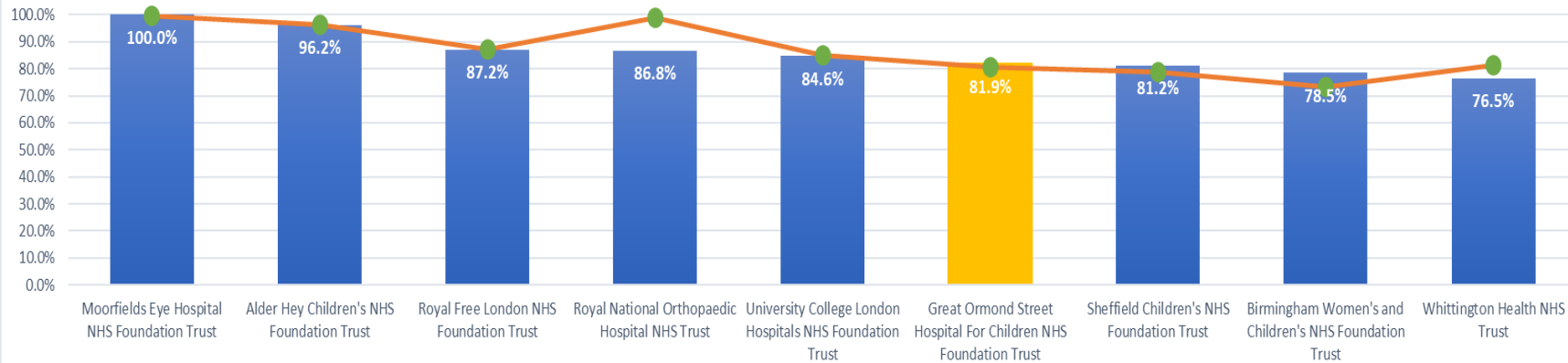
November 2025 % within 18 weeks NCL and Peers



Orange markers indicate October's performance. GOSH for the month of November is at third place amongst the selected Peers. GOSH is ranked 35th out of 149 providers, an increase of 2 places from October.

Diagnostics

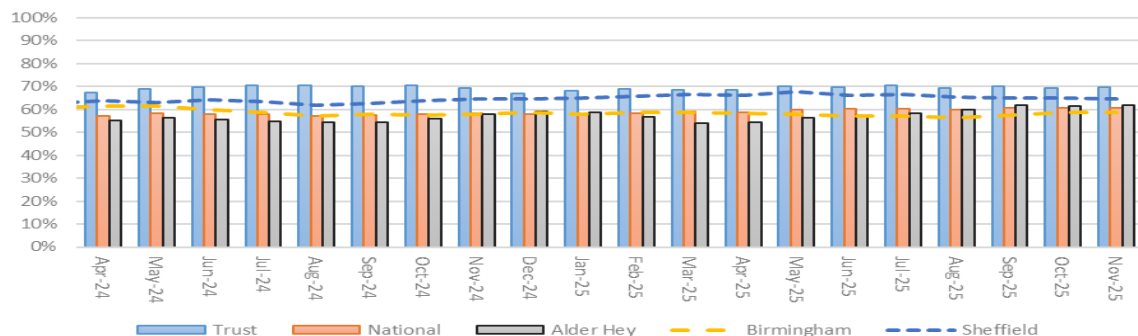
November 2025 % within 6 weeks NCL and Peers



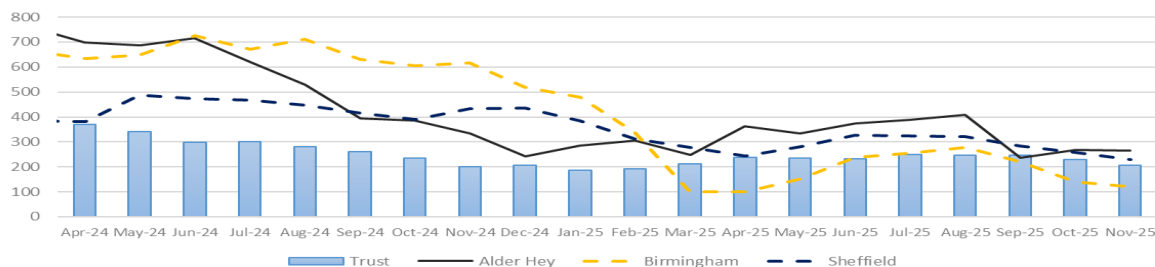
Green markers indicate October's performance. GOSH for the month of November is in fourth from bottom place, amongst selected Peers. GOSH is ranked 82 out of 148 providers, an increase of 7 places from October.

National and North Central London (NCL) RTT Performance – October 2025

RTT Performance against Children's Providers national standard 92%



Children's Providers RTT 52+ week waits



Nationally, at the end of November, 60.6% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks.

GOSH is tracking 8.8% above the national November performance at 69.5% and is in line with comparative children's providers. (RTT Performance for Sheffield Children (64.4%), Birmingham Women's and Children's (58.6%) and Alder Hey (61.9%))

The national position for November 2025 indicates a decrease in patients waiting over 52 weeks at 151,230 patients.

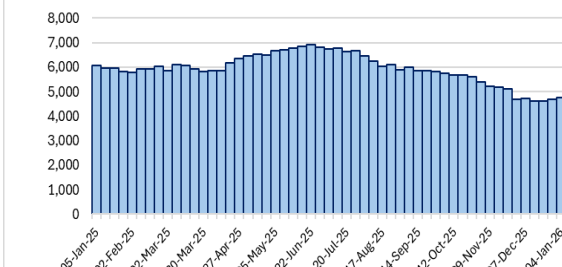
The number of patients waiting 52 weeks and over for GOSH is lower than Alder Hey and Sheffield Children.

Overall, for NCL the 52+ week wait position is at 4763 patients which is 1.5% of the total PTL. GOSH in comparison has 201 52+ wk waits as at 4th January which is 2.5% of the Trust's total PTL.

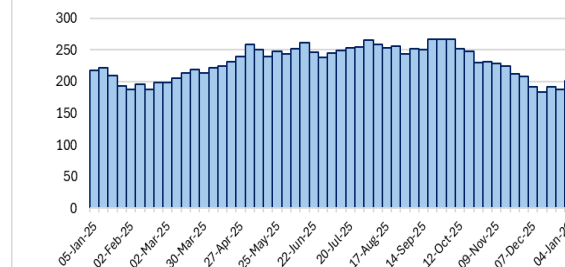
The 65 week wait national ambition of zero patients was to be achieved by 21st December 2025. NCL position is at 115 patients, with GOSH contributing 46% to the overall NCL cohort.

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 winter pressures and patient and staff sickness.

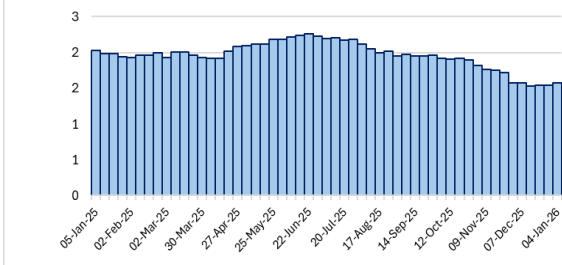
52+ Total WL - All Specialties



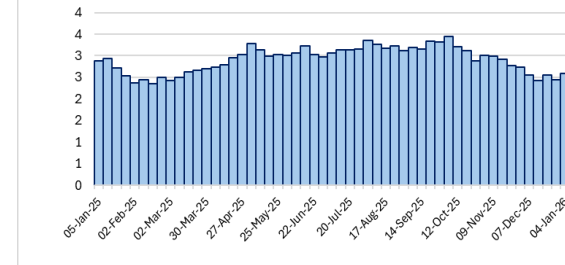
52+ Total WL - All Specialties



52wk Performance - Total - All Specialties



52wk Performance - Total - All Specialties



National Diagnostic Performance and 6 week waits – November 2025

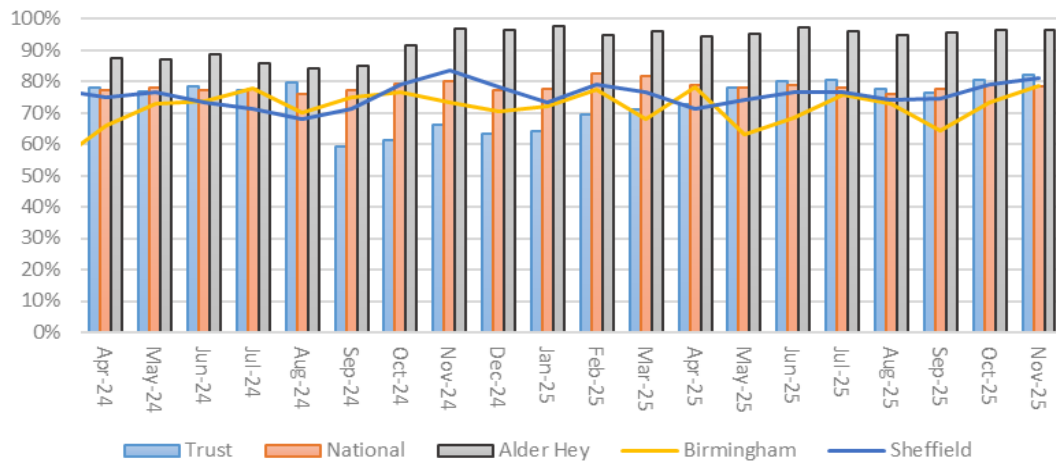
Nationally, at the end of November, 78.3% of patients were waiting under 6 weeks for a DM01 diagnostic test.

GOSH's November performance was 81.9%, 3.6% above the national performance but below Alder Hey (96.2%). DM01 Performance for Birmingham Women's and Children's (78.5%) and Sheffield (81.2%) is below GOSH's performance.

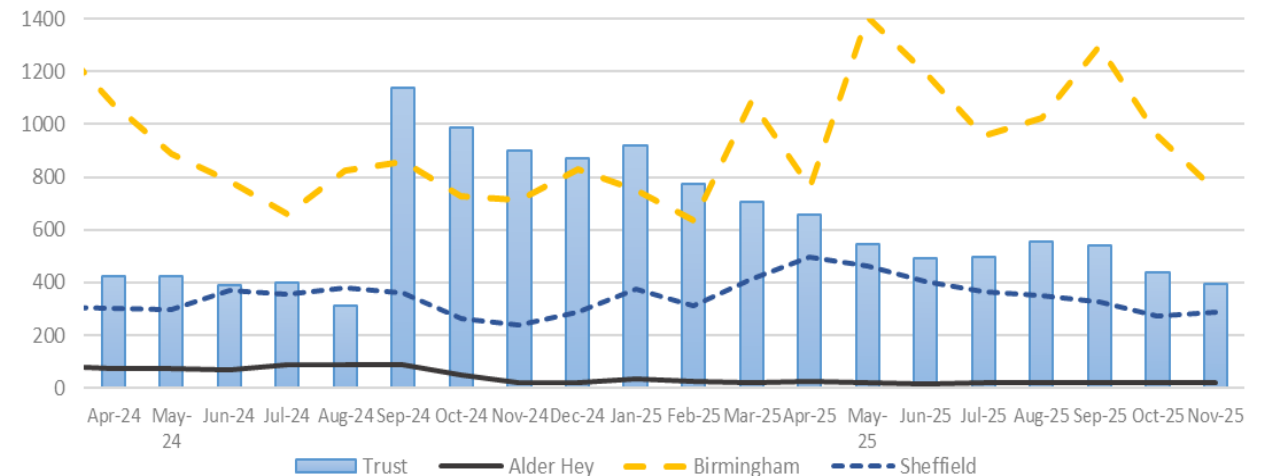
The national position for November 2025 indicates an increase of patients waiting over 6 weeks at 382,633 patients.

Compared to Alder Hey and Sheffield, GOSH has the highest number of 6+ week breaches and this is due to including the patients who have gone past their planned date for a diagnostic test.

DM01 Performance against Children's Providers
national standard 99%



Children's Providers DM01 6+ week waits



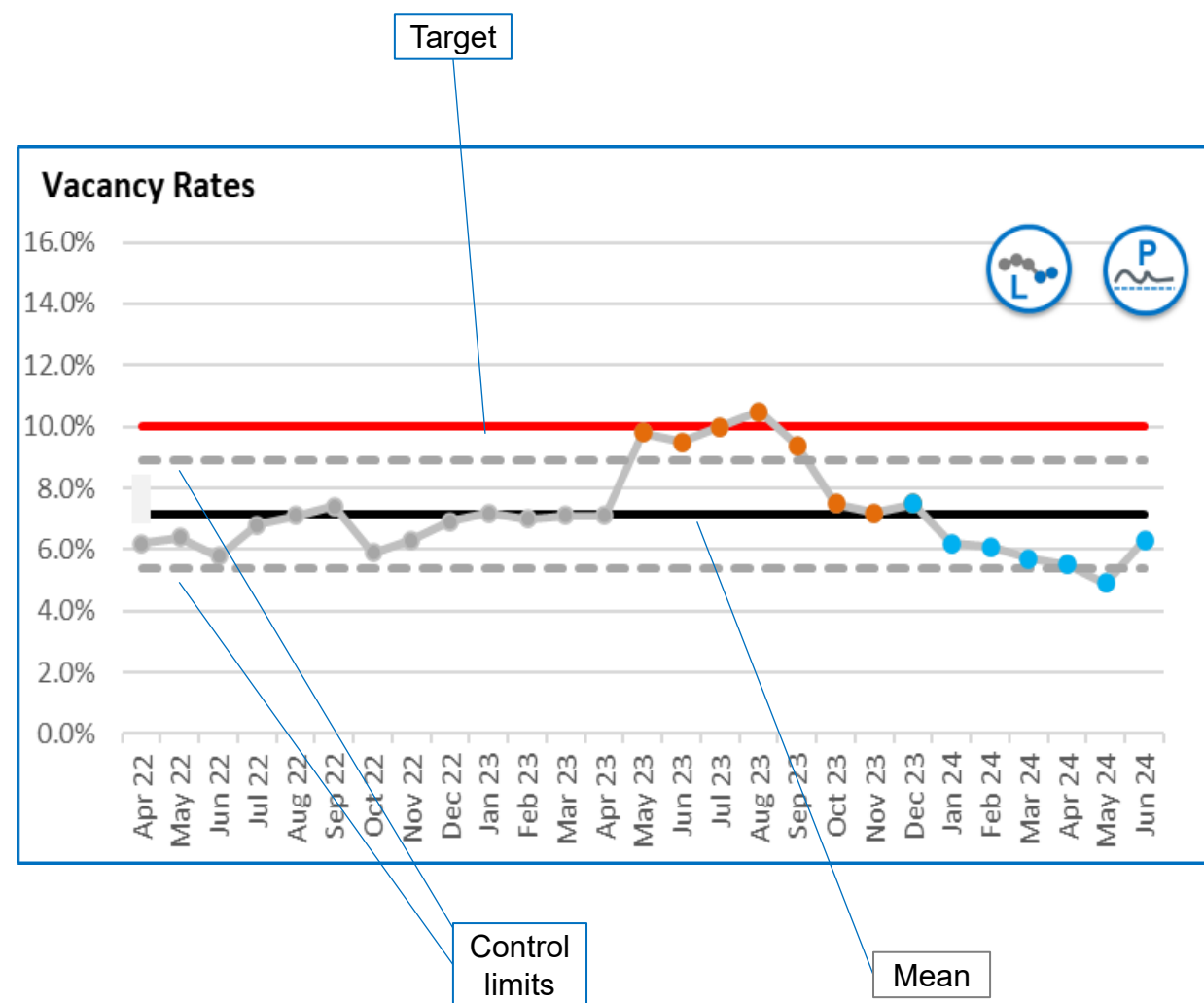
Appendix 2: SPC Charts

SPC charts (Statistical Process Control Charts) are used to measure changes in data over time. SPC charts help to augment RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes worth investigating (Extreme values) from normal variations.

Structure of a SPC Chart:

- A line graph showing the data across a time series. To make it statistically relevant there should be at least 15 data points to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the **mean**. This is the sum of the outcomes, divided by the number of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower **control limits**. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- Where relevant, a horizontal line showing the **target**. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless systemic patterns occurs. .



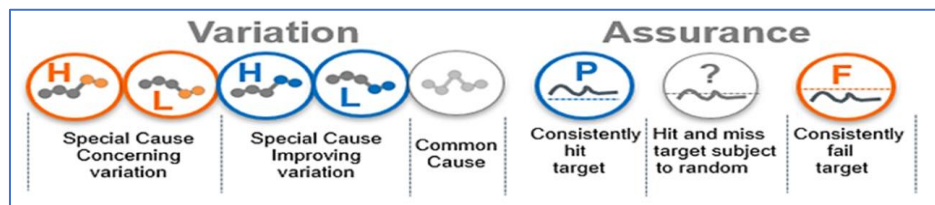
Systemic patterns

Normal variation - fluctuations in data points that sit between the upper and lower control limits that do not reach the criteria for a Trend. (Called common cause)

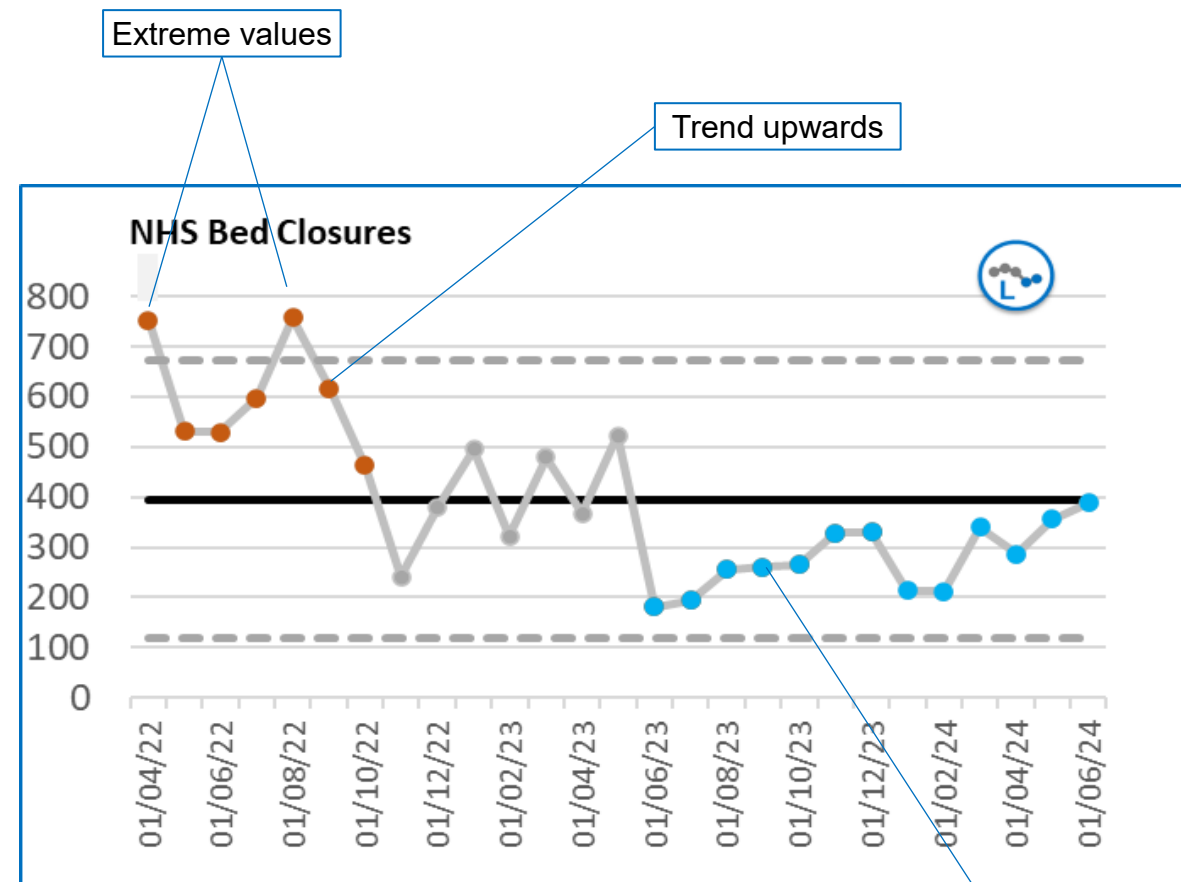
Extreme values - any value on the line graph that falls **outside the control limits**. These will need investigation. (Called special cause)

Trend - a trend may be identified where there are **7 consecutive points** in either a pattern that could be; a downward trend, and upward trend, or string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome.

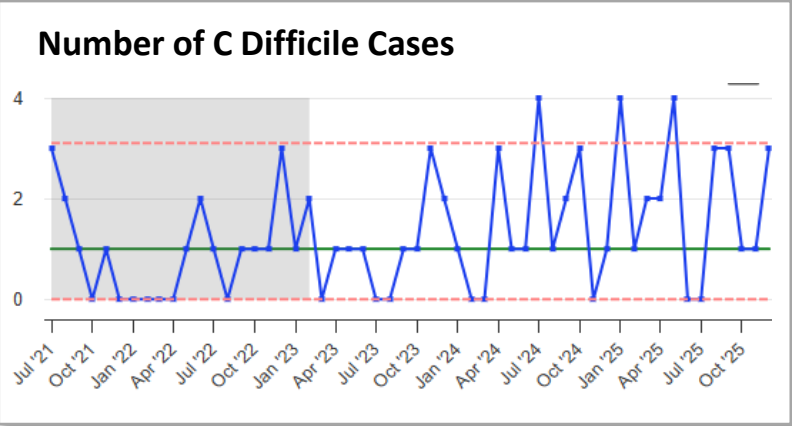
Standard NHS Icons are used in this report to quickly identify the patterns being identified in the charts. In the Summary charts we have highlighted variation trends on with simplified icons:



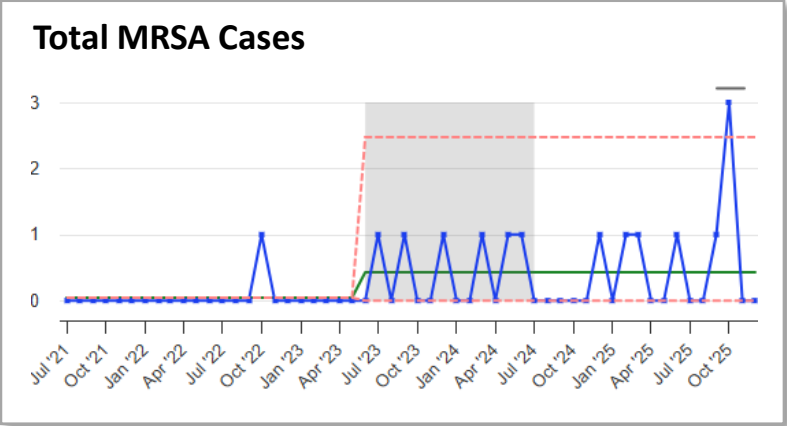
← simplified icons



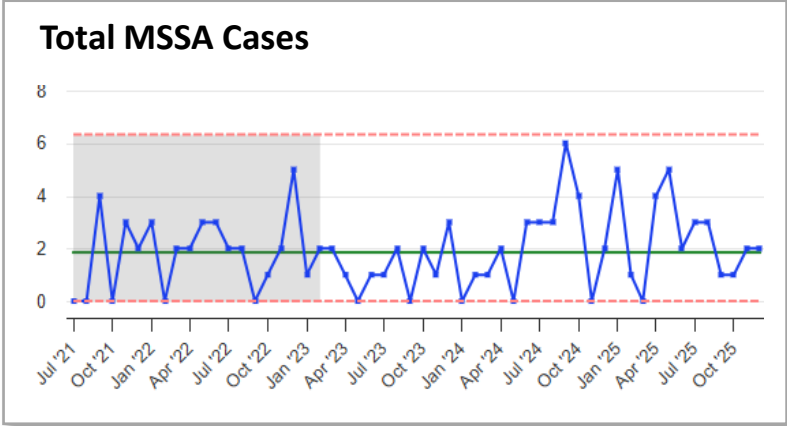
Patient Safety - Infection & mortality (1 of 2)



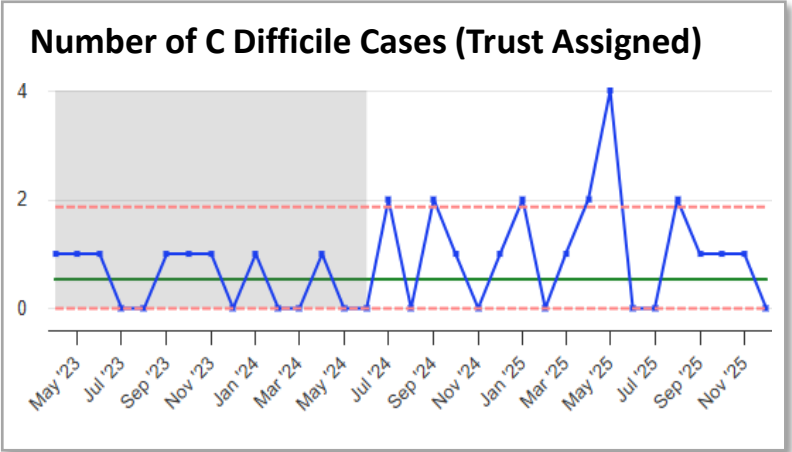
No significant variation



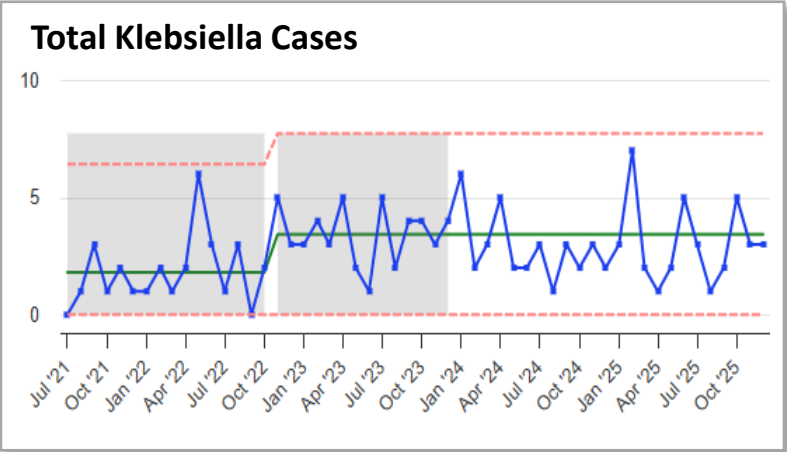
No significant variation



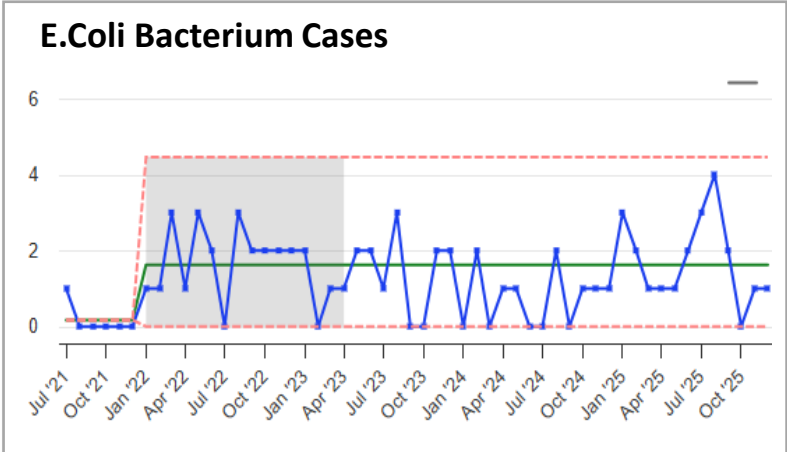
No significant variation



No significant variation

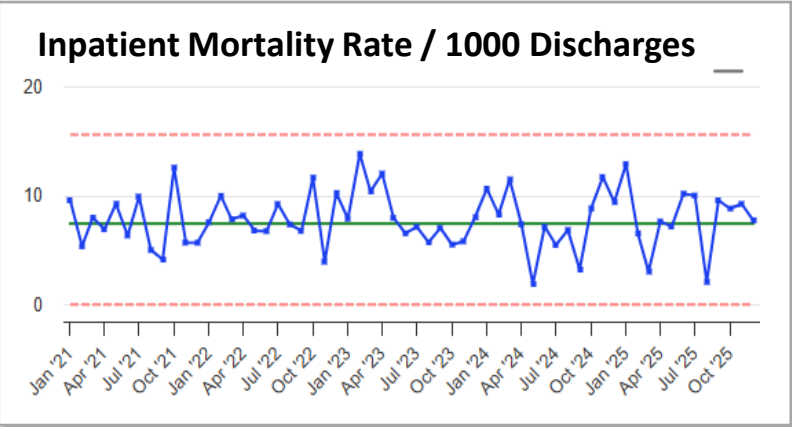


No significant variation

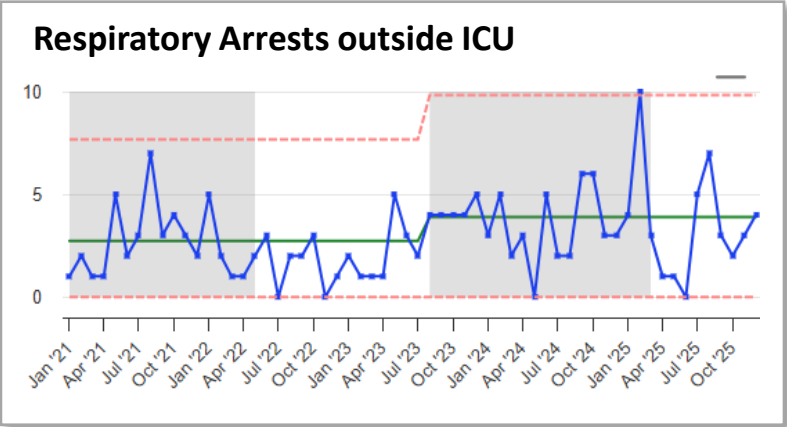


No significant variation

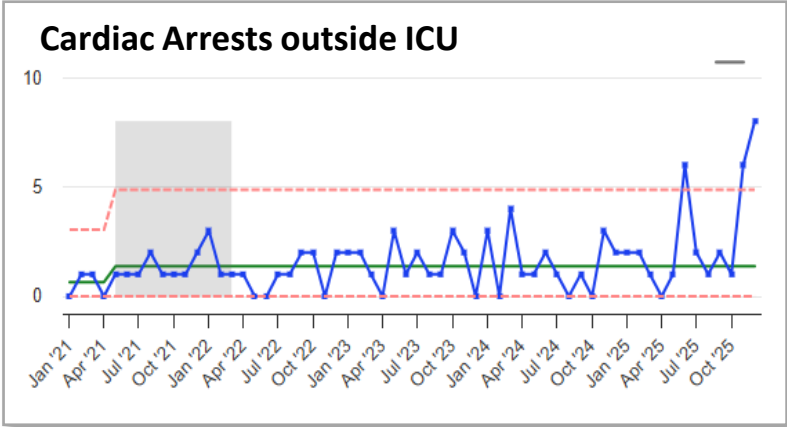
Patient Safety - Infection & mortality (2 of 2)



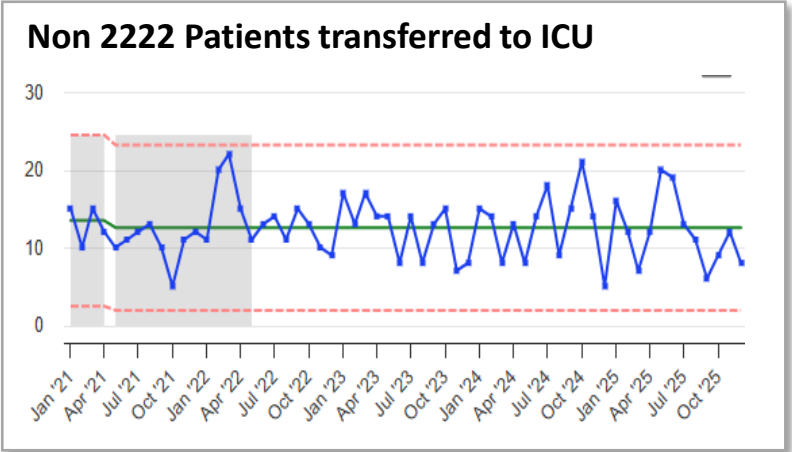
No significant variation



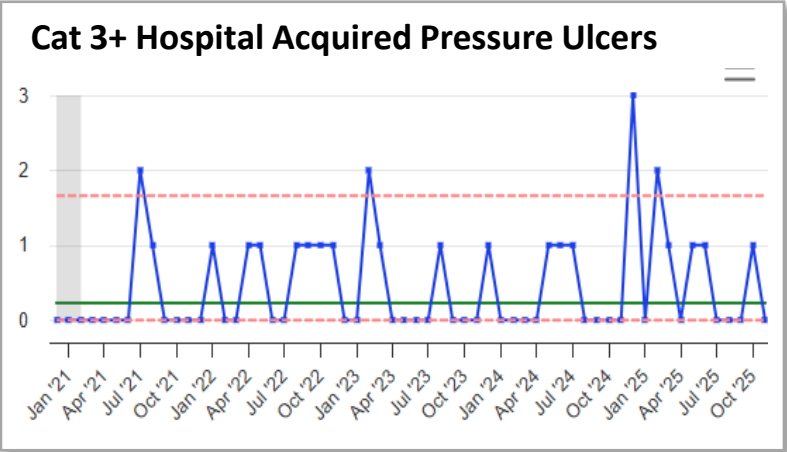
No significant variation



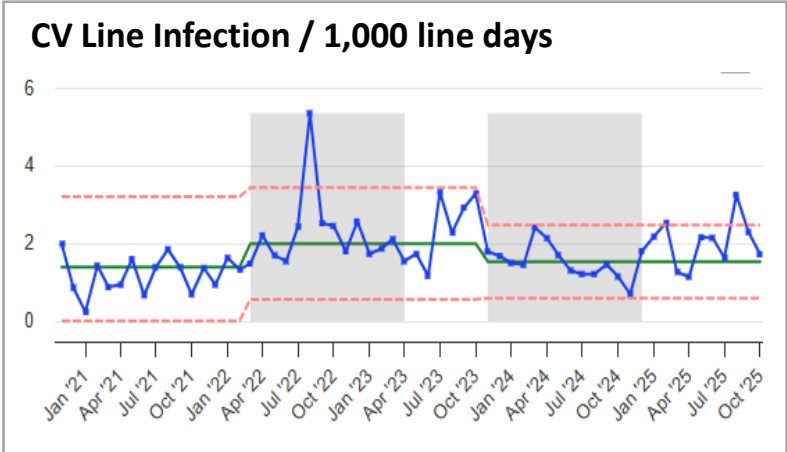
No significant variation



No significant variation



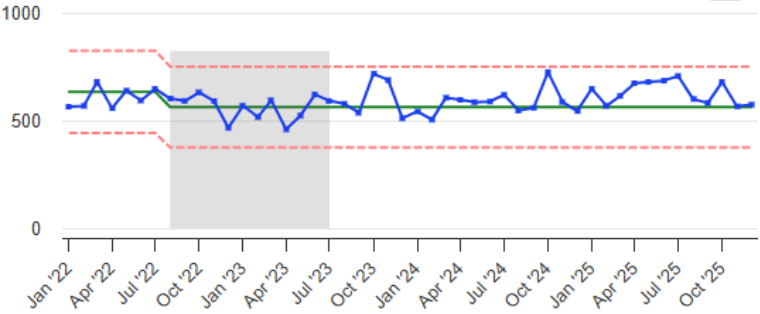
No significant variation



No significant variation

Patient Safety - Incidents

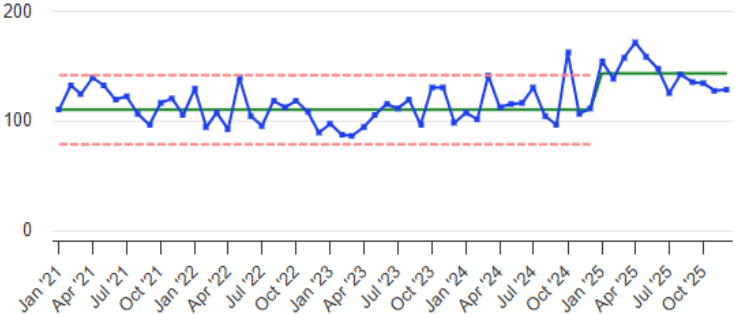
New Incidents



No significant variation



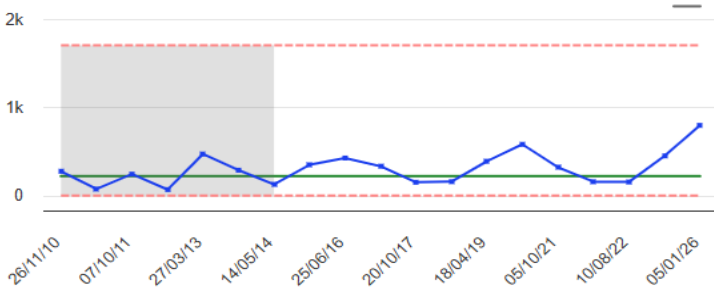
Medication Incidents



No significant variation



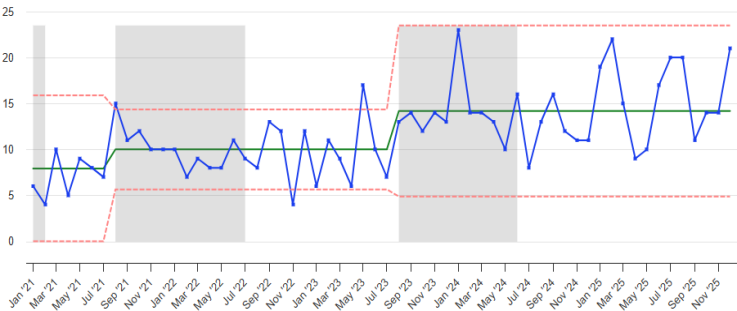
Days Since Last Never Event



No significant variation



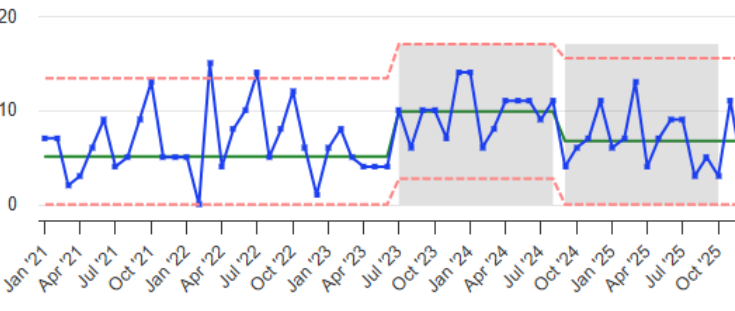
2222 Emergency calls outside ICU



No significant variation



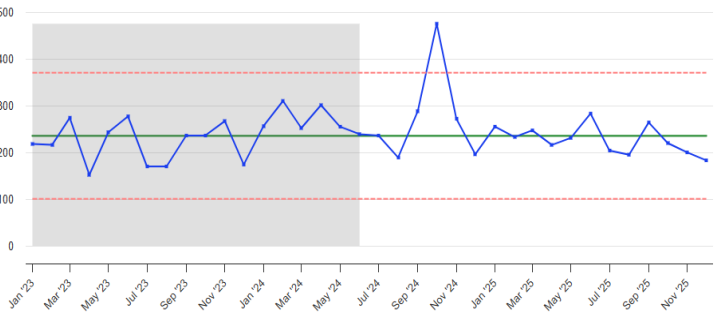
Hospital Acquired Pressure Ulcers (cat 2+)



Increase in 2024 – but no variation per bed day



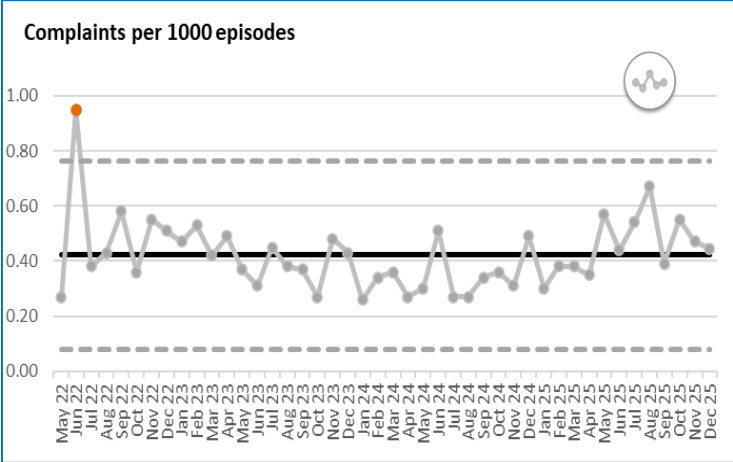
No of PALS cases



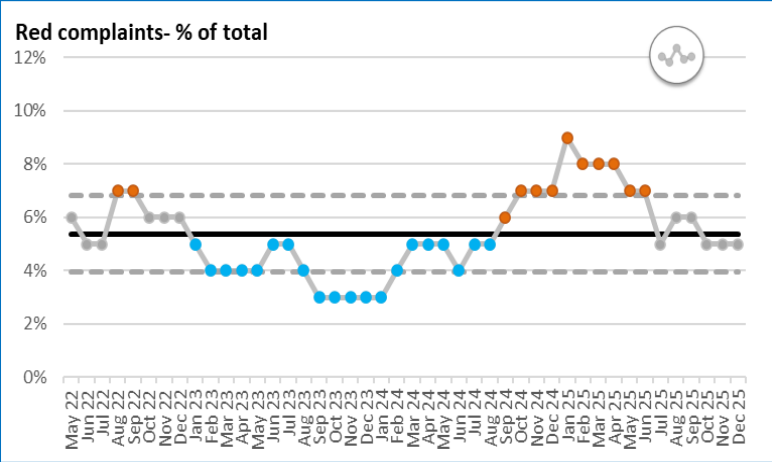
No significant variation



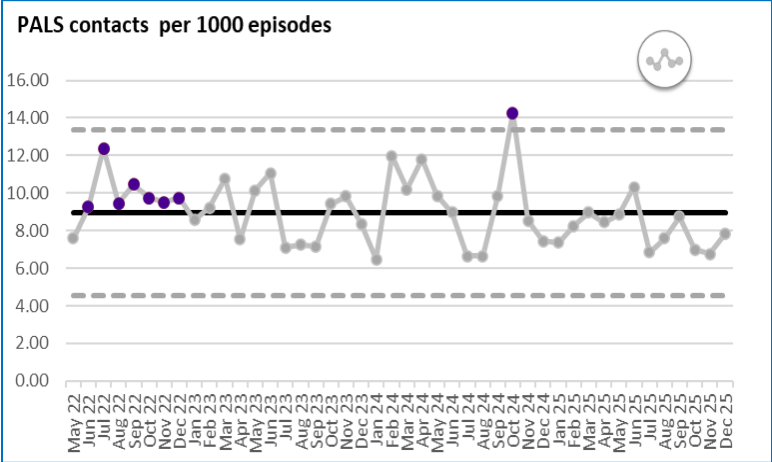
Patient Experience



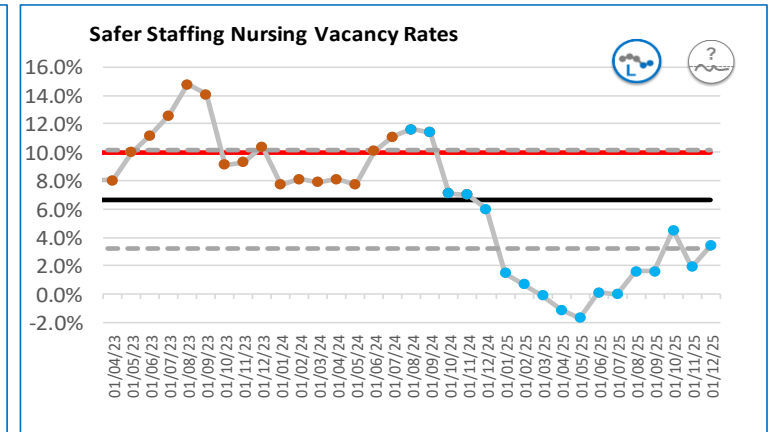
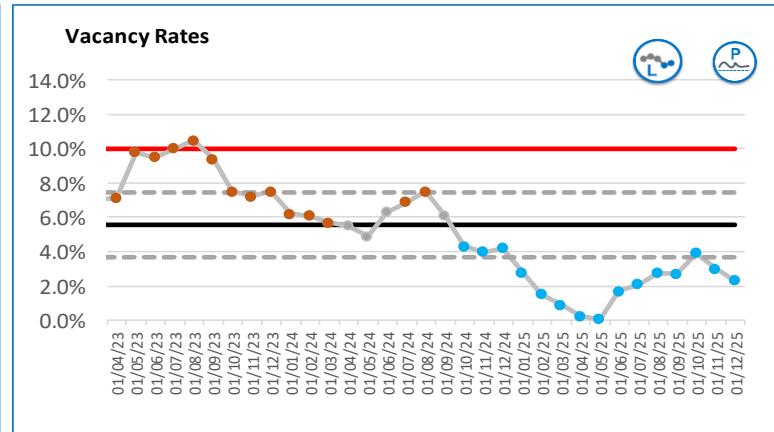
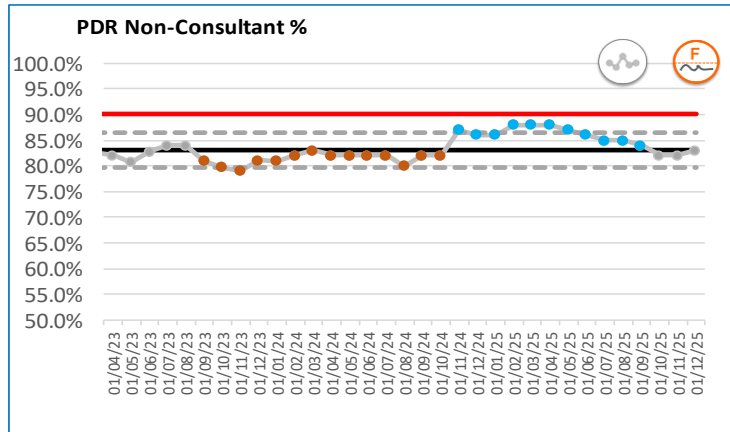
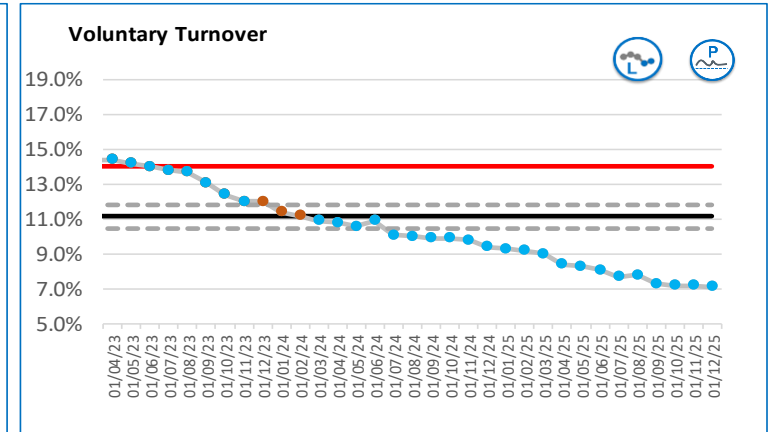
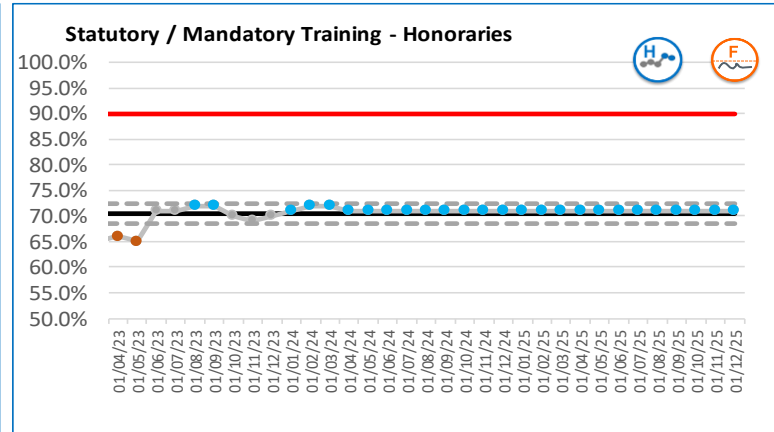
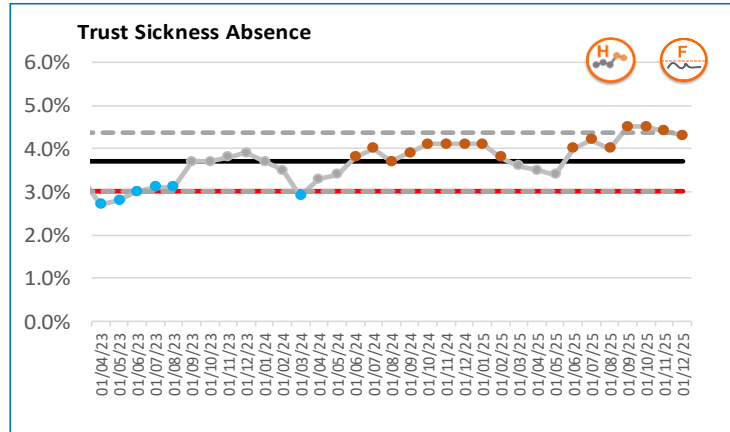
This has started to reduce and remains being closely monitored.



Plateauing over the last 3 months and remains being closely monitored.



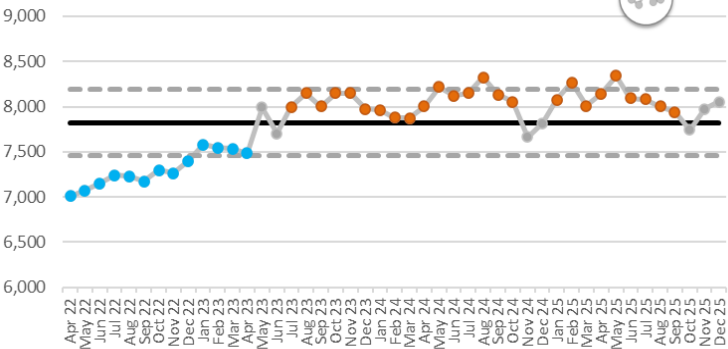
No significant variance over the last 6 months following spike last year



Over the past five months, trust sickness has risen and is largely related to stress/anxiety and colds. Although nursing vacancy rates had notably declined, they have begun to rise again in the last six months but remain below the Trust's target. Meanwhile, voluntary turnover within the Trust has experienced a substantial and ongoing decrease.

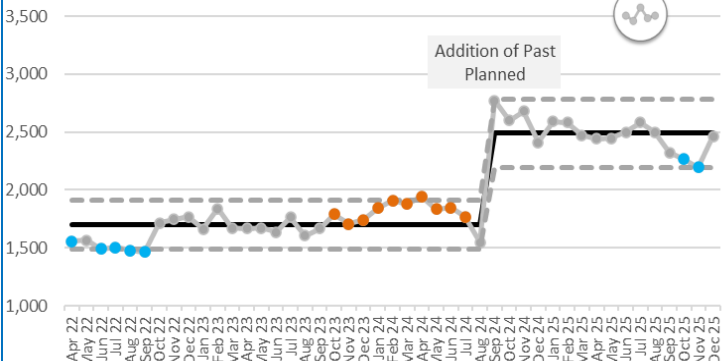
Patient Access

RTT Incomplete PTL



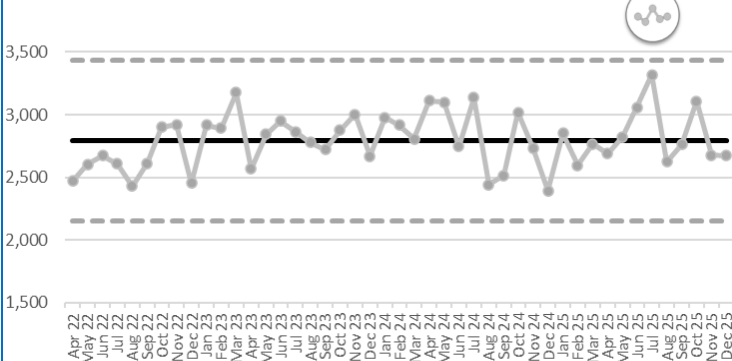
Decreases have been observed in overall PTL size

DM01 Waiting List



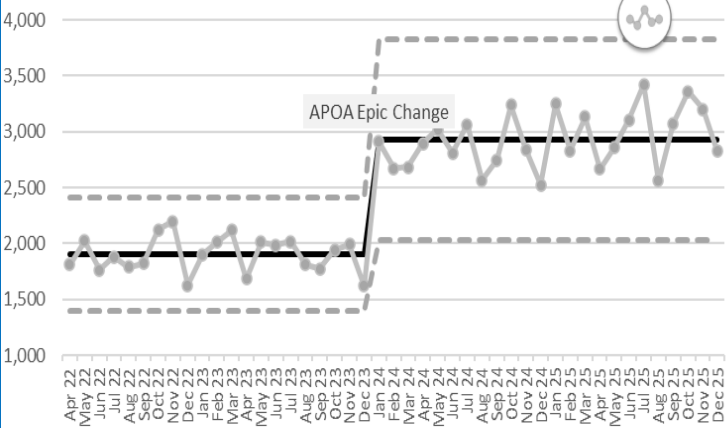
Increase in overall waiting numbers due to addition of planned past patients, however, this is decreasing as the backlog numbers reduce.

External NHS Referrals Received



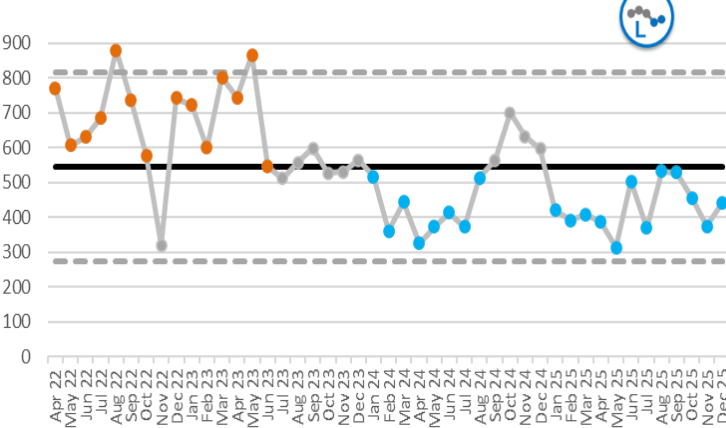
Referrals remain at consistent levels

Internal NHS Referrals Received



No significant variation, common cause

Total Bed Closures



Bed closures have reduced and show no significant variation

Appendix 3: Glossary

Patient Safety – Incidents and Risks

New incidents	An unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare. Whilst we want to avoid incidents, they are inevitable and reporting of these when they happen is a sign of a healthy safety culture. This allows issues to be assessed and addressed before they cause further harm.
Near misses	A patient safety incident not causing harm but which had the potential to cause injury or ill health.
New PSIs	Patient Safety Incident Investigations (PSIs) are a type of learning response led by the Patient Safety team, typically in response to a patient safety incident where significant systemic problems are identified or where there is potentially significant learning for the Trust.
Patient incidents by level of harm	Patient safety incidents are graded according to the level of harm sustained by the event. These range from Near Misses to Catastrophic harm. Statutory Duty of Candour is initiated when a moderate (semi-permanent) harm incident or above occurs.
Never events	A never event is defined by NHS England as a patient safety incident that is wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
Pressure Ulcers (3+)	Pressure ulcers (pressure sores or bed sores) are areas of damage to skin and the tissue underneath. They are caused when an area of skin is put under pressure, often when confined to lying in a bed or sitting for long periods of time. In grade 3 pressure ulcers, skin loss occurs throughout the entire thickness of the skin. The underlying tissue is also damaged, but the underlying muscle and bone are not.
Duty of Candour	Duty of Candour refers to the responsibility health professionals have to be honest and open with patients in their care when things go wrong. NHS bodies have a legal Duty of Candour under the Health and Social Care Act 2008. Stage 1 is a conversation with the patient/family, stage 2 is a written record shared with the patient/family within 10 working days outlining the detail of what was discussed during this conversation and expected timescales and stage 3 is the written sharing of the investigation findings (sent within a timescale agreed with the family but usually within 60 working days).
VTE assessment	A mandatory risk assessment carried out for all patients aged 16 and over admitted for more than 14 hours (i.e. not day-case) to evaluate their risk of developing venous thromboembolism (including deep vein thrombosis or pulmonary embolism).

Patient Safety – Infection Prevention & Control (cont.)

C Difficile cases	C Difficile is a bacteria which can be found in the gut of humans. It can cause mild/severe diarrhoea and infection and is often triggered by the use of antibiotics. It is significant because it can rarely cause severe illness and infection. Occasionally we receive patients from other hospitals that already have C Difficile, or we test outpatients who have not been in any hospital recently. It is important to distinguish between those cases where it is acquired externally vs those acquired at GOSH so that appropriate learning can be applied across the whole health economy
MRSA cases	Staphylococcus bloodstream infections include MSSA (sensitive staphylococcus) and MRSA (resistant staphylococcus) are caused by staphylococcus which is usually an organism found on the skin entering the bloodstream. This is significant in healthcare as we often penetrate the skin of our patients through surgery or the insertion of devices such as cannula and central lines. It is important we monitor the rates of these infections to look for and monitor improvements in skin decontamination at the insertion of these devices and as part of their ongoing care.
MSSA cases	
E.coli	These are all gram negative organisms which can usually be found in the guts of children and adults. Many of the children at GOSH have compromised absorptency and leakage through their guts making them susceptible to these infections. These organisms can also be resistant to many antibiotics which isn't a problem when they are in the gut but can make treatment options complicated and difficult if they enter the bloodstream. Prevention of these infections in paediatrics is very different and complicated from that in adults where the primary cause is urinary tract infections.
Pseudomonas Aeruginosa	
Klebsiella spp	
CV Line Infections	This is a GOSH internal quality improvement metric and not reported externally. It allows us to measure all bloodstream infections against a set criteria to determine whether the bloodstream infection (any organism) is likely to be related to a central line. This metric is then calculated against the number of lines each day in the trust giving a rate of per 1000 bed days. This metric is reported monthly and information shared with all departments. It allows us to see any changes in practice and provide a benchmark of central venous care we can monitor and investigate if we notice a deviation.

Patient Experience	
Friends and Family Test (FFT)	FFT is a mandatory feedback tool which enables patients and families to rate their experience of NHS services and provide further qualitative feedback. FFT data enables us to understand what is going well and areas for improvement. FFT data is reported to NHS England. Trust KPIs are 25% inpatient response (based on discharge) and 95% experience ratings.
PALS	PALS is the Patient Advice and Liaison Service. It is a way for patients/families to get in touch to ask questions, give compliments, raise any issues or questions and make suggestions. It is often used for informal queries and information requests (for example when families are unable to reach their clinical teams) and prompt resolutions.
Complaints per 1000 episodes	Each time a patient comes to the hospital it is regarded as an episode. We measure complaints per 1000 episodes as enables us compare complaint numbers across services with variable activity rates.
Red Complaints	A red complaint is assessed as high risk based on a number of factors including harm, risk and potential reputational damage. This is the highest risk rating, and all red complaints are reviewed to determine if they should be investigated as a Patient Safety Incident.

Research & Innovation (R&I)	
Trials recruitment %	DHSC (through the NIHR) expects that research Sponsors should manage their portfolios, and data should reflect the true performance of the studies' trajectory and give a valid picture of recruitment to time and target. Sponsors are required to maintain data indicating whether their studies are 'on track' via the NIHR Sponsor Engagement Tool. The expectation is that Sponsors should ensure that 80% or more of their studies are delivering to time and target.
CTIMP Recruitment	CTIMP are Clinical Trial of an Investigational Medicinal Product. So, this is a project including an experimental drug, rather than an observational study or qualitative project. This is Performance in Delivery (PID) data which was until recently required to be reported to the NIHR. It shows recruitment to commercial CTIMPs, and each quarter shows the data for the previous 12 months. This includes rare disease studies, some of which were withdrawn by the sponsor, usually due to recruitment closing globally or lack of eligible participants.
No. of Active CTIMPs	Clinical Trials of Investigational Medicinal Products that have been approved and are open during the quarter; either recruiting patients or following up patients that have started the treatment.
R&I Income	R&I Infrastructure income (not including grants/funding to individual studies)
Leveraged Income	External funding to projects leveraged from the NIHR Biomedical Research Centre funding award.
Partnerships	Number of unique funders to research projects

Well Led – Workforce Indicators	
Turnover (voluntary)%	A measure of the number of employees (WTEs) leaving the organisation as a percentage of the current workforce. Leavers (FTE) over the past 12 months, as a proportion of the average staff FTE over the same period. Junior Doctors are excluded (voluntary resignations only)
Vacancy %	The number of positions vacant on the first day of the month as a percentage of the current workforce (WTE). The proportion of Budget FTE that is vacant (Vacant FTE/Budget FTE). A negative rate indicates over establishment
Sickness %	Number of days lost to sickness as a percentage of the overall number of days for the current workforce. National sickness rates have been running at around 5.3% in the NHS, well above the rates experienced at GOSH. The sickness rate based on absences in a rolling 12-month period
Total WTE (inc. bank and agency)	This is a measure of the overall size of our workforce in Whole Time Equivalents. (This counts part time workers as a fraction of a WTE. Someone working 2 days a week would be 0.4 WTE). A measure of staffing levels as a proportion of a full time equivalent. Based on the sum of contracted FTE at a month end
Stability Index	Proportion of current staff who were working at GOSH one year ago. Staff on Fixed Term Contracts are excluded
Appraisal rate (Non-consultants)	Personal Development Review: Personal development is an ongoing process throughout the year, but everyone should have a PDR at least once in the year. This is the percentage of the PDRs completed against the total that should have been completed by this month. Proportion of AFC employees who have had a PDR in the past 12 months
Statutory & Mandatory Training %	For all staff there are a series of relevant training modules that must be completed on a regular basis. This includes subjects such as Infection Prevention, Resuscitation, Counter Fraud... This metric is the percentage of this training that has been completed against the number of courses that should have been completed at this time. Proportion of courses that staff must complete that are up to date

Well Led – Culture & Engagement	
Advocacy score	This is the percentage of staff recommending GOSH as a place to work as recorded in the Quarterly and Annual staff surveys.
Exit Survey return rate	All staff when leaving GOSH are asked to complete an exit survey. One question in this is “Would you return to work at GOSH?” This is the percentage of staff saying yes to this question.

Well Led – Equality Diversity & Inclusion	
% Staff from diverse backgrounds (BME)	This is the percentage of staff who identify as from Black & Minority Ethnic Groups
Gender pay gap	Percentage difference between average hourly earnings for men and women
Relative likelihood of staff being appointed from shortlisting across all posts	The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants.

Access	
RTT Open Pathways	Patients have the right to access treatment within 18 weeks of referral (Referral to Treatment) for consultant led services. The RTT figure represents the percentage of patients referred who are within the 18 weeks. The target is 92%. Since Covid less than 10% of Trusts have achieved this and NHS current average is 59.1% (May 2024).
Long waiters	Whilst the priority is given to clinically urgent cases, long waiters are also treated as a priority. Nearly all these cases will be non-urgent, but often involve complex multi-specialty treatment.
Diagnostics - % waiting less than 6 weeks	Patients have a right to access diagnostics within 6 weeks of being referred. This figure represents the percentage of patients who are within the 6 weeks for 15 key diagnostic tests. The target is 99%. Since Covid less than 10% of Trusts have achieved this and NHS current average is 77.9% (May 2024).
Cancer wait times	Shorter wait times targets are in place for cancer treatment. These metrics are the relevant performance against these targets.
Cancelled Operations for non-clinical reasons	This is a count of operations that have been cancelled on the day of the planned date/time where it has not been because of a clinical reason. Often these are due to urgent cases taking priority.
Cancelled Operations 28-day breach	If a patient has a short-term cancellation for non-clinical reasons, they are entitled to have that rescheduled within 28 days. This figure is the number of occurrences where this has not been achieved.
NHS Outpatient Appointment Cancellations	This will include appointments that are rescheduled. They can be initiated by the patient as well as the hospital. We specifically measure where these are initiated by the hospital.

Integrated Quality & Performance Report January 2026

Reporting December 2025 data



**Dena
Marshall**

Chief
Operating
Officer

**Tracy
Luckett**

Chief Nurse

**Sophia
Varadkar**

Acting Chief
Medical
Officer

**Caroline
Anderson**

Director of HR
& OD



**Great Ormond Street
Hospital for Children**
NHS Foundation Trust

Trust Board
29th January 2026

Month 9 2025/26 Finance Report Submitted by: Margaret Monckton, Chief Finance Officer	Paper No: Attachment Q ☐ For information and noting
Purpose of report To provide a summary of the Trust's financial performance for Month 9 of financial year 25/26.	
Summary of report - At M9 YTD, the Trust is reporting a cumulative deficit of £8m. This is £5.6m adverse to the original Trust plan and £1.5m behind the agreed recovery plan. - In month, the Trust position is £1.5m surplus which is in line with the recovery plan, although this has been achieved by additional non recurrent revenue from NCL ICB. The key drivers of the £8m YTD deficit position at M9 are: - Unidentified Best Value targets of £7.3m YTD (£4.7 pay and £2.6 on non pay) - Private practice activity income underperformance of £7.2m – mostly in Respiratory, Cardiac and Paediatric intensive care, driven by less than expected demand. - This is offset by favourable variance on NHS contract income of £5.2m, primarily owing to additional revenue from NCL ICB.	
Patient Safety Implications None	
Equality impact implications None	
Financial implications The current financial position triggers an override, placing the Trust in Segment 3.	
Strategic Risk BAF Risk 1: Financial Sustainability	
Action required from the meeting Trust Board is asked to note the Trust's financial position at M9 FY25/26.	
Consultation carried out with individuals/ groups/ committees None.	
Who is responsible for implementing the proposals / project and anticipated timescales? EMT	
Who is accountable for the implementation of the proposal / project? EMT	

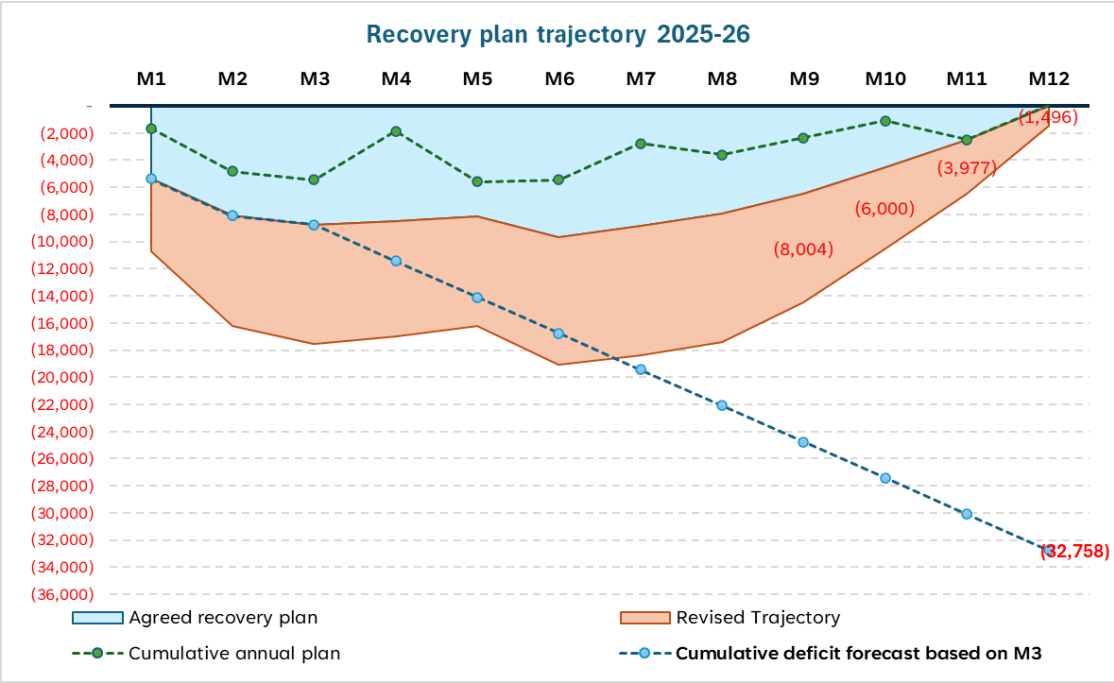
Month 9 Financial Position 2025/26



Summary Trust Position at Month 9

	Month 9				Year to Date			
	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG
Income	£60.4m	£63.0m	£2.7m	●	£544.9m	£565.5m	£20.6m	●
Pay	(£37.1m)	(£38.4m)	(£1.3m)	●	(£333.4m)	(£350.4m)	(£17.0m)	●
Non-Pay inc. owned depreciation and PDC	(£22.0m)	(£23.2m)	(£1.2m)	●	(£213.9m)	(£223.1m)	(£9.2m)	●
Surplus/(Deficit) excl. donated depreciation	£1.3m	£1.5m	£0.2m	●	(£2.4m)	(£8.0m)	(£5.6m)	●

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

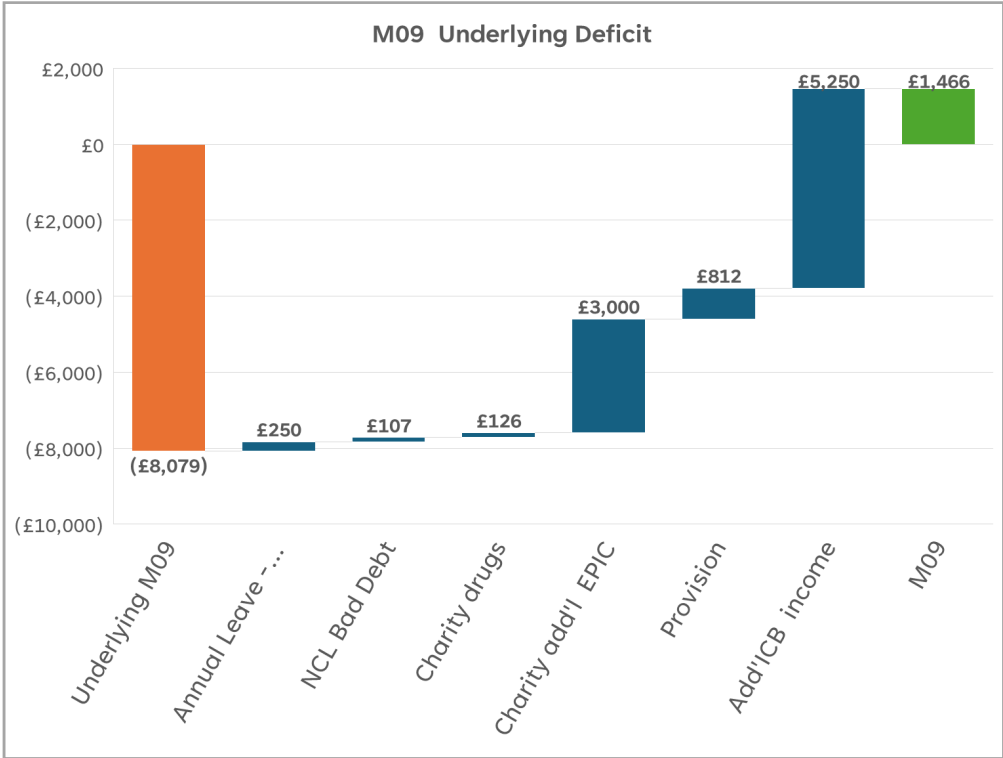
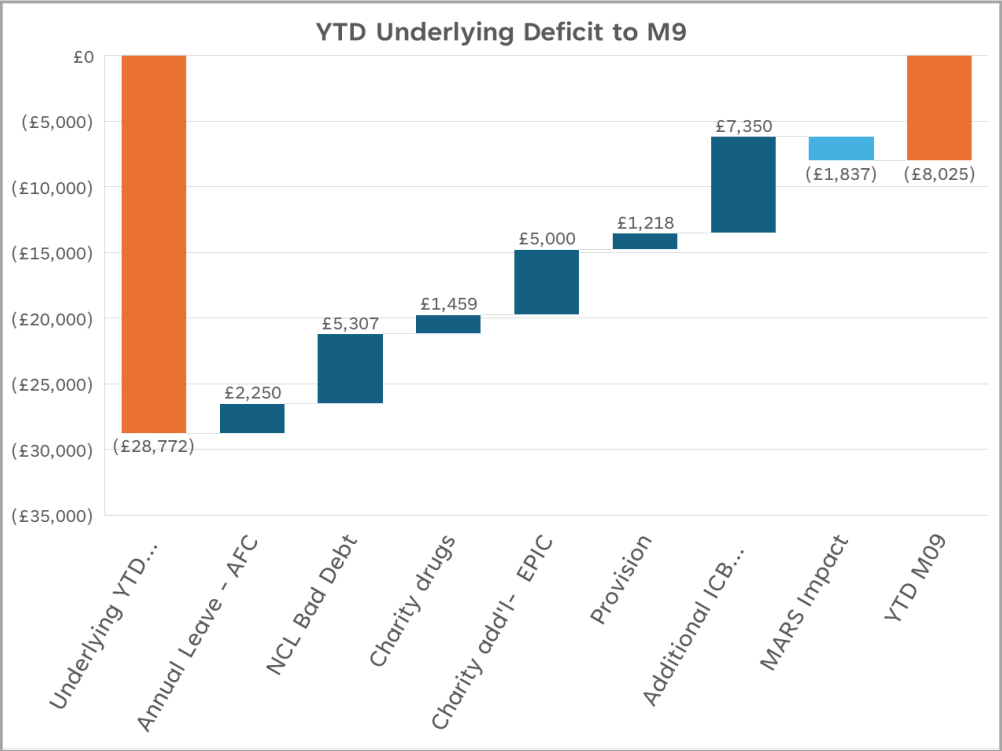


- At the start of the 2025/26, the trust agreed a breakeven plan with NHSE.
- Following M3 reported position, which indicated a significant deficit by the end of the year based on extrapolated run-rate, the trust agreed a recovery plan with NCL ICB to deliver a breakeven position by year end.
- At M9 YTD, the Trust is reporting a cumulative deficit of £8m.** This is £5.6m adverse to the original Trust plan and £1.5m behind the agreed recovery plan. The £1.5m represents redundancy costs which are expected to be funded centrally.
- The recovery trajectory required the Trust to deliver a £1.4m surplus in month 9 .** The reported position shows achievement of the recovery plan in M9, primarily owing to additional non-recurrent contract revenue from NCL.
- The key drivers of the £8m YTD deficit position at M9 are:**
 - unidentified Best Value targets of £7.3m YTD (£4.7 pay and £2.6 on non pay)
 - Private practice activity income underperformance of £7.2m – mostly in Respiratory, Cardiac and Paediatric intensive care, driven by less than expected demand.
 - This is offset by favourable variance on NHS contract income of £5.2m
- NHS Clinical activity revenue has seen a seasonal downturn in months 8 and 9 due to Christmas holidays, although this has been compensated by other income sources, notably Charity income and income from NCL contract.
- Non pay overspend is largely driven by unidentified CIP and high-cost drugs, offset by revenue
- Pay cost, although showing improvement on the run rate are above the affordable plan inclusive the CIP target by £17m year to date.

Underlying Position Year to Date and In month

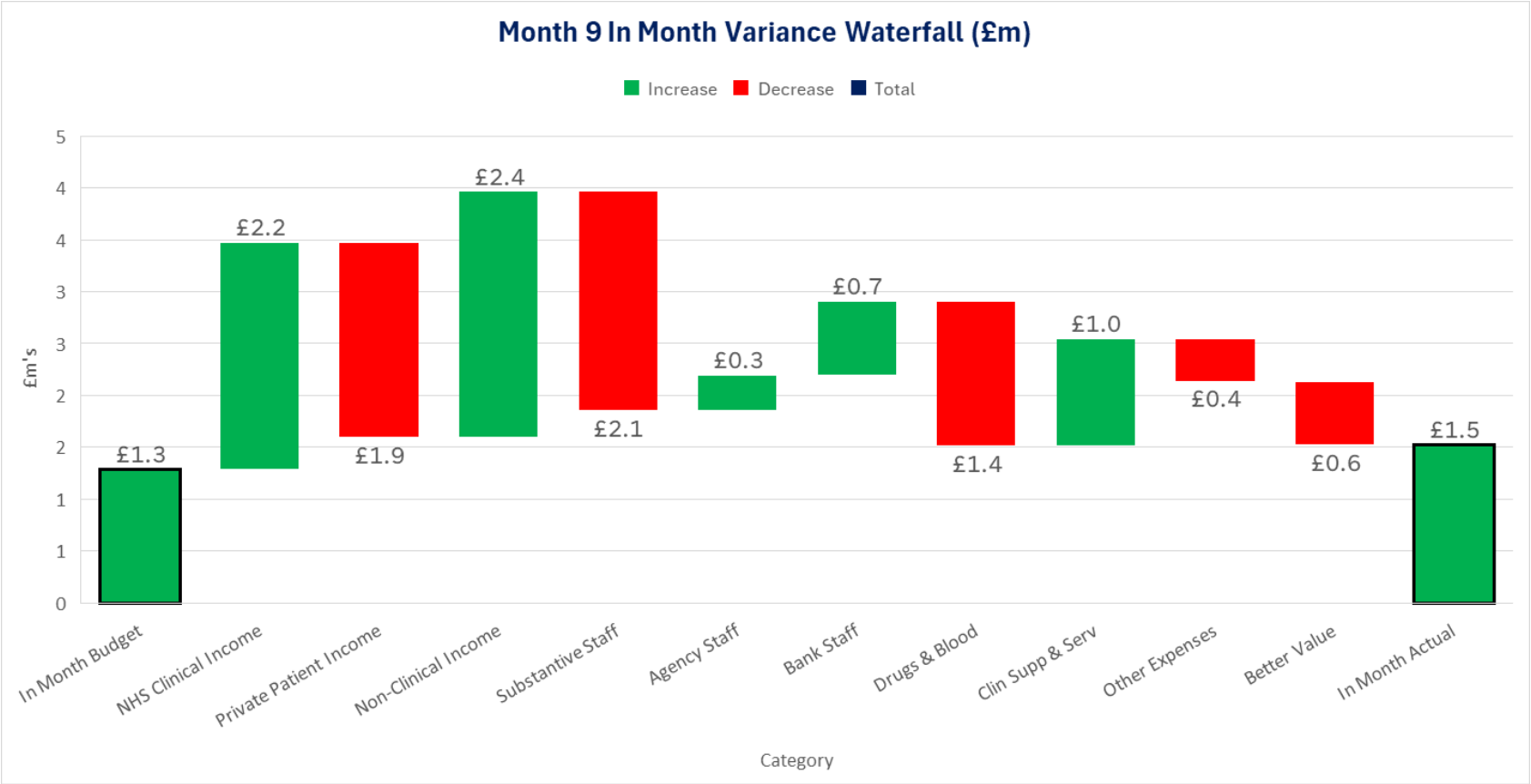
- At M9 YTD, the trust has an underlying deficit of £28m. £8m of this position occurred in M9 which is a marked deterioration in the run-rate.
- Both in month and YTD position have had the benefit of a series of non-recurrent measures to restore financial performance in line with the agreed recovery plan.
- This includes technical adjustments, such as release of provision and annual leave accrual and additional funding streams –primarily from charity and extra contractual revenue support from NCL. (£20.7m in YTD, £9.5m in month)

Movement from the underlying to the adjusted financial position is illustrated by the two graphs below.



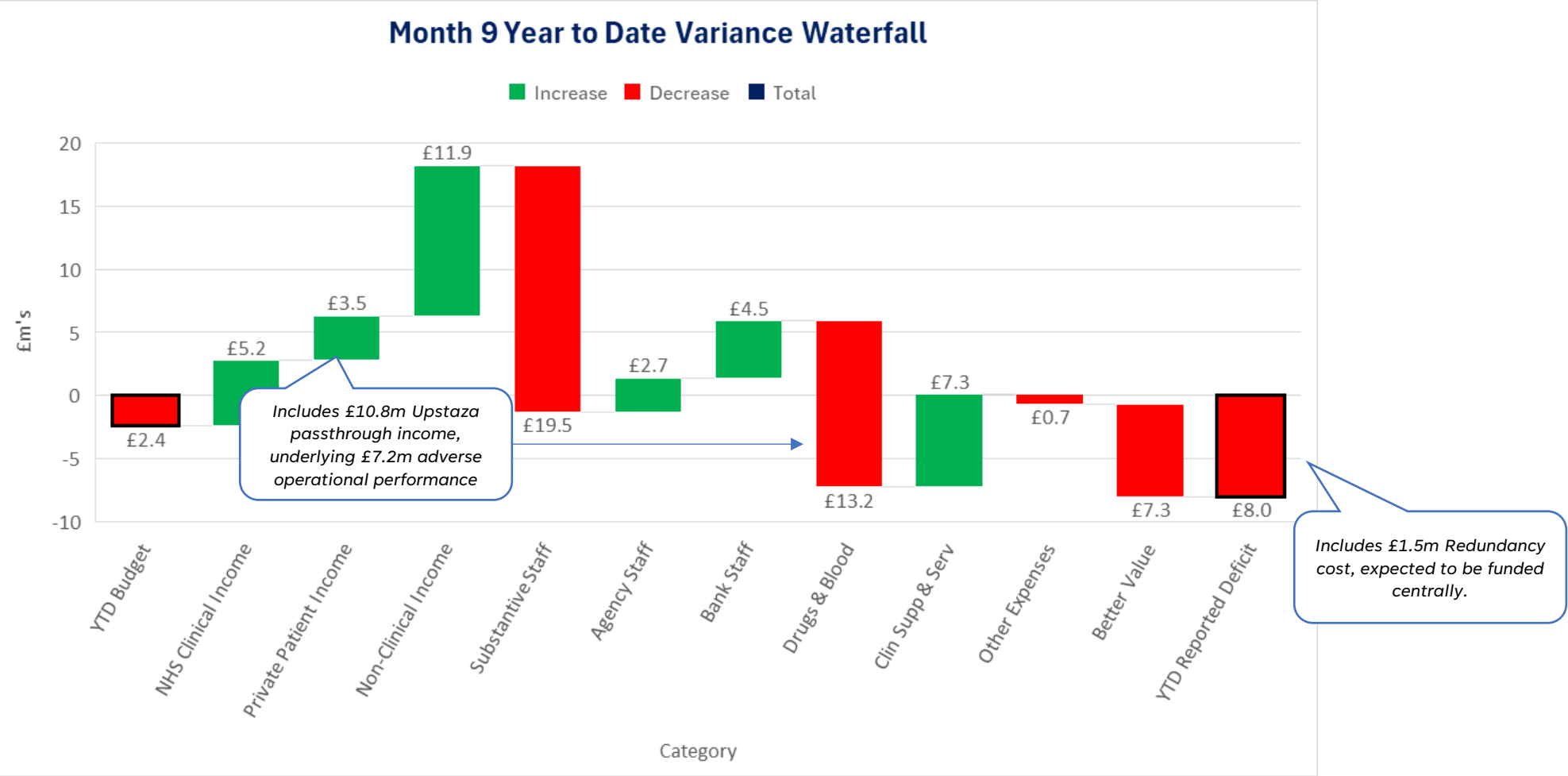
Key Drivers of the reported position in M9

- The chart below highlights the key drivers of the reported position in M9.
- Favourable variance in clinical income £2.2m is driven by non-activity funding from NCL which mitigates in-month adverse variance in activity income.
 - Private patient income is worse than plan by £1.9m due lower than anticipated demand in Respiratory, Cardiology and PICU
 - Non-clinical income is mostly attributable to additional charities funding
 - Substantive staffing is adverse to plan due to unidentified better value savings target and this is partially offset by savings in bank and agency (£1m)



Key drivers of the reported position Year to date

- The chart below highlights the key drivers of the reported position in M9.
- It should be noted that this position is shown against the original Trust plan submitted to NHSE. The agreed recovery plan with NCL is set at £6.4m YTD deficit, recognizing worsening run-rate in the first quarter of 25/26.
 - Private patient income is showing £3.5m overall positive position – including Upstaza income. Adjusting for £10.8m Upstaza income gives £7.2 adverse operational performance YTD.
 - Non-clinical income is mostly attributable to additional charities funding
 - Substantive staffing is adverse to plan due to unidentified better value savings target and this is partially offset by savings in bank and agency.

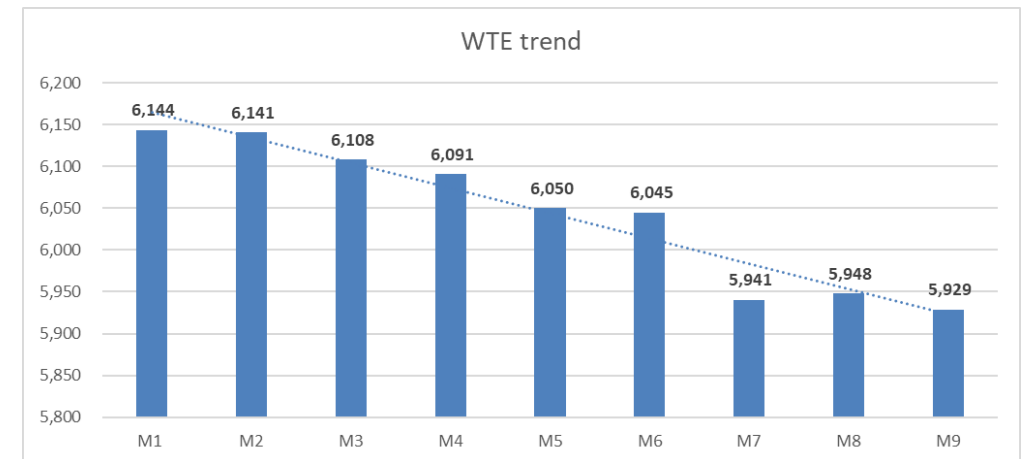
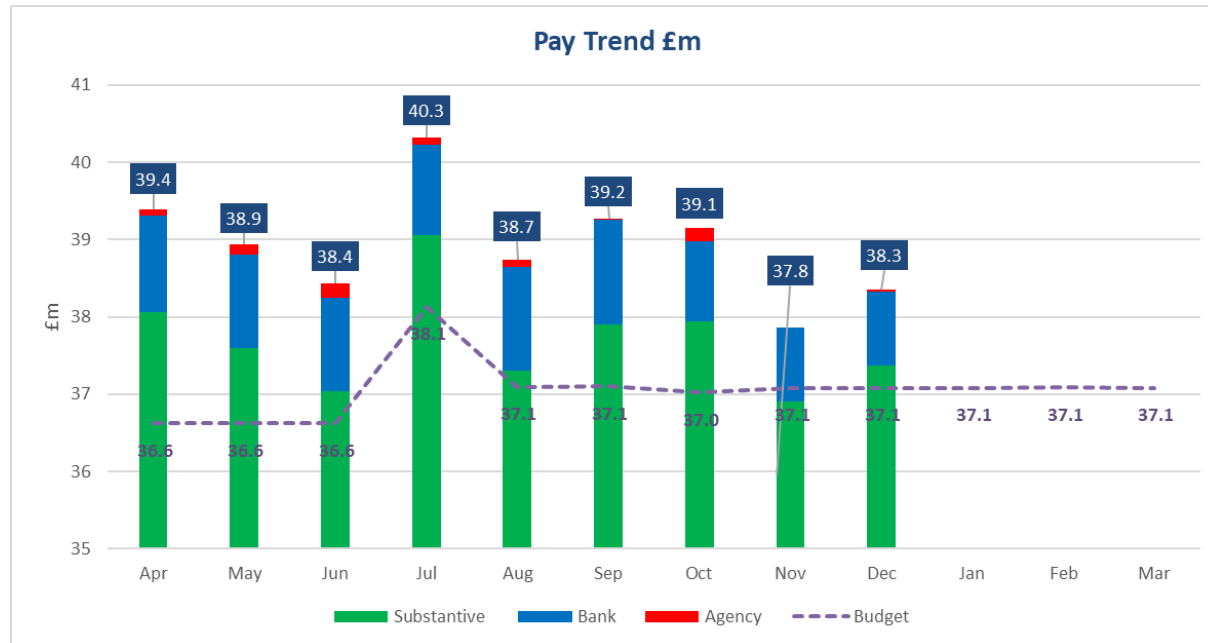


Trust Income & Expenditure Position at Month 9

2025/26										
Annual Plan	Income & Expenditure	Month 9				Year to Date				Rating
		Plan	Actual	Variance		Plan	Actual	Variance		
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	Variance
558.9	NHS & Other Clinical Revenue	46.44	48.63	2.19	5%	419.59	424.77	5.19	1%	G
86.1	Private Patient Revenue	7.17	5.29	(1.88)	(26%)	64.55	68.07	3.52	5%	G
81.0	Non-Clinical Revenue	6.75	9.12	2.37	35%	60.74	72.65	11.90	20%	G
726.0	Total Operating Revenue	60.36	63.04	2.68	4%	544.88	565.49	20.61	4%	G
(420.1)	Permanent Staff	(35.04)	(37.37)	(2.33)	(7%)	(314.97)	(339.19)	(24.21)	(8%)	R
(4.5)	Agency Staff	(0.38)	(0.03)	0.35	92%	(3.39)	(0.73)	2.66	78%	G
(20.0)	Bank Staff	(1.67)	(0.95)	0.71	43%	(15.01)	(10.48)	4.54	30%	G
(444.6)	Total Employee Expenses	(37.08)	(38.36)	(1.27)	(3%)	(333.38)	(350.40)	(17.02)	(5%)	R
(124.2)	Drugs and Blood	(10.32)	(11.71)	(1.39)	(14%)	(93.25)	(106.41)	(13.17)	(14%)	R
(57.8)	Supplies and services - clinical	(3.01)	(1.98)	1.03	34%	(44.58)	(37.25)	7.33	16%	G
(74.9)	Other Expenses	(6.62)	(7.53)	(0.91)	(14%)	(57.64)	(62.20)	(4.56)	(8%)	R
(256.9)	Total Non-Pay Expenses	(19.95)	(21.22)	(1.27)	(6%)	(195.47)	(205.86)	(10.39)	(5%)	R
(701.6)	Total Expenses	(57.03)	(59.58)	(2.54)	(4%)	(528.85)	(556.24)	(27.40)	(5%)	R
24.4	EBITDA (exc Capital Donations)	3.33	3.46	0.14	4%	16.03	9.25	(6.79)	(42%)	R
(24.4)	Owned depreciation, Interest and PDC	(2.04)	(1.99)	0.05	3%	(18.42)	(17.26)	1.16	6%	
(0.0)	Surplus/Deficit	1.29	1.48	0.19	15%	(2.39)	(8.01)	(5.63)	(236%)	
(16.7)	Donated depreciation	(1.41)	(1.40)	0.00		(12.53)	(12.62)	(0.09)		
(16.7)	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	(0.12)	0.07	0.19	15%	(14.92)	(20.63)	(5.72)	(236%)	
0.0	Impairments & Unwinding Of Discount	0.00	0.00	0.00		0.00	0.00	0.00		
0.0	Capital Donations	0.00	1.68	1.68		0.00	16.74	16.74		
(16.7)	Adjusted Net Result	(0.12)	1.75	1.87	1,605%	(14.92)	(3.90)	11.02	74%	

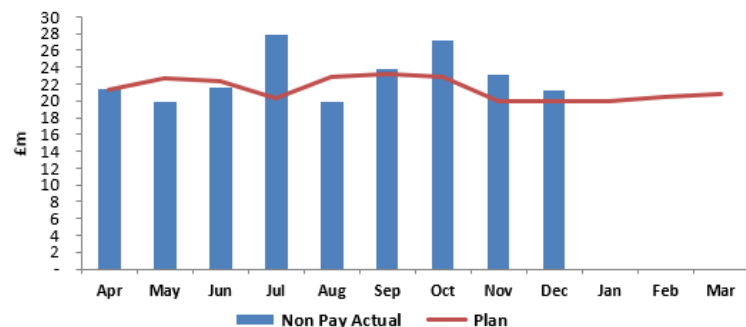
Trust Pay Position as at Month 9

- In month 9 we spent £38.3m on pay (£37.37 on substantive, £0.9m on bank and £0.03m on agency). This is £1.3m higher than plan in month.
- Bank and agency spend is £1m lower than plan in month, however substantive spend is £2.3m higher. This is driven by underperformance against Better Value target.
- Overall WTE trend shows sustained reduction in staff levels on last year.
- The reported variance to plan year to date (of £17m) is due to higher than budgeted substantive staffing spend (£24.2m year to date) linked under-delivery of Better value programmes. This is partly offset by lower than budgeted spend on bank and agency of £7.2m
- Substantive staff cost in month increased by £0.5m on M8 – although this relates to new BRC related costs coming through in R&I which is offset by income. After normalising for this non-recurrent cost, the pay cost in M9 falls back in line with M8.

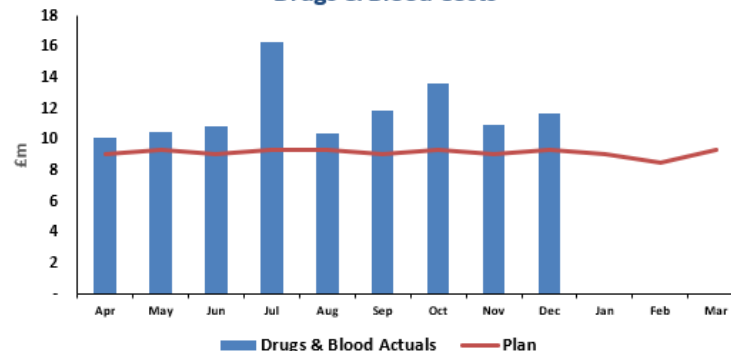


Non Pay Trend Analysis as at Month 9

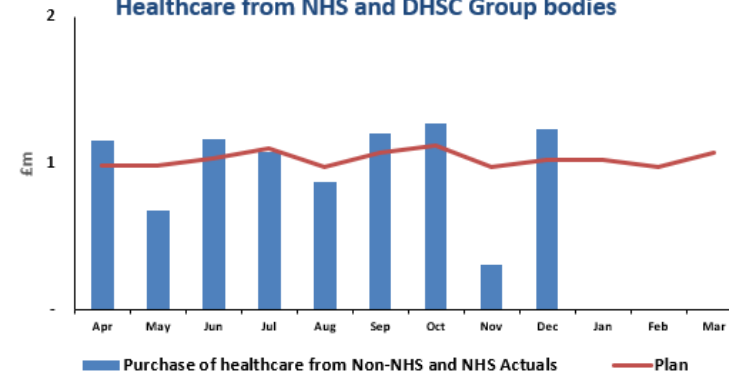
Non Pay Cost Trend



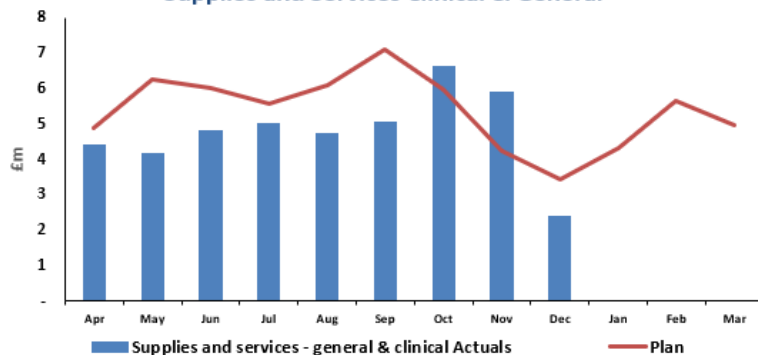
Drugs & Blood Costs



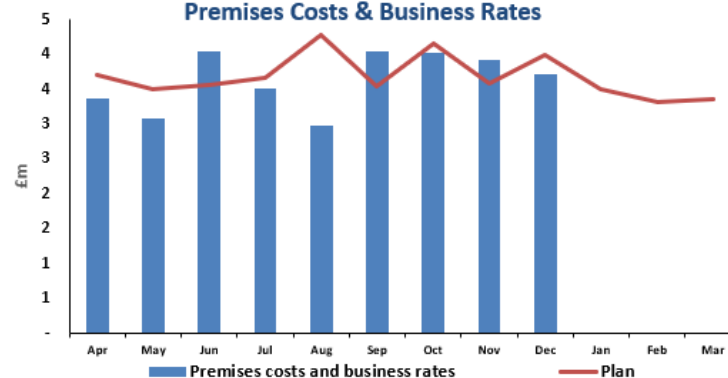
Healthcare from NHS and DHSC Group bodies



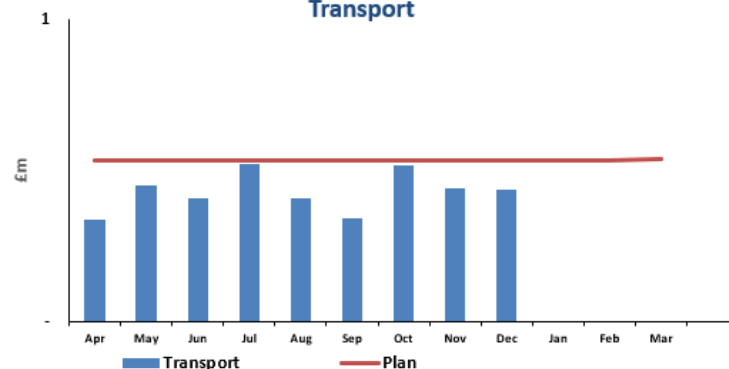
Supplies and Services Clinical & General



Premises Costs & Business Rates



Transport



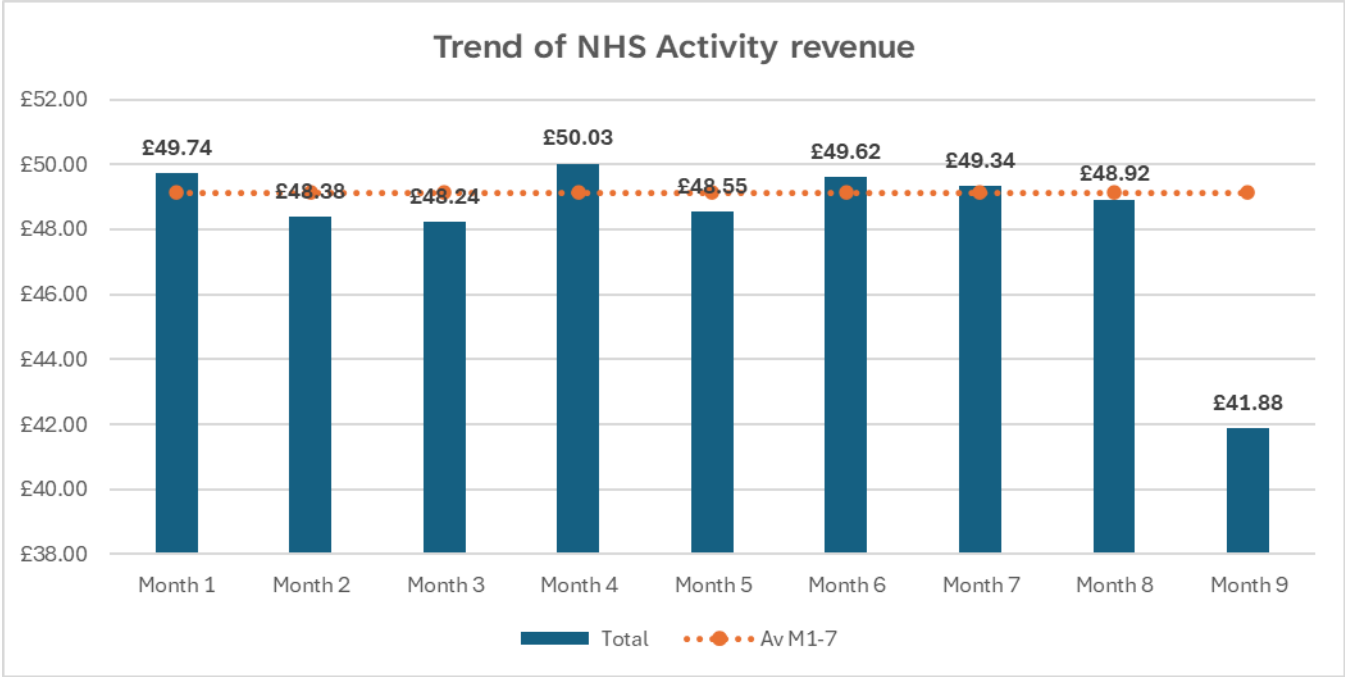
Summary

Supplies and services are £1m lower than plan in month mainly driven by realignment of passthrough drugs and devices cost - Offset against drugs and blood cost overspends.

Drug and blood costs are £1.4 higher than plan in month mainly driven by realignment of passthrough drugs and devices cost - Offset against supplies and services underspends

Other expenses are £1m adverse in month predominantly driven by the underperformance on unidentified CIP targets.

Clinical Income



Clinical Income

NHS Clinical Income is £2.2m favourable in Month 9 and £5.2m YTD, although this position is largely driven by non-recurrent funding streams.

- M9 Revenue from clinical activity has seen a significant fall on the average run-rate to date.
- Some of this revenue is expected to be recovered as coding completeness improves during the month, although activity volumes in key income-generating points of delivery (elective/day case and regular day admissions) is down by 4% on previous month
- Some of this has been anticipated by the plan which is phased on working days, although not to the full extent.

Other income drivers:

- £1m underperformance on Genomics due to lower contract value and activity under performance.
- £1.3m underperformance on Gender due to not being fully recruited.

Clinical Directorate Positions as at Month 9

Annual Plan (£m)	Directorates - Clinical	In Month				Year to Date				RAG	Main drivers Causing YTD Variance
		Plan (£m)	Actual (£m)	Variance (£m)	%	Plan (£m)	Actual (£m)	Variance (£m)	%	YTD Var	
(108.8)	Core Clinical Services	(9.1)	(9.5)	(0.4)	(4.9%)	(81.6)	(84.3)	(2.7)	(3.3%)	R	The in-month performance is £0.4m adverse to plan. Pay was £0.3m behind plan driven by under performance against Better Value. Non-pay £117k adv in month mainly driven by pathology reagents and BME repairs.. YTD the directorate remains £2.7m behind plan, largely due to pay costs driven by slippage against Better Value targets which is partly offset by higher income (£0.45m) linked to pathology testing (£0.3m) and clinical trials (£0.2m).
(68.1)	Heart & Lung	(5.6)	(7.2)	(1.6)	(27.9%)	(51.0)	(57.2)	(6.2)	(12.2%)	R	The in-month performance is behind plan (£1.6m); this is driven by an underperformance on private patients (£1.3m) and underperformance on pay BV target (0.3m).The year-to-date variance to plan (£6.2) is largely linked to underperformance on pay Better Value (£2.3m) and a shortfall on private patient income (£4.1m).
(42.8)	Blood Cells & Cancer	(3.6)	(3.4)	0.2	6.3%	(32.5)	(33.1)	(0.6)	(1.9%)	R	In month position is 0.2m fav predominantly driven by.The YTD position is (0.6m) behind plan, this is largely due to pay spend driven by Vacancy Factor target and the Better Value target. The main areas include Junior Dr and Nursing/HCA spend due to one-to-one care.
(41.1)	Body Bones & Mind	(3.5)	(3.2)	0.2	6.3%	(30.7)	(31.7)	(0.9)	(3.1%)	R	The in-month position is £0.2m fav to plan driven by overperformance on IPC income (£0.13m) as a result of increase in renal and ortho related activate and the remaining is driven by underspends within non pay. The year-to-date position is £0.9m behind plan. This is mainly driven by (£1.3m) under-performance against pay Better Value; these are partly offset by savings within consultants due to delayed recruitment, however there are also pressures within nursing (£0.1m) due to patient acuity, staff sickness and the support of newly qualified nurse earlier on in the year. YTD private patient income is favourable by £0.13m.
(34.9)	Sight & Sound	(2.9)	(2.8)	0.1	2.1%	(26.1)	(26.5)	(0.4)	(1.3%)	A	The in-month performance is almost in line with the plan. The YTD adverse variance is largely due to the pay spend which relates to the 24/25 Vacancy Factor target and the 25/26 Better Value target (Junior doctors and Nursing).
(29.8)	Brain	(2.5)	(2.6)	(0.1)	(4.2%)	(22.4)	(23.4)	(1.0)	(4.6%)	R	The in-month performance is £0.1m adv to plan mainly driven by underperformance against BV targets.. The YTD adverse variance (£1m) is driven by higher pay costs attributable to undelivered Better Value, bank spend on junior doctors due to a combination of strikes and rota gaps and nursing due to sickness/absence and underperformance against private patients (£0.16m).
11.2	Nt Genomic Medicine Service	0.9	1.0	0.1	13.7%	8.4	8.2	(0.2)	(2.0%)	A	In-month performance is £0.1m favourable to plan predominantly driven by income catch up. YTD adverse variance is mainly due to the underperformance against the income plan. This is due to the main North Thames GLH contract being considerably lower than last financial year. The remaining gap is due to undelivered Better Value.
37.3	International And Private Care	3.0	2.6	(0.3)	(11.8%)	28.5	40.2	11.7	41.1%	G	The in-month variance of (£0.35m) adverse is due to less than anticipated activity mainly in respiratory and diminishing demand for ICU. The Directorate is ahead of plan by £11.7m YTD, including Uptaza drug income of £10.8m (the associated costs are held outside the directorate) and remaining £1.7m is driven by underspends in non pay .
(277.1)	Surplus/Deficit	(23.3)	(25.2)	(1.8)	(7.9%)	(207.4)	(207.7)	(0.3)	(0.1%)	A	

Trust Summary & Corporate Directorate Positions as at Month 9

RAG Key

G	Green Favourable YTD Variance
A	Amber Adverse YTD Variance (< 5%)
R	Red Adverse YTD Variance (> 5% or > £0.5m)

Annual Plan	Trust Position	In Month			Year to Date		
		Plan (£m)	Actual (£m)	Variance (£m)	Plan (£m)	Actual (£m)	Variance (£m)
(115.7)	Directorates - Corporate	(9.0)	(9.1)	(0.1)	(81.2)	(82.8)	(1.5)
(278.2)	Directorates - Clinical	(23.3)	(25.2)	(1.8)	(207.4)	(207.7)	(0.3)
390.8	Central Income	32.5	35.6	3.2	293.4	288.3	(5.1)
29.3	Central Expenditure	3.3	2.2	(1.2)	12.6	12.8	0.2
(18.3)	Depreciation	(1.5)	(1.5)	0.1	(13.7)	(12.7)	1.0
(7.9)	Dividends Payable	(0.7)	(0.7)	(0.0)	(5.9)	(5.9)	(0.0)
0.1	Total Trust - Surplus / Deficit	1.3	1.5	0.2	(2.4)	(8.0)	(5.6)

ICT is £0.1m adverse in month mainly driven by VAT related adjustments.

Clinical and Medical Operations is in line with plan in month.

Corporate Affairs is £0.1m adverse in month mainly driven by catch up on maintenance contracts. YTD the directorate is behind plan by £0.3m, this is attributable to underperformance on Better Value.

HR is inline with plan in month; YTD the directorate is £0.3m behind plan due to underperformance on Better Value pay.

Nursing and patient experience is in line with plan in month and broadly in line year to date

Finance is in line with plan in month, YTD the directorate is £0.3m behind plan this is attribute to £0.1m of consultancy costs in relation to procurement support and £0.1m of additional audit costs in relation to 24/25 and overspend on pay mainly attributable to underperformance against Better Value.

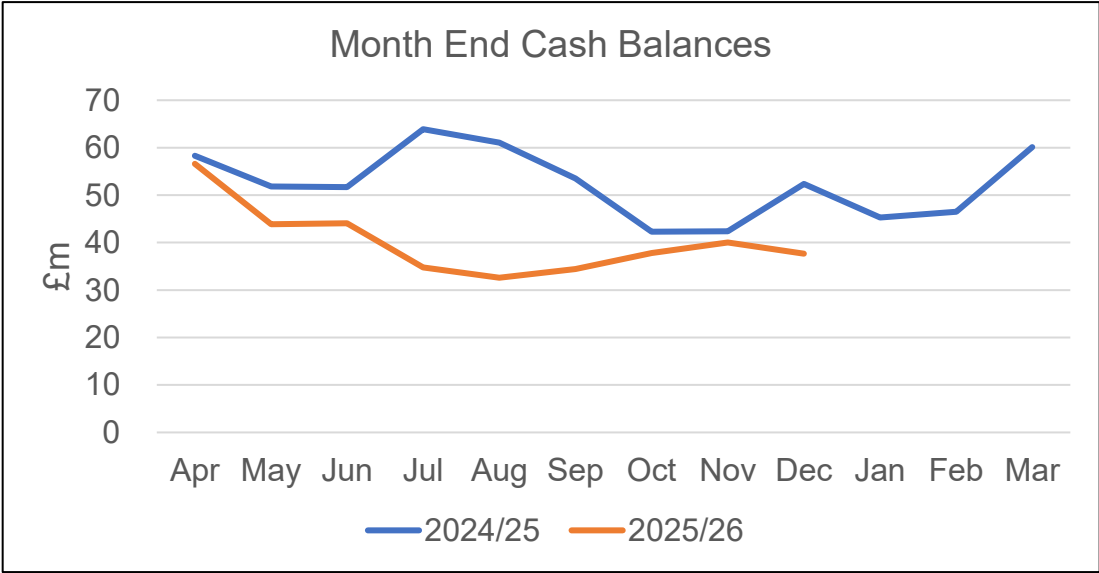
Innovation is in line with plan in month £0.2m and £0.2m YTD primarily due to delays in the production of Leucid Bio.

R&I is behind plan in month and YTD due to lower than forecast income driven by activity based commercial contracts and a backlog of commercial billing.

Space & Place £0.2m favourable in month mainly due to YTD correction of Bank related costs. YTD 0.6m favourable to plan mainly driven by Charity income to cover cost of rent.

Annual Plan (£m)	Directorates - Corporate	In Month				Year to Date				YTD RAG Var
		Plan (£m)	Actual (£m)	Variance (£m)	%	Plan (£m)	Actual (£m)	Variance (£m)	%	
(53.3)	Space And Place	(4.4)	(4.2)	0.2	6%	(40.0)	(39.4)	0.6	1%	G
(12.8)	ICT	(1.1)	(1.1)	(0.1)	(5%)	(9.6)	(9.7)	(0.1)	(1%)	A
(11.2)	EPR	(0.9)	(0.9)	0.1	7%	(8.4)	(8.1)	0.2	3%	G
(7.8)	Clinical & Medical Operations	(0.6)	(0.6)	(0.0)	(0%)	(5.8)	(6.0)	(0.2)	(3%)	A
(13.2)	Medical Director	(1.1)	(1.0)	0.1	11%	(9.9)	(9.7)	0.2	2%	G
(6.6)	HR & Organisational Development	(0.5)	(0.6)	(0.0)	(2%)	(4.9)	(5.2)	(0.3)	(6%)	R
(3.3)	Nursing And Patient Experience	(0.3)	(0.3)	(0.0)	(14%)	(2.5)	(2.6)	(0.1)	(3%)	A
10.7	Learning Academy	0.9	0.8	(0.1)	(15%)	8.0	7.6	(0.4)	(5%)	A
(4.3)	Corporate Affairs	(0.4)	(0.5)	(0.1)	(27%)	(3.2)	(3.6)	(0.3)	(11%)	R
(6.0)	Finance	(0.5)	(0.5)	(0.0)	(9%)	(4.5)	(4.8)	(0.3)	(8%)	R
(0.8)	Innovation	(0.1)	(0.0)	0.0	50%	(0.6)	(0.8)	(0.2)	(27%)	R
0.2	Research And Innovation	0.0	(0.1)	(0.1)	(735%)	0.2	(0.4)	(0.6)	(370%)	R
(108.3)	Surplus/Deficit	(9.0)	(9.1)	(0.1)	(1%)	(81.2)	(82.8)	(1.5)	(2%)	R

Balance Sheet Summary as at Month 9



Key metrics	Trend	Nov-25	Dec-25	Plan / Target	RAG
Cash (£m)		40.0	37.9	49.1	
I&PC Debtor days		195	173	150	
Creditor days		37	42	30	
NHS Debtor days		4	4	6	
Non NHS Debtor days		73	85	30	
BPPC Non NHS (£)		86%	87%	95%	
BPPC NHS (£)		66%	64%	95%	

Capital Programme	Full Year Plan £m	YTD Plan M9 £m	YTD Actual M9 £m	YTD Variance M9 £m
Total CDEL – Trust Funded	26.2	16.7	17.8	(1.1)
Total PDC	5.5	4.9	0.4	4.5
Total Donated and Grants	53.4	39.0	16.7	22.3
Grand Total	85.0	60.7	35.0	25.7

- Trust CDEL is above plan by £1.1m – this is predominantly due to the Trust's investment in equity and incurring a Redevelopment project charge of £1.2m last month. This is offset against slippage in expenditure for Medical Equipment (£2.0m), Property & Plant (£1.4m) and ICT (£1.0m).
- The cash balance decreased in month as a result of the increase in R&I debt which is offset against the increase in I&PC cash receipts in month. This has led to a reduction in I&PC debtor days as well as Non NHS debtor days in month. There will be a greater focus on R&I debt collection in January. The M09 position includes an accrual for additional funding from NHSE of £5.2m; a cash receipt is expected in January.
- Contract receivables decreased slightly in month as a result of the movements in R&I and I&PC debt as described above.
- Creditor days increased in month due to the receipt of two large invoices which are both payable in January.
- Non NHS BPPC statistic for December was 92%. This has increased the year to date statistic from 86% to 87%.

Capital Expenditure as at Month 9

Funding Stream	Area	Annual Plan £m	YTD Plan Dec 2025 £m	YTD Actual Dec 2025 £m	YTD Variance £m
Trust Funded - CDEL	Children's Cancer Centre	5.6	4.2	4.2	0.0
Trust Funded - CDEL	Information Technology & Intangibles	4.5	3.3	2.3	1.0
Trust Funded - CDEL	Property & Plant - Estates Infrastructure	4.5	3.1	2.0	1.0
Trust Funded - CDEL	Property & Plant - Redevelopment	3.1	1.9	1.5	0.4
Trust Funded - CDEL	Property & Plant - Office Decant Projects	0.1	0.1	0.2	(0.1)
Trust Funded - CDEL (IFRS 16)	Property & Plant	(0.7)	(0.5)	(0.5)	(0.0)
Trust Funded - CDEL	Medical Equipment	8.3	4.1	2.6	1.4
Trust Funded - CDEL (IFRS 16)	Medical Equipment	0.8	0.6	0.0	0.6
Trust Funded - CDEL subtotal		26.2	16.7	12.3	4.4
Trust Funded - CDEL	Acquisition of shares - investment	0.0	0.0	4.3	(4.3)
Trust Funded - CDEL	Property & Plant - On-Call Rooms MNH	0.0	0.0	1.2	(1.2)
Trust Funded - CDEL grand total		26.2	16.7	17.8	(1.1)
PDC	Information Technology & Intangibles	0.1	0.0	0.0	0.0
PDC	Medical Equipment	3.0	2.5	0.2	2.3
PDC	Property & Plant	2.4	2.4	0.2	2.2
PDC Total		5.5	4.9	0.4	4.5
Total CDEL (CDEL + PDC)		31.7	21.7	18.3	3.4
Grant/Donations	Children's Cancer Centre	50.4	36.8	15.0	21.9
Grant/Donations	Property & Plant	0.9	0.7	(0.1)	0.8
Grant/Donations	Medical Equipment	2.0	1.5	1.9	(0.4)
Grant/Donations Total		53.4	39.0	16.7	22.3
Grand Total		85.0	60.7	35.0	25.7

- The Trust is £1.1m ahead of plan on CDEL funded schemes.
- This position is driven by the Trust's investment in equity and a Redevelopment project charge of £1.2m in the previous month. However, this is offset against capital projects progressing gradually than expected resulting in a behind plan position for Medical Equipment (£2.0m), Property & Plant (£1.4m) and ICT (£1.0m).
- The PDC scheme expenditure is behind plan by £4.5m, mainly driven by the delay in the Theatre 3 refurbishment project and the due to the non commencement of the CT Imaging project . Property & Plant have received approval under the Building Safety Act and although enabling works have commenced, there will be a delay in the full refurbishment of Theatre 3 due to downtime in other Theatres for Estates work. The CT imaging project will not be delivered within this financial year due to other on-going CT works and the requirement of a BSA application.
- PDC schemes are funded/cash backed and the Trust will draw down funding as and when expenditure is incurred..
- The Donated expenditure schemes are behind plan by £22.3m; the majority of this relates to the Children's Cancer Centre, which is £21.2m behind plan, due to a 11-week known delay.

Statement of Financial Position as at Month 9

Audited Actual as at 31 Mar 2025	Asset//Liability	Actual as at 30 Nov 2025	Actual as at 31 Dec 2025	Change in month
£m		£m	£m	£m
	Non Current Assets			
601.3	Property, plant and equipment and Intangible assets	610.9	611.8	0.9
67.5	Right of use assets	62.9	62.4	(0.5)
0.0	Other investments / financial assets	4.3	4.3	0.0
6.7	Trade and other receivables	6.6	6.9	0.3
675.5	Total Non Current Assets	684.7	685.4	0.7
	Current Assets			
14.4	Inventories	13.4	14.2	0.8
16.0	Receivables: due from NHS and DHSC group bodies	19.8	26.4	6.6
98.0	Receivables: due from non-NHS/DHSC group bodies	107.3	99.9	(7.4)
(12.3)	Credit Loss Allowances	(6.2)	(7.0)	(0.8)
60.1	Cash and cash equivalents	40.0	37.9	(2.1)
176.2	Total Current Assets	174.3	171.4	(2.9)
	Current Liabilities			
(13.3)	Trade and other payables: capital	(8.7)	(9.4)	(0.7)
(111.9)	Trade and other payables: non-capital	(112.2)	(111.5)	0.7
(3.4)	Borrowings	(3.2)	(3.4)	(0.2)
(1.4)	Provisions	(1.4)	(0.2)	1.2
(9.7)	Other liabilities: deferred income including contract liabilities	(29.3)	(27.0)	2.3
(139.7)	Total Current Liabilities	(154.8)	(151.5)	3.3
36.5	Net Current Assets	19.5	19.9	0.4
712.0	Total Assets less Current Liabilities	704.2	705.3	1.1
	Non Current Liabilities			
(23.5)	Borrowings	(21.7)	(21.2)	0.5
(1.7)	Deferred income: NCL	(1.5)	(1.4)	0.1
(2.6)	Provisions for liabilities and charges NCL	(2.5)	(2.5)	0.0
(27.8)	Total Non Current Liabilities	(25.7)	(25.1)	0.6
684.2	Total Assets Employed	678.5	680.2	1.7
	Financed by Taxpayers' Equity			
134.9	Public dividend capital	134.9	134.9	0.0
364.3	Retained earnings	358.6	360.3	1.7
(0.2)	Financial Asset reserve	(0.2)	(0.2)	0.0
185.2	Revaluation reserve	185.2	185.2	0.0
684.2	Total Taxpayers' Equity	678.5	680.2	1.7

- **Non Current assets:** The Property, Plant and Equipment (PPE) and Intangibles and ROU balance increased by £0.4m in month, due to capital expenditure of £3.2m, less depreciation and amortisation of £2.9m.
- **Current assets:** The decrease in non NHS receivables largely relates to I&PC debt including accruals as a result of higher than expected payments from Embassies. NHS receivables includes an accrual for additional funding from NHSE of £5.2m; a cash receipt is expected in January.
- **Current liabilities: Provisions** decreased in month following the release of provision brought forward at the beginning of the year.
- **Other liabilities – deferred income** also decreased in month as the end of quarter receipts are released. This is expected to increase in M10.
- **Taxpayers' Equity:** Retained earnings decreased in the year to date as a result of the year to date deficit. The M09 position improved by £1.7m as a result of the in month surplus.

Statement of Cashflows as at Month 9

Audited Actual as at 31 Mar 2025 £m	Cash inflow/outflows	Actual as at 30 Nov 2025 £m	Actual as at 31 Dec 2025 £m	Change in month £m
	Cash flows from operating activities			
(10.9)	Operating deficit - excluding charitable capital expenditure contributions	(16.8)	(16.1)	0.7
0.0	Impairment and Reversals	0.0	0.0	0.0
18.3	Charitable capital expenditure contributions	15.1	16.7	1.6
7.4	Operating surplus/(deficit)	(1.7)	0.6	2.3
33.5	Depreciation and amortisation	22.5	25.3	2.8
6.4	Decrease/(Increase) in trade and other receivables	(19.2)	(17.7)	1.5
(1.1)	(Increase)/decrease in inventories	1.0	0.2	(0.8)
10.5	Increase /(decrease) in trade and other payables	(0.4)	(1.8)	(1.4)
(6.6)	(Decrease)/Increase in other current liabilities	19.4	16.9	(2.5)
0.0	Decrease in provisions	0.0	(1.3)	(1.3)
42.7	Net cash inflow/(outflow) from operating activities	23.3	21.6	(4.5)
	Cash flows from investing activities			
3.1	Interest received	1.4	1.6	0.2
0.0	Purchase of financial assets / investments	(4.3)	(4.3)	0.0
(49.7)	Purchase of property, plant and equipment and Intangibles	(32.5)	(35.2)	(2.7)
(46.6)	Net cash outflows from investing activities	(35.4)	(37.9)	(2.5)
	Cash flows from financing activities			
0.7	Public Dividend Capital received	0.0	0.0	0.0
(7.4)	PDC dividend paid	(4.5)	(4.5)	0.0
(2.4)	Capital element of lease payment	(1.5)	(1.7)	(0.2)
(0.3)	Interest element of lease payment	(0.2)	(0.2)	0.0
(9.4)	Net cash outflows from financing activities	(6.2)	(6.4)	(0.2)
(5.9)	Decrease in cash and cash equivalents	(20.0)	(22.1)	(2.1)
65.9	Cash and cash equivalents at period start	60.0	60.0	0.0
60.0	Cash and cash equivalents at period end	40.0	37.9	(2.1)

- **Operating activities: Receivables:** I&PC debt including accruals decreased in month due to higher than expected receipts. Receivables includes an accrual for additional funding from NHSE of £5.2m; a cash receipt is expected in January.
- **Inventories:** the increase in inventories largely relates to pharmacy stock.
- **Trade and other payables:** the decrease in trade payables largely relates to I&PC deposits which is lower than M08.
- **Other liabilities (deferred Income):** this decreased in month, in line with previous quarters, as amounts received in cash at the beginning of the quarter have been released into the position to match expenditure.
- **Investing activities:** Purchase of intangibles and property, plant and equipment is slightly higher than the previous month.

Top 20 Debtors and Charity Billing as at Month 9

Debtor	Category	Balance (£000)	Overdue Amount (£000)
Kuwait Health Office	I&PC	28,234	23,205
Qatar Embassy - Medical Section	I&PC	6,163	3,533
International Patient Care Department	I&PC	4,422	4,077
Kuwait Military Affairs Office	I&PC	2,902	2,897
Barts Health Nhs Trust	NHS	1,731	1,676
Dubai Health Authority	I&PC	1,710	1,085
Bupa	I&PC	1,673	1,557
Saudi Health Office	I&PC	1,515	835
Ppd Global Ltd	R&I	620	649
University College London	NHS	529	267
Nhs Tayside	NHS	528	474
Uclh Nhs Foundation Trust	NHS	523	455
Axa Ppp Healthcare	I&PC	522	389
North West London Pathology	NHS	502	457
Cigna International	I&PC	448	422
Biomarin Pharmaceuticals Inc	R&I	411	413
Oman Embassy - Health Attache	I&PC	408	415
Clinical Research	Commercial	401	401
Biogen	R&I	398	82
University Hospitals Bristol And Weston Nhs FT	NHS	389	385
Other debtors	OTHER	13,140	14,085
GRAND TOTAL		67,168	57,759
TOP 20 / TOTAL DEBTORS %		78%	72%

Priority Area	Executive Lead	Awarded (£000)	Amount Remaining (£000)	Awaiting Signed Award Letter
Cross Cutting		520	382	1
	Cymbeline Moore	320	320	1
	Mat Shaw	200	62	0
Education		36,589	15,829	0
	Sophia Varadkar	36,589	15,829	0
Environment		58	17	0
	Tracy Lockett	58	17	0
Patients and Families		17,827	15,625	6
	Tracy Lockett	17,827	15,625	6
People		1,204	1,045	1
	Caroline Anderson	463	304	0
	Jason Dawson	741	741	1
Research		17,006	12,994	2
	Dena Marshall	744	24	0
	Kiki Syrad	16,262	12,970	2
Restricted Funding		1,636	412	0
	Kiki Syrad	1,351	360	0
	Tracy Lockett	285	52	0
Technology and Innovation		8,235	6,474	2
	Margaret Monckton	1,541	889	1
	Mat Shaw	272	272	1
	Sophia Varadkar	6,422	5,313	0
Grand Total	Grand Total	83,075	52,778	12

Month 9 Better Value Position Year to Date

Better Value Forecast	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25		
£m	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Total YTD	Plan YTD
B/F FYE from 24/25	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Contract Management	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	2.2	1.5
Additional Advice & Guidance	-	-	-	-	-	-	-	-	-	-	0.5
EPR Optimisation	-	-	-	-	-	-	-	-	-	-	0.1
VAT reclaim	-	-	-	-	0.6	-	-	-	-	0.6	0.4
Commercial & Research	-	-	-	-	-	-	-	-	-	-	0.6
Holiday pay accrual	-	-	0.8	0.3	0.3	0.3	0.3	0.3	0.3	2.3	3.8
Medicine	-	-	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.4
WTE reduction	0.2	0.2	0.2	-	0.2	0.7	0.3	0.4	0.3	2.6	9.0
Bank and agency	0.7	0.7	0.6	0.8	0.9	0.4	0.8	1.2	1.1	7.2	3.9
GLA & DRIVE	-	-	-	-	-	-	-	-	-	-	1.2
Labs savings + rate card	-	-	-	-	-	-	-	-	-	-	0.2
Other savings (unidentified)	-	-	0.1	0.1	0.1	0.1	0.1	0.1	-	0.6	1.6
Better Value Total	1.1	1.1	2.0	1.4	2.3	1.9	1.8	2.3	2.0	15.9	23.3

Contract management: YTD delivery totals £2.2m: this is made up of savings from both the Better Procurement workstream and savings identified by Directorates.

Additional advice and guidance: There is no delivery YTD, as commissioners have not agreed this.

VAT reclaim: £0.6m has been achieved YTD.

Holiday pay accrual: To date £2.3m has been released; £0.3m this month.

Medicine: Savings are on track to exceed target by £0.1m; these savings are captured centrally as a separate workstream. Delivery to date totals £0.4m.

Bank and agency savings are ahead of plan, reflecting the controls that have been put in place. In month savings against plan total £1.1m. The YTD savings total £7.2m.

GLA & DRIVE Risks remain as to whether DRIVE schemes will land in 25/26.

Substantive staff reduction savings to date total £2.6m (this includes the impact of the MARS scheme from M8).

Other savings (including the 2% blanket saving allocation) remain a key risk area, with only £0.6m delivered year to date.

2025/26 Trust Forecast as at Month 9

EMT 19 January 25

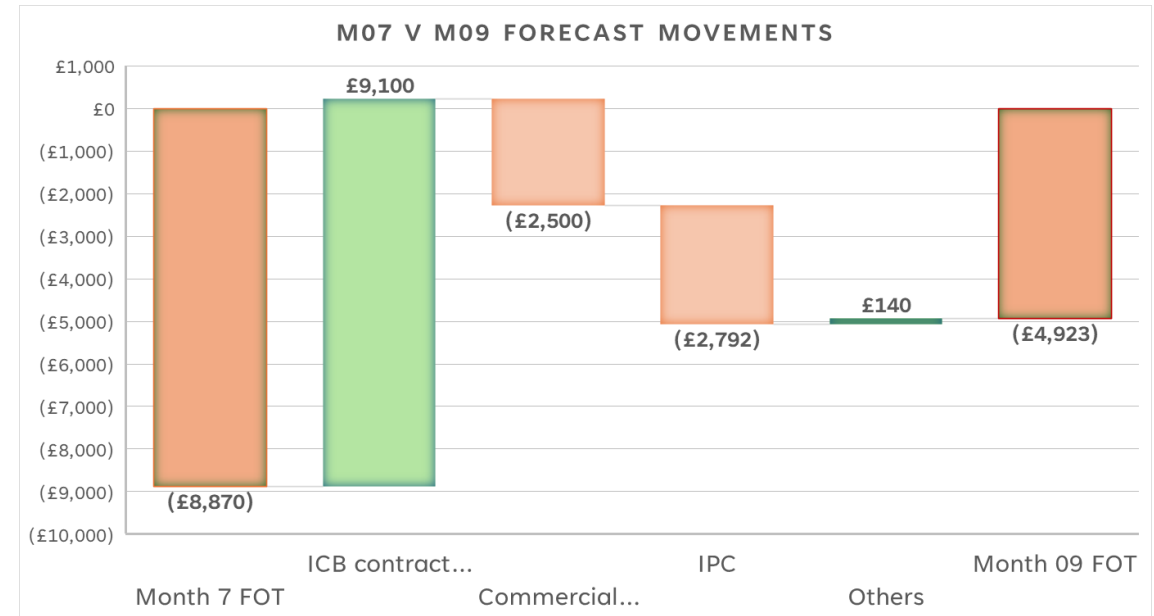
Petra Black
Deputy Chief Finance Officer



25/26 Month 9 Forecast

At M7, our full year forecast for 25/26 was £8.9m deficit. At M9, our best view of forecast stands at £4.9m which is an improvement of £4m although this is still worse than our breakeven plan. We had plans to bridge the gap through non-recurrent funding stream from NCL ICB. Although this benefit materialised, our run-rate between M7 and M9 deteriorated further, mostly owing to delayed realisation of an assumed commercial benefit (£2.5m) and shortfall in IPC revenue of £2.8m - leading to a revised forecast **£4.9m deficit**.

Type	Type Detail	Annual Budget	Forecast	Forecast Variance	FOT vs Previous FOT
		£m's	£m's	£m's	£m's
Income	Nhs Clinical Income	£551.7	£564.1	£12.4	£5.0
	Non Clinical Income	£81.0	£98.7	£17.7	(£0.8)
	Non-Nhs Clinical Income	£93.3	£95.7	£2.5	(£2.1)
Income Total		£726.0	£758.5	£32.6	£2.0
Non Pay	Non Pay Costs	(£256.9)	(£274.0)	(£17.1)	(£0.2)
	Other Revenue / Expenditure	(£24.4)	(£25.0)	(£0.6)	£0.1
Non Pay Total		(£281.4)	(£299.0)	(£17.7)	(£0.2)
Pay	Agency	(£4.5)	(£0.8)	£3.7	£0.5
	Bank	(£20.0)	(£450.0)	(£29.9)	£0.9
	Substantive	(£420.1)	(£464.4)	(£19.8)	£2.2
Pay Total		(£444.6)	(£464.4)	(£19.8)	£2.2
		(£0.0)	(£4.9)	(£4.9)	£4.0

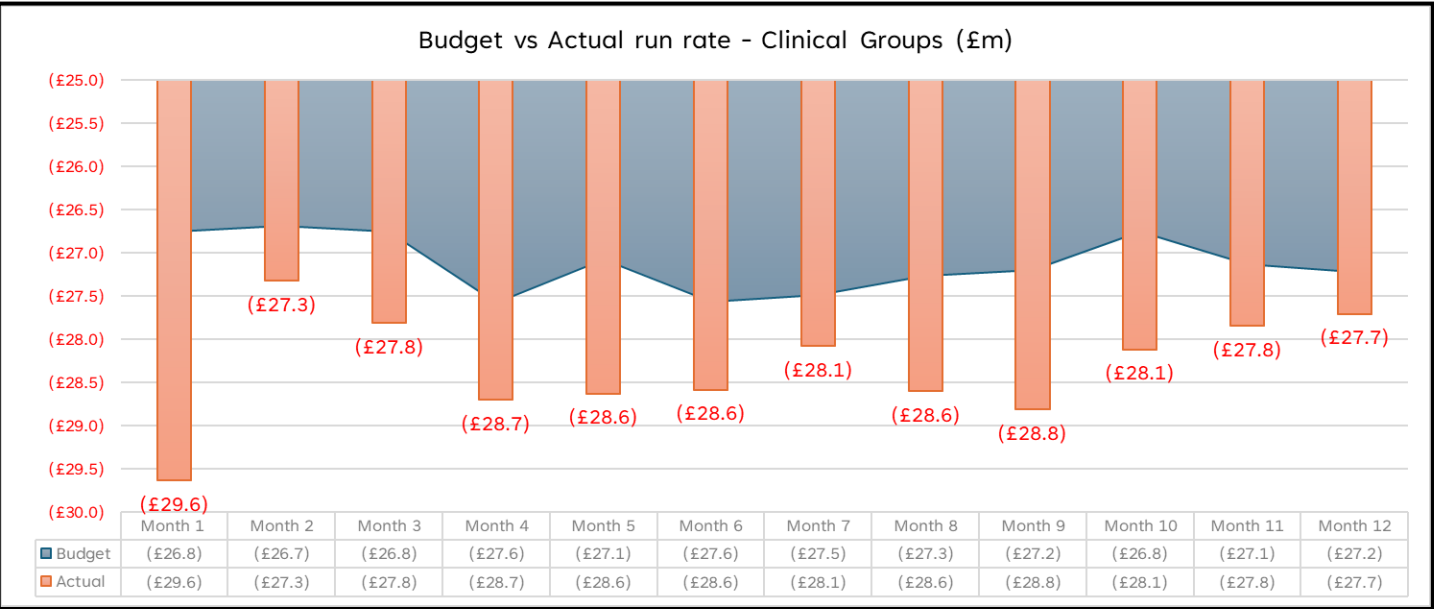


KEY HEADLINES :

- **NHS Clinical Income** - £5m movement from previous FOT mainly driven by one off contractual revenue stream from NCL – offsetting a seasonal downturn in clinical income due to Christmas holidays
- **Non-Clinical Income** - £0.8m deterioration from previous FOT mainly driven by reduction in Charitable funds offset by expenditure.
- **Non-NHS Clinical Income** - £2.1m deterioration compared to previous FOT mainly driven by less than anticipated demand in PP activity in December
- **Non-Pay** - £0.2m increase compared to previous FOT mainly driven by increase in ward drugs cost.
- **Pay** - £2.2m improvement as a result of improved grip and control measures and MARS.

25/26 Clinical Directorates Exit Run rates and variance

Clinical Groups	Annual Budget	Forecast outturn at M9	Previous FOT at M7	Movement on previous forecast	Variance to budget (full year)
	£m	£m	£m	£m	£m
Blood Cells & Cancer	(£42.8)	(£43.2)	(£43.6)	£0.4	(£0.5)
Body Bones & Mind	(£41.1)	(£42.6)	(£43.0)	£0.4	(£1.4)
Brain	(£29.8)	(£30.9)	(£30.8)	(£0.0)	(£1.0)
Core Clinical Services	(£108.8)	(£112.2)	(£112.0)	(£0.2)	(£3.4)
Heart & Lung	(£68.1)	(£75.7)	(£71.3)	(£4.4)	(£7.7)
Sight & Sound	(£34.9)	(£35.3)	(£35.3)	£0.0	(£0.4)
	(£325.5)	(£339.9)	(£336.0)	(£3.8)	(£14.4)

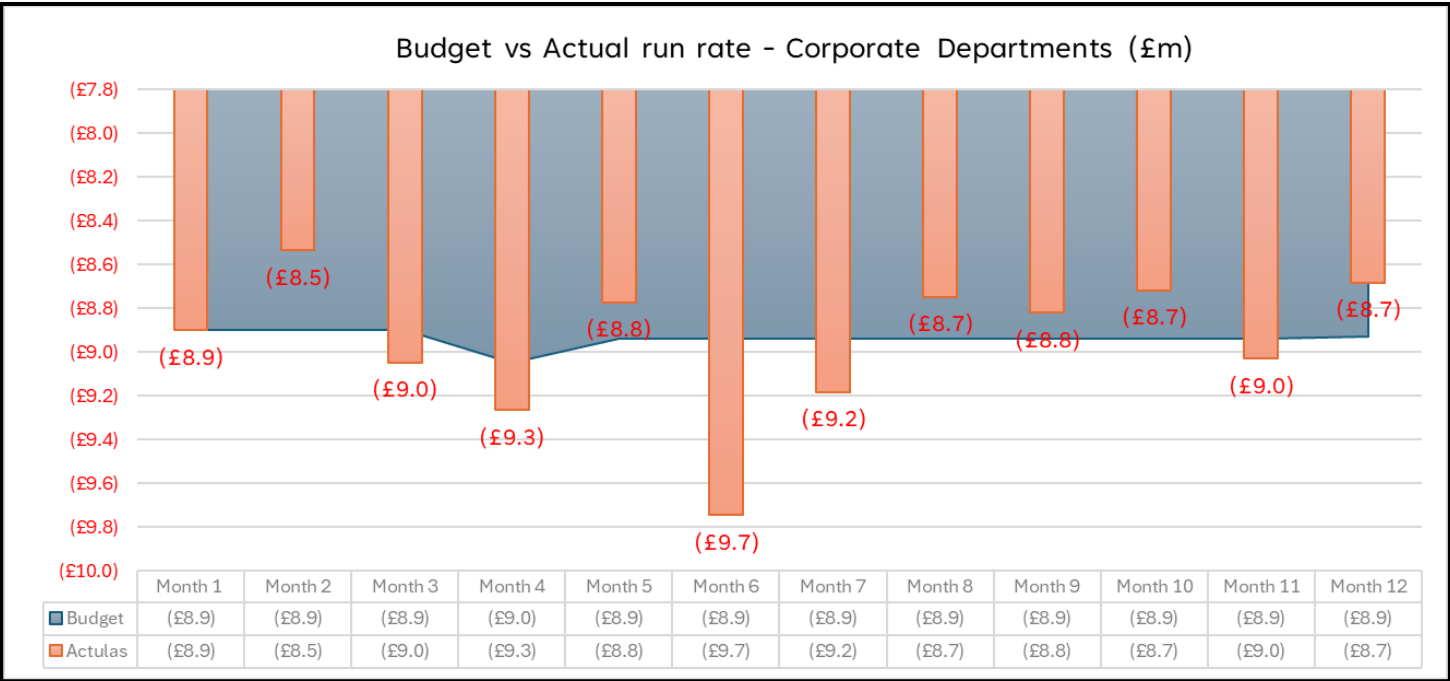


- Exit run rate in Clinical groups represents operating expenditure, net off IPC income.
- Clinical activity and drug income is held centrally.
- Overall, the net exit run rate in clinical groups **based on M9 performance** is forecast at **£339.9m** which **£14.4m** worse than annual plan.
- **Between M7 and M9**, the forecast run rate worsened by **£3.8m**, primarily due to reduced revenue from IPC activity in Heart and Lung Directorate. This is due to a lower than anticipated demand in Cardiology, Respiratory and Peadiatric intensive care
- **The most significant driver** of the forecast over-spend in Clinical groups is **pay spend** which hasn't reduced in line with the budget.
- Although Clinical services achieved a marked reduction in headcount on M1, a significant value of unidentified CIP remains to drive the gap between the plan and actual spend at M9
- In Q1 and Q2, average gap to plan reduced from £1.5m to £1.2m, in Q3 stabilised at £1.2m and is forecast to improve to £0.9m in Q4.
- The forecast improvement in run-rate in Q4 is a combination of assumed sustained savings in workforce, partially offset by the continued pressure on IPC revenue due to low demand.

25/26 Corporate Departments Exit Run rates and variance

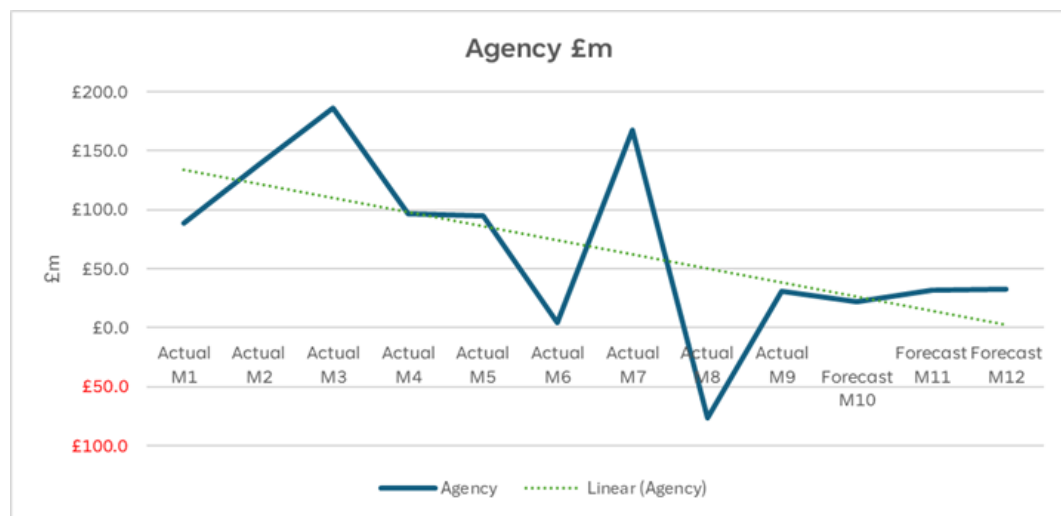
Corporate Departments	Annual Budget	Forecast outturn at M9	Previous FOT at M7	Movement on previous forecast	Variance to budget (full year)
	£m	£m	£m	£m	£m
Clinical and Medical Operations	(£7.8)	(£7.8)	(£7.8)	(£0.0)	(£0.1)
Corporate Affairs	(£4.3)	(£4.5)	(£4.4)	(£0.1)	(£0.2)
Finance	(£6.0)	(£6.5)	(£6.6)	£0.1	(£0.5)
HR & Organisational development	(£6.6)	(£7.2)	(£7.1)	(£0.1)	(£0.7)
ICT	(£12.8)	(£12.8)	(£12.8)	£0.0	£0.0
Medical Director	(£13.2)	(£12.9)	(£12.7)	(£0.1)	£0.3
Nursing and Patient Experience	(£3.3)	(£3.4)	(£3.3)	(£0.0)	(£0.0)
Space and Place	(£53.3)	(£52.3)	(£52.3)	(£0.0)	£1.0
Grand Total	(£107.2)	(£107.4)	(£107.2)	(£107.2)	(£0.2)

- Exit run rate in Corporate departments represents mostly staffing expenditure.
- Overall, the net exit run rate in corporate departments **based on M9 performance** is forecast at **£107.4m** which **£0.2m** behind plan set for the year..
- Between M7 and M9**, the forecast run rate stated relatively stable.
- The spike in M6 run-rate represents recognition of redundancy cost linked to MARS scheme.



25/26 Trust total - Agency run-rate and savings

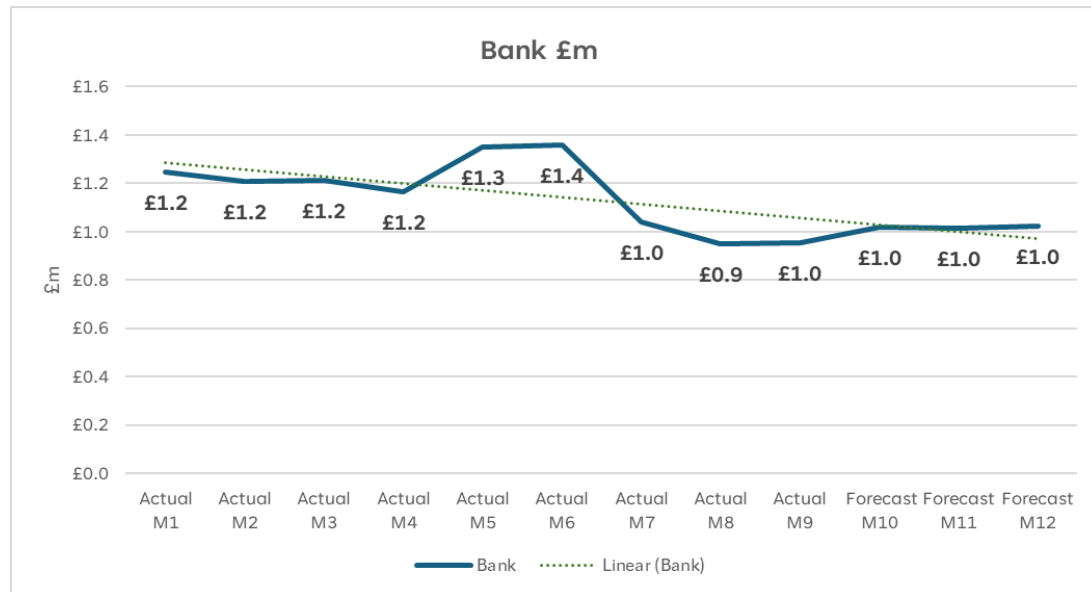
Pay Types	Cat	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Forecast M10	Forecast M11	Forecast M12	Annual Budget	Full Year FOT	FOT Variance
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Agency	Admin	(£29)	(£113)	(£125)	(£33)	(£57)	(£23)	(£131)	£55	(£13)	(£8)	(£18)	(£19)	(£2,271)	(£513)	£1,758
Agency	Estates & Ancillary Staff	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Agency	Healthcare Assist & Supp	(£4)	(£3)	(£11)	(£13)	(£4)	(£11)	(£11)	£40	£0	(£2)	(£2)	(£2)	£0	(£23)	(£23)
Agency	Medical	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	(£29)	£0	£29
Agency	Nursing Staff	£4	£0	£0	(£3)	(£3)	£0	£0	£3	£0	(£0)	(£0)	(£0)	(£43)	£0	£43
Agency	Scientific Therap Tech	(£59)	(£23)	(£50)	(£48)	(£31)	£30	(£25)	(£21)	(£18)	(£12)	(£12)	(£12)	(£2,179)	(£280)	£1,899
Agency Total		(£88)	(£138)	(£186)	(£97)	(£95)	(£4)	(£167)	£77	(£31)	(£22)	(£31)	(£33)	(£4,522)	(£816)	£3,706



- We entered the year with an average spend on agency in Q1 of £138K per month **(0.4 % of our total pay bill)** .
- By Q2, this spend reduced by nearly 50% and the forecast for Q4 is to exit the year at approx. £30k per month **(0.2% of our total pay spend)**
- This represents 80% reduction on Q1 run rate and **full year saving of £3.7m**
- The remaining spend on agency is in Admin staffing (£19k/month) and Scientific Therap. Technician category of £12k/month

25/26 Trust total - Bank run-rate and savings

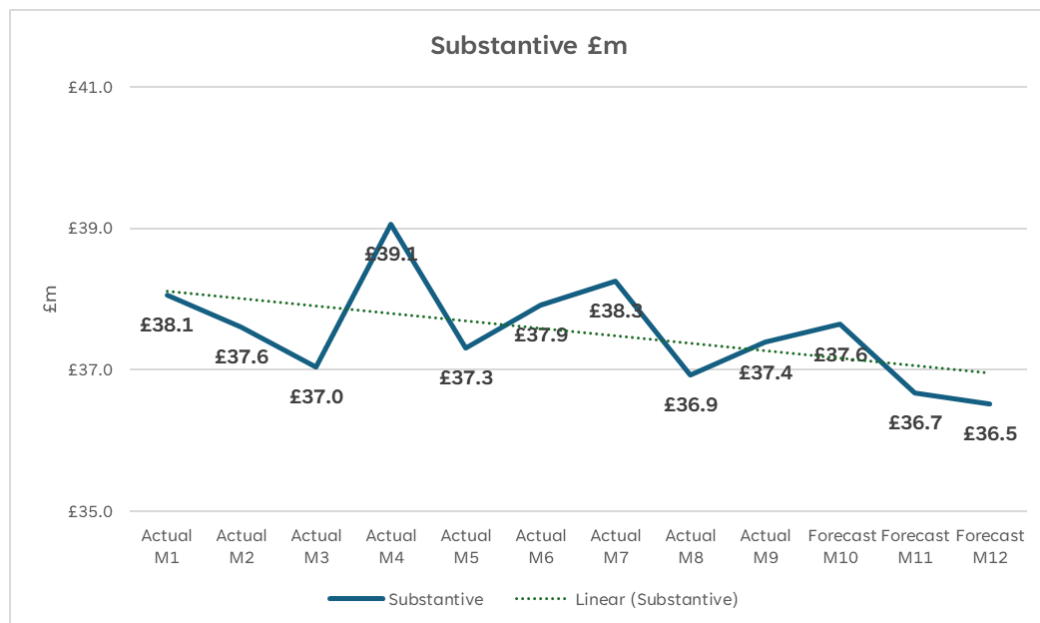
Pay Types	Cat	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Forecast M10	Forecast M11	Forecast M12	Annual Budget	Full Year FOT	FOT Variance
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Bank	Admin	(£154)	(£153)	(£117)	(£145)	(£134)	(£141)	(£122)	(£81)	(£101)	(£86)	(£89)	(£89)	(£4,477)	(£1,412)	£3,065
Bank	Directors & Senior Manage	£0	£0	£0	£0	(£0)	£0	£0	£0	£0	£12	£12	£12	£0	£35	£35
Bank	Estates & Ancillary Staff	(£185)	(£108)	(£105)	(£147)	(£108)	(£197)	(£128)	(£212)	(£20)	(£124)	(£124)	(£124)	£0	(£1,582)	(£1,582)
Bank	Healthcare Assist & Supp	(£59)	(£81)	(£69)	(£71)	(£71)	(£57)	(£36)	(£26)	(£34)	(£43)	(£43)	(£43)	(£932)	(£633)	£299
Bank	Medical	(£316)	(£304)	(£374)	(£280)	(£435)	(£407)	(£385)	(£306)	(£444)	(£345)	(£345)	(£345)	(£5,338)	(£4,286)	£1,052
Bank	Nursing Staff	(£431)	(£417)	(£404)	(£400)	(£450)	(£435)	(£227)	(£202)	(£224)	(£298)	(£290)	(£296)	(£7,794)	(£4,073)	£3,721
Bank	Scientific Therap Tech	(£103)	(£144)	(£143)	(£121)	(£151)	(£119)	(£141)	(£122)	(£132)	(£134)	(£134)	(£136)	(£1,467)	(£1,579)	(£112)
Bank Total		(£1,246)	(£1,206)	(£1,212)	(£1,163)	(£1,349)	(£1,356)	(£1,039)	(£950)	(£954)	(£1,019)	(£1,014)	(£1,022)	(£20,008)	(£13,530)	£6,478



- We started the year with an average spend on bank in Q1 of £1.2m per month **(3 % of our total pay bill)** .
- This spend increased slightly to £1.3m/month on average as some agency staff switched to bank, however by Q3, the spending run rate decreased to £0.9m/month and is likely to stabilise at £1m/month in Q4
- This represents 20% reduction on Q1 run rate and **full year saving of £6.4m**
- The remaining significant areas of spending are medical and nursing staff which is expected to maintain flexibility and headroom to cover annual and sick leave

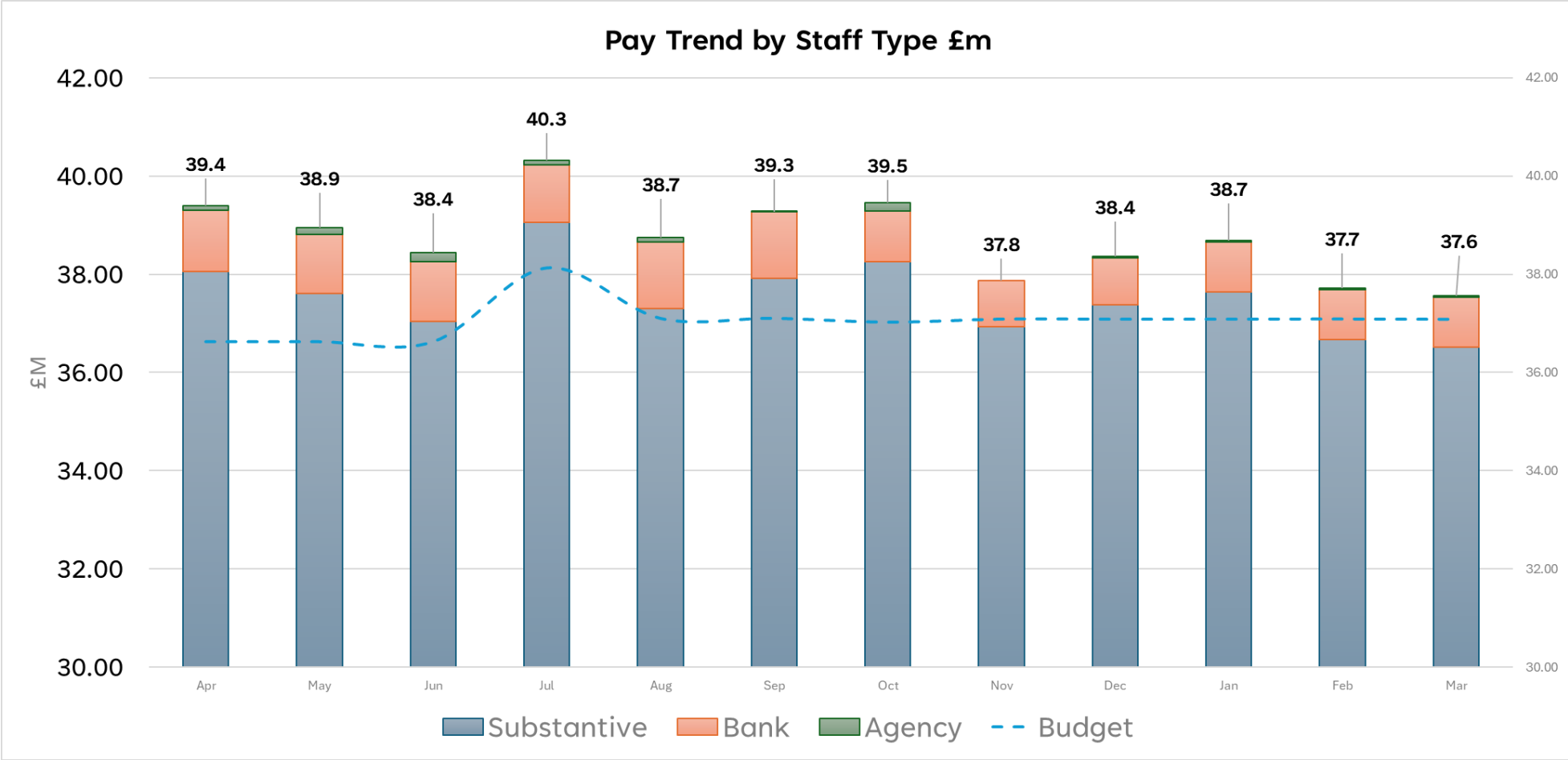
25/26 Trust total - Substantive run-rate and savings

Pay Types	Cat	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Forecast M10	Forecast M11	Forecast M12	Annual Budget	Full Year FOT	FOT Variance
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Substantive	Admin	(£5,192)	(£5,116)	(£4,322)	(£5,052)	(£4,852)	(£4,962)	(£4,985)	(£4,766)	(£4,722)	(£4,843)	(£3,821)	(£3,744)	(£60,758)	(£56,376)	£4,383
Substantive	Directors & Senior Manage	(£2,558)	(£2,586)	(£2,490)	(£2,628)	(£2,551)	(£2,625)	(£2,812)	(£2,454)	(£2,543)	(£2,476)	(£2,493)	(£2,493)	(£24,323)	(£30,710)	(£6,387)
Substantive	Estates & Ancillary Staff	(£1,379)	(£1,389)	(£1,407)	(£1,468)	(£1,278)	(£1,399)	(£1,419)	(£1,385)	(£1,376)	(£1,382)	(£1,382)	(£1,382)	(£19,035)	(£16,647)	£2,388
Substantive	Healthcare Assist & Supp	(£1,166)	(£1,134)	(£1,143)	(£1,161)	(£1,085)	(£1,117)	(£1,055)	(£1,028)	(£1,015)	(£1,077)	(£1,077)	(£1,077)	(£13,042)	(£13,135)	(£93)
Substantive	Medical	(£10,849)	(£10,219)	(£10,272)	(£11,077)	(£10,200)	(£10,613)	(£10,104)	(£10,515)	(£10,454)	(£10,599)	(£10,619)	(£10,541)	(£125,939)	(£126,061)	(£123)
Substantive	Nursing Staff	(£10,148)	(£10,200)	(£10,246)	(£10,577)	(£10,216)	(£10,191)	(£10,266)	(£10,115)	(£9,958)	(£10,141)	(£10,139)	(£10,134)	(£116,041)	(£122,330)	(£6,289)
Substantive	Scientific Therap Tech	(£6,769)	(£6,953)	(£7,159)	(£7,101)	(£7,118)	(£6,999)	(£7,305)	(£6,653)	(£7,312)	(£7,121)	(£7,142)	(£7,142)	(£81,753)	(£84,774)	(£3,020)
Substantive	Cips And Cres Unidentified	£0	(£1)	£0	(£0)	(£1)	£1	£0	(£1)	£0	£0	£0	£0	£20,794	(£1)	(£20,795)
Substantive Total		(£38,061)	(£37,598)	(£37,038)	(£39,063)	(£37,302)	(£37,905)	(£37,945)	(£36,917)	(£37,380)	(£37,639)	(£36,673)	(£36,513)	(£420,098)	(£450,034)	(£29,936)

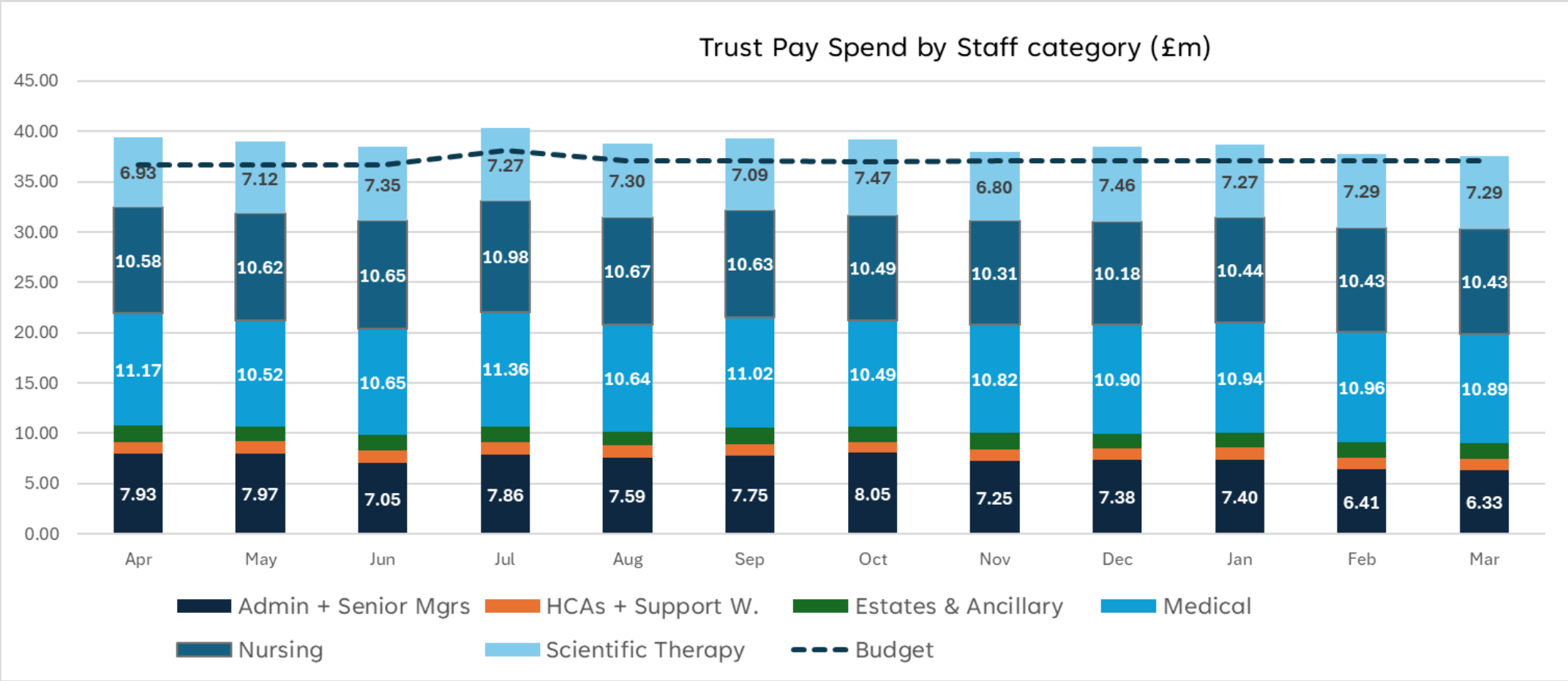


- Substantive workforce amounts to 97% of our total spend
- Our plan for Substantive workforce for the year was set at £420m – i.e. **approx. £35m per month**.
- We **started the year with an average spend of £38m** and gradually reduced the spending to **£36.5m/month** towards the end of the year.
- The cost savings have been achieved mostly in Admin and Estates & Ancillary staff group.
- Our plan for the year set an ambitious target reducing the cost of our substantive workforce by £20m through a combination of grip and control measures (vacancy factor) and better value schemes.
- By the end of the year, the forecast variance is **£29m overspend**. This is primarily driven by the cost improvement target which has not been delivered in full, coupled with overspends in Nursing and medical staffing of approx. £9m
- To close the gap between our spending run rate and budget, we need to aim for further WTE reduction of a minimum of 20 to 30 WTE on our current run-rate

25/26 Pay Trend by Staff Type



25/26 Pay Trend by Staff Category



Month 9: Approval

- NHSE from June 2025 that the Trust monthly financial returns must be signed off by the Chief Executive and Chief Finance Officer before they can be submitted.
- The financial return includes the main financial statements as well as additional information on capital spend, the achievement of Better Value schemes, forecast position, and underlying position.
- The Month 9 Provider Finance Return will be consistent with the information provided in this finance report.
- EMT is asked to **approve** the submission of the Month 9 Provider Finance Return to NHSE.

Trust Board 29 th January 2026	
Nursing Workforce Assurance Report Q3 & Safer Nursing Establishment Bi-Annual Review. Submitted by: Tracy Luckett, Chief Nurse	Paper No: Attachment R ☐ For information and noting
Purpose of report The purpose of this paper is to provide the Trust Board with an overview of the activity in relation to the nursing workforce including updates on recruitment, retention, and professional standards. review. The Summer bi-annual establishment review is also included in this paper.	
Summary of report To note the information in this report in relation to: • RN vacancies have decreased in Q3. • The rolling voluntary turnover remains improved and ongoing delivery plans continue to promote the key retention initiatives. The NWAQ is focused on the key retention priorities to promote flexible working, rewarding the workforce, amplifying their voice, and we are one team. • The active recruitment drive has resulted in vacancies being filled. There is now a pause on the centrally co-ordinated programme of recruitment events throughout the year, and this position will be monitored. • Absence due to sickness, remains just above the Trust target, with the main reasons for short-term absence being coughs and colds. The main reported reason for long-term absence remains due to anxiety and mental health disorders. • The NWAQ team continue to support the recruitment and retention of the GOSH nursing workforce. • The bi-annual review of safe nursing establishment has been undertaken and clear actions for monitoring and progression has been set.	
Patient Safety Implications None	
Equality impact implications None	
Financial implications None	
Strategic Risk BAF Risk 12: Inconsistent delivery of safe care	
Action required from the meeting Recommendations or actions for the Trust Board to consider	
Consultation carried out with individuals/ groups/ committees This paper has been presented to EMT on 21 January 2026.	

Attachment R

Who is responsible for implementing the proposals / project and anticipated timescales? N/A
Who is accountable for the implementation of the proposal / project? CNO Tracy Lockett

1.0 Introduction

The purpose of this paper is to provide the GOSH Trust Board with an overview of the Nursing Workforce, Assurance, and Quality Team's (NWAQ) activity. This quarterly report provides assurance that workforce activities are data driven and aligned with national, and regional priorities. The National Quality Board (NQB 2018) report, *Safe, Sustainable and Productive Staffing*, helps GOSH develop strategies for managing the nursing workforce. This quarterly report is framed around the National Quality Boards expectations for Children's Nursing, focusing on having the **right staff** with the **right skills**, in the **right place**, at the **right time**.

This paper will provide information and assurance over the reporting period of Oct-Nov 2025/2026 (Q3) on the:

Expectation 1: Right Staff

- 2.0 Nursing Workforce Data
- 3.0 Recruitment Activity

Expectation 2: Right Skills

- 4.0 Retention Initiatives
- 5.0 Professional Nursing Standards

Expectation 3: Right Place and Time

- 6.0 Workforce Gaps & Mitigation
- 7.0 Temporary Staffing.

Bi-annual Nursing Establishment

- 8.0 The report also includes an overview from the Bi-annual Safe Nurse Staffing Establishment reviews.

At the time of submitting this report to Board, the data for December 2025 was not available. This data will be reported alongside the Q4 data.

Expectation 1 Right Staff

2.0 Nursing Workforce Data

To provide assurance on the requirement of safe nursing standards, the Directorates' workforce data is reviewed monthly at the Nursing Workforce Assurance Group (NWAG) meeting, chaired by the Assistant Chief Nurse for NWAQ. The workforce data presented at the NWAG will now be discussed. The key areas described are vacancy, workforce absenteeism and any incidents attributed to safe staffing.

2.1 Vacancy Data

The latest registered nurse (RN) workforce position is based on validated data and illustrated below in Fig. 2.1

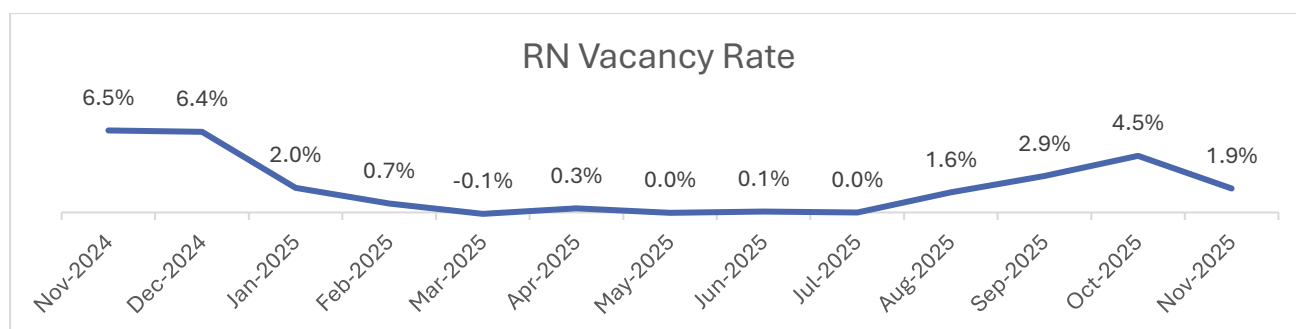


Fig 2.1 RN Vacancy Rate

There was a slight increase in vacancy rates in October however, reduced in November to 1.9% with the October cohort of Newly Registered Nurses (NRN).

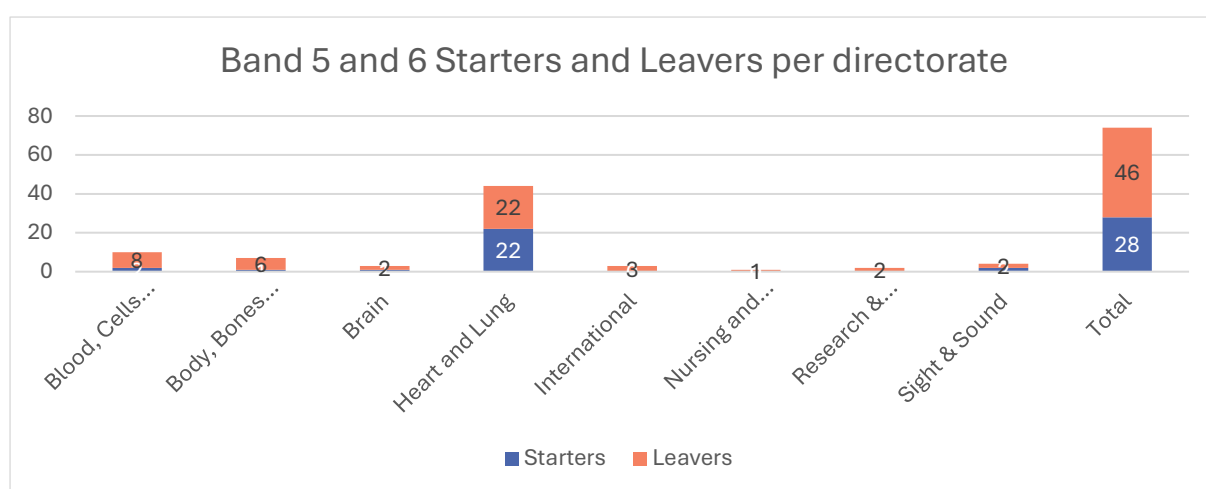


Fig 2.2 Band 5 & 6 starters and leavers in Q3

Fig 2.2 illustrates that the total number of leavers (n = 46) superseded the total number of starters (n= 28) in Q3. The main reported reasons for leaving included relocation and work life balance.

3.0 Recruitment Activity

The activity to track and improve recruitment processes will now be discussed.

3.2 Nursing Vacancy Approvals

Effective from August 2025, all nursing posts were subject to Directorate and Executive Management Team (EMT) review and approval.

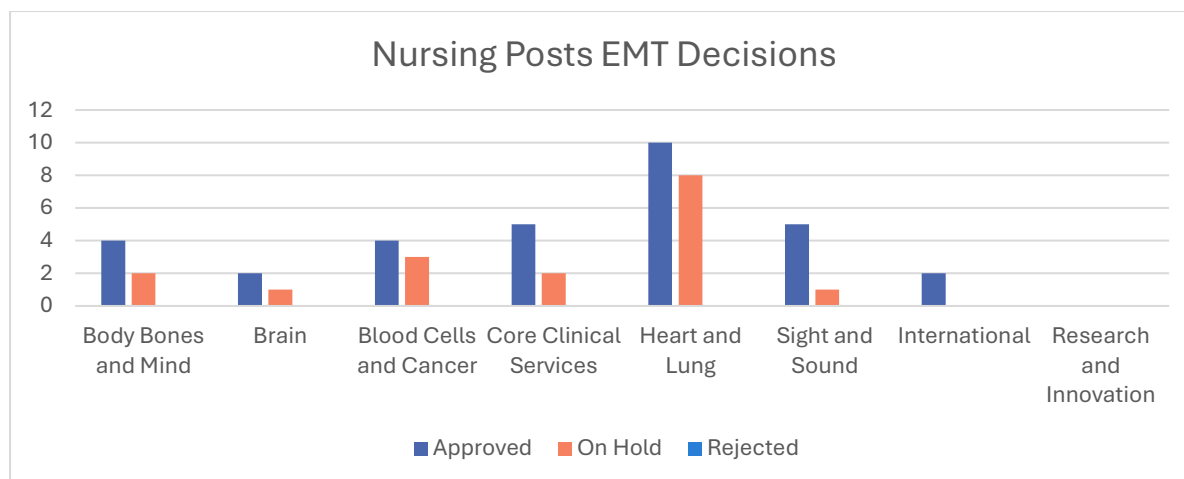


Figure 3.3 EMT Review of Nursing Vacancies

Figure 3.3 illustrates the nursing posts reviewed by the EMT during Q3. 49 total posts were submitted to EMT, with 32 nursing posts being approved and 17 posts were held, awaiting further Directorate information and assurance. In Q3, no nursing posts were rejected by the EMT.

3.3 NWAQ Nursing Vacancies Review Process.

In Q3 the NWAQ team continued to provide further assurance on posts approved via Directorate vacancy review and EMT authorisation. In November, all nursing posts (Bands 4 – 9) became subject to NWAQ review following approval at the Recruitment and Retention meeting. This is NWAQ review process provides oversight, ensures transparency, equity and retention, whilst minimising an increase in the total workforce. The NWAQ team has assisted in reviewing recruitment processes and advertising strategies, while also helping managers consider alternative approaches to meet service requirements. This support was provided in collaboration with the Recruitment Team and the Directorate HR Business Partner.

During Q3, the NWAQ team reviewed a total of 79.7 WTE positions (Fig 3.4):

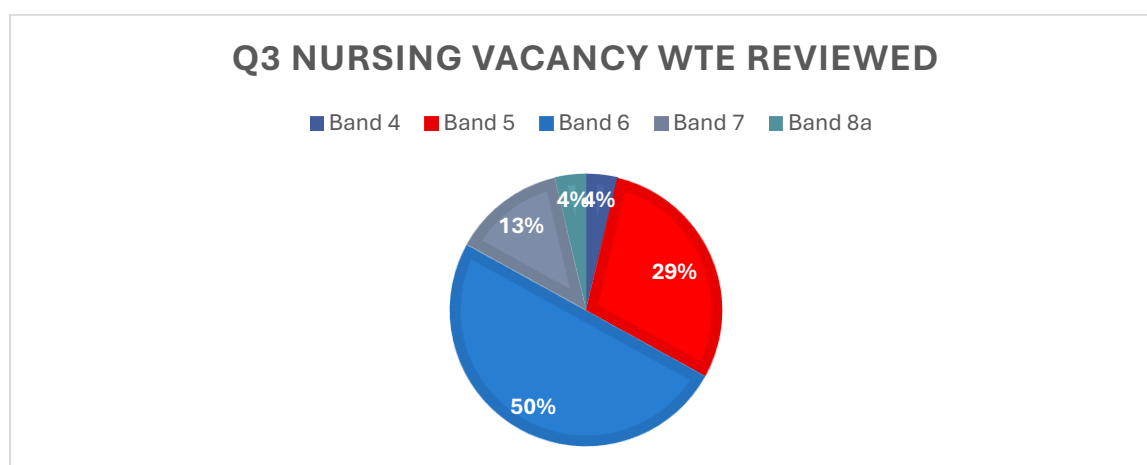


Fig 3.4 Positions Reviewed by the Central Nursing Workforce Team by Band

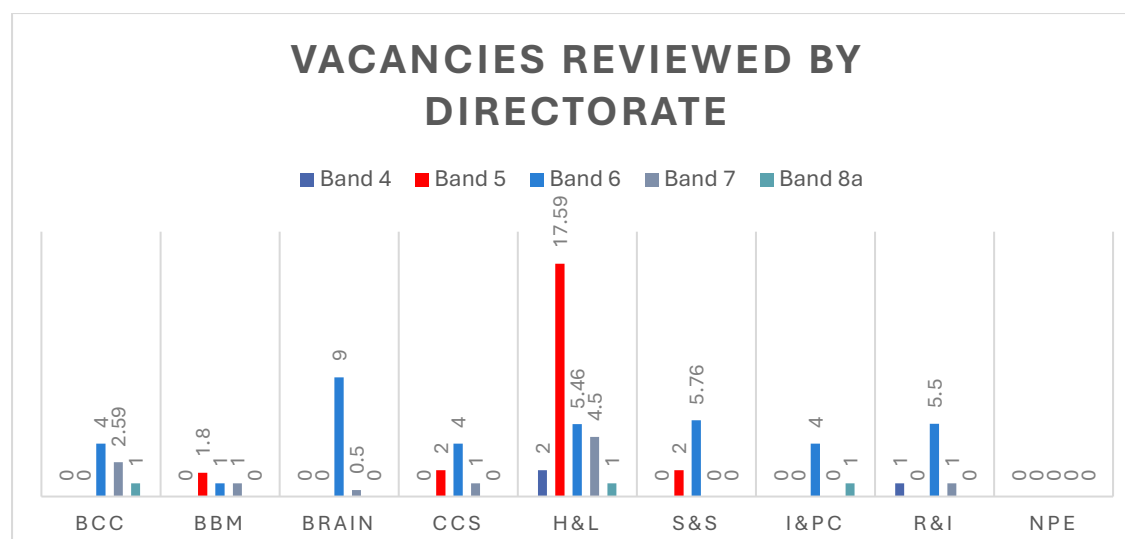


Figure 3.5 Overview of all Nursing Roles per Directorate reviewed by NWAQ Team

Over 76% of reviewed WTE were permanent replacements and in Q3, and only one recruitment episode was withdrawn from recruitment after NWAQ referral to the HRBP.

3.4 Newly Registered Nurses (NRNs)

In Q3, a robust process to recruit the October cohort of GOSH NRNs, into vacant posts only, was completed. This approach consisted of the following methods:

- Given the expectation of a greater number of applicants than available positions, Host NRNs were invited to attend interviews for recruitment into vacant roles. The interview questions were distributed to candidates beforehand. All candidates interviewed very well and fed back positively on this interview experience.
- Candidate interview feedback was offered and was accepted by 58% (n=7) of candidates.
- Clinical area allocation decisions were based on vacancy availability, with recognition of previous host student placement experience or preference.
- Regular communication with the candidates and the NWAQ team prior to allocation and throughout the on-boarding process.
- Co-ordination of virtual meet and greet sessions throughout September for each Directorate to welcome in NRNs to their new teams.

The below table (3.5) shows the number of NRNs due to start in Q3 and in Q4.

Table 3.5 NRN Pipeline

Central recruitment intakes	Commenced in post
October 2025	24 offered. 19 commenced
January 2026	12 offered. 12 to commence
April 2026	4 conditionally offered

From 2026, the approach to centrally recruiting Newly Registered Nurses (NRNs) will change to ensure recruitment is aligned with organisational demand rather than anticipated vacancies.

As a result, the following changes will apply from 2026, and all centralised Band 5 vacancies will be required to follow the same recruitment processes as other roles and will be subject to EMT approval. This change is being communicated to all stakeholders, including student nurses and recruiting managers, during Q4. The necessary process changes will be implemented in a planned manner to support the successful embedding of this new way of working.

3.5 Central IEN Recruitment

A total of 4 IENs (3.0 WTE) were interviewed and offered positions in Q3:

- 3.0 WTE Staff Nurse positions in PICU.
- 1.0 WTE in CCS where a current Theatre Support Worker member has independently gained Adult NMC registration and successfully interviewed via an internal vacancy.

Expectation 2 Right Skills

4.0 Retention Initiatives

The rolling voluntary turnover remains improved in Q3, with an average of 8.1%. This level continues below the Trust target of 10% and the impact of the varied retention initiatives, is evident.

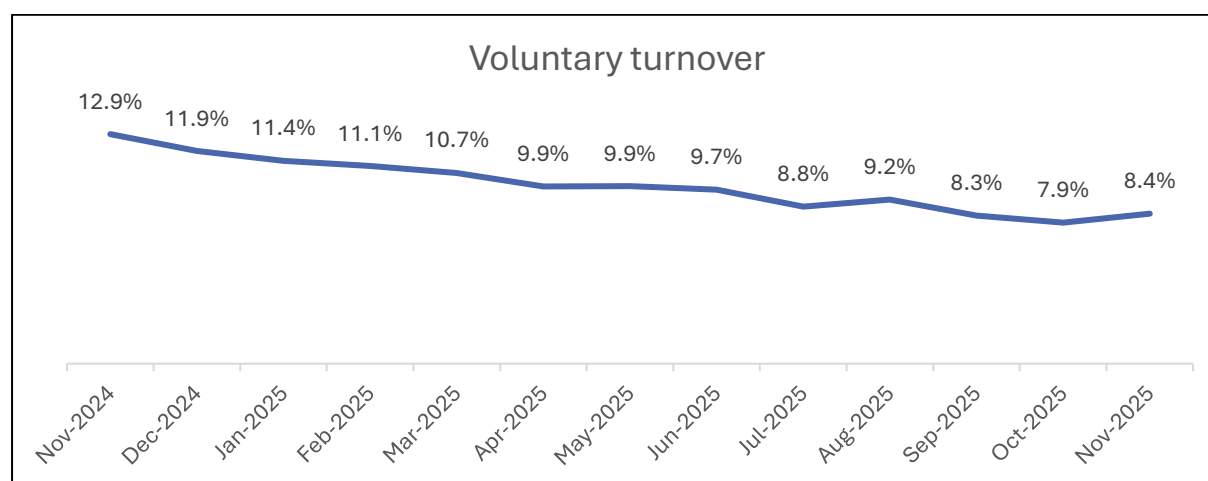


Fig. 4.1 Rolling Voluntary Turnover

The senior nursing team apply delivery plans, aligned to the GOSH Nursing Strategy, to improve the retention of nurses at GOSH. The multiple initiatives adopted to reduce voluntary turnover, will now be described.

4.2 Internal Transfers Process

The Internal Transfers Process has been paused to allow a more transparent procedure for GOSH nurses to apply for posts during this time of limited nursing vacancies. From 1 August 2025, all internal nursing opportunities are advertised and managed through the standardised recruitment process. This change ensures a consistent, fair, and equitable approach for all internal applicants. The majority of nurse posts are initially advertised internally to allow GOSH staff to apply first.

4.4 Career Conversations and Interview Preparation

The Career Clinic offers professional advice to all nursing staff. In Q3, there was only one career conversation and one interview prep session. To better support staff development, the clinic will continue to run weekly. It is promoted through various channels, including the monthly NWAQ on Wheels trolley and the NWAQ newsletter.

4.5 Retention and People Promise Initiative

In Q3, the People Promise Exemplar Programme continued to deliver key initiatives aligned to GOSH commitments. These initiatives were:

4.5.1 We work flexibly

The GOSH Employee Access Request System (GEARS) platform is currently utilised to oversee and manage flexible working applications, enhancing process efficiency and supporting fairness and transparency. In addition, we are collaborating with local teams through the Shared Governance framework to facilitate discussions and listening events regarding flexible working, thereby promoting shared accountability and supporting sustainable, flexible work practices in alignment with organisational priorities.

4.5.2 We each have a voice that counts

In Q3, 14 listening events were delivered to 116 staff, including a dedicated focus group to capture values and behaviours that will inform the new organisational values and behaviours framework. Additionally, seven coaching sessions were provided to support career progression and leadership development.

4.5.3 We are recognised and rewarded

The new benefits platform, ValueYou, has been launched, enabling staff to access all available benefits and to recognise and reward colleagues. Since the platform launch, 44% of staff (n=2,960) have registered, generating 20,746 e-cards and 239 nominations.

4.5.4 We are a team

We continued to engage with staff across all directorates and staff groups, ensuring feedback from the meeting informs changes for the next council meeting to strengthen collaboration. In Q3, the first Leadership Council meeting was held, which was well received, seen as positive, supportive, and inclusive, with strong representation from senior leaders and nursing. This marks a promising start for Shared Governance Councils.

4.6 NWAQ on Wheels (NoW)

The NWAQ team provides visible, proactive support to team, bringing information to those in the clinical environments. The 'NWAQ on Wheels' initiative is designed to enhance retention strategies, collect qualitative insights, and identify areas requiring additional focus, particularly those that are traditionally more challenging to reach. This model also presents meaningful opportunities to acknowledge and reward the exceptional contributions made by staff in helping to ensure GOSH remains an outstanding workplace. Since adopting a monthly visit schedule, the initiative has seen an increase in visibility and the ability to reach a wider range of clinical areas from Q2 to Q3. During Q3, the team visited 22 wards, accompanied by GOSH Charity colleagues who actively promoted the financial grant support available to teams.



5 Professional Nursing Standards

To uphold patient safety and maintain rigorous professional standards, GOSH implements processes to address staff performance or conduct, employing nurses who align with the Trust's core values and behaviours. In instances of serious misconduct, referrals to the Nursing and Midwifery Council (NMC) are initiated when appropriate. During Q3, there were four open NMC referrals concerning current or former GOSH employees, two of whom had practice restrictions in effect. One new NMC referral was made and subsequently closed following investigation, as it was determined that there was no case to answer. The ongoing referral process has experienced significant delays, which have been escalated to both the NMC and the Chief Nursing Officer (CNO). The Assistant Chief Nurse for NWAQ continues to serve as the primary liaison with the NMC, ensuring regular communication regarding the progress of any open cases.

Expectation 3 Right Place and Time

6 Workforce Gaps & Mitigation

6.1 RN Sickness Rates

Registered Nurse (RN) sickness rates peaked in November 2025 to 5.5%, to date the highest level over the past 12 months (Fig 6.1). Continued monitoring and targeted wellbeing support will be important to help stabilise sickness levels in the coming months.

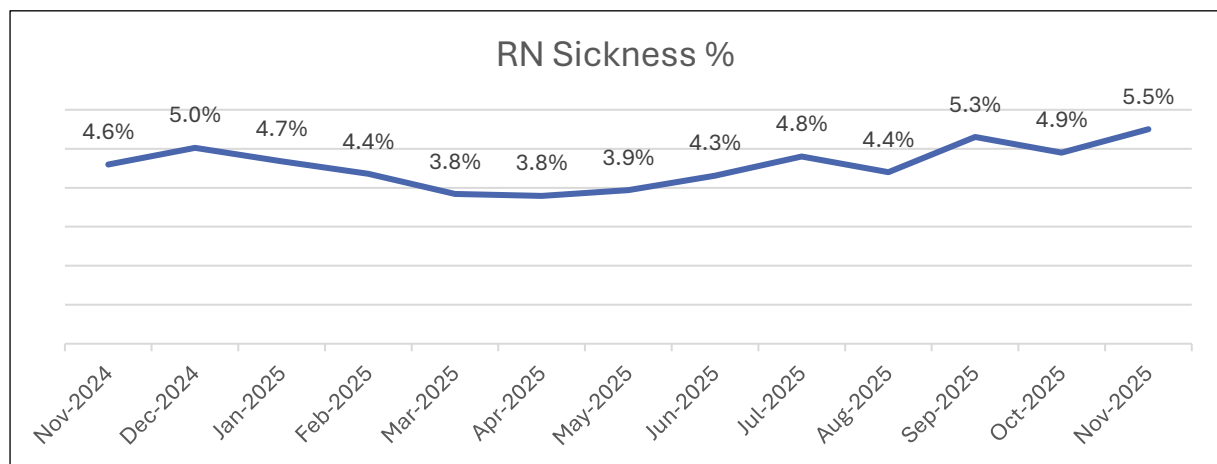


Fig. 6.1 12 months rolling average of RN sickness rates.

The figure below (Fig 6.2) demonstrates the rolling comparison between short term (STS) versus long term (LTS) absence.

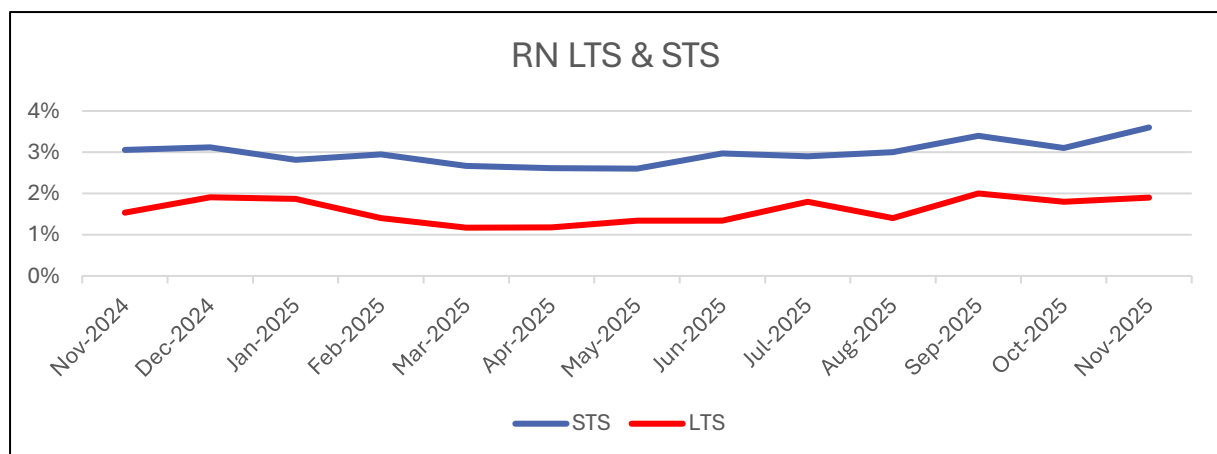


Fig. 6.2 12-month rolling average of RN sickness rates breakdown of Long-Term Sickness (LTS) vs Short-Term Sickness (STS)

In Q3, the main reasons for LTS absences were mental health issues and respiratory illnesses. STS has seen an increase in reported absence due to coughs and colds and absence due to anxiety/mental health and depression.

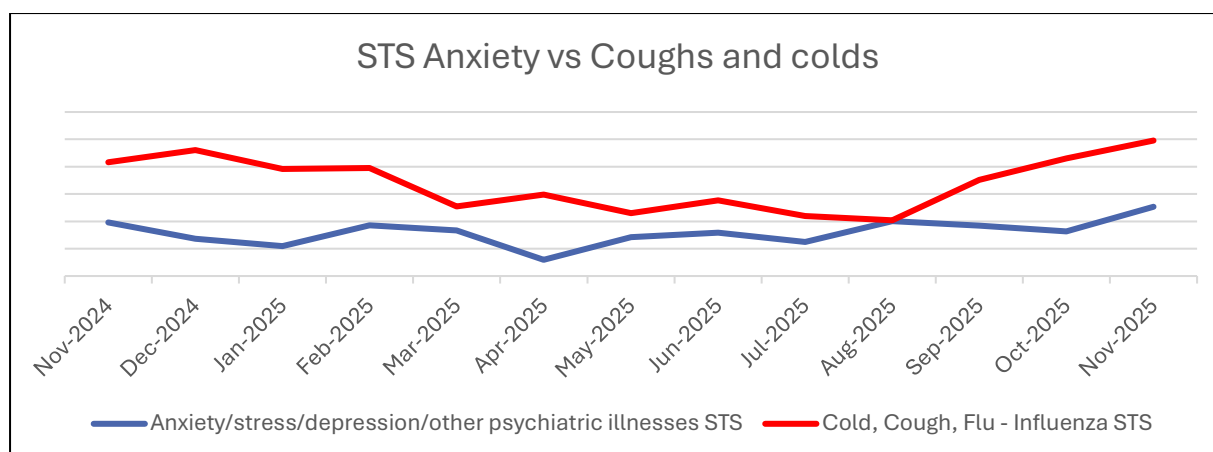


Fig 6.3 STS Top Reported Reason for Sickness Absence

6.2 Maternity Leave

As a predominantly female workforce, RN levels of maternity leave are monitored to evaluate and forecast gaps in the workforce. In Q3 the maternity leave rates remained static. While this stability is positive, maternity leave remains above the 2% headroom allowance, indicating a continued level of pressure on workforce capacity. Over the past 12 months, maternity levels have fluctuated between 3.3% and 4.1%, showing only minor variation but consistently sitting above the planned allowance.

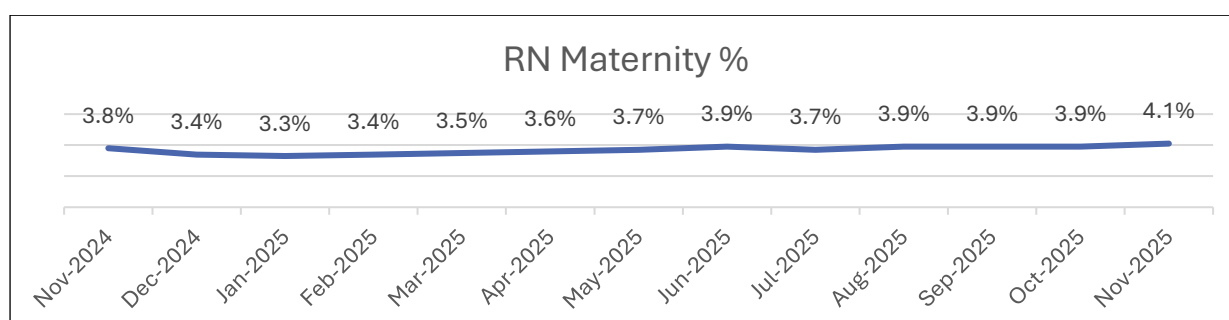


Fig. 6.4 Twelve months rolling RN maternity leave.

6.3 Safe Staffing Incidents

Forty-one safe staffing incidents were reported in October and November of Q3), which is an increase as compared to Q2 (n=27). These incidents were raised across most of the clinical directorates and were classified as resulting in 'no harm' to patients. Key themes identified include:

- Sub-optimal staffing levels (n=30)
- Training/Competencies inadequate (n=7)
- Poor Skill mix (n=4)

All incidents are reviewed by the Associate Chief Nurses (ACN) and actions are taken to mitigate the risk of future occurrences.

Table 6.5 Reported Safe Staffing Incidents per Directorate Q3

Directorate	October 2025	November 2025	Directorate total
BBM	0	2	2
BCC	11	5	16
Brain	2	3	5
CCS	5	3	8
H&L	2	1	3
S&S	0	5	5
I&PC	2	0	2
R&I	0	0	0
Monthly total	22	19	

6.4 Care Hours Per Patient per Day (CHPPD)

CHPPD includes the total staff time spent on direct and indirect patient care over a 24-hour period. It captures information on all registered and non-registered nurses but excludes student nurses. CHPPD relates only to inpatient hospital wards where patients stay overnight. However, CHPPD does not reflect the total amount of care provided, nor does it provide assurance that care is safe, effective, or responsive. In October 2025, the Trust-level CHPPD was 16.2, remaining broadly in line with the established rolling average and demonstrating continued stability in care hours per patient per day. In November 2025, CHPPD decreased slightly to 15.6. While this represents a modest reduction compared to October, overall performance remains consistent with the wider 12-month trend, indicating no significant deterioration in staffing provision across inpatient wards

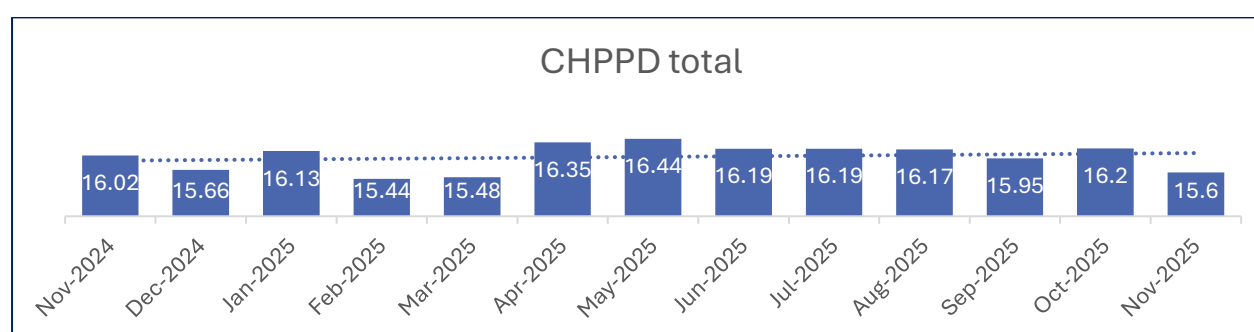


Fig. 6.6 CHPPD 12 months rolling trend.

CHPPD would be most useful when benchmarking against comparable areas, in other settings.

7. Temporary Staffing

In October 2025, the level of authorisation of temporary staffing shifts increased from Matron to ACN level approval. There has been a reduction in bank shifts being requested as compared with last year (November 2024, n=3293) with only 844 bank shifts being requested in November 2025. In Q3 the use of agency staff remained

low across GOSH and is primarily used to provide Registered Mental Health Nurses (RMNs). Acacium aims to use the lowest cost agencies (Tier 0) to reduce cost further. Processes are also in place to move towards RMN Bank nurses to reduce further the use of agency nurses.

Table 7.1 Requests & Fill Rate for Bank in Q3

Month	Total Shifts Requested	Total Shifts Filled	% Shifts Filled	Total Shifts Filled With Bank Staff	% Shifts Filled with Bank Staff	Shifts Filled By Agency Staff	% Shifts Filled by Agency Staff	Unfilled Shifts	% Unfilled Shifts
Oct-25	1,080	922	85%	922	85%	0	0%	158	15%
Nov-25	844	727	86%	727	86%	0	0%	117	14%

The use of bank nurses continues to be an area of focus at the NWAG meeting and reasons for temporary staff usage is usually explained as due to short notice absence or increased patient acuity.

8.0 Summer Bi-annual Establishment Review report

8.1 Executive Summary

This report provides a comprehensive review of nursing staffing establishments across the GOSH Directorates, aligning with NHS Developing Workforce Safeguards (2018) and CQC Key Lines of Enquiry. Each ward or department staffing requirements were assessed, with particular focus on the number and skill mix of registered and unregistered nurses, based on bed numbers and patient acuity.

The reviews largely concluded that nursing establishments remain sufficient to ensure safe staffing in most areas, though a high proportion of junior staff presents ongoing challenges in maintaining a robust skill mix and specialist competencies. Enhanced educational support is in place to mitigate risks arising from these gaps.

Across all Directorates, actions are underway to address identified gaps, support recruitment and retention, and adapt workforce models to evolving needs. Professional judgement, triangulation of quality measures, and benchmarking underpin the assurance of safe nurse staffing, with continued focus on education and quality improvement initiatives.

8.2 Purpose

Since April 2019, all Trusts are assessed bi-annually for compliance with the National Quality Board (NQB) guidance through the Single Oversight Framework (SOF) as described in the [Developing Workforce Safeguards \(NHSI, 2018\)](#). To provide assurance that the Trust is maintaining safe nursing levels and to review progress against the implementation of recommendations, bi-annual nursing establishment reviews are undertaken every Winter and Summer.

This report will provide an overview of the outcomes of the Directorate establishment review panels held in November 2025.

9.0 Introduction

Great Ormond Street Hospital (GOSH) has a responsibility to ensure that it has a safe and sustainable nursing workforce. All Trusts should show compliance with a 'triangulated approach' to deciding nurse staffing requirements as defined by the NQB (NHS Improvement 2018). This approach combines evidence-based staffing tools, professional judgement, and quality outcomes to ensure the right nursing staff, with the right skills, are in the right place, and at the right time.

9.1 The NQB guidance states that providers:

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

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

Requirement	Compliance Status
Using a systematic, evidence-based approach to decide the number and skill mix of staff required	
Using a valid and reliable acuity/dependency tool	
Exercising professional judgment to meet specific local needs	
Where possible benchmarking with peers	
Taking account of national guidelines, bearing in mind they may be based on professional consensus.	
Obtaining feedback from children, young people, and families on what is important to them and how well their needs are met.	

In addition to the requirements, the NQB recommends verifying that the assurance methods employed include the following:

- Children and young people's ward managers should use at least two methods for calculating ward workload and staffing requirements.
- Boards should ensure there is no local manipulation of the identified nursing resource from the evidence-based figures in the tool being used, as this may adversely affect the recommended establishment figures and remove the evidence base.

- Children and young people's acuity/dependency tools should include a weighting for parents/carers, so their impact on the ward team is reflected in ward establishments.
- Time-out percentages (uplift/headroom) should be explicit in all ward staffing calculations. Managers should articulate any reasons for deviation from the 21.6% to 25.3% range. At GOSH, the nursing uplift is set at 22% in all areas.
- Staffing resource, aligned to levels of patient acuity/dependency should be realistic and determined on quality assured services.
- Adjustments should be made to workforce plans to accommodate ward geography, for example, single-room design wards.
- Two registered children's nurses should always be on duty in an inpatient ward.
- Allocate time within the establishment for regular events such as patient inter-hospital transfers and escort duties for patients requiring procedures and investigations.
- Allow time for staff to respond effectively to changes in patient need and other demands for nursing time that occur often but are not necessarily predictable: for example, patient deterioration, admissions, and end-of-life care.
- Capacity to deal with unplanned events should be built into the ward establishment using professional judgement.

10.0 Methodology for Calculating Nursing Numbers

The Children's & Young People's Safer Nursing Care Tool (C&YP SNCT), has been fully implemented across all inpatient services within the Trust with the most recent collection of data gathered over a 5-week period in September 2025.

The tool measures patient acuity and/or dependency to inform evidence-based decision making on staffing in CYP in-patient wards. The tool, when used with Nurse Sensitive Indicators (NSIs), is a reliable method against which to deliver evidence-based workforce plans. Day case units, and outpatient departments rely on professional judgement as no validated tool currently exists. Other areas such as critical care and peri-operative settings use consensus professional guidance and recommendations. Finally, the tool is not validated in non-NHS settings, such as private healthcare providers.

Decision support tools, such as those for measuring acuity/dependency, help managers determine safe, sustainable staffing levels and remove reliance on subjective judgements. Professional consensus suggests no single tool meets every area's needs, so NHSE recommend combining methods.

To ensure a triangulated evidence-based approach, comprehensive data packs were shared with the Directorate Associate Chief Nurses (AssoCN), General Managers, and Chiefs of Service. The review panel was chaired by the Assistant Chief Nurse for Nursing Workforce, Assurance and Quality (NWAQ). Panel composition was expanded to enhance the robustness of discussions and provide further challenge alongside the Nursing Teams. and panel members included the Deputy Chief Nurse, AssoCN, Associate Director of Finance and Deputy Chief Operating Officer, senior representation from Human Resources and the Operations Team. Matrons and ward managers were also invited to collaborate to the discussions.

Finally, the procedure for supporting data discussion during this Establishment Review has been revised. To better synchronise with Directorate budget planning meetings, the period for assessing children's acuity and dependency was moved to September. This scoring window was also increased from 20 to 25 days to enable more comprehensive data collection. In addition, data from the previous twenty-four months was analysed rather than twelve, improving accuracy. An exemplar of the summary workforce data presented can be found in Appendix A.

Data packs were shared with all panel members in advance to provide time for review. These packs include information on:

- The existing budgeted staffing establishment.
- Bed base including HDU bed numbers/telemetry beds.
- Safer Nursing Care Tool (SNCT) calculations for guidance based on patient acuity.
- Direct clinical care time provided by the ward or department managers, and practice educators.
- Calculations based on national guidance for that specialism e.g., Association for Perioperative Practice (AfPP), Paediatric Critical Care Society (PCCS) standards.
- Registered/unregistered nursing workforce skill mix proportions.
- Variance between data sets and recommended numbers.
- Overview of Datix incidents reported since the previous review, to identify any themes, trends, or areas of concern.
- Quality metrics.
- Patient & family feedback.
- Complaints and PALs contacts.
- Student placement experience feedback.
- Roster management.
- Temporary staff usage.
- Framework to guide professional judgement, as determined by the AssoCN and clinical teams ([Saville et al \(2023\)](#)).
- For the first time, a summary slide of the ward/department safe staffing reviewing the SNCT scoring for 24 months and including a 'Care Thermometer' was included in all data packs. An example of this can be found in Appendix A.

11.0 Staffing Establishments

Review questions align with the [NHS Developing Workforce Safeguards \(2018\)](#) and the Care Quality Commission (CQC): Key Lines of Enquiry.

The staffing requirement for each ward was reviewed and cross referenced with Directorate information. It is important to recognise that the review focuses on the required number and skill mix of registered and unregistered nursing workforce to provide safe staffing care based on the number of open/funded beds and patient acuity. Roles such as Advanced Clinical Practitioners and Clinical Nurse Specialists were not included in this review.

11.1 Outcome of the Reviews

Overall, the reviews concluded that current nursing establishments are sufficient in most areas to support safe staffing. There remains to be a high concentration of junior or less experienced staff in the ward environments, maintaining a robust skill mix and appropriate level of specialist competencies is challenging. Nevertheless, there continues to be a high level of educational input mitigate risks and support reducing the gaps in knowledge and skill.

It was also recognised that whilst acknowledged in the Summer 2025/26 establishment reviews, the response rate from nursing students to provide constructive feedback remains low and therefore not useful. This will continue to be an outstanding action to be reviewed prior to the next establishment reviews.

A summary of the establishment reviews and associated action plans for each Directorate will now be described.

11.1.2 Brain - The Directorate AssoCN confirmed the following:

- **Koala:** The ward has had significant nursing workforce gaps (14.4% vacancy in Aug) with a junior nursing team. The ward manager, matron and AssoCN have worked hard to recruit. It was reported that the establishment and skill mix on Koala is currently safe, once budgeted establishment is fully reconciled. The ward managers work across Koala and Possum and work clinically a minimum of 25% their time. The Clinical Band 7 role has been disestablished.
- **RANU on Alligator:** The current staffing establishment is safe. It was acknowledged that this team is a small, easily destabilised if staff are off sick or leave. The ward manager works a combination of supervisory and clinical shifts.
- **Squirrel Endo-Met:** The current staffing establishment is safe based on the existing bed base. It was also acknowledged, that although not a designated High Dependency Area (HDU), this ward does manage complex patients. The ward manager works a minimum of 25% clinical shifts.
- **Kingfisher:** The current staffing establishment is safe and correct. There is a high level of vacancy (20%). As Kingfisher is a nurse-led area, there is a higher proportion of Band 6 nurses to support the clinical decision making. The Kingfisher ward manager covers workforce gaps. A review of the high proportion of Level 3 patients reported during the scoring period will be undertaken prior to the next establishment review.
- **Possum:** Possum has now been open for almost 12 months. The establishment is reported as safe but still awaiting reconciliation of the budget.

Summary

The team reported that the Directorate has reviewed all nursing posts to ensure that areas are appropriately established, in line with agreed budgets.

Significant work has focused on improving the quality and culture in ward areas, in particular responding to the staff survey and from staff feedback. The team have a plan to support the changes to the workforce.

Actions

Support has been offered by the central NWAQ team to assist with ongoing recruitment and integration of the new starters.

Review the scoring approach of the patients on Kingfisher requiring frequent venepuncture and currently scoring as a Level 3 dependency patient.

11.1.2 Body, Bones and Mind (BBM) – The Directorate AssoCN confirmed the following:

- **Squirrel Gastro:** The staffing establishment is safe and correct. The AssoCN explained the complex social aspects of care and how this can result in episodes of conflict between families and the teams. The ward manager works at least 25% of their time clinically.
- **Chameleon:** The staffing establishment numbers are safe. The ward has a significant number of babies (approx. 20%) who require 1:1 nursing. It was recognised that the unpredictability of the patient cohorts and acuity presents challenges. Whilst the SNCT scoring indicated an over establishment, professional judgment confirmed that this establishment is correct for the acuity, ward layout and cohort of patients. The ward manager works a minimum of 25% clinical work and often more.
- **Eagle:** The current establishment covers both the ward and the dialysis unit. The proportion of high acuity patients on Eagle ward was raised as concerning and prompts the need for further review. Both ward managers work a period of clinical time to support activity.
- **Sky Ward:** The staffing establishment is safe based on current activity levels. However, the changes to patient acuity and the impact of managing patients who outlie in other areas, requiring additional support continues to be raised as a concern. The AssoCN will review this and feedback at the next establishment review. The ward manager works a minimum of 25% clinical hours.
- **Mildred Creek Unit (MCU):** Establishment is correct and now fully established but there are currently vacancies at Band 5. The decision to implement a mental health safe staffing assessment tool (MHOST) has been paused as this tool is not designed to be used in a children's and young people's (CYP) setting. Once the CYP safe staffing tool is available this will be implemented. The team were challenged on the minimum staffing levels of RNs at night, and the panel were reassured that this is being reviewed and a minimum of two RNs on nights will be actioned once the Band 5 vacancies are filled. This will be reviewed at the next establishment meeting.
- **Gastro Suite** This area is safely staffed based on current activity levels. The impact of the transfer of services from the Royal Free Hospital is still being evaluated.

Summary

BBM has high levels of bed occupancy and are managing any workforce gaps, proactively. They have a low level of safety incidents and high levels of positive feedback from families. Mandatory training levels are of an acceptable level with plans.

Action

The NWAQ team will help support the Directorate review of the Eagle Ward (HDU area) and Sky to ensure the concerns raised are addressed.

The MCU RN cover, especially on nights, will be reviewed at the next review.

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

- **Panther ENT:** The staffing establishment is correct but there remain workforce gaps due to vacancies (23% Aug 25) and fluctuating acuity and dependency of the patients and ward layout. The acuity of the patients, and in particular the need for staff to be competent in tracheostomy care, was acknowledged. A programme of education is being implemented, but this remains a challenging area. The leadership provided by the ward manager was commended, who works a minimum of two shifts a month and supports the clinical care well above 25% of their time.
- **Panther Urology:** Establishment is correct, and gaps remain due to vacancies (16% Aug 25) and changes in patient acuity, resulting on a reliance on temporary staff. There is a high number of ward attenders, but these children are managed by the CNS teams. The fixed term HDU ward manager was positively evaluated; however, the currently financial constraints means this role will be disestablished.
- **Outpatients:** OPD remains staffed across four locations instead of the usual three. This has implications when supporting staff especially if there is a clinical emergency or workforce gaps. A review of the workforce model including nurse associates has been undertaken with a reconfiguration of the skills mix composition.

Summary

Bed occupancy remains within an acceptable range, but the acuity of the patients remains high. Work has progressed on upskilling staff to care for the child with a tracheostomy, and this remains an area to be monitored.

Action

The central NWAQ Team will continue to assist in the ongoing recruitment and retention within the Directorate. The Quality KPIs will continue to be a focus in the in-patient areas. The Directorate was commended for their ongoing review of services and looking a new way of working to support levels of care.

11.1.4 Blood, Cells, and Cancer (BCC)

The Directorate AssoCN and the nursing leads confirmed the following:

- **Elephant:** the staffing establishment was confirmed as correct, whilst recognising that the ward is often working with a high bed occupancy. Junior staff are working towards competency which impacts on workforce capacity.

- **Giraffe:** the staffing establishment was confirmed as correct, but it was acknowledged that the workforce is developing their skills and competency and whilst this is evolving these impacts on the capacity of the workforce.
- **Lion:** the staffing establishment has been confirmed as correct.
- **Fox:** The staffing establishment was confirmed as correct. It was recognised that the activity during the scoring period was lower than usual and that due to the size of the ward (<12 beds), the SNCT cannot be relied on. Professional judgement was applied to the confirmation of the correct establishment.
- **Robin:** The staffing establishment was confirmed as correct. A review of skill composition to increase the baseline of seniority is currently being considered.
- **Pelican:** The establishment was confirmed as correct to support the inpatient activity. However, there remains workforce gaps.
- **Safari:** The current establishment is not reflective of the service in Safari and is part of the overall nursing establishment review.

Summary

All areas in BCC are being reviewed as part of the Cancer Build project. The nursing workforce has started a process of extensive review, led by the ACN with further service transformation planned. The NWAQ team will be supporting this process.

The ward managers and matrons discussed the challenges they have using the SNCT as it may not accurately capture the nuances of the care of the child with cancer. However, the importance of professional judgement to support the decisions around confirming the safe nursing establishment was reiterated.

The Senior Nursing Leadership and NWAQ team, a targeted approach to ensure the workforce is responsive to meet the needs of the Directorate, now and in the future.

The BCC directorate have identified a number of initiatives to support staff wellbeing including 'Wellbeing Week' and team away days.

Actions

The NWAQ Team will continue to support ongoing recruitment, and retention within the Directorate.

An in-depth, Directorate-led review of the areas identified will be supported by the NWAQ team. Alternative workforce models will also be scoped with support from the Workforce Team.

11.1.5 International and Private Care (I&PC)- SNCT scoring is designed for the NHS activity and does not consider the private experience and expectations of patients and their families.

Therefore, professional judgement is applied to reflect the additional challenges such as the cultural differences, language barriers and service user expectation, which may impact on care in these areas. The Directorate is benchmarked against other private providers to ensure that the patient experience is matched with competitors. However, other providers have lower nurse to patient ratios of 1:2 compared to GOSH's 1:3.

The Directorate AssoCN in consultation with the clinical teams confirmed the following:

- **Bumblebee:** The current establishment was confirmed as correct. Acuity in this area remains high with children requiring enhanced levels of care due to having a tracheostomy and additionally being isolated in a cubicle for infection prevention and control reasons.
- **Butterfly:** The nursing establishment was confirmed as correct, based on current activity. The SNCT scoring was conducted during period of reduced activity. The ward also acts as a shared care unit with patients having immediate access from home which requires a flexible approach to staffing.
- **Hedgehog:** The nursing establishment was confirmed as correct, based on current activity levels. However, the location of this ward makes it vulnerable. The ward also admits children with additional needs such as an artificial airway.
- **Caterpillar:** SNCT does not score outpatient activity. However, the staffing establishment was confirmed as correct and the department manager is now in post.

Summary

IP&C have a clear understanding of the quality of care delivered with reported high levels of positive F&FT and low numbers of complaints.

Action

The Directorate has achieved a positive change in reducing vacancies and increasing retention. This is reflected in positive quality impacts reported.

The final SNCT calculations for the areas was asked to be shared and this has been actioned (Nov 25). Finally, the Private Healthcare Information Network ([PHIN](#)) outpatient satisfaction data will also be included in the next establishment reviews.

11.1.6 Heart & Lung (H&L)- The Directorate AssoCN with the senior nursing team confirmed the following:

- **Bear & Alligator:** the budget for both Bear and Alligator is shared. It was reported that establishment is not correct and this is being reviewed. However, no safety concerns were raised. The budget therefore requires reconciling.
- **Walrus:** data not reported by the Directorate.
- **Kangaroo:** Patient acuity in the area has also increased. There is a provisional plan to increase the HDU beds and if so, the establishment is not correct. The ACN and triumphant are reviewing this plan.
- **Leopard:** The staffing levels require a review as it was reported to be under established there has been an increase in acuity as patients are being stepped down earlier from the intensive care units.
- **Intensive care units: NICU, CICU, PICU:** All units' current establishment was reported as safe and correct, whilst recognising below National Professional standards. This includes both headcount and Qualified in Speciality (QIS). NICU reported that, whilst there are enough QIS RNs, these nurses are not in Band 6 roles.

- Nevertheless, concern continues to be raised that the headroom (uplift) for these clinically intensive areas is not adequate due to the significant hours of essential training required to keep nursing staff competent. This is an area that further investigation will be undertaken.

Summary

The quality and staffing data about H&L concluded that the most areas are safely established but a review of Leopard is required. Concerns were also raised about the increase in acuity and the lack of flexibility in the critical care nursing workforce due to the narrow headroom.

Actions

The ACN for NWAQ has shared with HR a review of headroom in the critical care areas but is awaiting feedback.

Walrus to be included in the next Establishment Review.

NWAQ to support the Directorate-led review of the nursing establishment on Leopard and support the recruitment into the Band 5 vacancies all the H&L areas, in particular: PICU, CICU and Kangaroo.

11.1.7 Core Clinical Services (CCS)- The Association for Perioperative Practice (AfPP) guidelines and professional judgment was used to determine the safe staffing establishments in theatres, as the CYP SNCT is not applicable. The Directorate AssoCN and the senior nursing team confirmed the following:

- **Anaesthetics:** The current establishment was reported as correct and safe.
- **Anaesthetic pre-operative assessment (APOA):** The current establishment was reported as correct and safe.
- **Interventional Radiology:** The current establishment was reported as correct and safe.
- **Pain team:** The current establishment was reported as correct and safe. It was recognised, that training of staff across the Trust by the Pain Team, is impacting on their capacity. This will be monitored.
- **Sedation Team:** The current establishment was reported as correct and safe. It was recognised that the requests to the sedation team has increase and this will be monitored. The department has reviewed the non-registered workforce and as these posts were not seen as having a positive impact, these roles have been converted to Band 5 RNs.
- **Recovery:** The current establishment was reported as correct and safe.
- **Scrub:** The current establishment was reported as correct and safe. There is a well-established rotational programme to improve cover and enhance retention.
- **Woodpecker/ Nightingale:** The current establishment was reported as correct and safe. However, ongoing review of the workforce needed to expand the service, is in progress.
- **Cath lab:** The current establishment is safe and correct with an ongoing review of the on-call arrangements.

Summary

There is currently, no validated tool to measure establishment, in these areas. However, using professional judgement, professional guidance, and triangulation of quality measures: the AssoCN reassured the panel that the workforce establishment was safe.

It was highlighted that the provision of play in CCS has improved, an outstanding action from the previous review.

Action

Continue to support the internal establishment reviews, particularly the review of the Pre-Med Hub, opened in May, and the demand on the service.

11.1.8 Clinical Operations (CO): The Clinical Site Practitioner (CSP) team establishment was reviewed an overview of the nursing establishment. As these services are not validated by a nursing staffing tool: professional judgement, review of the quality metrics and peer benchmarking was used to review and provide assurance. The CSP Lead Nurse confirmed the following:

- **CSP:** The CSP establishment is correct. The team assist in addressing nursing gaps within the Trust and are an essential workforce in supporting the safety and quality of care delivery. It was confirmed that the headroom for the CSP team is 22% and does not reflect the advanced clinical practice requirements for the role nor the enhanced training obligations. The Discharge Co-ordinator is also currently in the CSP budget.
- **Vascular Access Team (VAT):** this team provide an 'in hours' service and are an integral part of the hospital. This is a fragile service with a small team of highly skilled individuals who, due to their expertise, are difficult to cover if there are workforce gaps. There is currently no budget for OOH work.

Summary and Actions

The finance partner will review budgets to explore the support the expansion of the VAT. Review of the headroom allowance for the CSPs to ensure this is reflective of the essential role requirements and training. Broader peer benchmarking of other CSP services such as at Birmingham Children's and Alder Hey Hospitals. The importance and necessity to ensure the CSP team are better incorporated into the senior nursing leadership (including Corporate Nursing) was also acknowledged.

11.1.9 Research and Innovation (R&I)

The AssoCN for R&I explained that there is currently, no validated tool to measure establishment in this area. Professional judgement, professional guidance (UKCRF Study Intensity tool and NIHR costing template), and triangulation of quality measures was used to provide assurance. Nurse staffing levels are determined by research funding grants and are managed by a substantive core infrastructure. Therefore, most nursing posts are flexibly recruited on fixed contracts.

- **R&I Infrastructure;** The AssoCN confirmed that there are a number of vacancies that are currently delayed awaiting approval, including a senior

nurse leadership (Matron) role. It was recognised the challenges required to provide an agile workforce to respond promptly to research study needs.

Summary & Actions

The R&I is currently safely established but capacity to undertake further research may be impacted upon due to reduced flexibility in the workforce.

12.0 Summary and Recommendations from the Summer (September 2025) Bi-Annual Review

The bi-annual review for the Directorates has identified several recommendations to be actioned before the next review (April 26). These actions are detailed at the end of each Directorate summary in section 4.0. and are also summarised in the below action log (Table 11.1).

Table 11.1 Action Log. Summer Establishment Reviews 2025

Action	Description	Directorate/Ward	Responsible	Date to be Actioned	Comments
Review Student Feedback	Increase response rate and utility of nursing student feedback prior to next establishment reviews.	All Directorates	Education Team / Directorate Leads	Before next review	Remains outstanding from Spring 2025/26 review.
Recruitment Support	Assist with ongoing recruitment and integration of new starters.	Brain (Koala, Possum, Kingfisher, RANU, Squirrel Endo-Met)	NWAQ Team	Ongoing	Vacancies remain in some wards.
Review Scoring Approach	Review scoring approach for Kingfisher patients requiring frequent venepuncture.	Brain (Kingfisher)	Ward Manager / NWAQ Team	Next review	High proportion of Level 3 patients noted.
Support Eagle & Sky Workforce Review	Review Eagle Ward (HDU area) workforce and address concerns.	Body, Bones & Mind (Eagle Ward)	NWAQ Team / Directorate Leads	Next review	High acuity patients require review.
Review RN Cover in MCU	Review minimum RN cover on MCU at night; implement minimum 2 RNs once Band 5 vacancies filled.	Body, Bones & Mind (MCU)	MCU Ward Manager / Directorate Leads	Next review	Awaiting Band 5 recruitment.
Recruitment & Retention Support	Continue support for ongoing recruitment and retention.	Sight & Sound; Blood, Cells & Cancer	NWAQ Team	Ongoing	High vacancy rates persist in some wards.
Service Transformation Review	Directorate-led review of under-established areas and alternative workforce models.	Blood, Cells & Cancer	NWAQ Team / Workforce Team	Ongoing	Part of Cancer Build Project.
Review Headroom in Critical Care	Review headroom in critical care areas (NICU, CICU, PICU), awaiting HR feedback.	Heart & Lung	ACN for NWAQ / HR	Pending	Essential training hours not fully accounted for.

Include Walrus in Review	Walrus to be included in next establishment review.	Heart & Lung (Walrus)	Directorate Leads	Next review	Data not reported for Walrus.
Support Leopard Workforce Review	Review nursing establishment on Leopard; support Band 5 recruitment in PICU, CICU, Kangaroo.	Heart & Lung (Leopard, PICU, CICU, Kangaroo)	NWAQ Team / Directorate Leads	Next review	Increase in acuity noted.
Support Pre-Med Hub Review	Continue review of Pre-Med Hub and demand on service.	Core Clinical Services	Directorate Leads	Ongoing	Opened May 2025.
Expand VAT Budget	Finance partner to review VAT budget for expansion and OOH service.	Clinical Operations (VAT)	Finance Partner / Directorate Leads	Next review	Currently in-hours only; fragile service.
Review CSP Headroom	Review headroom allowance for CSPs to reflect role and training requirements.	Clinical Operations (CSP)	Finance Partner / Directorate Leads	Next review	Current headroom 22% does not reflect advanced practice needs.
Benchmark CSP Services	Broader peer benchmarking of CSP services at other children's hospitals.	Clinical Operations (CSP)	Directorate Leads	Next review	Include Birmingham Children's & Alder Hey Hospitals.
Enhance CSP Leadership Integration	Better incorporate CSP team into senior nursing leadership (including Corporate Nursing).	Clinical Operations (CSP)	Directorate Leads	Next review	Recognised as necessary by panel.
Approve R&I Vacancies	Approve delayed vacancies, including senior nurse leadership roles.	Research & Innovation	R&I AssoCN / HR		Agility of workforce impacted by delays.
Use PHIN feedback for F&FT	Use Private Patient feedback for areas	IP&C	AssoCN	Next Review	

13.0 Conclusion:

In conclusion, the Summer 2025 bi-annual review of nursing establishments across all Directorates demonstrates that, overall, current staffing levels are sufficient to maintain safe and effective care in most areas. While there are ongoing challenges related to workforce vacancies, high concentrations of junior staff, and the need to continually upskill nurses to meet patient acuity and specialist requirements, significant progress has been made in recruitment, education, and retention.

Professional judgement supported by established guidelines and quality metrics, has been essential in areas where validated staffing tools are lacking or not fully applicable. Directorate specific action plans have been developed to address identified gaps, such as improving student feedback, reviewing skill mix, reconciling budgets, and enhancing workforce flexibility.

Continued collaboration between the NWAQ team, HR, and senior leadership will be crucial to address outstanding issues, particularly in critical care, high-dependency areas, and services with unique or evolving demands.

In conclusion, this report highlights the importance of ongoing monitoring, responsive workforce planning, and a commitment to maintaining high standards of patient care and staff support as organisational needs change.

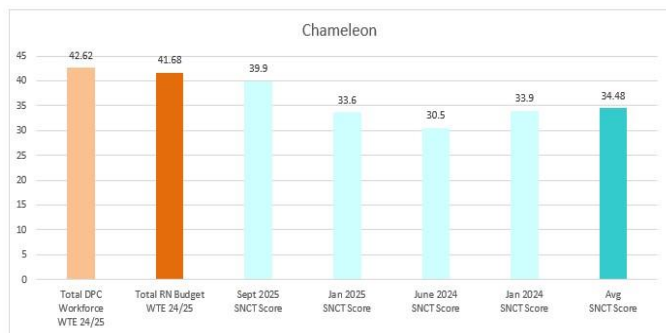
14.0 Summary of the Report

- RN vacancies have decreased in Q3.
- The rolling voluntary turnover remains improved and ongoing delivery plans continue to promote the key retention initiatives. The NWAQ is focused on the key retention priorities to promote flexible working, rewarding the workforce, amplifying their voice, and we are one team.
- The active recruitment drive has resulted in vacancies being filled. There is now a pause on the centrally co-ordinated programme of recruitment events throughout the year, and this position will be monitored.
- Absence due to sickness, remains just above the Trust target, with the main reasons for short-term absence being coughs and colds. The main reported reason for long-term absence remains due to anxiety and mental health disorders.
- The NWAQ team continue to support the recruitment and retention of the GOSH nursing workforce.
- The bi-annual review of safe nursing establishment has been undertaken and clear actions for monitoring and progression has been set.

Nursing Workforce Assurance Report Q3 2025/2026

Appendix A. Exemplar of Summary Workforce Data at a Glance

Chameleon



Total Bed
Base Inc
HDU
14

Top left graph demonstrates the comparison between the budgeted staffing and the recommended staffing according to the SNCT alone.

Bottom Graphs - SNCT levels of care

Level 0 - Child/young person requires hospitalisation - needs met through normal inpatient care

Level 1a - Child /young person is acutely ill requiring close supervision and monitoring, or is unstable with a greater potential to deteriorate usually available through normal inpatient care

Level 1b - Child/young person is stable but dependent on nursing care interventions/intensive therapy to meet most or all their care.

Level 2 - Child/young person who may require closer observation & monitoring than is usually available through normal inpatient care.

Level 3 - Child/young person is unstable and requires advanced respiratory and therapeutic support for multiple organ problems.

Professional Judgement

Please use the [Professional Judgement Framework](#) to support your discussion and justification (Saville et al., 2023)

SNCT scores must not be looked at in isolation.

Wards with less than 12 beds require an additional level of professional judgement regarding the SNCT Scores.

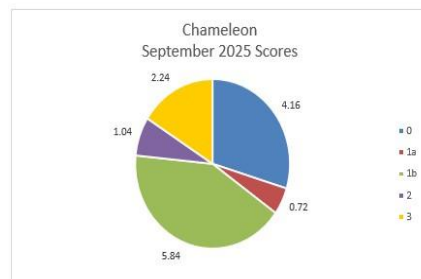
Consideration must also be given to ward environment (eg. single cubicles), skill mix and speciality recommendations.

SNCT scores do not include the Ward Manager role, which must be added. This will be discussed during the staffing establishment review.

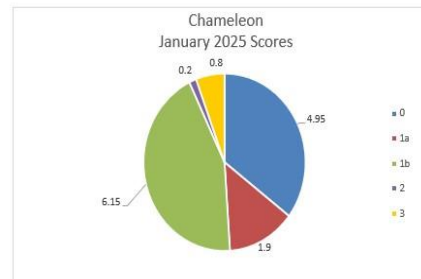
Ward
Accreditation
SILVER

* DPC - direct patient care

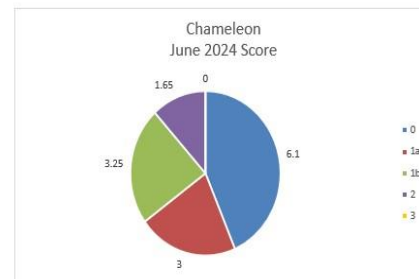
NB. All totals exclude ward manager role as should be supervisory



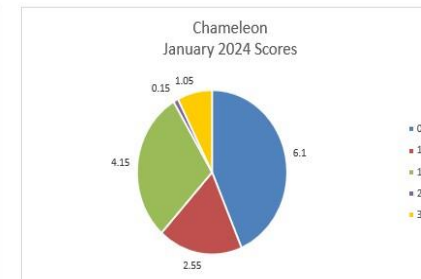
14 beds scored



14 beds scored



14 beds scored



14 beds scored

Nursing & Midwofery Care Thermometer																	
			Input - Staffing	Input - Process of care					Outcome - Incidents of harm					Outcome - Patient Experience			
Ward	Directorate	RN Est vs Avg SNCT score	Avg. Bed Occupancy	Nursing Vacancy % (August)	Nursing Sickness % (August)	Nursing Maternity Leave %	Sat/ Man Training	PDR compliance	Incidents of harm - moderate or above					Friends & Family Test			
									All Harm	Psychological Harm	Physical Harm	Line Bacteraemias	Medication Errors	Response Rate	Experience Rating	PALS contac	
Chameleon	BBM	7.2	91.25%	-9.4%	5.1%	4.7%	93.10%	90.00%	x	x	2	8	3	49%	99%	3	



**Great Ormond Street
Hospital for Children**
NHS Foundation Trust

Trust Board
29th January 2026

Learning from deaths report —Q2 2025/26

Submitted by:

**Simon Hannam, and Finella Craig - Joint
Medical Lead for Child Death Reviews**
Andrew Pearson, Clinical Audit Manager

Paper No: Attachment S

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 nine GOSH CDRMs held at GOSH between 1st July and 30th September 2025.

The reviews highlighted:

- In no cases were modifiable factors identified by the CDRM in the care provided at GOSH. In two cases modifiable factors were 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 five cases.
- Excellent aspects of care, the co-ordination of care and communication at GOSH were highlighted by the CDRMs in seven cases.

There are no specific themes identified in this period.

Wider thematic review

A thematic review of learning identified from all 288 GOSH CDRMs concluded 1st October 2021 – 30th September 2025 identifies wider themes outside of this reporting period, and that updated analysis is included in the report.

Completion of CDRM meetings – 48 CDRMs have not been completed within 12 weeks of the child's death at the time of the report being written.

Risk adjusted mortality

The PICANet *State of the Nation Report 2025* was published in December 2025 and covers the calendar years 2022-24. The report shows GOSH PICU, NICU and CICU risk adjusted mortality as within expected range. GOSH was notified that NICU had a positive outlier for mortality, which occurred in June 2025. This means that the NICU had fewer deaths than might have been expected given the case mix of babies who are admitted onto the unit. This has been reviewed by the NICU team and a comprehensive report provided to PICANet in line with the PICANet outlier process in December 2025. PICANet have commended the quality of the response provided by GOSH.

Action from September 2025 Trust Board

Matthew Shaw suggested that the Trust should consult with colleagues from other Children's

Hospital Alliance Trusts to understand how they shared information from CDRMs. He also emphasised the importance of creating a “safe space” for clinical teams to come together, often with differing views, to learn from these events. It was agreed that this topic should be brought back to the Board for further discussion and clarity.

It was agreed that the question of whether parents were given direct sight of the CDRM form would be raised with the Head of Bereavement

Update

Following September Trust Board this has been raised with the Head of Bereavement Services. It has been confirmed that the national guidance is for the CDRM to be a professional only meeting – and arrangements for feedback into and out of the meeting is through the GOSH bereavement key worker.

Bereavement meetings are offered with the treatment team. The final document and outcome of the CDRM meeting is shared with the CDOP and to the National Child Mortality Database anonymously. It is not shared with families, and that is in line with national guidance. CDRM leads at two other children’s hospitals have been contacted by one of Medical Leads for Child Death Reviews as to how they share information from CDRMs.

Action required from the meeting

There are no recommendations for the Board to consider.

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 is to be tabled at the first available Clinical Governance Committee

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

Medical Leads for Child Death Reviews

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

Acting Chief Medical Officer

Learning from deaths report –learning from GOSH Child Death Review Meetings. Q2 2025/26

Aim of this report

To highlight learning from child death review meetings (CDRMs) concluded between 1st July and 30th September 2025 at GOSH.

Summary

Child Death Review Meetings (CDRMs) are the final meetings to confirm learning in the mortality review process following the completion of all necessary investigations and reviews. This report focuses on learning from nine CDRMs held at GOSH between 1st July and 30th September 2025.

The reviews highlighted:

- In **no** cases were modifiable factors¹ identified by the CDRM in the care provided at GOSH. In **two** cases modifiable factors were 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 **five** cases.
- Excellent aspects of care, the co-ordination of care and communication at GOSH were highlighted by the CDRMs in **seven** cases.

Theme identified in this period

There are no specific themes identified in this period.

Wider thematic review

A thematic review of learning identified from all 288 GOSH CDRMs concluded 1st October 2021 – 30th September 2025 identifies wider themes outside of this reporting period, and that updated analysis is included in the report.

Completion of CDRM meetings

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 48 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, and a number of meetings cannot be completed pending coronial investigations.

Further information follows this executive summary.

Content	Pages
Completion of child death review meetings	3
Outcomes of GOSH CDRMs 1st July to 30 th September 2025 • Cases where modifiable factors were identified following the conclusion of the CDRM. • Summary CDRMs - learning points and excellence	4
Aggregation of learning -themes from CDRMs concluded 1st October 2021 -30th September 2025	5-6
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Appendix i: 1st July to 30th September 2025. Cases where modifiable factors were identified following the conclusion of the CDRM.	7
Appendix ii: Learning points identified, and excellence practice noted from CDRMs 1st July to 30th September 2025	8-9
Appendix iii: The mortality review process at GOSH	9

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)

21st December 2025

Simon Hannam, and Finella Craig. Joint Medical Lead for Child Death Reviews
Andrew Pearson, Clinical Audit Manager

Completion of child death review meetings

Nine CDRMs were held at GOSH between 1st July and 30th September 2025

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 48 GOSH CDRMs have not been completed within 12 weeks of the child's death:

- 16 could not take place until the completion of necessary coroner/external investigations.
- 32 are being scheduled at the time of writing due to challenges in clinical staffs' capacity, chair availability and work required to arrange and attend the meetings.

Trajectory over reporting periods

Table 1 : number of outstanding CDRMs meetings at each time point based on when the learning from deaths report was written

	Month Learning from Deaths Report written									
	February 2023	June 2023	September 2023	January 2024	April 2024	August 2024	January 2025	April 2025	July 2025	Dec 25
N of cases not reviewed within 12 weeks of death	34	39	53	46	55	39	39	34	46	48

Outcomes of GOSH CDRMs 1st July to 30th September 2025

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

In **no** cases were modifiable factors identified by the CDRM in the care provided at GOSH.

In **two** cases modifiable factors were identified by the CDRM where there is learning outside of GOSH

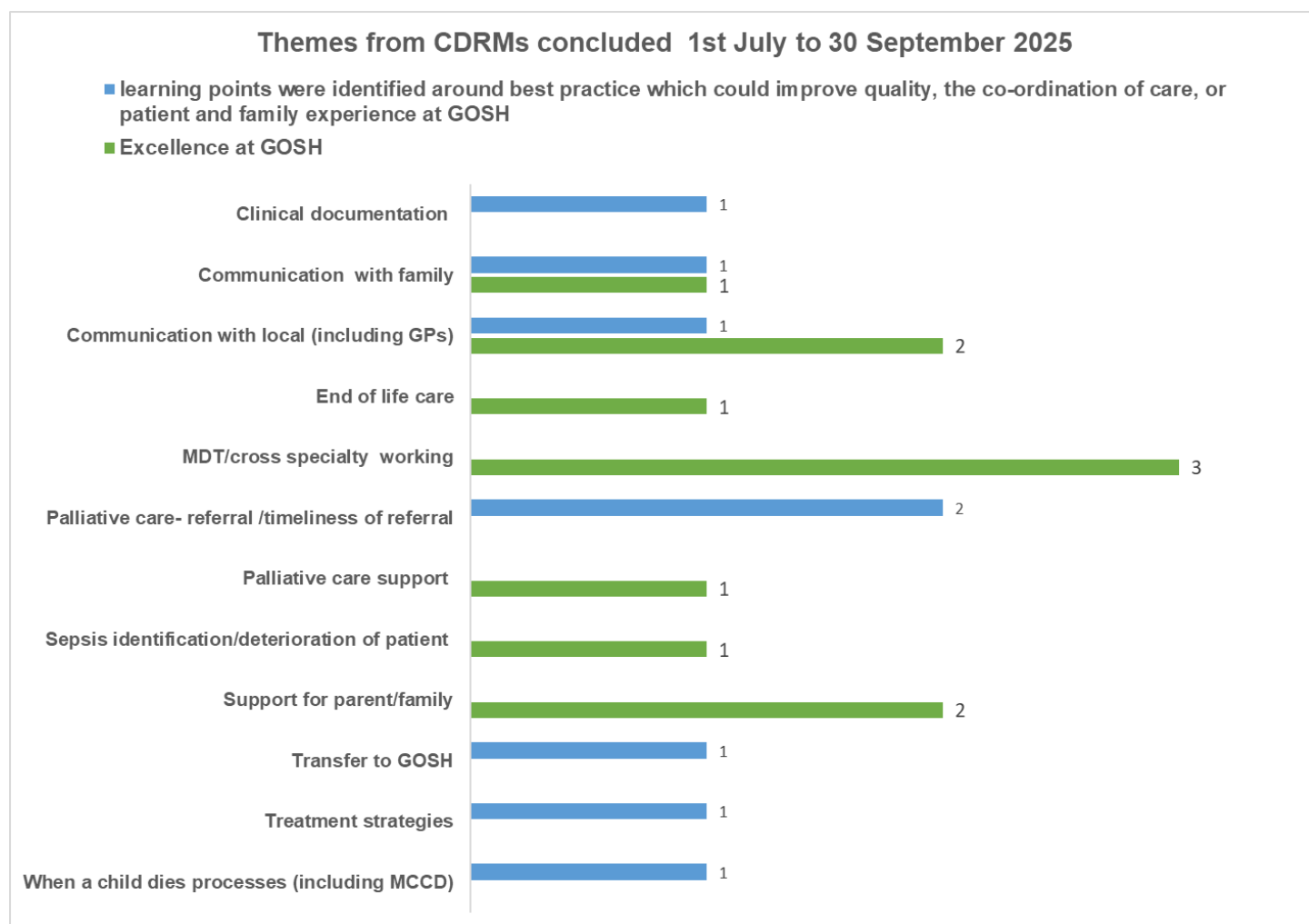
- Delay in recognising illness (myocarditis vs URTI) with misinterpretation of chest x ray which showed cardiomegaly.
- Weight loss at 5 days should have been escalated for earlier review

Local teams attend GOSH held CDRMs- and outcomes may reflect actions from investigations which inform the CDRM and will be managed by those organisations. Outcomes of CDRMs are shared with the Child Death Overview Panel (CDOP). A role of the CDOP is to review CDRM outcomes and to identify learning arising from the child death review process that may prevent future child deaths nationally.

Appendix i provides a summary of cases of modifiable factors identified where there is learning outside of GOSH in this period.

Summary of themes from CDRMs

Chart 1. A summary of themes from CDRMs concluded in this period



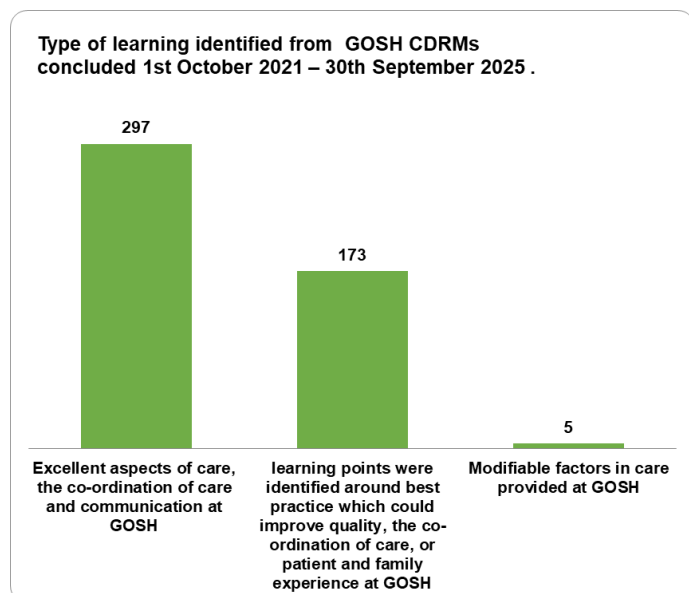
Appendix ii outlines more detail on learning points identified and excellence practice in this period

Aggregation of learning -themes from CDRMs concluded 1st October 2021 -30th September 2025

This report highlights learning from CDRMs concluded 1st January – 30th September 2025. We conduct a thematic review of learning identified from CDRMs over a longer period to aggregate and identify themes.

Two hundred and eighty-eight CDRMs have been concluded 1st October 2021 –30th September 2025
it should be noted that each CDRM may identify more than one learning point.

Chart 2. Types of learning identified from GOSH CDRMs 1st October 2021- 30th September 2025



Themes identified from CDRM meetings at GOSH

Modifiable factors in care at GOSH (5)

Theme	Dates of death where identified
Sepsis identification/management (2)	Dec 2019 October 2021
Access to diagnostics (2)	April 2022
Access to GOSH (1)	April 2022
Management of field safety notice (histoacryl glue) (1)	March 2021

Learning and actions relating to cases where there have been modifiable factors at GOSH have been reported in previous learning from deaths reports. Investigations were managed and followed up through patient safety investigations at the time.

There were two cases where sepsis identification/management had been highlighted

- One Serious Incident (SI) investigation was completed at GOSH, and actions were implemented including training for BCC staff for on sepsis in the immunocompromised patients, to highlight patients at a greater risk of infection and to identify early signs of sepsis and updated Paediatric Haematology & Oncology: Supportive Care Protocols.
- In one case an SI investigation was completed at the local hospital around a delay in administration of antibiotics locally until after discussion with GOSH

GOSH has a mature Trust wide quality improvement programme is in place to support the identification and management of the deteriorating patient.

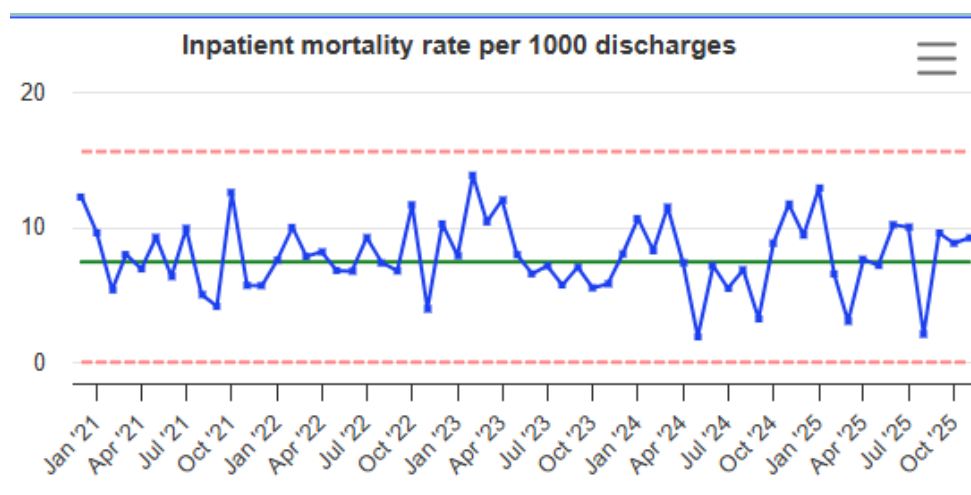
A Serious Incident was managed at GOSH relating to management of field safety notices. An action plan was implemented by the Safety Surveillance team resulting in changes to improve control and monitoring of the Central Alerting System and national patient safety alerts.

Most frequent themes which could improve quality		Most frequent themes identified around excellence	
Theme	% of CDRMs where identified	Theme	% of CDRMs where identified
Communication with local (including GPs)	9.7%	Excellent care of child and family	28.8%
When a child dies processes (including MCCD)	8.7%	MDT/cross specialty working	10%
Communication with family	6.3%	End of life care	14.6%
Palliative care- referral /timeliness of referral	5.9%	Communication with family	6.9%
Treatment strategies	5.2%	Communication with local (including GPs)	5.9%
Access to GOSH	4.5%	Palliative care support	5.2%

Mortality rate and risk adjusted ICU data

The inpatient mortality rate is within normal variation.

Chart 3. Inpatient mortality rate



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 for our ICU deaths, which considers how unwell the patient was on admission and the likelihood of death as a potential outcome. This is important, as in 2024-25 81% of GOSH deaths were on an ICU. The gold standard for measuring paediatric ICU mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANet). The PICANet State of the Nation Report 2025 was published in December 2025 and covers the calendar years 2022-24. The report shows GOSH PICU, NICU and CICU risk adjusted mortality as within expected range.

The Paediatric Intensive Care Audit Network (PICANet) offer a method to monitor real time risk adjusted mortality in each site. Real time risk adjusted mortality is monitored by the ICU teams using the PICANet resetting sequential probability ratio test (RSPRT) plot. This has identified a NICU *positive* mortality outlier which was notified by PICANet as occurring in June 2025. This means that the NICU had fewer deaths than might have been expected given the case mix of babies who are admitted onto the unit. This has been reviewed by the NICU team and a comprehensive report provided to PICANet in line with the PICANet outlier process in December 2025. Reviewing data, high-risk diagnosis on admissions, and deaths between March and September 2025 has not identified an obvious single cause for the positive outlier. PICANet have commended the quality of the response provided by GOSH.

Appendix i 1st July – 30 September 2025. Cases where modifiable factors were identified following the conclusion of the CDRM.

In **no** cases were modifiable factors identified by the CDRM in the care provided at GOSH.

In **two** cases modifiable factors were identified by the CDRM where there is learning outside of GOSH

Month of death	Location of learning	Modifiable factor – noted from outcome of CDRM
March 2023	Local Hospital	Recommendations that had been made for the local team to address findings that directly impacted on the outcome of the incident 1. Increase awareness amongst paediatric staff cross site and across the local Trust about the possibility of myocarditis in viral infection seasons in children with tachycardia. 2. Education on evaluating cardiac size on chest x-ray. 3. Agreed process for deciding where to intubate a child (with a recognition that decisions may need to be made on a case-by-case basis) and, where required, how to perform a transfer to theatre in a timely manner. 4. There should be early consideration of the need for an ECG for patients presenting with tachycardia and with persisting tachycardia. 5. All paediatric patients should have a blood pressure taken on initial assessment in ED and on admission to the ward and ensure difficulties with achieving this are escalated and documented.
Nov 24	Local team (Health visitor):	Discussion at CDRM: weight loss at day 5 was not referred for further follow up but should have been. Not seen again until day 13 when acutely unwell. Earlier diagnosis of HSV infection may have been helpful and may have been picked up at earlier review

Appendix ii –Learning points identified, and excellence practice noted from CDRMS held 1st July to 30th September 2025

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	Admitting specialty	Summary of learning noted at CDRM	Category of learning
Dec 24	BMT	(1) communication with families - recurrent theme - consider broader staff training (2) Access to mortuary viewing - there is work in progress to improve this (training of additional staff to facilitate viewings) (3) earlier referral of BMT patients to palliative care	Communication with family When a child dies processes (including MCCD) Palliative care- referral /timeliness of referral
Oct 24	BMT/PICU	Management of haemorrhagic cystitis - already changed current approach to joint review with palliative care and pain team when needed	Treatment strategies
Nov 24	ID team	Consider referral or re-referral to palliative care for children where there are long term risk factors for premature death	Palliative care- referral /timeliness of referral
Dec 24	Nephrology, PICU	1) Communication with local paediatrician to be improved (2) Ensure retrieval team pass on full history to PICU team for recording on PANDR	Communication with local (including GPs) Transfer to GOSH
Dec 24	Immunology	Discharge summary not completed post death	Clinical documentation

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

Month of death	Specialties /teams	Summary noted at CDRM	Category of learning
Aug 24	SNAPS/Cardiology	All present at the CDRM reflected that this child was offered every chance and that MDT working between the local hospital and GOSH, and management of complexity within the GOSH MDT was as good as it could be.	MDT/cross specialty working
Nov 24	Multiple	Went through full Ethics process + 2nd-3rd (external) opinions. Consultant reached went through wider GOSH cohort w/ same condition + also to wider national/international colleagues for opinion/discussion re best practice/evidence base. PICU team regularly trying to help family re visa etc.	MDT/cross specialty working
Oct 24	BMT, PICU	Good MDT working, death well managed, local teams highlighted really good communication, especially from BMT team and post death	MDT/cross specialty working Communication with local (including GPs) End of life care
Nov 24	ID team	Good communications links between different trusts to ensure best care provided.	Communication with local (including GPs)

		Rapid recognition of deteriorating child on GOSH ward with input of appropriate urgent clinical teams in timely fashion.	Sepsis identification/deterioration of patient
Aug 24	NICU	Good communication, parents cooperative, death managed well	Communication with family
Dec 24	Nephrology, PICU	Parents were very grateful for chaplaincy support Since home have been referred to genetics at parents request and have received appointments.	Support for parent/family
Dec 24	Immunology/ IPP	Arabic advocacy team very helpful in translating and offering support to the family. Good palliative care support for the family. good support from nursing team on Butterfly	Support for parent/family Palliative care support

Appendix iii The mortality review process at GOSH

Mortality reviews take place through two processes at GOSH:

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

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



**Summary of the Quality, Safety and Experience Assurance Committee meeting
held on 14 January 2026**

Quality and Safety at GOSH: Chief Medical Officer Report (BAF Risk 12: Inconsistent delivery of safe care)

The Trust had a new CQC relationship manager and a positive meeting had taken place including a walkround of the hospital site.

Discussion took place around the outcome of an external review into speech outcomes in the Cleft Service after concerns had been raised. Reviewers had been satisfied with the service and had made findings around the consistency of outcome scoring rather than the outcomes themselves. The Committee welcomed the process whereby the team had raised concerns and they had been independently investigated.

There had been a considerable increase in the number of claims received and a paper would be presented to the Audit Committee. This was primarily driven by the orthopaedics review however there had also been a national increase in claims of a low financial value. This would continue to be monitored.

Quality and Patient Experience: Chief Nurse Report (BAF Risk 12: Inconsistent delivery of safe care)

The first Teenage Healthcare Group had been held which had focused on healthcare transition, experiences of MyGOSH and improving the independence of young people which were also key matters for the Young People's Forum. The number of complaints received continued to be higher than normal and work had taken place with PALS which identified that patients and families were more likely to move straight to a complaint rather than contact PALS in the first instance. Work would be taking place to ensure that patients and families were aware of the routes to raise concerns.

The use of temporary staffing had reduced and there had been no subsequent increase in incidents or a need to increase staffing. The team would continue to review workforce modelling.

The infection prevention and control team had been working on surgical site surveillance for a number of years and this was now in place for spinal surgery and would be rolled out to cardiac. Work was taking place with the Children's Hospital Alliance to review infection control data and understand the elements that were critical for paediatric patients and provide feedback to NHS England.

Quality Operational report: Chief Operating Officer (BAF Risk 12: Inconsistent delivery of safe care)

The Trust's Referral to Treatment performance had trended at around 70% since January 2024 and there had been a significant reduction in long waiting patients. Patients waiting 52 weeks had reduced from 450 to below 200 and patients waiting 65 weeks had reduced from 250 to 49. Although this was above the target that had been agreed with NHS England, there had been a number of cases in which patients had been cancelled due to patient illness or patient choice and late referrals which were outside of GOSH's control. Compliance in clinical harm reviews had increased and was now above 80% and discussion took place around active management of waiting lists. It was confirmed that waiting lists

were managed by considering a patient's broader health, taking in to account other conditions the patient may have and treatment they may be receiving, so as to ensure that additional delays were not experienced as a result of these interdependencies.

Discussion took place around the reduction that was required in clinic letters turnaround time and the backlog of letters which was reducing slowly but required more work. The committee emphasised the importance of this communication and it was noted that the rollout of Tortus more widely would support this work.

Ward accreditation and Quality Visits Update

A quality assurance programme had been implemented over the last year which was primarily focused on ward accreditation and being a good hospital every day. A key element of the programme was the multidisciplinary review approach. Thirty-one inpatient areas had been reviewed for ward accreditation and summary reports were provided to the areas including recommendations to improve scores. Two gold ratings had been awarded, 17 silver and 12 areas continued to work towards accreditation. The quality assurance process had been aligned to Pathway to Excellence requirements to ensure that this programme could be more easily rolled out in future. A second wave of quality visits would begin and the committee requested an update on progress in a year's time.

Update from the Risk Assurance and Compliance Group on the Board Assurance Framework

Work was required to map BAF risks to the Trust's new strategy 'Together We Power Care'. It was proposed that BAF risk 2 Strategy Delivery; BAF risk 3 Operational Delivery and BAF risk 4 Integrated Care System were merged and it was agreed to recommend a revised risk statement this to the Audit Committee. An overview of the revised BAF template was also provided and accepted.

Escalations to Board and deep dives for next meeting

It was agreed that the national review of hearing services would be presented to the Committee at its October 2026 meeting. Discussion took place around healthcare transition which continued to be important to the Young People's Forum. It was noted that some complaints had been received in this area and it was agreed that a triangulated piece of work around quality, safety and patient experience of healthcare transition would be brought to the committee.



Summary of the Audit Committee meeting held on 21 January 2026

The Committee received updates from the following assurance committee meetings:

- Quality, Safety and Experience Assurance Committee – November 2025 and January 2026
- People and Education Assurance Committee – November 2025
- Finance and Performance Committee – October 2025 and December 2025

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

The Committee agreed to recommend a proposal to the Trust Board to merge the following BAF risks:

- BAF risk 2: Strategy Delivery
- BAF risk 3: Operational Delivery
- BAF risk 4: Integrated Care System

It was noted that the new risk, Strategic Delivery, would be overseen by the Trust Board with elements to be considered by the Audit Committee and QSEAC. Discussion took place around a new BAF template, and the committee welcomed the simplification of the information provided and the opportunity to see the movement of the net risk score over the previous three quarters. Work would take place to refresh the risk appetite statement and map existing BAF risks to the new strategy considering whether there were any gaps. Discussion took place around key performance indicators for BAF risks and the challenge of identifying and monitoring a large number for the BAF as a whole. It was agreed that deep dives would include the requirement for risk owners to consider relevant KPIs. The Committee agreed to adopt the revised BAF template.

Compliance with the GOSH Risk Management Policy

Significant work had been taking place to refresh risk governance and develop a more holistic approach to risk management in which the interconnected nature of risks was considered alongside common themes which could be used to identifying structural issues. A risk management strategy was being delivered which would have a one, three and five year approach. A number of risks were articulated differently in different areas and work was taking place to link them and implement a cross organisational lead. It was agreed that a deep dive would take place into one of these risks at a future meeting.

Board Assurance Framework Deep Dives (including application of risk appetite for these risks):

- BAF Risk 5: Unreliable data

Comprehensive processes were in place to ensure there was oversight of operational data and there was a focus on the clinical and operational data produced by Epic. There was a good level of confidence in the quality of this information however there remained shadow data in local teams and an overall structure was required to provide greater oversight in these areas. Data and AI strategies were in place however in order to move forward with this work, improvement was required in data maturity in some areas. The committee emphasised the importance of ensuring that education was in place for staff to understand the importance of data entry and foundational aspects of data quality management to enable the Trust to move forward in areas such as AI.

Losses and Write offs

The Committee approved the bad debt write offs for the period.

IFRS 9

A complex methodology for calculating bad debt provision had previously been in place and discussion had taken place annually with the Trust's former external auditors as to its level of prudence. As a result, the methodology had been revised in line with a published paper. The Committee highlighted the challenge of predicting future geopolitical issues which could significantly impact the provisioning requirement but agreed that based on historical data the revised methodology was appropriate.

External Audit Initial Risk and Progress Update

The engagement letter for the Trust's new audit firm had been signed on 9 December 2026 and data had begun to be transferred to the new firm. Work was also taking place with the previous auditor, and it was confirmed that no concerns had been raised which would impact the firm's ability to rely on their conclusions.

The value of claims and the drivers behind the increase

The Trust had received a number of claims related to one ongoing case, however notwithstanding this case there had been a slight increase in claims and it was anticipated that this had been as a result of a change to NHS Resolution guidance around the timelines of reporting matters to them. Trusts were now required to submit triangulated data to predict the likelihood of a claim being received. It was noted that alongside a national increase in claims there was also a national increase in complaints. The committee emphasised the importance of communication at the bedside in order to identify any concerns from patients and families and manage them at the earliest possible stage.

Internal Audit Progress and Action Tracking Report and Trust update on progress with Internal Audit recommendations and actions

There were five overdue actions and the committee noted that a number would come due at the turn of the financial year. It was noted that position of these actions would impact of the Head of Internal Audit Opinion, and it was confirmed that the Executive Team continued to focus on actions arising from internal audits and had approved extensions to deadlines where appropriate.

Final reports were received for the following reviews:

- Better Value Programme – Partial assurance with improvements required. The rating was in line with management expectations. At the time of the fieldwork additional progress had been required to ensure that the volume of savings required could be delivered. Good progress had now been made and the foundation had been laid for the 2026/27 better value programme. The Committee emphasised the importance of the cultural aspect of making savings.
- Supply chain management - Partial assurance with improvements required. The rating was in line with management expectations and actions would be addressed by the implementation of a new procurement operating model which was being introduced in two phases. A further review would be carried out once this was complete, although it was anticipated that this would take 18 months.
- Workforce controls: Bank and agency – Significant assurance with minor improvement opportunities. Oversight of the use of temporary staff in nursing was strong although at the time of the review oversight had been less strong in others areas. It was noted that robust processes were now in place.

Local Counterfraud Progress Report

Twenty three referrals had been received so far in 2025/26 which had surpassed referrals for the whole of

the previous year which was positive. One case had been formally taken forward and the committee discussed the relative number of days used for this case compared others. It was noted that Terms of Reference for the case had been agreed setting out the time allocated. The committee welcomed the timely closure of cases and noted that there was good engagement from finance and HR teams to support this work.

Year End Update

The Committee approved the proposed accounting policies. Discussion took place around accounting treatment of the financial outcome of GOSH's relationship with a commercial company. It was noted that there was some precedent in this area and a formal paper would be provided at the next meeting.

Audit Committee Effectiveness survey – questions

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

Update on Procurement Waivers

There had been a small reduction in the use of waivers since the previous report.

Governor feedback

Discussion took place around salary payments in the NHS. Salaries and Terms and Conditions were negotiated NHS wide under Agenda for Change.

Finance and Performance Committee Update – January 2026

Since the last report, the Finance and Performance Committee (FPC) met on 16 December 2025 for an extraordinary session. The primary purpose of the meeting was to review progress and status of the Medium-Term Financial Plan (MTFP) ahead of submission to NHS England.

Key developments, discussions, and actions are summarised below.

1. Wider Environment & Sector Risks

The Committee discussed the ongoing financial pressures across the NHS, noting that several Trusts were planning for significant deficits and challenging cost improvement plans. The Committee agreed to maintain a watching brief on sector-wide planning and revisit assumptions at its February 2026 meeting.

2. Integrated Plan Update

The Committee approved the approach to activity planning and the process for developing the final MTFP. Emphasis was placed on aligning productivity improvements and service developments with the NHS 10-Year Plan. The Board Assurance Statement was reviewed and approved for submission, with further benchmarking and deep dives scheduled for future meetings.

3. Medium Term Financial Plan (MTFP)

The Committee received an update on the development of the Medium-Term Financial Plan and the Integrated Plan.

The focus of the item was to seek Committee approval of *the process* for deriving what final financial targets would be in February 2026, rather than deriving the numbers themselves now (although a draft set of figures were provided which reflected a deficit position) with further refinement expected in the coming months.

The Committee noted the importance of scenario planning, particularly regarding income sources such as private patients and charitable contributions, and the need for robust planning assumptions.

4. Financial Position

The Committee reviewed the financial forecast, which projects a deficit for 2026/27 and 2027/28. The downturn in income was attributed to changes in national guidance and the timing of key income streams.

The Committee discussed the sensitivity of the model to changes in assumptions and the importance of early, difficult conversations to accelerate recovery, with a target to return to surplus by 2030/31.

5. Operational Performance

The Committee noted ongoing challenges with Referral to Treatment (RTT) long-wait cohorts. Specifically, how cancellations and sickness impact the ability to meet targets by year-end. The trajectory for improvement remained positive, but further work is required.

The impact of industrial action and winter illnesses was discussed, with elective procedures cancelled but overall activity remaining above plan.

6. ImageWise

The Committee endorsed the business case for joining the regional PACS and VNA replacement programme, noting significant cost savings, operational and clinical benefits, and a robust procurement process.

7. Innovation and Partnerships

The Committee discussed the strategic benefits of joining the UCLPartners health innovation collaborative, including financial modelling, governance arrangements, and the importance of focusing on high-impact innovation opportunities. Further engagement and assurance were agreed.

End

Key Points from the People and Education Assurance Committee (PEAC) held on 12 November 2025

Workforce Metrics Update (as at 30 September 2025)

The Committee noted that the Trust continued to perform well against strict targets for temporary staffing set by NHS England for 2025/26. There had been significant reductions in the use of agency and bank staff. Sickness absence had increased in the past year, coinciding with seasonal flu and higher rates of COVID-19. However, the Trust's sickness rate remained slightly below the national average. The most common reasons for absence were anxiety, stress, and respiratory illnesses. Compliance with mandatory training remained strong, consistently above the 90% target. Completion of Personal Development Reviews (PDRs) remained a challenge, with overall compliance static at 84%.

Nursing Workforce Assurance Report Q2

The Committee received the Quarter 2 Nursing Workforce Assurance Report, which covered recruitment, retention, sickness absence, and workforce controls. Vacancy rates had increased slightly, partly due to budget alignment and ongoing workforce controls. Recruitment activity had slowed, with fewer Newly Qualified Nurses (NQNs) appointed. All NQNs recruited were host students who trained within the organisation; no roles were offered to external candidates. Central recruitment campaigns had been paused, and there had been a reduction in the recruitment of internationally educated nurses. Voluntary turnover remained below the Trust target of 10%. Sickness absence among nursing staff had increased, particularly for short-term absences, with mental health and anxiety as leading causes. Changes to the authorisation process for temporary shifts had led to a significant reduction in bank staff usage.

Diversity and Inclusion Annual Report 2024-25

The Committee received the Diversity and Inclusion Annual Report for 2024–25, which would also be presented to the Trust Board as part of statutory requirements. The report demonstrated compliance with statutory duties and progress against the People Strategy. Improvements had been made in the gender pay gap, the Workforce Race Equality Standard (WRES), and the Workforce Disability Equality Standard (WDES), supported by comprehensive benchmarking. The RISE programme was highlighted as a positive initiative. The overall gender pay gap had reduced significantly. Race equality remained a top focus and it was noted that 40% of the workforce was from a global majority background, a notable figure for a London-based organisation. The Committee approved the report for submission to the Trust Board and endorsed continued delivery of key priorities for 2025–26, including refreshing the Seen and Heard Framework, scaling up the RISE programme, embedding the Anti-Racism Action Plan, and strengthening staff networks.

Annual Nursing Report 2024-25

The Committee received the first comprehensive Annual Nursing Report, which consolidated activities delivered under the four pillars of the Nursing Strategy. The report demonstrated the impact of the People Promise, with improvements in staff survey results and positive trends in retention and vacancy rates. A new flexible working policy had been introduced, contributing to improved staff experience. Work continued to strengthen nursing research capability, including the development of a gap analysis and dashboard. The accelerated programme for internationally educated nurses had halved the time required for competency sign-off, supporting inclusion and retention.

Medium Term Integrated Plan

The Committee received an update on the development of the Medium-Term Integrated Plan, which represented a significant change from previous NHS planning requirements. Trusts were now required to produce a three-year numerical plan by December 2025, followed by a five-year narrative plan in early 2026. Workforce considerations included ongoing service redesign to maximise efficiency and improve

care, a commitment to reduce temporary staffing, and a goal to achieve zero agency spend by 2029/30. There would be a continued focus on equality, building on anti-racism initiatives and addressing sexual safety, supported by the Trust's recent sign-up to the Sexual Safety Charter. Oversight of the plan would be provided by the Executive Management Team, supported by the Operations Board and Financial Sustainability Board.

Update on the Board Assurance Framework (BAF)

All Board Assurance Framework risks were reviewed by the Risk Assurance and Compliance Group and the Audit Committee. No changes were proposed to the PEAC risks. The culture risk had been updated, and a deep dive was undertaken during the meeting. It was noted that culture was challenging to quantify, and that staff survey results remained an important metric. Work was underway to use clinical intelligence to identify areas of concern and understand why team metrics differed, adopting a more proactive approach. It was agreed that values and behaviours work was central to shaping culture, with leadership playing a critical role in setting the organisational tone.

Draft PEAC effective survey questions

The Committee discussed the approach to testing the effectiveness of assurance committees. A full survey would now be undertaken, replacing the previous table-top exercise. The survey would seek feedback from a wide range of stakeholders, including committee members, executives, regular presenters, governor observers, and Board members who do not attend PEAC.

Raising Concerns in the Workplace Update Q2 (July – September 2025)

Freedom to Speak Up and Human Resources processes were presented as a combined report. Quarter 2 had nine contacts in August and September, but October had a significant increase to 27 contacts, the highest monthly figure for several years. The staff groups most represented were nurses, allied health professionals, and administrative staff. Some of the increase in concerns related to organisational change processes. During Quarter 2, there were no new formal Dignity at Work or grievance cases, although three dignity cases and four grievance cases were closed. Themes emerging from the quarter included concerns from neurodivergent staff. The Committee agreed that communication and feedback must remain a priority during this period of change.

Staff story

The Committee received an update on work to improve the experience of Resident Doctors. The story focused on the Resident Doctor voice through lived experience and the implementation of the national 10-Point Plan, a national directive intended to be localised within each organisation to address issues such as rota gaps and payroll processes. The Resident Doctor Forum Chair shared insights from personal experience, noting challenges around transparency in employment processes and payroll. A plan was in place to address these issues.

Summary of the Council of Governors meeting held on 26 November 2025

Reports from Board Assurance Committees

The Council of Governors received updates for the following Board Assurance Committees:

- Quality, Safety and Experience Assurance Committee (September and November 2025)
- People and Education Assurance Committee (November 2025)
- Audit Committee (October 2025)
- Finance and Performance Committee (September and October 2025)

GOSH Strategy and Trust Values

The Council received the refreshed Trust Strategy *“Together We Power Care”*, with implementation work underway ahead of April 2026. The Council noted strong engagement in the launch of the strategy.

An update was given on the programme to refresh Trust values, emphasising the need for cultural alignment with the new strategy. An online engagement session for Governors will be arranged.

Medium – Term Integrated Plan

The Council received an outline of new NHS planning requirements. A three-year numerical plan is due in December 2025, followed by a five-year narrative plan in early 2026. The plan focuses on access, research, digital and patient experience. Further discussion would take place at the Council meeting in February 2026.

Chief Executive Report

The Chief Executive highlighted ongoing focus on the Trust Strategy, anti-racism work and the refreshed values programme. Performance metrics remained broadly positive. Workforce spending remained an area of financial pressure.

Month-7 financial position showed a £6.7m deficit, driven by MARs costs, IPC and drugs spend. Clinical income was on plan.

Update from the Young People’s Forum (YPF)

The YPF had taken part in a beatboxing workshop celebrating the Chapel’s 150th anniversary, development of the Trust strategy particularly the pillar ‘Together we embrace the whole.’ The Council noted that the YPF had participated in the Mental Health Framework launch.

Appointment of Deputy Chair and Senior Independent Director

The Council approved the appointment of Camilla Kingdon as Deputy Chair and Senior Independent Director from 1 December 2025.

NED Recruitment

The Council noted that the recruitment for one Non-Executive Director was ongoing. A stakeholder panel and interviews were scheduled for December 2025. The appointment would be brought to the Council of Governors for approval in due course.

Governance Update

The Council approved the appointment of two Governors to the Council's Nominations and Remuneration Committee. The nomination window for ten Governor seats opened in November 2025 and would close in December 2025.

Governors' activities

Governors participated in a range of activities, including the Trust Annual General Meeting (AGM), a Lunch and Learn session on the Sexual Safety initiative, and the Royal Bank Canada Race for Kids membership recruitment event.