

## Meeting of the Trust Board Thursday 24 October 2024

Dear Members

There will be a public meeting of the Trust Board on Thursday 24 October 2024 at 2:45pm in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.

Company Secretary Direct Line: 020 7813 8330

### AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment	Timing
1.	Apologies for absence	Chair	Verbal	2:45pm
<b>Declarations of Interest</b> 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 11 September 2024	Chair	J	
3.	Matters Arising/ Action Checklist	Chair	K	
4.	Patient Story	Chief Nurse	L	2:55pm
5.	Chief Executive Update	Chief Executive	M	3:10pm
6.	Update on Orthopaedic Service Review	Chief Executive/ Chief Medical Officer	N	3:20pm
7.	Feedback from Non-Executive Director walkrounds	Chair and Non-Executive Directors	Verbal	3:35pm
	<u>PERFORMANCE</u>			
8.	Integrated Quality and Performance Report (Month 5 2024/25) August 2024 data	Chief Medical Officer/ Chief Nurse/ Chief Operating Officer	O	3:45pm
9.	Finance Report (Month 5 2024/25) August 2024 data	Acting Chief Finance Officer	P	4:00pm
	<u>ASSURANCE</u>			
10.	<b>Board Assurance Committee reports</b> <ul style="list-style-type: none"><li>Quality, Safety and Experience Assurance Committee – September 2024</li><li>Audit Committee – October 2024</li><li>Finance and Performance Committee Update – October 2024</li></ul> <i>There has been no meeting of the People Education Assurance Committee since the last Trust Board.</i>	Chair of QSEAC  Chair of the Audit Committee  Chair of the Finance and Performance Committee	Q  Verbal  Verbal	4:10pm

	<b><u>GOVERNANCE</u></b>			
11.	<b>Board Assurance Framework</b>	Company Secretary	<b>S</b>	<b>4:20pm</b>
12.	<b>Any Other Business</b> (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.)			
13.	<b>Next meeting</b> The next public Trust Board meeting will be held on Thursday 5 December 2024.			



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

**DRAFT Minutes of the meeting of Trust Board on  
11 September 2024**

**Present**

Ellen Schroder	Chair
Prof Helen Cross	Non-Executive Director
Gautam Dalal	Non-Executive Director
Amanda Ellingworth	Non-Executive Director
Kathryn Ludlow	Non-Executive Director
Adrian Joseph	Non-Executive Director
Suzanne Ellis	Non-Executive Director
Matthew Shaw	Chief Executive
Caroline Anderson	Director of HR and OD
Tracy Lockett	Chief Nurse
John Beswick	Chief Finance Officer
Prof Sanjiv Sharma	Chief Medical Officer

**In attendance**

Jason Dawson	Interim Director of Estates and Facilities
Cymbeline Moore	Director of Communications
Dr Kiki Syrad	Director of Research and Innovation
Lore Lippmann*	Deputy Chief Finance Officer
Andrew Pearson*	Clinical Audit Manager
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Rose*	Former GOSH patient, member of the YPF, YPF Appointed Governor
Claire Williams*	Head of Patient Experience
Shelby Davies*	Children and Young People's Co-Production Facilitator
Jessie Gungor*	Healthcare Transition Improvement Manager
Helen Dunn*	Director of Infection Prevention and Control
Rachel Millen*	Emergency Planning Officer
Michelle Nightingale*	Assistant Chief Nurse for Safeguarding and Learning Disability
Jacqueline Gordon*	Governor (observer)
Two members of staff	
Four members of the public	

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

<b>75</b>	<b>Apologies for absence</b>
75.1	Apologies for absence were received from Chris Kennedy, Associate Non-Executive Director.
<b>76</b>	<b>Declarations of Interest</b>
76.1	No declarations of interests were received.

<b>77</b>	<b>Minutes of Meeting held on 19 June 2024</b>
77.1	The Board <b>approved</b> the minutes of the previous meeting.
<b>78</b>	<b>Matters Arising/ Action Checklist</b>
78.1	Action 53.5 – It was noted that work to move the google pins to the new hospital main entrance was ongoing.
78.2	Action 55.10 – Ellen Schroder, Chair confirmed that she would be attending a meeting of the Junior Doctors' Forum.
<b>79</b>	<b>Patient Story</b>
79.1	Claire Williams, Head of Patient Experience said that 37% of the Trust's patients were adolescents and their experience at GOSH was receiving focus.
79.2	Rose, former GOSH patient and member of the Young People's Forum said that she had been a patient at the Trust since she was a few hours old and had undergone a kidney transplant in 2021. She had now transitioned to adult services but remained a member of the YPF and was a YPF Governor on the Council of Governors. Rose said that the positives about her time at GOSH included the reassurance she and her family had in feeling that she was receiving the best care and the full trust they had in her team. She had the opportunity to take part in clinical trials and had been supported by the play team. The renal ward had two playrooms including one for adolescent patients which had been helpful.
79.3	Rose said that she had very different experiences of transition to adult services from the two services she was under. As part of her transition for renal services, the process had begun a long time in advance. The team from the adult hospital had attended one of her appointments at GOSH and a GOSH renal nurse had attended an appointment at the adult hospital. The adult hospital employed young adult workers which had also been helpful.
79.4	Appointments with the bowel and urology team had been less frequent and Rose said that although she had been referred to the adult hospital, her appointment had been delayed and therefore she had only recently been discharged from GOSH. She said that if this had been her only experience of transition, she would not have felt well informed or supported.
79.5	The YPF had developed a transition workbook with tips from the YPF and pages to write about the process experienced. The YPF had also produced a seven-episode podcast which would be released in October 2024 and one of the episodes focuses on healthcare transition. Rose said she felt it was important that former patients were able to continue as members of the YPF until a year after they had transitioned to adult services, or until age 21, to collate feedback on these experiences.
79.6	Jessie Gungor, Healthcare Transition Improvement Manager said that currently work was taking place with the YPF to understand the resources that would be helpful from a non-clinical perspective and an adolescent website was being created which would be launched in adolescent week in October 2024. This had been co-designed with young people to support them to take ownership of their healthcare needs. Claire Williams, Head of Patient Experience said that there was work was still required to improve healthcare transition and to ensure that a more consistent approach was taken across

	services.
79.7	Jason Dawson, Interim Director of Estates and Facilities welcomed the role that the YPF had taken on sustainability. He said that the honest feedback received was vital and the Space and Place team was also taking part in Takeover Week. Rose welcomed the opportunity for YPF members to sit on the sustainability working group.
79.8	Tracy Lockett, Chief Nurse said that discussion had taken place at Operations Board about the importance of raising awareness of healthcare transition across all specialties. Ellen Schroder said that it was often challenging to ensure that former patients had a positive experience at their adult hospital and Jessie Gungor said that a project had begun to follow up with adult services to ensure that former GOSH patients had received their first appointment and the timeline for this was variable across organisations. He said that improvements were being made to documentation around healthcare transition in Epic.
79.9	Amanda Ellingworth, Non-Executive Director asked whether Rose had advice for the Board about areas for focus and Rose said that it was important to support young people to have independence in their healthcare and to advocate for themselves. She said that in adult hospitals the experience was very different, and it was important that patients felt able to give feedback when they needed action to be taken such as around prescriptions being available or appointments made at the appropriate time. She added that this was challenging, particularly when a young person was unwell however learning to have independence in the social as well as the clinical aspects of healthcare was vital.
<b>80</b>	<b>Feedback from Non-Executive Director walkrounds</b>
80.1	Ellen Schroder said that she had visited Panther Ward and a good discussion had taken place with the Sight and Sound Directorate leadership team. She said that the ward was a nice environment with substantial space including good space for play with separate adolescent and sensory spaces. The team had reported that the number of beds was currently insufficient for the service and additional nurses were required particularly at night. There had been an increase in staff turnover and work had been taking place to introduce listening events and to limit the administrative burden including by maximising the impact of the Thrive programme and empowering nurses to take this forward.
80.2	The team reported that it had been challenging to maintain morale particularly at times when two wards were merged which led to a 25 bedded area across a number of specialties. Matthew Shaw, Chief Executive said that many services had grown organically over time and work would be taking place over the coming months to identify the space they required and restack parts of the hospital. Panther Ward was currently using bed space in International and Private Care. Tracy Lockett agreed that the mix of specialties on the wards was challenging and some work had been taking place around culture.
80.3	Amanda Ellingworth said that she had visited Bear Ward which was an area in which morale had previously been low and was now improving and the addition of a family liaison nurse had been extremely beneficial. Kathryn Ludlow suggested that this role would be helpful in other areas of the Trust.
80.4	Suzanne Ellis, Non-Executive Director had visited Kangaroo Ward which had closed beds, and a business case was being developed to enable them to be opened. Discussion had taken place around empowering families and working in the community.

	<p>She met a patient who had been at GOSH for four years and could not be discharged as appropriate local authority housing was not available and this had been escalated to NHS England which had illustrated the complexity of the work taking place in the organisation. Discussion had taken place on the walkround around national skills deficits and the work that was underway to develop the required skills internally. Accommodation was essential for staff and patients and was being discussed with the GOSH Charity.</p>
80.5	Gautam Dalal, Non-Executive Director said that staff had been enthusiastic about the improvements that could be made as a result of the Thrive programme and had recommended that it was run regularly to ensure the Epic continued to be used well.
<b>81</b>	<b>Chief Executive Update</b>
81.1	Matthew Shaw said that progress continued to be made with long waits and it was anticipated that by the end of September 2024 there would only one patient waiting 104 weeks and 23 patients waiting 72 weeks.
81.2	In May 2024, Matthew Shaw said that he had spoken at the public Board meeting about the outcome of an external review of the Trust's orthopaedic service and had apologised to patients and families. GOSH had commissioned a review by the Royal College of Surgeons in response to concerns raised by staff and patient and the review had made recommendations, which the Trust had accepted in full. As a result, reviews were taking place of the care of all patients who had been under one surgeon. Matthew Shaw said that GOSH was deeply sorry and regretted the impact on patients and families and said that the Trust was committed to ensuring that the lessons learnt were taken forward. The review of patients was taking place in a risk-based way and conversations had taken place with patients and families with focus being placed on ensuring they were kept informed.
81.3	Initial concerns had been raised locally by staff and once these concerns had been received by the Executive Team the Trust had acted swiftly and had thanked the member of staff who had acted bravely to raise concerns. World Patient Safety Day was taking place on 17 September 2024 and Matthew Shaw reiterated that safety was GOSH's core purpose and confirmed that the Trust would continue to strive for high standards of quality and safety as the review process continued.
81.4	<b>Action:</b> Ellen Schroder asked for an update on the support that had been offered to staff during the recent riots and Matthew Shaw said that good feedback had been received about the strong message sent by the Trust. He said that feedback was that staff had felt supported. It was agreed that the Board's thanks would be sent to the security team who had played a key role in supporting staff during that time.
<b>82</b>	<b>Integrated Quality and Performance Report (Month 4 2023/24) July 2024 data</b>
82.1	Tracy Lockett said that positive feedback continued to be received for both inpatient and outpatient services as part of the Friends and Family Test. Over the reporting period there had been a small decrease in the number of complaints received when compared to the previous month and there had been no themes identified or areas of triangulation between incidents, complaints and staff wellbeing.
82.2	There had been an increase in PALS contacts many of which had been queries around appointments and cancellations.

82.3	Sanjiv Sharma, Chief Medical Officer said that there was a high number of open incidents and focused work was taking place across August and September 2024 to reduce this. Work was also taking place with Directorates to ensure that actions arising from the review of incidents were implemented and evidence of their implementation was available. An update on this work would be provided to the QSEAC.
82.4	The performance and patient safety teams were developing a refreshed set of metrics to be presented to the Board which would aim to provide better oversight of patient safety and identify challenged areas.
82.5	Matthew Shaw said that work had taken place to reduce bed closures, and this had been impactful. Focus was also being placed on communications such as discharge summaries and clinic letter turnaround time.
82.6	Discussion took place around waiting times and Matthew Shaw said that some services at GOSH had national challenges and the Trust was working with other centres to ensure that patients could be seen as quickly as possible. Average waiting times were reducing; however the waiting list as a whole had grown by 11% and Matthew Shaw said that it was important to understand this growth in the context of a declining birth rate. The Board emphasised the importance of expanding capacity within the existing resources.
82.7	Kathryn Ludlow said that staff on walkrounds had given feedback about the increase in patients' complexity and asked whether this trend was likely to continue. Matthew Shaw said that there had been an increase in patients with myocarditis which could lead to heart failure and meant that patients required ventricular assist devices. Patients were living longer with conditions which previously would have ended their life and Matthew Shaw said that there was a balance to be struck between preserving life, quality of life and the changes to infrastructure which were required to enable organisations to continue with this work. Sanjiv Sharma said that GOSH was not unique in this respect and added that the deteriorating patient group was working well to keep patients safe alongside the transformation project which was ongoing to transform the provision of high dependency care.
82.8	Suzanne Ellis highlighted that emergency entry levels were lower than planned and asked for a steer on the causes of this. Matthew Shaw said that GOSH was increasingly able to assess patients and admit them electively and Sanjiv Sharma added that this was also dependent on where patients were admitted from.
82.9	Gautam Dalal asked about diagnostic waiting times and Matthew Shaw said it was anticipated that there would be a downturn in performance in this regard over the coming months as a result of a change to the way that waiting lists were calculated. Plans were in place to reduce waits however it would take time to bring waiting times down. Nationally there was a shortage of radiographers.
<b>83</b>	<b>Finance Report (Month 4 2023/24) July 2024 data</b>
83.1	Lore Lippmann, Deputy Chief Finance Officer said that the month 4 position was £4million deficit year to date which was a variance of £1.5million below plan. Clinical income was favourable to plan however international and private care was behind plan but improving. Pay was on plan which was positive, however adverse performance was driven by non pay as a result of Better Value performance being behind plan.
83.2	The cash position was improved at £64million and the Trust was ahead of plan on capital spend which was positive.

83.3	Gautam Dalal highlighted that as at month six the Trust had identified Better Value schemes of £15million against a target of £22million. He asked about the level of risk associated with the unidentified £7million and the level of confidence that the identified schemes would be delivered. Lore Lippman said that target was comprised of both cost reduction and contribution from International and Private Care (I&PC) and I&PC income was increasing which would support the Better Value position. Focus was being placed on cross Trust schemes particularly around procurement and a number of possible schemes would be worked up in the coming weeks. Lore Lippmann said that excellent work took place in transformation, and it was important to ensure that the Better Value impact of these programmes, which were likely to be multiyear, was captured. Matthew Shaw said that it was important to improve the Trust's maturity around better value and added that it was imperative that GOSH achieved a breakeven position for 2024/25.
<b>84</b>	<b>Learning from Deaths report- Child Death Review Meetings – Q4 2023/24</b>
84.1	Andrew Pearson, Clinical Audit Manager said that whilst quarterly reports were provided to the Board as required the short timeframe made it challenging to identify themes. Therefore, work had taken place to review the outcomes of Child Death Review Meetings from October 2021 to March 2024 which had provided a good insight into the areas where the Trust worked well such as providing excellent holistic care to patients and families and good cross specialty working. Areas for improvement included challenges around communicating with patients' local teams including GPs. There were also challenges around the When a Child Dies process, particularly around the certification of death.
84.2	Reports to the Board had identified challenges around progress with completing Child Death Review Meetings within 12 weeks of death as required. There had been an increase in resource in the team in April and there was now greater capacity to support the Mortality Review Group which fed into the process and there were early signals that the number of overdue Child Death Review Meetings was reducing.
84.3	Andrew Pearson said that the clinical teams in PICU and NICU had noted in real time that there had been an increase in risk adjusted mortality. As a result, a consultant had scrutinised each death in PICU over an extended period and this review had concluded in advance of the Trust being notified of the change by PICANET. This work had highlighted that for some PICU deaths the score used as an indicator of predicted mortality was not an accurate predictor of death as a likely outcome. This was likely to be as a result of GOSH's patients' likelihood of considerable comorbidities which were not necessarily reflected in the scoring methodology. In order to provide additional assurance a review of any signals from the Mortality Review Group of PICU and NICU deaths in February – April 2024 would be taking place in October 2024.
84.4	Sanjiv Sharma said that Child Death Review Meetings required the involvement of all professionals involved in a patient's care which was challenging for GOSH as patients were often complex and were referred to the Trust from throughout England and Wales. Ellen Schroder asked whether the process was independent, and Sanjiv Sharma said that the Trust worked with UCLH to provide paediatric expertise and their Medical Examiner reviewed GOSH's cases prior to coronial referrals. The Coroner was satisfied with this process.
84.5	Tracy Lockett highlighted the theme of communication which had been identified as an area for improvement and said that investment that the Trust had made for family liaison nurses would improve communication with families. Andrew Pearson said that the report also focused on communication between organisations when a patient's

	status was changing, often rapidly, and it was important to prioritise this work.
84.6	Suzanne Ellis welcomed the additional resource that had been provided in this area and highlighted that there was a theme around embedding the work of palliative care. She asked how these types of complex recommendations were being taken forward. Sanjiv Sharma said that the QSEAC had received a good presentation from Palliative Care which was about ensuring that the Trust was able to support teams throughout the hospital to involve Palliative Care. The team had made some good consultant appointments recently which would support them to increase their work in the hospital and to highlight that their work was not solely focused on end-of-life care.
84.7	Adrian Joseph, Non-Executive Director asked if there was any impact around socioeconomic background or English as an additional language and Andrew Pearson said that GOSH's data fed into a national report the last annual report of which highlighted challenges in particular populations and the impact of deprivation on mortality. Tracy Lockett said that the Trust was looking at access and outcomes in terms of health inequalities.
<b>85</b>	<b>Annual Reports 2023/24</b>
85.1	<u>Annual Director of Infection and Prevention Control Report 2023/24</u>
85.2	Helen Dunn, Director of Infection Prevention and Control said that the team had launched in-house microbiological plating team which had significantly reduced the time required to verify specialist ventilation and reduced the number of closed bed days. The team had spent time embedding the Patient Safety Incident Response Framework (PSIRF) which had supported an increase in responsiveness and a focus on learning.
85.3	A clinical sepsis training package would be launched later in the year and an in-house surgical site surveillance system had been built which would go live shortly. The team continued to work alongside colleagues in Space and Place to ensure that the information received was timely and that routine maintenance was carried out in a timely manner.
85.4	Blood stream infections had increased in line with the national position and work was taking place to identify the cause. The team was identifying many patients who were colonised with infections and good work was taking place with the Quality Improvement Team to improve levels of stool screening. The Central Venous Line infection rate was slightly above target but had decreased substantially since the COVID19 pandemic. Good work was taking place around Infection Prevention and Control audits. Good observations were taking place around hand hygiene and the results were stable.
84.5	No outbreaks of healthcare associated infections (HCAI) had been reported in year and the team recognised the importance of screening. The previous annual report had shown a number of outbreaks of Carbapenemase Producing Enterobacteriaceae, particularly in International and Private Care and therefore a screening programme had been launched which had successfully prevented outbreaks. As a result, a screening programme for Candida had also been introduced.
84.6	Kathryn Ludlow welcomed the report and the achievements in year. She asked whether there were areas of concern where more resource was required, and Helen Dunn said that action plans were in place for areas which required additional focus and improvement continued to be made on maintenance of the estate. Further work was required on the planned verification of Positive Pressure Ventilation Lobby rooms (PPVL) however good progress had already been made.

84.7	Tracy Lockett thanked the team for their work throughout the year.
84.8	<u>Safeguarding Annual Report 2023/24</u>
84.9	Michelle Nightingale, Assistant Chief Nurse for Safeguarding and Learning Disability said that the annual report had been presented to QSEAC at its July 2024 meeting and gave an overview of national issues that families were experiencing that were also present at GOSH. Data collection was a key focus to ensure that data was being captured around patients who were not brought to appointments and that flags were noted as required. Work was taking place around geo mapping to understand where patients were from and their potential health inequalities in order to help the Trusts meet their needs.
84.10	Tracy Lockett said that the safeguarding, social work, learning disability and healthcare transition teams had been merged which enabled better data collection about referrals in the hospital both in terms of the teams who were submitting them, and the types of referrals being received to enable the team to focus on gaps.
84.11	There were five areas in which the Trust was commissioned to provide services to patients over the age of 18 and these patients required additional support. A Named Professional for adults was in the process of being appointed who would focus on parity of esteem, learning disability and PREVENT. Sanjiv Sharma said that the previous NHS 10-year plan had referenced paediatric services seeing patients up to age 25 as had the Cass Review and it was likely that GOSH would see increasing numbers of adult patients.
84.12	<u>Business Continuity Annual Report 2023/24</u>
84.13	Rachel Millen, Emergency Planning Officer said that the Trust had submitted its self-assessment against the core standards on 6 September 2024 and was pursuing full compliance in line with the previous year. The deep dives for 2024/25 would focus on cyber security which would ensure that ICT was part of the wider Emergency Planning Group's work programme for 2025.
84.14	In 2023/24 a lock down exercise had taken place in which the security team tested their ability to lock down every building in the hospital. Lock down processes were also tested on the new hospital main entrance for the first time.
84.15	The Board welcomed the Trust's compliance with the core standards which was challenging to achieve, and Matthew Shaw said that excellent progress had been made in recent years in order to become compliant. Consideration was being given to developing more challenging testing and the Board welcomed this additional challenge. Suzanne Ellis said the Finance and Investment Committee had discussed the potential for a geopolitical event to impact one of GOSH's major income streams and the subsequent effect that this would have on the support the Trust could provide to the wider NHS.
<b>85</b>	<b>Nursing Workforce Report Quarter 1 2024/25</b>
85.1	Tracy Lockett said that the Trust continued to recruit nurses, the majority of whom were newly qualified and there had been an increase in the proportion of nurses who carried out part of their training at GOSH going on to apply for roles. Focus was being placed on recruitment of more experienced nurses and a plan was in place to do this domestically. Work was also taking place to recruit international nurses and the retention of previous cohorts had been excellent.

85.2	Tracy Lockett said that it was vital to reduce nursing turnover and although this had been achieved in year, there had been a subsequent increase. Retention initiatives had begun in 2023 and included 'Stay' conversations and reporting metrics as well as work that would be taking place with the People Promise Manager. Cost of living was a key cause of nurses leaving the organisation and discussions were taking place with GOSH Charity around accommodation. The People Promise Manager had been discussing nurse's priorities and they reported that working flexibly and work/life balance were key concerns.
85.3	Tracy Lockett said that work was taking place around ensuring that nurses had a voice in the organisation and Adrian Joseph asked how this progress would be measured. Caroline Anderson said that the annual staff survey would show progress and the Trust also issued a quarterly pulse survey.
85.4	<b>Action:</b> It was agreed that Adrian Joseph would be provided with the Nursing Strategy.
<b>86</b>	<b>Board Assurance Committee reports:</b>
86.1	<u>Quality, Safety and Experience Assurance Committee – July 2024 and September 2024</u>
86.2	Amanda Ellingworth, Chair of the QSEAC said that much of the QSEAC agenda had already been discussed by the Board. The Parliamentary Health Service Ombudsman (PHSO) had been reviewing the care of a patient who had sadly died at GOSH in 2012. She said that the committee had been clear about the importance of transparency and of learning from the outcome of the review.
86.3	The September QSEAC meeting had taken place in the week prior to Board and discussion had taken place about the early warning signals around PICU mortality and the Thrive programme which aimed to increase the benefits the Trust gained from the use of Epic.
86.4	<u>Audit Committee June 2024 including approval of revised Audit Committee Terms of Reference</u>
86.5	Gautam Dalal, Chair of the Audit Committee said that the June 2024 meeting had been focused on annual reporting. The audit of the accounts was now complete however there had been a small delay to the completion of the auditors' work and learning had been identified from this. An unqualified audit opinion had been received. A key area of judgement was around provisioning for international and private care debt and a clear methodology was in place which had been approved by the Committee. Discussion took place annually with the auditors on the prudence of the policy however the Audit Committee remained satisfied with the approach taken.
86.6	A presentation had been received on Epic benefits realisation. GOSH had been an early adopter of the electronic patient record and organisations had since changed the way that benefits were identified in business cases. The committee had highlighted the importance of identifying the softer benefits such as the change in the use of clinicians' time and improvements in patient and family experience.
86.7	Jason Dawson, Interim Director of Space and Place said that GOSH had received a planned, routine asbestos inspection by the Health and Safety Executive in May 2024. Recommendations had been made as a result of the inspection and the HSE had confirmed that they were satisfied with the action the Trust was taking.

86.8	The Board considered and <b>approved</b> the revised Audit Committee Terms of Reference.
86.9	<u>Finance and Investment Committee Update – August 2024 including approval of Finance and Performance Committee Terms of Reference</u>
86.10	Suzanne Ellis, Chair of the Finance and Investment Committee said that the most recent meeting of the committee had discussed the refresh of the Committee's Terms of Reference (ToRs) in order to increase the focus on performance which included a change to the Committee's name to the Finance and Performance Committee. The Committee had recommended the revised ToRs to the Board for approval and the Board <b>approved</b> the terms of reference for the Finance and Performance Committee.
86.11	The meeting had discussed income and debt levels and their impact on cash. Costs associated with the Children's Cancer Centre development were also reviewed as well as activity levels and waiting times. Suzanne Ellis said that the committee was focused on reviewing financials from a patient safety perspective and ensuring that performance was sustainable.
86.12	<u>People and Education Assurance Committee Update – July 2024</u>
86.13	Kathryn Ludlow, Chair of the PEAC said that the committee had received a report from the GOSH Learning Academy which continued to perform well but faced challenges around increasing income, space and facilities. A brief update had been received on progress to implement the People Strategy and Kathryn Ludlow said that culture was a large part of this work; a Board Development Session focused on culture would be taking place in September 2024. Discussion had also taken place on the potential changes to employment law under the new Government.
86.14	An inspiring staff story had been received from a member of the domestic team who enjoyed her job and had provided valuable feedback. Discussion had taken place about workforce sustainability noting that a prescribed methodology was in place for monitoring the nursing workforce but not in other professions. Amanda Ellingworth welcomed the staff story that had been received but said that it was important to also receive challenging stories from staff who had had difficult experiences at GOSH and where improvements could be made in the way that patient stories were received at Trust Board.
86.15	Adrian Joseph welcomed that colleagues involved in the staff networks had protected time to undertake this work and said that it was important that their activity in this area was reflected in their appraisals. Caroline Anderson, Director of HR and OD said that discussions took place with individuals' line managers to ensure that they were supported to be released from their substantive roles to undertake their work with the networks.
<b>87</b>	<b>Update from the Council of Governors</b>
87.1	Anna Ferrant, Company Secretary said that the Council of Governors met on 4 July 2024 and received an update on the timeline for the refresh of the Trust's Strategy. An update on the People Planet was also received and Governors had been keen to hear about the Staff Survey results. An update on operational performance during the time that the Chief Executive had been Acting Chief Operating Officer was also received and the Council had been keen to understand the activity that was taking place to reduce cancellations and improve waiting times. Ellen Schroder welcomed the engagement from Governors.

<b>88</b>	<b>GOSH Annual Report 2023/24</b>
88.1	Anna Ferrant presented the designed version of the Annual Report which had been uploaded to the GOSH website and laid before parliament. The Annual General Meeting and Annual Members' Meeting would be held on 25 September 2024.
<b>89</b>	<b>Any other business</b>
89.1	There were no other items of business.

**TRUST BOARD – PUBLIC ACTION CHECKLIST**  
**September 2024**

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
108.15	30/11/23	Gautam Dalal requested a cascade diagram to depict the cumulative progress that would be made as a result of the transformation programme.	Jennifer McCole	December 2024	Not yet due: This will be provided alongside an update on Transformation.
31.4	09/05/24	GOSH Green Plan: Ellen Schroder asked that costings were applied to the plan and Suzanne Ellis confirmed that it would be coming to the Finance and Investment Committee.	JD	December 2024	Passed to the Finance and Performance Committee for December 2024
51.3	19/06/24	Quality Report: Ellen Schroder said that it was important to ensure the report was as engaging as possible to encourage readership and asked whether it should be summarised to support this. Sanjiv Sharma said that the report helped the Trust to share successes arising from the quality improvement programme and added that a monthly summary from the quality team was uploaded to the intranet. Ellen Schroder said that NHS Impact required that all Trusts had well documented and understood quality improvement programme and added that it would be important that the Board was clear about this. Sanjiv Sharma said that a deep dive had taken place at QSEAC, and it was agreed that it would also take place at a future Board Development Session.	SS	December 2024	Not yet due: To be scheduled before end 2024 at a Board Development session.
81.4	11/09/24	Ellen Schroder asked for an update on the support that had been offered to staff during the recent riots and Matthew Shaw said that good feedback had been received about the strong message sent by the Trust. He said that the cost had been minimal and had led to staff feeling supported. It was agreed that the Board's thanks would be sent to the security team who had played a key role in supporting staff during that time.	ES/JD	October 2024	In progress
85.4	11/09/24	It was agreed that Adrian Joseph would be provided with the Nursing Strategy.	TL	October 2024	In progress

**Trust Board**  
24 October 2024**Patient Story: Experiences of communication and being heard at GOSH**

**Submitted by** Tracy Lockett, Chief Nurse  
**Prepared by** Claire Williams, Head of Patient Experience

**Paper No: Attachment L**☐ **For information and noting****Purpose of report**

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

**Summary of report**

Aisha, aged 16, was referred to GOSH when she was four years old following a diagnosis of Crohn's (a form of inflammatory bowel disease). She has been under the care of several specialties at GOSH and attends the hospital regularly. Aisha is an advocate for raising awareness for invisible disabilities and passionate about the importance of building resilience and self-confidence and making a difference.

Aisha will attend Trust Board in person to share her experiences of communication at GOSH, making sure she is heard and how this is essential preparation for transition to adult care.

Aisha has just been elected Chair of the Young People's Forum and will also speak about how her role will support the voice of children and young people across GOSH.

**Patient Safety Implications**

None

**Equality impact implications**

None

**Financial implications**

N/a

**Strategic Risk**

BAF Risk 12: Inconsistent delivery of safe care

**Action required from the meeting**

N/a

**Consultation carried out with individuals/ groups/ committees**

N/a

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

Head of Patient Experience

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

Chief Nurse

Trust Board 24 October 2024	
<b>Chief Executive's Report</b>  <b>Submitted by: Matthew Shaw, Chief Executive</b>	<b>Paper No: Attachment M</b>  <b>For information and noting</b>
<b>Purpose of report</b> Update on key operational and strategic issues.	
<b>Summary of report</b> An overview of key developments relating to our most pressing strategic and operational challenges, namely: <ul style="list-style-type: none"> <li>• Supporting our people</li> <li>• Developing and transforming our services</li> <li>• Expediting activity and access to care for children's and young people &amp; working with system partners</li> <li>• Financial sustainability and advocating for a fair settlement for children and young people with complex health needs</li> </ul>	
<b>Patient Safety Implications</b> <ul style="list-style-type: none"> <li>• No direct implications (relating to this update in isolation).</li> </ul>	
<b>Equality impact implications</b> <ul style="list-style-type: none"> <li>• No direct implications (relating to this update in isolation).</li> </ul>	
<b>Financial implications</b> <ul style="list-style-type: none"> <li>• No direct implications (relating to this update in isolation).</li> </ul>	
<b>Strategic Risk</b> BAF risk 14: Culture	
<b>Action required from the meeting</b> <ul style="list-style-type: none"> <li>• None – for noting</li> </ul>	
<b>Consultation carried out with individuals/ groups/ committees</b> Not Applicable	
<b>Who is responsible for implementing the proposals / project and anticipated timescales?</b> Executive team	
<b>Who is accountable for the implementation of the proposal / project?</b> CEO	

### Supporting and celebrating our staff

Many of us spent an uplifting evening on 10<sup>th</sup> October at the 2024 Staff Awards. This was a wonderful event that offered a snapshot of the achievements from some of the amazing individuals and teams working here at GOSH.

This year, 74 teams and 317 individuals were nominated for an award. Through a series of videos, the nominators really brought to life why the shortlisted individuals and teams were exceptional.

The winners across the 11 categories were:

- Volunteer of the Year Award - **Toby Hancock**
- Patient Safety Team Award - **The Cardiac Transition Team**
- Commitment to Learning Award - **Yamini Suyal**
- Patient and Family Award - **Ashley Reid**
- Making GOSH an Inclusive Place to Work Award - **Shiuli Ali**
- Research Team of the Year - **The Haematology / Oncology Research Delivery Team**
- Green Champion Award - **Rachel Naunton and James Kiely**
- Contribution to making GOSH a kind place to work award - **Wendy Doyle**
- Leader of the Year - **Louisa Hill**
- GOSH Exceptional Members of Staff (GEMS) Individual winner award - **Anastasia Rousou**
- GOSH Exceptional Members of Staff (GEMS) Team winner award - **Eagle Ward**

We are incredibly grateful to the GOSH Charity for their support to organise and contribute to the costs of event. And of course, to our HR and Comms teams who have worked tirelessly behind the scenes to make it all happen.

### Mission GOSH: A week of activities to celebrate and develop our Trust strategy

From 8<sup>th</sup> – 11<sup>th</sup> September 2024 we hosted the #MissionGOSH open week in the staff side of the Lagoon, with stands and the ever-popular coffee cart, celebrating our progress to deliver the Above and Beyond strategy and sparking important discussions about where GOSH should go next.

Teams including those from Research and Innovation, the GOSH Learning Academy, Transformation, The Children's Cancer Centre and Nursing and Allied Health Professionals were on hand to share their latest developments and speak to staff about what they think is important about the next iteration of our strategy. The event was able to reach hundreds of staff and more than 350 people responded to the #MissionGOSH survey.

There was also an impressive array of activities on display in the Lagoon for Adolescent Health Week, arranged in partnership with our Young People's Forum and Adolescent and Health Inequalities teams. Patients, families, and staff took part in art workshops, virtual reality activities, had a visit from Camden Police and were able to join information sessions on topics from digital health inequalities to mental and sexual health support.

It was a wonderful opportunity to celebrate what our teams have achieved and start important conversations about the role we all play in shaping the Future of GOSH. We look forward to hearing an analysis of the feedback from the strategy team.

**End**

Trust Board 24 <sup>th</sup> October 2024	
<b>Orthopaedic Service Review Update and Report Sharing.</b>  <b>Submitted by:</b> Sanjiv Sharma, Chief Medical Officer and Nikki Fountain, Business Manager to the CMO	<b>Paper No: Attachment N</b>  <input type="checkbox"/> <b>For information and noting</b>
<b>Purpose of report</b> This report provides an overview of the Orthopaedic Service Improvement Programme and supports the release of a redacted version of the report from the Royal College of Surgeons of England (RCS) into our paediatric orthopaedics/the lower limb lengthening and reconstruction/Ilizarov service.	
<b>Summary of report</b> The Trust apologises to those families who are impacted by the review, and who were under the care of a Lower Limb Orthopaedic Surgeon. This is not what our patients or families should expect from Great Ormond Street, and we apologise for the distress this has caused.  Following receipt of the report from the RCS, the Trust expanded the scope of the recall programme to include all patients seen by the specific surgeon, this number now stands at 723 and does not include patients who were the under the care of the other Surgeons within the service. Progress has been made with the recall of the patients, with 61 patients having had their care reviewed by external and independent experts.  An overarching action plan is in place to address the recommendations from the RCS' report, and these are overseen by a comprehensive improvement programme overseen by the Chief Medical Officer. Progress has been made against these actions, with a focus on supporting those staff working within the service recognising the impact the findings within, and subsequent sharing of, the report has had on them.	
<b>Patient Safety Implications</b> The theme of patient safety runs throughout the update and the redacted report.	
<b>Equality impact implications</b> None	
<b>Financial implications</b> There are no potential financial implications from the paper specifically, however the Trust will be in a position to understand the financial implications once the Trust is further along with the review.	
<b>Strategic Risk</b> This paper links to the Inconsistent Delivery of Safe Care risk, which is number twelve on the Board Assurance Framework.	
<b>Action required from the meeting</b> The Trust Board are asked to note the progress update.	

## Attachment N

<b>Consultation carried out with individuals/ groups/ committees</b> This update has been discussed with the Executive Management Team.
<b>Who is responsible for implementing the proposals / project and anticipated timescales?</b> Sanjiv Sharma, Chief Medical Officer
<b>Who is accountable for the implementation of the proposal / project?</b> Mat Shaw, Chief Executive

# Orthopaedic Service Review Update and Report Publication

## Introduction:

We wish to say we are deeply sorry to all the families impacted by the review of care given by a Lower Limb Orthopaedic Surgeon. We are also sorry to families who have been impacted by the findings of the wider review into the service. This is not what they should expect from any service at our hospital, and we apologise for any distress that the review, and subsequent media scrutiny has caused.

The Trust asked the Royal College of Surgeons (RCS) to review the Paediatric Orthopaedic service at GOSH, after concerns were raised by patient, families and staff. As a highly specialist Trust it is vital that we work closely with organisations such as the RCS. The RCS were able to provide an expert, and importantly, impartial view of the service and it is vital that Trusts undertake these kinds of reviews to ensure a culture of continuous improvement.

The Trust's priority after receiving the report into the service by the RCS was to work through their recommendations. One of these was to review specific cohorts of patients who were under the care of one Consultant Orthopaedic Surgeon. This included those patients who previously had lengthening nails to ensure they had been removed, those who were waiting for nails or plates, those who had received an amputation, and those who have reached adult age to review transition arrangements. In response to this recommendation, and due to the concerns raised by the RCS, the Trust expanded the scope of the review to include all patients who were under the care of the Surgeon. This number now stands at 723 patients.

The reviews of each patient will be carried out by an external reviewer and we have engaged with several experts from the United Kingdom and have approached those working internationally to support this review. Importantly, the RCS did not recommend a review of the care provided by the other surgeons in the department.

A small number of individual patients had their clinical records reviewed by the RCS as part of their review. Where concerns were raised by the RCS and harm was found, we have contacted those families, and they were then the first to have their care reviewed by our independent experts. Where the RCS did not find harm, our independent experts will also review their care and we will contact them when this has been completed.

The Trust developed an overarching action plan to address the other recommendations contained within the report. Further to this, the Trust provides progress updates to the RCS, our Commissioners at both NHS England Specialised Commissioning and North Central London Integrated Care Board, and to the Care Quality Commission at regular intervals. These are also presented to the Trust's Quality, Safety and Experience Assurance Committee and to the Trust Board.

## Progress to Date:

As of 18 October 2024, 61 patients have been reviewed, with a focus on those patients who were deemed as a higher clinical priority following an initial assessment. This means the Trust is reviewing those patients who are in a higher clinical priority first, and therefore could potentially have disproportionately higher levels of harm identified.

Of note, we are aware that some of our patients have been treated at other centres by the Surgeon, and the Trust has established a working group with those providers to share information safety. Whilst

## Attachment N

a complex piece of work, this will enable the Trust to complete a comprehensive review of those patients involved, which will inform the reviews being completed.

From those reviews completed to date, no patient has required any additional surgical intervention. For those patients who have come to harm, and who have wanted to, the Trust has discussed the findings directly with those patients and/or families and have provided copies of the review notes as per their preferences.

In response to the RCS review, the Trust has established an overarching improvement programme which is led by the Chief Medical Officer and supported by the wider Executive Management Team, as part of this a weekly programme board meets to provide oversight of progress on both the patient recall and the action plan, and has NHS England Specialised Commissioning (London Region) as members as the Trust's direct Commissioners.

The action plan developed incorporates all the recommendations resulting from the RCS review, is themed against the seven pillars of clinical governance and brings in external guidance to support where required. The key areas of focus have been around the governance arrangements for the programme, and in sharing the findings and recommendations with staff involved in the service, the Trust Board, Regulators and Commissioners and in creating the improvement programme. To ensure that a robust programme is in place, as part of the Trust's internal audit plan the programme's governance will be audited by the internal auditors and a formal, independent, report will be presented to the Trust's Audit Committee in quarter four of 2024/25.

The recall of those patients under the care of the Orthopaedic Surgeon is underway, and the Trust has sought additional resources to support this review process. This is a highly specialised area of orthopaedic surgery and therefore there are not large numbers of experts available in the United Kingdom who can support this and as a result the Trust has contacted experts internationally to provide additional capacity to the review. We are grateful to those experts who are supporting these reviews as the Trust recognises this is being done in addition to their own clinical practice.

Recruitment is underway for an additional Surgeon to join the department, and additional capacity has been sourced from Consultants from other specialist Paediatric centres supporting existing patient pathways. The Trust recognises the impact the findings from the RCS review, the publication of the report and the level of distress from patients and their families has had on the team, which has been further exacerbated by events over the last four weeks. Therefore, the remainder of the actions taken to date have focused on supporting the Orthopaedic Service team. Listening events have taken place with those directly within the Service, and those with whom the service works alongside to ensure that everyone is able to contribute the development of the action plan, and so that everyone has been able to have a voice; this includes those working in theatres and Junior Doctors for example.

### Report Sharing:

The Trust wrote to those families who are part of the review in February 2024 and have been providing updates on a regular basis. Once a patient's care has been reviewed, the expert's report is shared in full with the family and any recommended actions are discussed along with next steps.

The Trust carefully considered when and how to share the information in the RCS report with families, recognising the contents of the report would be worrying for patients, families, and staff within the service, but also on those within other areas of the Trust.

The Trust intended to share an update at the Trust Board meeting in public in December 2024 once progress had been made in the review of those patients directly affected and addressing the recommendations. This would allow the Trust to provide a greater level of assurance to those who are part of the review and to provide answers to their questions where possible, prior to the contents of

## Attachment N

the report being shared in the public domain. We are sorry that our patients, their families, and our staff may have read elements of the report in the media before we shared the information directly.

Earlier this month, the Trust wrote to all those patients and families who are part of the review, to ascertain if and how they wanted to receive a copy of the RCS report and have shared the report with those families who have requested to receive it. We wanted to be as open and transparent as possible, while accommodating a range of families' needs and understood that some did not want to receive the report and have respected their wishes.

### Format of the report:

Our staff were open and honest with the RCS team, which led to them being able to produce a robust and comprehensive report. In considering the publication of the report, the Trust was mindful that there is a duty to protect the personal data of our staff. GOSH's orthopaedic department is small, so the personal data included names and roles where individuals could be identified.

Further to this, the report does not contain an executive summary and is not written in a way which was intended for wider publication. It is written for a medical audience and not in a way that the Trust would usually communicate with patients and families. With that in mind, the Trust considered whether it would be appropriate to provide our own summary of the report and concluded that it would not be possible to provide a summary which was wholly reflective of the report itself.

The Trust's aim was to be transparent and open, leaving as much original text as possible, whilst maintaining the privacy of individuals and complying with the law in respect of the personal data of individuals. The Trust has therefore released a redacted version (where the text is blacked out) of the report, as feel there is a public interest in this information being made available.

It is redacted because the Trust is legally obliged to remove any information from the report that identifies individuals or shares personal data. Where it has been possible, a factual narrative of what the redacted section contains has been included. The redactions have been applied only where individuals are identifiable; the Trust has not sought to minimise any of the conclusions drawn. Where information is redacted but no narrative is included, this is information that is about an individual or individuals, where it was not possible to summarise or provide a factual narrative without revealing information that could identify a specific person or persons.

### Next Steps:

The Trust will be providing an update on the numbers of patients reviewed on a quarterly basis, but will not be providing updates on the level of harm until the recall process has been completed in its entirety. This is because the Trust understands the level of distress this may cause for those patients and families who have yet to have their care reviewed and do not want to further compound their distress.

The Trust intends to invite the RCS back in 2025 to complete a follow up review of the Orthopaedic Service, and to provide assurance to our patients and families, the Trust Board, Regulators and Commissioners that the Trust has suitably addressed the recommendations.

**Dr Sanjiv Sharma,**

**Chief Medical Officer and Deputy Chief Executive**

**October 2024**

# Invited Service Review Report



Royal College  
of Surgeons  
of England  
ADVANCING SURGICAL CARE

## Report on the paediatric orthopaedics/the lower limb lengthening and reconstruction/Ilizarov service on behalf of

## Great Ormond Street Hospital for Children NHS Foundation Trust

Review visit carried out on: 22-24 February 2023<sup>1</sup>

Report issued: 31 October 2023

### A service review on behalf of:

The Royal College of Surgeons of England

The British Orthopaedic Association

### Review team:

The names of the members of the review team have been redacted as this is personal data and this information is not currently in the public domain.

**PRIVATE AND CONFIDENTIAL**

<sup>1</sup> Supplementary interviews took place remotely using video-conferencing facilities on 11 April 2023, 26 April 2023 and 31 May 2023

**The Royal College of Surgeons of England**

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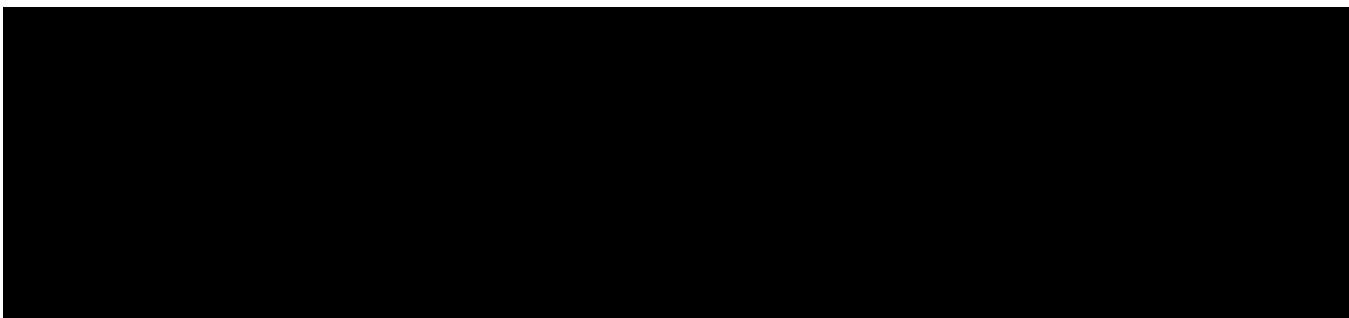
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Appendix F & G set out conclusions and recommendations for the practice of individuals. This information is the personal data of those individuals.

Appendix G – [REDACTED]



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# 1. Introduction and background

On 28 September 2022 Dr Sanjiv Sharma, Chief Medical Officer for Great Ormond Street Hospital for Children NHS Foundation Trust ('the Trust'), wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of paediatric orthopaedic services. A specific focus of the review was the lower limb lengthening and reconstruction/Ilizarov (LLLRI) surgical service, part of the Body, Bones and Mind Directorate, which includes the spinal and orthopaedic department of Great Ormond Street Hospital ('GOSH'). The Trust asked that this review focused on orthopaedics, and not the spinal aspects of the department.

Within the orthopaedic department there were two consultant paediatric orthopaedic surgeons who conduct lower limb lengthening and reconstruction procedures using circular<sup>2</sup> frames. [REDACTED]

[REDACTED] This section sets out that concerns were raised which related to clinical decision making [REDACTED] and surgical complications within the department. [REDACTED]

[REDACTED] It was unclear whether these concerns were shared by other members of the orthopaedic department, as no cases had been declared as serious untoward incidents following discussion at departmental mortality and morbidity (M&M) meetings. [REDACTED]

[REDACTED] This section sets out that a number of clinical cases would be voluntarily submitted for external [REDACTED] review. [REDACTED]

Within the invited review request, the Trust indicated that certain supervision arrangements were in place for surgeons within the orthopaedic department which needed to be assessed for adequacy. It was highlighted that the Trust wished for a review of whether individual practices or wider systematic processes had contributed to isolation and wider team working issues developing between the surgeons within the department. The Trust requested a review of the culture of the department, governance structures and leadership, current service delivery and areas for future service improvement, particularly given the complex nature of the work involved in the LLLRI service.

Furthermore, it was raised by the Trust that there had been instances of certain behaviours being displayed by individuals in theatre, and therefore they wished for consideration to be given to team working, collaboration and inclusivity amongst colleagues, including staff of different disciplines, as well as the wider operation and effectiveness of the multi-disciplinary team (MDT). The Trust highlighted consideration be given to the robustness of morbidity and mortality (M&M), MDT and other governance processes, including suggestions for ensuring accurate record keeping and learning being disseminated to the wider team appropriately. The Trust also sought advice on improving the quality of care offered more broadly, to ensure that the service is fit for the future.

As part of the invited service review, the Trust requested consideration of the following within the LLLRI service and wider orthopaedic department:

- The quality and safety of surgical care;
- Behaviours, communication, collaboration and team working;
- The operation and effectiveness of MDT working;
- Theatre safety practices;
- Current service delivery; and
- Clinical governance practices and processes.

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<sup>2</sup> Circular frame surgery is an orthopaedic external fixation procedure performed to reconstruct, reshape or lengthen bones, especially the limb bones. This surgery was first developed by the Russian surgeon Gavriil Ilizarov. Circular frames, or Ilizarov techniques, are used to help heal complex fractures (complicated broken bones), lengthen long bones and correct congenital or traumatic deformity of the bones.

The Trust also requested a clinical record review, to run concurrently with the invited service review with a focus on the following matters:

- Consideration of [REDACTED] complication rates within a sample of [REDACTED] cases, and whether these complication rates were acceptable for the work being performed and in line with national and international standards;
- The experience, training, scope of practice of and support provided to [REDACTED], and whether any recommendations could be made about further training, remediation, support and supervision.

The information that has been redacted relates to some detail about the review being carried out that could identify the individual or individuals involved.

This request was considered by the Chair of the Royal College of Surgeons of England ('RCS England') IRM and a representative of the British Orthopaedic Association ('BOA'), and it was agreed that an invited service review would take place, with a clinical record review involving a sample of [REDACTED] cases running concurrently.

An invited review team ('the review team') was appointed and an invited review visit was held at the Trust on 22-24 February 2023.

During the review visit, it was not possible for the clinical reviewers to complete their review of the [REDACTED] cases [REDACTED] as remote access to the Trust's electronic patient record system software, Epic<sup>3</sup>, had not been correctly facilitated. As a result of technical difficulties, the reviewers were able to review only three cases during this visit. It was clear that these were complex cases, which for many patients, spanned a number of years and the review team were advised that the Trust would facilitate arrangements for the clinical reviewers' access to Epic in order to complete the review of the cases, including exploration of a further on-site visit with training/support in how to navigate the system.

A further review visit was undertaken by the clinical reviewers at the Trust on 19-21 April 2023. Whilst progress was made, it was not possible to complete the review of the totality of the cases, given the complexity of the cases. In addition, there were continued difficulties in arranging the clinical reviewers' access to Epic and the Trust's PACS<sup>4</sup> system to review the relevant imaging, as well as being able to navigate these systems.

In light of the difficulties incurred up to, and during, the visit in April 2023, it was agreed between the RCS England and the Chief Medical Officer on 5 May 2023, to establish two separate reports, in order to expedite the service report and enable the Trust to progress those recommendations as soon as possible. The [REDACTED] clinical record review would progress separately and be issued as a supplementary report.

In addition to the interviews which were held with staff during the review visit in February 2023, supplementary interviews took place remotely using video-conferencing facilities on 11 April 2023, 26 April 2023 and 31 May 2023.

The review team made a request to interview fellows or specialty trainee level doctors within the service. The Trust made efforts to contact such individuals, however many had either rotated out of the service, were unavailable at the time requested or did not respond to the invitation.

There is some specific information about one individual in here, which is not relevant to the overall conclusion of the paragraph that no trainees were available to be interviewed. The review team were therefore unable to interview any trainees despite their request.

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<sup>3</sup> Epic is a supplier of electronic patient record systems. All patient notes, investigations and theatre records are within Epic patient records: <https://www.epic.com>

<sup>4</sup> PACS is a Picture Archiving Communications System commonly used in NHS settings for digitally storing and viewing radiological examinations.

The appendices to this report list the members of the review team, the individuals interviewed, the service overview information, the documents provided to the review team and the information provided to the review team from the documentation considered and the interviews held.

The review team's conclusions are primarily based on the information provided to them during the course of interviews and through reviewing documentation submitted. These are set out in section three. Recommendations based on these conclusions are set out in section four.

[REDACTED]

A number of events unfolded after the review visit which was held on 22-24 February 2023. This narrative has been set out in Appendix H.

Observations, conclusions and recommendations relating to the review team's review of the [REDACTED] cases [REDACTED] will be set out in the supplementary invited clinical record review report.

### **Overview of the Trust, GOSH and the orthopaedic department**

GOSH is an international centre of excellence for children's healthcare, hosting the only paediatric National Institute for Health Research Biomedical Research Centre, along with their research partner, the UCL Great Ormond Street Institute of Child Health. GOSH is dedicated to finding new and better ways to treat childhood illnesses. Most children cared for within GOSH are referred from other hospitals in the UK and overseas, with the provision of over 60 different clinical specialties. GOSH is the largest paediatric centre in the UK for paediatric intensive care, cardiac surgery, neurosurgery, paediatric cancer services and nephrology and renal transplants<sup>5</sup>.

The GOSH orthopaedic department is a tertiary and quaternary<sup>6</sup> centre for specialist paediatric orthopaedic lower limb with some upper limb conditions. Many patients travel from afar, including from the devolved regions of the UK, the Republic of Ireland, Gibraltar, Malta as well as all over England. GOSH is a predominantly elective only centre, with no accident or emergency, or trauma covered within the site. There are five substantive consultant orthopaedic surgeons within the orthopaedic department, [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]. There are a further six consultant surgeons (spinal and plastic) within the wider department. There are an equivalent of 4.8 full time surgical registrars and an equivalent of 2.5 full time junior doctors.

A weekly MDT case conference takes place, involving a radiologist, orthopaedic consultants, junior doctors and the Clinical Nurse Specialist (CNS) team, with approximately 10 patients discussed during each meeting. Vascular (led by the interventional radiology team, with an Orthopaedic Consultant attending) and neuromuscular (led by the neurology team with an Orthopaedic Consultant attending) MDT meetings take place monthly.

An orthopaedic and spinal M&M meeting takes place quarterly, with attendance from all consultants, junior doctors, nurses, physiotherapists and the wider team. This involves discussion of on average 12 orthopaedic cases and eight spinal cases.

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<sup>5</sup> <https://www.gosh.nhs.uk/about-us/who-we-are/>

<sup>6</sup> Quaternary is an extension of tertiary care, considered to be more specialised and highly unusual. It tends to involve experimental medicine and procedures and uncommon and specialised surgery.

In addition, a monthly risk and governance meeting takes place to review risks and incidents related to spinal and orthopaedics. These are also presented to the wider team at a monthly specialty review meeting.

Between November 2020 and November 2022 there were 192 incidents where orthopaedics was the main specialty, two serious untoward incidents (both of which are now closed), five high level/formal patient complaints, 132 informal/low level patient complaints and no Never Events<sup>7</sup>.

Orthopaedic consultants have audit days scheduled into their job plans, with clinical activity cancelled to enable all clinical staff to attend. From 2021 until 2022 audit days (typically taking place as half day sessions) occurred on 29 September 2021, 8 December 2021, 16 March 2022, 29 June 2022 and 28 September 2022<sup>8</sup>.

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<sup>7</sup> A Never Event is a serious incident, usually entirely preventable, due to guidance or safety recommendations being available at a national level, which should have been implemented locally by the healthcare provider.

<sup>8</sup> Appendix C – Service Overview Information, information up to date as of November 2022.

## 2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the review visit between the RCS England and the Trust commissioning the review.

Review of the lower limb lengthening and reconstruction/Ilizarov surgical service at Great Ormond Street Hospital for Children NHS Foundation Trust ('the Trust') under the Invited Review Mechanism (IRM).

### Background

The Trust have requested a review of their paediatric orthopaedic department, with a specific focus on the lower limb lengthening and reconstruction/Ilizarov (LLLRI) surgical service. This request arose following [REDACTED]

This section sets out that a member of staff arose concerns. [REDACTED]

[REDACTED]. It was unclear whether these concerns were shared by other members of the department, and no cases were raised as serious untoward incidents at mortality and morbidity (M&M) meetings. [REDACTED] did raise concerns about the robustness of the M&M meetings. [REDACTED]

The review team will consider the standard, quality and safety of surgical care provided by the LLLRI service.

### Review

The review will involve:

- Consideration of background documentation regarding the LLLRI surgical service, within the paediatric orthopaedic department.
- A clinical records review of [REDACTED] cases [REDACTED], put forward by the Trust.
- Interviews with members of staff within the LLLRI service and other relevant members of staff within the Trust.

### Terms of Reference

In conducting the review, the review team will consider the standard, quality and safety of surgical care provided by the LLLRI service, with specific reference to:

1. The standard, quality and safety of surgical care provided to patients, including:
  - a) Assessment including history taking, examination and diagnosis.
  - b) Investigations and imaging undertaken.
  - c) Treatment including clinical decision-making, obtaining patient consent, case-selection, operation or procedures.
  - d) The presence of and timely identification, management and discussion of complication rates, and whether or not these were acceptable and in line with rates experienced at other national and international centres.
  - e) Record keeping, including the quality of operative, post-operative ward round and discharge notes.
2. The experience and training of [REDACTED] given their current scope of practice and an assessment of the current levels of support provided to them. In addition,

whether information from the clinical records review indicates that any alterations to their scope of practice and the support that they may require is necessary, or if a period of further training is indicated.

3. Team working, including culture and behaviours; collaboration and communication between staff of different disciplines; the inclusivity of other professions and the operation and effectiveness of multi-disciplinary team (MDT) working.
4. Theatre safety practices, for example the use of the World Health Organisation checklist.
5. The effectiveness of existing clinical governance practices, including:
  - a) Whether current MDT and M&M processes are transparent, considered and robust enough to maintain patient safety, and whether there are any considerations to strengthen such processes.
  - b) Formal arrangements for covering patients during periods of leave, including sickness absence.
6. Whether current service delivery is adequate to meet demand and maintain patient safety and what needs to be done to future proof the service and improve quality.

## Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard, quality and safety of surgical care provided by the LLLRI service including whether there is a basis for concern in light of the findings of the review.
- Make recommendations for the consideration of the Chief Medical Officer of the Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

**The above terms of reference were agreed by the College, the healthcare organisation and the review team on 16 January 2023.**

## 3. Conclusions

The following conclusions are based on the information provided to the review team from the interviews held, the documentation submitted and any clinical records reviewed. They are largely organised according to the Terms of Reference agreed prior to the review but also take account of the themes that emerged whilst reviewing this information.

### 3.1. General conclusions

The review team accepted that some of the finalised Terms of Reference focused primarily on the practice of [REDACTED]. However, the Trust had commissioned a service review, and therefore it would not be usual practice to focus on individual [REDACTED], but to look at the practice of all surgeons within the service, and wider members of the MDT, alongside other specific areas requested by the healthcare organisation. Therefore, where possible, the following conclusions focus on the service as a whole, and any specific conclusions and recommendations relating to [REDACTED] are set out in [REDACTED].

Occasionally there are areas of the conclusions where there is overlap between different categories of the Terms of Reference, which should be borne in mind when reviewing this report. The review team were provided with a breadth of information, from the interviews conducted and the background documents considered, and therefore it has not always been possible to separate information, including matters pertaining to [REDACTED]. The Trust should therefore carefully review this report, and consider sensitivities and obligations towards staff, before sharing the report more widely.

Furthermore, the Trust originally requested this invited review to assess the LLLRI service. From the information obtained throughout the course of the service review, the review team understood that the LLLRI service was a specific part of the orthopaedic department. The work being undertaken within this service was complicated in nature, with many LLLRI patients having a lengthy and complex history. Whilst [REDACTED] were specifically appointed to provide the LLLRI service, the review team understood that other surgeons occasionally provided their assistance. The review team heard a breadth of information about the orthopaedic department as a whole, which provided a specific context for them to assess broader matters such as MDT and team working, clinical governance, clinical leadership, service management and service delivery. This report therefore reflects not only the review team's findings about the LLLRI service, but also the orthopaedic department within the Trust, as well as making occasional wider organisational observations.

Overall, the review team wished to highlight that they met many committed staff, in clinical and non-clinical roles, within the service and the department, who worked their hardest every day to provide the best care possible to their patients. There were clearly a number of challenges and constraints within the service and department, which have been set out in this report. However, within those constraints, the review team 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.

### 3.2. Standard, quality and safety of surgical care

#### 3.2.1. Assessment including history taken, examination and diagnosis

Overall, the review team considered that assessment of patients within the service was of a good standard, with the involvement of the full MDT in this process, including surgical consultants, registrars and fellows, clinical nurse specialists (CNS), physiotherapists and occupational therapists, managed and facilitated by non-clinical service managers and administrative staff. This was particularly demonstrated by teams holding separate pre-assessment clinics, where the whole of the team involved in the care of the patient would go

through matters in detail with patients and families. In addition, the review team noted that the teams would not hesitate to bring patients and families back for further pre-assessment/pre-operative appointments if there were any doubts regarding their understanding of the process, such that this could impact on the success and follow through of their treatment. Whilst this was broadly the case, the review team did not find this good standard of assessment extended to the entirety of the LLLRI service, with variable and individualised approaches to patient care.

The review team identified various issues within outpatients, including lengthy waiting lists, poor management of incoming referrals and appointments being cancelled three to four times before the patient was seen. Additionally, the review team considered there were occasions when long-waiters were 'bumped' to prioritise urgent follow-ups and other such appointments. The review team found very experienced and committed staff, both clinical and non-clinical, who worked hard to mitigate these risks and keep patients safe. However, the burden of responsibility and service time in caring for the time critical needs of these patients was less than ideal. It appeared the service management and administrative staff had a lack of control over the issues stemming from outpatients, which were impacting referral to treatment times and theatre wait lists, as well as follow-up care.

When reviewing cases (of which further detail will be set out in the separate clinical record review report), the review team were unable to open links from the patient record in Epic to the Trust's TraumaCad radiology software. It was not always easy to identify or confirm if pre-operative planning had been undertaken or was accurate for specific patients. The review team therefore found this to be an area of improvement, to demonstrate this standard of care. It also appeared to the review team that patients were often seen, examined and listed for surgery prior to the completion of radiology requests, when ideally the patient and family would have had opportunity for further assessment and discussion with clinicians once imaging results were available. The review team accepted that this may have been due to the set-up of outpatient clinics, in terms of where they were located in comparison to where radiological imaging was performed, although they had limited information regarding the physical set-up within the department. Alternatively, the review team were unaware if capacity prevented timely acquisition of imaging when patients attended for their appointments.

### **3.2.2. Investigations and imaging undertaken**

The review team found that waiting times for investigations for patients appeared to be within acceptable ranges, notwithstanding the issues mentioned with regard to long waits for new and follow-up appointments, and considering the effects of the COVID-19 pandemic on the National Health Service (NHS). It appeared that when urgent investigations were required, this was accommodated in a timely manner for patients. The review team found the quality of imaging and investigations taken for patients to be good in supporting and informing the clinical decision-making and treatment being offered.

As mentioned in [section 3.2.1](#), the Trust should take steps to ensure pre-operative planning is available within the clinical record on Epic, with clear documentation as to when pre-operative investigations are reviewed.

### **3.2.3. Treatment including clinical decision-making, obtaining patient consent, case-selection, operation and/or procedures**

Overall the review team considered that staff within the orthopaedic department worked hard to provide high quality care and treatment to patients. They were impressed by the number of committed, experienced clinicians, including the CNS and physiotherapists, who did their best within the constraints of a very busy service, to provide high quality and safe care, and to ensure patients were seen close to the time of their listed surgical procedures for pre-operative discussion and confirmation of consent.

The review team considered that the consent process and engagement with patients and their families could be improved by ensuring consistent language support was available, during pre-operative processes and in theatre, for patients and families for whom English was not their first

language. This includes patient and family access to MyGOSH<sup>9</sup>. The review team found that robust processes existed for patient assessment and consent, with thorough appointments to go through relevant matters with patients and their families, however this did not apply consistently across the service and department. The review team therefore considered the need for consistency, particularly to ensure that consent was detailed and reviewed on two occasions whenever possible. Furthermore, as set out in various areas of this report, the review team identified a lack of consistency in MDT working, particularly pre-operative discussions, and this could impact on more cases resulting in concerns and complications. The review team therefore considered the need for more standardised effective MDT working, with advice, discussion and agreement to support clinical decision-making, across the LLLRI service and orthopaedic department.

### Outpatients

As detailed at section 3.2.1 within the report, the review team considered that many problems within the patient pathway stemmed from outpatients, with long waits for new and follow-up appointments, and a number of patients being cancelled several times before being seen. The review team found there was a lack of robust clinic management system, and inefficiency in managing workflow, including instances of poor management when there was staff absence. For example consultants continued to receive referrals whilst away, with significant delay before these time critical patients were re-routed to other consultants. The review team heard of an expectation that outpatient clinics could be managed by an unsupervised fellow or registrar. The review team noted that the LLLRI service was primarily run by two consultants [REDACTED] [REDACTED], and whilst they did not consider their waiting lists were particularly high (compared to some of the other orthopaedic consultants), and in line with what would be expected within the LLLRI service, having regard to the current context of national challenges, the waiting lists were poorly managed. In addition to more effective clinic management, the review team considered that the LLLRI service would benefit from support from more staff, particularly during periods of staff absence.

### Wards

The review team were encouraged to hear of a daily ward round system, which was usually registrar or fellow led, and that there were no complaints about the ability to escalate medical concerns directly to paediatricians. However, the review team heard from staff that they felt the majority of, but not all, orthopaedic consultants were not interested in the post-operative care and management of their patients and were rarely present on the ward. The review team were concerned to hear reports that when staff had concerns about patients, they were not able to readily contact the named consultant or the on-call consultant for help, advice and/or to review the specific patient. There appeared to be a lack of consultant ownership. Furthermore, the review team found that there was often a delay in patient discharge due to unclear goals for inpatient treatment, for example, with patients who had been admitted to the ward for physiotherapy.

### Theatres

The review team's full findings in relation to theatre safety practices are set out at section 3.5.

The review team found that there was a good understanding by anaesthetic and theatre team staff about the requirement for and use of the World Health Organisation (WHO) theatre

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<sup>9</sup> MyGOSH is a safe and secure online portal which enables children, young people and families to have access to specific parts of the electronic patient record at GOSH, to allow everyone to manage their health and care online.

checklist<sup>10</sup>, and they worked hard to adhere to this, with the implementation of their own safety processes, with regular checks and opportunities for discussion amongst the team.

The review team were concerned to hear reports by theatre team staff that they did not always feel confident to raise questions or issues with surgeons regarding important elements of patient care, equipment or surgical planning during team briefs, or other stages of theatre lists. It also appeared that not all surgeons were available or present for the end of day sign-out or de-briefs. Anaesthetic teams described how surgeons requested pain relieving interventions were not to be given to patients as they would 'take too long'. The review team heard that staff encountered delays when sending for patients, due to staff having to check for required equipment. This was due to insufficient notice by consultants of their requirements, despite staff attempts to check with consultants about these particular matters in advance, including during the morning briefs. Many staff commented about problems with equipment, which was in part due to reluctance by surgeons to confirm equipment prior to starting the case, and last minute intra-operative requests, with the assumption that the surgical support team would know and have planned for such equipment requirements.

The review team also considered that there were several instances of over-listing cases at weekends, and overrunning of those theatre lists, with staff starting work shortly before 08:00, and leaving work as late as 21:00/22:00. The review team considered that all of these issues had the potential to compromise patient safety.

#### **3.2.4. Identification, management and discussion of complication rates and comparison with national and international rates**

In respect of outcomes within the orthopaedic department as a whole, the review team considered these generally to be of a good standard. This was supported by views from staff, who described good outcomes and patient satisfaction scores, including for complex cases, from the orthopaedic surgeons. However, the review team heard that many staff were upset about the standard of care provided to patients within the LLLRI service, which was described as unsatisfactory.

The review team were aware that the nature of this type of surgery was highly complex in nature, with certain procedures running a considerable risk of significant complications, which should be explained to patients and their families as part of the consent process.

The review team considered that the discussion of complications should be expected to occur in M&M meetings. The review team considered that complications and adverse outcomes were generally tabled for M&M meetings and discussed appropriately amongst the orthopaedic department, which was clear from their sight of M&M data and the PowerPoint slides made available.

It was noted by the review team that consultants kept track of their own cases and complications, and they considered that the majority of surgeons within the department were forthcoming in bringing their complications and adverse outcomes to M&M meetings in an open manner for sharing, reflection and discussion amongst colleagues in order to ensure learning, future improvements and to deliver best practice. They noted that wider team members expressed concern that they would sometimes recommend a case be placed for the M&M meeting, but were told by the consultant it did not warrant discussion, or should be discussed at a later date, with the hope of clinical improvement in the interim. The review team considered that this would prevent timely sharing of lessons learned, or discussion on subsequent interventions, and may reflect a lack of transparency. They considered that there should be a clear agenda of expectations for the M&M meeting and all team members should be able to

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<sup>10</sup> <https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources>

table cases. Further detail regarding the review team's conclusions about M&M meetings is set out at section 3.6.2.

It was noted by the review team that the five orthopaedic surgeons in the department were expert sub-specialists in surgical fields with little overlap. Consequently, an understanding of all the sub-specialties could not be guaranteed from colleagues in-house. The review team therefore considered that some of the described complications warranted discussion with a wider network of sub-specialty experts. The review team found there was a variability between the surgeons who utilised this wider experience within either a formal or informal network, and inconsistency in documenting whether this had occurred within the patient record.

The review team considered that a formal local network should be established for all of the sub-specialty surgeons, to ensure regular pre-operative complex case discussion and sub-specialty specific M&M meetings for all surgeons. Minutes should be taken during these meetings, and the outcomes should be recorded within the patient records.

The review team identified that there was a lack of consistency in robust pre-operative MDT discussions, documentation of pre-operative and post-operative planning and discussion of complications to support clinical decision-making, and that this was apparent when cases were brought to M&M. It was possible that some complications could have been avoided with more thorough discussion prior to operation, in order for colleagues to sense check and debate the appropriateness of certain decisions. The review team therefore found that there was not always a sense of appreciation of risk, and pre-empting and managing of such complications.

It was not possible to benchmark the outcomes for the LLLRI service with other comparative national and international centres, as there are no such defined rates, in particular complication rates, within LLLRI surgery, and the denominator was not known. However, more robust M&M processes may have confirmed concerns regarding the themes and frequency of complications within the department. Further detail in this regard, [REDACTED] will be made available within the separate clinical record review report.

### **3.2.5. Record keeping**

#### Epic

The review team considered that the Trust's Epic software, which had been brought into the organisation in 2019, provided a comprehensive patient clinical record, including entries from every patient encounter from all involved healthcare professionals, encompassing clinical correspondence, both written (emails and letters) and telephone contact events uploaded for each patient.

However, at times the review team found it difficult to navigate the system (which they used to review the cases as part of the clinical record review) and identify pertinent entries due to the volume of data Epic stored. The review team found this of concern, and considered it may prevent members of staff in the identification of and access to important information, with an effect on patient care. The review team considered that the Trust should press Epic to allow specific clinical records to be highlighted as important to other healthcare professionals, including a lack of patient engagement with other services, for example psychology. In light of the breadth of the software, with the volume of data stored in relation to all patient interactions, the review team considered this would be useful for clinicians getting up to speed with a patient's journey in a timely and effective manner. The review team also found it unclear whether formal MDT decisions were recorded within the patient's record within Epic, and considered that clinicians should also be able to easily identify such information. It also did not appear that all patient specific emails were entered into Epic.

It was apparent from interviews that whilst this software was brought into the Trust in 2019, and training had been made available, some members of staff had found the transition easier than others. The review team identified that a number of members of staff struggled with use of technology, and thereby relied on administrative support for routine tasks such as reviewing

referral letters and other clinical correspondence. The review team did not consider this to be an efficient way of running the department, and considered that all members of staff, in particular the consultant surgeons, should be trained and compelled to navigate the patient record system, and to input the information clinical and non-clinical team members require to support the delivery of patient care.

The review team also heard about practices where registrars or fellows uploaded entries onto patient records, for example, operation notes, without clarity as to whether this had been appropriately checked and signed-off by consultants, which would be best practice.

#### Theatres

The review team noted there were sometimes delays in returning patients to the ward whilst waiting for operation notes to be completed. They therefore considered more streamlined processes were required to reduce the time spent by patients waiting in recovery.

#### MyGOSH

The review team considered that the MyGOSH system provided an effective way for patients and families to connect with patient records, ask questions and ensure their concerns were addressed, with excellent documentation of such conversations. However, it was clear that this was an effective way for patients and families for whom English was their first language, to engage with the service and patients' treatment, but it was not apparent how those who were unable or less able to communicate in written English could contact the service.

#### TraumaCad

As set out at section 3.2.1 there were links from the patient records within Epic to the TraumaCad radiology software. However, the review team could not use these links or identify pre-operative planning information within Epic for complex cases, including analysis of imaging. Assuming this planning had occurred, the review team considered this information should be routinely identifiable and uploaded to the relevant entries in the patient record.

The review team considered it was not always clear which clinicians were in attendance at the pre-assessment clinic, or what level of involvement the consultants had in this. It was assumed by the review team that the consultant had seen the patient if they had signed the consent form.

The review team concluded the review of images should be made clearer within the patient record, especially when they are requested between the clinic and surgical encounters.

### **3.3. Experience, training, support and scope of practice of [REDACTED], and whether any alterations to their scope of practice or additional support and training are required.**

The review team were asked to comment on the experience, training and scope of practice of [REDACTED], including levels of support provided to them, and whether information arising out of the clinical record review indicated that any alterations to their scope of practice were required, or whether additional support or further training was necessary. The review team's conclusions and recommendations arising out of their review of [REDACTED] cases [REDACTED] will be set out in the separate clinical record review report. The review team's specific conclusions in relation to the experience, training, support and scope of practice of [REDACTED] have been set out in Appendix F and Appendix G respectively.

This section describes how, in respect of some elements of the review, the RCS team identified no patient safety concerns, but that serious patient safety concerns were found in respect of other elements under review.

[REDACTED] The Trust will need to take immediate action to ensure all patients are safe, further detail of which has been set out in the recommendations section of this report.

The review team were made aware of a complex narrative which arose, and led to disharmony [REDACTED], culminating in this invited review being requested. They heard different perspectives from staff, and did not seek to comment on such matters, which fell outside of the review team's remit.

### 3.4. Team working, communication, behaviours, inclusivity, culture and the effectiveness of MDT working

#### 3.4.1. Team working, communication, inclusivity and behaviours amongst the consultant surgeons and with staff of other disciplines

The review team found that there were a number of committed members of staff across all disciplines working within the LLLRI service and the orthopaedic department. The review team found them to be really engaged during interviews, and it was clear that there were a number of individuals who enjoyed working for the Trust, who were passionate about patient care, and worked hard to make the hospital a better place for staff and patients. However, there was a serious and palpable lack of effective team working in the department, which the review team considered to be largely dysfunctional. The review team learned of a lack of connection and inclusivity between staff of different disciplines. The review team found a number of instances of members of staff feeling undervalued, particularly junior or non-medical staff by senior colleagues, and instances of unacceptable and unprofessional behaviours and disrespect, particularly during theatre, and in front of other members of staff and patients. This extended to poor communication from some of the consultant surgeons to other members of the MDT, for example in relation to theatre planning, including what equipment would be required and any other pertinent matters to ensuring the efficient running of theatre sessions and the success of surgical procedures.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] This section describes how, notwithstanding issues within the department, [REDACTED] the importance of team working was recognised and case discussion and [REDACTED] moral support was provided where required. Reflection and recognition of [REDACTED] mistakes took place in the context of working effectively as a team and [REDACTED] improving the department. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

What was clear to the review team was the existence of outdated and unacceptable hierarchical behaviours [REDACTED] to junior members of staff and staff of different disciplines, including anaesthetists, physiotherapists, CNS, and the theatre and scrubs teams. The review team considered this [REDACTED]

[REDACTED] was not confined to individuals. The review team found that the consultant surgeons were mostly either unapproachable or difficult to contact when it came to attending ward rounds, reviewing patients and when escalation was required. The review team considered that this put patient safety at risk and non-medical staff tended to rely on registrars and other junior doctors when they required assistance. The review team were of the view that teams would benefit from more consultant visibility and input on wards, in terms of ownership of their own patients, and to provide leadership, including to assist staff with bed management and discharge planning.

The review team were concerned to hear reports from interviewees of poor communication from consultant surgeons, including instances of behaviours such as sarcasm, 'eye rolling', dismissiveness and hostility, when more junior members of staff asked questions or raised concerns about patients. The review team found that such behaviours were not necessarily displayed to more senior members of staff, or to other surgeons, and therefore they considered this to be hierarchical in nature. The review team found that some of the consultants were either unwilling, or in some instances, outright refused, to work with more junior members of staff, and/or to only be on the rota with specific members of staff. The review team considered that this impacted on staff morale, and would make theatre management and coordination difficult for those managing theatre lists. In addition, it impacted junior staff with their learning, knowledge

and experience in the acquisition of specialist skills and learning the preferences of different consultants.

It appeared to the review team that some of the consultant surgeons were less open to feedback and constructive criticism and reflecting on their behaviour and development, as well as being rigid and resistant to change and new ways of working. The review team found that such individuals appeared to be determined to stick with the status quo. The review team considered this had a negative impact on staff performing their duties and communicating and managing relationships with the consultants, with some instances of particularly unreasonable demands, for example, requesting to only work with particular individuals in theatre. The review team were grateful for the candidness of the interviewees in describing these issues (which they often found difficult to talk about) during the course of the review, including on behalf of members of their teams. It was evident that a number of staff were committed to change, with a desire for an improvement in relationships, and for the wellbeing and healing of the department, in order to move forward and provide as effective and safe a service to patients as possible.

### **3.4.2. Culture within the LLLRI service and orthopaedic department**

Given the issues identified with team working, communication, behaviours and culture, the review team found there were serious concerns in relation to the working culture within the LLLRI service and orthopaedic department. The review team found a lack of a cohesive, united and functional team and department. They understood a number of difficulties had arisen, with the narrative and conflict described in this report [REDACTED], with a number of factors having contributed to this. The review team considered that, as a result, politics and disharmony had emerged with the department, including gossip. This did not extend to all members of staff, whom the review team considered to be committed, passionate, professional and hardworking, doing the utmost for their patients each day within the constraints of these challenges. However, this disharmony became more obvious to the review team during the interviews, with different perspectives being provided in relation to these issues, and individual members of the department.

The review team found this issue was compounded by a lack of direction and effective management and leadership (both clinical and non-clinical) within the department. For example, the review team were made aware of a number of instances of staff raising concerns [REDACTED] [REDACTED], but they did not feel those concerns were being escalated with the sense of urgency expected. The review team were also concerned to find that when staff raised concerns they did not always receive adequate support. The review team considered it essential for all staff to feel psychologically safe to speak up and raise concerns. Such concerns should be escalated and addressed appropriately, with incidents being investigated, in order to develop and share best practice. The review team found it particularly concerning to hear of the way whistle-blowers had been treated. The review team considered that the Trust should be particularly concerned by this, and should follow-up with staff members who have previously raised concerns to ensure that they are being appropriately dealt with, and that staff have received adequate support and their wellbeing has not been negatively impacted.

Whilst acknowledging that the Trust is a respected centre of excellence, the review team found that a number of staff would not agree with such a description, given these and other matters highlighted in this report. The review team learned that some individuals had expressed an interest in working for the Trust, but did not end up following through and applying for, or taking up, positions. The review team considered that whilst LLLRI is a niche and particularly specialist area of practice and therefore recruitment would be challenging, [REDACTED] reputation was also likely to be a contributing factor,.

The review team considered it essential that more direction is provided by the management and leadership within the department to work on healing the divisions which have emerged, to put an end to gossip and disharmony and to allow opportunities for staff bonding, in order to bring about a more united department with a common purpose. The review team considered that this was not only important for the wellbeing of members of staff, but also for the safety of patients within the service, as such ongoing divisions and disharmony have the potential to seriously

compromise patient safety. The review team accepted that these divisions were long-standing and complicated, and there would be no 'quick fix' solution, however, this was no excuse not to focus and prioritise important work. This would require dedication and commitment from managers and leaders, and the ability to think creatively. External facilitation may be required, as well as options such as buddying, mentoring, coaching and mediation. In addition, the review team would suggest staff have regular opportunities for face-to-face meetings for meaningful discussions, whether on a formal or informal basis. The review team considered that the Trust should focus on reputational restoration within the LLLRI service and orthopaedic department, so that all staff are enthusiastic about where they work, and so that patients and their families have a good experience utilising services.

### **3.4.3. Operation and effectiveness of MDT working**

As a result of the difficulties and ongoing divisions within the department, poor team working and culture, and described lack of direction and effective leadership, the review team considered that variable, individualised practices, and silo working had developed within the department. The review team acknowledged it would not be unusual for members of staff to try and distance themselves from the divisions and difficulties within the department to ensure they stayed focused on their patients and their practice. However, the review team found that consultant surgeons had formed their own ways of working, and this extended to their teams working to support them. The review team heard this had a considerable impact on staff of other disciplines, in terms of having to learn and adapt to different practices for each of the consultants. The review team did not consider this to be an efficient way of working when it came to more junior members of staff, and ensuring the build-up of an appropriate specialist skills mix, knowledge and experience, and learning the requirements of different consultants. The review team considered that this impacted managers, in terms of coordinating teams to work with the consultant surgeons, and this was also significantly impacted by some of the [REDACTED] surgeons being unwilling or refusing to work with particular members of staff, thereby affecting staff training and learning. The review team found that this extended to staff working in non-clinical roles, including administrative staff and those managing the service, in terms of clinic management. The review team considered that silo mentality and individualised practices had an impact on patients, with consultants describing patients as 'belonging to them', and being unwilling to allow other consultants to provide care to them. The review team found this unacceptable, as they were patients of the service, department and Trust, and all staff had a responsibility towards them.

The review team considered that whilst certain MDT meetings and practices existed, such as a weekly consultant meeting, it was clear that some of the consultant surgeons were not necessarily engaging in pre-operative MDT discussion as would be expected for complex surgical procedures. The review team found an absence of a clear system for pre-operative case discussion, and for presentation of pre-operative planning, as well as documentation of such discussions. This was of concern to the review team given that some surgeons were working in a more isolated manner, without appearing to discuss and seek the advice and agreement of colleagues. The review team found this was an area that the Trust should turn attention to, in terms of development of more structured and effective MDT processes and practices, further detail of which has been set out in the recommendations section of this report.

The review team found it positive that certain surgeons, [REDACTED], participated in regional MDT forums, where consultants from other units brought cases and topics for discussion. The review team considered such mechanisms to be a good opportunity for learning, sharing and discussing best practices. However, they noted that not all consultant surgeons within the department would attend such MDT forums and considered that the Trust should encourage them to do so. The review team also noted that informal links existed between the Trust and the Royal National Orthopaedic Hospital (RNOH), [REDACTED]. [REDACTED] The review team were encouraged to hear that those links had been strengthened over the course of this review, and would encourage continuing to develop and solidify such working arrangements, so that staff within the service and department can benefit from such expertise.

Best practice would advocate consistent and common practices for patient pathways within the LLLRI service and orthopaedic department, for example, through the creation of written standard operating procedures (SOPs) or patient protocols. The review team were of the view that this would assist with training for junior and incoming members of staff of different disciplines, as opposed to the challenge of learning different preferences for different surgeons. It would ensure that pre-operative MDT discussion is embedded into surgical practice, and also assist in breaking down silos and individualised practices, to create more of a cohesive department.

### **3.5. Theatre safety practices**

#### **3.5.1. Safety and adherence to the World Health Organisation (WHO) checklist and theatre planning and management**

The review team considered that, for the most part, members of staff, in particular the anaesthetic and theatre team staff, had an excellent understanding of theatre safety practices and procedures, including the need for, use of, and adherence to the WHO checklist, with the Trust introducing its own supplementary safety processes and safety checks. The review team were advised theatre lists ran according to these safety requirements, with the morning briefs and 'huddles', sign-ins, confirmation of consent and appropriate post-operative management after surgery had been completed. The review team found members of staff, in particular the anaesthetic and theatre staff, had good practices to ensure they understood all patient needs and requirements prior to their planned operations, which included the specific devices and equipment that would be needed, and anaesthetic requirements. The review team considered that there was appropriate attendance and engagement with morning briefs and huddles, and end of day debriefs, as well as other routine parts of theatre lists. The review team found the staff interviewed to be invested in ensuring the smooth and efficient running of theatre lists. Epic was used to check for information about patients' operations, including the equipment requirements, and staff would check with individual consultants when such information was not forthcoming.

However, the review team found there were instances when it transpired that not all elements of the WHO checklist had been completed. The review team heard of significant issues in relation to patient consent. The review team found there were instances when planned procedures would change intra-operatively when unpredictable events or complications arose, which they accepted could happen with this type of surgery. However, what was of concern to the review team was that the medical teams did not explain this to patients' families, either during or after the procedure. In addition, the review team found the medical teams did not reflect decision making or discussions on Epic to reflect the rationale or whether any discussion had taken place.

The review team noted that when theatre staff were checking the patient record in advance of theatre lists it was sometimes unclear as to the equipment and devices required, as well as other relevant matters relating to those patients' needs. The review team found that when staff raised this with the operating surgeons, they did not always receive the information they needed in order to help plan and ensure those theatre sessions ran smoothly, efficiently and safely for the patient. The review team found that this resulted in delays on the day of theatre and during cases when the required equipment was not available, especially as theatre set up meant equipment was kept across two floors.

#### **3.5.2. Communication and behaviours in theatre**

Whilst there were a number of staff within theatre who communicated effectively and professionally with each other, the review team learned of concerns regarding communication and behaviours from some of the consultant surgeons in theatre. For example when certain matters were identified, such as an intra-operative change to the procedure, when surgeons were notified of the need to discuss this with the patients' families and update the patient record, staff found themselves to be dismissed and subject to unacceptable and unprofessional behaviours, including verbal aggression in front of other staff members, patients and their families.

The review team considered that theatre teams felt they could not question consultant surgeons regarding elements of patient care, equipment or the theatre plan during team briefs, and that when they did question or raise such matters, they were often dismissed and/or met with hostility. The review team found that a number of consultant surgeons were reported to rush briefs and that they were late to these briefs or absent completely, and most notably for the end of day debriefs. The review team noted that staff felt devalued and disrespected, as if their time was not as valuable as that of the consultant surgeons. The review team noted that some staff felt able to raise these matters with individual surgeons, and whilst surgeons would initially be receptive to the feedback and modify their approach accordingly, after some time the behaviour would repeat itself.

This section sets out that a number of aggressive outbursts occurred in theatre

The review team noted that whilst there were apologies and reflection from individual consultants, leaders approached the issue by taking staff off rotas with particular surgeons, although this had not been requested. The review team were concerned that managers were avoiding dealing with these problems in a meaningful way, as staff wanted an apology and acknowledgment of what had happened, to prevent recurrence, as opposed to not working with individuals again. They were also concerned that whilst some more experienced staff were able to question surgeons, raise concerns and 'stand up for themselves', there were a number of new and more junior members of staff who may not have the confidence to do so. The review team considered that this was more than likely to impact on the development, wellbeing and retention of these junior staff.

The review team found that whilst staff tried to seek clarification and understanding of the requirements of particular operations in advance, including what equipment or devices would be required, to plan for accordingly, consultant surgeons were not forthcoming and willing to provide this information. Those staff then found themselves at the end of frustration and poor behaviour from consultant surgeons when the required equipment and devices were not readily available during theatre, despite efforts to ensure this was available in advance. The review team noted that this led to delays, with anaesthetised patients waiting on the operating table whilst such equipment and devices were sought from other locations. The review team therefore considered that the communication from consultant surgeons was inefficient, ineffective and dysfunctional.

It is important for all consultants to be made aware of the need to communicate clearly about what is required for surgery in advance, whether through specifying the required detail on Epic and/or providing the required information in a professional and patient manner when asked by members of staff (as opposed to assuming all staff should already know this). The review team were concerned that some of these behaviours and communication difficulties were long-standing and ingrained, with the development of a status quo. They therefore considered that real attention and commitment was required by managers and leaders to effect change with urgency, particularly for those described as inflexible and resistant to change, and working with individuals to address entrenched behaviours on a long-term basis.

The review team were told that some consultants were often unavailable or not easily approachable when their input was required for patients. There was a lack of ownership despite being the named consultant for patients. This made post-operative management of patients and discharge planning challenging. The review team considered that there needed to be better visibility and input from consultants on the ward. The Trust should explore a consultant of the week/day model, with clear expectations of the dedicated consultant, when they should be contacted, and with shared responsibility for the care of patients admitted under the orthopaedic team. The review team were also of the view that physiotherapist led discharge should be the standard if the patient is recommended to 'go home when safe'.

The need to communicate effectively and professionally is an inherent part of being a clinician. There is a real need for leaders to address these communication issues and behaviours within theatre with the consultant body, to send a clear message about professionalism and what will and will not be accepted. There is a need to treat all members of staff, no matter their discipline or level, with respect. The review team had sight of the Trust's Grievance Policy (dated March

2021) and understood such expected mechanisms and structures existed. The review team's view was that if behaviours have not been successfully addressed with individuals on an informal basis, leaders should not hesitate to escalate this with more formal processes, and seek the input of appropriate individuals and departments, such as HR, in order to enforce employee duties and responsibilities. The review team understood that there appeared a reluctance for managers to address such issues directly, with many staff within the Trust having worked together for a long time and resulting close friendships developing. However, this is not a reason to avoid dealing with unprofessional behaviour, and if this is a matter of supporting managers and leaders with appropriate training, this should be facilitated.

### **3.5.3. Theatre planning and access to equipment, including utilisation of Epic for managing planned operations**

As set out at [section 3.5.2](#), the review team considered that there was poor advance communication from the consultant surgeons as to the requirements for operations, including the required equipment and devices. They understood that the planning requirements for theatre should have been evident when reviewing the patient record on Epic, including the code the procedure was booked under. However, what was clear to the review team was a variation in consultant surgeons' utilisation of Epic to enable such efficient planning to take place, and that there was a variation in their understanding and familiarity with such technology. The review team found that procedures were often booked under incorrect codes on Epic, leading to unclear expectations for theatre staff.

This ineffective communication in advance of surgery affected the efficient and smooth running of theatre lists. The review team considered that all consultant surgeons should book procedures under the correct codes on Epic, and upload specific requirements for those operations, including the equipment and devices that would be needed, and consider anything that may be required if there was a change of plan, so that everyone involved had the same understanding. This should involve ensuring information is up to date, within the consultant's reasonable sphere of awareness, prior to surgery.

The review team had regard to the breadth of the Epic software, and considered it inevitable that if staff were not familiar with such a vast system, that they would have difficulties booking procedures under the correct code and inputting required information, including placing more reliance on administrative staff for this. If this was the case, the review team considered consultants needed to provide clear instructions to administrative staff. Training should be provided to those who required it, to assist them with navigating the system.

In terms of equipment, the review team found a variation in theatre staff members' knowledge, skills and ability to utilise such equipment during theatre. The review team heard that there were company representatives who would be able to show staff how to use equipment, however there were certain consultant surgeons who reportedly would not allow them to attend. The review team found this unhelpful, and considered that such mechanisms should be made available to staff if needed, to ensure they were appropriately trained and to avoid unnecessary delays and inefficiency, and to help ensure the safety of patients. The review team considered it appeared consultant surgeons had little patience and assumed everyone should know how to use equipment, despite a variation in staff training and experience. The review team also noted that consultant surgeons were unwilling or sometimes refused to work with certain theatre staff, for the reason of their lack of experience, and there were instances when staff were told that they did not know how to do their job in front of patients and other staff. The review team found this to be unacceptable, and again, considered it likely that surgeons assumed all staff should be up to the same level of skills, experience and knowledge, with little patience for guidance, training and support. The review team considered there was a need for guidance and training to incoming and junior staff members, to build up their skills and experience to the level of more senior staff. Consultants also need a reminder to treat all staff with respect. The review team considered that sales representatives should be allowed to assist staff in the use of equipment when required, that surgeons should not be able to refuse to work with certain individuals, and those managing theatre lists and rotas should be supported in challenging surgeons who express such unreasonable demands. The review team found there were issues with staff retention, and low

staff morale, and they considered that addressing these issues and behaviours was fundamental to preventing the disengagement and loss of staff.

The review team found that there was overbooking of theatre lists. This was of concern given the complexity of procedures, and their consequent length, which the review team considered should be appreciated when planning theatre lists. The planning of lists by theatre managers and coordinators was also dependent on procedures being booked under the correct codes. As a consequence of overbooking, many theatre lists tended to overrun, leading to theatre staff working late, which was not particularly safe for patients, or staff. The review team also considered that it may have had a direct impact on the approaches and behaviours of consultant surgeons, with their tendency to rush briefs, and be in a rush to leave or be absent from debriefs. There was a risk that consultants would rush through lists, and this had the potential to compromise patient safety. The review team heard that some consultant surgeons requested that pain relieving interventions were not performed as this would 'take too long'. This was of concern, particularly if such interventions were in patients' best interests.

The review team noted that some consultants have particularly high waiting lists, resulting in weekend sessions to clear their backlogs. This was in addition to the contracted working hours for many staff, and is dependent on their good will in volunteering to undertake weekend shifts. The review team were made aware of an increasing reluctance of staff to volunteer their time due to an awareness of complexity of the procedures and duration of the working day. The review team noted weekend lists were especially likely to be overbooked and that a typical Saturday theatre list would start around 08:00, with staff arriving before this, and they would finish around 20:00 or 21:00; later than expected. The review team considered such lengthy days to be unreasonable and unsafe, particularly when less staff were available should complications arise. The review team considered that this needs careful attention, to ensure that there is an effective system to provide staff cover for weekend lists. There should not be overbooking of procedures, and the review team considered that staff may be more willing to come in on weekends if they knew sessions would not significantly overrun. In order to assist with the appropriate booking of theatre lists, managers need to have the required information about the complexity of procedures in advance.

The review team noted that when some consultant surgeons had space on their theatre lists they were unwilling to add suitable patients from other surgeons' waiting lists. They accepted that this did not extend to all surgeons, but it appeared to be the norm for a majority within the orthopaedic department. There are clearly challenges with waiting lists, and all staff should assist where possible; surgeons should not be able to refuse to treat other consultants' patients, particularly when they have time available. The review team also considered that there should be willingness to explore a range of options, including pooling routine cases, and better use of fellows and registrars to backfill lists and perform suitable cases, with pre-arranged supervision from consultants.

## **3.6. Effectiveness of existing clinical governance practices**

### **3.6.1. MDT meetings and processes**

In terms of existing MDT processes, the review team noted that a weekly case conference was held with the consultant orthopaedic surgeons, a radiologist, junior doctors and the CNS team, with approximately 10 patients discussed at each meeting. They noted monthly vascular and neuromuscular MDT meetings.<sup>11</sup>

As set out in [section 3.4.3](#), the review team considered there was a lack of unified, consistent approach to patient pathways and MDT practices within the LLLRI service and the orthopaedic department. They considered that practices were dependent on the approach and preferences of individual consultant surgeons, and their surrounding teams of CNS, physiotherapists, fellows, registrars, occupational therapists and non-clinical staff, including secretaries, had to learn and adapt to such practices when working with those particular consultants. The review team did not consider this to be an efficient way of working, and noted it caused difficulty for incoming and

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<sup>11</sup> [Appendix C - Service Overview](#). Information provided by the Trust in November 2022.

junior staff, in terms of training, learning and building up skills, knowledge and experience within the department, as well as being professionally inconsistent. The review team found that individual consultants preferred to work with specific allied healthcare professionals, which the review team found to be unacceptable and unprofessional.

The review team concluded there was a lack of consistent approach to pre-operative planning, presentation and case discussion, as well as documentation of such discussions, which are integral to such complex procedures. The review team found certain consultants had good patient pathway practices, which were structured and included all of the MDT. These involved sufficient opportunities to discuss and explore different approaches to clinical decision-making, and therefore seeking the consensus of the team. However, it was unclear whether shared pre-operative discussion and decision-making extended across the entire consultant body. There is a need for uniform processes across the department, involving structured MDT discussion and agreement, and documentation of such decisions, including within the patient record. The review team suggested that developing SOPs or clear pathway protocols would assist with this, and the Trust should identify where MDT best practice is already taking place, either within the department or the wider Trust, and seek to replicate this.

Weekly case conference meetings were a good opportunity for such discussions to take place, and whilst these may have been paused or moved to video-conferencing facilities during the COVID-19 pandemic, it appeared that regular opportunities for consultants to meet face-to-face had since been reinstated. However, it was unclear whether all consultants and staff participated in such meetings, and the review team were not provided with meeting minutes, nor was attendance taken at such meetings, in order to establish this. The review team were also unaware of how long these meetings were scheduled for.

In order to build on existing processes, case conference meetings should have a dedicated amount of time set aside, with agendas to include the patients to be discussed, attendance taken, minutes captured, and this information being available in a central location to all staff after the meeting. Formalising these processes should not replace the ability of consultants to have informal ad hoc discussions, including face to face, in order for meaningful conversations to take place. Staff should have time protected to prepare for and participate in such meetings, to benefit from discussion and wider learning, as well as seeking advice and agreement pre-operatively from colleagues. The review team were of the view that the department should explore a specific meeting for LLLRI practice, to present upcoming and completed cases, reviewing pre-operative plans and post-operative imaging, and that this meeting could involve consultants within the wider department and at other units.

The review team were encouraged to hear about consultants at the Trust being invited to participate in regional MDT meetings, for case discussion, learning and sharing best practice, and they considered that consultants should continue to utilise such opportunities. The review team noted that links existed between the Trust and the RNOH, with referrals for second opinions and at transition to adult services. They considered that the Trust should also continue to strengthen and build more formal links with units like the RNOH, to benefit from the expertise of their clinicians.

### **3.6.2 M&M meetings and processes**

The review team noted that orthopaedic and spinal surgery M&M meetings were held every three months, with attendance from all consultants, junior doctors, nurses, physiotherapists and the wider team including ward and theatre staff, with senior leaders and managers being invited to attend. They noted that one hour and a half was scheduled for these meetings, with an average 12 orthopaedic and eight spinal cases discussed. The review team had regard to the fact that an attendance register was only started in September 2022<sup>12</sup>, therefore typical consultant attendance prior to the review visit in February 2023 was not able to be described.

M&M data for all of the consultant surgeons within the orthopaedic department from 2021 and 2022, as well as PowerPoint slides from M&M meetings from December 2019 until December

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<sup>12</sup> Appendix C - Service Overview. Information provided by the Trust in November 2022.

2022 was seen by the review team. They considered the slides were of good quality, and demonstrated clearly which patients were discussed, with points for reflection and learning.

The review team learnt that consultants would decide which, and when, cases would be discussed at M&M meetings, in discussion with their wider teams. They noted that when other team members raised concerns and asked for certain patients to be discussed at M&M, consultants had the final word, and some consultants had reluctance to discuss patients, for example, when waiting to see how a patient's condition progressed. The review team thought this potentially missed early opportunities to raise and address concerns and to discuss, reflect and learn. They noted that allied healthcare professionals may have raised concerns about post-operative outcomes, or identified cases which needed direction, but these staff were either prevented from bringing those cases to M&M, or found that the final agenda did not include those cases.

The review team found that non-medical staff did not feel listened to or engaged with during M&M meetings. The LLLRI work is a particularly specialised field, and there appeared to be an assumption that staff outside of this sub-specialty could not comment on the risks and outcomes of these patients. The review team considered this to be unhelpful for wider learning and developing best practice, and not in line with how departmental M&M processes should be run.

Some adverse outcomes, such as pressure sores or missed outpatient appointments will, in the review team's view, benefit more from local M&M review, and shared learning. Sub-specialty specific complications such as regenerate fracture or nerve injury require detailed discussion with other sub-specialists and, due to the small size of the orthopaedic department, the review team were of the view that such discussions should take place in a regional network setting.

Oversight to ensure any learning and action points were completed following M&M meetings was lacking. The review team considered it positive that attendance records were introduced in September 2022, and that this should continue, and be reflected in documentation kept. Whilst the M&M PowerPoint slides were good, and centrally available to all staff, it did not appear that minutes were taken during meetings. Therefore, there was no record of discussions during these meetings which the review team found unacceptable, and unhelpful for staff who were not able to attend.

More robust M&M processes should be implemented and any member of staff within the department, not just consultants, should be able to table cases for consideration at M&M and/or at other clinical governance meetings. The review team considered that formal criteria for referral to M&M meetings should be available for all staff, with a defined mechanism for escalation and action points.

The review team considered that there needed to be a culture change within M&M, to value, encourage and listen to the contributions of all staff. The practice of waiting to see how a patient's condition developed before discussion at M&M should be stopped, to take advantage of early opportunity for discussion, reflection, learning and best practice, and potential interventions for patients at that stage.

Attendance and minutes should be recorded for M&M meetings, which should be checked for accuracy and routinely available to all staff. It should be clear to anyone looking at the minutes what the points of discussion were, as well as clear action points, which should be completed within an appropriate timeframe. The patient record should be updated as appropriate. These action points should be checked at the next meeting to ensure completion. The review team accepted that such preparation and participation in M&M processes may lead to increased workload, and therefore suitable resources should be provided to help deliver these responsibilities, as well as adequate job planned time for consultants and clinicians for preparation, attendance and input into these meetings.

### **3.6.3 Other clinical governance meetings and processes**

#### **3.6.3.1 Audits**

The review team had regard to the information provided about orthopaedic and spinal clinical audits which had been previously undertaken and closed in 2022, and those which were active and ongoing. They considered that the selection offered were not suitable audit topics, lacking

relevance within the service and the department, and were more suited to research topics. The review team questioned whether all audits performed by junior doctors were registered within the service.

They also noted that the Trust submitted data into the Clinical Practice Information Portal<sup>13</sup> and that audit mornings were typically held between 08:30 and 12:30 every three months, during which M&M meetings would also take place. The review team noted that all orthopaedic consultants would have job planned time for these audit mornings, where clinical activity would be cancelled, to enable all clinical staff to attend.<sup>14</sup>

### **3.6.3.2 Other clinical governance practices**

In addition to the case conference and M&M meetings, the review team noted there were Local Faculty Group Meetings with Post-Graduate Education, a monthly risk and governance meeting to review incidents and risks related to orthopaedics and spinal, which would be presented to the wider team at monthly specialty review meetings. The review team had sight of the risk and governance reports for January and February 2023. They found these helpful in seeing the way learning from incidents, including Datix<sup>15</sup> reports, was shared on a department and Trust level. They noted, from viewing these two reports and from interviews, that there were a number of incidents and issues which appeared to be ongoing for some length of time carried forward a number of times to subsequent meetings. The review team explored such incidents with interviewees whose name appeared as owner of these items on the documents. They accepted that there were constraints, including with staffing and resources, and sometimes other matters had to take priority on a Trust level.

The review team also noted the existence of internal reviews to decide whether there was patient harm, and executive incident review panel meetings, to determine if cases constituted serious incidents. They considered that the latter was a useful tool for feeding back to bodies such as NHS England, as well as providing areas of improvement for staff and teams. However, the review team were unsure if there was feedback and learning for cases which did not result in serious incidents being declared, despite processes existing. They noted the existence of risk leads, a monthly risk and governance group and a Datix review group. There were also formal Trust wide documents available, to identify issues which were common across different specialties. Therefore, the review team considered that a range of mechanisms existed in respect of governance, and to ensure feedback was disseminated. The review team considered that the formalising and development of existing governance processes, including M&M, as highlighted in this report at [section 3.6.2](#), may go some way to more effectively capturing learning and ensuring oversight of this, in order for it to lead to the development of better practice. This would also require the engagement and investment of all staff when it comes to managing risk, complications and incidents.

### **3.6.3.3 Complaints and incidents**

The review team had regard to the data provided regarding the number of incidents, serious untoward incidents and complaints between November 2020 and November 2022. They also noted the information provided in relation to incidents raised with the Patient Advice and Liaison Service, which included two written complaint response letters, as well as the open complaint correspondence. Having regard to the two closed complaint responses, and the severity of concerns and distress on the part of patients and their families, the review team would urge the Trust to improve the quality of their responses, including the manner and tone, in which it responds to complaints. They also considered that the Trust should prioritise resources to ensure complaints are investigated and responded to in a timely and efficient manner, according to expected timescales. The review team requested further information on all complaints within the department, but apart from those mentioned, and verbal information

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<sup>13</sup> Clinical Practice Information Portal (CPIP) is an online database providing access to clinical information and resources for healthcare professionals in the UK, including information on clinical guidelines, best practice, patient safety and other topics related to healthcare.

<sup>14</sup> [Appendix C - Service Overview](#). Information provided by the Trust in November 2022.

<sup>15</sup> Datix is an incident management system used by the NHS to help manage incidents, risks and compliance, with tools for reporting, investigation, analysis and corrective action tracking.

provided in interviews, no further information was forthcoming. The review team accept and understand there may have been difficulties in providing this information whilst investigations and handling of complaints remained ongoing. However, the lack of any explanation regarding this was noticeable.

### **3.6.4 Clinical leadership and processes for raising concerns**

The review team had significant concerns about clinical leadership within the LLLRI service and orthopaedic department. They considered there to be a serious disconnect between the leaders and other health care professionals. The review team heard of a number of instances of staff raising concerns with those in leadership positions, and a lack of any decisive action being taken. This was evident from some of the written correspondence the review team had sight of, in which those in leadership/managerial positions were copied into correspondence raising concerns, but responses suggested they did not treat these issues with the sense of urgency which they required. The review team accepted that some of those within leadership positions were not from a surgical discipline, and therefore may not have understood the particular requirements, complexities and challenges of LLLRI practice and orthopaedics. However, in the opinion of the review team, there should still have been an appropriate, timely response when concerns were raised. Leaders should do their utmost to understand the issues, provide their time and support to staff members raising concerns and to ensure they are escalated, actioned and resolved, with opinion sought from the local specialist network if necessary. The review team noted that a number of staff raised concerns more than once, verbally and in writing, and were met with either a lack of decisive action, or in some cases, no response at all, and on other occasions it was considered by staff that leaders did not take responsibility and placed the blame elsewhere.

The review team considered that this resulted in staff lacking confidence in the strength of the management and leadership of the department. [REDACTED]

[REDACTED] The review team noted there was a defined term of service for the role of clinical lead, but it did not appear others were willing to come forward to take on this role, [REDACTED] The review team also noted that it was not possible to identify anyone else suitable to take on such leadership roles within the department, given management within the department were aware when concerns were raised, but did little to respond. The review team considered that there was rising frustration amongst the team, who wished to move forward. [REDACTED]

Accordingly, in a bid to escalate concerns, individuals sought to raise their concerns with the review team candidly during interviews, as well as putting some of these concerns in writing (in the background documentation submitted). It should be noted that it is outside of the Terms of Reference for this invited review and the remit of the review team to examine individual concerns. The review team noted that some staff also utilised the Trust's Freedom to Speak Up mechanism. They considered it unacceptable that staff felt they had exhausted all mechanisms, including resorting to the provision of anonymous submissions to the review team, due to a lack of trust in leaders to respond appropriately to concerns, and also the fear of repercussions, given how members of staff had reportedly been treated in the past. This was all the more worrying to the review team when members of staff were raising concerns regarding the care and treatment of young, sometimes time-critical patients with highly complex needs. Appropriate action and escalation would directly impact the safety and wellbeing of those patients and their families. The review team also found it unacceptable that patients and families were having to seek resolution elsewhere, including obtaining opinions from private providers abroad, and with staff within the LLLRI service having to resort to referral of certain patients to other units such as the RNOH.

These findings also applied to some of the non-clinical service management, which appeared to lack effectiveness and stability. The review team noted a real commitment and drive towards change, in terms of addressing some of the key problems within the department, from some members of staff, and indeed found there had been talented individuals within the service working to address some of these ongoing issues who were keen to work with the whole

department, and to bring unity and move forward from an incredibly difficult period. However, the review team noted that some of these individuals had been on temporary contracts and the Trust had failed in extending their contracts and recruiting them to permanent positions, meaning they had secured permanent substantive roles outside of the department to its detriment.

The review team heard that over the months preceding the review visit there was significant staff turnover, causing a lack of stability, with certain positions remaining unfilled, or seconded out to those performing other roles at the same time. Members of staff expressed concerns about the service management, including the fact that the solutions proposed were not realistic considering the particular sub-specialty of the LLLRI service. It was apparent to the review team that certain managers focused on waiting lists and meeting targets, without an appreciation for the nuances, complexity, length and challenges of staff working to provide the LLLRI service. There was also a lack of willingness to meet with those staff members to understand their concerns and work with them to address these challenges. The review team found these issues were directly contributing to the management of new referrals, follow-ups and waiting lists becoming more constrained. [REDACTED]

As well as the need for effective clinical management systems, with all staff having the training and support to manage patient flow, the review team considered that managers and leaders, both clinical and non-clinical, should be able to work effectively and collaboratively with the clinicians, in order to address these ongoing challenges. This included taking concerns raised by staff, whether regarding patient safety or in relation to other departmental matters, seriously, escalating them and taking appropriate action, whilst keeping those staff members updated on progress in relation to such matters.

The review team found that at the time of the review there were no effective structured processes for staff to raise concerns, with expectations of how they would be dealt with, which was unacceptable. The review team were of the view that thorough processes should be developed according to best practice. They should be embedded amongst all managers and leaders, in the department and the Trust, to ensure staff are listened to, that they feel psychologically safe and supported in raising concerns, and know that those concerns will be taken seriously.

The review team were particularly saddened to hear sentiments expressed by some staff that they felt that leaders and managers did not care about the LLLRI service and orthopaedics, and a belief that they were not given the same attention, priority and resources as other specialties within the Trust. The review team considered that the department and Trust should turn its attention to this, and prioritise thinking about ways to break down disconnects which exist between managers and leaders and clinicians. This could involve arranging clinicians to spend time regularly with management and the leadership team, to build unity as well as a direct forum for raising issues in a constructive manner.

The review team also noted concerns expressed regarding leadership in terms of communication regarding this invited review, and staff not being made aware of the concerns and issues to be considered in advance of the review taking place.

### **3.6.5 Arrangements for providing cover for patients during periods of leave**

The review team considered that there did not appear to be formal arrangements and structures in place within the LLLRI service and orthopaedic department for providing cover for patients when consultant surgeons were on planned or unplanned absence leave [REDACTED]

[REDACTED]. The review team also found issues arose when other consultants took leave within the department, which led to ad hoc arrangements to provide cover to their patients, and difficulty for administrative staff in managing this.

The review team understood that when new patient referrals came in for particular consultants, they were sent to their inbox on Epic. The review team were told that if a consultant was due to be on leave, their inbox should be closed during this period, so that new referrals did not come

in, and that any of their existing referrals and existing patients under their care would then need to be redirected to other appropriate consultants within the department. [REDACTED]

[REDACTED] This section sets out that patient referrals continued to be made to a consultant who [REDACTED] had planned leave, due to their referral inbox not being closed down, which meant [REDACTED] that consultant was not able to assess those patients. [REDACTED]

[REDACTED] The review team were told that this then required service management, administrative staff and other consultants to triage the referrals and redirect them to other appropriate consultants within the department. This was a particular challenge for LLLRI patients, [REDACTED] and the review team heard about reluctance from other surgeons to take on those patients. The review team noted that [REDACTED] had previously seen [REDACTED] patients [REDACTED] however this had reportedly led to challenges when observing and managing complications, [REDACTED]. Specific individuals are referred to, and there is reference to an issue with one [REDACTED] person being prescriptive about who could provide cover for patients. [REDACTED]

[REDACTED] The review team considered that these conflicts left difficulties for the staff who were reviewing existing patients and new referrals and considering where to redirect these. The review team also questioned the practice of individual surgeons deciding who would cover their patients when they were due to take leave, when this should have been decided collaboratively as a service and department.

It was the conclusion of the review team that silo, individualised working practices were contributing to these problems. Whilst accepting that the LLLRI was a sub-specialised and niche area of surgery, as well as many of the orthopaedic surgeons having their own sub-specialised practices, the review team found there was a sense of 'my patients' and 'your patients', when the reality was that these were patients of the department and Trust. Therefore, if other surgeons could treat those patients, they should be doing so. The review team considered that this was interlinked with the fact that team working was dysfunctional, with a lack of unity and cohesion within the department. The review team considered that there needed to be more integration of surgeons within the department, so there was a shared understanding that they all had a responsibility towards patients of the department. The review team did not consider that this applied to all consultant surgeons, and they heard of individuals who were always willing to assist, particularly if this stopped theatre lists and procedures from having to be cancelled. However, the review team considered it unfortunate that this only appeared to apply to a minority of consultants, including those who had large waiting lists and other clinical priorities.

These issues were linked to the fact there had been a lack of consultant cover within the LLLRI service, and the review team considered there needed to be more than two consultants, and/or cross-site working with local hospitals, for the situation of providing cover during staff leave. The review team considered that the lack of sustainability of existing cover within the service was evident with the events which had occurred over the past few years, notwithstanding the stand still in elective activity, and recovery after the COVID-19 pandemic. The review team accepted the challenges in recruiting to a substantive position for such a sub-specialised role in London, [REDACTED]

[REDACTED] In order to gain more control over this situation in the future, the review team considered that there should be a minimum of three consultants providing the LLLRI service, who could work across the orthopaedic department, meaning that there is sufficient cover during periods of leave, and for managing volume and demand within the service, including urgent and time critical patients.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

The review team considered that the Trust should continue to recruit to permanent substantive appointments. The review team accepted there may be recruitment challenges, and considered that the Trust should look at processes and consider ways to make roles more attractive,

including seeking candidate feedback and modifying adverts accordingly. This could also involve looking at recruitment policies to make them more flexible. Given the issues mentioned regarding team working, cohesion and wider culture, the review team accepted that this would be a long-term project, and that restoring reputation would affect people willing to come and work within the department.

Better stability needs to be established within the LLLRI service to manage patient referrals and waiting lists, by addressing deficiencies in the clinic management system. There needs to be a better system to identify when staff are on leave and to flag this with service management and administrative staff, to ensure that referrals and existing patients are appropriately re-directed, and that referral inboxes are closed down on Epic as required. This would also provide accountability towards patients and families, given it was noted that referrals continued to be made despite consultants being unavailable to respond. Furthermore, the review team considered that when consultants are planning to take leave, they should work with service management and administrative staff to find an appropriate way to cover their patients, which considers the urgency of their patients' needs, their safety and gives sufficient direction to those managing their clinics. The review team also considered that the Trust should establish clear guidelines for consultants covering the case load of other consultants in the event of unexpected, or planned, absence of their colleagues, so that staff were aware of their own responsibilities and line of accountability and their commitments should be adjusted to facilitate the increased workload.

### **3.7 Adequacy of current service delivery to meet demand and maintain patient safety and future proofing the service to improve quality**

The review team did not consider that service delivery was currently safe for patients or adequate to meet demand.

The review team were of the opinion that there needs to be considerable invested effort to provide a good, safe and reliable service to patients now and to improve quality and safety in the future.

Further private and confidential correspondence between the RCS England and the Trust in relation to concerns regarding the ongoing stability and management of the service took place following the review visit, which is detailed in Appendix H.

#### **3.7.2 Management of patient referrals, follow-ups and waiting lists, theatre lists and planning, clinic management and administrative support**

The review team considered the management of new referrals and existing patients dysfunctional and disjointed, which contributed to difficulties in managing waiting lists, and booking new patient appointments and follow-ups. There was a poorly managed workflow for new patient referrals, with delays in triage, and on some occasions, double or triple handling. The review team found there were long waits for new clinic appointments, resulting in long referral to treatment times, before patients were even seen for the first time. Some patients' appointments were cancelled three to four times before they were seen, and when some patients attended for clinics they could still be cancelled to prioritise other urgent patients. The review team were made aware that administrative staff sometimes had to plead with consultants and clinicians to move patients up waiting lists. They also noted long waits for follow-up appointments. Having regard to the complex and challenging nature of patients' needs which resulted in care within the LLLRI service, the review team found this of particular concern. The review team considered that these were time critical patients and therefore review and follow-up care intervals were important, given the risks of complications and poor outcomes. The review team also noted the expectation that clinics could be managed by unsupervised fellows or registrars, which was of concern, again having regard to the complex and specialised nature of the LLLRI service.

Poor management of referrals and existing patients was noted by the review team [REDACTED]

[REDACTED] They noted that [REDACTED] referral inbox was not closed on Epic, meaning referrals continued to build and the review team were concerned about the impact on patients and families. The review team were concerned that similar issues were being faced when other consultants took leave, with a total lack of control and effective system to manage this within the service and department.

The review team found this was compounded with insufficient resources and support provided to administrative staff. Administrative staff were being told by clinical staff to make decisions regarding patient appointments and referrals, when they were not clinically qualified to make such assessments and guarantee patients were safe. The review team noted that clinics could be cancelled at short notice by surgeons, however administrative staff were on the receiving end of blame for patients then being missed. As mentioned at [section 3.6.5](#), the review team found there were insufficient arrangements for cover when surgeons took leave, which also resulted in administrative staff having to decide which patients would have to be prioritised in terms of long waiters and new patients. The review team found this to be inappropriate, and considered it was not acceptable for administrative staff to be making such decisions, and that surgeons and other clinicians should take more ownership for their patients and more responsibility for making these decisions.

These issues were further complicated by some of the orthopaedic consultants having particularly lengthy waiting lists, compared to other consultants within the department. The review team found that a number of consultants were refusing to take on and assist with other consultants' patients, including when there was capacity within their theatre lists and noted that some consultants refused to do ad hoc clinics, and raised challenges about being paid before agreeing to see patients or take on additional clinics. Whilst this is undoubtedly unhelpful, a robust service cannot depend on additional waiting list activity. However, the review team found this did not extend to all consultants, and it appeared that some, including those with large waiting lists of their own, were more willing to offer their assistance to the rest of the department, in an effort to continue service provision. The review team noted that the consultants had very sub-specialised practices, which may have contributed to reluctance to take on each other's patients, however there may be some areas of overlap and some general cases that could be better shared.

It was particularly concerning to learn that there were a number of patients with highly complex needs who had been waiting a significant amount of time for procedures. This included procedures [REDACTED] which were not possible, with devices not licensed on the UK market; yet patients had been consented for such surgery. Some patients and their families were then adamant about having the surgery [REDACTED] for which they had given their consent, despite this not being possible as a result of inappropriate decision making, implant availability and advice given. The review team noted there were also patients [REDACTED] who had reached adult age whilst on the waiting list, and were consequently being referred to the RNOH for care and treatment. The review team also found there were patients [REDACTED] who were being seen within the service for follow-up care and treatment, who were presenting with complications and poor outcomes. Such patients and their families were referred to the RNOH for second opinions.

At the time of their review visit, the review team were surprised that some patients were being referred outside of the Trust, when apparently it appeared entirely possible to manage them within the service. As further information was gathered, it appeared appropriate that a number of patients had sought second opinions or were transferred to adult services at other hospitals including the RNOH. However a number of patients had transition of care to adult services having not completed their treatment within the Trust in a timely manner, thereby losing their childhood waiting, which the review team considered to be unacceptable. A further subset of patients appeared to be transferred to various other hospitals within the London region for no good clinical reason, as other clinicians in the department had the relevant expertise to treat them. The review team observed this practice [REDACTED], with no clear motive.

It was reassuring to the review team that notwithstanding all of these constraints and challenges, there were committed, professional, skilled and experienced clinicians within the service and department, doing their utmost each day for their patients, amongst running busy clinics and managing a high workload volume. This included seeing patients to obtain and confirm consent, close to the time of their scheduled surgery. The review team were encouraged to hear many staff enjoyed working within the service and department, and to hear interviewees describe particular staff, including the CNS team and the physiotherapists, as the ones keeping patients and services safe and running.

Given that problems throughout the patient pathway appeared to stem from lack of control over the issues within outpatients, the review team considered the development of a robust outpatient clinic management system to assess priority, manage demand, volume and waiting lists and to ensure timely access to treatment, to be a pressing issue. This should include improvement in managing workflow when consultants are on leave, as well as a method to highlight time critical patients to clinicians when clinics are cancelled in order to maintain control over any risks to patients. The review team considered that establishing a better system within outpatients would enable the service and department to gain better control over theatre and other waiting lists. In order to ensure the successful implementation of such a system, administrative staff will need sufficient support, training and resources.

As detailed earlier in this section there were issues with theatre planning, with some consultants less willing to work with junior staff, and consultants refusing to take on other patients, and some of this reluctance could have been due to the sub-specialised practice of the orthopaedic consultants. The review team also considered this was likely to be due to conflicts arising with private practice and other similar commitments of consultants. They accepted this did not apply to all of the consultants, some of whom went above and beyond to offer their assistance and this extended to running theatre sessions on weekends. However, the review team noted that complex and lengthy procedures were being listed on weekends, which tended to overrun, resulting in long working days, which they did not consider to be safe for patients and staff. They noted that there would be reduced immediate medical assistance available at weekends, in the event of complications and emergencies which needed escalation. The review team considered that the weekend theatre lists were reliant on the good will of staff volunteering to work on Saturdays, and given there were so few volunteers, this was primarily taken on by team leaders and coordinators. However, the review team noted that given the frequent occurrence of sessions overrunning, and theatre lists finishing significantly late, even those staff were now reluctant to attend on weekends.

The review team considered that this system needed urgent review, considering the suitability of cases which are listed at weekends and better planning in terms of the number of procedures added to theatre lists. This would require staff to have the relevant information about procedures in advance, being booked under the correct codes on Epic, and having important details uploaded. The system for weekend cover of theatre lists also requires review, with additional incentive for staff volunteering to work on weekends, through extra sessions being paid at an additional rate. There should be effort to ensure such initiative lists are equitably allocated, and to ensure oversight of the number of shifts, with a limit on the number of consecutive lists that an individual can volunteer to take on. In this respect, the team leaders/coordinators should not be able to take on an excessive number of shifts, which the review team considered could put the routine weekly service at risk. The review team also considered that staffing should be reviewed, and if there are too few staff available, weekend lists should not be able to go ahead. There would be value in trialling such a system, and monitoring whether it helps to make the theatre day manageable for staff, and to avoid excessive overrunning of lists.

Having regard to sub-specialised practice, the review team noted that it was particularly specialist consultants who had large waiting lists, which is why they required more theatre lists at weekends to manage their backlogs, and they did not have other appropriately specialised colleagues to help tackle these waiting lists. The review team noted that a business case had been submitted for a neuromuscular consultant, but it appeared staff were unaware of the

progress on that matter, and the review team considered that this required prioritisation with better communication and oversight from managers and leaders. The review team considered that leaders within the department and Trust should ensure staff are kept informed in this regard.

### **3.7.3 Service management, administrative support and clinical leadership**

There appeared to be a significant lack of collaboration and cooperation from clinical staff with administrative staff and service management. The review team found that solutions had been proposed by the service management to these long-standing issues, in an effort to work creatively with the clinicians and restore unity to the department. However, they noted that service management were met with resistance, and sometimes hostility from some of the consultants and clinicians. Some of the clinicians expressed a lack of understanding from service management about the way the LLLRI service and orthopaedic department worked, and believed some of the service management's suggestions were unrealistic and inappropriate. However, the review team considered that, whilst the service management appeared to be flexible and willing to work with the consultants and clinicians to reach a way forward, they were not always met with that same willingness and constructiveness in order to reach resolution. It was evident to the review team that the issues identified in respect of team working and cohesion within the department extended to a division between service management and administrative staff, and the surgeons and other clinical staff, when there was a need for the parties to work collaboratively and cooperatively, including being open and flexible to new ways of working. This was another area which required a shift in working culture in the opinion of the review team.

It appeared to the review team that there was variability in the ability of administrative staff to manage patient referrals, which alluded to a lack of sufficient training, support and resources. The review team noted reports of preferences for particular secretaries by some of the consultants and/or refusal to work with specific individuals. It appeared that there were long-standing historical issues with performance of some administrative staff, which had not been adequately dealt with by a number of managers over a period of time, and there was also a lack of support given to specific individuals and recognition of the challenges which they were experiencing. In this respect, the review team heard about staff who had reportedly been under performance management processes for a substantial period of time, with it appearing that these issues had not been sufficiently dealt with by previous managers (albeit they heard different perspectives from staff around sufficient support and training for said administrative staff).

The review team noted there was a large turnover of non-clinical staff and a consequent lack of ongoing stability, preventing staff getting to grips with the clinic management system and the issues faced within the service, and to be able to see through solutions on a long-term basis. This was evident with examples of underperforming non-clinical staff, with issues being passed through multiple managers and not sufficiently handed over, and moving individuals to work with different consultants, rather than addressing the specific issues with their performance and their individual needs.

The review team noted that this had contributed to strains with resources, leaving gaps within the service, and difficulty amongst service management to ensure a fair allocation of administrative resources to clinicians, whilst being constrained with the ability to hire more administrative staff. It is imperative that administrative staff are supported and properly trained, in order to be able to manage a robust clinic management system, and to work effectively with consultants and other clinicians. It is also imperative that service management and leaders have a firm handle on performance management processes, to address them sufficiently, consider everyone's needs and bring them to resolution, supporting the individuals concerned, for the benefit of the wider department, as well as thinking creatively about how to utilise current administrative staff and resources in the most effective manner for the service.

These serious issues were compounded by the variability of consultants' understanding and being able to utilise established protocols for managing their patients, through Epic and written correspondence. It was noted that some consultants requested all clinical correspondence to be physically printed, which was an onerous administrative task. The review team considered this

was unreasonable and that consultants should be able to navigate the system. The review team also heard that administrative staff faced unacceptable and unprofessional behaviours from particular consultants if things did not run how they expected. It did not appear to the review team that these consultants valued the administrative staff, and this had contributed to a divide between the consultants and administrative staff.

Having regard to turnover within the department and the poor management of this, the review team found a lack of stability amongst the service management, which became evident over the course of this review. They noted that there had been vacancies which took a long time to fill, that staff on fixed term contracts were not provided with sufficient notice of managers recruiting substantively for their positions and/or kept informed as to what was occurring in a proactive and efficient manner, resulting in them finding permanent positions elsewhere in the Trust for security. The review team considered that there was a lack of foresight and recruitment planning, despite leave arrangements within the service management team being known about. The review team noted staff commented upon the loss of particular talented individuals within the service management, who made good headway in learning the roles, enjoyed their work and who had made good progress in addressing some of the challenges described. The review team found this disappointing, and considered that with better foresight and a proactive approach, such individuals could have had their contracts extended. It was noted that positions were not filled internally, resulting in external appointees, and lengthy notice periods where vacancies still remain unfilled. Alternatively, these positions were filled with interim roles, with individuals seconded from, and still performing existing roles at the same time, in other departments. As a result the review team found there were periods where the department lacked sufficient cover due to these poor arrangements, and with the high turnover, staff were not building up enough experience to guide administrative staff in the way they needed, and not addressing long-standing challenges within the service. The review team considered that these interruptions led to mistakes and directly contributed to current difficulties in terms of maintaining control over referrals and waiting lists.

It was concerning to hear that, whilst these issues were persisting, there were lengthy periods when incoming service managers, including those in interim positions, had not met with the consultant body. It was noted that current service management appeared to focus on the patient tracking list and waiting lists within the service. Whilst these were important issues, it appeared there was a lack of understanding that the focus on bringing down waiting lists, and the requests made or suggestions proposed, were not achievable, with regard to the complex nature of LLLRI patients, and the fact that these patients had challenging needs, and may often require multiple appointments to facilitate the right decisions regarding their treatment. The review team were also concerned that this was the main focus of service management, but there was no information to suggest that they were willing to engage with clinicians about other issues which impacted them. The review team considered it likely that time was a factor in this, particularly for individuals seconded from departments where they were continuing to undertake duties at the same time. However, the review team found that this left staff feeling let down and left behind, and with the perception that orthopaedics was not given the same level of priority as other services within the Trust. The review team could understand staff feeling this way, and this being compounded by new members of staff being less willing to engage with the clinicians in a meaningful way to understand their day-to-day challenges. The review team considered that such issues were contributing to disharmony and an increasing divide between clinicians and non-clinical staff.

It was noted that when potential patient safety concerns were raised with service managers, they were not always dealt with with the level of urgency expected. The review team noted that when such concerns were raised, staff were reportedly told that a plan was in place, and that managers were 'doing what they could', but there was no further communication and feedback, and in many cases staff had to chase what was being done. The review team found no information to suggest that these were being prioritised, either by service managers, or clinical leaders in the department.

The review team considered the lack of stability and disorder within service management, and lack of functional working relationships with clinicians was contributing to the wider dysfunctional

team working within the department. The Trust should ensure vacant substantive positions amongst service management are filled as soon as possible in order to maintain service delivery, ensure patient safety, and to provide reassurance to all staff. The review team considered that every effort should be made to keep individuals in posts, avoiding the need for interim positions and reliance on fixed term or other less secure employment contracts, even if this means creating dual positions and/or renegotiating other roles when staff return from periods of planned extended leave.

The review team considered that the challenges described also affected recruitment and finding consultant cover, including the disruptions impacting the amount of time it took to find cover [REDACTED]. Furthermore, they noted that clinical fellows had been due to start in the service in January 2023, however this was delayed by three or four months, as letters were not sent on time. The review team accepted this may have been impacted by HR processes, and communication with this department. However, they considered effective cross-departmental communication was essential to prevent such inefficiency in the future.

The review team considered that the ongoing breakdown in relations between [REDACTED], the lack of team working and consequent dysfunctional department is something which should have been addressed by having proper leadership and governance arrangements in place. The review team found that the leadership had manifestly failed in their responsibility in this regard. The review team found that from Board level, to the level of clinical lead, there was clearly an absence of ownership in a visible problem, which was protracted in its duration. The review team considered that the deterioration of the service overtime sat within the responsibility of all of those within leadership positions, but they were of the view that the Chief of Service and Chief Medical Officer should have a clear role in their responsibility for this situation, and in ownership of the service improvements which are required.

### **3.7.4 Consultant cohort and recruitment and long-term sustainability of the service and department**

During interviews the review team explored whether the LLLRI service was considered safe for patients and had the capacity to meet demand, [REDACTED].

[REDACTED], during which time the review team considered that patients and their families were likely to have been impacted by sub-optimal practice. The review team also had concerns regarding there being only two surgeons providing such a complex sub-specialist service within the orthopaedic department. Given this, and [REDACTED], the review team considered that the Trust had not been delivering a safe service for patients.

It was clear to the review team that vulnerabilities within the service were historical, [REDACTED]. However, they considered that these issues were compounded by poor practice, and disharmony developing when concerns were raised about such poor practice. The review team noted, from interviews and background documentation, that there were concerns about [REDACTED].

— This section describes that there were historic issues within the Trust, including “sub-optimal practice” which does not relate to anyone employed at GOSH at the time of the review, which “could have led to poor practice developing unchecked, which then took a long time to surface in the department”.

The review team noted that a former surgeon who provided the LLLRI service left the Trust [REDACTED], but the Trust did not advertise for their replacement until some 18 months later, [REDACTED]. In between that time, there appeared to be a lack of adequate

communication from leaders, as [REDACTED] was reported to have ‘just turned up one day’ without any discussion with the rest of the consultant body.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] This section explains the temporary arrangements that were put in place to support clinical staff within the LLLRI service, but states that “*this arrangement was no longer sustainable for the service and the department*”.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] The Trust should therefore ensure risks of this continuing indefinitely are addressed, and that any future reliance on such support arrangements, including with use of honorary contracts (which there appeared to be an over-reliance on), are clearly defined with stricter time periods, so that they do not overrun, and impact on the unity and running of the department.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] This section describes how the department has changed since the request for a review was made, and sets out that the staff need “*support, guidance, training, teaching and mentoring*” in order to ensure the practice and confidence of staff is not affected.

It was the review team’s view that significant attention is needed to consider and plan for the sustainability of the service in the future. This includes having a sufficient cohort of permanent/substantive consultants, in order to provide collegiate support, MDT advice and case discussion, and cover during periods of planned or unplanned absence. This was particularly so given the review team’s concerns over the existing processes in place to ensure regular MDT discussions, and other structures and clinical governance processes within the department. The review team accepted there have been recruitment challenges for permanent substantive sub-specialised roles and noted that the LLLRI service was a niche area, with a discrete number of suitable candidates who were willing to apply and take up such a position within the Trust. Addressing concerns regarding reputation, culture and leadership will have an impact on the willingness of candidates to apply, but the review team were of the view that a tertiary referral centre of international reputation should be able to recruit within existing and experienced consultant cohorts within the UK. The Trust should explore creative and innovative recruitment processes, offering flexible options, and thinking about how to make positions more attractive. As well as considering business cases for more consultants, the department could consider cancelling activities in order to prioritise clinic capacity. [REDACTED]

[REDACTED]  
The review team considered a combination of some full-time and part-time clinicians could help. In addition to reducing reliance on locum contracts, the Trust could consider requesting direct support from consultants in other units, including inviting consultants on secondments from their base organisations to cover gaps in the service. The Trust could also consider an official liaison with other orthopaedic units, to increase the base number of consultants, to be able to better provide consultant cover during leave, and more stability within the service. There could also be more dual consultant operating to support less experienced clinicians. The review team were of the view that the Trust could better utilise the wider MDT, including CNS staff, physiotherapists,

registrars and fellows, to see patients alongside and/or instead of a consultant, as long as there is sufficient supervision or support available within close vicinity. Any external support arrangements should be carefully managed.

This attention to 'outside-of-the-box' options for recruitment and cover could extend to other sub-specialty provisions within the department, noting earlier observations around the business case for a neuromuscular consultant, with no further communication to staff around this. With the very sub-specialised practices which exist within the department, there should be sufficient resources, and if staff raise concerns about this, leaders and managers should listen and see what they can do to prioritise these issues. If this is not feasible, staff should be kept routinely updated, rather than being left with no information for lengthy amounts of time.

The review team had regard to consultants' workloads, alongside some undertaking private practice. Whilst the latter was outside of the remit of this review, they did consider that managers and leaders should explore and bear this in mind, if it was impacting the time and capacity of clinicians to deliver good services within the NHS, and having an impact on the wider MDT. This was particularly so given the review team's observations concerning the variation in willingness of some of the consultants to assist with patients and theatre lists of other consultants. They considered it unreasonable that certain consultants were refusing to assist with patients in the department, where that assistance was required, and this was not a reasonable position to take when working as part of a team and consultant body. The review team considered that this will require real creative and serious commitment on the part of the Trust to address, particularly if there is an issue of conflicts with private practice and other commitments of clinicians, which the review team accepted was complex and sensitive in nature.

Having regard to the sub-specialised practice within the department, the review team considered there appeared to be consultants employed who had little experience of complex paediatric work. This is something the Trust should bear in mind when recruiting to more substantive positions in the future. The review team were also made aware that there were senior clinicians approaching retirement, and some who had reduced programmed activity to balance their time with other commitments. [REDACTED]

[REDACTED] The Trust should turn its attention to succession planning, when considering arrangements to handover the practice of long-standing colleagues, which will take some time to plan for, alongside work to provide minimum levels of sufficient cover within the service, and to withstand staff taking leave. The review team considered this was all critical to ensure the long-term viability of the LLLRI service and orthopaedic department, to ensure patient safety and prevent patient harm. In addition, this is needed to support the training, professional development and wellbeing of all staff, clinical and non-clinical, with adequate opportunities for mentoring, assistance, supervision, discussion and training, to restore a high standard and quality of service provision to patients, and to re-build the service after significant challenges.

### **3.7.5 Utilisation of specialist practice registrars, fellows and allied healthcare professionals**

It was the review team's view that consultants appointed within the department should have a minimum of two years of experience working in paediatrics. They considered this important not only given the fact that this was a tertiary unit with a reputation as a centre of excellence, but also because of the Trust's reputation for teaching and training. Consultants within the department should have sufficient skills, knowledge, experience and expertise to identify suitable cases fellows and registrars can train and learn from. At the time of the review the review team did not consider this was sufficiently occurring, which they considered sub-optimal, as it was believed by staff that they were under-utilised and an un-tapped resource for running clinics and routine theatre lists. Better utilisation of registrars and fellows would work well, as long as appropriate supervision was available from consultants, and this could help plug gaps in the service, and prevent appointments and theatre lists from being cancelled. The department could also make better use of the wider MDT, including CNS and physiotherapists, to see patients, as long as there was appropriate identification of cases, and this was flagged within the clinic management system, and appropriate on-hand assistance was available. The review team

considered given the Trust was a teaching hospital, such arrangements would help in terms of restoring reputation and status within the department.

Generally, there should be more working across different teams, rather than the current silos which had developed around specific consultants. Cross-working of CNS and physiotherapists across different consultant teams would be an important part of developing this service and department, to support broad skills mixes, and training for incoming and junior staff, to learn the different requirements and preferences for different consultant sub-specialised practices. The review team had similar observations around nurses and other allied healthcare professionals working in theatre with consultants, and considered that rota staff should be supported in flexibility for placing all staff with consultants, and consultants should not be able to refuse to work with certain individuals. Again, this would assist in developing skills, knowledge and experience, and learning a range of preferences and requirements, for new staff. This would support their development, growth, and ideally, retention within the Trust, as well as allowing more effective theatre coordination and management.

### **3.7.6 Hub and spoke working**

The review team understood informal links were being built with the RNOH, [REDACTED], and referrals were made there for second opinions and when patients had reached adult age. However, aside from this, there appeared to be limited hub and spoke working between the department and other local units.

In the opinion of the review team there were a number of options to build upon hub and spoke working and existing links with the RNOH and other units. This could help to plug gaps in service delivery, maintain cover and service provision and help future proof the service. One option could be to formally combine the LLLRI service with the RNOH, to provide a transitional link from paediatric to adult patients, as well as building on MDT structures and processes in clinical decision-making. The review team considered that official cross-site working could help build a larger department with more resilience, in order to meet service demands and the needs of patients. It could be that surgeons working at the RNOH practised as visiting surgeons at the Trust, with ward round rotation supervision, and some of the Trust's clinical fellows could be placed to work at the RNOH. Such arrangements could be effective when visiting surgeons required the specialist anaesthetic, CNS and other speciality care available within the Trust. There could be exploration of a surgeon of the week model, where consultants rotated their base unit on a weekly basis and/or with surgeons being job planned to divide their time across two sites. Alternatively, it could be that there were surgeons who worked on the ground at each unit on a daily basis, and this would provide better continuity of care for patients.

The challenges with building such links with the RNOH or other units were recognised by the review team, who noted reports that there may be reluctance from the RNOH consultants to get involved with the Trust in light of ongoing problems. Furthermore, the review team understood that the RNOH did not appear to have the equivalent level of paediatric medical support as the Trust, being purely an orthopaedic hospital. Having the LLLRI service at the Trust as purely spoke to the hub of the RNOH may also cause difficulties with the day-to-day management decisions of the physiotherapists and nursing staff. This will therefore require careful consideration by Trust leaders, and ongoing discussions, to come to agreement on arrangements which would work well for everyone, including building trust between the consultants in different units.

The review team noted that [REDACTED] engaged in regional/London MDT meetings through invitations to attend, participate and collaborate, although it did not appear that all consultants took up such invitations. The review team would advise the Trust encourage more of the consultants within the orthopaedic department to make use of such opportunities, in order to seek advice, discuss cases and obtain and share best practice. The department could enhance MDT processes and structures through attendance at the RNOH MDT meeting, where all clinicians could benefit from the sharing of expertise. The review team would also encourage the Trust to work closely with local private providers to learn from each other, including in relation to incidents, concerns which should be investigated, and those which should result in practice

restrictions, to support action being taken in a timely manner when required. They considered this to be important having regard to the matters expressed in this report regarding the handling of and responding to concerns about patient safety, and what appeared to be protracted processes for escalating such concerns.

In the review team's experience it was rare for any service/department to function properly with only a few consultants, [REDACTED]. Having regard to the unique challenges which exist within the department and the Trust, unless there are creative attempts to utilise links with other units including the RNOH, the review team did not consider that the service is sustainable to run safely and effectively at all in the future. Therefore, in addition to evaluating a range of recruitment options, the review team considered it is essential to build such formal links with other orthopaedic units.

### **3.8 Other**

The review team made observations in relation to the following matters, which they considered formed part of important contextual factors in relation to this review. Some of these matters were briefly referred to previously in this report, in so far as they overlapped with the review team's other findings.

#### **3.8.1 Culture and leadership within the Trust and priorities given to orthopaedics**

As mentioned at sections [3.4.2](#) and [3.6.4](#), the review team had concerns regarding the culture and leadership within the department, given concerns were not treated with priority, and staff did not always feel listened to and supported. Furthermore, the review team did not consider that leaders and managers had a firm handle on running the service, which affected staff on a daily basis, when it came to delivering patient care.

The review team considered that this poor culture extended to the wider leadership and governance within the organisation, with it appearing that those at Trust Board and governance levels were either not particularly involved or proactive in relation to, or did not have sight of, these matters. There was little or no 'ward to Board' oversight. This was evident to the review team from some of the incidents and issues reported in risk and governance meetings, which appeared to remain as ongoing issues for extended periods of time, without sufficient update and action to take them forward. This also extended to requests for business cases for more resources, including staffing, with a failure to keep staff updated on progress and outcomes in this regard.

The review team noted from interviews that leaders reported that the 'noise in the department' had not reached their ears. The review team accepted that some staff may have been reluctant to raise concerns with those in senior positions for various reasons. However, they considered that staff had made multiple attempts to raise concerns with leaders, regarding patient safety, service delivery and issues with members of staff, but leaders did not appear to take timely and effective action, before problems escalated. Individuals appeared to shirk responsibility, passing blame elsewhere, and making it appear that their hands were tied. In the view of the review team, there was no excuse for the failure to listen to staff, support them and escalate matters of concern. It was encouraging to know that expected clinical governance practices such as the risk and governance meetings and executive incident review panels existed, and that the Trust would utilise these when required and appropriate, however they did not appear to be used enough. As well as building on such existing processes to ensure they are more robust, the review team considered that senior leaders and managers need to do better when it comes to staff reporting their concerns, verbal and written, to show that they take matters seriously.

The review team found that a divide existed between clinicians and leaders, with clinicians not feeling as if leaders understood orthopaedics and the LLLRI service. They heard reports from staff that other specialties and departments within the Trust appeared to be given more priority and resources than orthopaedics, including cardiac surgery, intensive care and cancer services, with a new 'state of the art' cancer centre currently being built. Some staff believed that the

Trust 'did not care about orthopaedics', and this also fed into the reluctance of some clinicians to take their concerns to the top level of the organisation. Such sentiments were disheartening to hear, but this was a valid feeling amongst staff, and the review team considered that there needs to be more commitment from leaders to changing this perception.

There needs to be a serious culture change and commitment from leaders and managers, to ensure the longevity of orthopaedic services. This would involve understanding staff needs, taking their priorities seriously, and giving all departments the resources they needed to improve patient safety, including communicating with them when this was not possible. The Trust has a number of issues to address in order to improve the LLLRI service and orthopaedic department, and to make the changes required to run a high quality and functioning department and service in the long-term for patients, families and staff. These changes should prioritise restoring the reputation and quality of these services for the future and addressing wider cultural and leadership issues.

### **3.8.2 Private practice**

During the course of the review it became apparent that competition for lucrative private practice in nearby units had become a source of conflict between different consultants. The review team accepted that this was an external matter for individual staff, and outside of the remit of this review, but did consider it could impact staff, their behaviours towards each other, and engagement with the patients and needs of the service. The review team therefore considered this had the potential to impact patient safety, and considered it to be directly linked to some of the background of this review. The review team understood there was a level of freedom to undertake commitments outside of NHS work. However, they considered that there was a lack of clarity around how consultants were providing services to Trust patients from other units, and there appeared to be a lack of clear governance structure between said private and NHS practice. Therefore this lacked a transparent line of accountability. For example, concerns were raised about care provided to Trust patients, who had subsequently been reviewed and treated in the private sector, but this reportedly had not been fed back to the Trust. No concerns appeared to have surfaced in this regard, but that did not prevent a risk, and of conflicts of interest materialising in the future. Consultants had large waiting lists and patient volumes, and the review team considered that there were only a finite number of hours in the day to undertake such duties alongside private practice arrangements on different sites. The review team were made aware of concerns regarding rushed decision-making, and rushing through briefs and aspects of theatre lists, including it being difficult to find consultants on wards and during end of the day theatre de-briefs. The review team therefore considered if these additional commitments, were affecting consultant time, capacity and availability, which impacted other staff and patient care at the Trust.

It was accepted that the Trust would have limited control over the commitments that clinicians took on outside of NHS work, including private practice. However, given the serious risks and impact this could have on service provision and patient care, the review team considered that the Trust should consider robust management and mechanisms to prevent this, as well as any conflicts of arising between private practice and NHS services within the Trust. The review team also considered that there is a limit to the number of demanding deformity cases which can be tolerated by a surgeon at any one time, and this, compounded by a busy private practice, could lead to unhealthy work-life balance. The Trust could therefore consider if limits are appropriate, to prevent mental overload, and to support the wellbeing of consultants.

The review team accepted that many clinicians sought private practice in order to meet their various living expenses. The review team considered that the Trust could consider offering financial incentives to medical staff who do not have private practice, such as regular waiting list work, in order to retain staff and avoid a 'brain drain' to other units, including overseas. This could be another way of addressing current challenges posed, and helping to tackle waiting lists. Consideration could also be given to M&M and other case review of private practice work, within NHS governance structures, to aid appraisal, identify problems and to share learning and best practice. This could be an extension of exploring creative suggestions for joint working and

formalised links with other orthopaedics units, and having more consultant participation in regional MDT meetings.

## 4 Recommendations

### 4.1 Urgent recommendations to address patient safety risks

The recommendations below are considered to be highly important actions for the healthcare organisation to take to ensure patient safety is protected.

1. The Trust should review the contents of this report and take any action that is considered appropriate to ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20<sup>16</sup>.
2. The Trust should review the contents of this report, and discuss them with all relevant staff within the orthopaedic department and LLLRI service and the Trust. Prior to doing so, it should consider its obligations towards staff, in relation to confidentiality, and to patients, in relation to GDPR<sup>17</sup>. To improve and promote transparency the Trust is encouraged to share as much of the full report within the orthopaedic team as possible.
3. The findings of this report should be brought to the attention of the highest levels of senior management of the Trust for their consideration.
4. The Trust should follow-up with all staff who have raised concerns, through all different mediums, in relation to patient safety, [REDACTED], and provide adequate support to those utilising whistleblowing processes. This would include patients who did not form part of the separate clinical record review (where detail regarding those [REDACTED] patients will be set out in a supplementary report). The Trust will need to investigate further (including consideration of a formal review, whether internal or external), seek assurances around patient harm, and where appropriate, consider Duty of Candour disclosures to patients and families. The mediums through which the review team were told about patient concerns are listed in Appendix C, which should be a starting point for management to respond and escalate as required.
5. The Trust should follow-up patients in relation to the following:
  - a) Patients who have previously had a lengthening nail to ensure these have been removed.
  - b) Those who were waiting for lengthening plates or nails, to assess if these are time critical and/or if there are other suitable treatment options.
  - c) Any cases resulting in amputation.
  - d) Those who have reached adult age, to ensure appropriate transition arrangements have been made.
6. The Trust should consider having a minimum of two, and at least three surgeons, to provide the LLLRI service with sufficient cover during periods of leave. Efforts should be maintained for a substantive and long-term appointment, with sufficient experience, within the service. In order to assist with having a sufficient cohort of staff for LLLRI and other orthopaedic service delivery:

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<sup>16</sup> The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: <http://www.legislation.gov.uk/ukxi/2014/2936/contents/made>

<sup>17</sup> The General Data Protection Regulation (GDPR) 2016: <https://gdpr-info.eu/>

- a) Consideration should be given to cancelling certain activities to prioritise clinical capacity when required.
  - b) A range of full-time and part-time clinicians should be available within the department.
  - c) Request direct support from consultants in other units e.g. inviting consultants on secondments from their base organisations to cover any gaps within the service.
  - d) Consider official liaison with other orthopaedic units in order to increase the number of consultants who can support the service.
  - e) More effective utilisation of registrars, fellows and the wider MDT, including CNS staff and physiotherapists, should be considered to plug gaps within the service and run clinics, with supervision from consultants as required, which will be assisted by the development of a more robust clinic management system.
  - f) Develop clear guidelines establishing consultant responsibilities and accountability when providing cover for patients during periods of absence.
  - g) Pay attention to succession planning, for the senior consultants within the department who are approaching retirement and lessening clinical activity.
7. The Trust should ensure consistency in pre-operative processes for clinical decision-making, MDT case discussion and consent, as well as making sure such processes are clearly defined. Matters should be discussed thoroughly, with the MDT, and with patients and their families, prior to agreeing on decisions, and such discussions must be documented within the patient record, and signed off on the consent form when required.
8. Developing structured MDT processes as follows:
- a) Consistent, defined pre-operative processes for assessment, MDT case discussion, clinical decision-making and consent, which are discussed thoroughly amongst the MDT, with patients and their families, and documented clearly in the patient record, including a cooling off period for the consent process which should take place over at least two encounters whenever possible.
  - b) Identifying current best practice amongst consultants and their teams, and seeking to replicate this across the department.
  - c) Having regular scheduled MDT case discussion meetings with time set aside, formal agendas, minutes and attendance taken, and documentation available to all staff following meetings in a centrally available location.
  - d) Ensure MDT decisions are captured within the patient record.
  - e) Build on existing case conference mechanisms to establish specific, regular scheduled meetings for LLLRI work, to allow for case discussion, advice and assistance, MDT agreement on decision-making, and feedback on post-operative cases. These meetings could involve wider consultants within the department, in the Trust and/or in other units.
  - f) Establishing a formal local network for sub-specialty surgeons, to ensure regular pre-operative complex case discussion.
  - g) Encourage consultants to participate in regional MDT forums, such as at the RNOH, and any other useful mechanisms to support LLLRI and other complex practice.
  - h) The department should utilise more dual consultant operating, to support less experienced clinicians and assist with complex procedures.
  - i) Provide resources to support these processes, including ensuring staff have protected time to engage and participate, balancing this with clinical commitments.
9. The practice of holding pre-operative assessment and consent clinics should be encouraged as best practice. There should be sufficient time for pre-operative assessment and obtaining consent, with plenty of opportunity to consider and document findings of examinations and investigations, and to discuss all treatment

options with patients. This information should be clearly recorded within the patient record, particularly for the benefit of any clinicians taking over the patient's care.

10. Making M&M processes and meetings more robust as follows:

- a) Produce formal agendas, listing patients to be discussed, and circulating these before meetings.
- b) Produce formal, written criteria for referring cases to M&M, including defined mechanisms for escalation and action points, and ensuring all staff are aware of these criteria.
- c) Ensure any allied healthcare professional within the MDT is able to raise concerns and put patients forward for discussion at M&M, including patients whose care is ongoing, and discouraging any prevention of discussion whilst waiting to see how patients' conditions progress.
- d) Efforts should be made to ensure meetings run collegiately, with all staff feeling psychologically safe to participate and that their contributions are valued.
- e) In addition to capturing discussions and updating the PowerPoint slides after meetings, salient points of discussion and learning should be recorded within meeting minutes, which along with the slides, are circulated after the meeting and can be accessed by all staff in a centrally available location.
- f) M&M meetings should be used as an opportunity for not only discussing complications and worries, but also sharing best practice, achievements and positive cases and wider learning.
- g) Sub-speciality specific complications should be discussed with other sub-specialists, with sub-specialty M&M meetings as part of a regional network.
- h) The department should monitor and evaluate learning and action points discussed during meetings to ensure they are acted upon and lead to improvement. This could include keeping track of arising actions from meetings within formally captured minutes, and seeking updates on their progress at subsequent meetings.
- i) Preparation for, recording and documentation produced at M&M meetings should be supported with sufficient resources, as well as clinicians having sufficient job-planned time to input into these processes.

11. To improve team working, communication and the unity of the department:

- a) Ensure concerted effort to integrate incoming and junior members of staff of all disciplines into the department, including providing guidance, training and support, to ensure the development of a mix of skills, experience and knowledge, in order to support the day to day running of the department.
- b) Explore tools such as mediation, coaching, reflection, buddying and mentoring, with external facilitators where appropriate, to resolve long-standing tensions and entrenched behaviours, to promote healing from a difficult period and to restore cohesion within the department.
- c) Explore informal activities to restore a sense of a united department.
- d) Address unprofessional and hierarchical behaviours and poor communication directly with individuals promptly, to send a message that this will not be tolerated. Trust policies should be enforced, to remind employees of their responsibilities and the need to treat everyone with respect. Where informal discussions do not lead to resolution, formal processes should be utilised, including seeking guidance of the HR department where necessary.
- e) Managers and leaders should be invested in addressing poor practices and behaviours, responding to concerns appropriately, with sensitivity, and in improving working culture. To assist with this appropriate training to managers and leaders in responding to concerns and unprofessional behaviours should be provided, as well as ensuring leadership in managing the day to day challenges of the department. Sufficient resources and priorities should be given to the LLLRI service and

- orthopaedics, with investment in bridging the gaps between managers and leaders with clinicians, to enable all staff to work effectively together.
- f) Consultants should not be able to refuse to work with particular members of staff, across all aspects of patient care, as well as working with non-clinical staff.
  - g) Maximise opportunities for face-to-face discussions within the department, on a formal and informal basis, for clinical and other matters.
  - h) Facilitate regular meetings between those in management and leadership positions with clinicians, to break down divides, build unity and provide a direct forum for clinicians to raise issues in a constructive manner.
12. The service and department should maintain efforts to build a more robust clinic management system which can assess priority, manage demand, volume and waiting lists as follows:
- a) Devise and implement a better system to identify when consultants are on leave, to flag this to service management, in order to appropriately re-route referrals and provide cover for existing patients.
  - b) When consultants are on lengthy periods of leave, this should be flagged to appropriate staff, and their referral inboxes on Epic should be closed accordingly.
  - c) Time critical patients who urgently need to be booked into clinics should be easily highlighted, including when clinics are cancelled.
  - d) Highlight which patients require consultant input, and those which can be managed by fellows, registrars and the wider MDT.
  - e) Flag patients reaching adult age that require transition referral to other units.
  - f) Easily highlighting and notifying consultants of referrals which need triaging, including of delays.
  - g) Ensure sufficient resources and support within the service management and administrative staff teams. Thorough training should be provided to administrative staff.
  - h) Collaboration from consultants and clinicians when working with administrative staff. This may include further training for clinicians in using systems like Epic, to enable the successful working of a clinic management system, and to adapt to current ways of working. Staff should not have to print out electronic clinical correspondence.
13. Exploring an effective system for providing consultant cover for patients during absence, with clearly defined guidelines setting out the responsibilities of staff, with existing patients and referrals re-directed to other consultants, and Epic referral inboxes shut down as required. Consultants should be willing to offer assistance, and be flexible with arrangements such as ad hoc clinics and supporting fellows/registrar to see patients where possible, working collaboratively with administrative staff to achieve this.

## **4.2 Recommendations for service improvement**

The following recommendations are considered important actions to be taken by the healthcare organisation to improve the service.

14. To improve clinical record keeping and communication with patients and families:
- a) Have a clearer system to link radiology from the TraumaCad system to the patient's record on Epic so that pre-operative planning can be understood by others accessing the system.
  - b) Streamline processes for completing operation notes, to reduce times spent by patients waiting in recovery.
  - c) Ensure any clinical notes completed by fellows/registrar are appropriately checked and signed off by the operating consultant.

- d) Provide support to clinicians, including further training where required, with use of Epic and/or other technology to enable them to work effectively and ensure patient records are kept updated efficiently. This should be mandatory, with all staff, clinical and non-clinical, knowing how to use Epic and complete essential functions.
  - e) All clinical staff should be made aware of all essential tasks and functions, including triaging referrals within a timeframe, adding a 'fail safe date' to patient referrals, booking surgical procedures under specific theatre codes and uploading required surgical details, including specialist equipment.
  - f) The Trust should explore whether there is a way for certain information within Epic which is important to be highlighted to other professionals e.g. a lack of patient engagement with specific services.
  - g) Explore automated translation within MyGOSH, for patients and families for whom English is not a first language. The Trust should ensure language support is routinely available for such patients and families, in outpatient and theatre settings, to improve communication with and access for these groups.
15. To improve the safety and smooth running of theatre processes and practices:
- a) For consultants to work professionally and communicate effectively with all members of theatre teams, in order to provide the information required to ensure theatre lists run as efficiently as possible, they should work collaboratively with staff when it comes to peri-operative care, safety processes, equipment and timings of procedures. This should include uploading required information to Epic in advance and communicating professionally during briefs and other stages of theatre lists.
  - b) The Trust should consider developing guidelines for behaviours within the theatre environment, if they do not already exist, and ensure these are enforced.
  - c) Consultants should ensure procedures are booked under the correct code on Epic, in order to enable their preference sheets to appear automatically, to assist with theatre planning.
  - d) Consultants should confirm their equipment and preference needs, including 'on the shelf' equipment if there are any changes following the patient's pre-operative assessment appointment.
  - e) Ensure that when procedures change intra-operatively, all surgical teams pause, and seek updated consent to continue if possible. The rationale should be explained to patients' families, and this should be documented in the patient record.
  - f) Consultants should not be able to refuse pain relieving interventions, if they are clinically indicated, in addition to certain anaesthesia requirements.
  - g) The Trust should consider investing in laminar flow theatres to maintain infection control for complex, lengthy procedures and implant work.
  - h) Consultants should be briefed about the importance of training, support and guidance to build the skills, knowledge and experience of incoming and junior staff in theatres, including allowing sales representatives to come in to show staff how to use specialist equipment. Consultants should be unable to refuse to work with specific individuals in theatre.
  - i) Review the listing of theatres urgently, and explore and implement a better and fairer system for weekend theatre lists. Weekend sessions should be paid at an additional rate, with effort to ensure initiative lists are equitably allocated. There should be a limit on the number of consecutive weekend lists an individual can volunteer to take on, and team leaders should not be able to undertake an excessive number of shifts. Staffing should also be reviewed, and weekend shifts should be unable to go ahead if too few staff are available.
  - j) Give consideration to bringing the two orthopaedic theatre areas in closer physical distance, to reduce the burden on theatre staff when having to obtain specialist equipment at short notice.
  - k) The department could trial sending for patients, but not anaesthetising them, whilst equipment is checked, to find out whether this is an effective method for reducing delays in theatre.

- l) More proactive theatre planning, with the pooling of less complex cases, which could be used to fill theatre slots, alongside identifying suitable cases, to be given to registrars/fellows to manage, with appropriate oversight from consultants on site.
- 16. There should be more consultant ownership of their named patients, so that they are easily available to review patients and provide assistance when they need escalation by ward staff, as well as helping with discharge planning and bed management. The Trust could explore a consultant of the week/day of the week model, with clear guidelines for what consultants should be contacted for, with shared oversight for the work of the team.
- 17. The Trust should ensure regular audit and governance meetings take place, incorporating the patient experience as part of the MDT process.
- 18. Existing governance meetings, including case conference and radiology should be documented, with agendas, minutes and attendance taken, and documentation available to all staff after meetings.
- 19. Physiotherapist led discharge should be the norm in cases where the recommendation is for the patient to 'go home when safe'.
- 20. The department should consider developing written SOPs and/or pathway protocols, to ensure best practice in delivering patient care, as well as unified approaches across the department, to support staff training, build broad skills mixes and to enable cross-working of allied healthcare professionals with different consultants.
- 21. The Trust should involve a governance committee in overseeing new techniques, equipment and devices, to ensure that guidelines are followed.
- 22. The Trust should make dedicated efforts to build stronger and formalised links with other orthopaedic units, including the RNOH in Stanmore:
  - a) Continue to encourage consultants to participate in regional MDT forums to discuss cases and seek pre-operative advice and agreement, as well as the sharing of best practice amongst those with expertise.
  - b) Build on existing mechanisms for seeking second opinions and referring patients of adult age to the RNOH, including exploring a transitional link for when paediatric patients reach adult age.
  - c) The Trust should engage in frank and open discussions with the RNOH to consider a range of options for building links between the two units. This could involve combining the two services, with cross-site working, to create a larger department with more resilience and structured MDT processes. It could involve consultants from the RNOH working as visiting surgeons at the Trust, and providing clinical fellows from the Trust to work at the RNOH. There could be exploration of a surgeon of the week model, with consultants rotating their base unit on a weekly basis, or surgeons being job-planned to divide their time across sites, or alternatively, for surgeons to have one base, to provide more continuity of care to patients.
- 23. Leaders should feedback to staff in relation to the business case for another neuromuscular consultant.
- 24. The department should utilise more dual consultant operating to provide assistance with complex procedures and support less experienced clinicians.
- 25. Managers and leaders will need to effectively manage any outstanding performance management processes, so that this does not impact on the wider teams and

department. Careful consideration should be given to the pairing of administrative staff with consultants, to ensure that everyone can work effectively together.

### 4.3 Additional recommendations for consideration

The following recommendations are for the healthcare organisation to consider as part of its future development of the service.

26. Improving the manner, tone and speed at which patient complaints are responded to, and ensuring sufficient resources are given to investigating and dealing with complaints in a timely manner.
27. Formalised, robust and transparent processes should be developed for staff to raise concerns, with appropriate routes of escalation if there is a lack of adequate response. This should be embedded in Trust training at all levels.
28. To address recruitment and retention challenges, the Trust should consider:
  - a) Modifying job advertisements to make roles more attractive, including seeking and responding to potential candidate feedback. Consideration should be given to the fact that suitable applicants may not be actively seeking work, and peer led 'head hunting' may be required to encourage applicants to apply.
  - b) Exploring flexible recruitment options, offering a range of full-time, part-time, job-share and similar arrangements.
  - c) Turning attention to staff retention, to ensure continuity of services and staff wellbeing. Addressing wider concerns with team working, leadership and culture, through responding to soft intelligence such as the results of staff surveys, in order to make the organisation a better place to work.
  - d) Ensuring recruitment processes are as efficient as possible, with correspondence being sent to candidates and appointees in a timely manner, and effective cross-departmental communication.
  - e) Avoiding over-reliance on less permanent employment contracts, including fixed-term, honorary and locum positions, where possible, and looking at the experience which already exists within department. Where requesting assistance, for example, with honorary arrangements, this should be managed on a defined basis, with clear starting and end points, and periodic reviews.
  - f) Making efforts to keep individuals on short term contracts who are performing well in their posts, through exploring dual positions or renegotiation of existing roles when staff return from leave, in order to maintain adequate service delivery, with support and advice from HR.
29. The Trust should review its processes to improve staff induction and training, to better integrate incoming and junior staff, and provide more effective forms of learning and support beyond observation and supervision, including exploring tools such as buddying and mentoring. New staff should be supported in building up a range of skills, knowledge and experience working in a specialist unit, through working across different sub-specialties and with all consultants within the service.
30. The Trust should work closely with local private providers, to learn from each other in relation to how concerns and incidents are investigated and dealt with, and to share best practice, in order to aid clinical governance practices. This could also involve considering M&M and case reviews of private work within NHS governance structures.
31. The Trust should have oversight over private practice arrangements, to identify any potential conflict of interest and impact on the department, including with the time, capacity and workload of the consultants. Consultants should have checks in place to

aid their wellbeing, considering limits to prevent 'mental overload' with such complex cases. The Trust could explore financial incentives for staff who do not undertake private practice e.g. regular waiting list work, to aid staff retention and service provision.

#### **4.4 Responsibilities in relation to this report**

This report has been prepared by The Royal College of Surgeons of England and the British Orthopaedic Association under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the contents of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.<sup>18</sup>

#### **4.5 Further contact with the Royal College of Surgeons of England**

Where recommendations have been made that relate to patient safety issues, the Royal College of Surgeons of England will follow-up with the healthcare organisation to request confirmation that timely action has been taken to address these recommendations.

If further support is required, the Royal College of Surgeons of England may be able to facilitate this. Additionally, if it is considered that a further review would help to assess improvements that have been made the Royal College of Surgeons of England's IRM service may be able to help facilitate this.

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<sup>18</sup> The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: <http://www.legislation.gov.uk/uksi/2014/2936/contents/made>

## Appendix A - Information provided to the review team

The following section represents a summary of the information provided to the review team during the interviews held and in the documentation submitted by the healthcare organisation.

This section is largely organised according to the Terms of Reference agreed prior to the review but also takes account of the themes that emerged whilst reviewing this information.

Information provided by interviewees during their interviews is presented as it was reported to the review team at the time of their interview and circumstances may have changed subsequently. Where possible, this information is summarised in an amalgamated and anonymised format, having regard to the particular circumstances and background to how this review progressed. The Trust should review the contents of this report carefully, and bear in mind obligations towards staff, when sharing the report findings with relevant staff concerned.

The information presented will sometimes reflect the viewpoints of individual staff members and some viewpoints described may be contradictory or may have been expressed in the absence of further substantiating information. Noting these viewpoints is not intended to imply their factual accuracy. The information in this section does not necessarily represent the review team's final findings, which are provided in the conclusions section of this report.

### 1. Standard, quality and safety of surgical care provided to patients

The review team were provided with various information about the standard, quality and safety of care within the LLLRI service and wider orthopaedic department, during the course of the review. Some of this is set out in further categories of the Terms of Reference as set out below, as there was overlap with a number of the areas the review team explored during this review.

#### Assessment including history taking, examination and diagnosis

The review team heard information about the pre-operative assessment process for LLLRI patients. Whilst CNS staff were not always involved in the pre-assessment process, they had become involved since 2006, when the pre-assessment and outpatient clinics became coordinated, and this process would involve consultants and physiotherapists. The review team heard that pre-assessment clinics would take place on a specific date, to allow patients time to go through their care. They were told that some consultants did this as part of their normal clinic, whereas other staff preferred to do this on a separate day, in case any other members of staff were required. Interviewees mentioned that they would ask their consultants to pre-operatively assess everything in order to identify any issues prior to surgery.

The review team also heard from physiotherapists that if there were any concerns about a patient or family's understanding of their care, for example, about weight bearing status, which could impact the success of surgery and post-operative care, they would be brought back into the clinic for another pre-operative assessment, in order to go through these matters, and ensure patients and families had the required understanding for follow through with their care.

#### Investigations and imaging undertaken

The review team were provided with the summary reports from the orthopaedic and spinal risk and action group from January and February, within which there was information about open risks, including one which was said to have been opened in September 2015, relating to a lack of intra-operative imaging for complex cases, resulting in delays in patient management or transfer of care. A bid had been submitted for a CT scanner to be used in the operating theatres during complex spinal surgery to give a multi-dimensional view of the spine, to improve the accuracy and quality of surgery compared to existing techniques. As of November 2022, the scanner was due to be installed and as of 25 January 2023, the scanner had been installed on-site, and was

working, but the training of all staff on this machine remained in progress. This incident was due to be closed at the next risk and action group meeting.

Within these documents, there was also information about the PACS system timing out very quickly, and that if this happened during surgery, it could run the risk of increased intra-operative time. This incident had been opened in January 2021. Within the document it said that this issue would occur if PACS was opened through Epic, but that 'ZPF PACS' had been set up for theatre users to log out after eight hours, and that theatre work stations were set up not to log out of PACS at all, but there may be some work stations which had been missed and still log out, which would need addressing. As of November 2022, this remained an ongoing issue, and as of January 2023, it was indicated that this needed escalating due to a lack of traction. The review team explored this issue with staff in interviews. They were informed that this remained an ongoing issue, which involved complicated technology and three different departments. However, they were also informed that a different PACS system was in use in theatre, which if projected onto a screen, would stay open for as long as possible. The review team heard that not all staff had learnt the correct way to log into Epic to enable this, and were therefore using old methods, but they had since been re-trained and this had now been resolved.

#### Treatment including clinical decision-making, patient consent, case-selection, operation and/or procedures

The review team heard information about communication with families and the consent process. They were told that even if interpreters were not present in pre-assessment clinics, for patients and families for whom English was not their first language, this would always be arranged at consent clinics if required. They heard that if a procedure changed mid-theatre for such families, such patients and families could utilise the Trust's language line for assistance.

The review team were provided with information about the consent process for LLLRI patients, although this was consultant specific. They were told that patients were seen in outpatients, then put onto a waiting list and then one to three months prior to their surgery were brought into a pre-assessment clinic, which included the whole MDT: consultant, physiotherapist, CNS and occupational therapist, who would see the patient and obtain consent. On the day of surgery, the registrar or consultant would confirm consent again with the patient and family.

Despite this process existing, the review team heard that some aspects of this patient journey had been lost in the system. They heard about families who were 'terrified' on behalf of their children, and that more needed to be done to sit down with patients' families and talk them through the clinical decision-making, in order to provide holistic care. They heard of instances where patients [REDACTED] had had consent forms signed for surgery, despite being placed onto waiting lists for devices which were not available on the UK market at the time of such consent being signed off. They were told it was therefore not possible to assess the risks and benefits of procedures contemporaneously, and when it came to subsequently reviewing these patients, it was determined that such procedures were not suitable. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The review team heard a view that across the board follow-up arrangements for patients had become inadequate, with registrars improperly supervised, meaning that they were missing things.

Information was provided regarding active spinal and orthopaedic clinical audits within the department, including one registered in June 2022 regarding the complex patient pathway. This had been discussed with members of the MDT who attended weekly nurses' meetings. The aim of the audit was *"for our complex patients to have the correct preparation/work up - with reduced intra-operative complications and optimal recovery post-operatively. The audit aims to review the areas we have progressed in and also highlight the areas requiring further development. The Team's aim has been to facilitate a smooth pathway for our complex patients undergoing orthopaedic surgery. The pathway focuses on early identification of their medical condition and*

*enabling optimisation [of] their care pre- operatively and anticipating their post-operative needs so that they have an improved outcome”.*

#### Identification, management and discussion of complication rates and whether these are in line with national and international standards

The review team were told that the Trust wished to find out nationally agreed outcomes and standards, particularly for the LLLRI work, what sort of complications exist and therefore how to benchmark their own outcomes. The review team heard that in the past some of the consultants had worked together on research projects and gathering outcomes, although there had been some frustration in trying to get educational programmes off the ground, and implement the systems to gather outcome measures, including having the required NHS personnel to support these processes. They were also told that staff had spoken to theatre managers about collecting data on durations for surgery across consultants, in order to compare averages, and whether certain surgeons had longer durations than others, in order to identify whether further support was required.

Interviewees informed the review team that the surgeons within the department were good at orthopaedic surgery, and that they had good outcomes, patient satisfaction scores and results for complex patients. However, they were also told that within the LLLRI service and across the orthopaedic department, consultants were not always good at predicting complications and being vigilant about them.

In terms of discussing complications, the review team were provided information about M&M processes, more of which is set out in section 5 of this appendix. The review team were told that surgeons would record their cases and they were relied upon to report their own complications. They heard that, generally, surgeons were open about their complications and had a good balance in reporting these. [REDACTED]

The review team were told that in M&M, the department probably did not discuss complex cases as well as it should. It was reported that during the COVID-19 pandemic, the lack of face-to-face meetings, and reliance on video-conferencing facilities, made it difficult to have honest and meaningful conversations about worries and complications, and whilst it was hoped that this would get better over time, further distance had been created within the department.

The review team heard about two patients who had developed alopecia after surgery, which was discussed at M&M. This led to reflections from staff involved, having never seen such complications before, and staff considered that one factor could be duration of surgery.

The review team were provided with orthopaedic surgical outcomes data for November 2021-November 2022, which included the following:

- Discharge spells broken down by month and consultant, where there was at least one orthopaedic episode in the spell.
- Orthopaedic episodes broken down by consultant and discharge month.
- Orthopaedic episodes broken down by coded procedures per discharge month.
- [REDACTED] returns to theatre – for patients undergoing two orthopaedic cases in a defined period of within 30 days of each other, either both cases were emergency cases, or an elective case followed by a non-elective case. It could not be certain if the returns to theatre were due to a poor surgical outcome.
- 105 readmissions – two admissions within 30 days of each other, with at least one orthopaedic spell contained within.

## Record keeping

The review heard of general issues with poor record keeping, with trainees often being left to complete operation notes, and consultants not always checking them for accuracy. [REDACTED]

[REDACTED]

The review team were told that in theatre there were delays when patients were in recovery, when they were ready for transfer, but the operation notes had not yet been completed, and it would be ideal if this could be done before the patient went to the ward. They heard that within Epic, consultants did not always give adequate surgical detail as to what was required pre-operatively for specific procedures. This included specifying the equipment which would be required, as well as using the correct surgical procedure code for the theatre list. The review team heard that sometimes the amount of time a procedure was booked for (e.g. five hours) did not always reflect the actual duration of the procedure. They were told that these factors affected the smooth running of theatre sessions and lists.

The review team were made aware that the Trust introduced the Epic software in 2019, and that some members of staff within the department struggled with knowing how to use it, as well as with the use of technology generally. They were told that Epic was an American system, and even professionals in the United States reportedly did not understand why the Trust had incorporated it. The review team were told that surgeons generally would dictate, rather than type in, letters.

Information regarding active spinal and orthopaedic clinical audits within the department was provided, including one registered in March 2022 about the timing of uploading clinical consent forms to Epic. The aim of the audit was *“To look at how long it takes to have paper consent forms for orthopaedic surgical procedures to be uploaded to Epic. Clinical consent forms are a part of a patient’s clinical record. As such it is essential that they remain a part of the patient’s electronic patient record. We wish to see if these consent forms are being uploaded in a timely fashion, and if not what avoidable delays can be identified”*.

## **2. Experience, training, support and scope of practice of** [REDACTED]

This section, and following pages, contains specific comments about individuals working in the department and makes comment on their practice. The information in this section cannot be extracted in a way which could remove the personal data of individuals and at the same time leave any meaningful information for publication.

### **3. Team working, communication, inclusivity and the effectiveness of MDT working**

#### Team working, communication, behaviours, inclusivity and culture

The review team were informed that there had historically been challenging behaviours within the department, which was reportedly one of the reasons why this invited review was requested. They were told that line managers often lacked the resources, training and capability to directly address these behaviours with individuals. This was complicated by over-familiarity amongst many staff who had trained at the Trust and were friends. The review team heard that the Trust were reportedly concerned that their processes and systems were not robust to allow for healthy disagreement and challenge, whilst maintaining psychological safety.

The review team heard from a number of staff that they enjoyed their roles and had good relationships with their colleagues. A number of staff had worked at the Trust for a number of years and told the review team it was a good place to work, and people wanted to come and work in the hospital. A number of those interviewed told the review team that, generally, staff of all disciplines worked well together, that their colleagues were great, they had a good working relationship with everyone, that they were able to obtain advice when needed and they had not witnessed any poor behaviours beyond someone 'having a bad day'. A number of staff spoke positively about individual staff, including specific consultants, physiotherapists, nursing staff and CNS', occupational therapists and service managers. It was said that the wider MDT running the LLLRI service really cared, worked well together and were 'holding up the service completely'. Whilst the review team were told that some of the nursing staff were quite junior for a specialist hospital, thereby sometimes requiring more regular input, there were good trainees, and the registrars were very flexible.

The review team were informed that, generally, there was good team working amongst the consultants, who would approach and speak to each other about things, listen to everyone, and that consultants got on well with other staff, being available to provide advice when required. Particular [REDACTED] consultants within the department were spoken highly of, with it being reported that they were always willing to work with staff, to do what they could to help including making themselves available for advice if staff were not getting responses at night, picking up extra lists and thinking outside of the box to find solutions to problems. The review team heard that, as individuals, the consultants were 'lovely'. Some staff said they were happy with all of the consultants they worked with, and most would be happy for their friends and family to be operated on by everyone in the team. Whilst it was reported that the tensions which had arisen [REDACTED] had started to affect the wider teams, staff still said that they 'loved' working within the orthopaedic department.

The review team were told that the service management and administrative staff all worked well together, aside from challenges with reportedly dealing with performance management [REDACTED] [REDACTED]. It was said that the administrative staff were all united and would help each other.



[REDACTED]

The review team heard nurses did not always feel valued by surgeons, and that historically there had not been a good relationship between the nursing team and orthopaedic surgeons, as the surgeons were not easy to contact, they were dismissive and generally did not engage well with nursing staff. The review team heard that theatre and scrubs staff observed particularly difficult and challenging behaviours from consultants repeatedly, and the review team heard there needed to be an improvement in these relationships across the MDT for everyone to work well together. This was described as a particular issue given that theatre teams were already short staffed, staff retention was not great and therefore surgical nurses needed to be able to work confidently with surgeons. The review team were told that there were lots of instances of sarcasm and difficult behaviours from surgeons during briefs, as well as preferences to only work with senior and not junior staff. This included junior staff being subjected to unprofessional treatment despite surgeons knowing they were new, and nurses had reportedly resigned due to this. With preferences to work only with senior nurses, it was reported that that junior nurses were not learning and building up a skills mix, including the preferences of all the surgeons. The review team were told that nurses had been shouted at by surgeons in front of other staff and patients. The surgeons were said to not be clear in terms of what they required in theatre, either during briefs, or from the notes they made on Epic. The review team heard that, whilst surgeons thanked the theatre staff at the end of procedures, and theatre staff could see when things were difficult and the surgeons were stressed, whilst thanks were appreciated it did not make up for the stress during the day. It was reported that whilst nurses 'loved' working with the spinal surgeons, they felt uncomfortable and unsafe working with the orthopaedic surgeons. The review team heard that the theatre and scrubs staff were happy this review was taking place, as an opportunity to improve communication and relationships between the surgeons and the nurses.

The review team heard that there were some issues between consultants and secretaries, but a lot of this was reportedly down to poor communication.

[REDACTED]

Overall, the nursing team were described to be a cohesive unit speaking with one voice, with no real issues, but that they had been impacted by recruitment issues over the years.

There were views that many staff worked part-time and that staff did not meet often enough to make the department work well together.

The review team were told that with there being a lack of unity within the department, and a lack of cohesion amongst the surgeons, 'factions' ended up arising, meaning that people 'looked the other way when concerns arose'. This reportedly had an impact on the wider team, including physiotherapists and CNS' in the LLLRI service, who felt worried and not listened to. The review team heard that due to the 'factions' and disparate nature of the department, individuals ended up focusing on their work, and building a network around them for support, meaning that there was

some team working, albeit fragmented. It was reported to the review team that this resulted in imbalance, with certain individuals choosing to work with specific consultants, or consultants having preferences to work with certain staff, resulting in a lack of such staff available for other consultants. The department was described as feeling 'toxic', with disappointment that certain consultants 'kept themselves to themselves'.

Whilst some staff said that people approached their colleagues, other surgeons or their mentors for advice, overall, the dysfunctional team working was evident, particularly with the staff satisfaction rate having gone down from the previous year, from the results of the most recent staff survey. The review team were told there were constant recruitment drives for some disciplines but there was a struggle to retain staff, and that the attitude of surgeons needed to change to assist with this. When considering some of the difficult behaviours, the review team were told that a bullying and harassment policy existed within the Trust, which reportedly all staff should know about, but there were views that staff were probably not encouraged to use it as much as they should be. It was also reported that staff of different disciplines probably did not celebrate each other's success well.

The reports of staff getting on well as individuals but not as a team was said to be not exclusive to orthopaedics, but was similar in other parts of the Trust, which was described as a political organisation.

The review team were provided with copies of the Trust's safe and respectful behaviour policy, dated 10 October 2022 and grievance policy, dated 12 March 2021.

#### The effectiveness of MDT working

The review team heard that a big issue within the orthopaedic department was isolated and individualistic practice, with everyone wanting to focus on what they were doing, and not wanting to look at what others were doing, or for others to question their own work. 'Factions' had reportedly arisen and when issues or problems were raised, it was said that people 'turned the other way', mechanisms for healthy disagreement were lacking and individuals wanted to avoid conflict. Staff were said to get on with their own work, and leave the 'bigger stuff' to clinical leads to deal with. The review team heard that [REDACTED] consultants reportedly came in to do their operations and then 'disappeared', meaning that the identity of one department, where people worked hard to improve to ensure it was working at its best, had been lost. The review team heard that individualised practices based on conflict carried the biggest risk, and that the team should be able to support each other, and manage such personality clashes.

Part of the issue was reported to be sub-specialised practice of each consultant, with focus on their own patients and type of work. It meant that consultants referred to patients as 'their own', rather than patients of the department; [REDACTED]

[REDACTED] The department lacked unity with such poor communication, and this was reportedly not helped by the turnover within service management. It was reported that service management had made suggestions on ways to improve the LLLRI service, such as running post-operative clinics alongside consultant clinics, as well as doing hub and spoke clinics to present and discuss patients. [REDACTED]

It was mentioned that the issue of surgeons practising in isolation extended to a lack of structured MDT approach to practice, including pre-operative discussions with colleagues as part of clinical decision-making. Whilst some consultants were reportedly good at discussing cases with their colleagues, this did not extend to all consultants. This was reported to be an issue when cases came to M&M, and that through thorough pre-operative decision-making and discussion, certain decisions could have been questioned before they developed into issues and complications. It was therefore stated that there needed to be a more developed MDT overall.

The review team were told that, whilst the service and department was small, there were experienced people in the team, and there was a need for an embedded MDT, to discuss things

non-judgementally. At the time of the review, it was reportedly unknown if the correct processes were being followed, or if these were defined, in order to ensure safety. The high-risk nature of the work meant that the ability to converse and raise issues, when working individually, with MDT type agreement for cases, was all the more important, in order to bolster individual practice. However, the personalities in the room were reported to be the fundamental issue. It was reported that there was a need for an embedded MDT, with pre-operative agreement for cases, and enough participants to bolster individual practice

The review team heard that the COVID-19 pandemic had impacted the department, with 18 months of staff meeting online, rather than face to face, making it difficult to have honest and meaningful clinical conversations about worries, complications and difficult decisions. It was said that whilst M&Ms existed, the department did not discuss complex cases as well as they should. Whilst there was hope for better team working and discussion of cases, due to the issues which arose [REDACTED], individual staff ended up focusing on their own priorities.

The review team heard about MDT processes within the LLLRI service. Pre-assessment clinics took place on separate dates, involving the whole team: consultants, physiotherapists and the CNS, allowing time to go through things with patients. The review team heard that some consultants did this as part of their normal clinic, but others did this on a separate day, in case anyone else was needed. The review team were told that if there were any concerns about a patient not fully engaging with the process, which could impact their treatment and outcomes, staff would speak to a consultant or CNS. It was reported that an MDT clinic was previously held in the LLLRI service, where the patient would come in for an hour and a half appointment, with the consultant, physiotherapist, psychologist, nurse and registrar present. The review team were told the entire team would go through the procedure, amongst themselves, and with the patient. This was described to be a real pre-operative set up involving the whole MDT to prepare the patient, however, there were views that perhaps this approach was not now taking place for some consultants. Whilst there was a good MDT approach reported for the LLLRI service, as there had always been two consultants, it was reported that their MDT had become separate, attached to those particular consultants. It was said that there were hopes for a more joined up unit but this did not work when individual consultants had not worked well together in the past.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] It was said that the separate nature of MDTs, with CNS' working with specific consultants, was something which current staff wanted to address, including cross-working amongst other consultants. This was said to be a challenge given the consultants were all so specialised, and even when consultants 'did a bit of everything', they could not necessarily offer the required expertise.

The review team were told that the days of single-handed practice were gone, and that collaboration with other units was important, as people worked better together by discussing cases openly and documenting this. The 'hands off' approach was reported to complicate things, making it difficult to know who would take things on. It was said it would be great to have involvement with a regional MDT to assist with such collaboration, as everyone could learn from one another, particularly with very junior staff working at the Trust.

The review team heard information about a regional MDT [REDACTED], where consultants from London hospitals were invited to attend and bring cases along for discussion and advice. The MDT ran at the RNOH clinic in Bolsover street, London and was a mixture of a formal and social group. The review team were told that this assisted with cases where additional input was required, in order to obtain peer support and advice. It said to be an open and collegiate forum which had developed and worked well. [REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]. Whilst there was said to be no formal arrangement between the Trust and the RNOH, it was reported that some leaders were keen to build on this to create a more formal arrangement, although it appeared the RNOH were concerned about getting 'caught up with the problems' within the Trust.

In terms of staff working with consultants on the ward, the review team were told that the nurses had issues with getting senior support from consultants across the whole department. The review team heard it was hard to contact consultants, making it difficult to escalate patients when there were surgical complications. The review team were told that staff would rarely ring consultants to see a patient and they would ask registrars instead. The review team heard this was because historically there was not a good relationship with the consultants, although reportedly there was a better relationship between nurses and registrars who had since gone on to become consultants. Whilst surgeons were described to be good at orthopaedic surgery, with good outcomes, outside of this the nursing team reportedly struggled, and would not contact them to review deteriorating patients. The review team were told that the nursing team would not contact surgeons whose patient it was as they did not trust they would do anything to help, and that despite being the named consultants, they reportedly did not take ownership over their patients.

The review team heard that surgeons did not attend nursing ward rounds, which could compromise patient safety; however this was apparently mitigated by escalating matters to an on-call orthopaedic surgeon or a junior doctor to cover any gaps. The review team were told that daily ward rounds were MDT led, run by the registrars, with attendance from physiotherapists and occupational therapists, and then surgeons would run rounds after they had operated. Staff told the review team that nursing, medical and surgical handovers were separate; that the morning handover involved everyone in the MDT, and that post-operatively, the nurses would 'not really have handovers' with surgeons.

The review team were told that the surgeons did not communicate well regarding discharge planning, and that having more consultant presence would aid with discharge planning and bed management, rather than nurses having to ask junior doctors. The review team heard that nurses often did not know about admitting patients for physiotherapy, which made bed management difficult. It was said that physio-led discharge was consultant dependent, and that most consultants did not allow this. The review team heard that some consultants would come to see how things were going with patients, but overall, they did not take ownership. Whilst surgeons operated on the patients' limbs, it was considered by some that nurses took more ownership in dealing with the patients holistically, and often sought more assistance from paediatricians.

The review team heard from interviewees that whilst procedures and processes existed, it was unknown if these were being followed or clearly defined to ensure safety, given different consultant preferences. In certain areas, including theatre list planning and running, processes were said to be lacking.

#### **4. Theatre safety practices**

##### Theatre safety checklist processes

The review team heard about the safety processes introduced within theatres within the Trust:

1. Surgical team briefs took place at 08:15, involving the whole operating team.
2. The patient came and signed in, and the team undertook checks to identify the correct patient, the surgery and site for the procedure, to avoid any mistakes.
3. The patient would come into the anaesthetic room, and checks would be made against the consent form, marking the correct site and checking any patient allergies.
4. The patient would be anaesthetised and go to theatre. A surgical and anaesthetic pause would take place to check it was the correct patient and procedure.
5. There would be checks for equipment and antibiotics.

6. The team would sign off against the consent form to ensure they have done the correct procedure for the patient, and any specimens taken would be sent to the laboratory.
7. At the end of the theatre list, the team would do a de-brief, to make sure all checks had been completed correctly and to identify if anything had gone wrong and needed reporting, as well as noting any improvements which could be made in the future.

The review team heard that there were a number of checks in theatre to ensure the patient was safe and to avoid any risk of injury. The review team were told that if there operative changes to what the patient had been consented for, the team should pause, speak to the patient's family and take consent for the change in procedure, and this would be reflected on the patient record.

#### Communication, behaviours and equipment

The review team heard that some of the biggest issues in theatre involved communication in advance about specific requirements of procedures, included booking procedures under the correct surgical code on Epic. It was reported that, whilst there may be a brief note, what was recorded on the system was usually either incorrect or not thorough, meaning that this would be discussed in briefs, and a new list would have to be made on the day of theatre. It was said that the surgeons needed to ensure the correct code was on Epic, for the efficiency of the final list, but that this was not happening in practice. The review team heard that this affected the availability of the correct equipment meaning that there were then delays in attending to patients, lists would take longer, and theatre lists would overrun and staff could not leave on time. The review team were told that if specialist equipment was required, this should be specified on Epic ideally two weeks prior to surgery, so that it could be ordered in advance; to help with day to day running of theatres, to lessen stress on staff and deliver optimum care. In addition, the review team heard that X-ray requests were often not completed in advance, and tended to be requested on the day with 15 minutes notice.

The review team heard that there were issues with surgeons communicating the specific requirements of procedures, including equipment, during morning briefs. The review team heard that orthopaedic equipment was specific, and could take 5-10 minutes to locate from other locations at short notice, with theatres situated on the third floor and basement, in addition to ensuring it was clean. Therefore, when surgeons did not specify in advance what equipment would be required, whilst accepting that things could change intra-operatively, staff said that this caused delays and stress, including delays in sending for patients, or having to wake patients up. The review team heard that, despite requesting clarification in advance, surgeons became impatient when staff had to locate equipment at short notice, when this could have been avoided. The review team were told that surgeons may sometimes say what they needed, but they did not give clear instructions. The review team heard that whilst anaesthetic start time was important, so were those few minutes of clear communication, to ensure things ran smoothly. The review team were told that orthopaedics was an equipment dependent speciality, and so it was important to have equipment easily available, and there were lots of lists where kit was unavailable, causing complications when moving around theatres. Reportedly whilst theatre staff were good at managing this, it contributed to the loss of identity for the department. The review team were also told that whilst scrub nurses could request sales representatives to come in to show them how to use equipment they had not used before, reportedly orthopaedic surgeons tended to stop this from happening, despite staff needing that expertise.

Lists overrunning as a result of communication issues described was reported to be a particular issue for weekend theatre lists for complex neuromuscular cases of one of the consultants. The review team heard that the weekend lists were reliant on staff volunteers, which was not easy, so team leaders often ended up picking up these lists. The review team were told that often what appeared on Epic for procedures changed when it came to the day. An example was given of when a member of staff looked up a Saturday list the day before, and it appeared manageable, but when they attended on the Saturday, three complex patients had been added, and that the staff member ended up not leaving until 21:00/22:00. It was reported that on weekend lists, staff started work just before 08:00, and the last patient went into recovery at 21:00, meaning they did not go home until about 22:00. This was reported to be unsafe, when staff were tired and doing complex cases on a weekend when they did not want to be there. The review team heard reports

of multiple instances of lists overrunning and staff staying late, which really affected staff as once cases were finished they also needed to ensure equipment and things were ready for the next day. Therefore, staff strongly wished for lists to start and finish on time. Another issue which was reported to cause delays was when patients were in recovery, and they were ready to be transferred, but staff were waiting for operation notes to be completed. Staff told the review team it would be ideal if operation notes could be completed before the patient went to the ward.

The review team heard about challenging behaviours amongst some of the surgeons in theatre, which affected other theatre staff. One example was given of a procedure booked for five hours on Epic, but which was completed within three and a half hours. [REDACTED]

[REDACTED]

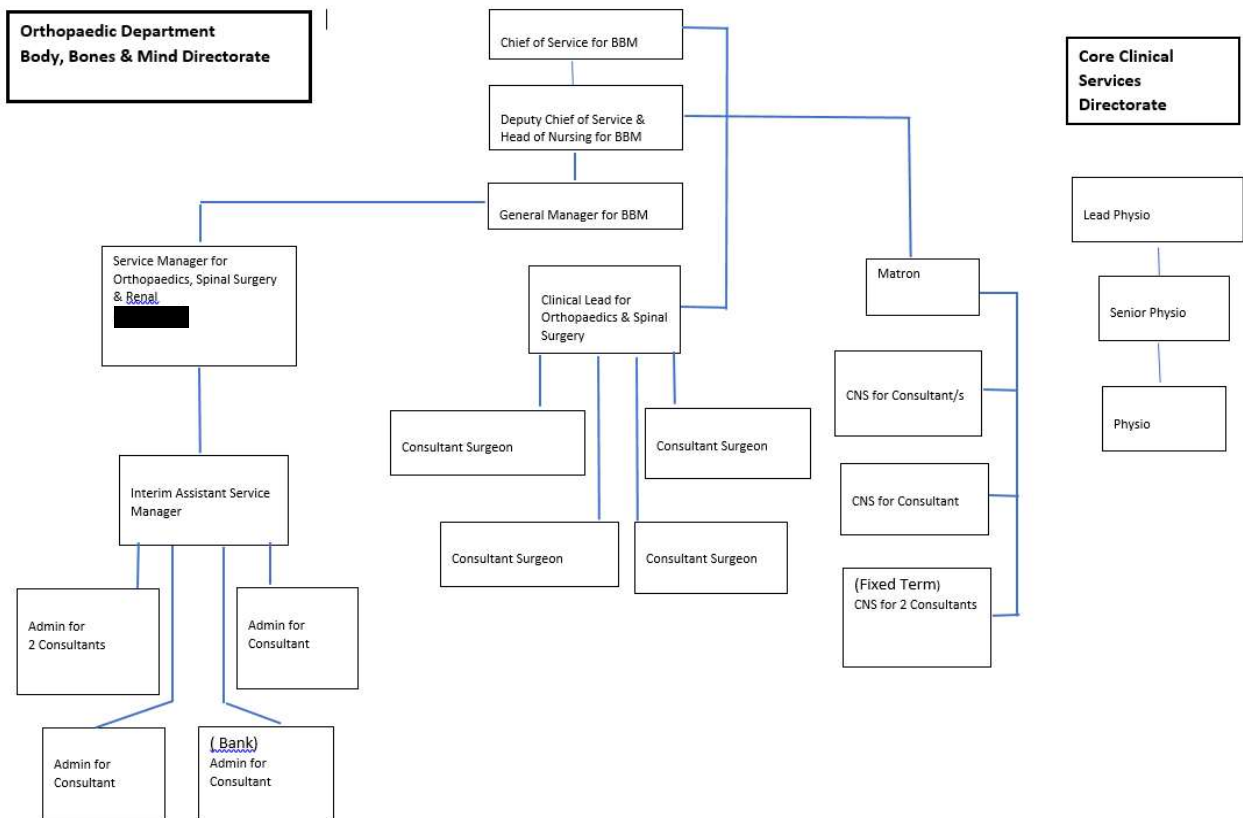
The review team heard that theatre staff were 'not the type to refuse to work' with any of the surgeons, but due to communication and behaviours, theatre staff had consultants who were not their favourite to work with. The review team were told that, in orthopaedics, it 'always felt as if something was not right', reportedly with staff often walking around to find missing equipment, certain surgeons not anticipating what they needed and communication being unclear; and these issues would later come up in theatre. It was reported that surgeons would say the WHO checklist was complete, but it would later transpire this was not done as thoroughly as it should have been. Theatre staff reported they did not like doing orthopaedic theatre lists for these reasons.

## **5. Effectiveness of clinical governance practices**

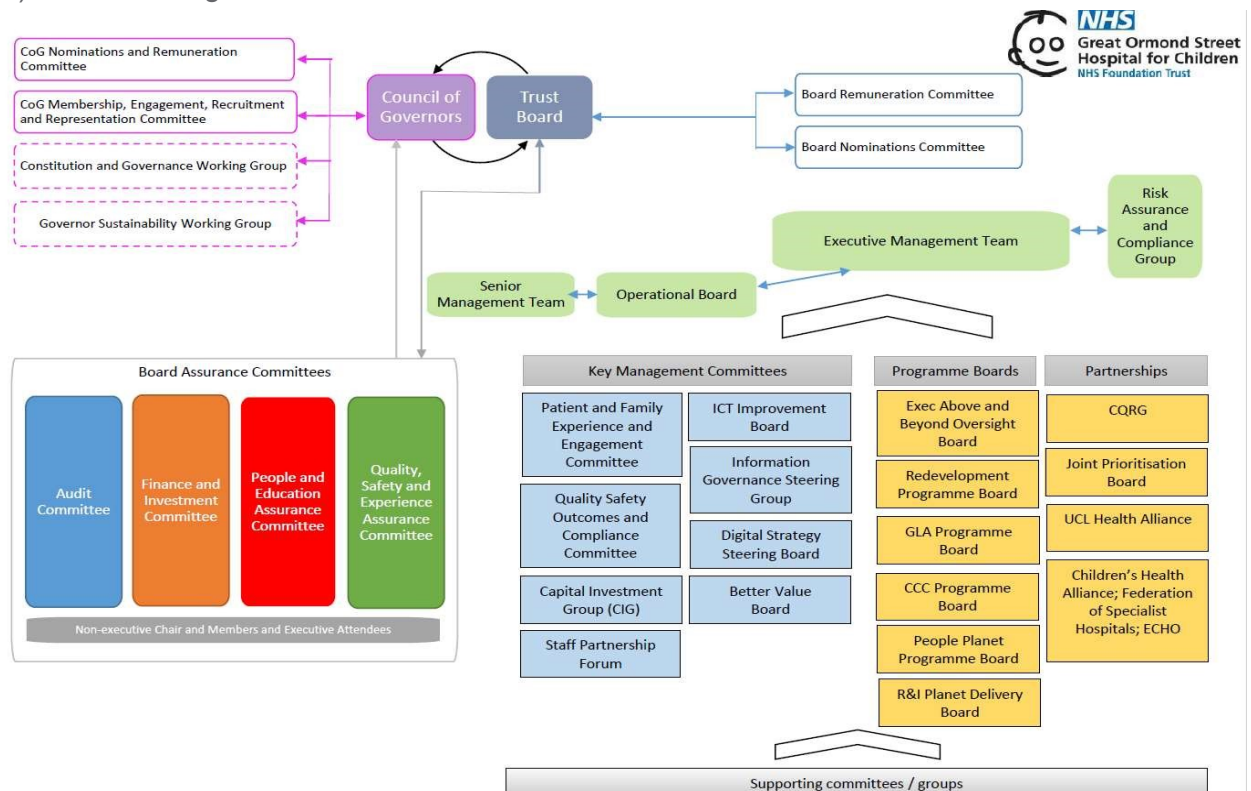
### Department and governance structures

The review team were provided with the following organisational charts.

- 1) Body, Bones and Mind directorate/orthopaedic department (as of January 2022):



## 2) The Trust's governance structure:



## Raising concerns, incidents and processes

The review team heard about governance processes for raising concerns and reporting incidents, and staff views on the way they were handled and escalated by managers and leaders. The review team were told that at a governance and leadership level, staff looked at risks ratings, reporting, financial running, strategy, operations and generalist aspects of governance. They heard that leaders would address concerns with individuals as required, and provide advice around the correct responses and learning from concerns. The review team heard that when concerns were raised a Datix report would be submitted, although staff reported this was usually quite a late occurrence, by which time the event was already being managed. Datix reports were reported to be circulated to around 47 staff, and managers would be responsible for reviewing them. It was said that many Datix reports were about minor incidents, but the most serious incidents would be sent to the Chief of Service, and then escalated as required. The review team were told that the Trust brought in a Datix review group to look at issues reported on a weekly basis. [REDACTED]

The review team heard that when Datix reports were submitted, there would be an internal review to decide if there was harm, and then it would go to an Executive Incident Review Panel to decide if a serious incident enquiry was needed. If cases were declared as serious incidents, Duty of Candour disclosures would be made to the patient and family, and then a summary report would be sent to NHS England, who could come back requesting further information or suggesting minor amendments. There would then be periodic reporting back to NHS England with any feedback from serious incidents shared in risk and governance meetings. The review team were told that these documents were made available and formally reported Trust wide for common issues across specialties, to identify if there was a bigger network of problems. It was also reported that there was a monthly risk group, which did not cover acute incidents, only themes. The review team heard that, for cases which did not constitute a serious incident, a root cause analysis would be done, by someone within the safety committee or a head of department and the outcome and learning would be shared within M&M. Therefore, for cases not reaching serious incident threshold, attending the M&M, and discussing these particular cases, was the way the department would learn from them.

However, the review team were told by some staff members that it was unknown how much the orthopaedic department learnt from these processes, and whether they were properly assessing the associated risk; some staff were more passionate about this than others. It was said that, other than for serious incidents, it did not appear that the department uncovered the specific detail of what had unfolded in cases of concern, in order to get staff who were involved to reflect, and to get true discussion and feedback.

The review team heard that there was room for improvement with complaints processes which reportedly 'took forever to resolve' with responses often 'hefty'. [REDACTED]

[REDACTED] This section describes a number of patient complaints made in relation to [REDACTED] the department between October 2014 and February 2023. The complaints [REDACTED] were made to either GOSH or the Trust's Patient Advice and Liaison [REDACTED] Service. Thirteen complaints are mentioned in this paragraph; it is unclear [REDACTED] whether there is any overlap between them, or if these are thirteen separate [REDACTED] complaints. [REDACTED]

The review team heard about specific incidents within the LLLRI service and orthopaedic department, and how they were handled, [REDACTED]

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<sup>21</sup> The Ponseti technique is used to straighten the foot using manipulation and stretching.

\_\_\_\_\_ This section explains that a complaint was made in relation to a specific patient's care. \_\_\_\_\_  
\_\_\_\_\_ An internal review was carried out; this involved an individual who described themselves \_\_\_\_\_  
\_\_\_\_\_ as having a conflict of interest in the matter. The report was duly completed by that \_\_\_\_\_  
\_\_\_\_\_ same individual in 2020. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ However, the review team heard that, as of April 2023, there had reportedly been no  
feedback from the Trust regarding this complaint, and that the Trust tended to 'drag things out'  
instead of dealing with them. It was reported that there was no feedback after raising concerns  
\_\_\_\_\_ and that the Trust needed to  
feedback on this and other complaints, which needed caution and resolution, \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_. It was said that concerns were reported but  
management did not take them forward, \_\_\_\_\_  
\_\_\_\_\_, culminating in this invited review.

The review team heard of a Datix report for an incident \_\_\_\_\_, which  
was escalated to an Executive Incident Review Panel to decide if a serious incident needed  
declaring, with a lot of 'noise' around the case. It was said this case ended up being delegated to  
a registrar lacking the required skill set, when it should have been reviewed by someone more  
senior, and then it had to be re-reviewed. (The review team were provided with various  
documentation regarding a case which was escalated to an Executive Incident Review Panel,  
although they could not verify that this was in relation the same case).

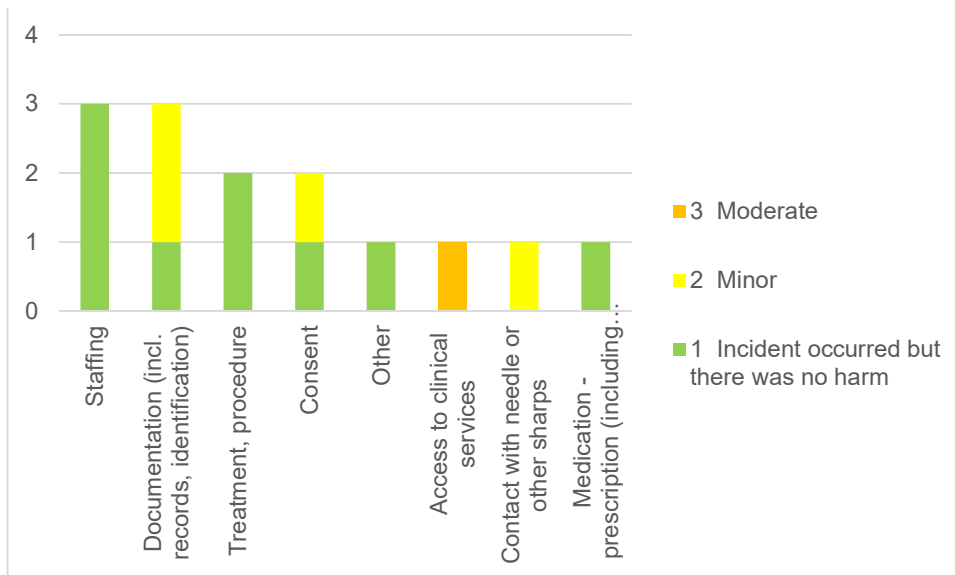
It was reported to the review team that there had been concerns about a specific patient who was  
operated on \_\_\_\_\_, which was causing anxiety amongst ward staff in terms of  
communication with the patient's family. \_\_\_\_\_

This section sets out that case was not discussed at the M&M it was first scheduled for; this was  
because the patient's outcome and recovery were awaited. \_\_\_\_\_

The case was discussed \_\_\_\_\_, with the X-rays reviewed, and staff raised it as a  
clinical concern, and recommended review to decide if it constituted a serious incident. The  
review team heard that the case then went to a review meeting, where it was decided it did not  
constitute a serious incident and it was handled appropriately. However, some staff were  
concerned about how anaesthetists making up the review panel could be able to make such a  
determination.

The review team were provided with summary documents from the Orthopaedic and Spinal Risk  
Action Group, from January and February 2023, which showed a summary of open and closed  
serious incidents. These showed Trust wide learning, incidents and risks for orthopaedics and  
spinal, a grading matrix for risks and incidents and any general updates shared with departments.  
Orthopaedic incidents related to: access to clinical services, consent, documentation, prescription  
of medication, contact with sharps, staffing and procedures/treatment.

Incidents for orthopaedics ( \_\_\_\_\_ This is a two month period. \_\_\_\_\_):



No incidents where orthopaedics was the main specialty were reported within the next risk and governance reporting period (██████████).

Within these reports from January and February 2023, there were outstanding incidents detailed, open since January 2021, regarding increased waiting times above national guidance for the Ponseti clinic (which had approximately 160 patients) due to understaffing of the service. The most recent update as of November 2022 was that the business case for increased staffing levels would not get through in the current financial year, but that it was being prepared to go through in the next financial year. The review team explored this in interviews and were told that one of the orthopaedic consultants was presently job planned to cover this service. However, they were also told that the financial situation within the Trust was 'dire', with different directorates trying to bring tangible business cases in relation to their issues. Reportedly, the Trust had to prioritise clinical need, and this issue was not high priority, and therefore remained on hold.

## Clinical management and leadership

In terms of management and leadership structures, the review team heard that that one of the orthopaedic surgeons was the clinical lead for spinal and orthopaedic surgery. There was a Chief of Service of the Body, Bones and Mind Directorate, as well as a Safety Associate Medical Director, who reported to the Trust's Chief Medical Officer. The Chief Medical Officer reported to the Trust's Board.

This section describes significant problems with management and leadership within the department and a consequent difficulty in ensuring improvements could be made. It is drafted in a way in which individuals are specifically mentioned, and it is not possible to extract any further information from this section without infringing on the rights of individuals.

[REDACTED]

[REDACTED]

A number of staff reported that certain leaders within the department and Trust did not understand the LLLRI service and orthopaedics, including surgery, being from different medical backgrounds; therefore they were not always able to provide staff with what they needed. It was reported that management was 'weak' and that the department needed stronger leaders. The review team heard that management was reluctant to take decisive action when concerns and evidence was presented in front of them, 'dragging out' complaints and not dealing with them. The review team were told that it would be expected that responsible managers would show leadership, and improve the way they work, with the right resources, rather than be 'passive'. ■

[REDACTED]

[REDACTED]. It was suggested that new leaders would need to be sought from outside of the department, who could look at the issues in a structured meaningful way, at an MDT and department level, and consider processes to ensure people worked within their competency and to resolve wider issues.

This culture of weak management of concerns was reported to the review team by a number of staff, with specific examples given. [REDACTED]

— This section sets out that some concerns had been raised and were not dealt with within [REDACTED]  
— the department. It also states that some patients were not managed for a period whilst one [REDACTED]  
— individual was away. [REDACTED]

[REDACTED] It was reported that names of those who could take over the care of these patients were put forward, and that service managers thought such individuals would apply, but by the time the position was advertised, individuals had found other jobs. In the meantime, it was reported that time sensitive patients were 'flagging'. Whilst this was reported [REDACTED], the review heard views that they did not seem to be 'fully aware' and did not understand the LLLRI service.

Following the February 2023 review visit issues were raised with the review team relating to additional concerns [REDACTED], and it was reported that, due to high turnover, there was no stable management to direct concerns to. It was said that whilst certain leaders were involved when concerns were initially raised [REDACTED], they had not been involved with these recent and ongoing issues. Concerns were

raised about the way [REDACTED] was reportedly treated when raising concerns, and that safety processes for whistle-blowers were not adhered to in practice. The review team heard the Trust always supported those who were the subject of concerns, which was important, but they did not support those raising concerns.

### M&M meetings and processes

The M&M meeting process was described as follows:

- M&M meetings took place every three months, with attendance from the whole orthopaedic core MDT, including invitations to the clinical director, chief nurse and matron.
- It was up to consultants to monitor their practice, including keeping track of and reporting complications, and then bring cases to M&M in relation to infection, pressure sores etc.
- Discussions would take place with between consultants and registrars in order to select cases for M&M.
- Registrars would populate PowerPoint slides, with X-rays, and sections on systematic and human factors, which would be reviewed and amended as required by consultants, and registrars would present the complications at the meeting, following which a discussion would take place, which registrars would keep a record of.
- The slides were then formatted after the meetings with discussion, learning points and recommendations added, and these were finalised with the consultants whose case it was, to create one document with the consensus of all those present.
- The slides were then saved to the M&M file in the shared drive, but it was unknown whether a record was kept from a Trust perspective.
- The review team heard that there was no formal agenda and that minutes and attendance registers did not appear to be taken at M&M meetings.

The review team heard that there was a 'low threshold' for bringing cases to M&M, but it did not appear written criteria were set out. The review team were told that whilst the wider MDT, including physiotherapists and CNS' attended M&M meetings, it tended to be consultants, in collaboration with registrars, who would decide which cases were selected for discussion. If staff wanted patients to be discussed, they would ask the consultants about this. The review team were told that sometimes patient input would lead to cases being discussed at M&M, with staff indicating they would discuss cases and seek advice before providing feedback to patients and families. The review team heard that certain consultants would ask staff involved in the care of particular patients to attend M&M if that patient was due to be discussed, and when it would be useful for them to attend.

It was reported that if physiotherapists had concerns they would not necessarily bring cases to M&M, but would exercise their own routes for raising concerns: going to the team leader, a registrar or fellow or directly to the consultant. If they did not feel listened to, they would go back to a team leader to look at the issue from a different angle. The review team heard that physiotherapists could suggest cases but they did not always make it to the final M&M list, as that went through the consultant. Some of the allied healthcare professionals reported not being 100% sure of the referral criteria but they wondered why particular patients were not presented at M&M meetings. The review team heard that the department wanted to explore physiotherapists and nurses bringing cases to M&M but, at present, they tried to resolve things arising in clinic, and then the registrars would put the cases forward at the next M&M. The review team heard that the review group and safety department evaluated cases against criteria to decide if something was a serious incident or not, and that these outcomes were reported back at M&M, including to the owner of a particular M&M slide. Therefore attending M&Ms provided learning in relation to serious incidents. In addition, it was reported that there may be an article shared or a discussion in relation to cases which had gone well on occasion at M&M.

In terms of existing M&M processes and practices, the review team heard that there was a perception that M&M was ineffective, with hints of underreporting and things not being discussed as rigorously as they should be. However, as there was a low threshold for bringing cases for

discussion, certain staff felt confident everything came through M&M, with no reason to believe otherwise. It was said that most surgeons were 'open' and struck a good balance with reporting their complications, [REDACTED]

[REDACTED]

Various views about the effectiveness of M&M processes and practice were put forward including:

- 18 months of not being able to meet face to face during the COVID-19 pandemic had affected the ability of the department to have honest meaningful clinical conversations about worries, complications and difficult decisions.
- While M&M processes existed, complex cases were not discussed as well as they could be, although it was also reportedly hard to know how healthy M&M discussions were without seeing minutes. The review team heard that if someone had a series of complications, they should be able to come forward and say they were worried about this, but perhaps the department lacked the culture of healthy discussion and disagreement whilst remaining collegiate and professional.
- M&M was an opportunity for discussion and sharing thoughts, however, there were concerns about how it was run, and it needed to be more robust to deal with complications. In addition, there needed to be more developed pre-operative MDT case discussions to 'thrash out' issues before they reached the stage of M&M.
- Whilst M&M meetings were documented, and records were available, there did not appear to be action in taking issues discussed at the meetings forward and keeping track of that progress. In this respect, it was reported that M&M appeared to be more of a tick boxing exercise, with the records being 'put back in the drawer' after the meetings, rather than being used as a learning tool to change practice.

The review team were provided with orthopaedic M&M data for March 2021-June 2022, broken down by each consultant:

- March 2021: 3 patients (2, 1 by surgeon).
- June 2021: 2 patients (1 surgeon).
- September/October 2021: 12 patients (3, 6, 2, 2, 1, 1 by surgeon).
- December 2021: 4 patients (2, 2 by surgeon).
- March 2022: 3 patients (2, 1 by surgeon)
- June 2022: 15 patients (2, 6, 3, 4 by surgeon).
- September 2022: 12 patients (2, 2, 5, 3 by surgeon).
- December 2022: 11 patients (4, 2, 1, 2, 2 by surgeon).

The review team were also provided with 15 sets of M&M PowerPoint slides for the department between December 2019 and December 2022.

#### Other governance and case discussion meetings

The review team heard that monthly consultants' meetings were attended by orthopaedic consultants, with occasional attendance from one spinal surgeon, but no one from management. These were held to catch up on logistics and the day-to-day business and running of the department, as opposed to case discussion.

It was reported that radiology case discussion meetings could place weekly on Wednesdays, mostly consisting of going through X-rays for a mixture of pre-operative, post-operative and diagnostic cases. This was said to be a teaching meeting, presenting patients of interest to registrars, but also a forum for discussion and advice.

The review team heard that the orthopaedic department attended weekly case conference meetings on Wednesdays to discuss urgent matters, which was almost an 'acute M&M', with more formal and structured M&M meetings taking place every three months. There was reported

to be no written criteria for what was brought to these meetings, and minutes were not taken. The review team heard that the attending registrar would add records to Epic, and ensure this was communicated to staff.

The review team heard that case discussion meetings for the LLLRI service were more ad hoc. ■

— This section explains that weekly LLLRI service case discussion meetings were planned, but did this —  
— did not materialise due to difficulty with timings. —

## Audits

The review team were provided with information about audits undertaken for spinal and orthopaedics in the last 12 months prior to the review visit in February 2023, as well as current active audits within the department. These audits were in relation to the following matters:

- 'Global safety of posterior spinal fusion ending in L5 in patients with Duchenne Muscular Dystrophy' (closed October 2022).
- 'Defining a Core Outcomes Set for use in Clinical Trials of the Management of Idiopathic Club Foot' (closed June 2022)
- 'Is pelvic fixation necessary for scoliosis surgery in non-ambulatory patients with cerebral palsy?' (registered December 2022).
- 'Complex Patient Pathway' (registered June 2022).
- 'Timing of uploading clinical consent forms to Epic' (registered March 2022).

## Arrangements for covering patients during periods of leave

The review team were provided with the orthopaedic consultant and fellow/registrar on-call rotas for 2021-2023, including the weekend rotas.

The review team heard from interviewees that orthopaedic surgeons would rotate on-call on different days of the week, and during weekends, on-call arrangements would be shared with the spinal surgeons. The review team were told that within the LLLRI service, given the difficulty of the work at this level with complex cases which required discussion at a local MDT level, it would be preferable to have at least two surgeons doing the same sort of work, who were happy to discuss things with each other and manage each other's patients in their absence. It was said it would also be preferable to have someone within the department to cover the LLLRI service during holidays.

The review team heard various reports about the arrangements for providing cover for ■ patients ■

■, not having been adequate. ■

— This section describes the challenges of having support structures in place in a small —  
— department, when one individual is off work. It also sets out that there was "a lack of clarity on —  
— who would be making decision and have overall responsibility for the patients" in this situation. —

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] This section describes the issues that arose in trying to find cover within the department. Various options were proposed, but there “*did not appear to be any process of advertising for this role*” and no individual applied. At the time of the report no cover had been found and that, although names were put forward, no one had been appointed to the role.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] The process of finding cover was described to be ‘disastrous’.

The review team were told that this issue was discussed in consultant meetings, where it was said that the issue had been escalated to leaders, and come back down again, and in this respect, it appeared clinical leaders had no executive influence. [REDACTED]

[REDACTED]

[REDACTED] It was said that this was not appropriate, and soon (at the time of the February 2023 review visit), a locum consultant, [REDACTED], was due to start within the service. The review team heard that this locum consultant was due to start their role in April 2023, [REDACTED]. Staff reported thinking that all required plans would have been in place. The review team were told that the locum had been appointed to work at the Trust for a year, [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] It was reported that management was unsure what arrangements were agreed for new patients, and it may be that only urgent patient referrals were being accepted, and that follow-ups were being covered by someone else within the department.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

This section sets out a number of administrative issues which occurred during periods of leave which resulted in delays in patients being seen as a *“result of consultants canceling clinics and not rebooking patients”*.

[REDACTED]

It was proposed that there needed to be better system for providing cover for patients when consultants were on leave.

## 6. Adequacy of current service delivery and future proofing

### Cover within LLLRI service and recruitment

[REDACTED]

[REDACTED]

This section explains the system of supervision and cover within the LLLRI service, and that this was not adequate. In particular it is stated that *“it was evident that there were problems within the service, with registrars not being properly supervised”*. It is not possible to extract further detail from this section as it largely comprises the personal data of the individuals involved.

[REDACTED]

[REDACTED] The review team were told that LLLRI work was difficult and complex, and therefore a local and robust MDT was required for surgeons to be able to discuss what they were doing, [REDACTED] so that people were available every now and then to assist with certain procedures as required. [REDACTED]

[REDACTED]

The review team heard views in relation to challenges in recruiting surgeons within the LLLRI service:

- Staff reported that certain individuals could have applied for previous positions, but that they did not want to, and established surgeons did not want to take on the role, therefore it would be difficult to find someone experienced.
- It was reported that it was difficult to recruit individuals with sufficient experience, and that salaries offered did not cover individuals' lifestyles.
- It was said that it was hard to recruit in London, due to the difficult nature of the work and the lack of private practice, and therefore paediatric limb reconstruction did not appear to

This section describes how a number of time sensitive patients were not transferred to the care of other individuals within the department, or to other hospitals, during a period of extended leave. In some cases this resulted in some patients reaching the age of 18-20, "*and therefore it was no longer appropriate to treat them at the Trust*". This was despite patients being identified, where their care could be transferred.

- ██████████ The review team heard that service management were supposed to make these transfers but this did not happen. It was reported that ██████████ was on the receiving end of anger from patients' families, and it was not appropriate for patients aged 18-20 to start a procedure with a different consultant in a children's hospital. The review team heard that some of these patients had been referred to the RNOH, which calmed the patients' families, but that this should have happened a long time ago.

[illegible]

This section sets out the capacity of consultants within the department and the presence of long waiting lists in respect of some individuals.

It was

therefore reported that there were concerns about succession planning within the department. The review team also heard that secretaries 'carried' the consultants, so it was a big risk when a consultant left, in terms of what would happen to their secretary.

#### Adequacy of current service provision and maintenance of patient safety

One of the most commonly reported issues within the LLLRI service was the longest waiters and patient tracking list, with patients and their families reportedly 'anguishing' waiting for their treatment:

- The review team heard that the long waits were mainly in outpatients for new patients and follow-ups, which then affected clinics and theatre waits.
- There was a reported issue with lack of theatres and beds, with it being 'normal' to have to cancel patients on theatre lists due to a lack of beds. This was said to have been an impact of recovery after the COVID-19 pandemic.
- Within the service it was reportedly common for patients to have patients moved three or four times before they were seen, some patients were 12 months over their referral to treatment time, and new patients ended up being moved to accommodate older patients.
- It was reported that urgent patients often had to be prioritised, meaning long waiters were 'bumped'.
- At the time of the February 2023 review visit, it was reported that patients were not being seen for the first time until 30 weeks, meaning targets would already be breached. A big factor in this was clinic management of patients, with administrative staff and service management being unsure how urgent new patients were, and being reliant on the information on Epic and what they were told to do.
- It was reported that the department was highly dependent on CNS' presenting which cases should be done, with consultants having little control and oversight over what was put on their lists. It was reported that this had led administrative and service management staff to 'beg' CNS' to put long waiters onto a list as soon as possible, due to their urgency, however those patients still ended up getting 'bumped' and that this system needed overhaul and the whole team needed to find a way to work better together in order to find solutions.

There were views that there were enough LLLRI surgeons in the service at present, and the waiting lists were not 'overly long', but the issue was the way the lists were organised.

In terms of waiting lists for the orthopaedic surgeons, this was reported to be in the region of (as of February 2023):

- 150 patients
- 130 patients
- 40-50 patients
- [REDACTED] – 30 patients
- [REDACTED] – 30 patients

The review team heard about problems with a large number of referrals into the service not having been triaged to any particular surgeon. They heard views that service management 'dug into' patients waiting from January-September 2022, under the impression they were triaged, but then discovered they had not been. It was reported that these patients did not come to harm, but the service was left with reviewing these patients to find out who needed seeing, [REDACTED]  
[REDACTED]

The review team heard that when a referral was allocated to a surgeon, it would need to be triaged within five days. It was reported that the clinical lead was surprised when approached about un-triaged referrals, and claimed these should have been managed, and that previous service management should have been monitoring the situation. The process was described that secretaries would normally remind a consultant if the referral had not been triaged within three days, and if there was no response this would be escalated to an Assistant Service Manager and

then a Service Manager, with the audit trail evident on Epic. However, it was reported that there had been issues with [REDACTED] secretarial support.

The review team were provided with an overview of the referrals, triaging and clinic management process. There were two types of referrals:

1. Dear Dr/'unnamed' referral – central booking admin team would upload this onto Epic, create a waiting list and start referral to treatment clocks.
2. Named referral – this would go to a specific surgeon's basket for triage, with each surgeon having their own named inbox on Epic.

The review team heard that within the LLLRI service, referrals tended to come in-house from various departments, usually from non-LLLRI consultants, and from local hospitals, with all surgeons working close to each other.

[REDACTED] This section explains the process for 'unnamed' referrals. It sets out that one [REDACTED] individual is responsible for accepting or rejecting the referral, and deciding who the [REDACTED] referral should go to. The manual process of directing the referral to the correct [REDACTED] surgeon's basket on Epic was not being done, leading to duplication of work and [REDACTED] wasting of time. There was no system of delegation for this work to be done when [REDACTED] the responsible individual was away. [REDACTED]

The review team heard that when referrals were received by a surgeon, the process was to choose a priority score (1a, 1b, 2 or 4) and what clinic it would go into e.g. registrar led, physiotherapist clinic or consultant clinic. The consultant should also add a fail-safe date, which was the date by which a patient must be seen by, in order to help the administrative team when organising clinics and moving patients around. However, the review team heard that the consultants often did not add a fail-safe date. The referral would then go back to the central administrative booking team to book in. The review team heard that if no appointment was available within the fail-safe date, the central administrative booking team would indicate it would need pushing by two months. The review team heard that, sometimes, this team would try and bring the appointment forward, but when the patient got to clinic, they would still need pushing back if an urgent appointment needed prioritisation.

The review team heard of serious complications with LLLRI patients, with staff reportedly seeing more amputations in recent times than they ever had within the service. There was a view that whilst LLLRI work was not the sort where it would risk a patient's life per se, some patients had had such a bad experience that they did not want to go through it again.

The review team heard about issues with capacity within the LLLRI service, amongst consultants and the wider MDT, as well as issues with management.

As of May 2023, it was reported there was a [REDACTED] who was 'not very present', an [REDACTED] who 'did not know much about the service' and no [REDACTED]. It was reported that this would all impact patient safety but, when raised, insufficient responses were given and there was no plan in place, and staff therefore did not know who to trust in the department. Reportedly managers had also said 'we are not aiming for excellence' but were just 'trying to get things done'; this did not sit right with staff, given the Trust's reputation. It was also reported that a [REDACTED] knew a colleague was out of their depth, but they had said to 'just put up with it'.

It was reported that the workload within the LLLRI service exceeded more than was possible for two LLLRI surgeons to manage. Whilst there were not many LLLRI services available it was reported that some patients were going to other services in Sheffield and further afield, which was preventing the workload from being even greater. [REDACTED]

██████████. It was reported that the CNS staff were very busy, working for two consultants each therefore there were concerns about CNS capacity within the service, particularly when the new locum started. It was also reported that secretaries needed close management, with weekly one to ones, and therefore support and capacity within the service was required.

Whilst there were a lot of reports about capacity issues, the review team also heard views that the department was functioning well in terms of theatre list distribution. The review team heard that the CNS team were 'fantastic' and holding the service together, and that safety netting was provided by a highly skilled ward nursing team, and without them there would be more incidents.

The review team heard various reports of isolated practices, with individuals focusing on what they were doing, and 'not worrying about others', leading to staff worrying about patients being avoidably harmed.

- It was reported that some individuals tended to 'bite off more than they could chew', in terms of not being good at predicting complications and being vigilant about them.
- It was said that follow-up arrangements were not adequate within the service.
- It was reported that whilst allied healthcare professionals, such as CNS' and physiotherapists, were worried about patient care, they were not always listened to.
- It was raised that staff were not sure if the correct processes were followed to ensure safety and/or whether such processes were clearly defined, and that individual practices based on conflict carried the biggest risk.

There were various reports regarding dysfunctional team working, which was affecting the service and department:

- A lot of issues reportedly boiled down to poor communication, including when secretaries and consultants had not met each other face-to-face.
- As the orthopaedic department was a small one, with only five consultants, the tiniest problems or politics could become an enormous issue and it was acutely felt if staff were not getting on.
- There had been 'too much politics' ██████████, which had a detrimental effect on the teams, in particular the administrative and service management teams. It was reported that it was difficult to protect the surrounding teams, including the CNS' and physiotherapists from these issues.
- Some staff reported finding it difficult working with ██████████, who were said to change their minds often, so much so that something would be agreed, summarised and written down, only for this to be changed later. This reportedly made it difficult to work with these surgeons, and staff considered their patients were not safe as a result.
- It was said that there was a gap between the clinical and management/operations staff, which extended to the wider culture of the Trust, and there remained work to be done to bridge this gap.
- The review team also heard the view that the service and department appeared to be influenced from people outside of the Trust, ██████████ ██████████, and this was a driving force in terms of the way the current situation in the department had played out.

The review team heard that service management had thought 'outside the box' to propose a number of solutions to respond to the problems within the service. This included:

- Running post-operative clinics, parallel to consultant clinics, managed by physiotherapists and CNS', to free up consultant capacity.

- Making better use of the MDT, with brilliant physiotherapists and CNS' available, and better utilising senior fellows and registrars to see patients (who often sat in consultants clinics in LLLRI, which was described to be a 'waste' for a teaching hospital).
- Running hub and spoke clinics, for staff to come in, present and talk about patients.
- Doing general cases within waiting lists when there were slots in theatre lists, including simple cases, which could be done by senior fellows to maximise teaching abilities.
- Running pooled waiting lists when a consultant was on-call and available in the building.

However, the review team heard that these suggestions were reportedly either not considered, or outright rejected [REDACTED]. It was reported that this was disheartening, given the level of thought put into this to try and improve the service, and that service management would still receive emails to say it was their fault patients were missed. There were views that this was because surgeons wanted absolute control over their patients, and would not trust others to manage them, which is why they rejected suggestions like post-operative clinics. Alternatively, if a suggestion was agreed, when a documented plan was put together, [REDACTED] were said to then change their mind. It was recognised by service management that surgeons had their own specialty practices, hence suggestions being made about general cases, and being able to fill slots on theatre lists, however this was also reportedly outright rejected. Reportedly, when consultants were on leave, a whole list was lost, and in August 2022, the service handed back 80 lists for reallocation to other services. The review team heard that, occasionally, a consultant would step in to assist to ensure a list went ahead, but this assistance tended to be offered by those who lacked time and capacity with large waiting lists themselves.

The review team explored with interviewees whether current service delivery was adequate to meet demand and keep patients safe:

- A number of staff reported that service delivery was not adequate, and that they would not be happy for friends and family to be operated on within the LLLRI service and orthopaedic department, and would have them send to another hospital.
- There were views that whilst there were no 'qualms about the LLLRI service', staff would prefer their friends and family to receive care at the RNOH, where 'everything was better'. This was largely due to the service's wait times and to the complications arising in surgery, and that whilst the 'patient mix was fantastic' at the Trust, there were many issues which needed resolving.
- However, the review team also heard some staff report they would be happy for their friends and family, including their children, to be operated on by everyone within the orthopaedic department, particularly if they needed specialist expertise for a complex procedure. [REDACTED]
- It was reported that some of the consultants were 'fantastic', and were desperate to help in any way, including taking on extra lists and working with service management to think outside the box. However, they were reportedly 'victim(s) of circumstance', with large waiting lists and not enough capacity.
- The review team heard that the Trust should be the 'leading light' in the paediatric orthopaedic world, but it was disappointing that this had not been reached, although there remained potential. With these issues, it was reported staff focused on their own work, hoping this went well.
- Some staff stated that whilst none of the consultants were 'bad', they would have preferences for specific individuals for certain procedures.
- Some staff reported that the surgeons were good at orthopaedic surgery, with good outcomes including for complex surgery and patient satisfaction scores, and therefore they were all said to be good at their jobs.

The review team heard views that despite reported issues, the LLLRI service was a great one, with fabulous CNS', physiotherapists, ward team, theatres and pathology and the support of

senior colleagues if staff needed to discuss things. A number of staff interviewed said they enjoyed working within the service and department.

### Service management, administrative support and clinic management

A range of issues were reported with regard to the style, cover, capacity and stability of service management. It was reported that there were challenges with the management style [REDACTED], and that whilst [REDACTED] had been 'outstanding' at their job, since then, there had been [REDACTED], who had been good, but were not in their roles long enough to gain the experience to guide the administrative staff in the way they needed.

It was reported that [REDACTED] knew the department and consultants well, and had been making headway with the teams, responding to previous challenges.

[REDACTED]  
[REDACTED] This section explains that a management position had been filled by [REDACTED]  
[REDACTED] an interim who, due to arrangements not being properly in place, was [REDACTED]  
[REDACTED] not extended in their role; this "was described as a 'tragedy'". [REDACTED]  
[REDACTED]  
[REDACTED]

The review team heard that, as of May 2023, the [REDACTED] role had reportedly not been filled. Issues arising as a result of not being able to secure a substantial [REDACTED] [REDACTED] were described including issues the tackling the patient tracking list and waiting lists. The review team heard there was a lack of stable service management to raise concerns with, with staff 'coming and going', and if issues were raised staff did not get adequate responses or a plan to keep time critical patients safe.

The review team heard that there was a difficult relationship between clinical and clerical staff, with a lack of understanding of where responsibilities lay. The review team heard that secretaries were told to move patients and did as instructed, but they were not clinically qualified to assess how long patients were safe to wait until being seen. Despite this, they were reportedly still blamed when patients were missed even though this was due to consultants cancelling clinics and not rebooking patients. The review team were also told that secretaries should not be making such decisions impacting patient safety, and having to make such ad hoc arrangements when surgeons took leave. [REDACTED]  
[REDACTED]

It was reported that, generally, administrative staff and service managers worked well together, with the administrative staff being 'the ones who carried the service'. It was said that all clerical staff were united and helped each other. [REDACTED]  
[REDACTED]  
[REDACTED]

It was reported that, as of February 2023, whilst there should be one full time secretary for two consultants, there was one secretary, who was due to work with the incoming locum consultant, and there were two part-time secretaries working for one consultant, each working three days a week.

The review team heard that issues with administrative support were difficult to manage and the service was reportedly overspent on secretaries, meaning that they could not advertise for another position. The review team also heard that the issues with cover amongst service management, including an assistant service manager position which was unfilled as of May 2023, meant that it was likely the administrative team were not getting the close support they required.

### Hub and spoke working

The review team heard reports about hub and spoke working, in particular the possibility of collaborating with other units providing LLLRI services, most notably the RNOH in Stanmore. It

was reported that the RNOH was larger than before, that it carried out a lot of work of a complex nature and that, reportedly, 'everything was better' at the unit. The review team heard views that single-handed practice was outdated, and therefore collaboration with other units was important, as things would work better when people worked together, discussed cases openly and documented this.

The review team were told that the question of working more closely with the RNOH for LLLRI work had been explored over many years, with the RNOH being in a good position to support Trust patients and that the possibility of such collaboration had been discussed for 'decades' at a professional and executive level, and staff had been approached about this, but nothing had ever come of it. The review team heard there was a compelling case for the units to work closely together, with a similar and complimentary case mix, because the Trust tended to see younger patients, who were often handed over to the RNOH when they became adults. This was significant for LLLRI work, which tended to be a sequence of operations, meaning the early treatment could influence the outcome 10 years down the line. It was reported that some of the Trust's patients could not be operated on at the RNOH, which tended to be better for older children without too many co-morbidities, as they did not have the same level of comprehensive paediatric back up as the Trust, which was another area for potential collaboration between the two units.

There was an informal link, with consultants being invited to attend the regional LLLRI MDT at the RNOH, but staff viewed that a more formal relationship would mean that if something did not go well there would be accountability with questions being asked, such as whether the surgeons attended an MDT. The review team heard that there could be a joint limb reconstruction unit, and that whilst there was some geographical distance between the two units (located about an hour away from each other), it would not be impossible to start a working relationship, with committed people. It was said that clinical leaders were keen to explore such a working arrangement. However, staff reported it appeared that RNOH consultants were reluctant to get caught up in the problems which had arisen at the Trust and that leaders would need to speak frankly to those at the RNOH, to build confidence in the Trust, in order to build links, even if this was simply to provide some consultant cover within the LLLRI service, given the difficulties in recruitment.

#### Future proofing the service

The review team heard about various ways to future proof and improve the LLLRI service and orthopaedic department:

- The most significant reported issue was staffing levels, with a need for sufficient consultant cover within the LLLRI service. Therefore, there was a need to recruit a sufficiently experienced LLLRI colleague, [REDACTED], in order to provide support.
- [REDACTED]
- It was reported that it would be optimal to have two more consultant surgeons, to have local MDT discussion and agreement when doing cases, and to provide cover when leave was taken. This was given the difficult and complex nature of LLLRI work, and so the ability to discuss cases between individuals who got on well with each other was important.
- There was a need for colleagues to sit down and discuss cases, including raising issues, with MDT type agreement, in order to bolster individual practice.
- In addition, there was a need to sit down and talk patients' families through decision-making. Families were reportedly 'terrified' about their children's care, and therefore it was mentioned that more needed to be done to provide them with holistic care to help them; an aspect of the patient journey which had been 'lost in the system'.

[REDACTED]

[REDACTED]

The review team heard that there would be benefit in having more external support and new team members, including an additional physiotherapist and CNS, and that this would lead to real potential for the service and department. It was said there would be value in having more consultant presence on the wards, which would be useful for discharge planning to assist ward staff with bed management. The review team heard that there was a struggle to retain staff, with constant recruitment drives for scrubs nurses, and that the staff satisfaction rate had gone down within the most recent staff survey. It was mentioned that many younger staff tended to come to the Trust to gain as much experience as possible but, as London was expensive, after doing so they wanted to move away to be closer to their families. It was also reported that in order to retain staff the attitude and behaviours of surgeons needed to change, otherwise the service would continue to struggle with filling the gaps.

The review team heard that it was standard practice for staff learning to observe a procedure, to do one, teach one and then observe others doing the procedures and that there needed to be a 'better system' in place for training.

### Other

The review team heard about themes which formed important contextual issues to this review, some of which have been referenced elsewhere within this report.

#### Private practice

It was reported that private practice was one of the routes of tensions behind this review being commissioned, [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] Interviewees told the review team they were unaware of the formal arrangements to provide care to patients on a private basis within the different services at the Trust.

[REDACTED]  
[REDACTED]  
[REDACTED]

#### Wider Trust leadership and culture and priorities given to orthopaedics

The review team heard various reports regarding wider Trust culture and leadership, which was reported to affect the LLLRI service and orthopaedic department:

- It was said that with the Trust's high profile and reputation, there was almost a temptation that staff did not 'need to try hard'.
- Conversely, the review team heard the view that the Trust appeared to want 'ideal' but did not provide support to staff in delivering this.
- Some staff believed as if the Trust leadership did not want LLLRI service and orthopaedics within the hospital, as it was seen as 'too much effort', with specialist equipment being required, and there being no staff stability.
- A number of staff reported that orthopaedics were the 'bottom of the pile' and the 'poorer relation' at the Trust, without the same priorities and level of investment as other specialties, including intensive care, general surgery, cardiac and cancer, in terms of

funding, resources and staffing. This was said to be the case with the new cancer centre being the present priority for the organisation.

- This perceived lack of priority given to orthopaedics was considered evident by staff with it being described that paint was peeling off the walls in outpatients, the two operating areas being some physical distance away from each other, between the third floor and basement and equipment often not being easily available. Staff described often having to run between these two areas for equipment with the basement being a more isolated environment, with staff choosing to work on the third floor if they could. This was said to become complicated when moving between theatres, and was said to contribute to a wider loss of identity for the orthopaedic department. It was hoped by staff that once the new cancer building was complete, the basement theatre in 'Ocean'<sup>22</sup> could move upstairs to be on the third floor, on the same level as the other orthopaedic theatre.
- There were views that it was considered the department did not tick the right 'boxes' to be considered a top performing and appreciated unit by the Trust's leadership.
- It was reported that it was part of the organisation's culture for gaps to exist between management and operations and the clinical staff, and a lot needed to happen to bridge this gap.
- The review team heard views that the Trust is a 'political organisation', which was seen in its leadership, making it difficult to raise concerns with those at an executive level, for whom it was reported 'did not care about orthopaedics'.
- It was reported that the Trust claimed to be a public leader, and an internationally renowned tertiary centre, but the orthopaedic department did not match this description, and it could not attract staff.
- Lack of resources and investment in the orthopaedic department was said to be a long-standing issue.

However, the review team also heard views that it was not a case that the Trust were 'against' orthopaedics:

- It was reported that efforts had been made to try and appoint another surgeon within the LLLRI service. Leaders reportedly saw the need for recruitment, and it was not the case they did not want to help, but there were only so much resources. It was reported that business cases needed to be made, and certain issues needed prioritisation over others, although it was accepted that orthopaedics could do with more support and resources.
- The review team heard there were leaders outside of orthopaedics looking after their respective directorates, trying to put tangible business cases forward to deal with certain issues, and the Trust had to prioritise where they gave resources depending on clinical need. Whilst interviewees accepted that this was not ideal, at present it was reported that the Trust had to look more urgently at other departments such as cardiac and intensive care. It was recognised by staff that these other departments and specialties had more acute patients, although they still had very large waiting lists to bring down.

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<sup>22</sup> Ocean is a building within the Trust where operating theatres are located.

## Appendix B – Service Overview Information

Prior to the review visit the Trust was asked to complete the following 'service overview form'. The information presented below is what was provided to the RCS England in November 2022.

Local information		
Catchment population		<p>GOSH Orthopaedics is a tertiary and quaternary centre for specialist Paediatric Orthopaedic lower limb with some upper limb conditions. This means, many of our patients travel from afar, including the devolved regions, Ireland and some other areas such as Gibraltar and Malta, as well as all over England.</p> <p>There is no A&amp;E or trauma covered within GOSH, so it is a predominantly an elective only centre.</p>
Sites providing specialty service		<p>Currently there are no hub and spoke arrangements within GOSH Paediatric Orthopaedics. Other NCL centres provide general orthopaedic services to the immediate NCL catchment areas</p>
Personnel numbers		
Consultant Surgeons within specialty service		<p>There are five substantive consultants within the speciality service.</p>
Surgeons within wider team		<p>There are five substantive and one locum consultant within the wider team.</p>

Surgical registrar posts		<p>2.0WTE x Senior Clinic Fellows at ST7 level (employed until 31/12/2022, with 2 new starters from 01/01/2022)</p> <p>2.8WTE x Deanery Trainee Registrars at ST5-ST6 level (employed until 04/04/2023)</p> <p>There are currently no vacancies</p>
Junior doctors supporting the service		<p>1.5 WTE Senior House Officers across Orthopaedics and Spinal Surgery (should be 2.5 WTE however there is 1 vacancy due to be filled in February 2023).</p> <p>1.0 WTE Physicians Associate</p>
<b>Details of on-call</b>		
Consultant surgeon on-call	1:9	<p>The on-call rota is covered by both Spinal and Orthopaedic Consultants.</p> <p>4 of the Orthopaedic surgeons cover Monday-Thursday on a weekly basis. Currently [REDACTED], Thursdays are now being covered by [REDACTED] Orthopaedic Consultants for locum rates in a 3-weekly pattern.</p> <p>The Weekends are split between 9 Spinal and Orthopaedic Consultants.</p>
Surgical registrar on-call	1:8	<p>The Registrar on-call rota is split between 8 Orthopaedic Fellows, Registrars and Spinal Fellows. There is someone on-call every day for 24 hours a shift, with an expectation that they also cover usual clinical activities 8am-5pm. Out of hours, they are non-residential on-call but with agreement that they should be within 30 minutes travel time of the hospital should an emergency arise.</p>

		<p>On-call accommodation is provided should a junior doctor require,</p> <p>There is also a Surgical SHO on-call rota, which operates across all surgical specialties within GOSH. There is an 'standard day' Orthopaedic SHO employed by Orthopaedics, then there is a 'long day' and 'night' shift SHO who covers all surgical specialties across GOSH.</p>
<b>Facilities</b>		
Service dedicated ward beds	14*	<p>NHS Orthopaedic and Spinal team have a dedicated ward called Sky. There is space for 18 beds, *however currently there is only adequate staffing for 14 beds, 4 of which can be converted to HDU beds.</p> <p>Some patients can be cared for on Bumblebee which is the private ward, depending on whether they are suitable or there are available beds.</p>
ICU beds	17*	<p>There is funding for 17 beds within PICU at GOSH, *however these beds are used by all specialties across GOSH and are not ring-fenced for Orthopaedics.</p>
HDU beds	4*	<p>As mentioned above, Sky ward has the ability to convert 4 beds to HDU beds should the need arise.</p>
Theatres used by the service		<p>There are 2 dedicated Orthopaedic theatres called Ocean Theatres. These are used daily by both Orthopaedics and Spinal Surgery.</p> <p>2 Surgeons are not in Ocean Theatres regularly and are within the main GOSH 'VCB' Theatre complex.</p>
Inpatient elective lists per week		<p>There are 4 all day theatres lists, and 2 half day lists per week, split between 5 Surgeons</p>

Day case elective lists per week		There are no specific day-case elective lists as day-cases are performed on the Inpatient elective lists
Emergency lists per week		There is a half day emergency list available within the main theatre complex each day for all of GOSH Specialties
New patient clinics per week		<p>New patients are seen within each consultants' main clinics, therefore each see a different number of new patients depending on their clinic templates.</p> <p>At present there is capacity for 18 new patients per week within the main Consultant led clinics.</p> <p>Limb Recon: 6</p> <p>Neuro-Muscular: 2</p> <p>General: 4</p> <p>Hip: 2</p> <p>(Please note that the above capacity is the clinic run by Orthopaedics, and not the joint MDT clinics which our Orthopaedic Surgeons partake in).</p> <p>We also have a physio-led Ponseti service where there is capacity to see 15 patients per week whether they are new or follow-up.</p>
Follow up clinics per week		<p>There is capacity for 77 follow up patients per week:</p> <p>Limb Recon: 23 patients per week</p> <p>Neuro-Muscular: 13 patients per week</p> <p>General: 30 patients per week</p> <p>Hip: 11 patients per week</p> <p>Alongside the Consultant clinics, some of the consultants also have a registrar/fellow clinic and also a physiotherapy clinics which the above numbers account for.</p>

		Please note that the above capacity is the clinic run by Orthopaedics, and not the joint MDT clinics which our Orthopaedic Surgeons partake in.
<b>Activity numbers per year for the past two years</b>		
Data has been taken from May 2019-October 2022 due to 2020/21 year being the Covid Pandemic		
Outpatients seen		May 2019-Nov 2022: 21,198 patients were seen (face-to-face, telephone and video). This is an average of 502 per month over 42 months
Acute admissions		There have been 93 Non-Elective admissions since May 2019. This is an average of 2.7 per month over 42 months
Elective admissions		<p>There have been 1474 Elective admissions since May 2019. This is an average of 35 per month over 42 months. It is important to note that since May 2021 when Elective Activity could begin with Covid precautions, the average per month is 69 patients per month.</p> <p>There have been 1123 Day case admissions since May 2019. This is an average of 28 per month, however it is important to note that all patients who undergo Orthopaedic Pre-Admission clinic are brought in as a day-case.</p>
Number of patients undergoing surgery – specify total and number of emergency, inpatient and day case procedures		<p>Since May 2019 there have been:</p> <p>1330 Elective theatre cases</p> <p>92 Non-Elective/Emergency theatre cases</p> <p>151 Day Case theatre cases</p>
18 week breaches		<p>As of 14/11/2022 there are 379 patients on the RTT patient tracking list with 204 of them above 18 weeks.</p> <p>There are:</p> <p>108 between 18-40 weeks</p> <p>41 between 40-52 weeks</p> <p>52 between 52-77 weeks</p> <p>3 between 78-104 weeks</p>

Patients on elective waiting list		As of 14/11/2022 there are 394 patients on the elective waiting list
<b>Clinical governance arrangement for the past two years</b>		
MDT meeting frequency	Weekly/ Monthly	<p>There is a case conference each week with a radiologist, Orthopaedic Consultants, junior doctors and CNS team.</p> <p>Vascular MDT occur once per month led by the Interventional Radiology team and attended by an Orthopaedic Consultant</p> <p>Neuromuscular MDT occurs once per month and is led by the Neurology team and attended by an Orthopaedic Consultant</p>
Time scheduled for MDTs		Approximately 10 patients are discussed at the Orthopaedic case conference
Average consultant surgeon MDT attendance (%)		Currently no attendance is taken at the weekly case conference meeting.
M&M meeting frequency	Quarterly	Every 3 months there is an audit morning, which is when an Orthopaedic and Spinal Surgery M&M meeting is held with attendance from all consultants, junior doctors, nurses, physios and the wider team including staff from theatres and the ward.
Time scheduled for M&M		1.5 hours is scheduled for the M&M, with often around 12 Orthopaedic cases discussed, and 8 Spinal cases.
Average consultant surgeon M&M attendance (%)		An attendance registrar has begun in September 2022, therefore it is not possible to give an accurate average attendance for each consultant
Number of audit days last year		<p>All Orthopaedic Consultants have these audit days scheduled into their job plans. Clinical activity is cancelled so all clinical staff can attend. These meetings also include the Local Faculty Group meetings with PGME.</p> <p>As these are held quarterly, audit days occurred on:</p>

		29/09/2021 08/12/2021 16/03/2022 29/06/2022 28/09/2022
Time scheduled for audit days		These are typically half day sessions (8.30am-12.30pm occurring quarterly).
Other regular governance meetings		There is a monthly Risk & Governance meeting to review incidents and risk related to Spinal & Orthopaedics which are also presented to the wider team at a Specialty Review meeting once a month.
National databases submitted to		CPIP <sup>23</sup>
<b>Complaints, incident reporting and SUIs in the last two years</b> <b>All data below is between November 2020-November 2022</b>		
Number of incidents		There have been 192 incidents where Orthopaedics were the main specialty. The breakdown between 'no harm', 'minor harm' and 'moderate harm is below: No Harm – 146 Minor Harm – 39 Moderate – 7
Number of SUIs		There have been 2 SUIs since November 2020, one of which was declared on 24/02/2021 and the other 17/05/2021, both of which are now closed.
Number of patient complaints		High level, formal complaints = 5 Low level, informal complaints = 132
Number of never events		There have been no never events in this time period

<sup>23</sup> Clinical Practice Information Portal (CPIP) is an online database providing access to clinical information and resources for healthcare professionals in the UK, including information on clinical guidelines, best practice, patient safety and other topics related to healthcare.

## Appendix C – Documents received during the review

The following items of documentation were provided to the review team before, during or after the review visit in February 2023. It is requested that the healthcare organisation responsible for commissioning the review retains a copy of all items of documentation for its own records, and to be in a position to make it available on request and to comply with information access requests. Once the RCS England issues the report, it will not keep a copy of this information indefinitely.

1. Appendix C – Service Overview Information
2. Organisational Chart for Body, Bones and Mind Directorate/Orthopaedic Department
3. Governance Structure Chart for the Trust
4. Mortality and Morbidity Data 2021-2022
5. PowerPoint Slides and PDF documents from Mortality and Morbidity Meetings:
  - a) December 2019-March 2020
  - b) March 2020-June 2020
  - c) October 2020
  - d) October 2020
  - e) November 2020
  - f) December 2020
  - g) March 2021
  - h) June 2021
  - i) September 2021
  - j) October 2021
  - k) December 2021
  - l) March 2022
  - m) June 2022
  - n) September 2022
  - o) September 2022-December 2022
6. Spinal and Orthopaedic Clinical Audits 2022
7. Outcome Data 2021-2022, broken down by surgeons within the orthopaedic department and spells, episodes, coded procedures, return to theatres and readmissions
8. Consultant Orthopaedic and Spinal Surgeon On-Call Rota 2021-2023
9. Orthopaedic and Spinal Risk Action Group Reports:
  - a) January 2023
  - b) February 2023
10. Formal Complaint Response Letters from the Trust to Patients' Families:
  - a) October 2020
  - b) December 2021
11. Open Complaint Letter from a Patient's Family, dated ■ January 2023
12. Patient Advice and Liaison Service Incidents Spreadsheet, October 2014-March 2022

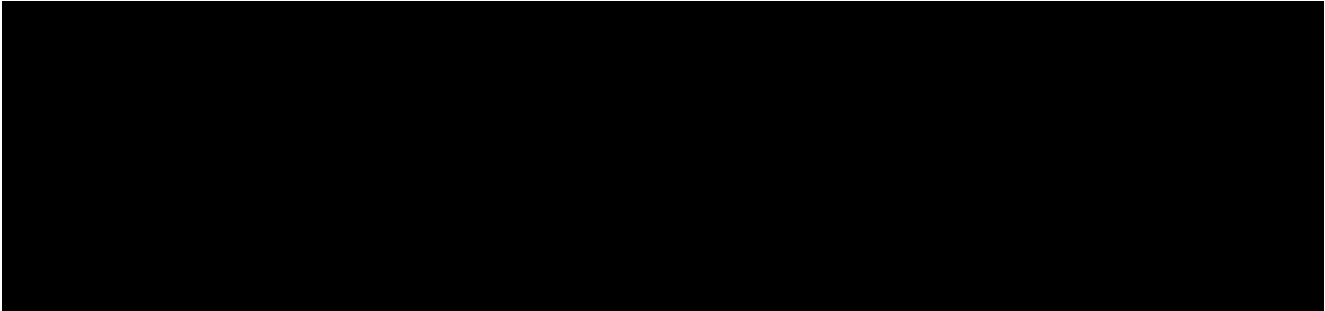
13. Datix Reports (in respect of patients reviewed as part of the clinical records review of ■ cases)
14. Cases of concern raised by members of staff within department (some of these patients were included in the list of ■ cases to be assessed as part of the clinical records review, although there were many patients falling outside this cohort):
- a) Email correspondence from GOSH dated 24 February 2023 regarding 15 patients on waiting list for an IM nail (many of whom were put on this list whilst the nail was off the market. This list had also been previously submitted to the Trust's Freedom to Speak up Officer).
  - b) 19 cases of concern submitted to the review team in March 2023 (which had also previously been raised with the Trust's Freedom to Speak up Officer).
  - c) Eight cases of concern submitted to the review team in May 2023 (raised anonymously).
15. Staff Policies:
- a) Sickness and Attendance Management, 4 March 2021
  - b) Grievance, 12 March 2021
  - c) Safe and Respectful Behaviour, 10 October 2022
  - d) Honorary Contracts, 10 November 2020
16. Staff Survey
- a) Copy of Results Spreadsheet 2021-2022 with Comparison between the Trust and Body, Bones and Mind Directorate
  - b) Directorate Report, 2021
17. Documentation provided by ■:
- a) Curriculum Vitae
  - b) Educational and training records
  - c) 11 email correspondence submissions (between the consultant surgeon and other staff within the orthopaedic department)
18. Documentation provided by ■:
- a) Training report
  - b) Letter confirming awarding of the Certificate of Completion of Training
  - c) Curriculum Vitae
  - d) Statement, dated 1 March 2023
  - e) Statement, dated 24 April 2023
  - f) Email and written correspondence between consultant surgeon and the Trust
19. Email correspondence from ■:
- a) Internal Trust correspondence
  - b) Correspondence between previous consultant and staff at the Trust
  - c) Email to the review team, dated 1 June 2023

## Appendix D – List of interviewees

The following individuals were interviewed as part of this invited review. The RCS England provided guidance on who it considered relevant to the Terms of Reference and the individuals listed were selected by the healthcare organisation which commissioned this review. In addition, some of these individuals were requested to be interviewed by the review team.

Individuals were interviewed during the review visit on 23-24 February 2023, and others subsequently on 11 April 2023, 26 April 2023 and 31 May 2023 by remote video-conferencing facilities. Their job titles reflect the roles they were conducting at the time of their interview.

This section lists the names and job roles of the individuals who were interviewed as part of this review



## Appendix E – Royal College Review Team

This section lists the members of the review team, along with providing a short CV for each member.



## Appendix H – Post-review visit Private and Confidential correspondence timeline<sup>31</sup>

At the conclusion of the review visit on 24 February 2023, the review team provided immediate feedback to the Trust, which was confirmed in a letter dated 7 March 2023. As well as bringing immediate themes regarding the service to the attention of the Trust, the review team advised that, [REDACTED]

[REDACTED] As the review team continued to make progress with the clinical records review, they provided further immediate feedback to the Trust on 2 May 2023, [REDACTED]

[REDACTED] The Trust provided written confirmation of taking such action to the review team on 11 May 2023, and that they had been advised, [REDACTED]

there was no ongoing risk to patient safety, and therefore all information, including any further action arising, would be considered upon receipt of the final service review report.

As the review team continued to consider further information gathered throughout the course of the review, the RCS England provided further feedback to the Trust in a letter dated 7 June 2023. [REDACTED]

[REDACTED] The review team also sought assurance on what consideration was being given and actions taken to protect the ongoing safety and stability of the service, in light of other concerns which had been reported to the review team. The Trust provided written confirmation of the actions taken in response on 14 June 2023. This included confirmation [REDACTED]

[REDACTED], that locum arrangements would be strengthened and that planning was underway to ensure the long-term viability of the service. The Trust advised they would consider any obligations in respect of Duty of Candour upon receipt of the service and clinical record review reports, and that they were due to meet with the Care Quality Commission ('CQC') to seek advice. [REDACTED]

[REDACTED]

[REDACTED]

<sup>31</sup> All correspondence issued by RCS England was on a Private and Confidential basis.

[REDACTED]

[REDACTED]

In light of this response, the RCS England and the review team acknowledged that [REDACTED]  
[REDACTED] no further immediate action was required. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

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<sup>32</sup> <https://resolution.nhs.uk/services/practitioner-performance-advice/hpans/>



**Trust Board  
24 October 2024**

**October 2024 IQPR (August 2024 Data)**

**Submitted by:**

Matthew Shaw, Chief Executive

**Co-Authors**

Dr Sanjiv Sharma, Chief Medical Officer

Tracy Luckett Chief Nurse

Caroline Anderson Director of HR & OD

**Paper No: Attachment O**

**Appendix 1: IQPR August 2024 data**

**Appendix 2: Update on red rated metrics**

☐ **For discussion**

**Purpose of report**

The Trust remains committed to delivering high quality care for patients effectively and doing so in a timely manner. Over the course of 2023/24, industrial action impacted activity levels and patient access. As at M5 of 24/25 all activity was 1.4% above plan and above 2023/24 (4.8%). Electives are behind plan at -14.4 % and day cases are just above plan at 1.06%.

The focus remains on long waiting patients, and the Trust has seen a huge reduction in patients waiting over 78 weeks. In August, we reported 28 patients waiting over 78 weeks, a significant reduction from May when we reported 60. The patients that remain are a combination of capacity challenges in a few specialties, patients choosing to wait due to summer school holidays and exams and very complex patient cases that require careful planning and management. The Referral to Treatment (RTT) rate has slightly increased at 70.5% indicating patient management across the patient tracking list (PTL) and despite further challenges that arise with bouts of acute sickness often preventing children and young people from being admitted.

The Trust is also in the process of reviewing patients who are past their planned date for their diagnostic test. This cohort of patients are mainly waiting for MRIs, Cardiac MRIs, Sleep Studies and Ultrasound. We are putting on additional capacity where we can, to ensure these patients are seen as quickly as possible and where appropriate reviewing referral criteria with other providers.

Patient safety and experience remain good with Inpatient Friends and Family Test (FFT) experience ratings still above target. There was an increase in complaints compared to last month. There has been reduction in the number of families contacting PALS (Patient Advisory Liaison Service) reflecting an annual reduction during the school holidays. Families contacted Pals for accommodation enquiries, requests for rescheduled appointments/ procedures and transport, and information regarding medication, the status of referrals and rejected referrals as well as regarding the Orthopaedic review.

Incident numbers continue to reduce as directorates focus on closing incidents. Three stage 2 letters and three stage 3 reports were due in August. Although all reports have been sent, there were delays across both stage 2 and stage 3 DOC which has reduced compliance. This is to be picked up through weekly patient safety meetings and Risk Action Groups. There was an increase in the percentage of high risks who went past their review date and this was due to a number of Risk action Groups or equivalent business meetings being cancelled in August. Performance is expected to bounce back in September.

The Trust sickness rate for August was slightly over the Trust target but performs extremely well when benchmarked against the national average for the NHS for August which was 4.92%. Mandatory training compliance remained stable at 93%. Non consultant appraisal rate decreased to 80% this month whilst consultant appraisal rate increased to 84% but still below target. Nursing vacancy rate continued to increase this month to 11.6% and is being

## Attachment O

<p>monitored closely. Substantive staff in post has remained below the planned level of 5800 FTE.</p> <p>YTD the Trust has achieved £3.6m Better Value against a plan of £5.4m, largely made up of pay schemes. A handful of new schemes have been added in to the programme but there remains a significant gap in the forecast out-turn position.</p> <p>An update on red rated metrics is attached at <b>Appendix 2</b>.</p>
<p><b>Patient Safety Implications</b></p> <p>The IQPR includes metrics and analysis on Patient Safety.</p>
<p><b>Equality impact implications</b></p> <p>There are no specific metrics on equality, but the report includes metrics on Access, Freedom to speak up and Patient experience.</p>
<p><b>Financial implications</b></p> <p>The IQPR only includes metrics on Better Value and no other specific metrics on Finance, but access and activity performance will also have implications on revenue.</p>
<p><b>Action required from the meeting</b></p> <p>None</p>
<p><b>Consultation carried out with individuals/ groups/ committees</b></p>
<p><b>Who is responsible for implementing the proposals / project and anticipated timescales?</b></p> <p>Chief Operating Officer</p>
<p><b>Who is accountable for the implementation of the proposal / project?</b></p> <p>Chief Executive</p>

# Integrated Quality & Performance Report

## September 2024

Reporting August 2024 data



**Mat Shaw**

Chief Executive

**Tracy Luckett**

Chief Nurse

**Sanjiv Sharma**

Chief Medical Officer

**Caroline Anderson**

Director of HR & OD

Report Section	Page Number
Executive Summary	3
Patient Safety	5
Effectiveness	9
Patient Experience	10
Well Led	14
Patient Access	22
Appendices	

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The Trust is also in the process of reviewing patients who are past their planned date for their diagnostic test. This cohort of patients are mainly waiting for MRIs, Cardiac MRIs, Sleep Studies and Ultrasound. We are putting on additional capacity where we can, to ensure these patients are seen as quickly as possible and where appropriate reviewing referral criteria with other providers.

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The Trust sickness rate for August was slightly over the Trust target but performs extremely well when benchmarked against the national average for the NHS for August which was 4.92%. Mandatory training compliance remained stable at 93%. Non consultant appraisal rate decreased to 80% this month whilst consultant appraisal rate increased to 84% but still below target. Nursing vacancy rate continued to increase this month to 11.6% and is being monitored closely. Substantive staff in post has remained below the planned level of 5800 FTE.

YTD the Trust has achieved £3.6m Better Value against a plan of £5.4m, largely made up of pay schemes. A handful of new schemes have been added in to the programme but there remains a significant gap in the forecast out-turn position.

# Integrated Quality & Performance Report, August 2024

## Patient Safety

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

## Patient Experience

FFT Experience		→
FFT Response		→
PALS		↘
Complaints		→

## Well Led

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

## Patient Access

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

## Effective



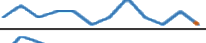






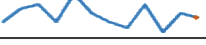

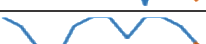
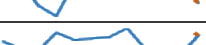
Clinical Audits		↗
QI Projects		→
Outcome reports		→
Better Value		-

Review of key metrics underway for 2024/25 and summary headlines will be updated once complete

# Patient Safety - Incidents & Risks

## Overview

- Incidents:** Incident numbers continued to drop as directorates focus on closing incidents. There remains a backlog of incidents awaiting closure with health and safety in particular, which are being worked on.
- Patient Safety Incident Investigations:** No new PSIs were declared within the month of August.
- Duty of Candour:** Three stage 2 letters and three stage 3 reports were due in August. Although all reports have been sent, there were delays across both stage 2 and stage 3 DOC which has reduced compliance. This is to be picked up through weekly patient safety meetings and Risk Action Groups.
- Risks:** High risks must be reviewed monthly to be compliant, and 19 risks of 42 were not reviewed in August. This was due to a large number of Risk Action Groups or equivalent corporate business meetings being cancelled in August. This is typical for this period of the year and performance is expected to bounce back in September.
- Clinical Harm review:** 55.4% of patients who were waiting 65+ weeks (on RTT and Non RTT pathways) had their clinical harm review completed by the end of August. Directorates are undertaking work to review the outstanding volume.

Patient Safety - Incidents		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Last 12 months	RAG			Stat/Target
New Incidents	Volume	521	645	628	521	621	579	599	581	620	602	666	548		No Threshold			Target
Total Incidents (open at month end)	Volume	2438	2247	2572	1914	2021	2162	2409	2206	2363	2347	2325	2245		No Threshold			Target
New Serious Incidents	Volume	1	3	1	2	2	0	1	4	1	0	2	0		No Threshold			Target
Total SIs (open at month end)	Volume	5	8	7	6	6	5	5	6	5	5	5	4					Target
Overdue SI Actions	Volume	9	8	7	3	3	2	8	24	23	19	31	34		>20	10 - 20	0 - 9	Target
Patient Safety Incidents involving physical harm	%	10%	9%	13%	12%	13%	13%	10%	13%	14%	15%	12%	10%		>25%	15%-25%	<15%	Target
Paient Safety incidents involving psychological harm†	%								10%	9%	6%		5%		>25%	15%-25%	<15%	
Never Events	Volume	0	0	0	1	0	0	0	1	0	0	0	0		>=1		0	Stat
Pressure Ulcers (3+)	Volume	0	0	0	1	0	0	0	0	1	0	1	0		>1	=1	=0	Stat
Duty of Candour Cases (new in month)	Volume	2	5	6	2	8	4	2	1	6	7	4	3		No Threshold			Target
Duty of Candour – Stage 2 compliance (case due in month)	%	3/4	2/2	3/6	1/1	1/2	4/4	2/2	0/0	1/4	3/3	3/3	1/3		<75%	75%-90%	>90%	Target
Duty of Candour – Stage 3 compliance (case due in month)*	%	1/1	4/5	1/4	0/0	4/5	1/1	2/2	1/2	2/2	1/1	4/5	1/3		<50%	50%-70%	>70%	Target
High Risks (% overdue for review)**	%	31%	15%	11%	50%	34%	37%	40%	62%	14%	9%	4%	45%		>20%	10% - 20%	<10%	Target

† From May 2023 harm was split between physical and psychological harm. Statistics prior to this date describe harm as a combined figure.














\* Following introduction of PSIRF at GOSH, Serious Incidents are no longer declared. The trust carries out PSIs in line with PSIRF.






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

# Patient Safety - Infection Control & Inpatient Mortality

## Overview

- Central line infections remain stable and within target range.
- SWARMS are underway for healthcare acquired mandatory bloodstream infections.
- One case of Cdiff in an outpatient.
- Both the number of cardiac arrests and respiratory arrests outside of ICU/theatres are within normal variation.
- The inpatient mortality rate is within normal variation
- In March 2024 we identified a signal in our real time risk adjusted PICU/NICU mortality data that has been reviewed (note 1)



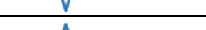

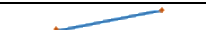



Infection Control		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	2024/25 YTD	Last 12 months	RAG (23/24 threshold)	Stat/ Target
Total C Difficile cases	In Month	1	1	3	2	1	0	0	3	1	1	4	1	10			Stat
C difficile Trust Assigned	Annually	1	1	1	0	1	0	0	1	0	1	2	0	3		>6 N/A <=6	Stat
Total MRSA cases	In Month	1	0	0	1	0	0	1	0	1	1	0	0	2			Stat
MRSA Trust Assigned	In Month	1	0	0	0	0	0	1	0	0	1	0	0	1		>0 N/A =0	Stat
Total MSSA cases	In Month	0	2	1	3	0	1	1	2	0	3	3	3	8		No Threshold	
MSSA Trust Assigned	In Month	0	2	0	2	0	0	1	1	0	1	2	1	4		No Threshold	
Total E.Coli Bacteraemia cases	In Month	0	0	2	2	0	2	0	1	1	0	0	2	4			Stat
E.Coli Bacteraemia Trust Assigned	In Month	0	0	1	2	0	2	0	1	0	0	0	1	2		>12 N/A <=12	Stat
Total Pseudomonas Aeruginosa	In Month	3	4	1	4	0	0	2	1	0	0	2	0	3			Stat
Pseudomonas Aeruginos Trust assigned	In Month	2	3	1	3	0	0	1	0	0	0	2	0	2		>19 N/A <=19	Stat
Total Klebsiella spp	In Month	4	4	3	4	6	2	3	5	2	2	3	1	11			Stat
Klebsiella spp Trust Assigned	Annually	3	3	3	4	4	2	3	3	2	1	2	0	7		>34 N/A <=34	Stat
CV Line Infections	In Month	2.6	2.3	1.2	1.7	1.5	1.4	2.5	2.1	1.7	1.1	1.2	1.2	1.8		>1.6 N/A <=1.6	T

Inpatient Mortality & Cardiac Arrest	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Last 12 months	RAG	Stat/ Target
Number of In-hospital Deaths	7	5	6	7	11	8	12	7	2	7	6	7		No Threshold	
Inpatient Mortality per 1000/discharges	6.9	5.4	5.7	7.9	10.5	8.2	11.3	7.4	1.9	7.1	5.5	6.7		No Threshold	
Cardiac arrests outside ICU/theatres	1	3	2	0	2	0	4	1	1	2	1	0		No Threshold	
Respiratory arrests outside ICU/theatres	4	4	4	5	3	4	2	3	0	5	2	2		No Threshold	
Inquests currently open	14	15	15	17	15	14	16	15	18	18	15	14		No Threshold	

Note1: The Paediatric Intensive Care Audit Network (PICANet) is the national audit that benchmarks UK PICU data, including offering 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) plots. Proactive real time monitoring identified on the 27th March 2024 that there were signals in the PICU/NICU mortality data that require internal review to identify a cause in line with PICANet guidance. A comprehensive review has led by Dr Sophie Skellett, PICU Consultant, and Deputy Chief of Service- Heart and Lung. The response to the RSPRT has been reviewed at the August 2024 QSOCC , outlining the causes and next steps. A summary of this was also provided in the Learning From Deaths report presented to Trust Board on the 11th September.

### Better Value:

YTD the Trust has achieved £3.6m Better Value against a plan of £5.4m, largely made up of pay schemes. A handful of new schemes have been added in to the programme but there remains a significant gap in the forecast out-turn position. This reflects the fact that I&PC patient activity has not reached plan levels, especially in NHS wards, as well as adverse variance in the non-pay element of the programme. Fortnightly meetings with each directorate remain focused on closing the gap, reporting into the executive chaired better value delivery group. Directorates are still being encouraged to submit paperwork for all identified schemes, an EQIA panel review is scheduled to take place in September.

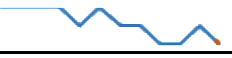



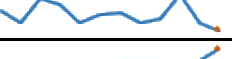
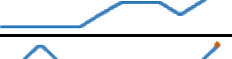

Effectiveness	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Last 12 months
Speciality led clinical audits completed (actual YTD)	30	50	60	66	70	74	94	5	5	29	41	49	
Outcome reports published (YTD)	5	5	6	7	8	8	9	4	6	6	6	6	
QI Project completed	1	1	4	0	1	3	0	0	0	0	0	0	
QI Projects started	15	19	17	5	18	18	13	10	8	18	15	10	
NICE guidance currently overdue for review	0	0	0	2	0	1	1	0	0	0	0	0	
Better Value YTD Actual	£2,679,000	£3,214,000	£3,582,000	£4,438,000	£5,063,000	£6,856,000	£9,467,000	N/A	N/A	£1,495,000	£2,503,000	£3,617,670	
% value of schemes identified compared to their Better Value target	63.70%	63.70%	63.70%	75.90%	72.90%	72.40%	66.70%	N/A	N/A	41.25% (exc. IPC) 56.26% (inc. IPC)	72.15%	73.91%	
Number of schemes identified	122	122	122	91	76	75	73	N/A	N/A	40	72	77	
Number of schemes fully signed off and EQIA assessed	22	37	45	53	65	73	73	N/A	N/A	0	0	0	
Number of schemes identified but not signed off	100	86	78	38	11	2	0	N/A	N/A	40	72	77	

### Overview:

The FFT experience rating (97%) and response rating (34%) for Inpatients were met in August. The experience score for outpatients (93%) remained just below the Trust target for the eighth consecutive month. The ongoing recurrent issues for outpatients include the faulty lifts and the lack of refreshments in some areas. The lifts are on a refurbishment programme and the outpatient areas will have a snack trolley that will be rolled out by the volunteers. Short notice appointment location changes are also being addressed through changes to how location information is shared with patients and families.

5 formal complaints were received in August 2024. There has been a slight decrease in complaint numbers compared to last month (8) and the same reporting period last year (9). In addition to the complaints received, there have been enquires regarding the Lower Limb Review and there continues to be a trend of complexity in cases. The Complaints Team also received the first formal complaint relating to the Gender Service.

There was a significant reduction in Pals contacts from 237 to 188. Contacts related to the Orthopaedic review, requests for information relating to rescheduled appointments/ procedures and transport, and information regarding medication, the status of referrals and rejected referrals. Families also contacted Pals regarding the Orthopaedic review. Cancellation of outpatient appointments (OPA)/ admissions decreased from 21 in July to 13 in August.

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Last 12 months	RAG		
FFT Experience rating (Inpatient)	99.0%	99.0%	99.0%	99.0%	98.0%	99.0%	98.0%	98.0%	97.0%	97.0%	98.0%	97.0%		<90%	90-94%	>=95%
FFT experience rating (Outpatient)	95.0%	96.0%	95.0%	95.0%	93.0%	93.0%	93.0%	92.0%	92.0%	94.0%	93.0%	93.0%		<90%	90-94%	>=95%
FFT - response rate (Inpatient)	26.0%	32.0%	31.0%	21.0%	21.0%	30.0%	39.0%	36.0%	27.0%	32.0%	32.0%	34.0%		<25%	N/A	>=25%
PALS - per 1000 episodes	7.16	9.43	9.83	8.37	6.47	11.99	10.2	11.8	9.86	8.97	6.64	7.02		No Threshold		
Complaints- per 1000 episodes	0.37	0.27	0.48	0.43	0.26	0.34	0.36	0.27	0.3	0.51	0.27	0.2		No Threshold		
Red Complaints -% of total (note 1)	3%	3%	3%	3%	3%	4%	5%	5%	5%	4%	5%	6%		>12%	10-12%	<10%
Re-opened complaints - % reopened (2)	2%	2%	3%	2%	2%	2%	0%	1%	2%	2%	2%	3%		>12%	10-12%	<10%

**Contractual staff in post:** Substantive staff in post numbers in August was 5584.6 compared to 5659.7 FTE for the previous month, which is a decrease of 75.1 FTE. The headcount was 6115 (-20 on the previous month).

**Unfilled vacancy rate:** August 2024 vacancy rates for the Trust have increased to 7.5% (from 6.9% in July). The vacancy rates are highest in Research and Innovation (38.2%), Medical Directorate (23.8%) and International and Private Care (23.4%)

**Turnover:** is reported as voluntary turnover over a rolling 12-month period. Voluntary turnover has decreased slightly to 10.0% from 10.1%, and is within the Trust KPI




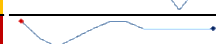
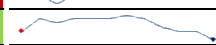
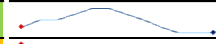

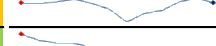



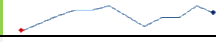

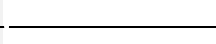
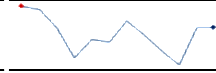

**Agency usage:** Agency usage for August 2024 is 1.3%, this remains within the 2% Trust target. Finance (13.6%) is the highest spending directorate.

**Statutory & Mandatory training compliance:** August 2024 training rate for the Trust remains stable at 93%, with all directorates meeting the target.

**Appraisal/PDR completion:** The non-medical appraisal rate for August 2024 slightly decreased to 80%. Medical appraisal rate for the month increased to 84%.

**Sickness absence:** August 2024 sickness is slightly over the trust target at 3.7% In order to benchmark GOSH sickness more accurately, and provide a more realistic target, the Trust has incorporated the national NHS sickness rate into its RAG rating (see Well led page for details). The national rate for August was 4.92%,.

**Freedom to Speak Up:** There were 16 new substantive contacts to the FTSU Guardian in August, which is the same number as July (1 further request to meet where a meeting has not yet taken place and will be included in later months if appropriate). Inappropriate behaviours/ attitudes, and staff safety/wellbeing were the highest themes seen (each case often has more than one theme) and staff speaking up came from a variety of professional backgrounds.

Well Led Metrics Tracking	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Last 12 months	RAG Levels			Stat/Target	
Mandatory Training Compliance	92.0%	93.1%	93.5%	94.3%	95.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		<80%	80-90%	>90%	Stat	
Stat/Man training – Medical & Dental Staff	86.0%	87.0%	87.0%	88.0%	91.0%	89.0%	87.0%	87.0%	87.0%	87.0%	87.0%	86.0%		<80%	80-90%	>90%	Stat	
Appraisal Rate (Non-Consultants)	81.0%	79.8%	79.0%	81.1%	81.0%	82.0%	83.0%	82.0%	82.0%	82.0%	82.0%	80.0%		<80%	80-90%	>90%	Stat	
Appraisal Compliance (Consultant)	95.0%	95.0%	95.0%	86.0%	95.0%	92.0%	92.0%	92.0%	87.0%	TBC	82.0%	84.0%		<80%	80-90%	>90%	Stat	
Honorary contract training compliance	72.0%	70.0%	69.0%	70.0%	71.0%	72.0%	72.0%	71.0%	71.0%	71.0%	71.0%	71.0%		<80%	80-90%	>90%	Stat	
Safeguarding Children Level 3 Training	93.0%	96.0%	95.0%	96.0%	96.0%	96.0%	97.0%	96.0%	94.0%	93.0%	93.0%	91.0%		<80%	80-90%	>90%	Stat	
Safeguarding Adults Level 2 Training	92.0%	93.0%	93.0%	94.0%	95.0%	95.0%	94.0%	93.0%	92.0%	91.0%	91.0%	91.0%		<80%	80-90%	>90%	Stat	
Resuscitation Training	86.0%	84.0%	82.0%	83.0%	86.0%	86.0%	85.0%	86.0%	86.0%	86.0%	85.0%	85.0%		<80%	80-90%	>90%	Stat	
Sickness Rate <small>see note 3</small>	3.7%	3.7%	3.8%	3.9%	3.7%	3.5%	2.9%	3.3%	3.4%	3.8%	4.0%	3.7%		>5.3%	3-5.3%	<3%	T	
Turnover Rate (Voluntary)	13.1%	12.4%	12.0%	12.0%	11.4%	11.2%	10.9%	10.8%	10.6%	10.9%	10.1%	10.0%		>15.4%	14-15.4%	<14%	T	
Vacancy Rate – Trust	9.4%	7.5%	7.2%	7.5%	6.2%	6.1%	5.7%	5.5%	4.9%	6.3%	6.9%	7.5%		>11%	>10-11%	<10%	T	
Vacancy Rate - Nursing	14.1%	9.1%	9.3%	10.4%	7.7%	8.1%	7.9%	8.1%	7.7%	10.1%	11.1%	11.7%		No Threshold			T	
Bank Spend	5.8%	5.9%	5.8%	5.8%	5.8%	5.9%	5.7%	6.4%	5.8%	5.4%	5.5%	5.5%		No Threshold			T	
Agency Spend	1.2%	1.2%	1.3%	1.3%	1.3%	1.3%	1.3%	1.2%	1.3%	1.3%	1.3%	1.3%		>2%	N/A	<2%	T	
Quarterly Staff Survey - I would recommend my organisation as a place to work					68.0%				52.0%			56.0%					No Threshold	T
Quarterly Staff Survey - I would be happy with the standard of care provided by this organisation					87.0%				89.4%			81.5%					No Threshold	T
Quarterly Staff Survey - Overall Staff Engagement (scale 0-10) <small>See note 1</small>					7.2				6.6			6.8					No Threshold	T
Quarterly Staff Survey - Communication between senior management and staff is effective <small>See note 1</small>					44.0%				N/A			N/A					No Threshold	T
Number of people contacting the Freedom To Speak Up Service	22	21	16	8	13	12	18	14	10	6	16	16		No Threshold			T	
Number of Themes of concerns raised as part of Freedom to Speak Up Service (note 2)	12	32	30	22	17	22	22	26	32	8	19	27		No Threshold			T	

Note 1 - Survey runs in January, April and July.

Note 2 - people contacting the service can present with more than one theme to their concern

Note 3: Sickness rate target has changed to the national average from Nov 22

# Directorate KPI performance August 2024

	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Core Clinical Services	NT Genomic Medicine Service	Heart & Lung	Sight & Sound	International	Clinical Operations	Corporate Affairs	ICT	Space and Place	Finance	Human Resources & Organisational Development	Medical Directorate	Nursing & Patient Experience	Research & Innovation	Transformation	Innovation
Voluntary Turnover	14%	10.0%	12.7%	13.7%	9.7%	9.4%	13.9%	10.4%	7.2%	14.5%	12.7%	11.0%	2.2%	5.3%	5.5%	15.2%	9.7%	10.2%	8.6%	4.7%	13.5%
Sickness (1m)	3% - National Average (4.92%)	3.7%	3.8%	3.3%	4.8%	3.1%	1.9%	3.3%	5.4%	5.1%	4.1%	2.4%	2.7%	6.1%	4.9%	1.3%	0.5%	3.7%	3.3%	0.5%	2.3%
Vacancy	10%	7.5%	8.7%	3.2%	9.5%	0.3%	-9.1%	8.6%	6.6%	23.4%	4.6%	-22.2%	4.8%	9.7%	10.8%	6.0%	23.8%	5.9%	38.2%	5.0%	-16.3%
Agency YTD	2%	1.3%	0.0%	0.0%	0.5%	1.4%	0.0%	0.6%	0.0%	4.8%	0.0%	0.8%	0.1%	4.8%	13.6%	1.6%	9.4%	-0.2%	0.3%	0.0%	3.7%
PDR	90%	80%	76%	79%	78%	78%	94%	79%	86%	84%	75%	61%	73%	83%	85%	85%	81%	83%	84%	67%	76%
Stat/Mand Training	90%	93%	91%	90%	93%	93%	99%	92%	93%	96%	94%	95%	97%	95%	93%	93%	94%	96%	97%	96%	95%

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

# Annual Staff Survey Metrics 2022/2023/2024 – Core Questions

Question	April 2022 (QSS)	July 2022 (QSS)	2022 NHS Staff Survey	April 2023 (QSS)	July 2023 (QSS)	2023 NHS Staff Survey	Jan 2024 (QSS)	Apr 2024 (QSS)	Jul 2024 (QSS)
Response Rate	12%	13%	43%	13%	14%	54%	13%	2%	6%
I look forward to going to work.	51%	52%	54%	52%	50%	56%	57%	40%	45%
I am enthusiastic about my job.	68%	68%	68%	67%	65%	69%	69%	55%	61%
Time passes quickly when I am working.	75%	73%	75%	73%	71%	74%	74%	65%	73%
There are frequent opportunities for me to show initiative in my role.	72%	69%	74%	69%	65%	76%	66%	61%	68%
I am able to make suggestions to improve the work of my team / department.	71%	70%	73%	72%	64%	73%	68%	64%	68%
I am able to make improvements happen in my area of work.	60%	57%	57%	60%	53%	58%	56%	51%	58%
Care of patients / service users is my organisation's top priority.	83%	82%	84%	82%	80%	85%	83%	78%	79%
I would recommend my organisation as a place to work.	65%	62%	66%	64%	60%	71%	68%	52%	56%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	88%	87%	87%	87%	86%	87%	87%	89%	82%

\* April 2024 quarterly survey was only partially completed as commenced in the last week of April, due to changing of providers to NHS People Pulse hence the low response rate.

# Safer Staffing- Nursing only

**Vacancy rate:** Registered nurse (RN) vacancy rate has increased this month, a signal we saw over the past two months . Central recruitment campaigns continue. Central and local recruitment drives are having a positive impact on vacancy rate, second cohort of international nurses joined GOSH in September. We continue to carefully monitoring this increase.

**Voluntary Turnover:** Based on a 12-month rolling average, the vol. turnover for August is under trust target (<14%) at 12.8%. We continue to drive forward the retention actions to retain our skilled and experienced nurses, and this will be monitored through the Nursing Delivery Committee and targeted monthly Recruitment and Retention meetings. The People Promise manager has established key priorities for retention and focus for the Trust : *We each have a voice that counts/We work flexibly/We are recognised and rewarded.*

**Sickness absence:** Nursing sickness rates in August have remained stable, at 4% .



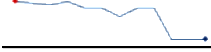


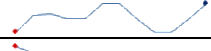
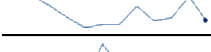


**Care Hours per Patient Day (CHPPD)** is a benchmarking metric to provide a picture of care, it does not reflect true skill mix or patient acuity. CHPPD reflects the staffing levels based on open and occupied beds. This is static in August , at 15.5 This yearly trend and will be continued to be monitored.

**CHPPD Actual vs Plan:** The Trust average was 92.6% and continues above the target of 90%.

**Temporary staffing spend:** There was 2% agency use in August. Bank fill rates at 65% in August and remain below target. Work with Bank Partners and HR continues to address below target achievement.

**Safe Staffing Incidents:** A total of 3 incidents related to safe staffing were summarised as: short notice absence, and unexpectedly high patient acuity. No patient harm occurred.

**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 however this impacts on patient and family experience, delayed treatment and patient outcomes. The total number of beds closed in August was 514 an increase but continuing below average over the last 12months. In July, a collaborative workshop to explore the ways to improve GOSH bed base was held, and workstreams from this day are being agreed.


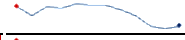


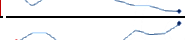
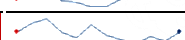
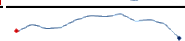

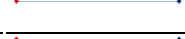

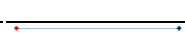





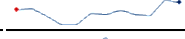



Safer Staffing Metrics	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Last 12 months	RAG Levels			Stat/Target
Vacancy Rate - Nursing	14.1%	9.1%	9.3%	10.4%	7.7%	8.1%	7.9%	8.1%	7.7%	10.1%	11.1%	11.6%		>11%	10.1% - 11%	<= 10%	T
Turnover Rate (Voluntary)	16.3%	15.7%	15.0%	14.8%	14.1%	13.8%	13.6%	14.0%	13.6%	13.4%	12.7%	12.8%		>14%	N/A	<14%	T
Sickness Rate see note 3	5.0%	4.6%	4.5%	5.0%	4.0%	4.0%	3.0%	4.0%	4.0%	4%	4%	4%		>5.3%	3-5.3%	<3%	T
Care Hours per Patient Day (CHPPD)	16.8	14.4	14.5	13.7	15.9	15.4	15.6	14.9	15.5	15.6	16.1	15.5		No Threshold			T
Care Hours per Patient Day (CHPPD)- Actual vs Plan	94%	88%	89%	93%	97%	95%	92%	94%	96%	95.2%	95.5%	92.6%		<80%	80-90%	>90%	T
Agency Spend	0.0%	1.2%	1.3%	1.0%	1.0%	2.0%	2.0%	1.0%	0.0%	0.0%	1.0%	2.0%		>2%	N/A	<2%	T
Safe Staffing incidents	12	10	7	4	1	2	2	7	3	4	10	3		No Threshold			T
Bank fill rate	62%	62%	67%	61%	61%	74%	66%	62%	65%	64%	62%	65%		No Threshold			T
Total monthly Bed closures	598	527	434	564	516	414	536	326	373	347	379	514		No Threshold			T

# Directorate performance for Safer Staffing – Nursing Only Aug 2024

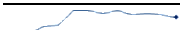

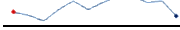

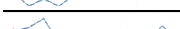









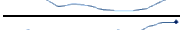

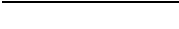


Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Core Clinical Services	Heart & Lung	Sight & Sound	International	Research & Innovation
Voluntary Turnover	14%	12.8%	15.4%	13.8%	12.7%	10.8%	11.5%	15.5%	19.7%	5.2%
Sickness (1m)	3%	4%	4.5%	4.5%	6.2%	3.7%	3.6%	4.8%	4.3%	4.8%
Vacancy	10%	11.6%	9.2%	14.8%	15.8%	5.1%	12.5%	12.5%	26.8%	4.7%
Agency YTD	2%	1%	0%	0%	0%	1%	1%	0%	5%	0%
PDR	90%	81%	74%	80%	86%	78%	84%	92%	84%	81%
Stat/Mand Training	90%	93%	92%	93%	95%	93%	93%	95%	96%	95%
CHPPD		15.5	15.2	11.8	11.9	N/A	20.4	14.1	13.0	N/A
CHPPD Actual vs Planned		92.6%	93.4%	91.4%	90.6%	N/A	87.1%	108.6%	104.2%	N/A
Incidents		3	0	1	0	0	0	2	0	0

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

# Patient Access Metrics

Access Metrics Tracking	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Trajectory	Last 12 months	RAG Levels			Stat/Target
RTT Open Pathway: % waiting within 18 weeks	66.7%	68.6%	67.5%	66.8%	66.2%	66.1%	66.1%	67.2%	68.9%	69.7%	70.3%	70.5%	Below		<92%	N/A	>=92%	Stat
Waiting greater than 18 weeks - Incomplete Pathways	2,662	2,562	2,648	2,646	2,694	2,669	2,671	2,622	2,556	2,461	2,419	2,460	-		No Threshold			-
Waiting greater than 52 weeks - Incomplete Pathways	438	424	408	385	445	440	409	371	341	298	301	281	Above		>0	N/A	=0	Stat
Waiting greater than 78 weeks - Incomplete Pathways	104	96	116	123	146	124	89	86	60	32	35	28	Below		TBC			T
Waiting greater than 104 weeks - Incomplete Pathways	16	10	14	13	16	19	14	12	10	10	8	7	Below		>0	N/A	=0	Stat
18 week RTT PTL size	8005	8149	8148	7976	7961	7881	7871	8003	8220	8123	8150	8327	-		No Threshold			-
Diagnostics- % waiting less than 6 weeks	80.0%	82.2%	83.6%	79.7%	78.0%	81.7%	79.2%	78.0%	76.5%	78.5%	77.3%	79.9%	Below		<99%	N/A	>99%	Stat
Total DM01 PTL size	1,668	1,789	1,709	1,741	1,844	1,909	1,880	1,946	1,833	1,847	1,769	1,549	-		No Threshold			-
Cancer waits: 31 Day: Referral to 1st Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-		<85%	N/A	>85%	Stat
Cancer waits: 31 Day: Decision to treat to 1st Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-		<96%	N/A	>96%	Stat
Cancer waits: 31 Day: Subsequent treatment – surgery	100%	100%	100%	100%	100%	100%	100%	-	100%	100%	100%	100%	-		<94%	N/A	>94%	Stat
Cancer waits: 31 Day: Subsequent treatment - drugs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-		<98%	N/A	>98%	Stat
Cancer waits: 62 Day: Consultant Upgrade	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-		No Threshold			-
Cancelled Operations for Non Clinical Reasons (note 1)	42	46	56	39	26	24	49	44	55	46	23		-		No Threshold			-
Cancelled Operations: 28 day breaches	7	4	8	13	6	2	3	5	3	4	4		-		>0	N/A	=0	Stat
Number of patients with a past planned TCI date (note 4)	1,763	1,759	1,886	2,085	2,032	2,126	1,939	1,946	2,030	2,009	1,885	1,519	-		No Threshold			-
NHS Referrals received- External	2,722	2,874	3,000	2,668	2,979	2,916	2,807	3,110	3,099	2,744	3,135	2,441	-		No Threshold			-
NHS Referrals received- Internal	1,777	1,945	1,994	1,620	2,908	2,672	2,685	2,896	3,023	2,807	3,062	2,569	-		No Threshold			-
Total NHS Outpatient Appointment Cancellations (note 2)	6,690	6,751	6,240	5,644	5,629	6,452	6,401	6,694	6,417	6,296	7,460	7,191	-		No Threshold			-
NHS Outpatient Appointment Cancellations by Hospital (note 3)	1,541	1,672	1,220	1,232	1,509	1,695	1,892	1,653	1,331	1,358	1,716	1,474	-		No Threshold			-
Outpatient Clinic utilisation																		-

# Patient Access Metrics (cont.)

Access Metrics Tracking	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Trajectory	Last 12 months	RAG Levels	Stat/Target
RTT Priority 2 patients	683	698	745	750	853	844	828	848	816	831	820	798	-		No Threshold	
RTT Priority 2 patients beyond fail safe date	178	181	170	210	201	224	197	171	139	151	163	153	-		No Threshold	
Diagnostics- waiting greater than 6 weeks	334	319	280	354	405	349	392	428	431	397	401	311	-		No Threshold	-
Diagnostics- waiting greater than 13 weeks	70	55	49	46	66	59	53	56	57	63	76	70	-		No Threshold	-
Main Theatre Utilisation (NHS Only)	70.4%	64.5%	67.9%	64.7%	69.3%	69.6%	74.6%	70.9%	70.7%	75.8%	70.9%	74.0%	-		<77% N/A >77%	T
Main Theatres Late Start Minutes	8,097	8,813	10,182	6,533	7,830	7,568	6,438	7,464	8,413	6,551	9,124	7,072			No Threshold	
Main Theatres Overrun	4,054	3,625	6,590	2,625	3,506	3,798	5,659	5,449	3,880	6,122	4,916	4,737			No Threshold	
Bed Occupancy (All Wards NHS & PP)	82.5%	79.2%	87.1%	79.5%	80.8%	84.0%	82.1%	83.1%	81.0%	83.4%	82.3%	77.5%			<80% 80-84% =>85%	T
Bed Occupancy (NHS Wards Only)	78.2%	80.2%	87.8%	81.1%	82.8%	85.7%	83.3%	85.5%	83.6%	85.7%	84.9%	79.2%			<80% 80-84% =>85%	T
Bed Closures (All Wards NHS & PP)	598	527	530	564	516	361	444	326	373	414	373	514			No Threshold	
Bed Closures (NHS Wards Only)	261	265	328	331	214	212	340	287	356	388	304	415			No Threshold	
PICU/ NICU Refused Admissions	4	9	11	20	3	9	7	10	2	2	2	3			No Threshold	
Cardiac CATS Refused Admissions	2	2	2	2	2	1	5	1	2	2	1	3			No Threshold	
PICU Readmissions within 48 hours	2	3	3	3	0	2	2	1	4	3	2	0			No Threshold	
CICU Readmissions within 48 hours	2	0	3	1	2	0	0	0	1	0	0	0			No Threshold	
NHS Discharge Summaries within 24 hours	74.6%	78.5%	76.9%	82.1%	81.7%	79.9%	80.5%	84.8%	79.2%	85.0%	84.0%	79.7%			<100% N/A 100%	T
Number of NHS Discharge Summaries not sent (ytd)	255	181	155	78	100	93	57	44	37	63	122	178			No Threshold	
NHS Clinic Letters sent within 7 days	55.1%	56.6%	52.1%	51.5%	50.4%	52.6%	52.4%	56.5%	54.7%	57.3%	58.8%	59.2%			<100% N/A 100%	T
Number of NHS Clinic Letters not sent (ytd)	5468	5401	6172	5915	5050	5013	4717	4085	4197	3996	3848	4102			No Threshold	

Note 1 - Elective cancelled operations on the day or last minute

Note 2 - Patient and Hospital Cancellations (excluding clinic restructure)

Note 3 - Hospital non-clinical cancellations between 0 and 56 days of the booked appointment

Note 4 - Planned Past TCI date includes patients with no planned date recorded

# Patient Access - Activity Monitoring at Month 5

## Overview:

Trust activity overall is 1.4% above 2024/25 plan and above 2023/24 (4.8%)\*.

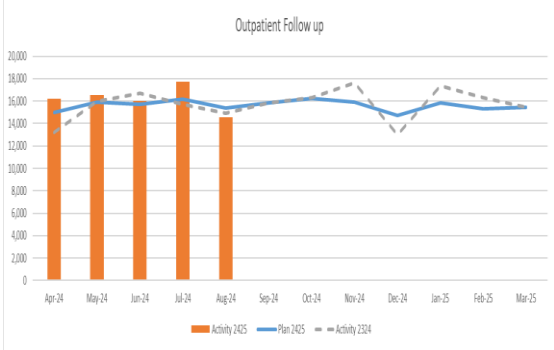
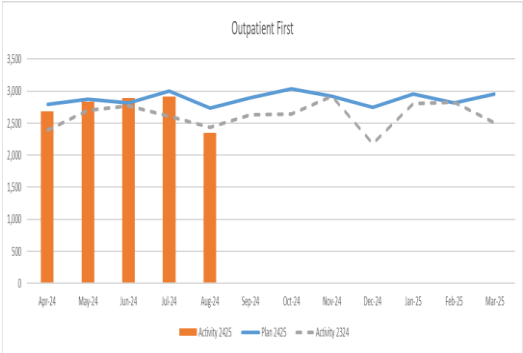
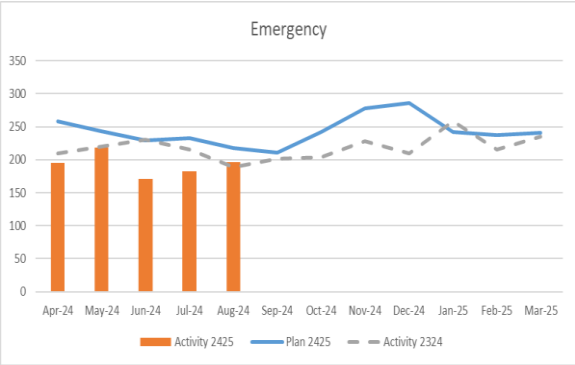
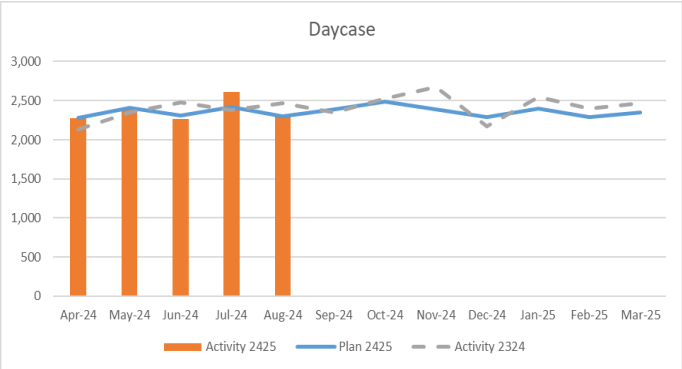
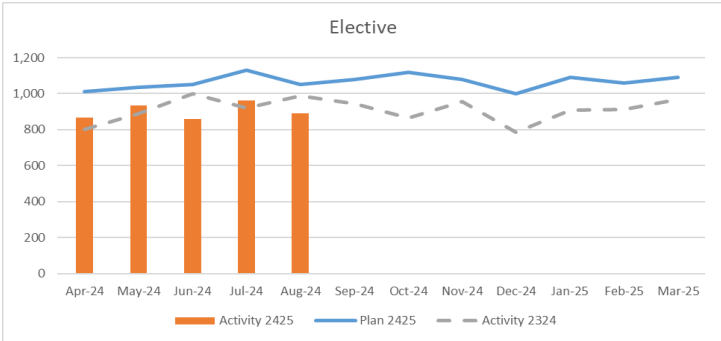
Electives continue to be less than plan at -14.4 % and day cases are just above plan at 1.06%.

As at YTD M5 24/25, Body, Bones & mind, Core Clinical Services and Heart & Lung were above plan. With previous strikes and bed closures continuing this has impacted the delivery of activity, RTT and DM01 waiting time improvements. Continued focus remains on optimising bed capacity, theatres and reducing long waits.

*\* 1<sup>st</sup> April in 23/24 was a Saturday therefore w/c 1<sup>st</sup> April is skewed in terms of variance*

## Overview 2024-25

POD	Plan 2425	Activity 2425	Activity 2324	% of 23/24	% of Plan
Daycase	11,712	11,836	11,803	100.28%	101.06%
Elective	5,282	4,516	4,598	98.22%	85.50%
Emergency	1,181	962	1,066	90.24%	81.45%
First OPA	14,217	13,682	12,915	105.94%	96.23%
Follow-up OPA	78,147	81,089	76,535	105.95%	103.76%
Grand Total	110,539	112,085	106,917	104.83%	101.40%



## Overview

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

- **RTT** Performance for August 2024 was **70.5%**, an increase of 0.2% since last month. This is the second time in 18 months the Trust has been above 70% and reflects work carried out across the whole of the PTL. The overall PTL size has slightly increased in comparison to last month (8327 vs 8150). None of the directorates met the 92% standard this month. RTT performance has been affected by the national strikes, inherited breaches, patient and staff sickness, and bed pressures.
- There are 7 patients who are waiting above **104 weeks**, a slight decrease from previous month, when we reported 8. Four patients have already been treated or discharged in September (3 x **dental**, 1 x **MaxFax**). One **dental** patient has a TCI in October, whilst the other patient was unable to have dental chair treatment and now needs to have treatment under GA. One **Cardiology** patient is very complex, and family are having thinking time to consider treatment options.
- **78 week waits** have decreased this month to 28. Focus continues on reducing long wait patients with weekly oversight at executive level. This is expected to decrease in September.
- **52 week waits** have decreased to 281. The long waiters are predominantly in Plastic Surgery (81), ENT (28), Orthopaedics (26), Dental (21), Audiological Medicine (19), Ophthalmology (15), SNAPS (11). Sight & Sound and Body, Bones and Mind directorates are the most challenged.
- **DM01** performance for August 2024 was **79.9%**, an increase of 2.6% from the previous month. The number of 6 week breaches has decreased this month to 311, compared to 401 last month. 13 week breaches have decreased to 70 from 76 last month. The Trust is performing above the backlog forecasted in the trajectories for MRI, CT and Ultrasound but is performing better than trajectory for Endoscopy. Work continues in reviewing patients past their planned date.
- **Cancer:** It is projected for August that all of the five standards will be met.

## Challenges and actions taken

Junior doctor's and consultant strikes resulted in reduced activity and patients experiencing longer waits

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

Continued focus and prioritisation on reduction of long wait patients. Reviewing changing outpatient capacity to theatre in order treat patients during August/September.

Specialist surgeon availability predominantly for joint cases and complex patients

Community/local physiotherapy capacity for the SDR pathway

Increases in inherited waits above 52 weeks as other providers reduce backlogs. (Where patients arrive from referring hospitals with a significant time already on the clock).

Mutual aid with RNOH for Orthopaedics

Scope other treatment centres for Mutual aid Orthopaedic and Plastic Surgery patients

Recruitment of locum consultants in Orthopaedic and Plastic Surgery to support those services

Unexpected theatre maintenance and closures

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

Running theatre lists in parallel, planned overruns, Saturday lists

Bed closures due to combination of patient acuity and staff sickness

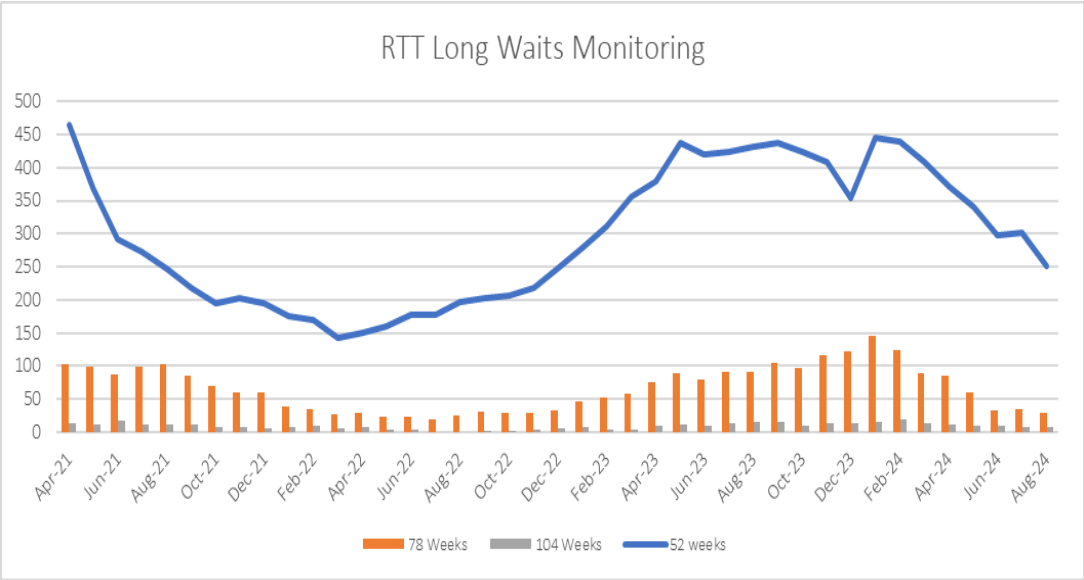
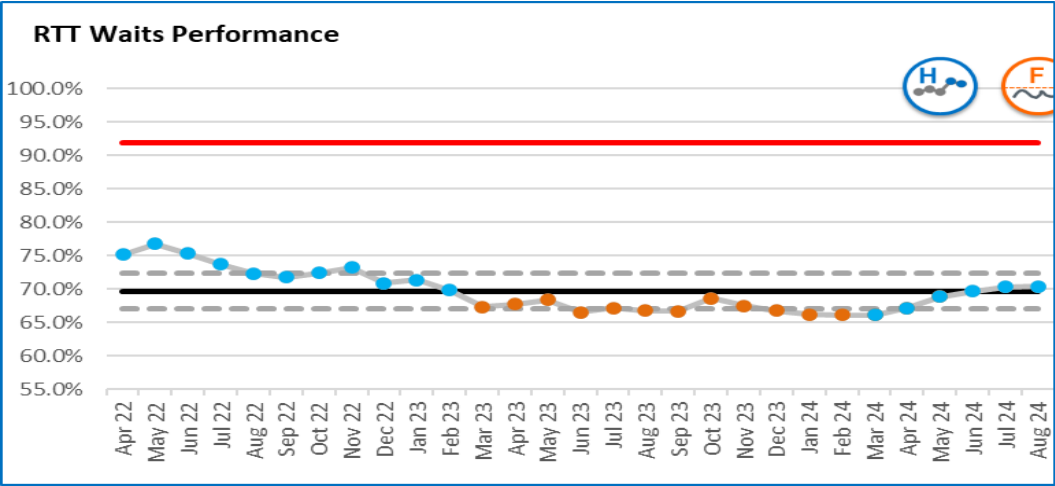
Day-case project commenced reviewing Nightingale Ward usage

Inpatient bed re-stacking project will commence in the coming months


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

Waiting List initiatives being held in September for MRI, Cardiac MRI and Ultrasound to support booking patients past their planned date and long waits

# Referral to Treatment times (RTT)




**RTT:**

**70.4%**  0.1%


People waiting less than 18 weeks for treatment from referral.

**>52 Weeks:**

**281**  **20**


Patients waiting over 52 weeks

**>78 Weeks:**

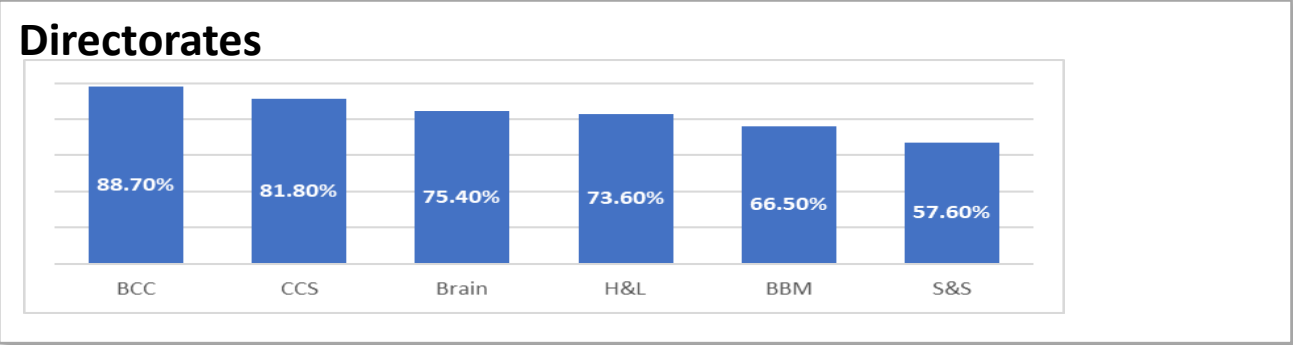
**28**  **7**

Patients waiting over 78 weeks

**>104 Weeks:**


**7** 

Patients waiting over 104 weeks




## RTT PTL Clinical Prioritisation – past must be seen by date


**P2**

**153**  **10**

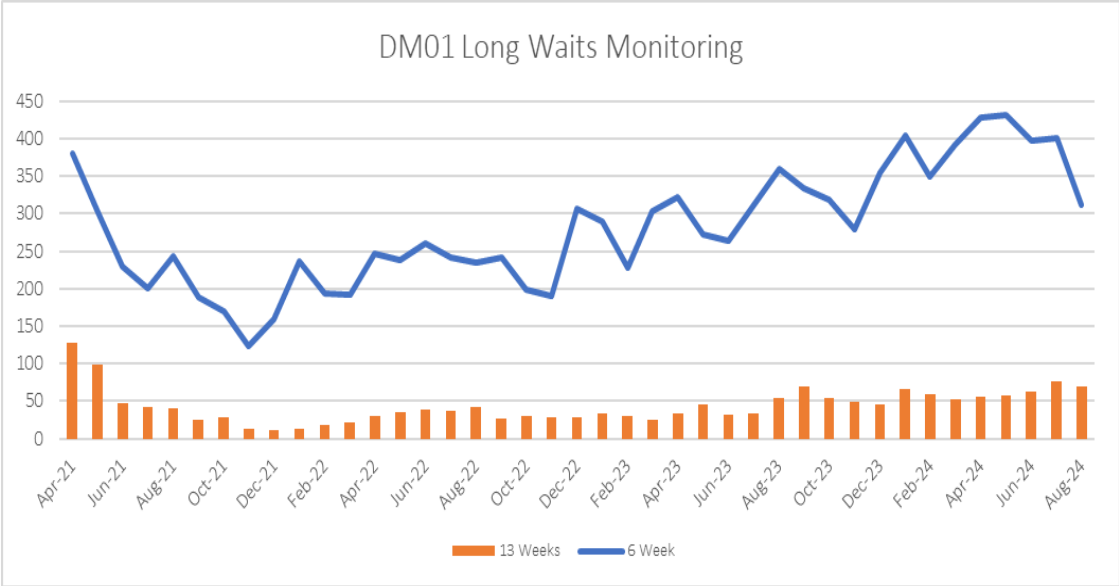
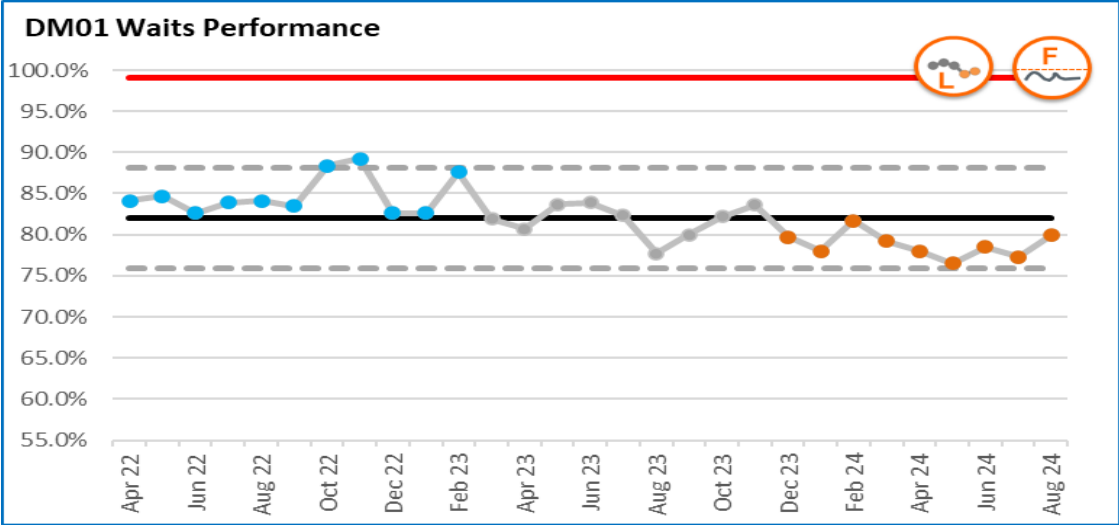
**P3**


**403**  **4**


**P4**

**357**  **15**

# Diagnostic Monitoring Waiting Times (DM01)

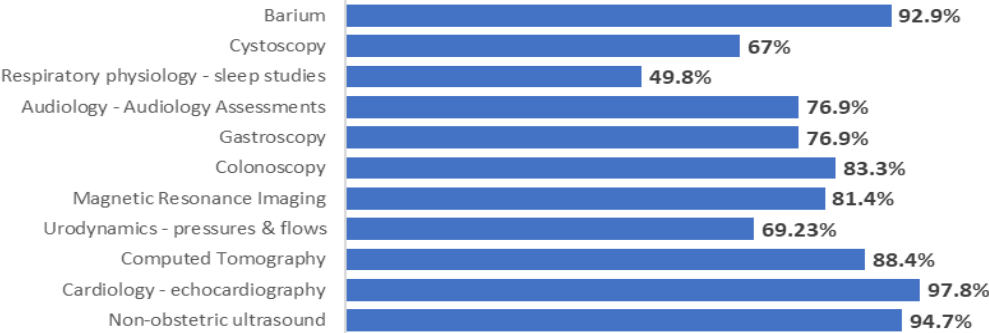


**DM01:**  
**79.9%**  **2.6%**  
People waiting less than 6 weeks  
for diagnostic test.

**>6 Weeks:**  
**311**  **90**  
Patients waiting over  
6 weeks

**>13 Weeks:**  
**70**  **6**  
Patients waiting over  
13 weeks

## Modalities not meeting 99% standard

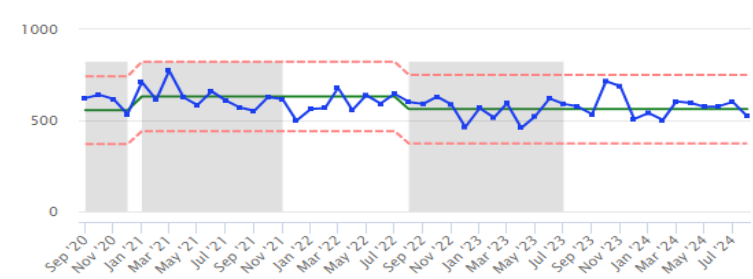


# Appendix

## Integrated Quality & Performance Report

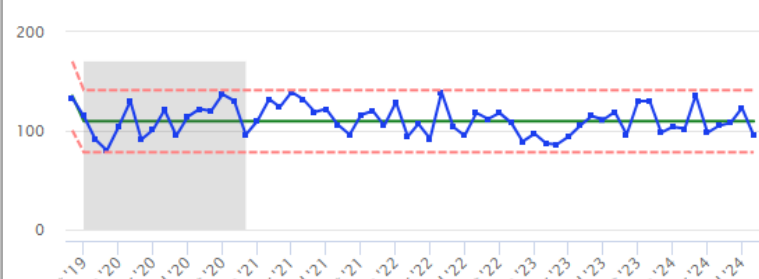
# Appendix 1: Patient Safety (incidents & risks)

New Incidents



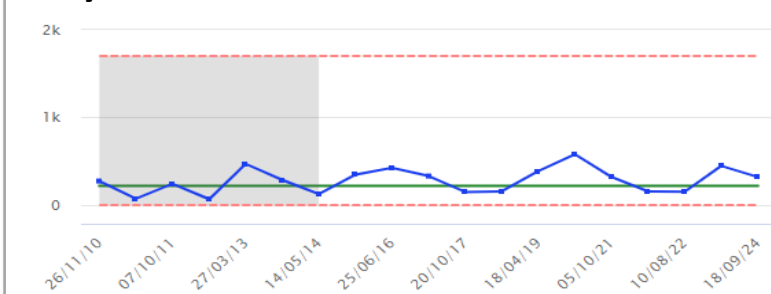
No significant variation, remains in expected limits

Medication Incidents



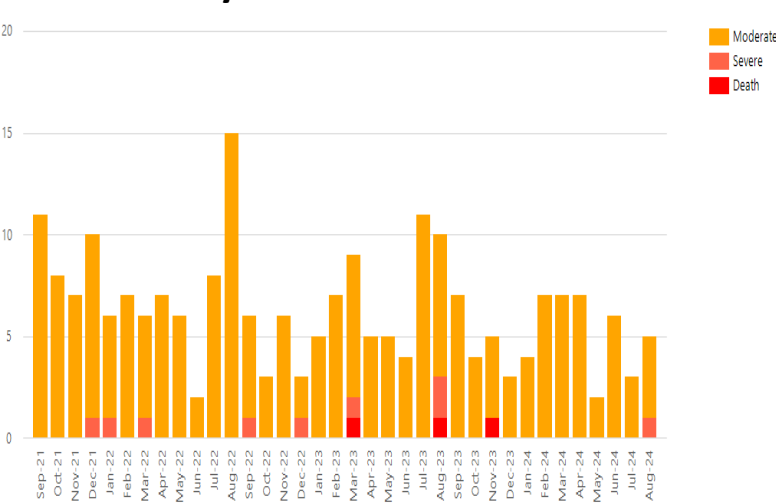
No significant variation, remains in expected limits

Days Since never events



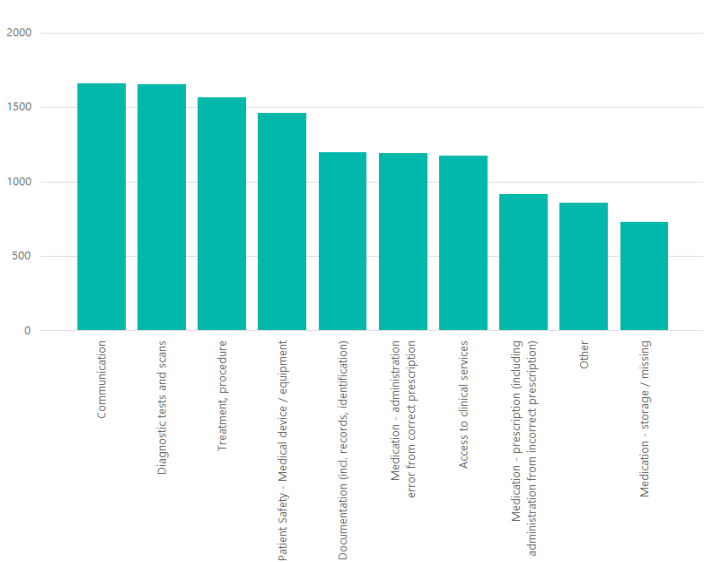
No significant variation, remains in expected limits

Incidents by Harm



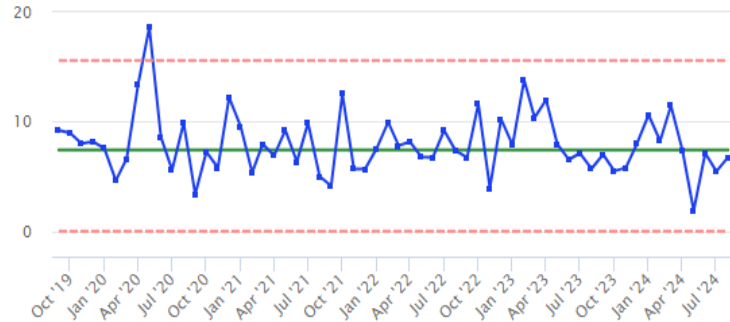
April 24 – August 24

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



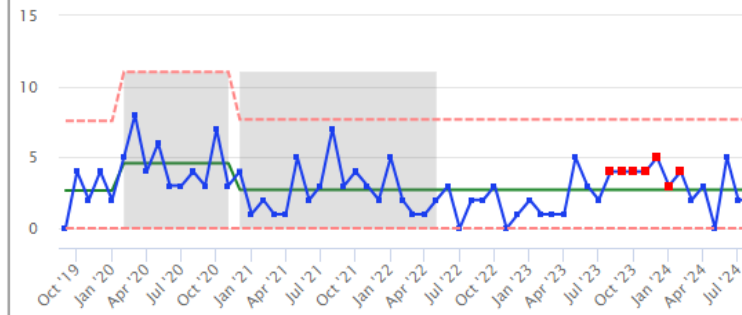
# Appendix 2: Patient Safety (Infection & mortality)

## Inpatient Mortality Rate / 1000 Discharges



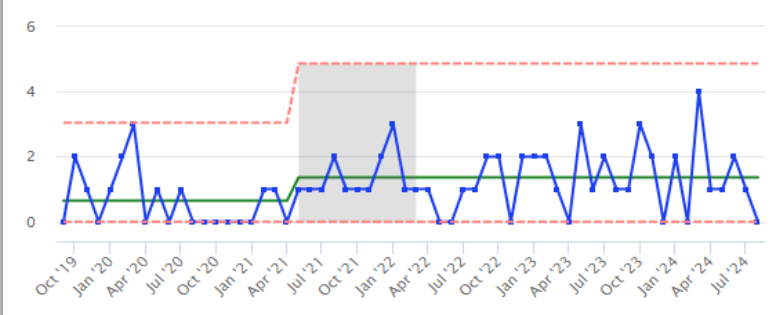
No significant variation

## Respiratory Arrests outside ICU



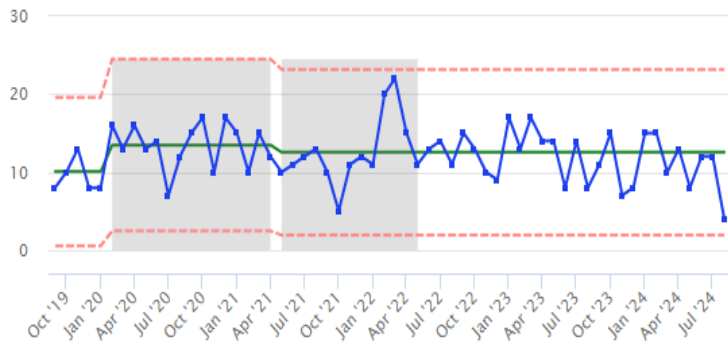
No significant variation

## Cardiac Arrests outside ICU



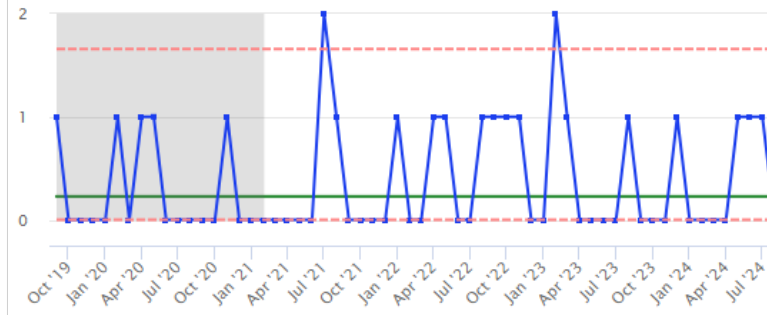
No significant variation

## Non 2222 Patients transferred to ICU



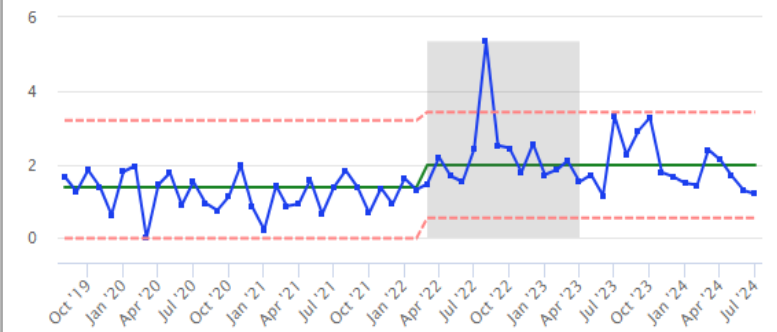
No significant variation

## Cat 3+ Hospital Acquired Pressure Ulcers



No significant variation

## CV Line Infection / 1,000 line days



No significant variation

# Appendix 3: Friends and Family Test

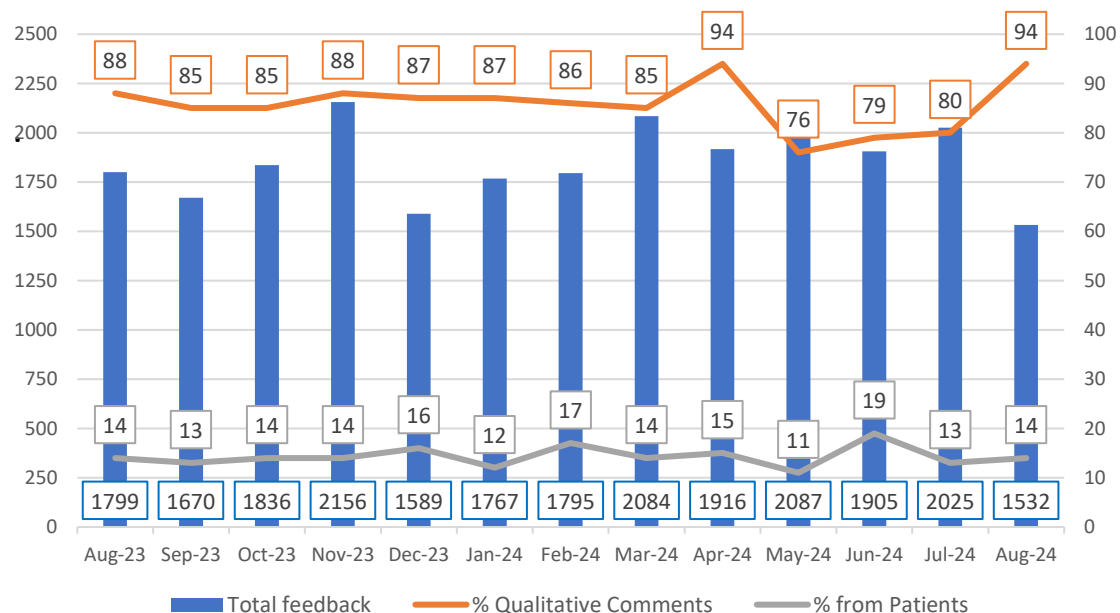
**Overview:** The FFT experience rating (97%) and response rating (34%) for Inpatients were met in August. The outpatient experience rating (93%) remained under the 95% target with recurrent themes including short notice amendments to clinic locations, the faulty lifts in RHLIM and the lack of toys and activities in outpatient waiting areas.

The new FFT dashboards are now fully operational across the Trust and can be accessed via this link: [FFT Dashboard](#)

The themes are from the Patient Experience Framework. The theme with the most positive comments is Respect for Patient Centred Values. The theme with the most negative comments is Access to Care.

## Headline:

- Inpatient response rate – **34%** (increased from July).
- Experience measure for inpatients – **97%** (decreased from July).
- Experience measure for outpatients – **93%** (same as July).
- Total comments received – 1832 (reduced from July).
- **14%** of FFT comments are from patients.
- **94%** of responses had qualitative comments



*"This is the best hospital I have ever known, everything is great, from the doctors, the staff, and the infrastructure is great, thank you to the hospital and the team, doctors who helped my son. I always recommend to everyone. Thank you so so much"*

## Positive Areas:

- Kind, caring and supportive staff.
- Helpful volunteers.
- Play team.
- Therapy dogs.
- Entertainers.
- Reception staff.
- Excellent medical care.
- Calm and positive atmosphere.
- Welcoming environment.
- Patients felt that they were in safe hands.

## Areas for Improvement:

- Condition of some of the IPC wards
- Cost of food in the Lagoon.
- Parent beds.
- Provide approximate timings for investigations before arriving at the hospital.
- Lack of refreshments being available in outpatients.
- Temperature on the wards.
- Delays with hospital transport.
- Lifts in RLHIM
- Appointment location/ clinic room changes.

The Patient Feedback Manager has met with the Service Manager of outpatients to understand the issue with relocation of clinic rooms. Due to the CCC there are 11 less outpatient clinic rooms which have resulted in the rooms being allocated at 4pm the day before the clinic at which point a text message is sent with a confirmed location. The first text message sent to families approx. 3 weeks before the clinic used to contain the location. In September this was updated to a generic message which does not contain a location, which will hopefully alleviate some of the confusion.

# Appendix 3: Complaints

**Headline:** 5 formal complaints were received in August, a small decrease from the month prior (8) and August 2023 (9).

There has been a slight decrease in complaint numbers, however in addition to the complaints received, there have been enquires regarding the Orthopaedic Review and continues to be a trend of complexity in cases. Formal complaints also related to:

## Care Incidents on the ward

- A discontinued medication was prescribed and nearly administered more than once before these attempts were averted. An anaesthetic cream, to which the patient is allergic to, was also prescribed.
- Concerns regarding repeated requests for suctioning, which was not carried out by the team, and a lack of response to the patient alarm.

## The clinical advice given

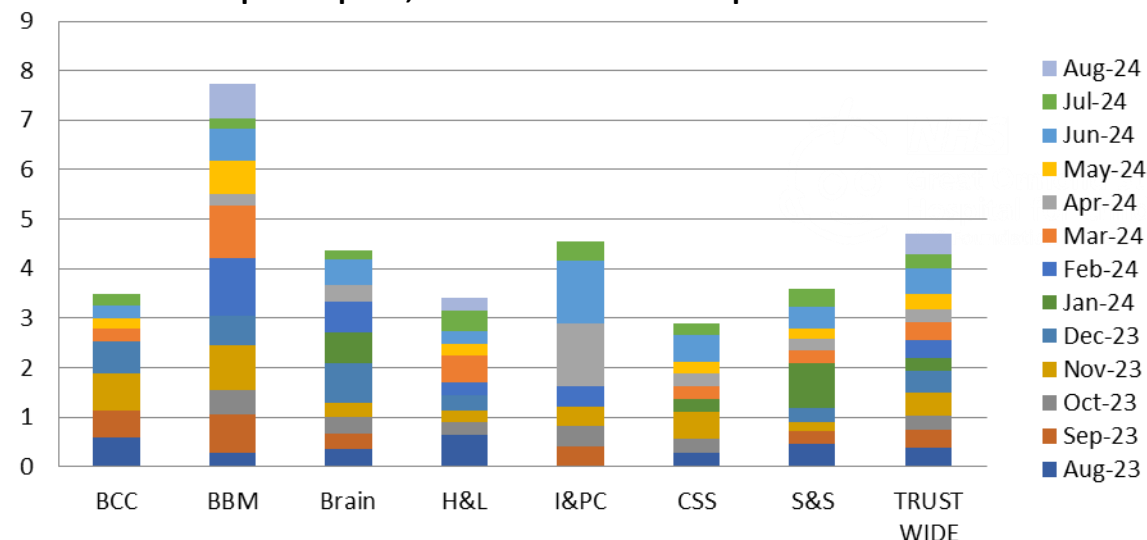
- The family expressed dissatisfaction with the advice given to the local services and the decision to decline a referral to another GOSH team.
- Parents expressed their concern with the advice given which that they feel is unsafe and unrealistic; and the team's subsequent decision to discharge from the service.

The Complaints Team also received the first formal complaint relating to the Gender Service, including the assessment process and staff behaviour.

## Closed Complaints Since April 2024

55 complaints have been closed since April 2024. 28 of those complaints (51%) were responded to on time. 49% of drafts were received from directorates early or on time.

**Complaints per 1,000 Combined Patient Episodes**



## Learning actions/ outcomes from a complaint closed in August 2024

The following actions and learning has taken place in response to a complaint regarding the difficult management of aftercare following patient's kidney transplant:

- Recognising that there was a need for more adolescent support for long stay admissions, the team have recruited a Youth Worker, who will start in September 2024.
- To ensure a consistent message regarding the details of the kidney donor, the Clinical Lead will review GOSH guidance to ensure it is in line with NHS Blood & Transplant Service (NHSBT) guidelines.
- Patients with frequent or long admissions will have weekly meetings with the Transplant Nephrologists and also access to the Hospital School support.
- Nephrostomy Care to be added to all Renal Care courses.

# Appendix 3: PALS

**Headline:** Pals contacts fell from 237 in July to 188 in August reflecting an annual reduction during the school holidays. Families contacted Pals for accommodation enquiries, requests for rescheduled appointments/ procedures and transport, and information regarding medication, the status of referrals and rejected referrals. Families also contacted Pals regarding the Orthopaedic review. Cancellations of outpatient appointments (OPA)/ admissions decreased from 21 in July to 13 in August.

## Contacts resolved within 48 hours decreased to 73%

**Care Queries:** Pals received 42 contacts from families sharing concerns about information received from clinical teams, cancelled admissions and OPA. Families also wanted to bring forward OPA/Admission dates, and share health updates with clinical teams.

**Significant areas of focus:** Aligned with the ongoing review, the highest number of contacts related Orthopaedics which stayed stable at 14. Spinal surgery saw a marked rise in contacts from 3 to 10 in August. Reasons for contacts included: confirmation of transport bookings, requests for second opinions, transfer of care, accommodation and medication enquiries. Gastroenterology contacts reduced from 13 to 10 in August.

## Learning/Service Improvement: Travel reimbursement eligibility.

In August Pals received numerous visits from families challenging the reimbursement criteria as the medical team had completed the green form during an OPA/ Admission visit authorising them to be reimbursed. It became apparent that wider learning needs to be shared with all staff to help make them aware of the criteria for the reimbursement scheme.

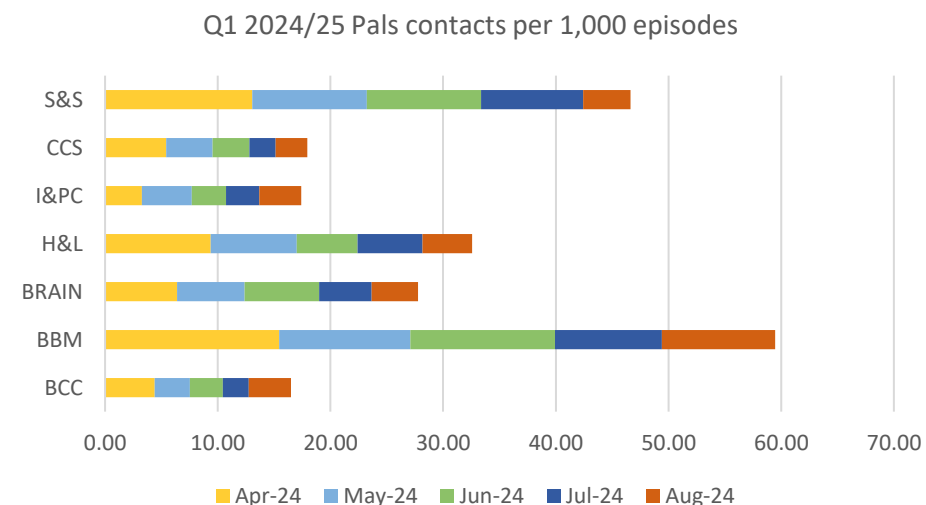
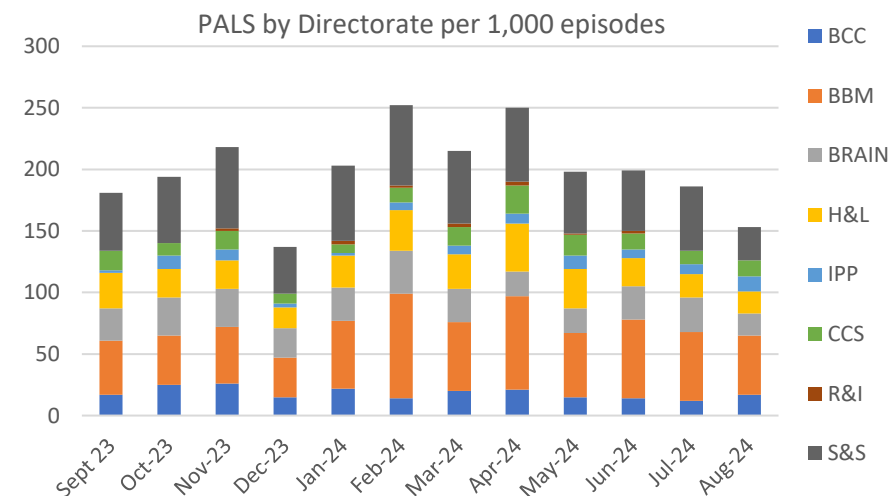
The green form entitles one carer only to be reimbursed, if the family are advised they need to commute via taxi this must be signed by the clinical team and there needs to be a valid medical reason why e.g. immunocompromised AND/OR be clinically assessed as too ill, weak, or disabled to travel via public transport, without this the family will not be reimbursed. – attached is a help sheet.

There are also changes for families from Scotland, Ireland and Wales will need to reclaim their travel expenses from their referring organisation and not from GOSH.

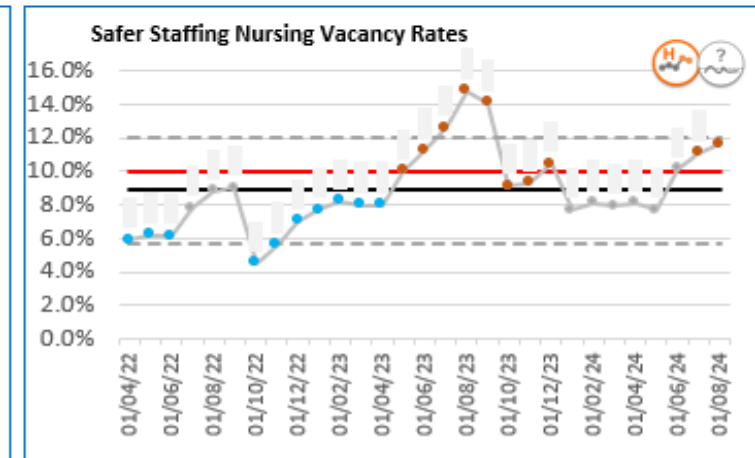
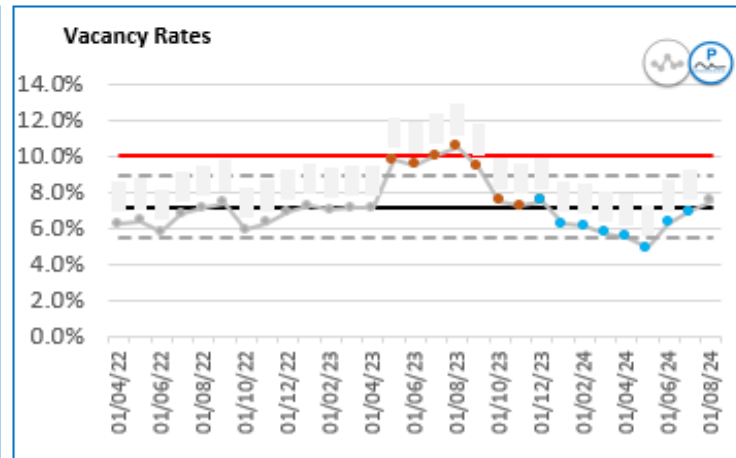
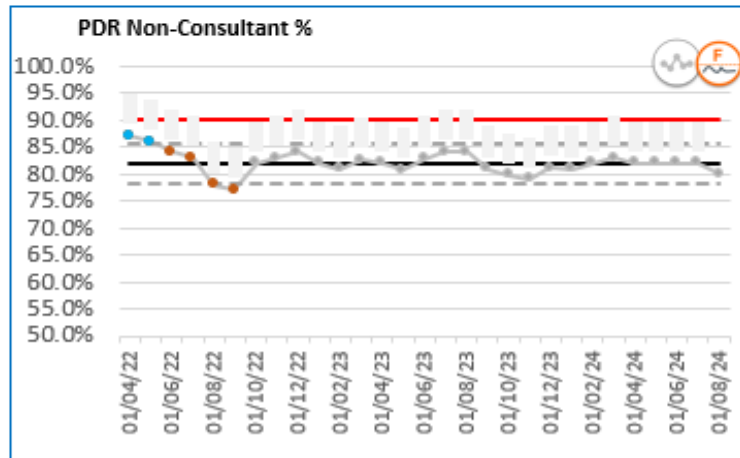
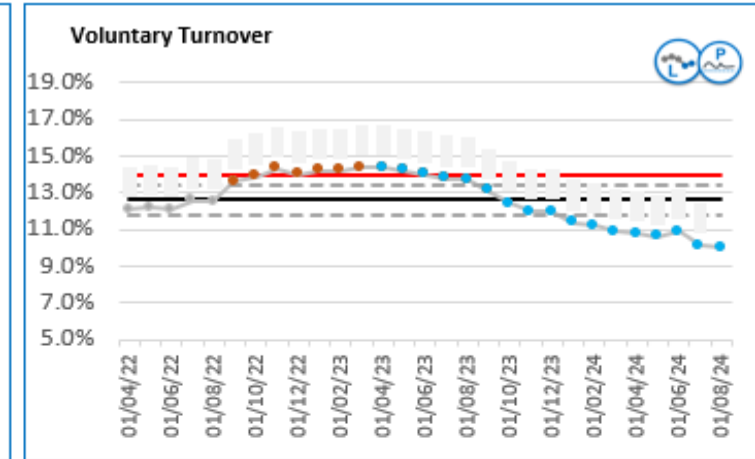
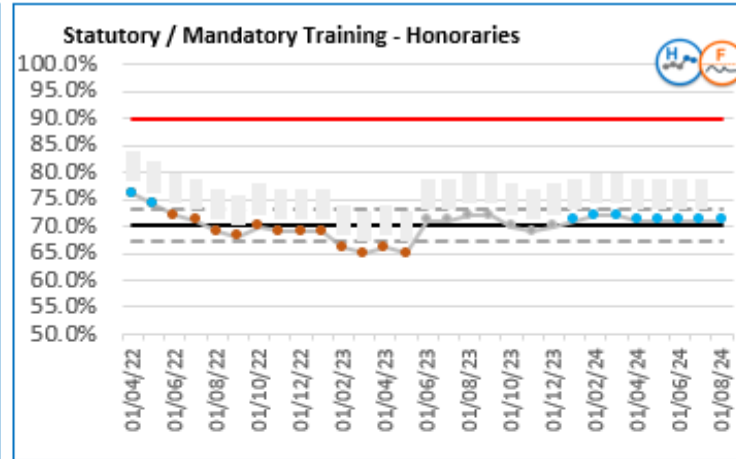
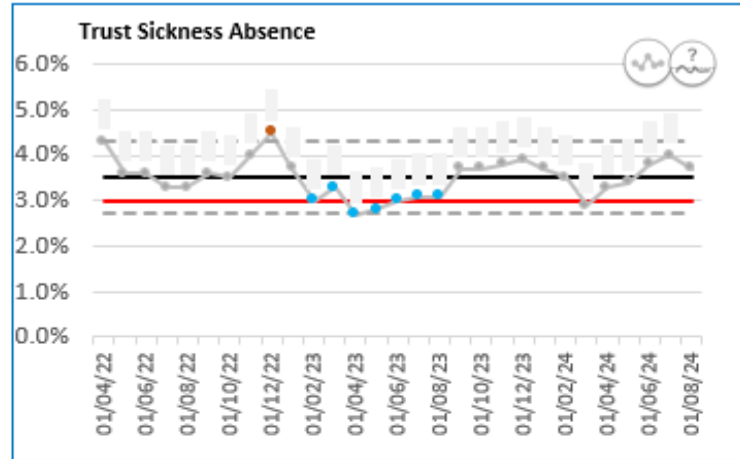
Wales - [Get help with NHS travel costs | GOV.WALES](#)

Scotland - [Travel Costs \(to hospital for NHS treatment\) - Help with health costs \(HCS1\): information booklet - August 2021 - gov.scot \(www.gov.scot\)](#)

Ireland - [Cross Border Directive - How to get healthcare abroad - HSE.ie](#)



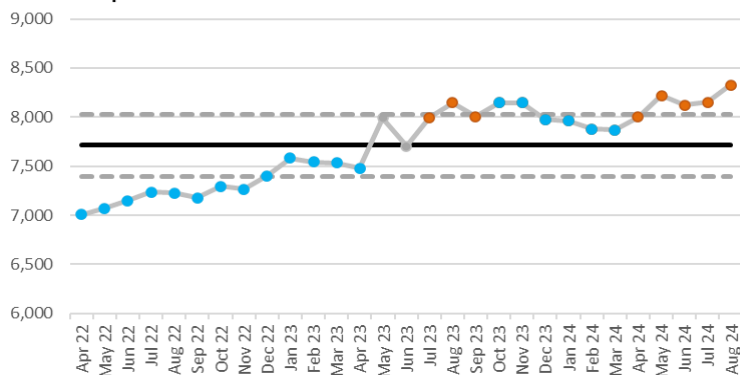
# Appendix 4: Workforce SPC Analysis



Nursing vacancy rate is slowly increasing; however, this is being closely monitored.  
Trust Voluntary Turnover has seen an improving trend, likewise in vacancy rates.

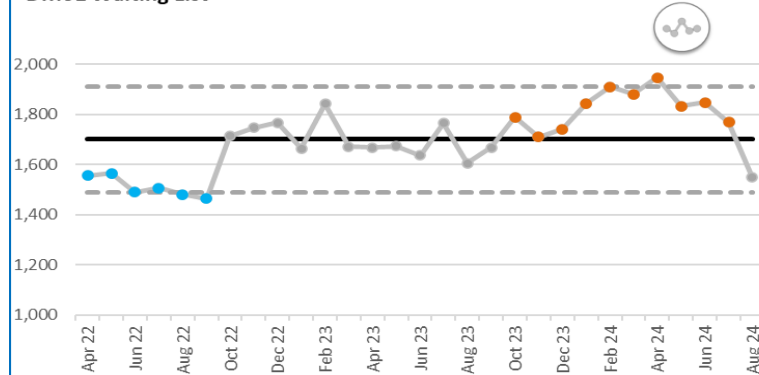
# Appendix 5: Patient Access SPC Trends

RTT Incomplete PTL



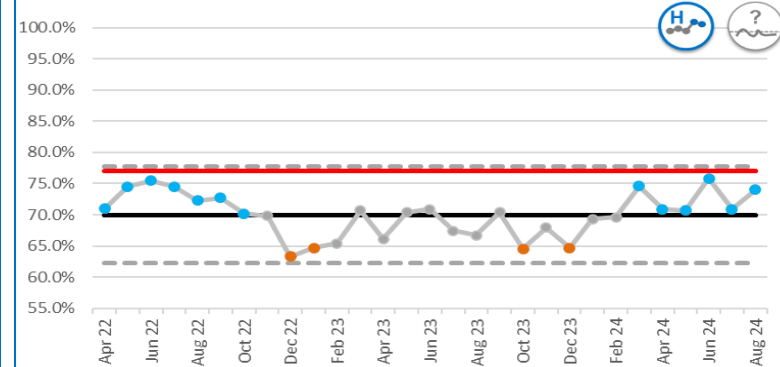
Marginal upward trend in volume, strikes have impacted

DM01 Waiting List



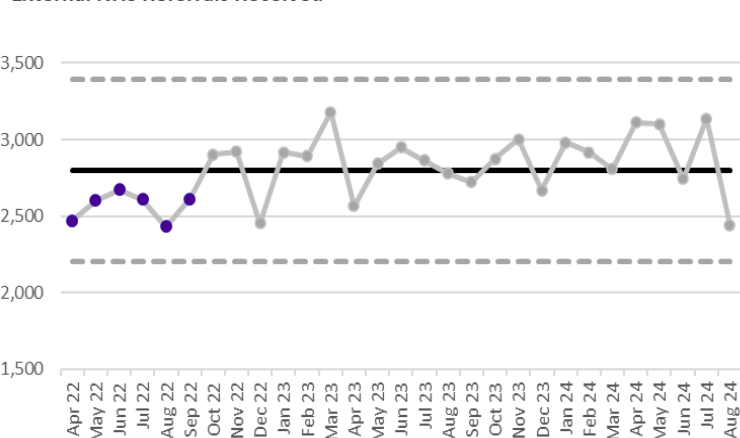
Increase in overall waiting numbers which is being monitored, strikes have impacted

Main Theatre Utilisation



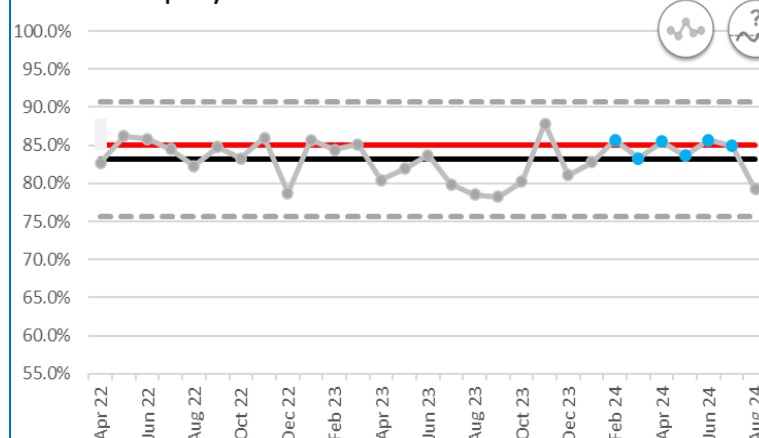
No Significant variation

External NHS Referrals Received



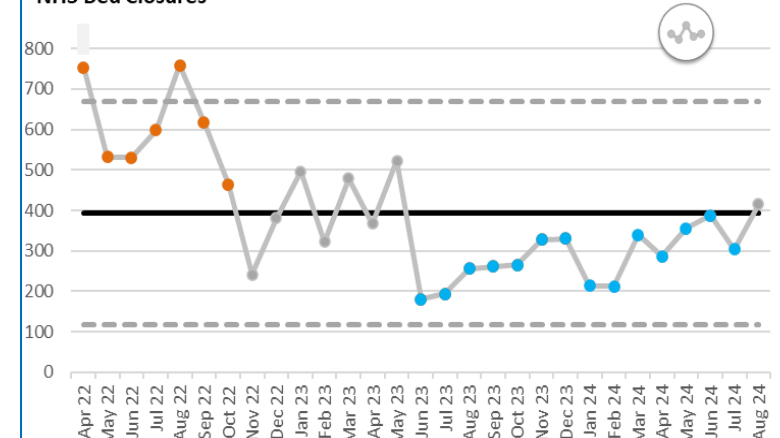
No significant variation, common cause

NHS Bed Occupancy



No significant variation, common cause

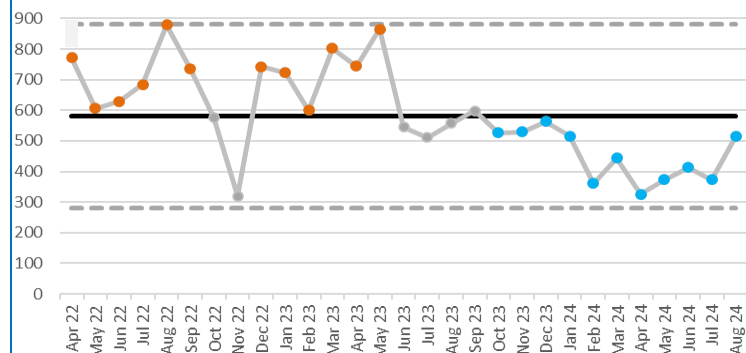
NHS Bed Closures



Common cause variation

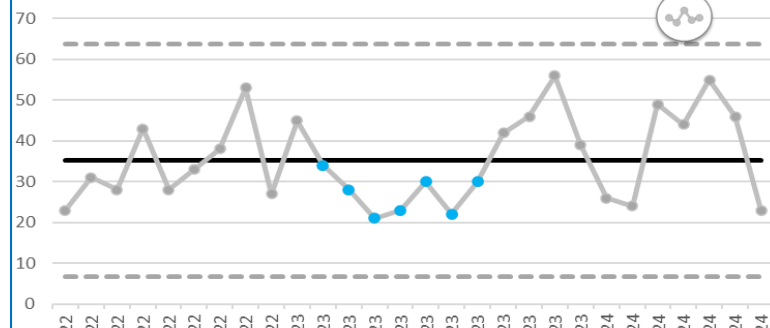
# Appendix 5: Patient Access SPC Trends Continued

**Total Bed Closures**



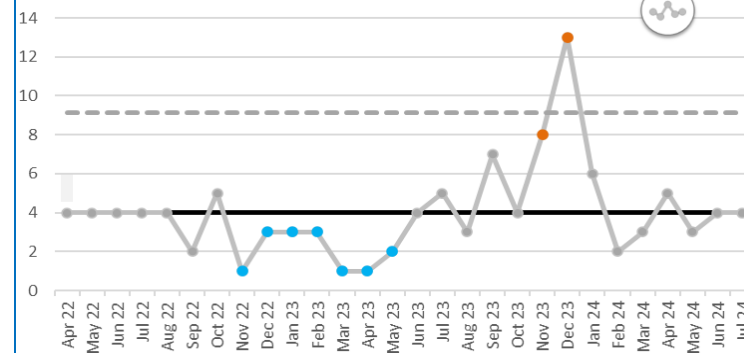
Improving variation

**Cancelled Operations for Non-Clinical Reasons**



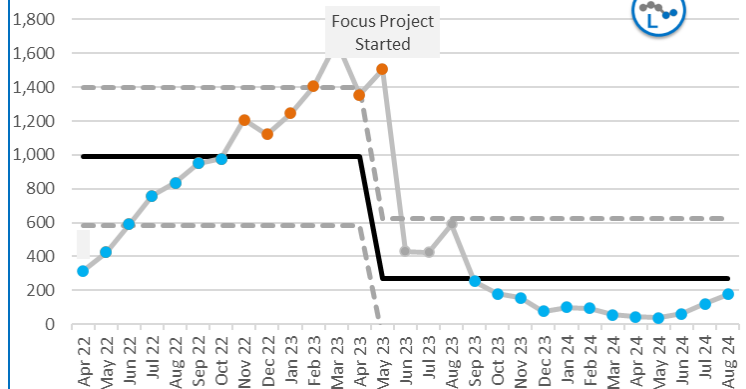
No significant variation

**Cancelled Operations: 28 Days Breaches**



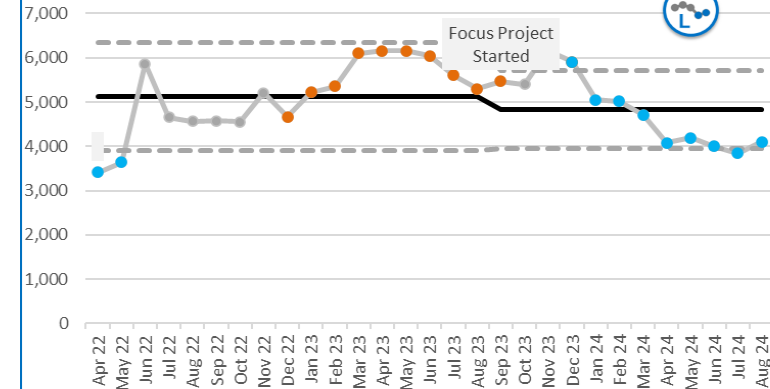
No Significant variation

**Number of NHS Discharge Summaries not sent (ytd)**



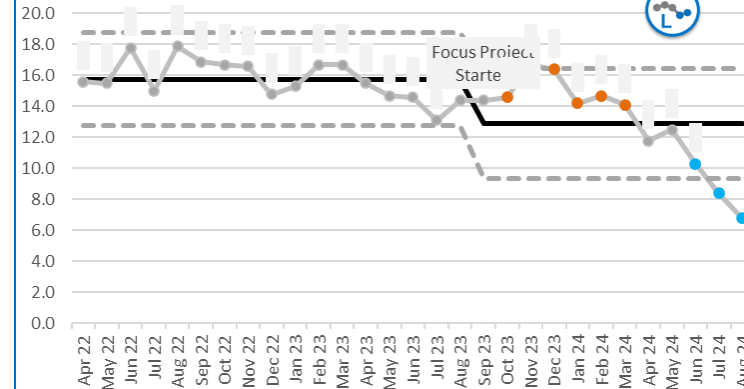
Improving variation and within control limits

**Number of NHS Clinic Letters not sent (ytd)**



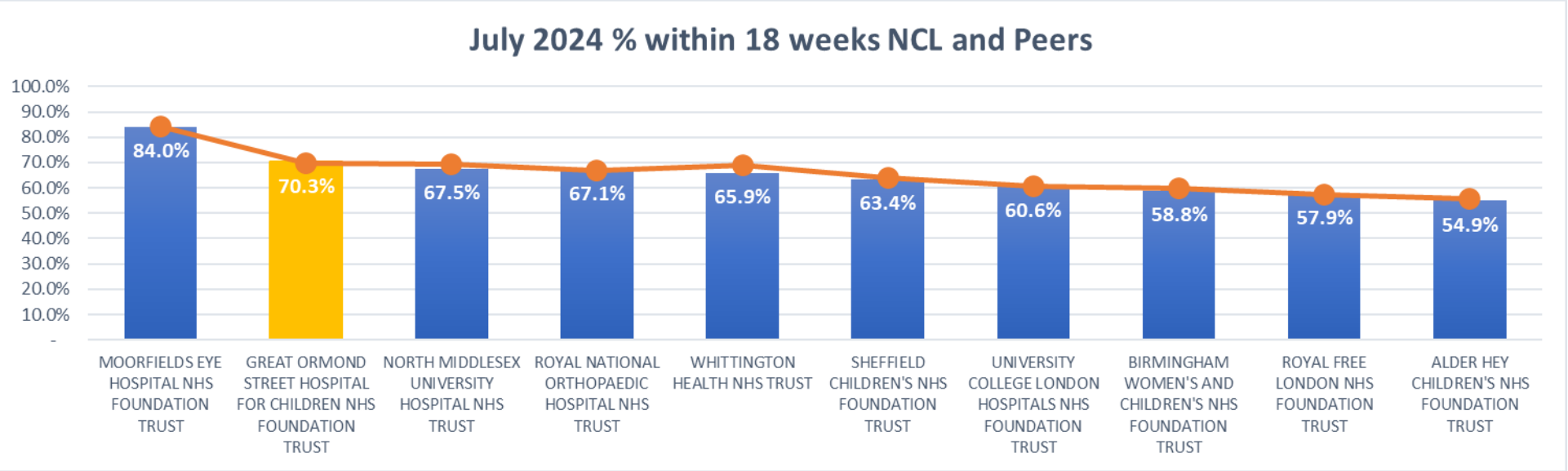
Improving variation

**Average Number of Calendar Days to send NHS Clinic Letters**



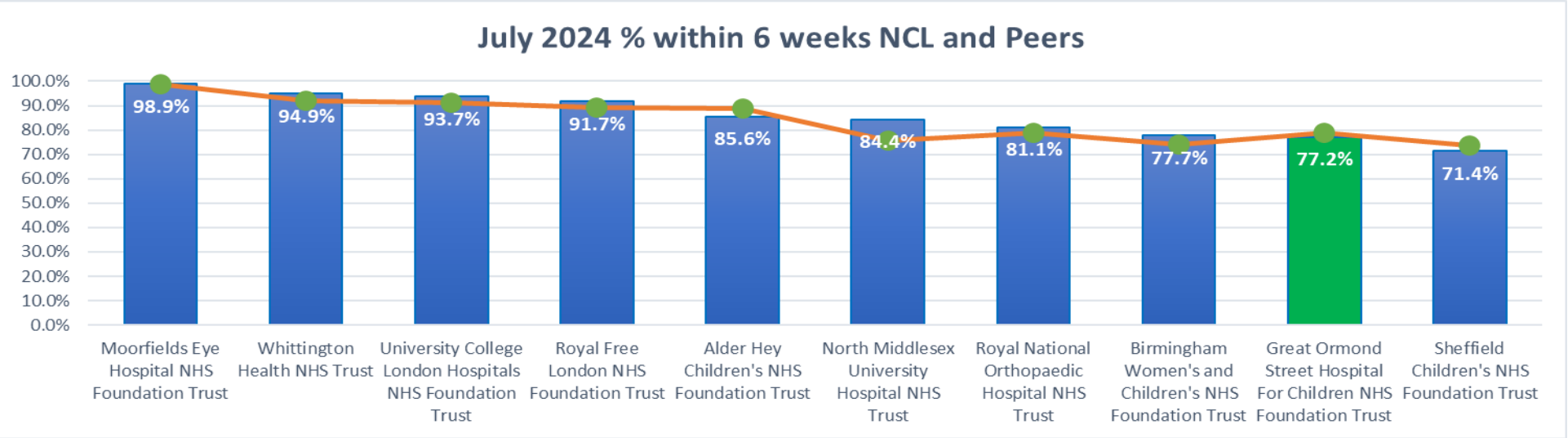
Improving variation

## Referral to Treatment



Orange markers indicate June's performance. GOSH for the month of July is at second place amongst the selected Peers. GOSH is ranked 27<sup>th</sup> out of 154 providers, an increase of 1 place since June.

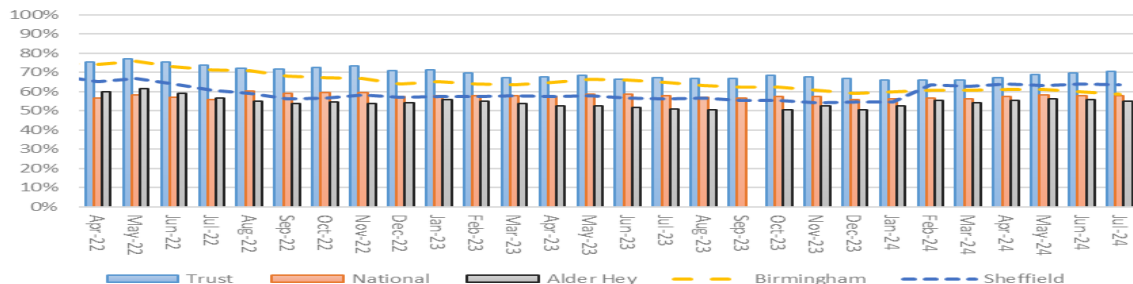
## Diagnostics



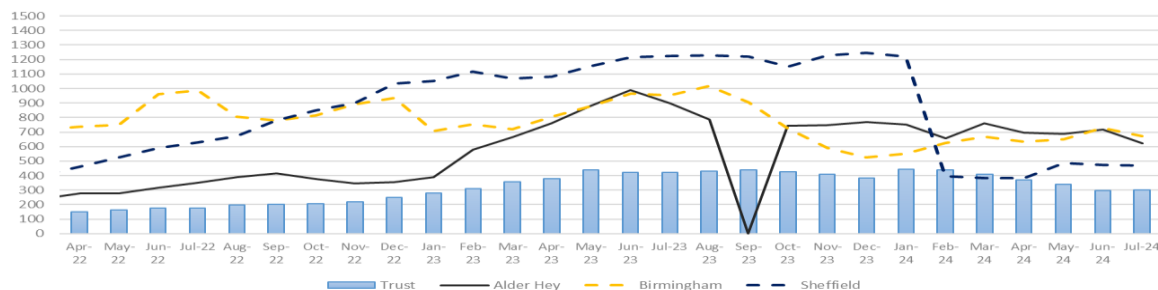
Green markers indicate June's performance. GOSH for the month of July is in the 2<sup>nd</sup> bottom place, amongst selected Peers. GOSH is ranked 99 out of 151 providers, a decrease of ten places from June.

# Appendix 5: National and NCL RTT Performance –July 2024

RTT Performance against Children's Providers  
national standard 92%



Children's Providers RTT 52+ week waits  
national standard 0



Nationally, at the end of July, 57.9% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks.

GOSH is tracking 12.4% above the national July performance at 70.3% and is in line with comparative children's providers. (RTT Performance for Sheffield Children (63.4%), Birmingham Women's and Children's (58.8%) and Alder Hey (54.9%))

The national position for July 2024 indicates a decrease in patients waiting over 52 weeks at 284,422 patients.

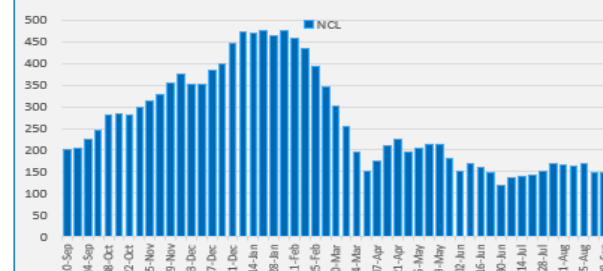
Compared to Birmingham, Alder Hey and Sheffield, the number of patients waiting 52 weeks and over for GOSH is lower than all these providers for July.

Overall for NCL the 78+ week wait position is at 147 patients. Royal Free has the largest volume of 78+ wk waits.

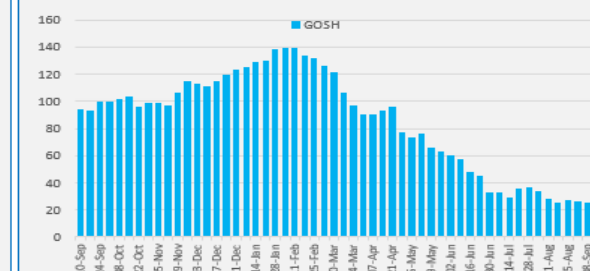
The 65 week wait national ambition of zero patients is to be achieved by September 2024. NCL position is at 1876 patients, with GOSH contributing less than 10% to the overall NCL cohort.

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 Junior Doctor and Consultant strikes.

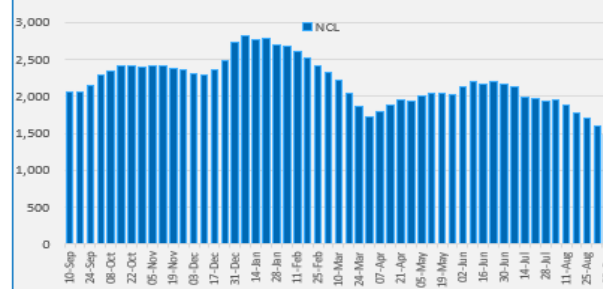
NCL (All Specialties) 78+ Week Wait Cohort



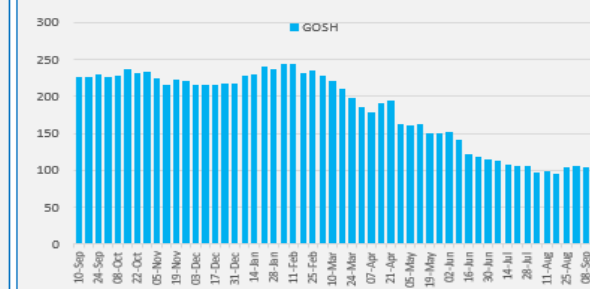
GOSH (All Specialties) 78+ Week Wait Cohort



NCL (All Specialties) 65+ Week Wait Cohort



GOSH (All Specialties) 65+ Week Wait Cohort



# Appendix 5: National Diagnostic Performance and 6 week waits – July 2024

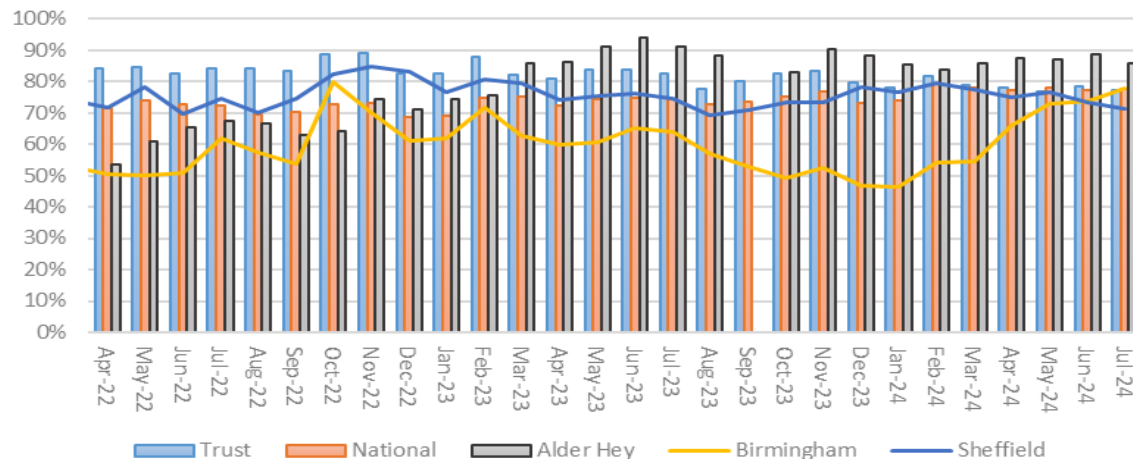
Nationally, at the end of July, 77.2% of patients were waiting under 6 weeks for a DM01 diagnostic test.

GOSH is tracking -0.4% below the national July performance and is in line with comparative children's providers. DM01 Performance for Sheffield Children (71.4%), Birmingham Women's and Children's (77.7%) and Alder Hey (85.6%).

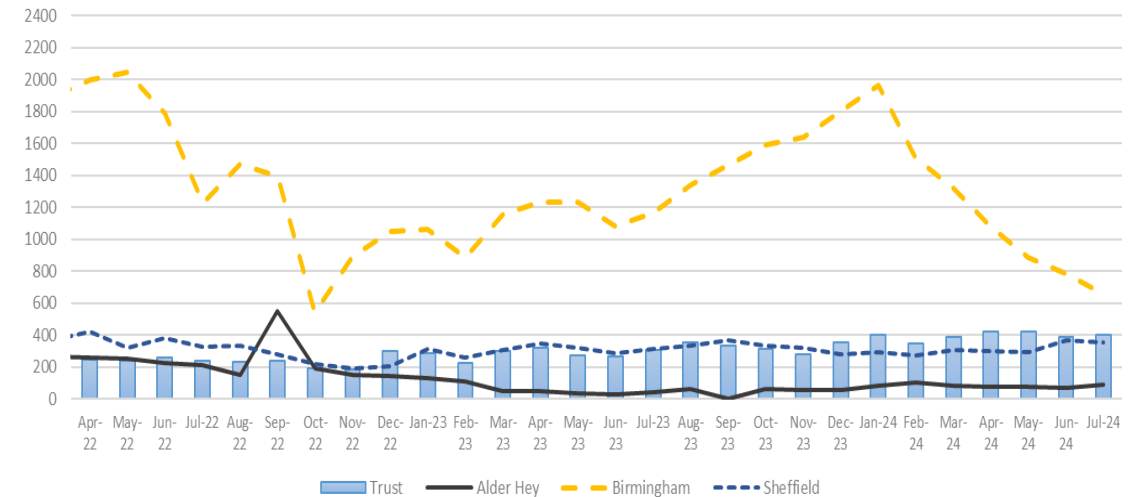
The national position for June 2024 indicates a decrease of patients waiting over 6 weeks at 364,544 patients.

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

DM01 Performance against Children's Providers  
national standard 99%



Children's Providers DM01 6+ week waits



# Integrated Quality & Performance Report

## September 2024 (Reporting August 2024 data)

Attachment O: Trust Board Update on Red Metrics

Metric	Drivers	Mitigation/Actions
RTT Open Pathway: % waiting within 18 weeks	Junior doctor's and consultant strikes resulted in reduced activity as well as receiving referrals from other Trusts where patients have been waiting more than 18 weeks. Many of these patients have on average 8.9 diagnoses per admission, making their treatment pathways very complex. Capacity constraints in Orthopaedics and Plastic Surgery. Specialist surgeon availability predominantly for joint cases and complex patients	Waiting list initiatives Recruitment of locum orthopaedic surgeon, review of theatre lists from half day to full day for some services. Mutual aid with RNOH for Orthopaedics- free up capacity for more complex patients Exploring further orthopaedic mutual aid at other paediatric centres such as Birmingham and Southampton (for patients near those centres) Running of parallel theatre lists in Plastic surgery as well as overruns to accommodate more patients on lists.
Waiting greater than 52 weeks - Incomplete Pathways		
Waiting greater than 78 weeks - Incomplete Pathways		
Waiting greater than 104 weeks - Incomplete Pathways		
Diagnostics- % waiting less than 6 weeks	Challenges in diagnostic capacity particularly for MRI 5, MRI sedation, Endoscopy, Echo and Sleep Studies	Demand and capacity modelling for our challenged areas. Waiting List initiatives being held in September for MRI, Cardiac MRI and Ultrasound to support booking patients past their planned date and long waits
Main Theatre Utilisation	Last minute cancellations, list overruns, late starts, time needed to clean theatres if infectious patients were on the list all impact the utilisation theatre sessions	Improving booking process, further embedding of 6-4-2, reducing late starts.
NHS Discharge Summaries sent within 24 hours	The Trust has seen a significant improvement in the last few months, with a reduction in backlog	These standards are being monitored through monthly Directorate meetings. Focus also continues at consultant meetings and directorate boards to improve performance. Job panning to ensure clinicians have time to complete letters
NHS Clinic letters sent within 7 days	Some specialties require quite a detailed letter to be completed involving multi disciplinary teams, clinic and theatre time can sometimes take priority	
Honorary Mandatory training compliance	The honorary contract policy changes agreed in 2023 require a change of process in how we monitor training compliance for people with another NHS contract.	

Metric	Drivers	Mitigation/Actions
		contract holders will be engaged with to ensure they are compliant with the new policy, which is supported by the new GOLD system allowing us to provide reminders of outstanding training required for people who may not regularly be at GOSH.
CV line infection rate	Represents the increased acuity and complexity of children we are seeing.	As the year has progressed we have worked hard on central line care compliance focusing on this within our IPC audit days and working with the epic team to optimise documentation and as a result we have seen our rates drop to within the target rate. It is worth noting that the definition allows children to be counted more than once (as happened in this case) if two blood cultures are taken that grow slightly different organisms. Line infection rates continue to be at a lower rate than were seen in May of 2024
Overdue SI actions	These are being reviewed and themed to form an overall organisational safety action plan which will be monitored via the Organisational Learning and Assurance Forum. It is apparent that there are many actions with the same theme which means multiple services are working on these separately and is not an effective use of resources and does not support overall organisational change.	
High Risks (% overdue for review)	19 risks of 42 were not reviewed in August. This was due to a large number of Risk Action Groups or equivalent corporate business meetings being cancelled in August. This is typical for this period of the year and performance is expected to bounce back in September.	

**Trust Board**  
24 October 2024**Month 05 - 2024/25 Finance Report****Submitted by: Lore Lippmann, Acting Chief  
Finance Officer****Paper No: Attachment P**☐ **For information and noting****Purpose of report**

To provide a summary of the Trust's financial performance for Month 5 of financial year 24/25.

**Summary of report**

The Trust is reporting a YTD **£4.2m control total deficit** for the period ended 31<sup>st</sup> Aug 2024 (M5) and an adverse position to budget YTD of **£1.2m**. In M5 the Trust is reporting a **£0.3m** favourable position to plan.

This result marks an improvement from the prior month, although the improved position is largely driven by non-recurrent items:

- **£0.4m** central adjustment for IP&C cash payments on account (>7 years)
- **£2.8m** adjustment on Clinical Income for specially commissioned delegated services
- **£0.6m** VAT benefit.

The table below summarises the Trust's financial position at Month 5 and YTD position for FY24/25:

£m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income	£57.2	£60.3	£3.1	£282.1	£285.3	£3.2
Pay	(£34.4)	(£34.3)	£0.2	(£172.0)	(£171.9)	£0.2
Non-Pay	(£21.4)	(£24.4)	(£3.0)	(£104.3)	(£109.1)	(£4.8)
Finance Costs	(£1.8)	(£1.7)	£0.0	(£8.8)	(£8.5)	£0.3
<b>Surplus/(Deficit)</b>	<b>(£0.5)</b>	<b>(£0.1)</b>	<b>£0.3</b>	<b>(£3.0)</b>	<b>(£4.2)</b>	<b>(£1.2)</b>

**Income:**

Total Income YTD is £3.2m ahead of plan, this is split between, Clinical Income, Private Patients and Other operating income.

Clinical Income YTD is **£4.3m** favourable due to a combination of factors:

- £2.3m – funding received in M4 from NHSE for prior year income (Pass-through Drugs)
- £2.8m – updated position for specialist commission delegation
- £0.5m - underperformance on ERF, including £0.7m of strike impact and estimates for uncoded activity. MDT activity has been included in the numbers and confirmation for approval of the activity by end of the month.
- The Trust remains behind on the CYP Gender services due to delays in recruiting sufficient staff to deliver planned activity.
- Passthrough drugs are overperforming by £4.6m due to increased activity. Note this income is largely matched by passthrough costs.

Private Patients Income YTD stands at **£33.3m** and this is **£2.4m** behind plan YTD.

- M5 is £0.4m behind plan largely due to reduced private activity in core NHS directorates. In M5 the Trust recognised a £0.4m central IP&C adjustment in relation to payments on accounts aged more

than 7 years (this approach to releases has been agreed with the Trust's external auditors).

Other Operating Income YTD is **£3.1m** behind plan.

- This is largely driven by billing on charity grants for CCC Demolition, EPR and Palliative Care at £3.4m being behind plan. This adverse performance is partially offset YTD due to Education and Training income (£0.6m)

#### Pay:

- The YTD pay position is **£0.2m** favourable to plan, however **£0.9m** of this is driven by the central reserves budget for business cases. This means that the underlying pay position is **£0.7m** overspent YTD. Underspends against substantive posts continue to be offset against planned vacancy factors.
- The table below illustrates the Trust WTE position in comparison to M4 and the 24/25 target of 5812 WTE.

	24/25 Target	M4 Actuals WTE	M5 Actuals WTE	Movement between M3 and M4	Movement between M4 and 24/25 Target
Permanent Staff	5,409	5,482	5,482	-	(73)
Bank Staff	330	346	312	34	18
Agency Staff	73	62	49	13	24
<b>TOTAL</b>	<b>5,812</b>	<b>5,890</b>	<b>5,843</b>	<b>47</b>	<b>(31)</b>

- When compared against M4, the 31 WTE reduction in posts is largely driven by a decrease in bank shifts due to seasonal leave, vacancies, and sickness.
- When compared to the 24/25 target, the Trust is reporting WTE in excess of this target by 31. This is largely driven by substantive posts at 73 WTE offset against reductions in Bank at 18 WTE and agency of 24 WTE.

#### Non-Pay:

- Non-pay costs and finance costs are **£3.0m** adverse to plan in month and **£4.5m** for the year. There are some underlying overspends which include Drugs (£2.3m) and Supplies and Services (£2.3m) which is mainly driven by Theatres, Pathology and Reagents, and Non-Pay BV schemes at £3.1m of which £0.5m is being delivered against active schemes.

#### Better Value:

- YTD the Trust has achieved £3.6m Better Value against a plan of £5.4m, largely made up of pay schemes.

#### Trust cash and debt:

- The Trust cash balance decreased from £63.9m (M4) to £61m (M5) this is due to higher creditor payments.

#### Capital expenditure:

- Capital Expenditure (CDEL) was £12.9m on 31st August 2024, which was £2.6m ahead of plan. Several schemes, particularly those in Space & Place, have proceeded more quickly than expected. Donated capital expenditure was £3.3m, £9.3m below plan.

The key movements to note on the balance sheet at year end are:

Indicator	Comment
Cash	Cash balance decreased from £63.9m (M4) to £61m (M5)
NHS Debtor Days	NHS debtor dropped to 3 days.
I&PC Debtor Days	I&PC debtor days decreased from 240 in M4 to 232 in M5.
I&PC Overdue Debt	I&PC overdue debt increased in month from £36.4m to £37.2m in M5
Creditor Days	Creditor days decreased from 48 days in M4 to 33 days in M5.

**Patient Safety Implications**

None

**Equality impact implications**

None

**Financial implication**

ns  
None

**Strategic Risk**

BAF Risk 1: Financial Sustainability

**Action required from the meeting.**

Board are asked to note the Trust's financial position at M5 FY24/25.

**Consultation carried out with individuals/ groups/ committees.**

The M5 FY 24/25 position has previously been shared with the EMT.

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

Chief Finance Officer

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

Chief Finance Officer

# Finance and Workforce Performance Report Month 5 2024/25

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## ACTUAL FINANCIAL PERFORMANCE

	In month				Year to date			
	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG
<b>INCOME</b>	£57.2m	£60.3m	£3.1m	●	£282.1m	£285.3m	£3.2m	●
<b>PAY</b>	(£34.4m)	(£34.3m)	£0.2m	●	(£172.0m)	(£171.9m)	£0.2m	●
<b>NON-PAY inc.</b> owned depreciation and PDC	(£23.2m)	(£26.2m)	(£3.0m)	●	(£113.1m)	(£117.7m)	(£4.6m)	●
<b>Surplus/Deficit</b> excl. donated depreciation	(£0.5m)	(£0.1m)	£0.3m	●	(£3.0m)	(£4.2m)	(£1.2m)	●

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

## KEY AREAS OF NOTE

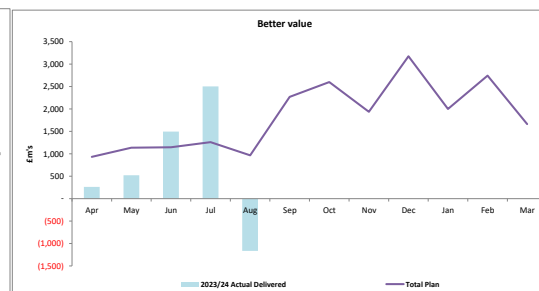
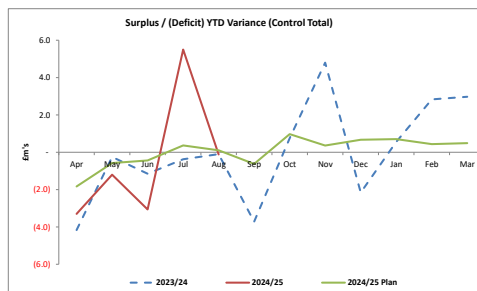
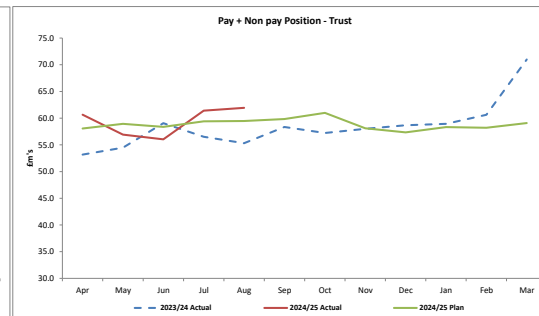
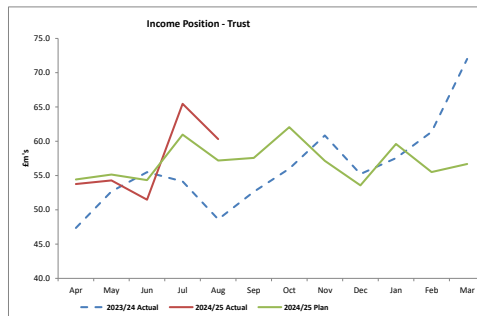
The Trust is reporting a YTD £4.2m control total deficit for the period ended 31st Aug 2024 (M5); an adverse position to budget YTD of £1.2m. This result marks an improvement from the prior month, largely driven by non-recurrent items such as a £0.4m central adjustment for IP&C cash payments on account (>7 years), a £2.8m adjustment on Clinical Income for specially commissioned delegated services and a £0.6m VAT benefit).

Income YTD is £3.2m ahead of plan, this is largely due to £2.3m of funding received in M4 from NHSE for prior year income and a £2.8m income recognition in M5 relating to LVF (low value flow) specially commissioned income this was confirmed after a clarification and assurance process with NHSE. This is partially offset against an underperformance on private income which stands at £33.3m (which is £2.4m behind plan YTD). In M5 the Trust also recognised a £0.4m central IP&C adjustment in relation to payments on accounts aged more than 7 years (this approach to releases has been agreed with the Trust's external auditors). Operating income is also £3.1m adverse to plan YTD which is largely driven by a £3.4m underperformance on income from charity grants relating to CCC Demolition, EPR and Palliative Care expenditure.

The YTD pay position is £0.2m favourable to plan, however £0.9m of this is driven by the central reserves budget for Business Cases so the underlying pay position is £0.7m overspent YTD. Underspends against substantive posts continue to be offset against planned vacancy factors.

YTD non-pay is £4.8m overspent, this is largely driven by Drugs spend which is £2.3m overspent YTD, Clinical supplies at £2.3m over YTD (driven by Theatres, Pathology and Reagents) and Non-Pay BV schemes at £3.1m of which £0.5m is being delivered against active schemes.

The Trust cash balance decreased from £63.9m (M4) to £61m (M5) this is due to higher creditor payments. Capital Expenditure (CDEL) was £12.9m on 31st August 2024, which was £2.6m ahead of plan. Several schemes, particularly those in Space & Place, have proceeded more quickly than expected. Donated capital expenditure was £3.3m, £9.3m below plan.



## PEOPLE

	24/25 Target	M4 Actuals WTE	M5 Actuals WTE	Movement between M3 and M4	Movement between M4 and 24/25 Target
<b>Permanent Staff</b>	5,409	5,482	5,482	-	(73)
<b>Bank Staff</b>	330	346	312	34	18
<b>Agency Staff</b>	73	62	49	13	24
<b>TOTAL</b>	5,812	5,890	5,843	47	(31)

## AREAS OF NOTE:

The table above illustrates the Trust M5 WTE position in comparison to M4 and the 24/25 target of 5812 WTE. This is based on ledger information held within Finance.

Improvement in M5 compared to M4 of 47 WTE, this is largely driven by a reduction in Bank and agency usage in M5.

Genetics and Research & Development posts are the two highest outliers when compared to the 5812 target. This is largely due to hosted staff and posts related to Grants and Studies.

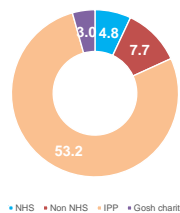
Substantive posts have held between both months.

## CASH, CAPITAL AND OTHER KPIs

Key metrics	Jul-24	Aug-24
<b>Cash</b>	£63.9m	£61.1m
<b>I&amp;PC debtor days</b>	240	232
<b>Creditor days</b>	48	33
<b>NHS Debtor days</b>	4	3
<b>BPPC (£)</b>	83%	82%

Capital Programme	YTD Plan M5	YTD Actual M5	Full Year Plan
<b>Total CDEL - Trust funded</b>	£10.3m	£12.9m	£30.8m
<b>Total PDC</b>	£0.0m	£0.0m	£0.1m
<b>Total Donated and grants</b>	£12.6m	£3.3m	£30.2m
<b>Grand Total</b>	£22.9m	£16.2m	£61.0m

## Net receivables breakdown (£m)



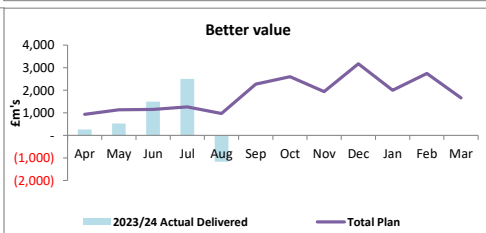
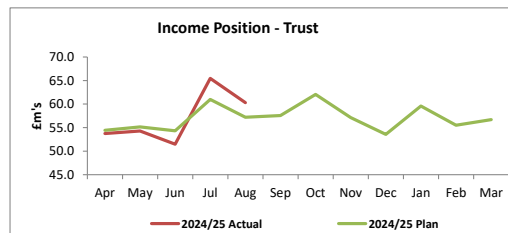
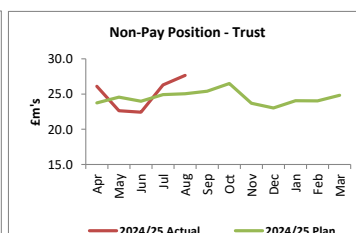
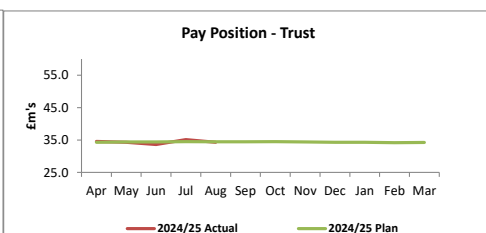
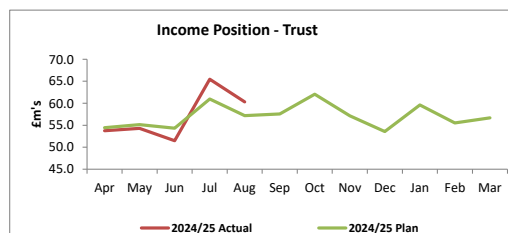
## AREAS OF NOTE:

- Cash held by the Trust decreased in month from £63.9m to £61.1m.
- Capital expenditure for the year to end of August 2024 was £16.2m. Trust-funded expenditure was £12.9m; which includes Right of use (leased) asset expenditure and PDC funded expenditure was £13k. In addition, capital expenditure funded by GOSH Charity was £3.3m YTD.
- I&PC debtors days decreased in month from 240 to 232 days. Total I&PC debt (net of cash deposits held) increased in month to £53.2m (£52.4m in M4). Overdue debt also increased in month to £37.2m (£36.4m in M4).
- Creditor days decreased in month from 48 to 33 days.
- NHS debtor days remained the same as the previous month at 4 days.
- In M05, 82% of the total value of creditor invoices were settled within 30 days of receipt; this represented 72% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.

## Trust Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024



Annual Plan	Income & Expenditure	2024/25								Rating
		Month 5				Year to Date				
		Plan (£m)	Actual (£m)	Variance (£m)	%	Plan (£m)	Actual (£m)	Variance (£m)	%	
(£m)										
514.30	NHS & Other Clinical Revenue	42.53	47.56	5.03	11.83%	214.55	223.46	8.91	4.15%	G
90.03	Private Patient Revenue	7.95	7.55	(0.40)	(5.08%)	35.70	32.98	(2.72)	(7.63%)	R
79.89	Non-Clinical Revenue	6.71	5.22	(1.48)	(22.12%)	31.83	28.89	(2.94)	(9.25%)	R
684.22	Total Operating Revenue	57.19	60.33	3.14	5.50%	282.08	285.32	3.24	1.15%	G
(383.75)	Permanent Staff	(31.98)	(32.06)	(0.08)	(0.25%)	(159.90)	(160.22)	(0.32)	(0.20%)	A
(5.08)	Agency Staff	(0.42)	(0.36)	0.06	13.54%	(2.12)	(2.18)	(0.06)	(2.87%)	A
(23.56)	Bank Staff	(2.04)	(1.86)	0.18	8.78%	(10.00)	(9.45)	0.55	5.50%	G
(412.39)	Total Employee Expenses	(34.44)	(34.28)	0.15	0.45%	(172.02)	(171.85)	0.17	0.10%	G
(109.19)	Drugs and Blood	(9.03)	(11.88)	(2.85)	(31.53%)	(45.56)	(50.40)	(4.85)	(10.64%)	R
(44.81)	Supplies and services - clinical	(3.86)	(4.74)	(0.88)	(22.89%)	(18.48)	(21.42)	(2.94)	(15.91%)	R
(96.44)	Other Expenses	(8.54)	(7.82)	0.72	8.43%	(40.24)	(37.30)	2.94	7.31%	G
(250.43)	Total Non-Pay Expenses	(21.44)	(24.45)	(3.01)	(14.04%)	(104.27)	(109.14)	(4.86)	(4.66%)	R
(662.82)	Total Expenses	(55.87)	(58.73)	(2.86)	(5.11%)	(276.29)	(280.99)	(4.70)	(1.70%)	R
21.40	EBITDA (exc Capital Donations)	1.32	1.60	0.29	21.78%	5.79	4.33	(1.45)	(25.13%)	R
(21.30)	Owned depreciation, Interest and PDC	(1.77)	(1.72)	0.05	2.69%	(8.79)	(8.51)	0.27	3.11%	
0.09	Surplus/Deficit	(0.45)	(0.12)	0.33	74.15%	(3.00)	(4.18)	(1.18)	(39.37%)	
(22.00)	Donated depreciation	(1.83)	(1.49)	0.35		(9.17)	(7.47)	1.70		
	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	(2.28)	(1.60)	0.68	74.15%	(12.17)	(11.65)	0.52	(39.37%)	
0.00	Impairments & Unwinding Of Discount	0.00	0.00	0.00		0.00	0.00	0.00		
0.00	Capital Donations	0.00	(0.03)	(0.03)		0.00	3.31	3.31		
(21.91)	Adjusted Net Result	(2.28)	(1.63)	0.65	28.49%	(12.17)	(8.34)	3.83	31.47%	



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

### Summary

The Trust is reporting a YTD **£4.2m control total deficit** for the period ended 31st Aug 2024 (M5); an **adverse position to budget YTD of £1.2m**.

This result marks an improvement from the prior month, although the improved position is largely driven by non-recurrent items (**£0.4m** central adjustment for IP&C cash payments on account (>7 years), **£2.8m** adjustment on Clinical Income for specially commissioned delegated services, **£0.6m** VAT benefit).

### Notes

£2.3m for funding received in M4 from NHSE for prior year income (Passthrough Drugs), £2.8m income recognition in M5 relating to LVF (low value flow) specially commissioned income which was confirmed after a clarification and assurance process with NHSE was conducted. £0.5m underperformance on ERF, including £0.7m of strike impact and estimates for uncoded activity. MDT activity has been included in the numbers and confirmation for approval of the activity by end of the month.

The Trust-wide private income stands at **£33.3m** and this is **£2.4m** behind plan YTD. M5 is **£0.4m** behind plan largely due to reduced private activity in core NHS directorates. In M5 the Trust also recognised a **£0.4m** central IP&C adjustment in relation to payments on accounts aged in excess of 7 years (this approach to releases has been agreed with the Trust's external auditors).

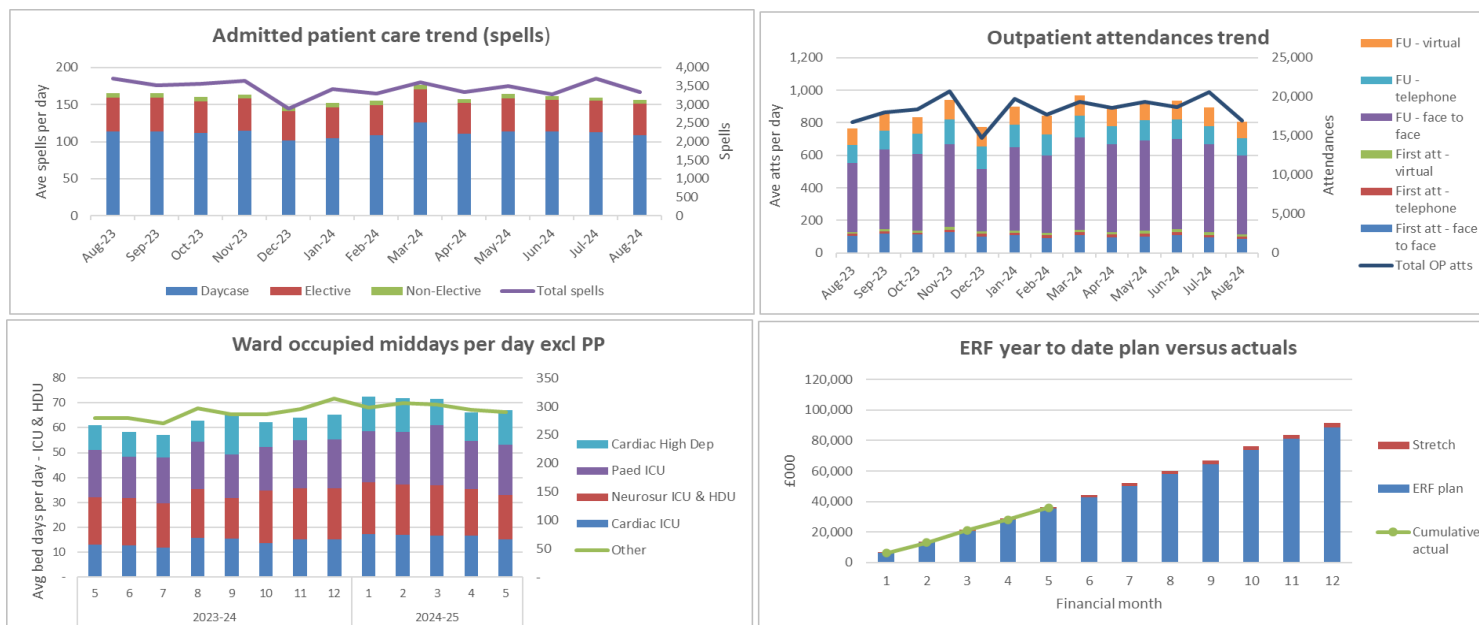
Non Other operating income is **£3.1m** adverse to plan YTD. This is largely driven by billing on charity grants for CCC Demolition, EPR and Palliative Care at £3.4m. Research & Innovation Income is behind plan by **£0.3m**. This adverse performance is partially offset YTD due to Education and Training income being ahead of plan by **£0.6m**.

The YTD pay position is **£0.2m** favourable to plan, however **£0.9m** of this is driven by the central reserves budget for Business Cases. The underlying pay position is **£0.7m** overspent YTD. Underspends against substantive posts continue to be offset against planned vacancy factors.

The Trust cash balance decreased from **£63.9m** (M4) to **£61m** (M5) this is due to higher creditor payments.

Capital Expenditure (CDEL) was **£12.9m** on 31st August 2024, which was **£2.6m** ahead of plan. Several schemes, particularly those in Space & Place, have proceeded more quickly than expected. Donated capital expenditure was **£3.3m**, **£9.3m** below plan.

## 2024/25 Overview of activity trends for the 5 months ending 31 Aug 2024

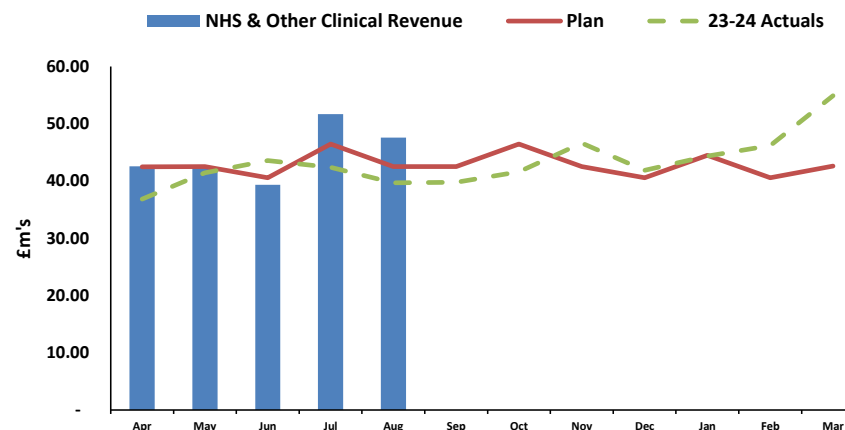


### Summary

- Admitted patient care per day in August is lower than July. For day case there has decrease of 3.99 spells per day (3.53%) in comparison to prior month and elective activity increase by 0.29 spells per day (0.69% reduction). Non-elective increased by 0.48 spells per day (10.49%). August activity has decreased per working day in comparison to July. August activity has decreased versus April (0.54 spells per working day); this is largely driven by lower day cases (1.90 spells) and higher electives (0.90 spells), non elective (0.46 spells).
- Bed days for August have decreased by 0.98% reflecting the activity trend and NHS critical care days are 0.89 per working day higher than July with an decrease in other bed days (4.44 per working day). It should be noted that critical care days for private activity was 1.23 per working day higher than July.
- Outpatient attendances decreased further across the board versus July with first attendances decreased by 13.98 attendances per day and follow ups decreasing by 72.93 attendances per day.
- On the basis of current ERF information, which includes some estimates for uncoded work in M4-M5 (July/ August) performance has an under-performance of £0.5m against the total plan, a improvement of £0.7m versus July due to update on uncoded activity for July and MDT (£1.5m) activity coding. The estimated impact of strikes within the year to date performance is £0.7m.

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

## 2024/25 Income for the 5 months ending 31 Aug 2024



### Summary

- Total Income is £3.2m ahead of plan YTD.
- Clinical Income YTD is £8.9m favourable largely due to £2.3m of funding received in M4 from NHSE for prior year income and a £2.8m income recognition in M5 relating to specially commissioned income this was confirmed after a clarification and assurance process with NHSE. Passthrough drugs are overperforming by £4.6m due to increased activity. Note this income is largely matched by passthrough costs.
- Further underperformance on ERF, including circa £0.7m of strike impact and estimates for uncoded activity.
- The Trust-wide private income stands at £33.3m and this is £2.4m behind plan YTD. M5 is £0.4m behind plan largely due to reduced private activity in core NHS directorates. In M5 the Trust also recognised a £0.4m central IP&C adjustment in relation to payments on accounts aged in excess of 7 years (this approach to releases has been agreed with the Trust's external auditors).
- Operating income is also £3.1m adverse to plan YTD which is largely driven by a £3.4m underperformance on income from charity grants relating to CCC Demolition, EPR and Palliative Care expenditure.

## Workforce Summary for the 5 months ending 31 Aug 2024

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

Em including Perm, Bank and Agency Staff Group	2024/25 actual		
	YTD (£m)	M04 Actual WTE	£000 / WTE
Admin (inc Director & Senior Managers)	33.4	1,424.6	56.3
Consultants	31.3	395.5	190.0
Estates & Ancillary Staff	7.3	450.8	38.6
Healthcare Assist & Supp	5.6	344.7	39.3
Junior Doctors	15.4	371.6	99.4
Nursing Staff	45.3	1,632.9	66.6
Other Staff	0.5	17.9	61.7
Scientific Therap Tech	30.9	1,156.4	64.1
<b>Total substantive and bank staff costs</b>	<b>169.7</b>	<b>5,794.3</b>	<b>70.3</b>
Agency	2.2	48.9	107.0
<b>Total substantive, bank and agency cost</b>	<b>171.9</b>	<b>5,843.2</b>	<b>70.6</b>
Reserve*	(0.0)	0.0	
Additional employer pension contribution by NHSE (M12)	0.0	0.0	
<b>Total pay cost</b>	<b>171.9</b>	<b>5,843.2</b>	<b>70.6</b>
Remove maternity leave cost	(1.1)		
<b>Total excluding Maternity Costs</b>	<b>170.7</b>	<b>5,843.2</b>	<b>70.1</b>

\*Plan reserve includes WTEs relating to the better value programme

### Summary

The YTD pay position is £0.2m favourable to plan, however £0.9m of this is driven by the central reserves budget for Business Cases. The underlying pay position is £0.7m overspent YTD.

Trust Bank and Agency usage has decreased slightly compared to M04 due to a reduction in summer holiday leave, vacancies and sickness.

Consultants & Junior Doctors are £0.9m underspent YTD, this includes the M2 arrears payments for consultants.

Estates & Ancillary are £0.34m underspent YTD to plan due to high levels of sickness within the cleaning service.

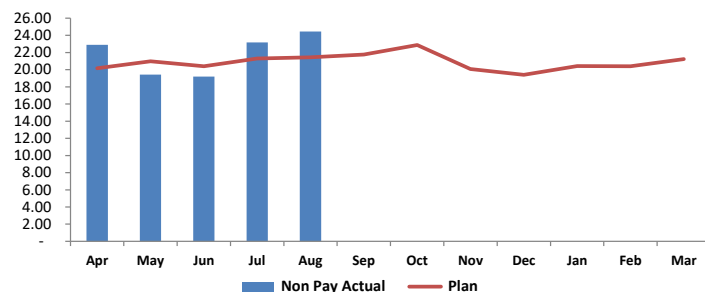
Scientific Therapeutic and Technical Staff are £0.56m underspent to plan YTD due to an increase in bank usage in order to deliver the services required while vacancies are recruited into and sickness cover.

Nursing are £2.56m underspent to plan YTD due to vacancies covered by Bank and Agency

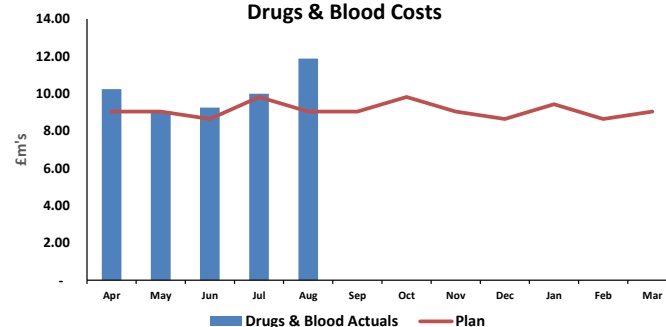
Healthcare Assistants £0.15m underspend due to vacancies

## Non-Pay Summary for the 5 months ending 31 Aug 2024

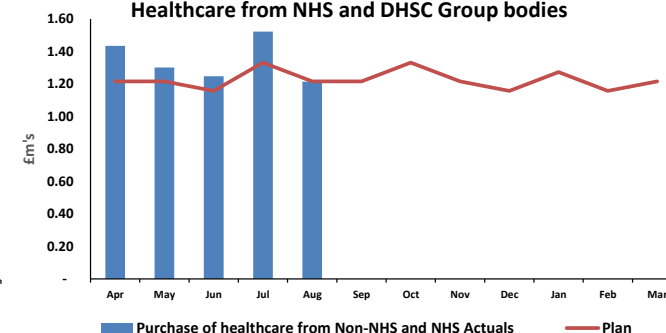
Non Pay Cost Trend £



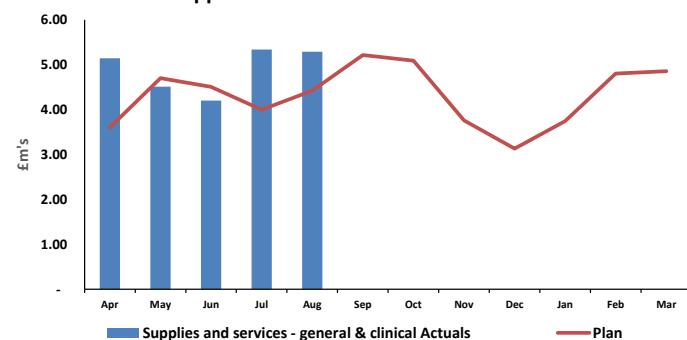
Drugs & Blood Costs



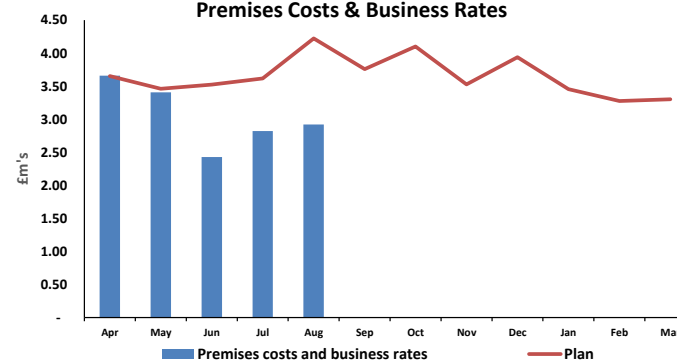
Healthcare from NHS and DHSC Group bodies



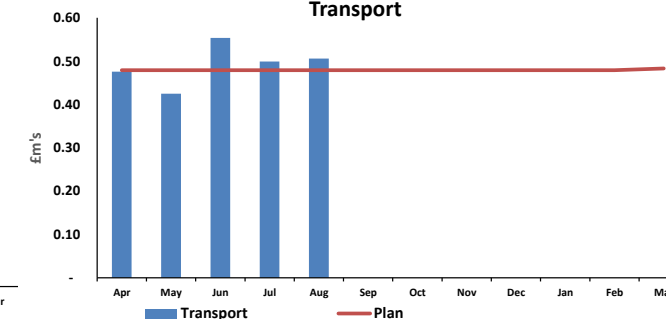
Supplies and Services Clinical & General



Premises Costs & Business Rates



Transport

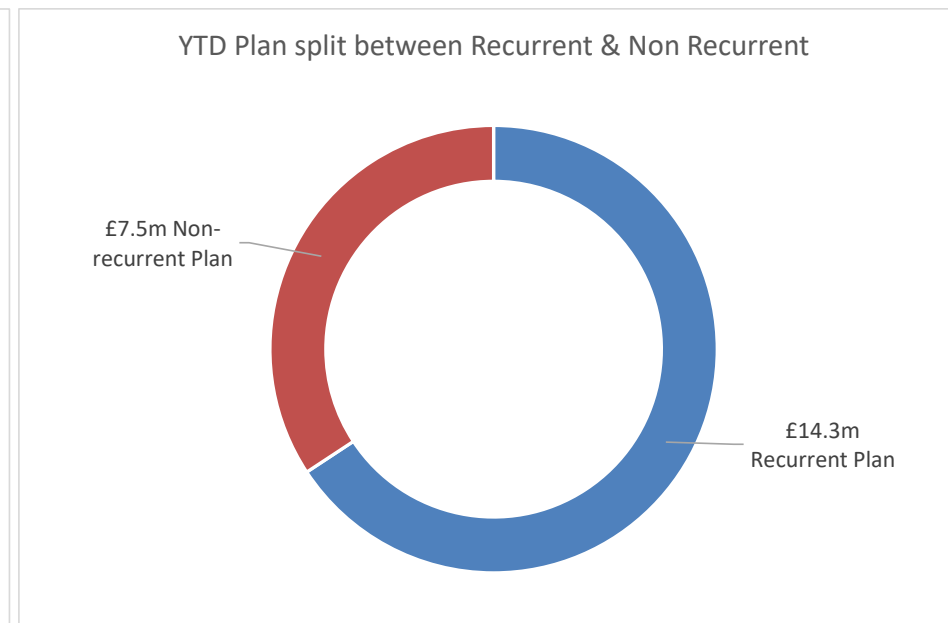
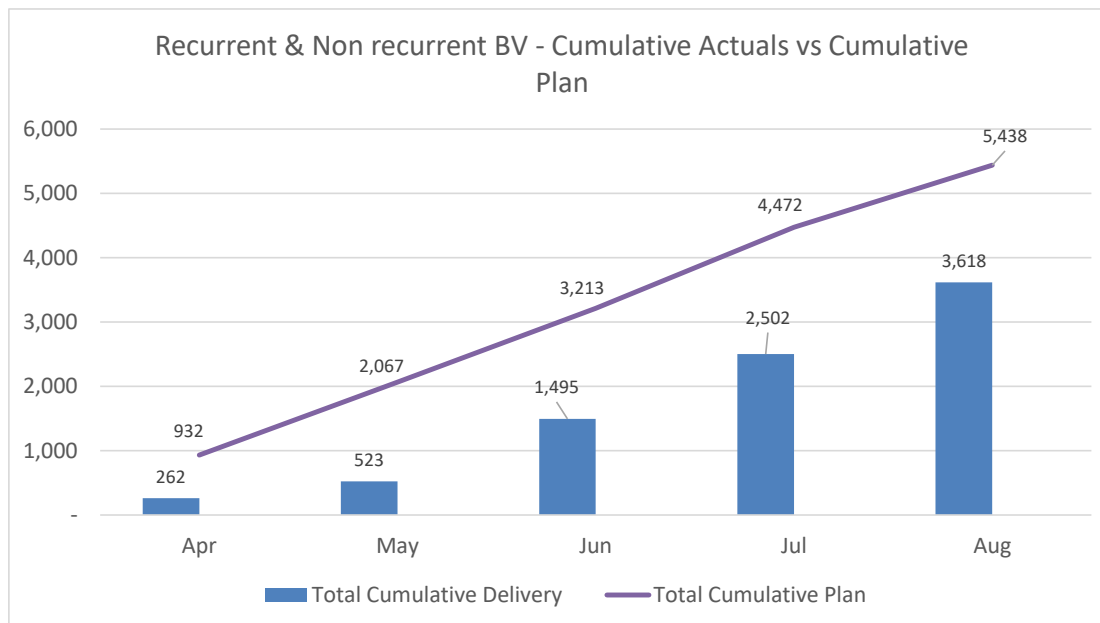


### Summary

YTD Non-Pay is **£4.8m** overspent, this is largely driven by the below:

- Drugs which are **£2.3m** overspent YTD
- S&S Clinical **£2.3m** over YTD (driven by Theatres, Pathology and Reagents)
- Non-Pay BV schemes at **£3.1m** of which **£0.5m** is being delivered against active schemes.

## Better Value for the 5 months ending 31 Aug 2024



### **Better Value:**

- 1 - YTD the Trust has achieved £3.6m Better Value against a plan of £5.4m, largely made up of pay schemes.
- 2 - This is refelecting delivery in month was ahead of plan which was set at £966k

Audited Actual 31 Mar 24	Statement of Financial Position	YTD Actual 31 Jul 24	YTD Actual 31 Aug 24	In month Movement
£m		£m	£m	£m
647.50	Non-Current Assets	648.52	648.70	0.18
122.30	Current Assets (exc Cash)	130.80	127.70	(3.10)
65.90	Cash & Cash Equivalents	63.90	61.10	(2.80)
(135.60)	Current Liabilities	(150.10)	(146.40)	3.70
(29.70)	Non-Current Liabilities	(29.50)	(29.20)	0.30
<b>670.40</b>	<b>Total Assets Employed</b>	<b>663.62</b>	<b>661.90</b>	<b>(1.72)</b>

31 Mar 2024 Audited Accounts	Capital Expenditure	Full Year Plan 2024-25	YTD Plan Aug 2024	YTD Actual Aug 2024	YTD Variance	RAG YTD variance
£m		£m	£m	£m	£m	
7.90	CCC	7.50	3.09	3.89	(0.81)	R
6.02	Medical Equipment	6.99	2.45	2.73	(0.27)	R
5.72	Property & Plant	11.56	2.21	4.15	(1.94)	R
6.60	Information Technology & Intangibles	4.71	2.54	2.14	0.40	G
<b>26.24</b>	<b>Total Trust Funded</b>	<b>30.76</b>	<b>10.29</b>	<b>12.90</b>	<b>(2.62)</b>	<b>R</b>
<b>0.35</b>	<b>PDC</b>	<b>0.07</b>	<b>0.03</b>	<b>0.01</b>	<b>0.02</b>	<b>G</b>
19.77	CCC	27.89	11.62	3.06	8.56	G
1.10	Property & Plant	-	-	0.00	(0.00)	G
1.54	Medical Equipment	2.28	0.95	0.25	0.70	A
<b>22.42</b>	<b>Total Donated and Grant funded</b>	<b>30.17</b>	<b>12.57</b>	<b>3.31</b>	<b>9.26</b>	<b>G</b>
<b>49.01</b>	<b>Total Expenditure</b>	<b>61.00</b>	<b>22.88</b>	<b>16.23</b>	<b>6.65</b>	<b>G</b>

31-Mar-24	Working Capital	31-Jul-24	31-Aug-24	RAG	KPI
6.0	NHS Debtor Days (YTD)	4.0	3.2	G	< 30.0
216.0	I&PC Debtor Days	240.0	232.0	R	< 120.0
29.6	I&PC Overdue Debt (£m)	36.4	37.2	R	0.0
92.0	Inventory Days - Non Drugs	88.0	91.0	R	30.0
36.0	Creditor Days	48.0	33.3	A	< 30.0
53.0%	BPPC - NHS (YTD) (number)	51.7%	53.4%	R	> 95.0%
70.6%	BPPC - NHS (YTD) (£)	57.7%	55.9%	R	> 95.0%
84.2%	BPPC - Non-NHS (YTD) (number)	75.1%	72.5%	R	> 95.0%
90.4%	BPPC - Non-NHS (YTD) (£)	85.4%	83.9%	R	> 95.0%
83.3%	BPPC - Total (YTD) (number)	74.6%	72.1%	R	> 95.0%
88.7%	BPPC - Total (YTD) (£)	83.4%	81.7%	R	> 95.0%

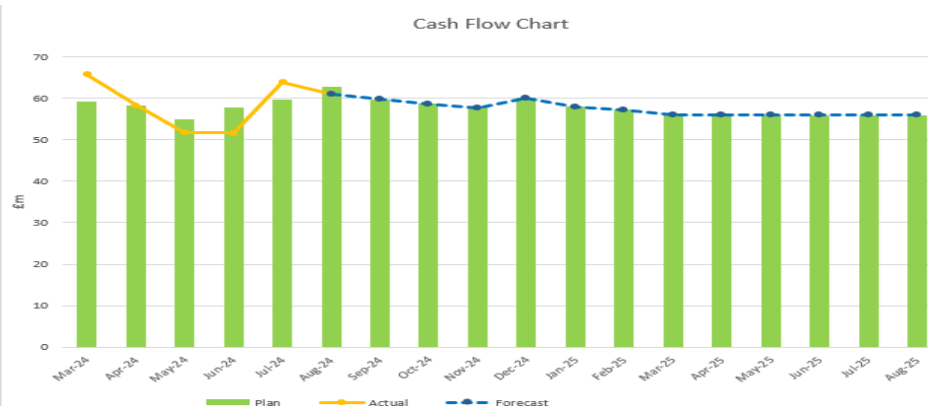
**RAG Criteria:**  
 NHS Debtor and Creditor Days:  
 Green (under 30);  
 Amber (30-40);  
 Red (over 40)

BPPC Number and £:  
 Green (over 95%);  
 Amber (90-95%);  
 Red (under 90%)

IPP debtor days:  
 Green (under 120 days);  
 Amber (120-150 days);  
 Red (over 150 days)

Inventory days:  
 Green (under 21 days);  
 Amber (22-30 days);  
 Red (over 30 days)

31-Mar-24	Liquidity Method	31-Jul-24	31-Aug-24	RAG
1.4	Current Ratio (Current Assets / Current Liabilities)	1.3	1.3	G
1.3	Quick Ratio (Current Assets - Inventories - Prepaid Expenses) / Current Liabilities	1.2	1.2	G
0.5	Cash Ratio (Cash / Current Liabilities)	0.4	0.4	R
36.7	Liquidity days Cash / (Pay+Non pay excl Capital expenditure)	33.3	31.9	A
63.1	Liquidity Days (Payroll) (Cash / Pay)	61.3	58.6	A



#### Comments:

- Capital expenditure for the year to end of August 2024 was £16.2m; the Trust-funded expenditure was £12.9m, which includes Rights of Use (leased) asset expenditure
  - The donated expenditure was £3.3m.
- Cash held by the Trust decreased in month from £63.9m to £61.1m.
- Total Assets employed at M05 decreased by £1.7m in month as a result of the following:
  - Non current assets totalled £648.7m (increasing by £0.2m in month).
  - Current assets excluding cash totalled £127.6m, decreasing by £3.1m in month. This largely relates to contract receivables invoiced (£1.7m lower in month); other receivables (£0.4m lower in month). and Capital receivables (£1.8m lower in month). This is offset against the increase in inventories (£0.5m higher in month) and Contract receivables not yet invoiced (£0.3m higher in month)
  - Cash held by the Trust totalled £61.1m, decreasing in month by £2.8m.
  - Current liabilities decreased in month by £3.7m to £146.3m. This includes other payables (£6.5m lower in month); NHS payables (£1.6m lower in month) and Capital creditors (£0.5m lower in month). This is offset against the increase in deferred income (£2.5m higher in month) and expenditure accruals (£2.4m higher in month).
  - Non current liabilities totalled £29.2m. This includes lease borrowings of £24.6m.
- I&PC debtors days decreased in month from 240 to 232 days. Total I&PC debt (net of cash deposits held) increased in month to £53.2m (£52.4m in M4). Overdue debt also increased in month to £37.2m (£36.4m in M4).
- In M05, 82% of the total value of creditor invoices were settled within 30 days of receipt; this represented 72% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.
- By supplier category, the cumulative BPPC for Non NHS invoices (by number) was 72% (75% in M5). This represented 84% of the total value of invoices settled within 30 days (85% in M4). The cumulative BPPC for NHS invoices (by number) was 53% (52% in M4). This represented 56% of the value of invoices settled within 30 days (58% in M4).
- Creditor days decreased in month from 48 to 33 days.

# Trust Income and Expenditure by Directorates Summary for the 5 months ending 31 Aug 2024



Annual Plan (£m)	Directorates - Clinical	2024/25								RAG	Main drivers Causing YTD Variance
		In Month				Year to Date				YTD Var	
		Plan (£m)	Actual (£m)	Variance (£m)	%	Plan (£m)	Actual (£m)	Variance (£m)	%		
(98.29)	Core Clinical Services	(8.2)	(9.0)	(0.9)	(10.68%)	(40.8)	(43.0)	(2.2)	(5.44%)	R	Unidentified Better Value, Theatres & Radiology Non pay
(51.70)	Heart & Lung	(4.3)	(4.4)	(0.1)	(2.97%)	(21.4)	(26.8)	(5.4)	(25.15%)	R	Reduced activity with I&PC Patients affecting income
(37.68)	Blood Cells & Cancer	(3.1)	(3.3)	(0.1)	(4.07%)	(15.7)	(16.5)	(0.8)	(5.25%)	R	BCC YTD adverse to plan, mainly attributable to underperformance in I&PC income.
(34.67)	Body Bones & Mind	(2.9)	(3.2)	(0.3)	(10.38%)	(14.4)	(15.9)	(1.5)	(10.42%)	R	Under performance in I&PC income and overspend in pay.
(31.54)	Sight & Sound	(2.6)	(2.8)	(0.2)	(5.76%)	(13.1)	(13.8)	(0.6)	(4.92%)	R	Sight & Sound YTD adverse to plan, mainly attributable to unmet Better Value targets and overspend of Clinical supplies which is activity related.
(26.07)	Brain	(2.2)	(2.4)	(0.1)	(5.61%)	(10.9)	(11.3)	(0.4)	(3.41%)	A	
12.32	Nt Genomic Medicine Service	1.0	1.0	(0.0)	(4.20%)	5.3	5.2	(0.0)	(0.79%)	G	
33.35	International And Private Care	2.7	2.6	(0.1)	(2.68%)	14.4	16.0	1.6	10.89%	G	
(234.30)	<b>Surplus/Deficit</b>	(19.6)	(21.5)	(1.9)	(9.81%)	(96.5)	(106.0)	(9.4)	(9.74%)	R	

## RAG Criteria:

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

# Trust Income and Expenditure by Directorates Summary for the 5 months ending 31 Aug 2024



Annual Plan (£m)	Directorates - Corporate	2024/25								RAG	
		In Month				Year to Date				YTD Var	Main drivers Causing YTD Variance
		Plan (£m)	Actual (£m)	Variance (£m)	%	Plan (£m)	Actual (£m)	Variance (£m)	%		
(51.75)	Space And Place	(4.3)	(4.3)	0.0	0.81%	(21.6)	(21.5)	0.1	0.30%	G	
(12.62)	ICT	(1.1)	(1.1)	(0.0)	(3.80%)	(5.3)	(4.9)	0.3	6.13%	G	
(10.24)	Transformation	(0.9)	(0.9)	0.0	0.23%	(4.3)	(4.2)	0.0	0.63%	G	
(7.85)	Clinical & Medical Operations	(0.7)	(0.6)	0.1	8.92%	(3.3)	(3.1)	0.2	5.89%	G	
(13.69)	Medical Director	(1.1)	(0.8)	0.4	31.76%	(5.7)	(4.2)	1.5	26.97%	G	
(6.31)	HR & Organisational Developmen	(0.5)	(0.5)	0.0	4.07%	(2.6)	(2.8)	(0.1)	(4.85%)	A	
(4.61)	Nursing And Patient Experience	(0.5)	(0.5)	(0.1)	(13.25%)	(2.3)	(1.9)	0.4	16.32%	G	
(3.65)	Corporate Affairs	(0.3)	(0.1)	0.2	55.01%	(1.5)	(1.5)	0.0	1.45%	G	Corporate Affairs' YTD £100K adverse to plan driven by NTP expenditure which will be funded by NHSE Network allocation.
(3.59)	Finance	(0.3)	(0.3)	0.0	7.46%	(1.4)	(1.3)	0.1	4.94%	G	
(0.88)	Innovation	(0.1)	(0.1)	(0.1)	(89.61%)	(0.4)	(1.0)	(0.7)	(180.28%)	R	Underachievement of income for several contracts across GMP (e.g. Leucid Bio, LifeArc and John Anderson project ) due to delays in manufacturing and commencement of the projects respectively.
1.51	Research And Innovation	0.1	(0.1)	(0.2)	(146.51%)	0.6	0.4	(0.2)	(28.82%)	R	
(113.67)	<b>Surplus/Deficit</b>	(9.6)	(9.2)	0.3	3.27%	(47.6)	(46.0)	1.6	3.44%	G	

## RAG Criteria:

Green Favourable YTD Variance

Amber Adverse YTD Variance ( < 5%)

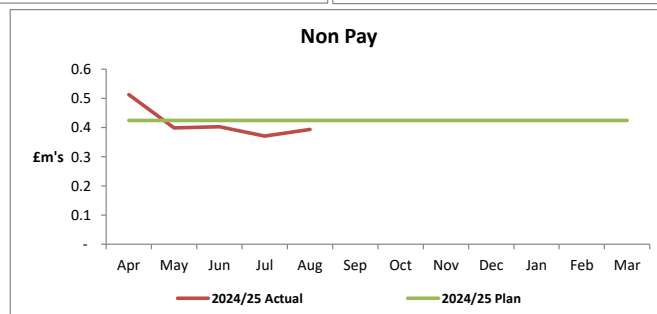
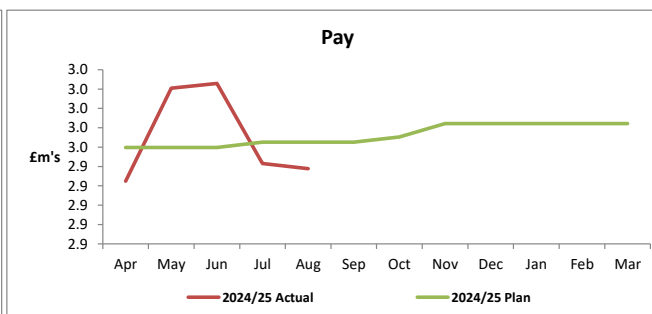
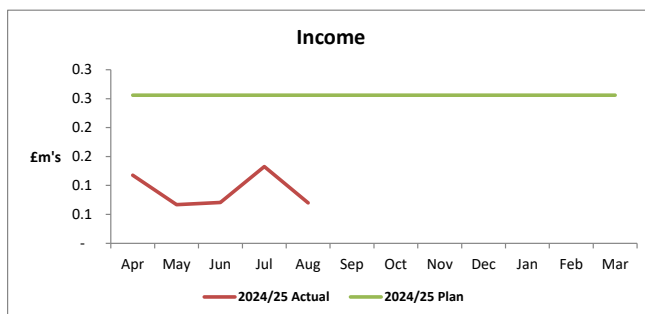
Red Adverse YTD Variance ( > 5% or > £0.5m)

Annual Plan	Trust Position	Plan (£m)	Actual (£m)	Variance (£m)	Plan (£m)	Actual (£m)	Variance (£m)
(113.67)	Directorates - Corporate	(9.56)	(9.25)	0.31	(47.60)	(45.97)	1.64
(234.04)	Directorates - Clinical	(19.58)	(21.50)	(1.92)	(96.55)	(105.95)	(9.41)
374.91	Central Income	30.93	32.43	1.50	156.51	158.42	1.91
(2.64)	Central Expenditure	(0.21)	0.17	0.27	(5.27)	(0.82)	4.34
(16.56)	Depreciation	(1.38)	(1.32)	0.06	(6.90)	(6.55)	0.35
(7.92)	Dividends Payable	(0.66)	(0.66)	0.00	(3.30)	(3.30)	0.00
0.10	<b>Total Trust - Surplus / Deficit</b>	(0.46)	(0.13)	(0.32)	(3.11)	(4.18)	(1.18)

\*The above table is a summary of the trust position including Clinical, Corp and Central areas.

## Blood Cells & Cancer Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024

Annual Plan	Income & Expenditure Blood Cells & Cancer	2024/25							
		Month 5				Year to Date			
		Plan	Actual	Variance		Plan	Actual	Variance	
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
2.29	Private Patient Revenue	0.19	0.01	(0.18)	(95.36%)	0.95	0.06	(0.89)	(93.55%)
0.78	Non-Clinical Revenue	0.07	0.06	(0.00)	(6.24%)	0.33	0.40	0.07	21.82%
<b>3.07</b>	<b>Total Operating Revenue</b>	<b>0.26</b>	<b>0.07</b>	<b>(0.19)</b>	<b>(72.73%)</b>	<b>1.28</b>	<b>0.46</b>	<b>(0.82)</b>	<b>(64.25%)</b>
(35.39)	Permanent Staff	(2.94)	(2.82)	0.13	4.27%	(14.69)	(14.07)	0.63	4.26%
0.00	Agency Staff	0.00	(0.00)	(0.00)	0%	0.00	(0.00)	(0.00)	0%
(0.28)	Bank Staff	(0.02)	(0.12)	(0.10)	(416.93%)	(0.11)	(0.78)	(0.67)	(581.90%)
<b>(35.67)</b>	<b>Total Employee Expenses</b>	<b>(2.97)</b>	<b>(2.94)</b>	<b>0.03</b>	<b>0.92%</b>	<b>(14.81)</b>	<b>(14.85)</b>	<b>(0.04)</b>	<b>(0.29%)</b>
(0.92)	Drugs and Blood	(0.08)	(0.03)	0.04	54.94%	(0.38)	(0.16)	0.23	59.16%
(1.47)	Supplies and services - clinical	(0.12)	(0.15)	(0.02)	(18.95%)	(0.61)	(0.63)	(0.01)	(2.28%)
(2.70)	Other Expenses	(0.22)	(0.21)	0.01	5.48%	(1.12)	(1.29)	(0.17)	(15.03%)
<b>(5.09)</b>	<b>Total Non-Pay Expenses</b>	<b>(0.42)</b>	<b>(0.39)</b>	<b>0.03</b>	<b>7.34%</b>	<b>(2.12)</b>	<b>(2.08)</b>	<b>0.04</b>	<b>2.07%</b>
<b>(37.68)</b>	<b>Control total</b>	<b>(3.13)</b>	<b>(3.26)</b>	<b>(0.13)</b>	<b>(4.07%)</b>	<b>(15.65)</b>	<b>(16.47)</b>	<b>(0.82)</b>	<b>(5.25%)</b>



### Summary –General Manager

The BCC Directorate M5 YTD position is £0.82m adverse to plan and is £0.13m adverse in month. The key contributor to the YTD position is the £0.89m underperformance in I&PC which is partially offset by favourable variance from Blood underspend. Air filtering work and nursing vacancies caused some bed closures, affecting patient activity.

### Income

- Overall YTD Income is £0.82m adverse to plan driven by I&PC Income underperformance of £0.89m due to delays in Private Thymic patients' programmes within BCC wards. Earlier in the year there had been unavailability of tissues and generally, there have been fewer patients suitable for the transplant last 5 months. Marketing exercises has consistently been done with help of I&PC to try secure more patients.

### Pay

- Overall YTD Pay is £0.04m adverse to plan and £0.03m favourable in month, mainly driven by backfilling medical staff absences with Locum. Vacancies in Nursing staff are mostly covered by Bank and Locum. Despite this, £0.33m of better value has been delivered YTD.

### Non-Pay

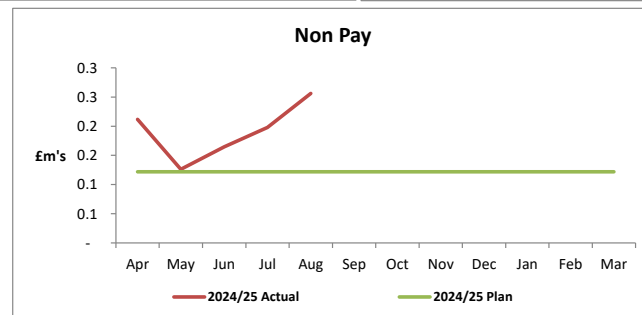
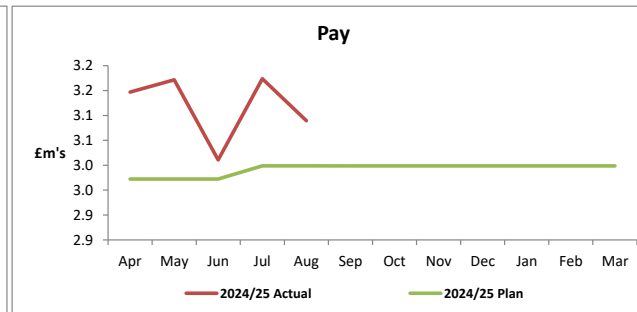
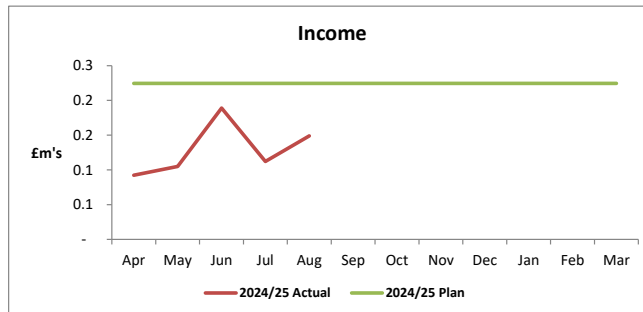
- Non-Pay is £0.04m favourable to plan YTD and £0.03m favourable in month, main driver being lower Blood usage and stable tissue typing and harvest costs.

### Better Value

- The 24/25 BV target for the directorate is £1.44m, of which £1.07m is identified as vacancy factor. YTD Pay BV target is £0.44m, of which £0.33m has been delivered. Unallocated Non-Pay BV target is £0.16m YTD, initiatives are on-going for scoping various work

## Body Bones & Mind Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024

Annual Plan	Income & Expenditure	2024/25							
		Month 5				Year to Date			
		Plan	Actual	Variance		Plan	Actual	Variance	
(£m)	Body Bones & Mind	(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
2.16	Private Patient Revenue	0.18	0.14	(0.04)	(24.06%)	0.90	0.44	(0.46)	(50.71%)
0.53	Non-Clinical Revenue	0.04	0.01	(0.03)	(72.40%)	0.22	0.20	(0.02)	(8.57%)
<b>2.69</b>	<b>Total Operating Revenue</b>	<b>0.22</b>	<b>0.15</b>	<b>(0.08)</b>	<b>(33.66%)</b>	<b>1.12</b>	<b>0.65</b>	<b>(0.48)</b>	<b>(42.34%)</b>
(35.91)	Permanent Staff	(3.00)	(2.85)	0.15	4.91%	(14.91)	(14.34)	0.58	3.87%
0.00	Agency Staff	0.00	0.00	0.00	0%	0.00	(0.00)	(0.00)	0%
0.00	Bank Staff	0.00	(0.24)	(0.24)	0%	0.00	(1.25)	(1.25)	0%
<b>(35.91)</b>	<b>Total Employee Expenses</b>	<b>(3.00)</b>	<b>(3.09)</b>	<b>(0.09)</b>	<b>(3.03%)</b>	<b>(14.91)</b>	<b>(15.59)</b>	<b>(0.68)</b>	<b>(4.55%)</b>
(0.08)	Drugs and Blood	(0.01)	(0.01)	(0.00)	(30.62%)	(0.03)	(0.05)	(0.02)	(67.53%)
(1.21)	Supplies and services - clinical	(0.10)	(0.12)	(0.02)	(16.94%)	(0.50)	(0.49)	0.01	1.91%
(0.18)	Other Expenses	(0.01)	(0.13)	(0.12)	(779.51%)	(0.07)	(0.41)	(0.33)	(453.24%)
<b>(1.46)</b>	<b>Total Non-Pay Expenses</b>	<b>(0.12)</b>	<b>(0.26)</b>	<b>(0.13)</b>	<b>(110.12%)</b>	<b>(0.61)</b>	<b>(0.96)</b>	<b>(0.35)</b>	<b>(56.93%)</b>
<b>(34.67)</b>	<b>Control total</b>	<b>(2.90)</b>	<b>(3.20)</b>	<b>(0.30)</b>	<b>(10.38%)</b>	<b>(14.40)</b>	<b>(15.90)</b>	<b>(1.50)</b>	<b>(10.42%)</b>



### Summary -General Manager

As at M5, the directorate financial position is showing £0.30m adverse variance to plan in month and £1.5m adverse variance to plan YTD. The main contributor to the YTD position is under performance in I&PC income and overspend in pay.

#### Income

I&PC income is £0.46m adverse variance against plan YTD. Private activity is low across all the specialities. Non clinical income is showing an under achievement of £0.02m YTD which is driven by reduction in court work income and education and training income. Outreach SLAs for this year has all been sent out.

#### Pay

Pay is reporting a £0.68m adverse to Plan YTD. £0.4m of underlying pay overspends are being driven by medical staffing; scientific and Tech staff overspent by £0.11m; offsetting against nursing vacancies.

#### Non-Pay

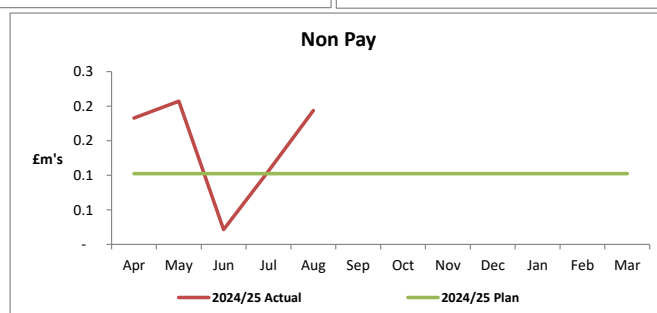
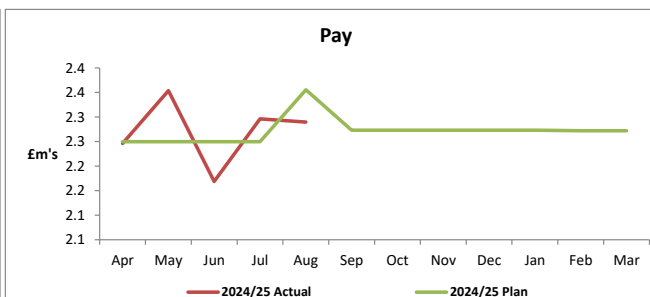
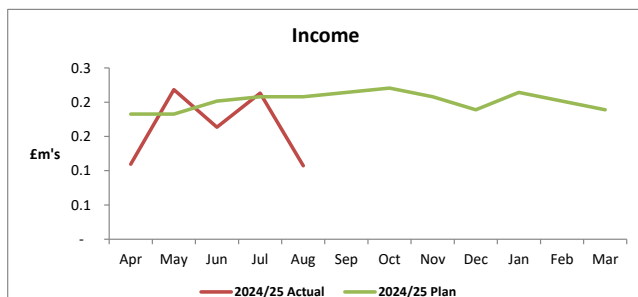
Non pay costs are £0.35m adverse to plan YTD. The main driver for this variance is under achieved non-pay BV of £0.25m YTD.

#### BV

24-25 BV target for the division is £1.33m of which £0.73m is against pay and £0.59m against non-pay. Part of the pay BV has been achieved from nursing vacancies.

## Brain Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024

Annual Plan	Income & Expenditure Brain	2024/25 Month 5				Year to Date			
		Plan	Actual	Variance		Plan	Actual	Variance	
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
1.26	Private Patient Revenue	0.11	0.05	(0.07)	(58.51%)	0.50	0.53	0.03	5.50%
1.16	Non-Clinical Revenue	0.10	0.06	(0.04)	(36.73%)	0.48	0.28	(0.20)	(41.25%)
<b>2.42</b>	<b>Total Operating Revenue</b>	<b>0.21</b>	<b>0.11</b>	<b>(0.10)</b>	<b>(48.43%)</b>	<b>0.98</b>	<b>0.81</b>	<b>(0.17)</b>	<b>(17.39%)</b>
(27.27)	Permanent Staff	(2.36)	(2.16)	0.19	8.20%	(11.35)	(10.73)	0.62	5.49%
0.00	Agency Staff	0.00	(0.01)	(0.01)	0%	0.00	(0.05)	(0.05)	0%
0.00	Bank Staff	0.00	(0.12)	(0.12)	0%	0.00	(0.57)	(0.57)	0%
(27.27)	<b>Total Employee Expenses</b>	(2.36)	(2.29)	0.07	2.79%	(11.35)	(11.35)	(0.00)	(0.00%)
(0.09)	Drugs and Blood	(0.01)	(0.00)	0.00	66.96%	(0.04)	(0.02)	0.02	43.41%
(1.18)	Supplies and services - clinical	(0.10)	(0.07)	0.02	24.26%	(0.49)	(0.41)	0.08	16.96%
0.04	Other Expenses	0.00	(0.12)	(0.12)	(3,844.67%)	0.02	(0.28)	(0.30)	(1,913.44%)
(1.23)	<b>Total Non-Pay Expenses</b>	(0.10)	(0.19)	(0.09)	(89.13%)	(0.51)	(0.71)	(0.20)	(38.95%)
(26.07)	<b>Control total</b>	(2.25)	(2.38)	(0.13)	(5.61%)	(10.88)	(11.25)	(0.37)	(3.41%)



### Summary - General Manager

The directorate is £0.13m adverse to plan in month and £0.37m YTD. YTD adverse is mainly driven by outreach clinics not yet accounted for due to unsigned SLA - £0.17m, work is ongoing to get this done, gap in the directorate Better Value unidentified target - £0.21m. Private patient income is performing better than plan by £0.03m YTD

#### Income

- Private patient income is performing better than plan by £0.03m YTD.
- Non-clinical revenue is behind plan YTD, SLAs for outreach clinics are yet to be signed and so income not yet recognised - £0.17m. Education and training income is slightly above plan
- Income from charitable income is slightly behind plan.
- R&D income YTD is behind plan £0.03m but these could be driven by when billing is done.

#### Pay

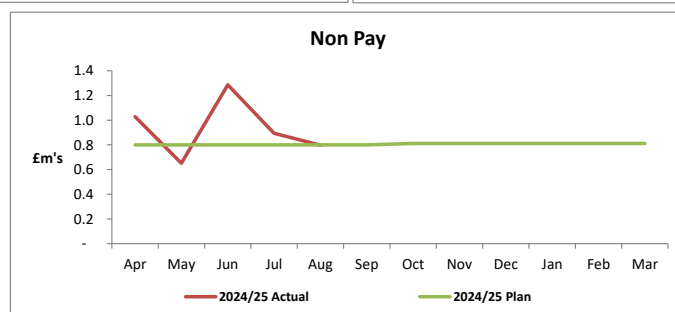
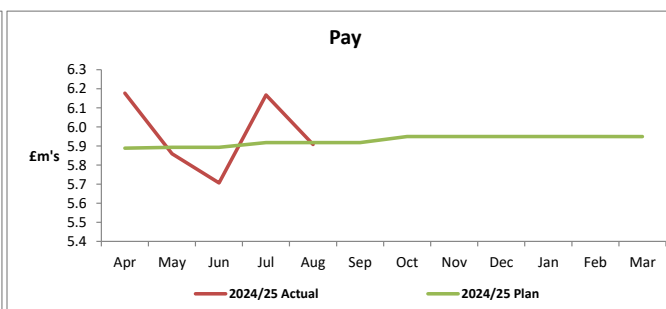
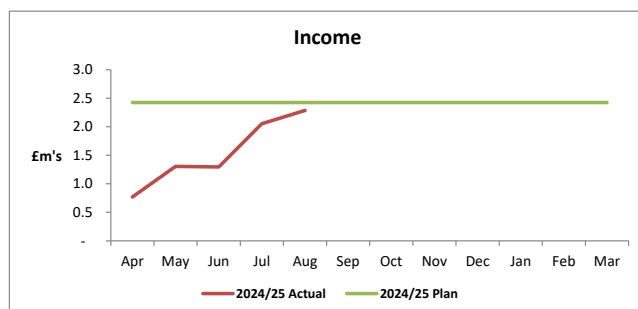
- In month pay position is £0.07m favourable to plan and broke even YTD.
- There are vacancies across the division within Consultants and Nursing but recruitment drive ongoing within Nursing.
- Approved SDR BC Funding received in month 5

#### Non-Pay

- Non-pay costs is £0.09m adverse to plan in month and £0.20m adverse to plan YTD. YTD is mainly driven by the gap in unidentified better value target £0.21m offset by underspend within clinical supplies.

## Heart & Lung Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024

Annual Plan	Income & Expenditure Heart & Lung	2024/25 Month 5				Year to Date			
		Plan	Actual	Variance		Plan	Actual	Variance	
		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
28.24	Private Patient Revenue	2.35	2.24	(0.12)	(4.95%)	11.77	7.48	(4.29)	(36.47%)
0.85	Non-Clinical Revenue	0.07	0.05	(0.02)	(31.52%)	0.36	0.23	(0.12)	(34.04%)
<b>29.09</b>	<b>Total Operating Revenue</b>	<b>2.42</b>	<b>2.29</b>	<b>(0.14)</b>	<b>(5.73%)</b>	<b>12.12</b>	<b>7.71</b>	<b>(4.41)</b>	<b>(36.40%)</b>
(70.87)	Permanent Staff	(5.91)	(5.39)	0.52	8.81%	(29.45)	(27.32)	2.13	7.25%
0.00	Agency Staff	0.00	(0.05)	(0.05)	0%	0.00	(0.19)	(0.19)	0%
(0.25)	Bank Staff	(0.01)	(0.48)	(0.47)	(4,094.35%)	(0.06)	(2.31)	(2.26)	(3,972.31%)
<b>(71.12)</b>	<b>Total Employee Expenses</b>	<b>(5.92)</b>	<b>(5.91)</b>	<b>0.01</b>	<b>0.16%</b>	<b>(29.51)</b>	<b>(29.82)</b>	<b>(0.31)</b>	<b>(1.04%)</b>
(1.29)	Drugs and Blood	(0.11)	(0.09)	0.01	13.45%	(0.54)	(0.49)	0.05	9.24%
(6.10)	Supplies and services - clinical	(0.51)	(0.57)	(0.07)	(12.96%)	(2.54)	(2.76)	(0.22)	(8.79%)
(2.28)	Other Expenses	(0.18)	(0.13)	0.05	28.96%	(0.92)	(1.40)	(0.48)	(52.58%)
<b>(9.67)</b>	<b>Total Non-Pay Expenses</b>	<b>(0.80)</b>	<b>(0.80)</b>	<b>0.00</b>	<b>0.24%</b>	<b>(4.00)</b>	<b>(4.66)</b>	<b>(0.66)</b>	<b>(16.43%)</b>
<b>(51.70)</b>	<b>Control total</b>	<b>(4.29)</b>	<b>(4.42)</b>	<b>(0.13)</b>	<b>(2.97%)</b>	<b>(21.39)</b>	<b>(26.77)</b>	<b>(5.38)</b>	<b>(25.15%)</b>



### Summary -General Manager

As at M5, the directorate financial position is reporting £0.13m adverse variance in month and £5.38m adverse to plan YTD. The main contributor for the YTD position is the underachievement of I&PC income.

### Income

- I&PC income is £4.29m adverse to plan YTD. The trend is similar to Q1 last year. The division is expecting an increase in I&PC activity towards the later part of the year.

Non clinical income is £0.12m adverse YTD which is mainly due to unsigned Outreach SLAs for 24-25. Majority of the SLAs has now been sent out.

### Pay

Pay costs are £0.31m overspent YTD. The main reason for pay variance is the Consultant pay arrears paid in M2 and strike cover.

Medical Staffing pay is overspent by £0.55m YTD  
Nursing staff pay is underspent by £0.98m YTD net off against bank spend. Bank spend on nursing is £0.95m YTD which offsets against vacancies.

### Non-Pay

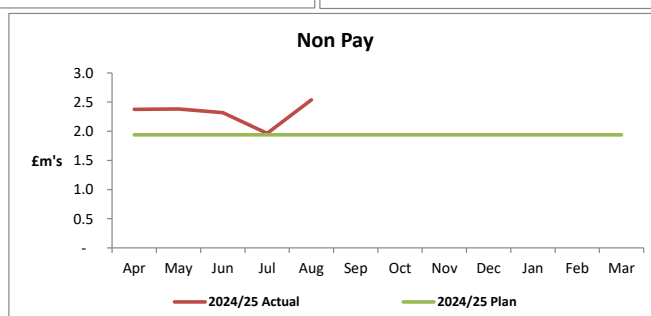
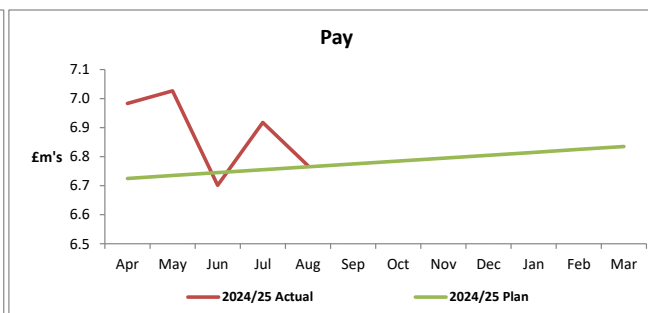
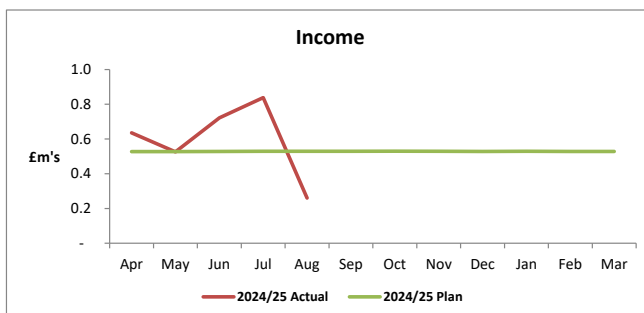
Non pay costs are overspent by £0.66m YTD. The main drivers are the Supplies & Services -Clinical and the cost of Cardiology cases undertaken at the Portland (£0.26m), which has been funded from PCC SDF funds. An unallocated non-pay BV target of £0.2m in also included in the YTD position.

### BV

24-25 BV target for the directorate is £1.92m of which £1.45m is against pay and £0.47m is against non-pay. The division has achieved their pay BV target as at end of M5

## Core Clinical Services Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024

Annual Plan	Income & Expenditure Core Clinical Services	2024/25							
		Month 5				Year to Date			
		Plan	Actual	Variance		Plan	Actual	Variance	
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.02	0.02	0%
0.08	Private Patient Revenue	0.01	0.01	0.00	62.26%	0.03	0.05	0.02	64.84%
6.26	Non-Clinical Revenue	0.52	0.25	(0.28)	(53.04%)	2.61	2.91	0.30	11.55%
<b>6.34</b>	<b>Total Operating Revenue</b>	<b>0.53</b>	<b>0.26</b>	<b>(0.27)</b>	<b>(50.83%)</b>	<b>2.64</b>	<b>2.98</b>	<b>0.34</b>	<b>12.87%</b>
(81.36)	Permanent Staff	(6.76)	(6.42)	0.34	5.09%	(33.72)	(32.54)	1.18	3.51%
0.00	Agency Staff	0.00	(0.11)	(0.11)	0%	0.00	(0.48)	(0.48)	0%
0.00	Bank Staff	0.00	(0.24)	(0.24)	0%	0.00	(1.37)	(1.37)	0%
<b>(81.36)</b>	<b>Total Employee Expenses</b>	<b>(6.76)</b>	<b>(6.77)</b>	<b>(0.00)</b>	<b>(0.06%)</b>	<b>(33.72)</b>	<b>(34.40)</b>	<b>(0.67)</b>	<b>(2.00%)</b>
(0.90)	Drugs and Blood	(0.07)	(0.05)	0.03	37.21%	(0.37)	(0.32)	0.05	14.01%
(20.50)	Supplies and services - clinical	(1.71)	(2.17)	(0.46)	(27.18%)	(8.54)	(9.62)	(1.08)	(12.61%)
(1.87)	Other Expenses	(0.16)	(0.32)	(0.16)	(105.02%)	(0.78)	(1.64)	(0.86)	(110.35%)
<b>(23.27)</b>	<b>Total Non-Pay Expenses</b>	<b>(1.94)</b>	<b>(2.54)</b>	<b>(0.60)</b>	<b>(30.96%)</b>	<b>(9.70)</b>	<b>(11.58)</b>	<b>(1.89)</b>	<b>(19.45%)</b>
<b>(98.29)</b>	<b>Control total</b>	<b>(8.18)</b>	<b>(9.05)</b>	<b>(0.87)</b>	<b>(10.68%)</b>	<b>(40.78)</b>	<b>(43.00)</b>	<b>(2.22)</b>	<b>(5.44%)</b>



### Summary - General Manager

The CCS directorate expenditure in month is £9.31m, Income in month is £0.26m giving a net spend for M5 of £9.05m. This compares adversely with previous months due to prior year income credit notes adjustments of £0.57m. The budgetary deficit after month 5 was £2.22m, including the application of Better Value Targets.

### Income

Income declined to £0.26m with a £0.57m reduction for prior years credit notes with the majority from HSL, UCLH and BWCH. The budgetary variance has also reduced to £0.34m surplus.

### Pay

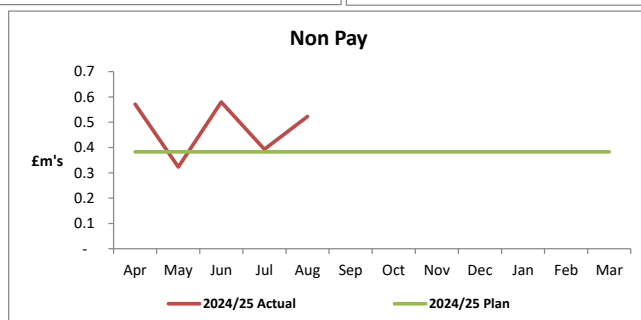
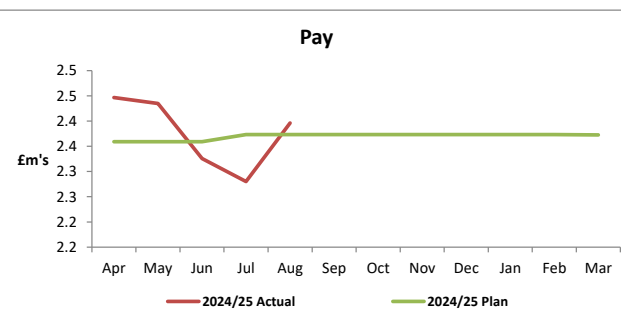
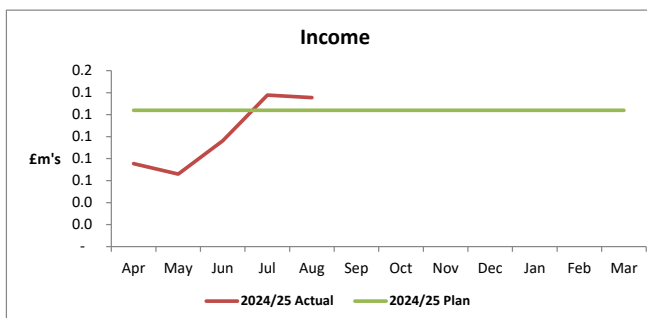
- Pay costs of £6.77m were lower than month 4 and broke even in month, with a reduction in bank costs of £0.1m. There is a cumulative overspend of £0.67m, of which £0.1m relates to consultant arrears. The 5.5% AFC pay award has only been reflected at the original 2% level in line with budgets.
- Bank costs were £0.24m, which was a reduction of £0.10m from month 4. Total costs are now £1.37m.
- Agency costs total £0.11m in month and £0.48m to date, this is £0.27m lower than at the same point in 23-24. Pharmacy & Radiology remain the big users of agency in line with national shortages.

### Non-Pay

- Non Pay costs rose to £2.54m following the release of old year accruals in month 4 of £0.83m. The overspend now amounts to £1.89m of which Clinical Supplies account for £1.08m, driven by Pathology and Theatres consumable costs, related to activity levels and price increases.
- The unidentified Better Value Target of £1.9m accounts for £0.79m of the Non Pay overspend. The Division delivered £1.8m during budget setting and is currently forecasting £2.06m including a 2% Vacancy Factor of £1.6m that is being achieved through recruitment controls.

## Sight & Sound Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024

Annual Plan	Income & Expenditure Sight & Sound	2024/25 Month 5				Year to Date			
		Plan	Actual	Variance		Plan	Actual	Variance	
		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
0.92	Private Patient Revenue	0.08	0.10	0.02	29.58%	0.38	0.39	0.01	1.87%
0.56	Non-Clinical Revenue	0.05	0.04	(0.01)	(24.02%)	0.24	0.12	(0.12)	(49.41%)
<b>1.49</b>	<b>Total Operating Revenue</b>	<b>0.12</b>	<b>0.14</b>	<b>0.01</b>	<b>9.25%</b>	<b>0.62</b>	<b>0.51</b>	<b>(0.11)</b>	<b>(17.58%)</b>
(28.06)	Permanent Staff	(2.34)	(2.24)	0.10	4.13%	(11.67)	(11.17)	0.50	4.29%
0.00	Agency Staff	0.00	(0.00)	(0.00)	0%	0.00	(0.00)	(0.00)	0%
(0.38)	Bank Staff	(0.03)	(0.15)	(0.12)	(378.32%)	(0.16)	(0.72)	(0.56)	(354.87%)
<b>(28.44)</b>	<b>Total Employee Expenses</b>	<b>(2.37)</b>	<b>(2.40)</b>	<b>(0.02)</b>	<b>(0.96%)</b>	<b>(11.82)</b>	<b>(11.88)</b>	<b>(0.06)</b>	<b>(0.51%)</b>
(0.03)	Drugs and Blood	(0.00)	(0.00)	(0.00)	(7.70%)	(0.01)	(0.01)	0.00	27.10%
(3.79)	Supplies and services - clinical	(0.32)	(0.40)	(0.09)	(26.94%)	(1.58)	(1.69)	(0.12)	(7.33%)
(0.78)	Other Expenses	(0.07)	(0.12)	(0.05)	(84.35%)	(0.33)	(0.69)	(0.36)	(111.66%)
<b>(4.59)</b>	<b>Total Non-Pay Expenses</b>	<b>(0.38)</b>	<b>(0.52)</b>	<b>(0.14)</b>	<b>(36.59%)</b>	<b>(1.91)</b>	<b>(2.39)</b>	<b>(0.48)</b>	<b>(24.86%)</b>
<b>(31.54)</b>	<b>Control total</b>	<b>(2.63)</b>	<b>(2.78)</b>	<b>(0.15)</b>	<b>(5.76%)</b>	<b>(13.12)</b>	<b>(13.76)</b>	<b>(0.64)</b>	<b>(4.92%)</b>



### Summary - General Manager

Sight & Sound Directorate YTD position at M5 is £0.64m adverse to plan and £0.15m favourable in month. Key contributors to the position are £0.24m unmet Better Value targets under non-pay, £0.14m unbilled outreach clinics, £0.12m overspend of clinical supplies and £0.11m patient travel re-imbursements which are both activity related.

#### Income

- M5 YTD Total Income is £0.11m adverse to plan. £0.14m relates to an unsigned Outreach SLA therefore unbilled, the clinical lead and service manager are working towards a resolution.
- Private Patient Income has slightly overperformed at £0.01m year to date, there has been a consistent flow of ENT and Urology private patients in recent months, lifting the M5 position to £0.02m ahead of target.

#### Pay

- Pay costs YTD is £0.06m adverse to plan, mainly driven by medical staff Locum costs covering maternity leave, sickness and activity related. Nursing and HCA Bank costs continued to be incurred to cover vacancies and patient load/activity. Better Value in Vacancy Factor has been delivered to date (£0.27m).

#### Non-Pay

- Non-Pay costs is £0.48m adverse to plan, mainly driven by unidentified Better Value target of £0.24m, the Directorate is working towards several better value schemes that will be delivered later in the financial year.
- £0.11m overspend in patient travel claims is being assessed and plans will be put in place to minimise the overspend.

## International And Private Care Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024

Annual Plan	Income & Expenditure International And Private Care	2024/25 Month 5				Year to Date			
		Plan	Actual	Variance		Plan	Actual	Variance	
		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
55.07	Private Patient Revenue	4.59	4.60	0.01	0.22%	22.95	23.61	0.67	3%
0.37	Non-Clinical Revenue	0.03	0.08	0.05	150.53%	0.16	0.34	0.19	120%
<b>55.44</b>	<b>Total Operating Revenue</b>	<b>4.62</b>	<b>4.68</b>	<b>0.06</b>	<b>1.23%</b>	<b>23.10</b>	<b>23.96</b>	<b>0.86</b>	<b>4%</b>
(14.71)	Permanent Staff	(1.30)	(1.02)	0.28	21.54%	(5.61)	(5.35)	0.26	5%
(0.24)	Agency Staff	(0.02)	(0.07)	(0.05)	(238.02%)	(0.10)	(0.31)	(0.22)	(219%)
(0.04)	Bank Staff	(0.00)	(0.14)	(0.14)	(4,509.89%)	(0.02)	(0.84)	(0.82)	(5,422%)
<b>(14.99)</b>	<b>Total Employee Expenses</b>	<b>(1.32)</b>	<b>(1.23)</b>	<b>0.10</b>	<b>7.29%</b>	<b>(5.73)</b>	<b>(6.50)</b>	<b>(0.77)</b>	<b>(14%)</b>
(0.15)	Drugs and Blood	(0.01)	(0.00)	0.01	99.43%	(0.06)	0.01	0.07	120%
(1.57)	Supplies and services - clinical	(0.13)	(0.10)	0.03	22.59%	(0.65)	(0.35)	0.30	46%
(5.39)	Other Expenses	(0.45)	(0.72)	(0.27)	(59.65%)	(2.24)	(1.13)	1.11	50%
<b>(7.11)</b>	<b>Total Non-Pay Expenses</b>	<b>(0.59)</b>	<b>(0.82)</b>	<b>(0.23)</b>	<b>(38.12%)</b>	<b>(2.96)</b>	<b>(1.47)</b>	<b>1.49</b>	<b>50%</b>
<b>33.35</b>	<b>Control total</b>	<b>2.71</b>	<b>2.63</b>	<b>(0.07)</b>	<b>(2.68%)</b>	<b>14.41</b>	<b>15.98</b>	<b>1.57</b>	<b>11%</b>

### Trust wide IPP Income Summary

24/25 Plan	Directorates	M01	M02	M03	M04	M05	YTD	YTD Plan	YTD
55.44	International And Private Care	4.68	5.06	4.58	4.96	4.68	23.96	23.10	0.86
28.24	Heart & Lung	0.72	1.26	1.25	1.99	2.24	7.46	11.77	(4.31)
2.16	Body Bones & Mind	0.06	0.08	0.08	0.09	0.14	0.45	0.90	(0.45)
0.92	Sight & Sound	0.07	0.04	0.06	0.12	0.10	0.40	0.38	0.02
1.26	Brain	0.07	0.15	0.12	0.15	0.05	0.53	0.50	0.03
2.29	Blood Cells & Cancer	0.02	0.02	0.02	0.01	0.01	0.07	0.95	(0.88)
(0.00)	Central Expenditure (Phasing)	-	(0.12)	0.12	-	0.41	0.41	(1.78)	2.19
0.08	Core Clinical Services	0.01	0.01	0.01	0.01	0.01	0.05	0.02	0.03
<b>90.40</b>	<b>Grand Total</b>	<b>5.63</b>	<b>6.49</b>	<b>6.25</b>	<b>7.33</b>	<b>7.63</b>	<b>33.32</b>	<b>35.84</b>	<b>(2.52)</b>

### Summary - Deputy Director

The I&PC Directorate delivered £2.63m contribution in August which is £0.07m adverse to plan. YTD the I&PC Directorate has delivered £15.98m contribution against a plan of £14.41m which £1.57m ahead of plan.

### Income

Trust wide IPP income was £7.63m in August, which is £0.31m above July's performance of £7.33m. Consequently, the YTD Trustwide IPP income is £2.52m behind the plan target.

- The income generated by the I&PC directorate for August reached £4.68m, representing a positive variance of £0.06m. This increase can be attributed to a rise in the utilisation of high-cost drugs and the admission of a patient undergoing a Thymus transplant.
- NHS Directorate income in month was £2.95m which is an improvement of £0.58m compared to July but was still £0.41m behind target. The improvement was due a higher number of patients requiring access to ICU and due to a balance sheet release of £0.41m.

### Pay

- Pay in the month was £1.23m which was £0.10m positive to budget. YTD pay is £0.77m adverse to budget impacted by high bank spend due to delivering care to complex patients and maintaining bed capacity (which has been supporting NHS activity as above). Agency spend relates to non-clinical areas and will reduce once a consultation is finalised and implemented.

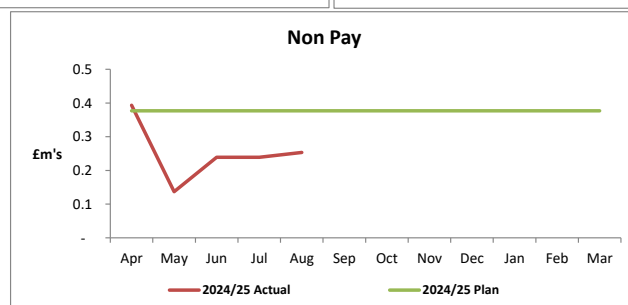
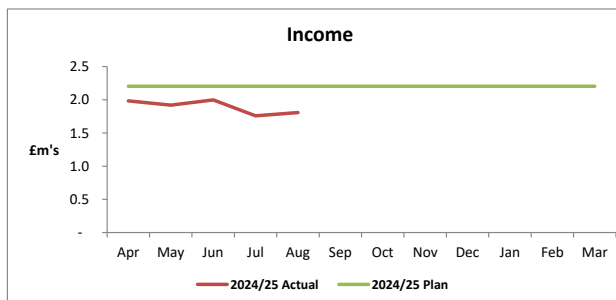
### Non-Pay

- Non-Pay was £0.06m better than plan in August and continued to be positive to plan by £0.50m due to savings in clinical supplies, tissue typing and blood costs.

### Bad Debt reserve

- Bad-Debt provision was £0.50m in month which was £0.29m adverse to plan due to reduced collections in month, nevertheless YTD it remains £0.99m ahead of plan..

Annual Plan	Income & Expenditure Research And Innovation	2024/25							
		Month 5				Year to Date			
		Plan	Actual	Variance		Plan	Actual	Variance	
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
0.00	NHS & Other Clinical Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
0.00	Private Patient Revenue	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
26.44	Non-Clinical Revenue	2.20	1.81	(0.40)	(17.97%)	11.02	9.46	(1.55)	(14.10%)
<b>26.44</b>	<b>Total Operating Revenue</b>	<b>2.20</b>	<b>1.81</b>	<b>(0.40)</b>	<b>(17.97%)</b>	<b>11.02</b>	<b>9.46</b>	<b>(1.55)</b>	<b>(14.10%)</b>
(20.37)	Permanent Staff	(1.70)	(1.59)	0.11	6.35%	(8.49)	(7.66)	0.83	9.76%
0.00	Agency Staff	0.00	(0.01)	(0.01)	0%	0.00	(0.02)	(0.02)	0%
(0.03)	Bank Staff	(0.00)	(0.01)	(0.01)	(288.47%)	(0.01)	(0.07)	(0.06)	(412.64%)
<b>(20.40)</b>	<b>Total Employee Expenses</b>	<b>(1.70)</b>	<b>(1.61)</b>	<b>0.09</b>	<b>5.16%</b>	<b>(8.50)</b>	<b>(7.75)</b>	<b>0.75</b>	<b>8.81%</b>
0.00	Drugs and Blood	0.00	(0.00)	(0.00)	0%	0.00	0.00	0.00	0%
(0.72)	Supplies and services - clinical	(0.06)	(0.03)	0.03	58.06%	(0.30)	(0.11)	0.19	64.78%
(3.80)	Other Expenses	(0.32)	(0.23)	0.09	28.02%	(1.58)	(1.16)	0.43	27.01%
<b>(4.52)</b>	<b>Total Non-Pay Expenses</b>	<b>(0.38)</b>	<b>(0.25)</b>	<b>0.12</b>	<b>32.78%</b>	<b>(1.88)</b>	<b>(1.26)</b>	<b>0.62</b>	<b>33.04%</b>
<b>1.51</b>	<b>Control total</b>	<b>0.13</b>	<b>(0.06)</b>	<b>(0.18)</b>	<b>(146.51%)</b>	<b>0.63</b>	<b>0.45</b>	<b>(0.18)</b>	<b>(28.82%)</b>



### Summary - Director for Research and Innovation

Overall, the Directorate is behind plan by (£0.18m) in M5 and is (£0.18m) behind plan YTD with a net contribution of £0.45m against a full year target of £1.51m

#### Income

The M5 income position is (£0.4m) behind plan in month and (£1.55m) behind plan YTD; main drivers are:

- Low non-commercial income, mainly due to various BRC funded external posts and pump priming projects yet to commence.
- Commercial income was below the previous quarter due to lower commercial activity. This is however is projected to improve later in the quarter with increase in various project milestones recognition.
- The overall non-commercial income is also low due to reduction of annual NIHR Research Capability Funding (RCF) by £0.13m.

#### Pay

The M5 pay position is £0.09m ahead of plan in month and £0.75m ahead of plan YTD, The main drivers are;

- End of several charity funded, NIHR and non-commercial projects.
- Several BRC funded posts yet to commence.

#### Non-Pay

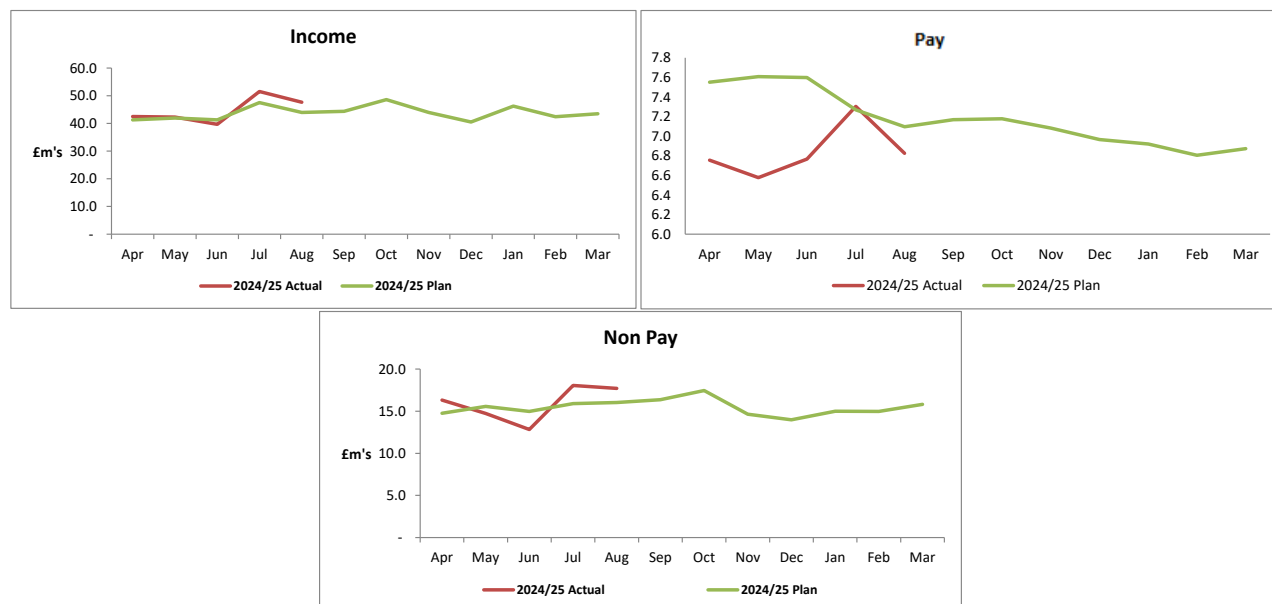
The M5 Non Pay position is £0.12m ahead of plan in month and £0.62m ahead of plan YTD. The main drivers are;

- Various pump priming project yet to start as well as receipt of a £0.2m credit note from ICH for underutilised Old BRC (2017-22) award.

# Corporate and Others Income and Expenditure Performance Summary for the 5 months ending 31 Aug 2024

Annual Plan	Income & Expenditure	2024/25				Year to Date			
		Month 5							
		Plan	Actual	Variance		Plan	Actual	Variance	
(£m)	Corporate and Others	(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%
514.30	NHS & Other Clinical Revenue	42.53	47.55	5.03	11.82%	214.55	223.44	8.89	4.14%
(0.00)	Private Patient Revenue	0.44	0.41	(0.03)	(7.64%)	(1.78)	0.41	2.19	123.04%
42.93	Non-Clinical Revenue	3.62	2.87	(0.75)	(20.73%)	16.43	14.93	(1.50)	(9.10%)
<b>557.22</b>	<b>Total Operating Revenue</b>	<b>46.60</b>	<b>50.84</b>	<b>4.24</b>	<b>9.10%</b>	<b>229.19</b>	<b>238.78</b>	<b>9.59</b>	<b>4.18%</b>
(69.82)	Permanent Staff	(5.67)	(7.57)	(1.90)	(33.44%)	(29.99)	(37.05)	(7.06)	(23.54%)
(4.84)	Agency Staff	(0.40)	(0.12)	0.28	70.47%	(2.02)	(1.12)	0.90	44.70%
(22.58)	Bank Staff	(1.96)	(0.36)	1.60	81.43%	(9.64)	(1.53)	8.11	84.10%
<b>(97.24)</b>	<b>Total Employee Expenses</b>	<b>(8.04)</b>	<b>(8.05)</b>	<b>(0.01)</b>	<b>(0.18%)</b>	<b>(41.65)</b>	<b>(39.70)</b>	<b>1.96</b>	<b>4.69%</b>
(105.73)	Drugs and Blood	(8.75)	(11.69)	(2.95)	(33.70%)	(44.12)	(49.37)	(5.25)	(11.89%)
(8.27)	Supplies and services - clinical	(0.81)	(1.13)	(0.32)	(38.85%)	(3.25)	(5.35)	(2.10)	(64.52%)
(79.49)	Other Expenses	(7.14)	(5.85)	1.29	18.04%	(33.20)	(29.29)	3.91	11.79%
<b>(193.49)</b>	<b>Total Non-Pay Expenses</b>	<b>(16.70)</b>	<b>(18.67)</b>	<b>(1.98)</b>	<b>(11.83%)</b>	<b>(80.58)</b>	<b>(84.01)</b>	<b>(3.43)</b>	<b>(4.26%)</b>
<b>266.49</b>	<b>EBITDA (exc Capital Donations)</b>	<b>21.87</b>	<b>24.12</b>	<b>2.25</b>	<b>10.29%</b>	<b>106.97</b>	<b>115.08</b>	<b>8.11</b>	<b>7.58%</b>
(21.30)	Owned depreciation, Interest and PDC	(1.77)	(1.72)	0.05	2.69%	(8.79)	(8.51)	0.27	3.11%
<b>245.19</b>	<b>Control Total</b>	<b>20.10</b>	<b>22.40</b>	<b>2.30</b>	<b>11.44%</b>	<b>98.18</b>	<b>106.56</b>	<b>8.39</b>	<b>8.54%</b>
(22.00)	Donated depreciation	(1.83)	(1.49)	0.35	18.96%	(9.17)	(7.47)	1.70	18.52%
<b>223.19</b>	<b>Net (Deficit)/Surplus (exc Cap. Don. &amp; Impairments)</b>	<b>18.26</b>	<b>20.91</b>	<b>2.65</b>	<b>14.49%</b>	<b>89.01</b>	<b>99.09</b>	<b>10.09</b>	<b>11.33%</b>

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



## Notes

### NHS & Other Clinical Income

- All NHS income has been centralised. NHS income is predominantly under a block contract. The trust is £9.59m favourable to plan YTD.

### Pay

- The pay position is £1.96m favourable to plan YTD due to phasing on annual plan and vacancies.

### Non-Pay

- Non pay is £3.43m adverse to plan YTD. This is due to phasing of annual plan.

# Statement of Financial Position as at 31 Aug 2024

Audited Actual as at 31 Mar 2024 £000		Actual as at 31 Jul 2024 £000	Actual as at 31 Aug 2024 £000	Change in month £000
	<b>Non Current Assets</b>			
569,832	Property, plant and equipment / Intangibles	573,174	573,946	772
69,976	Right of Use Assets (IFRS 16)	68,578	68,066	(512)
5	Other investments / financial assets	5	5	-
7,684	Trade and other receivables	6,761	6,721	(40)
<b>647,497</b>	<b>Total Non Current Assets</b>	<b>648,518</b>	<b>648,738</b>	<b>220</b>
	<b>Current Assets</b>			
13,293	Inventories	12,864	13,370	506
75,672	Contract receivables (IFRS15): invoiced)	73,346	72,816	(530)
17,381	Contract receivables (IFRS15): not yet invoiced)	25,122	25,417	295
(8,241)	Allowance for impaired contract receivables	(8,487)	(9,665)	(1,178)
6,836	Receivables due from NHS charities - capital	5,852	4,017	(1,835)
9,330	Other receivables - revenue	12,664	13,315	651
(152)	Allowance for impaired other receivables	(141)	(155)	(14)
6,122	Prepayments	8,762	8,431	(331)
1,579	VAT receivable	784	90	(694)
65,874	Cash and cash equivalents	63,913	61,123	(2,790)
<b>188,181</b>	<b>Total Current Assets</b>	<b>194,679</b>	<b>188,759</b>	<b>(5,920)</b>
<b>835,678</b>	<b>Total Assets</b>	<b>831,597</b>	<b>843,197</b>	<b>11,600</b>
	<b>Current Liabilities</b>			
(14,387)	Other trade payables - capital	(8,613)	(8,118)	495
(16,789)	NHS payables - revenue	(15,095)	(13,459)	1,636
(6,965)	Other trade payables - revenue	(23,852)	(15,898)	7,954
(5,657)	Other payables	(4,537)	(4,253)	284
(6,848)	Private Patient Cash on Account	(7,142)	(8,210)	(1,068)
(55,182)	Expenditure accruals	(45,874)	(48,313)	(2,439)
-	- PDC dividend payable	(2,153)	(2,813)	(660)
(4,529)	Social Security costs	(4,142)	(4,155)	(13)
(4,800)	Other taxes payable	(4,486)	(4,415)	71
-	- Vat Payable	-	-	-
(15,940)	Deferred income: contract liabilities (IFRS15)	(28,796)	(31,299)	(2,503)
-	- Lease incentives	-	-	-
(1,291)	Provisions for liabilities and charges	(2,184)	(2,184)	-
(3,217)	Borrowings	(3,217)	(3,217)	-
<b>(135,605)</b>	<b>Total Current Liabilities</b>	<b>(150,091)</b>	<b>(146,334)</b>	<b>3,757</b>
<b>52,576</b>	<b>Net Current Assets</b>	<b>44,588</b>	<b>42,425</b>	<b>(2,163)</b>
<b>700,073</b>	<b>Total Assets Less Current Liabilities</b>	<b>693,106</b>	<b>691,163</b>	<b>(1,943)</b>
	<b>Non Current Liabilities</b>			
(25,006)	Borrowings	(24,890)	(24,647)	243
(2,127)	Deferred income: NCL	(1,994)	(1,960)	34
(2,616)	Provisions for liabilities and charges NCL	(2,583)	(2,574)	9
<b>(29,749)</b>	<b>Total Non Current Liabilities</b>	<b>(29,467)</b>	<b>(29,181)</b>	<b>286</b>
<b>670,324</b>	<b>Total Assets Employed</b>	<b>663,639</b>	<b>661,982</b>	<b>(1,657)</b>
	<b>Financed by Taxpayers' Equity</b>			
134,183	Public dividend capital	134,183	134,183	-
362,628	Retained earnings	355,943	354,286	(1,657)
(160)	Financial Asset reserve	(160)	(160)	-
173,673	Revaluation reserve	173,673	173,673	-
<b>670,324</b>	<b>Total Taxpayers' Equity</b>	<b>663,639</b>	<b>661,982</b>	<b>(1,657)</b>

## Notes

Current assets excluding cash at 31 August totalled £127.6m, £3.1m lower in month).

This is largely due to the following:

- Accrued Income (increased by £0.3m in month to £25.4m).
- Charity Capital receivables (decreased by £1.8m in month to £4.0m).
- Invoiced debtors (decreased by £1.7m to £72.8m).
- Other receivables (decreased by £0.4m in month to £21.8m)
- Inventories (increased by £0.5m in month).

Current Liabilities at 31 August totalled £146.3m, which is £3.7m lower than the previous month. The movement in month includes the following:

- Capital payables decreased by £0.5m in month.
- Deferred income increased by £2.5 in month to £31.3m.
- Expenditure accruals increased by £2.4m in month.
- NHS payables decreased by £1.6m in month).
- Other payables decreased by £6.5m. Invoices which became overdue at the previous month end in relation to Information Technology; pharmacy drugs and non NHS tests were settled in month.

- The Property, Plant and Equipment (PPE) and Intangibles and ROU balance increased by £0.3m in month, due to capital expenditure of £3.1m, less depreciation and amortisation of £2.8m.
- NHS debtor days remained the same as the previous month at 4 days and this falls within target of 30 days.
- I&PC debtors days decreased in month from 240 to 232 days. Total I&PC debt (net of cash deposits held) increased in month to £53.2m (£52.4m in M4). Overdue debt also increased in month to £37.2m (£36.4m in M4).
- Creditor days decreased in month from 48 to 33 days.
- Non-Drug inventory days increased in month from 88 to 91 days.

# Statement of Cash Flows for the 5 months ending 31 Aug 2024

	Actual For YTD Ending 31 Mar 2024 £000	Actual For YTD Ending 31 Jul 2024 £000	Actual For YTD Ending 31 Aug 2024 £000	Change in month £000
<b><u>Cash flows from operating activities</u></b>				
Operating deficit - excluding charitable capital expenditure contributions	(23,545)	(8,467)	(9,690)	(1,223)
Impairment and Reversals	(7,812)	0	0	0
Charitable capital expenditure contributions	22,416	3,343	3,312	(31)
<b>Operating deficit</b>	<b>(8,941)</b>	<b>(5,124)</b>	<b>(6,378)</b>	<b>(1,254)</b>
<b><u>Non-cash income and expense</u></b>				
Depreciation and amortisation	42,827	11,216	14,026	2,809
Impairments and Reversals	7,812	0	0	0
Proceeds on disposal	29	0	0	0
Increase in trade and other receivables	(12,781)	(8,452)	(4,776)	3,676
(Increase)/decrease in inventories	(997)	429	(77)	(506)
(Decrease)/increase in trade and other payables	(780)	4,358	(2,072)	(6,430)
Increase in other current liabilities	4,260	12,724	15,193	2,469
(Decrease)/increase in provisions	(301)	860	851	(9)
<b>Net cash inflow from operating activities</b>	<b>40,069</b>	<b>21,135</b>	<b>23,145</b>	<b>2,009</b>
<b><u>Cash flows from investing activities</u></b>				
Interest received	4,236	1,153	1,439	286
Purchase of financial assets	0	0	0	0
Purchase of property, plant and equipment and Intangibles	(40,296)	(18,349)	(21,914)	(3,565)
	<b>(36,060)</b>	<b>(17,196)</b>	<b>(20,475)</b>	<b>(3,279)</b>
<b><u>Cash flows from financing activities</u></b>				
Public Dividend Capital received	352	0	0	0
PDC dividend paid	(9,199)	0	0	0
Capital element of lease payment	(2,192)	(701)	(944)	(243)
Interest element of lease payment	(325)	(76)	(99)	(23)
<b>Net cash outflows from financing activities</b>	<b>(11,364)</b>	<b>(777)</b>	<b>(1,043)</b>	<b>(266)</b>
<b>Decrease in cash and cash equivalents</b>	<b>(16,297)</b>	<b>(1,961)</b>	<b>(4,751)</b>	<b>(2,789)</b>
<b>Cash and cash equivalents at period start</b>	<b>82,171</b>	<b>65,874</b>	<b>65,874</b>	<b>0</b>
<b>Cash and cash equivalents at period end</b>	<b>65,874</b>	<b>63,913</b>	<b>61,123</b>	<b>(2,789)</b>

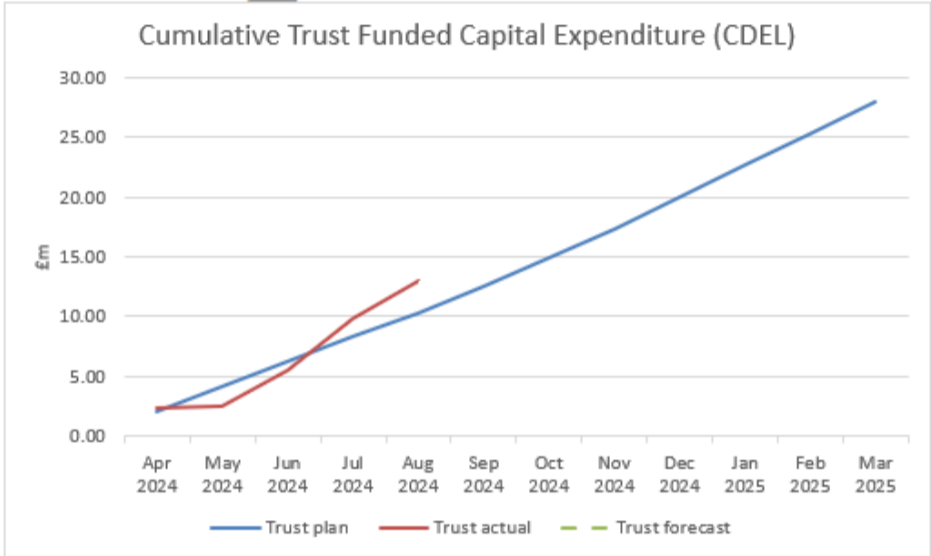
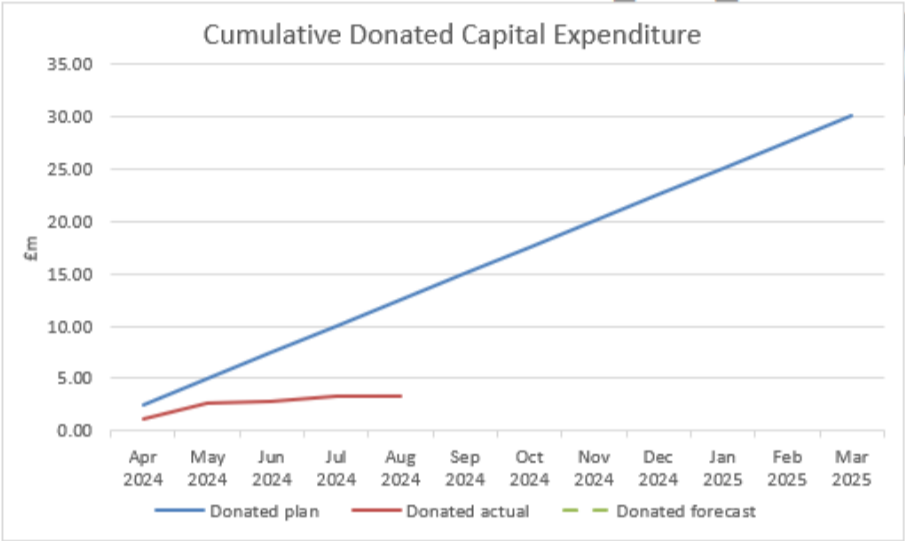
## Notes

- Cash held by the Trust totalled £61.1m decreasing in month by £2.8m.
- Depreciation charge on Trust funded PPE, Intangibles, and ROU assets for the year to date was £6.6m, and £7.5m for donated assets for the year.
- In M05, 82% of the total value of creditor invoices were settled within 30 days of receipt; this represented 72% of the total number of creditor invoices paid in month. The percentage of invoices paid in both categories (value and number) is below the NHSE target of settling at least 95% of invoices within 30 days.
- By supplier category, the cumulative BPPC for Non NHS invoices (by number) was 72% (75% in M5). This represented 84% of the total value of invoices settled within 30 days (85% in M4). The cumulative BPPC for NHS invoices (by number) was 53% (52% in M4). This represented 56% of the value of invoices settled within 30 days (58% in M4).

Funding		Plan £000	Plan £000	YTD Actual £000	Variance £000	Notes
Trust Funded - CDEL	CCC	7,500	3,085	3,890	(805)	A
	Medical Equipment	6,989	2,453	2,728	(275)	
	Property & Plant	11,558	2,212	4,151	(1,939)	
	Information Technology & Intangibles	4,712	2,535	2,135	400	
Total Trust Funded - CDEL		30,759	10,285	12,905	(2,620)	
Total - PDC	ICT	72	30	13	17	
Donated / Grant Funded	CCC	27,890	11,621	3,058	8,562	B
	ICT	-	-	4	(4)	
	Medical Equipment	2,275	948	250	698	
Total Donated/Grant Funded		30,165	12,569	3,312	9,257	
GRAND TOTAL		60,996	22,884	16,230	6,654	

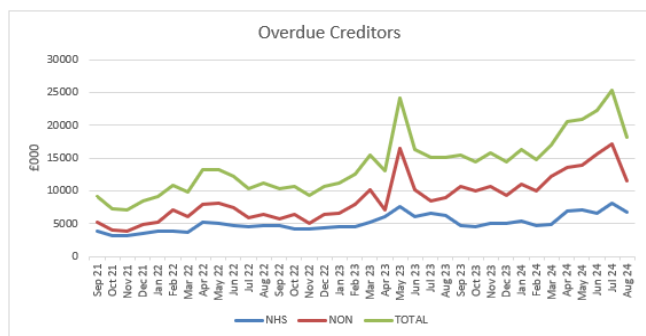
Notes on YTD variance

A	The CDEL capital programme is ahead of plan at month 5. The key drivers for this are: - A number of schemes, particularly those in Property & Plant, have proceeded more quickly than expected. - The Medical Equipment expenditure includes costs in relation to an MRI scanner £1.3m (recognised in July 24) as the equipment came on site and Medical Equipment orders raised at the end of last financial year, again with the equipment being received at the beginning of 2024/25. - The CCC programme expenditure was £1.5m in August 24, all of this was funded by Trust capital funds.
B	Majority of Donated expenditure relates to the GOSHCC contribution towards the Childrens Cancer Centre.



31 Mar 2024 Audited Accounts £m	Capital Expenditure	Full Year Plan 2024-25 £m	YTD Plan Aug 2024 £m	YTD Actual Aug 2024 £m	YTD Variance £m	RAG YTD variance
7.90	CCC	7.50	3.09	3.89	(0.81)	R
6.02	Medical Equipment	6.99	2.45	2.73	(0.27)	R
5.72	Property & Plant	11.56	2.21	4.15	(1.94)	R
6.60	Information, Technology & Intangibles	4.71	2.54	2.14	0.40	G
26.24	Total Trust Funded	30.76	10.29	12.90	(2.62)	R
0.35	PDC	0.07	0.03	0.01	0.02	G
19.77	CCC	27.89	11.62	3.06	8.56	G
1.10	Property & Plant	0.00	0.00	0.00	(0.00)	G
1.54	Medical Equipment	2.28	0.95	0.25	0.70	A
22.42	Total Donated and Grant funded	30.17	12.57	3.31	9.26	G
49.01	Total Expenditure	61.00	22.88	16.23	6.65	G

## Overdue Debtors and Creditors as at 31 Aug 2024

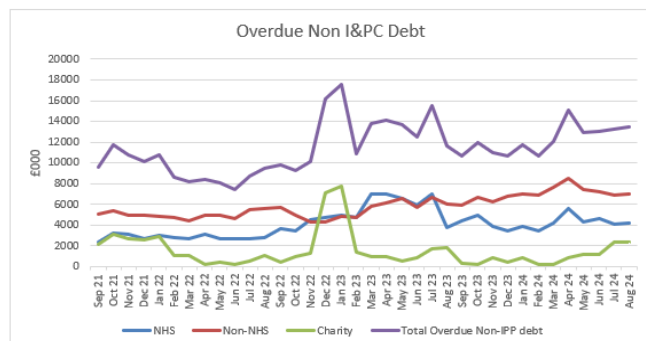


### Overdue Creditors

Overdue creditors totalled £18.2m at 31 August 2024 (£25.2m in M4). This is made up of amounts due to NHS organisations which totalled £6.7m (£8.1m in M4) and Non NHS organisations of £11.5m (£17.1m in M4).

Overdue Non NHS creditors decreased by £5.6m since the previous month. The decrease largely includes settlement of invoices relating to Information technology and Pharmacy purchases which were included in the previous month end overdue totals.

The 3 largest overdue balances with non NHS suppliers total £4.2m (which largely relates to research and staff recharges; Information Technology related expenditure and other NHS Clinical recharges).



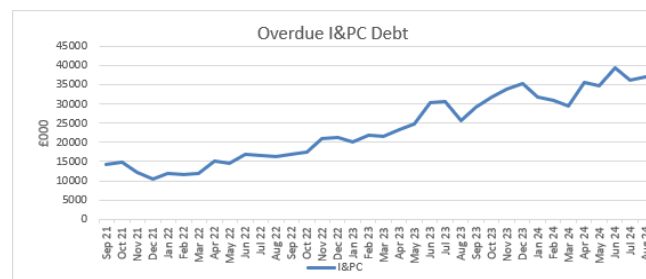
### Overdue Non-I&PC Debt

Non-I&PC overdue debt totalled £13.5m at 31 August 2024 (£13.3m in M4); of this total £4.2m related to NHS (£4.1m in M4), £7.0m related to Non-NHS (£6.9m in M4) and £2.3m related to GOSHCC (£2.3m in M4).

Overdue NHS debtors increased by £0.1m in month. Barts Health currently has the largest overdue balance (£0.9m) followed by Guy's and St Thomas' (£0.3m).

Overdue non-NHS debtors increased by £0.1m in month. Customer invoices relating to other Non NHS activity (such as fellowship and other training) became overdue in month.

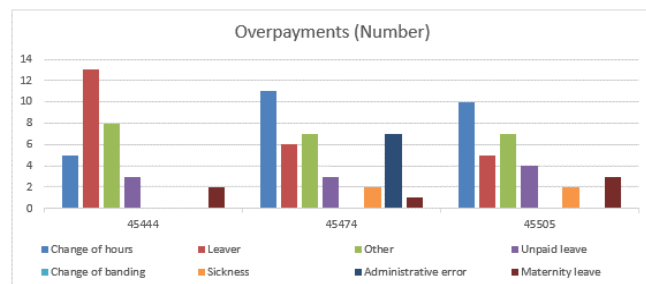
Overdue debt with GOSH Charity is £2.3m (£2.3m at M4).



### Overdue I&PC Debt

Overdue I&PC debt was £37.1m at 31 August 2024 (£36.4m in M04). Overdue Embassy debt totals £32.4m (£31.6m in M4). This category includes the debtor with the largest overdue balance £21.8m (£22.6m in M4).

The total overdue debt due from IPP other is £0.4m (£0.5m in M4); Insurance companies is £3.6m (£3.6m in M4); and Self funded customers is £0.7m (£0.7m in M4).



### Notes

There were 34 overpayments identified in month (37 in M4). Of this total, The Trust has already recovered the full overpayment value from 17 individuals (which totalled £6k); recovery plans have been agreed with 11 individuals; and 3 of these are under query.

The overpayments in month totalled £76k (£113k in M4).

The largest individual overpayment occurred as a result of payments made whilst staff was on unpaid sick leave, which totalled £35k.

In addition, 1 other overpayment related to the same reason (late notification of unpaid sickness dates, which totalled £4k). 10 further overpayments related late notification of change of hours/sessions (which totalled £11k); 6 related to late notification of leaving dates (£14k); and 4 related to late notification of unpaid leave (£11k).

There were also 7 overpayments which related to other reasons such as incorrect bank holiday enhancement rates, incorrect spine point and travel allowances (which totalled £2k).

\*Due to change in payroll provider, salary overpayments will be a month in arrears

## Discretionary Costs Summary for the 5 months ending 31 Aug 2024

### Summary

Attached are three tables that show the areas of discretionary spend that have been spent by the Trust YTD in 2024/25.

- **Table 1** - shows the main discretionary spend categories across the Trust and the spend so far YTD. "Subscriptions" and "Course Fees" make up the two largest areas of spend across the Trust
- **Table 2** - shows a breakdown of "Subscriptions" by directorate with "Medical Director" and "HR & Organisational Development" directorates being the main areas of spend. *(Note - In M05 there was an accrual for the University College London Library Subscription which was dropped, as invoice seemed to have been received in previous months - resulting in a credit in month.)*
- **Table 3** - shows the breakdown of "Course Fees" by directorate. It shows the main areas of spend are within "Nursing And Patient Experience" and "Core Clinical Services".

**Table 1**  
**Discretionary Spend (£000)**

Expenditure Type	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Total	Full Year Run Rate	Annual Budget
Subscriptions	118	70	101	285	(82)								492	1,181	932
Course Fees	13	96	105	128	94								436	1,046	1,835
Other Professional Expenses	101	96	13	131	60								401	962	1,941
Travel (Non-patient)	101	(15)	107	73	82								348	835	1,614
Printing and Stationery	63	12	17	12	63								167	401	317
Postage and Delivery	31	26	32	26	38								153	367	314
Advertising	21	23	18	46	18								126	302	293
Telephones	6	23	1	60	4								94	226	90
Hotel costs (Non-patient)	(3)	4	5	1	38								45	108	614
Consultancy Fees	23	(33)	94	(83)	24								25	60	209
Subsistence	(1)	5	6	6	(2)								14	34	50
<b>Total</b>	<b>473</b>	<b>307</b>	<b>499</b>	<b>685</b>	<b>337</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>2,301</b>	<b>5,522</b>	<b>8,209</b>

**Table 2**  
**Subscriptions (£000)**

Division	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Total	Full Year Run Rate	Number of approvers
Medical Director	42	24	33	140	(66)								173	2,076	18
Hr & Organisational Development	21	21	23	20	21								106	1,272	15
Nursing And Patient Experience	36	15	31	104	(106)								80	960	26
Finance	17	6	6	7	39								75	900	8
Corporate Affairs	0	8	5	5	26								44	528	5
Core Clinical Services	0	0	0	3	2								5	60	106
Brain	0	1	2	1	1								5	60	22
Body Bones & Mind	0	0	(3)	6	0								3	36	37
Blood Cells & Cancer	0	0	1	0	2								3	36	21
Space And Place	(1)	2	0	0	0								1	12	21
Nt Genomic Medicine Service	0	0	0	0	0								0	0	6
Heart & Lung	0	0	0	0	0								0	0	36
International And Private Care	0	0	0	0	0								0	0	22
Ict	3	(6)	0	0	0								(3)	(36)	7
<b>Grand Total</b>	<b>118</b>	<b>71</b>	<b>98</b>	<b>286</b>	<b>(81)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>492</b>	<b>5,904</b>	<b>350</b>

**Table 3**  
**Course Fees (£000)**

Division	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Total	Full Year Run Rate	Number of approvers
Nursing And Patient Experience	(58)	39	17	42	47								87	1,044	26
Core Clinical Services	2	16	15	18	16								67	804	106
Research And Innovation	(1)	11	55	(12)	10								63	756	130
Medical Director	18	(15)	2	25	5								35	420	18
ICT	4	14	11	4	(4)								29	348	7
Nt Genomic Medicine Service	11	0	1	6	7								25	300	6
Clinical & Medical Operations	11	2	0	0	11								24	288	12
HR & Organisational Development	2	8	(2)	10	6								24	288	15
Blood Cells & Cancer	4	2	(1)	16	(3)								18	216	21
Corporate Affairs	2	12	1	0	2								17	204	5
Finance	6	2	2	11	(5)								16	192	8
Space And Place	11	(1)	1	(2)	6								15	180	21
Body Bones & Mind	3	5	1	3	(2)								10	120	37
Brain	0	3	0	2	0								5	60	22
Innovation	0	0	3	0	0								3	36	6
Transformation	0	3	0	0	0								3	36	6
Sight & Sound	2	0	0	2	(1)								3	36	30
Genetics	0	0	0	0	0								0	0	11
International And Private Care	0	0	0	0	0								0	0	22
Central Expenditure	0	0	0	0	0								0	0	6
Heart & Lung	(3)	(4)	0	0	(1)								(8)	(96)	36
<b>Grand Total</b>	<b>14</b>	<b>97</b>	<b>106</b>	<b>125</b>	<b>94</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>436</b>	<b>5,232</b>	<b>551</b>

## Purchase Orders for the 5 months ending 31 Aug 2024

### Summary

Attached are two tables that show purchase orders and invoice analysis that has been spent by the Trust YTD in 2024/25.

- **Table 4** - A summary of the purchase orders raised and numbers raised after the invoice was raised by directorate
- **Table 5** - A summary of unpaid invoices received relating to unreceipted purchase orders

**Table 4**

Directorate	Total PO £	No of PO related invoices	No of POs raised after invoice date	% POs raised after invoice date
Blood Cells & Cancer	1,116,618	95	11	12%
Core Clinical Services	390,822	175	137	78%
International And Private Care	56,966	59	11	19%
Sight & Sound	47,747	25	23	92%
Heart & Lung	51,817	42	39	93%
Brain	19,057	14	12	86%
Genetics				
Body Bones & Mind	4,382	4	4	100%
<b>Subtotal</b>	<b>1,687,409</b>	<b>414</b>	<b>237</b>	<b>57%</b>
Space And Place	1,386,165	297	223	75%
Transformation	2,004,042	67	59	88%
Finance	328,547	8	8	100%
HR & Organisational Developmen	110,080	36	36	100%
Innovation	99,871	4	4	100%
Nursing And Patient Experience	90,854	41	37	90%
Medical Director	131,839	29	27	93%
Research And Innovation	110,649	57	42	74%
ICT	190,444	6	5	83%
Corporate Affairs	33,575	10	9	90%
Clinical & Medical Operations	60,186	12	10	83%
Capital Cost Collection	829,644	49	37	76%
Genomics	46,070	12	12	100%
<b>Subtotal</b>	<b>5,421,966</b>	<b>628</b>	<b>509</b>	<b>81%</b>
<b>Grand total</b>	<b>7,109,375</b>	<b>1,042</b>	<b>746</b>	<b>72%</b>

**Table 5**

Directorate	Invoice Value £000	Count of Invoice No
Core Clinical Services	397	306
Brain	253	88
Heart & Lung	224	81
Research And Innovation	150	25
Sight & Sound	115	94
Body Bones & Mind	87	77
Blood Cells & Cancer	65	53
International And Private Care	32	35
<b>Sub Total - Clinical</b>	<b>1,323</b>	<b>759</b>
Capital Cost Collection	857	78
Space And Place	325	89
Genomics	293	36
Innovation	113	61
Nursing And Patient Experience	74	189
ICT	63	15
Finance	59	7
Transformation	46	1
HR & Organisational Developmen	30	6
Corporate Affairs	17	2
Medical Director	3	13
Balance Sheet	3	2
<b>Sub Total - Corporate</b>	<b>1,883</b>	<b>499</b>
<b>Total</b>	<b>3,206</b>	<b>1,258</b>

## **Summary of the Quality, Safety and Experience Assurance Committee meeting held on 5 September 2024**

### **Matters arising**

The Committee discussed reporting from the Ethics Committee and noted that the team was meeting with the Chief Medical Officer on a fortnightly basis and was working towards developing a strategy. It was agreed that an update on the plan that had been developed would be provided at the next QSEAC meeting.

### **Quality and Patient Experience: Chief Nurse Report**

There had been an increase in complaints in International and Private Care around billing and play-rooms which had been closed due to an increase in infections. Work was taking place to improve in-room play. No themes had been identified from triangulation of complaints, PALS contacts and Friends and Family Test feedback or incidents. Focus was being placed on improving the timeframe for responding to complaints.

The safeguarding team was working to improve level 3 training to ensure that there was a trajectory to maintain compliance going forward. Discussion took place around the work that was being undertaken as a result of an increase in referrals for people in a position of trust and staff experiencing personal difficulties. Substantial work was taking place to promote safe workplaces and highlight the importance of reporting concerns and the committee requested benchmarking data around reporting.

Changes had been made in the infection prevention and control team to the way Root Cause Analyses were carried out as a result of the introduction of the Patient Safety Incident Response Framework (PSIRF) which had led to earlier discussions which fewer delays. There had been challenges around the increase in cases of pertussis and measles in the community and the increase in patients with pertussis in particular. Focus was being placed on staff vaccination through occupational health. The committee welcomed the improvements that had been made in team working between the IP&C and estates teams.

### **Updated Action Plan from the Independent Review by NICHE of the AVH Case**

Work continued on the recommendations arising from the report which had been broad. So far 90% of actions were complete. Outstanding work included an action on national work with NHS England about fungal management which was being discussed. Work was taking place to bring aspergillus testing on site to avoid delays.

### **GOSH Patient Safety Response to the Infected Blood Inquiry Report – August 2024**

Of the twelve recommendations made in the report four were directly applicable to GOSH. A broad recommendation had been made around learning and a recommendation had also been made about Duty of Candour. The key work for GOSH was around practice for blood transfusions and work had begun to implement actions for each area of the recommendation. A recommendation had been made around patient voice and GOSH was a pilot site for the introduction of Martha's Rule.

### **Quality and Safety at GOSH: Chief Medical Officer Report**

There had been a significant increase in the number of claims received which was in line with the experience of other Trusts. No themes had been identified and the specialties involved in the claims were spread throughout the hospital.

The Trust had identified an early signal of an increase in risk adjusted mortality and a review had been undertaken by a consultant which had identified process errors which had contributed to a score which would

have been an ineffective indicator of predicted mortality. Work was taking place with PICANET to correct this process and the team was assured that there was no increased mortality and PICANET agreed with this position.

The Patient Safety Incident Response Framework had now been in place for six months and seven investigations had been completed in that time. Focus was being placed on demonstrating that learning was being implemented.

- Focus on Safety

There were risks around two coronial cases in which Preventing Future Deaths (PFD) notices could be issued and further information was being provided to the coroner. The Committee discussed the significant increase in claims that had been received by the legal team who were also managing a number of high court applications; a business case was being developed to recruit an additional team member to support this increase in activity.

### **Proposed Epic Thrive Programme Update**

The Committee noted that a theme of complaints and PALS contacts was around communication and therefore it was important to ensure that processes were standardised to improve patient experience and timeliness of care. Work would take place to improve the quality of workflow and the system was able to identify the way it was being used and tailor training accordingly. Learning had taken place from organisations in the US which had enabled GOSH to consider increased functionality.

### **Bed management at GOSH**

Focus was being placed on ensuring that outlying patients who were on a ward which was not within their main specialty remained safe. SNAPS was a key specialty in this regard and a capacity and demand analysis had shown that approximately six additional beds were required. Four additional beds were being opened and work was taking place to ensure that lower risk patients were outliers.

### **Update from PEAC – July 2024**

The Committee noted the update from the July PEAC meeting.

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

All risks had been updated by risk owners and discussion had taken place around the risk appetite for the estate's compliance risk. Given the complex estate it was not anticipated that the Trust would reach the risk appetite of 'averse' and therefore a proposal to move to a 'minimal' risk appetite would be discussed by the Audit Committee. The group had also discussed the risk appetite for medicines management and highlighted that different aspects of the risk were likely to have different appetites. Discussion would take place with the Chief Pharmacist.

### **NHS Children and Young People's Gender Service (London) End of Quarter One Quality and Performance Update**

The Committee welcomed the excellent patient experience results which had been received by the service following its launch in April 2024. Focus had been placed on identifying a permanent estate and recruitment and the service and appointments had been made to 80% of posts including 75% of clinical posts which was very positive. Data collection and research was a priority for the service.

### **Internal Audit Update on progress with quality related IA recommendations**

GOSH had five overdue internal audit recommendations related to the same review and it had been agreed that an action plan would be developed to move the recommendations forward.

**Update on access to Palliative Care at GOSH**

GOSH's Palliative Care Team was one of the biggest in Europe and access was dependent on referral criteria as well as staff awareness of the service and families' willingness to be referred. Discussion took place around families' wishes for patients to die in hospital, which was increasing, and the impact this had on staff. It was important to ensure that more senior staff were able to support junior staff, particularly in nursing.

**What went well/ could be better in the meeting**

The Committee agreed that further consideration was required around the balance between detailed information and assurance in papers.

**Governor Feedback**

Governors reported that they felt assured that extremely complex issues were being thoroughly discussed.

Trust Board 24 October 2024	
<b>Update on the Board Assurance Framework</b>  <b>Submitted by:</b> Anna Ferrant, Company Secretary	<b>Paper No: Attachment S</b>
<p>The purpose of this paper is to provide an update on the Board Assurance Framework (BAF) and to remind Board members of the status of the Trust's strategic risks. A summary of all risks is presented at <b>Appendix 1</b>.</p> <p>The Risk Assurance and Compliance Group (RACG), chaired by the Chief Executive, monitors the BAF monthly, reporting to the Audit Committee, Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee.</p> <p>The Audit Committee considered recommendations from the RACG at its meeting in October 2024 as outlined below.</p> <p><u>BAF Risk 9. Estates Compliance (Net score 4 x 4) (Risk Appetite Averse (2-5))</u></p> <p><b>Recommendation to Trust Board:</b> An 'Averse' risk appetite means avoidance of risk and uncertainty and taking activities that will only be considered to carry virtually no inherent risk. The Audit Committee noted that work was ongoing to consider the appropriateness of the initial assessment of risk appetite for each of the BAF risks. The Committee discussed the current 'Averse' risk appetite for the estates risk and agreed that context to setting the risk appetite was key and that in this case, the complexity and age of the estate meant that a risk appetite of 'minimal' (6-11) would be more appropriate. The Committee sought assurance that this change did not diminish management's continuous approach to ensuring the estate is safe at all times and this was confirmed.</p> <p>As directed by the Audit Committee, the RACG has been reviewing the use of KPIs against each of the BAF risks as a proxy to understand whether the controls are working/ delivering mitigations. Work will continue to determine how best to collate and apply these KPIs. In addition, work continues piloting the <i>Path to Green Assurance</i> – an approach for considering the gaps and actions cited under the BAF risks and determining how these actions will bring the BAF net risk score down to the risk tolerance levels (and by when).</p>	
<b>Action required from the meeting</b> Board members are asked to note the update to the BAF and approve the recommended change to the Estates and Facilities BAF risk.	
<b>Financial implications</b> None	
<b>Legal issues</b> None	
<b>Who is responsible for implementing the proposals / project and anticipated timescales</b> Risk Owners	
<b>Who is accountable for the implementation of the proposal / project</b> N/A	

## Great Ormond Street Hospital for Children NHS Foundation Trust: Board Assurance Framework (11 October 2024)

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite/ Risk Tolerance Score	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
					L x C	T	L x C	T							
1	Financial Sustainability	<b>Principle 4: Financial Strength</b>		Failure to continue to be financially sustainable	5 x 5	25	4 x 5	20	Cautious/ 12-15	1-2 years	Chief Finance Officer	<b>Acting Chief Finance Officer</b>	22/08/2024	Finance and Investment Committee/ Audit Committee	June 2024 – Annual Accounts
2	Workforce Sustainability	<b>Principle 3: Safety and quality</b>	<b>Priority 1: Make GOSH a great place to work</b>	Failure to attract, support and develop a sustainable and highly skilled workforce.	4 x 4	16	3 x 4	12	Cautious/ 12-15	1-2 years	Director of HR and OD	<b>Associate Director of HR and OD/ Director of HR and OD</b>	19/08/2024	People and Education Assurance Committee	February 2024
3	Operational Performance	<b>Principle 3: Safety and quality</b>	<b>Priority 2: Deliver a Future Hospital Programme / Priority 3: Improve and speed up access to urgent care and virtual services</b>	Failure of our systems and processes to deliver efficient and effective care that meets patient/carer expectations and supports retention of NHS statutory requirements and the FT licence.	4 x 5	20	3 x 5	15	Minimal/ 6-11	1 year	Chief Operating Officer	<b>Chief Data Officer</b>	09/08/2024	Audit Committee/ QSEAC	February 2024 (QSEAC)
4	Integrated Care System	<b>All Strategy Principles</b>	<b>All priorities</b>	Whilst participating fully in the North Central London Integrated Care System, there is a risk of erosion of the Trust's ability to maintain highly specialised services for patients nationally and internationally and deliver its strategy 'Above and Beyond' because of NHS system complexity, localised delivery of healthcare and an evolving statutory environment.	4 x 4	16	3 x 4	12	Cautious/ 12-15	5-10 years	Chief Executive	<b>Company Secretary</b>	20/08/2024	Audit Committee	June 2024
5	Unreliable Data	<b>Principle 3: Safety and quality</b>	<b>Priority 2: Deliver a Future Hospital Programme</b>	Failure to establish an effective data management framework	4 x 4	16	4 x 3	12	Minimal/ 6-11	1-2 years	Chief Operating Officer	<b>Chief Data Officer</b>	09/08/2024	Audit Committee	March 2024
6	<a href="#">Research</a> infrastructure	<b>Principle 3: Safety and quality/ Principle 4: Financial Strength</b>	<b>Priority 5: Accelerate translational research and innovation to save an improve lives</b>	The risk that the Trust is unable to accelerate and grow research and innovation to achieve its full Research Hospital vision due to not having the necessary research infrastructure.	3 x 5	15	2x 4	8	Minimal/ 6-11	1-2 years	Director, Research & Innovation	<b>Director of R&amp;I</b>	21/08/2024	Audit Committee	February 2024 Trust Board
7	Cyber Security	<b>Principle 3: Safety and quality</b>	<b>Priority 2: Deliver a Future Hospital Programme</b>	The risk that the technical infrastructure at the Trust (devices, services, networks etc.) is compromised via electronic means.	5 x 5	25	3 x 5	15	Averse/ 2-5	1-2 years	Chief Operating Officer	<b>Chief Information Officer</b>	11/10/2024	Audit Committee	October 2024
8	Business Continuity	<b>Principle 3: Safety and quality/ Principle 5: Protecting the Environment</b>	<b>Priority 2: Deliver a Future Hospital Programme</b>	The trust is unable to deliver normal services and critical functions caused by unexpected events; external challenges (global/ social/ political/ technological/ environmental) and/ or inadequate business continuity planning. Impact: An adverse effect on the trust's operational performance and continuity of delivery of safe, effective care.	4 x 5	20	4 x 3	12	Minimal/ 6-11	1-2 years	Chief Operating Officer	<b>Emergency Planning Officer/ Chief Operating Officer</b>	21/08/2024	Audit Committee	June 2024

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No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite/ Risk Tolerance Score	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
					L x C	T	L x C	T							
9	Estates Compliance	<b>Principle 3: Safety and quality</b>	<b>Priority 2: Deliver a Future Hospital Programme</b>	Inadequate maintenance of the estate affects the safety of the environment in which care is delivered by staff to patients and carers.	5 x 4	20	4 x 4	16	Averse/ 2-5	1 year	Interim Director of Space and Place	<b>Interim Director of Space and Place</b>	20/08/2024	Audit Committee/ QSEAC	May 2024 QSEAC
10	Climate Emergency	<b>Principle 5: Protecting the Environment</b>	<b>All priorities</b>	The Trust fails to deliver against its commitment to deliver a net zero carbon footprint, which is fundamental to deliver the Trust's Climate and Health Emergency declaration (by 2040 for the emissions the Trust controls <u>and</u> influences).	5 x 4	20	4 x 4	16	Minimal/ 6-11	1-5 years	Interim Director of Space and Place	<b>Interim Director of Space and Place</b>	22/08/2024	Audit Committee	October 2024
11	Medicines Management	<b>Principle 3: Safety and quality</b>	<b>Priority 2: Deliver a Future Hospital Programme</b>	Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.	5 x 5	25	3 x 5	15	Averse/ 2-5	1-2 years	Chief Operating Officer	<b>Chief Pharmacist</b>	21/08/2024	Quality, Safety and Experience Assurance Committee	February 2024
12	<a href="#">Inconsistent</a> delivery of safe care	<b>Principle 3: Safety and quality</b>	<b>Priority 2: Deliver a Future Hospital Programme</b>	BAF Risk 12: Risk of (severe/serious) patient harm arising from a failure to follow safety standards, foster a culture of openness and transparency, and use data to support improvement: <ul style="list-style-type: none"> <li>Patients are not consistently cared for within a comprehensive safety system which ensures they are protected from avoidable harm through compliance with regulatory standard</li> <li>The organisation does not consistently focus on openness, transparency and learning when things go wrong, or use the opportunity to learn from when things go well.</li> <li>The organisation does not use its own safety performance data as a tool to guide improvement, interventions or actions, training and learning</li> </ul>	4 x 4	16	3 x 4	12	Averse/ 2-5	1-2 years	Medical Director	<b>Chief Medical Officer</b>	20/08/2024	Quality, Safety and Experience Assurance Committee	Reports on quality of services at every Board and QSEAC
13	Mental Health Strategy	<b>Principle 3: Safety and quality</b>	<b>Priority 2: Deliver a Future Hospital Programme</b>	A lack of strategic focus on the delivery of mental health services at GOSH contributes to inequitable access to safe, effective care for children and young people with psychological needs.	4 x 4	16	3 x 4	12	Averse/ 2-5	1 -2 years	Chief Nurse	<b>Chief Nurse</b>	20/08/2024	Quality, Safety and Experience Assurance Committee	May 2024
14	Culture	<b>Principle 2: Values led culture</b>	<b>Priority 1: Make GOSH a great place to work</b>	There is a risk that GOSH fails to develop a culture where our people feel well led, well managed and are supported, developed and empowered to be their best	4 x 4	16	3 x 4	12	Averse/ 2-5	1-5 years	Chief Executive	<b>Director of HR and OD</b>	19/08/2024	Trust Board/ People and Education Assurance Committee	September 2024 (Board)
15	<a href="#">Cancer Centre</a>	<b>All Strategy Principles</b>	<b>Priority 6: Create a Children's Cancer Centre to offer holistic, personalised and coordinated care</b>	Failure to deliver a modern Cancer Service at GOSH supported by development of a new Children's Cancer Centre that provides holistic, personalised and coordinated care. This risk incorporates the following: <ul style="list-style-type: none"> <li>Transformational programme is not delivered to plan and on time and does not: <ul style="list-style-type: none"> <li>deliver holistic, personalised, and coordinated care.</li> <li>meet expectations for an enhanced patient experience.</li> <li>Deliver agreed sustainability targets.</li> </ul> </li> </ul>	4 x 4	16	3 x 4	12	Averse/ 2-5	1-5 years	Interim Director of Space and Place	<b>Interim Director of Space and Place/ Children's Cancer Centre Delivery Director</b>	22/08/2024	Finance and Investment Committee	May 2024 TB June 2024 FIC

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					L x C	T	L x C	T							
				<ul style="list-style-type: none"> <li>GOSH Charity Fundraising target not achieved/ Trust financial position worsens (BAF Risk 1: Financial Sustainability)</li> <li>Decant of the site is delayed with a subsequent delay to works commencing.</li> <li>Risk of redevelopment timetable slipping with associated operational and financial impact.</li> <li>Risk that the demand and capacity modelling is not realised and/or changes over time.</li> <li>Changes in clinical brief required to maintain Works Cost Limit or additional funds required to fund an increase over and above budget (including inflation pressures).</li> </ul> <p>Risk of time elapsing and the building remaining relevant and fit for purpose.</p>											
16	GOSH Learning Academy	<b>Principle 2: Values led culture / Principle 3: Safety and quality</b>	<b>Priority 1: Make GOSH a great place to work/ Priority 3: Develop the GOSH Learning Academy</b>	Risk of the GOSH Learning Academy not establishing a financially sustainable framework, impacting on its ability to deliver the outstanding education, training and development required to enhance recruitment and retention at GOSH and drive improvements in paediatric healthcare.	4 x 3	12	2 x 3	6	Cautious/ 12-15	1-2 years	Chief Nurse	<b>Chief Nurse/ Director of Education</b>	12/08/2024	People and Education Assurance Committee	May 2024
17	IP&C and Commercial	<b>Principle 4: Financial Strength</b>		The risk that the financial sustainability of the Trust is significantly impeded by a failure to deliver IP&C and commercial contribution targets.	4 x 4	16	3 x 4	12	Cautious/ 12-15	1-2 years	Chief Operating Officer/ Chief Finance Officer	<b>Managing Director IP&amp;C</b>	19/08/2024	Finance and Investment Committee	Trust Board June 2024 FIC
18	Health Inequalities	<b>Principle 3: Safety and quality</b>	<b>All priorities</b>	The Trust's strategies, systems, processes, policies and service delivery exacerbate health inequalities of our patients (differences in the care people receive and the opportunities they have to lead healthy lives (Kings Fund – June 2022)), impacting negatively on their physical and mental health status, their access to care and services and the quality and experience of the care provided.	4 x 4	16	3 x 4	12	Minimal/ 6-11	2-3 years	Chief Nurse	<b>Chief Nurse</b>	16/08/2024	Quality, Safety and Experience Assurance Committee	July 2024
19	Transformation	<b>All Strategy Principles</b>	<b>All priorities</b>	Failure to establish an environment (capability, culture, resources, systems and processes) to transform services thereby hampering delivery of improvements in patient safety and experience, service design and productivity and efficiency.	4 x 4	16	3 x 4	12	Cautious/ 12-15	1-5 years	Chief Operating Officer	<b>Director of Transformation</b>	19/08/2024	Finance and Investment Committee/ Quality, Safety and Experience Assurance Committee	July 2024 (QSEAC)

Attachment S

GOSH BAF Risks – Gross Scores October 2024

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

GOSH BAF Risks – Net Scores October 2024

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

QSEAC & Audit Committee

QSEAC

Audit Committee

Trust Board

People and Education Assurance Committee

Finance and Investment Committee

FIC & QSEAC

