Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Tuesday 28th January 2014

Dear Members

There will be a public meeting of the Trust Board on Tuesday 28th January 2014 at 2:00pm in the **York House Conference Room, Level 2,** Great Ormond Street, London, WC1N 3JH.

Company Secretary
Direct Line: 020 7813 8230
Fax: 020 7813 8218

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment
1.	**Apologies for absence**	Chairman	**Verbal**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 27th November 2013**	Chairman	**N**
3.	**Matters Arising/ Action Checklist**	Chairman	**O**
4.	**Interim Chief Executive Report**	Chief Executive	**Verbal**
	STRATEGIC ISSUES		
5.	**Board Assurance Framework Summary Update**	Director of Planning and Information	**P**
6.	**Annual (2013) Fire Safety Report**	Chief Operating Officer	**Q**
7.	**Equality and Diversity Annual Report**	Chief Nurse and Families' Champion	**R**
	PERFORMANCE		
8.	**Performance Report** • **Quality and Safety** • **Targets and Indicators** • **Finance** • **Patient Experience**	Chief Executive Co-Medical Director Chief Operating Officer Chief Finance Officer Chief Nurse and Families' Champion	**S**
9.	**Redevelopment Update**	Director of Redevelopment	**T**
10.	**Research and Innovation Report**	Director Research and Innovation	**U**

	FOR APPROVAL		
11.	**Monitor Self Certification Q3 2013/14**	Chief Finance Officer	**V**
12.	**Register of Seals**	Company Secretary	**W**
13.	**Responsible Officer Appointment**	Chief Executive	**X**
14.	**Revised Clinical Governance Committee Terms of Reference**	Company Secretary	**Y**
15.	**Matters reserved for the Board**	Company Secretary	**Z**
	REPORTS FROM COMMITTEES		
16.	**Audit Committee update – January 2014 meeting**	Chair of the Audit Committee	**Verbal**
17.	**Clinical Governance Committee update – January 2014 meeting**	Chair of the Clinical Governance Committee	**Verbal**
18.	**Members' Council Update – November and December 2013**	Chairman	**1**

Any Other Business
(Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)

Next meeting
The next Trust Board meeting will be held on Thursday 27th March 2014 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT N

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on Wednesday 27th November 2013

Present

Baroness Tessa Blackstone	Chairman
Mr Jan Filochowski	Chief Executive
Ms Mary MacLeod	Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Mr John Ripley	Non-Executive Director
Mr David Lomas	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Prof Rosalind Smyth	Non-Executive Director
Dr Barbara Buckley	Co-Medical Director
Mr Robert Burns	Director of Planning and Information
Professor Martin Elliott	Co-Medical Director
Mrs Liz Morgan	Chief Nurse and Families' Champion
Mrs Claire Newton	Chief Finance Officer
Mr Ali Mohammed	Director of Human Resources and OD

In attendance

Mr Robert Burns	Director of Planning and Information
Mr Matthew Tulley	Director of Redevelopment
Dr John Hartley	Director of Infection Prevention and Control
Dr Lesley Rees	Clinical Lead and Consultant, Nephrology
Mr Nick Towndrow	Service Manager, Adolescent Medicine, Endocrinology, Metabolic Medicine, Nephrology
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Ms Jenny Gimple	Senior Press Officer
Two members of the public	

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

120	**Apologies for absence**
120.1	Apologies for absence were received from Ms Rachel Williams, Chief Operating Officer
121	**Declarations of interest**
121.1	No declarations of interest were received.
122	**Minutes of previous meetings**
122.1	The minutes from the meeting of 25th September 2013 we **approved** with no amendments.
123	**Matters arising / action checklist**

123.1	Mrs Mary MacLeod, Non-Executive Director reported that she had visited Boston Children's Hospital to look at the management of Clinical Ethics and Clinical Governance.
124	**Chief Executive's Report**
124.1	Baroness Blackstone, Chairman noted that it would be the Chief Executive's last meeting and thanked him for his contribution to the Trust.
124.2	Mr Jan Filochowski, Chief Executive reported that the Trust had won the Health Service Journal national patient safety award and that in addition, three of the top 50 innovators identified in the NHS were from GOSH. It was reported that the Trust had hosted the launch of the national Rare Diseases Strategy and the London Living Wage announcement. Mr Filochowski added that a CQC themed inspection had taken place at the Trust which focused on transition to adult care and a national report would be produced in early 2014.
124.3	Mr Filochowski told the Board that the elective chest wall service was being temporarily suspended following concerns raised within the Trust. He confirmed that the Trust had commissioned an independent review which would begin early in the New Year.
124.4	It was reported that the Trust had been asked by the Information Commissioner to sign an undertaking to improve information governance processes following four incidents of letters containing personal information being sent to incorrect addresses. Mr Filochowski stressed that he was satisfied that procedures were being put in place to minimise the risk of this happening again.
124.5	Mr David Lomas, Non-Executive Director queried whether the staff vacancies on Intensive Care Unit had been filled. Mrs Liz Morgan, Chief Nurse and Families' Champion said that recruitment had taken place however vacancies did still exist. It was stressed that if there were insufficient staff numbers the beds would not be opened.
125	**Matters arising**
125.1	<u>Update on Outpatient 'Do Not Attends' (DNAs) and Clinic Cancellations</u>
125.2	Mr Robert Burns, Director of Planning and Information said that the levels of DNAs in the Trusts compared favourably against those of other paediatric and major hospitals.
125.3	The Board agreed that DNAs were an inefficient use of resources but noted that re-referring this group of patients was not always appropriate as they were an at risk group and needed to be followed up. The Chairman emphasised that this issue was vital to both achieving efficiency and fulfilling 'The Child First and Always.
125.4	<u>Clinic cancellations</u>
125.5	Mr Burns told the Board that the overall level of clinic cancellations was 11%. He confirmed that problem areas would be tackled.
125.6	**Action:** It was agreed that this item would be revisited at a future meeting (March 2014).

125.7	The Board **noted** the update.
126	**Clinical Presentation - Nephrology**
126.1	Dr Lesley Rees, Clinical Lead and Consultant in Nephrology and Mr Nick Towndrow, Service Manager gave a presentation covering the following areas of the service: · Overview of the team · Clinical outcomes and benchmarking · Risks · Patient experience · Finances · Growth
126.2	It was noted that the service made a negative financial contribution to the Trust despite being an essential clinical service which scored highly in terms of child health and wellbeing and was well recognised nationally and internationally.
126.3	It was reported that the service offered a large number of daily consults to other areas of the hospital, as many children with complex illness suffered kidney problems.
126.4	The Board **noted** the presentation.
127	**Update on action plan for extended working**
127.1	Mr Robert Burns reported that the action plan had been developed based on discussions which took place at the October senior staff meeting. He said that senior staff were engaged with the action plan and a proactive communications strategy would be developed to support engagement.
127.2	**Action:** It was agreed that the next update should provide information about the potential additional activity and the clinical and financial benefits which would arise from extended working.
127.3	**Action:** Mr Charles Tilley, Non-Executive Director said that many companies had found that proactively working with customers had led to a reduction in their cost base. It was agreed that this would be discussed further outside the meeting.
127.4	The Board **noted** the update.
128	**Annual Plan mid-year review**
128.1	Mr Robert Burns, Director of Planning and Information presented the report focusing on the series of five 'must do' areas which had been identified as measures to ensure the key elements of the Annual Plan were being met.
128.2	Mr Burns reported that good progress was being made especially in terms of the expansion of the Intensive Care Unit where beds were being opened. He added that activity was significantly higher than at the same point last year with a workforce of approximately the same size.

128.3	**Action:** It was noted that the IT strategy would be discussed at the Trust Board meeting in January 2014.
128.4	The Board **noted** the update.
129	**Audit Committee update – October 2013**
129.1	Mr Charles Tilley, Non-Executive Director and Chairman of the Audit Committee reported that the Trust had appointed new internal auditors from KPMG. He told the Board that the Trust would be going out to tender for external audit services in the new year.
129.2	The Board **noted** the update.
130	**Performance report**
130.1	<u>Quality and Safety</u>
130.2	Professor Martin Elliott told the Board that there had been a rise in CVL infections in the Infection, Cancer and Immunity Division and in ICU. Professor Elliott confirmed that this was associated with high activity, complex patients and a drop in compliance with the care bundles. A practice educator had been appointed in ICI to improve the quality of training. It was stressed that infection rates overall were at the low end of national figures.
130.3	<u>Finance</u>
130.4	Mrs Claire Newton, Chief Finance Officer reported that her three key concerns were rising agency costs, levels of IPP debt and CRES pressures.
130.5	The Board discussed the challenge of recruiting nurses. It was noted that there was a limited pool of paediatric nurses to recruit from and that the Trust was looking for a high level of expertise.
130.6	The Board **noted** the updates.
131	**Bed Management**
131.1	Mr Robert Burns reported that by targeting staff recruitment in particular areas and a change in recruitment processes had led to a lower number of closed beds. He added that there had been a lack of medical engagement and the Bed Management Forum was looking at how engagement could be increased.
131.2	**Action:** It was agreed that a paper would be presented at the January Clinical Governance Committee meeting which would look at where Health Care Assistants could be used instead of nurses.
131.3	**Action:** It was agreed that consideration would be given to whether closed beds could be measured in terms of value across the hospital.
131.4	Dr Barbara Buckley, Co-Medical Director reported that a lot of improvement would be gained by teams working more efficiently for example ward rounds taking place earlier in the day to allow earlier discharge of patients. She added that the 'consultant of the week' approach would lead to a group of individuals who could be

	used to work collaboratively and share beds.
131.5	Mr Ali Mohammed, Director of Human Resources and OD reported that, unusually, a quarter of the Trust's staff turnover was a result of renewal of fixed term contracts. He added that he would look at extending notice periods in order to reduce risk and reduce reliance on agency staff.
131.6	The Board **noted** the update.
132	**Performance Report continued**
132.1	<u>Targets</u>
132.2	Mr Robert Burns said that there had been a marginal improvement in discharge summary performance which was now being monitored weekly with people held to account. He added that focused work was taking place in Rheumatology.
132.3	<u>Patient Experience</u>
132.4	It was reported that work was on-going to develop a shared commitment and to address the issues that arose from the Listening Event in June 2013.
132.5	The Board **noted** the updates.
133	**Infection prevention and control update**
133.1	Dr John Hartley, Director of Infection Prevention and Control confirmed that the Trust had reported no cases of MRSA and that the incidence of CVL had reduced almost to target. He confirmed that a high level of training was taking place in the Trust but that recording of it was variable without an electronic record.
133.2	The Board **noted** the update.
134	**Proposed changes to the Trust's CRES delivery processes**
134.1	Mrs Claire Newton reported that proposed changes to the CRES process were the result of an independent review. She confirmed that meetings had taken place with Divisional General Managers in order to identify themes which could be implemented across the Trust.
134.2	The Board **approved** the proposed changes.
135	**Timetable for Trust Board evaluation**
135.1	Dr Anna Ferrant, Company Secretary said that the next Trust Board evaluation would involve an independent evaluation. She recommended that this should be delayed in order for a substantive Chief Executive to be appointed.
135.2	**Action:** The Board **agreed** that an internal questionnaire would be completed in the interim period and the external evaluation would be delayed until the appointment of a substantive Chief Executive.

136	**Register of Seals**
136.1	The Board **endorsed** the use of the Seal.
137	**Medical revalidation and appraisal update**
137.1 137.2	Dr Barbara Buckley, Co-Medical Director reported that the Trust had reached 75% revalidation rate. She stressed that completing these tasks was a doctor's professional responsibility and the Trust was ensuring that clinical excellence awards would not be considered and private practice privileges revoked if recipients were not up to date with appraisals. The Board **noted** the update.
138	**Clinical Governance Committee update – November 2013**
138.1 138.2	Mrs Mary MacLeod, Non-Executive Director and Chairman of the Clinical Governance Committee reported that she had met with KPMG and was assured that agreement had been reached about working together on clinical governance matters. The Board **noted** the update.
139	**Finance and Investment Committee – November 2013**
139.1	The Board **noted** the update.
140	**Members' Council**
140.1 140.2	Baroness Blackstone told the Board that the Council had been advised of the decision of the Chief Executive to retire and that an extraordinary meeting of the Members' Council would be arranged to approve the appointment of an Interim Chief Executive. The Board **noted** the update.
141	**Any other business**
141.1	There were no items of any other business.
142	**Next meeting**
142.1	It was noted that the next Trust Board meeting would take place on Tuesday, 28th January 2014.

ATTACHMENT O

Attachment O

TRUST BOARD - ACTION CHECKLIST
January 2014

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
85.1	25/09/13	It was agreed that further discussion would take place around minute 60.4: provision on the Board for a Non-Executive Director with a medical background at the next Board review.	TB	Q3 2014/15	Not yet due - This will be considered as part of the Board evaluation process later in the year (see action 135.2 below)
88.3	25/09/13	Baroness Blackstone, Chairman requested information on the number of papers published; lectures given and research undertaken by consultants working at GOSH and ICH as a means to demonstrate that world class research is taking place.	DG	January 2014	On agenda
88.6	25/09/13	The Board agreed that future research performance reports should: • focus less on research income • provide a better understanding of the impact of research on children's medicine, for example by linking number of publications with improvements for children • provide clarity around the areas of the hospital which are strong or weak in terms of research • provide a plan to improve areas which are less successful in research terms	DG	January 2014	On agenda

Attachment O

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
90.3	25/09/13	It was agreed that formal feedback on the outpatient improvement project would be provided by Meridian who would give a presentation around improvements in six months' time.	RB	March 2014	Not yet due
94.3	25/09/13	It was agreed that the outpatient improvement project would be used to develop performance measures for short notice cancellation of outpatient clinics.	RB	March 2014	Not yet due
125.6	27/11/13	It was agreed that DNAs and clinic cancellations would be revisited at a future meeting.	RB	March 2014	Not yet due
127.2	27/11/13	It was agreed that the next update on extended working should provide information about the potential additional activity and the clinical and financial benefits which would arise from extended working.	RB	May 2014	Not yet due
127.3	27/11/13	Extended Working Hours - Mr Charles Tilley, Non-Executive Director suggested that many companies had found that working with customers had led to a reduction in their cost base. It was agreed that this would be discussed further outside the meeting.	CT&RB	May 2014	Not yet due
128.3	27/11/13	It was noted that the IT strategy would be discussed at the Trust Board meeting in January 2014.	RB	January 2014	On agenda
131.2	27/11/13	It was agreed that a paper would be presented at the January Clinical Governance Committee meeting which would look at where Health Care Assistants could be used instead of nurses.	LM	January 2014	On January 2014 Clinical Governance Committee

Attachment O

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
131.3	27/11/13	Bed Management - It was agreed that consideration would be given to whether closed beds could be measured in terms of value across the hospital.	RW	January 2014	Verbal Update
135.2	27/11/13	The Board agreed that an internal Trust Board evaluation questionnaire would be completed prior to the appointment of the substantive Chief Executive and the external evaluation would be delayed until the appointment of a substantive Chief Executive.	AF	January 2014	Work in progress – an assessment against the requirements detailed in the corporate governance statement will be conducted and a short questionnaire disseminated to all directors in February 2014

Trust Board
28th January 2014

Board Assurance Framework Summary Update **Submitted by:** Robert Burns, Director of Planning & Information	**Paper No: Attachment P**

Aims / summary
To provide an update to the Trust Board on the Board Assurance Framework (BAF) risks.

All Executive Directors were requested to review their appropriate risks for relevance (are any required to be re-worded, split, archived etc.) and to update them with the current position.

On the summary sheet of the attached BAF, those highlighted in grey have not been updated this quarter and those highlighted in gold are new risks with completion underway and state NEW RISK.

A summary of actions underway for risks with an assurance rating of red or amber is detailed below.

Red and Amber Assurance:
1C – Lack of clear Information Technology (IT) investment priorities.
This risk will be discussed at the January 2014 Trust Board meeting.

1D – Failure to effectively specify and manage commercial and contracted out services. (Red)
A verbal update on this risk has been provided at the January 2014 Audit Committee by the Chief Finance Officer.

1F – Failure to gain fully informed consent from the appropriate person.
(Amber)
The development of pre-populated consent forms and information leaflets is currently in the process of being completed for the top 10 procedures. Information leaflets for consent and consent forms are currently being developed.

2B – Loss of key services which are critical to GOSH remaining a credible tertiary paediatric centre. (Amber)
We have assessed all specialties against the nationally agreed matrix of clinical specialty co-dependencies and inter specialty referral rates. 11 have been identified as essential. 10 of these specialties have vibrant referral bases and activity levels. The priority in the next quarter is to develop a long term plan to ensure all 11 are viable.

2G – Difficulties in recruiting and retaining highly skilled staff with specific experience. (Amber)
Latest data (for November 2013) shows a slight increase in turnover – 18.06% compared to 17.86% in July. However, these figures have been inflated by a number of TUPE episodes over the last 12 months and numbers of fixed term contracts coming to an end. These equate to approximately 4%. Vacancy levels appear reasonably static at approximately 10%.

As background, shortages of skilled staff are being experienced nationally across the NHS. We will therefore continue to pursue a range of both tactical and strategic approaches to address recruitment and retention, such as: monitoring and tackling local issues which are driving turnover; the use of education and training to grow-our-own staff as well as attract staff; initiatives to make GOSH an employer of choice; targeted overseas and domestic recruitment campaigns; workforce redesign. These will be utilised as required but the highly specialist nature of GOSH and its central London location means the Trust will continue to experience recruitment and retention of staff as a risk for the foreseeable future.

2H – Insufficient capacity to meet referrals, particularly ICU capacity which is required to deliver other clinical services within the hospital. (Amber)
Work continues around recruitment of ICU nurses and managing flow across the hospital to free up ICU capacity with increased emphasis on bed management meetings and establishment of a new bed management forum. There arrangements will be reviewed at the end of January 2014. In parallel, conversations are on-going with commissioners about the situation pan-London and development of a business case to increase capacity at GOSH.

2J – Failure in quality of service provision:
- to provide timely, efficient and effective patient pathways
- to ensure children are kept safe - through lack of staff training or ineffective employment processes
- to recognise and respond to patients deterioration in a timely manner
- to provide an environment and service which minimises the risk of patients' acquiring infections and the risk of medication errors
- not responding to feedback from staff about service provision and environmental concerns. (Amber)
Work is underway to split this risk into its component parts – a verbal update will be provided at the January 2014 Clinical Governance Committee.

2K – Failure to have reliable processes for booking the follow up care of patients. (Amber)
It is proposed that this risk is reworded as follows: **Failure to have reliable processes for follow-up care of patients** – an update on the controls and assurances for this risk will be provided at the April 2014 Clinical Governance Committee meeting.

2L – Managing complex patient pathways. (Amber)
This risk has been reviewed in light of the work underway to split out risk 2J - a verbal update will be provided at the January 2014 Clinical Governance Committee meeting.

3H – Lack of comprehensive multi-faceted strategy. (Amber)
Whilst certain individual strategies have made some progress during 2013, no progress has been made on the overall corporate strategy. The risk will be mitigated and eventually removed if the Trust proceeds in developing a corporate strategy. At the time of writing this issue is being considered by the interim CEO

4A – Loss of Research and Development (R&D) funding streams in climate of greater competition and limited funding, for example the Biomedical Research Centre (BRC). (Amber)
Over the last six months we have introduced a programme of work to mitigate against the loss of research funding and we would expect to see the benefits of these over the next 12 months:

Developing a comprehensive grants advice service including the appointment of a Senior Research Project Manager with a remit to support teams applying for NIHR funding. Appointment to a joint post with the UCL Translational Research Office with a specific remit to support translational research grants. Appointment to a Clinical Academic Programme Coordinator - Nursing and Allied Health with a remit of supporting nurses and AHPs applying for research fellowships.

Our commercial research funding policy was introduced in November 13, and provides an incentive to those leading commercial research studies to both continue and expand their commercial research portfolio. A new internal Research Capacity Building Fund has been announced with the aim to build capacity in some of the key support areas which in turn will allow the Trust to take on / support more research. We will undertake a review of non- NIHR portfolio projects to understand why they were not eligible for the NIHR portfolio (projects on the NIHR portfolio attract network funding, therefore an increase in portfolio projects should lead to an increase in network funding).

6A – Lack of a systematic approach to development of organisation and people may compromise our effectiveness of service. (Amber)
This risk will be discussed in detail at the January 2014 Clinical Governance Committee.

6C – Difficulty in ensuring contractors and honorary staff (that is, staff who are not directly employed by the Trust but allowed onto Trust premises) are properly authorised, have had appropriate pre-engagement checks, been issued with appropriate documentation, and are properly managed once on site. (Amber)
A wide-ranging review of honorary contracts and employment practices within the Trust is currently being undertaken. The review is considering a large number of issues of all those staff in the Trust in an honorary capacity. The project has an agreed completion date of 31 March 2014.

7A – Inadequate management of infrastructure redevelopments may result in poor value for money (VFM), patient experience, function or space utilisation. (Amber)
The last internal audit report found the management and governance structures of redevelopment to be strong and provided significant assurance of good governance. The new Deputy Director has been in post for 5 months and a structured handover from the out-going deputy was well managed. It is proposed this risk is rated Green.

7B – Failure to maintain site to safe and sustainable level. (Amber)
Feasibility Study carried out on new PPM system, the proposal is for the support and helpdesk to move off-site. The Trust is currently obtaining a new PPM system comparison costings for the business case, due by the end of January 2014. In parallel, the PPM Job list review is underway and scheduled for completion at the end of February 2014. Site wide condition survey is 70% complete, with the remaining areas to be surveyed by the end January 2014. The electrical infrastructure survey has been completed and the mechanical infrastructure survey is underway and will be complete by the end of February 2014.

All out of date policies have been reviewed and the 11 of updated documents will be submitted to PAG for approval on 27th January 2014.

7C – Co-ordinating potentially competing demands, e.g. service growth and

decants / redevelopment programme. (Amber)
For this risk to be mitigated to Green, GOSH needs to complete the update of the clinical services strategy and ensure this is reflected in the refresh of the Development Control Plan.

8A – Reduction in funding available to NHS organisations. (Amber)
This is a long term risk. Improving the Board assurance on it for 2014/15 will only be achieved if we conclude a reasonable commissioning contract with NHS England. The current timescales for 2014/15 assume contracts will be agreed by the end of February 2014 but this timescale is extremely challenging and it is more likely to be the end of March 2014. However risk relating to years beyond 2014/15 will remain without satisfactory assurance due the uncertainty regarding funding available to all NHS organisations in 2015/16.

This response and risk is also linked to 8F of the BAF.

8F – Failure to deliver a feasible commissioning contract. (Amber)
Please see response to risk 8A.

8H – Inefficient use of resources (e.g. theatres, beds etc.).
This risk has been discussed in detail at the January 2014 Audit Committee.

8I – Failure to have adequate data quality systems and processes. (Amber)
Considerable work is in progress to monitor data quality within the centrally managed systems, in particular the Patient Administration System (PAS) which should record patient demographic and actively data across the Trust. A review of all PAS business procedures is underway and a series of data quality reports are supplied to operational users highlighting instances of inaccurate or missing data recording.

Concerns remain that data quality principles are not in place for Information system managed within local departments. A review of the local Information Asset Owner role was designed to encourage the adoption of these principles although a means of monitoring this is not currently in place. A review of data quality KPI reporting at both Trust and division/department level needs to be undertaken. The data quality policy is under review to ensure the local ownership of data quality is clearly articulated.

Those risks that have been re-worded, archived or are new are detailed below.

1E – Poor patient and family experience through not effectively communicating with families or listening to and acting upon feedback.
Re-worded and is now '**Failure to deliver excellent experience for patients and families'.**

2A – Loss of priority for specialist paediatrics in DH policy.
This risk has been archived for duplication purposes as is covered elsewhere in the assurance framework

2I – Failure to effectively control access to patients - e.g. safeguarding.
Re-worded and is now '**Failure to safeguard children and young people from maltreatment and neglect'.**

2J – Failure in quality of service provision:
- to provide timely, efficient and effective patient pathways
- to ensure children are kept safe - through lack of staff training or ineffective

employment processes
- to recognise and respond to patients deterioration in a timely manner
- to provide an environment and service which minimises the risk of patients' acquiring infections and the risk of medication errors
- not responding to feedback from staff about service provision and environmental concerns.
This risk has been archived and replace by risks 2M, 2N, 2O, 2P, 2Q and 2R.

2M – Failure to provide an environment and service which minimises the risk of patients acquiring infections.
This is a new risk following the split of risk 2J.

2N – Failure to ensure children are kept safe through lack of staff training and ineffective employment processes.
This is a new risk following the archive of risk 2J.

2O – Failure to provide an environment and service which minimises the risk of medication errors.
This is a new risk following the archive of risk 2J.

2P – Failure of estates and facilities to deliver high quality services that are fit for patient care.
This is a new risk following the archive of risk 2J.

2Q – Failure to provide coordinated care both internally and with referring trusts.
This is a new risk following the archive of risk 2J.

2R – Failure to recognise and respond to patient deterioration in a timely manner.
This is a new risk following the archive of risk 2J.

2S – Failure to have reliable processes for follow up care of patients.
This is a new risk in conjunction with risk 2K.

3A – Planning / rationalisation blight due to Department of Health (DH) / Commissioners inability to deliver change during transition period.
This risk has been archived.

3E – Failure to establish effective clinical network leadership position.
This risk has been archived.

3F – Adverse impact on achievement of strategic objectives or funding targets from weaknesses in relationships with key stakeholders:
- research partners / University College London (UCL) / Institute of Child Health (ICH) / Institute of Cardiothoracic Surgeons (ICS)
- referrers / commissioners
- key private referrers
- members' council
- GOSH charity
- UCL Partners / Local Education and Training Board (LETB) from medical and nursing training perspective.
This risk has been archived and replaced by risks 3J and 3K as listed below.

3J – Adverse impact on research strategy and key funding streams (e.g. BRC) from weaknesses in relationships with key stakeholders.
This is a new risk developing on from the previous risk 3F.

3K – Adverse impact on patient care and activity levels by failing to meet referrer's communication expectations.
This is a new risk developing on from the previous risk 3F.

5A – Failure to manage the increasing demand on the Trust for specialist training and support.
Re-worded and is now 'Failure to manage on a day-to-day basis the increasing demand on the Trust for all training and support'.

6A – Lack of a systematic approach to development or organisation and people may compromise our effectiveness at individual, team and organisational level.
Re-worded and is now 'Lack of a systematic approach to development of organisation and people who may compromise our effectiveness of service'.

6B – Failure to ensure that staff and managers are aware of their critical but less obvious responsibilities i.e. personal responsibility.
Re-worded and is now 'Failure of staff and managers to be fully aware of their relevant codes of professional conduct and / or to practice in a manner consistent with Trust values'.

6C – Difficulty in managing staff who work for us who are not our employees (i.e. honorary staff).
Re-worded and is now 'Difficulty in ensuring contractors and honorary staff (that is, staff who are not directly employed by the Trust but allowed onto Trust premises) are properly authorised, have had appropriate pre-engagement checks, been issued with appropriate documentation, and are properly managed once on site'.

6D – Difficulty in ensuring volunteers are properly authorised, have had appropriate pre-engagement checks, been issued with appropriate documentation, and are properly managed once on site.
This is a new risk in conjunction with 6C.

8D – Loss of strong position in national tariff discussions as a result of national changes.
This risk has been archived and the information merged with risk 8A.

Action required from the meeting
To note the changes and current position of the Board Assurance Framework risks.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Effective management of risk is a primary role of the Board.

Financial implications
N/A

Who needs to be told about any decision?
Executives

Who is responsible for implementing the proposals / project and anticipated timescales? N/A
Who is accountable for the implementation of the proposal / project? Chief Executive

Assurance Framework - Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

Key:

Objective 1: Consistently deliver an excellent and compassionate experience for our patients and their families.	**Objective 5:** Continue to deliver high quality specialist paediatric multi-professional healthcare education.
Objective 2: Consistently deliver world class clinical outcomes.	**Objective 6:** Equip all staff with the knowledge, skills and training to deliver high quality compassionate care.
Objective 3: Work with clinical networks, partner providers and referrers to deliver streamlined patient pathways.	**Objective 7:** Continue to redevelop and improve the hospital's estate to provide high quality accommodation for current and future patients.
Objective 4: With partners maintain and develop our position as the UK's top children's research and innovation organisation.	**Objective 8:** Be a financially stable organisation and promote the sustainable use of resources.

	Risk	Risk Category	Reviewed By	Director Lead	Assurance Committee	Initial Risk Score	Current Risk Score					Risk Appetite Score					Key Score Differences	Assurance Rating	Date Reviewed	Date Reviewed by Assurance Committee
							L	x	C	=		L	x	C	=					
1B	Public criticism post Francis which seriously adversely affects the hospital's reputation.	EA	Sarah Dobbing	Medical Director	Clinical Governance	6	2	x	3	=	**6**	1	x	3	=	**3**	3	Green	06.09.2013	
1C	Lack of clear Information Technology (IT) investment priorities.	BC	Claire Newton	Chief Finance Officer	Audit	20	4	x	4	=	**16**	2	x	4	=	**8**	8	Amber	09.01.2014	20.01.2014
1D	Failure to effectively specify and manage commercial and contracted-out services.	CO	Rachel Williams	Chief Operating Officer	Audit	20	5	x	4	=	**12**	2	x	4	=	**8**	12	Red	13.01.2014	02.10.2013
1E	Failure to deliver an excellent experience for patients and families.	CO	Caroline Joyce	Chief Nurse	Clinical Governance	10	2	x	5	=	**10**	2	x	5	=	**10**	0	Green	10.12.2013	22.01.2014
1F	Failure to gain fully informed consent from the appropriate person.	CO	Rob Evans	Medical Director	Clinical Governance	12	3	x	4	=	**12**	2	x	4	=	**8**	4	Amber	06.12.2013	10.04.2013 and 22.10.2013
2B	Loss of key services which are critical to GOSH remaining a credible tertiary paediatric centre.	BC	Robert Burns	Director of Planning & Information	Clinical Governance	15	2	x	5	=	**10**	1	x	5	=	**5**	5	Amber	13.01.2014	
2C	Failure for planned expansion to deliver capacity required to support internal clinical and external referral.	BC	Barbara Buckley	Chief Operating Officer	Clinical Governance	16	2	x	4	=	**8**	1	x	4	=	**4**	4	Green	02.12.2013	
2D	Non-compliance with regulations (infrastructure not set up properly, people not sure how).	CO	Rachel Williams	Chief Operating Officer	Clinical Governance	15	2	x	5	=	**10**	2	x	5	=	**10**	0	Green	13.01.2014	
2E	Risk that all patients at all times don't receive safe medical cover.	CO		Medical Director	Clinical Governance	12	2	x	4	=	**8**	1	x	4	=	**4**	4	Green	11.09.2013	
2F	Failure to develop adequate live information to enable us to monitor and ensure good outputs and outcomes.	CO	Meredith Mora	Medical Director	Clinical Governance	8	3	x	2	=	**6**	2	x	2	=	**4**	2	Green	25.11.2013	
2G	Difficulties in recruiting and retaining highly skilled staff with specific experience.	CO	Helen Cooke	Director of Human Resources	Clinical Governance	16	3	x	4	=	**12**	2	x	4	=	**8**	4	Amber	17.12.2013	
2H	Insufficient capacity to meet referrals, particularly ICU capacity which is required to deliver other clinical services within the hospital.	CO	Rachel Williams	Chief Operating Officer	Clinical Governance	20	4	x	4	=	**16**	3	x	4	=	**12**	4	Amber	13.01.2014	
2I	Failure to safeguard children and young people from maltreatment and neglect.	CO	Jan Baker	Chief Nurse	Clinical Governance	15	2	x	5	=	**10**	1	x	5	=	**5**	5	Green	13.01.2014	22.01.2014
2K	Failure to have reliable processes for booking the follow up care of patients.	CO	Rachel Williams	Chief Operating Officer	Clinical Governance	20	4	x	4	=	**16**	2	x	4	=	**8**	8	Amber	13.01.2014	
2L	Managing complex patient pathways.	CO	Rachel Williams	Chief Operating Officer	Clinical Governance	12	3	x	3	=	**9**	2	x	3	=	**6**	3	Amber	13.01.2014	
2M	Failure to provide an environment and service which minimises the risk of patients acquiring infections.	CO	Deirdre Malone	Chief Nurse	Clinical Governance	NEW RISK!!														
2N	Failure to ensure children are kept safe through lack of staff training and ineffective employment processes.	CO	Geoff Speed	Director of Human Resources	Clinical Governance	NEW RISK!!														
2O	Failure to provide an environment and service which minimises the risk of medication errors.	CO	Judith Cope	Co-Medical Director (CC)	Clinical Governance	NEW RISK!!														
2P	Failure of estates and facilities to deliver high quality services that are fit for patient care.	CO	David Phillskirk	Chief Operating Officer	Clinical Governance	NEW RISK!!														
2Q	Failure to provide coordinated care both internally and with referring trusts.	CO	Cathy Cale	Co-Medical Director (CC)	Clinical Governance	NEW RISK!!														
2R	Failure to recognise and respond to patient deterioration in a timely manner.	CO	Martin Elliott	Co-Medical Director (ME)	Clinical Governance	NEW RISK!!														
2S	Failure to have reliable processes for follow up care of patients.	CO	Rachel Williams	Chief Operating Officer	Clinical Governance	NEW RISK!!														
3B	Unable to meet the capacity needs of patients transferred from another de-designated provider	EA	Robert Burns	Director of Planning & Information	Clinical Governance	9	2	x	3	=	**9**	2	x	3	=	**6**	3	Green	28.11.2013	

Assurance Framework
Summary

	Risk	Risk Category	Reviewed By	Director Lead	Assurance Committee	Initial Risk Score	Current Risk Score					Risk Appetite Score					Key Score Differences	Assurance Rating	Date Reviewed	Date Reviewed by Assurance Committee
							L	x	C	=		L	x	C	=					
3C	Lack of local paediatric in-patient and community services to facilitate repatriation or discharge of patients to local services.	CE	Robert Burns	Director of Planning & Information	Clinical Governance	15	4	x	3	=	**12**	3	x	3	=	**9**	0	Green	28.11.2013	
3D	Risk of sustained adverse publicity that prejudices our ability to maintain and develop services.	CE	Cymbeline Moore	Medical Director	Clinical Governance	20	2	x	5	=	**10**	2	x	5	=	**10**	0	Green	12.09.2013	22.01.2014
3G	Not making the right choices on external business opportunities.	BC	Robert Burns	Director of Planning & Information	Audit	9	2	x	3	=	**6**	1	x	3	=	**3**	3	Green	02.12.2013	
3H	Lack of comprehensive multi-faceted strategy.	BC	Robert Burns	Director of Planning & Information	Audit	12	3	x	4	=	**12**	1	x	4	=	**4**	4	Amber	02.12.2013	
3I	Potential high profile disputes with individual members of staff not handled effectively.	CO	Ray Conley	Director of Human Resources	Clinical Governance	16	2	x	4	=	**8**	2	x	4	=	**8**	0	Green	17.12.2013	
3J	Adverse impact on research strategy and key funding streams (e.g. BRC) from weaknesses in relationships with key stakeholders.	CE		Director of Research & Innovation	Audit	NEW RISK!!												Green	10.01.2014	
3K	Adverse impact on patient care and activity levels by failing to meet referrer's communication expectations.	CE		Co-Medical Director (CC)	Audit	NEW RISK!!														
4A	Loss of Research and Development (R&D) funding streams in climate of greater competition and limited funding, for example the Biomedical Research Centre (BRC).	BC	Emma Pendleton	Director of Research & Innovation	Audit	20	3	x	4	=	**12**	2	x	4	=	**8**	4	Amber	27.11.2013	17.04.2013
5A	Failure to manage on a day-to-day basis the increasing demand on the Trust for all training and support.	CO	Geoff Speed	Director of Human Resources	Clinical Governance	8	2	x	4	=	**8**	2	x	4	=	**8**	0	Green	17.12.2013	
6A	Lack of a systematic approach to development of organisation and people may compromise our effectiveness of service.	BC	Geoff Speed	Director of Human Resources	Clinical Governance	15	2	x	5	=	**10**	1	x	5	=	**5**	5	Amber	15.01.2014	17.04.2013 and 22.01.2014
6B	Failure of staff and managers to be fully aware of their relevant codes of professional conduct and / or to practice in a manner consistent with Trust values.	CO	Helen Cooke	Director of Human Resources	Clinical Governance	9	2	x	3	=	**6**	1	x	3	=	**3**	3	Green	17.12.2013	17.04.2013
6C	Difficulty in ensuring contractors and honorary staff (that is, staff who are not directly employed by the Trust but allowed onto Trust premises) are properly authorised, have had appropriate pre-engagement checks, been issued with appropriate documentation, and are properly managed once on site.	CO	Ray Conley	Director of Human Resources	Clinical Governance	6	3	x	2	=	**6**	1	x	2	=	**2**	4	Amber	17.12.2013	22.10.2013
6D	Difficulty in ensuring volunteers are properly authorised, have had appropriate pre-engagement checks, been issued with appropriate documentation, and are properly managed once on site.	CO		Director of Human Resources	Clinical Governance	NEW RISK!!														
7A	Inadequate management of infrastructure redevelopments may result in poor value for money (VFM), patient experience, function or space utilisation.	BC	Stephanie Williamson	Director of Redevelopment	Audit	12	2	x	4	=	**8**	2	x	4	=	**8**	4	Amber	20.12.2013	
7B	Failure to maintain site to safe and sustainable level.	CO	David Phillisкirk	Chief Operating Officer	Audit	15	2	x	5	=	**10**	1	x	5	=	**5**	5	Amber	10.01.2014	22.10.2013
7C	Co-ordinating potentially competing demands, e.g. service growth and decants / redevelopment programme.	CO	Stephanie Williamson	Director of Redevelopment	Audit	12	3	x	4	=	**12**	2	x	4	=	**8**	4	Amber	20.12.2013	

Assurance Framework
Summary

	Risk	Risk Category	Reviewed By	Director Lead	Assurance Committee	Initial Risk Score	Current Risk Score					Risk Appetite Score					Key Score Differences	Assurance Rating	Date Reviewed	Date Reviewed by Assurance Committee
							L	x	C	=		L	x	C	=					
8A	Reduction in funding available to NHS organisations.	EA	Claire Newton	Chief Finance Officer	Audit	20	3	x	5	=	**15**	1	x	5	=	**5**	10	Amber	09.01.2014	24.05.2013 and 02.10.13
8B	Reduction in funds raised by the GOSH charity.	CE	Claire Newton	Chief Finance Officer	Audit	15	3	x	5	=	**15**	1	x	5	=	**5**	10	Green	09.01.2014	20.01.14
8C	Competitor action results in activity growth targets not being achieved.	CE	Rachel Williams	Chief Operating Officer	Audit	8	2	x	4	=	**8**	2	x	4	=	**8**	0	Green	13.01.2014	
8E	Failure to achieve financial targets including required efficiencies gains - Cash Releasing Efficiency Savings (CRES).	CO	Rachel Williams	Chief Operating Officer	Audit	15	3	x	5	=	**15**	2	x	5	=	**10**	5	Green	13.01.2014	24.05.2013
8F	Failure to deliver a feasible commissioning contract.	CO	Claire Newton	Chief Finance Officer	Audit	15	2	x	5	=	**10**	1	x	5	=	**5**	5	Amber	09.01.2014	20.01.2014
8G	Failure to achieve International Private Patient (IPP) income strategy.	CO	Joanne Lofthouse	Director of International Private Patients	Audit	10	2	x	5	=	**10**	2	x	5	=	**10**	0	Green	02.12.2013	
8H	Inefficient use of resources (e.g. theatres, beds etc.).	CO	Katharine Goldthorpe	Chief Operating Officer	Audit	16	5	x	4	=	**20**	2	x	4	=	**8**	12	Amber	10.12.2013	20.01.2014
8I	Failure to have adequate data quality systems and processes.	CO	Geoff Bassett	Director of Planning & Information	Audit	8	3	x	2	=	**6**	2	x	2	=	**4**	2	Amber	02.12.2013	

Risk Categories:
BC - Business Change
CE - Core External Risks
CO - Core Operations
EA - Emerging Areas

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **28th January 2014**	
Annual (2013) Fire Safety Report **Submitted by:** Rachel Williams, Chief Operating Officer	**Paper No: Attachment Q**
Aims / summary The report is an annual update for the Board on Fire Safety issues across the Trust covering issues of note in the last 12 months and a summary of proposed actions over the next reporting period.	
Action required from the meeting • To note the report • To note and support the Fire Plan for 2014 • To note the DATIX Fire High Risk concerning the Southwood Building compartment issue. • To note the planned London Fire Brigade financial charges for Unwanted Fire Signals. • To support the introduction of a call time delay to the London Fire Brigade in the instances of fire alarm activations.	
Contribution to the delivery of NHS Foundation Trust strategies and plans To support the Trust's Zero Harm and CQC compliance.	
Financial implications	
Who needs to be told about any decision?	
Who is responsible for implementing the proposals / project and anticipated timescales? 1) Fire & Security Committee 2) Health & Safety Committee	
Who is accountable for the implementation of the proposal / project? Estates & Facilities Directorate	

Attachment Q

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual Fire Safety Report for the Trust Board Meeting on 28th January 2014

DATE:	20th January 2014
REPORTING PERIOD:	1st January 2013 to 31st December 2013 **Note:** includes summary of proposed Fire actions until the next reporting period of 31st December 2014
AUTHOR:	Steve Moxley; Facilities Manager (Fire/Security/Records)

1.0 Introduction

The Secretary of State for Health requires the submission of an annual report to the Executive Board informing them of the current state of fire safety in all premises for which the Board is responsible.

The report is an annual appraisal of all Fire safety requirements that have been implemented over the past year and a summary of proposed actions over the next reporting period to 31st December 2014.

2.0 Fire Risk Assessments (FRAs)

FRAs are divided into 3 risk categories and are performed on an annual basis irrespective of their risk status:

1) High Risk: Wards & Theatres
2) Medium Risk: Plant rooms & Outpatient areas
3) Low Risk: Office areas

FRA Table: (as of 17/1/2014)

Risk	Total No of FRA required	% completed
High	27	100%
Medium	70	100%
Low	141	91%

Summary:

- All FRAs required in high risk areas were completed by 16/09/2013.
- All FRAs required in medium risk were completed by 31/10/2013.
- All FRAs required in low risk areas are to be completed by 31/01/2014.
- All FRAs required in public areas are to be completed by 28/02/2014. (Communal areas such as thoroughfares/ corridors / stairwells /lift lobbies.

Upon completion of FRAs in all low risk areas, all High Risk FRAs will be re-audited commencing March 2014.

3.0 Fire Safety Maintenance Improvement Programme

The Trust is committed to constant fire safety improvements through works initiated by the Projects Dept and a fire safety maintenance improvement programme generated by FRAs.

All identified actions arising from FRAs are recorded on the Master Fire Action Sheet and the person(s)/department(s) responsible for their completion are notified accordingly. Monitoring of actions required is performed at Fire/Security Committee fortnightly meetings to ensure they are completed in an appropriate timeframe.

It is expected that there will be an increase in support required from the Trust's Estates function to complete the volume of tasks emanating from the review of low and medium risk areas (e.g.: High Volume of low risk work) and additional funding may be required to enable procurement of the work packages.

4.0 Fire Training

During 2013 fire training has been carried out at 4 levels:

1) Induction training for new staff
2) Mandatory annual refresher training, including computer based training
3) Nominated Responsible Person training for individuals having day to day responsibility for fire safety.
4) Local Fire Training

Managers are aware that they have a duty to ensure staff under their managerial control receive mandatory fire training. This is not only a directive of Firecode, but is also statutory requirement under Article 21 of the Regulatory Reform (Fire Safety) Order 2005.

5.0 Fire and False Alarm Incidence

5.1 The Trust continues to manage an internal reporting system to analyse Unwanted Fire Signals (UwFS). All UwFS are monitored at the fortnightly Fire/Security committee meetings

5.2 There was 1 incident of actual fire during the reporting period:

4th October 2013: Vending Machine Fire - Level 3 Cardiac Wing

Events

The fire alarm (code 1) was activated at 14.12 by a member of staff, who also alerted the Accommodation Office and Dinosaur ward.

Due to the spread of smoke, Dinosaur, IR and Meerkat evacuated as a precaution. Theatres put all lists on hold, but continued operating on those cases already in progress.

The fire was put out by Andy Warman, Security, within 10 minutes of fire alarm activation. The London Fire Brigade (LFB) arrived shortly after at 14.30. Due to the nature of the fire, smoke began to spread, and a Major Incident was declared.

In their inspection of the fire area LFB discovered that a set of doors signed as a fire exit were locked. These were not a live fire exit as they had been disabled due to the adjacent redevelopment site, but the LFB were concerned that the signage was misleading and their appeared to be some confusion from staff over the status of this exit. As a result of their concerns the LFB called in a senior inspector to investigate. As part of their investigation the brigade also identified a smoke detector which had been obscured by the erection of a hoarding for the adjacent redevelopment project. This was the detector covering the area of the vending machine, hence why the alarm was not triggered automatically, and instead had to be activated by staff operating a break glass.

The area was eventually cleared of smoke, and services able to return to normal, the Major Incident was stood down at 15.27.

Following the incident, all vending machines on site were immediately decommissioned and fuses removed. An engineer inspected all machines over the weekend of 5th and 6th October, they were eventually cleared and reinstated, and are now fully working again. The faulty machine has been removed by the contractors who will carry out an investigation.

Since the incident a full root cause analysis of the incident has been carried out, and key findings can be seen in **Appendix 1: Vending Fire Recommendations.**

5.3 No & Causes of Unwanted Fire Alarm Signals (UwFS) on the GOSH site

The number of UwFS on the Trust site for 2013 totalled 47. (47 attendances to the GOSH site by the London Fire Brigade)

Illustration 1 below provides a breakdown of UwFS that occurred in each GOSH Building.

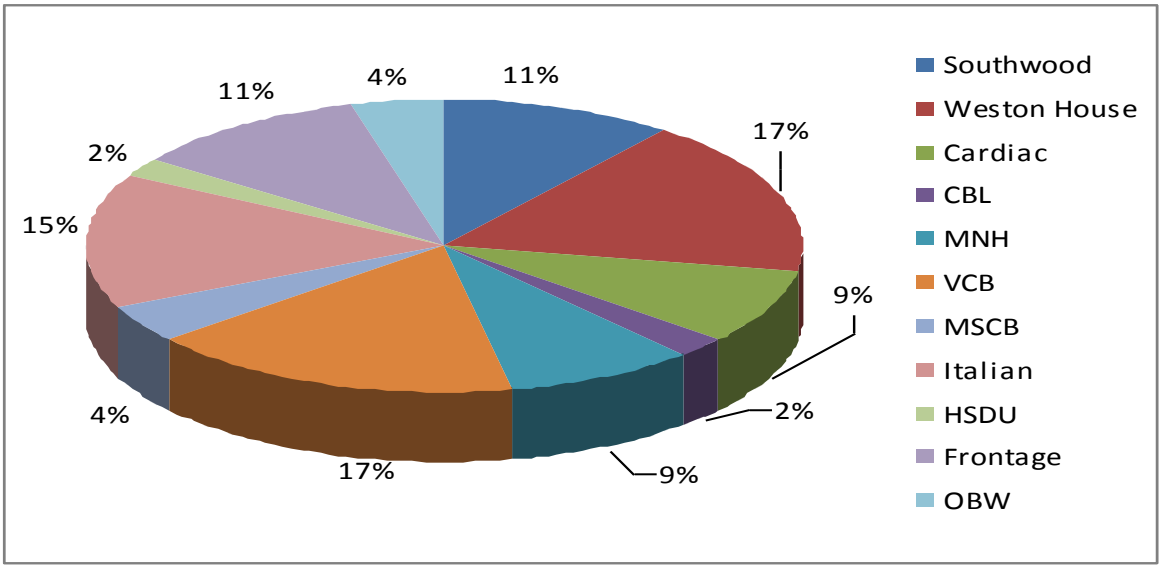
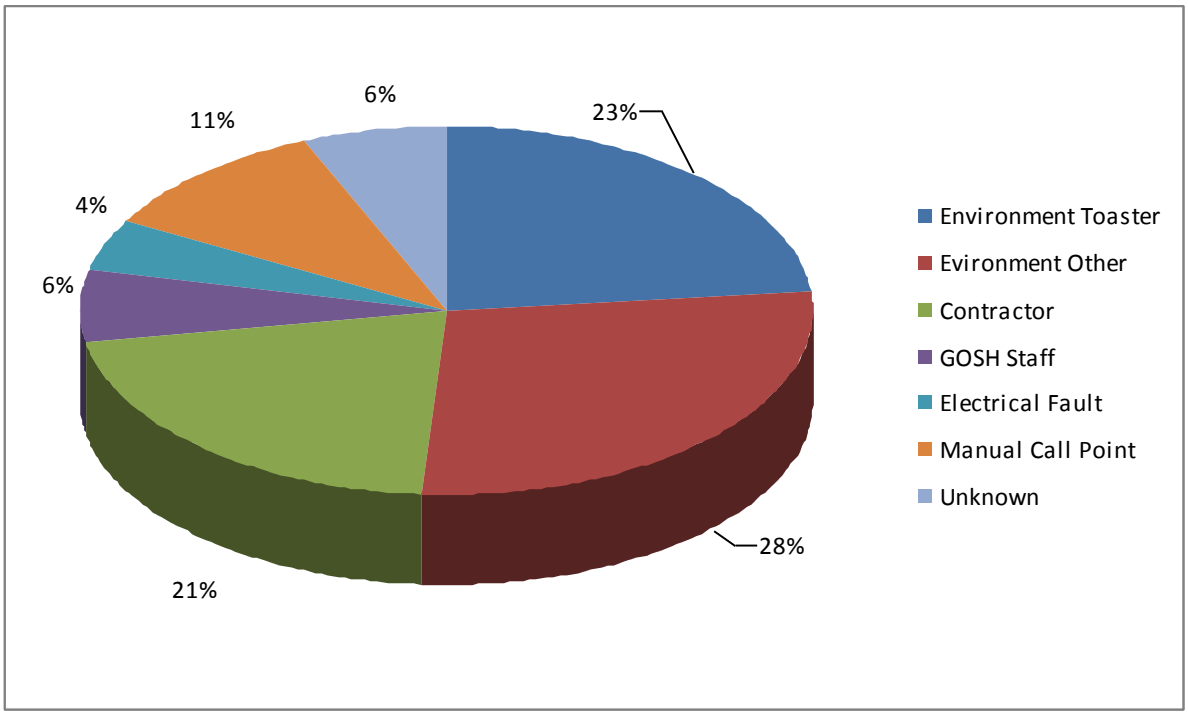


Illustration 2 below provides a breakdown of the causes of all UwFS that occurred on the GOSH site.



UwFS Summary

- As can be seen from the reporting mechanism two areas had a high number of UwFS, Weston House (8) and Italian Building (7). And these represented 32% of all UWFS on the GOSH site.
  These 15 UwFS were predominantly caused by toasters; therefore in autumn 2013 a decision was recommended by the Fire Officer and introduced by the Trust to remove toasters from these areas to further reduce the amount of UwFS in these buildings.

- Another UwFS hot spot for the Trust with 10 incidents was false alarm incidents caused by contractors working on the GOSH site. This issue is being addressed by the Estates and Redevelopment teams who are reinforcing protocols around hot work permits, and focusing on increasing awareness with contractors.

- The next highest category is wards; and the main reason for incidences of UwFS from these areas was toasters (6) and "Environmental Other", e.g. - steam from showers, use of microwaves, or use of deodorants. Awareness of these issues is therefore being highlighted in local fire training.

- 3 UwFS were caused for unknown reasons.

6.0 Serious Untoward Incidents (SUI) & High Risks

6.1 SUI

There was only 1 SUI incident in the last 12 months reporting period, and this was the Vending Machine fire detailed in section 5.2 of this document.

6.2 High Risks

GOSH currently has 1 High Risk on the Trust DATIX Fire Risk Register; the issue concerns the Southwood Building and fire compartments.

Summary of Risk and Remedial Actions:
Ducts were discovered when redevelopment work was started on level 3 in Southwood. The ducts go the whole height of the building and need to be sealed at each floor level to prevent fire and smoke travelling through the building and breaching current compartmentation. These ducts are large and were used for ventilation from the old kitchens and fume cupboards.

When the problem was identified the Trust took immediate action to protect patients and staff, through increasing staff awareness and through exploring additional fire protection at each point where access to a duct had been identified.
The Redevelopment team have now installed compartment separation on levels 1, 2, 3 7, and 8, with the remaining actions on floors 4, 5, and 6 due for completion by 31st March 2014.

Monitoring for the completion of the remaining works will be performed by the Fire & Security Committee and the Health & Safety Committee.

7.0 GOSH liaison with the London Fire Brigade (LFB)

7.1 Contact is maintained via the Trust Fire Officer.

7.2 LFB Site Visit: 16/12/2013

The LFB inspected the following buildings; Weston House / Italian Wing / 10 Guilford Street / Cardiac / and Southwood.

The Brigade were accompanied on their inspections by the GOSH Fire Officer, and the Trust is now awaiting written feedback from LFB on their findings along with any actions required.

The LFB did not give a timeframe as to when the Trust would receive their report.

8.0 LFB Industrial (Strike) Action

Since September 2013 to the time of this report being created the LFB have called intermittent industrial action over government reforms to the firefighters' pension scheme.

During periods of strike action it is foreseeable that:

- Fire Brigade attendance times to some incidents will increase
- Only a contingency level of service will be available
- Crews attending may not be familiar with premises or the local geography
- A fire appliance may not attend an Unwanted Fire Alarm.

Since the commencement of the strikes the GOSH response has been as follows:

- No 'hot works' to be undertaken 12 hours before and during the day of action
- No removal of fire doors for maintenance
- Kitchen & Lagoon staff to be more vigilant
- No Generator tests to be carried out
- All windows and doors closed, including doors held open by automatic release units once the room is vacated
- Works department will remove all fuses from toasters approximately 2½ hours before the strike commences for the duration of each strike period.
- Increased Security patrols and Security to liase with MITIE Cleaning contractor regarding noticeable build up of rubbish identified anywhere within the Trust.
- Additional trained members of staff added to the GOSH Fire Response Team.

To date, in responding to the recent sequence of LFB strikes, the Trust response has proven robust and no issues of note have arisen that have affected the day to day operation of the Trust.

9.0 LFB: Financial Charges for Unwanted Fire Signals

Introduction:
The LFB have advised that they are introducing charges for Unwanted Fire Signals from Fire Alarm System(s) from January 2014. A single charge of £290 +VAT will apply for fire alarm attendance to the GOSH site. These charges would be levied on the Trust after the first ten calls in a rolling 12 month period.
These charges were debated at a London Fire Brigade/NHS Concordat meeting on 16 October 2013

The LFB hopes the scheme will encourage the proper use and management of automatic fire alarm systems to make sure those responsible for them have the right process in place to reduce the number of false alarms. The charges are set to recover the LFB costs, not penalise the buildings concerned.

Current Situation:
When the Fire Alarm operates, an automatic signal is sent to switchboard at Guy's who alert the GOSH Fire Response Team to attend the incident and call the Fire Brigade to attend. The Fire Response Team then responds immediately and proceeds to the incident location to assess what is required. When they arrive they will contact the Security Control Room to provide an update on the incident and if this requires the fire brigade or not. GOSH staff will meet the fire brigade, show them to the location of the incident and await their permission before resetting the alarm as required.

The Trust has comprehensive maintenance systems in place for its alarm system and all activations are monitored and discussed at the fortnightly Fire and Security meetings. As part of the review the committee identify if there are any actions that can be taken to reduce the likelihood for further false alarms. Recent actions include the permanent removal of toasters from the Italian Building and Weston House. Where issues can be rectified by changes to the alarm system, this is carried out by our on site contractors.

Proposals Moving Forward:
The Department of Heath, through the latest release Firecode guidance covered in HTM 05-03 Part H, is now recommending that organisations consider the use of time delays in making the call to the Fire Brigade where false alarms have be a problem, provided that internal response procedures are in place, and Fire Response Team's trained accordingly.

The Trust has considered this and through the Fire and Security Committee agreement has been reached to proceed with implementing a time delay for Trust buildings.
This will bring the Trust in line with a large proportion of NHS Hospitals in London and across the country where this is now established practice.

The new procedure consists of the following:

- Introduce a 5 min delay into the system, this delay will allow time for staff to investigate a fire alarm before the fire brigade are called. The process would be similar to the current system except the call to the switchboard would only operate the pager alert system and not call the LFB. The Fire Response Team would have 5 minutes to get to the incident location and radio back to Security Control if the fire brigade were required or not. There are 2 safeguards in the system:
    1. If the Security control room does not receive any communication from the Fire Response team within 5 minutes, they call the LFB straight away, a dedicated 'phone line is already in place.
    2. If another fire detector or a fire alarm break glass call point is activated, the control room will call the fire brigade straight away. This is referred to as a 'double knock system' and is commonly found in a range of industries.
- Keep a written record of all Fire Alarm actions e.g. Zone shut downs and resets.
- Limit any cooking to designated areas, ensure correct fire detection installed.
- Remove all unauthorised cooking equipment including items' brought from home' kettles, microwaves toasters etc. from all areas of our buildings.
- Fire Training is to include measures to reduce false alarms.
- KPI's to be set for further reductions and reported annually.

Conclusion
Charges for Unwanted Fire Signals could be significant for the Trust if it does not manage the incidence of false alarms. Whilst the introduction of the 5 minute delay does not necessarily reduce alarm calls it will allow the LFB to target its resources more effectively and reduce the risk of unnecessary charges being levied on the Trust. Where this system has been implemented in

other Hospitals it has also shown to improve the patient experience as it significantly reduced the disturbance from false alarms as Trust staff can reset the system following a false alarm with having to wait for the Fire Brigade to attend site.

Action: The Trust Board are requested to note the proposed change and to support this initiative, and that the Trust Fire Policy will be updated to reflect the changes.

10.0 Fire Maintenance Tender

In autumn 2013 a full tender process for a 5 year maintenance contract of all Life Safety Systems across the whole site was completed utilising the London Procurement Programme Framework (LPP).

This new contract includes the following disciplines:

- Fire extinguishers (site-wide)
- Dry risers
- VESDA Systems
- Gas Suppressant System in The Lagoon Kitchen
- Fire Hydrant Servicing
- Sprinkler Systems, MSCB & OBW

The contract has been awarded to Thameside Fire who commenced on 11 January 2014.

11.0 Trust Fire Officer Recruitment

The Trust has now agreed a partnership with Essentia, part of Guys and St Thomas' NHS Foundation Trust, for the provision of Fire Officer support to the Trust. Alan French is the nominated site based Fire Officer for GOSH, and can be contacted about any fire related issues including training and risk assessments on ext 8372 or email Alan.french@gosh.nhs.uk
The additional benefits of the partnership with Essentia are that the Trust has access to an extended range of professional fire support in addition to the Fire Officer based on site, and full cover is in place for incidents and any absences.

12.0 Fire Safety Policy

The policy is currently under review and the revised draft will be presented to Trust's Policy Action Group scheduled for 28th January 2014 for final ratification.

13.0 Fire Plan 2014:

A summary of the planned actions for 2014 is as follows:

1) FRAs for all areas of the Trust, including high, medium, low risk areas, will be completed by end of February 2014. Re-audit of the high risk FRAs will commence starting in March 2014.

2) The Estates team to complete the volume of tasks emanating from the all FRAs completed.

3) Complete all actions identified contained in the Vending Fire Report **(See Appendix 1)** by 31st March 2014.

4) Southwood Building compartment issues to be resolved led by the Estates team by 31st March 2014.

5) Introduction of a time delay in the process to call the LFB via the GOSH Fire Response Team to minimise Unwanted Fire Signals on the Trust site and potential London Fire Brigade charges. (To occur after the new Security contract, start date 1st April 2014 is bedded in)

6) Trust Fire policy to be reviewed and ratified at the Trust Policy Action Group.

7) Review of the Trust Fire Risk Assessment process; to include;
   - To reduce the number of assessments
   - Review fire risk assessment documents to be produced from guidance in HTM's and PAS 79.
   - Guidelines are produced to define, in fire terms, High, Medium and Low risk and the fire risk assessments are graded.
   - Fire risk assessments are commenced with the priority being:
     - New areas/refurbishments;
     - High risks as defined above and then medium and low risk;
     - A monitoring process is put in place to follow up findings of fire risk assessments and Fire Books to be updated during the year.

8) The current list of Responsible Persons (RRO 2005) to be reviewed in line with the fire alarm zone maps and the fire compartment drawing to ensure accurate records and accountability are defined. Training is to be provided for these individuals.

9) A review of Trust GOSH Fire Training/ Refresher programme to be set up for all staff in conjunction with the Training and Development department

Appendix 1: Vending Fire Recommendations

	Directorate			**Datix ID:**		**STEIS Ref:**	
No.	**Recommendation**	**Action / implementations**	**Outcome Measure (how will we know that this has been achieved?)**	**Lead person**	**Date for compliance**	**Signed off by & dated**	**Monitoring Committee/ Group**
1	Each Building Project must have written approval/sign off from the Trust Fire Advisor**.**	Each project undertaken has a project folder which contains Pre/during and post project Fire Risk Assessments / Risk Impact Assessments/ Method Statements and Risk Assessments. Each Project must get sign off from the Trust Fire Advisor.	The Folders will be audited quarterly by the Health and Safety Team and the Fire Advisor.	Head of Projects	01/12/2013	Mark Ward 09/01/14	Projects Health and Safety Committee. Trust Health and Safety Committee.
2	Fire risk assessments of the all communal areas must be completed.	All thoroughfares/ corridors / stairwells /lift lobbies.	Updates presented at the bi-weekly fire and security meeting.	Head of Fire and Security	01/03/2014	Steve Moxley	Fire and Security Bi-weekly meeting. Health and Safety Committee
3	Review of local fire risk assessments after each fire alarm by the Trust Fire Advisor**.**	After the receipt of a DATIX incident form reporting a code 1 or 2 there must be a review of the local fire arrangements.	Updates presented at the bi-weekly fire and security meeting.	Head of Fire and Security	01/02/2014	Steve Moxley	Trust Health and Safety Committee.
4	Local Fire training requires review.	Review of all Fire training, including numbers trained and content.	Updates presented at the bi-weekly fire and security meeting.	Head of Fire and Security	31/03/2014	Steve Moxley	Trust Health and Safety Committee.
5	Greater cohesion between Corporate Facilities/Estates and Projects	Formal communication strategy/SLA between corporate departments. Corporate Facilities and Estates are joining to become one single division.	There will be a reduction in the amount of serious incidents relating to communication failings between Projects and Estates and facilities.	Director of Estates and Facilities and the Director of Redevelopment	01/01/14	Matthew Tulley	Estates Health and Safety Committee/Projects Health and Safety Committee/Trust Health and Safety Committee.

Trust Board 28th January 2014	
Equality & Diversity Annual Report **Submitted by:** Co-Medical Director/ Director of HR & OD	**Paper No: Attachment R**
Aims / summary To provide Trust Board with assurance that the Trust is meeting its statutory obligation under the Equality Act 2010. To inform the Board about progress in working towards the Trust's equality objectives.	
Action required from the meeting To note the content of the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Meeting statutory duty to report publically on this activity. Work promotes fairness and equity in service delivery and employment.	
Financial implications None.	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Family and Staff Equality and Diversity Groups.	
Who is accountable for the implementation of the proposal / project? Co-Medical Director for families and Director of HR & OD for staff.	

Equality and Diversity Annual Report 2013

Introduction

The Equality Act came into force on 1st October 2010, simplifying existing equalities law into one single source of Statute. In addition to the Act, a new statutory duty (the Equality Duty) came into force in April 2011 which is applicable to all public sector bodies. As a Trust we must demonstrate that we comply with the Equality Act and are meeting the Equality Duty through the work we do, the involvement we have of the Trust Board in this work and through publishing a range of equalities data on an annual basis. This paper sets out how we are meeting the general and specific duties of the Equality Act 2010.

To comply with the first specific duty of the Act, the Trust is legally required to publish equality data relating to both service users and staff annually at the end of January. A copy of the latest edition of this report is available on the GOSH website at www.gosh.nhs.uk/about-us/equality-and-diversity/. The report covers information/data regarding all of the protected groups and will be updated and published on an annual basis in order to maintain legal compliance.

The second part of the specific duty requires the Trust to 'prepare and publish equality objectives, which should be specific and measurable, setting out how progress towards these objectives should be measured'. Through using the NHS Equality Delivery System, and using the information contained within the Trust's data report, four equality objectives covering the period 2012 – 2015 were approved by the Trust Board.

Trust Equality Objectives and Progress Achieved

The following four objectives were agreed by the Trust.

Objective 1:

We aim to reduce the number of patients for whom ethnic group and religion is 'not asked' by ten per cent year on year.

This objective forms part of a wider plan to revisit data collection and usage at GOSH, which will enable more meaningful analysis and action in future. An example of this is the development of advice letters highlighting facilities for specific religious groups, the use of which is dependent on accurate data. The latest data report shows that 34 per cent of patients were 'not asked' their ethnic group and 52 per cent 'not asked' their religion. Further work is planned with the Outpatient department, where the majority of patients have their first contact with GOSH, to increase the rate at which families are being asked their ethnicity and religion.

Objective 2:

We aim to increase the percentage of respondents stating that they agreed that the hospital understood these needs and put arrangements in place to meet them year on year.

This objective forms part of a wider plan to improve our services for children with disabilities, which is required by Monitor and other organisations.

The 2011/12 Ipsos MORI inpatient survey asked:

- Does your child have any special needs or disabilities? For instance, a physical disability or learning disabilities? 44 per cent of respondents said yes
- To what extent do you agree or disagree that the hospital understands these needs and puts arrangements in place to meet them? 85 per cent agreed (62 per cent strongly and 23 per cent fairly)

When the same questions were asked in the 2012 Ipsos MORI outpatient survey, 44 per cent of respondents said yes that their child has special needs or disabilities, and 81 per cent (64 per cent strongly and 17 per cent fairly) felt that GOSH understands these needs and puts arrangements in place to meet

them. Members of the Family Equality and Diversity (FED) group felt that 80 to 85 per cent was a reasonable rate of agreement with the statement and aimed to maintain this level.

We are pleased to have an expert Nurse Consultant in Learning Disabilities working at GOSH from September 2013, with an initial emphasis placed on raising awareness of the particular needs of families with a child/young person with learning disabilities with staff members and ensuring pertinent information about our patients children is available to anyone with whom they come into contact. Various options for developing a 'hospital passport' are being investigated – with versions for families to complete and hold as well as staff-initiated documents. Provision of Easy Read information continues to be a priority and many more Easy Read information sheets are available on our website.

Objective 3:

Following on from the Trust objective to increase appraisal rates for all staff to at least 80%, we aim to achieve a year on year improvement of the percentage of staff from protected groups having appraisals.

Target: By 2013 the appraisal rates for all protected groups will match the appraisal rates of all other staff.

Background

The Trust identified shortfalls in the numbers of staff receiving appraisals and made this a priority area of action. Data showed that BME staff in particular were disproportionately over-represented in the numbers of staff without appraisals.

The number of staff having a current PDR appraisal has remained stable over the last 12 months, reaching a peak of 82% from March-May 2013. The compliance figure as at 9th December 2013 is 74.4%. Analysing staff with appraisals by ethnicity, gender and age group indicates that compliance across all ethnicities is down, although unfortunately there has been a bigger fall in percentage terms for BME and particularly black staff. Male staff continue to have disproportionately fewer appraisals than female staff. These patterns are similar to those of disciplinary activity, in which male and BME staff are disproportionately more likely to be subject to disciplinary action.

This data is shown in more detail below: (Please note this data is generated by the Trust's training database and therefore includes staff on maternity leave and long term sick (who may therefore have PDRs outstanding), and does not currently include consultant medical staff. It also cannot currently report on a number of protected characteristics including disability, religion or sexual orientation. This limited functionality will be addressed by the procurement of a new training database in 2014).

ETHNICITY	**% of staff of stated characteristic with current PDR's 2013**	**% of staff of stated characteristic with current PDR's 2012**
White	70.2%	73.1%
BME*	62.7%	69.5%
Other / Mixed	76.8%	72.3%
Asian	70.6%	66.6%
Black	59.5%	70.5%
Chinese	64.1%	72.5%
Not Stated (n=16)	43.8%	47.4%
GENDER		
Female	69.6%	73.6%
Male	60.8%	66.5%
AGE		
16-24	65.6%	63.3%
25-34	70.3%	71.9%

ETHNICITY	% of staff of stated characteristic with current PDR's 2013	% of staff of stated characteristic with current PDR's 2012
35-44	68.4%	74.8%
45-54	67.8%	76.0%
55-64	60.4%	74.8%
65+	46.9%	58.3%

*nb BME is the summary categorisation of non-white staff. The other categories shown are subsets of BME. The Trust recognises that ethnic groups are not homogenous but in line with other organisations reports in this way in order that the experience of non-white staff can be effectively compared against white staff in significant numbers.

PDR appraisal rates are monitored at divisional performance reviews. Data by demographic group is considered by the Equality and Diversity Group, which includes senior members of the Trust's Learning, Education and Development team. Actions to understand and address the failure to meet the Equality objective include:

- Procurement of a new Learning Management System/Training database in 2014 to improve capture and reporting of data
- The new database will also facilitate timely follow up of managers and staff who are not holding appraisals
- Strengthened Mandatory Training and Compliance policy to more robustly manage performance manage staff at all levels who fail to complete mandatory training requirements
- Discussion with the GROW (BME network of staff) on underlying reasons why BME staff may not be having appraisals

It is noted BME staff and male staff are also likely to be disproportionately subject to disciplinary action in the Trust. The Equality and Diversity Group has commissioned a number of actions to better understand, monitor and address this issue, which it is felt will also contribute to the work on appraisals. These actions include:

- First pilot of cultural competence training for managers run November 2013, with next steps being considered by the Trust E&D Group
- Cultural competence training for all HR and OD staff will take place as part of a new HR & OD Development programme
- Training of diverse staff to act as advisors in disciplinary/harassment/bullying/grievance issues where ethnicity, religion, gender etc are issues
- Analysis of experience of BME staff in 2013 staff survey will take place following publication in February 2014

Objective 4:

There will be a year on year increase in the percentage of tests used in recruitment selection processes.

Target: January-December 2012 – 50% of recruitment episodes will include tests
January-December 2012 – 75% of recruitment episodes will include tests

Background

Data showed that across all recruitment episodes people from ethnic minority groups were presently less likely to be appointed to jobs at GOSH than white people. The use of testing is intended to ensure an objective element in the selection process or a more "open" element, i.e. one that includes the involvement of a range of measures rather than the selection decisions of the interview panel alone.

TARGET		ACTUAL (number of tests against number of interviews)	
Date	**%**	**Date**	**%**
Jan – Dec 2011	No target set at this point	2011	20% (estimated figure)
Jan – Dec 2012	Target 50%	TOTAL Jan – early Dec 2012	**46%**
Jan – Dec 2013	Target 75%	TOTAL Jan – mid Nov 2013	**52%**

The table above shows that **52%** of all selection processes included some form of test. This is an increase of 6% compared with 2012. It should be noted that for the purposes of collecting data for this report, the information does not include a complete final month and the data also does not include junior doctor appointments, which are managed separately (nb our medical staff are our most ethnically diverse staff group).

Around 55% of the tests conducted are referred to as 'unseen tests'. These are typically administrative type tests relevant to the job role (e.g. correcting patient letters for Medical Secretaries/Pas). The variety of tests has increased throughout the course of the year. In addition, psychometric testing and informal meetings continue to form part of the process for senior appointments of which there were a significant number in the last year.

The target of tests conducted against the number of interviews for 2013 had been set at 75% and this target has not been reached despite a number of strategies to increase testing such as discussing selection methodology with recruiters at the start of the recruitment episode, inclusion as part of the recruitment and selection training course and implementing bespoke application forms with scenario questions for easier shortlisting.

Notably, the Nursing Workforce Group has made significant progress to embrace testing as part of the selection process for nursing positions. At both Newly Qualified Nursing fairs this year, candidates have been required to undergo full day assessment centres. In addition, from 1st November 2013 all Band 5s are required to undertake a numeracy and literacy test as part of their application and selection process. Over time the aim is to build up a bank of literacy and numeracy papers for nurse recruiting managers to access.

In 2014 we will be developing the use of a wide range of selection and assessment methods for medical staff.

The data below shows that although the number of white and BME applicants is roughly equitable, the numbers of BME staff who are subsequently appointed falls significantly. In reviewing the data (below), this trend continues but there do appear to be some indications that numbers of BME staff being appointed in the Trust has increased. Although it is too early to identify trends through this data, and indeed whether it is the use of selection tests that have contributed to this figure, the use of selection tests will in any event provide additional reassurance to applicants about the rigour and objectivity of the selection process. The Recruitment team monitor the relevance and appropriateness of each test and will continue to scrutinise this to ensure that there is no opportunity for unfair bias.

Ethnic Origin	% of total applicants 2013	(2012)	(2011/12)	% of total applicants appointed 2013	(2012)	(2011/12)
White	**48.6%**	51.2%	49%	**65%**	79.9%	73%
BME*	**47.4%**	46.8%	48.3%	**26.7%**	19.1%	24.4%
Black/Black British	**15.6%**	15.7%	15%	**7%**	4.9%	5.5%
Asian	**23.4%**	23.6%	25%	**14.8%**	9.9%	14%
Chinese	**1.4%**	1.4%	1.6%	**1.2%**	0.5%	0.6%
Mixed race	**3.5%**	2.7%	3.4%	**2.8%**	2%	2.7%
Other	**3.5%**	3.4%	3.3%	**0.9%**	1.8%	1.6%
Not disclosed	**1.7%**	1.8%	2.1%	**1.7%**	1.0%	2.3%

(please note percentages may not add up to 100 due to rounding)

*nb as before BME is the summary categorisation of non-white staff in order that the experience of non-white staff can be effectively compared against white staff in significant numbers.

A new target has been set for 2014 and the aim will be for 66% of all interviews to incorporate a test as part of the selection process. In order to achieve this, the Recruitment team will;

- Continue to discuss selection methodology in greater detail at the start of the recruitment episode and as part of the recruitment and selection training courses
- Encourage the use of scenario questions to design bespoke application forms for specific posts
- Investigate the cost of administering psychometric testing for a wider range of senior positions either in-house or through establishing a regular contract with an external provider
- Facilitate mandatory numeracy and literacy testing for all Band 5 nursing posts
- Explore the use of online maths testing for nursing posts
- Look to provide guidance and a bank of sample tests for managers on the intranet
- Increase the number of informal group panels for senior appointments
- Conduct a review of Consultant recruitment in order to incorporate testing elements to the process.
- Provide further open training sessions, especially to those in lower bands, to improve their skills in writing applications and undertaking interview and selection processes.

In addition, actions relating to Objective 3 (for example, cultural competence training) will contribute to the ability of managers to recognise and address unfair bias in their recruitment practices.

Other work to meet the General Duty

In addition to making progress against our four equality objectives, GOSH is also required to report on an annual basis how we are meeting the General Duty to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Family Equality and Diversity (FED) Group

In the past year, a number of focus groups with families have been held to better understand the experience of families of children with autism, Jewish families and those who have used the complaints progress at GOSH. The learning from these focus groups is now being addressed, specifically:

- Working with the Outpatient department to provide quiet zones for families of autistic children
- Increasing the amount of information that is provided in Easy Read format for children with learning disabilities

- Working with specialists in learning disability to enable our staff to work more effectively with children and young people with learning disabilities, such as communication and dealing with challenging behaviour.
- Working with ultra-Orthodox Jewish groups such as Bikur Cholim and Ezra Umarpeh to spread understanding about the religious observances of this population
- Improving the information provided about our complaints process, in which families in the past have lacked confidence

This is in addition to advisory work with other departments at GOSH such as Redevelopment and Corporate Facilities.

Staff Equality and Diversity (SED) Group

As well as the objectives outlined above and required by law, other work has been ongoing throughout the year to progress specific equality issues:

- SED and senior members of the HR and OD teams continue to support the work of the GROW network. The Network aims to enhance interpersonal skills, provide networking opportunities and accredited learning and development to enhance knowledge, skills and career progression of BME staff. The GROW network ran an event to celebrate Black History Month in October 2013, the first of its kind at GOSH. Speakers from within and outside GOSH attended, including the Director of HR and OD, and extremely positive feedback was received from those who attended, which included staff from all ethnic groups.
- A new interactive Equality, Diversity and Human Rights package has been developed internally and will form part of corporate induction and mandatory update.
- Preliminary indications from the 2013 staff survey indicate a significant improvement in the numbers of staff reporting having received equality and diversity training over the last 12 months.
- External benchmarking has taken place to investigate the issue of over-representation of GOSH BME staff at disciplinary hearing and seek expert opinion and advice from external agencies (including the RCN and NHS Employers). Whilst this exercise showed that this situation is not unique to GOSH or indeed to the public sector, the SED group endorsed a series of actions to address the discrepancies and these will be implemented over the coming year. Actions include trialling reverse mentoring (where a member of BME staff mentors a more senior manager), introducing cultural competency training for managers/supervisors (again on a trial basis), using decision trees to aid managers in exploring all disciplinary options open to them in a consistent manner and revised and simplified key HR policies supported by Frequently Asked Questions in order to improve accessibility and understanding for all staff.
- At our invitation, an equality and diversity lead from the RCN attended a meeting of the SED Group. She participated fully in the discussions and endorsed our work, commenting on the open, persistent and committed approach we take to E&D at GOSH.
- The first pilot session of cultural competence training took place as part of a programme for new managers on creating a positive working environment. This was provided by an expert external trainer and is currently being evaluated. A similar session will be run for all HR staff as part of the HR Development Programme in 2014.
- We introduced a new suite of E&D reports which provide clearer analysis of the experience of different demographic groups in the Trust. This allows us to focus attention more closely on disproportionally negative experiences and monitor changes.

Future Actions

Objectives 1 and 2 will continue to be formally monitored by FED and objectives 3 and 4 by SED. Progress against each objective will be reviewed by the appropriate group every six months. Progress against all objectives will be formally reported to Trust Board annually. Later during the course of this year an exercise will be undertaken to develop the equality objectives for the period 2015 – 2018.

Action required

Trust Board are asked to note the contents of this report.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th January 2014

Performance Summary Report **Submitted by:** Julian Nettel, Chief Executive	**Paper No: Attachment S**

Quality and Safety (Co-Medical Director)

In month, 1 case of MRSA and 2 cases of C.difficile were reported. The number of cases of C.difficile remains the most significant risk to not achieving the Monitor quality governance risk rating in Quarter 4 with 10 cases reported to date against a de minimis level of 12.

The Trust is close to a statistically significant reduction in the number of cardiac and respiratory arrests. There has been a pan-trust effort to increase the awareness of the deteriorating patient, which has been facilitated through a number of actions including increased exposure to simulation training, review of all 2222 calls and feedback to the teams involved, introduction of ward huddles to highlight patients of concern and an increase in the number of staff trained in resuscitation skills.

The International and Private Division (IPP) have undertaken targeted work on the early identification and escalation of the deteriorating child. In month the division achieved a statistically significant improvement with the accuracy of the Children's Early Warning Score (CEWS) reported at the electronic Patient Status at a Glance (ePSAG) board during a daily huddle, compared to the actual CEWS written on the observation charts at the bedside. The measure identifies the percentage of inaccurate scores reported at the huddle when compared to the recorded CEWS scores at the bedside. There have been a number of changes that have resulted in this improvement including improved accuracy in CEWS scoring, no 'observations in pockets' and increased educational support at the bedside.

Targets and Activity (Director of Planning & Information)

Patient spells remain above plan year to date. The Trust continues to deliver above plan on Intensive Care Unit bed days reflecting our successful implementation of our plan to increase Intensive Care Unit beds. The number of outpatient attendances fell over December reflecting seasonal variation.

The Trust saw an 11.2% increase in formal complaints in quarter 3 compared to the previous quarter. It is thought that this is primarily due to an increased promotion of the complaints service following family and patient feedback. The key themes in quarter 3 include a lack of communication with parents, pain management and management of sedation. Action plans are developed following investigation and where it is deemed appropriate to ensure that issues are addressed. These cases are added to an 'actions log' and followed up by the Complaints Team to ensure that the agreed actions have been put into practice. The actions log is shared with all divisions on a monthly basis to ensure Trust wide learning. A detailed quarterly report of complaints, trends and action plans is presented the Quality & Safety Committee.

With the exception of December, discharge summary rates have remained above 80% since June 2013. The dip in performance is similar to last year and largely related to staff leave over the Christmas holiday. Trust performance in January has improved to 88%.

The Trust remains 'green' against Monitor's governance risk rating at Quarter 3 demonstrating compliance against all service performance measures including all cancer, elective admitted and non-admitted treatment waiting times.

Finance and CRES (Chief Finance Officer)

Total income for the nine months to the end of December was £278.6m, £3.3m ahead of

budget. EBITDA was £20.4m, £5.1m ahead of budget. The EBITDA margin at 7.3% compares well with the budgeted margin of 5.6%.

The results in December continued the trend experienced in previous months other than in International where income was below plan due to lower surgical activity. NHS clinical activity remains strong and ahead of plan in most areas. Expenditure remains overall below plan by £1.9m.

Cash levels are ahead of plan, in part due to delays in capital expenditure but NHS debtor levels are increasing due to external procedural delays.
We continue to prioritise pursuing debtors, managing agency costs down and delivering the CRES target.

Patient Experience & Pals (Chief Nurse & Families Champion)

Our major Consultation with staff, patients and families to identify shared values and behaviours is now underway and will continue to the end of March. It is anticipated that following analysis of the findings in April, there will be presentations to Members Council and Trust Board; a public event to present the findings to staff, patients, parents and Members; and an engagement plan put in place to embed the values in a meaningful, accountable, visible and sustainable way.

The national 'friends and families test' is being implemented in GOSH. All inpatient wards have been provided with materials to routinely offer all discharged patients and their families the friends and family test. The next stage is to roll out the test to outpatients and day cases. In addition to the existing manual system, other methods such as token systems, kiosks, smart Apps etc. are being considered for Outpatients.

The fieldwork for the annual in-patient satisfaction survey commissioned from IPSOS Mori began this month and results will be with GOSH by end of March. We anticipate that the Care Quality Commission may require GOSH to participate in a national paediatric in–patient survey later in 2014 but details are not yet confirmed.

Action required from the meeting
Trust Board to note performance for the period.

Contribution to the delivery of NHS Foundation Trust strategies and plans
To assist in monitoring performance across external and internal objectives.

Financial implications
Failure to achieve contractual performance measures may result in financial penalties.

Legal issues
N/A

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
The Members' Council receive a copy of the performance report and Commissioners receive a sub-section of the performance report monthly.

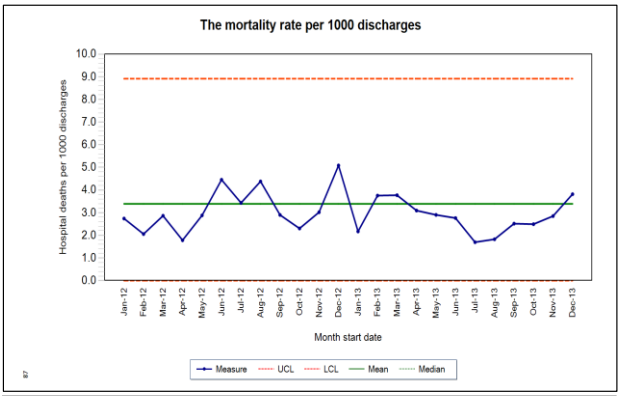
Who needs to be told about any decision?
Executive Directors.

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

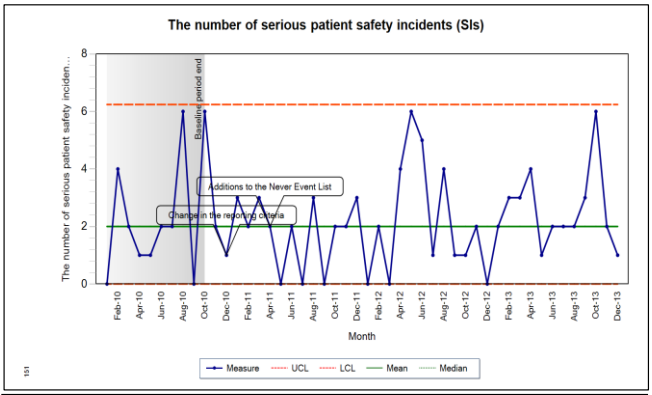
Who is accountable for the implementation of the proposal / project?
Executive Directors.

Quality and Safety report

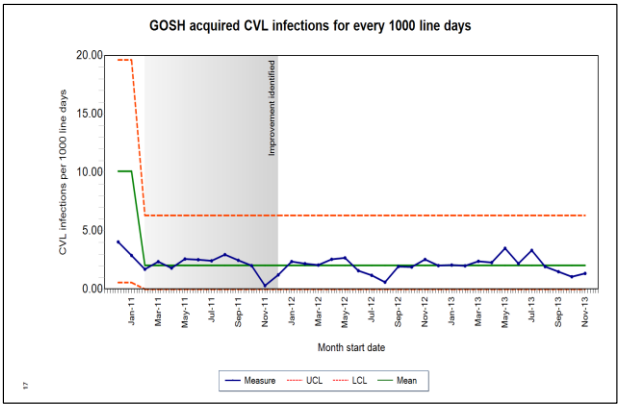
Quality and Safety Indicators



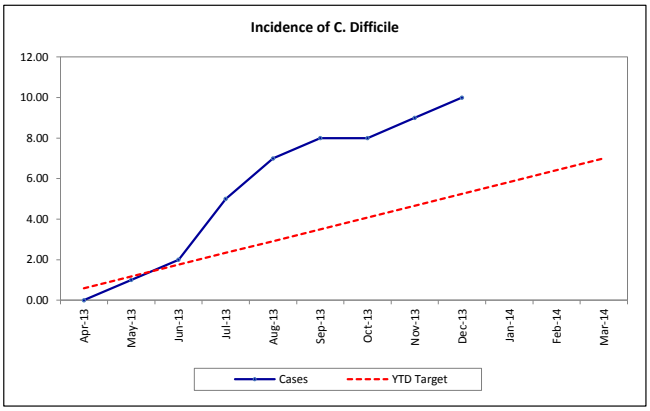
Description: The mortality rate per 1000 discharges
Target: Internal target: Year on year reduction
Trend: Performance sustained
Comment: Performance remains within statistical tolerance



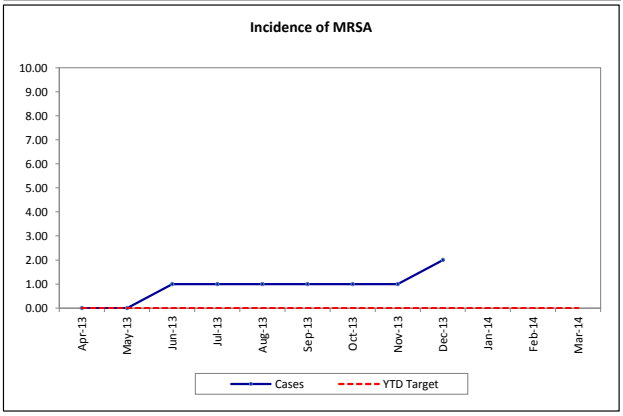
Description: Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'
Target: Internal target: To remain within control limits
Trend: Performance sustained
Comment: Performance remains within statistical tolerance



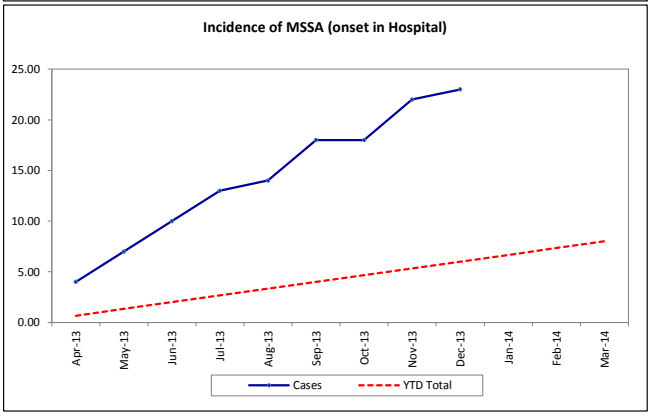
Description: The number of CVLInfections for every 1000 Bed Days acquired at the Trust
Target: Internal target: <=1.5
Trend: Performance sustained.
Comment: Performance remains within tolerance.



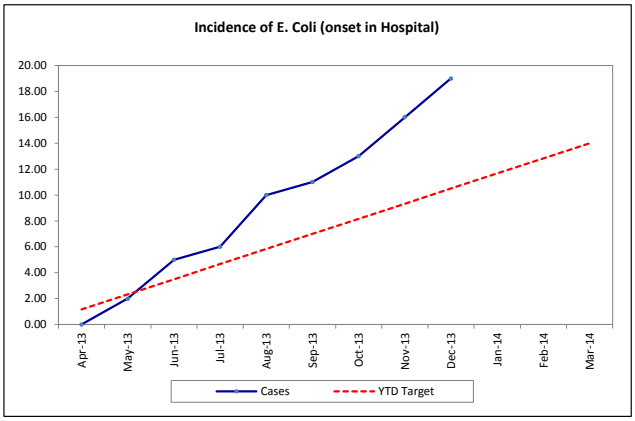
Description: **Cases detected after 3 days (admission day = day 1) are assigned against trust trajectory**
Target: No more than seven cases per year
Trend: Trend above trajectory
Comment: 10 cases reported at m9. Further reported cases will be reviewed by NHS England to identify any weakness in systems and care provided. An action plan to resolve any findings will need to be put in place and resourced.



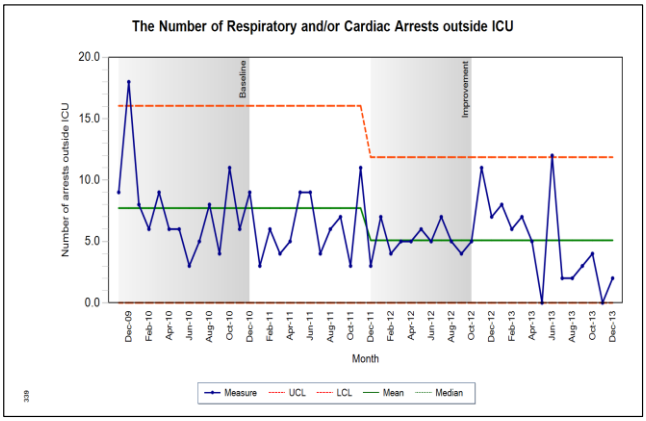
Description: MRSA bacteraemias
Target: Zero cases
Trend: Two case s reported to date
Comment: Over contractual target of zero. No financial penalty. However within Monitor de minimus level.



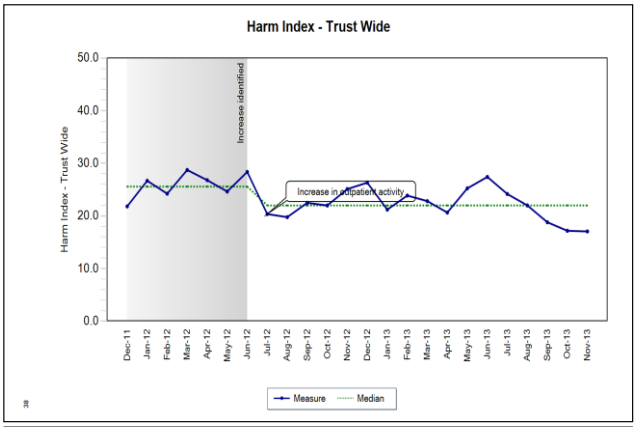
Description: Cumulative incidence of MSSA bacteraemia episodes (Methicillin sensitive S. aureus)
Target: Internal Target no more than eight cases
Trend: Performance continues above trajectory
Comment: Performance being monitored closely



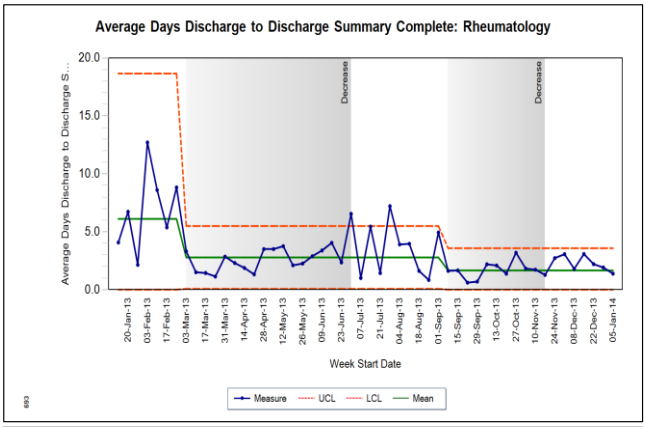
Description: **Cumulative incidence of E. coli bacteraemia**
Target: Internal Target no more than fourteen cases
Trend: Performance reported above trajectory at m9
Comment: Performance being monitored closely



Description: The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)
Target: Internal target: 50% reduction
Trend: Performance sustained
Comment: The Trust is close to a statistically significant reduction in the number of cardiac and respiratory arrests.



Description: Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers
Target: Internal target: Year on year reduction
Trend: Performance sustained
Comment: Performance remains within statistical tolerance



Description: Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers
Target:
Trend:
Comment: Work continues to improve to process in Rheumatology. The electronic discharge summary is now in place. Interventions for improving the process, for allocating and completing summaries are underway.

Targets & Indicators Report

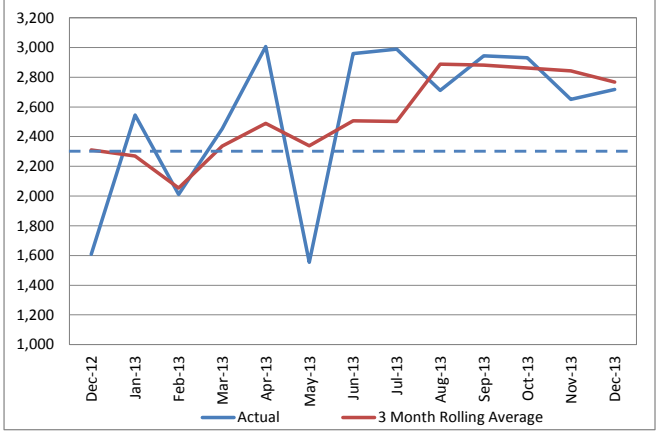
	Indicator	Graph	YTD Target	YTD Performance	Monthly Trend													
					Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Activity & Use of Resources	Number of patient spells	1	16,275	**24,468**	2,545	2,010	2,452	3,007	1,555	2,960	2,990	2,711	2,943	2,932	2,652	2,718			
	Number of outpatient attendances	2	83,881	**111,211**	12,010	10,887	10,742	11,857	12,106	11,729	13,891	10,400	12,380	14,006	13,619	11,223			
	DNA rate (new & f/up) (%)		<10	**8.2**	9.5	8.7	8.8	8.5	8.5	8.0	7.7	8.2	8.6	8.3	7.3	8.5			
	Number of ITU bed days	3	5,749	**7,313**	791	664	802	712	717	814	824	866	854	842	778	906			
	Number of unused theatre sessions		137	**190**	14	16	8	26	25	7	15	14	21	27	5	50			
Patient Access	18 week referral to treatment time performance - Admitted (%)	4	90	**91.5**	91.1	90.1	92.0	90.4	90.3	90.7	90.5	90.2	90.5	93.1	93.8	93.9			
	18 week referral to treatment time performance - Non-Admitted (%)	4	95	**95.7**	95.4	97.1	95.7	95.3	95.9	95.3	95.4	95.7	96.2	95.1	95.0	97.6			
	18 week referral to treatment time performance - Incomplete Pathways (%)	4	92	**92.7**	93.7	92.8	92.9	92.5	92.8	92.9	93.9	92.5	92.3	92.2	92.3	92.6			
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)		98	**100**	100	100	100	100	100	100	100	100	100	100	100	100			
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	5	<=1	**0.48**	0.57	0.28	0.75	0.54	0.36	0.65	0.50	0.28	0.59	0.15	0.50	0.72			
Patient / Referrer Experience	Number of complaints		81	**92**	5	9	17	6	10	12	14	10	7	11	9	13			
	Number of complaints - high grade		4	**8**	0	0	1	0	0	0	2	3	1	0	1	1			
	Discharge summary completion (%)	6	85	**81.3**	77.4	76.3	72.7	77.1	77.1	81.4	87.8	80.5	85.8	82.2	85.5	74.5			
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	7	50	**22.8**	19.0	17.6	15.2	19.4	20.7	22.3	14.0	29.6	21.8	32.2					
	Patient refusals		<259	**219**	37	43	35	43	36	49	28	17	25	21					
Work - force	Sickness Rate (%)		2.99	**2.7**	3.0	2.9	2.9	2.9	2.8	2.7	2.6	2.8	2.6	2.6	2.7	2.5			
	Trust Turnover (%)		14.13	**17.6**	16.3	16.5	16.7	16.8	17.0	17.5	17.9	18.1	17.8	17.8	18.1	17.6			

Monitor		YTD Target	YTD Performance	Quarter 4			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Monitor governance risk rating 13/14		0 - 0.9	0	0	0	Green	0	0	Green	0	0	Green	0	0	Green			

Activity and Use of Resources

1. Patient spells

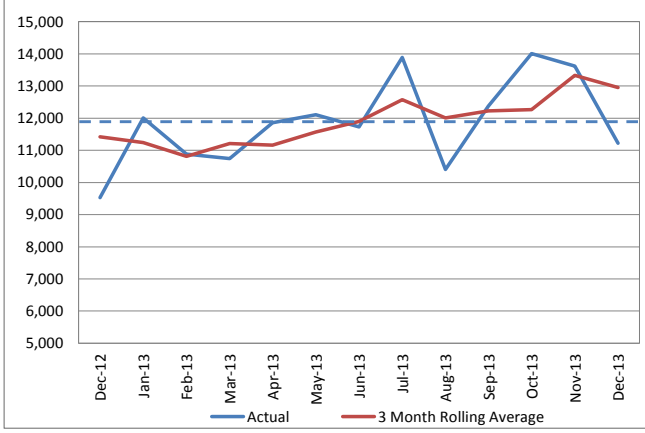
Desired direction of travel ↑



Description: **The total number of patient spells (including day case, elective and non-elective)**
Target: *Contractual target:* 2325 spells per month
Trend: Upward Trend
Comment: Performance remains above plan year to date, which is largely due to a significant increase in daycases

2. Outpatient Attendances

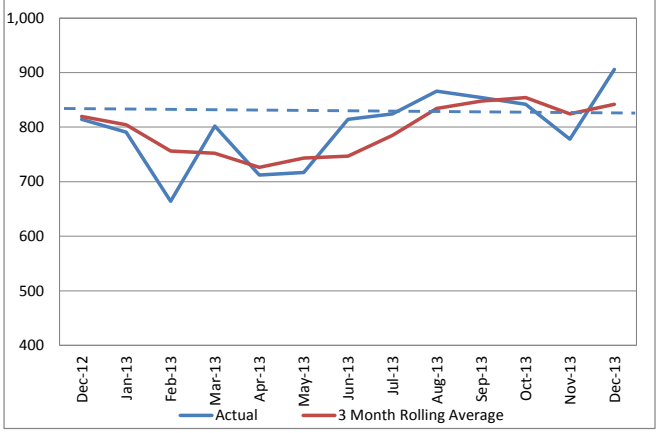
Desired direction of travel ↑



Description: **Total number of new & follow-up consultant-led chargeable appointments**
Target: *Contractual target:* 11,983 attendances per month
Trend: Upward trend against previous month
Comment: Performance remains above plan year to date

3. ITU Bed Days

Desired direction of travel ↑

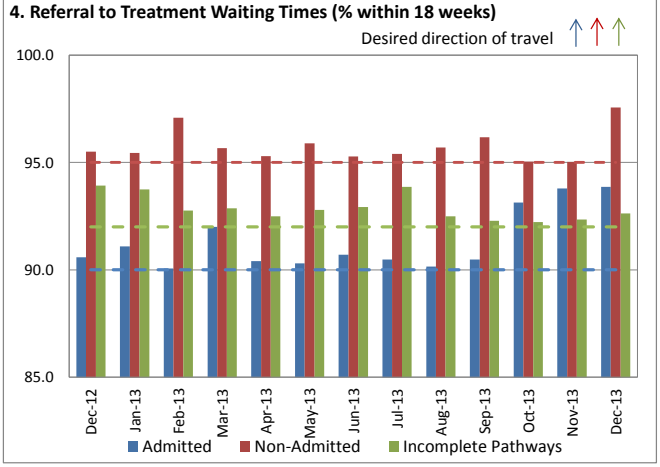


Description: **Total number of ITU bed days used per month**
Target: *Contractual target:* 821 bed days per month
Trend: Increase in ITU Bed days since May 13
Comment: Year to date performance remains above plan

Patient Access

4. Referral to Treatment Waiting Times (% within 18 weeks)

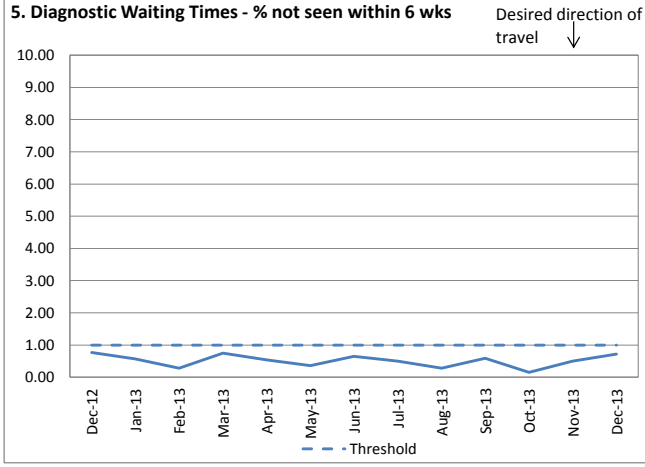
Desired direction of travel ↑ ↑ ↑



Description: **Referral to treatment waiting times for admitted and non-admitted patient pathways**
Target: *Monitor/Contractual target:* Admitted 90%, Non-admitted 95%, Incomplete pathways 92%
Trend: Performance sustained above standards. Trend tends to mirror activity levels
Comment: Higher number of breaching admitted patients identified in Surgery impacting on performance. Plan in place to reduce

5. Diagnostic Waiting Times - % not seen within 6 wks

Desired direction of travel ↓

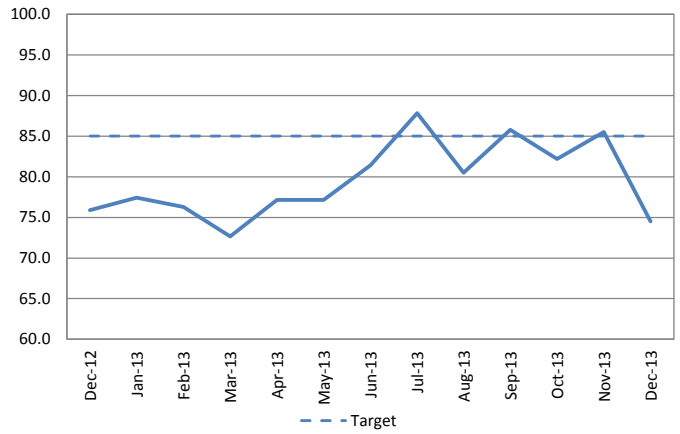


Description: **The proportion of patients waiting no more than 6 weeks for diagnostic test (across 15 national key diagnostic areas)**
Threshold: *Contractual target* <1%
Trend: Small positive movement against previous month
Comment: Performance sustained under 1% threshold

Patient / Referrer Experience

6. Discharge Summary Completeness (%)

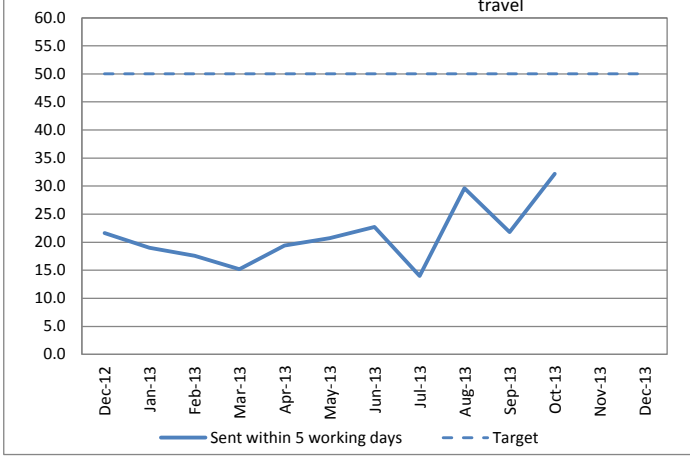
Desired direction of travel ↑



Description:	**The percentage discharge summaries completed and sent within 24 hours of patient discharge**
Target:	*Internal target:* 85%
Trend:	Downward Trend
Comment:	Decline in performance seen against previous month. Key specialty for inmprovment identified as Rheumatology with plans in place to improve.

7. Clinic Letter Turnaround - % sent within 5 days

Desired direction of travel ↑



Description:	**The percentage of clinic letters sent within five working (and average days) following patient clinic attendance & recorded on the Clinical Document Database (CDD)**
Target:	*Internal target:* 50%
Trend:	Significant improvement on previous month
Comment:	The project team continue to progress performance with the aim of achieving the 50% target by year end.

Great Ormond Street Hospital for Children NHS Foundation Trust
Financial Performance Report - Nine Months to 31 December 2013

Commentary:

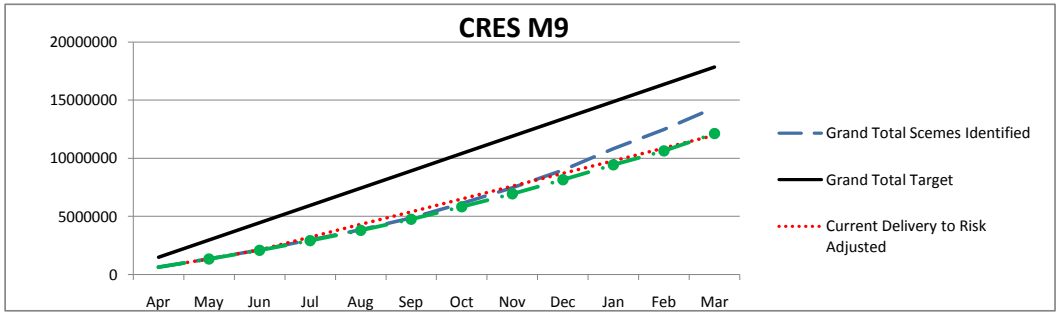
The EBITDA of £20.4m is £5.1m ahead of Plan; EBITDA margin at 7.3% (Plan 5.6%)
NHS income is ahead of plan; activity other than bed days is above plan; CQUIN achievement is also above Plan
Private patient income is below plan due to lower than plan activity outside of the dedicated private wards
Pay is below planned levels as staff growth has not been as high as anticipated and agency costs have been contained.
Non pay adverse variances reflect higher cost clinical supplies in areas of growth, renewal of PCs & some reclassifications from pay to non pay
Cash levels are higher than planned due to delays in Trust funded capital expenditure and the benefit of higher than planned EBITDA.
The overdue International Debt levels have improved in month but the NHS levels have increased reflecting delays by commissioners which are being actively pursued.

Statement of Financial Position	31-Mar-13 £m	30-Nov-13 £m	31-Dec-13 £m
Non-Current Assets	336.5	336.0	336.6
Current Assets (exc Cash)	39.9	55.3	56.1
Cash & Cash Equivalents	38.4	45.1	46.0
Current Liabilities	(43.9)	(55.8)	(57.3)
Non-Current Liabilities	(7.8)	(7.4)	(7.4)
Total Assets Employed	**363.1**	**373.2**	**374.0**

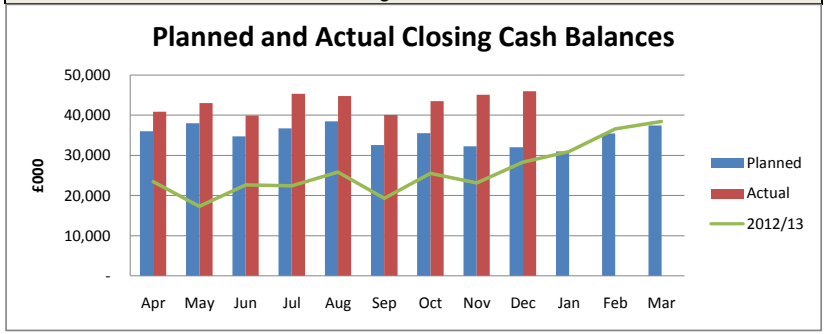
I&E	Current Month Budget (£m)	Actual (£m)	Variance (£m)	Year to Date Budget (£m)	Actual (£m)	Variance (£m)	RAG Rating
NHS Clinical Revenue	17.7	18.7	0.9	168.1	172.9	4.8	G
Pass Through	3.7	4.0	0.3	34.8	35.4	0.6	
Private Patient Revenue	3.5	2.9	(0.6)	32.5	31.2	(1.3)	G
Non-Clinical Revenue	4.4	4.7	0.3	40.0	39.2	(0.9)	A
Total Operating Revenue	29.4	30.2	0.8	275.4	278.6	3.3	
Permanent Staff	(17.6)	(15.7)	1.9	(156.9)	(142.2)	14.8	G
Agency Staff	(0.0)	(0.4)	(0.4)	(0.4)	(3.5)	(3.1)	R
Bank Staff	(0.0)	(1.1)	(1.0)	(0.5)	(8.7)	(8.2)	G
Total Employee Expenses	(17.7)	(17.3)	0.4	(157.8)	(154.3)	3.5	
Drugs and Blood	(1.2)	(1.4)	(0.2)	(11.2)	(10.0)	1.2	G
Other Clinical Supplies	(2.5)	(3.1)	(0.6)	(24.4)	(26.0)	(1.6)	A
Other Expenses	(3.6)	(3.4)	0.1	(31.9)	(32.5)	(0.6)	G
Pass Through	(3.7)	(4.0)	(0.3)	(34.8)	(35.4)	(0.6)	
Total Non-Pay Expenses	(10.9)	(11.9)	(1.0)	(102.3)	(103.9)	(1.6)	
EBITDA (exc Capital Donations)	**0.8**	**1.1**	**0.3**	**15.3**	**20.4**	**5.1**	
Depreciation, Interest and PDC	(2.7)	(2.3)	0.4	(24.1)	(22.4)	1.7	G
Net Surplus (exc Capital Donations)	(1.9)	(1.2)	0.7	(8.8)	(1.9)	6.9	
EBITDA %	2.6%	3.5%		5.6%	7.3%		
Capital Donations	3.7	1.9	(1.7)	23.3	12.8	(10.5)	

Capital Expenditure	Annual Plan £m	Actual YTD £m	Forecast Outturn £m
Redevelopment - Donated	24.2	10.5	15.1
Medical Equipment - Donated	8.7	1.8	4.4
Estates - Donated	1.2	0.4	0.5
IT - Donated	0.0	0.1	0.2
Total Donated	34.1	12.8	20.2
Estates & Facilities - Trust Funded	6.7	2.6	5.1
IT - Trust Funded	6.4	2.6	4.9
Medical Equipment - Trust Funded	2.3	0.1	1.5
Facilities - Trust Funded	0.1	0.1	0.2
Total Trust Funded	15.5	5.6	11.7
Total Expenditure	**49.6**	**18.4**	**31.9**

Continuity of Service Risk Rating	2013/14 Plan	30-Nov-13	31-Dec-13	RAG Rating
Liquidity	4	4	4	G
Capital Servicing Capacity	4	4	4	G



Closing Cash Balance



Financial Performance Report - Nine Months to 31 December 2013

ACTIVITY AND INCOME

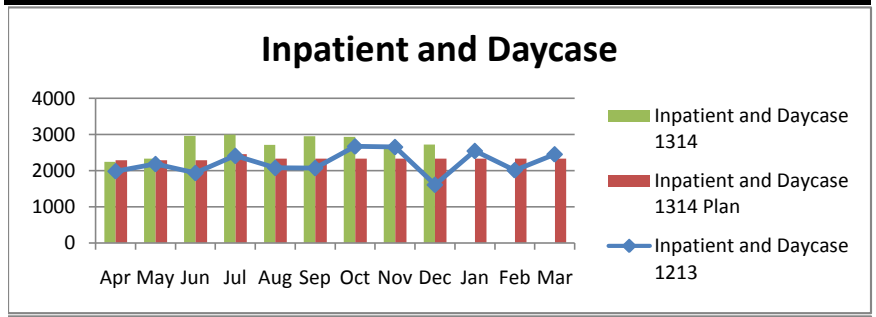
Income from NHS clinical activity £M year to date

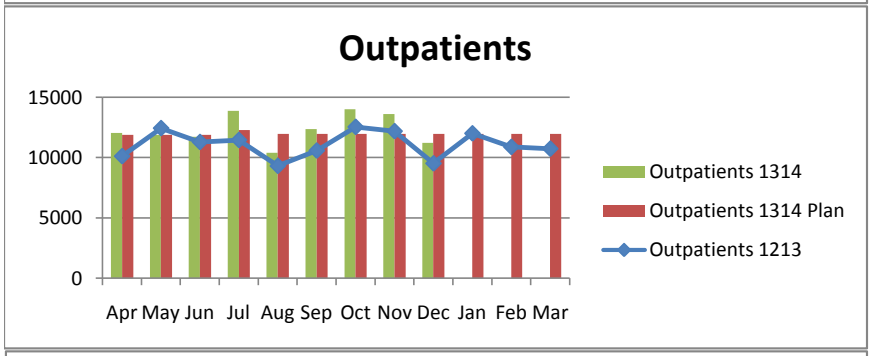
	13/14 Actual	Var v plan		Var v LY	
Inpatients/ Daycases	**69.5**	1.6	2.4%	11.8	20.3%
Bed days	**32.8**	(0.7)	-2.0%	(0.9)	-2.7%
Outpatients	**27.9**	0.8	2.7%	2.9	11.4%
Other eg. Highly Specialised	**42.6**	2.9	6.9%	(0.5)	-1.1%
Total	**172.7**	4.7	2.7%	13.2	8.3%

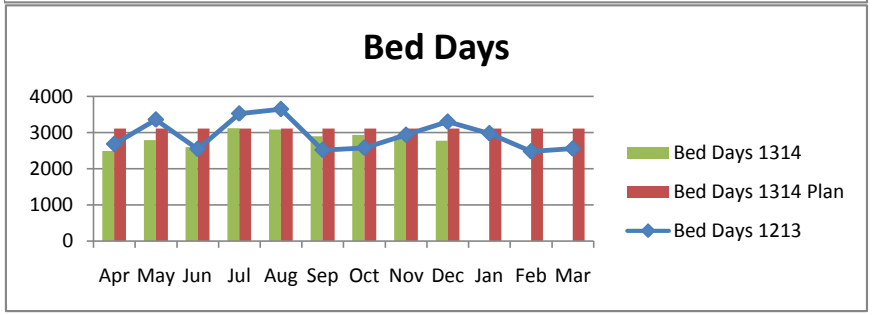
Activity

YTD 13/14 Actual	Var v plan		Var v LY	
24,468	3,543	14.5%	4,880	24.9%
25,567	(2,386)	-9.3%	(1,505)	-5.6%
111,211	4,521	4.1%	11,717	11.8%

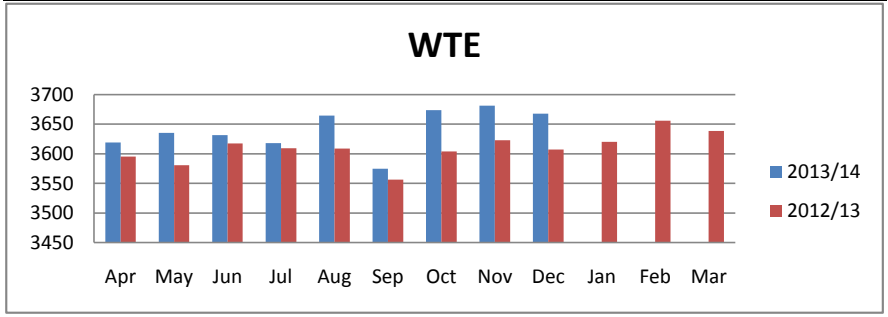
PATIENT ACTIVITY

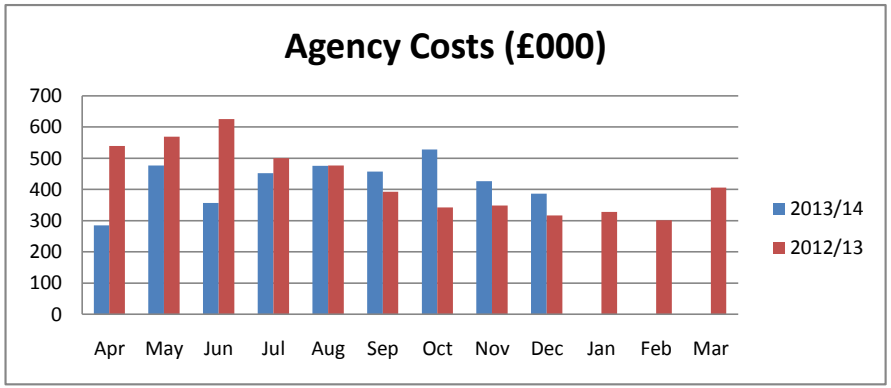






STAFF





	31-Mar-13	30-Nov-13	31-Dec-13	RAG Rating
NHS Debtor Days (YTD)	9.87	14.19	15.88	G
IPP Debtor Days	130.92	150.23	142.00	R
Creditor Days	29.88	28.64	27.53	G
BPPC - Non-NHS (YTD) (number)	85.5%	86.7%	86.7%	A
BPPC - Non-NHS (YTD) (£)	85.5%	90.8%	90.8%	G

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th January 2014

Redevelopment Report **Submitted by:** Matthew Tulley Director of Redevelopment	**Paper No: Attachment T**

Aims / summary
To inform Trust Board of progress with the redevelopment programme. We are making good progress with all strands of the redevelopment scheme. A number of milestones have been passed in delivering 2b enabling but there is still significant risk that these works may impact on the start date of Phase 2b. We intend to sign the contract for Phase 2b in February. The Stage C design phase of 3a is progressing well and is due to report in March.

Action required from the meeting
Trust Board to note progress of the programme.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Continue to redevelop and improve the hospital's estate to provide high quality accommodation for current and future patients

Financial implications
None

Who needs to be told about any decision?

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

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital Redevelopment Programme

Trust Board – 28th January 2014

1.0 Executive Summary

1.1 2b enabling works have made good progress but the complexity and scale of the programme means there is still significant risk about meeting the planned 2b start date. The Cardiac Wing is now programmed to be handed over to contractors on 9th June 2014.

1.2 The 2b procurement is coming to a close and a recommendation of the preferred contractor has been made to the Trust Board. Subject to agreeing final detailed points contract signature is planned for the end of February.

1.3 Phase 3a is progressing through the Stage C design phase. A revised brief was agreed at the beginning of the phase and the design team is working with this. The report is due to be issued early March.

2.0 Morgan Stanley Clinical Building

2.1 All defects are due to be closed out by the end of January. This will trigger the payment of the final retention.

2.2 A Post Occupancy Evaluation report is nearing completion. The Medical Architectural Research Unit (MARU) from Southbank University is undertaking this work. The report has been discussed at the MSCB Operational Commissioning Group and following final amendments will be circulated.

3.0 2b enabling works

3.1 Overall the 2b enabling works are progressing well and we have started to move services out of Cardiac Wing. A significant milestone was achieved at the end of December with outpatients moving out of L2 CW.

3.2 The three major outstanding schemes are angio/PACU, Same Day Admission Unit and Badger Ward relocation. The first two are due to complete during April. The works to L8 Southwood were delayed due to unforeseen works in the area which required additional fire safety works. These are now complete and the works have been re-programmed with Badger Ward now planned to move at the end of May 2014. The overall redevelopment impact of this has been to move the planned start date of 2b to 9th June 2014. This was anticipated within the 2b procurement.

3.3 In addition to the three schemes mentioned above there are a large number of smaller schemes all requiring completion prior to CW handover. Although none of the schemes are significant in themselves there are various interdependencies that means the completion date may be at risk should one of the schemes be delayed. 2b enabling remains within the overall budget. The programme has been included for information at appendix A.

4.0 Phase 2b – Premier Inn Clinical Building

4.1 The major activity has been completion of the procurement process to appoint the contractor for the main Phase 2b works. Subject to finalising a small number of contractual issues it is anticipated contracts will signed at the end of February 2014.

4.2 The start date for the works is now programmed for 9th June 2014 which gives a completion date of February 2017.

4.3 We have started the detailed planning of the early works phase in partnership with the imaging department who have amended working hours during the demolition period of the project. An operational liaison committee will be established with the contractor to ensure this phase of the works has minimal impact on clinical services.

4.4 The next phase of activity all relates to the establishment of the works and handover of the Cardiac Wing to the contractor.

4.5 The financing agreement with GOSHCC for 2b is to be finalised. The revised 2b budget is still being settled and will be between £89m-91m. This compares to the FBC approved budget of £103m.

5.0 Phase 3a – Centre for Children's Rare Diseases Research

5.1 The feasibility report was approved in September and authority to proceed to Stage C design was given subject to finalising all design team appointments. These were completed in October and Stage C commenced. A revised detailed design brief was agreed between GOSH and UCL which the design team are now working to.

5.2 A number of user group meetings are interacting with the design team to develop the scheme. The main focus at this stage is to ensure functionality and consistency within the internal layout and to gain a good understanding about how the building will operate. Although there will be some development of the "architectural" elements of the scheme this aspect of the project will be developed during Stage D whilst the detailed planning application is being produced.

5.3 The Stage C report will be issued in mid-March to the 3a Project Board and Strategy Groups..

6.0 Queen's Square Neurosciences Project

6.1 A detailed feasibility study is being progressed to understand the opportunities around the QSH project. Clinical planning consultants have been engaged by GOSH to assist in creating the GOSH requirements for this scheme. UCL lead the project with support from UCLH and GOSH. Hawkins Brown have been appointed to compile the feasibility study. It is planned to report in February.

Matthew Tulley

Director of Redevelopment

20th January 2014

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th January 2014

Research and Innovation Report **Submitted by: David Goldblatt, Emma Pendleton**	**Paper No: Attachment U**

Aims / summary

This report is to provide Trust Board with an oversight of research activity and performance at GOSH and has been formatted in light of discussions at (and following) the September 13 Trust Board meeting.

Income: This report is less focused on research income; limited to Table 1. Table 1 provides a breakdown of income to date; Tables 2 and 3 show directly funded research staff and projects respectively.

Publications and impact: Details of publication numbers are provided over a five year period (Table 6). In addition a summary of the detailed bibliometric analysis completed by Thomson Reuters is detailed on pages 3&4 (Research Impacts). The analysis completed by Thomson Reuters provides evidence of the impact of research undertaken by GOSH and UCL-ICH, along with our position against comparator organisations. Two short case studies are provided as examples of our leading research, the impact and potential impact this research will have on child health and details of income and relevant publications. The report does not cover lectures given as this is not a metric maintained by the Research and Innovation team *(Trust Board is asked to consider if this would be a useful metric)*.

Strengths and weaknesses: The analysis completed by Thomson Reuters identifies areas of strength and weakness. This is the first such analysis we have commissioned; it is proposed that we undertake a further analysis internally taking into account level of input (income, directly funded research staff). Future analyses could be at the level of clinical unit and could specifically address the work of the GOSH-UCL Biomedical Research Centre.

Plan to improve: No specific plans identified until further analysis completed.

Action required from the meeting

Trust Board is asked to consider (i) the revised format of the report to ensure future reports are fit for purpose (ii) the value of the Thomson Reuter's analysis and remit of any future analysis.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Research is one of the Trust's strategic objectives: With partners maintain and develop our position as the UK's top children's research and innovation organisation.

Financial implications

Loss of research income is on the Trust's Risk Register, the Trust needs to ensure there is a strategy and systems in place to retain and increase research income.

Who needs to be told about any decision?

Professor David Goldblatt, Director of Research and Innovation

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

Emma Pendleton, Deputy Director of Research and Innovation

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

Emma Pendleton, Deputy Director of Research and Innovation

Research and Innovation January 2014

This report is to provide Trust Board with an oversight of research activity and performance at GOSH and to address the main questions raised at the September 13 Trust Board meeting.

Research Inputs

1. **Research Income**
   The table below provides details of Trust research income at month 9.

Table 1 Direct Funding to GOSH

Funding Type	Funding Source	Income as at Month 9 (£000)
A. Centre Grants and Infrastructure, Research Delivery Support		
Biomedical Research Centre	NIHR	5,183
Research Capability Funding	NIHR	1,283
Local Comprehensive Research Network	NIHR	1,158
Medicines for Children Research Network	NIHR	610
B. Programme and Project Grants		
NIHR Programme, Project Grants	NIHR	764
Charity Research Project Grants	Variable*	1,366
European Union Research Project Grants	EU	129
Commercial Research Contracts	Variable	823
Other	Variable	167
Total income at month 9		**11,482**
Total Budget at month 9		**11,951**
Total Forecast Year End Income		**15,332**

* Charity funding is mostly GOSH Children's Charity

2. **Directly funded research staff**:
   112 WTE are directly funded through the research income sources detailed in Table 1 above.

Table 2: Directly funded research staff

Staff Group	Number
Administration, Data Managers, Trial Coordinators	34
Consultants	7
Directors & Senior Managers	6
Junior Doctors	2
Nursing Staff	26
Nursing Staff Bank	2
Scientific, Therapeutic, Technical	35

Note**:** This does not include research active clinicians whose substantive employment contract is with UCL, nor the research components of a clinician's job plan where this is not directly funded through the sources in Table 1. R&I will initiate a project in quarter 3 of 2014 with Divisional General Managers to review research activity and clinical contracts to help quantify the latter.

Research outputs

3. **Research Projects**:
   The table below provides details of the number of projects directly funded by the Programme and Project Grant income detailed above in Table 1B only.

Table 3: Directly funded research projects

Funding Stream (Direct Income to GOSH)	Number of directly funded projects
NIHR Programme and Project Grants	7
Charity Research Project Grants	44
European Union Research Project Grants	5
Commercial Research Contracts	52
Total	**108**

In addition, many research projects taking place at GOSH are:

a. Funded through grants held at UCL-ICH (and more recently the UCL Institute of Cardiovascular Sciences) where (i) GOSH costs are not eligible as research costs; or (ii) the Principal Investigator and research staff are substantively employed by UCL-ICH (with honorary GOSH contracts) and there are minimal GOSH costs.

b. Small pilot studies or student projects which do not have independent funding sources (classed as own account). Currently 45% of projects are recorded as own account; however we believe this is an overestimate and are currently cleaning our database to remove own account research that is either complete or dormant, this work is on-going.

Table 4: Total number of research projects (directly and indirectly funded, plus own account) by Clinical Division at month 9 13/14

Division	Total number of projects	NIHR portfolio
Critical Care and Cardio-Respiratory	67	16
Medicine, Diagnostic and Therapeutic Services	145	63
Infection, Cancer and Immunity-LM	157	54
Neurosciences	89	25
Surgery	29	5
Total	**487**	**163**

4. **Research recruitment**
   Accurate recruitment to research projects is currently only recorded for projects accepted on to the NIHR Research portfolio (acceptance is based on projects in receipt of external funding awarded via open competition and peer review), GOSH receives additional income for each patient recruited hence the need to keep accurate records.
   Note: Although recruitment is listed by Division recruitment across Divisions is not directly comparable as this will be relevant to the patient base.

Table 5: Patient recruitment to NIHR portfolio studies as at month 9 (compared to recruitment at month 9 12/13)

Division	Patient Recruitment 12-13	Patient Recruitment 13-14
Critical Care and Cardio-Respiratory	221	100
Medicine, Diagnostic and Therapeutic Services	1,185	1,117
Infection, Cancer and Immunity-LM	305	383
Neurosciences	180	399
Surgery	171	142
Total	**2,062**	**2,141**

Research Outcomes

5. **Publications**

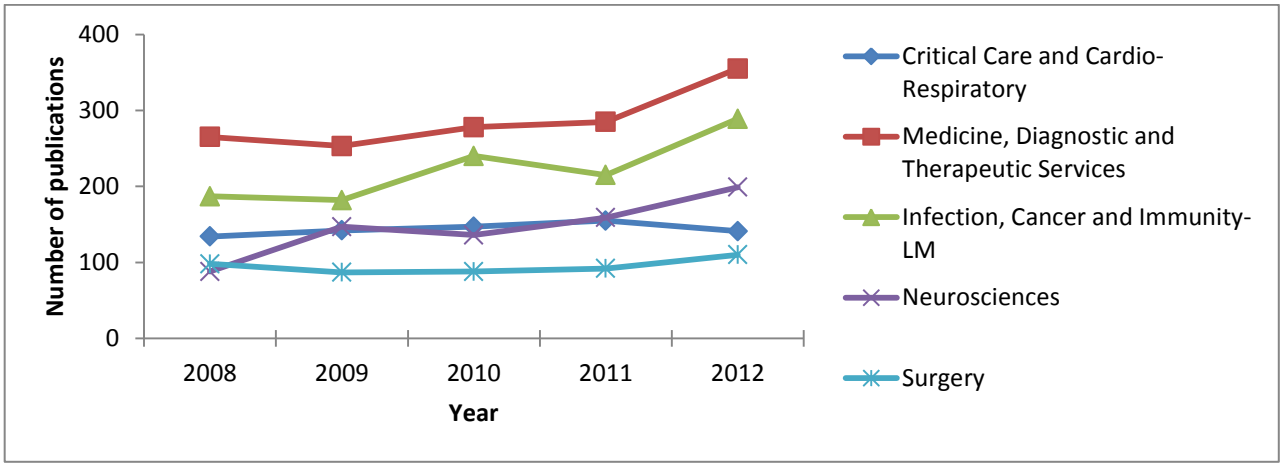
Publication numbers for a 5 year period (2008-2012) are shown below; the numbers include all publication types (articles, reviews, proceedings papers, letters, editorials, book chapters etc.) and are recorded based on organisation address as listed on the publication. Trust Board is asked to note the year on year increase in publications, with a particularly large increase in 2012.

Table 6: Number of publications split by GOSH, GOSH&ICH and ICH 2008-2012

Organisation address	2008	2009	2010	2011	2012
GOSH	370	355	445	413	525
GOSH & ICH	251	297	290	271	338
ICH	589	649	630	660	733
Total	1,210	1,301	1,365	1,344	1,596

Publication numbers are also provided by Clinical Division for the same 5 year period.

Figure 1: Number of publications by Clinical Division



Research Impacts

Publication numbers alone are not a particularly useful metric as they do not provide information on the quality or impact of research published. A publications analysis was commissioned from Thomson Reuters (Evidence). This analysis considered a 5 year period (2008-2012) and analysed relevant publications from GOSH and ICH (identified by address) using Thomson Reuters (Evidence) citation databases. The key findings are detailed below:

- Research output has **grown** over the 5-year time period with a substantial increase in 2012.
- Combined GOSH-ICH research is **well-cited**. Citation impact (1.59) is well above world average (1.0) and nearly one-fifth (17.5%) of papers are highly-cited. ICH research (research with only ICH as the relevant organisation) is particularly well-cited with citation impact (1.83).

- **International collaboration** is a key feature of combined GOSH-ICH research. Half of all GOSH-ICH papers had an international co-author, with more than 100 countries represented. US is the most frequent partner country; 18.5% of papers.

- The combined GOSH-ICH portfolio is concentrated in **Paediatrics** research but has additional strengths outside this journal category.
- Strong performance of GOSH research in neurosciences and neurology. Ranked third for output, Neurosciences research has the highest citation impact and percentage of highly-cited papers of the clinical divisions.

- Relative to **UK children hospital comparators:**
  - GOSH research is ranked top by percentage of highly-cited papers and is less likely to remain uncited over time than research from UK comparator paediatric hospitals (Alder Hey, Birmingham, Bristol and Sheffield Children's Hospitals).
  - GOSH shows strong performance in Paediatrics, Clinical Neurology and Cardiac & Cardiovascular Systems

- GOSH-ICH performs well in Paediatrics and shows strong performance in Clinical Neurology, Public, Environmental and Occupational Health and Research and Experimental Medicine.
- Though **internationally** ranked fifth by overall output, GOSH-ICH research is ranked joint third by citation impact. It has similar performance to Cincinnati Children's Hospital and Toronto Sick Kids and outperforms Necker-Enfants Malades and Children's National Medical Center. Boston Children's Hospital shows the strongest performance with citation impact twice world average.

Case Studies
The final section of this report provides details of two high impact case studies, the first highlights research which has already had an impact on clinical care for children and the second is a trial taking place across Europe.

Case Study 1 Gene Therapy: Professor Adrian Thrasher, Professor Bobby Gaspar: UCL-ICH Professors of Paediatric Immunology and Honorary Consultants in Paediatric Immunology at GOSH

Our gene therapy research programme is an example of research which spans the spectrum from basic science in UCL-ICH through to Clinical Research and implementation (Clinical Trials) in GOSH.

The research programme is led by Professor Adrian Thrasher and Professor Bobby Gaspar and is funded through multiple sources: the GOSH-UCL NIHR Biomedical Research Centre award provides core funding to the Gene and Stem Cell Therapy theme. Professor Adrian Thrasher is a GOSH CC Research Leader award, Wellcome Trust Senior Clinical Research Fellow and NIHR Senior Investigator. Professor Bobby Gaspar is a GOSH CC Research Leader. Grant funding for the gene therapy programme includes funding from the Medical Research Council, European Union, Genethon, Department of Health and Promethera Biosciences. Total live time value of active research grant awards is £4.8m.

Just over 10 years ago, GOSH, UCL-ICH became one of the few centres in the world to begin trials of a revolutionary new form of therapy for children born with a genetic disorder called X-linked severe combined immunodeficiency (X-SCID). Since 2002, 32 patients have been treated with four different primary immunodeficiency disorders. In total we have treated 12 patients with severe combined immunodeficiency (SCID-X1), 13 patients with adenosine deaminase deficient severe combined immunodeficiency (ADA-SCID), 5 patients with chronic granulomatous disease (CGD) and 2 patients with Wiskott-Aldrich syndrome (WAS). Most of the patients have been successfully treated and are at home, off all therapy.

Children with these conditions have a compromised immune system, which means they are unable to fight infection and have to live in a sterile environment. This is the result of a mutation in a gene that affects either the development or the function of cells in their immune system. The conventional treatment for these conditions is bone marrow transplantation (haematopoietic stem cell transplantation - HSCT). This can have excellent results when a fully matched donor is found, but results are less successful with an unmatched donor.

Gene therapy uses the child's own cells to fix the genetic defect. A vector – a disabled virus – acts to place a working copy of the gene, manufactured in the laboratory, into a child's bone marrow cells. These modified cells are then reintroduced to the body. Now armed with the vital genetic instructions that they previously missed, these bone marrow cells grow into the full spectrum of immune cells, which are crucial for fighting disease. The hope is that the results of the gene therapy programme will mean it will now be seen as an alternative to standard treatment.

The last 10 years has seen an expansion of the laboratory and clinical team and development of relationships with international groups which have led to several new clinical studies. The team is broadening this therapy to treat other genetic conditions such as metabolic disorders, HIV and skin disorders. As a world-leading centre for gene therapy, the team are also developing new approaches to fix the faulty gene itself. The team are developing an alternative genetic method in which molecular 'scissors' cut the faulty gene away and replace it with the correct gene. The team hopes to make gene therapy available to more patients with immune disorders in the future. The aim is to scale this up to more patients here and nationally so they too can benefit from the significant clinical improvements. An expansion of dedicated gene therapy facilities will provide the infrastructure to develop this form of genetic medicine for more patients.

Economic benefits: The cost of gene therapy compared to the only other comparable treatment, HSCT, is reduced because the patient has a significantly shorter stay in hospital (4-6 weeks for gene therapy compared to 8 weeks on average for HSCT). The cost of enzyme replacement for ADA-SCID is estimated at £350,000 p.a. minimum cost for the life-time of a patient. A significant number of our patients are now off enzyme replacement treatment, with gene therapy thus offering an overall total cost saving of £5 million to date.

Professor Gaspar and Thrasher's work is published in some of the world's top medical journals including the Lancet, Science Translation and Nature. One of their papers (Howe, SJ *et al.* (2008) Insertional mutagenesis combined with acquired somatic mutations causes leukemogenesis following gene therapy of SCID-X1 patients, Journal of Clinical Investigation, 118:3143-3150) is listed as one of Thomson Reuters hot papers which puts it in the top 0.1% of the world's research literature.

Case Study 2: Professor Persis Amrolia, NIHR Professor of Transplantation Immunology UCL-ICH and GOSH Honorary Consultant

Persis Amrolia is Professor of Transplantation Immunology at the UCL Institute of Child Health and honorary consultant at GOSH. As an academic clinician-scientist his work focuses on improving immunity, preventing relapse and reducing toxicity after transplantation of the stem cells involved in blood cell formation. Professor Amrolia has an outstanding record of research in the areas of immunotherapy and stem cell transplantation, translating cutting edge science into measurable health benefits for patients.

Following an extremely competitive application process in 2013, Professor Amrolia was awarded a prestigious National Institute of Health Research (NIHR) Research Professorship. These awards are open to health researchers with an outstanding record of clinical and applied research and its effective translation for improved health (five year fixed funding). The posts are designed to support the country's most outstanding research leaders during the early part of their careers, promoting effective translation of research from 'bench to bedside' and strengthening research leadership at

the highest academic levels. Just five NIHR Research Professorships were awarded nationally in 2013.

As part of his research programme Professor Amrolia, working with Dr Martin Pule, Senior Lecturer in Haematology at UCL, is leading a land mark trial across Europe to help children with leukaemia who have the highest risk of relapse, and whose disease is unresponsive to existing treatments. This trial is at the very forefront of immunological, genetic, and cellular research. Acute lymphoblastic leukaemia (ALL) is the most common form of childhood cancer. Fortunately, the majority of children with this disease can now be cured by front-line chemotherapy. For those whose leukaemia persists, many will need a bone marrow transplant. But if this also fails, traditionally there has been no further curative treatment to offer. The limitations of existing treatments were twofold. Firstly, these patients have had the maximum amount of chemotherapy and radiotherapy it is possible to give – their bodies would not tolerate further exposure. Secondly, because the donated immune cells of a transplant do not recognise ALL, their immune systems could not mount an attack.

The study is a multi-centre, Phase I/II trial sponsored by UCL and will be performed in 10 centres across 4 EU countries. The study is fully funded (£2 million from EU STREP, Leukaemia Lymphoma Research, Children with Leukaemia, JP Moulton Foundation and UK Department of Health).

Professor Amrolia's trial uses genetically-modified T cells – one of the body's disease-fighting white blood cells – to target and attack leukaemia cells in a manner similar to how the immune system recognises and attacks cells infected by a virus or bacteria:

"Cells with ALL display a protein called CD19 on their surface and we needed to find a way to target the body's natural disease-fighting mechanisms against ALL. So we genetically re-programmed T cells, modifying them to carry a receptor that can recognise this CD19 protein.

"Our laboratory tests showed that these modified T cells could attack and prevent the spread of ALL. Also, as CD19 is not expressed on any cells outside of the bone marrow, these T cells do not target other organs. This should reduce the risk of organ damage and a potentially lethal complication of more standard treatments, called graft-versus-host disease."

With a clever piece of scientific forethought, the team chose to genetically engineer T cells specific for Epstein-Barr virus (EBV), an infection that most people have been exposed to. This means that if the persistence and survival of the chimeric T cells in patients is poor, they will be able to boost the anti-leukaemic response, by vaccinating with EBV-containing cells. This could prove crucial to maintaining an effective level of leukaemia-fighting cells in patients' bloodstreams. This is the first clinical study of T cell gene therapy for paediatric ALL. To get this far has taken five years of painstaking scale-up work, involving colleagues across the hospital, UCL and its Cancer Trial Centre, and numerous collaborating centres across Europe. The study is now open at 3 sites in the UK and 4 in Germany. 14 patients have been recruited to date and of these 5 have so far received the genetically modified T-cells.

Professor Amrolia hopes that if this treatment can be shown to be safe and effective, it might cure children with otherwise untreatable leukaemia, and open up an entirely new approach to combating high-risk paediatric cancer.

Several of Professor Amrolia's papers describing his clinical research at Great Ormond Street Hospital have been published in some of the world's leading journals including the Lancet:
Straathof, KC; Rao, K; Eyrich, M; Hale, G; Bird, P; Berrie, E; Brown, L; Adams, S; Schlegel, PG; Goulden, N; Gaspar, HB; Gennery, AR; Landais, P; Davies, EG; Brenner, MK; Veys, PA; Amrolia, PJ (2009). Haemopoietic stem-cell transplantation with antibody-based minimal-intensity conditioning: a phase 1/2 study. Lancet, 374 (9693), 912-920.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28 January 2014

Quarter 3 Monitor Return (3 months to 31 December 2013) **Submitted by:** Claire Newton, CFO	**Paper No: Attachment V**

Aims / summary

This paper summarises the Trust's 2013/14 Quarter 3 (Q3) Return to Monitor, the independent regulator of NHS Foundation Trusts.

The Trust is reporting a Continuity of Service Risk Rating of **4** for the period 1 October to 31 December 2013.

Key points:

Finance

- The financial information included in the template is entirely consistent with the Month 9 Board report.
- The Trust is forecasting a Capital Service Cover rating and Liquidity rating of 4 for the remaining quarter of the financial year 2013/14.

Governance

- The Trust is reporting that it has met all relevant governance targets in Q3.
- The Trust has plans in place to ensure on-going compliance with all relevant governance targets and is committed to comply with all known targets going forward.

Other

- Staff and patient/service user governor elections were held in the quarter.
- There are no matters arising in the quarter requiring an exception report to Monitor.

Action required from the meeting

The Board is asked to approve the Quarter 3 'In-Year Governance Statement' (see overpage) prior to submission to Monitor.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Financial Stability and Health

Financial implications

An unqualified return is important for ongoing sustainability

Who needs to be told about any decision?

Monitor

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

CFO re the submission

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

CEO re the good governance of the Trust

####

Click to go to index

####

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see

	For finance, that:	**Board Response**
4	The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	
	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	
	Otherwise	
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 21, Diagram 6) which have not already been reported.	
	Signed on behalf of the board of directors	
	Signature	Signature
	Name	
	Capacity	[job title here]
	Date	

The proposed Board Response to all of these statements is “CONFIRMED”

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th January 2014

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment W**

Aims / summary
Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since end November 2013.

Date	Description	Signed by
11/12/13	GOSHCC, GOSH and Great Ormond Street International Promotions Ltd Deed of Agreement relating to the Premier Inn Clinical Building (naming rights)	Jan Filochowski and Claire Newton

Action required from the meeting
To endorse the application of the common seal and executive signatures.

Contribution to the delivery of NHS / Trust strategies and plans
Compliance with Standing Orders and the Constitution

Financial implications
N/A

Legal issues
Compliance with Standing Orders and the Constitution

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

Who is accountable for the implementation of the proposal / project
Anna Ferrant, Company Secretary oversees the register of seals

Trust Board
28th January 2014

Responsible Officer Appointment **Submitted by:** Catherine Cale, Interim Co-Medical Director	**Paper No: Attachment X**

Aims / summary

The Medical Profession (Responsible Officer) Regulations came into force on 1 January 2011. They were amended on 1 April 2013. The regulations require all designated bodies to nominate or appoint a responsible officer (RO).

Duty to nominate or appoint responsible officers

(1) Subject to the following provisions of this regulation, every designated body must nominate or appoint a responsible officer.

(2) The Board must nominate or appoint a sufficient number of responsible officers.

(3) When a responsible officer nominated or appointed in accordance with paragraph (1) or (2) ceases to hold that position, subject to paragraph (4), the designated body must nominate or appoint a replacement as soon as reasonably practicable.

(4) When a responsible officer nominated or appointed in accordance with paragraph (2) ceases to hold that position, the Board is not required to nominate or appoint a replacement if, in its opinion, there remains a sufficient number of responsible officers appointed or nominated under that paragraph.

The responsible officer will be answerable to the GMC and his or her nominating or appointing organisation for ensuring that there are appropriate systems and processes in place for collecting and holding information that informs the evaluation of fitness to practise. This will include ensuring there are robust systems of appraisal in place to support doctors in improving their practice. Where conduct or performance is falling below the usual high standards that doctors are expected to work to, it is important to identify them early and take the appropriate action to avoid potential harm to patients and to support doctors to get back on track. It is the responsibility of the organisation to ensure that these systems are properly resourced, reviewed and maintained.

The role of the responsible officer will primarily be to ensure that systems within his/her organisation support doctors in delivering quality care that is constantly improving. Where a doctor falls below the standards set, the responsible officer will need to ensure that appropriate action is taken to bring the doctor back on track while ensuring the safety of patients.

Action required from the meeting

The Board is asked to **ratify** the appointment of Dr Catherine Cale, Interim Co-Medical Director as the Responsible Officer.

Contribution to the delivery of NHS Foundation Trust strategies and plans

High quality appraisal processes are key to the continuation of GOSH as a world class children's hospital.
Financial implications
Who needs to be told about any decision? All GOSH employed Doctors
Who is responsible for implementing the proposals / project and anticipated timescales? Interim Chief Executive
Who is accountable for the implementation of the proposal / project? Interim Chief Executive

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th January 2014

Clinical Governance Committee Terms of Reference **Submitted by: Dr Anna Ferrant, Company Secretary**	**Paper No: Attachment Y**

Aims / summary

The terms of reference for the CGC have been reviewed in light of discussions at the June and October CGC meeting.

The following actions have been taken:

- The Director of HR and OD and the Director of Planning and Information have been added as permanent members of the committee.
- The wording around the CGC annual self-assessment has been amended to reflect the in depth nature of the assessment.
- The areas against which the committee requires assurance have been highlighted in the terms of reference under 'purpose'.
- The workplan has been updated to reflect the request to review the impact of external reviews and policy and deeper discussions around areas of concern.

Amendments are highlighted in coloured text.

Action required from the meeting

The Board is asked to approve the revised terms of reference and workplan.

Contribution to the delivery of NHS / Trust strategies and plans
The purpose of this review is to ensure that the committee fulfils its role in adequately assuring the Board on the control of clinical risk

Financial implications
No direct financial implications.

Who is accountable for the implementation of the proposal / project
Clinical Governance Committee Chairman

Great Ormond Street Hospital for Children NHS Foundation Trust

Draft Clinical Governance Committee Terms of Reference

1.0 Authority & Scope

1.1 The Clinical Governance Committee is a sub-committee of the Trust Board and is chaired by a Non Executive Director.

1.2 It has delegated authority from Trust Board to be assured that the correct structure, systems and processes are in place within the Trust to manage Clinical Governance and quality related matters and that these are monitored appropriately.

1.3 It is accountable to the Trust Board and required to assure the Board that work being undertaken by the clinical divisions, departments, standing committees and any sub groups in respect of clinical governance and improvement is co-ordinated and prioritised to meet the Trust's objectives.

2.0 Purpose

The purpose of the Clinical Governance Committee is:

2.1 To be assured that the structures and processes are in place to provide the framework to support an environment in which excellent clinical care will flourish.

2.2 To be assured that when an issue occurs which threatens the Trust's ability to enable excellent clinical care to flourish, that this is managed and escalated appropriately and actions are taken and followed through.

2.3 To assure the Trust Board that the controls to mitigate risk within the areas of responsibility of the committee are in place and working within a regulatory and legislative framework.

2.4 To assure the Board that appropriate action is taken to identify implications for clinical care provided by the Trust arising out of recommendations from external investigations of other organisations/ systems and processes

2.4 To assure the Trust Board that the internal audit plan and clinical audit plan are aligned and focused on the appropriate clinical governance risks

2.5 To assure the Board that the Trust is implementing the Quality Strategy and meeting reporting requirements for the Quality Report (Quality Account).

2.6 To recommend action to be taken by individuals or relevant committees so as to ensure that any identified risks are resolved and improvements in the Trust's practice can be demonstrated.

2.7 To work in partnership with the Audit Committee and ensure that implications for clinical care of non-clinical risks and incidents are identified and adequately controlled.

3.0 Reporting

3.1 In order to fulfil this requirement, the Clinical Governance Committee will receive reports as outlined in the committee workplan (see attached).

3.2 The Clinical Governance Committee will require internal audit:

- to initiate special projects or investigations on any matter arising from within its terms of reference;
- to monitor the implementation of audit recommendations by management and report progress at every meeting;
- to consider any other relevant matters, as determined by the Committee.

3.3 The Clinical Governance Committee Chairman will present a summary report to the Trust Board following every meeting.

3.4 A summary of the Clinical Governance Committee will be shared with the Audit Committee (and vice versa). There is cross membership between these two committees and additional members may be required to attend when necessary to inform the committee on specific aspects of risk.

4.0 Membership

4.1 Three Non-Executive Directors, one of whom shall chair the meeting.

4.2 The remaining membership will comprise the

- Chief Executive
- Co-Medical Director
- Chief Operating Officer
- Chief Nurse and Families' Champion
- Director of Planning and Information
- Director of Human Resources and Organisational Development
- Internal Auditor
- Head of Risk

4.3 Additional members may be added or invited to attend as appropriate.

4.4 For a quorum, there must be at least one Non Executive Director and a minimum of two members of the Executive team present..

4.5 The Company Secretary shall be the Secretary to the Committee.

5.0 Frequency of meetings

5.1 The Committee will meet quarterly and committee dates will be sent out at the beginning of the year

5.2 Members are expected to attend a minimum of 3 meetings per year.

5.3 Requests for submission of items for the agenda will be made three weeks prior to the next meeting.

5.4 Papers for the meeting will be sent out one week before the meeting.

6.0 Monitoring

6.1 The Committee shall review its terms of reference on an annual basis, including attendance at meetings, coverage of the terms of reference and workplan requirements during the year. The views of members of the committee, staff attending the meeting and receiving requests for reports will be sought as part of the review. Recommendations will be brought to the committee for consideration and approval..

6.2 The Chair of the committee shall draw to the attention of the Board any issue that requires disclosure to the full Board or requires executive action.

6.3 The Chair will give an account of the committee's work in the Trust's annual report.

Great Ormond Street Hospital for Children NHS Foundation Trust

FINAL Clinical Governance Committee Annual Work-plan 2013-14

Agenda Item/Issue	April 2014	June 2014	October 2014	January 2014
Risk management				
Board Assurance Framework (including focus on relevant risks) – written updates on all risks and accountable officers attend for risks over 12, with a 5 for consequence or a major gap between risk score and appetite score	✓	✓	✓	✓
CRES Safety Overview	✓	✓	✓	✓
High level risk register monitoring – movements, numbers, top 3 risks and deep dive into problem areas via separate reporting by accountable manager	✓		✓	
Performance Report (for information)	✓	✓	✓	✓
Risks/ issues arising between meetings (as discussed with the Chairman)	✓	✓	✓	✓
Compliance				
CQC compliance – assurance of controls to close gaps including deep dive into problem areas via separate reporting by accountable manager	✓	✓	✓	✓
NHS Litigation Authority Update				✓
Health and Safety Update – report on 6 monthly basis for assurance purposes	✓		✓	
Child Protection and Safeguarding Update –including updates on SCR actions annually	✓	✓	✓	✓
Head of Nursing Report - – report on 6 monthly basis for assurance purposes		✓		✓
Research Governance Update – report annually for assurance purposes (this will be monitored via the assurance framework/ CQC monitoring by the RACG)	✓			
Quality Report		✓		
Compliance with any national reports/ enquiries/ investigations i.e. Francis Report at every meeting	✓	✓	✓	✓

Agenda Item/Issue	April 2014	June 2014	October 2014	January 2014
Monitoring and assurance				
Quality Strategy Progress report			✓	
Receive Internal Audit Plan		✓		
Review of Internal Audit Progress Reports (clinical governance)	✓	✓	✓	✓
Receive Clinical Audit Plan		✓		
Clinical Audit Report, including update on management of confidential enquiries and NICE guidance and annual update of approval of NICE new technology recommendations	✓	✓ (NICE technology updates)	✓	✓
Updated from Learning, Improvement and Monitoring Board (LIMB) covering • progress with all action plans • Complaints • Claims • Health & safety • Clinical incidents • PALS (Q and S report) • Legal learning	✓		✓	
Staffing Information Report – report on a 6 monthly basis for assurance purposes – staffing information will eventually be included in heat maps as well		✓		✓
Annual Education and Training Report		✓		
Governance matters				
Annual Freedom of Information Update	✓			
Review of terms of reference and self-assessment of committee's effectiveness, including survey of staff attending the meeting		✓		
Note business of specified committees and review inter-relationships - Quality and Safety Committee - Risk, Assurance and Compliance Group - Audit Committee - Ethics Committee	✓	✓	✓	✓

Approved by CGC in October 2013

Trust Board
28th January 2014

Schedule of matters reserved for the Board **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment Z**

Aims / summary
The Code of Governance requires that there should be a formal schedule of matters specifically reserved to the Board of Directors. The purpose of this document is to define those powers specifically reserved to both the Board of Directors and the Members' Council.

The Board of Directors remains accountable for all of its functions, including those delegated to the Chair, Chief Executive and Board members, and will therefore receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

The schedule is in the process of being updated to reflect the delegations to Board committees, Members' Council and to the Chief Executive and other Board members and officers.

The Audit Committee has requested that the Board is provided with a summary of the matters specifically reserved to the Board of Directors. This is attached.

Action required from the meeting
To consider and note the matters specifically reserved to the Board of Directors

Contribution to the delivery of NHS Foundation Trust strategies and plans
Compliance with the Code of Governance and clarity about roles and responsibilities of the Board, its committees and directors and officers

Financial implications
None

Who needs to be told about any decision?
N/A

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

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

Matters Reserved for the Board of Great Ormond Street Hospital
Consideration or approval is required of the Board for the following:

Strategy

1. Responsibility for the overall leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed.
2. Setting the strategic aims of the Trust and ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance
3. Setting the Trust's vision, values and standards and ensure its obligations to members, patients and other stakeholders as understood, clearly communicated and met
4. Review of performance in the light of the Trust's strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken
5. Ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS and regulatory bodies.
6. Responsibility for ensuring compliance with its provider licence, constitution, mandatory guidance issued by regulatory bodies, relevant statutory requirements and contractual obligations.
7. Establishing the values and standards of conduct for the Trust and its staff and operating a code of conduct that builds on these values
8. Capital plan to implement the strategic directions
9. Approval of an annual business plan
10. Borrowing requirements of any sort
11. Any decision to cease to operate all or any material part of the Trust's business
12. Determine major changes to the Trust's corporate structure, including, but not limited to, acquisitions, mergers, separations or dissolution of the Trust and significant transactions falling within the definition agreed in the Trust's Constitution
13. Extension of the Trust's activities into new business or geographic areas.
14. The establishment of subsidiary companies, charities, partnerships, joint ventures or other corporate entities linked to or managed by the Trust
15. Major changes to the Trust's management and control structure including any binding commitment to enter into a material strategic alliance, joint venture, partnership

Oversight, Control and Assurance

1. Annual Report, Annual Accounts, FTCs and Summary Financial Statements
2. Ensuring maintenance of a sound system of internal control and risk management including:
    - Receiving reports on and reviewing the effectiveness of, the Trust's risk and control processes to support its strategy and objectives
    - Undertaking an annual assessment of these processes
    - Approving an appropriate statement for inclusion in the annual report

3. Approval of governance and other compliance declarations to Monitor, the CQC and other relevant regulatory bodies, requiring board approval by statute, regulation or under contractual obligations.
4. Continuous appraisal of the Trust's financial and operational performance, including income from contracts

5. Standing Financial Instructions and amendments thereto
6. Expenditure in excess of the financial limits in the Scheme of Delegation
7. Opening of bank accounts in the Trust's name

Contracts

1. Approval of major capital projects (>£1m)
2. Contracts which are material strategically or by reason of size, entered into by the Trust [or related subsidiary] in the ordinary course of business, for example, bank borrowings with a repayment period of over one year or acquisitions or disposals of fixed assets [above £1 million].
3. Contracts of the Trust [or any subsidiary] not in the ordinary course of business, for example loans with a repayment period of over one year or major acquisitions or disposals [above £1 million]
4. Major investments [including the acquisition or disposal of interests or more than 5% in the voting shares of any company or the making of any takeover offer]
5. All investments which fall within the Regulator's definitions of High Risk Investments

Corporate Governance

1. Continuation in office of any director, including consideration of the fit and proper person test for all directors and the suspension or termination of an executive director's service as an employee, subject to the law and their service contract
2. The nomination of the Deputy Chairman for ratification by Members' Council
3. Appointment of the Senior Independent Director and the Responsible Officer
4. The division of responsibilities between the Chair, Chief Executive and other executive directors
5. Determining the remuneration policy for the directors and other senior executives
6. Annual review of (whole) Board effectiveness, including Board assurance committees
7. Approval of Internal Audit arrangements
8. Review of the Trust's overall corporate governance arrangements
9. Approval of corporate policies and procedures where the board has overarching responsibility for ensuring compliance with statutory and regulatory obligations
10. Approval of the schedule of 'Matters Reserved for the Board and Scheme of Delegation' and Trust Standing Orders and amendments thereto, or suspension thereof
11. The establishment of Board of Directors' sub-committees, their Terms of Reference and the delegation of authority to them. Monitoring reports from these committees in respect of their exercise of delegated powers
12. Determining the independence of directors
13. Changes to the structure, size and composition of the board of directors, following recommendations from the remuneration and nomination committee
14. Proposed amendments to the Constitution (for final approval by the Members' Council and membership (in relation to the duties of the Council)
15. Serious untoward incidents

Other

1. Approval of the appointment of the Trust's principal professional advisers (excluding external audit)
2. Any decision likely to have a material impact on the Trust from any perspective, including, but not limited to, financial, operational, strategic or reputational impact.

ATTACHMENT 1

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council update

A Members' Council meeting was held on Saturday, 23rd November.

Mr Jan Filochowski, Chief Executive spoke to the Council about his recent announcement that he would retire. The Chairman provided an update on the arrangements for recruiting an Interim Chief Executive.

The Council received an update on food at GOSH and agreed to receive an update at the meeting in April 2014.

Discussion took place around the results of the Members' Council performance evaluation and actions arising from it and the next steps for the Council. The Chairman stressed the importance of the Members' Council and Non-Executive Directors working in partnership and the Council reached agreement on the structuring of the meetings' agendas.

The Council received an update on the Trust's performance against the Quality Strategy and discussed the implications of the rise in Clostridium Difficile levels.

The Chief Executive updated the Council on the improvement in the levels of discharge summary completeness, the suspension of the Chest Wall service and the ICO undertaking which had recently been signed by the Trust. An update was also provided on the shared commitment, which was being developed with councillors following the Listening Event in June.

The plan for engaging with members around the Annual Plan was outlined as was the Councillor engagement on the appointment of the external auditor.

The Members' Council received updates from the Non-Executive Directors on the business of the Trust Board assurance committees and the Chair of the Membership and Engagement Committee.

The Members' Council approved the process for the appraisal of the Chairman and Non-Executive Directors.

An extraordinary Members' Council meeting was held on Friday 6th December.

An extraordinary meeting of the Members' Council was held to approve the appointment of an Interim Chief Executive Officer.

The Council was informed that Mr Julian Nettel had been appointed (subject to approval of the Members' Council) as Interim Chief Executive following an interview with a panel

comprising the Chairman and two additional Non-Executive Directors. The members of the interview panel and the Lead Councillor outlined Mr Nettel's work experience and provided an overview of their meetings with Mr Nettel.

The Council **approved** the appointment of Mr Julian Nettel as Interim Chief Executive.