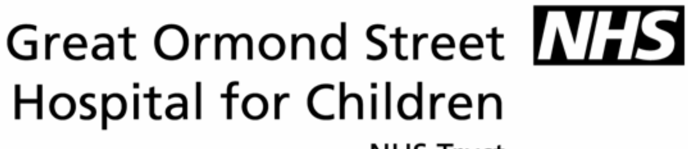


Meeting of the Trust Board
27th April 2011

Dear Members

There will be a public meeting of the Trust Board on Wednesday 27th April 2010 commencing at **3.30pm** in the **Charles West Room, Level 2, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item	Presented by	Attachment
	STANDARD ITEMS		
1.	**Apologies for absence**	Chair	
	Declarations of Interest The Chair and members of this meeting 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, as soon as practicable after the commencement of the meeting 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 30th March 2011**	Chair	**G**
3.	**Matters Arising / Action point checklist**	Chair	**H**
4.	**Chief Executive's Update** • **Haringey Children's Services Update** • **Safe and Sustainable Review Update**	Chief Executive	**Verbal**
5.	**Zero Harm Report**	Co-Medical Director (RE)	**I**
	ITEMS FOR APPROVAL		
6.	**NHS Blood and Tissue Authority contract**	Chief Finance Officer	**J**
7.	**Key deliverables against our strategic objectives for 2011-12**	Chief Operating Officer	**K**
8.	**Assurance Framework – revised risks 2011-12**	Chief Operating Officer	**L**
	UPDATES		
9.	**Performance Report**	Chief Operating Officer	**M**
10.	**Finance Report – end of year report 2010-11**	Chief Finance Officer	**N**
11.	**Foundation Trust Update**	Chief Operating Officer	**O**

12.	**Trust Wide Risk Register**	Co- Medical Director (ME)	**P**
13.	**Care Quality Commission Registration Update**	Chief Executive/ Company Secretary	**Q**
14.	**Summary of results from 2010-11 Staff Survey**	Chief Operating Officer	**R**
15.	**Trust Board Members' Activities**	Chair	**Verbal**
	ITEMS FOR RATIFICATION		
16.	**Consultant appointments**	Chair	**Verbal**
	ITEMS FOR INFORMATION (These items will not be discussed unless a Member gives prior notification of an intention to do so.)		
17.	**Patient and Family Satisfaction Survey Results 2011**	Chief Nurse and Director of Education	**S**
18.	**Summary of Audit Committee Meeting on 27th April 2011**	Audit Committee Chair	**Verbal**
19.	**Management Board minutes – 17th February 2011**	Chief Executive	**T**
20.	**UCL Partners Management Report**	Chief Executive	**U**

21. 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.)

22. Next meeting

The next public Trust Board meeting will be held on Wednesday 25th May 2010 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.

Draft Minutes of the meeting of Trust Board held on 30 March 2011

Present

Baroness Tessa Blackstone	Chairman
Ms Yvonne Brown	Non-Executive Director
Dr Barbara Buckley	Co-Medical Director
Prof Andy Copp	Non Executive Director
Dr Jane Collins	Chief Executive
Ms Fiona Dalton	Deputy Chief Executive
Prof Martin Elliott	Co-Medical Director
Mr Andrew Fane	Non-Executive Director
Ms Dorothea Hackman	Associate Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mrs Liz Morgan	Chief Nurse and Director of Education
Mrs Claire Newton	Chief Finance Officer

In attendance

Mr Stephen Cox	Head of Communications
Dr Anna Ferrant	Company Secretary
Mr William McGill	Director of Redevelopment
Mrs Elle Schlaphoff	Minutes Secretary

3 Members of the Public

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

281.	**Apologies for Absence**
281.1	No apologies for absence were received and it was noted that Mr Charles Tilley had joined the meeting via telephone.
282.	**Declarations of Interest**
282.1	No Declarations of Interest were made.
283.	**Minutes of the Meeting Held on 26 January 2011**
283.1	The minutes of the Trust Board meeting held on 26th January 2011 were received and the Chairman requested the Board Members to check them for accuracy.
283.2	The minutes were **approved** as an accurate record.

284.	**Matters Arising/Action Point Checklist**
284.1	**<u>Minute 243.7 – Comments on information for inclusion in the Performance Report</u>** The Deputy Chief Executive confirmed that Board Members had requested regular receipt of a summarised version of the performance report including commentary on exceptions. She confirmed that this request had been fulfilled.
285.	**Chief Executive Update**
285.1	**<u>Safe and Sustainable</u>** The Chief Executive reminded the Board that Safe and Sustainable Cardiac Surgery and Neurosurgery National reviews on the provision of these services were being conducted. She said that a national consultation regarding children's cardiac surgery services was in progress and current options for change suggested reducing the number of Trusts providing services in London from three to two.
285.2	The Chief Executive said that although all of the current services in London provided high quality care, if the options for change were implemented individual hospitals could lose the right to offer children's cardiac surgery services. She said that the Royal Brompton and Harefield NHS Foundation Trust had requested a Judicial Review of the process and the timescale for completion for the consultation would be dependent on its outcome.
285.3	The Chief Executive advised Board Members that it had been initially planned for the consultation to end in July with recommendations due for publication in September or October. She said that if there were no changes in London following consultation, there was a risk that the current numbers of patients seen by the Trust could fall.
285.4	**<u>Haringey Community Children's Services (HCCS)</u>** The Chief Executive reported that as a result of the tendering for the provision of children's services in Haringey, the management of the service was due to pass to Whittington Health. She confirmed that the Trust had not entered the tendering process.
285.5	The Chief Executive said that the transfer of the service had been due to take place on the 1 April 2011 but had been delayed until 1 May 2011. She said that staff had been consulted and the transfer had been formally considered by the Board. The Chief Executive confirmed that all parties were committed to ensuring that no gaps would be experienced by service users during the transfer.
285.6	**<u>Foundation Trust Authorisation</u>** The Chief Executive said that the Foundation Trust application was proceeding but the Trust had been informed that the Department of Health (DoH) would require additional time to examine its submission. She said that unlike Integrated Business Plans (IBP) that had been submitted by previous applicants, the IBP produced by Great Ormond Street had used a new set of economic assumptions and it was the first of its kind to be received by the DoH.

285.7	The Chief Executive said that an administration error at the DoH had caused an additional delay in the request for clarification on other aspects of the application submission. She said that the timetable for authorisation had been amended accordingly.
285.8	The Chief Executive reported that an event held for prospective Member Councillors had been very successful and well attended. She said that similar events had been held for staff and a range of people had registered their interest in standing for election.
286.	**Zero Harm Report**
286.1	The Zero Harm Report was received from the Co-Medical Director (ME). He reminded Board Members that the Paediatric Trigger Tool was used to establish a measurement of harm events occurring at the Trust. He said that the current level of harm was between 10-12% and was very encouraging as it represented a steady decline. It was noted that a majority of the harm was reversible and would have been previously unreported.
286.2	The Co-Medical Director (ME) said that data obtained by the Trigger Tool had been used to identify trends in the harm events and had enabled programme resources to be allocated appropriately.
286.3	Professor Copp asked why Surgical Site Infections (SSI) appeared to be lower in neurosurgery and spinal surgery compared with other specialities. The Co-Medical Director (ME) said that at present there was no benchmark data available for Cardiac and the type of procedures conducted in each speciality could be significant. It was noted that intensive monitoring of SSIs in selected areas of the Trust had also reduced the incidence of SSIs in other areas.
286.4	Mr Fane confirmed that case notes were chosen randomly in order to obtain data for the trigger tool and asked whether any other triggers could be used to aid note selection. The Co-Medical Director (ME) said that other triggers were being monitored to assess their usefulness but the current method of random selection was important to provide robust baseline data.
286.5	Ms Hackman said that she felt the use of the term 'difficult children' in relation to difficulty experienced in cannulation was not appropriate. The Co-Medical Director (ME) said that an alternative term would be used in future reports.
286.6	The Co-Medical Director said that he was not confident that the Trust would achieve the harm reduction target of 50% before the end of the current year but advised Board Members that the lower percentage of 25% should be possible.
286.7	It was noted that bars in the graph on page 6 of the report were not in the same order as the labels printed beneath it.
286.8	The report was **noted.**

287.	**Update on Trust Objectives 2011-12**
287.1	A paper containing a review of achievement against the 2010-11 Trust Objectives and details of the revised Trust Objectives for 2011-12 was received from the Deputy Chief Executive.
287.2	The Deputy Chief Executive reported that good progress had been made against the objectives set for 2010-11. She highlighted the objectives that currently had red rated actions against and provided details regarding why they had been rated in this way.
287.3	The Deputy Chief Executive said that there were fewer objectives for 2011-12 to allow a greater focus on key areas and each objective had been allocated with a 'responsible committee' and an 'assuring committee'.
287.4	It was noted that the Clinical Governance Committee (CGC) had been designated as the assuring committee for many of the new objectives and Board Members discussed whether its current workload may be too much because of this. The Co-Medical Director said that the CGC was the most appropriate Committee to provide assurance as many of the objectives were focused on delivery of the patient pathway. The Chief Nurse and Director of Education said that the CGC would be viewed more favourably than other committees and would enhance staff engagement.
287.5	Mr Tilley said that it would be more important for the objectives to focus on outputs rather than inputs. The Chief Finance Officer asked if the objectives for 2010-11 could be analysed in this way to demonstrate achievement against them. **Action:** Deputy Chief Executive
287.6	Ms MacLeod suggested that the headline objectives and actions for Research and Development should be revisited. **Action:** Deputy Chief Executive
287.7	Mr Tilley said that the Chairs of the Trust Board and its subcommittees would be meeting on the 14 April and would discuss the content of the paper further.
287.8	The Deputy Chief Executive said that she would complete additional work on the document as requested and confirmed that similar documents would also be completed for each of the clinical units.
287.9	The paper was noted.
288.	**Annual Financial Plan 2011-12**
288.1	The Annual Financial Plan 2011-12 was received from the Chief Finance Officer. She said that the plan represented the first year of the current version of the Long Term Financial Model (LTFM).

288.2	The Chief Finance Officer advised Board Members that the Trust intended to return a net surplus of approximately £6.9m. She said that this was lower that the forecast out-turn for the current year but was due to the need for more challenging assumptions to enable various internal projects and overcome a variety of external cost pressures.
288.3	The Chief Finance Officer said that a majority of the Primary Care Trust (PCT) contracts had now been agreed but contracts with the National Commissioning Groups had not yet been finalised. The Chief Executive said that the annual commissioning round had been extremely challenging and she commended the Chief Finance Officer and her team on the progress made to date. It was noted that the Chief Finance Officer had been working with the commissioners to examine ways to improve the process in the future.
288.4	The Chief Finance Officer said that the capital plan for 2011-12 was just above the current level of depreciation. She said that further amounts had also been earmarked for a future project in ICT.
288.5	The Chief Finance Officer asked Board Members if there were any further questions or comments in relation to the plan. There were none.
288.6	The Annual Financial Plan 2011-12 was **approved**.
289.	**Foundation Trust Self Certification Documents**
289.1	The Deputy Chief Executive said that the self certification Documents had been discussed in the development session held prior to the meeting. She said that quality was a central theme for the Trust and Board Members had agreed that they were able to sign up to the principles that the documents represented.
289.2	The Foundation Trust Self Certification Documents were **approved.**
290.	**Business Rates payment for 2011-12 and Approval of NHSLA Premiums 2011-12**
290.1	The Chief Finance Officer said that both the Business Rates payment and NHSLA Premium were annual costs that required approval from the Board because they exceeded the upper level specified in the Standing Financial Instructions.
290.2	The Chief Finance Officer confirmed that additional bills of smaller values were received in relation to other properties owned by the Trust. Mr Tilley asked if the costs had increased since the previous year. The Chief Finance Officer said that the NHSLA premium had increased by approximately 14% and the rates payment had increase by approximately 2%. It was noted that despite the increase in cost, the NHSLA was still considered to be the most appropriate provider of clinical negligence insurance for the Trust.
290.3	The Business Rates payment for 2011-12 and the Approval of NHSLA Premiums for 2011-12 were **approved.**

290.4	Mr Fane asked if the Trust was intending to apply for assessment under NHSLA level 3. The Chief Executive confirmed that it was, later in 2012.
291.	**Register of Seals**
291.1	The Register of Seals was received from the Company Secretary. She said that the document provided details of seals affixed and authorised between 19 January 2011 and 23 March 2011.
291.2	The Register of Seals was **approved**.
292.	**Performance Exception Report – Month 11**
292.1	The performance report was received from the Deputy Chief Executive. She said the report had been presented in a new format and now included market share summaries as an appendix.
292.2	It was noted that Management Board had expressed concern regarding the deterioration of waiting times and a 'deep dive' into the issue would be conducted at the next meeting.
292.3	It was reported that the annual incidence of MRSA was expected to be below the maximum level of infections that had been specified but C Difficile above it. .
292.4	The Co-Medical Director reminded Board Members that infection targets were not negotiable and said that he was surprised that the Trust still had an upper level of C Difficile infections that it was expected to adhere to. It was noted that the response to C.Difficile infection in children was very different compared to adults. He said that Great Ormond Street had been working in conjunction with a number of other paediatric hospitals to establish a case for the targets to be adjusted to reflect this.
292.5	Mr Fane asked if the Trust was still monitoring progress against the 18 week waiting time target. The Deputy Chief Executive confirmed that the Trust was continuing to meet the target and a considerable administration effort was still required to enable it.
292.6	The Chief Finance Officer asked if the results of the market share analysis were as expected. The Deputy Chief Executive said that longer term targets for improvement had been established.
292.7	*Dr Liz Jackson, Mr Sven Bunn and Mr Ray Conley joined the meeting at this point.*
293.	**Six Day Working (Presentation)**
293.1	The Deputy Chief Executive introduced the agenda item on six day working. She said that the concept was being considered in response to a variety of issues and would provide a way for the Trust to maximise the potential of its assets.
293.2	The Deputy Chief Executive said that the business case developed in relation to the six day working proposal was economically robust but had

	presented a number of HR and contractual issues that would be explored in the presentation that followed.
293.3	The Deputy Chief Executive said that the business case had been taken to each of the Clinical Units and discussed by their boards. She said that initial feedback suggested that the Trust should seek ways to maximise current efficiency during normal business hours and concentrate on extending current working days or introducing weekend working but not both. It was noted that additional theatre accommodation was required and a balance needed to be struck between the extent to which the staff were asked or told about the proposed changes to their roles.
293.4	Dr Jackson said that challenges were faced in relation to securing the engagement of consultant staff. Mr Fane asked how many consultants currently practiced at the weekend on a private basis. Dr Jackson said that some did run lists at this time but the activity was not extensive.
293.5	Mr Conley said that a variety of both clinical and non-clinical staff would have to be involved to ensure the success of the proposal and a number of decisions would have to be made in the early stages to shape the approach that the Trust would take to the programme.
293.6	Mr Conley outlined the specific HR and operational issues surrounding the proposal. It was noted that some departments had been more receptive to the proposal than others and pilots could begin. Mr Conley said that although the benefits had not yet been defined, the support of the Board could help to improve future levels of engagement.
293.7	The Co-Medical Director (ME) said that the facilities at the Trust were currently under used and should be optimised. He said it was important to clarify what was to be understood by the term '6 day working' as, if staff were to understand it to mean additional working rather than more flexible working, it could cause unnecessary resistance. The Chairman agreed that how the proposal was marketed to staff was extremely important.
293.8	The Chairman said that she felt that it was important to commence pilots in areas that were already engaged with the proposals. She said that as a world class hospital the Trust should act as a leader by promoting more efficient ways of working. The Chief Executive suggested that successful pilots could help to increase engagement in other departments
293.9	Ms Hackman asked if the solutions could be tailored to better meet the needs of different staff groups. She said that some staff had chosen to work in the occupations that they did because of the flexibility that it afforded them and the proposals could unfairly penalise them.
293.10	Board Members agreed that patient surveys had emphasised the need for more choice over the times of appointments. The Chairman said that being able to offer appointments outside of normal working hours could help to reduce the amount of schooling missed by children receiving ongoing medical care.
293.11	The Chief Nurse and Director of Education said that the Trust already

	provided a nursing service that operated on a 24/7 basis. She said at present fewer nurses worked at weekend and numbers would need to be increased if the proposals were implemented. Ms MacLeod suggested a rostering analysis could be used to measure the impact that would be caused. The Co-Medical Director (ME) said that a 7 day working week was commonplace for all staff in many hospitals in Asia.
293.12	The Co-Medical Director (BB) said that she felt that the presentation had over concentrated on the negative aspects of the proposal. Mr Conley said that it was important that Board Members were aware of all of the major issues.
293.13	Professor Copp noted that outpatients had not been mentioned during the presentation. Mr Bunn said that implementation of the proposal in outpatients would present the same range of issues that had already been raised by other departments.
293.14	Mr Tilley suggested that attempts should be made to get other hospitals to focus on the concept of 6 day working more widely.
293.15	The Chief Executive said that more detailed plans for the implementation of the proposal in pilot areas would be required prior to the Board making any decision on how it would be progressed. The Chairman suggested that presenting staff with a measure of how many Saturdays they would be expected to work per annum could be useful and said that it was important to reference the fact that many staff already had less traditional working hours. **Action:** Deputy Chief Executive /Mr Bunn
293.16	The Chairman thanked Dr Liz Jackson, Mr Ray Conley and Mr Sven Bunn for their presentation and work to date on the proposal.
293.17	*Dr Liz Jackson and Mr Ray Conley left and Mr Mark Large joined the meeting at this point*
294.	**Information and Communications Technology (ICT) Strategy**
294.1	The ICT Strategy was presented by Mr Mark Large, Director of ICT on behalf of the Chief Finance Officer. He said that the current ICT strategy had been due for renewal and some projects had now been discontinued.
294.2	Mr Large advised Board Members that since the previous strategy had been approved, work on the ICT infrastructure was nearing completion and a wireless network had been established that enabled asset tracking to an accuracy of two metres. He said that whereas the previous strategy had concentrated on creating stability, the new strategy had a greater emphasis on the delivery of front line services.
294.3	Mr Large said that a consultation was in progress to identify the information needs of the business and drive future ICT business cases. He said that the new strategy included a selection of guiding principles that would help to create a vision for the future ICT provision at the Trust and aid prioritisation of projects within available funds.

294.4	Mr Large said that the new ICT Strategy focused on automation, mobility and the secure sharing of data. Ms MacLeod asked if data was currently stored in a 'data cloud'. Mr Large said that at present the data was stored locally but 'cloud' storage could be included in future disaster recovery plans. He said that 'cloud' storage presented a number of security issues that would need to be addressed prior to its use.
294.5	Ms MacLeod asked if the Trust still intended to pursue a Business Process Management (BPM) solution. Mr Large said that the issues that halted the previous project to install a BPM solution within the Trust still existed but the ICT department were now examining alternative tools to achieve it.
294.6	The Trust Board **approved** the ICT Strategy.
294.7	*Mr Large left the meeting at this point.*
295.	**Finance Report – Month 11**
295.1	The Finance Report for Month 11 was received from the Chief Finance Officer. She said that there were no exceptions to report and advised Board Members that the first set of final figures were due to be filed with the DoH prior to Easter.
295.2	The report was **noted.**
296.	**Foundation Trust (FT) Update**
296.1	The Foundation Trust Update was received from Mr Sven Bunn on behalf of the Deputy Chief Executive. He asked if there were any questions. There were none.
297.	**Update on C Difficile**
297.1	It was noted that the current situation in relation to C. Difficile had been addressed during discussion of the Performance Report.
298.	**Heads of Nursing Report**
298.1	The Heads of Nursing Report was received from the Chief Nurse and Director of Education. She said that the format of the report had been revised to meet the necessary infection control reporting requirements.
298.2	The Chief Nurse and Director of Education reported that work regarding the use of Children's Early Warning Score (CEWS) and SBARD communication system continued. She said progress had been made but there were gaps in accuracy that needed to be addressed.
298.3	The Chief Nurse and Director of Education said that senior nursing staff had learnt a model that explained systematic migration from guidelines and processes and had applied this to the medications administration process.

298.4	The Chief Nurse and Director of Education said that future challenges were anticipated as a result of opening of the new clinical building in 2012. She said that safety would be a priority and clear plans would be required to ensure that staff had received sufficient training and support in the lead up to the transition.
298.5	The report was **noted.**
299.	**Trust Board Members' Activities**
299.1	The Chief Executive said that she was continuing to lead a programme of work called Project Diamond that aimed to improve the position of London hospitals claiming top-up payments for specialist work. She said that the work of Project Diamond complemented similar work that was currently being undertaken by the Chief Finance Officer.
299.2	Ms Hackman said that the penultimate meeting of the Members Forum would now take place in May as it had been suggested that the final meeting could now be held on the 14 July which had been previously confirmed in diaries for a pre-authorisation meeting of the Member's Council.
300.	**Annual Declarations of Interests 2010/11**
300.1	The 'Annual Declarations of Interests 2010/11' was received from the Chief Executive. The Company Secretary said that there were separate registers for staff and directors and the documents covered the period from 1 April 2010 to 30 March 2011.
300.2	The Annual Declarations of Interests 2010/11 was **approved.**
301.	**Register of Gifts and Hospitality**
301.1	The Register of Gifts and Hospitality was received by the Board. It was noted that the document covered the period from 1 April 2010 to 30 March 2011.
301.2	The Register of Gifts and Hospitality was **approved.**
302.	**Risk Management Strategy**
302.1	The Risk Management Strategy was received from the Co-Medical Director (ME). It was noted that the strategy had been submitted to the meeting of the Trust Board in January and amendments had been requested. The Co-Medical Director (ME) confirmed that the requested amendments had been completed.
302.2	The Risk Management Strategy was **approved**.
303.	**Health and Safety Policy**
303.1	The Trust Health and Safety Policy was received from the Chief Executive. She said that the Board were required to review the policy on

	annual basis.
303.2	The Company Secretary said that there had been no significant changes to the revised policy and the document had recently been ratified by the Management Board.
303.3	Ms MacLeod said that the title 'Modern Matron' should be replaced with 'Head of Nursing' throughout the document.
303.4	Subject to the suggested amendments the Health and Safety Policy was **approved**.
304.	**Consultant Appointments**
304.1	The Chairman advised Board Members that the following Consultants had been appointed since the last meeting :- o Dr Tanzina Chowdhury – Consultant in Oncology o Dr Darren Hargrave – Consultant in Oncology o Dr Olga Slater – Consultant in Oncology o Dr Rachel Andrews - Consultant in Paediatric Cardiology o Dr Kshitij Mankad – Consultant in Paediatric Neuro-Radiology o Dr Sanjay Bhate – Consultant Paediatric Neurologist
304.2	The Board **approved** the new Consultant appointments.
305.	**Code of Conduct for NHS Managers**
305.1	The Code of Conduct for NHS Managers was received from the Company Secretary. She advised Board Members that they were required to acknowledge and adopt the Nolan principles on Standards in Public Life, the Code of Conduct/Code of Accountability in the NHS and the Code of Conduct for NHS Managers on an annual basis.
305.2	Board Members **acknowledged** the requirements and **confirmed** that they would continue to be met.
306.	**Assurance Framework Summary**
306.1	It was noted that the' Assurance Framework Summary' had been included for information. The Chairman asked if there were any questions or comments. There were none.
307.	**Update on Bribery Act**
307.1	It was noted that the' Update on Bribery Act' had been included for information. The Chairman asked if there were any questions or comments. There were none.
308.	**Audit Committee Minutes October 2010**
308.1	It was noted that the' Audit Committee Minutes October 2010' had been included for information. The Chairman asked if there were any questions

	or comments. There were none.
309.	**Clinical Governance Committee Minutes November 2010**
309.1	It was noted that the' Clinical Governance Committee Minutes November 2010' had been included for information. The Chairman asked if there were any questions or comments. There were none.
310.	**Management Board – Minutes December 2010 and January 2011**
310.1	It was noted that the' Management Board – Minutes December 2010 and January 2011' had been included for information. The Chairman asked if there were any questions or comments. There were none.
311.	**UCL Partners Management Report**
311.1	It was noted that the' UCL Partners Management Report' had been included for information. The Chairman asked if there were any questions or comments. There were none.
312.	**Any Other Business**
312.1	No other business was declared.
313.	**Date of the Next Meeting**
313.1	The date of the next meeting was confirmed as 27 April 2011

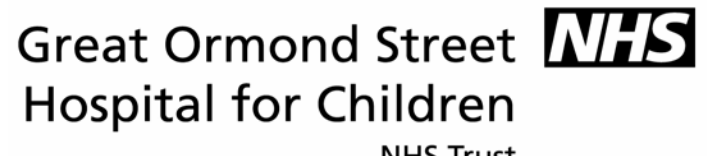
ATTACHMENT H

TRUST BOARD - ACTION CHECKLIST
27 April 2011

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
193.7	24/11/10	The Chairman said that the Education Strategy paper was currently aspirational and would require milestones and implementation markers. She suggested that 4 or 5 priorities were selected for development and the strategy should be resubmitted to the Board in 6 months time.	LM	May 2011	Not Yet Due
195.6	24/11/10	The Chairman thanked Professor Goldblatt for his report and asked if his next report could include information on how the research conducted by UCL Partners was linking with global health initiatives.	DG	June 2011	Not Yet Due
196.4	24/11/10	It was noted that a further report on the Management Board reporting structure would be submitted to the Trust Board Away Day in February.	AF	Deferred to April 2011	Not Yet Due
198.3	24/11/10	Ms MacLeod suggested that further work would be required to clarify the roles and responsibilities of the different hospital committees outlined in the Constitution. The Chairman said that it was important that there were no misunderstandings.	AF	Deferred to April 2011	Not Yet Due
287.5	30/03/11	Mr Tilley said that it would be more important for the objectives to focus on outputs rather than inputs. The Chief Finance Officer asked if the objectives for 2010-11 could be analysed in this way to demonstrate achievement against them.	FD	April 2011	On agenda
287.6	30/03/11	Ms MacLeod suggested that the headline objectives and actions for Research and Development should be revisited.	FD	April 2011	Revised work programmes and actions on agenda
293.15	30/03/11	The Chief Executive said that more detailed plans for the implementation of the 6 day working proposal in pilot areas would be required prior to the Board making any	FD	TBC	Verbal update

ATTACHMENT H

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		decision on how it would be progressed. The Chairman suggested that presenting staff with a measure of how many Saturdays they would be expected to work per annum could be useful and said that it was important to reference the fact that many staff already had less traditional working hours.			



Trust Board Meeting **27th April 2010**	
Zero Harm Report **Martin Elliot Co-Medical Director**	**Paper No: Attachment I**
Summary This paper provides an update on the following issues: ▪ Paediatric Trigger Tool ▪ Zero Harm Dashboard ▪ Surgical checklist	
Action required from the meeting To note the report	
Contribution to the delivery of NHS / Trust strategies and plans This is one of the strategic objectives of the Trust	
Financial implications Nil	
Legal issues Nil	
What consultation has taken place Not Applicable	
Who needs to be told about the policy? Not Applicable	
Who is accountable for the monitoring of the policy? Not applicable	
Author and date Peter Lachman 16 April 2011	

Attachment I

Zero Harm Report for the Trust Board
April 2011

Zero Harm Strategy of GOSH approved July 2010

High reliability requires anticipation of potential safety issues and containment of and learning from safety events. This will incorporate the following:

- Leadership and the development of a culture of safety
- Understanding and measuring harm
- Development of standardised processes wherever possible.
- Elimination of unnecessary variation
- Training in safety, human factors and simulation.
- Prospective examination of safety and reliability for all the Trust's activities
- Organisational learning by retrospective analysis of accidents or incidents and implementation of change as needed.
- The innovative blending of improvement methodology into existing learning Pathways

The *Zero Harm* programme aims to ensure that the patient receives the correct treatment or action the first time every time. This is measured by the decrease in harm as measured by the paediatric trigger tool and by individual measures in specific programmes.

To achieve the strategy follows the interventions recommended by the Patient Safety First Campaign. The elements of the campaign are:

- Leadership for safety
  - Executive WalkRound™, Safety on the Board agenda,Safety climate and culture surveys)
- High-risk medications
  - Prescribing, dispensing, administration and reconciliation
- Peri-operative care
  - Briefing, WHO checklist, surgical site infections
- Critical care
  - Ventilator Associated Pneumonia, Central line Infections).
- Deteriorating patient
  - ICON15 outreach, SBAR16, CEWS17
- Decreasing Serious Untoward Incidents.
- Human factors training.
- Improving standardisation of processes and eliminating variation where possible

The above are the strategic aims of the Trust with regard to Zero Harm
This report will focus on one of the areas each month, reporting successes and challenges.

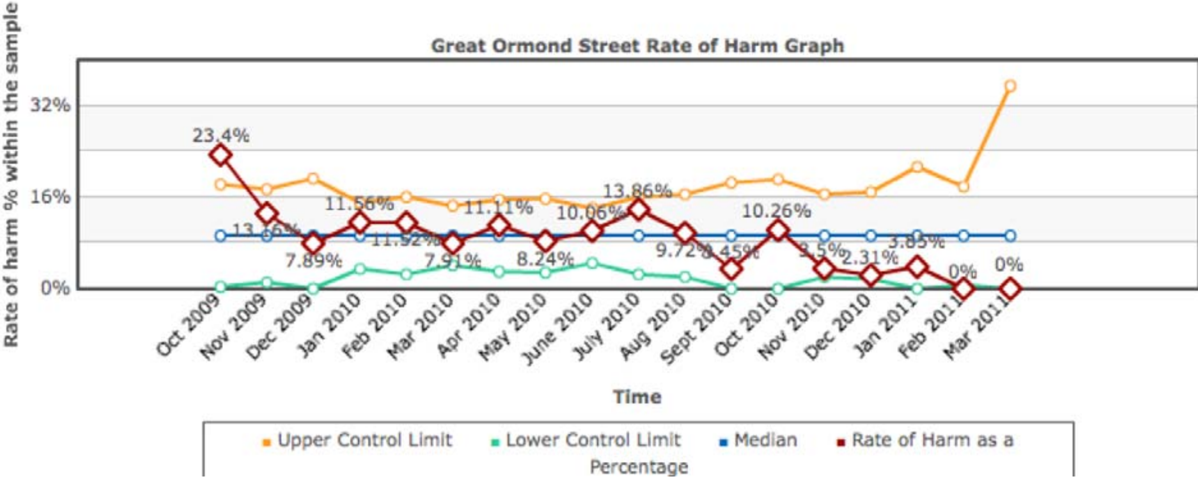
1. Measurement of harm[1] and aim for the programme

The use of "triggers," or clues, to identify adverse events (AEs) is an effective method for measuring the overall level of harm in a health care organisation. The question is how significant can this bee if one only reviews 20 sets of notes per month. Roger Resar, one of the originators of the tool, has confirmed that the Trigger Tool methodology we follow is correct.

The team continues to strengthen and the themes that have emerged are now part of the improvement plans of each of the Units. Units are examining these themes to see which are appropriate for intervention in individual Units. The next step would be for individual units to have a Trigger tool measurement, which will emphasise Unit specific rates of harm.

The harm detected needs to be seen in the context of other measures – SUI, risk, mortality reviews, and all the Zero harm programmes

The rate has continued to fall but this is not yet significant and is due to random sampling.



We will be monitoring this carefully and recommend that we consider extending the trigger tool to unit specific assessments. This be considered once the Patient Safety Officers are in Post for each Unit.

Action The Board is requested to consider the report on the trigger and note the progress being made.

[1] NHS III Safer Care website provides greater detail.
http://www.institute.nhs.uk/safer_care/paediatric_safer_care/get_started.html

2. Dashboard

The system-wide dashboard is shown in Figure 2 and demonstrates ongoing challenges. Over the next 3 months we intend to review the Dashboard and update it so that it remains pertinent to the aim of achieving zero harm.

Action
The Board is requested to specify which measures it requires on the system wide

Safety System Wide Dashboard

FAQs Desired direction of change:

For each chart, click on a data point to display further detail.

High System Measures

The number of serious patient safety incidents. Area: System Wide — Further Detail

The mortality rate per 1000 discharges. Area: System Wide — Further Detail

Infections

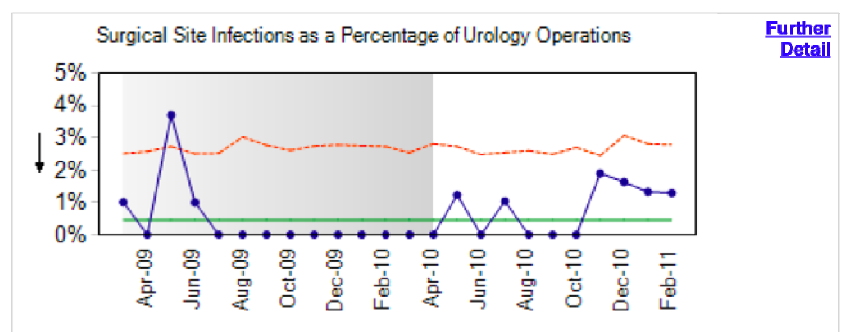
GOSH acquired CVL infections for every 1000 line days. Area: System Wide — Further Detail

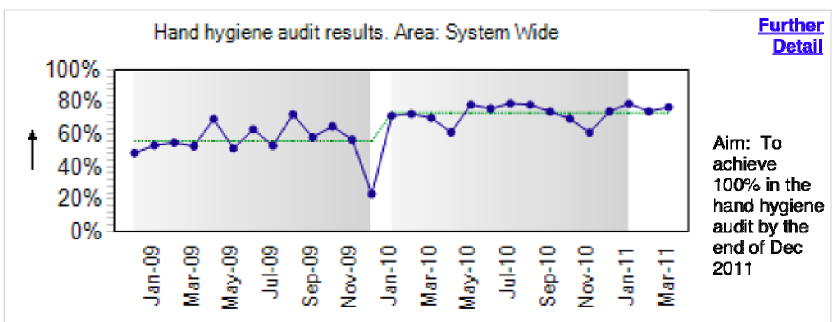
Aim: To achieve zero CVL infection by the end of Dec 2011

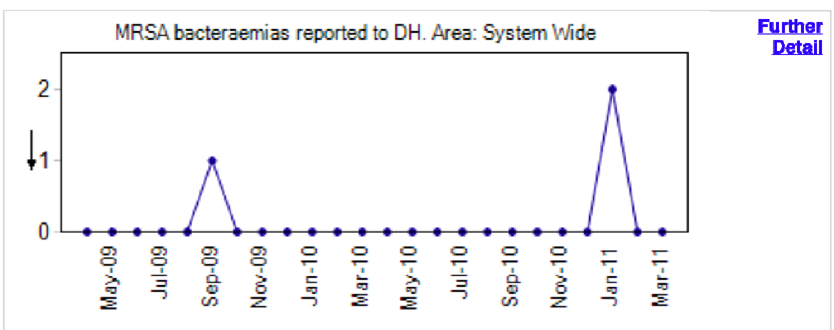
Time between VAPS. Area: System Wide — Further Detail

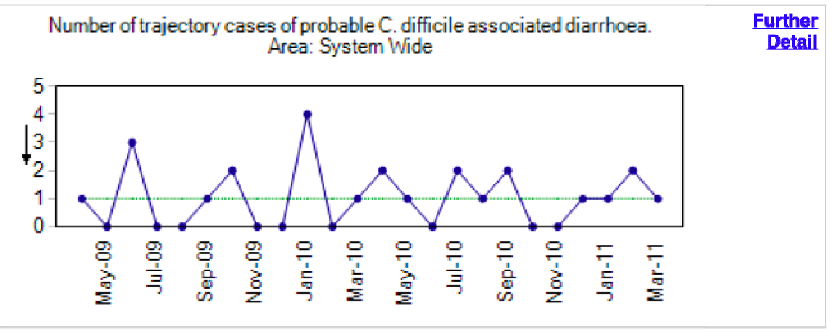
Aim: The Trust will aspire to eliminate VAPs by the end of Dec 2011

Attachment I

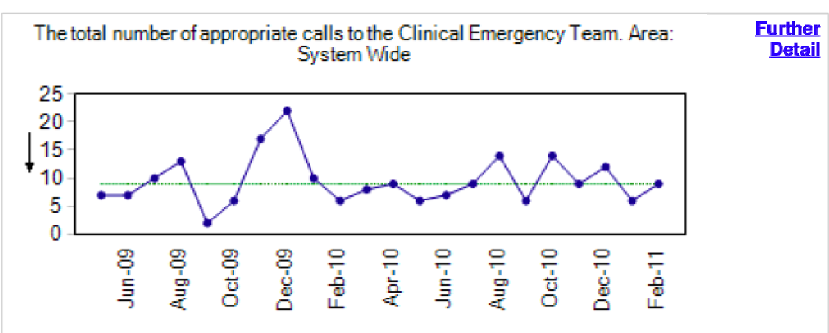








Outreach



3. Update on Challenge noted on Medical Records

Individual Units are trying out different methods at clinical team level to improve the standard of medical records. This is a long-term project and as we have results they will be reported.

4. Highlighted report of the month: WHO Surgical and Procedure Checklist

Research undertaken by Haynes and Guwande[2] and a multi centre team concluded that implementation of the surgical checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing non-cardiac surgery in a diverse group of hospitals. It applies to all surgery and procedures now.

The WHO Safe Surgery Checklist was adapted for GOSH by Dr Isabeau Walker and her team and has gradually been introduced into the Trust. It is now expected that the checklist is standard practice for all surgical procedures in theatre, and now for procedures in other parts of the Trust. The checklist identifies three phases of an operation, each corresponding to a specific period in the normal flow of work:

- Before the induction of anaesthesia (“sign in”),
- Before the incision of the skin (“time out”)
- Before the patient leaves the operating room (“sign out”).

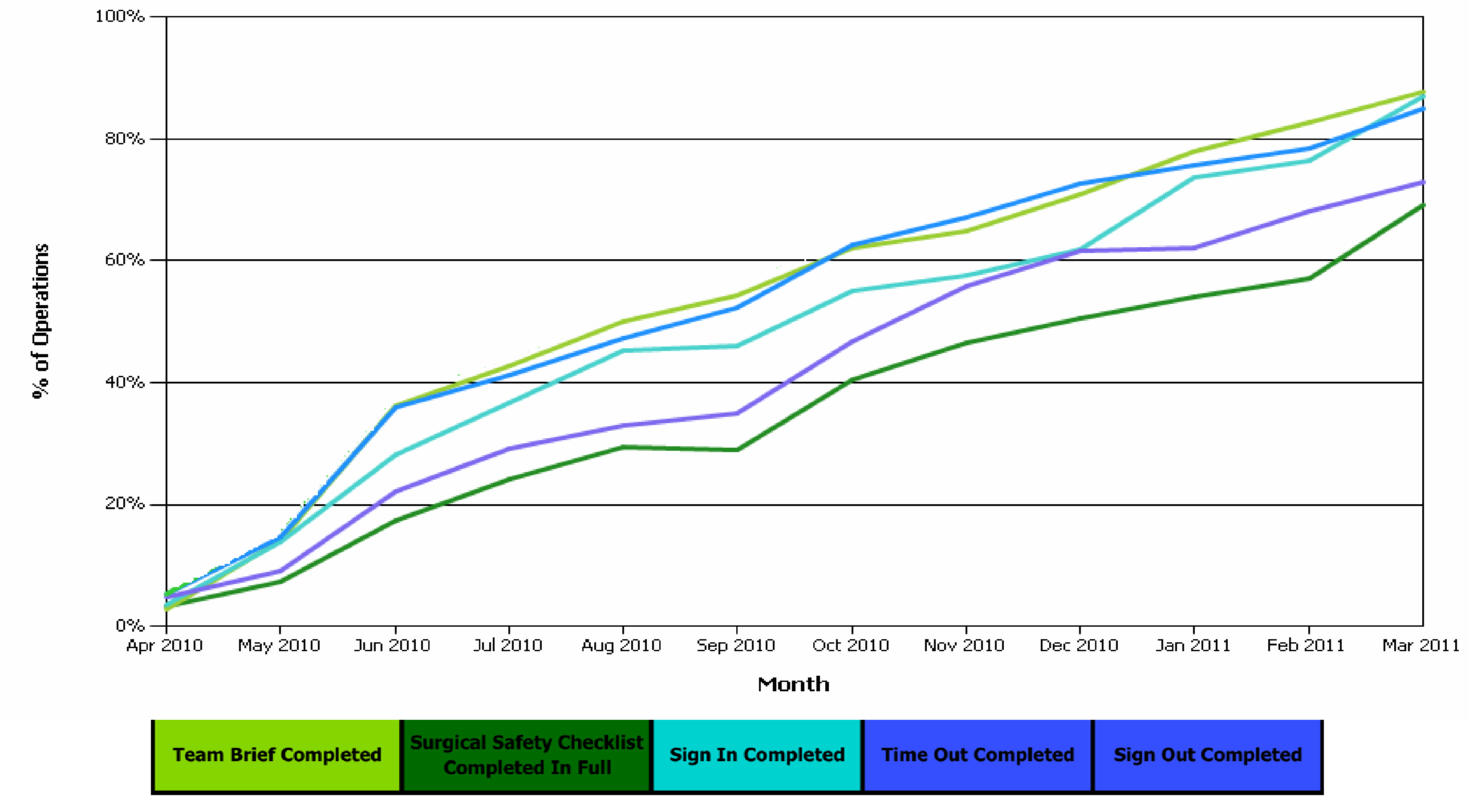
In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation. It is key that all of the team is present particularly the surgeon who will be performing the operation.

Good progress has been achieved but there is still some way to go before the Trust achieves the target of 100% of all procedures having all elements of the Checklist implemented. All Units have this as part of their improvement plans.

Action
The Board is requested to note the good progress made. However the Board should note that the target remains 100% compliance.

[2] Haynes et al A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. New England Journal of Medicine January 29 2009.

Attachment I



Attachment I

Surgical and procedure checklist monthly reports

WHO Surgical Safety Checklist Dashboard

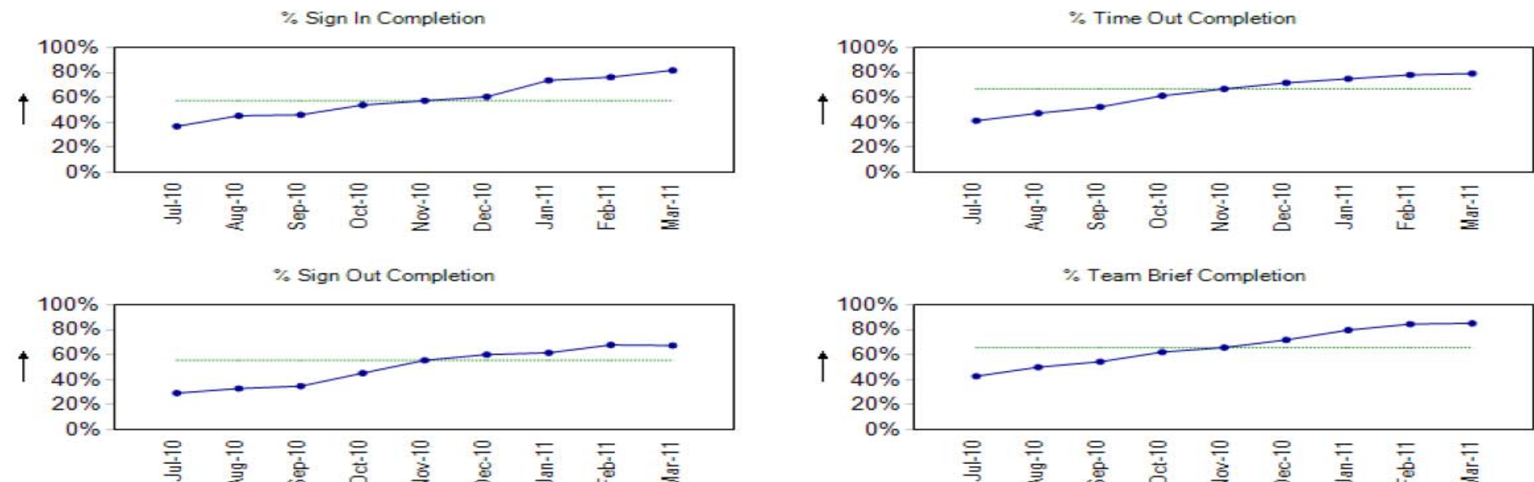
Desired direction of change ↑ ↓

Theatre: All Theatres **Service: All Specialties**

For each chart, click on a data point to display further detail and definitions. **Click here to display weekly measures**

Total Checklist Completion

Breakdown



Surgical and procedure checklist weekly reports

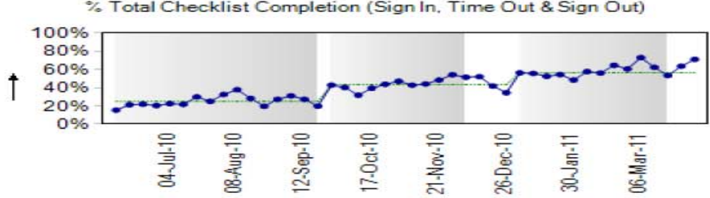
WHO Surgical Safety Checklist Dashboard

Desired direction of change ↑↓

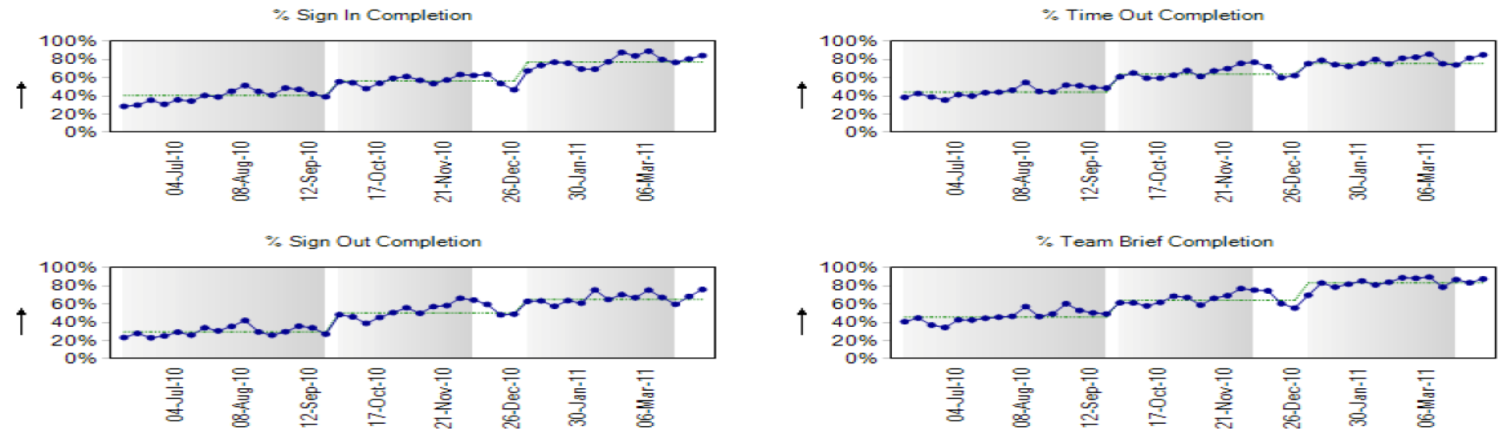
Theatre: All Theatres **Service: All Specialties**

For each chart, click on a data point to display further detail and definitions. Click here to display monthly measures

Total Checklist Completion



Breakdown



This dashboard displays weekly data. To view monthly data click here for the WHO Surgical Safety Checklist Dashboard - Monthly

Trust Board
27th April 2011

Approval of NHSBT contract – three years to April 14 **Submitted on behalf of:** Claire Newton	**Paper No: Attachment J** **For APPROVAL**

Aims
To seek Board approval to sign the contract to NHSBT.

Summary
The Trust has three year agreements with NHSBT for the supply of blood and other specialist products. The annual spend on this contract is between £2.0m to £2.5m
The last contract expired on 31st March 2011 but we were only sent the new contract in April.

There is currently no delegated authority to approve the contract due to its high value over three years.

The contract distinguishes two services:

- Supply of blood (based on price list notified to GOSH annually)
- Red Cell immunology services (RCI)
- Histocompatibility and Immunogenetics (H&I)
- Reagents

There is no alternative supplier for these services. NHSBT is a Special Health Authority within the NHS responsible for managing the national blood service, UK transplant and bio products laboratory.

The contract is designed for all NHS providers, whether they be Foundation Trusts or NHS Trusts. Certain clauses apply differently once the Trust becomes an FT in order to recognise the differences between the constitutions of an FT.

Action required from the meeting To approve the expenditure

Contribution to the delivery of NHS / Trust strategies and plans
Good governance is an essential foundation for delivery of the Trust's strategy

Financial implications Routine expenditure

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? General Managers responsible for the budgets

Who needs to be told about any decision? The Board

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

Who is accountable for the implementation of the action plan Estates

Author and date Claire Newton 19.04.11

Trust Board Meeting
April 2011

Title of document Key deliverables against our strategic objectives for 2011-12 **Submitted on behalf of** Fiona Dalton	**Agenda item/Paper No** **ATTACHMENT K**

Aims / summary

The Trust is in the final year of it's three year strategic objectives. We have reviewed the work-streams and actions required to deliver these objectives which were presented to Management Board and Trust Board in March. As requested by Trust Board, the actions against the Research and Innovation objective have been subject to further review and the key deliverables of this work programme have been identified. The strategic objectives and work-streams are:

Strategic Objective	Work-stream
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	Maintain our focus on Zero Harm
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	Continue to reduce waiting times further through our 'no waits' programme
	Improve the standard of customer service that we offer patients and families
	Continue to improve our relationships with referrers in order to achieve our market share objective.
	Continue to improve the patient environment through major upgrades, working closely with our charitable partners
3. Successfully deliver our clinical growth strategy	Deliver our planned in year growth
	Maintain IPP service growth
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards
4. With partners maintain and develop our position as the UK's top children's research organisation	Deliver the Research Strategy
	Continue to improve the mechanisms for the management of research within the Trust
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK
6. Deliver a financially stable organisation	Agree achievable CRES plan and ensure delivery through robust project and performance management
	Improve efficiency through our Transformation Programme
	Ensure appropriate funding for our clinical services from commissioners
	Support the charity to raise targeted funds
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	Make progress towards becoming a Foundation Trust
	Ensure that the Trust is compliant with regulatory requirements
	Improve efficiency of business processes

The revised work-streams and actions for Research and Innovation are:

4. With partners maintain and develop our position as the UK's top children's research organisation	**Deliver the Research Strategy**	4.1	Renew and deliver the Biomedical Research Centre in paediatrics
		4.2	Continue to develop partnership working with ICH, University College London Partners (UCLP) and UCL Business
		4.3	Increase research activity and income for the Trust by 10%
	Continue to improve the mechanisms for the management of research within the Trust	4.4	Continue to improve the mechanisms for the management of research within the Trust

The proposed key deliverable outcomes from this work programme for 2011-12 are:

	Key Deliverable
1	To achieve a 10% reduction in harm as defined by the global trigger tool
2	To double the number of specialties that have clinical outcome measures published on our internet site
3	Ensure the Morgan Stanley Clinical Building is ready for occupation
4	To meet our growth targets for both NHS and International and Private Patient activity
5	To increase our research publications and income for the Trust by 10%
6	To achieve excellent ratings in the Post Graduate Medical Education and Training Board and Quality Assurance Agency for higher education reviews
7	To meet our budget
8	To attain authorisation as a Foundation Trust

Accountability

Management Board are accountable for the delivery of the work programme. We have agreed that the performance of the work-streams and progress towards our key deliverables will be monitored at Management Board through a monthly summary and a quarterly in-depth report. Executive directors will provide a summary of progress that will be reported to Trust Board quarterly.

Assurance

The Assurance Framework has been updated to take account of the risks presented by the agreed actions. Risks will be identified and monitored by the Risk Assurance and Compliance Group. Assurance will be sought from the relevant assuring committee; Audit Committee and Clinical Governance Committee. A summary of the risks against the Assurance Framework will be regularly reported to Trust Board.

Action required from the meeting

- To agree the revised Research & Innovation work-streams and actions
- To agree the key deliverables for 2011-12
- To note the governance arrangements

Contribution to the delivery of NHS / Trust strategies and plans To ensure that the Trust is working coherently and effectively towards our Strategic Objectives
Financial implications None
Legal issues None
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? Senior Management Team
Who needs to be told about any decision Senior Management Team
Who is responsible for implementing the proposals / project and anticipated timescales Work-stream leads
Who is accountable for the implementation of the proposal / project Executive directors
Author and date Daniel Dacre, Planning and Performance Manager (18 April 2011)

Great Ormond Street Hospital for Children NHS Trust NHS

Trust Board **27th April 2011**	
Title of document Revised risks on the Assurance Framework **Submitted on behalf of** Chief Operating Officer	**Paper No: ATTACHMENT L**
Aims / summary The Assurance Framework provides an overview of the principal risks to achievement of the Trust's corporate objectives. In 2010-11, there were 26 risks documented on the framework (see **appendix 1**). The Audit Committee and the Clinical Governance Committee are responsible for seeking assurance of the adequacy of the controls in place to manage these risks. As at the date of this report, no risks are rated as red, 1 as amber and 25 as green. This rating relates to the assessment of the controls in place, any outstanding actions and internal/external assurances available. The risk rated as amber is: **1F Lack of appropriate clinical response to the deterioration in children** Although several controls have been put in place around this risk, for example the appointment of general paediatricians, increased nursing cover, the CEWS and SBARD communication/ scoring systems and the establishment of the ICON team, the Executive team still believe that there is further work to do to ensure these controls are fully implemented and integrated. The Audit Committee and Clinical Governance Committee reviewed all of its risks throughout the financial year 2010-11, as outlined in **appendix 2**. The Risk, Assurance and Compliance Group (RACG) reviews and manages the Assurance Framework. At its meeting in April, the RACG reviewed the existing risks to check they are fit for purpose for 2011-12, and reflect the true risks facing the organisation. The review took account of the risks on the trust wide risk register; the agreed work programmes for 2011-12; regulatory findings/ requirements; and audit recommendations. A summary of the changes are included at **appendix 3**. A draft copy of the revised risks is attached at **appendix 4**. The Audit Committee reviewed these revised risks at its meeting today (27th April) and the Chair of the Audit Committee will summarise the Committee's comments on these risks.	
Action required from the meeting To approve the draft risks on the Assurance Framework for 2011-12.	
Contribution to the delivery of NHS / Trust strategies and plans Covers all Trust objectives	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?	

N/A
Who needs to be told about any decision N/A
Who is responsible for implementing the proposals / project and anticipated timescales
Who is accountable for the implementation of the proposal / project
Author and date Anna Ferrant, Company Secretary 13th April 2011

Appendix 1 Assurance Framework Update

No.	Principal Risk	Accountable Executive	Responsible Assurance Committee	Initial Principal Risk Score	Revised principle risk score (after mitigations)	Assurance status	Date updated	Date reviewed by assurance committee	Date reviewed by AFG/ RACG
	STRATEGIC OBJECTIVE 1: Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world								
1A	Children may be harmed through medication errors	MD (ME)	CGC	25	**20**	GREEN	11/10/10	Nov-10	11-Oct-10
1B	Children may not be appropriately identified as being at risk of abuse and subsequent actions not taken	DN & Ed	CGC	20	**15**	GREEN	11/04/11	Jul-10	11-Oct-10
1C	Children, staff and parents may be put at risk from failure to adequately maintain the estate and non clinical equipment	DRedev	AC	25	**10**	GREEN	02/03/11	Apr 10 & Jun 10	13-Jan-11
1D	Children may be at risk from hospital acquired infection (includes decontamination & cleanliness)	MD (ME)	CGC	20	**15**	GREEN	11/10/10	Feb-11	13-Jan-11
1E	The organisation, management, administration and practice of clinical services may not always optimally deliver the best outcomes	COO	CGC	20	**12**	GREEN	07/04/11	Feb-11	13-Jan-11
1F	Our clinical equipment may be inadequate for excellent clinical care and enhanced patient experience	COO	CGC	15	**10**	GREEN	22/03/11	May-10	13-Jan-11
1G	Staff in post may not be appropriately competent to deliver care	DN & Ed	CGC	15	**10**	GREEN	11/04/11	Feb-11	
1H	We may not be able to recruit and retain key staff	COO	CGC	20	**12**	GREEN	07/04/11	Feb-11	
1I	We may not be able to benchmark outcomes against partners and national indicators.	COO/ MD (ME)	CGC/ AC	9	**6**	GREEN	07/04/11	May-11	Apr-11
1J	Clinical outcomes and patients' experiences may suffer as a result of a lack of appropriate management focus	COO	CGC	9	**6**	GREEN	10/01/11	May-11	Apr-11
1K	Lack of appropriate clinical response to the deterioration in children	MD(ME)	CGC	20	**15**	AMBER	12/01/11	Nov-10	11-Oct-10
	STRATEGIC OBJECTIVE 2: Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations								
2A	We may not be able to measure, report and act on patients' experience	DN & Ed	CGC	9	**4**	GREEN	11/11/11	Feb-11	11-Oct-10
2B	Patients may have to wait longer than is reasonable for consultation or treatment (initial proxy being national waiting time targets)	COO	CGC	12	**9**	GREEN	07/04/11	Jul-10	
2C	We may not meet referrers and other health and social care expectations around communication and accepting appropriate referrals	COO	CGC	12	**9**	GREEN	22/03/11	Nov-10	12-Jul-10

	STRATEGIC OBJECTIVE 3: Successfully deliver our clinical growth strategy								
3A	We may fail to get Commissioner 'buy in' to Trust growth plans and service developments	CFO	AC	20	**16**	GREEN	21/02/11	Jan-11	12-Jul-10
3B	We may fail to influence and capitalise on regional and national reconfiguration opportunities	COO	AC	12	**6**	GREEN	07/04/11	Oct-10	23-Aug-10
3C	We may not deliver our strategy for International Private Patients	Dir of Internat patients	AC	20	**10**	GREEN	21/02/11	Jun-10	
	STRATEGIC OBJECTIVE 4 : With partners maintain and develop our position as the UK's top children's research organisation								
4A	We may not deliver our research strategy and fail to attract research funding	D Research	CGC	12	**6**	GREEN	11.01.11	Nov-10	11-Oct-10
	STRATEGIC OBJECTIVE 5 : Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK								
5A	We may not deliver our education strategy and fail to maintain our position as leader of paediatric education and capitalise on the business opportunities resulting from the position	DN & Ed	CGC	12	**9**	GREEN	11/04.2011	Mar-10	13-Jan-11
	STRATEGIC OBJECTIVE 6 : Deliver a financially stable organisation								
6A	We may overspend on budgets by not maintaining control of costs and failing to achieve planned CRES targets	COO	AC	12	**8**	GREEN	07/04/11	Apr-10	Apr-11
6B	Sustainable funding solution for each activity within the Trust strategy may not be secured.	CFO	AC	20	**15**	GREEN	21/02/11	Apr 10 & Oct 10	12-Jul-10
	STRATEGIC OBJECTIVE 7 : Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation								
7A	We may fail to maintain compliance with regulatory and legilslative requirements (in particular CQC Registration Standards, NHSLA, ALE, Health and Safety at Work Act, NHS Constitution, Research Governance Framework, IG Toolkit)	MD (ME)	AC	20	**12**	GREEN	11/10/10	Apr-11	Apr-11
7B	IT Infrastructure may not be resilient or deliver the organisation's needs which creates the risk of clinical systems failing and delays investment in front line systems	CFO	AC	15	**12**	GREEN	21/02/11	Jan-11	
7C	The Trust may fail to achieve Foundation Trust status within a defined timescale	COO	AC	12	**8**	GREEN	07/04/11	Jan-11	
7D	We may not recognise or utilise the potential benefits arising from membership of UCL Partners	COO	AC	12	**6**	GREEN	12/01/11	Apr-11	Apr-11
7E	The redevelopment of the site may not meet delivery timescales or operational expectations	DRedev	AC	12	**8**	GREEN	09/02/11	Jan-11	

Appendix 2

Review of Audit Committee Assurance Framework risks 2010-11

2010-11 risk no.	Risk	Assurance Committee	Date reviewed by Assurance Committee
1A	Children may be harmed through medication errors	Clinical Governance Committee	Nov 2010
1B	Children may not be appropriately identified as being at risk of abuse and subsequent actions not taken	Clinical Governance Committee	July 2010
1C	Children, staff and parents may be put at risk from failure to adequately maintain the estate and non clinical equipment	Audit Committee	April 2010 and June 2010
1D	Children may be at risk from hospital acquired infection (includes decontamination & cleanliness)	Clinical Governance Committee	Feb 2011
1E	The organisation, management, administration and practice of clinical services may not always optimally deliver the best outcomes	Clinical Governance Committee	Feb 2011
1F	Our clinical equipment may be inadequate for excellent clinical care and enhanced patient experience	Clinical Governance Committee	May 2010
1G	Staff in post may not be appropriately competent to deliver care	Clinical Governance Committee	Feb 2011
1H	We may not be able to recruit and retain key staff	Clinical Governance Committee	Feb 2011
1I	We may not be able to benchmark outcomes against partners and national indicators.	Clinical Governance Committee	Not reviewed – revised for 2011-12
1J	Clinical outcomes and patients' experiences may suffer as a result of a lack of appropriate management focus	Clinical Governance Committee	Not reviewed – revised for 2011-12
1K	Lack of appropriate clinical response to the deterioration in children	Clinical Governance Committee	Nov 2010
2A	We may not be able to measure, report and act on patients' experience	Clinical Governance Committee	Feb 2011
2B	Patients may have to wait longer than is reasonable for consultation or treatment (initial proxy being national waiting time targets)	Clinical Governance Committee	July 2010
2C	We may not meet referrers and other health and social care expectations	Clinical Governance Committee	Nov 2010

2010-11 risk no.	Risk	Assurance Committee	Date reviewed by Assurance Committee
	around communication and accepting appropriate referrals		
3A	We may fail to get Commissioner 'buy in' to Trust growth plans and service developments	Audit Committee	January 2011
3B	We may fail to influence and capitalise on regional and national reconfiguration opportunities	Audit Committee	October 2010
3C	We may not deliver our strategy for International Private Patients	Audit Committee	June 2010
4A	We may not deliver our research strategy and fail to attract research funding	Clinical Governance Committee	Nov 2010
5A	We may not deliver our education strategy and fail to maintain our position as leader of paediatric education and capitalise on the business opportunities resulting from the position	Clinical Governance Committee	March 2010
6A	We may overspend on budgets by not maintaining control of costs and failing to achieve planned CRES targets	Audit Committee	April 2010
6B	Sustainable funding solution for each activity within the Trust strategy may not be secured.	Audit Committee	April 2010 and October 2010
7A	We may fail to maintain compliance with regulatory and legislative requirements (in particular CQC Registration Standards, NHSLA, ALE, Health and Safety at Work Act, NHS Constitution, Research Governance Framework, IG Toolkit)	Audit Committee	April 2011
7B	IT Infrastructure may not be resilient or deliver the organisation's needs which creates the risk of clinical systems failing and delays investment in front line systems	Audit Committee	January 2011
7C	The Trust may fail to achieve Foundation Trust status within a defined timescale	Audit Committee	January 2011
7D	We may not recognise or utilise the potential benefits arising from membership of UCL Partners	Audit Committee	April 2011
7E	The redevelopment of the site may not meet delivery timescales or operational expectations	Audit Committee	January 2011

Appendix 3

Revised risks (2010-11 to 2011-12)

*Risks not detailed remain the same.

Existing risk	New risk/ comment
1E The organisation, management, administration and practice of clinical services may not always optimally deliver the best outcomes.	*REVISED WORDING – to ensure that the necessary controls are covered* **The organisation, management, administration and practice of clinical services may not always optimally deliver the best outcomes (to include record management, consent, nutrition, staff competency, clinical/ management focus)**
1F Our clinical equipment may be inadequate for excellent clinical care and enhanced patient experience	*REMOVED- agreed that this risk is covered under revised risk 1E*
1G Staff in post may not be appropriately competent to deliver care	*REMOVED- agreed that this risk is covered under revised risk 1E*
1I We may not be able to benchmark outcomes against partners and national indicators.	*REVISED WORDING – to accurately reflect the Trust's position in leading and developing outcomes.* **We do not make sufficient progress in developing benchmarks and demonstrating world class clinical outcomes**
1J Clinical outcomes and patients' experiences may suffer as a result of a lack of appropriate management focus	*REMOVED- agreed that this risk is covered under revised risk 1E*
3B We may fail to influence and capitalise on regional and national reconfiguration opportunities.	*REVISED WORDING – to reflect the fact that the Trust operates in a competitive market* **We may fail to influence and capitalise on regional and national reconfiguration opportunities and expand our market share**
7B IT Infrastructure may not be resilient or deliver the organisation's needs which creates the risk of clinical systems failing and delays investment in front line systems.	*REVISED WORDING – update to the risk* **We may not deliver the IT and information strategies resulting in failure to achieve process efficiencies and to deliver effective electronic patient information and record systems in support of our clinical strategy.**
7D We may not recognise or utilise the potential benefits arising from membership of UCL Partners	*REMOVED- agreed that this is not a risk but a lost opportunity*

Appendix 4

No.	Principal Risk	Accountable Executive	Responsible Assurance Committee	Initial Principal Risk Score	Revised principle risk score (after mitigations)	Assurance status	Date updated
	STRATEGIC OBJECTIVE 1: Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world						
1A	Children may be harmed through medication errors	MD (ME)	CGC	25	**20**	GREEN	11/10/10
1B	Children may not be appropriately identified as being at risk of abuse and subsequent actions not taken	DN & Ed	CGC	20	**15**	GREEN	24/02/11
1C	Children, staff and parents may be put at risk from failure to adequately maintain the estate and non clinical equipment	Dredev supported by COO	AC	25	**10**	GREEN	02/03/11
1D	Children may be at risk from hospital acquired infection (includes decontamination & cleanliness)	MD (ME)	CGC	20	**15**	GREEN	11/10/10
1E	The organisation, management, administration and practice of clinical services may not always optimally deliver the best outcomes (to include record management, consent, nutrition, staff compenency, clinical/ management focus)	COO	CGC	20	**12**	GREEN	07/04/11
1F	Lack of appropriate clinical response to the deterioration in children	MD(ME)	CGC	20	**15**	AMBER	12/01/11
1G	We may not be able to recruit and retain key staff	COO	CGC	20	**12**	GREEN	07/04/11
1H	We do not make sufficient progress in developing benchmarks and demonstrating world class clinical outcomes	COO supported by MD (ME)	CGC	9	**6**	GREEN	07/04/11
	STRATEGIC OBJECTIVE 2: Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations						
2A	We may not be able to measure, report and act on patients' experience	DN & Ed	CGC	9	**4**	GREEN	24/02/11
2B	Patients may have to wait longer than is reasonable for consultation or treatment (initial proxy being national waiting time targets)	COO	CGC	12	**9**	GREEN	07/04/11
2C	We may not meet referrers and other health and social care expectations around communication and accepting appropriate referrals	COO	CGC	12	**9**	GREEN	22/03/11
	STRATEGIC OBJECTIVE 3: Successfully deliver our clinical growth strategy						
3A	We may fail to get Commissioner 'buy in' to Trust growth plans and service developments	CFO	AC	20	**16**	GREEN	21/02/11
3B	We may fail to influence and capitalise on regional and national reconfiguration opportunities and expand our market share	COO	AC	12	**6**	GREEN	07/04/11
3C	We may not deliver our strategy for International Private Patients	Dir of Internat patients	AC	20	**10**	GREEN	21/02/11
	STRATEGIC OBJECTIVE 4 : With partners maintain and develop our position as the UK's top children's research organisation						
4A	We may not deliver our research strategy and fail to attract research funding	D Research	CGC	12	**6**	GREEN	11.01.11
	STRATEGIC OBJECTIVE 5 : Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK						
5A	We may not deliver our education strategy and fail to maintain our position as leader of paediatric education and capitalise on the business opportunities resulting from the position	DN & Ed	CGC	12	**9**	GREEN	10/01/11

	STRATEGIC OBJECTIVE 6 : Deliver a financially stable organisation						
6A	We may overspend on budgets by not maintaining control of costs and failing to achieve planned CRES targets	COO	AC	12	**8**	GREEN	07/04/11
6B	Sustainable funding solution for each activity within the Trust strategy may not be secured.	CFO	AC	20	**15**	GREEN	21/02/11
	STRATEGIC OBJECTIVE 7 : Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation						
7A	We may fail to maintain compliance with regulatory and legilslative requirements (in particular CQC Registration Standards, NHSLA, ALE, Health and Safety at Work Act, NHS Constitution, Research Governance Framework, IG Toolkit)	Company Secretary	AC	20	**12**	GREEN	11/10/10
7B	We may not deliver the IT and Information strategies resulting in failure to achieve process efficiencies and to deliver effective electronic patient information and record systems in support of our clinical strategy.	CFO	AC	15	**12**	GREEN	21/02/11
7C	The Trust may fail to achieve Foundation Trust status within a defined timescale	COO	AC	12	**8**	GREEN	07/04/11
7D	The redevelopment of the site may not meet delivery timescales or operational requirements	DRedev	AC	12	**8**	GREEN	09/02/11

Attachment M

<table>
<tr><td colspan="2">Trust Board
April 2011</td></tr>
<tr><td>Title of document
Key Performance Indicator Report

Submitted on behalf of.
Fiona Dalton, Chief Operating Officer</td><td>Paper No: Attachment M</td></tr>
<tr><td colspan="2">Aims / summary
The Key Performance Indicator (KPI) report monitors progress against the Trust's seven strategic objectives, providing traffic light analysis against each of the supporting work streams with further supporting graphs representing key outcome measures.
Remedial actions, where performance is not being maintained or achieved, are being addressed through Management Board.</td></tr>
<tr><td colspan="2">Action required from the meeting
Trust Board to note progress.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
To assist in monitoring performance against internal and external defined objectives and NHS Plan targets.</td></tr>
<tr><td colspan="2">Financial implications
None</td></tr>
<tr><td colspan="2">Legal issues
None</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Our lead Commissioner receives a copy of the executive summary on a quarterly basis.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
Senior Management Team.</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Each Trust objective task has an identified person responsible for implementation and an Executive Director nominated as the accountable officer.</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
As above.</td></tr>
<tr><td colspan="2">Author and date
Janine Gladwell, Capacity and Access Manager. April 2011</td></tr>
</table>

KPI Exception report

1. C. difficile (Report page 2 Graph 1)
In month the Trust reported 1 case of C. difficile.

The Trust has reported a year end total of 11 cases against a trajectory of 9. The Department of Health (DH) have not yet agreed to a paediatric target different from adult. The DH advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) will be presenting our opinion on this again soon.

2. Inpatients waiting list profile by weeks waiting (Report page 4, Graph 12)
Performance has decreased in month with 60 patients reported as waiting over 26 weeks for inpatient treatment. A large majority of these relate to surgical specialties, and in particular Orthopaedics who report 22 long waiting patients. The specialty management team are undertaking demand and capacity analysis of this service.

3. Outpatients waiting list profile - GP to first consultant appointment (Report page 4, Graph 13)
The number of patients waiting over 13 weeks for a first consultant outpatient appointment decreased from a February position of 42 to 32 following data validation.

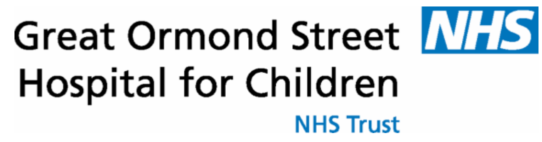
4. Clinic outcome form completeness. (Report page 5, Graph 15)
There are Clear differences across Clinical Units and Specialties in the current level of outcome form completeness with some achieving 100% or near and others well below 50%. This has meant that overall level is stalled around 60%.

The Transforming Outpatients Group has discussed and disseminated two methods for achieving improvement in scores currently being carried out by Cardiac and Surgery. Operational and Service Managers have been tasked with following the method best suited to their teams in order to achieve improvement.

5. Staff who have a current Personal Development Review (PDR) in the last 13 months (Report page 12, Graph 41).
Both clinical and non-clinical PDR rates increased slightly to 74% and 75% respectively against a year end target of 80%. Services and departments are encouraged to continue to review staff currently identified as not receiving an appraisal.

6. Information governance training
The total uptake of training remains low at 23%. The deadline for all staff to complete information governance mandatory training is mid-June. The training is now hosted locally on GOLD. Reports have additionally been sent to managers listing the staff who haven't yet undertaken the training.

7. Mixed Sex Accommodation
There were no formal breaches reported last month.



Trust Board

Key Performance Indicator Report

Mar-11

Key Performance Indicator Report

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	Mortality Figures		Internal	2
	Serious Patient Safety Incidents		Internal	3
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	Surgical Site Infection - Urology	CQUIN		3
	Ventilator-associated pneumonia	CQUIN		3
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	Inpatients waiting list profile	Contractual		4
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	Number of GP referrals waiting over 13 weeks	Contractual		4
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	Valid coding for ethnic category (GOSH & Haringey)	National		5
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Appendix 2.ICT service desk changes and incidents				14

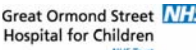
Key Performance Indicator Report

Dashboard

Objective / Indicator	YTD Target/Trajectory (10/11)	YTD Performance	In month / quarter performance	Performance against previous reporting period	Reported	YTD RAG
1. Consistently deliver clinical outcomes that place us amongst top 5 Children's Hospitals in the world						
Incidence of C.difficile	9	11	1	↑	Monthly	Red
Incidence of MRSA	1	1	0	↔	Monthly	Green
Incidence of MSSA	TBC	20	3	↔	Monthly	-
Mortality figures	Within tolerance	126	12	↓	Monthly	Green
No. of NICE recommendations unreviewed	<3	-	1	↔	Monthly	Green
Medication errors reported (per 1000 bed days)	Data under review	-	-	-	-	-
Serious incidents	Within tolerance	-	2	↑	Monthly	Green
Incidence of Central Venous Line related infections (per 1000 bed days)	2.4	2.64	2.04	↓	Monthly	Amber
Surgical site infections as a percentage of Urology operations	Within tolerance	0.77	1	↔	Monthly	Green
Incidence of Ventilator-Associated Pneumonia (VAP)	0	3	No March data		Monthly	Amber
Surgical Checklist completed - Sign in (%)	75	-	81.4	↑	Monthly	Green
Surgical Checklist completed - Time out (%)	75	-	79.5	↔	Monthly	Green
Surgical Checklist completed - Sign out (%)	75	-	68	↓	Monthly	Amber
2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations						
Inpatient waits >26wks	<5	-	60	↓	Monthly	Red
Outpatient wait >13wks	<5	-	32	↑	Monthly	Red
18 week RTT performance - Admitted (%)	90	94.32	90.96	↑	Monthly	Green
18 week RTT performance - Non-Admitted (%)	95	96.78	96.34	↓	Monthly	Green
Clinic outcome form completeness (%)	95	69.77	61	↔	Monthly	Red
Valid coding for ethnic category - inpatient (%)	85	88.1	93.2	↑	Monthly	Green
Discharge summary completion (%)	95	81.92	77.73	↑	Monthly	Amber
Did not attend - outpatients (%)	TBC	8.6	7.4	↑	Monthly	-
3. Successfully deliver our clinical growth strategy						
Theatre Utilisation - U4 (%)	77	-	61.9	↓	Monthly	Amber
Follow up to new ratio	4.5	-	3.71	↑	Monthly	Green
No. of External emergency referrals to PICU/NICU refused	To reduce		No March data	-	-	-
Income variance - Budget against actual		-				Green
4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation						
External Research Grants - Commercial and non-commercial (£)	TBC	29,206,818	291,474	↓	Monthly	-
Clinical trials - number recruited	TBC	2198	2198	↑	Annually	-
5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK						
MPET SLA Value (£)	-	-	6,815,876	↓	Quarterly	-
6. Deliver a financially stable organisation						
CRES delivered (£000) - Released from budgets	16,605	11,960	-	↑	Monthly	-
Bank and Agency Total expenditure (£000)	TBC	17,697	1,674	↑	Monthly	-
Monitor Risk Rating	3	-	3	↔	Monthly	Green
Charity fundraising target	61,985,311	63,051,742	6,461,695	↑	Monthly	Green
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation						
Sickness absence rate (%)*	TBC	-	3.2	↔	Quarterly	-
No. of staff in post FTE	TBC		3435	-	Quarterly	
Vacancy rate (%)	TBC	-	7	↑	Quarterly	-
Turnover rate (%)*	TBC	-	17.8	↑	Quarterly	-
NHS Number completeness - FCE inpatient (%)	95	98.1	99.24	↔	Monthly	Green
NHS Number completeness - outpatient (%)	95	97.8	98.43	↔	Monthly	Green
Staff PDR completeness - clinical (%)	80	-	74.1	↑	Monthly	Amber
Staff PDR completeness - non clinical (%)	80	-	75.4	↑	Monthly	Amber
Network Availability (%)	99.99	-	99.99	↔	Monthly	Green
Average Key Server Availability Monthly (%)	-	-	100	↑	Monthly	Green
Monthly Key Application Availability	-	-	98.32	↑	Monthly	Green

* Rolling 12 month position

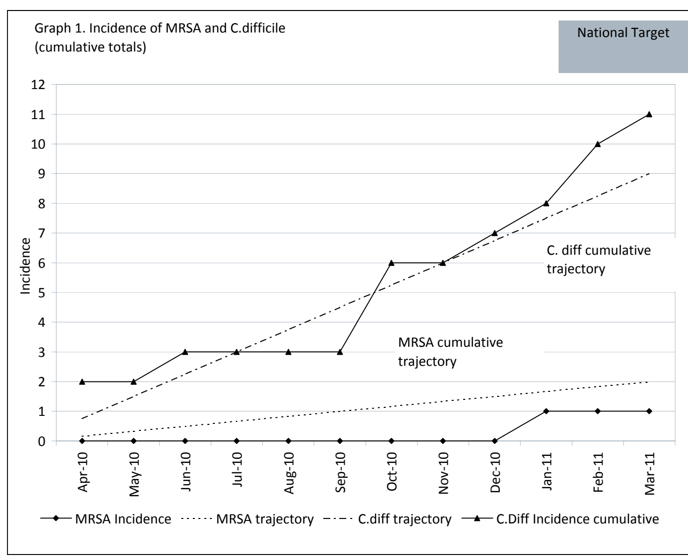
Key Performance Indicator Report

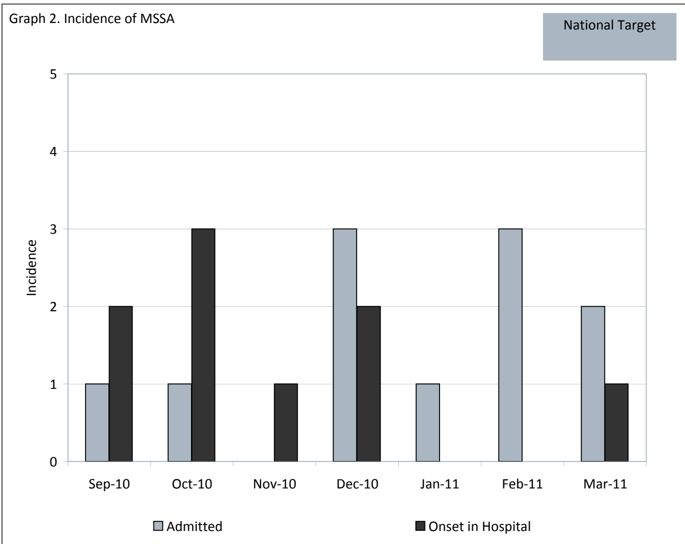


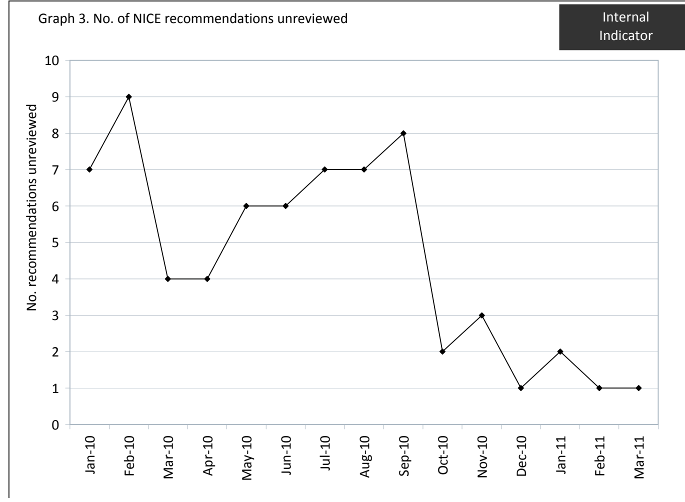
1. Consistently deliver clinical outcomes that place us amongst top 5 Children's Hospitals in the world.

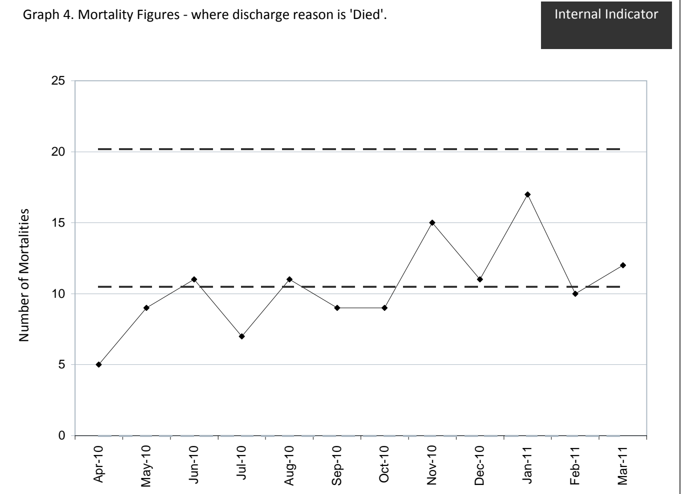
Key deliverables		RAG analysis
1	Publish the Quality Account and demonstrate world-class benchmarked clinical outcomes	Green

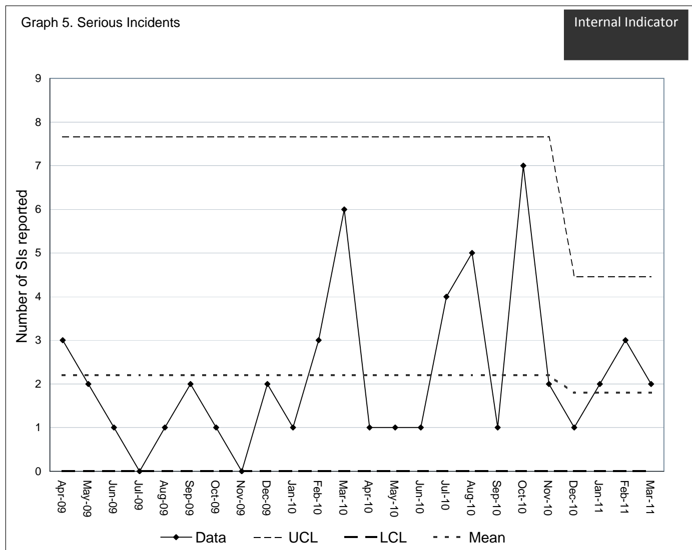
Key workstreams:			Exec Lead	Last update	RAG
1	Maintain our focus on Zero Harm	Review the Intensive Care Outreach team (ICON) pilot and the current 'Hospital at Night Team' and build on the successes of these two services to deliver integrated support for the sickest children on our ward.	ME	11-Feb	Green
		Continue the development of systems to decrease adverse drug events by concentrating on high risk medications and high risk areas in the Trust with the aim of a 50% reduction in adverse drug events in each high risk clinical area.	ME	10-Feb	Amber
		Maintain Child Protection structures and processes to support safe child protection practice. Child protection supervision policies to be fully implemented.	LM	27-Jan	Green
		Achieve compliance with infection control national standards.	ME	15-Apr	Red
		Achieve reduction in each specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year. (Graphs 6,7,8)	ME	11-Feb	Amber
		Implement the Priority Actions for Health Plan for phase 2 (Jan - June 2010) and phase 3 (July 2010 onwards) identified in the safeguarding plan for Haringey (Joint Area Review action plan).	LM	11-Oct	Green
		Spread the Situation, Background, Assessment, Recommendations and Decision (SBARD) communication tool and the Children's Early Warning Score (CEWS) throughout the Trust to ensure it is used by all staff.	LM	15-Mar	Amber
		Continue weekly Executive walkabouts and audit actions quarterly.	FD	16-Feb	Green
		Ensure Safety First is a key agenda item for all appropriate meetings	JC	11-Feb	Green
		Introduce surgical check list before 100% theatre sessions.	ME	10-Mar	Amber
		Establish base lines where the global trigger tool has been introduced and set a percentage reduction target of trigger incidents.	ME	27-Jul	Green
2	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	Report Clinical Outcomes/Patient-Reported Outcome Measures (PROMS) through operational performance reviews and agree actions to improve.	ME	10-Feb	Amber
		Continue to monitor new National Institute for Clinical Excellence / National Service Framework (NICE/NSF) guidance through the Quality and Safety meetings.	ME	10-Mar	Green
		Develop benchmarking standards with international best practice across all units.	ME	10-Feb	Amber
		To develop and publish a trustwide Quality Account by June 2010 in line with the Department of Health (DH) Quality Account Toolkit Advisory guidance.	ME	31-Mar	Green
		To finalise our Quality and Innovation (CQUIN) measures with our lead commissioners and start reporting against these by May 2011.	CN	14-Feb	Amber

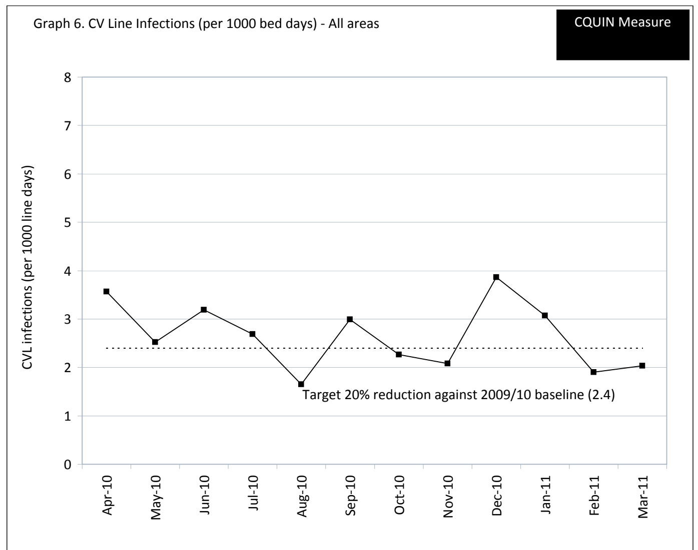


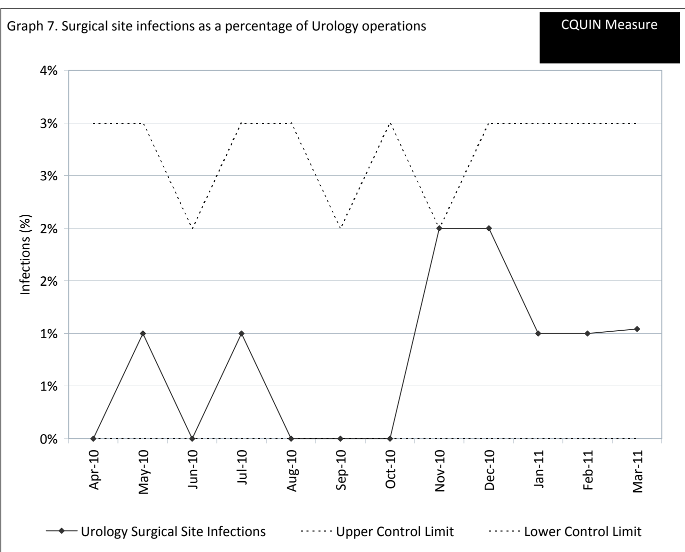


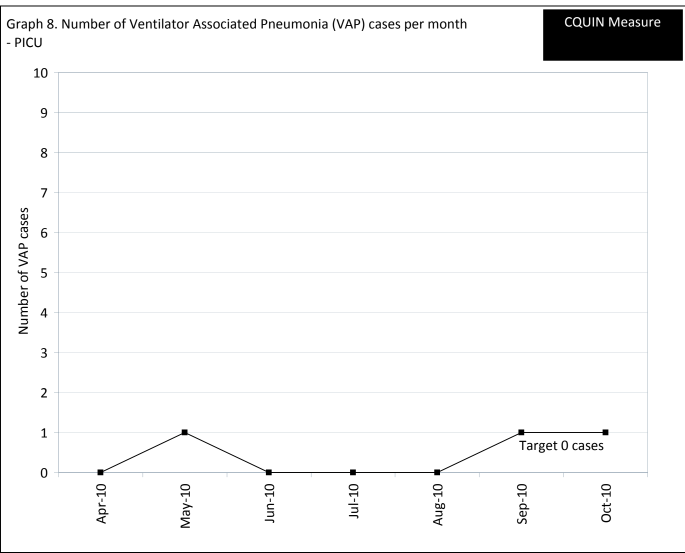


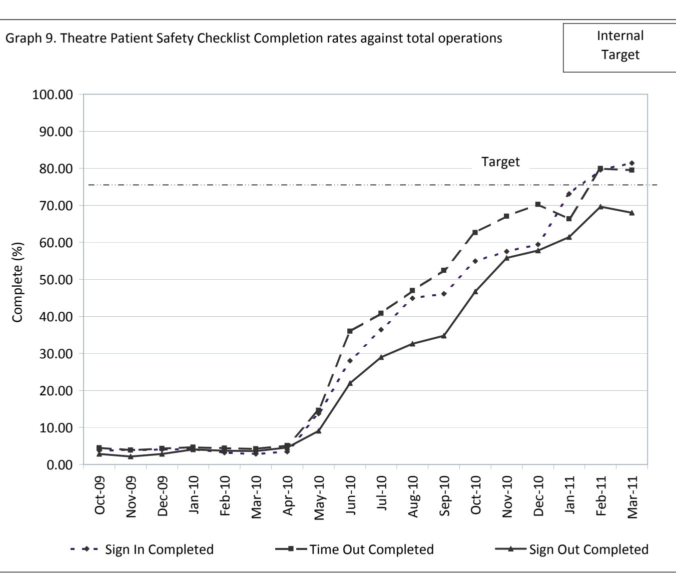


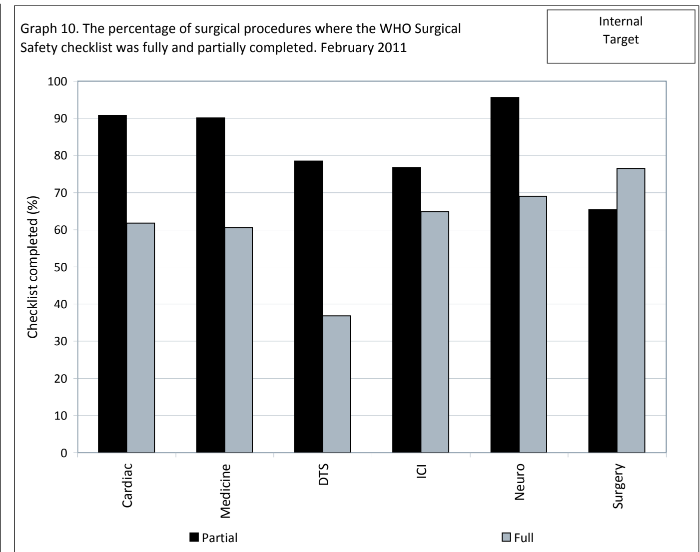






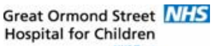






Commentary:

Graph 10. Fully completed defined as Sign In, Time Out and Sign Out all completed on the surgical safety checklist. Partially completed defined as one or more of these factors completed on the surgical safety checklist.

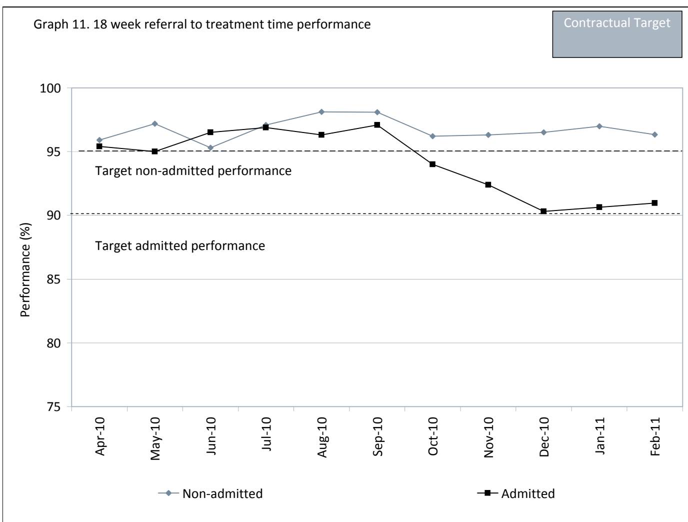


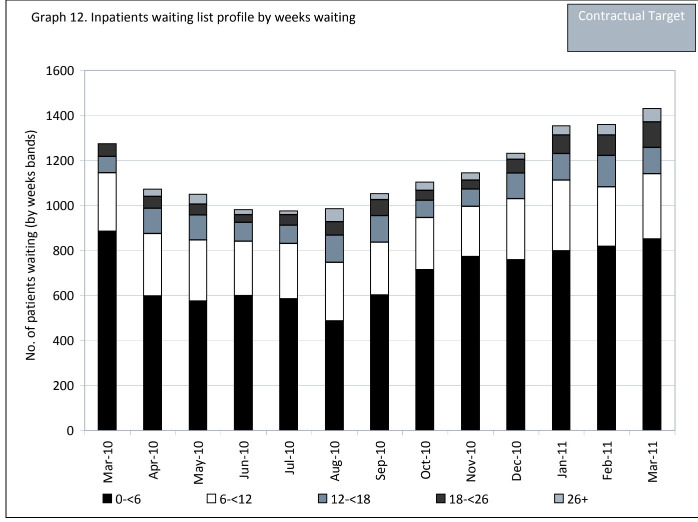
Key Performance Indicator Report

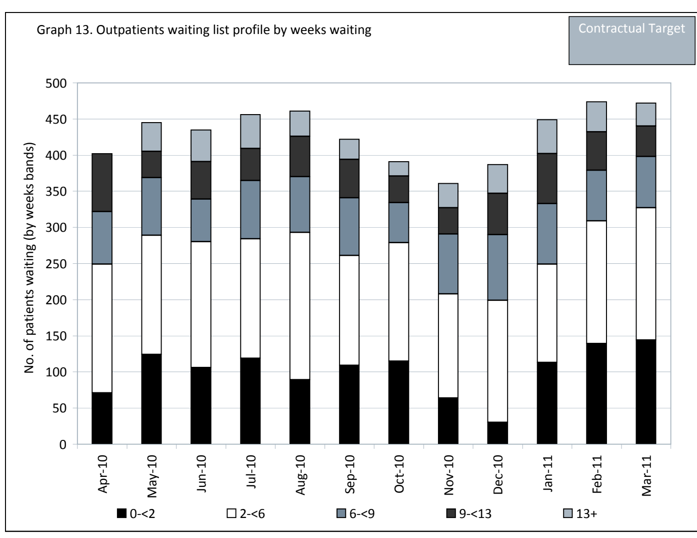
2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations

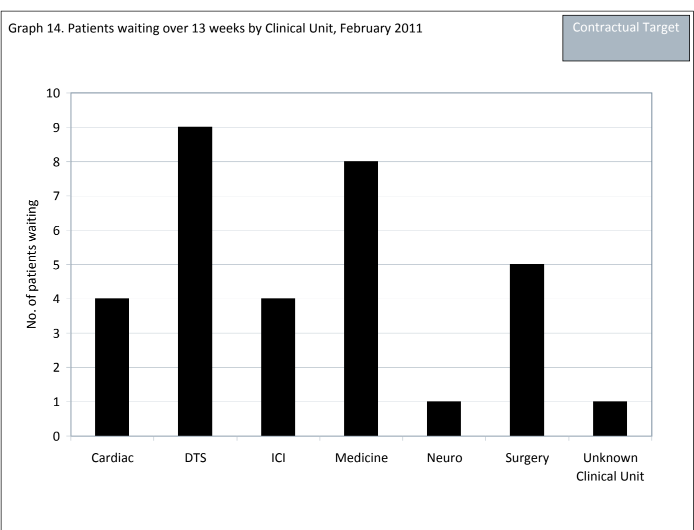
	Key deliverables	RAG analysis
1	Complete the referrer survey and progress an agreed action plan	Green
2	Progress Phase 2A building and 2B planning to meet future clinical needs	Green

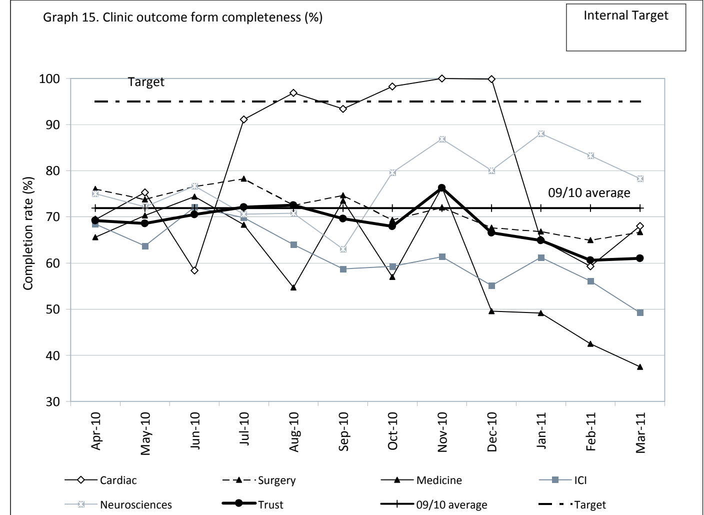
	Workstream	Actions	Exec Lead	Last updated	RAG
1	Develop a reliable and robust system for capturing real time patient and family experience feedback.	Implement Patient and Public Involvement/Engagement Strategy.	LM	10-Mar	Green
2	Continue to reduce waiting times further through our 'no waits' programme.	Complete the roll-out of the Advanced Access Outpatient project across all specialties.	FD	11-Feb	Red
		Ensure we have a robust action plan to continue to meet all national access targets as described in the Trust Access Policy including: 18 week referral to treatment time, 6 week diagnostic waits and cancer targets. (Graph 13)	FD	11-Feb	Green
3	Improve the standard of customer service that we offer patients and families	Continue to improve the patient and family experience and measure effectiveness, specifically focussing on areas highlighted in the Ipsos MORI survey.	LM	07-Jan	Green
		Ensure all staff receive an appropriate level of customer service training via inductions, update or bespoke events.	LM	13-Mar	Green
4	Improve our understanding of our referrers, and their requirements and improve our service to meet these requirements	Achieve contractual standards for discharge summaries.	FD	11-Feb	Amber
		Undertake an analysis of our referral patterns, market share and competitors across all specialties to better understand our key referrers.	FD	10-Feb	Green
		Review this analysis in conjunction with our pattern of outreach clinics and consider a more formalised model of partnership with referring hospitals	FD	10-Feb	Green
		Develop an action plan for improvement following the results of the Referrer Survey.	FD	10-Feb	Green
5	Continue to improve the patient environment through major upgrades, working closely with our charitable partners.	Continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011	WMcG	21-Mar	Green
		Invest within our 10 year capital programme to improve the patient environment within our existing buildings. Key deliverables will include at least one ward refurbishment; enhancement of out Patient facilities; upgrading public toilets in the Variety Club Building (VCB) and the start of renewing the patient entertainment system trust wide.	WMcG	21-Mar	Green
6	Through the Foundation Trust process increase membership and develop a strategy to involve members effectively	Achieve required membership trajectory.	FD	11-Feb	Green
		Formally agree constitution including election.	FD	11-Feb	Green
		Integrate members into our management and governance processes.	FD	11-Feb	Green



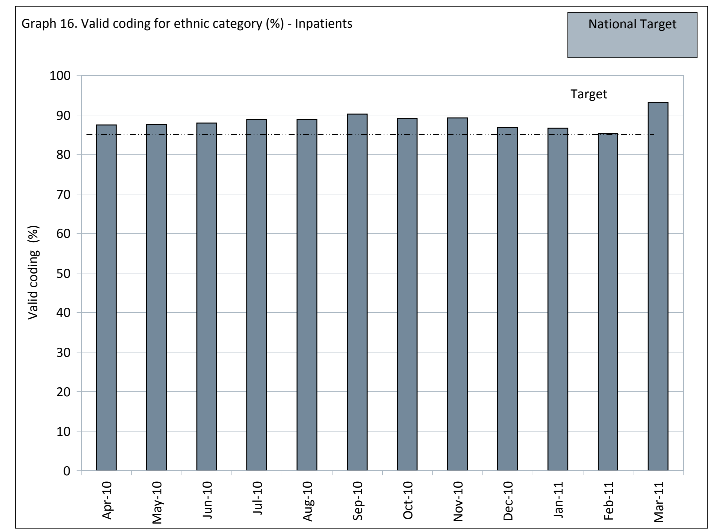




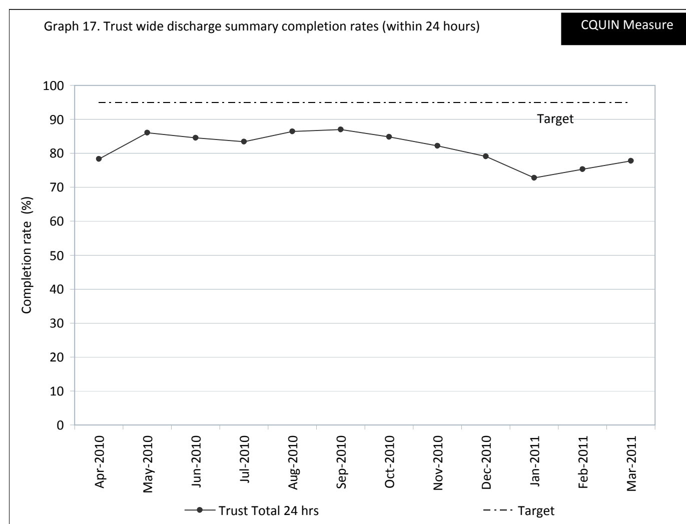




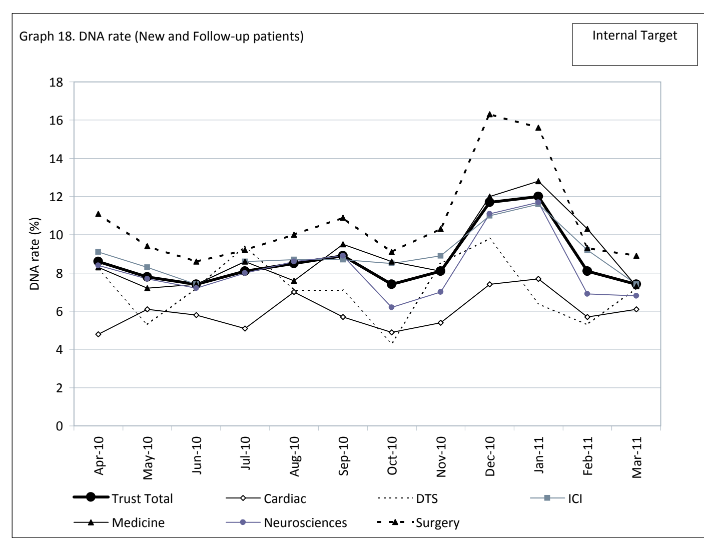
Graph 15. Clinic outcome form completeness (%)
Internal Target
Target
09/10 average
Completion rate (%)
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Cardiac
Surgery
Medicine
ICI
Neurosciences
Trust
09/10 average
Target



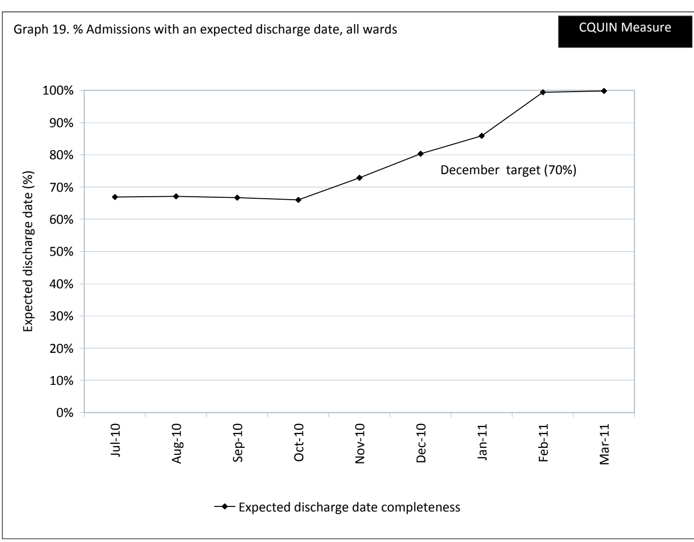
Graph 16. Valid coding for ethnic category (%) - Inpatients
National Target
Target
Valid coding (%)
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11



Graph 17. Trust wide discharge summary completion rates (within 24 hours)
CQUIN Measure
Target
Completion rate (%)
Apr-2010
May-2010
Jun-2010
Jul-2010
Aug-2010
Sep-2010
Oct-2010
Nov-2010
Dec-2010
Jan-2011
Feb-2011
Mar-2011
Trust Total 24 hrs
Target



Graph 18. DNA rate (New and Follow-up patients)
Internal Target
DNA rate (%)
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Trust Total
Cardiac
DTS
ICI
Medicine
Neurosciences
Surgery



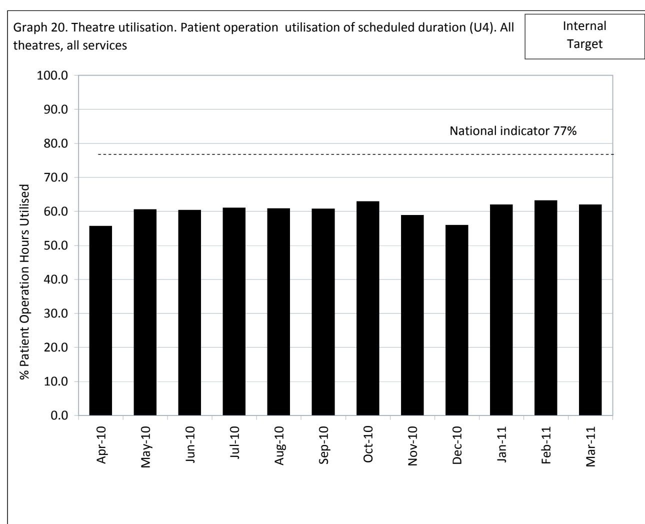
Graph 19. % Admissions with an expected discharge date, all wards
CQUIN Measure
December target (70%)
Expected discharge date (%)
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Expected discharge date completeness

Key Performance Indicator Report

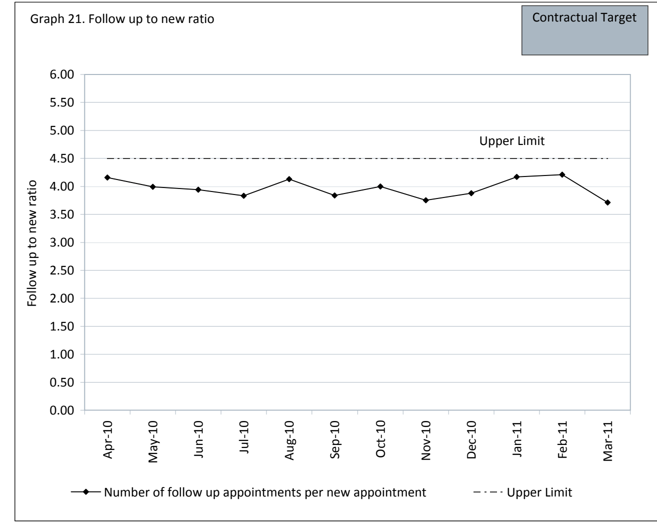
3. Successfully deliver our clinical growth strategy

	Key deliverables	RAG analysis
1	Secure advantages from the national paediatric cardiac and neuro surgery reviews	Green

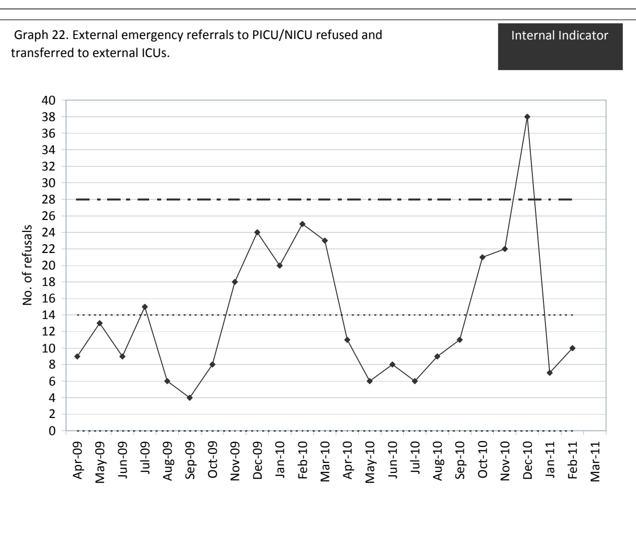
	Workstream	Actions	Exec Lead	Last update	RAG
1	Deliver our planned in year growth	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	FD	10-Feb	Green
		Monitor compliance with new Access policy to minimise refusals.	FD	14-Feb	Green
		Supported by the Transformation Team, deliver growth by redesigning processes to: Better utilise our assets; increase working hours e.g. Saturday; continue to reduce length of stay; improve theatre utilisation and increase day case rates	FD	10-Feb	Green
		Identify early in year and work up potential future National Commissioning Group (NCG) bids. This includes the timely submission of phase 1 and 2 proposals to maximise success of proposals on a yearly basis.	FD	11-Feb	Green
2	Revise future activity and growth plans	Revise and update our IBP growth plan, considering general population increase, clinical and market share growth.	FD	10-Feb	Green
3	Maintain IPP service growth	Review International and Private Patient (IPP) workforce.	TC	15-Feb	Green
		Increase IPP physical and staffed capacity.	TC	15-Feb	Green
		Review activity and improve efficiency.	TC	15-Feb	Green
		Develop a formal IPP strategy and agree an action plan to deliver the strategy.	TC	10-Mar	Green
4	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	Work with the Barts and the London (BLT) to support the development of a paediatric trauma centre.	FD	08-Feb	Amber
		Work with partners to implement the agreed North West London Paediatric Surgery network.	FD	16-Mar	Green
		Pending the outcome of consultation, work with North Middlesex University Hospital NHS (NMUH) to implement the	FD	10-Feb	Green
		Work with local government partners and other statutory bodies to ensure Haringey community paediatric services are working in partnership for the benefit of children.	BB	11-Feb	Green
		Achieve accreditation as a national paediatric cardiac centre through the new national processes, and plan to accommodate any further growth that arises from this process.	FD	10-Mar	Green
		Establish a north London tertiary paediatric network.	FD	11-Feb	Amber



Graph 20. Theatre utilisation. Patient operation utilisation of scheduled duration (U4). All theatres, all services

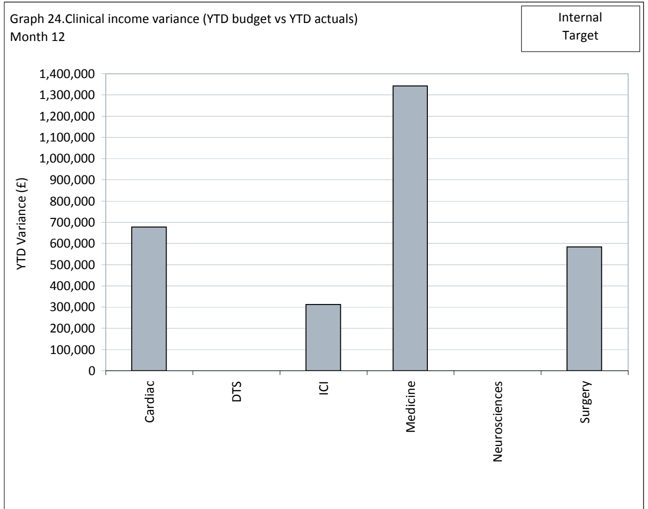


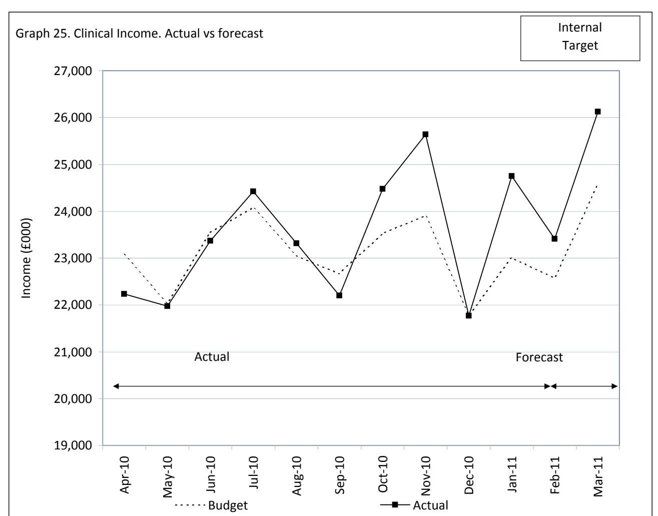
Graph 21. Follow up to new ratio

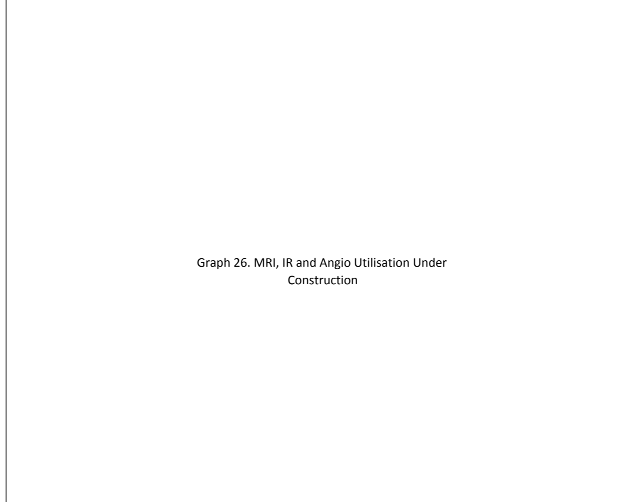


Graph 22. External emergency referrals to PICU/NICU refused and transferred to external ICUs.

Graph 23. Patient refusals by clinical unit will be updated following validation of data.


Graph 24.Clinical income variance (YTD budget vs YTD actuals)
Month 12
Internal
Target
YTD Variance (£)
1,400,000
1,300,000
1,200,000
1,100,000
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
Cardiac
DTS
ICI
Medicine
Neurosciences
Surgery

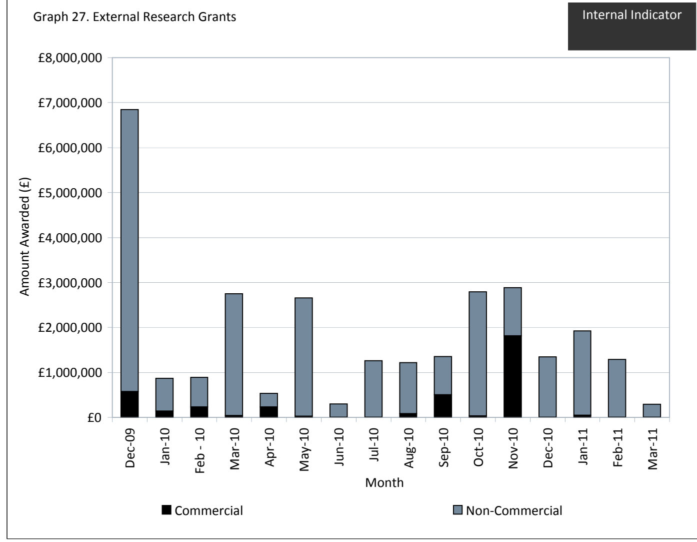

Graph 25. Clinical Income. Actual vs forecast
Internal
Target
Income (£000)
27,000
26,000
25,000
24,000
23,000
22,000
21,000
20,000
19,000
Actual
Forecast
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Budget
Actual

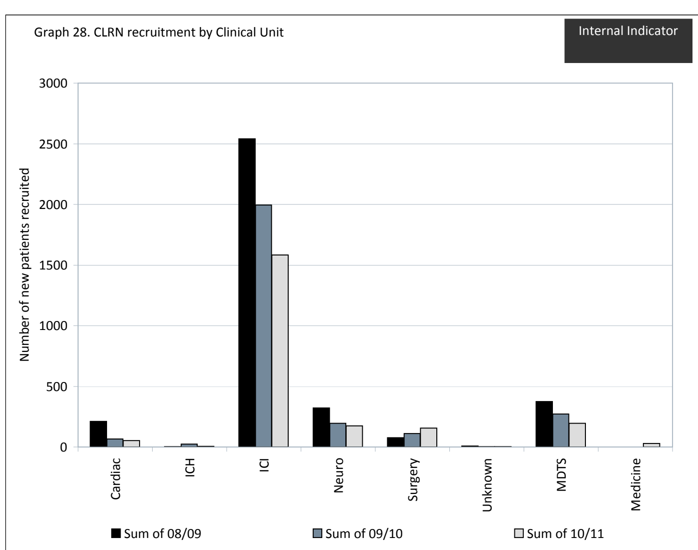

Graph 26. MRI, IR and Angio Utilisation Under
Construction

4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation

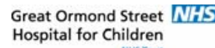
Key deliverables		RAG analysis
1	Improve congruency of clinical and R & D strategies	Green
2	Leverage R&D and non R&D benefits from UCLP	Amber

Key workstreams:			Exec Lead	Last update	RAG
1	Continue to develop partnership working	Continue to work with University College London Partners (UCLP) and leverage benefits from this.	DG	08-Feb	Green
		Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding and costs are within the appropriate organisation.	DG	08-Feb	Green
2	Develop and agree R&D strategies at clinical service level	Agree the Trust's R&D strategy and ensure Clinical Unit R&D strategies fit with this.	DG	08-Feb	Green
3	Increase research income	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.	DG	08-Feb	Green
		Continue to develop our R&D activities and ensure it is adequately funded. Carry out a review of the progress made in the first year of the clinical Research Facility (CRF) and confirm strategy for the next five years.	DG	14-Jun	Green
		Agree a financial plan for R&D which is consistent with The National Institute for Health Research (NIHR) priorities and	DG	14-Feb	Amber
		Ensure there is an appropriate funding transition for activities currently funded by GOSH Children's Charity.	DG	13-Jan	Green





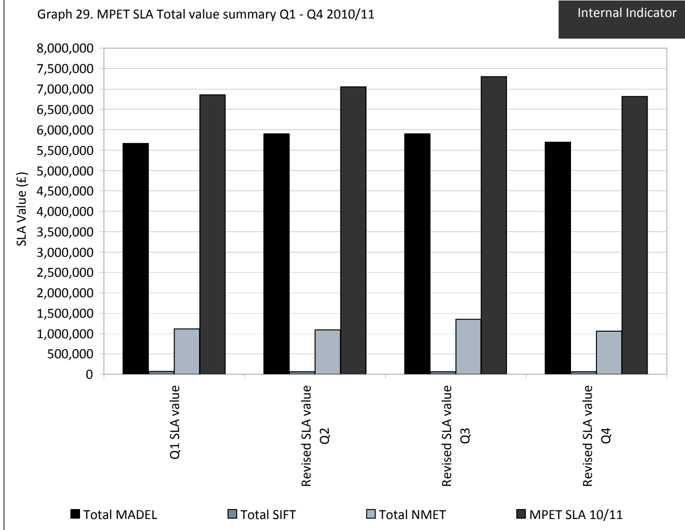
Key Performance Indicator Report

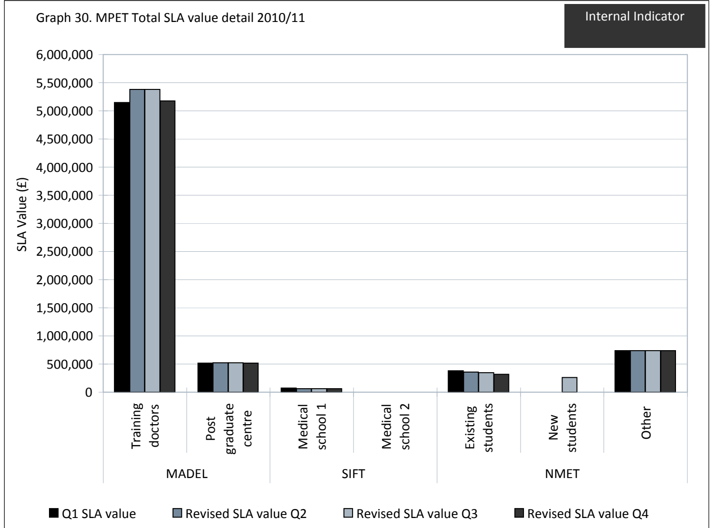


5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK

	Key deliverables	RAG analysis
1	Achieve better than NHS average staff satisfaction scores by ensuring all staff work in a supportive team environment with good training and education opportunities	Green

	Key workstreams:		Exec Lead	Last Update	RAG
1	To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	Commissioning of high quality educational programmes from HEI.	LM	11-Feb	Green
		Ensure successful bids for Multi Professional Education and Training Levy (MPET) funding, Medical & Dental Education Levy (MADEL) and Non Medical Education and training (NMET) - including additional recognition of specialist national paediatric activity.	LM	11-Feb	Green
		Continue to develop the use of new technologies for innovative delivery of educational programmes. This Includes further development of skills laboratories & the GOLD e-learning site; not only a one stop campus, accessible for work or home, but also a secure open source platform for supervision and to encourage a learning community.	LM	11-Feb	Green
		Understand and fulfil a lead role within University College London (UCL) Partners and realise potential for training in child health by ensuring developments in the treatment of the patient are fed into the education and training prospectus for medical and clinical workforce.	LM	11-Feb	Green
		Realise potential of Health Innovation and Education Cluster (HIEC) to ensure GOSH meets obligation to play a key national and international role in the development of child health professionals.	LM	27-Jul	Green
		Develop our role as a leading education and training provider for other organisations e.g. North Middlesex University Hospital and Kuwait.	LM	19-Oct	Green

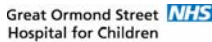




Commentary

The total MPET SLA position for 2010/11 = £6,815,876 is down on last years final position of £7,192,841. The shortfall is due to:
- Trainee Grade Doctors one ST3 post down - £46,518 (PGME looking into this)
- Existing Salary support AHPs & Scientist - £16,908
- Nothing is in yet for any new salary support so there's currently a big gap of £287,147 but NHSL only include funding in the LDA when a training place has been confirmed for a named employee and they are actively in training.
- Preceptorship - £35,575 (now expected to come out of CPD funding line)

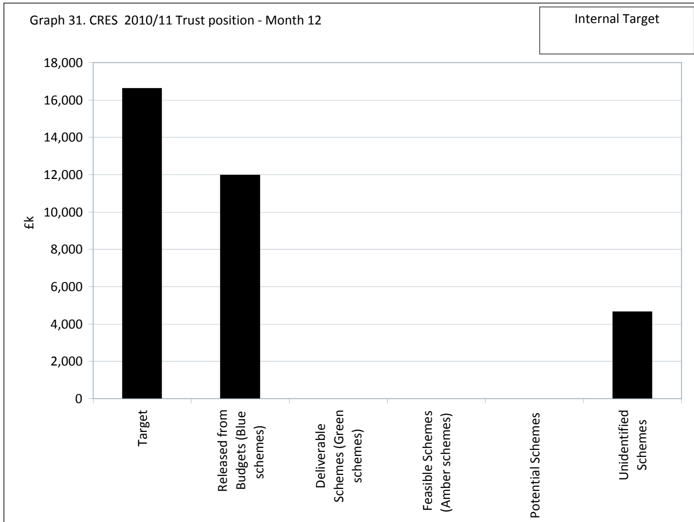
Key Performance Indicator Report

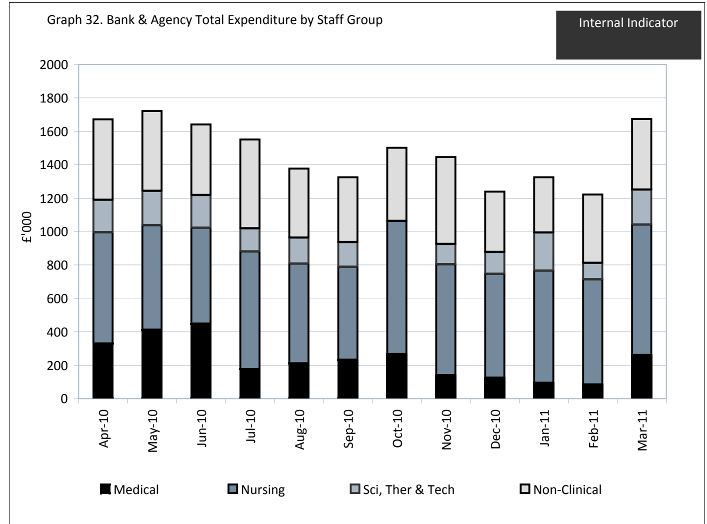


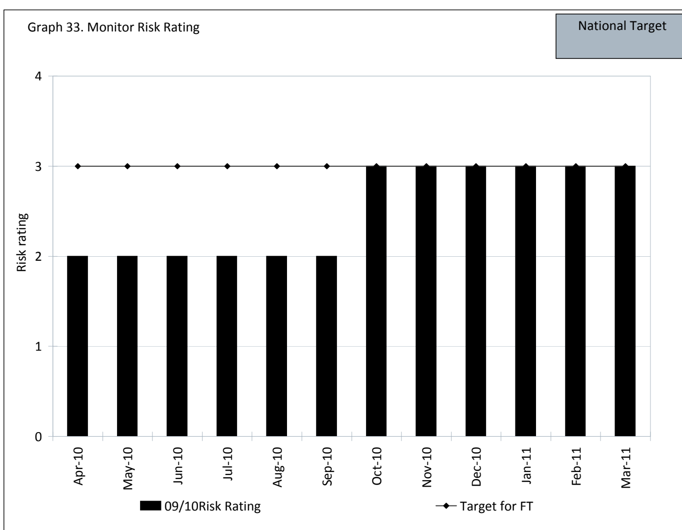
6. Deliver a financially stable organisation

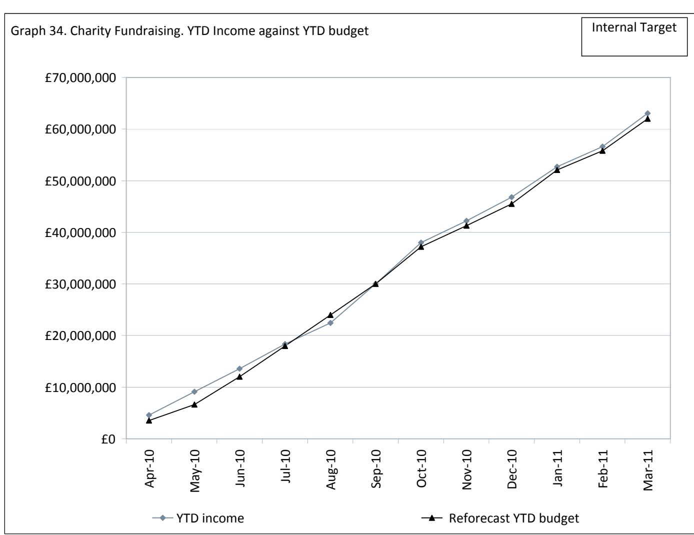
Key deliverables		RAG analysis
1	Deliver planned financial surplus through achieving income and efficiency goals	Amber

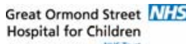
	Key workstreams:		Exec Lead	Last Update	RAG
1	Agree achievable CRES plan and ensure delivery through robust project and performance management	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered through clear project and performance management.	FD	11-Apr	Amber
		Invest within our capital programme to support increased revenue and decreased costs, including: Additional bed in Badger ward; additional outpatient capacity; reorganisation of Genetics and release of savings from the core lab development.	WMcG	08-Feb	Amber
		Agree a robust 5 year CRES programme, with external scrutiny, to fit with our overall Integrated Business Plan.	FD	11-Apr	Green
		Manage services within budget, delivering efficiency e.g. reducing agency spend.	FD	11-Feb	Green
2	Improve efficiency through rolling out Managing Variability Programme	Continue the roll-out of Variability and Flow (V&F) projects across the Trust, continuing to monitor the success of the cardiac project and completing the second wave of projects (Neurology, General Surgery, IPP, Medicine / ICI, Cardiology day case), before starting the third wave, which will include Neurosurgery and Oncology. Ensure that each project delivers improvements in both safety and productivity.	FD	10-Feb	Amber
3	Ensure appropriate funding for our clinical services from commissioners	Ensure issues with Service line Reporting (SLR) system are resolved by Quarter 1 and the system is fully implemented and in use by the units by Quarter 3.	CN	14-Feb	Amber
		Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.	CN	14-Feb	Green
		Complete revisions of funding baselines for the remaining National Commissioning Group (NCG) services (Transplant, Neuromuscular, Extracorporeal membrane oxygenation (ECMO) & Bridge to transplantation (BTT).	CN	14-Feb	Green
4	Support the charity to raise targeted funds	Work within the GOSH charity to support their work to achieve the targeted level of fund-raising.	JC	14-Mar	Green







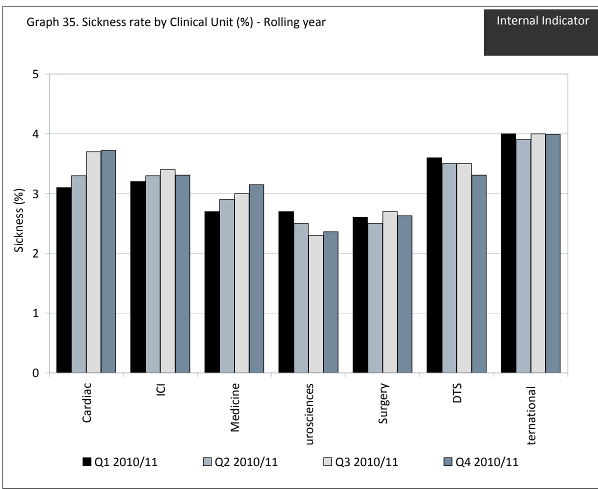


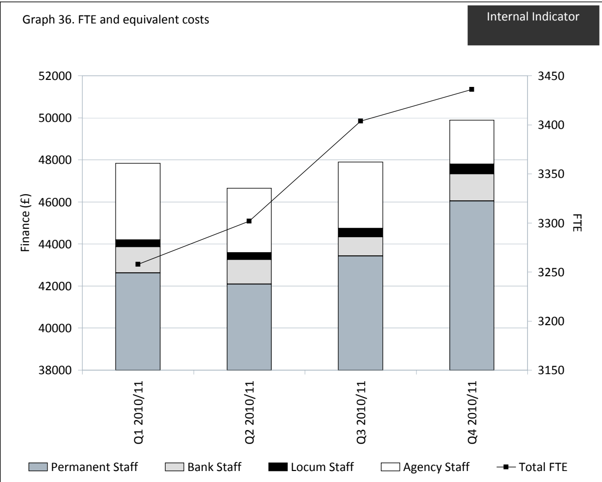


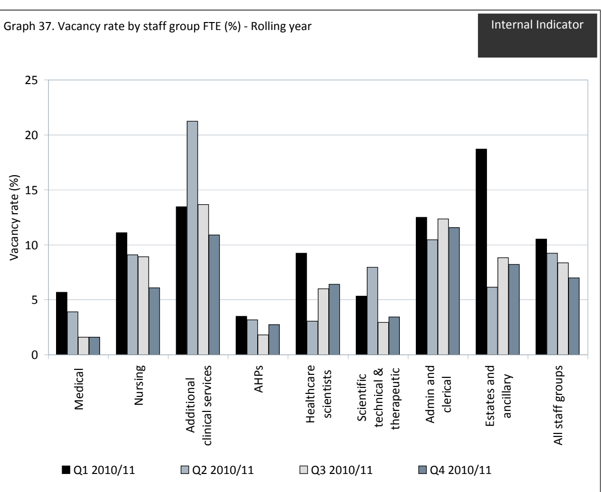
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation

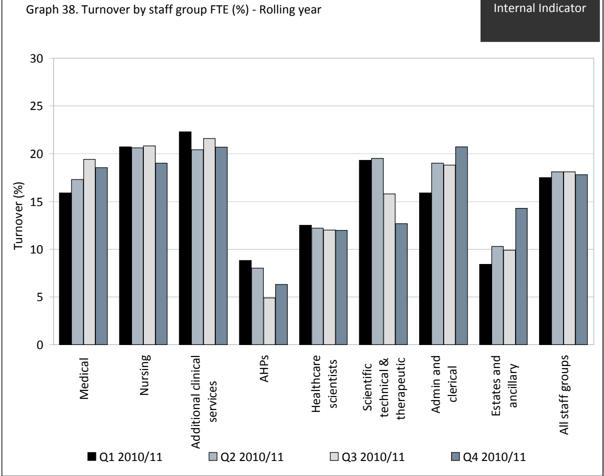
	Key deliverables	RAG analysis
1	Progress Foundation Trust application	Green
2	Ensure GOSH retains full CQC registration by delivering key safety improvements and governance structures	Green
3	Deliver IT improvements to plan	Green

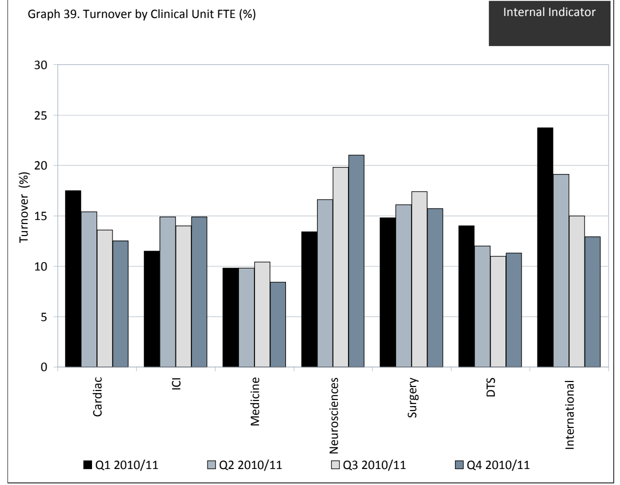
	Key workstreams:		Exec Lead	Last Update	RAG
1	Make progress towards becoming a Foundation Trust	Submit Foundation Trust (FT) application by agreed timetable with SHA.	JC	08-Feb	Green
		Ensure the Trust has a robust Long Term Financial Model (LTFM) for use in the FT application process. Ensure all financial matters required to achieve FT status are delivered e.g. working capital facility; insurance programme.	CN	14-Feb	Green
2	Ensure that the Trust is compliant with regulatory requirements	Work towards achieving NHS Litigation Authority (NHSLA) level 3 Risk Assessment early in 2011.	ME	08-Feb	Green
		Ensure that the Trust retains registered status with Care Quality Commission (CQC).	JC	04-Jan	Green
		Ensure the Trust score in financial reporting is improved.	CN	29-Jul	Green
		Ensure that Information Governance processes are strengthened and the self assessment score in the Information Governance toolkit is improved.	CN	14-Feb	Green
		Ensure delivery of specific Information Governance requirements e.g. Pseudonymisation, NHS No, Data quality.	CN	14-Feb	Amber
		The Public Health Action Plan is delivered in line with the Health and Adult Social Care Registration System.	BB	09-Feb	Green
		Ensure that the Trust achieves best practice in Data Quality standards for all information supporting decision making.	CN	14-Feb	Green
3	Strengthen the Trust's IT infrastructure	Deliver all projects included as current year projects within the Information Technology (IT) investment strategy approved by Trust Board in March 2010.	CN	14-Apr	Green
		If approved by Board, ensure Business Process Management (BPM) project progresses and meets all milestones in first year of implementation and there is a recognised improvement in Referral to Treatment (RTT) processes as a result of the pilot.	CN	14-Feb	Red

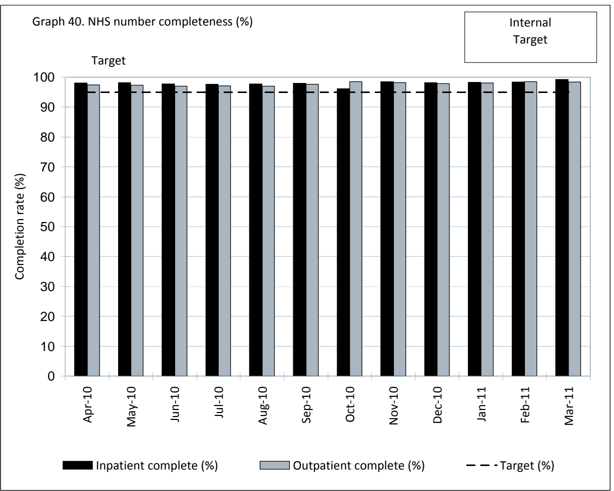


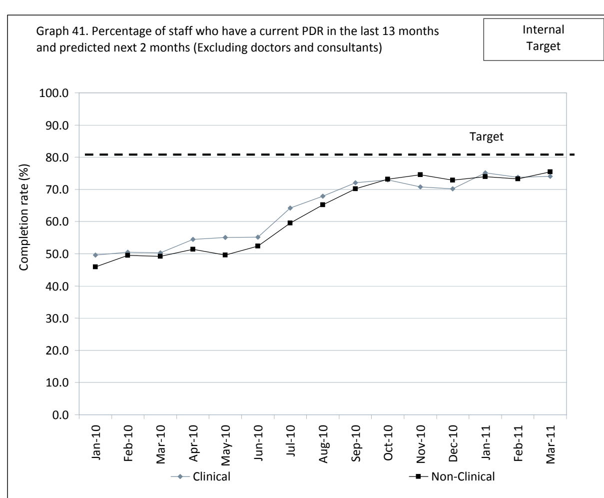


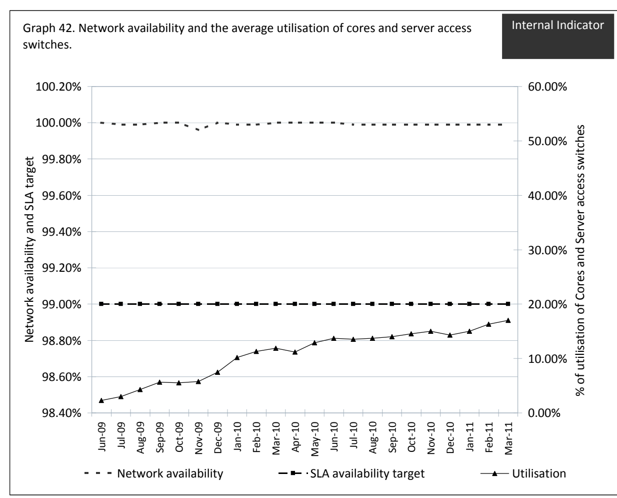


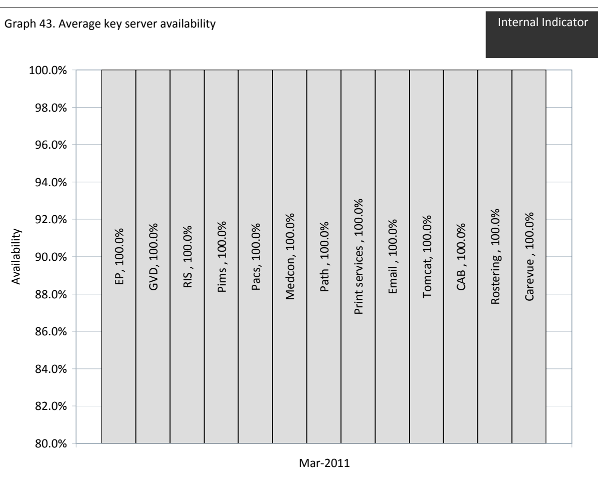


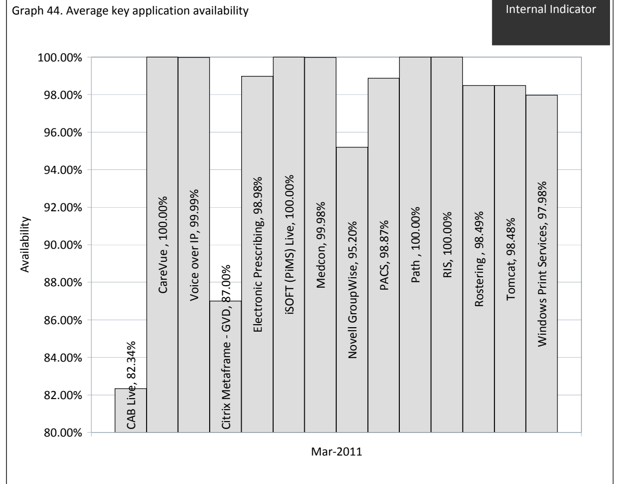

Graph 39. Turnover by Clinical Unit FTE (%)
Internal Indicator
Turnover (%)
Cardiac
ICI
Medicine
Neurosciences
Surgery
DTS
International
Q1 2010/11
Q2 2010/11
Q3 2010/11
Q4 2010/11


Graph 40. NHS number completeness (%)
Internal Target
Target
Completion rate (%)
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Inpatient complete (%)
Outpatient complete (%)
Target (%)


Graph 41. Percentage of staff who have a current PDR in the last 13 months and predicted next 2 months (Excluding doctors and consultants)
Internal Target
Target
Completion rate (%)
Clinical
Non-Clinical


Graph 42. Network availability and the average utilisation of cores and server access switches.
Internal Indicator
Network availability and SLA target
% of utilisation of Cores and Server access switches
Network availability
SLA availability target
Utilisation


Graph 43. Average key server availability
Internal Indicator
Availability
EP, 100.0%
GVD, 100.0%
RIS , 100.0%
Pims , 100.0%
Pacs, 100.0%
Medcon, 100.0%
Path , 100.0%
Print services , 100.0%
Email , 100.0%
Tomcat, 100.0%
CAB , 100.0%
Rostering , 100.0%
Carevue , 100.0%
Mar-2011


Graph 44. Average key application availability
Internal Indicator
Availability
CAB Live, 82.34%
CareVue , 100.00%
Voice over IP, 99.99%
Citrix Metaframe - GVD, 87.00%
Electronic Prescribing, 98.98%
iSOFT (PIMS) Live, 100.00%
Medcon, 99.98%
Novell GroupWise, 95.20%
PACS, 98.87%
Path , 100.00%
RIS, 100.00%
Rostering , 98.49%
Tomcat, 98.48%
Windows Print Services, 97.98%
Mar-2011

Appendix 1. Monitor Governance Risk Rating

Targets - weighted 1.0 (national requirements)		Thresholds	Weighting	Monitoring period	Q1 Performance score	Q2 Performance score	Q3 Performance score	Q4 Performance score
1	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)	0	1	Quarterly	1	1	0	1
2	MRSA - meeting the MRSA objective	0	1	Quarterly	0	0	0	0
3	All cancers: 31-day wait for second or subsequent treatment comprising **either:**	TBC	1	Quarterly	0	0	0	0
	Surgery	94%			0	0	0	0
	anti cancer drug treatments	98%			0	0	0	0
	radiotherapy (from 1 Jan 2011)	94%			0	0	0	0
4	Maximum time of 18 weeks from point of referral to treatment in aggregate and by specialty for admitted patients	90%	0.5/1.0	Quarterly	0	0	0	0
5	Maximum time of 18 weeks from point of referral to treatment in aggregate and by specialty for non- admitted patients	95%	0.5/1.0	Quarterly	0	0	0	0
6	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	0	0
7	Screening all elective in-patients for MRSA	100%	0.5	Quarterly	0	0	0	0
8	Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	Annual				
				Overall governance risk rating	**Amber-Green**	**Amber-Green**	**Green**	**Amber-Green**

Monitor governance rating	
Green	Less than 1.0
Amber-green	from 1.0 to 1.9
Amber-red	from 2.0 to 3.9
Red	4.0 or more

Risk rating	**Description (risk of significant breach of authorisation)**
Green	No material concerns
Amber-green	Emerging concerns
Amber-red	Potential future significant breach if not rectified
Red	Likely or actual significant breach

Appendix 2. ICT Service desk changes and incidents

Service desk changes

Service desk incidents

Attachment N

Great Ormond Street Hospital for Children NHS Trust

Trust Board
27 April 2011

Unaudited financial results for 2010/11 and Annual Accounts Status Report **Submitted by:** Claire Newton	**Paper No: Attachment N** **For information**

Aims

To brief the Trust Board on the current status of the draft Annual Accounts for 2010/11. A more detailed financial report will be distributed to Board Members prior to the meeting.

Summary

- The draft financial results – subject to audit – are to be submitted to the DH by 9am 21st April and we are expecting to report a net surplus after impairments relating to building revaluations **of c £7.2m or £8.6m (2.6% margin) excluding the impairment**;

⇒ Income at £336m (0910 £318m) is ahead of Plan of £323m

⇒ Patient activity has grown relative to 0910; Inpatients 4.7%; Daycases 0.9% and Outpatients 11%

⇒ Fixed assets have increased by £71m to £320m, **£77.3m** being capital additions, a net increase in valuation of **£8.0m** less depreciation of £**13.5m & disposals of £0.6m.**

⇒ Capital expenditure is within the planned CRL

⇒ Capital expenditure on the Redevelopment programme was behind Plan due to delays and rephrasing of expenditure but the completion date for Phase 2A is expected to remain the same

⇒ Year end cash has increased to over £30m from £8m due to the combined effect of the net operating surplus, reductions in debtors, increases in creditors, receipt of funding in advance which will be matched by cash expenditure early in 2011/12 and some much quicker payments from PCTs of invoices immediately prior to the year end

⇒ The Trust achieved its CRES target

There are no significant changes in the format of the accounts or the Annual Report this year although the Audit Commission is requiring an external auditors review of the Quality Accounts which are included in the Annual Report. The final audited accounts will be submitted to the Trust Board on 8th June and to the DH by 9am 10TH June 2011

The preliminary figures are in line with previous forecasts and are also consistent with the out-turn included in the LTFM submitted to the DH, although there are some small differences in income and expenditure categories.

Action required from the meeting
To note the status report

Contribution to the delivery of NHS / Trust strategies and plans
The Trust needs to deliver a surplus and build cash reserves in order to be in a strong position for FT status

Financial implications
No direct financial implications.

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
N/A

Who needs to be told about any decision
The Trust Board

Who is responsible for implementing the proposals and anticipated timescales?
DFD and CFO

Who is accountable for the implementation of the proposal
CEO

Author and date
Claire Newton 20.04.11

Attachment O

Trust Board 27 April 2011	
Title of document: Foundation Trust application update **Submitted on behalf of:** Fiona Dalton	**Paper No: Attachment O**

Aims / summary

The attached paper sets out the current position for the Trust against the assessment criteria used by the SHA and the Secretary of State for Health to determine readiness for Foundation Trust status.

The "Evidence of meeting statutory targets" criteria have been rated amber (no change). The number of c. diff cases is over trajectory for the third quarter (10 cases against trajectory of 8.25).

The overall "Financially viable" assessment is rated amber (no change). The main financial risks are CRES delivery and commissioner contract requirements.

Following DH review of the application, further work has been completed to revise the integrated business plan (IBP) and the long term financial model (LTFM). Due to delay in receiving feedback from the DH, their decision is now expected in April. This means that the Monitor assessment won't be completed until September and an earliest authorisation date of 1 October 2011.

Key actions for the next month:

- Complete DH assurance process
- Commence election process for the Members' Council
- Commence Monitor assessment process.

Action required from the meeting

To note the current position

Contribution to the delivery of NHS / Trust strategies and plans

Achievement of Trust objective to secure Foundation Trust status

Financial implications: None

Legal issues: None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?

Formal consultation has been completed (18 June 2010)
A set of commissioner meetings have been held with lead commissioners.

Who needs to be told about any decision Not required

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

Sven Bunn, FT Programme Manager

Who is accountable for the implementation of the proposal / project

Jane Collins, Chief Executive

Author and date

Sven Bunn
5 April 2011

Attachment O

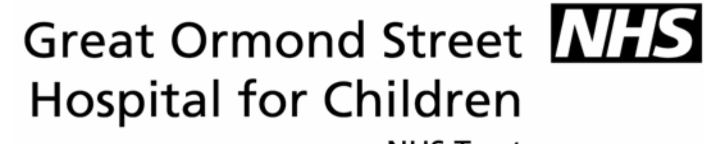
Foundation Trust application – April 2011 position

Assessment of current performance for Great Ormond Street Hospital against the seven domains of the Secretary of State assurance process:

1. Legally constituted and representative		**Green**
The trust's proposed NHS foundation trust application is compliant with current legislation	• Draft constitution completed and approved by Trust Board (July 2010). Confirmation of compliance with NHS Act 2006 received from Capsticks (Jan 2011). • Principles for membership and representation agreed (age limits and constituencies). • Members' Council and Board of Directors' standing orders drafted.	Green
The trust has carried out due consultation process	• Consultation commenced on 9 Feb 10 and was completed on 18 June 2010. • A broad range of consultation meetings were held for both public and staff consultation processes. • Consultation feedback was provided on 13 August 2010.	Green
Membership is representative and sufficient to enable credible governor elections	• Currently ~7,500 members. • Opt-out system for staff membership; appointment of FT ambassadors to promote involvement • Face to face and direct mail recruitment activities have been restarted to replace members who have moved.	Amber
2. Good business strategy		**Green**
Strategic fit with SHA direction of travel	• Participation in London specialised children's services review. Support development of specialist paediatric networks. • Paediatric cardiac review • Paediatric neurosurgery review	Green
Commissioner support to strategy	• Meetings held with NCG, NHS London and local commissioners supported principles of growth • Support letters received from NHS North Central London, London SCG, East of England SCG and National Commissioning Group (84% of NHS contract income).	Green
Takes account of local/national issues	• Thorough and detailed market assessment completed • Involved in national service reviews • Anticipate tougher economic conditions from 11/12 onwards.	Green
Good market, PEST and SWOT analyses	• Specialty based market assessments which encompass portfolio, strategic and competitor analysis. • SWOT and PEST analyses updated as part of IBP development. • External assurance of market assessment completed.	Green
3. Financially viable		**Amber**
FRR of at least 3 under a downside scenario	• Currently 3 in all years • Risks from CRES delivery	Amber
Surplus by year three under a downside scenario and reasonable level of cash	• As above.	Green
Above underpinned by a set of reasonable assumptions	• Assumptions generated and downside modelling completed. • External assurance completed.	Green
Commissioner support for activity and service development assumptions	• Support letters received from NHS North Central London, London SCG, East of England SCG and National Commissioning Group (84% of NHS contract income) • Risks to income from 11/12 commissioner proposals.	Amber

4. Well governed		Green
Evidence of meeting statutory targets	• Current CQC assessment: Fair – quality of service; Good – financial performance. • Would have achieved "Excellent" rating for quality of service in 2009/10. • Performance against c. diff. target is above trajectory (10 cases against plan of 8.25).	Amber
Declaring full compliance or robust action plans in place	• Achieved full CQC registration. • Robust action plan has been developed as a result of boiler failure. HSE improvement notice now lifted.	Green
Comprehensive and effective performance management systems in place	• Well developed corporate and clinical unit level performance management and risk management systems. • Further work is required on specialty and service level systems.	Green
5. Capable board to deliver		**Green**
Evidence of reconciliation of skills and experience to requirements of the strategy	• Board effectiveness assessment and board development process completed. Board skills analysis will be completed by December 2010. • Clinical unit development started in March 10. • External support for board development has been provided.	Green
Evidence of independent analysis of board capability/capacity	• Board effectiveness assessment completed. • External assurance programme completed. • On-going board development programme.	Green
Evidence of learning appetite via NHS foundation trust processes	• Board development programme. • External board assessment	Green
Evidence of effective, evidence based decision making processes	• Governance structure • Existing TB and MB minutes	Green
6. Good service performance		**Green**
Evidence of meeting all statutory and national/local targets	• Good performance management system • C. diff. target over trajectory	Amber
Evidence of no issues, concerns, or reports from third parties, e.g. HCC and in future CQC	• HSE improvement notice relating to boiler incident has been lifted (July 2010). • Awaiting final HSE report.	Green
Evidence that delivery is meeting or exceeding plans	• Good performance management system	Green
7. Local health economy issues / external relations		**Green**
If local health economy financial recovery plans in place, does the application adequately reflect this?	• Participation in London specialised children's services review. • Participation in national reviews	Green
Any commissioner disinvestment or contestability	• None	Green
Effective and appropriate contractual relations in place	• Commissioner Forum • Risk to commissioner agreement with growth plans	Green
Other key stakeholders such as local authorities, SHAs, other trusts, etc.	• Good working relationships	Green

Sven Bunn
4 April 2011



<table>
<tr><td colspan="2">Trust Board
27th April 2011</td></tr>
<tr><td>Title of document
Risk Register Analysis Report</td><td>Paper No: Attachment P</td></tr>
<tr><td>Submitted on behalf of

Prof. Martin Elliott
Co-Medical Director</td><td>Date considered by Management Board (or other committee if applicable)</td></tr>
<tr><td colspan="2">Aims / summary

To provide the Trust Board with an overview of key trends and themes arising from the Trust Risk Register. This includes movement of risk within the risk register and any appropriate links to incidents or complaints which have been reported in January –March 2011</td></tr>
<tr><td colspan="2">Action required from the meeting

To review the document and identify whether any further action is required. Act on recommendations as appropriate.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans

Zero Harm</td></tr>
<tr><td colspan="2">Financial implications

N/A</td></tr>
<tr><td colspan="2">Legal issues
N/A</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
N/A</td></tr>
<tr><td colspan="2">Who needs to be told about any decision

Assistant Director of Clinical Governance & Safety</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
N/A</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project

N/A</td></tr>
<tr><td colspan="2">Author and date

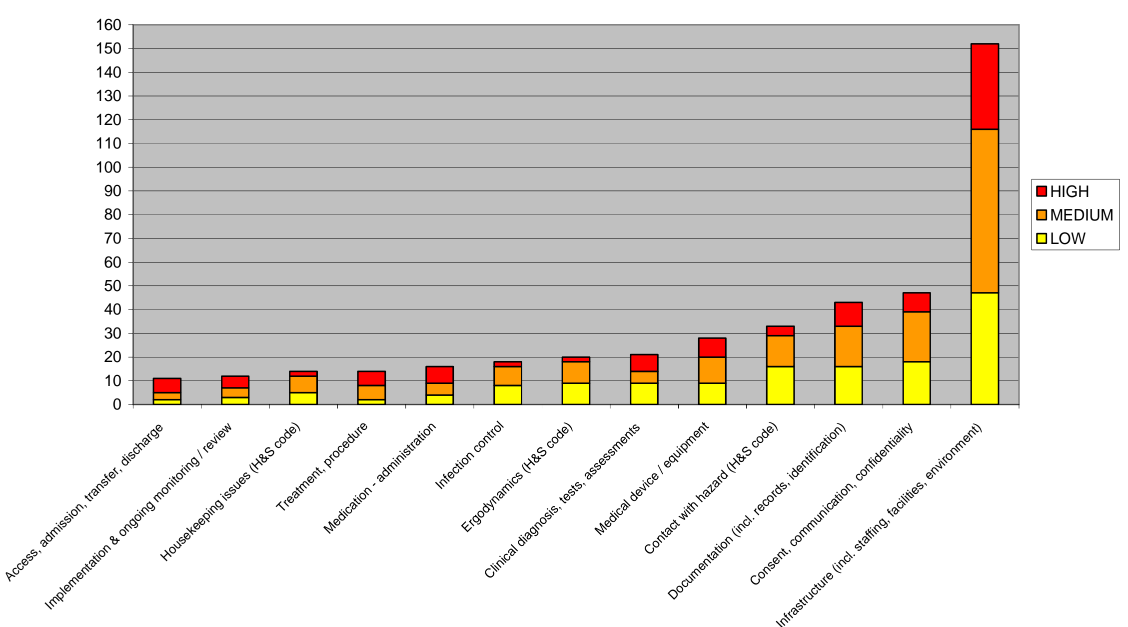
Roisin Mulvaney
Patient Safety Manager
18th April 2011</td></tr>
</table>

Attachment P
Trust Board April 2011
Risk Register Analysis Report

Overview

- There are currently 515 risks recorded on the Datix Risk Management System.
- 74 Risks have been closed in Q4 (24 High, 24 Medium, 26 Low)
- There have been 50 new risks added in Q4 (14 High, 23 Medium and 13 Low)

Each risk is categorised upon entry to the datix system to allow for analysis. Within each category the number of risks at each risk grade (High, Medium, Low) can be seen in the chart below. Only categories which have more than 10 risks are included.



Movement of Risks

High Risks

- There are 118 high risks (140 in Q3) on the Datix system
- There have been 14 new high risks added in Q4.
- 24 high risks have been closed October – December 2010 on the basis of controls introduce and actions taken.

Medium Risks

- There are 212 medium risks on the Datix system (194 in Q3)
- There have been 23 new medium risks added in Q4.
- 24 Medium risks were closed on the basis of controls introduce and actions taken.

Low Risks

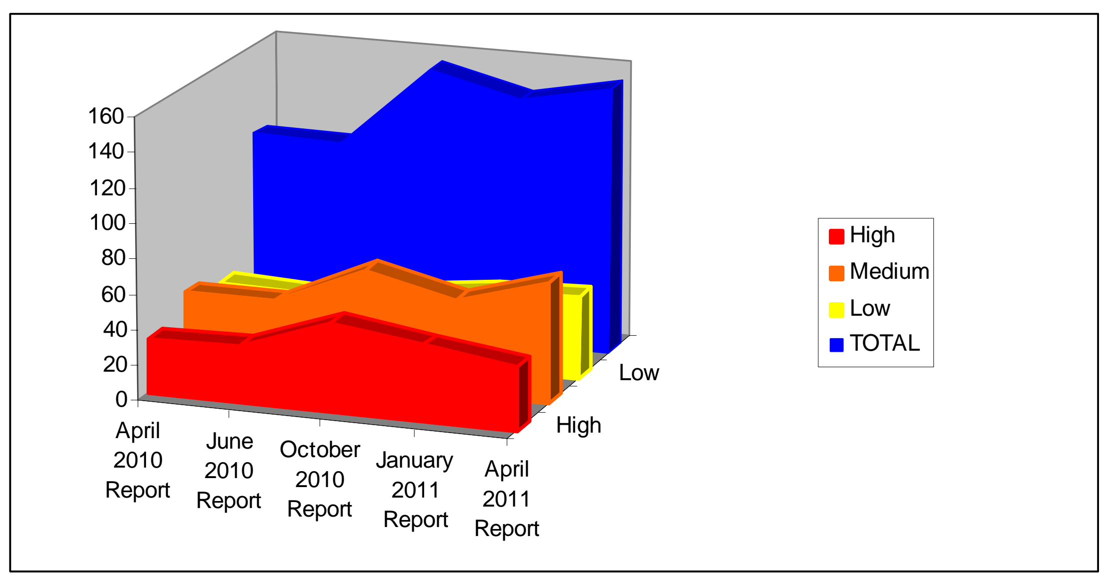
- There are 185 low risks on the Datix system (172 in Q3)
- There have been 13 new low risks added in Q4.
- 26 low risks were removed from the risk register on the basis of controls introduce and actions taken.

RMulvaney
Patient Safety Manager
18th April 2011

Attachment P
Trust Board April 2011
Risk Register Analysis Report

Analysis of Risks

The majority of risks in the Trust fall under the '**Infrastructure**' Category. This includes staffing, facilities and environment. Over the last year, we have continued to see an increase in the total number of infrastructure risks reported. Within that total, we appear to be seeing a decrease in the number of high risks. The rise in the number of medium risks may be attributable to the implementation of controls to manage these previously high risks. The number of low risks also seems to be seeing a slow but steady increase.



	April 2010 Report	June 2010 Report	October 2010 Report	January 2011 Report	April 2011
High	31	32	50	43	36
Medium	43	43	66	54	69
Low	35	33	39	45	47
TOTAL	109	108	155	142	153

14 infrastructure risks were closed during Q4 (8 High, 2 Medium, 4 Low)

18 new infrastructure risks were opened in Q4 (5High, 10 Medium, 3 Low).

During Q4, we have also seen 81 (78 in Q3) incidents reported by local teams which have also been classified as infrastructure. This represents 9% of incidents processed during that time. (compared with 10 % in Q3 and 6% in Q2). The top types of incidents reported:

IT / telecommunications failure / overload	9
Staff shortage - nursing	9
Inadequate check on equipment / supplies	13

RMulvaney
Patient Safety Manager
18th April 2011

Failure / delay in collection / delivery systems	19

21 of the incidents have been graded locally as being of high risk (12 in Q3)
Key themes include:

- Deficiencies identified in emergency equipment audits
- Nursing shortages/high agency usage
- Unavailability of equipment for theatre procedures
- Inability to access CDD/Test request forms

Consent, Communication & Confidentiality

46 risks relating to consent, communication and confidentiality are managed via the local risk register. The number of risks in this area remains very stable, with little movement of risks on or off the register.

	April 2010 Report	June 2010 Report	October 2010 Report	January 2011 Report	April 2011 Report	
High	10	8	7	7	7	
Medium	25	24	26	19	21	
Low	23	18	19	19	18	
TOTAL	58	50	52	45	46	

2 new consent/communication/confidentiality risks have been opened in Q4 and 3 which have been closed.

There were 95 incidents reported by the Trust in the Q4 (10% of all incidents which represents a 1% decrease since Q3).

The top types of incidents reported:

Discrepancy of consent	6
Communication failure - outside of team	11
Communication failure - with patient / parent / carer	21
Communication failure - within team	46

18 of these incidents were graded as high risk. The key themes include:

- Lack of information regarding clinical needs of patient during handovers between areas in the Trust e.g. ward to ward, theatre to ward, ward to radiology.
- Failure to handover infection status to recovery.
- Limited communication between teams and in notes relating prior to admission
- Difficulties with families booking accommodation
- Lack of clarity regarding patient's ventilatory needs prior to admission
- Absence of pims alert regarding child protection status

Documentation
41 risks relating to documentation are managed via the local risk register.

	April 2010 Report	June 2010 Report	October 2010 Report	January 2011 Report	April 2011 Report
High	7	9	9	11	10
Medium	24	18	20	14	16
Low	12	14	29	16	16
TOTAL	43	41	49	41	42

8 documentation risks have been closed and removed from the register and 9 new risks have been added.

There were 57 incidents reported by the Trust between in Q4 (6% of all incidents processed in that period – which is the same percentage as in Q3).
14 of these have been risk assessed locally as being high risk.
Key themes include:

- Patient notes missing or unavailable for a procedure (MRI under GA cancelled)
- Red traceability tags for blood transfusion not received
- Incomplete sets of medical records.

Effectiveness of controls to manage risks on Trust Wide Register

One of the ways in which the Trust can assess the effectiveness of the controls currently in place to manage the risks on the Trust Wide Risk Register is through review and analysis of reported incidents, complaints and informal concerns. Incidents, complaints or informal concerns in which patients have suffered significant harm or had a significant impact on their experience at the Trust may be seen as indications that the controls are not working effectively or are not sufficiently robust to prevent the incident. It will not be possible to eradicate all risks in the Trust, but it is important to ensure that our controls are adequate in the circumstances.

949 incidents have been processed in the Trust between in Q4 2010-11. There are currently 14 SUIs open in the Trust . These all relate to significant incidents in which patients

- have suffered significant harm
- there has been a significant near miss
- there has been a significant impact on the patient's experience of the Trust.

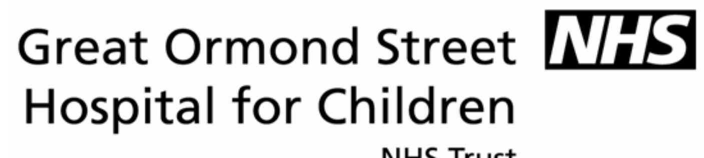
Key risk issues that these have identified:

- Difficulties with communication in relation to the bed management process
- Infection control practices (2 x MRSA bacteraemias)
- Competency assessments for medical staff
- Incomplete medical records
- Difficulties in external hospitals contacting the 'right' staff member at GOSH.

39 formal complaints have been made about the Trust in Q4. Key issues that have been identified include:

- Lack of communication with parents
- Pain management
- Correspondence with Local Teams (cc lists)

- Delayed diagnosis
- Inappropriate Treatment



<table>
<tr><td colspan="2">Trust Board
27th April 2011</td></tr>
<tr><td>Update on Compliance with Care Quality Commission Standards and Registration

Submitted on behalf of
Jane Collins, Chief Executive</td><td>Paper No: Attachment Q</td></tr>
<tr><td colspan="2">Aims / summary
To update the Trust Board on the current status of the Care Quality Commission (CQC) registration standards.

The CQC has issued the Trust with the March 2011 Quality Risk Profile (QRP). This is a tool for the CQC, providers and commissioners to use in monitoring compliance with the essential standards of quality and safety

Actions required to address any deficits identified are managed and monitored through the Risk, Assurance and Compliance Group and also reported to the Clinical Governance Committee and Audit Committee.</td></tr>
<tr><td colspan="2">Action required from the meeting
To review the summary of the current status of registration against the 16 essential outcomes.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
It is a requirement under the Health & Social Care Act that the Trust is registered for the services it provides and that it actively seeks to maintain this registration.</td></tr>
<tr><td colspan="2">Legal issues
Registration is a legal requirement.</td></tr>
<tr><td colspan="2">Financial implications
Should deficits be identified, registration can be removed or maintained with conditions. This can have financial penalties for the Trust including damage to reputation.</td></tr>
<tr><td colspan="2">Author and date
Anna Ferrant, Company Secretary
13th April 2011</td></tr>
</table>

Attachment Q

Compliance with Care Quality Commission Standards and Registration

Summary

The following paper summarises the current status against all 16 essential registration outcomes as reported in the CQC's Quality Risk Profile for the Trust.

Quality Risk Profile

The Quality Risk Profile (QRP) is produced by CQC on a monthly basis. It brings together a wide range of information about a provider and is seen as a key tool for gathering information about the Trust. It is used by the CQC to prioritise any areas identified as being at risk, and may trigger a responsive review of compliance with registration. For each type of data, the analysis method is designed to measure the difference between the observed result and an expected level of performance on a common scale. Results are displayed as a coloured dial, which has been designed to be a quick method for interpreting risk at the outcome level. The dial represents the level of risk running from 'low' on the left to 'high' on the right and the colour ranges from green (low risk) to red (high risk).

The QRP will also be used by commissioners in assessing quality of service provision and to identify areas of lower or higher than expected levels of performance.

Trust's contextual risk estimate

The Trusts 'overall contextual risk estimate' in March 2011 was as indicated below (please note: L=Low Risk, H=High Risk)

The overall contextual risk estimate is calculated by considering contextual risk grouped in four categories; inherent risk, population risk, situational risk and uncertainty risk. Contextual risk assists the CQC to make an informed assessment of compliance and to evaluate the extent to which the Trust is able to make the necessary improvements. If outcome risk estimates (see below) are high and contextual risk is also high, the improvement challenge is likely to be greater for the organisation.

An overview of the March 2011 QRP is attached for information at **appendix 1**. Between February 2011 and March 2011, the risk estimates for 15 of the 16 outcomes did not change.

Outcome 14 (supporting staff) moved from an assessment of high green to low neutral. The outcome states: '*People who use services are safe and their health and welfare needs are met by competent staff*'.

Analysis of the data items used to produce this aggregated assessment reveals the following:

Attachment Q

1. A new data item was included under the outcome measuring the proportion of published Violence Against Staff (VAS) figures reported to Physical Assaults reporting System for most recent year. The Trust was scored 'worse than expected' for this. It is understood that the data originates from a national return which the Trust is required to complete. It is thought that the numbers may be higher than usual due to the fact that assaults are recorded by the number of individuals involved in an assault rather than the number of assaults in total. For example, 3 nurses may be involved in preventing a child/ young person from harming themselves. If all 3 nurses are subjected to violence during the incident (however minor), this would be reported as three separate assaults, rather than one incident.

   The Local Security Management Specialist (LSMS) reviews every reported incident of violence or aggression against staff and carries out an investigation to establish the cause, and where necessary, sanctions which should be considered. The Trust maintains and continues to develop close links with relevant organisations such as the Police and Community Safety Partnerships and proactively seeks to undertake partnership working and information exchange. The number of Trust staff who attended Conflict Resolution training in the last financial year was 579.

2. A new data item has been included under the outcome measuring the attendance of the LSMS at CFSMS quarterly/ regional LSMS meetings. There is a potential anomaly with the reported data and this is being raised with the CQC local assessor.

The Clinical Governance Committee is responsible for assessing the adequacy of the evidence available for all the 16 essential standards monitored by the QRP. The Audit Committee receives a summary report on compliance with the CQC outcomes and also monitors 3 corporate/ financial focused outcomes.

The Risk, Assurance and Compliance Group oversees the management of the CQC Trust database and recommends actions where data needs to be challenged or scores improved.

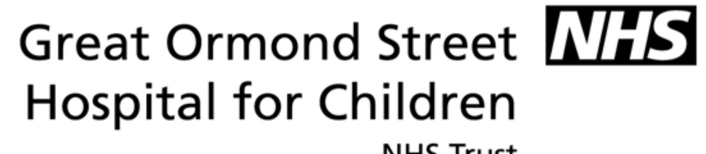
Appendix 1

Quality Risk Profile: February 2011- March 2011

Outcome	Outcome Risk Estimate February 2011	Outcome Risk Estimate March 2011	Direction of Travel
Outcome 1 Respecting and Involving People who use Services	Low Green	Low Green	↔
Outcome 2 Consent to Care and Treatment	Not Enough Data	Not Enough Data	↔
Outcome 4 Care and Welfare of People who use Services	Low Green	Low Green	↔
Outcome 5 Meeting Nutritional Needs	High Neutral	High Neutral	↔
Outcome 6 Cooperating with Other Providers	Low Green	Low Green	↔
Outcome 7 Safeguarding People who use Services from Abuse	Not Enough Data	Not Enough Data	↔
Outcome 8 Cleanliness and Infection Control	Low Neutral	Low Neutral	↔
Outcome 9 Management of Medicines	Low Neutral	Low Neutral	↔
Outcome 10 Safety and Suitability of Premises	Low Green	Low Green	↔
Outcome 11 Safety, Availability and Suitability of Equipment	Low Neutral	Low Neutral	↔
Outcome 12 Requirement relating to workers	Low Neutral	Low Neutral	↔
Outcome 13 Staffing	Low Green	Low Green	↔

Appendix 1

Outcome	Outcome Risk Estimate February 2011	Outcome Risk Estimate March 2011	Direction of Travel
Outcome 14 Supporting Staff	High Green	Low Neutral	↓
Outcome 16 Assessing and Monitoring Quality of Service Provision	Low Green	Low Green	↔
Outcome 17 Complaints	Low Neutral	Low Neutral	↔
Outcome 21 Records	Not Enough Data	Not Enough Data	↔



Trust Board Meeting 27 April 2011	
Title of document **Results of 2010 Staff Survey** **Submitted on behalf of** **Fiona Dalton, Chief Operating Officer**	**Agenda item: ATTACHMENT R** **Paper No:** **Date considered by Management Board**
Aims / summary To summarise results for Trust Board and propose actions to respond to issues raised Results show improvement in 6 areas, with a deterioration in 2 (handwashing and reporting of errors) compared to the 2009 scores.	
Action required from the meeting ➢ Note the results ➢ Endorse actions being planned and support them once implemented	
Contribution to the delivery of NHS / Trust strategies and plans Provides feedback on Trust's objectives including Zero Harm for internal and external use. Contributes to CQC consideration of the Trust's ratings.	
Financial implications None (any expenditure should be contained within broader projects)	
Legal issues	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, members, children and families) and what consultation is planned/has taken place? Plans to feed back to staff the results of the survey and proposed actions is included in the paper	
Who needs to be told about any decision Staff	
Who is responsible for implementing the proposals / project and anticipated timescales Individuals or specific Trust groups are accountable for actions relating to action areas. All managers responsible for supporting the delivery of these actions.	
Who is accountable for the implementation of the proposal / project Accountability held within individual project plans	
Author and date Helen Cooke Head of Workforce Planning and Development 11 April 2010	

Summary of all Key Findings for Great Ormond Street Hospital for Children NHS Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2009

! Red = Negative finding, e.g. worse than average, worse than 2009

'Change since 2009 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2009 survey

-- Because of changes to the format of the survey questions this year, comparisons with the 2009 score are not possible

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better

	Change since 2009 survey	Ranking, compared with all acute specialist trusts in 2010
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	• No change	! Below (worse than) average
KF2. % agreeing that their role makes a difference to patients	• No change	✓ Above (better than) average
KF3. % feeling valued by their work colleagues	• No change	✓ Above (better than) average
KF4. Quality of job design	✓ Increase (better than 09)	✓ Above (better than) average
* *KF5. Work pressure felt by staff*	• No change	! Above (worse than) average
KF6. Effective team working	--	• Average
KF7. Trust commitment to work-life balance	• No change	• Average
* *KF8. % working extra hours*	• No change	! Above (worse than) average
KF9. % using flexible working options	--	• Average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed.		
KF10. % feeling there are good opportunities to develop their potential at work	• No change	✓ Above (better than) average
KF11. % receiving job-relevant training, learning or development in last 12 mths	• No change	✓ Above (better than) average
KF12. % appraised in last 12 mths	✓ Increase (better than 09)	✓ Above (better than) average
KF13. % having well structured appraisals in last 12 mths	• No change	✓ Above (better than) average
KF14. % appraised with personal development plans in last 12 mths	✓ Increase (better than 09)	✓ Above (better than) average
KF15. Support from immediate managers	✓ Increase (better than 09)	✓ Above (better than) average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF16. % receiving health and safety training in last 12 mths	✓ Increase (better than 09)	! Below (worse than) average
* *KF17. % suffering work-related injury in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % suffering work-related stress in last 12 mths*	• No change	! Above (worse than) average
Infection control and hygiene		
KF19. % saying hand washing materials are always available	• No change	! Below (worse than) average

Summary of all Key Findings for Great Ormond Street Hospital for Children NHS Trust (cont)

	Change since 2009 survey	Ranking, compared with all acute specialist trusts in 2010
Errors and incidents		
* *KF20. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Above (worse than) average
KF21. % reporting errors, near misses or incidents witnessed in the last mth	✓ Increase (better than 09)	✓ Above (better than) average
KF22. Fairness and effectiveness of incident reporting procedures	• No change	✓ Above (better than) average
Violence and harassment		
* *KF23. % experiencing physical violence from patients, relatives or the public in last 12 mths*	--	• Average
* *KF24. % experiencing physical violence from staff in last 12 mths*	--	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	--	• Average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	--	• Average
KF27. Perceptions of effective action from employer towards violence and harassment	! Decrease (worse than 09)	• Average
Health and well-being		
* *KF28. Impact of health and well-being on ability to perform work or daily activities*	! Increase (worse than 09)	! Above (worse than) average
* *KF29. % feeling pressure in last 3 mths to attend work when feeling unwell*	! Increase (worse than 09)	! Above (worse than) average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF30. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF31. % able to contribute towards improvements at work	• No change	✓ Above (better than) average
ADDITIONAL THEME: Staff satisfaction		
KF32. Staff job satisfaction	✓ Increase (better than 09)	✓ Above (better than) average
* *KF33. Staff intention to leave jobs*	• No change	! Above (worse than) average
KF34. Staff recommendation of the trust as a place to work or receive treatment	• No change	• Average
KF35. Staff motivation at work	• No change	✓ Above (better than) average
ADDITIONAL THEME: Equality and diversity		
KF36. % having equality and diversity training in last 12 mths	• No change	! Below (worse than) average
KF37. % believing the trust provides equal opportunities for career progression or promotion	• No change	! Below (worse than) average
* *KF38. % experiencing discrimination at work in last 12 mths*	--	• Average

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST

Paper to the Management Board from the Chief Operating Officer

Summary of results from 2010 Staff Survey
April 2011

Introduction and background

For the eighth year this survey was undertaken on behalf of the Trust by Picker, with the results from all trusts being co-ordinated on a national basis by the Care Quality Commission. In 2010, the response rate was 41% (that is, 346 staff responded), a decrease from 44% in 2009 and below average for acute specialist trusts.

The 2010 results show an improvement on last year's scores in 7 areas, with a deterioration in 3 (perceptions of effective action on bullying and harassment; impact of health on ability to perform at work; feeling pressure to attend work when unwell). GOSH performs better than average in 14 of the 38 key scores, worse than average in 13, and average in 10. The Summary in appendix 1 shows the Trust's scores in the CQC's key areas

Some key results to note:

Staff job satisfaction and CQC assessments

The Care Quality Commission have not indicated which, if any, of the results they will use as part of their 2011 assessment process. However, the Survey provides data that the Trust can and will utilise both as evidence for a range of audits and to support action plans, such as that for the hand hygiene group (see below).

Providing care

- 74% of staff are satisfied with the patient care they deliver (average for acute specialist trusts is 79%)

Health, wellbeing and safety

- 97% of staff who witnessed errors/incidents/near misses in the last month reported them, improvement from 90% in 2009 and better than average for acute specialist trusts.
- No statistically significant change in the percentage of staff witnessing events (42% compared to 33% nationally)
- No change in numbers of staff who say hand washing materials are always available (48% in 2009 compared to 52% in 2009. Average for acute specialist trusts is 68%).
- GOSH is worse than average for numbers of staff reporting having received health and safety training (75% in 2010 compared to 84% for average acute specialist trusts) but this score has improved from 65% in 2009.
- Scores on staff working extra hours and suffering work related pressure/stress are unchanged and continue to put GOSH below average in this area.
- The Trust also showed a deterioration in scores this year on the extent to which physical health and emotional problems have impacted on the ability of staff to perform work; and on feeling pressure to attend work when feeling unwell. GOSH scores less than average in these areas.
- Staff motivation, job satisfaction and support from line manager are all above average at GOSH.

Appraisals and Training

- Increase in number of staff reporting an appraisal in the previous 12 months (85% in 2010 compared to 77% in 2009)
- Scores related to receiving relevant training and development and feeling there are good opportunities to develop their potential at work are both above average.

Bullying and Harassment

- 14% of staff report experiencing bullying, harassment or abuse from staff. The wording of this question changed in 2010 so cannot be compared to last year's results. This score is average for acute specialist trusts. The perception of effective response to bullying allegations from the Trust has deteriorated since last year and is now average. (3.69 in 2010 compared to 3.73 in 2009– out of maximum of 5).

Equality and Diversity

- Scores on having equality and diversity training and believing the Trust offers equality of opportunity in career progression are unchanged and all place the Trust as worse than the average-performing acute specialist trust. Numbers of staff who say they experience discrimination at work are average compared to other specialist trusts.
- BME staff share many of the same scores as white comparators, although significantly more report experiencing discrimination at work and fewer feel the Trust provides equal opportunities for career progression. Similar numbers of BME and white staff report experiencing bullying and harassment from colleagues.

Conclusions

The Trust has shown particular improvements in areas related to training and appraisals, which have been given focused attention for several years. Scores relating to stress and health are concerning, although it is interesting to note that staff report the greatest pressure to attend work when unwell comes from themselves. Scores on handwashing and perceptions of equal treatment at work remain largely unchanged, in spite of work over the last 12 months.

Compared to the survey conducted in 2008, out of the 27 questions in which it is possible to make comparison (ie those in which the same question has been asked) the Trust has either shown no statistically significant change or the scores have improved.

Actions proposed

It is important to find a balance between taking seriously the concerns that are raised through the survey and taking proportionate action in cases in which numbers of respondents are very small. It is therefore proposed that the following areas are highlighted for action:

- Handwashing
- Equality and Diversity training and equality of opportunity particularly for BME staff
- Stress and staff health

Each of these areas will be owned by a named individual or group, as follows:

- Facilities and Hand Care Group are responsible for the actions relating to handwashing (see attached paper)
- A proposal is being taken to the Trust's Black and Asian Minority Ethnic Network to deliver an increased programme of awareness and training for members of this group, which is open to all. Mentoring is also being discussed with the Network and representatives from Education and Training. Training on equality and diversity will be rolled out following finalisation of the 2010 Equality Act. Consideration is also being given to how to include cultural awareness training within existing management development programmes.
- The Working Lives Group will continue to be accountable for work on stress, with completion of the Health and Wellbeing strategy and associated action plan by the summer. Market testing for the staff counselling service is underway, and the annual audit amongst managers in the Trust of awareness of existing and support to address stress and what further help they would welcome will be undertaken shortly.

- Results and actions will be communicated to staff.

Action Required

Management Board is asked to review the results and endorse the actions proposed.

GREAT ORMOND STREET HOSPITAL FOR SICK CHILDREN NHS TRUST

Staff survey and hand washing

I have discussed these results with Dr. John Hartley, Jane Collins and Liz Morgan on March 15th and decided on the following;

- Conducted a staff survey using Survey Monkey to explore these results, I will be analysing these results w/c 11th April 2011. The survey asked the participants to identify which building are they based most of the time, identify if there are problems with the supply of water, soap, paper hand towels etc
- We continue to teach hand hygiene to all staff as part of their induction, annual updates
- May 5th is International Hand Hygiene awareness day and the Infection Prevention & Control Team will be hosting a stand in the reception area. This to promote the importance of hand hygiene to all staff, patients and visitors to the Trust
- The Hand Hygiene Committee is currently reviewing options to raise the profile of Hand Hygiene within the Trust through a guidance and information campaign.

Deirdre Malone
Lead Nurse Infection Prevention & Control
11th April 2011

<table>
<tr><td colspan="2">Trust Board Meeting
27th April 2011</td></tr>
<tr><td>Title of document
Inpatient Experience Survey Results 2010/11 summary presentation results

Submitted on behalf of

Liz Morgan</td><td>Paper No: Attachment S

For Information</td></tr>
<tr><td colspan="2">Aims / summary
To make the board aware of the results of the Annual Inpatient survey.</td></tr>
<tr><td colspan="2">Action required from the meeting
To note results for information</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
To provide information to the board on how the Trust is performing in relation to its goal of delivering an excellent patient experience and exceeding expectations.</td></tr>
<tr><td colspan="2">Financial implications
N/A</td></tr>
<tr><td colspan="2">Legal issues
N/A</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Information will be provided in Roundabout and to Management board and other relevant meetings, issues will be picked up as part of the patient experience strategy and action plan.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
N/A</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
N/A</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
N/A</td></tr>
<tr><td colspan="2">Author and date

Caroline Joyce Assistant Chief Nurse, Quality, Safety and Patient Experience
8.04.2010</td></tr>
</table>

Great Ormond Street Hospital for Children
NHS Trust
NHS
Patient and family satisfaction
Survey results
March 2011

Aims and objectives

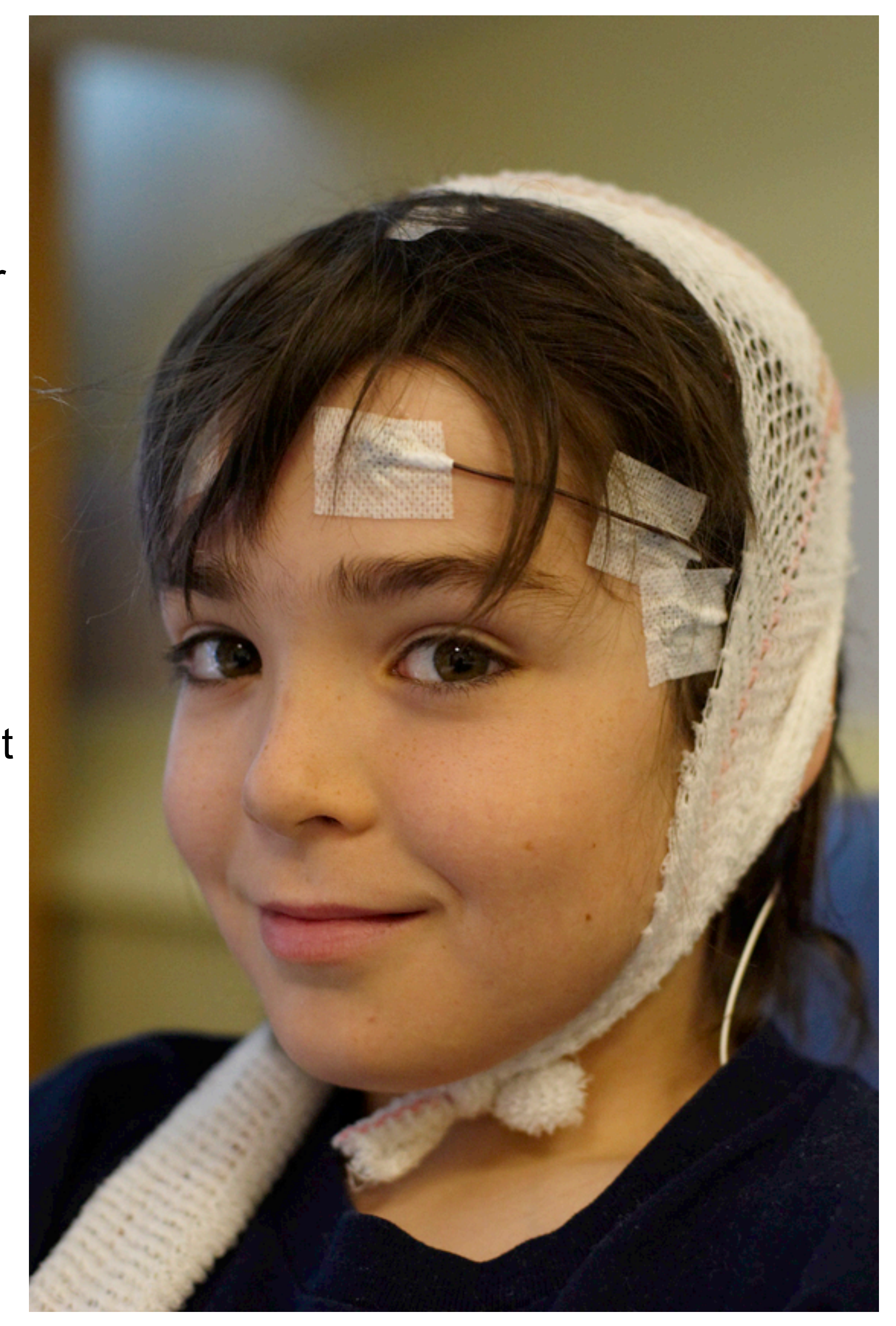
•To provide a benchmark measure of patient and parent satisfaction levels for the Trust and track our performance over time.

•To focus on those key drivers of patient satisfaction identified in previous quantitative and qualitative research conducted by the Trust

•To identify areas for quality improvement across the Trust

•To enable us to provide independently audited results of patient feedback to all our stakeholders

•To complement locally based research as per the patient and public (PPI) involvement strategy



Survey Methodology

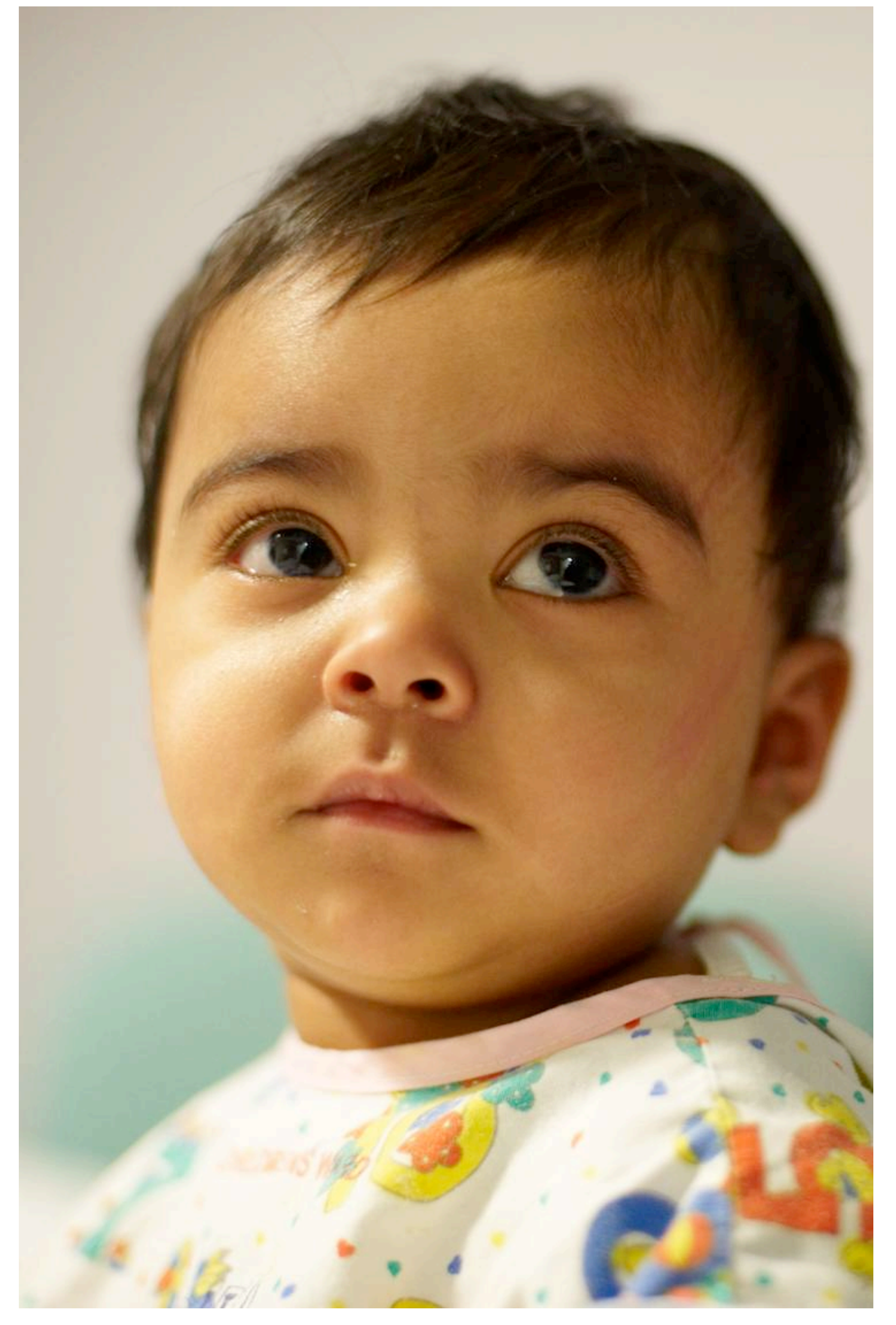
•Telephone survey - February 2011

•750 interviews conducted with in-patients and their parents
(612 parents,138 patients aged 10 to 16 years)

•Survey lasted 10 minutes with three questionnaires used – adults, children aged 10 to 12 years and young people aged 13 to 16 years

•Representative sample of overall profile of patients discharged from 25 June to 30 September 2010 based on age, gender, ethnicity, length of hospital stay and clinical unit.

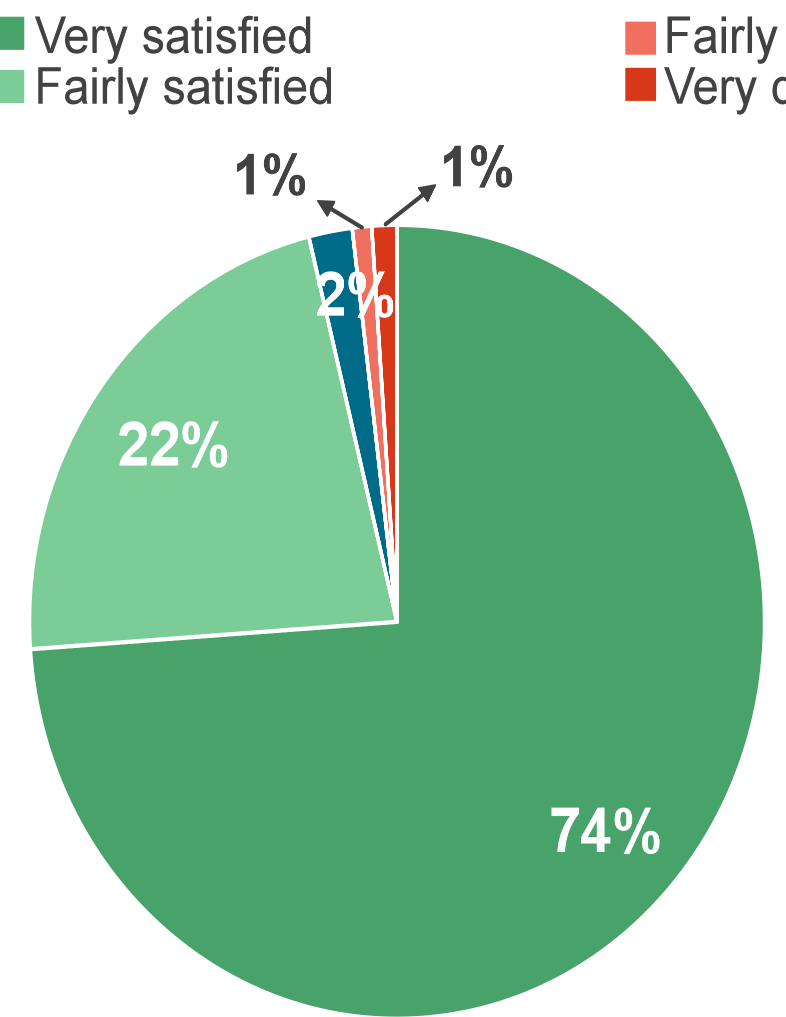
•Survey conducted by independent research organisation, Ipsos MORI



Topline Survey Results

Satisfaction with visit

Q2 Overall, how satisfied or dissatisfied were you with your last visit to Great Ormond Street Hospital?



	Overall 2010/11	Overall 2009
Satisfied %	96	94
Dissatisfied %	2	4
Net satisfied %	+94	+90

Base 2010/11: All GOSH patients and parents of GOSH patients (750), 4th – 20th February 2011
Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Reason for dissatisfaction

Q3 Why were you dissatisfied?

TOP NUMBER OF MENTIONS		2009 Mentions
Poor level of care/service	8	12
Staff inefficiency	5	4
Lack of/inaccurate information	4	8
Rudeness/attitude of staff	4	9
Waiting for treatment	4	8
Not enough/poor standard of food	2	-
Poor level of hygiene/cleanliness	2	-
Lack of staff	1	2
Other	9	12

Base 2010/11: All who were dissatisfied with their last visit to GOSH (17)
Base 2009: All who were dissatisfied with their last visit to GOSH (32)

Advocacy

Q4 PARENT WORDING: How likely or unlikely would you be to recommen d Great Ormond Street Hospital to a friend or relative if their child ne eded treatment?

Q4 COMBINED CHILD WORDING: If a friend or relative of yours needed treatment, how likely or unlikely would you be to recommend Great Ormond Street Hospital (say Great Ormond Street Hospital is a good place to receive care)?

	% Very likely	% Fairly likely	% Neither / nor	% Fairly unlikely	% Very unlikely	% Don't know	
2010/11 Overall	87	9	2	1	1	1	Base: 750
2009 Overall	88	8	2	1	1	1	Base: 750
2010/11 Child patient	76	18	3	1	1	1	Base: 138
2009 Child patient	80	15	3	1	1	1	Base: 138
2010/11 Parent of patient	89	7	1	1	1	*	Base: 612
2009 Parent of patient	90	7	1	1	1	1	Base: 612

Base: Defined at each sub-group, 4th – 20th February 2011 (2010/11 survey) and 3rd – 12th November 2009 (2009 survey)

Treatment and service

Q6 I would like you to tell me whether you agree or disagree with these statements.

Statement	% Strongly agree	% Tend to agree	% Neither / nor	% Tend to disagree	% Strongly disagree	% Don't know/no answer	2010/11 Agree %	2009 Agree %
I had confidence and trust in the doctors treating my child	88	10	1	1	[illegible]	*	97	96
Staff were polite to us at all times	83	12	3	1	2	*	95	96
I had confidence and trust in the nurses treating my child	80	15	1	1	2	*	95	95
Staff introduced themselves to us	77	17	2	3	1	1	94	93
Staff explained their role to me	71	22	2	3	2	*	93	90
My experience as a parent was valued by staff (Parents only – base 612)	71	19	3	2	3	1	90	90
I felt I could complain and it would be taken seriously	62	20	6	2	4	6	82	83

Base 2010: All GOSH patients and parents of GOSH patients (750), 4th – 20th February 2011

Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Communication and service

Q7 Last time you saw a doctor or nurse at the hospital, how good were they at…?

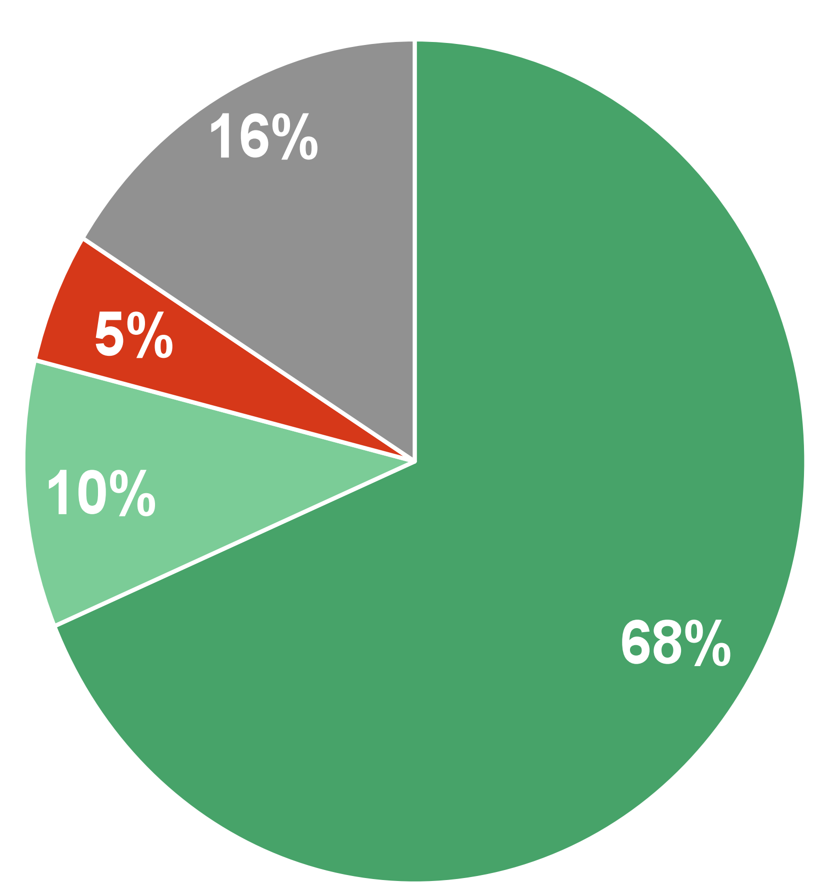
	% Very good	% Good	% Neither / nor	% Poor	% Very poor	% Don't know	2010/11 Good %	2009 Good %
Explaining what would happen in the treatment or tests	76	19	2	1		*	95	93
Explaining why your child needed treatment or tests	75	20	2	2		1	95	96
Involving you in decisions about your child's care	73	21	3	1		1	94	93
Answering you or your child's questions	72	23	2	1		*	95	96
Taking you and your child's concerns seriously	70	23	3	2		1	93	93
Spending enough time with you and your child	63	29	4	3		*	92	93
Asking you questions about how you and your child were feeling	59	30	6	3	2	1	89	88

Ipsos MORI

Base 2010/11: All GOSH patients and parents of GOSH patients (75 0), 4th – 20th February 2011
Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Overnight accommodation

Q5 Were you able to stay overnight with your child when you wanted to?



	Overall 2010/11	Overall 2009
Yes %	78	77
No %	5	4
Net yes %	73	73

Base 2010/11: All GOSH patients and parents of GOSH patients (750), 4th – 20th February 2011
Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

General experience on the ward

Q11 I would like to you to tell me whether you agree or disagree with these statements?

Statement	% Strongly agree	% Tend to agree	% Neither / nor	% Tend to disagree	% Strongly disagree	% Don't know / no answer	2010/11 Agree %	2009 Agree %
My child had enough privacy when the doctors/nurses examined him/her	78	16	3	2	1	*	94	93
My child had enough privacy when the doctors/nurses talked about his/her treatment	76	16	3	2	1		92	92
There were enough staff on the ward to help when my child needed something	63	24	3	5	5	3	86	83
I felt if I complained for offered feedback it would be taken seriously	63	22	6	2	3	4	85	N/A
The ward was well designed for children of my child's age	57	21	4	7	7	4	78	77
I knew how to complain or offer feedback	52	23	8	7	6	6	74	N/A
My child was kept awake at night by noise	11	9	4	14	38	25	20	19

Ipsos MORI

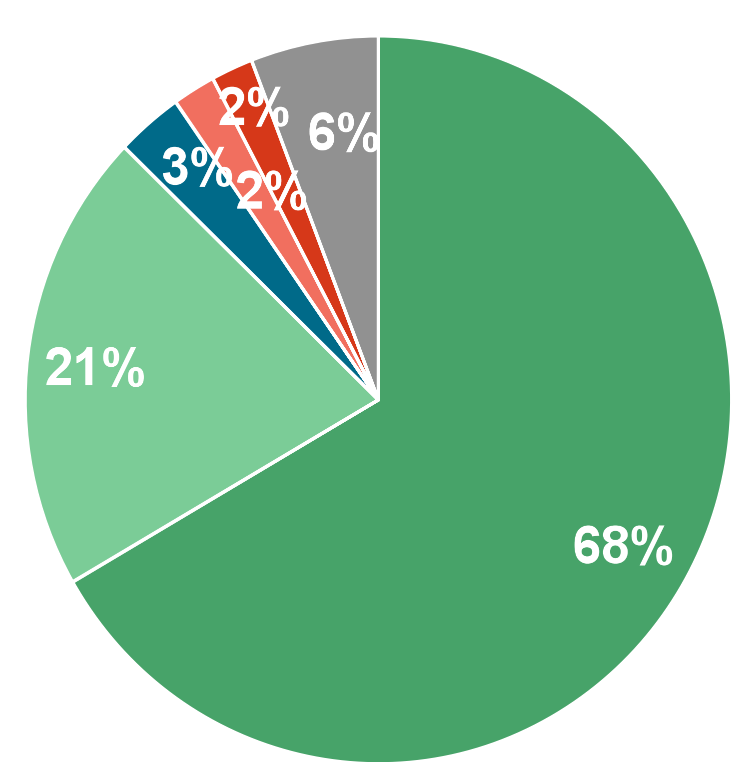
Base 2010/11: All GOSH patients and parents of GOSH patients (75 0), 4th – 20th February 2011

Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Pain control

Q12 During your stay at Great Ormond Street Hospital how satisfied or dissatisfied were you with each of the following?

How your child's pain was controlled



	Overall 2010/11	Overall 2009
Satisfied %	88	85
Dissatisfied %	4	4
Net satisfied %	+84	+81

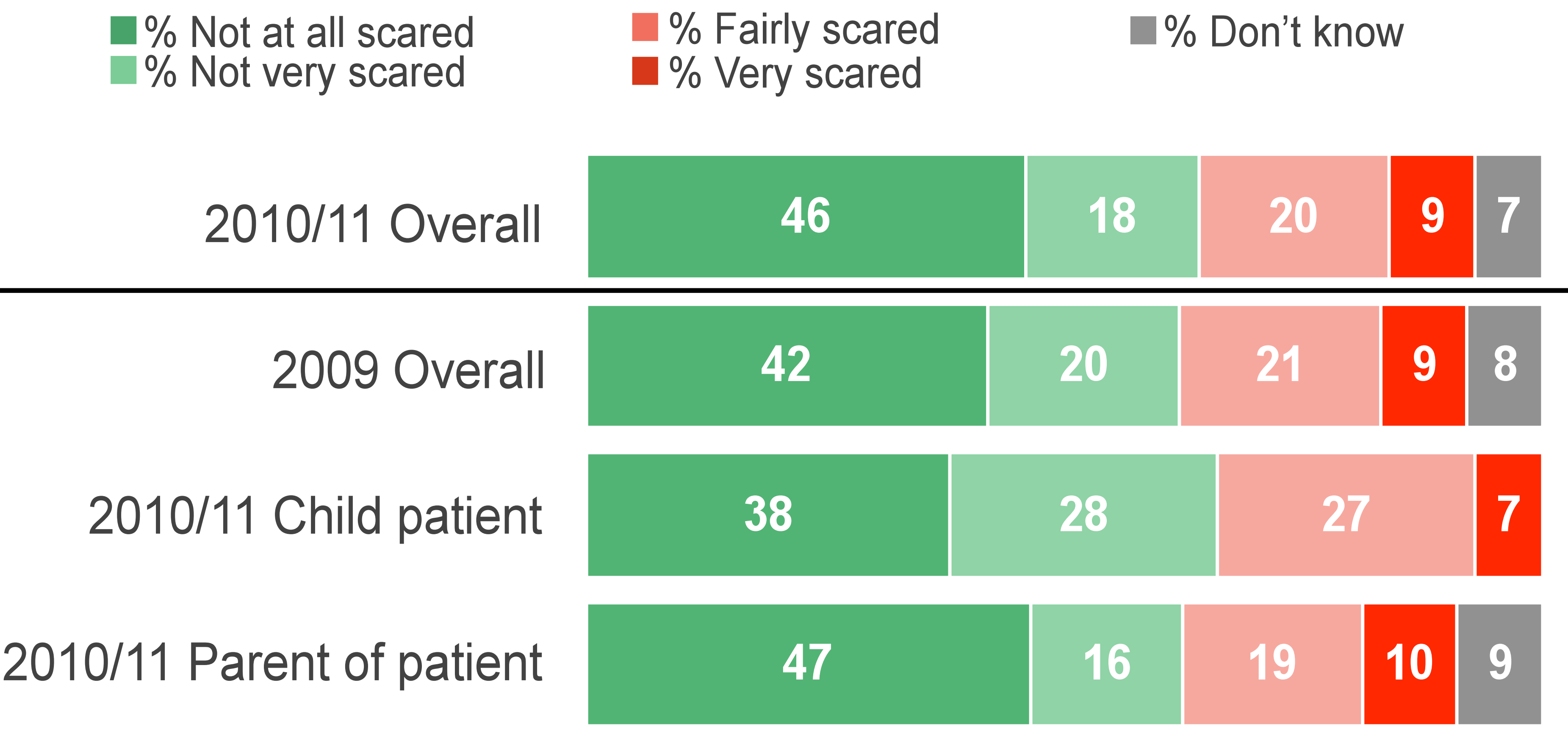
Base 2010/11: All GOSH patients and parents of GOSH patients (750), 4th – 20th February 2011

Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Feeling scared

Q8 PARENT WORDING: How scared, if at all, was your child when visi ting the hospital?

COMBINED CHILD WORDING: How scared, if at all, were you in the hospital?



Base 2010/11: All GOSH patients and parents of GOSH patients (750), child patients (138) and parents of patients (612), 4th – 20th February 2011

Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Top 10 reasons why patients were scared

Q9 PARENT WORDING: What was your child scared/frightened of?

Q9 COMBINED CHILD WORDING: What were you scared/frightened of?

Reason	2010/11	2009 %
Treatment in general	35%	24
Injections	28%	29
Operation/surgery	26%	18
Unfamiliar surroundings	17%	18
Unfamiliar people	16%	12
Scared of not knowing what would happen	3%	3
Staying over night	3%	6
Being put to sleep/anaesthetic	2%	3
Does not like hospitals/scared of being in hospital	2%	6
Find staff uniform frightening/associated staff uniform with pain	2%	2

Ipsos MORI

Base 2010/11: All who were ever scared when visiting hospital/felt their child was scared (231)
Base 2009: All who were ever scared when visiting hospital/felt their child was scared (234)

Alleviating fears

Q10 PARENT WORDING: And how well do you think the staff dealt with your child's fears?

COMBINED CHILD WORDING: And how well do you think the staff dealt with your fears? By dealt with, I mean helped you feel less scared.

% Very well
% Fairly well
% Not very well
% Not at all well
% Don't know

61%
28%
5%
5%
2%

	Overall 2010/11	Overall 2009
Well %	88	91
Not well %	10	8
Net well %	78	83

Base 2010/11: All who were ever scared when visiting hospital/felt their child was scared (231), 4th – 20th February 2011
Base 2009: All who were ever scared when visiting hospital/felt their child was scared (234), 3rd – 12th November 2009

Cleanliness

Q13 And how clean, if at all, did you think the following areas were?

	% Very clean	% Fairly clean	% Not very clean	% Not clean at all	% Don't know / no answer	2010/11 Clean %	2009 Clean %
The place where your child was treated	80	15	1	1	2	96	97
The ward where your child stayed	72	22	1	1	4	94	95
The bathrooms and toilets	61	34	2	1		95	96

Base 2010/11: All GOSH patients and parents of GOSH patients (750), 4th – 20th February 2011

Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Leaving hospital

Q15 I would like to you to tell me whether you agree or disagree with these statements?

% Strongly agree
% Tend to agree
% Tend to disagree
% Strongly disagree
% Neither / nor
% Don't know / no answer

I was confident about how to care for my child once at home (Parents only – base 612)

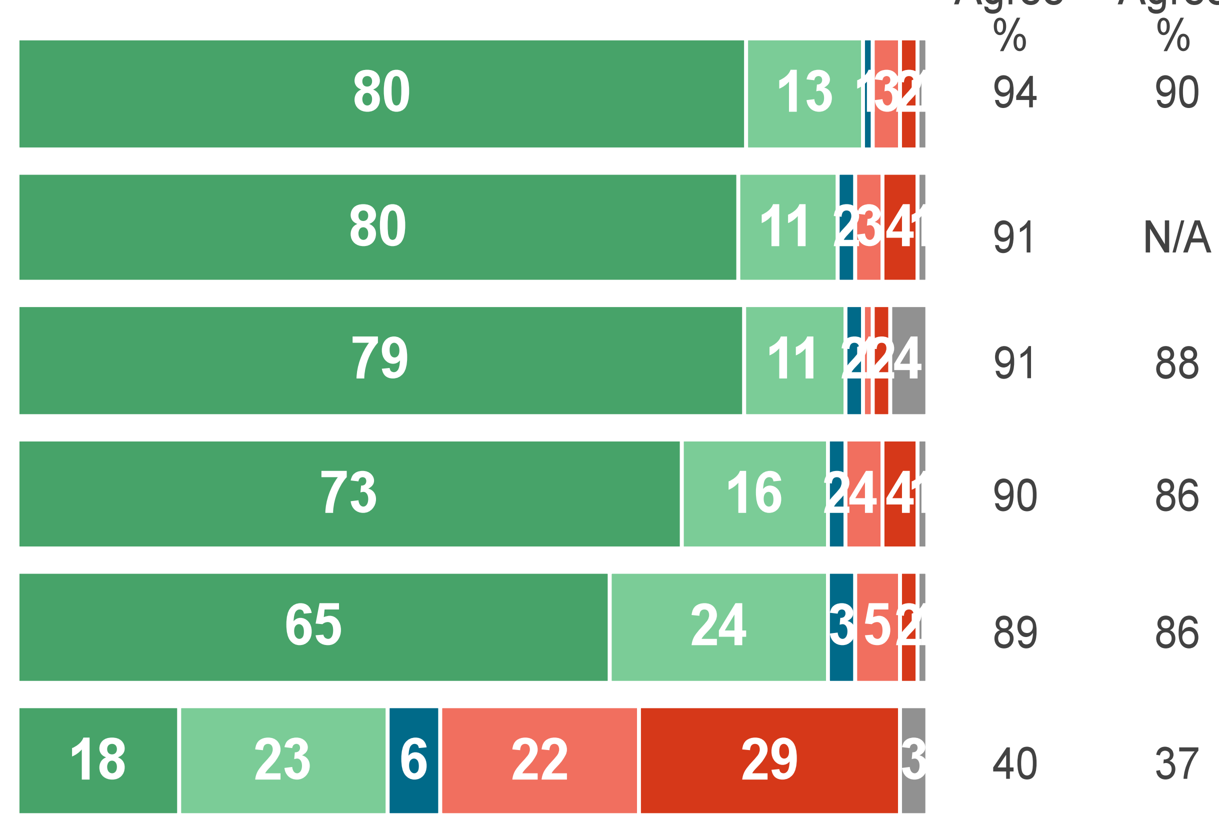
I knew who to contact if I had a question when I got home (Parents only - base 612)

I had enough information about any medicine

I had enough information about what would happen next and any other care my child might need

The process was easy

The process took a long time



Base 2010/11: All GOSH patients and parents of GOSH patients (75 0), 4th – 20th February 2011
Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Top 10 suggested improvements

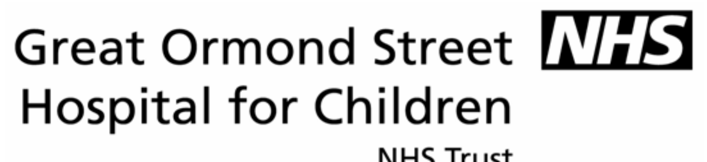
Q16 PARENT WORDING: Was there anything that could have been improved about your child's hospital visit?

Q16 COMBINED CHILD WORDING: Was there anything that could have been improved about your hospital visit?

Suggested improvement	2010/11 %	2009 %
Shorter waiting times at hospital/shorter waiting time at pharmacy	9%	10
Accommodation being sorted out earlier/more beds/privacy/ sleeping accommodation for families	6%	9
Give out more/clearer information/give out information earlier	6%	6
Attitude of staff/more professional/friendly/helpful staff/more dedicated nurses/staff to listen to concerns	6%	6
More/better entertainment/games/more DVDs/more TVs/needs to appeal to teenagers/children with special needs	5%	9
Easier to contact/reach staff/hospital/ward/doctors are too busy/more staff nurses on ward/more time to discuss concerns	4%	3
Better food/more variety of food/healthier food	4%	7
Cleanliness/tidiness/better domestic staff/more had gel areas	3%	2
Lack of funds/resources/money unevenly distributed/more space/better decorated	3%	6
Better admin/receive letters earlier/return phone calls/reply to emails	3%	2

Base 2010/11: All GOSH patients and parents of GOSH patients (750), 4th – 20th February 2011
Base 2009: All GOSH patients and parents of GOSH patients (750), 3rd – 12th November 2009

Attachment T



MANAGEMENT BOARD
Thursday 17th February 2011

FINAL MINUTES

Present:

Jane Collins (JC)*	Chief Executive (Chair)
Jacqueline Allan (JA)	General Manager, Medicine and DTS
Barbara Buckley (BB)	Co-Medical Director
Sven Bunn (SB)	FT Programme Director
Robert Burns (RB)	Deputy Chief Operating Officer
Cathy Cale (CC)	ICI Unit Chair
Carlos De Sousa (CDS)	CU Chair, Neurosciences
Sarah Dobbing (SD)	GM Neurosciences
Martin Elliott (ME)	Co-Medical Director
Lorna Gibson (LG)	GM Research and Innovation
Allan Goldman (AG)	CU Chair, Cardio-Respiratory
Melanie Hiorns (MH)	CU Chair MDTS
Elizabeth Jackson (EJ)	CU Chair, Surgery Clinical Unit
Mark Large (ML)	Director of ICT
Anne Layther (AL)	GM, Cardiac
Joanne Lofthouse (JL)	GM, International Division
Elizabeth Morgan (EM)	Chief Nurse and Director of Education
Claire Newton (CN)	Chief Finance Officer
Tom Smerdon (TS)	GM, Surgery
Peter Wollaston (PW)	Head of Corporate Facilities, General Facilities

In Attendance

Alex Barnacle*	Consultant, IR
Derek Roebuck*	Consultant, IR
Jo Curry*	Consultant in General Surgery
Sue Chapman*	Nurse Consultant
Judith Cope*	Chief Pharmacist
Beki Moult*	Health Information and Language Manager
Andrew Pearson*	Clinical Audit Manager

**Denotes meeting part attended*

847	**Apologies**	
847.1 847.2	Apologies had been received from Melanie Hiorns, MDTS CU Chair; Rachel Williams, GM, ICI; and William McGill, Director of Redevelopment. Natalie Robinson attended on behalf of William McGill and Julie Bayliss on behalf of Rachel Williams. It was noted that FD would chair the first pat of the meeting.	
848 848.1 848.2	**Minutes of Management Board meeting held on 20 January 2011** A request was made to record the fact that FD was present at the meeting. ML had given apologies. Subject to the above changes, the minutes were approved as an accurate record.	
849 849.1 849.2 849.3 849.4 849.5 849.6 849.7 849.8 849.9 849.10 849.11	**Action Log and other matters arising** The following updates were received on the documented actions: 447.4 – this action was to be removed as the matter was now being dealt with as part of the PPI action plan. 673.3 – AF agreed to clarify progress on the pilot in Nephrology around the use of a generic email address for correspondence with patients. 700.3 – AF agreed to clarify progress on the expected date of delivery of the final draft of the policy. 743.4 – LM reported that a poster had been produced which outlined the Trust's policy on bare below elbows. The hand hygiene policy and uniform policy had both been reworded around requirements for bare below elbows. This was also highlighted in induction. Management Board agreed that everyone was responsible for reinforcing this. 779.1 – An update was requested on the availability of certificates for non EU workers, following a further change in government policy. **Action**: FD to provide an update on current policy 788.2 – approval of the anaesthetic machine was being taken forward with Daniel Dacre. 808.5 – Royal Wedding - An all user email would be circulated highlighting the fact that the wedding date was a Bank Holiday and that pay was being negotiated nationally. Elective work did not, in general, take place on Bank Holidays. 811.1 – NR reported that the lifts in CBW were 20 years old and funding was being sought to replace them. A review of the maintenance contract was underway and consideration given to storing central lift components on site to prevent maintenance delays. 811.5 – PICU beds - TS had spoken with JC and wanted to consider the data before writing to the Commissioner about securing funding for 4 additional PICU beds. CN stated she would be seeing the commissioner that afternoon and would take this matter forward at the meeting. It was requested that this remain an ongoing action.	 FD

849.12	**Action**: TS to provide an update at the March 2011 Management Board.	TS
849.13	816 – FD had spoken with Nick Lench and agreed that further work was required on the proposed service expansion of the genetic laboratories. It was agreed that this should be presented to the March Management Board.	
849.14	**Action**: FD to provide an update at the March 2011 Management Board.	FD
849.15	817 - LSD service – this business case was strategically important and the MDTS team had been asked to reconsider it.	
849.16	**Action**: MH to provide an update at the March 2011 Management Board.	MH
849.17	819 - PN – there was an in-year cost pressure to the business case for increased provision of Parental Nutrition and FD reported that this would be funded via budget setting.	
849.18	820 – Discussions had been held with the Charity's funding committee, where it had been agreed that two years' funding would be provided for the non statutory element of social care provision. During this time, the Trust would review its requirements for the service.	
849.19	823 – FD reported that the CIVAS service business case was being worked up in to full business case.	
849.20	828 – FD reported that voluntary redundancy had been offered to a number of staff this week.	
849.21	829 – BB had produced a draft licence agreement to replace the honorary contract for professionals to enter the hospital for specific purposes, the aim being to speed up the procedures. HR had been involved. CN asked for input from IT and the research department as well, as the previous honorary contract allowed access to IT facilities on site and provided authority to conduct research. An update was requested for the March Management Board.	
849.22	**Action**: BB to provide an update at the March 2011 Management Board. *JC joined the meeting and took the Chair.*	BB
850	**MDTS Revised Business Case: Increase in Provision of Interventional Radiology (IR) Service**	
850.1	Alex Barnacle, Derek Roebuck and Jude Cope attended the meeting. FD reported that the need for an enhanced IR service was clear and that the proposed increase in provision could not wait until next year, but there was no funding available. Following discussions with GMs, the following was agreed: • Recognition of the need to look at processes for accessing IR by prioritising resources from the Transformation team to look at the referral pathway; • That the increase in physical capacity for IR be achieved by moving cardiac-angio sessions. • All CUs agreed that CRES targets be increased for 2011/12 to pay for the investment. FD believed that CRES should also be increased for all corporate areas. • That this proposal deals with the current daytime demand for IR only. It did not resolve on call requirements as stipulated by national recommendations.	

850.2	TS asked why the start date of the service was December 2011 and whether, as a result of this, CRES would be applied part year only. It was explained that the delay in commencement of the service was due to timescales for appointing the necessary medical staff but agreed that the start date should be brought forward to September 2011.	
850.3	It was agreed that there was a need for a long term solution to the provision of IR, particularly out of hours. It was noted that the consultants already provided a flexible service out of hours but that this needed to be formalised which could only be done by further investment. It was requested that the term 'urgent' access be defined in the paper and Jude Cope stated that this definition would be included in the proposed vascular access policy.	
850.4	ME stated that it would help if all patients had individualised care plans so that there was a planned approach to the need for IR services.	
850.5	Management Board **agreed** the need to increase the service and that funding should be sought from CRES savings across both clinical and corporate areas. The risk of increasing current CRES targets was noted and a request was made to expedite the second phase of the IR business case.	
850.6	Management Board **noted** the content of the report.	
851	**GOSH IN HARINGEY**	
851.1	FD presented the report. The consultation on TUPEing staff to the Whittington Health was underway. The service was awaiting the formal response to OFSTED inspection earlier this year.	
851.2	Management Board **noted** the content of the report.	
852	**R & I Divisional Report**	
852.1	LG presented the report. The final meeting of the R&D committee had been held. All future R&D and R&I business would now be discussed at the R&I Divisional Board meeting. Financial pathways for the management of research were being developed for GOSH. From 1st March 2011, UCL Research Services would cover GOSH EU contracts, and the Trust would be joining with UCL Business for commercialisation and IP advice. Additionally, Key Performance Indicators were being drafted.	
852.2	Management Board **noted** the content of the report.	
	Clinical Unit and Zero Harm Reports	
853	**MDTS Deep Dive**	
853.1	JA presented the CU risk and zero harm report.	
853.2	There had been a surge of referrals for MRI scans and additional time had had to be purchased externally. There had been 2 refused nephrology admissions and 3 same day cancellations by parents. Nurse recruitment was underway in nephrology. Over 70% of CRES was identified for years 1 and 2.	
853.3	It had been 199 days since the last SI. The unit's measures of harm included drug errors, WHO, CEWS, SBARD and line infections.	

853.4	The unit had started collecting drug error data for the dashboard, and looking at administration and prescription errors, using a tick box tool for completion. JC commented that it was important to learn from how other areas across the hospital had reduced drug errors –ITU for example.	
853.5	The WHO checklist was being implemented and monitored in all areas.	
853.6	SBARD and CEWS audits were underway. CEWS data showed fluctuating use of the observation charts and completion of records. The need for more staff training was apparent. Children continued to trigger CEWS but because they were known to routinely have observations outside normal ranges, these observations were not being documented. LM asked that this finding be fed back to Sue Chapman.	
853.7	Admissions and cancellations would be audited. Bed meetings had been arranged to deal with delayed admissions to ward areas, especially short stay patients so as to decrease outliers and increase turnover. The team was working so that all breaches were reported.	
853.8	Work was underway to deal with patients admitted with an uncertain discharge dates and no care pathway, as this was blocking beds.	
853.9	Data was being collected for cancellations to gastro suite and IR, MRI and CT appointments. It was noted that in most cases, such cancellations were quickly refilled. The team was also auditing the number of crash calls and ICON calls.	
853.10	CVL infections were high on Rainforest ward and training was underway as a means to enhance clinical skills and decrease harm.	
854	**IPP**	
854.1	JC asked all units to feed back comments on the new style report template to RB.	
854.2	The unit had held successful interviews for Trust Fellows and the advertising programme for nursing staff was underway. Learning from Medicine would help IPP understand the reasons for prescribing error rates.	
854.3	The CRES target had been achieved for the year to date.	
854.4	There had been 2 delayed patients in January and 106 days since the last SI.	
855	**Cardio Respiratory**	
855.1	AG presented the report. It had been 69 days since the last SI. There had been a peak in CVL infections in December 2010.	
855.2	Over 90% of CRES had been identified for year 1 and there had been no refused admissions, but cancellations were still high.	
855.3	JC asked AG to update the Board on the Safe and Sustainable Review. The proposal was to reduce cardiac children's' centres from 11 to 6/7. Four options were out for consultation and in all 4 options GOSH had been recommended as one of the London centres. GOSH delivered the largest paediatric cardiac service and was ranked best unit for innovation and research and the only centre that could offer ECMO, Berlin heart, transplantation and tracheal work with room for expansion. The Trust's networks and protocols required further work, along with the number of refusals and cancellations. It was noted the expectation for each patient to have a named nurse.	
855.4	The opportunity created would increase throughput but also would expand the	

	respiratory elements of the GOSH service. It was important that sufficient clinical staff were available to enable the expansion of the service. It was noted that the Brompton were not on the list of selected London centres.	
855.5	AG tabled a paper on proposed changes to staffing in the cardiac team, with a restructuring enabling establishment of 4 cardiology posts (one to deal with general networks, one to work on fetal networks, one to run an electrophysiology service, one to cover pulmonary hypertension) and 1 CICU post.	
855.6	MB discussed the posts and agreed it was important to plan for the future and resolve existing capacity issues regardless of the safe and sustainable review. CN agreed to review the proposed posts and AG was asked to bring back a formal proposal to March meeting.	
855.7	**Action**: AG to present a formal proposal for changes to the cardiac team.	**AG**
855.8	LM requested that the consequences for other services in being able to cope with increased workload resulting from the additional posts be considered. AG stated that the pulmonary hypertension post was essential. JC stated that a meeting was due to take place with NCG on 1st March 2011 and suggested subject to this meeting recruitment should proceed with this particular post. An update would be provided at the March Management Board meeting.	
855.9	Julie Bayliss asked whether nurse consultants had been considered for supporting the network. AG stated there was a need for such support.	
856	**Infection, Cancer and Immunity**	
856.1	CC presented the report. The last SI occurred on 13th January 2011.	
856.2	Rates of CV line infections had increased, which, it was understood, was due to the acuity of patients and staff shortages.	
856.3	There had been a surge of admissions in haematology and oncology and high rates of refusals.	
857	**NEUROSCIENCES**	
857.1	SD and CDS presented the report.	
857.2	There had been some improvement in the use of the surgical checklist.	
857.3	There was concern that a lot of different solutions were being applied across the hospital for reducing medication errors. JC said PICU had improved by having dedicated protected time to prescribe drugs.	
857.4	It was agreed that the Transformation Board review the effectiveness of the different approaches. The need for a central transformation resource was crucial to support this work.	
857.5	**Action**: JC to request that PL conduct a review of the effectiveness of approaches aimed at reducing medication errors and report back in April 2011.	**JC**
857.6	There had been 3 refused admissions in January 2011.	
858	**Surgery**	
858.1	The last SI had occurred 9 days ago.	

858.2	It had been found that the WHO surgical checklist was not being recorded to a satisfactory level and work was underway to improve this.	
858.3	There had been a cluster of deaths for very complex spinal patients and an external review commissioned. Line infections on Woodland ward had increased. Identification of CRES was in progress.	
858.4	A consent issue had arisen in the CATS team and resulted in a suspension of a research programme. LG was asked to present the findings by R and I when the investigation was complete.	
859	**IV Access/Femoral Lines – minute 740.6**	
859.1	LM explained that an issue had arisen around children being discharged from ICU without what the receiving team considered adequate venous access, with ICU removing femoral lines because of concerns of infection. A workshop was held to discuss how to take the matter forward.	
859.2	Joe Brierly explained that CV lines were used for medication and TPN. A bundle of care was in place which required lines to be removed as quickly as possible due to the risk of infection. In 2010, the NPSA raised the prospect of increased risk of haemorrhage and death from CV lines and the need for protocols on the removal of these lines.	
859.3	The Interventional Radiology (IR) service inserted lines at GOSH. Problems had arisen with the provision of cover at night for line insertion, and the competence of junior doctors to insert lines.	
859.4	An audit found that children were facing multiple access attempts or access failed after a few hours and the escalation process to get access was not working well.	
859.5	Possible solutions ranged from establishing a line insertion team (as in Spain), lead by nursing staff; increased IR provision: leaving CVC lines in; or keeping children with CVC lines on ITU.	
859.6	LM stated that following the workshop, a number of actions had been agreed: - Development of a protocol on insertion of CVC lines - Development of a protocol on care of CVC lines - Looking at decisions to leave a line is in situ and when to remove - Need for training around aseptic non-touch technique - Developing an audit to gather data and monitor improvements - Review of the current escalation policy when line insertion attempts have failed - ICU to consider alternatives to CVC lines especially for those children who are likely to have a line in for long periods of time.	
859.7	It was agreed that better planning around when a CVC line was needed was important – such as an early warning approach.	
859.8	**Action**: A proposal would be brought back to the April Management Board.	**LM**
860	**Integrated Theatres – direction of travel**	
860.1	TS introduced Jo Curry, Consultant in General Surgery. The paper proposed developing 3 theatres in the VCB into 'integrated theatres'. It would enable equipment to be moved into same floor-print and then wheeled out. A key feature was an operating panel designed so that the integrated system could be used and controlled by the surgeon. It would benefit staff and patients. It also facilitated individualised	

	training; reduced malfunction through user error and allowed the WHO surgical checklist to be completed on the system. NR saw the potential of approaching this pre phase 2B. It was thought it could cost £450k per theatre.	
860.2	It was agreed that a business case be developed for further consideration.	
861	**Electronic Prescribing Review**	
861.1	Jude Cope presented the paper. There had been a review of electronic prescribing and it had recommended a number of proposals, including the appointment of a system manager; development of an e-learning package; establishment of sufficient hand held devices and improved support from ICT for the system.	
861.2	Management Board **approved** the recommendations and agreed that the results of the review should be communicated.	
862	**Medicines Management: Intelligent Storage Systems (ISS)**	
862.1	Sue Conner presented the report, which asked the Board to agree to tender for the implementation of an ISS for medicines/ high cost consumables in the Morgan Stanley Building (MSB); and to approve a pilot of the ISS for controlled drugs and high cost consumables.	
862.2	Management Board was informed that secure storage would help ward staff to operate more efficiently. A review had been conducted with the wards moving to MSB, which showed that this approach would deliver efficiency savings, reducing stock and use of space; opportunity to reduce delay; a reduction of the inventory; and stock waste. It was suggested that there would be a £229k annual efficiency saving from using this system.	
862.3	It was proposed that a cabinet be trialled on Ladybird ward. It would also be trialled for consumables for heart valves in the Cardiac wing.	
862.4	ME stated that in the US, the log-on method used finger print recognition to speed up access to the cabinet. This was seen as the preferred access method in the UK as well.	
862.5	It was agreed that there should be unit ownership of this new system, particularly; savings included on individual unit's CRES plans.	
862.6	RB asked about agency staff access to this to ensure that they had access provided.	
862.7	Management Board **supported** the proposed tendering.	
863	**Provision of High Dependency beds at GOSH**	
863.1	ME presented the report. Management Board had previously endorsed a review of HDU and ITU services. The proposal on the agenda related to the development of an interim solution for establishment of a surgical HDU/ step down facility, pending the completion of the wider ITU review.	
863.2	To accommodate this, the HD facilities would be expanded in Woodland ward. A medical registrar would be available at night to improve medical decision making; triage at night and redistribution of nursing staff so the proposal remained cost neutral. Patients would be cohorted according to need.	
863.3	The designated HDU would consist of two four-bed bays in VCB. The proposal would enable the Trust to be compliant with DoH recommendations on provision of HD care.	

863.4	Management Board **approved** the direction of travel as an interim solution pending the findings of the ITU review.	
864 864.1 864.2	**Re-development of the Trust Intranet** CN presented the report. Work was underway to consider moving the intranet to a new technology platform, improve content management, navigation and usability. The proposal would require a website consultant to undertake the initial architecture and design work at the cost of £24,380 (ex VAT). A waiver would be required so as to use the One Site partner to undertake this work and ensure consistency with the internet. Management Board **approved** the proposal.	
865 865.1 865.2 865.3 865.4 865.5	**Quality of Health Records Policy *and* Quality of Health Records Audit** Andrew Pearson presented the report. From the audit, it was found that 33% of records contained an illegible medical entry; and 35% of patient records contained loose filing. The remit of the audit did not consider whether the information in the record was accurate. The findings had been circulated to CU Chairs, General Managers and Matrons. An action plan was in the process of being finalised. This included a recommendation for a follow up audit in September 2011, following implementation of the revised policy. ME asked whether a continuous electronic record was a way forward. This was an IT solution that was under consideration. Even If this was taken forward, it was still important to have a plan on how to improve the paper records now. The IT strategy would include this issue and be considered at the March meeting. ME stated it was important to know what support was required to ensure successful implementation of an electronic record. Further thoughts were requested on this at a future meeting. It was requested the quality of temporary notes would be separately considered at the March Management Board meeting, in particular, the content of the notes. Management Board **approved** the policy and the direction of travel proposed as a result of the audit results.	
866 866.1 866.2	**Amscreen Operational Policy** The policy documented the process for submission of content to the GOSH Amscreens around the hospital. It outlined the type of content suitable for display. The reference to genetic testing required clarification. Subject to the above clarification, the policy was **approved**.	
867 867.1 867.2	**Reconfiguration of level 3 of Phase 2** Natalie Robinson presented the proposal to create a floor on level 3 of phase 2B for theatre and angiography based procedures. The proposal had been worked up by the Surgical Pathway Board and had involved stakeholder groups. This proposal replaced the two catheter laboratories which would be transferred them into level 3 VCB. The Board was assured that the risks arising from these changes had been reviewed. Management Board **approved** the proposal.	
868	**GOSH Child Protection Quarterly update October 2010 – December 2010**	

868.1	LM presented the report, which provided evidence of continued implementation of the Trust strategy to protect children. Overall the Trust continued to make good progress against planned activity. It was reported that Nick Lessof would replace Vic Larcher as the main site Named Doctor for Child Protection.	
868.2	Management Board **noted** the content of the report.	
869	**London Olympics 2012 – Briefing**	
869.1	FD presented the briefing paper, which confirmed that normal leave arrangements would apply during the Olympics 2012.	
869.2	Management Board **noted** the content of the report.	
870	**Review of Performance Management Arrangements**	
870.1	FD presented the results of an audit undertaken by the external auditors Deloitte on performance management arrangements at GOSH. The audit found that arrangements were effective and that Management Board had a strong understanding of CU performance.	
870.2	Management Board **noted** the content of the report.	
871	**Agency Staff policy and procedures**	
871.1	CN presented the procedure, which outlined robust rules for the use of agency staff.	
871.2	It was agreed that the term 'HoD' included CU Chair and would require clarification. The flow chats referred to Matrons and should refer to Heads of Nursing.	
871.3	The procedure was **approved** subject to the above amendments.	
872	**Pregnancy Testing on Girls of Child Bearing Age before Procedures and Treatments**	
872.1	The policy had been developed as a result of an NPSA alert in April 2010. The policy had been approved by the Quality and Safety Committee. LM and BB were asked to take the lead on implementation of the policy. A question on the pre admission checklist would be one way of ensuring the matter was raised, but it was recognised that training would be required to ensure that the question was posed sensitively.	
872.2	It was agreed that an update be brought back to the March Management Board.	
872.3	**Action**: BB to provide an update at the March Management Board	**BB**
873	**How to Produce Information for Children, Young People and Families**	
873.1	Beki Moult presented the policy. The main change was an extra step in to the production process of information sheets to coincide with the development of the One Site website.	
873.2	A document outlining the house style would be produced in the future.	
873.3	The policy was **approved**.	
874	**Request Loan of Health Records**	
874.1	The document sets out the policy for the loan of patient records for clinical research	

	and clinical audit purposes from the Health Records Department central library.	
874.2	The policy was **approved**.	
875	**Information Governance**	
875.1	CN presented the updated policy which had been amended to reflect the current governance structure and the updated role of the Information Governance Steering Group.	
875.2	The policy was **approved**.	
876	**Key Performance Report January 2011**	
876.1	RB presented the report. The following was noted: • Performance had decreased in month with 41 patients reported as waiting over 26 weeks for inpatient treatment following data validation, compared to a December 2010 position of 28. • In month, the number of patients waiting over 13 weeks for a first consultant outpatient appointment also increased from a December position of 40 to 47 following data validation. 37% of all long waiting patients were reported in Medicine. • There were differences across Clinical Units and Specialties in the current level of clinic outcome form completeness with some achieving 100% and others well below 50%. The overall level was 65%. • The Trust discharge summary completion rate had continued to fall steadily from a peak in September 2010 of 87% to 73% in January 2011. Work was underway to redesign the templates for producing the reports. • There had been a dip in 18 week performance. An exception report had been provided to the SHA – the trust would have breached the Monitor target for maintaining the 95th percentile. There had been a slight improvement in January. Most breaches were in surgery. It was a potential risk and the team were actively working on this.	
876.2	Management Board **noted** the contents of the Key Performance Indicator Report for January 2011.	
877	**Finance and Finance and Activity Report January 2011**	
877.1	CN presented the report and the following was noted:	
877.2	The Trust surplus was £6.9M, £1.6M favourable to budget and £1.9M to Original Provider plan. NHS Clinical and IPP income were ahead of budget and non pay costs for Blood and drugs were lower than budget.	
877.3	The forecast was for an £8.8M surplus and an estimated impairment of up to £1.5M on buildings, although the value of the impairment would not be certain until the District Valuer has concluded the valuation.	
877.4	Pay was £7.3 million higher than budget and non-pay, £3.2M lower than budget.	
877.5	SB queried the amount of in-month operating expenses of £2.2 million. CN explained that this overspend was corrected in February.	

877.6	Management Board **noted** the contents of the report.	
878 878.1 878.2	**Foundation Trust Application Update January 2011** SB presented the report. CRES delivery and commissioner support remained risks to achievement of Foundation Trust status. Management Board **noted** the report.	
879 879.1 879.2	**Review of three year Strategic Objectives** RB presented the review. The actions had been streamlined and new strategic actions proposed for 2011/12. Management Board **approved** the streamlined strategic actions.	
880 880.1	**Commissioners' Forum** Management Board **noted** the contents of the above document.	
881 881.1	**Capital and Space Planning Committee** Management Board **noted** the contents of the above document.	
882 882.1	**Technical Delivery Board** Management Board **noted** the contents of the above document.	
883 883.1	**Information Governance Steering Group** Management Board **noted** the contents of the above document.	
884 884.1	**CRES Steering Board** Management Board **noted** the contents of the above document.	
885 885.1	**Redevelopment Programme Steering Board** Management Board **noted** the contents of the above document.	
886 886.1	**Waivers** Management Board **approved** the waivers.	
887	**Any other business**	
887.1	There were no items of any other business.	

Managing Directors Report to the April UCL Partners Executive

1. Consolidation of corporate and clinical support services update

- Six partners continue to participate in the planning phase.
- The programme advisers - E&Y (core), KPMG (Pharmacy (out-patient dispensing) and Pathology (structures)) and Alsbridge (Pathology) - are all in place. The data collection phase has commenced.
- The Programme Steering Group has been reconstituted to include one representative from each trust and all work-stream leads. The finance work-stream remains unformed – although some planning is progressing despite this.
- Subject to successful completion of data collection, and ongoing engagement from work-streams, detailed plans will be available during June.

2. Cancer

- NHS London commissioners have circulated the pro forma for integrated cancer systems (cancer provider networks) to all CEOs and MDs in London.
- Crucial to improving care will be greater patient empowerment, earlier diagnosis, defragmentation of pathways, and focus on delivery of the many known benefits for patients such as enhanced recovery, day surgery and easy access to clinical trials. Whatever the configuration of our provider network building we should support our patients by ensuring these priorities are a requirement to participate in our network from the outset.

Locally in NCL with our continued development of the pilot cancer provider network this year:

- The current Cancer Programme Board is assuming a new governance arrangement from 1st April 2011 and will be chaired by UCLP with input from all providers in the current network.
- The UCL Partners cancer provider network is continuing with its work to develop integrated care pathways that place the patient at the centre of the thinking. Clinical Pathway Directors have been appointed to four pathways (Brain, Urology, Lung and Upper GI) and the details of their operational support are being worked through with their employing Trusts.
- The brain cancer patient language project has been completed and its findings presented and validated at a large patient information event. The findings will inform our approach to development of integrated cancer pathways.
- We are working up the options for the network-wide recommendation on electronic cancer MDT data capture, bearing in mind the forthcoming requirements for sharing data in the London Integrated Cancer Systems.

3. UCLPartners narrative, communications and upcoming national event

- Developing a consistent UCLP narrative for the basis of internal and external communications
- Website – re-worked – ready for end April.
- Co-hosting national meeting with Monitor on Value in Healthcare in 2011

4. Research Grants

- Currently grants awarded to UCL/UCLP for new activities relating to/enabled by the partnership exceed £15m

5. UCLPartners Mental Health and Wellbeing Programme

Collaboration between the 4 major Mental Health Trusts spanning NCL and NEL, with UCL has created substantially the largest academic and clinical Mental Health Programme in the UK .

6. UCLP Business model, expansion and accommodation requirements

The business model for delivery of UCLP programmes/projects is based on innovation and implementation by the PDs and central support team working with Partners. Currently 35 goal based projects active.

We are in discussion with UCLH Trustees about the location of the UCLP Offices.