Meeting of the Trust Board

27th July 2011

Dear Members

There will be a public meeting of the Trust Board on Wednesday 27th July 2011 commencing at **11:30am** 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 29th June 2011**	Chair	**L**
3.	**Matters Arising / Action point checklist**	Chair	**M**
4.	**Chief Executive's Update** • **Media Interest**	Chief Executive	**Verbal**
5.	**Zero Harm Report**	Co-Medical Director (BB)/ Peter Lachman	**N**
6.	**Paediatric Trigger Tool Presentation**	Co-Medical Director (BB)/Sue Chapman	**Presentation**
	ITEMS FOR DECISION		
7.	**Self Certification Statements:**	Chief Executive	
	• **Clinical quality, service performance, risk management and board roles and capacity**		**O**
	• **Quality governance board memorandum**		**P**
8.	**Business Continuity Plan**	Deputy Chief Operating Officer	**Q**
	UPDATES		
9.	**Performance Report – Month 3 2011-12**	Deputy Chief Operating Officer	**R**
10.	**Finance Report – Month 3 2011-12**	Chief Finance Officer	**S**
11.	**Foundation Trust Update**	Deputy Chief Operating Officer	**T**
12.	**Annual Director of Infection, Prevention and Control Report 2010-11**	Director of Infection, Prevention and Control,	**U**

13.	**Head of Nursing Report**	Dr John Hartley Chief Nurse and Director of Education	**V**
14.	**Trust Handover Process**	Co-Medical Director (BB)	**W**
15.	**CQC registration overview**	Chief Executive	**Y**
16.	**Assurance Framework**	Deputy Chief Operating Officer	**Z**
17.	**Trust Board Members' Activities**	Chair	**Verbal**
	ITEMS FOR RATIFICATION		
18.	**Consultant appointments**	Chair	**Verbal**

19. 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.)

20. Next meeting
The next public Trust Board meeting will be held on Wednesday 28th September 2011 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT L

Minutes of the meeting of Trust Board held on 29 June 2011

Present

Baroness Tessa Blackstone	Chairman
Ms Yvonne Brown	Non-Executive Director
Dr Barbara Buckley	Co-Medical Director
Dr Jane Collins	Chief Executive
Ms Fiona Dalton	Deputy Chief Executive
Professor Martin Elliott	Co-Medical Director
Ms Dorothea Hackman	Associate Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mrs Claire Newton	Chief Finance Officer
Mr Charles Tilley	Non-Executive Director
Mrs Janet Williss	Acting Director of Nursing and Education

In attendance

Dr Anna Ferrant	Company Secretary
Mr William McGill	Director of Redevelopment

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

113. Apologies for Absence

113.1 There were no apologies for absence.

114. Declarations of Interest

114.1 There were no declarations of interest received.

115. Minutes of the Meeting Held on 25 May 2011

115.1 The minutes of the Trust Board meeting held on 25th May 2011 were received and the Chairman requested the Board Members to check them for accuracy.

115.2 The minutes were **approved** as an accurate record, subject to the following changes:

115.3 **58.7:** The following sentence was to be removed as this was incorrect: "*Professor Copp stated that it was also important to demonstrate the impact of research on the organisation.* "

115.4 **67.3:** The sentence detailing provision of paediatric nursing education at UCL to read: "*The Chief Nurse explained that UCL did not provide any paediatric nursing education."*

116. Matters arising

116.1 There were no matters arising.

117. Research update

117.1 Professor David Goldblatt, Director of Research and Innovation (R and I) presented the report and introduced Lorna Gibson, General Manager of the R and I Division.

117.2 The Board was informed that the governance structures had been reviewed within the division. The R and I Board oversaw implementation of the Research Strategy and dealt with day to day management issues. Under the new structure, the Trust was now responsible for pre award and post award management of research projects. The work conducted between the Trust and the Institute of Child Health was now managed under one structure and streamlined processes.

117.3 Three clinical research facilitators had been appointed to support clinicians to develop research programmes for funding purposes.

The Chief Nurse and Director of Education welcomed the appointment of the facilitators and stated that they were proving helpful in getting patients involved with research programmes.

The Chief Executive stated that she had also received positive feedback about the role and work of the facilitators and also thanked David Goldblatt, Lorna Gibson, Fiona Dalton and Robbie Burns in managing the challenges around making changes to the previous structure.

117.4 Professor Andrew Copp, Non- Executive Director welcomed the appointment of the facilitators and asked how to protect them from being pulled in different directions and prevent them from concentrating on small value awards. Lorna Gibson stated that she had been monitoring their workload across different areas of the Trust to help manage this.

117.5 Dr Barbara Buckley, Co-Medical Director asked whether charitable research funding was managed via the R and I Division and the Director of R and I confirmed that this was the case. It was important that the system was set up in this way so as to manage overheads as effectively as possible.

117.6 Professor Martin Elliott, Co-Medical Director asked what support was available for qualitative research as opposed to laboratory based research. Professor Goldblatt stated that this was a new area of focus and that the Trust actively supported qualitative research. The National Institute for Health Research (NIHR) required research projects to include impact of treatment outcomes and the Division was tasked with trying to bring these measures to the forefront of researchers' applications. The Division was in the process of developing KPIs and would report these to the Board at the next update.

117.7 Professor Goldblatt informed the Board that the Trust had been invited to reapply for retention of Biomedical Research Centre (BRC) status. Monies applied for had been capped to £7.8 million per year, over 5 years. Interviews would be held on 19th July 2011. A DVD had been produced and it was agreed that this would be shown to the Board at the next meeting.

117.8 **Action**: Professor Goldblatt to present the DVD developed for the BRC application at the July Trust Board meeting.

117.9 Professor Goldblatt outlined the progress with the UCL Partner Child Health programme including development of a Patient Relationship Management approach, enabling children and their families to access evidence based care within their own homes.

Other work included improvement of the care of asthma in the community and translation of research on outcomes of obesity during pregnancy into interventions that improve pregnancy outcomes and mitigate long term effects on the infant:

Professor Andrew Copp stated that he was pleased to see emphasis on research in the community, for which there was a parallel strand of work underway at the Institute of Child Health.

117.10 Professor Goldblatt stated that the future actions were as follows:

- Attract increased research funding to GOSH;
- Develop incentivisation schemes for research within the Trust ;
- Ensure BRC delivers it's promised activity;
- Sustain high patient recruitment rate ;
- Publicise and raise awareness of our research.

117.11 Ms Mary MacLeod congratulated Professor Goldblatt on progress made and asked how quickly advances in research could be turned into treatment. Professor Goldblatt stated that this was something the Division was keen to measure, via development of the KPIs.

117.12 The Board **noted** the report.

118. UCLP Back Office Update

118.1 Mr Edward Lavelle presented the slides stating that the aim of the presentation was to update the Board on the progress made with the programme and highlight those areas for consideration and decision in the future.

118.2 The Board was updated on progress with the work streams, as follows:

- Pathology – it was proposed that a different model could deliver financial benefits and a step change in the level of pathology support in the sector. Centralising testing could improve efficiencies and drive down costs for each partner.
- Pharmacy – the work stream had focused on manufacturing, supply change and outpatient dispensing. Professional procurement across the partners could bring about cost savings.

- Procurement – the work stream had considered a different way of procuring at scale across all partners;
- Estates and Facilities – by contracting at scale and bringing operational processes together, efficiencies and savings could be recognised.
- Human resources – efficiencies and savings could be recognised through the joint procurement of temporary staffing services.
- Finance – benefits could be realised through establishment of shared transactional services. It was noted that this could incur upfront costs to streamline the various financial systems within each organisation.

118.3 The Chief Operating Officer stated that the relevant Heads of Departments for the work streams had been asked to provide a written summary of the impact of the proposed changes on delivery and workload. These summaries would be reviewed and challenged by customers of the services such as General Managers in Clinical Units and this information would be presented at Management Board and Trust Board in July 2011.

118.4 The Board requested for this information to be supplemented with data on the savings to be realised by each partner and how risks would be managed and mitigated.

118.5 **Action**: Chief Operating Officer and Mr Edward Lavelle to present the questions being asked of the Board alongside the impact statements and risk assessment and data on savings at the July Trust Board meeting.

118.6 Professor Elliott suggested that the pharmacy work stream consider potential efficiencies and savings from making up more drugs in pharmacy rather than on the wards.

118.7 Mrs Morgan stated that it would be helpful to understand the areas of work being reviewed under the HR work stream and whether this does also include education services.

118.8 Mr Lavelle confirmed that the level of savings per partner was dependent upon the number of partners involved in the work stream, although, in some cases the less partners involved could mean less cost upfront.

118.9 It was agreed that the Board would respond to the questions posed in the presentation at the July Board meeting.

118.10 The Board **noted** the report.

119. Clinical Unit Presentation – Haematology, Oncology and Bone Marrow Transplant (BMT)

119.1 Dr Cathy Cale, Clinical Unit Chair of Infection, Cancer, Immunity and Laboratory Medicine; Dr Nick Goulden, Consultant Haematologist; Dr Peppy Brock, Consultant Oncologist; Dr Paul Veys, BMT Consultant and

Mrs Julie Bayliss, Head of Nursing presented the slides.

119.2 Dr Cale gave an overview of the service provided by GOSH, which includes malignant haematology and oncology; non malignant haematology; malignant BMT and non-malignant BMT and laboratory haematology. Service activity had increased over time.

119.3 Dr Goulden explained that a third of childhood cancer presented as leukaemia, a third as brain tumours and a third as solid tumours. The Board was informed that cancer remains the largest cause of non accidental death for children and that the cost of treatment of childhood cancer was very high.

119.4 Prior to 1966, childhood cancer was incurable. In 2011, 70% of children were cured of cancer, mainly due to improvements based on randomised trials to optimise the use of drugs that had been in use over the past 40 years.

119.5 It was recognised that such trials increased the efficacy of treatments but also the intensity of treatments. It had been mandated that all patients presenting with cancer are entered into an open clinical trial. EU rules had been developed governing how such trials should be managed.

119.6 The Board was advised that the Trust has the highest proportion of chief investigators of national trials in the UK and was the principal cancer treatment centre for North London.

119.7 Dr Brock stated that neuroblastoma is the commonest cancer in children. It presents as a tumour that spreads to the bone marrow and the bones. Older children have a worse prognosis than younger children.

119.8 Once diagnosed the clinician has to get consent for entry to a clinical trial. The treatment aims to clear the disease out of bone marrow in 70 days. Stem cells are harvested from bone marrow, then surgery undertaken to remove the primary tumour. Following this, the child undergoes radiotherapy and the stem cells are reintroduced.

119.9 Dr Veys informed the Board that the Trust carries out about 80 BMT transplants a year and that BMT is used to treat over 50 different childhood diseases.

119.10 The Board was presented with a chart that showed that the number of patients undergoing BMT had risen and so too the survival rates. Since 1995, there had been a marked improvement in survival rates due to the availability of closely matched donors, coupled with the work to reduce the intensity of treatment.

119.11 Clinicians at the Trust had developed protocols for managing transplant patients, involving the separation of 'T' cells and marking of destructive cells.

119.12 Dr Cale stated that the teams were working to develop novel treatments for these patients in a regulated and appropriately controlled environment. Patients required intense clinical care packages and the CEWS and SBARD processes had helped to ensure that the Trust was making the optimal use of staff.

119.13 Work was underway to improve the management of medicines and establish dedicated Interventional Radiology (IR) lists. Central Venous Line infection rates had reduced considerably.

119.14 The Chair asked if it was possible to benchmark outcomes with other organisations, such as hospitals in the USA. Dr Cale stated that this was possible as data had been collected over several years. Dr Veys confirmed that he was involved in sharing data with American partners and emphasised the importance of this work due to the small number of patients presenting for treatment each year.

119.15 Professor Elliott stated that the oncology and BMT services provided good evidence of integrated working and emphasised how this approach was required in other disciplines.

119.16 The Chief Nurse asked if learning from the impact intense treatments have on families was being shared. Dr Brock stated that it was and a parent was also represented on national and international bodies where data was shared and reviewed. This research was important as increasingly funding for research from external bodies such as charities required information on the health economic case for certain treatments and quality of life measures. It was agreed that it was difficult to estimate 'whole life value' and further work was needed.

119.17 Professor Andrew Copp asked how many patients were recruited to trials. Dr Goulden stated that the Trust was the biggest recruiter of patients to clinical trials and that 60% of patients treated at the Trust had been recruited.

119.18 Ms Yvonne Brown asked about work undertaken to identify children at risk of these cancers. Dr Veys stated that genetic analysis work was underway and that this service also provided a place for families to discuss treatments and implications for their wider family.

119.19 The Board **noted** the content of the presentation and thanked the clinicians for their time in highlighting the work of these services.

120. Chief Executive Update

120.1 The Chief Executive informed the Board that the Care Quality Commission had undertaken a planned review of the Trust in early June and that there had been no major concerns reported at their feedback meeting. A report was expected in the next few weeks.

120.2 The Safe and Sustainable consultation phase was planned to finish the following day. The Judicial Review hearing brought by the Brompton was expected to commence in October 2011.

121. Zero Harm Report

121.1 Dr Barbara Buckley presented the report. She advised the Board that the Trust was applying for a patient safety programme offered by the Health Foundation. It was felt that this would add additional impetus to the Trust's Zero Harm aims.

121.2 Dr Barbara Buckley was the Executive sponsor. The Board **agreed** that Yvonne Brown would be the Board sponsor.

121.3 The Board **noted** the report.

122. Members' Forum Legacy Document

122.1 Ms Dorothea Hackman, Associate Non- Executive Director presented the report. The purpose of the Legacy Document was to pass on the Members' Forum's work to the successor body, the Members' Council as the inheritor of the engagement work, action plans, independent monitoring and watchdog responsibilities.

122.2 Ms Hackman highlighted the breadth of engagement work undertaken at the Trust and stated that the commitment of the clinical units to engage with patients and parents and carers was to be applauded. She stressed that it was important that the Trust maintained its focus on improving communication channels with patients, families, between departments at GOSH and with other health professionals, GPs and hospitals.

122.3 The Chief Nurse and Director of Education, Mrs Liz Morgan stated that the document would prove extremely useful to the Members' Council in providing an overview of the work undertaken and the issues at hand.

Ms Hackman informed the Board that this would be her last meeting as an ex officio member of the Trust Board. The Chair thanks Ms Hackman for all her hard work and involvement with the Board over the years.

The Board **noted** the report.

122.4

123. Annual Report 2010-11

123.1 The Company Secretary presented the draft annual report and asked Board members to forward comments or amendments to her by Monday 4th July.

The report would be published in time for the Annual General Meeting in September 2011.

123.2 The Board **noted** the request.

124. Performance Report

124.1 The Chief Operating Officer presented the report and highlighted the following areas:

- In month, the trust had reported 1 case of C. difficile. The trust had reported 3 cases against a year-to-date trajectory of 1.5. The trajectory for the year was 9 cases.
- Inpatients waiting list profile by weeks waiting**:** May performance had decreased with 73 patients reported as breaching the 26

week waiting standard. Specific concerns had been identified across several specialties, and work was underway to review the waiting list to identify issues.
- The trust achieved the 95th percentile targets for admitted and non-admitted pathway waits in April.

Professor Copp expressed concern about the use of arrows showing trajectory direction in the report. The Chief Operating Officer agreed to review the presentation of this information and report back to the next meeting.

124.2 **Action**: Chief Operating Officer to review the use of arrows in the report and report back to the next meeting.

The Board noted the changes in market share trends for priority specialties. Ms Mary MacLeod, Non-Executive Director asked what implications this had for the Trust's growth strategy and the Chief Operating Officer stated that the graphs provided an overview of where the Trust needed to focus its energy in order to remain competitive.

124.3 The Board **noted** the report.

125. Finance Report

125.1 The Chief Finance Officer presented the report.

At month two, the Trust was £2 million ahead of the original plan and had resubmitted the financial plan for 2011-12 to the SHA to reapportion the expenditure.

Pay was £2.1 million higher than budget and non- pay £3.3M lower than budget. Spend on agency staff continued to fall.

125.2 The Board **noted** the content of the report.

126. Foundation Trust update

126.1 The Chief Operating officer, Ms Fiona Dalton presented the report.

The Board was advised that the Trust had received a letter from the Department of Health confirming that it had been submitted to the final phase of the Foundation Trust authorisation process with Monitor. Ms Dalton highlighted the areas which had been assessed as amber and the work underway to improve the assurance assessment.

126.2 The Board **noted** the report.

127. PPI Annual Report 2010-11

127.1 The Chief Nurse and Director of Education presented the annual report and explained that it outlined the focus of activity over the last year in supporting and developing staff to work with children and families to help them contribute to development of the Trust; supporting Foundation Trust work and establishment of the Members' Council; and listening too and responding to patients.

The MORI Survey had shown 96% satisfaction with services at GOSH and this was to be commended. It was important that work continued around reducing children's level of fear when in the hospital, improvements in nutrition, supporting parents and carers to complain or raise concerns when they wanted to and reducing levels of boredom for long term patients.

The Chief Nurse stated that the Patient and Public Involvement and Engagement team were keen to encourage more parents and children to get involved in service redesign projects.

127.2 The Board **noted** the report.

128. Health and Safety Report

128.1 The Company Secretary presented the report, stating that it had been agreed by the Health and Safety Committee and considered at the recent Clinical Governance Committee in June.

128.2 The Board **noted** the content of the report.

129. Trust board member activities

129.1 The Chair informed the Board that she had attended a senior staff meeting in the previous week, held to update staff on the recent media activity and explain what information had been released during the investigations into the death of Peter Connelly. She stated that the meeting had been a valuable opportunity for senior clinical and corporate staff to express views and that the Chief Executive was given support from the meeting.

The Associate Non-Executive Director, Ms Dorothea Hackman informed the Board that she had sat as a representative on the national specialised commissioning team panel.

130. Consultant appointments

130.1 The Chairman advised Board Members that the following Consultant had been appointed since the last meeting:-

Dr Bran Sivakumar, Consultant in Paediatric Hand Surgery

130.2 The Board **approved** the new Consultant appointment.

131. Update from Clinical Governance Committee

131.1 Mr Andrew Fane, Non-Executive Director and Chairman of the Clinical Governance Committee updated the Board.

He stated that the committee had considered in detail the findings of the internal audit report into the management of medical equipment and devices across the Trust. The committee had sought assurances of actions in place to control these risks. The committee had been advised that the Trust was the only second trust in the country to implement a

tracking system for medical equipment and that this system would aid the management of the maintenance of equipment.

131.2 The Board **noted** the report.

132. Audit Committee Minutes – April 2011

132.1 It was noted that the 'Audit Committee Minutes April 2011 had been included for information. The Chairman asked if there were any questions or comments. There were none.

133. Update from Audit Committee June 2011

133.1 Mr Charles Tilley stated that the previous update provided at the 8th June meeting had highlighted all relevant points.

134. UCL Partners Update

134.1 It was noted that the 'UCL Partners Update' had been included for information. The Chairman asked if there were any questions or comments. There were none.

135. Any Other Business

135.1 There were no items of any other business.

136. Date of the Next Meeting

136.1 The date of the next meeting in public of the Trust Board was confirmed as 27th July 2011.

ATTACHMENT M

ATTACHMENT M

TRUST BOARD - ACTION CHECKLIST
27 July 2011

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
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.	AFe	Deferred to October 2011	Not Yet Due
17.2	27/04/11	An update on the six day working proposal would be provided later in the year.	FD	Sept 2011	Not Yet Due
17.4	27/04/11	Ms MacLeod said that a presentation received prior to the meeting about working with governors had highlighted the need for further work to clarify how patient, carers and the public members of the Trust engaged with the board and its subcommittees. It was agreed that the work would be revisited in the autumn once the Member's Council had been formed.	AFe	Oct 2011	Not Yet Due
57.6	25/05/11	Dr Lachman requested permission to present a proposal on how to bring the patient voice to the Board. The Board agreed to this and that it should include both patient and staff experiences.	Dr Peter Lachman	July 2011	On agenda under the Zero Harm Report
117.8	29/06/11	Professor Goldblatt to present the DVD developed for the BRC application at the July Trust Board meeting.	DG	July 2011	Postponed to September 2011 meeting
118.5	29/06/11	Chief Operating Officer to present the questions being asked of the Board alongside the impact statements and risk assessment and data on savings at the July Trust Board meeting.	FD	July 2011	On agenda
124.2	29/06/11	Chief Operating Officer to review the use of arrows in the KPI report and report back to the next meeting.	FD	July 2011	On agenda

ATTACHMENT N

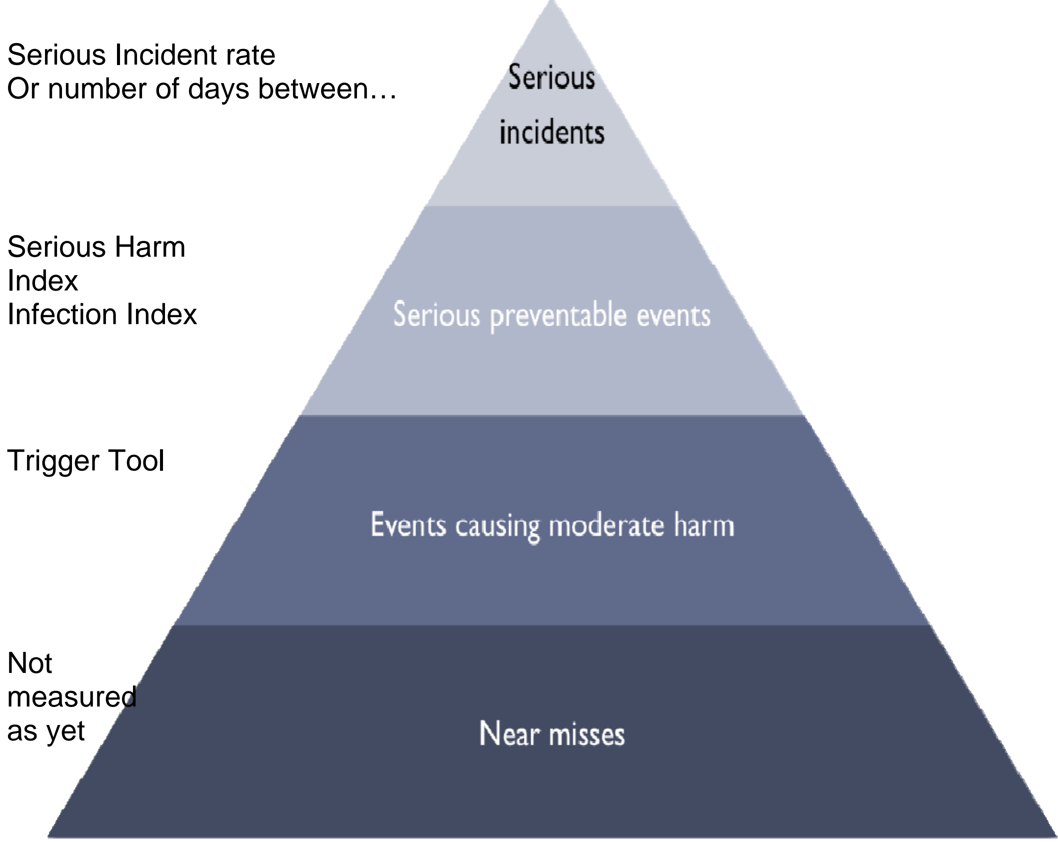
Trust Board Meeting 27th July 2010	
Title of document: **Zero Harm Report** **Martin Elliot Co-Medical Director**	**Paper No: Attachment N**
Summary This paper provides an update on the following issues: ▪ Development of the new Zero Harm Dashboard	
Action required from the meeting To note the progress made To anticipate the new system wide dashboard by September To place the first patient story as an agenda item in September/October	
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	

Zero Harm Report for the Trust Board
July 2011

A. New Dashboard

At the July meeting it was agreed that the following approach would be adopted for future Zero Harm reports – a new set of measures, measurement of culture, use if unit reports and the introduction of patient stories

New Measures

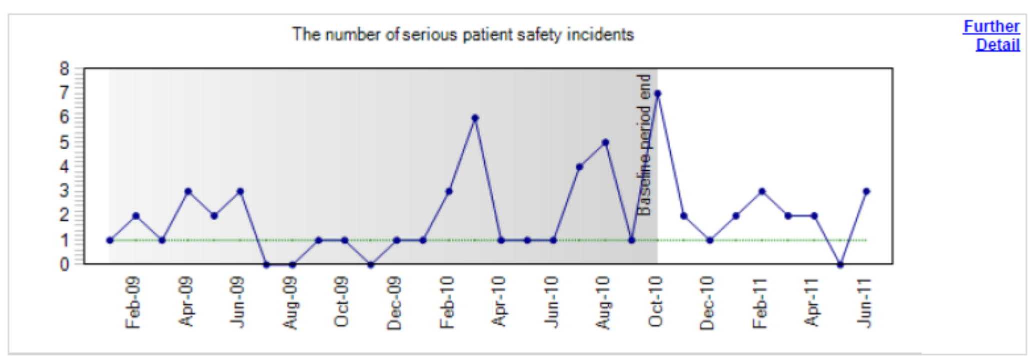


The data analysts have been working on the above as follows.

1. Obtained the definitions for the Indices from Cincinnati Children's and then translating these to the local context. Steve Meuthing from CCHMC has kindly shared all definitions with the analysts and we hope to have agreed definitions shortly.
2. Obtained agreement from the Infection Control Team on the Infections Index
3. Worked with the Safety Team to assess how best to develop the Serious Incident data set – this is ongoing
4. Developed the first prototype of the Dashboard as below. Further measures will be added as developed.

Zero Harm Trust Dashboard

Serious Patient Safety Incidents

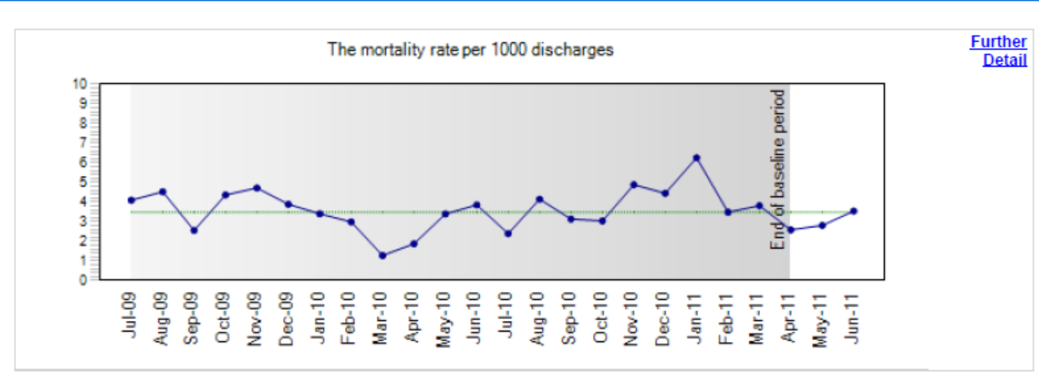


Definition: The number of serious patient safety incidents

Definition Source: Patient Safety

Data Source: Patient Safety

Mortality Rate



Definition: The mortality rate per 1000 discharges

Definition Source:

Data Source: PiMS

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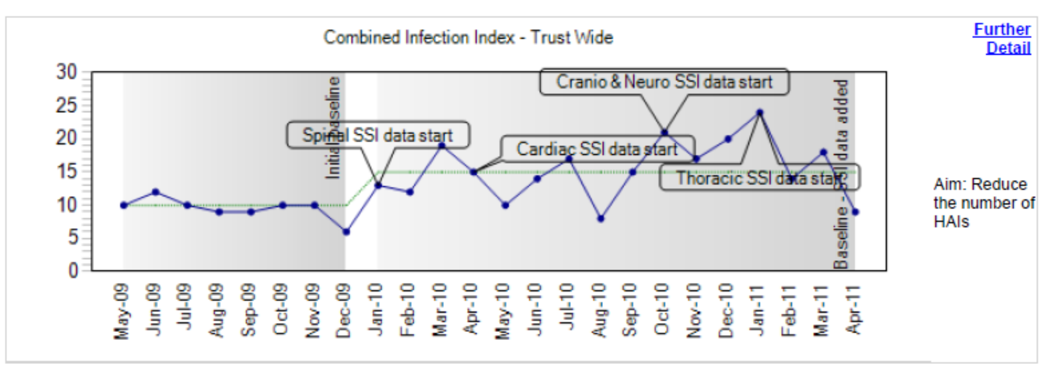
NHS Trust

Zero Harm Trust Dashboard

Combined Infection Index

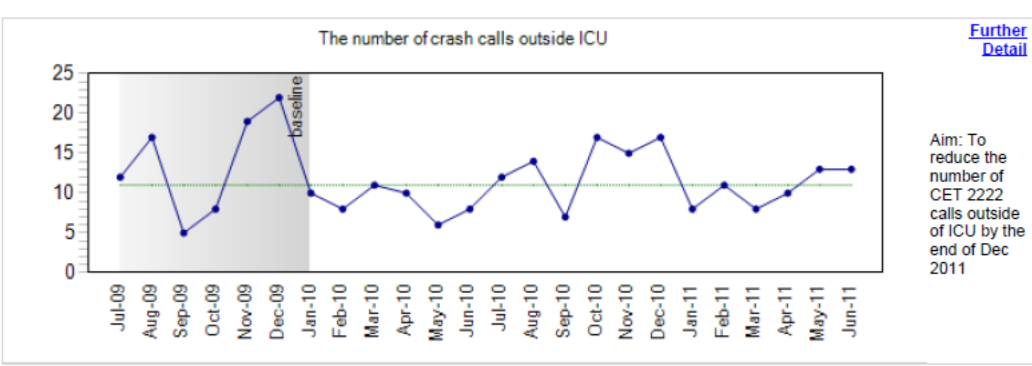


Definition: This index is the combined number of specified hospital acquired infections (HAI). It includes the total number of reported CVL, MRSA, C.Diff and SSIs across the Trust per month, once all infection types have been reported for that month.

Definition Source: Peter Lachman, Associate Medical Director

Data Source: Microbiology, Infection Control

Non-ICU Crash Calls



Definition: The monthly number of crash calls (calls made to the 2222 Clincal Emergency Team) outside of ICU wards

Definition Source: ICON/CET team

Data Source: Clinical Emergency Team

Great Ormond Street NHS Hospital for Children NHS Trust

Patient Stories

Caroline Joyce and Peter Lachman have been researching ways to bring stories to the Board. We believe the stories need to be handled sensitively. The plan is as follows:

1. To develop have a GOSH policy for how we do it at GOSH.

2. To train a small group to take this on

3. To have a gradual developmental approach over the next 6 months.

4. To have the first story at the Board by September or October.

5. We will test having a few stories based on current experience as part of the process at a unit level and then bring to the Board.

Culture

Peter Lachman and Caroline Joyce will be researching the best ways to measure culture. We anticipate this will be a longer term project

Unit Reports

ICI-LM presented their 6 monthly review of the Unit Zero Harm report. This is attached for information.

Peter Lachman
18th July 2011

ICI-LM
Zero Harm
Deep Dive

July 2011

Presented by:

Cathy Cale

Great Ormond Street
Hospital for Children
NHS Trust

Context

- **Zero Harm Deep Dive presented in January 2011**
- **Integration into the Unit and staff engagement**
  - **- Projects spanning all wards and specialties**
  - **- Safety is first on the agenda**
  - **- Dashboard discussed at key meetings**
- **Unit plan reviewed and realigned with Trust priorities**

Great Ormond Street
Hospital for Children
NHS Trust

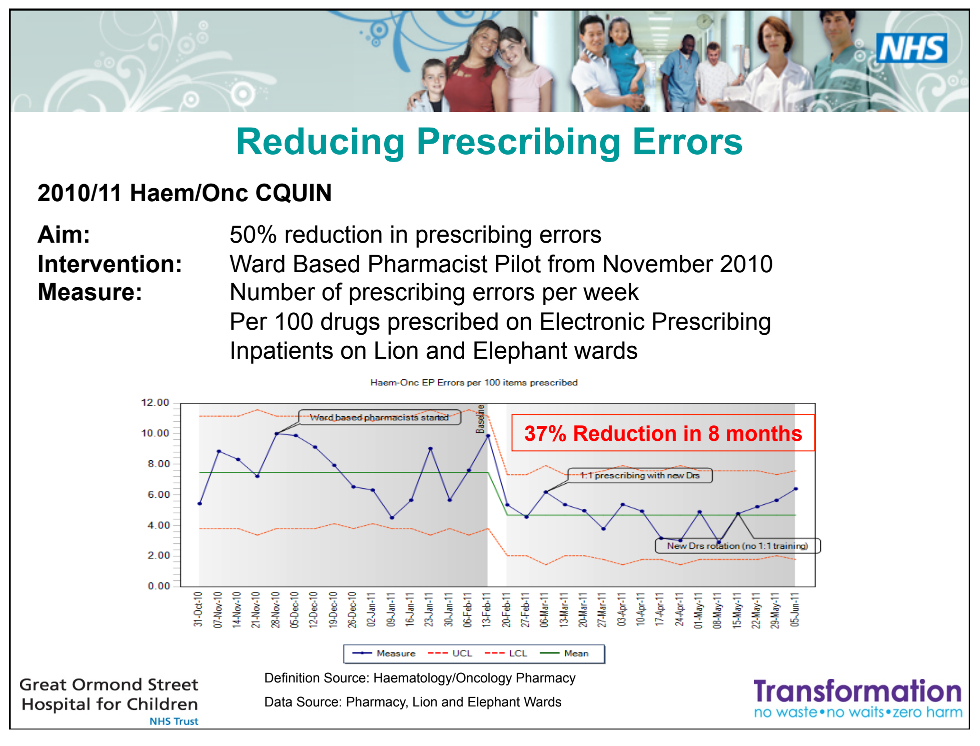
Transformation
no waste•no waits•zero harm

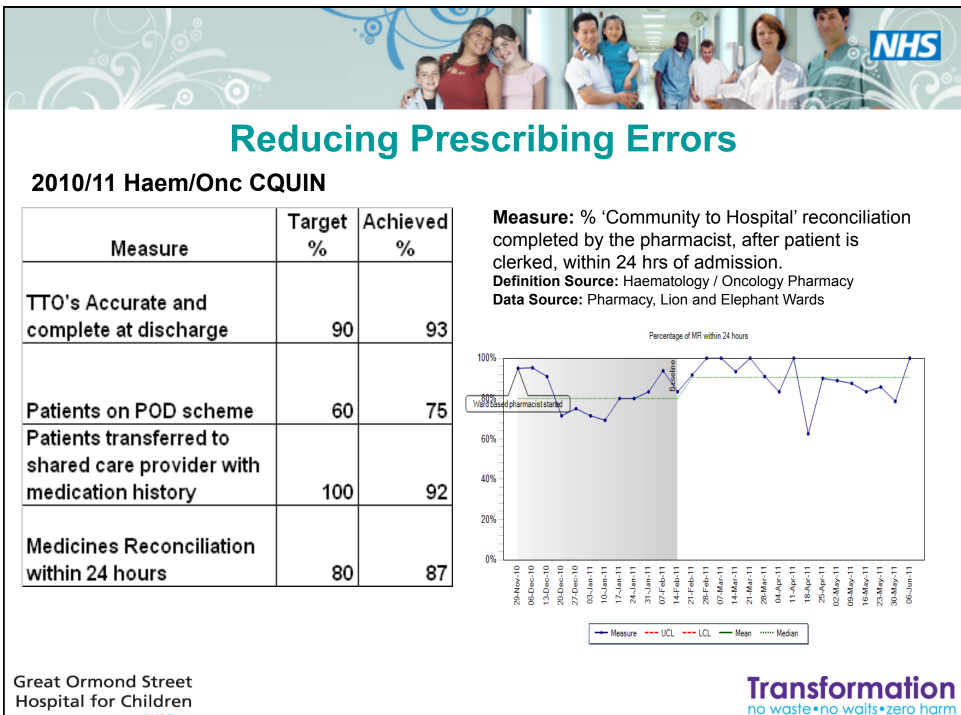
Zero Harm Initiatives

Project	Trust/ Unit Wide	Active/ Early Stage
Reducing Prescribing Errors	Trust	Active
Reducing Administration Errors	Trust	Active
Reducing Infections	Trust	Active
WHO Checklist	Trust	Active
Risk Reporting Process	Trust	Active
Medical Records	Trust	Early
Chemotherapy Administration Process	Unit	Early
LM Dashboard	Unit	Early
RCA for Crash Calls	Trust	Early

Great Ormond Street Hospital for Children NHS Trust

Transformation no waste•no waits•zero harm





Measure	Target %	Achieved %
TTO's Accurate and complete at discharge	90	93
Patients on POD scheme	60	75
Patients transferred to shared care provider with medication history	100	92
Medicines Reconciliation within 24 hours	80	87

Reducing Prescribing and Administration Errors

2011/12 Haem/Onc CQUIN
- All new medical staff to complete 1:1 prescribing training with ward based pharmacists
- Discharge counselling from the ward based pharmacists
- Linked to CIVAS Project

2011/12 BMT CQUIN
- Monitoring usage of anti-fungals for 6 months
- Develop protocol for anti-fungal prescribing in BMT patients

2011/12 BMT QIDIS
- To be approved
- Fox and Robin Wards
- Ward Based Pharmacists, 1:1 prescribing training, reduction in prescribing errors

Administration Errors
- Independent double checking on Robin Ward
- Step-wise roll out across ICI-LM wards

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Transformation
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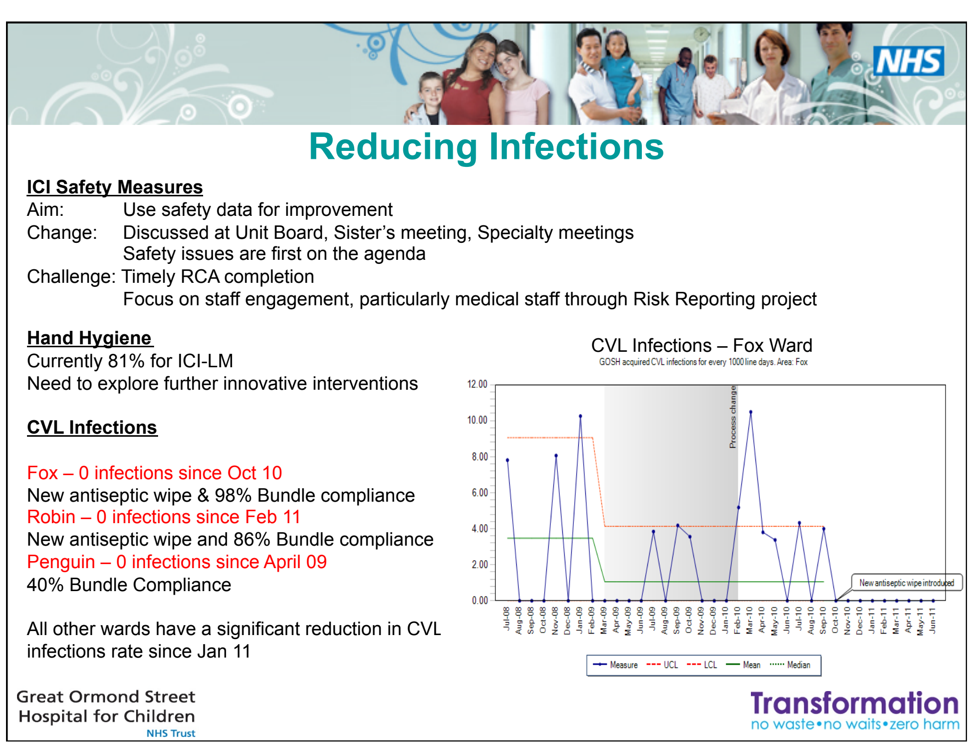

NHS
Reducing Infections
ICI Safety Measures
Aim: Use safety data for improvement
Change: Discussed at Unit Board, Sister's meeting, Specialty meetings
Safety issues are first on the agenda
Challenge: Timely RCA completion
Focus on staff engagement, particularly medical staff through Risk Reporting project
Hand Hygiene
Currently 81% for ICI-LM
Need to explore further innovative interventions
CVL Infections
Fox – 0 infections since Oct 10
New antiseptic wipe & 98% Bundle compliance
Robin – 0 infections since Feb 11
New antiseptic wipe and 86% Bundle compliance
Penguin – 0 infections since April 09
40% Bundle Compliance
All other wards have a significant reduction in CVL infections rate since Jan 11
CVL Infections – Fox Ward
GOSH acquired CVL infections for every 1000 line days. Area: Fox
Process change
New antiseptic wipe introduced
Measure
UCL
LCL
Mean
Median
Great Ormond Street Hospital for Children
NHS Trust
Transformation
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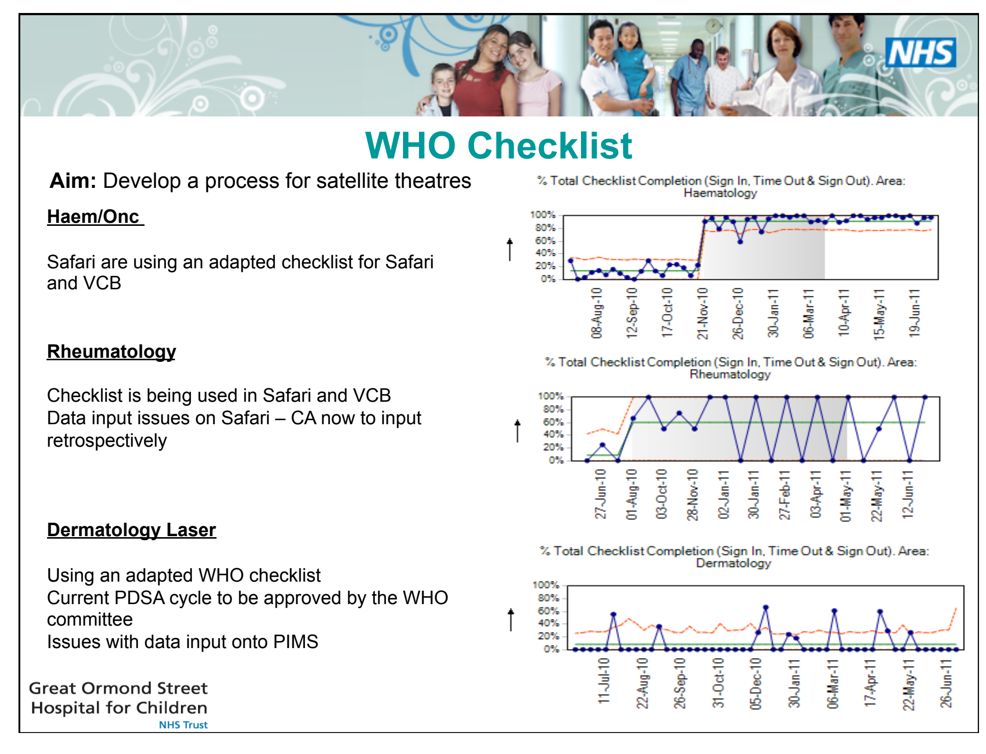

NHS
WHO Checklist
Aim: Develop a process for satellite theatres
Haem/Onc
Safari are using an adapted checklist for Safari and VCB
Rheumatology
Checklist is being used in Safari and VCB
Data input issues on Safari – CA now to input retrospectively
Dermatology Laser
Using an adapted WHO checklist
Current PDSA cycle to be approved by the WHO committee
Issues with data input onto PIMS
% Total Checklist Completion (Sign In, Time Out & Sign Out). Area: Haematology
% Total Checklist Completion (Sign In, Time Out & Sign Out). Area: Rheumatology
% Total Checklist Completion (Sign In, Time Out & Sign Out). Area: Dermatology
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Risk Reporting Process Review

Aim: Improve the risk reporting process and communication of risks within ICI-LM

Achievements
- Efficient RAG meeting
- Membership agreed
- TOR amended
- Action planning for risk mitigation
- Appropriate review of risk grading (High, Medium, Low)

Measures
- No of days to complete RCA
- Timelines for risk downgrading and action completion

Next steps
- PDSA changes to the RAG meeting
- Communicate the risk reporting pathway for all team members
- Ensure RCA completion is communicated within the unit (CVL, Arrests outside ICU)

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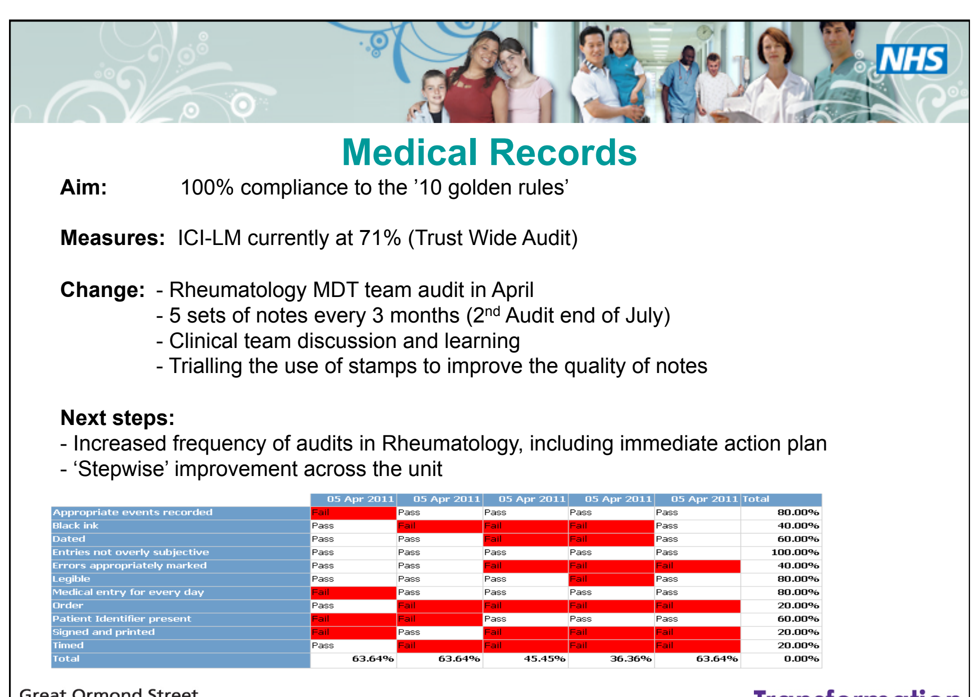
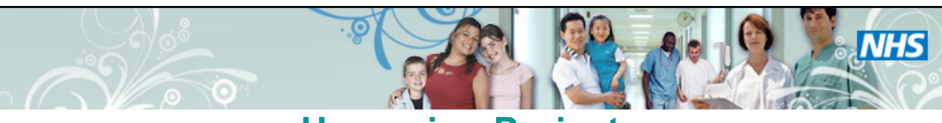


	05 Apr 2011	05 Apr 2011	05 Apr 2011	05 Apr 2011	05 Apr 2011	Total
Appropriate events recorded	Fail	Pass	Pass	Pass	Pass	80.00%
Black ink	Pass	Fail	Fail	Fail	Pass	40.00%
Dated	Pass	Pass	Fail	Fail	Pass	60.00%
Entries not overly subjective	Pass	Pass	Pass	Pass	Pass	100.00%
Errors appropriately marked	Pass	Pass	Fail	Fail	Fail	40.00%
Legible	Pass	Pass	Pass	Fail	Pass	80.00%
Medical entry for every day	Fail	Pass	Pass	Pass	Pass	80.00%
Order	Pass	Fail	Fail	Fail	Fail	20.00%
Patient Identifier present	Fail	Fail	Pass	Pass	Pass	60.00%
Signed and printed	Fail	Pass	Fail	Fail	Fail	20.00%
Timed	Pass	Fail	Fail	Fail	Fail	20.00%
Total	63.64%	63.64%	45.45%	36.36%	63.64%	0.00%



Upcoming Projects

Chemotherapy Administration Process
- Audit of delays presented to Haem/Onc Consultants and Mgmt Meeting
- Project team/ scope established end of July
- Develop a process to reduce delays for patients from admission to administering chemotherapy

Laboratory Medicine Dashboard
- LM Dashboard measures agreed
- Next step is data extraction from new Pathology system

IR Lines List for Haem/ Onc patients
- Reduce CVLs and wait times for insertion and removal of lines
- 1st PDSA cycle underway, ongoing data collection

RCA for Crash Calls
Aim – To ensure that an RCA or debrief is completed for crash calls where deteriorating children were not identified in a timely way

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Lessons Learnt

- Ward based pharmacists are effective in reducing prescribing errors
- 1:1 prescribing training for any new doctor starting on the ward
- WHO Checklist for procedures should be developed by the specialty team and ratified by the WHO checklist group
- Challenge to enter WHO checklist data onto PIMS without the ODP/ Scrub Nurse
- MDT Medical record audits offer effective peer review
- Zero CVL infections on Fox/ Robin due to good bundle compliance despite the high number of line days

Great Ormond Street Hospital for Children NHS Trust

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Great Ormond Street Hospital for Children NHS Trust

<table>
<tr><td colspan="2">Trust Board
27 July 2011</td></tr>
<tr><td>Title of document:
Foundation Trust application:
Board self-certification statements

Submitted on behalf of:
Fiona Dalton</td><td>Paper No: Attachment O</td></tr>
<tr><td colspan="2">Aims / summary
The Trust Board is required to make formal statements in support of its application to become a foundation trust relating to:
• Clinical quality
• Service performance
• Risk management
• Board roles and capacity

The attached document updates the version approved by Trust Board in March 2011. The main changes are:
• Statement 1 – includes references to Monitor’s Quality Governance framework, and the Trust’s analysis of complaints and serious incidents.
• Statement 3 – references to Haringey deleted.
• Statement 8 – failure to achieve level 2 compliance against the information governance requirements refers specifically to staff training.</td></tr>
<tr><td colspan="2">Action required from the meeting
To approve the revised statements.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
Achievement of Trust objective to secure Foundation Trust status</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?
Not required.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision Not required</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Sven Bunn, FT Programme Manager</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Jane Collins, Chief Executive</td></tr>
<tr><td colspan="2">Author and date
Sven Bunn
18 July 2011</td></tr>
</table>

Clinical quality, service performance, risk management and board roles and capacity

BOARD STATEMENT

CLINICAL QUALITY

1.The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its aspirant NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients;

To the best of its knowledge and using its own processes, the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements;

Evidence:

In April 2010, GOSH was registered under the health and Adult Social care Act Regulations 2010 for the following services: Diagnostic & Screening procedures; Treatment of disease, disorder and injury; Surgical Procedures and Transport. This registration was renewed in April 2011.

The Trust has identified leads for each of the standards and is in the process of ensuring that relevant subcommittees monitor compliance with the standards at an operational level.

A database has been established to document compliance with the standards – this includes reporting of risk/ incident information as well as assurances from internal and external audits. The assurance framework risks are mapped to the relevant standards and work is underway to map the local and national targets to these standards.

The Risk, Assurance and Compliance Group (formerly the Assurance Framework Group) reviews the assurance framework to ensure that risks have appropriate action plans in place, that these plans are being implemented and completed, and that compliance with CQC, NHSLA and health & safety standards are being maintained.

The Trust's performance management process ensures that performance against risks, targets, objectives and regulatory standards are monitored through structured review and the use of KPIs where appropriate.

Overview reports on compliance are reported to the Audit Committee and Clinical Governance Committee and a summary at Trust Board.

2. Processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

Evidence:

The Trust's recruitment and selection policy sets out the arrangements for the pre-employment checking of registration requirements for all clinical staff, including consultants and other doctors.

The application of the Consultant & Specialty Doctor Appraisal Policy and the Professional Registration Policy ensures on-going compliance with registration and revalidation requirements.

Assurance evidence is demonstrated by the following systems; recruitment KPIs, professional registration reports, recruitment activity reports, audits (including London Consortium (internal), Home Office, CRB and Deloittes), NHSLA assessments, appraisal rates and completed recruitment paperwork.

SERVICE PERFORMANCE

3. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and commits to comply with all known targets going forwards.

Evidence:

- Performance strategy implemented.
- Monthly Key Performance Indicator (KPI) report to Management Board and Trust Board providing performance analysis against national, commissioner and internally defined performance indicators and standards.
- Monthly commissioner report providing performance analysis against agreed operational standards.
- Management Board 'Deep Dive' analysis reports on specific key performance issues.
- Quarterly clinical unit strategic review meetings.
- Monthly clinical unit management board meetings will include unit performance issues.
- Weekly Chief Operating Officer (COO) led operational meetings addresses specific key performance issues at a clinical unit level as required.
- Fortnightly Clinical Unit 18 week Referral to Treatment time (RTT) operational meetings.
- Specific reports to the Trust Board (September 2010 and March 2011) on performance against the c. diff. target.
- Quarterly monitoring of national and local targets through KPI report to the Trust Assurance Committees.
- Clear reporting lines in place between speciality, units and senior management.
- Clear reporting lines between subcommittees and Board committees.

OTHER RISK MANAGEMENT PROCESSES

4. Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;

Evidence:

External and internal audit reports and other external party reports (including learning from other trust investigations) are reported to the Assurance Framework Group for assurance on development of action plans.

The recommendations and actions from these are used to inform and update the assurance framework risks and also compliance with the CQC standards.

The Trust currently holds level 2 against the NHSLA Risk Management Standards which have been mapped to the CQC registration requirements to provide additional assurance of compliance where appropriate.

Recommendations from these reports are considered by the relevant Trust Board assurance committees (Audit Committee and/ or Clinical Governance Committee) and the minutes of these committees shared between them and with the Trust Board. In some cases, where required by external parties or for approval purposes, a summary of findings are also reported to the Trust Board.

5. All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;

Evidence:

The Audit Committee uses an action and decision log to monitor progress with actions from previous meetings. The final minutes of the Audit Committee are sent to the Trust Board for information. As the Audit Committee meets quarterly, the Audit Committee Chair provides a brief overview of matters considered and assurances sought and received at the Trust Board immediately following the most recent Audit Committee meeting.

6. The necessary planning, performance management and risk management processes are in place to deliver the business plan;

Evidence:

- Business planning strategy implemented.
- Trust strategy and annual plan considered within the context of the Monitor's Annual Planning requirements for Foundation Trusts.
- Executive leads in place for all objectives and risks to objectives.
- Clinical unit local annual plans based on Trust strategic objectives.
- Monthly Key Performance Indicator (KPI) report to Management Board and Trust Board providing performance analysis against prioritised workstreams

to deliver strategic objectives.
- Bi-annual detailed analysis of progress against delivering strategic objectives to Management Board and Trust Board.
- Strategic review meetings undertaken with clinical units on a quarterly basis to monitor progress against annual plans and risks.
- Weekly Monday morning executive meetings to discuss forthcoming issues and risks.
- Trust assurance framework monitors high level risks against trust objectives.
- Clinical Governance Committee and Audit Committee seek assurance of controls against the strategic risks at each meeting.
- Clear reporting lines in place between speciality, units and senior management.
- Clear reporting lines between subcommittees and Board committees.

7. A Statement on Internal Control ("SIC") is in place, and the aspirant NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury (http://www.hm-treasury.gov.uk);

Evidence:

The most recent Statement on Internal Control (2009/10) is supported by the Head of Internal Audit Opinion and published in the Annual Report 2009/10.

8. The Trust has achieved a minimum of Level 2 performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit;

Evidence:

The Trust achieved a minimum of level 2 against all IGSOC requirements as part of the last submission in March 2010.

Due to the more demanding nature of the requirement in IG version 9, the Trust is not currently compliant with the level 2 requirement for information governance training for staff. Current performance against this measure is 84.5% (July 2011) compared with a target of 95% of all staff. A training programme is in place to achieve this requirement.

9. All key risks to compliance with their Authorisation have been identified and addressed.

Evidence:

- Board memorandum on quality governance.
- Integrated business plan.
- FT application risk register.

BOARD ROLES, STRUCTURES AND CAPACITY

10. The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board.

Evidence:

- Directors are required to declare any pecuniary, personal or family interest, whether that interest is direct or indirect, in any proposed contract or other matter that is under consideration or is to be considered by the Board of Directors. A family interest will include those of a director's spouse or partner. Any directors appointed subsequently shall declare such interests on appointment.
- A register of such interests will be retained by the Company Secretary.
- These requirements are laid down in the Board of Directors' Standing Orders
- The Directors' induction process will provide further details and an opportunity to discuss any such conflicts.
- Directors will be asked to declare any new conflicts arising at the beginning of each meeting.

11. The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

Evidence:

- Review of Executive Director job descriptions in line with Monitor example board job descriptions
- Appraisal of Executive Directors
- Skills analysis of Board members
- Development of competency requirements for Executive Directors
- Training database held for executive directors and non executive directors
- Regular reminders of forthcoming seminars, courses and conferences circulated by the Executive Offices to Board members.

12. The selection process and training programmes in place ensure that the non executive directors have appropriate experience and skills.

Evidence:

- Review of Non Executive Director job descriptions in line with Monitor example board job descriptions
- Appraisal of Non Executive Directors
- Skills analysis of Board members
- Development of competency requirements for Non Executive Directors
- Induction programme in place for non executive directors

13. The management team have the capability and experience necessary to deliver the business plan

Evidence:

- Executive skills analysis undertaken in October 2010 to review capability and experience of Board members
- Executives and senior managers appointed against reviewed job descriptions and person specifications and appointed subject to consultation and necessary testing of skills
- Annual appraisal of executive directors by the Chief Executive and non executive directors by the Chair
- Chief executive holds one-to-one meetings on a monthly basis with executive directors
- Senior manager performance reviewed as part of clinical unit performance reviews and appraised on an annual basis.
- Recent restructuring of specific departments to ensure appropriate capacity is available – research and innovation and transformation team

14. The management structure in place is adequate to deliver the business plan

Evidence:

- Business planning process in place – regular monitoring via performance report to Management Board and Trust Board
- Strategic review meetings undertaken with clinical units on a quarterly basis
- Executive leads in place for all objectives and risks to objectives
- Bi-weekly review lead by Chief Executive
- Weekly Monday morning executive meetings to discuss forthcoming issues and risks
- Risk, Assurance and Compliance Group meets regularly to review risks and take necessary actions
- Clinical Governance Committee and Audit Committee seek assurance of controls against the strategic risks at each meeting
- Clear reporting lines in place between speciality, units and senior management
- Clear reporting lines between subcommittees and Board committees

Signed for and on behalf of the board:

Title:

Date: **27 July 2011**

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

Great Ormond Street Hospital for Children NHS Trust

Trust Board
27 July 2011

Title of document: Foundation Trust application: Quality governance board memorandum **Submitted on behalf of:** Fiona Dalton	**Paper No: Attachment P**

Aims / summary
In support of its foundation trust application, the Trust Board is required to prepare and approve a quality governance board memorandum. This states that the trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

The attached document updates the quality governance board memorandum approved by Trust Board in March 2011. The main changes are:

- Page 4 – updated quality objectives to reflect the 2011/12 Annual Plan.
- Page 13 – updated to include information from the 2010/11 annual patient and family survey.
- Page 15 – updated list of KPIs
- Pages 16-17 – latest data used for quality improvement examples.

Action required from the meeting
To approve the revised board memorandum.

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?
Not required.

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
18 July 2011

Attachment P
DRAFT

Monitor – Independent Regulator of NHS foundation trusts
4 Matthew Parker Street
London
SW1H 9NP

27 July 2011

Quality Governance

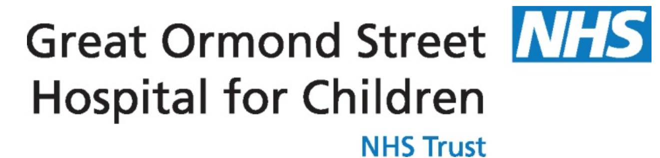
In connection with the application of Great Ormond Street Hospital for Children NHS Trust for NHS foundation trust status, the board of directors confirm that:

- The board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients, including:
  - Ensuring required standards are achieved (internal and external)
  - Investigating and taking action on substandard performance
  - Planning and managing continuous improvement
  - Identifying, sharing and ensuring delivery of best-practice
  - Identifying and managing risks to quality of care

- This encompasses an assurance that due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans) and that processes are in place to monitor their ongoing impact on quality and take subsequent action as necessary to ensure quality is maintained.

The basis of the board of directors' confirmation is set out in the attached board memorandum, dated 27 July 2011.

For and on behalf of the board of directors
Great Ormond Street Hospital for Children NHS Trust



Board memorandum on quality governance

1 Executive summary and conclusion

Our mission is:

- To deliver world class clinical care to the children we treat.
- To undertake new research which will lead to new and improved treatments for children everywhere
- To share our expertise through education and the training of children's healthcare professionals so that more children benefit from our work and reciprocally to learn from the paediatric breakthroughs achieved by other institutions.

At Great Ormond Street Hospital for Children (GOSH) we place quality at the top of our agenda. We set our standards high - we aim to be within the top five children's hospitals in terms of service delivery, research and patient experience.

To achieve and maintain excellent service provision, we have internal processes to check that we meet both our own internal quality standards and those set nationally.

Key performance indicators relating to each of the Trust's strategic objectives are presented, on a monthly basis, to the Trust Executive and Management Boards. This includes progress against external targets such as how we keep our hospital clean, the effectiveness of actions to reduce infection and ensure patients have access to our services when they need them.

Each specialty and clinical unit has an internal monitoring structure so that teams can regularly review their progress and identify areas where improvements may be required. This information links into the wider Trust governance framework where the units report on the progress of the care they provide at least once a year.

These updates are recorded through the quarterly strategic performance reviews and the committee structure of the Trust to ensure the quality of service delivery and monitoring is discussed and acted upon at the appropriate level within the Trust.

This is further supported by the use of specific, measurable targets.

Delivery of healthcare is not risk free and the Trust has a robust system for ensuring that the care delivered by our services is as safe and effective as possible. Our process has been externally assessed and we achieved level two in the National Health Service Litigation Risk Management Standards in November 2009.

Unless events are reported when the outcome of care is not as expected, the Trust cannot learn and make improvements. A good safety culture is one with high levels of reporting and where the severity of the event is low. The National Patient Safety Agency has consistently identified the Trust as meeting these criteria. Analysis of the types of risks identified by staff are incorporated into our assurance process to ensure management, performance and safety are closely aligned.

Through these methods, GOSH reviews all the data available on the quality of care in each of our specialties and services as part of our internal and external management and assurance process.

2 *Strategy*

Does quality drive the trust's strategy?

Description of Board's quality strategy:
The Trust's strategic priorities are to:

- Consistently deliver clinical outcomes that place us amongst top 5 Children's Hospitals in the world.
- Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations.
- Successfully deliver our clinical growth strategy.
- 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.
- To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK.
- Deliver a financially stable organisation.
- Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation.

The Trust's Quality Strategy defines how GOSH will deliver its principal objectives to provide safe, effective and timely care for patients and to enhance the experience of children, young persons and their families who use our services.

Our aim is to deliver the right care, at the right time in the right way, by well-trained and competent staff within a framework of integrated governance and safe systems.

The strategy sets out effective arrangements for monitoring and improving quality and safety. This includes defining the baseline from which improvement can be identified, the systems to monitor performance (against agreed quality standards, whether internal or externally driven), and the processes to identify failure. We use our governance and monitoring systems to manage performance.

Our quality strategy is based on high reliability theory, available evidence, national strategies and local needs determined at GOSH via the paediatric trigger tool, risk reports and patient experience. The strategy incorporates the aims as set out in the national campaign "Patient Safety First", as adapted for children.

Based on this evidence, the following programmes of work have been developed and implemented:

- Leadership for safety (Executive WalkRound™, Safety on the Board agenda, Safety climate and culture surveys)
- High-risk medications (Medicines management, focusing on prescribing, dispensing, administration and reconciliation)
- Peri-operative care (Briefing, WHO checklist, surgical site infections)
- Critical care (reduction in ventilator associated pneumonia and central line infections).
- Deteriorating patient (intensive care outreach (ICON), communication tools (SBARD), early warning scores (CEWS).
- Root cause analysis for serious untoward incidents
- Human factors training

Detail of quality goals and how they have been developed and communicated across the trust:
Specific goals have been set in the annual plan:

- Maintain our focus on Zero Harm
    - Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.
    - Continue our work to reduce 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.
    - Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.
    - Develop and monitor new structure for managing and learning from Serious Incidents (SIs)
    - Ensure effective provision of nutritional care for all patients
    - Ensure provision of safe services for the deteriorating and critically ill child.
- Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes:
    - Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations
    - Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly

Our goals have been communicated throughout the Trust through regular articles in the internal newsletter “Roundabout”, the transformation intranet site, and by participation in specific transformation projects.

B) Is the Board sufficiently aware of potential risks to quality?

The Trust’s approach to achieving efficiency improvements is based on the principle that providing high quality care provided in a timely manner also delivers cost effective care. We aim to give every patient the right high quality treatment first time, every time. Complications and sub optimal care lead to increased resources and hence cost in a patient pathway.

Description of Board’s approach to assessing initiatives for their impact on quality:
Our approach to risk management is set out in the Risk Management strategy. The strategy identifies:

- the organisational structure and reporting systems for the management of risk;
- the duties, scope, responsibility, accountability and authority of individuals, teams, departments, committees and subgroups;
- requirements for local management of risk to reflect this strategy and the link into existing committee structures, business monitoring and assurance processes;
- the management tools which enable the Trust to assess its risks systematically at strategic and operational levels, document the outcome of risk assessment and improve transparency of decision making;
- the process to ensure consideration of risks and options of managing them is integrated into the wider management and commercial processes of the Trust;
- the process to ensure regular review and monitoring of required actions;
- the process for monitoring compliance with the strategy at strategic and local level and to remedy any deficiencies identified;

- the process to disseminate the strategy and share lessons learned.

Description of how the Board is assured that the CIPs do not compromise the trust's ability to meet required quality standards; **description of how financial and operational initiatives are monitored for ongoing impact on quality (e.g. service redesigns, service developments):**
The risk management strategy is integrated into the management, performance monitoring and assurance systems of the Trust to ensure that safety and improvement is embedded in all elements of the Trust's work and business development. This enables early identification of factors whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring care is provided in a safe and cost effective way. It provides the framework within which risk can be managed and reduced regardless of source.

The Trust is committed to this positive approach to the consistent management of risk, where managing for safety, in a culture that is open and fair, supports learning, innovation and good practice for the benefit of the child.

The Board Assurance Framework (BAF) provides a record of the principal risks to the Trust achieving its strategic objectives. It is informed by the Trust risk register as well as internal, external and strategic risks which may affect the Trust's business. The BAF includes all risks, including service developments and CRES plans, identified by the Executive Team or any additional source where local controls are not sufficient to manage the risk.

The operational management of the Assurance Framework is delegated to the Risk, Assurance and Compliance Group which is chaired by the Chief Operating Officer, meets every six weeks and reports back to the Audit Committee and/or the Clinical Governance Committee depending on the specific issues raised.

One of the Co-Medical Directors and the Chief Nurse are members of the CRES (CIP) steering board. Their role includes the review of CRES schemes to ensure that they do not adversely affect safety. At clinical unit level, the CRES programme is lead by the clinical unit chair and head of nursing with the general manager, so that any risks to patient safety can be identified and addressed.

3 Capabilities and culture

A) Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?

Overview of leadership arrangements:
The Trust Board comprises six executive directors (Chief Executive, Chief Finance Officer, Deputy CEO/Chief Operating Office, Chief Nurse and two Co-Medical Directors that share a single vote) and five non-executive directors plus a Chairman. There are four further non-voting Directors (Information and Communication Technology, Redevelopment, International and Research and Development). These non-voting Directors attend Board meetings as required.

The Board currently meets ten times a year – eight times for formal meetings and twice informally to review its strategy.

The Trust has reviewed its current governance arrangements against the Monitor Code of Governance and the requirements of the Combined Code.

Non-Executive Directors chair each of the Board sub-committees (Audit Committee and Clinical Governance Committee), and membership of committees is based on the experience and skills of Non-Executive Directors and the portfolio of Executive Directors. The Trust's Non-Executive Directors have varied backgrounds and collectively bring a wide range of commercial, financial, clinical, political, corporate governance, advocacy and legal experience.

A review of required skills and experience is carried out to assist with succession planning before non-executive director terms of office are completed, or the retirement or resignation of executive directors.

Skills assessment review:
The Trust Board completed the NHS Institute's self assessment Board Development Tool between January and March 2010. The tool focused on the Board's performance in relation to emphasis on core business, delivery, effective teamworking, engagement with stakeholders and leadership of the Board. The findings from the assessment were extremely positive, with the Trust Board agreeing to specific actions to further improve performance, including:

- development of a strategic scorecard,
- enhanced engagement with staff,
- alignment of research and development outputs with strategic priorities of the Trust.

These actions were completed by January 2011.

The board holds all day strategic planning sessions two times a year, and half day training and development sessions eight times a year.

Description of board's approach to challenging quality performance:
The Board monitors the Trust's performance through the monthly KPI Report and Business Assurance Framework.

Each meeting of the Trust Board and Management Board receives a KPI report. The format and content of the KPI report is iterative, based on feedback from executives and Board members. The overall structure of the KPI report relates to the Trust's seven strategic priorities, each of which has identified deliverables, actions and targets / outcome measures. These strategic priorities drive the performance management framework.

For each strategic objective, the Trust has identified targets and outcome measures which comprise both national, CQUIN, contractual and internal targets.

Each strategic objective and the associated metrics form a section of the performance report. Identified metrics are assigned an executive lead and are RAG rated within the KPI report.

Performance against targets is represented in graphs within the KPI report, including targets and tolerances where these are applicable to the metrics.

B) Does the Board promote a quality-focused culture throughout the trust?

Explanation of the mechanisms used to drive quality agenda and promote an open culture:
The Trust Board, through its policies ("Being Open", "Incident Reporting and Management", "Raising Concerns in the Workplace"), encourages staff to always be as open and honest as

possible. All communication with families and other relevant parties should be clear and honest and should occur in a timely fashion.

Staff are required to report any incident, defined as any event or circumstance that could have or did lead to unintended or unexpected, harm, loss or damage. These may be clinical or non clinical events and can affect staff patients or visitors while on the Trust premises.

The Trust is committed to meaningful and effective communication with its staff and encourages a climate of openness and honesty in all of its services and business dealings. Individual members of staff are encouraged to raise with their manager(s) any matters of concern that they may have about health care issues related to the delivery of care or service to a patient or any concern relating to the possible existence of fraud or corruption in the Trust.

Harassment or victimisation of any member of staff raising a genuine concern will not be tolerated.

It is recognised that a member of staff may wish to raise a concern in confidence. If a staff member asks the Trust to protect their identity by keeping their confidence, the Trust will endeavour to do everything it can to do so.

Description of how the trust learns from incidents and complaints:
A root cause analysis (RCA) investigation will be held for all Serious Untoward Incidents (SUIs). The decision to undertake a root cause analysis for incidents not reportable as SUIs will be taken by the Head of Clinical Governance and Patient Safety, in discussion with senior clinicians and managers within the relevant specialty. An RCA investigation aims to identify the true cause of a problem and the actions that are necessary to either eliminate or significantly reduce the risk.

A concise RCA may be carried out for incidents which are not reportable as SUIs. Such incidents may include incidents of a moderate severity or near misses. The purpose of the concise RCA is to assist in departmental and organisational learning.

The Clinical Governance & Patient Safety Team compiles summaries of all reported incidents. Managers will use the reports identifying learning which are submitted to the Quality and Safety Committee and other Trust Committees to identify relevant learning points from incidents in other areas, and ensure these are discussed in their local Risk Action Group in conjunction with learning identified from complaints or claims.

For lower risk incidents, local managers are responsible for identifying relevant learning and ensuring that appropriate action is taken to prevent these incidents locally. The Quality and Safety committee receives a summary report each month of all incidents reported and key incident trends. This report is used at the local Risk Action Group to ensure that actions have been taken to reduce the risk of reoccurrence.

For higher risk incidents, the actions arising from investigations will be submitted to the Quality and Safety committee for discussion and approval. The Quality and Safety Committee will monitor progress against actions plans.

In addition to the Quality and Safety Committee there are other groups and committees in the Trust who have a role in ensuring that lessons learned as a result of incidents, or the aggregated analysis of incidents, complaints and claims are shared and actioned. These groups include but are not limited to:

- Risk Action Groups
- Clinical Unit Boards

- Specialty Meetings
- Clinical Practice Committee
- Records Management Committee
- Blood Transfusion Committee
- Drugs and Therapeutics Committee
- Clinical Ethics Committee
- Radiation Protection Committee
- Infection Control Committee
- Nursing Practice Educators Group
- Resuscitation Committee

The Trust identifies opportunities to share learning from incidents, complaints and claims (or the aggregation of these) with other Trusts and agencies.

4 Processes and structures

A) Are there clear roles and accountabilities in relation to quality governance?

Description of roles and committee structures and how responsibilities are cascaded through the organisation:

Trust Board
The Quality Strategy commits the Trust Board to:

- Spend more than 25% of its time on quality issues.
- Receive and discuss a formal quality and safety report not only a risk report.
- Interact with medical and clinical staff on the quality strategy.
- Listen to patient stories.
- Focus the senior executives' goals on quality performance.
- Identify the Executive Lead for quality.
- Set the Strategic Objectives to identify and give direction to the Trust approach to improving quality and the time scale in which these will be reviewed and updated
- Approve the metrics by which quality in terms of clinical outcomes, patient/service user safety and experience, and the expected levels of performance will be monitored;
- Ensure systems are in place to analyse this data to ensure an integrated approach to safety and quality improvement.
- Ensure that systems are in place to continuously improve quality and address any deficits identified.
- Monitor compliance with Trust objectives, healthcare targets, national standards and all relevant legislation including requirements of the Care Quality Commission and Monitor.
- Ensure systems are in place to identify, control and manage risks regardless of source.
- Maintain systems to monitor and report on improving and maintaining the patient and stakeholder environment including cleanliness, infection control and facilities;
- Establish and develop procedures to review and challenge performance at all levels of the organisation on an ongoing basis.
- Maintain a programme of internal audit review / independent assurance to consider all aspects of the Trusts work.
- Establish a management structure to ensure it receives assurance on each of these aspects either directly or by delegation to specific committees or officers of the Trust.
- Ensure the Trust's education & training portfolio consistently meets the needs of the quality agenda influencing content where appropriate.

- Ensure the Trust's research and development programme consistently meets the needs of the quality agenda influencing content where appropriate.

Trust Committees
The Trust Board is supported by the following three sub-committees:

- The Audit Committee comprises three Non-Executive Directors and an independent advisor. It oversees the integrated governance processes of the Trust – except where they relate to clinical governance. It also has a responsibility to ensure the integrity of the Trust's annual accounts and reviews the outputs from the external and internal auditors. The committee also reviews non clinical risk and the assurance available to the Board on such risks.
- The Clinical Governance Committee comprises three Non-Executive Directors, executive directors and senior managers. It has delegated authority from the Trust Board to be assured that the correct structure, systems and processes are in place within the Trust to manage clinical governance and that these are monitored appropriately.
- The Management Board is chaired by the Chief Executive and has delegated authority from Trust Board to oversee the operational management of the Trust.

In addition, the Quality and Safety Committee oversees safety management and quality initiatives to improve safety across the Trust. It reports directly to Management Board and to the Clinical Governance Committee.

Board Chairman & Non Executive Directors
The Chairman and Non Executive Directors will ensure through the reporting schedule to the Board that they receive appropriate levels of information to enable them to assess whether a quality service is being delivered. They hold the Chief Executive and Executive Directors to account, using their specific knowledge and expertise to challenge quality of care from a patient perspective. This will include consideration of the impact of trust objectives and service delivery on patient experience.

Chief Executive Officer
The Chief Executive is ultimately responsible and accountable for the quality of care delivered. She will ensure the appropriate resourcing, management and reporting structures are in place to deliver the quality agenda through the Trust Objectives and management structure. She will delegate specific roles and responsibilities to the appointed Executive Directors to ensure all quality and improvement work is co-ordinated and implemented equitably to meet the Trust objectives safely without detriment to patient care.

Executive Directors
Executive Directors are accountable for the delivery of quality services in the areas within their remit whether clinical or operational. They will ensure the quality agenda is effectively co-ordinated, resourced and implemented across the Trust in an integrated way. They will ensure actions taken to improve the quality of service delivery are completed, measured and shared to promote learning. In addition, the Chief Finance Officer will ensure appropriate resources for quality improvement where deficits are identified according to priorities set by the Board. Executive Directors are accountable for ensuring that the potential affect on the quality of service delivery is risk assessed prior to approval of any new business proposal. They will ensure that the infrastructure to enable staff to deliver high quality care within their areas of responsibility is in place.

Director of Nursing and Co-Medical Directors
The Director of Nursing has the responsibility to ensure nurses and allied professionals are focussed on quality and safety and participate in the quality programme.

The Co-Medical Directors have the responsibility for patient safety and to ensure quality and the best possible clinical outcomes, as well as to enable medical staff to achieve better outcomes and a safe service.

Clinical Units and Corporate Departments
Each clinical unit and corporate department have inclusive systems in place to ensure that all aspects of their work are subject to regular review across all specialties and teams. This will be identified within their documented governance structure and reflect the Trust requirement for specified outcomes for each aspect of service provision.

Senior Operational Managers
All Senior Managers will ensure systems are in place to implement and monitor programmes of quality improvement within their areas of responsibility in line with the Trust priorities. They will also ensure regular and adequate user feedback. They will comply with the reporting and governance requirements to ensure learning is shared across the organisation. They will monitor their staff and service compliance against identified standards and safe systems of work whether set nationally, professionally or within Trust policy, procedures and guidelines.

All Staff
All staff are accountable for the quality of services they deliver. They will comply with identified standards and safe systems of work specific to their roles, whether identified in national, professional or Trust policy, procedures, and guidelines. They will report quality issues however caused through identified channels to ensure prompt action can be taken using existing reporting systems within the Trust.

B) Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?

Description of arrangements in place to escalate issues:
The Trust has developed a comprehensive Key Performance Indicator (KPI) report to monitor progress against the priority objectives and the supporting work streams to deliver these - in addition to work that ensures the Trust continues to meet and remains compliant with the range of external reviews, targets and contractual standards. These include:

- CQC registration
- NHS Litigation Authority standards and assessment
- Information Governance Toolkit
- Independently commissioned Patient Surveys
- Commissioning of Quality and Innovation (CQUIN) and contractual standards
- Quality Account
- Monitor compliance framework

The performance framework will continue to develop to reflect changes to external policy and priorities throughout the year. The KPI report will additionally identify comparative data of other specialist paediatric trusts, where available, to benchmark performance.

Management Board will approve the monthly KPI report and identify remedial actions to address areas of poor performance. Management Board will also receive 'deep dive' analysis reports and presentations on areas of specific concern on an ad hoc basis. These reports are produced by relevant department / service leads.

Clinical Units develop local Annual Plans, detailing how they will meet the Trust objectives. Progress against plans and performance against key internal and external standards and

targets are monitored through Quarterly Strategic Performance Review meetings. These meetings are attended by Clinical Unit leads, Executive Team members and Heads of Department.

Lead commissioners will receive performance reports on agreed contractual and CQUIN measures.

Management of staff performance
The Trust's policy for managing staff performance sets out the actions to be taken when a member of staff fails to reach the performance standards or expectations required of them in their job role. In the event that a member of staff is under performing the manager will be required to discuss the reasons for this and provide support where possible, in order to assist them in reaching the required level of competence and performance. The aims of the policy are to:

- Assist members of staff to improve their performance, wherever possible, when such deficiencies exist
- Help managers to address performance shortfalls quickly and effectively in order to ensure the efficiency and quality of the services provided by the Trust
- Provide a fair and consistent means for managers to deal with performance issues without employing the formal disciplinary procedure
- Provide a foundation of evidence / information to be used during the formal disciplinary or attendance / absence processes should the poor performance issues continue or reoccur.

Description of how staff can raise concerns and issues:
Staff are encouraged to raise any issues or concerns with their manager. Managers should always:

- Take concerns seriously
- Consider them fully and sympathetically
- Recognise that raising a concern can be a difficult experience for some staff
- Seek advice from healthcare service professionals where appropriate.

Where a staff concern can be acted upon, action should be taken promptly and the member of staff notified quickly of the action taken. Where action is not considered practical or appropriate, the individual member of staff should be given a prompt and thorough explanation of the reason for this. They should also be told what further action is available under local procedures.

Where a member of staff feels it is inappropriate to raise a matter informally or is dissatisfied with the outcome they may register their concern formally through a formal procedure. This procedure allows for the matter to be heard by a Designated Officer (a Non Executive Director), to whom matters unresolved by immediate line managers can be referred directly by the member of staff concerned. If the member of staff remains dissatisfied or if they feel that the concerns being raised are so serious that they need to be handled outside the usual line management chain, the matter may be referred to the Chairman of the Trust Board.

Approach to clinical audit and how information is used to drive quality:
The annual clinical audit plan sets out the range of clinical audits required to address risk and patient safety priorities. The plan is approved by the Quality and Safety Committee.

The plan includes audits which cover:

- National schemes that the Trust must participate in (e.g. NICE reviews, NCEPOD)
- Trust patient safety objectives
- Supporting information required for Care Quality Commission registration

- NHLSA standards
- NPSA alerts where compliance testing is recommended by the Risk Management team
- Clinicians' individual interests. Each specialty is required to identify at least one audit that it will be completed in the year

Internal audit approach to quality governance arrangements:
The Director of Audit produces a three year strategic audit plan which is agreed by the Audit Committee. The annual operational audit plan is derived from the strategic plan and the Board Assurance Framework

The internal audit team's work focuses on four key areas:

- the Trust's core financial systems
- other systems (including IT and Information Governance systems)
- corporate governance and the Board Assurance Framework
- operational reviews

The Director of Audit prepares a progress report for the Audit Committee at each meeting. It provides a brief summary of the work carried out since the last meeting and identifies any major issues arising from issued reports, including the executive summaries of all issued reports.

Description of how the organisation acted on feedback received, including the resolution of complaints:
The annual clinical governance and patient safety report provides a summary and overview of clinical incidents, SUIs and complaints. The report is approved by the Trust Board and covers:

- Analysis of reporting levels
- Analysis of reported incidents
- Levels and types of harm reported
- Analysis of Trust wide themes and the management of identified risks at local level
- Levels of openness with families following incidents
- Incidents reported externally

Each Unit submits information regarding the key actions that their unit has taken to address risks. This can be based on the work being undertaken by their Risk Action Groups, through Transformational Projects, or actions being taken by individual specialties or wards to improve patient safety.

Some examples of improvements made as a result of follow up from complaints and incidents are listed below:

- Several complaints and incidents were related to the transfer of the neuromuscular service to GOSH in 2008. Complaints concerned the location of the clinic; changes to the orthotics service; unreliable lifts; and a lack of adolescent changing areas with hoists. As a result, the clinic has been re-sited, the orthotics service provider changed, and new change and toilet facilities have been provided.
- Poor customer care in Outpatients: A new Outpatient Manager was appointed who has focused on reducing absenteeism, improving morale and supporting the staff to provide an improved service. The PALS team has assisted in providing customer care training. In 2010, an independent and representative patient and family satisfaction survey shortly found high and improved levels of satisfaction.
- Delays in obtaining theatre time for central line changes: The Trust is developing a business case to expand the interventional radiology team to provide shorter waiting times for central line insertions and changes.

A patient and family satisfaction survey was commissioned from Ipsos Mori in 2009 to set a base-line from which to track future change and improvements. This tracker survey was repeated in 2010/11 and showed that overall satisfaction levels had increased by 2% to 96%. Action plans to improve satisfaction levels have been developed in relation to play, activities and entertainment, making a complaint, the quality and variety of food and pain management and these have combined with action plans at departmental and specialty level to create an overall three year patient involvement and experience action plan.

All units have detailed improvement plans for 2011/12 to improve the patient experience of their services

We also commissioned Ipsos MORI to conduct an independent survey of referrers, who were selected without input from the clinical teams. 94% were satisfied with our clinical care, and 79% were satisfied with our services to them as a referrer. Improvements already made include or in the process of development include:

- Improving the timeliness of our discharge summaries
- Putting processes in place to ensure that correspondence is copied to all relevant clinicians
- Establishing a two way communication team for supporting dialogue between clinical teams in provider organisations for patients undergoing in patient transfer.
- Changing the template for discharge summaries to ensure they contain the relevant information for referrers.
- Establishing a database of key referrers and producing a newsletter twice per year to update them on progress.
- Produce a referrer's guide to services at GOSH.
- Improving access to clinicians and general administrative services.
- Bed management; ensuring that all urgent / emergency referrals can be accommodated in a timely manner

C) Does the Board actively engage patients, staff and other key stakeholders on quality?

Description of how the Board engages with patients, staff and stakeholders:
The Trust's Patient and Public Involvement and Engagement (PPI) strategy was developed after extensive consultation with staff and Foundation Trust members and aims to encourage parents, patients and members of public to become engaged in Trust activity. The strategy includes a three year implementation and action plan.

A staff toolkit has been produced to give practical help and advice to staff considering engaging patients and parents in service planning. Procedures were agreed to support the recruitment of member representatives.

The Patient, Public Involvement and Experience Committee (PPIEC), chaired by the Director of Nursing, and including three parents, monitors implementation of the PPI strategy, responds to proposals from the Trust's Members Forum, and provides strategic direction for the overall patient experience agenda. The PPIEC is supported by a PPI Advisory group, which includes two parents, which advises staff on local PPI initiatives and has taken responsibility for the detailed work necessary in commissioning independent in-patient and out-patient surveys.

GOSH Members Forum, a non-elected Forum of patients, parents and public meets every two months and has contributed to consultations on:

- The strategic direction and corporate objectives of the Trust (the Chairman, the Chief Executive and the Deputy Chief Executive all attended a Members Forum meeting in–year), and the Trust's public consultation plans for Foundation Trust status.
- A communications strategy that presented the parents charter "GOSH Parents Say" to all clinical unit management boards, to all staff via their wages slips and distributed it to wards, waiting areas and staff rooms; promoted the use of the young people's DVD "GOSH What a Hospital" in inductions and staff training, and ensured that the key issues that parents and young people cared about were included in our independent patient and family satisfaction surveys commissioned from Ipsos MORI.
- The Single Equality Scheme
- Revision of the access policy
- Quality accounts and key performance indicators
- A workshop to explore the role of 'member representative', their experience to date and training/support needs

The PPI Strategy identified three levels at which the active involvement and engagement of patients and their families can take place – level 1 at the individual, one-to-one level, level 2 at the departmental/service level and level 3 at a corporate, strategic or trust-wide governance level. Examples of activity at each level is given below.

Level 1

- 'You are The Difference' customer care training, which built on the values underpinning the 'GOSH Parents Say' charter, was provided directly to 60% of all staff, and its principles have now been embedded in induction training for all staff.
- The Patient Bedside Entertainment and Education (PBEE) system, which has involved patients and parents at all stages of its development, is currently being piloted in two wards.
- Members are now invited to sit on all GOSH job interviews for posts that involve face-to-face dealings with patients and families.

Level 2

- 60 parents have been 'recruited' to a wide variety of working groups and committees. These include Redevelopment, Catering and Retail Review, the Food at GOSH Group, the regular Patient Environment inspections, Transforming Care on Your ward programme, Variability and Flow management programme, Medicines Management, and Advanced Access in Ophthalmology. Additional parents were 'recruited' in Neurology (who have had parent representation for many years) and a parent now co-chairs the Family Equality and Diversity Committee. Many services also engage patients and/or parents in weekly teas, forums (haematology/oncology invite parents to a monthly nursing forum) and annual consultations e.g. the NICU/PICU Forum and party.
- Patient satisfaction surveys; these included ward based surveys e.g. on Sky, Lion, Elephant wards, the respiratory sleep unit, Cardiac Day Care, Ladybird, Dinosaur, Safari wards and specialty surveys in for example neurodisability, CATS, neurosurgery, clinical genetics, haemophilia, pulmonary hypertension, transplant and ECMO.

Level 3

- Independent, representative surveys of GOSH in-patients, out-patients and their parents by Ipsos Mori reported very high overall levels of satisfaction with GOSH services.
- Parent representatives on GOSH'S Transformation Board produced a poster highlighting the value of bringing the patient experience to the Transformation

programme, and were successful 'role models' encouraging the involvement of parents in all transformation work streams.
- Members were fully represented in all workstreams and in all public consultation planning for the Trust's pending Foundation Trust application. Specific public and young peoples' consultation events took place.

5 Measurement

A) Is appropriate quality information being analysed and challenged?

Process adopted by the Board to select relevant quality information, details of what is reviewed:
The Trust board applies the following principles to determine the approach to identifying relevant quality information:
- Our purpose and values and the internal and external contexts in which we operate
- Drivers, opportunities and threats and reviewed, together with our own organisational capacity and capability to manage these effectively.
- Confirm that the strategic objectives are still fit for purpose
- Agree key deliverable outcome measures for the next twelve months

Details of how quality performance information reviewed by the Board is backed up by more granular information:
The following KPIs are reported monthly to the Trust Board:

Incidence of MRSA, MSSA and C. difficile	Cumulative total of reported MRSA, MSSA and C.Difficile against annual trajectory
Mortality figures	SPC chart showing the number of deaths in each month for the last 2 years
No. of NICE recommendations unreviewed	
Medication errors	Recorded medication errors per 1000 bed days.
Serious Incidents	Number of incidents and the level of reported incidents.
Central venous line (CVL) related blood-stream infections	CVL related bloodstream infections per 1000 bed days.
Reduction in Surgical Site Infection - Urology	Implementation of continuous surgical site infection surveillance for all inpatients for all patients and 30 days post discharge.
Ventilator-associated pneumonia	Remain below 50% below base line rate. Less than 7 cases a year.
Surgical Check list (Trust and Clinical Unit)	Total completed surgical check lists and breakdown of the 4 sections.
Inpatients waiting list profile	Weeks wait of patients waiting since the decision to admit.
18 week referral to treatment time performance	Trust performance in relation 95th centile national targets
Clinic outcome form completeness	Percentage of completeness for clinical units on all 18 week clinic outcome forms
Valid coding for ethnic category	Trust percentage of total ethnic category capture.
Discharge summary completion	Percentage of completed discharge summaries sent within 24 hours of a patients discharge.
Out-patient appointment did not attend	Percentage did not attends

Attachment P
DRAFT

B) Is the Board assured of the robustness of the quality information?

Details of Board's approach to assuring data quality; how internal audit is used to review robustness of data and a description of how findings are followed up:
The Data Quality Committee chaired by the Chief Finance Officer and attended by Operational Managers, Clinical Systems Managers and Heads of Department provides input into the performance management framework for data quality within the Trust. The purpose of the committee is to proactively consider information issues and concerns and facilitate the monitoring and auditing of clinical and operational data capture. The committee is focused on raising data quality awareness and the impact this has on the strategic and financial position of the Trust.

C) Is quality information being used effectively?

Examples of how quality information has led to improvements in quality; details of targets set and performance against targets:

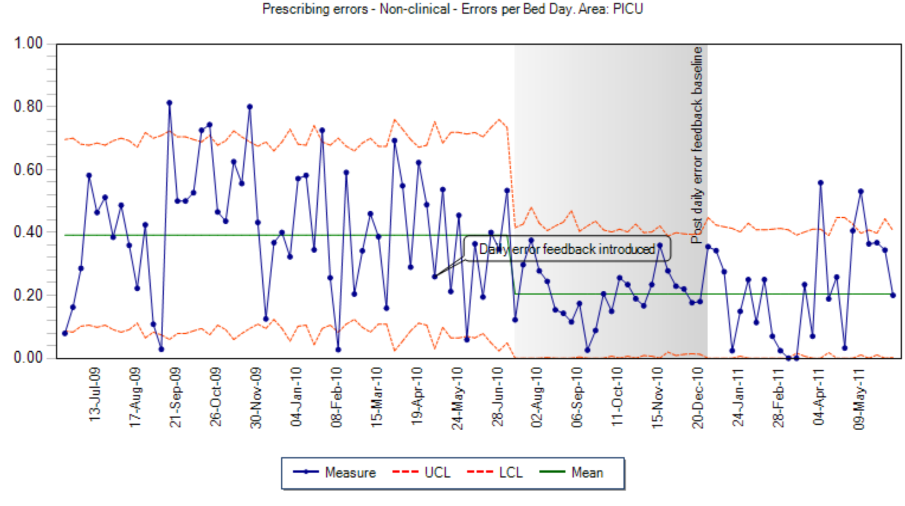
Two examples related to priority quality improvement objectives are given below:

Medicines Management
The project aims to provide safe and effective medicines management by reducing the number of adverse drug events (ADEs) that cause preventable harm to the patient by 25% by end of 2011.

This project follows the methodology promoted by the Patient Safety First Campaign. This entails a strategy of:

- Establishing baseline measurements for adverse drug events
- Identifying high risk areas in the Trust and focusing efforts in these areas.
- Identifying high risk medications in the Trust and decreasing the harm caused by these drugs
- Working with clinical teams to decrease adverse drug events (ADE)

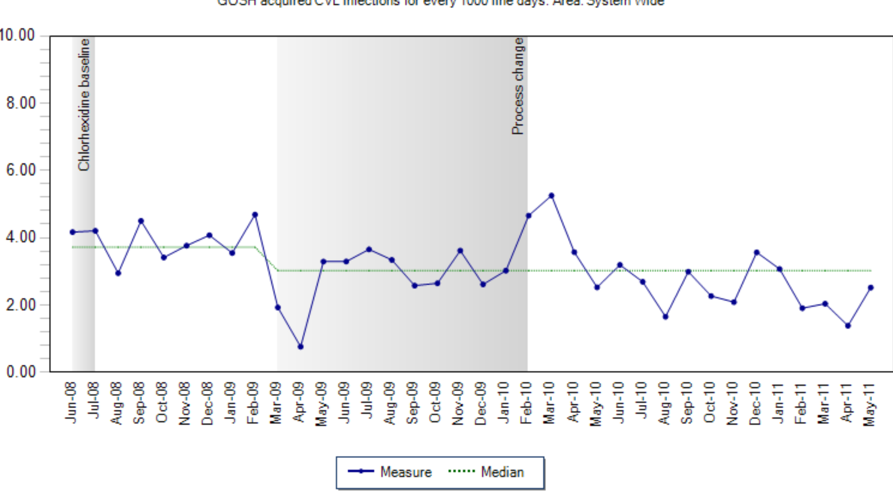
The graph below shows an example of an intervention in high risk areas within the Trust – the paediatric intensive care unit:



Central line infections
The aim is to prevent avoidable central venous catheter-related blood-stream infection through implementation of 'High Impact Intervention' care bundles. The specific target for

Attachment P
DRAFT

2011/12 is a further 50% reduction on previous year. We measure both the process issues around compliance with CVL bundle, hand hygiene guidance and recording of CVL 'days' and the outcomes in terms of number of CVL infections per 1000 line days acquired while in hospital.



6 *Factual accuracy*

The KPI report provided to the Board is accompanied by definitions and tolerances for each measure.

National targets are defined consistently within the Trust, in Board reporting, internal reporting and submissions.

All performance information collated and reported by the Trust is generated from a single source. The Trust data warehouse is managed by the information management team and is updated on a daily basis. The Trust's 2008/09 ALE assessment and coding audits provide further assurance in respect of arrangements to ensure data quality.

27 July 2011

Attachment Q

<table>
<tr><td colspan="2">Trust Board Meeting
27th July 2011</td></tr>
<tr><td rowspan="2">Title of document: Business Continuity Plan

Submitted on behalf of:
Fiona Dalton</td><td>Paper No: Attachment Q</td></tr>
<tr><td>Considered by Management Board on 21st July 2011</td></tr>
<tr><td colspan="2">Summary
This document seeks to build upon the experience gained and lessons learned from previous incidents to provide an overarching corporate business continuity plan that supports service-level planning and provides structure and guidance to continue service delivery during large-scale incidents.</td></tr>
<tr><td colspan="2">Action required from the meeting
To ratify the GOSH Business Continuity Plan.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
Establishes organisational structures for effective decision making and improvement.</td></tr>
<tr><td colspan="2">Financial implications
None anticipated in the implementation of the plan.</td></tr>
<tr><td colspan="2">Legal issues
As a Category 1 Responder under the Civil Contingencies Act 2004, the Trust has a legal responsibility to establish and maintain comprehensive business continuity plans and procedures.</td></tr>
<tr><td colspan="2">What consultation has taken place?
Consultation carried out with:
- Major Incident Planning Committee members (includes Estates, Facilities, ICT, and Press Office amongst others)
- General Managers
- CSP Team
- Executive Directors
- Health & Safety
- Patient & Staff Safety</td></tr>
<tr><td colspan="2">Who needs to be told about the policy?
Trust-wide publicity will be undertaken.</td></tr>
<tr><td colspan="2">Who is accountable for the monitoring of the policy?
Major Incident Planning Committee</td></tr>
<tr><td colspan="2">Author and date
Tom Luckraft – Emergency Planning Officer
15.07.2011</td></tr>
</table>

Business Continuity Plan

July 2011

Version 1.0

Document Control Information

Lead Author	Tom Luckraft	Author Position	Emergency Planning Officer
Additional Contributor (s)	Members of the Major Incident Planning Group and other staff following consultation		

Approved By	Management Board	Approver Position	
Read By			

Document Owner	Fiona Dalton	Document Owner Position	Chief Operating Officer

Document Version	Version 1.0 – July 2011	Replaces Version	N/A

First Introduced	July 2011	Review Schedule	Annually
Date approved		Next Review	**July 2012**

Who should know about this plan?

All Staff

IMMEDIATE ACTION

IF YOU ARE REQUIRED TO TAKE IMMEDIATE ACTION AND YOU HAVE NOT READ THIS PLAN BEFORE

!STOP!
DO NOT READ IT NOW

FIND THE RELEVENT ACTION CARD IN APPENDIX A AND FOLLOW THE INSTRUCTIONS

In the event of a Major Incident staff are required to remain on site until otherwise instructed

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Action Card 1: Generic business continuity considerations .... **Error! Bookmark not defined.**

Appendix B – Scenario-based Action Cards .... Error! Bookmark not defined.

Appendix C1 – Alternative Ward Locations .... Error! Bookmark not defined.

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Appendix D1 – Business Continuity Risk Assessments Matrix .... Error! Bookmark not defined.

Appendix D2 – Business Continuity Risk Assessments Summary ... Error! Bookmark not defined.

Appendix E1 – Priority Service Categories.............................. Error! Bookmark not defined.

Appendix E2 – Priority Service Functions Lists .... Error! Bookmark not defined.

Appendix F1 – Service Business Continuity Incident Status - Instructions .. Error! Bookmark not defined.

Appendix F2 – Service Business Continuity Incident Status Template (sample) Error! Bookmark not defined.

Appendix G – Business Continuity Programme Management........ Error! Bookmark not defined.

Appendix H – Map of Great Ormond Street Hospital................. Error! Bookmark not defined.

Appendix I – ICT Critical and Urgent Infrastructure, Clinical and Corporate Systems...... Error! Bookmark not defined.

Appendix J – Emergency Equipment and Vital Supplies .... Error! Bookmark not defined.

Appendix K1 – Emergency Contacts List .... Error! Bookmark not defined.

Appendix K2 – External Emergency Contacts List..................... Error! Bookmark not defined.

Appendix K2 – External Emergency Contacts List..................... Error! Bookmark not defined.

Appendix L – Incident Log Sheet.. Error! Bookmark not defined.

Appendix M - Training and exercises .... Error! Bookmark not defined.

Appendix N - Acknowledgments .... Error! Bookmark not defined.

1.0 Introduction

Business Continuity (BC) is a term that refers to the ability of an organisation to maintain business critical operations and services in the face of a disruptive event such as the loss of access to an office or clinical area, failure of information technology, loss of utility supply, non-availability of staff or breaks within the supply chain. As a Category 1 responder, identified within the Civil Contingencies Act 2004, Great Ormond Street Hospital NHS Trust has a legal responsibility to establish and maintain comprehensive business continuity plans and procedures.

In recent years Great Ormond Street Hospital has experienced a number of disruptive events. Some of those have been the result of external events impacting upon the operation of the hospital, such as the July 7th 2005 London bombings, the 'swine flu' pandemic in 2009 and the consequences of heavy snowfall in 2009 and 2010. However, there have also been a number of internal incidents such as the Ladybird ward fire and explosion in September 2008, boiler failure in October 2009, pharmacy storeroom fire in March 2010 and diesel spillage in October 2010.

In all of the above examples the Major Incident Plan and service-level business continuity arrangements have been activated to manage the situation and maintain or restore services in a timely manner.

1.1 Aim

This document seeks to build upon the experience gained and lessons learned from previous incidents to provide an overarching corporate business continuity plan that supports service-level planning and provides structure and guidance to continue service delivery during large-scale incidents.

1.2 Objectives

- To provide a framework for maintaining priority services in response to significant incidents
- To provide an overview of the Trust's people, premises, processes and priorities
- To link into the arrangements contained within the Trust's Major Incident and Pandemic Influenza plans
- To summarise the relationship and links between service level business continuity plans and corporate arrangements

1.3 Planning Assumptions

The following assumptions have been made:

- Any major incident that impacts on the Trust (whether of internal or external cause) will be managed using the command and control structure outlined in the Major Incident Plan.
- Key responders have received major incident training / exercised their role
- A reasonable worst case scenario planning assumption has been made that some GOSH resources (staff, premises, equipment etc.) would still be available in the immediate aftermath of an incident to enable some or all critical functions to be maintained.

1.4 Links to other documents

This Business Continuity Plan is an operational document, which is regularly reviewed and updated. The plan should not be read in isolation, but forms part of the hospital's response to an untoward incident and links to the Major Incident Plan, Pandemic Flu Plan, Lockdown Policy, Bomb Threat and Suspect Package Policy and Business Continuity Policy and Strategy.

2.0 Activation and Response

Minor service delivery problems faced within the Trust are dealt with on a day-to-basis by service managers, who may refer to service level business continuity arrangements to resolve a problem or, where required, escalate the issue to senior managers such as Heads of Nursing of General Managers. It is unlikely that such incidents would require the activation of corporate arrangements, but it may be appropriate for the managers involved to inform the Clinical Site Practitioner (CSP) of any ongoing minor problems within a service.

This document is designed to assist with the coordination of significant incidents that have the potential to affect the operation of a number of services and present ongoing challenges to the operation of the hospital. Some examples of the types of incidents that would require this document to be activated are listed in Table 3 within Appendix G.

2.1 Incident activation

The activation and command and control for a significant business continuity event follows exactly the same structure as that for any other major incident and is outlined in the Trust's Major Incident Plan as part of the response to internal incidents. A summary of these arrangements are provided below.

Any member of staff who becomes aware of a situation which is a major incident, or a situation which may lead to a major incident, must report it immediately to the on-site Clinical Site Practitioner (CSP) **on Bleep number 0313**

The CSP, receiving this notification must undertake a dynamic impact assessment and establish the following:

i) Nature and location of the incident

ii) The date and time of the incident, when notification was made, and when impact was assessed

iii) Hospital services affected

iv) Numbers of patients, staff, parents and visitors affected

v) Action taken so far

vi) Immediate action(s) required

vii) Graded assessment of impact

viii) Details of the person making the notification

This information should be recorded as a **MAJOR INCIDENT IMPACT ASSESSMENT.** Copies of this assessment document are kept in all wards and Departments.

<u>In Hours</u>

The CSP will inform the on-call Duty Manager of the outcome of the assessment and a decision will be taken whether to escalate. If escalation is required the on-call Duty Manager will pass these details to the Chief Executive, or the Chief Operating Officer who may activate the plan.

<u>Out of Hours</u>
The CSP will inform the on call Duty Manager of the outcome of the assessment and a decision will be taken whether to escalate. If escalation is required the on call Duty Manager will pass these details to the Executive Director on Call who may activate the plan.

In the event of Request to Standby, Switchboard will contact MIP team with the following message - **"Major Incident, Request to Standby, contact Incident Control Room"**

In the event of Request to Implement, Switchboard will contact MIP team with the following message - **"Major Incident Plan implemented report to Incident Control Room"**

In exceptional time-critical circumstances where a major incident clearly needs to be called (e.g. due to a major fire or explosion) the CSP is empowered to declare a major incident and activate the Major Incident Plan and Business Continuity Plan without seeking authorisation from the Duty Manager or Executive on-call.

2.2 Command and control arrangements

Upon declaration of a major incident or standby major incident, the hospital will adopt the following command structure, which mirrors that of the other emergency services:

- Strategic (gold) level
- Tactical (silver) level
- Operational (bronze) level

In most cases the response will be managed at Silver level with the Major Incident Team led by the Incident Coordinator. Further details of the roles and composition of Gold, Silver and Bronze groups can be found in the Major Incident Plan.

However, in exceptional circumstances where there is both an external major incident requiring GOSH assistance and significant internal disruption to service delivery, it may be necessary for the Incident Coordinator to delegate responsibility for ensuring that critical services and functions are maintained within the Trust to a CSP or other suitable manager. This would allow the Incident Coordinator to focus solely on providing the required response to the external major incident.

Roles and responsibilities of key individuals in a major internal incident are the same as for any other major incident. Please refer to the Major Incident Plan for the relevant roles and responsibilities and action cards. However, to supplement this information a generic business continuity considerations action card, for use by the Incident Commander, has been included in Appendix A. Furthermore, a number of scenario-specific action cards, detailing key actions for different types of internal major incidents have been added in Appendix B.

2.3 Communications

As with any other major incident, communication channels with between responders, with all staff and to external agencies must remain open throughout the response to an internal major incident to share information and maintain a clear understanding of operational priorities.

The following areas should be considered by those managing the incident from the outset:

- Maintain two way flow of information with staff / service managers – via all user email, intranet and/or runner message
- Ensure copies of the Emergency Contacts List (see Appendix K) are available and used to contact key stakeholders
- Ensure that either the Executive on-call or Duty Manger has notified NHS London and keeps them informed of incident developments. This may include the use of the NHS London Situation Report website (see Appendix K2 for details)
- Ensure accurate records / logs (see Incident Log Template Appendix L) are kept by the lead responders and other departments involved
- In prolonged incidents establish regular briefing times to meet with stakeholders
- Engage with the Press Office and ensure any media enquiries are directed to them
- Ensure debrief arrangements are communicated to staff involved in the response

GOSH employs a number of resilient communications methods to ensure we are able to contact staff, patients, families and stakeholders at all times, including during a major incident. In addition to both a wired and wireless IP Telephony and Internet Network and analogue landline phones, staff can also utilise work mobile phones / Blackberry's and access handsets to communicate internally on the Trust's radio system.

Should all of the above communications systems be unavailable in an incident, the following additional resilience methods are in place for critical communications (i.e. contact senior member of staff who are off-site or to notify NHS London of the tele-communications problems within the Trust):

- Deploy a runner to UCLH main hospital site to liaise with their Major Incident Team with regard to using the UCLH private telephone network. This works independently from normal landline systems and is more likely to be available in a telecoms incident.

- Deploy a runner to London Borough of Camden's Emergency Operations Centre (Dennis Geffen Annexe, Camley Street, London, NW1 0PS) to use the satellite phone within the control room. The runner should report to the Emergency Planning Team upon arrival at the Emergency Operations Centre.

Some of the main stakeholders who will require information during an incident are detailed in Figure 1 below.

Figure 1: Key stakeholders for communication during an internal major incident

2.4 Service prioritisation

To assist the Trust's decision making in the event of a large-scale disruption affecting a number of services, four categories of service priority have been identified. The Priority rating is P1 to P4;

- **Priority 1 (Critical):** Must continue to be provided
- **Priority 2 (Vital):** Must be resumed within 3 calendar days
- **Priority 3 (Necessary):** Must be resumed within 14 calendar days
- **Priority 4 (Desired):** Should be resumed as soon as practicable

Every service within the Trust has allocated a priority to each its main functions based on these categories. The service business continuity plans for areas that contain numerous P1 and P2 activities are appropriately more detailed than those that only contain P3 or P4 functions. The full definitions of the priorities are detailed in Appendix E1.

Table 1 below provides a summary of the Priority 1 and 2 clinical and non-clinical functions that have been identified by GOSH services. These are the areas that the Trust should look to maintain in the event of an incident where a lack of resources requires the rationalisation of services. In addition to the summary of clinical and non-clinical priorities below, Appendix E2 details all Priority 1 & 2 functions for each service within GOSH, based on information provided by managers of each area.

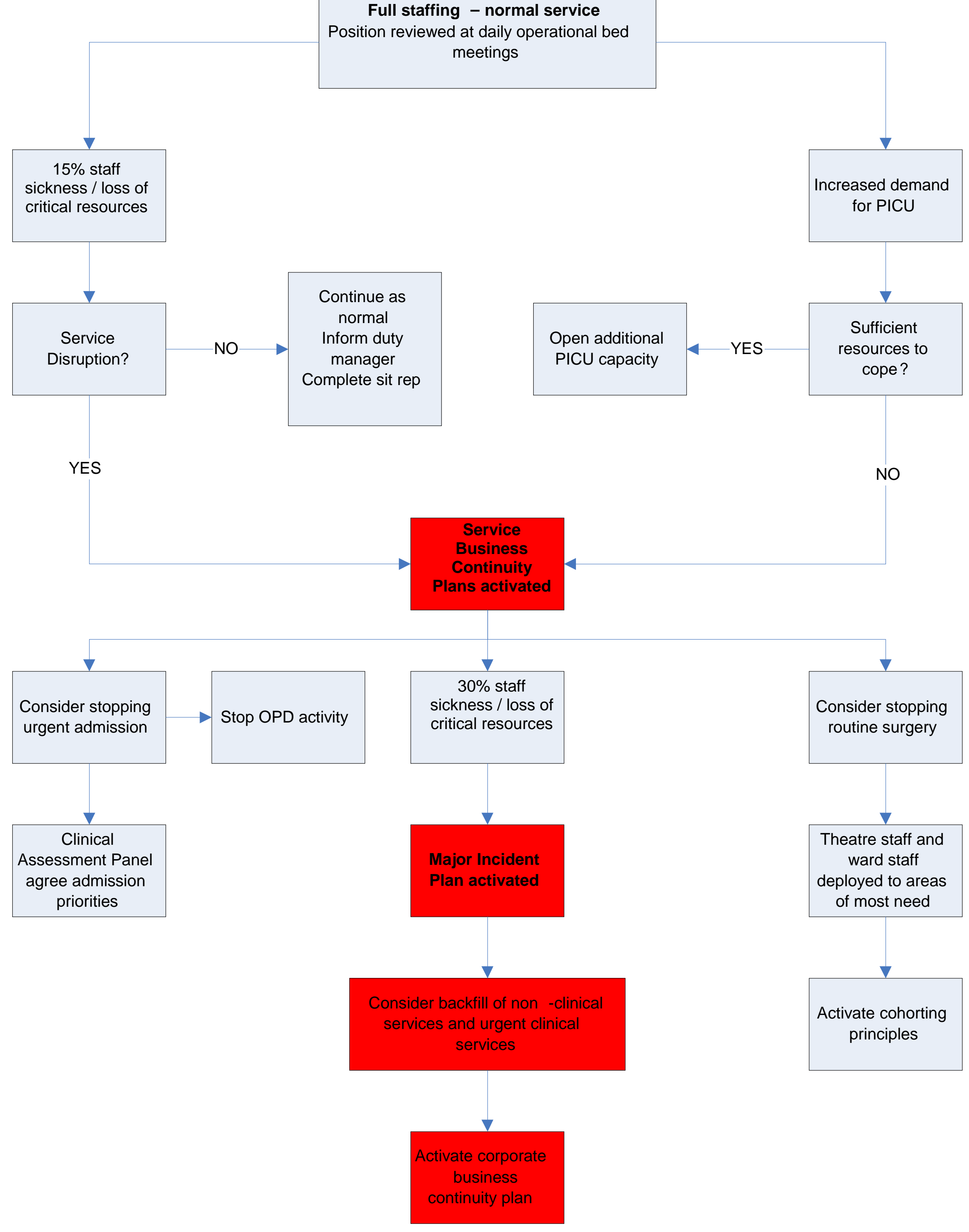
Table 1: Summary of the Priority 1 and 2 clinical and non-clinical functions

	Priority 1 Functions	Priority 2 Functions
Clinical Services	• Clinical Site Practitioners service • ECMO Beds • ITU Beds • HDU Beds • Theatres • Emergency Surgery • Tracheal service • Caring for children on Berlin Heart • Newborn cyanotic admissions • Post operative surgery care • Heart failure management (inotropic support) • Pulmonary Hypertension • Patients with acute infective complications with ongoing therapy • Clinical Pathology tests • Mortuary services • Surveillance, investigation, prevention and control of infection • Full range of diagnostic tests (MRI, ECG, ECHO etc.) • Blood sciences Laboratories and cell therapy • Provision (including storage) of blood components • Haematology / Oncology chemotherapy admissions • Bone marrow transplant service • Transplant service • Acute renal failure management • Haemodialysis service • Dietetics - special therapeutic feeds • In-patient Neuro treatment • CATS - intensive care ambulance to transfer the critically ill children into intensive care	• Emergency admission from other trusts • Acute & Chronic Respiratory Service • Cystic Fibrosis • Patients on Long term ventilation • Ward beds • Transitional Care beds • Pre-surgical assessments • Elective surgery • Heart/Lung transplant severe rejection / PLE / PTLD • Chemical Pathology – Routine and Blood sciences Laboratories • Newborn Screening Service • Provision of non-urgent diagnostic tests • Planned specialist surgical and medical admissions (inc. overseas) • Prenatal testing • Ward advice for critically ill children • Hypothyroidism • Disorders of sex development • Outpatient Clinics and assessments • Plasma exchange • Metabolic and Endocrine services • Prenatal Diagnosis – Cytogenetics and Molecular Genetics • Review of radiological examinations where expert opinion is required • Nuclear Medicine service for the Homerton and The Royal London NHS Trusts • DEXA service for NHNN • Respiratory assessment / treatment all wards surgical and medical • Acute in-patients requiring urgent assessment and intervention re feeding difficulties • Named Consultant for Child Protection • General Paediatrics service

	Priority 1 Functions	Priority 2 Functions
Non-Clinical Services	• Crash Bleep • Payroll • Telephony • E-Prescribing hardware/servers • ICT Network • ICT Storage, Servers Databases • Citrix and GOSH Virtual Desktop • 2222 Medical emergency • External pagers • DRAX fire alarms / pharmacy alarm • BMS Alarm Handler • 5999 Non-medical emergency • 0413 Black phone • Emergency religious rituals e.g. baptism, reading of the last rites or bereavement support • Child protection service • Clinical support e.g. including weights, measurements, blood sampling and urine specimen collection. • Team Specific administrative role e.g. supporting patients echo's, ENT procedures. • Arrangement and coordination of day case appointments • Coordination of study/clinical investigations, e.g. clinical examinations, ultrasounds, MRI, biopsies under general anaesthetic • Administration of study/trial medications	• Out of hours on call services • Weekly Fire Bell Test • Costing information for Management Accounts • Information on PAYE/NI for finance • Payments to Pensions agency/HM Inspector of Taxes • Email • Internal Bleep • Integration Services • Active Directory and Novell Directory • Desktop hardware • Printing • Obtaining payment funding authorisation/collection of deposit • Administrative support to outpatient clinics • Patient safety advice/support • Daily maintenance of CICU blood gas analysers • Financial and practical assistance (GOSH charity funds) • Statutory responsibilities in emergency situations • Provision of statutory, mandatory and safeguarding training • Provide Central Nursing function advice and support • Management - Child protection • Transport compensation administration • Patients' comfort fund administration • PALS / Advocacy for families and/or problem escalation • Clinic cancellations • Referrals administration • Registering new patients • Setting up new clinics on PIMS system • SSD (provision of sterile surgical instruments) and decontamination of flexible endoscope • Supply of health records to all clinics and wards

2.5 Service rationalisation triggers

In some situations it will be necessary to curtail the activities of non-critical functions in order to ensure sufficient resources are available to provide care to patients in critical functions. The diagram below outlines the triggers action actions that would be taken to make such decisions.



3.0 Staffing

Maintaining adequate staffing levels is essential to the continuation of critical services and ensuring patient safety is not compromised. Severe staff shortages (either to individual services or across the Trust) can occur for a number of reasons, including:

- Public transport disruption
- Severe weather (often closely linked to public transport disruption)
- Major epidemic / pandemic (e.g. pandemic influenza)
- Industrial action

3.1 Notification of staff shortages

During office hours Service managers should notify their General Manager / Head of Nursing of severe staff shortages, who will the pass information to the CSP Team. Outside of office hours service managers should notify the CSP Team directly, who will assess the impact and across the Trust and inform the Duty Manager as appropriate.

3.2 Strategies for management of staff shortages

There are a number of ways of mitigating against staff shortages, many of which are employed on a day-to-day basis to deal with minor problems at the service level. These include:

- Use of PulseBank staff to fill nursing vacancies within a shift for clinical areas.
- Redeployment of staff from one service to another – ensuring both services maintain the required staffing levels and the staff to be moved have the relevant qualifications, training and experience to perform the role.
- Temporary merging of two or more services to allow the pooling of available staff.
- Use of the Business Continuity – Service Status Tool by the CSP / Duty Manager (see Appendix F1) to assess the impact of staff shortages across the Trust.
- Closure of non-critical services with available staff redeployed to Priority 1 or 2 services.
- Use of remote working for those staff whose role can be performed away from the Trust.
- Take pre-emptive action where staffing level disruption can be predicted (e.g. in cases of NHS staff industrial action or forecasts of heavy snow). This can include rostering additional staff / agency workers for the anticipated disruption, and use of staff accommodation to ensure staff remain on-site and available to work.
- Ensure that support functions which enable staff to attend work (such as the Staff Nursery) have sufficient staffing levels and are able to operate to support critical areas.
- Use of mutual aid / support from neighbouring Trusts to supplement staffing levels in extreme cases – it should be noted that some incidents that affect GOSH staffing levels, such as severe weather disruption, may also impact upon other Trusts, meaning this option is not viable.

Further details for managing sustained staff shortages, absence reporting processes and significant service closures can be found in the GOSH Pandemic Flu Plan.

3.3 Staff contact details / telephone cascade

All service level business continuity plans contain mobile and home contact numbers for staff in that service. It may be necessary for service managers to use these details to contact staff who are not at work to either request their assistance or notify them of a change to shift patterns / working locations as the result of the incident. Human Resources also hold contact information for all staff if this is required by Service Managers. A copy of the Corporate Emergency Contacts List, detailing numbers for key members of staff can be found in Appendix K.

3.4 Staff welfare

Depending upon the nature of the incident there may be the need to provide practical and emotional support to staff affected. Practical help could include assistance with accommodation / means to get home where personal belongings have been left behind following an evacuation. Such support would be coordinated through the Psychosocial Services, PALS and the CSP Team.

For staff requiring additional support after an incident, contact should be made with the Staff Psychological & Welfare Service. They can be contacted on 08451555000 Ext.9800/9056 or email on staffpsychologicalwelfareservice@uclh.nhs.uk). This assistance should be encouraged alongside the debriefing of the incident within services and discussions with Occupational Health, where appropriate.

4.0 Premises

Great Ormond Street Hospital's clinical buildings are all located on the main hospital site (see Appendix H). Support functions are located both within the main hospital site and in adjacent buildings on Great Ormond Street and Lambs Conduit Street. The Trust's Charity and the Press Office are located on Bernard Street, some 200 metres away from the rest of the hospital.

As part of the phased programme of replacing older buildings in the Trust, the Morgan Stanley Clinical Building will open in Spring 2012 to provide additional clinical space and modern support facilities.

4.1 Evacuation and Fire Arrangements

Fire alarms, sprinkler systems, and fire extinguishers are located throughout the Trust, in accordance with all fire regulations. Fire evacuation and assembly point procedures are in place for all parts of the Trust.

The hospital's main buildings are interconnected to allow free movement of patients, staff and visitors between areas, both during normal conditions and during evacuations. However, fire compartmentalisation is in place to prevent incidents spreading beyond a single building.

For non-clinical buildings, the Trust has fire evacuation and assembly point procedures in place, whereby staff and visitors evacuate vertically downwards upon hearing the fire alarm and assemble at the pre-designated fire assembly point outside the building.

For clinical areas, the Trust follows a process of progressive horizontal evacuation whereby the patients are evacuated, in the first instance, to an adjoining area, or away from the immediate dangers of fire and smoke. The patients from the evacuated area may remain there until the fire is dealt with. If the fire danger increases and further movement of patients away from the area on fire becomes necessary, then, depending on the condition of the patients, they can either be evacuated down the nearest available stairway or bed escape lift or moved to other areas on the same level remote from the area of fire, where they can remain until the situation is dealt with. To this end all corridors in the hospital complex should be considered as protected routes.

Further details regarding these procedures can be found in the Trust Fire Policy on the Document Library.

4.2 Evacuation locations

As part of the business impact analysis completed by each service, all areas are now in the process of pre-identifying the evacuation locations to which they would ideally relocate in an emergency For clinical areas, this includes both horizontal and vertical evacuation options based on those areas that offer the most suitable infrastructure, utility connections and bed space capacity for the patients that would be evacuated. Appendix C1 provides a summary of relocation options for clinical wards. A full document detailing alternative work locations for all clinical and non-clinical services is held in hard and electronic copy in the Major Incident Control Room, and is updated regularly, based on information provided by service managers.

Nevertheless, this should only be viewed as a guide of where a service would ideally relocate to – during an incident a dynamic risk assessment should be taken by the Fire Team, CSPs and Duty Manager to identify the safest location for the relocation of the affected patients. In

some cases it may be necessary for patients to be moved to different areas of the Trust in an evacuation depending on their condition and the specialist skills available to care for that patient. Appendix C2 summarises those clinical areas whose staff have the necessary specialist skills to manage patients with different complex conditions. This should be referred to by the CSP and Duty Manager in the event of an evacuation of patients from a clinical area, particularly if more than one ward is affected and patients are being moved across different wards.

4.3 Service recovery following loss of premises

To enable the Trust to plan for the reconfiguration of services in the event of a catastrophic loss of premises following an incident, the following assumptions have been:

- Due to fire compartmentalisation arrangements, a reasonable worst case scenario would involve the total loss of access of one Trust building with the potential for partial loss of access to an adjacent second building.
- The timeframe for restoring access to the affected building is indeterminable (i.e. in the case of fire, access to a whole building may be lost for as long as it takes to rebuild / refit that structure).
- Should such an event occur, relocating priority 1 and 2 functions would take precedence. This may involve curtailing or suspending some priority 3 and 4 functions for a considerable period of time, which may impact upon the financial and reputational status of the Trust.

Depending upon the circumstances faced, some of the following options may be considered by the Trust's Management Board in such an event:

- Accepting the suspension of some non-critical functions for the time taken to restore access to the affected building(s).
- Combining / merging services to free up space for the relocation of affected services.
- Adapting non-clinical GOSH premises for use as clinical areas.
- Letting of commercial space near to the GOSH site for the relocation of non-clinical functions.
- Review and possible suspension of the Trust's property redevelopment programme to allow any vacant (but not yet demolished) areas to continue to be used whilst the affected building is repaired or rebuilt.

The greatest impact to the Trust would be caused by a loss of either Southwood, Cardiac Wing or Variety Club Building. This is due to the size of the buildings and the number of critical clinical functions contained within them. For the Trust's other smaller clinical buildings (Frontage Building and Octav Botnar Wing) there would be greater scope to relocate displaced services within other parts of the Trust.

4.4 Lockdown arrangements

Lockdown is the term used to prevent access or egress to parts or all of the hospital during an emergency situation where the free movement of people has the potential to cause harm to themselves or others.

To ensure the operational effectiveness of the hospital remains intact during a lockdown event, those persons managing the response should consider what critical services may be

affected, either directly or indirectly by the lockdown. A dynamic risk assessment will be required to determine the relative danger from the cause of the lockdown, and the risk of critical hospital functions (e.g. crash call response) not being able to operate effectively due to a lack of access.

In a partial lockdown, efforts should be made to encourage non-affected services to continue operations as normal unless instructed otherwise. Careful attention should be given to ensuring services are recovered in a timely manner once the lockdown has ended, and that there are sufficient staff available to provide critical hospital functions as well as provide support to persons affected by the lockdown.

A separate GOSH Lockdown Policy document can be found in the Document Library and provides greater detail of the process that would be followed in such an event. Where a lockdown situation is prolonged it should be used alongside this document to assess the impact on critical functions and ensure business continuity issues are being addressed throughout.

5.0 Infrastructure

Unplanned interruption to a utility supply (gas, water, electricity etc.), and unexpected equipment and service distribution failures (IT server failure, loss of medical gas supply etc.) pose a significant risk to patient safety and the continued delivery of critical services.

The potential impact of system failure may include serious interruption to care delivery, potential or actual harm (to patients, employees or the public), and serious adverse publicity for the Trust and financial implications, including litigation.

A review the resilience of each component in GOSH's infrastructure and its interconnections with other parts of the network has taken place. This review has included a detailed risk assessment for each area noting current mitigation measures and additional measures required to increase levels of resilience (see Appendix D2). A summary of the key utility connections and back-up arrangements is provided in Table 2 below.

Table 2- Summary of Infrastructure Resilience within GOSH

Service	Main Infrastructure	Resilience	Additional Back-Up
Electricity	2 x high voltage feed power supply from national grid sub-station	Low voltage diesel generator supply for all buildings	Uninterruptable power supply (UPS) batteries to ensure continuous power supply to intensive care areas, Theatres, ICT servers, lighting etc.
Gas	2 x mains gas feeds to separate boilerhouses	Dual feed hot water boilers that can be run on either gas or diesel	
Water	Separate mains water supplies to each building	Water tanks in place to provide supply in mains failure	Run temporary hoses between buildings to fill roof tanks
Oxygen	2 x VIE tanks	Manifold back-up in place -2 x 16 J size cylinders which provide a supply of oxygen to the main ring in the event of a failure of VIE tank (3 hour supply before cylinders require changing)	Ability to directly feed liquid oxygen into ring network during a long-term problem with the VIE tanks.
Medical Air	Separate medical air supplies to each building with connections between some buildings to redistribute supply during any outage	3 x Emergency Reserve Manifold back-up points in place (4-5 hour supply before cylinders require changing)	3 x Emergency medical gas kit that can be used to supply a ward if a supply pipe was damaged or severed
Suction	Separate suction supplies to each building with interconnections in key areas	'Sam 12' Portable suction pumps available for Theatres, ITU and other areas that require continuous suction	Laerdal portable pumps available in all clinical areas for short term suction.
Diesel	2 x operational diesel fuel tanks on-site with a	Process in place to secure delivery of additional fuel	GOSH qualifies as a priority user to receive fuel during

	combined capacity of 72,000 litres (supply for approx. 48 hours)	within a 6 hour timeframe	any fuel shortage as part of the National Fuel Emergency Plan. Please refer to the GOSH Fuel Supply Disruption Procedure for further details.
Telephony	IP phones in all areas (1/3rd of all phones) to provide capability for voice communications if analogue telephony is unavailable	Use of blackberry's / mobile phones to communicate if both analogue and IP networks are down	
Bleep system	Crash call voice bleeps on separate system to normal bleeps and has own UPS supply	Use of landline and mobile telephony to communicate during any bleep downtime	Alarm system to notify Switchboard staff of problem with bleep infrastructure
ICT Network	Medical grade network, full resilience - with no single points of failure	Dual datacentres that can support run the Trust's ICT network independently	Data backed up and taken offsite on a weekly basis.

6.0 ICT

Great Ormond Street Hospital (GOSH) relies on the availability of computer systems to support the various functions of medical and administrative staff across the Trust. In the electronic patient record era, inability to order results electronically or access patient records stored electronically can quickly lead to clinical risk.

Upgrades to the ICT infrastructure in recent years have removed single points of failure in the network, server room, storage systems and improved levels of reliability and resilience.

All ICT infrastructure, clinical and corporate systems have been categorised using the following headings:

- Critical: Where clinical risk exists and system unavailability could result in death or serious harm.
- Urgent: Where clinical risk exists and system unavailability would affect large numbers of patients.
- Non Urgent: Where no clinical risk would be incurred.

In the event of a business continuity incident, ICT staff will aim to restore critical systems as a priority, following by urgent and then non-urgent systems. A list of all Critical and Urgent ICT infrastructure, clinical and corporate systems can be found in Appendix I.

Please refer to the ICT department's business continuity plan, for a greater operational detail regarding the ICT response to a business continuity incident.

7.0 Mutual Aid

In extreme circumstances an incident may deplete available resources (personnel, equipment, facilities etc.) within the Trust to the extent that outside assistance is required to maintain critical and essential services. Before seeking mutual aid from outside the Trust, the Incident Commander and Executive on-call must be assured that all available options have been explored internally to resolve the problem.

In most cases requests for mutual aid should be addressed to NHS London who will be able to issue the request for assistance to other Trusts on GOSH's behalf. Written requests should be emailed by the Exec on-call / Incident Commander to NHS London, detailing what is required and within what timeframe. Any agreements reached with other organisations should be confirmed in writing, including any costs that GOSH will be expected to meet.

In some circumstances it may be more appropriate for GOSH to liaise directly with another Trust to obtain resources, particularly if a Service Level Agreement has been previously established or it is known that a specialist resource is required which can only be provided by that Trust. Service Managers should ensure that the CSP and/or Incident Commander is notified before any contact is made to request resources from another organisation during a business continuity incident.

8.0 Recovery and Debriefing

Once an incident has been brought under control and 'stood down', there are a range of actions that may be necessary depending on the size and impact of the incident that has occurred. Those managing the situation should refer to the following list of considerations as part of this process:

- Development of a recovery plan to restore normal services as soon as possible
- Ascertaining available capacity and resources to ensure priority functions are maintained
- Follow-up of any Serious Incident resulting from the event
- Repatriation of any patients, staff and services relocated during the incident
- Accommodation requirements and identification of timescales for any clean-up operation
- Identification of the financial cost of any damages following the incident and total expenditure on the incident response
- Legal issues, including the NHS Litigation Authority
- Consideration of possible medium and long term impacts, both tangible and non-tangible (e.g. staff fatigue)
- Communication with staff, families, patients and other stakeholders
- In significant incidents consider planning for receiving VIPs (MPs etc.) and any appropriate memorial services.

Debriefing of the incident should be led by the Incident Commander or the Executive on-call at the time of the event and follow the standard major incident debriefing template that can be found within the Trust's Major Incident Plan, ensuring that all recommendations are taken forward to learn lessons and improve the response to future incidents.

Following an incident, or potential incident, the Incident Coordinator must arrange a debrief session and complete a Debrief Report using the Trust's template. This should be submitted to the Chief Operating Officer (or designated manager in their absence), Trust's Management Board, Major Incident Committee and Quality & Safety Committee. The Chief Operating Officer will be responsible for evaluating the effectiveness of the response and for initiating any changes required to policies/procedures as a consequence.

Content of Debrief Report

- Description of the incident and the potential/actual consequences
- State who was in the Incident Coordination Team (core members and other key individuals involved).
- State the action taken and comment on its effectiveness and any resultant operational implications. For the latter state how they are being dealt with and who is responsible for monitoring/resolution (a responsibility which the Incident Coordinator should hand over to relevant managers once the incident has been declared over).

<u>Appendices are available to Board members on request.</u>

Trust Board **27th July 2011**	
Title of document Key Performance Indicator (KPI) report **Submitted on behalf of.** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment R**
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. In response to the KPMG Foundation Trust due diligence review the report has been updated to include additional trajectories, thresholds and targets against a range of indicators. In preparation for operating as a Foundation Trust the report has additionally been updated to include a quarterly governance risk score against the revised Monitor governance framework.	
Action required from the meeting Trust Board to note progress.	
Contribution to the delivery of NHS / Trust strategies and plans To assist in monitoring performance against internal and external defined objectives and NHS targets.	
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? Our lead Commissioner receives a copy of the executive summary on a quarterly basis.	
Who needs to be told about any decision Senior Management Team.	
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.	
Who is accountable for the implementation of the proposal / project All remedial actions will be taken up as items for discussion at Management Board.	
Author and date Janine Gladwell, Capacity and Access Manager. July 2011	

KPI Exception report

1. C. Difficile and MRSA (Report page 2 Graph 1)
In month the Trust has reported 1 case of C. difficile. Year-to-date the Trust has reported 4 cases against a year-to-date trajectory of 2.25. The Trust trajectory for the year is 9 cases.

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.

The Trust has reported 2 cases of MRSA to date – against an annual target of 0 cases.

2. Inpatients waiting list profile by weeks waiting (Report page 5, Graph 17)
In month performance has improved with 64 patients reported as breaching the 26 week waiting standard against a previous month position of 73. Specific concerns have been identified across several specialties:
Dental & Maxillofacial: Due to an over-subscription to Mr Ayliffes surgical waiting list.
Spinal Surgery: As a result of the closure of the service in previous months.
Orthopaedics: Long waits identified. The service is currently reviewing the waiting list to identify issues.

3. Referral-to-treatment Times (95th percentile and Median Waits)
The trust achieved the 95th percentile targets for admitted and non-admitted pathway waits in May. However, incomplete pathway waits are reported at 36.63 weeks against a standard of 28 weeks. Validation of incomplete pathways continues and we anticipate being within the 28week standard by August 2011.

The trust achieved the Median wait standard for admitted patient pathways in May. However, performance for non-admitted and incomplete pathways is reported over target. This is indicative of a specialist acute trust with a high number of tertiary referrals as many patients will arrive on an already ticking pathway. This position has been communicated to NHS London and our lead commissioners.

4. Clinic outcome form completeness. (Report page 6, Graph 22)
Overall performance decreased to 54.1% in June against a May position of 59.5%. Due to lack of achievement in this area an 18 week pathway project group has been established to identify and resolve specific issues, which includes a detailed review of the process for the recording of clinic outcomes and increased education and training in this area.

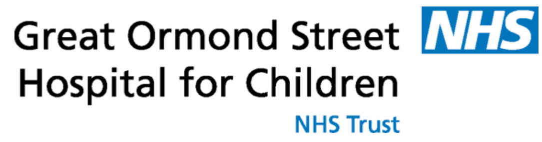
5. Staff who have a current Personal Development Review (PDR) in the last 13 months (Report page 13, Graph 47).
Both clinical and non-clinical PDR rates have remained consistent at 75.9% and 73.0% respectively against a target of 80%. Services and departments are encouraged to continue to review staff currently identified as not receiving an appraisal.

6. Information governance training (Report page 13, Graph 48).
The Trust did not meet the June 95% target. Performance has reached a plateau at 84.7%.

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

8. Monitor compliance framework
The Trust Monitor governance risk rating for quarter one is rated as 'amber-red'. This is due to

underperformance against MRSA, C.diff and Referral to treatment non-admitted median waiting times.



Trust Board

Key Performance Indicator Report

Jun-11

Key Performance Indicator Report

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	Incidence of E-Coli	National		2
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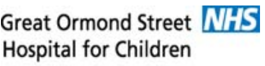
Key Performance Indicator Report



Dashboard

Objective / Indicator	YTD Target/Trajectory (11/12)	YTD Performance	In month / quarter performance	Performance against previous reporting period	Reported	RAG
1. Consistently deliver clinical outcomes that place us amongst top 5 Children's Hospitals in the world						
Incidence of C.difficile	1.5	4	1	↔	Monthly	Red
Incidence of MRSA	0	2	1	↓	Monthly	Red
Incidence of MSSA	TBC	2	1	↔	Monthly	-
Mortality figures	Within tolerance	26	11	↓	Monthly	Green
No. of NICE recommendations unreviewed	<3	-	7	↓	Monthly	Amber
Medication errors reported (per 1000 bed days)	Data under review	-	-	-	-	-
Serious incidents	Within tolerance	5	3	↓	Monthly	Green
Trust Board	1.5	2.52	-	-	Monthly	Green
Surgical site infections as a percentage of Urology operations	0.24%	0.64%	No June Data	↑	Monthly	Red
Incidence of Ventilator-Associated Pneumonia (VAP)	0	0	No May data	-	-	-
Surgical Checklist completed - Sign in (%)	100	-	89.3	↑	Monthly	Amber
Surgical Checklist completed - Time out (%)	100	-	85.4	↑	Monthly	Amber
Surgical Checklist completed - Sign out (%)	100	-	79.9	↑	Monthly	Amber
2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations						
Inpatient waits >26wks	<5	-	63	↑	Monthly	Red
18 week performance - Admitted (%)	90	-	91.34	↑	Monthly	Green
18 week performance - Non-Admitted (%)	95	-	97.63	↔	Monthly	Green
95th Centile RTT - Admitted	<23 weeks	-	21.25	↓	Monthly	Green
95th Centile RTT - Non-Admitted	<18.3 weeks	-	17.73	↓	Monthly	Green
95th Centile RTT - Incomplete Pathways	<28 weeks	-	36.63	↓	Monthly	Red
Median Wait - Admitted	<11.1 weeks	-	8.94	↑	Monthly	Green
Median Wait - Non-Admitted	<6.6 weeks	-	8.3	↓	Monthly	Amber
Median Wait - Incomplete Pathways	<7.2 weeks	-	10	↓	Monthly	Amber
Clinic outcome form completeness (%)	95	59.62	59.51	↑	Monthly	Red
Valid coding for ethnic category - inpatient (%)	85	91.6	90.3	↓	Monthly	Green
Discharge summary completion (%)	95	75.79	75	↑	Monthly	Red
Did not attend - outpatients (%)	10	6.35	5.7	↑	Monthly	Green
3. Successfully deliver our clinical growth strategy						
Theatre Utilisation - U4 (%)	70	-	62.21	↓	Monthly	Green
Follow up to new ratio	4.18	-	4.7	↓	Monthly	Amber
No. of External emergency referrals to PICU/NICU refused	To reduce	-	No June data	-	-	-
Income variance - Budget against actual	-	278,133	-	↑	Monthly	-
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 (£)		506,513	-	↑	Monthly	Green
Clinical trials - number recruited	TBC	340	209	↑	Monthly	Green
5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK						
MADEL SLA Value (£)	-	1435969	-	↔	Quarterly	Green
SIFT SLA Value (£)	-	15036	-	↔	Quarterly	Green
MPET SLA Value (£)	-	264594	-	↔	Quarterly	Green
6. Deliver a financially stable organisation						
CRES delivered (%) - Released from budgets 11/12	-	5	-	↑	Monthly	-
Bank and Agency Total expenditure (£000)	-	-	1,312	↑	Monthly	-
Monitor Risk Rating	3	-	2	↔	Monthly	Amber
Charity fundraising target	10,858,654	-	10,436,686	↓	Monthly	Amber
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation						
Sickness absence rate (%)*	TBC	-	3.27	↔	Quarterly	-
No. of staff in post - Costs*	TBC	-	£48,069	-	Quarterly	-
Vacancy rate (%)	TBC	-	6.66	↑	Quarterly	-
Turnover rate (%)*	TBC	-	20.9	↓	Quarterly	-
NHS Number completeness - FCE inpatient (%)	95	98.8	98.62	↔	Monthly	Green
NHS Number completeness - outpatient (%)	95	99.1	99.21	↔	Monthly	Green
Staff PDR completeness - clinical (%)	80	-	75.9	↑	Monthly	Amber
Staff PDR completeness - non clinical (%)	80	-	73	↓	Monthly	Amber
Staff trained on Information Governance by week (%)	-	-	84.57	↑	Monthly	-
Network Availability (%)	99.99	-	100	↔	Monthly	Green
Average Key Server Availability Monthly (%)	-	-	100	↑	Monthly	-
Monthly Key Application Availability	-	-	99.56	↑	Monthly	-

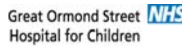
* Rolling 12 month position

KEY:

↑ Improvement in Performance against target in comparison to the previous month

↔ Performance remains unchanged

↓ Decline in Performance against target in comparison to the previous month



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	To achieve a 10% reduction in harm as defined by the global trigger tool	Green
2	To double the number of specialties that have clinical outcome measures published on our internet site	Green

Key workstreams:			Exec Lead	Last update
1	Maintain our focus on Zero Harm	Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.	ME	NULL
		Continue our work to reduce 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.	ME	NULL
		Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	LM	NULL
		Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)	ME	13-Jun
		Ensure effectivce provision of nutritional care for all patients	LM	06-Jul
		Ensure provision of safe services for the deteriorating and critically ill child.	LM	05-Jul
2	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations	ME	07-Jul
		Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly	CN	09-Jun

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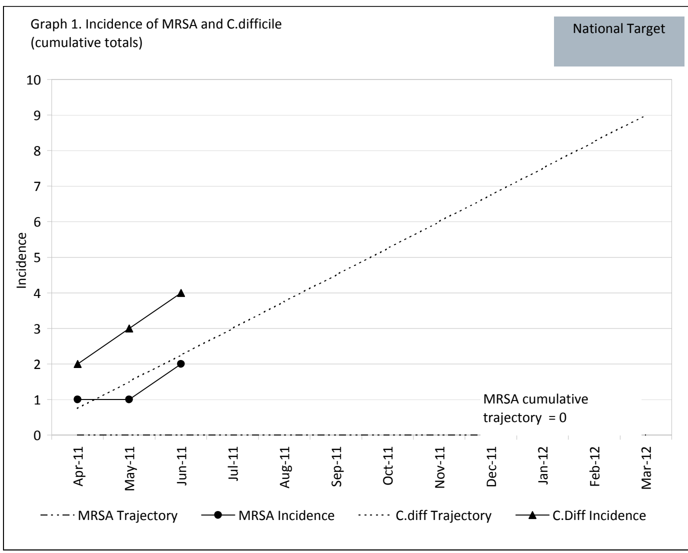
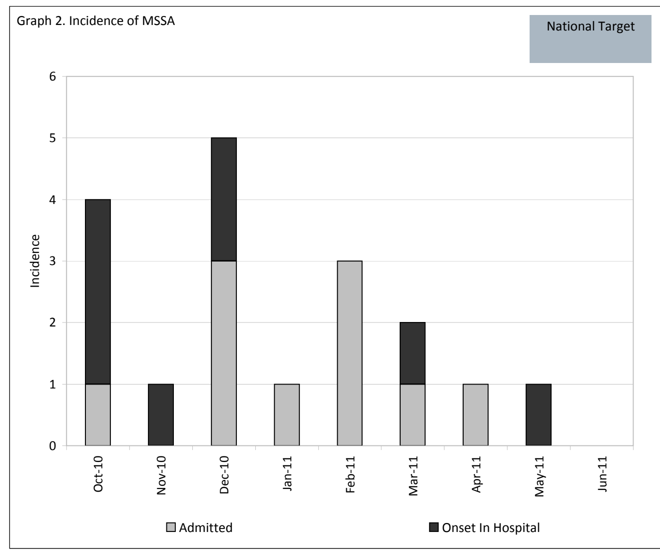
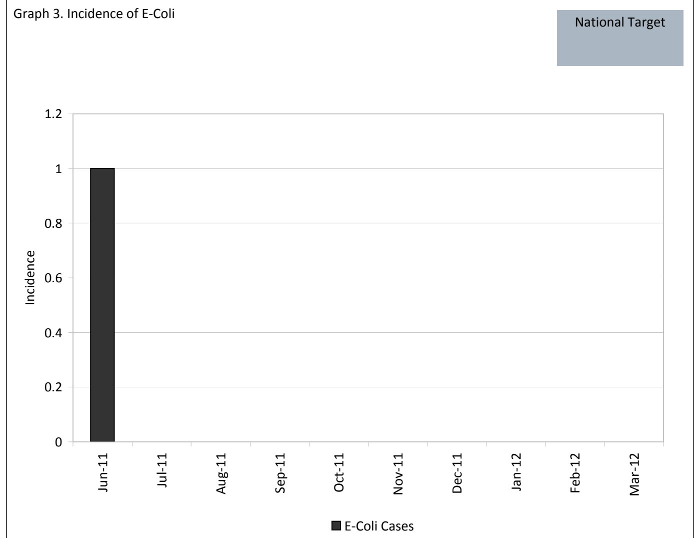
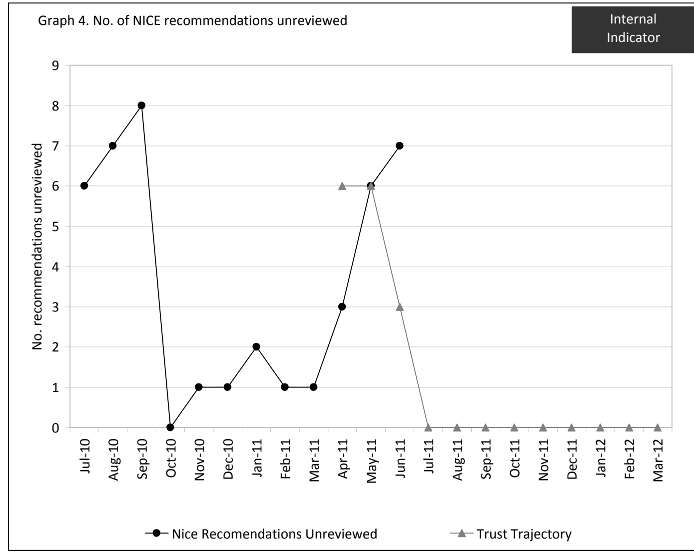
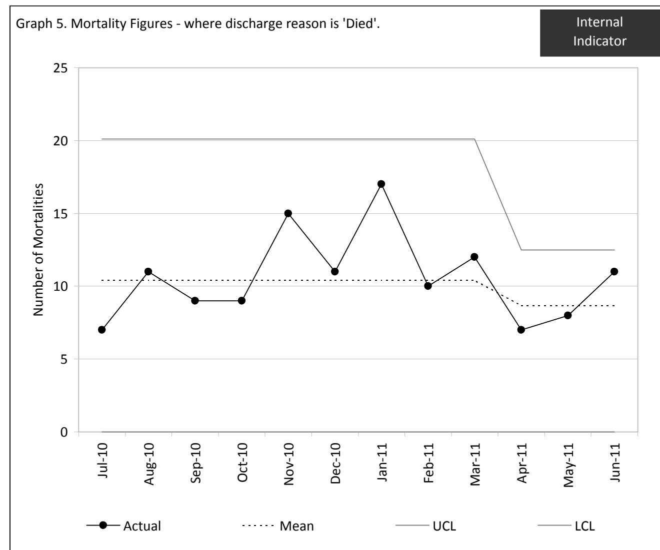
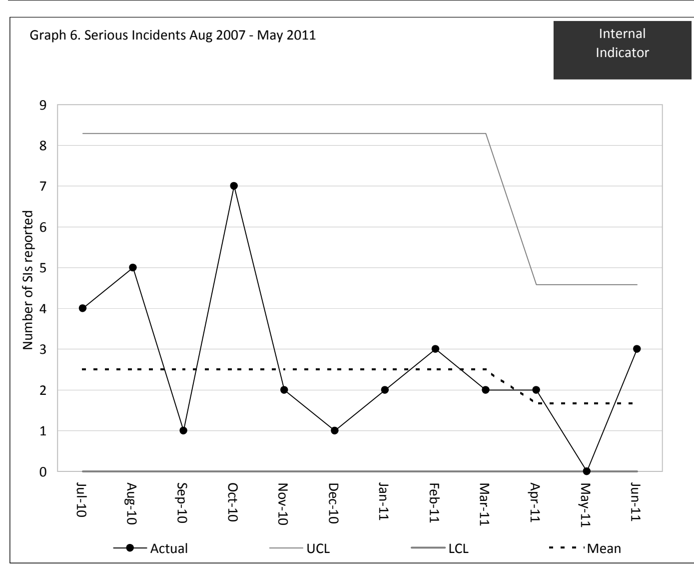


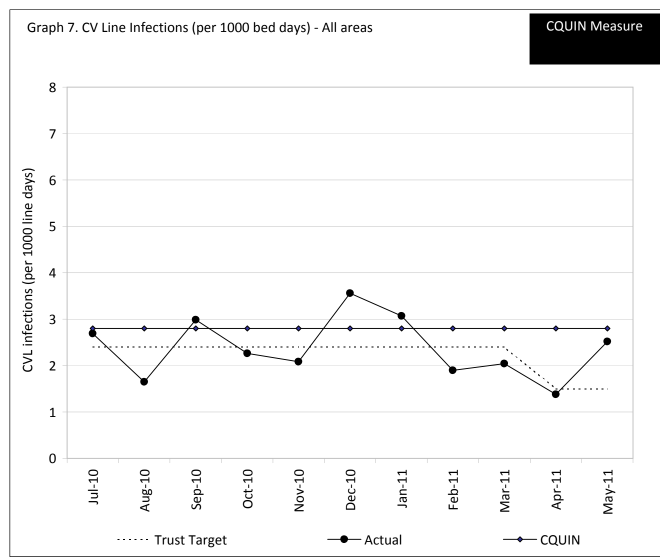


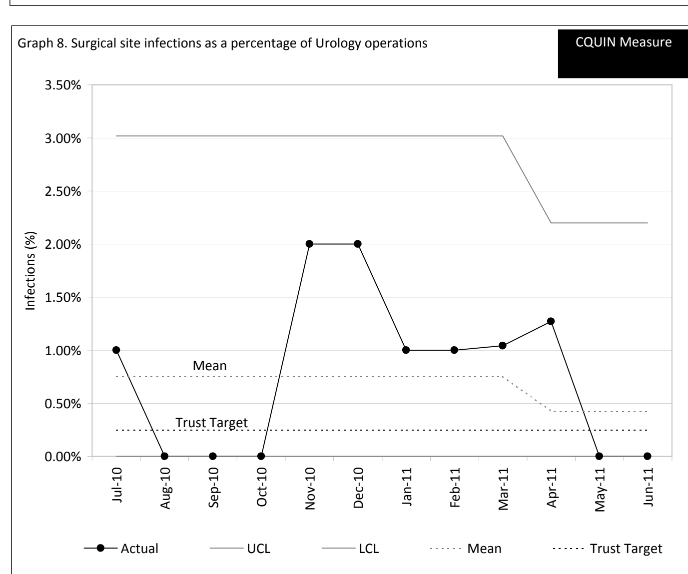


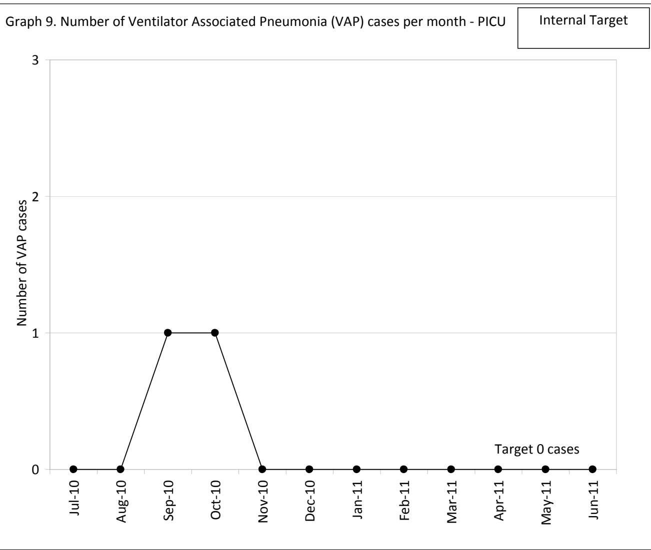

Graph 4. No. of NICE recommendations unreviewed
Internal Indicator
No. recommendations unreviewed
Nice Recomendations Unreviewed
Trust Trajectory


Graph 5. Mortality Figures - where discharge reason is 'Died'.
Internal Indicator
Number of Mortalities
Actual
Mean
UCL
LCL


Graph 6. Serious Incidents Aug 2007 - May 2011
Internal Indicator
Number of SIs reported
Actual
UCL
LCL
Mean

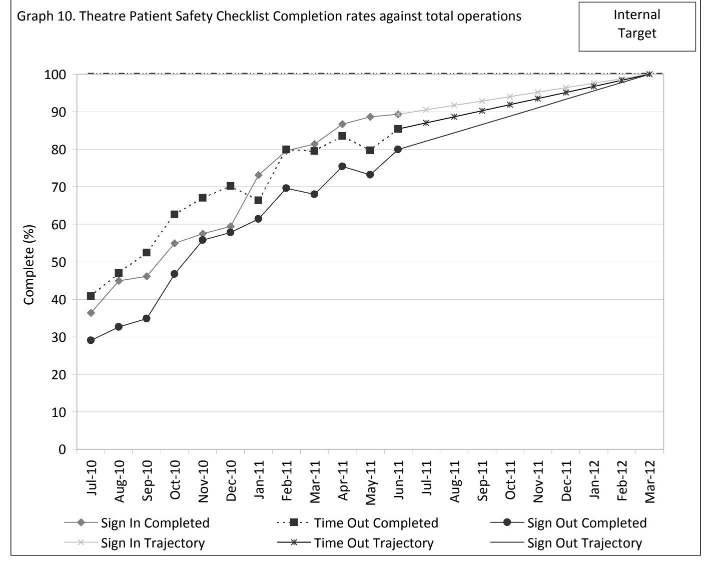

Graph 7. CV Line Infections (per 1000 bed days) - All areas
CQUIN Measure
CVL infections (per 1000 line days)
Trust Target
Actual
CQUIN


Graph 8. Surgical site infections as a percentage of Urology operations
CQUIN Measure
Infections (%)
Mean
Trust Target
Actual
UCL
LCL
Mean
Trust Target


Graph 9. Number of Ventilator Associated Pneumonia (VAP) cases per month - PICU
Internal Target
Number of VAP cases
Target 0 cases

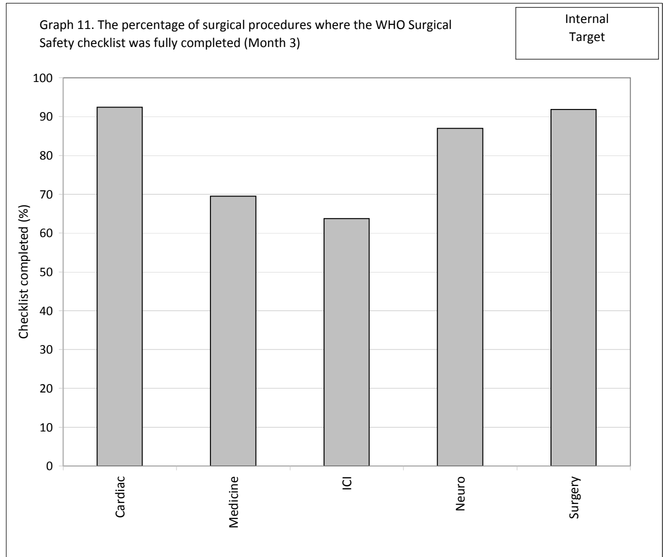
Graph 10. Theatre Patient Safety Checklist Completion rates against total operations

Internal Target



Graph 11. The percentage of surgical procedures where the WHO Surgical Safety checklist was fully completed (Month 3)

Internal Target



CQUIN Measure

Graph 12. New Indicator:
48 Hour readmission to ITU

CQUIN Measure

Graph 13. New Indicator:
Prescribing error Haemotology / Oncology

CQUIN Measure

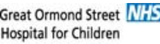
Graph 14. New Indicator:
Accidental extubation

CQUIN Measure

Graph 15. Data under review
Medication errors per 1000 bed days.

Commentary:
Graph 10. Fully completed defined as Sign In, Time Out and Sign Out all completed on the surgical safety checklist.

Key Performance Indicator Report

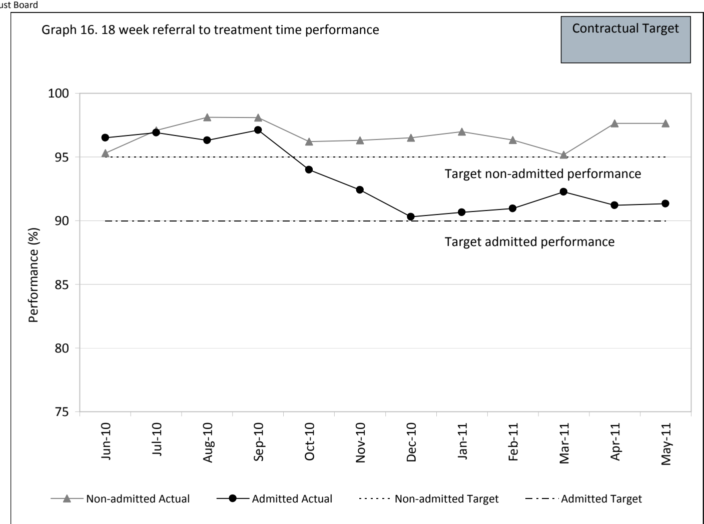


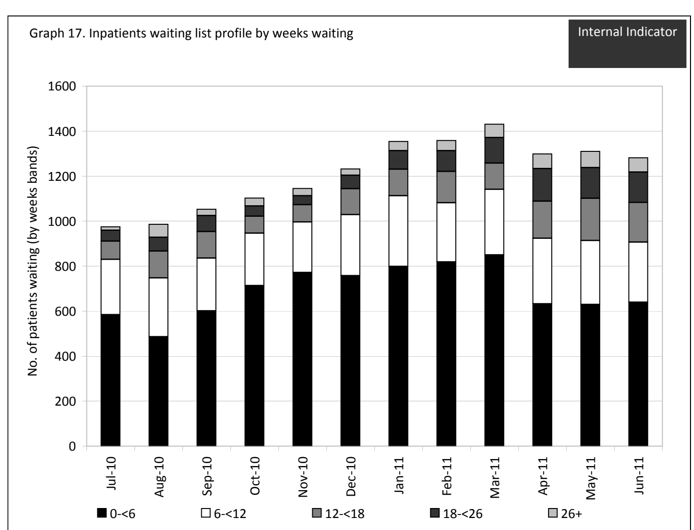
2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations

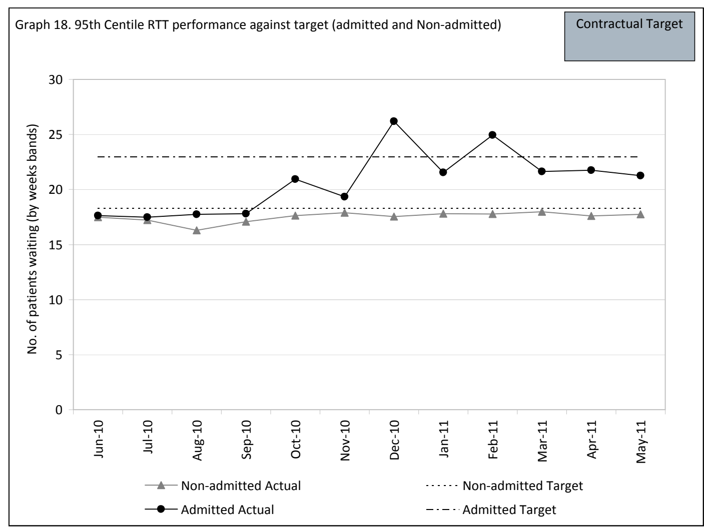
Key deliverables		RAG analysis
1	Ensure the Morgan Stanley Clinical Building is ready for occupation	Green

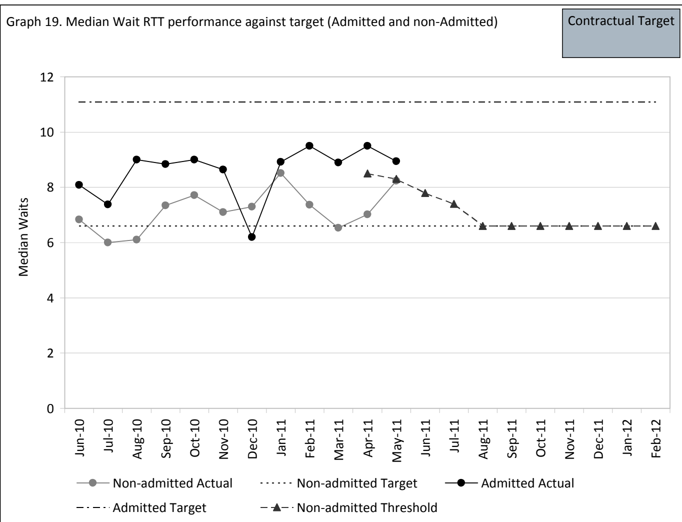
Workstream		Actions	Exec Lead	Last updated
1	Continue to reduce waiting times further through our 'no waits' programme	Continue to meet national and commissioning standards and improve the utilisation and efiiciency of our resources.	FD	16-May
2	Improve the standard of customer service that we offer patients and families	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	LM	06-Jul
3	Continue to improve our relationships with referrers in order to achieve our market share objective	Continue to implement the actions for improvement following the results of the Referrer Survey including producing a directory, holding referrer days along	BB	16-May
		Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building (MSCB) due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.	WM	NULL
		Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.	FD	05-Jul

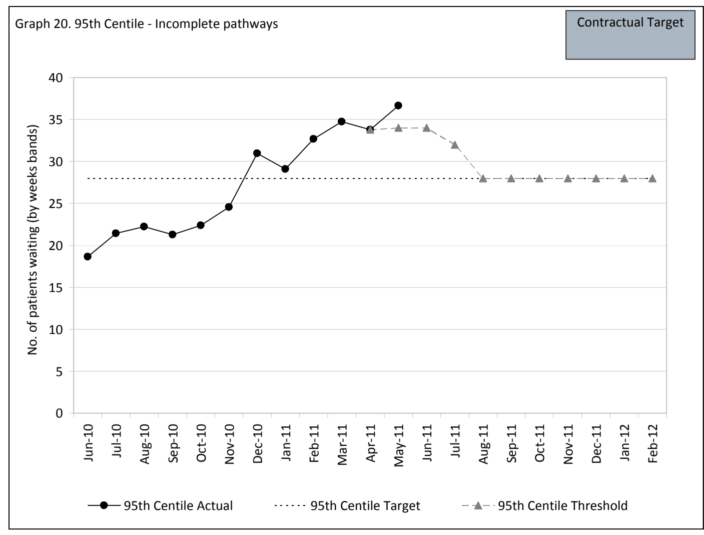
Trust Board

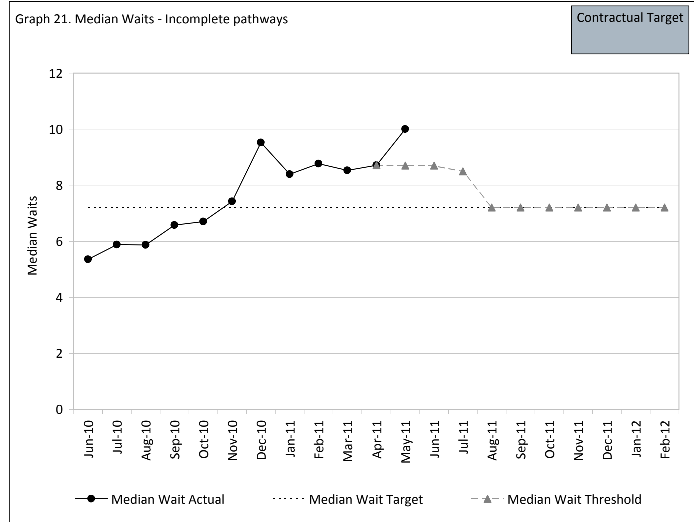


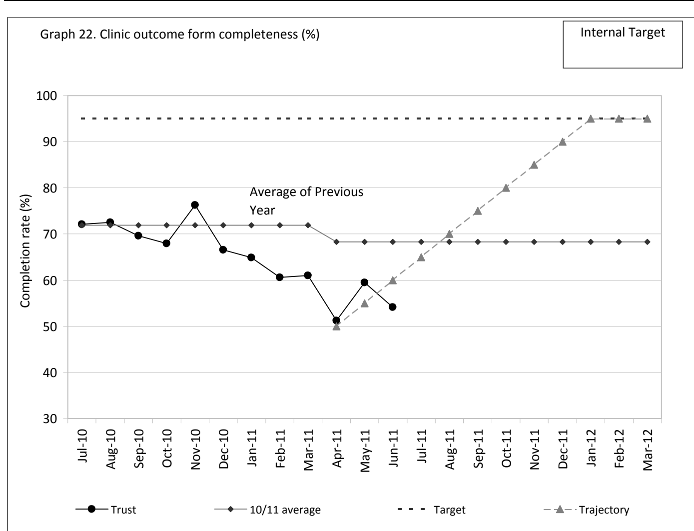


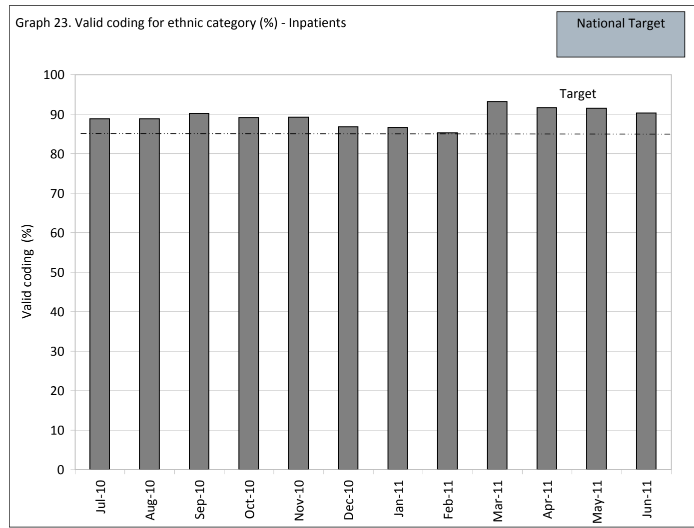


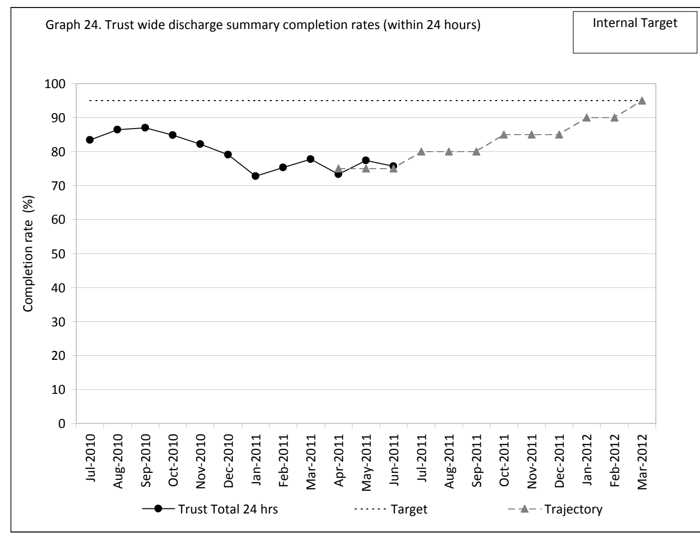


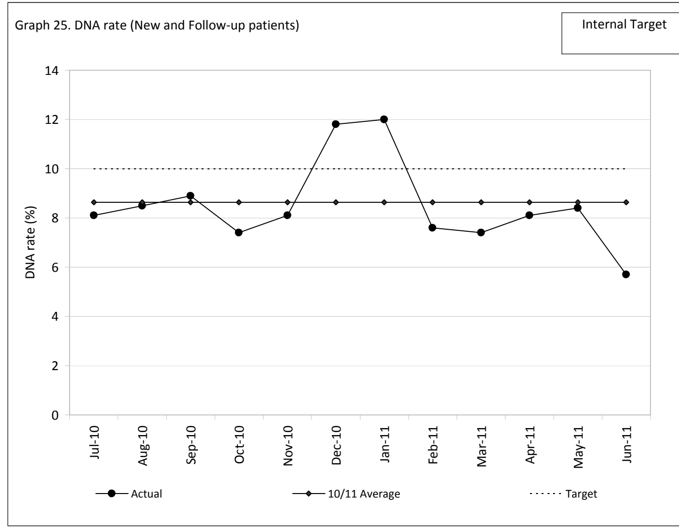

Graph 20. 95th Centile - Incomplete pathways
Contractual Target
No. of patients waiting (by weeks bands)
0
5
10
15
20
25
30
35
40
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
95th Centile Actual
95th Centile Target
95th Centile Threshold

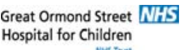

Graph 21. Median Waits - Incomplete pathways
Contractual Target
Median Waits
0
2
4
6
8
10
12
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Median Wait Actual
Median Wait Target
Median Wait Threshold


Graph 22. Clinic outcome form completeness (%)
Internal Target
Completion rate (%)
30
40
50
60
70
80
90
100
Average of Previous Year
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Trust
10/11 average
Target
Trajectory


Graph 23. Valid coding for ethnic category (%) - Inpatients
National Target
Valid coding (%)
0
10
20
30
40
50
60
70
80
90
100
Target
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11


Graph 24. Trust wide discharge summary completion rates (within 24 hours)
Internal Target
Completion rate (%)
0
10
20
30
40
50
60
70
80
90
100
Jul-2010
Aug-2010
Sep-2010
Oct-2010
Nov-2010
Dec-2010
Jan-2011
Feb-2011
Mar-2011
Apr-2011
May-2011
Jun-2011
Jul-2011
Aug-2011
Sep-2011
Oct-2011
Nov-2011
Dec-2011
Jan-2012
Feb-2012
Mar-2012
Trust Total 24 hrs
Target
Trajectory

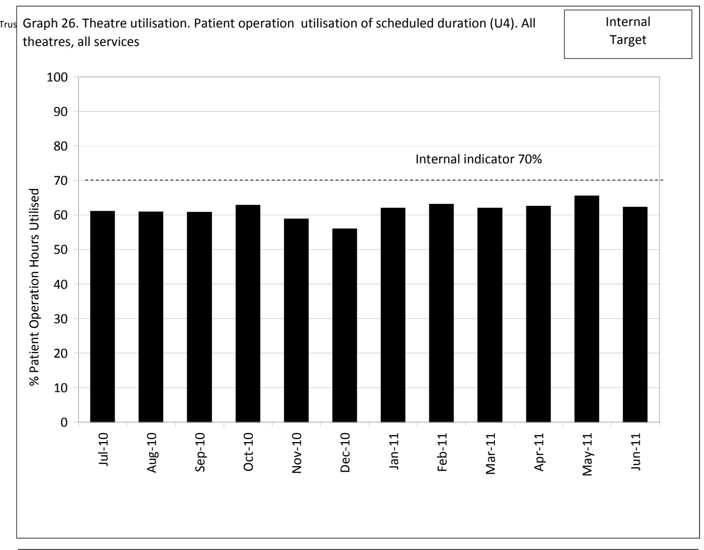

Graph 25. DNA rate (New and Follow-up patients)
Internal Target
DNA rate (%)
0
2
4
6
8
10
12
14
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Actual
10/11 Average
Target

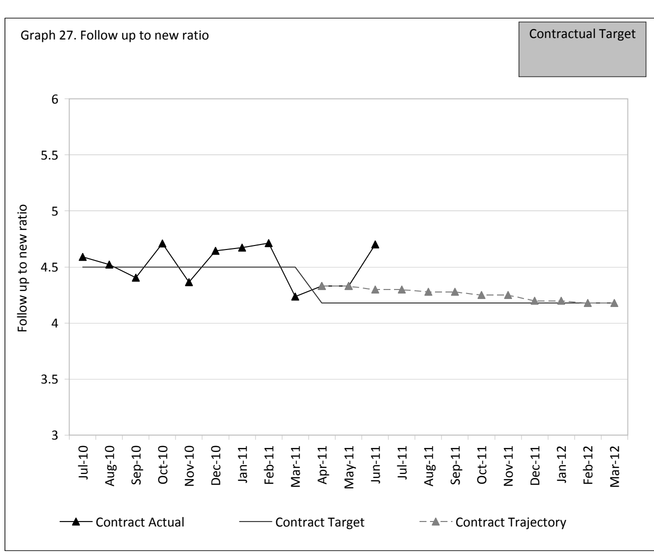


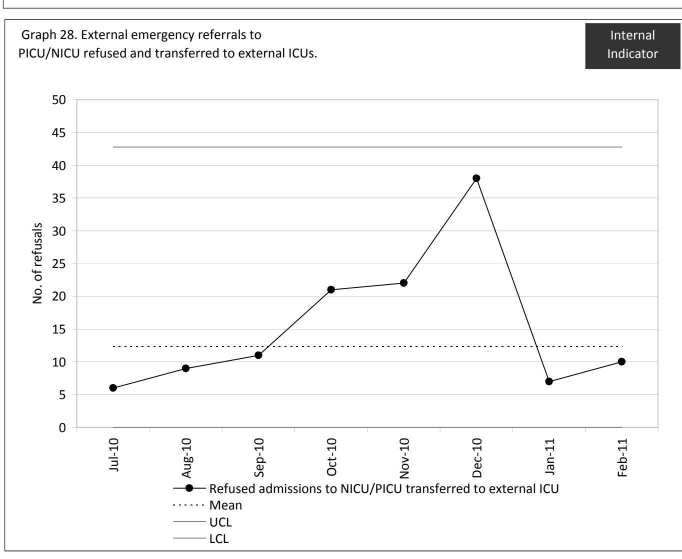
3. Successfully deliver our clinical growth strategy

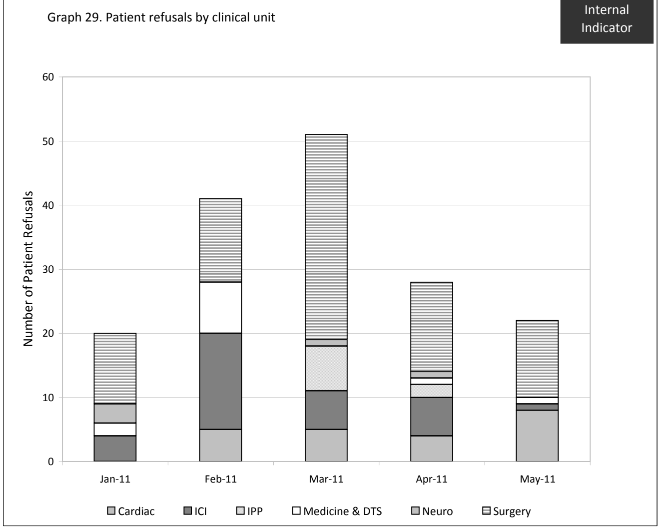
Key deliverables		RAG analysis
1	To meet our growth targets for both NHS and International and Private Patient activity	Green

	Workstream	Actions	Exec Lead	Last update
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	May-11
2	Maintain IPP service growth	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved	TC	Jul-11
3	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes and plan to accommodate any further growth that arises from this process.	FD	Jul-11
		Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.	FD	May-11





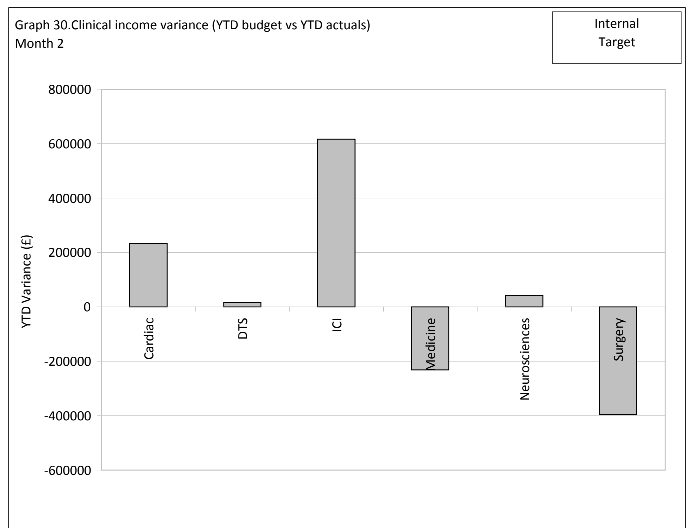


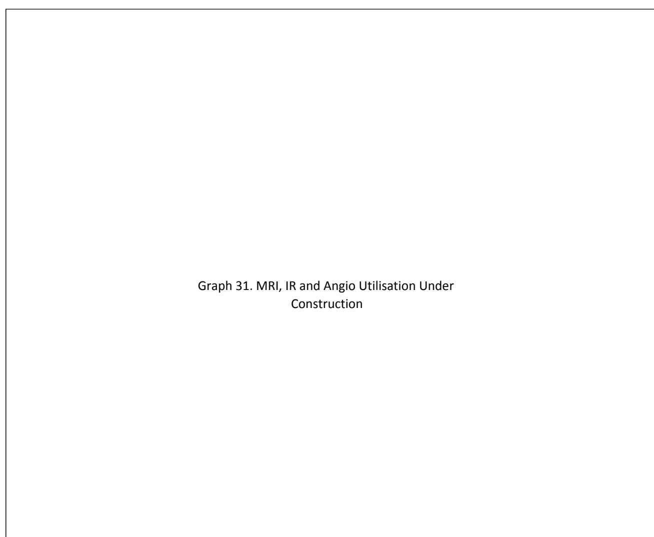


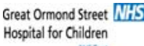
Commentary:

Graph 24. First to follow up ratios

1. Contract actual = the ratio of first to follow ups excluding the following criteria:
- Non-pct activity
- Haematology / oncology work
- Telephone clinics
- Outpatient Procedures


Graph 30.Clinical income variance (YTD budget vs YTD actuals)
Month 2
Internal
Target
800000
600000
400000
200000
0
-200000
-400000
-600000
YTD Variance (£)
Cardiac
DTS
ICI
Medicine
Neurosciences
Surgery


Graph 31. MRI, IR and Angio Utilisation Under
Construction

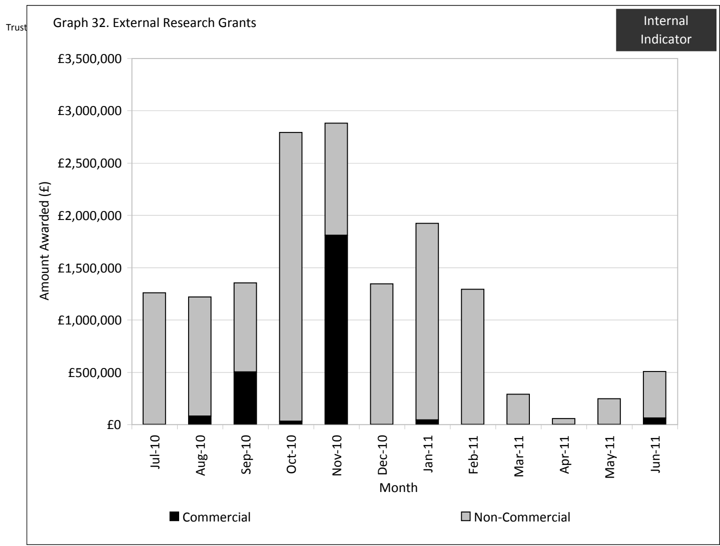


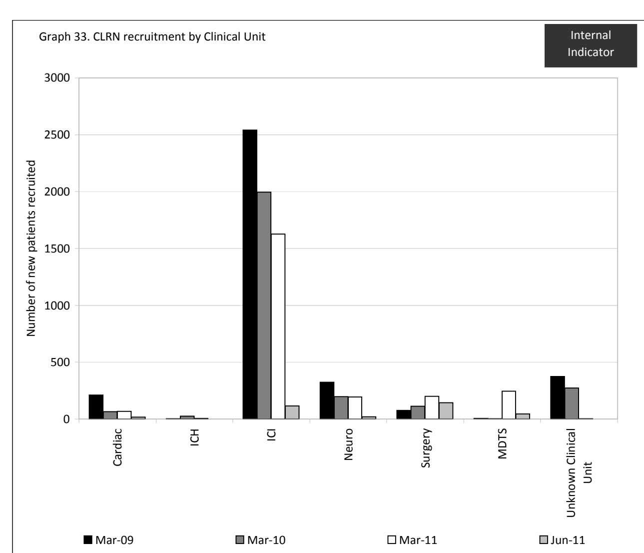
4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation

Key deliverables		RAG analysis
1	To increase our research publications and income for the Trust by 10%	Green

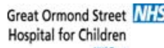
Key workstreams:			Exec Lead	Last update
1	Deliver the Research Strategy	Renew and deliver the Biomedical Research Centre in paediatrics	DG	12-Jul
		Continue to develop partnership working with ICH, University College London Partners (UCLP) and UCL Business	DG	12-Jul
		Increase research activity and income for the Trust by 10%	DG	12-Jul
2	Continue to improve the mechanisms for the management of research within the Trust	Continue to improve the mechanisms for the management of research within the Trust	DG	12-Jul

Trust





Key Performance Indicator Report

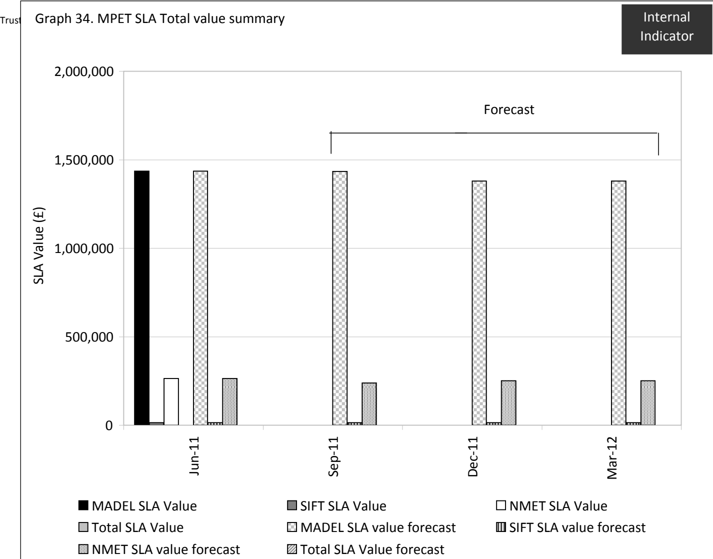


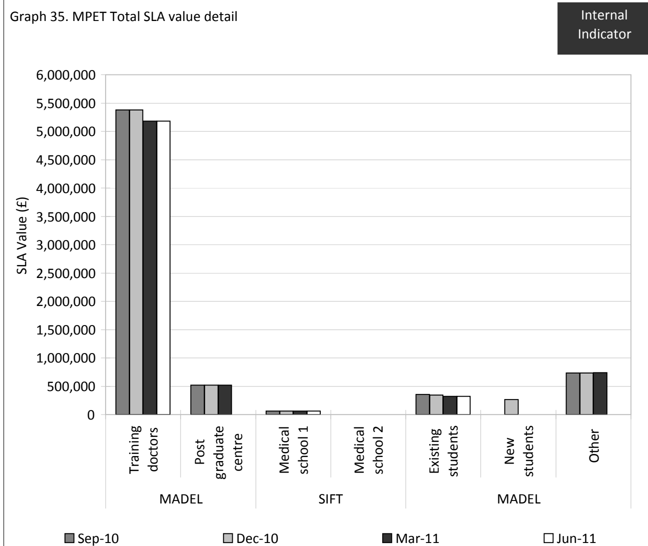
5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK

Key deliverables		RAG analysis
1	To achieve excellent ratings in the Post Graduate Medical Education and Training Board and Quality Assurance Agency for higher education reviews	Green

Key workstreams:			Exec Lead	Last Update
1	Deliver the Research Strategy	Renew and deliver the Biomedical Research Centre in paediatrics	DG	12-Jul
		Continue to develop partnership working with ICH, University College London Partners (UCLP) and UCL Business	DG	12-Jul
		Increase research activity and income for the Trust by 10%	DG	12-Jul
2	Continue to improve the mechanisms for the management of research within the Trust	Continue to improve the mechanisms for the management of research within the Trust	DG	12-Jul

Trust

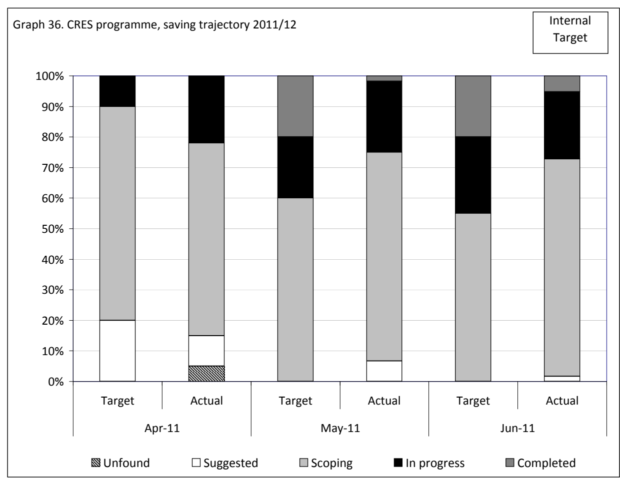


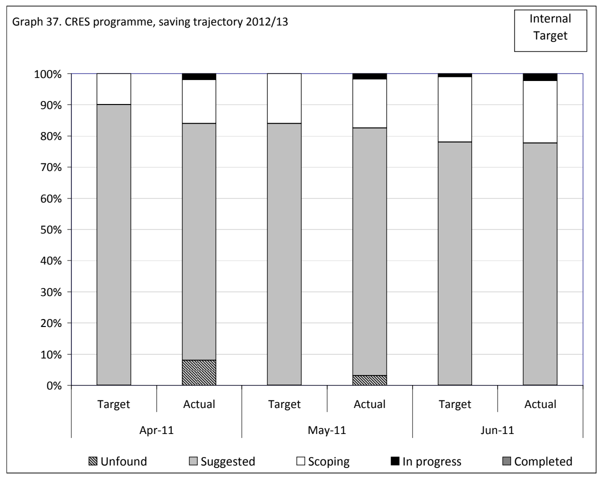


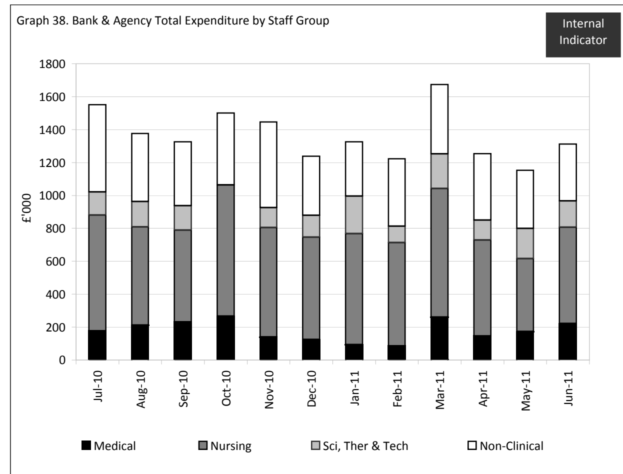
6. Deliver a financially stable organisation

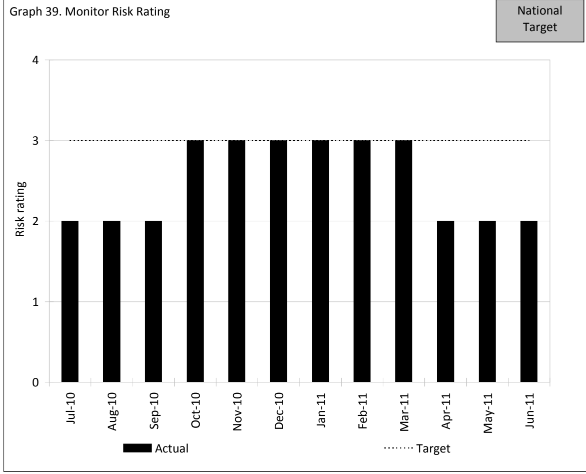
Key deliverables		RAG analysis
1	Deliver planned financial surplus through achieving income and efficiency goals	Green

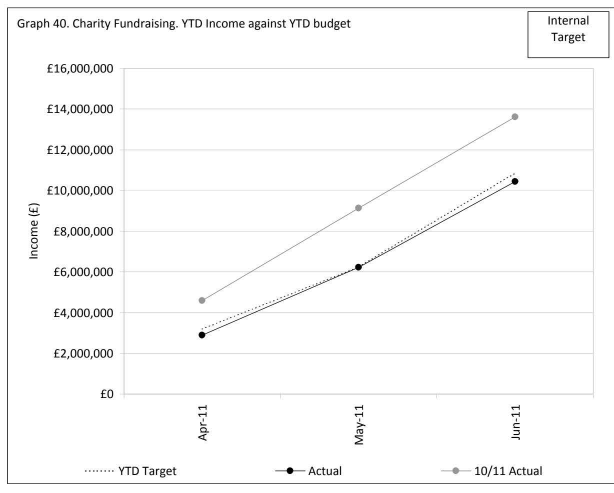
Key workstreams:			Exec Lead	Last Update
1	Agree achievable CRES plan and ensure delivery through robust project and performance management	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	FD	07-Jul
		Deliver surplus to plan.	FD	NULL
2	Improve efficiency through our Transformation Programme	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.	FD	NULL
3	Ensure appropriate funding for our clinical services from commissioners	Work with other specialist paediatric providers on work streams which will provide evidence to DH to support maintenance of specialist top up or targeted tariff design changes.	CN	NULL
		Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.	CN	NULL
4	Support the charity to raise targeted funds	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met	JC	NULL







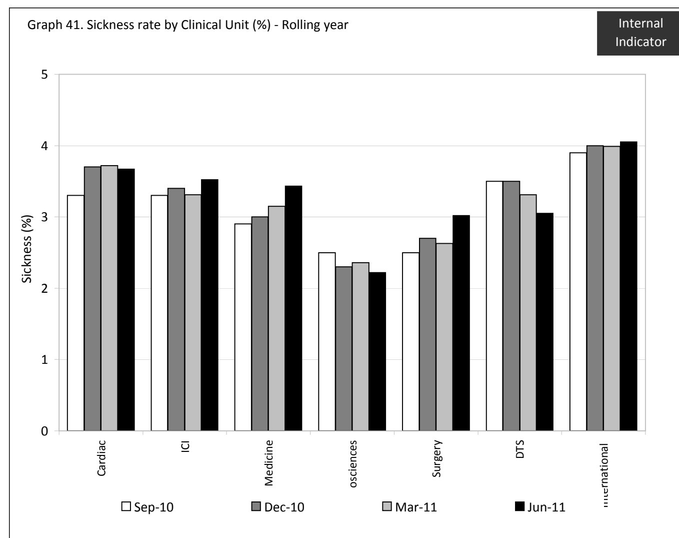




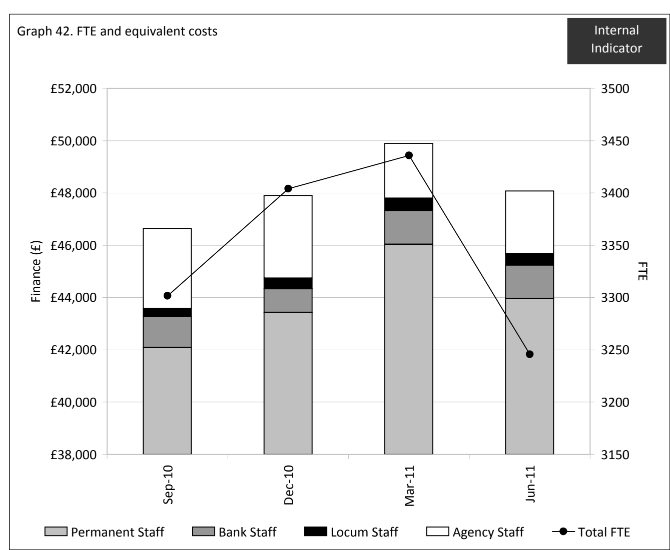
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation

Key deliverables		RAG analysis
1	To attain authorisation as a Foundation Trust	Green

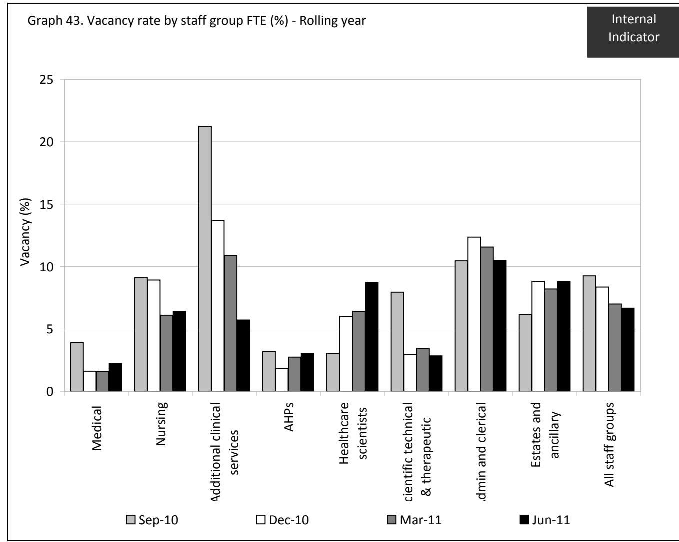
Key workstreams:			Exec Lead	Last Update
1	Make progress towards becoming a Foundation Trust	Complete monitor assessment, attain authorisation status and establish an effective members council.	FD	NULL
2	Ensure that the Trust is compliant with regulatory requirements	Ensure that the Trust retains registered status with CQC.	JC	NULL
		Ensure that Information Governance (IG) processes are strengthened and the self assessment score in the IG toolkit is improved.	CN	NULL
3	Improve efficiency of business processes	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	CN	NULL
		Deliver the first year of an agreed medium term IT strategy which ensures robust IT infrastructure and a credible and fundable replacement strategy for critical business applications.	CN	NULL
		Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.	JC	NULL



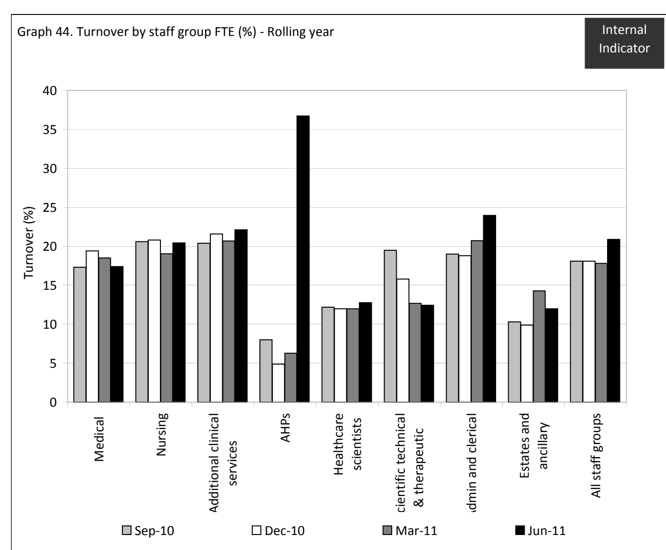
Graph 41. Sickness rate by Clinical Unit (%) - Rolling year



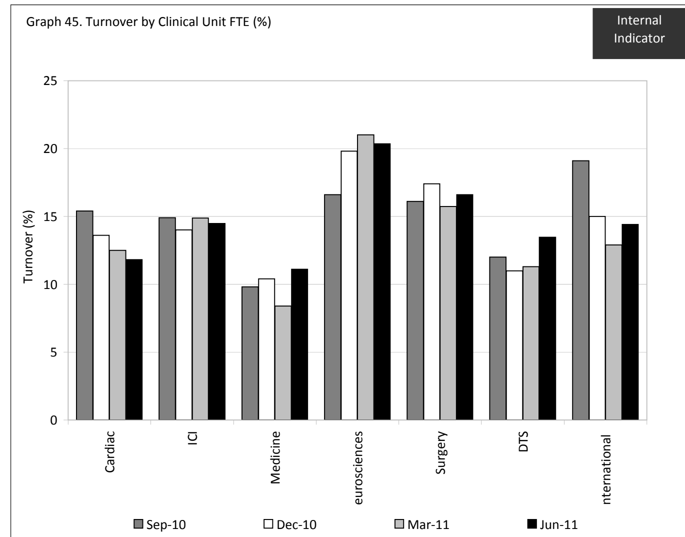
Graph 42. FTE and equivalent costs

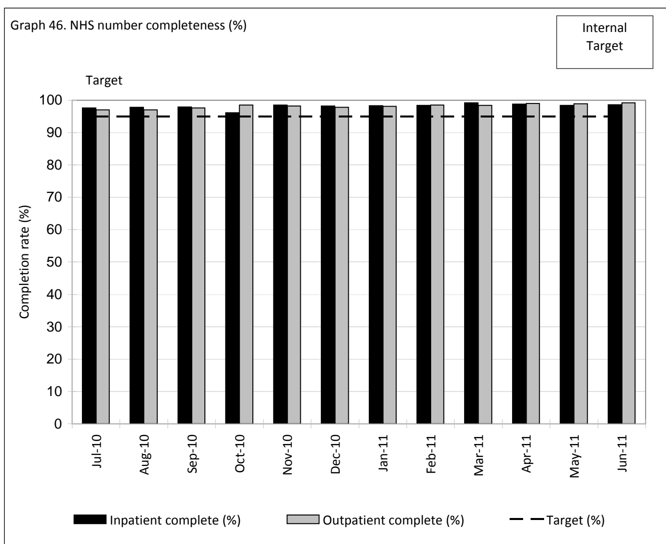


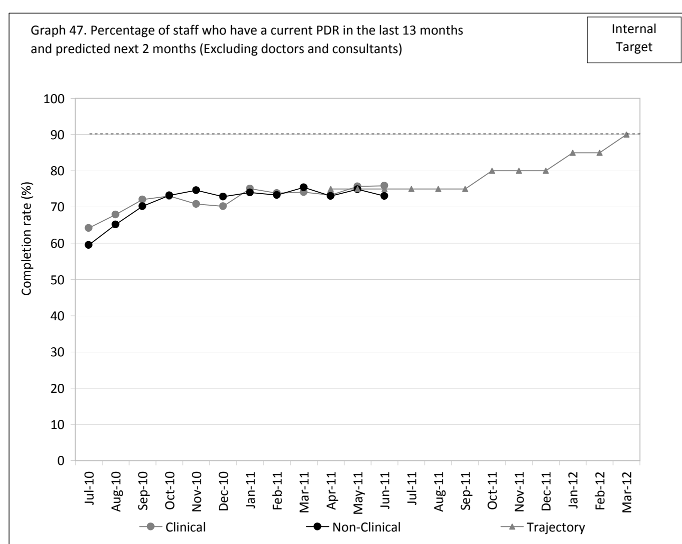
Graph 43. Vacancy rate by staff group FTE (%) - Rolling year

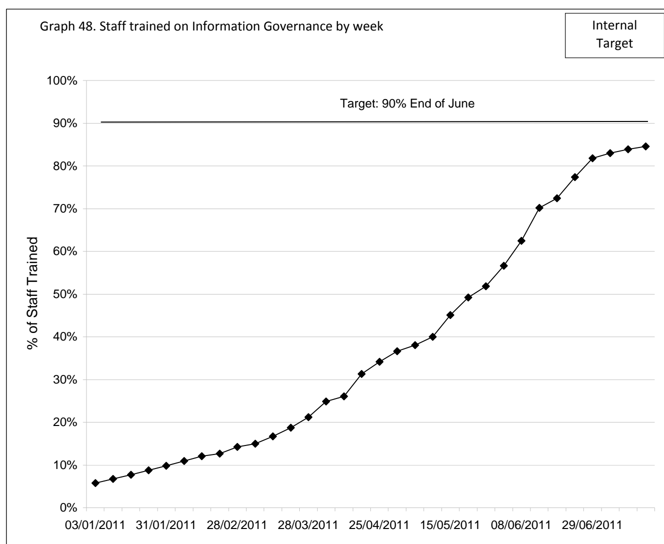


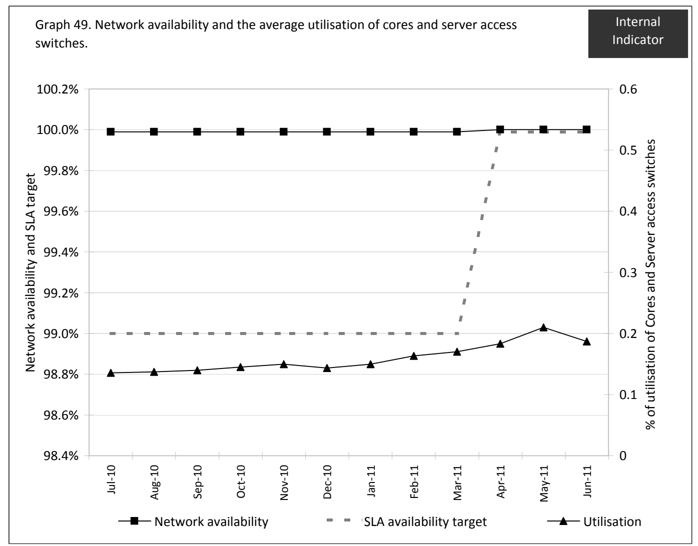
Graph 44. Turnover by staff group FTE (%) - Rolling year





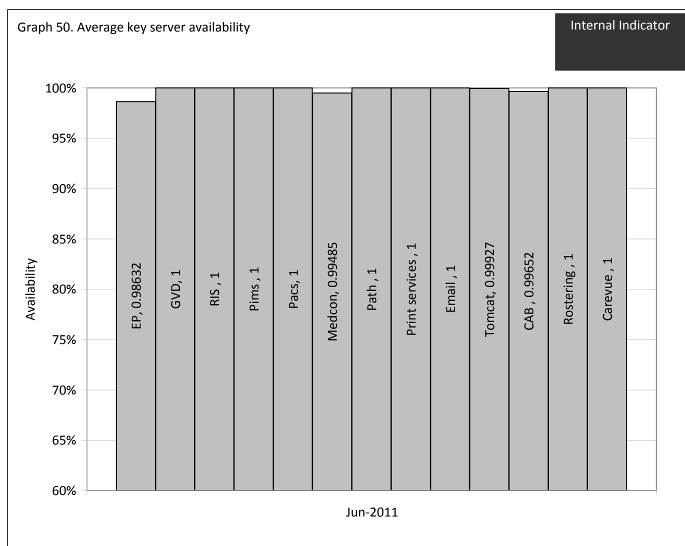


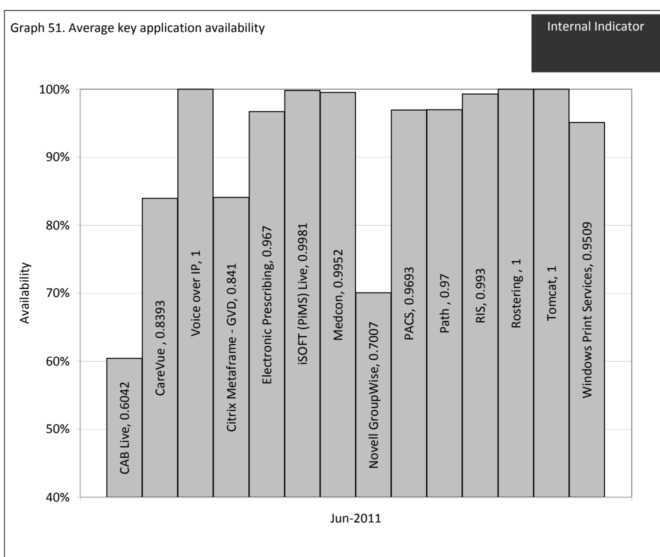


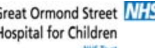


Commentary:

Workforce Planning will be moving to the new version of the data warehouse this month, which should correct many of the reporting issues experienced within the existing data warehouse. We will expect to see a decreases in 'Staff in Post' and increased accuracy in 'Turnover'. We will be moving to a different pathway for sickness information by April 2011 which should alter the sickness % to allow us to benchmark ourselves against external organisations.

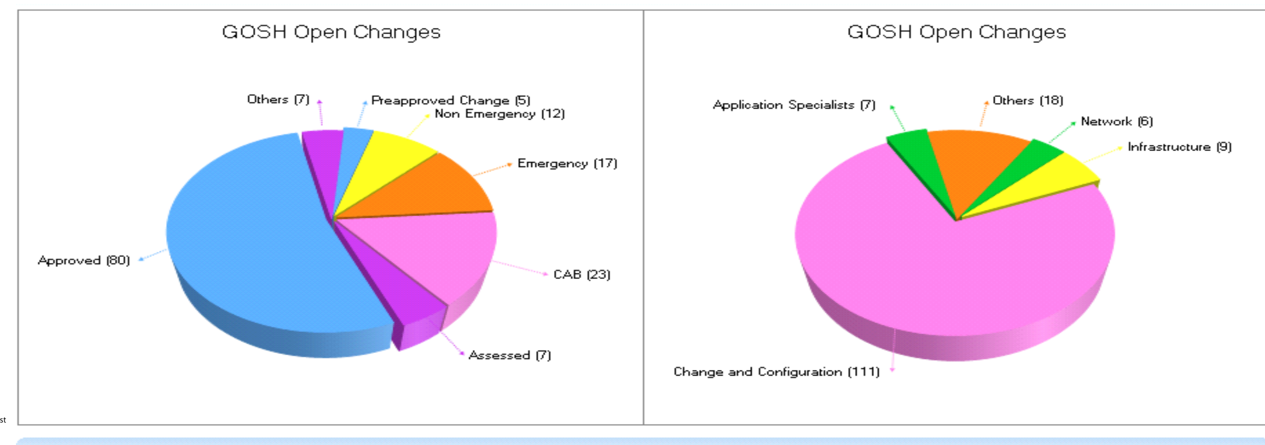

Graph 50. Average key server availability
Internal Indicator
100%
95%
90%
85%
80%
75%
70%
65%
60%
Availability
EP, 0.98632
GVD, 1
RIS , 1
Pims , 1
Pacs, 1
Medcon, 0.99485
Path , 1
Print services , 1
Email , 1
Tomcat, 0.99927
CAB , 0.99652
Rostering , 1
Carevue , 1
Jun-2011

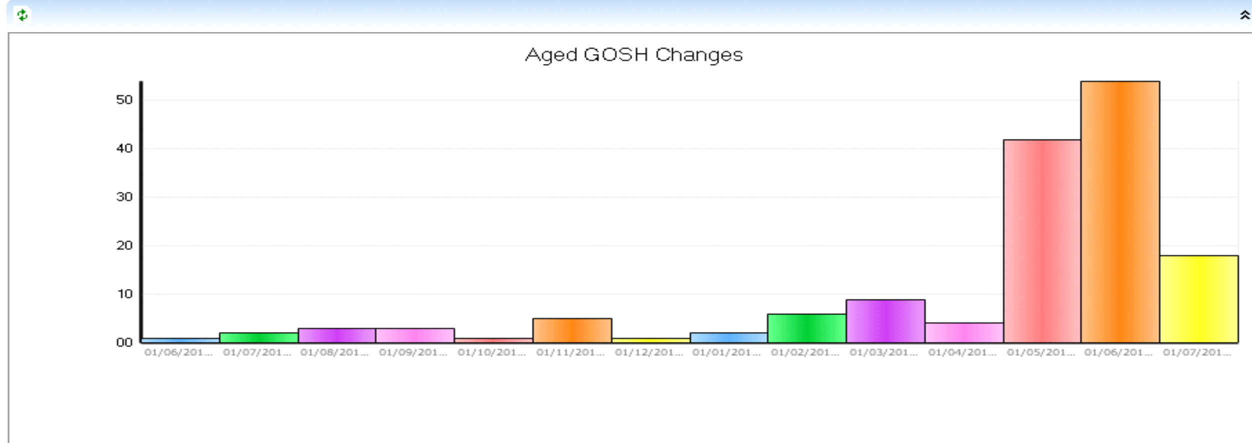

Graph 51. Average key application availability
Internal Indicator
100%
90%
80%
70%
60%
50%
40%
Availability
CAB Live, 0.6042
CareVue , 0.8393
Voice over IP, 1
Citrix Metaframe - GVD, 0.841
Electronic Prescribing, 0.967
iSOFT (PIMS) Live, 0.9981
Medcon, 0.9952
Novell GroupWise, 0.7007
PACS, 0.9693
Path , 0.97
RIS, 0.993
Rostering , 1
Tomcat, 1
Windows Print Services, 0.9509
Jun-2011



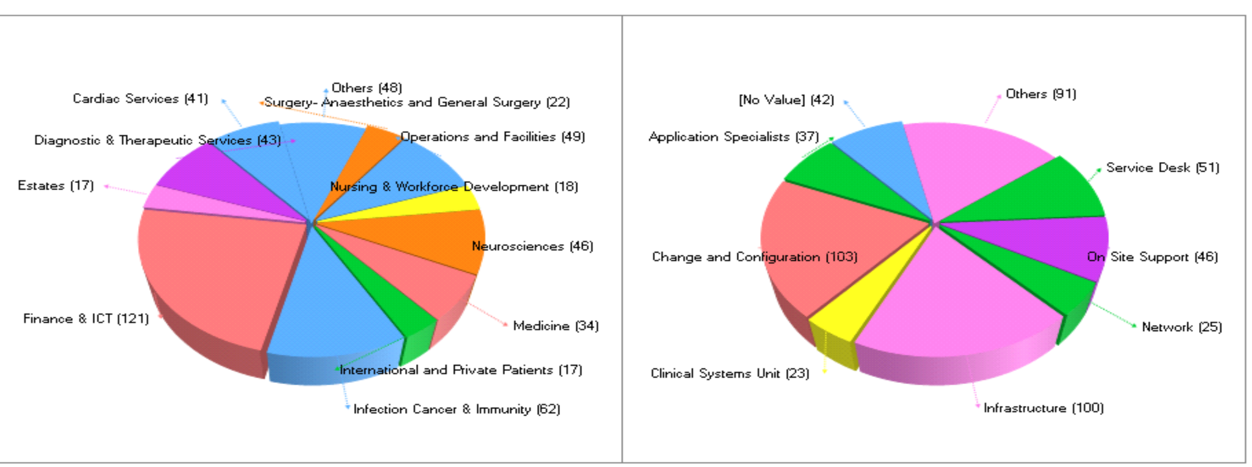
Appendix 1. ICT Service desk changes and incidents

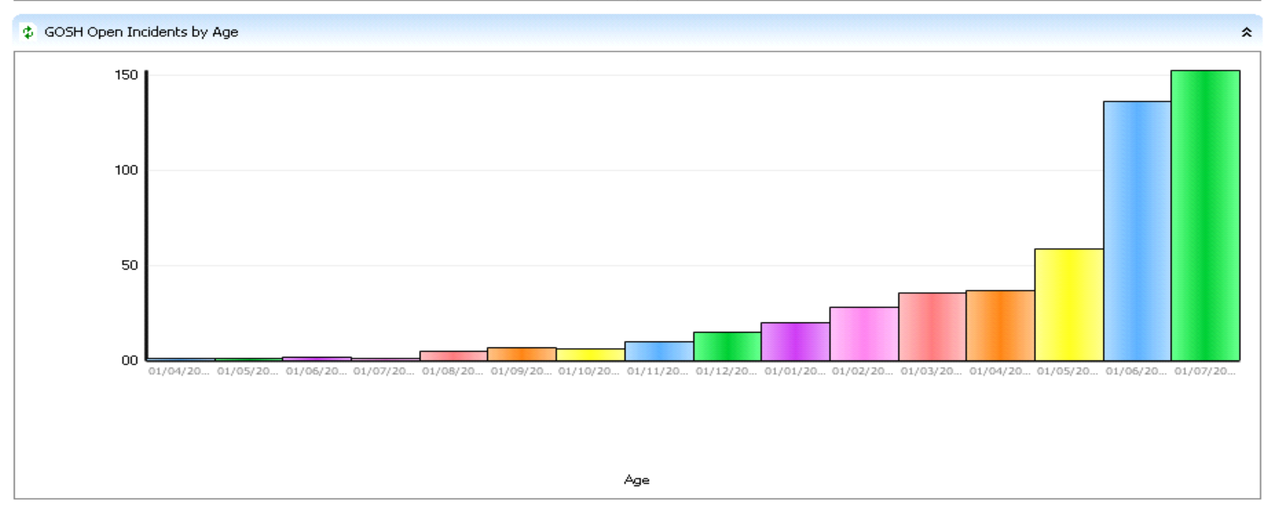
Service desk changes





Service desk incidents





Appendix 2. 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	MRSA - meeting the MRSA objective	0	1	Quarterly	1			
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)	0	1	Quarterly	1			
3	All cancers: 31-day wait for second or subsequent treatment comprising **either:**	TBC	1	Quarterly	0			
	Surgery	94%			0			
	anti cancer drug treatments	98%			0			
	radiotherapy (from 1 Jan 2011)	94%			0			
4	Admitted 95thCentile Performance	<23 weeks	0.5/1.0	Quarterly	0			
5	Non-Admitted 95thCentile Performance	<18.3 weeks	0.5/1.0	Quarterly	0			
6	Admitted Median Wait Performance	<11.1 weeks	0.5/1.0	Quarterly	0			
7	Non-Admitted Median Wait Performance	<6.6 weeks	0.5/1.0	Quarterly	1			
8	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0			
9	Screening all elective in-patients for MRSA	100%	0.5	Quarterly	0			
Overall governance risk rating					**Amber-Red**			

Trust B

Monitor	
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**
Green	No material concerns
Amber-green	Emerging concerns
Amber-red	Potential future significant breach if not
Red	Likely or actual significant breach

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Contents

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Trust Summary	2
Unit Summary and CRES Performance	3
Revenue Statement	4
Research and Development Activity	5
Ratio Analysis	6
Statement of Financial Position	7
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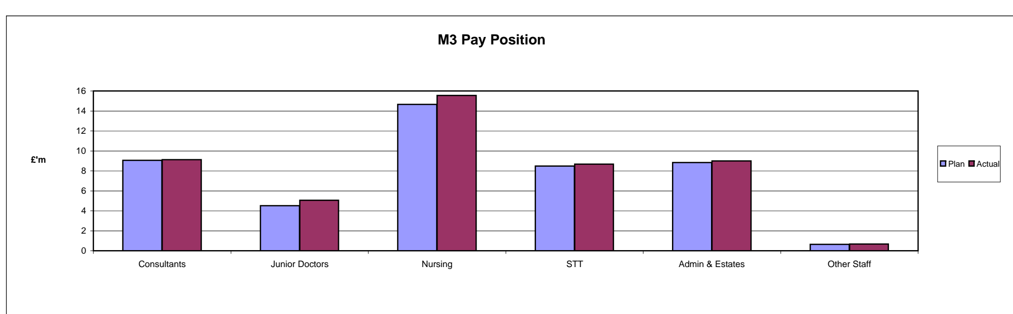
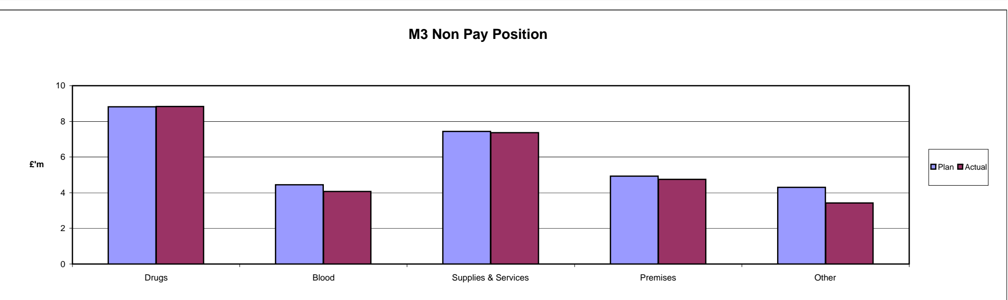
Activity	9
Cash Management	10
Cash Forecast	11
Receivables Management	12
Capital	13
WTE	14

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Trust Summary

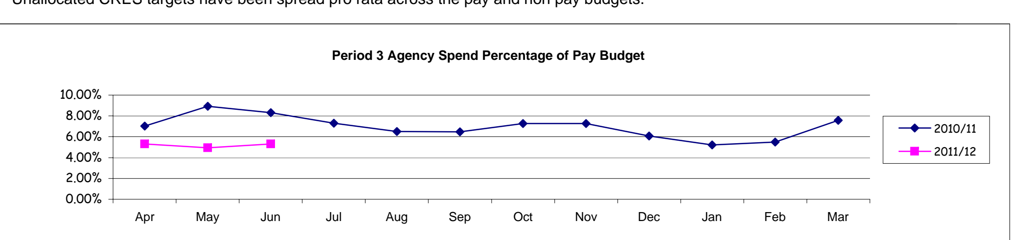
Statement of Comprehensive Income

	Current Month Actual £000	Current Month Plan Variance £000	YTD Actual £000	YTD Plan Variance £000
Revenue				
Revenue from patient care activities	23,598	603	72,341	2,015
Other operating revenue	3,866	(575)	11,775	(1,151)
Operating expenses	(25,767)	(2,142)	(80,062)	(926)
Operating surplus	**1,697**	**(2,114)**	**4,054**	**(62)**
Investment revenue	7	4	22	13
Other gains and (losses)	0	0	0	0
Finance costs	(3)	(1)	(10)	(4)
Surplus for the financial year	**1,701**	**(2,111)**	**4,066**	**(53)**
Public dividend capital dividends payable	(433)	45	(1,441)	0
Retained surplus for the year	**1,268**	**(2,066)**	**2,625**	**(53)**
Other comprehensive income				
Impairments put to the reserves	0	0	0	0
Gains on Revaluation	0	0	0	0
Receipt of donated and government grant assets	2,671	(1,518)	11,323	(1,917)
Reclassification adjustments:				
- Transfers from donated and government grant reserves	(522)	(22)	(1,508)	17
Total comprehensive income for the year	**3,417**	**(3,606)**	**12,440**	**(1,953)**





* Unallocated CRES targets have been spread pro rata across the pay and non pay budgets.



Staffing Staff Numbers	Budgeted Posts	WTE Paid	Maternity Paid	Temp Paid	Overtime Paid	Total Paid	WTE above plan
Admin and Other Support	825	785	12	84	5	886	(62)
Clinical Support	684	660	28	43	5	736	(51)
Medical	466	450	15	41	0	505	(39)
Nursing	1,284	1,194	94	141	4	1,433	(149)
Total	**3,259**	**3,089**	**149**	**308**	**14**	**3,560**	**(302)**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Unit Summary and CRES Performance

	YTD						
	Income*			Expenditure			Overall Unit Position
	2010 £000	Actual £000	Variance £000	2010 £000	Actual £000	Variance £000	Variance £000
Clinical Units							
Cardiac	12,814	13,789	187	(7,318)	(8,147)	(812)	(625)
Surgery	15,835	15,719	(583)	(14,964)	(14,743)	(742)	(1,325)
DTS	269	289	(185)	(4,679)	(4,938)	(111)	(296)
ICI	13,179	14,370	166	(13,042)	(13,874)	(614)	(448)
International	5,199	7,319	(37)	(2,166)	(3,103)	(620)	(658)
Medicine	9,803	10,748	(285)	(9,581)	(9,987)	(285)	(570)
Neurosciences	6,350	6,697	75	(4,975)	(5,329)	(326)	(251)
Haringey	2,370	1,607	23	(2,681)	(1,539)	45	68
North Mid.	678	5	5	(678)	(19)	(19)	(14)
Total Clinical Units	**66,498**	**70,543**	**(634)**	**(60,083)**	**(61,680)**	**(3,485)**	**(4,119)**
Central Departments							
Operations & Facilities	544	385	(25)	(4,258)	(4,154)	(165)	(191)
Corporate Affairs	16	14	(12)	(287)	(364)	67	55
Estates	138	131	(16)	(2,850)	(3,192)	(451)	(467)
Finance & ICT	39	48	1	(2,521)	(2,718)	(18)	(17)
Human Resources	135	154	(28)	(683)	(604)	106	78
Medical Director	27	8	(50)	(939)	(995)	2	(48)
Nursing And Workforce Development	503	520	79	(1,235)	(1,316)	71	150
Research And Innovation	2,978	3,299	(393)	(1,421)	(1,217)	406	14
Redevelopment Revenue Costs	124	106	(341)	(124)	(106)	65	(276)
Total Central Departments	**4,505**	**4,665**	**(784)**	**(14,318)**	**(14,667)**	**83**	**(702)**
Corporate Budgets	8,346	**8,906**	2,283	**(4,722)**	**(5,142)**	**2,486**	**4,769**
Net Position	**79,348**	**84,114**	**864**	**(79,123)**	**(81,489)**	**(917)**	**(53)**

CRES 2011/12		**Analysis of CRES Scheme Deliverability**					
	TARGET	**Released from Budgets**	**Deliverable Schemes**	**Feasible Schemes**	**Potential Schemes**	**Over identified Schemes**	**Total Risk**
CRES 2011/12 Target	**15,773**	**966**	**3,502**	**12,246**	**39**	**-980**	**14,807**
Status		**Delivered**	**RISK**	**RISK**	**RISK**	**RISK**	
Recurrent 2011/12		**915**	**3,483**	**11,995**	**39**		
Non recurrent 2011/12		**51**	**19**	**251**	**0**		
Expenditure		**966**	**2,319**	**3,696**	**29**		
Income		**0**	**1,183**	**8,550**	**10**		
CRES 2012/13		**0**	**363**	**3,450**	**12,476**		**16,289**
CRES 2013/14		**0**	**0**	**0**	**428**		**428**

Analysis	**Month 3**			*	**Month 3 New CRES**	**Schemes in progress**	
CLINICAL	**Target**	**BLUE**	**Variance**	**Posts released**	**New BLUE**	**On target (Green)**	**Feasible (Amber)**
Cardiac	2,073	**0**	-2,073	0.00	**0**	211	2,026
ICI	2,164	**0**	-2,164	0.00	**0**	839	1,243
IPP	664	**0**	-664	0.00	**0**	280	1,180
MDTS	2,622	**31**	-2,591	1.20	**31**	1,379	1,572
Neurosciences	1,418	**46**	-1,372	0.00	**46**	167	1,146
Surgery	3,357	**31**	-3,326	1.00	**0**	220	3,166
Total	**12,298**	**108**	**-12,190**	**2.20**	**77**	**3,096**	**10,333**
CORPORATE							
Clinical Ops	154	**48**	-106	0.00	**0**	123	0
Corporate Facilities	1,026	**450**	-576	11.10	**450**	95	337
Corporate Affairs	121	**121**	0	0.00	**9**	0	6
Estates	783	**57**	-726	0.00	**51**	0	726
Finance	732	**0**	-732	0.00	**0**	158	476
Medical Director	151	**0**	-151	0.00	**0**	0	103
Nursing and Education	283	**82**	-201	0.58	**0**	29	182
HR	192	**100**	-92	0.00	**100**	0	50
Reseach and Development	34	**0**	-34	0.00	**0**	0	35
Total	**3,476**	**858**	**-2,618**	**11.68**	**610**	**405**	**1,915**
Grand Total	**15,773**	**966**	**-14,807**	**13.88**	**687**	**3,502**	**12,246**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 03 2011/12
Revenue Statement

	11/12 Annual Budget £000	11/12 Mth 03 Actual £'000	11/12 Mth 03 Variance to Plan £'000	11/12 YTD Actual £'000	11/12 YTD Variance to Plan £'000	11/12 YTD Actual Variance to 10/11 YTD Actual £'000
Primary Care Trusts Tariff	64,349	**5,391**	-252	**16,926**	1,261	**2,200**
Primary Care Trusts Non Tariff	120,130	**9,813**	1,000	**28,615**	662	**298**
Primary Care Trusts Mff	18,754	**1,571**	-73	**4,938**	372	**301**
Strategic Health Authorities	45,155	**4,185**	422	**11,668**	379	**946**
Nhs Trusts	874	**66**	-7	**205**	-14	**-628**
Department Of Health	850	**6**	-65	**123**	-90	**-60**
Nhs Other	5,993	**396**	26	**2,516**	-143	**455**
Income CRES	7,441	**0**	-620	**0**	-1,860	**0**
Activity Revenue Nhs	**263,546**	**21,429**	**432**	**64,989**	**567**	**3,512**
Local Authorities	168	**0**	0	**164**	-4	**-88**
Private Patients	27,669	**2,012**	-287	**6,671**	-52	**1,589**
Non Nhs Other	3,602	**157**	-162	**514**	-357	**-249**
Income CRES	1,573	**0**	-131	**0**	-393	**0**
Activity Revenue Non Nhs	**33,012**	**2,170**	**-580**	**7,350**	**-806**	**1,252**
Patient Transport Services	1,216	**84**	-17	**277**	-27	**-49**
Education And Training	13,386	**1,107**	-31	**3,472**	43	**546**
Research And Development	13,148	**1,108**	12	**3,065**	-222	**74**
Charitable & Other Contrib	5,278	**255**	-217	**793**	-474	**-438**
Depreciation Income Transfer	6,773	**522**	22	**1,524**	17	**-227**
Non Patient Care Services	3,631	**340**	38	**921**	13	**312**
Revenue Generation	1,802	**140**	-10	**398**	-53	**91**
Other Revenue	6,305	**309**	-371	**1,326**	-447	**-309**
Income CRES	724	**0**	-60	**0**	-181	**0**
Other Operating Revenue	**52,262**	**3,866**	**-636**	**11,775**	**-1,332**	**2**
Directors & Senior Managers	-8,703	**-701**	31	**-2,114**	117	**-202**
Consultants	-36,975	**-2,947**	108	**-9,109**	135	**-114**
Junior Doctors	-18,428	**-1,629**	-93	**-4,799**	-192	**-371**
Junior Doctors Agy	11	**-90**	-91	**-258**	-260	**787**
Administration & Estates	-25,871	**-1,877**	238	**-5,766**	842	**-315**
Administration & Estates Agy	-659	**-346**	-306	**-1,104**	-939	**201**
Healthcare Assist & Supp	-2,252	**-185**	-7	**-558**	5	**-13**
Healthcare Assist & Supp Agy	0	**-42**	-42	**-44**	-44	**59**
Nursing Staff	-57,715	**-4,844**	-26	**-14,998**	-47	**-194**
Nursing Staff Agy	-21	**-206**	-201	**-560**	-554	**43**
Scientific Therap Tech	-32,832	**-2,684**	71	**-8,240**	411	**-266**
Scientific Therap Tech Agy	-53	**-145**	-138	**-428**	-414	**165**
Other Staff	-295	**-19**	6	**-80**	-6	**-6**
Pay Reserves	-7,620	**198**	833	**-11**	1,894	**-52**
Pay CRES	3,728	**0**	-311	**0**	-932	**0**
Pay Costs	**-187,685**	**-15,517**	**72**	**-48,067**	**14**	**-276**
Drugs Costs	-36,775	**-3,366**	-95	**-8,837**	48	**-1,463**
Blood Costs	-18,467	**-1,004**	634	**-4,066**	402	**621**
Supplies & Services - Clinical	-22,571	**-2,093**	-46	**-5,809**	-172	**-395**
Services From Nhs Organisation	-4,156	**-257**	104	**-768**	239	**265**
Healthcare From Non-Nhs Bodies	-1,959	**-124**	44	**-380**	105	**-41**
Supplies & Services - General	-1,468	**-123**	-1	**-414**	-49	**111**
Consultancy Services	-1,984	**288**	437	**-259**	238	**9**
Clinical Negligence Costs	-1,950	**-162**	0	**-487**	0	**-59**
Establishment Costs	-2,704	**-226**	-2	**-613**	74	**26**
Transport Costs	-2,882	**-225**	15	**-623**	107	**12**
Premises Costs	-19,283	**-1,180**	529	**-4,750**	221	**-359**
Auditors Costs	-420	**-24**	11	**-89**	16	**-3**
Education And Research Costs	-2,294	**-137**	77	**-276**	303	**36**
Expenditure - Other	-4,921	**-391**	-19	**-1,076**	162	**-575**
Non Pay Reserves	-10,131	**0**	-3,155	**0**	-1	**0**
Non-Pay CRES	860	**0**	74	**0**	-214	**0**
Non Pay Costs	**-131,102**	**-9,023**	**-1,393**	**-28,447**	**1,478**	**-1,814**
P & L On Disp Of Fixed Assets	0	**0**	0	**0**	0	**0**
Fixed Asset Impair & Reversals	-5,571	**0**	0	**0**	0	**0**
Depreciation & Amortisation	-17,164	**-1,219**	-23	**-3,522**	-18	**-284**
Interest Receivable	36	**7**	4	**22**	13	**10**
Other Revenue / Expenditure	-24	**-3**	-1	**-10**	-4	**-2**
Pdc Dividend Payable	-5,765	**-433**	47	**-1,441**	0	**23**
Corporation Tax	-234	**-8**	12	**-24**	35	**-24**
Other Revenue / Expenditure	**-28,723**	**-1,656**	**38**	**-4,974**	**26**	**-277**
Retained Surplus / (Deficit)	**1,309**	**1,268**	**-2,066**	**2,625**	**-53**	**2,400**

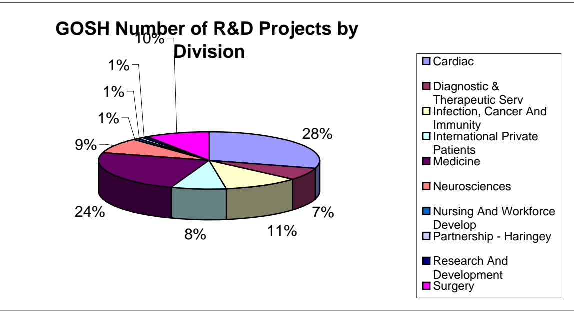
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Research and Development Activity

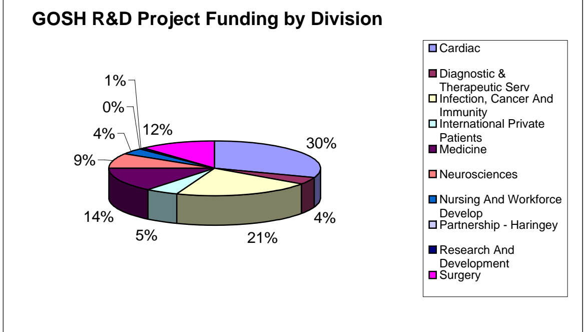
	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
Biomedical Research Centre including Clinical Research Facility				
- Income	(7,834)	(7,861)	(1,793)	(172)
- Income deferred from 10-11	(21)	(21)	(5)	0
- Commercial Trials Income	(255)	0	(5)	5
- Expenditure	2,812	2,811	546	157
	(5,298)	(5,070)	(1,257)	(10)
CLRN (PCRN) Income				
- Income CLR Activity Based (Non DH R&D)	(1,186)	(1,186)	(318)	22
- Income PCRN (R M&G, KSS, SS)	(183)	0	(24)	24
- Income PCRN (R M&G, KSS, SS) 09-10 C/FWD	0	0	0	0
- Income Non R&D (cc **CLR**)	0	(112)	0	(28)
- Expenditure CLR	100	198	54	(5)
	(1,269)	(1,100)	(288)	13
NIHR GRANTS				
- Income	(838)	(838)	(63)	(146)
- Expenditure	838	838	63	146
	0	0	0	(0)
R&D GOSH Charity Funded Projects				
- Income	(919)	(919)	(282)	(33)
- Expenditure	754	754	255	8
	(165)	(165)	(26)	(26)
R&D Development Office & Other Grants				
- Income non DH R&D	(625)	(770)	(22)	(34)
- Income R&D including Flexibility and Sustainability	(2,479)	(2,479)	(614)	(5)
- Expenditure	1,133	1,354	126	75
	(1,971)	(1,895)	(510)	36
TOTAL RESEARCH & DEVELOPMENT DIRECTORATE				
- R&D Income	(12,520)	(12,364)	(2,813)	(277)
- R&D Income Deferred from 10-11	(21)	(21)	(5)	0
- R&D Charitable Contribution	(919)	(919)	(282)	(33)
- Non Research Income	(880)	(883)	(26)	(57)
- Expenditure	5,636	5,955	1,045	382
	(8,703)	(8,231)	(2,082)	14
- Expenditure in Clinical Areas	8,673	8,673	2,168	(0)
Total R&D Division	(30)	442	86	13
Devolved Income				
- DTS : From CLRN Service Support	(76)	(189)	(19)	(28)
- Medicine : Grants	(94)	0	(9)	9
- ICI : From CLRN Support / NIHR Felowships	(156)	(66)	(50)	34
- Surgery : From Charitable Donation	(3)	0	(1)	1
Total Centrally Held and Devolved Income	(329)	(255)	(79)	16
TOTAL R&D INCOME				
-R&D Income Excluding Hosted network	(12,870)	(12,640)	(2,898)	(262)
-Income Generation GOS / Direct Credits	0	263	0	66
Total Income	(12,870)	(12,377)	(2,898)	(196)
Local Research Network MCRN *				
- Income DH to fund Network	(629)	(629)	(166)	(28)
- Income : Network Flexibility and Sustainability	(142)	(142)	0	0
- Income R&D :CLRN Network	0	0	0	0
- Income Other Non R&D	(17)	(17)	(6)	3
- Expenditure LRN	788	788	173	24
	0	0	0	0

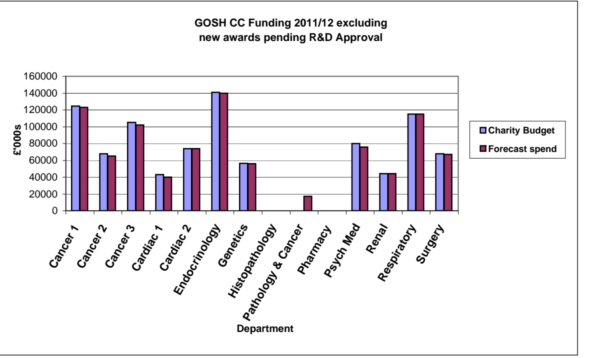
* GOSH is Hosting this service for Central and North East London

TOTAL R&D INCOME (as per Board Report)				
- R&D Income	(13,641)	(13,148)	(3,065)	(224)

The pie charts below show the % split of number and funding of research projects undertaken by GOSH staff per division. There may be further GOSH projects that are running with ICH staff as the lead.







Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Ratio Analysis

Provider Agency Rating	Target for FT Status	M3 11/12 Actual - FT	M02 11/12 Actual - FT	Forecast Outurn - FT		M3 FT Score
EBITDA Margin	5%	9.0%	8.3%	8.9%		4
EBITDA % Achieved	70%	99.0%	176.4%	100.0%		4
ROA	3%	1.2%	0.7%	3.8%		2
I&E Surplus margin	1%	3.1%	2.4%	2.0%		5
Liquidity Days	15.0	12	12	11		2
Weighted Average	3.0	3.3	3.0	3.2		3.3
Overall Rating	**3**	**2**	**2**	**3**		2
IPP Cap (Max 9.7%)	9.7%	9.2%	9.6%	9.6%		

Salary Overpayments		
Unit	**No.**	**Amount £'000**
Neuro	7	8.3
Surgery	2	0.5
Nursing & Workforce	1	0.5
Clinical Operations	1	0.4
DTS	1	0.3
TOTAL	12	10.0

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Statement of Financial Position

	Actual as at 1 April 2011 £000	Actual as at 31 May 2011 £000	Actual as at 30 June 2011 £000	Change in month £000
Non Current Assets :				
Property Plant & Equipment - Purchased	177,238	177,030	177,856	826
Property Plant & Equipment - Donated	141,526	149,190	151,379	2,189
Property Plant & Equipment - Gov Granted	363	353	347	(6)
Intangible Assets - Purchased	972	869	1,128	259
Intangible Assets - Donated	25	22	21	(1)
Trade & Other Receivables	9,505	9,439	9,400	(39)
Total Non Current Assets :	***329,629***	***336,903***	***340,131***	***3,228***
Current Assets :				
Inventories	5,156	5,521	5,275	(246)
NHS Trade Receivables	7,455	16,491	12,323	(4,168)
Non NHS Trade Receivables	10,360	11,765	8,236	(3,529)
Capital Receivables	6,571	7,746	7,005	(741)
Provision for Impairment of Receivables	(1,498)	(1,546)	(1,529)	17
Prepayments & Accrued Income	4,919	4,749	5,646	897
HMRC VAT	1,895	1,226	876	(350)
Other Receivables	807	860	898	38
Cash & Cash Equivalents	32,371	18,471	21,039	2,568
Total Current Assets :	***68,036***	***65,283***	***59,769***	***(5,514)***
Total Assets :	**397,665**	**402,186**	**399,900**	**(2,286)**
Current Liabilities :				
NHS Trade Payables	(7,722)	(5,556)	(4,683)	873
Non NHS Trade Payables	(2,519)	(1,214)	(2,882)	(1,668)
Capital Payables	(12,179)	(7,796)	(8,303)	(507)
Expenditure Accruals	(14,866)	(14,583)	(10,302)	4,281
Deferred Revenue	(6,280)	(8,391)	(5,639)	2,752
Tax & Social Security Costs	(4,022)	(4,122)	(3,978)	144
Other Payables	0	(1,008)	(1,441)	(433)
Payments on Account	(228)	(228)	(228)	0
Lease Incentives	(400)	(400)	(400)	(0)
Other Liabilities	(2,754)	(3,377)	(3,190)	187
Provisions for Liabilites & Charges	(2,867)	(2,732)	(2,683)	49
Total Current Liabilities :	***(53,837)***	***(49,409)***	***(43,729)***	***5,680***
Net Current Assets	**14,199**	**15,874**	**16,040**	**166**
Total Assets Less Current Liabilities :	**343,828**	**352,777**	**356,171**	**3,394**
Non Current Liabilities :				
Lease Incentives	(7,327)	(7,261)	(7,228)	33
Provisions for Liabilites & Charges	(1,250)	(1,257)	(1,234)	23
Total Non Current Liabilities :	***(8,577)***	***(8,518)***	***(8,462)***	***56***
Total Assets Employed :	**335,251**	**344,259**	**347,709**	**3,450**
Financed by Taxpayers' Equity :				
Public Dividend Capital	124,732	124,732	124,732	0
Retained Earnings	16,869	18,256	19,537	1,281
Revaluation Reserve	48,623	48,594	48,579	(15)
Donated Asset Reserve	141,551	149,212	151,400	2,188
Government Grant Reserve	363	353	347	(6)
Other Reserves	3,114	3,114	3,114	0
Total Taxpayers' Equity :	**335,251**	**344,259**	**347,709**	**3,450**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Statement of Cash Flow

Statement of Cash Flows	Actual For Month Ending 30 June 2011 £000	Actual For YTD Ending 30 June 2011 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	1,697	4,054
Depreciation and Amortisation	1,219	3,522
Transfer from Donated Asset Reserve	(517)	(1,508)
Transfer from the Government Grant Reserve	(5)	(16)
Decrease/(Increase) in Inventories	246	(119)
Decrease/(Increase) in Trade and Other Receivables	7,134	(2,406)
Decrease in Trade and Other Payables	(6,362)	(7,905)
(Increase)/Decrease in Other Current Liabilities	(220)	337
Decrease in Provisions	(77)	(210)
Net Cash Inflow/(Outflow) from Operating Activities :	***3,115***	***(4,251)***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	7	22
Payments for Property, Plant and Equipment	(3,705)	(17,804)
Payments for Intangible Assets	(275)	(202)
Net Cash Outflow from Investing Activities :	**(3,973)**	**(17,984)**
NET CASH OUTFLOW BEFORE FINANCING :	**(858)**	**(22,235)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Other Capital Receipts	3,426	10,903
Net Cash Inflow from Financing :	**3,426**	**10,903**
NET DECREASE IN CASH AND CASH EQUIVALENTS :	**2,568**	**(11,332)**

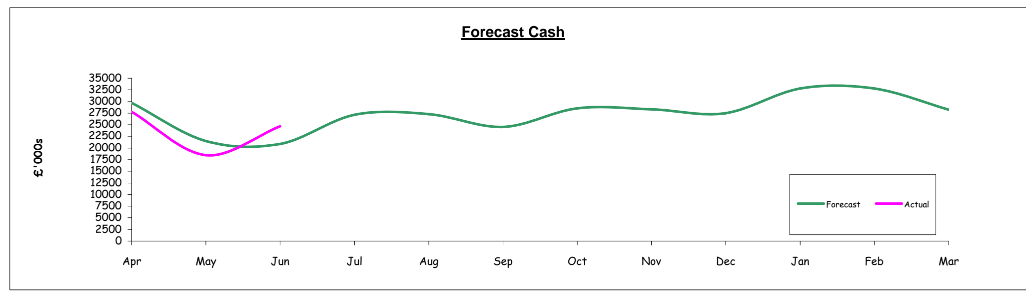
Cash and Cash Equivalents at the Beginning of the current period	**18,471**	**32,371**
Cash and Cash Equivalents at the End of the current period	**21,039**	**21,039**
Net Increase/ (Decrease) in Cash and Cash Equivalents per SOFP :	**2,568**	**(11,332)**

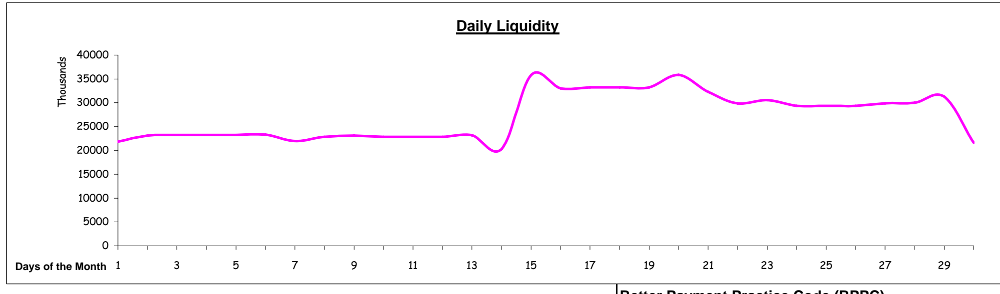
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/2012
Activity

June activities are based on April to May

	April	May	June	YTD 11/12 Actual	YTD 11/12 Plan	YTD 11/12 Variance	YTD 10/11	Variance 11/12 to 10/11
Elective PBR	1,425	1,510	1,701	4,636	4,364	272	4,238	398
Elective Non PBR	104	154	145	403	555	-152	416	-13
Same Day PBR				0	0	0	0	0
Same Day Non PBR				0	0	0	0	0
TOTAL ELECTIVE	1,529	1,664	1,846	5,039	4,919	120	4,654	385
Non Elective PBR	143	153	146	442	446	-4	524	-82
Non Elective Non PBR	3	1	2	6	13	-7	8	-2
TOTAL NON ELECTIVE	146	154	148	448	459	-11	532	-84
Outpatients PBR	5,604	6,758	7,357	19,719	19,917	-198	16,649	3,070
Outpatients Non PBR	4,265	4,849	5,277	14,391	14,240	150	15,012	-621
TOTAL OUTPATIENTS	9,869	11,607	12,633	34,109	34,157	-47	31,661	2,449
POC (Non Consortium)	812	799	806	2,417	2,635	-218	2,752	-335
BEDDAYS (includes PICU Consortium)								
Panda HDU (PBR HDU)	744	625	793	2,162	2,102	60	2,047	115
Transitional Care	140	176	155	471	372	100	372	100
Rheumatology Rehab	145	194	167	506	548	-43	537	-32
CAMHS	214	239	223	676	731	-56	679	-3
Cardiac ECMO	17	5	11	33	23	10	24	9
Neurosurgery HDU (NC)	0	5	2	7	10	-2	10	-2
Neurosurgery (PICU Consortium-ITU &	2	52	27	81	192	-111	190	-109
Neurosurgery ITU (NC)	1	6	3	10	6	5	5	5
Cardiac HDU (NC)	33	28	30	91	101	-10	98	-7
Cardiac ITU (NC)	61	101	80	242	286	-45	337	-95
Cardiac (PICU Consortium-ITU)	251	197	220	668	623	46	594	74
Paediatric ITU (NC)	48	68	57	173	207	-34	164	9
Paediatric ITU (PICU Consortium)	399	370	378	1,147	1,165	-18	1,133	15
TOTAL BEDDAYS	2,055	2,066	2,146	6,267	6,365	-98	6,189	78
HaemOnc Consortium*								
PBR	50	55	60	165	155	10	129	37
NON PBR	134	144	161	439	411	28	381	58
Panda HDU (PBR HDU)	223	262	189	674	674	0	608	67
TOTAL HAEMONC	407	461	410	1,278	1,240	38	1,117	161

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Cash Management





Commerical Bank Account Performance

Cumulative Average Balance

Thousands

50 45 40 35 30 25 20 15 10 5 0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Month

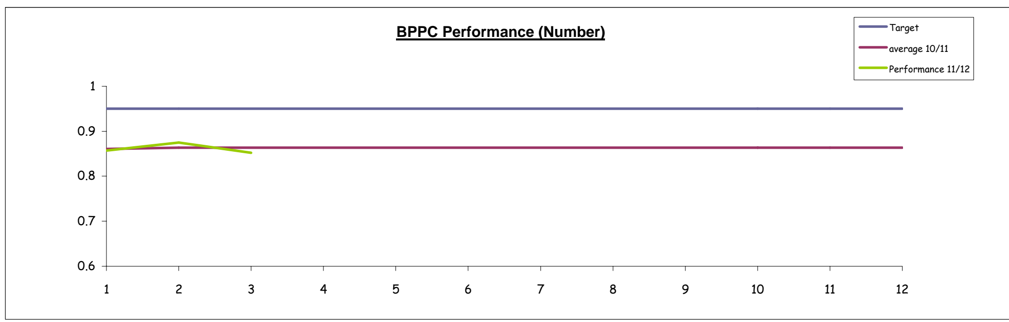
Limit
RBS Main
RBS Credit Card
LloydsTSB Dubai
Commerical Total

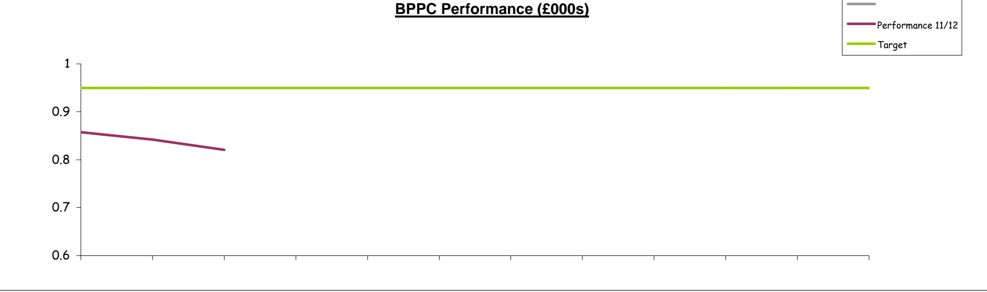
Payables Analysis

Days	Current Month	Previous Month	Movement in Month
	£000s	£000s	£000s
Not Yet Due	4,665	2,560	2,105
1-30	966	3,279	(2,313)
31-60	896	1,288	(392)
61-90	933	291	642
91-120	236	301	(65)
121-180	673	663	10
180-360	1,507	1,480	27
360+	1,573	1,487	86
	11,449	**11,349**	**100**

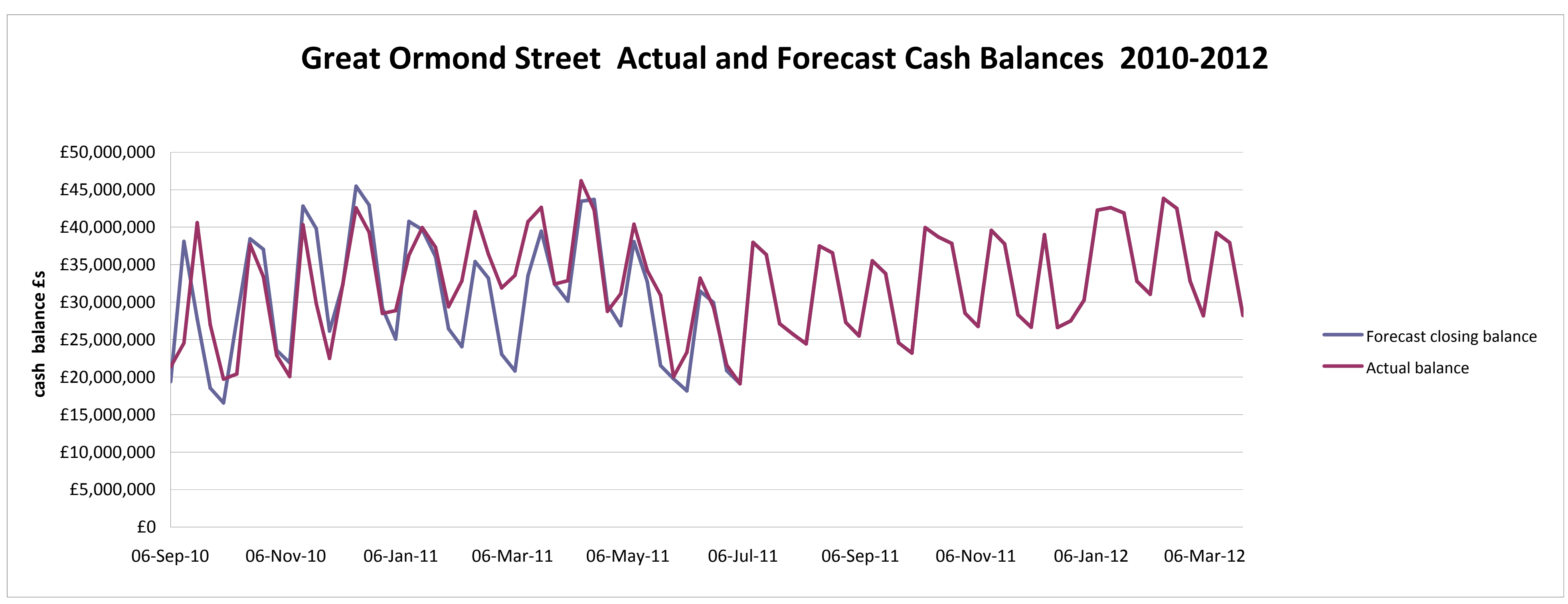
Better Payment Practice Code (BPPC)

	Number	£000s
Total Payables		
% of Invoices paid within target	85.2%	82.0%
Non-NHS Payables		
Invoices paid in the year	19058	55,258
Invoices paid within target	16548	46,588
% of Invoices paid within target	86.8%	84.3%
NHS Payables		
Invoices paid in the year	855	4,973
Invoices paid within target	418	2,828
% of Invoices paid within target	48.9%	56.9%





Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Cash Forecast



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	**6589**	-1435	3317	2086	927	391	228	32	378	665
NHS Credit Note Provision	-1104	0	0	0	0	0	-28	-31	-420	-625
Specific NHS Debt Provisions	0									
NHS Net Receivables	**5485**	**-1435**	**3317**	**2086**	**927**	**391**	**200**	**1**	**-42**	**40**
Non-NHS	**1451**	-16	306	282	68	225	67	78	273	168
Bad Debt Provision-Non NHS	-625	0	-46	-35	-10	-32	-19	-20	-291	-171
Specific Non-NHS Debt Provisions	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**827**	**-16**	**260**	**247**	**58**	**193**	**48**	**58**	**-18**	**-2**
International	**5955**	-1240	4620	871	185	251	191	182	288	607
Bad Debt Provision-International	-763	0	-3	-0	-1	-0	-38	-36	-85	-599
International Net Receivables	**5192**	**-1240**	**4618**	**871**	**184**	**251**	**153**	**145**	**203**	**8**
GOSH Charity Receivables	**891**	-1	815	44	2	31	1	0	-0	0
Specific Activity Provisions	0	0	0	0	0	0	0	0	0	0
Net Trust Receivables	**12395**	**-2692**	**9009**	**3248**	**1171**	**866**	**401**	**204**	**143**	**45**

Trust Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	6589	-1435	3317	2086	927	391	228	32	378	665
Non-NHS	1451	-16	306	282	68	225	67	78	273	168
International	5955	-1240	4620	871	185	251	191	182	288	607
Gross Trading Receivables	**13996**	**-2691**	**8243**	**3239**	**1180**	**868**	**486**	**292**	**939**	**1440**
GOSH Charity Receivables	891	-1	815	44	2	31	1	0	-0	0
Total Trust Receivables	**14887**	**-2692**	**9058**	**3283**	**1182**	**899**	**487**	**292**	**939**	**1440**

Movement in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
Gross Trading Receivables (as above)	14887	-2692	9058	3283	1182	899	487	292	939	1440
Gross Trading Receivables (last month)	19058	-2422	6100	4548	6492	856	544	488	1408	1046
Movement in Month	**-4172**	**-270**	**2958**	**-1265**	**-5310**	**43**	**-57**	**-196**	**-469**	**394**
Gross Trading Receivables (year end 10/11)	15481	-1747	11317	1550	779	524	423	515	1385	734
Movement in Financial Year	**594**	**946**	**2260**	**-1733**	**-402**	**-375**	**-64**	**224**	**446**	**-706**

Systems Schedule

Receivables in £'000's	Gross Receivables	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
eFinancial	8931	-1453	4437	2412	997	648	296	110	651	833
Compucare	5955	-1240	4620	871	185	251	191	182	288	607
Trust Receivables	**14887**	**-2692**	**9058**	**3283**	**1182**	**899**	**487**	**292**	**939**	**1440**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Capital Expenditure (£000s)

Capital Spend by Division	Year to Date (YTD)			
	Annual Plan	Year To Date Plan	Actual (YTD)	Variance (YTD)
Redevelopment Projects				
Trust/DH Funded	0	0	0	0
Donated Funded	36,372	12,376	10,263	(2,113)
Total :	**36,372**	**12,376**	**10,263**	**(2,113)**
Estates Maintenance Projects				
Trust/DH Funded	7,702	1,155	1,839	684
Donated Funded	1,250	189	9	(180)
Total :	**8,952**	**1,344**	**1,849**	**505**
IT Projects				
Trust/DH Funded	6,000	900	959	59
Donated Funded	1,000	150	0	(150)
Total:	**7,000**	**1,050**	**959**	**(91)**
Medical Equipment Projects				
Trust/DH Funded	90	15	8	(7)
Donated Funded	3,500	525	1,051	526
Total:	**3,590**	**540**	**1,059**	**519**
Total Additions in Year	**55,914**	**15,310**	**14,130**	**(1,180)**
Asset Disposals	0	0	0	0
Donated Funded Projects	(42,122)	(13,240)	(11,323)	1,917
Charge Against CRL Target	**13,792**	**2,070**	**2,806**	**736**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 3 2011/12
Staffing WTE

Permanent (Excludes Maternity Leave)

Unit	Period 1	Period 2	Period 3	Plan*	Variance
Cardiac	350	354	348	378	30
Surgery	650	644	640	697	57
DTS	354	356	354	338	-16
ICI	479	481	472	483	10
International	114	116	117	131	14
Medicine	280	284	275	249	-26
Neurosciences	261	264	254	275	21
Haringey	183	175	0	0	0
North Mid.	2	2	2	0	-2
Children's Population Health	7	8	8	4	-4
Operations & Facilities	202	203	208	239	32
Corporate Affairs	15	13	12	13	1
Estates	46	45	45	59	13
Finance & ICT	138	138	140	160	20
Human Resources	57	55	54	58	4
Medical Director	14	14	13	20	7
Nursing And Workforce Development	80	78	75	87	13
Research And Innovation	57	63	66	67	2
Redevelopment Revenue Costs	7	7	7	0	-7
TOTAL	3297	3300	3089	3259	170

Overtime

Unit	Period 1	Period 2	Period 3	Plan	Variance
Cardiac	6.3	2.4	1.0	0.0	-1.0
Surgery	3.3	2.4	1.8	0.0	-1.8
DTS	0.4	0.8	1.1	0.0	-1.1
ICI	0.4	0.3	0.1	0.0	-0.1
International	0.2	1.5	0.8	0.0	-0.8
Medicine	0.3	0.8	0.4	0.0	-0.4
Neurosciences	0.9	0.6	0.7	0.0	-0.7
Haringey	0.0	0.0	0.0	0.0	0.0
North Mid.	0.0	0.0	0.0	0.0	0.0
Children's Population Health	0.0	0.0	0.0	0.0	0.0
Operations & Facilities	3.6	4.0	4.3	0.0	-4.3
Corporate Affairs	0.0	0.0	0.0	0.0	0.0
Estates	2.0	1.2	1.4	0.0	-1.4
Finance & ICT	3.1	1.2	1.7	0.0	-1.7
Human Resources	0.1	0.0	0.0	0.0	0.0
Medical Director	0.0	0.0	0.0	0.0	0.0
Nursing And Workforce Development	0.0	0.1	0.0	0.0	0.0
Research And Innovation	0.1	0.3	0.6	0.0	-0.6
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	0.0
TOTAL	20.6	15.7	13.8	0.0	-13.8

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Plan	Variance
Cardiac	38	31	41	0	-41
Surgery	61	67	68	0	-68
DTS	11	11	22	0	-22
ICI	42	36	41	0	-41
International	44	48	40	0	-40
Medicine	29	23	23	0	-23
Neurosciences	27	19	22	0	-22
Haringey	5	6	1	0	-1
North Mid.	0	0	0	0	0
Children's Population Health	2	0	0	0	0
Operations & Facilities	9	18	17	0	-17
Corporate Affairs	0	1	0	0	0
Estates	5	15	7	0	-7
Finance & ICT	15	14	14	0	-14
Human Resources	5	0	4	0	-4
Medical Director	2	2	1	0	-1
Nursing And Workforce Development	3	2	3	0	-3
Research And Innovation	1	2	3	0	-3
Redevelopment Revenue Costs	0	0	3	0	-3
TOTAL	298	295	308	0	-308

TOTAL STAFFING (Excluding Maternity Leave)

Unit	Period 1	Period 2	Period 3	Plan	Variance
Cardiac	393	387	390	378	-12
Surgery	714	713	709	697	-12
DTS	366	368	377	338	-39
ICI	521	517	513	483	-30
International	157	166	158	131	-27
Medicine	310	307	298	249	-49
Neurosciences	289	284	276	275	-1
Haringey	188	181	1	0	-1
North Mid.	2	2	2	0	-2
Children's Population Health	9	8	8	4	-4
Operations & Facilities	214	225	228	239	11
Corporate Affairs	15	14	12	13	1
Estates	53	61	54	59	5
Finance & ICT	155	153	155	160	5
Human Resources	62	55	58	58	0
Medical Director	17	16	14	20	6
Nursing And Workforce Development	83	80	77	87	10
Research And Innovation	58	66	69	67	-2
Redevelopment Revenue Costs	7	7	11	0	-10
TOTAL	3,615	3,610	3,411	3,259	-152

* Wte plan has been adjusted pro rata across Units to reflect the unallocated pay CRES target.

Attachment: S

Great Ormond Street Hospital for Children NHS Trust

Trust Board July 2011	
Finance and Activity Report **Three months to 30 June 2011** **Submitted on behalf of** Claire Newton, CFO	**Paper No: Attachment S**
AIM To summarise the Trust's financial performance for the **THREE** months to **30 June 2011.**	

SUMMARY

Results year to date to end of period 3
Net surplus **£2.6M**, which is £0.05M lower than plan.

- Normalised EBITDA margin is 7.4% v Plan of 7.3%

Forecast
The forecast out-turn remains in line with 'plan' and this is a net surplus of **£6.9m** pre-impairment charges for Phase 2A; normalised EBITDA margin 6.8**%.**

Ratios (FT)

- Overall FT score of **3** for year to date which is at target
  - Liquidity days score 2
  - All other ratios score 3 or above

BPCC performance (Non NHS – cumulative) continues to need improvement

- Total payables – Value 85.2%
- Total payables – number – 82%

Agency ratio to total pay

- **4.9%** year to date (4.8% to period 2)

Staff overpayments

- 12 overpayments totalling £9.9K – the common cause was late notification of changes to staff hours, pay, sickness etc.

Expenditure

Pay is on budget and this month, the improvement from period 2 is mainly the result of CRES and reserves being allocated, this month, to the appropriate income and expenditure categories.
However within categories there are pay overspends & agency costs exceed plan:

- junior doctors, mainly in ICI, IPP and Surgery to cover rotas and reflecting high activity levels.
- o Higher than budgeted net costs of nursing staff, including agency, across a number of units but particularly IPP, cardiac and medicine. This is mainly to cover sickness, maternity and additional beds due to higher activity levels.

Non Pay expenditure is **£1.5M lower** than budget.
The principal issues are ;

- Some budget phasing benefit associated with activity planned later in the year
- Lower than planned drugs and blood costs, some of the lower blood costs are due to a number of patients transferring to clinical trials
- Lower non pay consumable costs across a range of areas

Income
IP activity is higher than last year; income is **£0.8M higher** than budget (before CRES). This

reflects;

- Higher than plan PBR inpatient income in Cardiac, ICI and Surgery
  Lower than plan outpatient income in Cardiac Echo offset by higher performance in Ophthalmology and Orthopaedics
- Lower levels of non tariff income and the causes include reduced spinal activity, lower than plan cochlear bilateral activity, lower neurosciences and medicine activity
- NCG activity is slightly ahead of plan
- IPP is broadly in line with plan
- Research and charitable income streams are behind plan and it is possible this will remain below plan due to some recent grant notifications being lower than expected

CRES

2011/12

- The target of 15.8M has been fully populated with schemes
- The schemes have been risk assessed and forecast to deliver the value included in the plan

2012/13

- Target of £16M has been set and schemes totalling this value have been identified
- 80% of the schemes are rated as RED at this point

2013/14

- Indicative target of £16M
- £0.5M of schemes identified

Capital

- CRL is forecast to be met
- The capital programme is £55.9M for the year and £1.2M behind plan at period 3
- Main under spend on the programme relates to the hospital redevelopment (£2.1M)

Statement of Financial Position (Balance sheet)

- Non Current Assets increased by £3.2M to £340M, reflecting capital additions net of depreciation
- Improvements to gross debt position of 4.2M, down to £14.9M
- Cash balances higher than forecast at £20.8M

Salary overpayments

- There were 12 salary overpayments totalling £9.9K

Contribution to the delivery of NHS / Trust strategies and plans
Financial sustainability and health

Financial implications As explained in the paper

Legal issues N/A

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

Author and date Andrew Needham - Deputy Finance Director 14 July 2011

Month 3 - 2011/12 FINANCE REPORT

(1) Year to date

The Trust generated a surplus of £2.6M surplus very close to the Plan which was rephrased to improve the accuracy of CRES and other items which don't accrue evenly over the year

(2) Forecast for fully year

The Trust is currently expecting to achieve a forecast surplus of £1.3M post impairment and £6.9M pre impairment.

(3) Summary

- The Trust has higher level of IP activity than in the same period last year but IPP is slightly behind plan. Other operating revenue behind plan for RD and Charity, in the main.
- Pay is in line with plan and there are under spends present on the blood budget, services from other trusts, transport and across a range of non activity related budgets.
- The depreciation and dividend position is close to plan.
- The CRES targets have been allocated to the appropriate income or expenditure category where the benefit is expected to occur, this has caused some movement in the financial position of the income and expenditure categories.

Activities other than IPP:	-£0.3M	Expenditure higher than budget
	+£0.9M	Income higher than budget
	+£0.6M	**Favourable to plan**

IPP

IPP	-£0.6M	Expenditure higher than budget
	£0.0M	Income on plan
	-£0.6M	**Adverse to plan**

Total Trust	-£0.9M	Expenditure higher than budget
	+£0.9M	Income higher than budget
	£0.0M	**On plan**

(3A) Pay

Pay expenditure totals £48.1M, which is on plan.

- Junior doctor pay is overspent by £0.5M YTD, reflecting the need to use agency to cover staff rotas in ICI and Surgery and IPP is overspent as a result of additional junior doctors needed to cover high activity levels.
- Nursing pay is overspent by £0.6M YTD and this is a continuation of spend levels seen in early months. Medicine, Surgery and ICI are all overspent a result of using temporary staff to cover maternity leave and vacancies. Cardiac is overspent by £0.2M as a result of increased staffing levels to open additional beds.
- Other pay categories are currently in line with plan but non-clinical agency remains high

Agency costs	
Junior doctors	£0.26M
Nursing	£0.56M
Sci, Ther, Tech	£0.43M
Non-clinical	£1.10M
Total	**£2.35M (representing 4.9% of the pay bill)**

(3B) Non pay

Non-pay expenditure is £28.5M excluding dividend and depreciation.
The principal variances to plan are detailed below;

- Blood is under spent by £0.4M YTD. This is predominantly on Factor 8 and is offset by income variances
- The clinical supplies & services budgets are overspent by £0.2M. There are activity related cost pressures within Cardiac of £0.1M and also within the diagnostic departments of £0.2M. These are partially offset by under spends on high cost spinal implants with Surgery as a result of low activity levels on these cases.
- Other cost lines are underspent

(4) INCOME

4.1 Income in the period totalled £84.1M and is £0.8M ahead of plan. The analysis is shown in the table below.

Category	Annual Budget	YTD Budget	YTD Actual	YTD Variance
	£M	£M	£M	£M
NHS Revenue Activity	256.1	62.6	65.0	2.4
Activity Revenue Non Nhs	31.4	7.8	7.3	-0.5
Other Operating Revenue	51.5	12.9	11.8	-1.1
Grand Total	**339.1**	**83.3**	**84.1**	**0.8**

** Please note the revenue statement totals vary to this table by the value of the CRES allocated to income totalling £2.4M YTD

4.2 NHS REVENUE

The PCT PbR Tariff Income is £1.3M ahead of Plan
Activity is over plan but the positive variance also includes some prior year income.

Outpatient activity was £60k lower than plan to period 2 and this was mainly in Cardiac, but offset partly by higher Ophthalmology and Orthopaedics activity.

PCT Non-Tariff Income is 0.7M ahead of plan
The main variances to plan include higher outpatient activity
Some inpatient activity is behind plan: Cochlear bilateral, Spinal implant work and lower than plan activity in Neurosciences and medicine.
Outpatient activity is £0.3M ahead of plan mainly in Audiological medicine and palliative care
Consortium activity is ahead of plan reflecting higher than plan levels of BMT work and Pass through income associated with Factor 9 is lower due to patients on clinical trials.

NCG ("SHA") income is circa £0.4M ahead of plan
The main income streams at variance to plan are;

- Small benefit from 2010/11 February and March activity being higher than estimated
- Lower than plan income for SCIDS and SCIDS drugs
- Release of funding from NCG for Neuroblastoma antibody not budgeted

Income from other NHS Trusts is on plan
This category includes Cytogenetic, Kings small bowel transplant and Retinoblastoma activity.

Income from DH is on Plan
New born screening income has been matched against expenditure.

Other NHS clinical income is £0.1M behind plan
This reflects the Haringey service until 23rd May when it was transferred

4.3 NON NHS REVENUE (Non-England and IPP)

Overall income is lower than plan by £0.4M (£0.8M once the CRES is taken into account)
The main variance is;

- Non England activity is behind plan by £0.4M behind plan

4.4 OTHER OPERATING REVENUE

Overall other income is £1.1M behind plan (£1.3M once the CRES is taken into account)
The main variations to plan are;

- R&D – this is a timing difference with spend expected to occur later in the year
- Charity income is also behind plan, but spend is expected to occur later in the year
- Other revenue is behind plan – this category contains, amongst others, outreach, medical staff recharges and hospice income. Additionally, NHS bank income is recorded here and spend is below plan at this point and as a result income is matched and behind plan.

(5) **CIP/CRES**

	2011/12	**2012/13**
BLUE	£1.0M	£0.0M
GREEN	£3.5M	£0.4M
AMBER	£12.2 M	£3.5M
RED	£0.04M	£12.4M
RED- excess over target	(£1.0)	(0.3M)
Total target	**£15.74M**	**£16.0M**

2011/12

- The Trust is targeting 7% CIP based on opening budget, adjusted for pass through items, and a further CIP to fund an Interventional Radiology. Schemes identified are valued at £1.0M more than the current target at this point pre risk assessment, an increase of £0.7M since the last report.
- The risk assessed values currently indicate that the programme will deliver the CIP modelled into its 2011/12 financial plan.

2012/13

- The Trust has set a target of £16.0M for 2012/13 using the same methodology as in 2011/12 and the current value of schemes totals £16.3M. The risk assessed value of these schemes is forecast to deliver the value in the Trust's financial plans for 2012/13.
- £12.4M (80%) of the schemes are classified as RED and will be developed over coming months to feasible schemes . There are £3.5M of schemes classified as AMBER and this represents progress of £1.0M, in this category, since the last report.

2013/14

- The Trust has commenced the scoping of schemes for 2013/14 and this will continue over the coming weeks. At this stage an indicative target of£16.0M has been set and £0.5M of RED schemes have been identified.

(6) CAPITAL PROGRAMME AND CRL

CRL
The Trust is expecting to meet its CRL target of £13.8M.

Overview
The Trust's capital plan is £55.9M with planned expenditure for the 3 months amounting to £15.3M. The total spend to date amounts to £14.1M representing an under spend to date of

£1.2M in total and £0.7M in respect of Capital counted against the CRL target – being non donated capital.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Redevelopment	36.3	12.4	10.3	2.1
Estates Maintenance	9	1.3	1.8	-0.5
IT Related Projects	7	1.1	1	0.1
Medical Equipment	3.6	0.5	1	-0.5
Total Additions ytd	**55.9**	**15.3**	**14.1**	**1.2**
Asset Disposals	0	0	0)	0
Donated	-42.1	-13.2	-11.3	-1.9
Charge Against CRL	**13.8**	**2.1**	**2.8**	**-0.7**

Redevelopment
Expenditure on the new clinical building is £2.1M behind plan. The expenditure recorded to date is based on data provided by our cost consultant's and the overall scheme is expected to come in within budget. The funding in the current financial year is 100% donated capital although the overall cost includes DH funding of £75M.

Estates IT and Medical equipment
Estates and Maintenance projects are overspent by £0.5M. An analysis of the current year capital programme reveals that only £1.5M of their £9M Annual Plan remains uncommitted and so the capital plan is quite advanced compared to previous years.

IT is currently just under budget and Medical Equipment £0.5M ahead of budget. These numbers reflected booked expenditure in the accounts and accrued receipts.

(7) STATEMENT OF FINANCIAL POSITION (SOFP)

The SOFP increased by £3.5M this month reflecting increases to Non Current Assets, decreases to Current Assets of £5.5M (including an increase of £2.6M in cash and cash equivalents) and a decrease to current liabilities £5.7M.

Non Current Assets
Non Current Assets at the end of June 2011 totalled £340M, a net increase of £3.2M and this increase was a combination of capital additions net of depreciation reductions. There were no disposals or impairments.

Current Assets (excluding Cash & Cash Equivalents) have decreased by £8.1M.

Capital Receivables (£0.7M decrease)	This represents invoices raised to the charity for the hospital redevelopment and includes BAM invoices.
NHS Trade Receivables (£4.2M decrease)	This is mainly as an effect of quarterly billed invoices in respect of NCG, Education & Training and R & D, receipts from quarterly bills and a decrease in the PCT actual performance.
Prepayments & Accrued Income (£0.9M increase)	The largely represents income accrued in relation to IPP work in progress.
Non NHS Trade Receivables (£3.5M decrease)	The decrease is due to an increase in cash receipts including cash from Kuwait Ministry of Health and a lower level of invoices raised for Private patient income
HMRC VAT (£0.4M decrease)	The May VAT debtor was high and included adjustments following the full year review of VAT.

Current Liabilities have decreased by £5.7M

NHS Trade Payables (£0.9M decrease)	The decrease reflects a lower level of Invoice Register accruals during the month as payments have been increased
Non-NHS Trade Payables (£1.7M increase)	This is due to an increase in the volume of invoices in the creditors ledger that will be processed for payment
Deferred revenue (£2.8M decrease)	This represents the release to the revenue position of advanced billing – this is normal and relates to quarterly advance billing.
Expenditure Accrual (£4.3M decrease)	A lower level of invoice accruals were made , this reflects increased levels of creditor payments processing.
Other Payables (£0.4M increase)	This represents an additional month of Public Dividend Capital accrual.

Taxpayers' Equity
Taxpayers' Equity has increased by £3.5M this month.

The principal movements were;
- Retained Earnings increased by £1.3M reflecting the surplus I and E position in month
- The Donated Asset Reserve increased by £2.2M representing mainly donated Hospital development spend net of transfers to I and E.

(8) WORKING CAPITAL MANAGEMENT

Cash
The Trust had cash holdings of £21.0M at the close June 11, and had operating cash balances of between £18.5M and £35.9M throughout the month. Cumulative commercial bank account balances at £0.01M was in line with the DH target maximum holding of £0.05M.

Payables
The cumulative performance for BPCC (total payables) is;
- Number (85.2%) & Value (82.0%).

The Finance team have embarked on a turnaround project within the AP function that will implement new IT systems and overhaul processes for the entire procure to pay journey. The result should be improved creditor performance.

Receivables
Gross trading debt is now £14.9M a decrease of £4.2M in the month. This reflects the settlement of the quarterly invoices and the outstanding SLAs 2011-12 for Haringey PCT. All debt over 360 days is provided for. The overall debt profile is as follows;

	30/06/2011		31/03/2011		30/06/2010	
Not yet Due	6,365	42.76%	9,571	61.82%	5,938	31.48%
1-90	5,364	36.03%	2,853	18.43%	9,781	51.85%
91-360	1,717	11.53%	2,323	15.01%	1,921	10.18%
360+	1,440	9.67%	734	4.74%	1,226	6.50%
	14,886	100%	15,481	100%	18,866	100%
NHS	6,589		4,543		11,584	
Non-NHS	1,451		2,830		1,650	
International	5,955		7,053		5,870	
Gosh CC	891		1,055		519	
	14,886		15,481		19,623	

There has been an increase in debt over 360 days to 9.67% from 5.0%. This is attributable to some longstanding debtors in NHS and IPP. These are currently under review as to the next steps to achieve recovery.

IPP debt, including cash in advance, has decreased this month to £5.1M from £6.5M last monthThere is debt totalling £458k due to 2 self-pay clients and the matter is currently with the legal department.

Non- NHS debt has decreased to 1.4M, a decrease of £0.8M in the month, due mainly to the settlement of the Kuwait invoice. The increase in debt over 180 days is due to the aging on the £107k due from Kuwait which is scheduled to be settled in July 11. Salary overpayments over 180 days total £127k.

(9) FINANCIAL RISK RATIOS

The five metrics used in determining the FT score are listed below.
The current and forecast scores are at 3. These are the required level of scores expected by MONITOR

Month 3

EBITDA Margin	4
EBITDA Achieved	4
ROA	3
Liquidity days	3
Weighted average	3

The scores are weighted and override restrictions come into play where there is any score of 1 and/or 2 scores of 2.
The EBITDA achieved decreased this month reflecting the rephrasing of the financial plan, which resulted in a more favourable position being planned at the beginning of the financial year.

(10) SALARY OVERPAYMENTS

There were 12 salary overpayments in June 2011 totalling £9.9K. Of these, 7 were related to Neurosciences and so Neurosciences will have to do pre-payroll checks, 2 were in surgery and 3 in corporate departments. The cause for all but 1 overpayment related to late notification of changes to staff circumstances such as; changes to hours, supplements, leavers, sickness and holiday overtaken.

Great Ormond Street Hospital for Children NHS Trust

<table>
<tr><td colspan="2">Trust Board
27 July 2011</td></tr>
<tr><td>Title of document:
Foundation Trust application update

Submitted on behalf of:
Fiona Dalton</td><td>Paper No: Attachment T</td></tr>
<tr><td colspan="2">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.
On 24 June, the Trust received approval from the Secretary of State to submit the application to Monitor, in independent regulator for foundation trusts. A meeting has been held with Monitor to review the application for a “batching” decision. The outcome of the meeting will determine the overall timetable for the assessment, but we are working towards a target authorisation date of 1 December 2011.
The “Evidence of meeting statutory targets” criteria have been rated amber (no change). Both hospital acquired infection indicators (c. diff – 4 cases; MRSA – 2 cases) are above trajectory. It is also noted that the 95th centile of admitted pathway waiting time was over 23 weeks in Nov 10 and Feb 11. This indicator replaces the previous 18 week waiting time indicator in the Monitor compliance framework.
The overall “Financially viable” assessment is now rated green (changed from amber). Commissioner contracts have been agreed and the Trust is performing to target. There is a remaining risk to CRES delivery for 11/12, and CRES plans for 12/13 and 13/14, but these risks are being managed effectively by the CRES steering board.
900 new members have been recruitment in out-patient clinics over the last two months.
Key actions for the next month:
• Complete updates for the integrated business plan, LTFM and other key documents.
• Commence election process for the Members’ Council.
• Commence Monitor assessment process.</td></tr>
<tr><td colspan="2">Action required from the meeting
To note the current position</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
Achievement of Trust objective to secure Foundation Trust status</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?
Formal consultation has been completed (18 June 2010)
A set of commissioner meetings have been held with lead commissioners.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision Not required</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Sven Bunn, FT Programme Manager</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Jane Collins, Chief Executive</td></tr>
<tr><td colspan="2">Author and date
Sven Bunn
18 July 2011</td></tr>
</table>

Attachment T

Foundation Trust application – July 2011 position

Assessment of current performance for Great Ormond Street Hospital against the seven domains of the Secretary of State assurance process (changes since June in **bold**):

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 ~8,000 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.	**Green**
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 • Reconfirmation of support 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		**Green**
FRR of at least 3 under a downside scenario	• Currently 3 in all years • Risks from CRES delivery	**Green**
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)	**Green**

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. • **HAI Performance (c. diff – 4 cases; MRSA – 2 cases).** • 95th centile of admitted pathway waiting time was over 23 weeks in Nov 10 and Feb 11.	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 • **HAI Performance (c. diff – 4 cases; MRSA – 2 cases)** • 18 admitted patient pathway over target	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
15 July 2011

Attachment U

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting 27th July 2011	
Title of document 2011 Annual Infection Prevention and Control Report **Submitted on behalf of** Director of Infection Prevention and Control - Dr John Hartley	**Paper No: Attachment U**
Aims / summary To assure Board that there is a functioning IP&C programme. To inform Board of achievements and targets in Infection Prevention and Control and Annual Plan	
Action required from the meeting Note and Approve (for public access – Full report is a public document)	
Contribution to the delivery of NHS / Trust strategies and plans Essential to achieve zero harm; minimising risk of infection is a central trust goal	
Financial implications Failure to prevent or control infections leads to harm and cost. Failure to meet CQUIN targets will result in financial penalties.	
Legal issues Compliance with the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance (from 1 April 2010) is a Statutory requirement for registration with the Care Quality Commission	
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? Report and Annual plan need to be presented to Quality and Safety Committee; presented already to Infection Prevention and Control Committee.	
Who needs to be told about any decision Infection prevention and control is responsibility of all staff. All Clinical and Corporate staff	
Who is responsible for implementing the proposals / project and anticipated timescales Clinical and Corporate Units and all staff – in conjunction with the Infection Prevention and Control Team,	
Who is accountable for the implementation of the proposal / project Director of Infection Prevention and Control	
Author and date Dr John Hartley 19/7/2010	

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 10 - March 11 (Part A)

and

ACTION PLAN April 11 - March 12 (Part B)

AUTHORS: Dr John Hartley - Director of Infection Prevention and Control
Deirdre Malone – Lead Nurse in Infection Prevention and Control

(Format - Modified from the template recommended in Health and Social Care Act 2008)

Contents

Part A **Executive summary: Activity in 2010/11** **Page 1**

Part B **Action Plan for 2011/12** **Page 6**

Full Report: Activity in 2010/11 – emailed to Board members and tabled at the meeting

Part A Executive summary

Overview of infection prevention and control activities in the Trust during 2010-11

(The numbers in this summary report relate to sections in full report)

2) Infection control arrangements

Infection Control Team:

Dr John Hartley continues as DIPC (since Aug 2009).

Lead Infection Prevention and Control Nurse changed twice in year, with Deirdre Malone starting in Feb 2011.

One full time CNS and 0.4 WTE clinical scientist were present throughout the year.

There remained minimal administrative support through the year, however, an IPC Team Administrator and Data Analyst has now been appointed to start Aug 2011.

Part time antibiotic pharmacist support was present through the year.
Tissue viability / pressure ulcer prevention / surgical site surveillance CNS post had transferred to IPC in Jan 2009 but then fell vacant in November 2009. After a period of temporary staff the post became vacant. The Tissue viability component of this post is now provided through the Plastic CNSs within the Surgery Unit.

The remaining Pressure Ulcer prevention/SSIS post was advertised twice but remained unfilled. The Pressure ulcer prevention service/post has now passed to the Corporate Nursing team.

Surgical site infection prevention and surveillance (SSIP&S) team funded for three years, started November 2009. This team has continued to be lead by an Administrator/ Data Manager with two surveillance officers, but the Practice Educator left in Jan 2011 and has not been replaced.

Infection Control Committee: the committee meet regularly and attendance was better, with named members for all Units now designated. Administrative support was not always available.

Clinical Unit local Infection Control structure:

A key component of Trust policy is the delegation to and acceptance of responsibility by all clinical staff, starting with Clincial Unit plans and structures. The Cardiorespiratory and Surgical Units now have dedicated IPC groups.

3) DIPC reports to Trust Board 2010-11

July 2010 – Presentation of Annual Report
Sept 2010 – Update on achievement against *C. difficile* target
Nov 2010 – Regular Infection Prevention and Control Update
Feb 2011 – Assurance Framework reviewed for Clinical Governance Committee
Mar 2011 – Update on achievement against *C. difficile* target

4) Budget allocation to infection control activities

Funding for the IPC Team lies with Department of Microbiology, Virology and Infection Prevention and Control. Funding was made available for the administrative support for IPC Team, with delay in filling post due to recruitment difficulties.

Full time finding has been made available through the Transformation Process, to provide a second experienced IPC practitioner (Clinical Nurse Specialist/Practice Educator) to enhance the Trust IPC activity towards the strategic goal of no avoidable infections. This post is ready to be advertised but has been delayed by funding issues.

SSIP&S team – this is supported by three year Special Trustees' funding. Plans need to be made during the year for funding of extension of this service.

Excellent Trust support is provided for emergency supplies of personal protective equipment as required.

Extensive routine and specialist laboratory support was provided by the Department of Microbiology/Virology and Infection Prevention and Control, GOSH

5) HCAI Statistics

GOSH complied with all mandatory HCAI surveillance schemes as well as completing a number of specific local surveillance programmes. This report does not include all local Speciality surveillance covering infection, which may be in Specialty reports.

5a) Mandatory reporting

- **MRSA bacteraemia** - total Trust apportioned cases during year = 1
  Remaining within annual National Target of 2 or less.
  (Next year target is zero – which has not been achieved)

- **Glycopeptide resistant enterococcal bacteraemia** – total during year = 1
  (No target)

- **Clostridium difficile** - Trust apportioned cases in national surveillance scheme (cases aged greater than 1 and in for 3 or more days when tested) = 11.
  National target for 2010/11 was less than or equal to 9.

- **Orthopaedic SSI**: The trust does not carry out the procedures nationally surveyed

- **S. aureus (methicillin sensitive) bacteraemia**
  Mandatory reporting was established Jan 2011, data for Jan to March – 1 trust apportioned case (6 others positive on or within 48 hours of admission)

5b) GOSH specific (non-mandatory) HCAI statistics

-<u>Central Venous Line related bacteraemia</u> acquired at GOSH = 2.6 per 1000 line days.

This equates to a further 20% reduction in rate year on year (episodes per 1000 line days 07/08 – 4.4; 08/09 - 3.7; 09/10 3.2) however we continue to aim to reduce this further.

- Ventilator associated infections in the PICU. 2010/11 surveillance detected 2 episodes.

- Surgical site infection surveillance

The SSI Surveillance team performed inpatient and post discharge surveillance in spinal inplant, cardiac (open and closed heart), craniofacial, neurosurgery and thoracic surgery patients for periods between 3 and 12 months.
All patient results for deep and organ/space infection show a rate of 1.2%; all infections were detected at a rate of 6.1%, with considerable variation.

- Urology continued specialty based SSI surveillance and detected the same low number of cases as last year (6 in a 1000 procedures).

Other Local surveillance

Viral infections acquired while in hospital

There were a relatively large number of episodes of viral respiratory and gastroenteritis infections present in children when admitted or developed while in hospitalised.

No major outbreaks occurred, but 3 wards were on restricted admission during the year because of gastroenteritis.

These infections transmit readily between patients, staff, parents and visitors. Continuous application of standard infection prevention and control precautions and high levels of cleanliness are required to help control.

Antimicrobial resistance

MRSA
136 newly colonised or infected children were detected on admission in 2010, with 10 probably or possible acquisitions within the trust in (compared to 9 previous year). There were no MRSA outbreaks.

Multiple resistant 'gram negative' organism colonisation or infection
(E coli, Pseudomonas and other related organisms as defined in admission screening policy)

- in 2010/11 124 children were found to be colonised with multiresistant gram negative organisms; 91 definitely came in colonised, 33 had no evidence of colonisation on admission but neither was there evidence of cross infection. This may be antibiotic selection.

Serious untoward incidents involving infection
In 2010/11 there was 1 SUI reported (the MRSA bacteraemia)

6) Hand Hygiene, Aseptic Protocols and care bundles (Saving Lives High Impact Interventions and other relevant bundles eg WHO, NICE)

A new online reporting system has improved reporting and compliance rates have increased but are still not 100%. This system was recently updated to incorporate additional staff groups e.g. housekeepers and physiotherapists. The practice educators are continuing to provide training on hand hygiene for staff within their units. The Infection Prevention & Control Team provides induction and annual update training on hand hygiene to all groups of staff. Each clinical unit has now incorporated infection prevention & control into there unit plans and this also includes hand hygiene. Hand hygiene rates have improved but are not consistently 100%.

The national staff survey reports lower than desired satisfaction with availability of facilities for all staff at all time. However, an in house survey confirmed that staff working in non clinical areas felt that they did not always have adequate hand washing facilities. The Care Quality Commission (CQC) did not identify any issues with the provision of hand hygiene facilities during a recent visit.

CVL care bundle – each ward / department conducts monthly compliance audits with the CVL care bundle. This data is displayed on the Trusts transformation dashboard and wards / departments are encouraged to print off and display their own data, this should also be discussed with staff at their ward meetings. Compliance should improve.

7) Corporate Facilities

Decontamination

The Trusts Decontamination services achieved accreditation in all three aspects: Sterile Services, Endoscopy and Medical Equipment to ISN standards. The Trust is part of the UCL Partners group which is looking at streamlining decontamination services across NC London. The Trust is currently reviewing a business case.

Facilities

Services remain outsourced to MITIE. Regular internal and external, including PEAT, audit is undertaken. A clinical service priority remains the resources for timely ‘infection’ related cleaning and all staff understanding their roles in cleaning and the correct process.

8) Estates

During this year the estates department and IP&C have approved a range of key documents where infection control is a key driver these include updating policies for Ventilation Systems, Construction (Design and Management Regulations) and Legionella control.

The Estates Department have awarded a contract to an external company to provide a fully managed building and engineering maintenance service on our plant. This will enable the Trust to commence a structured planned preventative maintenance programme for the organisation. This will be a 24/7 contract which will allow our estates employees to focus on the routine day to day tasks.

Legionella control policy is implemented and monitored through the Legionella Steering Committee.

A regular programme of risk assessment and audit is now in place to monitor estates work programmes which have an IP&C impact

9) Audit

A regular IPC audit programme is followed throughout the year. The audits are undertaken by the link practitioners on their respective wards/departments. In addition to auditing hand hygiene compliance and compliance with the CVL care bundle the following areas are covered as part of the 'Saving Lives' programme:

- Peripheral line care bundle (insertion and maintenance) audited 6-monthly
- Urinary catheter care bundle (insertion and maintenance) audited annually
- Renal dialysis care bundle audited annually
- Isolation precautions audited annually

Antibiotic prescribing – antibiotic policy review continues, assisted by a part time antibiotic pharmacist working one day per week. The Trust will be participating in a European Antibiotic Surveillance Survey later this year, where we will be carrying out a point prevalence survey on antimicrobial usage. The rational behind this survey is to look at an antimicrobial resistance

10) Occupational Health

The OH service and the IPC team have a close working relationship; further work is needed to strengthen the process to ensure that new and existing staff are screened and offered vaccination as appropriate. The Trust will be rolling out the staff flu vaccination programme on the first week of October

11) Targets and outcomes

See HCAI statistics and Hand hygiene (5 and 6)

12) Training activities

A short session is provided for all clinical and nonclinical staff on induction in IP&C; antimicrobial prescribing is provided for medical induction and annual update.
Local induction should provide additional training.

The annual infection control link network training was held from 05/10 to 09/10/2009 and was attended by 21 delegates. Further training session were held as part of the bi-monthly infection control link network meetings.

Part B (Numbers relate to sections in full report)

1) **Infection control Action Plan for the year 2011/12**

An extensive programme of activity is performed by the IP&C Team and local staff. All activities are not listed here.

2) **Infection control arrangements**

Infection Control Team:
Ensure funding is available and fill all vacant positions.

Infection Control Committee:
Review function.

Local IPC Team
Develop further each Clinical Units/Specialty local IPC structure and work closely with the local team.

3) **DIPC will report regularly to Board and other committees as requested**

4) **Budget allocation for infection control activities**

Ensure new post, funded following re-configuration of Transformation, is retained.
Devise business plan to allow continuation of SSI surveillance

5) **HCAI Statistics**

Increase regular feedback to Clinical Units, specialties and risk action groups.
Work with Transformation data analyst team to further improve dashboard and online auditing tools.

6) **Hand Hygiene, Aseptic Protocols and care bundles (Saving Lives High Impact Interventions)**

Continue to promote the NPSA hand hygiene campaign on the 5 moments for hand hygiene at point of care with all members of staff.
CVL - develop the CVC care bundle for all areas, to include insertion protocols
SSI – Continue surveillance and model of care roll out

7) **Corporate Facilities**

7:1 Decontamination

Decontamination – work with Decontamination group to ensure accreditation is maintained and strategy for future considers IPC. Assist trust in implementation of NICE IPG 176 and ACDPTSE working party guidelines for prevention of CJD/vCJD.

7:2 Facilities

Work with facilities to ensure highest standards are maintained and 'infection clean' requirement is met. Ensure all staff are aware of cleaning responsibilities and process.

8) Estates

Ensure a policy and procedure is in place for all critically ventilated areas with defined responsibilities for local users, estates and IP&C.

Work to ensure commissioning of MSCB is completed.

9) Audit

Continue scheduled IPC audits as published.
Additionally audit compliance with *C. difficle* care bundle and further investigate *C difficile* rates and control programme; compare again to other paediatric trusts.
Audit RCAs for *S. aureus* bacteraemia
Antibiotic prescribing – follow annual programme
Audit 'Infection Control Clean audits'

10) Occupational Health

Work towards ensuring all infection prevention and control information is stored on databases. Update those policies that relate to IPC. Assist with establishment of process to ensure all staff are assessed and vaccinated as necessary.

11) Targets and outcomes

- Trust: Meet trust and CQUIN targets on CVL infections, and SSIs.
- Assist trust in reconciliation of non- achievement of national performance targets on MRSA bacteraemia and *C. difficile* (or establish modified paediatric targets)

Extensive activity includes:

- Ensure compliance with CQC inspections of the H&SC Act
- Continue Annual review of polices with special emphasis on MRSA policy and policy for control of multi-resistant gram negative organisms.

12) Training activities

Further strengthen local induction and update with specific training on central and peripheral venous cannula (in line with new CPC guidelines) and SSI prevention (in line with model of care being developed).

Work towards ensuring infection prevention and control is included in all job descriptions and job plans, is a mandatory component of CPD and is included in the appraisal of all clinical staff.

Attachment V

Trust Board Meeting **27th July 2011**	
Title of document **Head of Nursing Report** **Submitted on behalf of** **Liz Morgan**	**Paper No: Attachment V**
Aims / summary To brief Trust Board members on some of the key achievements and challenges reported by the Heads of Nursing over the past four months.	
Action required from the meeting To note the report, the achievements and challenges reported by the Heads of Nursing.	
Contribution to the delivery of NHS / Trust strategies and plans Contributes to the strategic goal of 'zero harm'	
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 N/A	
Who is accountable for the implementation of the proposal / project N/A	
Author and date Heads of Nursing (SC) 18th July 2011	

Head of Nursing Trust Board Report
July 2011

Heads of Nursing
The team have now had a second facilitated away day. The purpose of these development days has been to design a set of success criteria for which we can be measured against. In addition we have all had a 360 degree appraisal which has been of enormous benefit to enable us to work better within our teams.

CEWS and SBARD
The CSPs continue to support the changes within the Head of Nursing team and are currently auditing night time surgical activity. New guidance has been distributed to wards on the management of blood pressure, and the compliance with CEWS is improving, also SBARD but at slightly slower pace.

Care of the deteriorating child
The transformation team have presented a proposal on developing a work stream in order to improve care of the deteriorating child. UCL have identified a similar work stream and it is hoped that this can be done in partnership. It is proposed that a steering group be formed headed by an executive director and include representation from transformation, education and training, resuscitation, general paediatricians, ICON and CSP. Areas to work on would be:

- Learn from SI's, RCA's
- Improve IV access
- Human factors training
- Handover
- Monitoring Plan
- Standardise observation taking
- Charts close to child
- Simulation training

Recruitment
We held the 3rd nurse recruitment fair in June approx 250 nurses attended, being able to meet nursing staff and have a tour of the hospital. The event is good PR for the hospital and is proving increasingly popular. The request for applications has resulted in 300 responses, the majority are from nurses about to qualify but there was also interest expressed by experienced nurses and those seeking Band 6 opportunities. Overall 98 vacancies were declared (58 Band 5 and 40 Band 6). The nurse rotation scheme received 151 applications.
From the event we hope to fill the majority of the Band 5 posts, historically Band 6 posts are harder to fill, this situation will clearly continue in the short term with just 17 applications received.

CQC
Following the CQC inspection in June a decision has been made by the senior nursing team to ensure that any nurse who is carrying out direct patient care regardless of the area must wear a uniform. This follows criticism from the inspectors with regards to a CNS observed not 'bare below the elbow' when caring for patients.

Improving nutritional care
The CNS for nutrition has now been appointed and is in place. She has significantly increased the pace and depth of work being developed in relation to food and nutrition. A nutrition policy is now in use. A nutrition screening flowchart has been

finalised and is currently being piloted on three wards. A trust wide rollout plan is being developed with a view to have full implementation by mid August 2011.
A comprehensive height audit has been completed that showed 55% compliance. An improvement target of 75% compliance has been agreed with the Heads of Nursing.

Delivering same sex accommodation
Quarterly audits continue to be undertaken among adolescent inpatients to measure compliance with single sex accommodation requirements. The most recent audit shows increased numbers (80%) have been asked if they have a preference, and had their preferences met. However, we still have work to do in ensuring that all young people are asked their preference. A new admission form for young people to complete themselves, expressing their care needs, is being piloted and we hope this will support compliance with this requirement. No breaches have been reported in the last quarter.
Consistently the audits have shown that the vast majority of young people would prefer to be with people their own age in mixed-sex accommodation rather than single sex accommodation with younger children and babies.

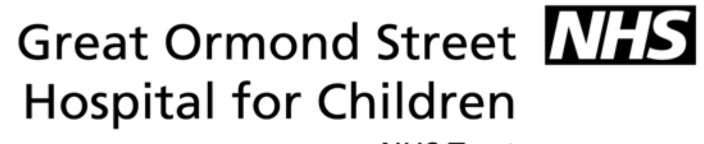
Quarterly nursing performance reviews
As a new initiative, a quarterly performance review of nursing performance indications for each clinical unit has been introduced, lead by the Chief Nurse and corporate nursing team. We have found these meetings to be a beneficial component of the assurance process for nursing quality.

Cardio-respiratory clinical unit
Our lead for advancing practice and a cardiologist have successfully completed the Advanced Training Program (ATP) course at Intermountain Health Care, Salt Lake City, Utah. This is a 20 day course divided into 4 sessions for Executives and QI leaders. The aim of the programme is to train senior leaders, middle management, and front line health professionals in the theory and application of cost and quality control as well as the health services academic infrastructure.
The ATP program's purpose is to give participants the understanding and tools necessary to conduct state of the art clinical practice improvement projects, use quality improvement methods to manage and integrate non-clinical processes, implement quality improvement programs, and conduct internal quality improvement training. It builds on the experience of Intermountain Healthcare and brings national experts together teaching theory and techniques of

- Guideline/protocol development
- Outcome measurement
- Research methods
- Cost-based accounting
- Medical informatics
- Total quality Management/continuous quality improvement
- Teams and teamwork

The two participants from the cardiac unit are using the skills and knowledge to lead on a discharge project "Pulling the patient through the System". Their project aim is to reduce over a 6 month period the hospital stay by 5% in children with congenital heart disease, by removing inefficiencies and improving quality of service provision, meanwhile ensuring that each child is discharged when medically ready.
Several members of clinical staff were recently invited to Birmingham Children's hospital to present their work on the "Fast Track Programme" it was very well received and has had excellent feedback.

Suzanne Cullen, Head of Nursing. July 2011.



Trust Board Meeting
27th July 2011

Update on Hospital at Night Hand- Over **Submitted on behalf of** **Dr Barbara Buckley**	**Paper No: Attachment W** **Date considered by Management Board**

Aims / summary
To in form and update the trust on an important feature of the clinical day in the trust. This is an important patient safety feature of the working day.

Action required from the meeting

For information and update of knowledge.

Contribution to the delivery of NHS / Trust strategies and plans
This works towards our Zero Harm goal

Financial implications
None

Legal issues

This improves out child protection work

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?
The clinical staff involved in this work have bee consulted about this on an ongoing basis.

Who needs to be told about any decision

Who is responsible for implementing the proposals / project and anticipated timescales
Lead executive Barbara Buckley on this project but with close support by Liz Morgan

Who is accountable for the implementation of the proposal / project

Author and date
Dr Jane Valente
18th July 2011

Attachment W

Handover at GOSH: Information for Trust Board July 2011

Background

Hospital at night handover at Great Ormond Street is an important area during which all vital in-patient information and clinical responsibility is handed over from well staffed highly skilled day teams to a significantly scaled down HaN night team.

The BUPA Foundation awarded a 2yr medical research grant to Allan Goldman and his team in January 2011 to create a safe hospital at night model. This team has worked extensively with the assistance of the senior management team to successfully introduce the HaN model into GOSH.

Following this the use of the SBARD tool (Situation, Background, Assessment, Recommendation, and Decision) throughout the hospital has been successfully implemented. GOSH leads other hospitals in being awarded the SHA green (RAG) rating for HaN.

From February 2011 the general paediatricians have been in post with a major remit to be responsible for the HaN process. The team work from 8.30-2100, Monday to Friday and Saturday morning, 9 30-12 30. They are present at all the weekday evening and the majority of the morning handovers. The presence of consultant pediatricians on the wards in the evening and at handovers is an important safety and educational factor.

Recent Advances in the HaN Handover

Following observation of the handover processes and in collaboration with Allan Goldman's research team the following changes have been effected to improve the HaN handovers further:

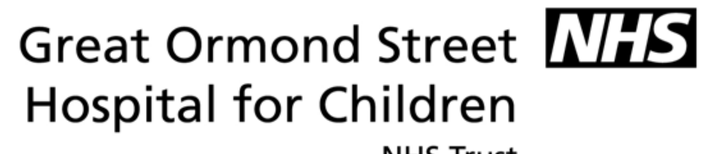
- Further engagement with parties to determine the relevant issues
- Restructuring of the standard operating procedure to make it shorter in format (currently in new draft format –out for consultation shortly)
- Slight modification of the handover structure
- Creating an 'O' drive for HaN (established) to further improve electronic communication.
- Establishing the morning handover occurs
- Establishing CSP involvement at morning handover
- Consultant Paediatrician attending evening handover addressing flagged patient lists
- Surgical involvement with handover –improved for the evening handover with the plan now to involve surgeons at the morning handover (recently agreed with the general surgical teams)

- Safeguarding issues now formally a part of handover
- Trial period of the CSP taking all surgical calls (very successful to date!)

Further areas to work on include:

- Lines of Accountability
- ICON's role

Attachment Y



Trust Board **27th July 2011**	
Update on Compliance with Care Quality Commission Standards and Registration **Submitted on behalf of** **Jane Collins, Chief Executive**	**Paper No: Attachment Y**
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 June 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.	
Action required from the meeting To review the summary of the current status of registration against the 16 essential outcomes.	
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.	
Legal issues Registration is a legal requirement.	
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.	
Author and date Anna Ferrant, Company Secretary 14th July 2011	

Attachment Y

Compliance with Care Quality Commission Standards and Registration

Summary

The Trust is currently registered with the Care Quality Commission (CQC) to provide a range of healthcare services.

The Trust is registered with the CQC for provision of the following four regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Transport services

The Trust is registered as one location with services delivered on the Great Ormond Street Hospital main site.

The types of services provided are declared as:

- **Acute** – providing medical and/or surgical investigations, diagnosis and treatment for physical illness or condition, injury or disease.
- **Transport –** the Children's' Acute Ambulance service which the Trust hosts.

Planned review for CQC

In June 2011, the CQC conducted a planned review of all 16 outcomes. The CQC is in the process of finalising the report

The assessors arrived at the Trust unannounced and visited a number of ward and public areas, interviewing patients, parents, carers and staff. Feedback from the team was positive, with some minor issues raised, relating to hygiene, uniforms and cleanliness. An action plan is being developed to deal with the matters raised. The CQC will issue a final report in the forthcoming weeks and this report will be published on the CQC website.

Quality and Risk Profile

The Quality Risk Profile (QRP) is produced by CQC on a 4-6 weekly basis and 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.

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

Appendix 1 provides an overview of the assessment systems used by the CQC to RAG rate each outcome.

Attachment Y

Trust's contextual risk estimate (latest report June 2011)

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

This overall contextual risk estimate remained unchanged in the November QRP.

The overall contextual risk estimate is calculated considering contextual risk grouped into 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.

Outcome risk estimates

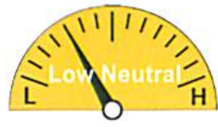
Individual data items reported in the QRP are matched to the registration outcomes and rated by the CQC as positive, neutral or negative, using terms such as 'much worse than expected', 'similar to expected' or 'much better than expected'. The presence of 'worse than expected' risk estimates within the QRP do not automatically affect registration status but may be used by the compliance inspectors to determine whether they need to target regulatory actions and responses.

Appendix 2 provides an update on registration against the sixteen key outcomes, as reported by the CQC in April and June 2011. As can be seen from the table, the risk estimates for 15 outcomes did not change and estimate of risk of non compliance for one outcomes improved (outcome 14 – supporting staff).

Ongoing Self Assessment

The QRP is reported to the Clinical Governance Committee and Audit Committee reviewed by the Risk, Assurance and Compliance Group, where action/ decisions are taken where data that feeds each outcome result needs to be challenged or improved.

A key to the dials in the QRP



Reducing risk of non-compliance

Increasing risk of non-compliance

Some data is available, but it is not sufficient to calculate a risk estimate.

There is no data available to inform this outcome or group of outcomes.

© Care Quality Commission 2011

Care Quality Commission's Quality Risk Profile: April 2011- June 2011

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

Outcome	Outcome Risk Estimate April 2011	Outcome Risk Estimate June 2011	Changes since previous month
Outcome 14 Supporting Staff	Low Neutral	High Green	**Improvement**
Outcome 16 Assessing and Monitoring Quality of Service Provision	High Green	High Green	**Unchanged**
Outcome 17 Complaints	Low Neutral	Low Neutral	**Unchanged**
Outcome 21 Records	Low Neutral	Low Neutral	**Unchanged**

Great Ormond Street Hospital for Children NHS Trust

Trust Board
27th July 2011

Title of document Assurance Framework **Submitted on behalf of** Chief Operating Officer	**Paper No: ATTACHMENT Z**

Aims / summary
The Assurance Framework provides an overview of the principal risks to achievement of the Trust's corporate objectives.

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. The Risk, Assurance and Compliance Group (RACG) reviews and manages the Assurance Framework.

As at the date of this report, no risks are rated as red, 1 as amber and 24 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.

Action required from the meeting
To note the risks, controls and assurances detailed in the Assurance Framework

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
14th July 2011

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
	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	25/05/11	Nov-10
1B	Children may not be appropriately identified as being at risk of abuse and subsequent actions not taken	DN & Ed	CGC	16	**12**	GREEN	31/05/11	Jul-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	25/05/11	Apr 10 & Jun 10 & Jun 11
1D	Children may be at risk from hospital acquired infection (includes decontamination & cleanliness)	MD (ME)	CGC	20	**15**	GREEN	04/02/2011	Feb-11
1E	The organisation, management, administration and practice of clinical services may not always optimally deliver the bes outcomes (to include record management, consent, nutrition, clinical/ management focus)	COO	CGC	20	**12**	GREEN	31/05/11	Feb-11
1F	Our clinical equipment may be inadequate for excellent clinical care and enhanced patient experience	COO	CGC	15	**10**	GREEN	31/05/11	May-10
1G	Staff in post may not be appropriately competent to deliver care	DN & Ed	CGC	15	**10**	GREEN	31/05/11	Feb-11
1H	We may not be able to recruit and retain key staff	COO	CGC	20	**12**	GREEN	31/05/11	Feb-11
1I	We do not make sufficient progress in developing benchmarks and demonstrating world class clinical outcomes	MD (ME)	CGC	9	**6**	GREEN	09/06/11	Jun-11
1J	Clinical outcomes and patients' experiences may suffer as a result of a lack of appropriate management focus	COO	CGC	9	**6**	GREEN	14/06/11	Jun-11
1K	Lack of appropriate clinical response to the deterioration in children	MD(ME)	CGC	20	**15**	AMBER	13/06/11	Nov-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	**3**	GREEN	30/05/11	Jun-11
2B	Patients may have to wait longer than is reasonable for consultation or treatment (initial proxy being national waiting tim targets)	COO	CGC	12	**6**	GREEN	31/05/11	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	31/05/11	Nov-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	**12**	GREEN	02/06/11	Jan-11
3B	We may fail to influence and capitalise on regional and national reconfiguration opportunities	COO	AC	12	**6**	GREEN	31/05/11	Oct-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	01/06/11	Nov-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	31/05/11	June 2011
	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	31/05/11	Apr-11
6B	Sustainable funding solution for each activity within the Trust strategy may not be secured.	CFO	AC	20	**15**	GREEN	02/06/11	Jun-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	31/05/11	Apr-11
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	02/06/11	Jan-11
7C	The Trust may fail to achieve Foundation Trust status within a defined timescale	COO	AC	12	**8**	GREEN	31/05/11	Apr-11
7D	The redevelopment of the site may not meet delivery timescales or operational expectations	DRedev	AC	12	**8**	GREEN	25/052011	Jan-11

STRATEGIC OBJECTIVE 1: A Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**1A Children may be harmed through medication errors**
Accountable Executive	**Medical Director (ME)**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	5
Initial Principal Risk Score	25
Key controls (list top 5 and number 1-5)	1. Medication administration policy in place. 2. Electronic Prescribing 3. Medicine management programme in place 4.Analysis of reported medication errors by type, location and frequency and feedback to clinical teams to share learning. 5. Inclusion on risk registers to ensure regular monitoring
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1 Policy is out of date (Expired June 2010) 2 Action plan to resolve EP issues sahred with April Q&S 3.As part of the Zero Harm agenda, reducing medication errors is one of the key aims of the Transformation programme. Baselines have been identified, targets set and each of the Clinical Units has a specific work plan. Progress is reported monthly to the Transformation Board. 4 - Under reporting of incidents on which analysis is based 5 - No gap
Internal assurance on controls	1. Audit of process of dispensing, preparation, administration and disposal of medications. 2. Electronic prescribing reports - ability to identify where changes to prescriptions are made to identify levels of captured error. 1&2 reports to DTC. Internal audit of electronic prescribing (December 2009) - 5 out of 5 key risks rated at reasonable assurance level - one limited assurance level 3.Medicines Management project reports into Transformation Board 4.Feedback monthly to clinical unit teams and quarterly to CGC on levels of reporting, aggregated analysis and progress against actions to reduce risk including any links to associated complaints and claims 5. Review of risk registers an internal KPI, included in operational reviews
External assurance on controls	1. CD monitoring 2. Article in Quality Safe Healthcare August 2010 - Paediatric Dosing Errors Before and After Electronic Prescribing - study shows that *Electronic prescribing appears to reduce rates of dosing errors in paediatrics, but larger studies are required to assess the effect on the severity of these errors and in different settings.* 1,4,5 NHSLA Level 2 compliant 3.Internal Audit on Medicine management programme due to be undertaken. 4. NPSA reporting compliance; 4. STEIS reporting compliance
Gaps in assurance	1&2 Reports to D&T committee -to be incorporated into schedule of reporting for committee to ensure occurring frequently. To be agreed at next meeting 2 No external assurance on reduction in harm from electronic prescribing
Actions / Milestones (including dates)	2 & 4. Electronic Incident Reporting System in place. Technical issues with Datix which is being managed via TDB. The Datix roll out is being monitored through Business Tracking system
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**5**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**4**
Revised principle risk score	**20**
Assurance status	GREEN
Registration Reference	**Outcomes 9A, 9B**
NHS Constitution Reference	**You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality**
NHSLA Reference	**NHSLA 4.6 Medicines management**
NHSLA Reference	4.6 Medicines Management 5.6 Analysis 2.1 Corporate Induction 5.2 Incident reporting 5.5 Investigation
Date Reviewed/ Updated	**11/10/10**

STRATEGIC OBJECTIVE 1: B Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**1B Children may not be appropriately identifed as being at risk of abuse and subsequent actions not taken**
Accountable Executive	**Chief Nurse and Director of Education**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	16
Key controls (list top 5 and number 1-5)	1.Child Protection policies in place, policy subject to audit 2.All staff receive CP training, attendance monitored via E&T 3.Clear structure implemented with funded Named Professionals input at GOSH. GOSH in Haringey NFA due to handover to Whittington Health on 24 May 2011. 4.SLA agreed with NMUH for CP advice and support 5. CP Supervision in place for approriate staff, policy subject to audit 6.Safe Recruitment Practice 7.Strategic partnership working, engagement in Camden main LSCB (currently represented on Quality and Learning Development Group in Camden). Harginey LSCB NFA due to handover to Whittington Health on 24 May 2011. 8.Attendance at relevant case conferences, policy subject to audit 9. Balanced score card immplemented to increase compliance with CP record keeping, supervision and level 3 training incoporated into CQUIN.
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1. No gap 2. NHS SIT in January 2011 recommended increase from 31.26% in level 3 provision to be met by 2014 (20% per annum over the next 3 years) to ensure compliance of 80% national target. 3. No gap 4. No gap 5. No gap 6.CRB delays- national issue 7. NHS SIT in January 2011 recommended that GOSH have representation on main Camden LSCB. NHS Sub-group chair (PL) has formally requested response to this in March 2011. Awaiting notification. 8.No gap 9. Compliance with record keeping currently 70% to be improved to 80% by 31.03.2011, compliance with clinical supervision for core staff involved in CP issues to be increased from 20% compliance to 50% compliance by 31.03.2011
Internal assurance on controls	Quarterly reports to Q&S, CGC and TB Audit results to CPMG and Q&S. Action plans developed to manage any gaps identified. Health Leadership for Safeguarding meeting lead on delivery of phase 3 JAR action plan Training and education quarterly reports Active cases available on SW database at GOSH. Personnel records available 5pm hand over of active cases to CSP's and Chief Nurse
External assurance on controls	Ofsted / CQC inspection January 2011 final report pending Professional registration / codes of conduct GOSH main site Safeguarding Inspection Team (SIT) visit in Jan 2011 - positive findings. Haringey (including GOSH in Haringey) SIT visit 2010 - positive findings
Gaps in assurance	
Actions / Milestones (including dates)	To work through the JAR / CQC recommendations as detailed in action plan incorporating: safe recruitment; training; supervision; improvements to record keeping Regular audit: record keeping, IMR quality compliance, case conference attendance, CP supervision Action in development to respond to SIT recommendations
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**4**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**3**
Revised principle risk score	**12**
Assurance status	**GREEN**
Registration Reference	**7A- 7L: Lead effectively to reduce the potential of abuse**
NHS Constitution Reference	**You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality**
NHSLA Reference	Child Protection no longer included in NHSLA assessment.
Date Reviewed/ Updated	**31/05/11**

STRATEGIC OBJECTIVE 1: C Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**1C Children, staff and parents may be put at risk from failure to adequately maintain the estate and non clinical equipment**
Accountable Executive	**Diector of Redevelopment**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**5**
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**5**
Initial Principal Risk Score	**25**
Key controls (list top 5 and number 1-5)	1 Responsibility for monitoring regulations clearly defined and resourced. Implementation plan has been developed. 2 Fire Safety Risk assessment at ward and department level, mitigation of risk/significant findings and re-assessment. Principle submitted to Management Board. 4 All significant works in Trust premises carried out under CDM Regulations, 5 Health and Safety Files in place and Risks identified prior to works comencement. 6.Fire alarm activations monitored monthly 7.Fire Training as part of Trust 7 Induction and Clinical and Non Clinical Update 8.Risk Impact assessments of Contractor Sites to review local Fire Procedures 9 PAT testing carried outsitewide 10 Procurement of equipment is on a risk assessed priority through the CASP Committee 11 Equipment maintenance is covered under PPM system /PAT testing or through Service contracts with specialist knowledge. 12 Regular reviews of Business Continuity Plans now in place
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	Recent audit by Health and Safety Executive (7&8th July 2010)gave assurance that internal controls and procedures in the Works Department and confirmation of the wider H&S procedures within the Trust were satisfactory
Internal assurance on controls	Project Risk registers reported to Redevelopment Committee Estates risks are reported to Estates H&S Committee Estates H&S Committee reports to Trust H&S Committee Estates high risks are regularly reviewed by the Audit Committee Regular fire reports to Trust Board Qtrly fire & safety committee Executive and Non Executive Walkrounds
External assurance on controls	Recent audit by Health and Safety Executive (7&8th July 2010)gave assurance that internal controls and procedures in the Works Department and confirmation of the wider H&S procedures within the Trust were satisfactory Capitec audit Regular audits by Fire officer from LFB
Gaps in assurance	No Gaps
Actions / Milestones (including dates)	Local fire training - Completed Fire Risk assessments completed on programme for 2011 Estate strategy approved by Board January 2011
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	2
Revised principle risk score	10
Assurance status	**GREEN**
Registration Reference	**10. Safety and suitability of premisies**
NHS Constitution Reference	You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality
NHSLA Reference	3.1 Secure Environment
Date Reviewed/ Updated	**25/05/11**

STRATEGIC OBJECTIVE 1D Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals i	
Principal Risk	1D Children may be at risk from hospital decontamination & cleanliness)
Accountable Executive	Medical Director (ME)
Assurance committee responsible for monitoring risk	Clinical Governance Committee
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	20
Key controls (list top 5 and number 1-5)	1.Cleaning manual identifies type of equipn responsibilities to do so. 2.Cleaning contracts for external contracto be cleaned 3.Antibiotic prescribing guidelines, policies 4. Infection Control Team and local assura of HCAI 5. Training programme for staff in place re a 6.Ability to track individual instruments in th
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1-6 No gaps
Internal assurance on controls	1 Local audits 2. Monitoring by contractors and overseen a 3. Monitoring of prescribing practice 4.HCAI events reported through Infection C 5. Monitoring and follow up process for atte training 6. Track and trace system implemented 7. Internal audit underway on medical equip Management Board from DIPC
External assurance on controls	1 &2 Follow up inspection by CQC identifie 1&2PEAT assessments 3,4,5 NHSLA 4.9 and 2.8 compliance requ 3,4,5 Reporting levels to NPSA, HPA and S
Gaps in assurance	1-5 None 6. implementation of instrument marking nc
Actions / Milestones (including dates)	6. Instrument marking commences 17th Ap
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Revised principle risk score	15
Assurance status	GREEN
Registration Reference	Outcome 8. Cleanliness and infection cc
NHS Constitution Reference	You have the right to be treated with a p appropriately qualified and experienced organisation that meets required levels c The NHS also commits to ensure that se environment that is fit for purpose, base
NHSLA Reference	2.5 Risk Management Training 2.6 Training Needs Analysis 2.8 Hand Hygiene 3.6 Innoculation Incidents
Date Reviewed/ Updated	

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l acquired infection (includes

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and procedures relating to HCA
ance framework in place for the managemen

all aspects of infection control managemer
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and followed up by facilities staf

Control Committee
endance and non attendance at mandatory

pment (November 2010) Paper tc

d no gaps (June 2009

uirement achieved at Level 2
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pril - supports tracking syster

ontrol

professional standard of care, by
staff, in a properly approved or registered
of safety and quality

ervices are provided in a clean and safe
ed on national best practice (pledge)

4.9 Infection control
3.7 Maintenance of Medical Devices and
Equipment

04/02/11

STRATEGIC OBJECTIVE 1: E Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**1E The organisation, management, administration and delivery of clinical services may not always optimally deliver the best outcomes (to include record management, consent, nutrition, clinical/ management focus)**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	20
Key controls (list top 5 and number 1-5)	1. Employment of professionally competent staff. 2. Clear JD's for Clinical Unit Management Team which include responsibility for clinical service organisation - regular appraisals against these JDs 3. Policies and procedures where required 4. Ongoing reviews of incidents and SUIs and investment agreed by Management Board where appropriate. 5. Extensive production of outcome and process data and reports 6. CRES challenge meetings (to ensure impact of CRES on clinical service delivery is understood) 7. Partnership with Cincinnatti (to ensure external challenge and input) 8. Formal quarterly reviews with each clinical unit cover clinical outcomes as well as patient experience and financial performance. 9. Effective rostering of staff 10. Use of CEWS and SBARD 11. Transformation Programme and Board 12. CESC prioritisation of equipment needs 13. Equipment database 14. ICON & general Paediatrician service 15. 6 monthly corporate department reviews 16. Audit and transformation workstreams aimed at improving clinical documentation and communicatio
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	None
Internal assurance on controls	Clinical Audit Programme. Regular Review of Complaints and Incidents Paediatric Trigger Tool Systematic Healthcare Delay Audit
External assurance on controls	External peer reviews e.g laboratory assessments, radiology accreditation CQC Assessments CNST Level 2
Gaps in assurance	
Actions / Milestones (including dates)	Further work required on management of deteriorating child, including increased use of SBARD and CEWS (July 11) Investment and expansion of IR service (Sept 11)
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**4**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**3**
Revised principle risk score	**12**
Assurance status	**GREEN**
Registration Reference	**4. Care and welfare of people who use services**
NHS Constitution Reference	**You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality**
NHSLA Reference	Standard 1 Governance Standard 2 Competent workforce Standard 3 Safe Environment Standard 4 Clinical Care Standard 5 Learning from experience
Date Reviewed/ Updated	**07/04/11**

STRATEGIC OBJECTIVE 1F Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**1F Our clinical equipment may be inadequate for excellent clinical care and enhanced patient experience**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	15
Key controls (list top 5 and number 1-5)	1 CESC properly prioritises requests for replacements/ new equipment 2 We have approved maintenance schedules 3 We have maintenance agreements in place where appropriate 4 We have systems whereby any concerns regarding equipment can be placed on the risk register and rapidly escalated for action to be taken. 5 We have an equipment database which records all equipment that we own and how it is maintained.
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	CESC ToR under review to ensure that subcommittee operates effectively and meets requrirments around auditing of equipment.
Internal assurance on controls	BME conducts internal audits as part of its BSI Accreditation. Safety walkaround
External assurance on controls	Clinical Units raise key issues (including equipment deficiencies) at Management Board each month
Gaps in assurance	
Actions / Milestones (including dates)	Review of CESC ToR underway. Equipment tracking pilot underway. New policy being implemented to ensure that all equipment maintenance contractors report on arrival to the hospital to BME. Proposal to develop Performance Indicators for PPE schedules on major pieces of equipment Long term strategic equipment plan being developed
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**5**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**2**
Revised principle risk score	**10**
Assurance status	**GREEN**
Registration Reference	**11. Safety, availability and suitability of equipment**
NHS Constitution Reference	**You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality**
NHSLA Reference	3.7 Maintenance of Medical Devices & Equipment 1.7 Responding to external recommendations
Date Reviewed/ Updated	**31/05/11**

STRATEGIC OBJECTIVE 1: G Consistently deliver clinical outcomes that place us amongst the top 5 Children's H	
Principal Risk	1G Staff in post may not be appropriatel
Accountable Executive	Chief Nurse and Director of Education
Assurance committee responsible for monitoring risk	Clinical Governance Committee
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	
Initial Principal Risk Score	
Key controls (list top 5 and number 1-5)	1. Recruitment processes. 2. Agency staff employed through approvec 3. Central and local induction for all (sustan 4. 18 month cycle of mandatory training witl 5. Specialist training provided though practi policy and funding application processes. 6. Preceptorship / mentorship / supervision mentorship training provided for Nursing sta 7. Bed Management policies - children care 8. KSF for all non medical staff. 9. Appraisal and ongoing PDP. Manager an 10.London Deanery quality management fra NMC quality assurance process 11. Performance management policies, con 12. All registered nurses are registered with 13. Education Tacking systems, central edu 14. On-line learning opportunities providing 15. Simulation strategy 16. Education Strategy approved by Trust a
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1.No gaps 2.No gaps 3. Some non-attendance of elements picke 4.Some non-attendance of elements. Staff s 5.No gaps. 6. Nurse Mentorship database inaccurate - 7. Staff vacancies / increasing dependency 8. Not all posts have a KSF. KSF gateways 9. PDR compliance rate improved to mid 70 10. No gaps. 11. No gaps 12. No gaps 13. Dbase now over 10 years old and need 14. Compliance over completion rates for o 15. Lack of appropriate space to run effecti 16. No gaps
Internal assurance on controls	KPIs exist for mandatory training and appra mandatory training reports quarterly to man local induction checklists reviewed by E&T E&T. gaps identified to support identificatio Board receives annual Training and Educat receives quarterly report of suspensions an SUI reports Staff survey feedback - annual report with s Internal Audit Staff Appraisal Process unde Managers sent reports on staff non attenda Education & Training Committee and Post
External assurance on controls	London Deanery quality management fram HEI annual quality review process / NMC q feedback
Gaps in assurance	
Actions / Milestones (including dates)	
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	2
Revised principle risk score	10
Assurance status	GREEN
Registration Reference	14. Supporting workers
NHS Constitution Reference	You have the right to be treated with a p approved or registered organisation that
NHSLA Reference	Standard 2 Competent workforce 1.9 Professional Clinical Registration 1.10 Employment checks
Date Reviewed/ Updated	

ospitals in the world

y competent to deliver care

5

3

15

d agencies.
ative, honorary, agency, contract) staff.
h quarterly central reporting to manager to follow up non attenders
ice educators / CSP team / speciality education leads / PGME / HEIs. Study and professional leave

of staff through clinical, professional, management structures and PDR processes. Preceptorship /
aff.
ed for on wards where teams have appropriate clinical skills. CSP team skills.

nd staff member sent reminders.
amework -local education providor annual assurance processes / HEI annual quality review process /

nduct and capability, disciplinary and poor perfirmance policies.
n the NMC - routine annual checks to and managers informed of approachign expiry dates
ucation database
assessment of knowledge

and Managment Board. Strategic priotires for 2011-12 agreed.

d up by tracking system but greater local accountability needed
survey suggess staff not recognsiing when they had attended H&S training updates

to be revised by 31.5.11. Medical staff training being developec
/ specific complex clinical needs can affect allocation of children to wards.
not used by managers
0% in 2010/11 target for improvement 90% by 31.03. 2012.

s replacing. Errors in reports can discredit credibility
n-line learning an issue. The tracking of which creates extra admin for central team.
ve simulation training

aisal / PDR rates — Induction a
agers to follow up non attenders
to assure compliance. — PDRs reviewed b
n of training needs
tion Report — Board Boa
d dismissals

staff perception of PDR rates, job related training, support from managers, understanding their role.
rtaken. Reasonable assurance given. Appraisal rates show steady increase.
nce at mandatory training and out of date PDRs.
Graduate Training Committee oversight on all education activity.

ework - local education providers reports
uality assurance process — Staff surv
CQC, NHSLA, SIT

rofessional standard of care, by appropriately qualified and experienced staff, in a properly
t meets required levels of safety and quality

Standard 4 Clinical Care

31/05/11

STRATEGIC OBJECTIVE 1: H Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**1H We may not be able to recruit and retain key staff**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	20
Key controls (list top 5 and number 1-5)	1. HR, Recruitment and Workforce Planning and Education and Training Strategies, Plans and Policies in place inc staff benefits to attract and retain key staff eg accommodation, education and training opportunities; auditing exit questionnaires 2. Specific recruitment strategies and plans in place for key hard-to- recruit areas 3. New systems (E-CRB and E-ARCU) to improve speed of recruitment 4. Monthly monitoring of vacancies, turnover, absence 5. Locums, bank and agency staff in place where required 6. Access policy and bed planning meetings organised to manage workload despite staff shortages. 7. Patients turned away / delayed by the hospital are reported by clinical units monthly to Management Board 8. Prioritisation of key staff in criteria for allocating limited certifcates of sponsorship for overseas staff 9. GOSH influencing education commissioning decisions via Trust workforce plan going to NHSLondon and participation in nurse commissioning process 10. Specific recruitment strategies for hard to recruit areas / professions 11. Trust strategy designated priority areas for development and hence recruitment 12. Long term workforce plan developed to be proactive about workforce needs and planning
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	Some areas difficult to attract locum staff in a timely manner
Internal assurance on controls	Reports to Trust Board and Management Board on staff vacancies and bank and agency usage. Regular in depth reports to Management Board in staffing Unit Risk registers and workforce KPI's reviewed at quarterly operational reviews Internal audit found satisfactory compliance with CQC outcome 13 - Staffing, Feb 2011 MB receives information on patients turned away. Safety walkarounds raise questions on staffing - recruitment and retention
External assurance on controls	Ability to achieve key performance targets CQC Assessments
Gaps in assurance	
Actions / Milestones (including dates)	Co-medical Director leading a review of junior doctor staffing across the Trust. Identification of small but very vital staff groups and the risk management required underway.
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**4**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**3**
Revised principle risk score	**12**
Assurance status	**GREEN**
Registration Reference	**Outcome 13. Staffing**
NHS Constitution Reference	**You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality**
NHSLA Reference	Standard 2 Competent workforce 1.9 Professional Clinical Registration 1.10 Employment checks
Date Reviewed/ Updated	**31/05/11**

STRATEGIC OBJECTIVE 1:I Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**1I We do not make sufficient progress in developing benchmarks and demonstrating world class clinical outcomes**
Accountable Executive	**Medical Director (ME)/ Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	3
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	9
Key controls (list top 5 and number 1-5)	1. Systems in place to ensure outcome measures for all specialties 2. Performance against these is monitored at the clinical unit quarterly reviews. 3. Dedicated project manager post to drive process 4. Clinical Outcomes Steering Board
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1. Within some specialties there are no internationally agreed measures so it is difficult for us to benchmark. 2. The chosen outcome measures will not apply to the full range of children seen within each specialty.
Internal assurance on controls	
External assurance on controls	1. Some specialties (eg renal transplant, cardiac surgery) have internationally agreed data sets which enable proper benchmarking with international best practice. 2. Public presentation of outcome measures
Gaps in assurance	
Actions / Milestones (including dates)	Double the number of specialties with outcomes published by March 2012 Develop at least 8 specialties with PROMS by March 2012 Benchmark outcomes in at least 8 specialties by March 2012 Plan to liaise with other top children's hospitals throughout the world to share outcomes reported and agreed benchmarkable measures Develop detailed project plan
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**3**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**2**
Revised principle risk score	**6**
Assurance status	**GREEN**
Registration Reference	
NHS Constitution Reference	
NHSLA Reference	None
Date Reviewed/ Updated	**09/06/11**

STRATEGIC OBJECTIVE 1: J Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**1J Clinical outcomes and patients' experiences may suffer as a result of a lack of appropriate management focus**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	3
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	9
Key controls (list top 5 and number 1-5)	1. Clinically-led management teams for each clinical unit, with clear objectives around clinical outcomes and patient experience. 2. Other projects (e.g. FT Application) properly and separately resourced to avoid over-load on existing staff. 3. Clinical unit representation on project boards (e.g. FT), with opportunity to feedback regarding workload pressure 4. Monitoring of clincal outcomes, patient experience and other KPIs 5. "The Child First and Always"; the zero harm program and improvement programme dedicates >50% to safety and quality
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	
Internal assurance on controls	Quarterly Clinical Unit Performance reviews focus on all strategic objectives including outcomes and experience All Trust meetings have avoiding harm as the first item on the agenda The first two strategic objectives are outcomes and experience
External assurance on controls	Benchmarked outcome measures (e.g. Cardiac Surgery) Patient experience surveys CQC Assessments CRES scheme process to ensure clincial care is not compromised
Gaps in assurance	
Actions / Milestones (including dates)	
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**3**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**2**
Revised principle risk score	**6**
Assurance status	**GREEN**
Registration Reference	**All**
NHS Constitution Reference	
NHSLA Reference	
Date Reviewed/ Updated	**14/06/11**

STRATEGIC OBJECTIVE 1: K Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	
Principal Risk	**Lack of appropriate clinical response to the deterioration in children**
Accountable Executive	**Co-Medical Director (ME)**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	20
Key controls (list top 5 and number 1-5)	1.CSP's act as a nursing rapid response team; 2.Use of SBARD to improve communication of clinical status 3.ICON service established to provide medical support 4. Review of all ICU, ICON and HDU services 5. Monitoring of internal collapses and deterioration 6. CEWS 7. Increased nursing cover
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1.None 2.No gap as still being rolled out 3 &4 None 5. None 6. Being rolled out 7. None
Internal assurance on controls	1. KPI on number of arrests and outcomes.CSP's and 'home' team continue to review all children highligthed to be at risk of deterioration. CSP's follow up children discharged from PICU/NICU for at least 48 hours. 2.Transformation project on SBARD reported to Transformation Board 3. Monitoring of ICON outcomes reported to Medical Director 4. Compliance with defined parameters of deterioration reported to Resus committee with overview to Quality & Safety Committee 5. None as yet - pilot only, transformation project 6. Internal audit undertaken on lack of appropriate response to the deterioration of children : July 2010 - reasonable assurance
External assurance on controls	1- 4.NHSLA Level 2 compliant. Existence of process reviewed as part of 4.8 but not its effectiveness 5. Gap
Gaps in assurance	5. Until CEWS rolled out and measures identified. Clinical Audit meeting with Transformation 8th Feb to identify measures
Actions / Milestones (including dates)	3. ICON in place and being monitored - ongoing. Reports received by Quality & Safety Committee .
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**5**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**3**
Revised principle risk score	**15**
Assurance status	**AMBER**
Registration Reference	**Outcome 4. Care and welfare of people who use services**
NHS Constitution Reference	**You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality**
NHSLA Reference	4.8 Resuscitation
Date Reviewed/ Updated	**12/01/11**

STRATEGIC OBJECTIVE 2:A Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	
Principal Risk	**2A We may not be able to measure, report and act on patients' experience**
Accountable Executive	**Chief Nurse and Director of Education**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	1
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	3
Key controls (list top 5 and number 1-5)	1. Patient Experience startegy and action plan in place 2. PPI and Patient Experience Liaision Officer post appointed to - start pending 3. Increasing volumes of local surveys being conducted. 4. Executive safety walkrounds act as a 'safety thermometer' enabling excutive members to keep in touch with patient and families real time experiences 5. Ipsos Mori inpatient survey 2010/11 revealed increase satisfaction level of 96% 6. Development work commenced with Trust board to agree a members strategy and way forward for members council pending FT approval.
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1. Process for reporting Patient Experience to CGC needs to be determind 2. No gaps 3. Patient Experience action plan will improve the availability of more regular patient experience feedback and guidance for staff 4. No gaps 5. No gaps 6. No gaps
Internal assurance on controls	PPIEC monitors progress on PPIE strategy PALs annual report to CGC Joint PALs / PPI annual report to TB
External assurance on controls	IPSOS Mori inpatient survey 2010/2011 CQUIN Overview and scrutiny committee Links (Health Watch)
Gaps in assurance	No frequent feedback system in place at present
Actions / Milestones (including dates)	1. Intellegent Board 2010 Report on Patient Expericnce to TB Dec10 2. Repeat inpatient IpsosMORI survey Dec 10 3. First draft of Patient experience strategy to go to PPIEC Dec 10
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**1**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**3**
Revised principle risk score	**3**
Assurance status	**GREEN**
Registration Reference	**16 Assessing and monitoring the quality of service provision & 17 - Complaints**
NHS Constitution Reference	
NHSLA Reference	
Date Reviewed/ Updated	**10/01/11**

STRATEGIC OBJECTIVE 2: B Consistently deliver an excellent experience that exceeds our patient, family and referrer expectati	
Principal Risk	**2B Patients may have to wait longer than is reasona being national waiting time targets)**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	3
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	12
Key controls (list top 5 and number 1-5)	1. Access Policy 2. Bed Management Policy 3. JDs in place to manage waiting lists 4. Weekly operational meeting to troubleshoot issues 5. Reporting to Transformation Board re progress on Ad 6. Reporting monthly to MB and TB 7. Reporting monthly to MB on number of patients turne 8. 18 week pathway project group
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	No robust trust-wide systems for measuring waiting time
Internal assurance on controls	Repoprting to Management Board and Trust Board on n previous national targets (13/6/26) Monitoring of complaints and Pals activity Reporting declined referrals
External assurance on controls	Internal audit on 18 weeks completed and recommendat including: clock start data not being made available; refe recording of patient choice pauses and incorrect recordi Monthly project review group established Membership includes operational, pathway and service
Gaps in assurance	
Actions / Milestones (including dates)	Trust wide bed management project has been initiated v (refusals / delays)
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	2
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Revised principle risk score	6
Assurance status	**GREEN**
Registration Reference	**4. Care and welfare of people who use services (4A)**
NHS Constitution Reference	**The NHS commits to provide convenient, easy acce the Handbook to the NHS Constitution (pledge);**
NHSLA Reference	N/A
Date Reviewed/ Updated	

ions
ble for consultation or treatment (initial proxy
ivanced Access d away
es for inter-hospital transfers
ational/ contractural targets (cancer, 18weeks) and
tions accepted and being acted upon. Identified issues erral turn around times not being met, incorrect ng of clock stop data. managers, information and central booking leads.
vith key early focus of measuring referral failures
ess to services within the waiting times set out in
31/05/11

STRATEGIC OBJECTIVE 2:C Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	
Principal Risk	**2C We may not meet referrers and other health and social care expectations around communication and accepting appropriate referrals**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	3
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	12
Key controls (list top 5 and number 1-5)	1. Statutory requirements around data sharing and policies to ensure adherence to this. 2. Contractual standards for communication timescales and quality 3. KPI report includes monitoring discharge summary production times 4. Report declined emergency referrals at MB
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1. Don't report outpatient letter production performance
Internal assurance on controls	1. Rolling audit of discharge summary quality 2. Rolling audit of outpatient letter turnaround times 3. Referrer's survey results presented to MB and TB 4. Specialty level referrer's survey results presented to CUCs
External assurance on controls	1. CQC / Ofsted re Haringey information sharing. 2. Independent referrer's survey undertaken 3. Established a Referrer's Experience Improvement Programme 4. Hospital wide referrer's conference arranged 5. Invite comments from referrers and run referrers days 6. Referrers newwletter 7. Referrer's Experience Improevement Group
Gaps in assurance	
Actions / Milestones (including dates)	Hospital wide referrer's conference (Oct 2011)
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**3**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**3**
Revised principle risk score	**9**
Assurance status	**GREEN**
Registration Reference	**Outcome 6**
NHS Constitution Reference	**PLEDGE: The NHS commits to make the transition as smooth as possible when you are referred between services (and to include you in the relevant discussions)**
NHSLA Reference	
Date Reviewed/ Updated	**31/05/11**

STRATEGIC OBJECTIVE 3A Successfully deliver our clinical growth strategy	
Principal Risk	**3A We may fail to get Commissioner 'buy in' to Trust growth plans and service developments**
Accountable Executive	**Chief Finance Officer**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	5
Initial Principal Risk Score	20
Key controls (list top 5 and number 1-5)	1. Regular meetings with Commissioners 2. Linked to a London Tertiary paediatric Strategy and National cardiac and Neuro surgery reviews 3. Past track record of significant year by year growth. 4. Letters of support received from majority of commissioners 5. Key item discussed at all appropriate internal and external FT meetings
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	4. Letters of support outstanding from South East Coast SHA
Internal assurance on controls	1.Commissioner Forum meeting minutes - reported to Management Board 2. Progress reports on reviews are in board minutes 3. Historic information underlying LTFM 4. Papers for Commissioners Forum and Review Group 5. Papers if relevant
External assurance on controls	Three way meeting with SHA and commissioners Ernst and Young audit of financial plans for FT application
Gaps in assurance	None
Actions / Milestones (including dates)	
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Revised likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Revised principle risk score	12
Assurance status	**GREEN**
Registration Reference	**Not applicable**
NHS Constitution Reference	**Not applicable**
NHSLA Reference	
Date Reviewed/ Updated	**02/06/11**

STRATEGIC OBJECTIVE 3B Successfully deliver our clinical growth strategy	
Principal Risk	**3B We may fail to influence and capitalise on regional and national reconfiguration opportunities**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	12
Key controls (list top 5 and number 1-5)	1. TB uses opportunity of strategic away days to review strategy and national policy. 2. Annual Plan explicitly includes responding to these opportunities. 3. Management Board maintains operational overview of collaborative work and challenges regularly 4. GOSH staff members on key national review committees 5. Ensure that future facility plans are able to manage the potential activity from any reconfigurations
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	
Internal assurance on controls	Monthly activity monitoring Quarterly clinical unit performance meetings review activity and growth plans. Quarterly market share information presented to Trust and Management Boards
External assurance on controls	Ernst & Young have reviewed IBP assumptions against the national reviews and have deemed them appropriate. KMPG has undertaken the same process as part of HDD for the FT application and come to the same conclusion.
Gaps in assurance	
Actions / Milestones (including dates)	1.IBP Activity plan complete 2.Oxford cardiac closure being monitored and gaining referrals from Northampton and Wexham Park (completed) 3. Capacity being developed around growth opportunities and potential reconfigurations (completed) 4. Proactive marketing of key services prone to reconfiguration (Ongoing) 5.Ernst & Young to produce independent report for commissioners assessing our assumptions and plans (Completed) 6. Establish Referrer's Experience Improvement Programme (Completed) 7. Establish specific marketing meetings with Clinical Units (Ongoing) 8. Encourage parents / staff and patients to feedback on National Cardiac Review (March - June 2011)
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	3
Revised likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	2
Revised principle risk score	6
Assurance status	**GREEN**
Registration Reference	**None**
NHS Constitution Reference	**You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.**
NHSLA Reference	Standard 5.4 Learning from Experience
Date Reviewed/ Updated	**31/05/11**

STRATEGIC OBJECTIVE 3C Successfully deliver our clinical growth strategy	
Principal Risk	**3C We may not deliver our strategy for International Private Patients**
Accountable Executive	**Director of International Private Patients**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	20
Key controls (list top 5 and number 1-5)	1. Recruitment & Retention Strategy; 2. Referal & Capacity Management; 3. Service Line Reporting; (in longer term) 4. Operational Performance Report.
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1. Implemented - not fully embedded as yet; 2. Implemented - not fully embedded as yet; 3. Work has commenced; 4. Implemented - report in use, further refinements to follow.
Internal assurance on controls	1. Level of staff turnover, vancanies, PDP's and training courses attended; 2. Length of stay, capacity, outliers; 3. None; 4. Report included in Management Board papers. 5. Internal audit underway
External assurance on controls	
Gaps in assurance	1. None; 2. None; 3. No work is or has been undertaken in regard to costing and ensuring that costs are covered for each medical procedure undertaken within IPP; 4. None.
Actions / Milestones (including dates)	1. Continued monitoring of control until fully embedded; 2. Continued monitoring of control until fully embedded; 3. Timescale and action plan needs to be created and implemented; 4. Continued development of report as Head of Finance and Information implements action plans.
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	2
Revised principle risk score	10
Assurance status	**GREEN**
Registration Reference	**3 Fees**
NHS Constitution Reference	
NHSLA Reference	N/A
Date Reviewed/ Updated	**21/02/11**

STRATEGIC OBJECTIVE 4 : A With partners maintain and develop our position as the UK's top children's research organisation	
Principal Risk	**4A We may not deliver our research strategy and fail to attract research funding**
Accountable Executive	**Clinical Director of Research and Development**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	3
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	12
Key controls (list top 5 and number 1-5)	1. A full review of the R&D office has been undertaken by an external consultant and recommendations made on how the process and working of the R&D office could be improved. These recommendations have been implented which included a complete restructure of the Joint R&D Office and the transfer of the responsibility for research governance to GOSH under a Division of Research and Innovation. 2. A recommendation of the review was the appointment of research facilitators who will support researchers in grant applications and governance process compliance. Three facilitators have been appointed and taken up post. Their work is to support researchers in their quest for research funding and will provide the extra input and support required for a successful grant application. Additional governance support and database monitoring is also now being provided which will allow a speedier governance process and accurate reporting. 3. The full costing of all research activity particularly within NIHR funding streams will allow GOSH to appropriately invoice for costs which historically had not been identified. Extra funding from the NE/C CLRN is being applied for in a systematic manner to achieve supplemental activity based funding and financial recognition for support services (such as pharmacy and radiology). 4. Closer working relationship between BRC CRF and R&D Office aims to improve the quality and quantity of research within GOSH.
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	None
Internal assurance on controls	*Increased overall grant income as a result iof the work of the research facilitiators and the improved financial management within GOSH
External assurance on controls	MHRA inspection undertaken in May 2011 - no critical findings, 2 major, and 7 other.
Gaps in assurance	Plans to undetake an annual audit of the division, including non sponsored child research (December 2011)
Actions / Milestones (including dates)	*R&D registration process revised and new process being put in place by Sept 2010 Achieved *New Research & Innovation Unit to be established at GOSH by 1 Sept 2010 Achieved
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	3
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	2
Revised principle risk score	6
Assurance status	**GREEN**
Registration Reference	**None**
NHS Constitution Reference	**None**
NHSLA Reference	4.3 Consent (for research)
Date Reviewed/ Updated	**01/06/11**

STRATEGIC OBJECTIVE 5 : A Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	
Principal Risk	**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**
Accountable Executive	**Director of Nursing and Education**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	12
Key controls (list top 5 and number 1-5)	1. E & T strategy for GOSH highlights commitment to national and international role in developing child health staff 2. Development of GOLD offers opportunity for learning innovation through web conferences and shared learning networks. GOLD redevelopment now complete with creation of further on-line learning on-going. 3 Education strategy agreed by Management and Trust Board Nov/Dec 2010 4 Development opportunities arising from IPP work, initially with Kuwait. International education lead appointed. 5 E&T SLA continue with NMUH. 6. E&T CRES plans highlight a number of business development opportunities 7. Simulation strategy agreed and Sim Group established - now looking for training area development opportunities. 8. Education services has recently be re-designed to allign structure to service needs & activity 9. Educations services revised governance structure with ETC reporting into MB on targets (e.g PDR uptake) 10. Education dashboard in development linking education activity to clinical outcomes
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1. No gaps 2. Education and ICT strategies need to be linked. At moment Trust systems cannto provide infrastructure to support some of the planned learning innovations. 3. Lack of capacity within Education to meet ambitious level of commercial activity could threaten future agreements. 4 As point 3. However, dedicated International education post now in post and makign positive impact in relation to Kuwait contract 5. No gaps. 6. CRES plans commitment to develop business opportunities 7. Lack of space for innovative learning opportunities makes trust less attractive compared with other providers. 8. No gaps 9. No gaps 10. No gaps
Internal assurance on controls	Education strategy agreed by Management and Trust Board Nov/Dec 2010 Strategic Priorities for 2011-12 agreed by MB and TB May 2011
External assurance on controls	Care Quality Commission Investors in People London Deanary quality management framework - local education providers reports
Gaps in assurance	
Actions / Milestones (including dates)	5 year strategic plan agreed by Management and Trust Board Nov/Dec 2010 Strategic Priorities for 2011-12 agreed by MB and TB May 2011 Further on-line learning developments - on-going throughtout 2011 GOSH submitted skills lab bid to Space Group -June 09. This now to be revised - June 2011
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	3
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	2
Revised principle risk score	9
Assurance status	**GREEN**
Registration Reference	**14. Supporting workers**
NHS Constitution Reference	**PLEDGE: The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.**
NHSLA Reference	Standard 2 Competent & Capable Wokforce
Date Reviewed/ Updated	**31/05/11**

STRATEGIC OBJECTIVE 6A Deliver a financially stable organisation	
Principal Risk	**6A We may overspend on budgets by no CRES targets.**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	12
Key controls (list top 5 and number 1-5)	1. Agreed budget for year including funding 2. Monthly budget statements. 3. Monthly financial reporting to Clinical Uni 4. Monthly financial review meeting for each forecast position. 5. 5 year CRES planning process, with Exe 6. CRES steering board chaired by CEO 7. Tracking of CRES planning performance 8. CRES targets set above level required to
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1. Potential for confusion regarding pass-thr 2. Prevention and identification of overpayr
Internal assurance on controls	Internal audit on control of the Trust's capita level Internal audit report on payroll (March 201(identification of overpayments - limited ass Internal audit on CRES (March 2010) - over
External assurance on controls	Ernst and Young Audit
Gaps in assurance	
Actions / Milestones (including dates)	Revised process for pass through costs <u>Capital projects internal audit - actions:</u> 1. A comprehensive guide to purchasing, te should be produced to provide guidance on projects and ensuring value for money is ob 2. The Business Case for proposed capital • Comply with current, or an impending cha • Respond to a clear preventative or reactiv These projects should be prioritised in term running and effectiveness of the Trust (Com 5. CASP spreadsheet updated (Completed) <u>Payroll internal audit (March 2010) - actions</u> 1. SRS training for new and existantr memb 2. Inclusion of overpayments in Trust wide r 3. Authorised signatories should be instruct when signing timesheets. Non-compliant or 4. User Access Forms should be completed 5. Any privileges granted on a temporary ba <u>Internal audit on CRES (March 2010) - actio</u> 1.An accurate and clear description of each 2. The monitoring spreadsheet detailing the 3. The Trust should review the processes fo 4. Prior to the formulation of the annual CRI 5. The Trust should ensure that presentatio 6. The Trust should carry out a formal asses
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	2
Revised principle risk score	8
Assurance status	**GREEN**
Registration Reference	**26. Financial position**
NHS Constitution Reference	**None**
NHSLA Reference	N/A

Date Reviewed/ Updated	

ɔt maintaining control of costs and failing to achieve planned

for recognised cost pressures.

ɪt Management Boards, Management Board and Trust Board.
ı clinical unit with COO and CFO, including updated year end

ːc sign-off meetings

with progress and risk assessments
ɔ deliver planned financial performance

rough costs, especially high cost drugs.
ments - as outlined in the Payroll internal audit (March 2010)

al projects (December 2009) - rated overall significant assurance

0) - Key payroll controls - significant assurance; Prevention and
surance
rall rating of reasonable assurance

endering and contracting, ideally in one working document,
ı financial, control and practical aspects of managing capital
otained from all purchasing activity (by March 2010)
projects should indicate whether the expenditure is required to:
nge in, legislation or regulations;
e maintenance issue.
s of the risk that they pose to the financial and operational
npleted)
)
s:
bers of staff (by April 2010)
risk register (April 2010).
ted to print their name and budget code next to their signatures
illegible forms should be returned. (March 2010)
d and retained securely for all new users of the ESR system and fo
asis should be speedily revoked when no longer required. (April 20
ons
ı initiative proposed in the CRES programme should clearly indicat
e description and progress of CRES schemes should continue to re
or selecting initiatives for inclusion in the CRES programme, for est
ES programme, the Trust should help units and/or departments ide
n of the savings realised against the CRES target is given greater
ssment of the potential effect of CRES schemes on the quality of p

31/05/11

STRATEGIC OBJECTIVE 6B Deliver a financially stable organisation	
Principal Risk	**6B Sustainable funding solution for each activity withi not be secured**
Accountable Executive	**Chief Finance Officer**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	4
Initial Principal Risk Score	20
Key controls (list top 5 and number 1-5)	1 Monitoring of adequacy of local prices changes includin 2 Monitoring of developments on 2011/12 Tariff and parti underpin Top Up rates working with Alliance and members 3 Development of Service Line and PLICS Reporting incl costs to support local tariff prices, 4 Improve understanding of future drivers of R&D funding; 5 Monitor developments on changes in Medical Education 2012/13 6 Manage impact of reduced funding from Charity
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	
Internal assurance on controls	1-3 Reports to Audit Committee. RE 1 Minutes of Commissioners Forum RE 2 Action points arising from DH Childrens PbR meetir assessments on 1011 Tariff when issued for roadtesting RE 4 Review of PLICS costs (Jan to June 2011) RE 5 Review of all financial aspects of R&D RE 6 Emails and minutes of external meetings with DH RE 7 Reports to TB (with budget paper in Mar 2011) Internal audit Report - assurance satisfactory
External assurance on controls	ALE financial sustainability score published October 2010 Reference costs published Jan 2011
Gaps in assurance	
Actions / Milestones (including dates)	RE 1 Prioritised review of costs of services subject to loca RE 2 Attendance at all meetings PbR subgroup for spec p Tariff etc; National lobbying (ongoing) ; impact assessme Roadtesting in Nov 11 RE 3 Complete and roll out SLR and PLICS to all units (being managed with supplier) RE 4Analytical review of PLICS costs RE 5 Financial assessment of R&D strategy; RE 6 impact analysis on E&T tariff proposed changes
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**5**
Revised likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**3**
Revised principle risk score	**15**
Assurance status	**GREEN**
Registration Reference	**26. Financial position**
NHS Constitution Reference	**None**
NHSLA Reference	N/A
Date Reviewed/ Updated	**02/06/11**

n the Trust strategy may

ng HD/CC bed day charging
cipating in project to
ship of childrens PbR group)
uding analysis of reference

tariff - now expected

ngs & Alliance; Impact

. SHA risk scores.

al prices
aeds; Project Diamond ; DH
nt will be carried out at

(issues with software are

STRATEGIC OBJECTIVE 7A Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	
Principal Risk	**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)**
Accountable Executive	**Company Secretary**
Assurance committee responsible for monitoring risk	**Clinical Governance Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	5
Initial Principal Risk Score	20
Key controls (list top 5 and number 1-5)	1. Identification of leads - leads are identified for managing external assessments and implementing regulatory/ legislative requirements. 2. Notifications of external assessments are escalated to the relevant executive director and the Chief Executive's Office 3. Database established for collation of evidence, including risks to non compliance and assurance/ outcome evidence 4. Risk, Assurance and Compliance Group (RACG) responsible for monitoring compliance with standards/ regulatory requirements 5. Programme of review and audit (internal audit annual plan and clinical audit annual plan eviewed together to avoid duplication) 6. Meetings held between the Company Secretary and each of the Acting Assistant Director of the CGST, Clinical Audit Manager and CQC standard and assessment leads to understand incidents, complaints or issues that arise and may affect registration/ compliance. 7. Evidence checks with standard leads and assessment leads 8. Where external assessments result in qualifications or recommendations, action plans are developed to bring the Trust into line with the regulatory/ legislative requirements.
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1. Review of leads underway to ensure that the appopriate people are identified 2. Database required to record all external assessments, planned and unnanounced 3. Database established on Excel - further work required to ensure that the databse supports the standard leads and that the Provide Compliance Assessment forms ae kept updated. 4. None 5. Audit programme to be integrated with reporting shcedules to relevant committees 6. None 7 and 8. Need for further staff resources to manage all regulatory/ legislative requirements and work with standard leads
Internal assurance on controls	Reports to CGC and relevant Trust Committees on progress against individual standards. Internal Audit review of specific standards across the year as part of rolling programme Clinical Audit review of compliance areas for each outcome incorporated into audit plan Whistle blowing internal audit (December 2009) - Public Interest Disclosure Act 1998 - Assurance leve rated significant. Internal audit into management of CQC compliance rated as reasonable Internal audit on learning disabilities - results awaited
External assurance on controls	1All these assist in assurance for compliance with current standards: NHSLA Level 2 achieved 2009; NPSA assessment, STEIS reporting, PEAT ase4ssment - average 2011 , Fire code. HSE lifted Improvement Notice on 8th July 2010 and praised H and S culture at Trust CPA accrediatation status maintained March 2011 Regulatory reform fire safety order 2005 - passed in February 2011 Quality Risk Profile recived from the CQC on a monthly basis - no amber or red ratings as of May 2011
Gaps in assurance	Awaiting outcome of HSE investogation inot boiler explosion
Actions / Milestones (including dates)	Review of audits relevant to outcomes Complete Map to existing audit programme, for clinical and possible internal auditors to review Complete Confirm leads and execs - by end June 2011 Gap analysis to identify with leads where additional work required- In progress - by end July 2011 Review of process to maintain central document evidence database, electronic rather than spreadsheet In progress Identificiation of additional resource - by September 2011
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Revised principle risk score	12
Assurance status	**GREEN**
Registration Reference	**None**
NHS Constitution Reference	**RIGHT: You have the right to be treated with a professional standard of care, by appropriately qualified and expereinced staff, in a properly appoved or registered organisation that meets required levels of safety and quality.**
NHSLA Reference	**Standard 5 Learning from Experience**
Date Reviewed/ Updated	**31/05/11**

STRATEGIC OBJECTIVE 7B Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	
Principal Risk	**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.**
Accountable Executive	**Chief Finance Officer**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	5
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	15
Key controls (list top 5 and number 1-5)	1 Targeted investment to strengthen infrastructure & effective project management of each investment project. 2 Maintenance agreements for all key systems. 3 Business continuity plan 4. Clear IT investment strategy to address infrastructure risks
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	1 No gap 2. No gap 3. No gap - although plan is subject to further improvements 4. Strategy currently being updated but current strategy has been progressively implemented and has achieved the targeted results
Internal assurance on controls	1 Minutes of Project Boards (Summarised for TDB) and Minutes of TDB (to Management Board) 2. Report will be produced for IGSG/TDB 3. Updated BCP 4. Audits included in IA Plan
External assurance on controls	Internal audit reviews
Gaps in assurance	
Actions / Milestones (including dates)	Various projects in progress with different timescales. Refer to minutes of TDB and programme managers report which is submitted monthly to TDB
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Revised principle risk score	12
Assurance status	**GREEN**
Registration Reference	**21. Records**
NHS Constitution Reference	**PLEDGE: The NHS commits to offer you easily accessible, reliable and relevant information to enable you to participate fully in your own healthcare decisions and to support you in making chaoices. This will include information on the quality of clinical services and accurate information available.**
NHSLA Reference	N/A
Date Reviewed/ Updated	**02/06/11**

STRATEGIC OBJECTIVE 7C Ensure corporate support processes are developed and strengthened in line with the c	
Principal Risk	**7C The Trust may fail to achieve Founda**
Accountable Executive	**Chief Operating Officer**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	12
Key controls (list top 5 and number 1-5)	1. Plan developed to address the three Mor assurance. 2. A project steering board and 3 working g 3. Financial controls as per finance risks 4. Shadow Members' Forum in place 5. Actions to monitor and maintain the Trus
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	External economic assumptions may result ratios
Internal assurance on controls	Regular reports to Trust Board and Manage position, performance against targets, progr Ernst and Young audit of IBP and review of
External assurance on controls	NHS London quarterly risk assessment. Monitor Financial risk rating score KPMG historic due diligence stage 1 and st External legal review of constitution ALE, CNST, CQC
Gaps in assurance	None at present
Actions / Milestones (including dates)	31 May 2011 - Awaiting SoS approval to be
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	2
Revised principle risk score	8
Assurance status	**GREEN**
Registration Reference	**26 Finance**
NHS Constitution Reference	**The NHS commits to engage staff in dec individually, through representative orga arrangements. All staff will be empowere services for patients and their families (p** **You have the right to be involved, directl healthcare services, the development an those services are provided, and in deci services.**
NHSLA Reference	**N/A**
Date Reviewed/ Updated	

:hanging needs of the organisation

ıtion Trust status within a defined timescale

ıitor criteria for assessment and the SHA seven domains of

roups established to manage delivery.

t's external scores ie CSBH, ALE, CNST etc

in the Trust having difficulty meeting minimum financial

ɜment Board on progress towards FT status, financial
ress reports re ALE and CQC registration
ᶠ market assessment

:age 2 reports

: submitted to Monitor

isions that affect them and the services they provide,
ınisations and through local partnership working
ɜd to put forward ways to deliver better and safer
ɔledge).

ly or through representatives, in the planning of
ıd consideration of proposals for changes in the way
sions to be made affecting the operation of those

31/05/11

STRATEGIC OBJECTIVE 7:D Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	
Principal Risk	**The redevelopment of the site may not meet delivery timescales or operational expectations**
Accountable Executive	**Director of Redevelopment**
Assurance committee responsible for monitoring risk	**Audit Committee**
Severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	4
Likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	3
Initial Principal Risk Score	12
Key controls (list top 5 and number 1-5)	1 All business cases are subject to rigourous approvals at Trust, SHA and Department levels 2 All key decisions are approved through Redevelopment Steering Board(RSB). 3 Risk issues are presented on monthly reports to the RSB. High level risks are reported through to Quality and Safety Committee (regarding risk of fire from works). 4 Finance and Activity groups, and Commissioning Boards monitor operational requirements of projects 5 Clinical teams sign off design layouts and operational requirements for individual specialties 6 All design and developmental works are managed by competent design teams in co-operation with the Trusts Clinical Planning Teams.
Gaps in controls (map each numbered key control to a gap - state no gap where none present)	None
Internal assurance on controls	Regular reporting on all major projects to Project Boards Redevelopment Board Trust Board Special Trustees
External assurance on controls	Projects to date have been subject to external approval at SHA DH Key stage Gateway reviews by Independent experts Design Reveiw Panels Due diligence undertaken by Special Trustees prior to their approval.
Gaps in assurance	None
Actions / Milestones (including dates)	Phase 2a - Construction Completion December 2011 Commissioned spring 2012 Phase 2b - Construction Enabling works programme commence August 2011 Board and charity approved May 2011 Enabling works programme complete June 2013 Demolition and Rebuild of Cardiac Wing commence August 2013 Demolition and Rebuild of Cardiac Wing complete April 2016
Revised severity of risk (1 = No harm,. 2= Minor, 3= Moderate, 4= Major, 5= Catastrophic)	**4**
Reviced likelihood of Risk (1 = Very Unlikely, 2 =Unlikely, 3= Possible, 4= Likely, 5= Very Likely)	**2**
Revised principle risk score	**8**
Assurance status	**GREEN**
Registration Reference	
NHS Constitution Reference	**None**

NHSLA Reference	None
Date Reviewed/ Updated	**25/052011**