Meeting of the Trust Board
28 September 2011

Dear Members

There will be a public meeting of the Trust Board on Wednesday 28 September 2011 commencing at **2:30pm** in the **Charles West Room, Level 2, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

Fax: 020 7813 8218

AGENDA

	Agenda Item **STANDARD ITEMS**	**Presented by**	**Attachment**
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 27th July 2011**	Chair	**K**
3.	**Matters Arising / Action Checklist**	Chair	**L**
4.	**Chief Executive's Update** • **Safe and Sustainable Cardiac Review** • **Ombudsman Report** • **Learning Disability Audit** • **NIHR Funding** • **Spinal Surgery Review** • **Biomedical Research Centre**	Chief Executive	**Verbal Update**
5.	**Clinical Unit Presentation (SNAPS)**		**Presentation**
6.	**Zero Harm Report , including update on work programmes for medicines management and deteriorating children**	Co- Medical Director (ME)	**M**
	ITEMS FOR APPROVAL		
7.	**Trust Board Terms of Reference**	Company Secretary	**N**
8.	**Dubai Office and Registration**	Director International Division	**O**
	UPDATES		
9.	**Performance Report Month 5 (2011-12)**	Chief Operating Officer	**P**
10.	**Update on achievement of C. difficile target**	Director of Infection	**Q**

		Prevention and Control	
11.	**Finance Report Month 5 (2011-12)**	Chief Finance Officer	**R**
12.	**Foundation Trust Update**	Chief Operating Officer	**S**
13.	**In-year review of Strategic Objectives and work-streams**	Chief Operating Officer	**T**
14.	**Child Protection Update (March – Now)**	Chief Nurse and Director of Education	**U**
15.	**Redevelopment Update**	Director of Redevelopment	**V**
16.	**PALS (Patient Advice and Liaison Service) Annual Report 2010-11**	Chief Nurse and Director of Education	**W**
17.	**Annual Aggregated risk, complaints and incident report 2010-11**	Co- Medical Director (ME)	**X**
18.	**Trust Board Members' Activities**	Chair	
	ITEMS FOR INFORMATION (These items will not be discussed unless a Member gives prior notification of an intention to do so.)		
19.	**Six Day Working Update**	Chief Operating Officer	**1**
20.	**Clinical Governance Committee (CGC) Minutes (June 2011)** **Update from Clinical Governance Committee (September 2011)**	Mr Andrew Fane, Chair of CGC	**2** **Verbal**
21.	**Management Board minutes** • **June 2011** • **July 2011**	Chief Executive	 **3** **4**
22.	**UCL Partners Management Report**	Chief Executive	**5**
23.	**Great Ormond Street Hospital NHS Trust Annual Report 2010/11**	Chief Executive	**To be tabled**
24.	**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.)		
25.	**Next meeting** The next Trust Board meeting will be held on Wednesday 30th November 2011 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT K

Attachment K

Minutes of the meeting of Trust Board held on 27 July 2011

Present

Baroness Tessa Blackstone	Chairman
Dr Barbara Buckley	Co-Medical Director
Ms Yvonne Brown	Non-Executive Director
Prof Andy Copp	Non-Executive Director
Dr Jane Collins	Chief Executive
Mr Andrew Fane	Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mrs Liz Morgan	Chief Nurse and Director of Education
Mrs Claire Newton	Chief Finance Officer
Mr Charles Tilley	Non-Executive Director

In attendance

Mrs Catherine Lawlor	PA to Chair and Chief Executive Officer
Mr Sven Bunn*	FT Programme Director
Mr Robert Burns	Deputy Chief Operating Officer
Ms Sue Chapman*	Nurse Consultant
Dr John Hartley*	Director of Infection, Prevention and Control
Mr William McGill	Director of Redevelopment
Mr David Lomas	Appointed Non-Executive Director
Dr Jane Valente*	Consultant in General Paediatrics

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

153. Apologies for Absence

153.1 Apologies were received by Ms Fiona Dalton, Deputy Chief Executive, Prof Martin Elliott, Co-Medical Director and Dr Anna Ferrant, Company Secretary. Mr Robert Burns, Deputy Chief Operating Officer attended in place of Fiona Dalton, Deputy Chief Executive.

154. Declarations of Interest

154.1 There were no declarations of interest received.

155. Minutes of the Meeting Held on 29 June 2011

155.1 The minutes of the Trust Board meeting held on 29th June 2011 were received and the Chairman requested the Board Members to check them for accuracy.

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

155.3 Prof Andrew Copp, Non-Executive Director and Mr Andrew Fane, Non-Executive Director attended the meeting.

154. Matters arising

154.1 There were no matters arising.

155. Chief Executive's Update – Media Interest

155.1 Dr Jane Collins, Chief Executive gave the Board an update on media issues. The Chief Executive reported that Mr Andrew Lansley, the Secretary of State for Health had stated in a letter addressed to the Chair that it an internal enquiry on the information shared with the Serious Case Review into the death of Peter Connelly would not be conducted. The Board welcomed this decision.

155.2 The Chief Executive stated that both Co-Medical Directors, Professor Martin Elliott and Dr Barbara Buckley were working hard on the few concerns raised by staff at the Trust. No new concerns had been raised and nothing new had come out of independent review that was commissioned.

156. Paediatric Trigger Tool (PTT) Presentation

156.1 Ms Sue Chapman, Nurse Consultant gave a presentation on the Paediatric Trigger Tool. The Board was informed about how the trigger tool worked, key findings, triggers by category, harm events and workstreams.

156.2 Ms Mary MacLeod enquired how the figure 7% was calculated if there were 163 harm events out of 400 case notes. Ms Sue Chapman, Nurse Consultant clarified that it was 163 harm events out of 400 children where more than one event would have been recorded for one child.

156.3 Ms Sue Chapman, Nurse Consultant invited Board members to attend and see a Trigger tool review being undertaken. The Chair thanked Ms Chapman.

157. Zero Harm Report

157.1 Dr Barbara Buckley presented the Zero Harm Report which was based on a new format. It had been agreed the new Dashboard would encompass a new set of measures, measurement of culture, use if unit reports and the introduction of patient stories. Information and ideas on measuring harm had been sought from partnership working with other hospitals such as Cincinnati Children's Hospital

157.2 The Board was advised that a number of other hospitals were looking to GOSH for new and innovative ideas of ways of working towards Zero Harm.

157.3 The Board **noted** the report.

158 Handover at Night (HaN)

158.1 Dr Jane Valente, Consultant in General Paediatrics presented the paper and informed the Boad that work had been undertaken to focus on handover at night at the Trust. . Vital in-patient information and clinical responsibility was handed over from well staffed highly skilled day teams to a significantly scaled down hospital at night team and it was essential that this handled effectively.

158.2 Dr Valente, stated that following observation of the handover processes and in collaboration with Allan Goldman's research team the following changes had been implemented to improve HaN:

158.3
• Restructuring of the standard operating procedure to make the handover process shorter in format;
• Slight modification of the handover framework;
• Improvements in electronic communication between teams.
• Establishing when the morning handover occurs
• Establishing Clinical Site Practitioner (CSP) , Consultant Paediatrician and Surgical involvement with handover during morning and evening sessions
• Safeguarding issues now formally a part of handover
• Trial period of the CSP taking all surgical calls.

158.4 Dr Valente, reported that work was also underway to review lines of accountability and the role of ICON.

158.5 The Board **noted** the report.

159. Annual Director of Infection, Prevention and Control Report 2010-11

159.1 Dr John Hartley, Director of Infection, Prevention and Control presented the report on Infection, Prevention and Control. The Trust had achieved current annual National Target of 2 during 2010-11. is the 2011-12 target was zero and it was reported that the Trust had already had one case during the year.

159.2 The number of cases of Clostridium Difficile reported in the national surveillance scheme was 11 for 2010-11 (cases aged greater than 1 and in for 3 or more days when tested). The National target for 2010/11 was less than or equal to 9.

159.3 The Board **noted** the report.

160. Head of Nursing Report

160.1 Mrs Liz Morgan, Chief Nurse and Director of Education presented the report. The Clinical Site Practitioners (CSPs) continued to support the changes within the Head of Nursing team and were currently auditing night time surgical activity. The transformation team had presented a proposal on developing a work stream in order to improve the care of the deteriorating child. UCL had identified a similar work stream and it was hoped that this work could be conducted in partnership.

160.2 **Action:** Prof Martin Elliott, Co-Medical Director and Liz Morgan, Chief

Nurse and Director of Education to liaise about setting up a steering group on improving the care of the deteriorating child and to report to the next Management Board in August 2011.

160.3 It was reported that the third nurse recruitment fair was held in June. Approximately 250 nurses had attended and were able to meet nursing staff and have a tour of the hospital.

160.4 Following the CQC inspection in June, a decision was made by the senior nursing team that any nurse who was carrying out direct patient care regardless of the area they worked in, must wear a uniform to ensure 'bare below the elbow' criteria was met.

160.5 Mrs Morgan informed the Board that a Clinical Nurse Specialist in Nutrition had been appointed to lead work on improving nutritional assessment across the hospital. Quarterly audits continued to be undertaken among adolescent inpatients to measure compliance with single sex accommodation requirements.

160.6 As a new initiative, a quarterly performance review of nursing performance indicators for each clinical unit had been introduced.

160.7 The Board **noted** the report.

161. Self Certification Statements

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

161.2 Dr Jane Collins, Chief Executive presented the Board's statement regarding clinical quality, service performance, risk management and board roles and capacity.

161.3 Mr Sven Bunn, FT Programme Director stated that there would be some minor changes to the Self Certification Statements.

161.4 **Action:** Mr Sven Bunn, FT Programme to make minor changes to the Self Certification Statements.

161.5 The Chair highlighted that non executive director appraisals were underway.

161.6 The Board **approved** the report with the caveat of information governance compliance. The chair agreed to take Chair's action on the certification reports following confirmation of the changes.

161.7 **Action:** The Chair to agree the minor changes to the Board's Self Certification Statements.

161.8 Quality governance board memorandum

161.9 The Board memorandum on quality governance was presented which included the Trust's mission statement, Strategy, Capabilities and culture and Processes and structures in place.

161.10 Mr Charles Tilley, Non-Executive Director highlighted that the report did

not make mention to the Chief Executive's appraisal and that ought to be included.

161.11 Mr Andrew Fane highlighted on page 3 under "Strategy" in the report it stated *"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*" which should read *"Currently we are partners with ICH and partners to UCL Partners with AHSC, maintain develop our position as the UK's top children's research organisation".* The Board agreed.

161.12 **Action:** Mr Sven Bunn, FT Programme Manager to make highlighted amendments to the Quality governance board memorandum.

161.13 The Board **noted** the report.

162. Business Continuity Plan

162.1 Mr Robert Burns, Deputy Chief Operating Officer presented the Business Continuity Plan which sought to build upon the experience gained and lessons learned from previous incidents to provide an overarching corporate business continuity plan that supported service-level planning and provided structure and guidance to continued service delivery during large-scale incidents.

162.2 The Board **agreed** the plan pending approval from Internal Audit.

162.3 The Chief Executive highlighted that the Olympics in 2012 could have an impact on the delivery of services at the hospital, and in particular, transport to and from the hospital. A paper would come back to the Board on this issue.

162.4 **Action:** Mr John Courtney to present paper to the Board on the impact of the Olympics on the delivery of services at the hospital.

163. Performance Report

163.1 It was noted that in preparation for operating as a Foundation Trust, the report had been updated to include a quarterly governance risk score against the revised Monitor governance framework.

163.2 In month, the Trust had reported one case of C. difficile. Year-to-date the Trust had reported 4 cases against a year-to-date trajectory of 2.25. The Trust trajectory for the year was 9 cases.

163.3 The Trust had reported two cases of MRSA to date – against an annual target of zero cases.

163.4 Inpatients waiting list profile performance had improved, with 64 patients reported as breaching the 26 week waiting standard against a previous month position of 73. Specific concerns had been identified across several specialties which were being investigated further.

163.5 The Trust achieved the 95th percentile targets for admitted and non-admitted pathway waits in May.

163.6 The Trust achieved the Median wait standard for admitted patient pathways in May. However, performance for non-admitted and incomplete pathways was reported over target. This position had been communicated to NHS London and lead commissioners.

163.7 Overall, performance for clinic outcome form completeness had 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 had been established to identify and resolve specific issues, which included a detailed review of the process for the recording of clinic outcomes and increased education and training in this area.

163.8 The Trust did not meet the June 95% target for staff achieving information governance training. Despite the focus on the training, performance had reached a plateau at 84.7%. It was reported that this would have a negative impact on compliance with the Information Governance Toolkit assessment.

163.9 The Trust Monitor governance risk rating for quarter one was rated as 'amber-red'. This was due to underperformance against MRSA, C.difficile and Referral to treatment non-admitted median waiting times.

163.10 The Deputy Chief Operating Officer reported that the arrows on page one of the report related to how performance had changed from the previous month.

163.11 The Deputy Chief Operating Officer was asked to ensure proper validation processes were in place in future to pick up patients with long wait times due to a lack of validation.

163.12 **Action:** Deputy Chief Operating Officer to ensure a proper validation process was in place in future to pick up patients with long wait times due to a lack of validation.

163.15 The Board **noted** the report.

164. Finance Report

164.1 The Chief Finance Officer presented the report, which was taken as read. At the end of month 3, the Trust was showing a net surplus of £2.6M, which was £0.05M lower than plan and normalised EBITDA margin was 7.4% verses a plan of 7.3%. The forecast out-turn remained in line with the plan.

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

165. Foundation Trust update

165.1 The Deputy Chief Operating Officer presented the report. On 24 June, the Trust received approval from the Secretary of State to submit its Foundation Trust application to Monitor, in independent regulator for foundation trusts. A meeting had been held with Monitor to review the application for a "batching" decision. The outcome of the meeting would determine the overall timetable for the assessment, but the Trust was working towards a target authorisation date of 1 December 2011.

165.2 The Chair requested a copy of the letter of approval.

165.3 **Action:** The Company Secretary to provide the Chair with a copy of the letter of approval to submit the Tust's Foundation Trust application to Monitor.

165.4 The Board **noted** the report.

166. CQC registration overview

166.1 The Chief Executive presented the report which updated the Board on the current status of the Care Quality Commission (CQC) registration standards.

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

166.3 Actions required to address any deficits identified were managed and monitored through the Risk, Assurance and Compliance Group.
The Chief Executive reported that there had been no changes since April 2011 to June 2011 except to Item 14, supporting staff and that work was underway to determine reasons for this change t the risk estimate.

166.4 The Board **noted** the report.

167. Assurance Framework

167.1 The Deputy Chief Operating Officer presented the report. The Assurance Framework provided an overview of the principal risks to achievement of the Trust's corporate objectives.

167.2 The Audit Committee and the Clinical Governance Committee were responsible for seeking assurance of the adequacy of the controls in place to manage these risks. The Risk, Assurance and Compliance Group (RACG) reviewed and managed the Assurance Framework.

167.3 As at the date of the report, no risks were 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 was lack of appropriate clinical response to the deterioration in children

167.4 Although several controls had 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 believed that there was further work to do to ensure these controls were fully implemented and integrated.

167.5 The Board **noted** the report.

168. Trust Board Members' Activities

168.1 The Chair reported that she and the Chief Executive attended a special Auction arranged by the Charity, which raised £500,000.

169. Consultant appointments

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

169.2 Dr Sam Stuart - Consultant in Interventional Radiology
Dr Shankar Sridharan - Consultant in Cardiology

169.3 The Board **approved** the new Consultants appointment.

170. Any Other Business

170.1 There were no items of any other business.

171. Date of the Next Meeting

171.1 The date of the next meeting in public of the Trust Board was confirmed as 28th September 2011.

ATTACHMENT L

Attachment L

TRUST BOARD - ACTION CHECKLIST
28 September 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/ Sven Bunn	September 2011	On agenda
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	October 2011	Not Yet Due
117.8	29/06/11	Professor Goldblatt to present the DVD developed for the BRC application at the July Trust Board meeting.	DG	September 2011	On development session agenda
160.2	27/07/11	Prof Martin Elliott, Co-Medical Director and Liz Morgan, Chief Nurse and Director of Education to liaise about setting up a steering group on improving the care of the deteriorating child and to report to the next Management Board in August.	ME & LM	September 2011	Considered at the August 2011 Management Board meeting – verbal update from ME/LM
161.4 161.7	27/07/11	Mr Sven Bunn, FT Programme Manager to make some minor changes to the Self Certification Statements. The Chair to agree the minor changes to the Board's Self Certification Statements	SB TB	September 2011	Actioned July 2011

Attachment L

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
161.12	27/07/11	Mr Andrew Fane highlighted on page 3 under "Strategy" in the report it stated *"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*" which should read *"Currently we are partners with ICH and partners to UCL Partners with AHSC, maintain develop our position as the UK's top children's research organisation".* The Board agreed. Mr Sven Bunn, FT Programme Manager to make highlighted amendments to the Quality governance board memorandum.	SB	September 2011	Actioned July 2011
162.4	27/07/11	The Chief Executive highlighted that the Olympics in 2012 could have an impact on the delivery of services at the hospital, and in particular, transport to and from the hospital. A paper would come back to the Board on this issue. Mr John Courtney to present a paper on Impact of the Olympics on the Trust	John Courtney	November 2011	The Olympic Planning Group is in the process of risk assessing service delivery during August 2012. A plan is being developed and will be reported to Management Board in October 2011
163.12	27/07/11	<u>Performance Report</u> Deputy Chief Operating Officer was asked to ensure that a proper validation process was in place in future to pick up patients with long wait times due to a lack of validation.	RB	September 2011	Verbal Update
165.3	27/07/11	The Company Secretary to provide the Chair with a copy of the letter of approval to submit the Trust's Foundation Trust application to Monitor.	AFe	September 2011	Actioned

<table>
<tr><td colspan="2">Trust Board

28th September 2010</td></tr>
<tr><td>Zero Harm Report

Professor Martin Elliot, Co-Medical Director</td><td>Paper No: Attachment M</td></tr>
<tr><td colspan="2">Summary
This paper provides an update on the following issues:
1. Updated Quality and Safety Strategy and responsibilities of the Trust Board
2. Patient Safety Officers
3. Progress on new dashboard and measures
4. Central Venous Line Infections
5. Updates on Medicine Management
6. Update on Seriously Deteriorating Children
7. Patient Story progress
8. Unit Deep Dive - Medicine</td></tr>
<tr><td colspan="2">Action required from the meeting
To note the progress made</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
This is one of the strategic objectives of the Trust</td></tr>
<tr><td colspan="2">Financial implications Nil</td></tr>
<tr><td colspan="2">Legal issues Nil</td></tr>
<tr><td colspan="2">What consultation has taken place Not Applicable</td></tr>
<tr><td colspan="2">Who needs to be told about the policy? Not Applicable</td></tr>
<tr><td colspan="2">Who is accountable for the monitoring of the policy? Not applicable</td></tr>
<tr><td colspan="2">Author and date Peter Lachman 18th September 2011</td></tr>
</table>

Zero Harm Report for the Trust Board
September 2011

1. Quality and Safety Strategy

The Quality and Safety Strategy has been updated and is in alignment with the Trust Strategic Objectives as well as latest safety theory.

The Quality Strategy defines how Great Ormond Street Hospital 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. We aim to proved services that demonstrate value for the money spent. The 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 seeks to establish 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. Management of failure will occur through existing governance and monitoring systems, which are described elsewhere.

Key in the strategy is the responsibility of the Trust Board:

- 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 and improvement.
- Ensure all Executives have quality at the core of their work.
- 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;
- Support initiatives to develop a Trust culture which is conducive to continual quality improvement.
- Monitor compliance with Trust objectives, healthcare targets, national standards and all relevant legislation including requirements of the Care Quality Commission and Monitor.

The responsibility of the Management Board is as follows:

- Ensure all Unit management teams have quality and safety at the core of their work.
- 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.
- 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.
- Continually recognise and acknowledge significant improvements in quality, and those staff that have been instrumental in achieving them.
- Support initiatives to develop a Trust culture which is conducive to continual quality improvement.

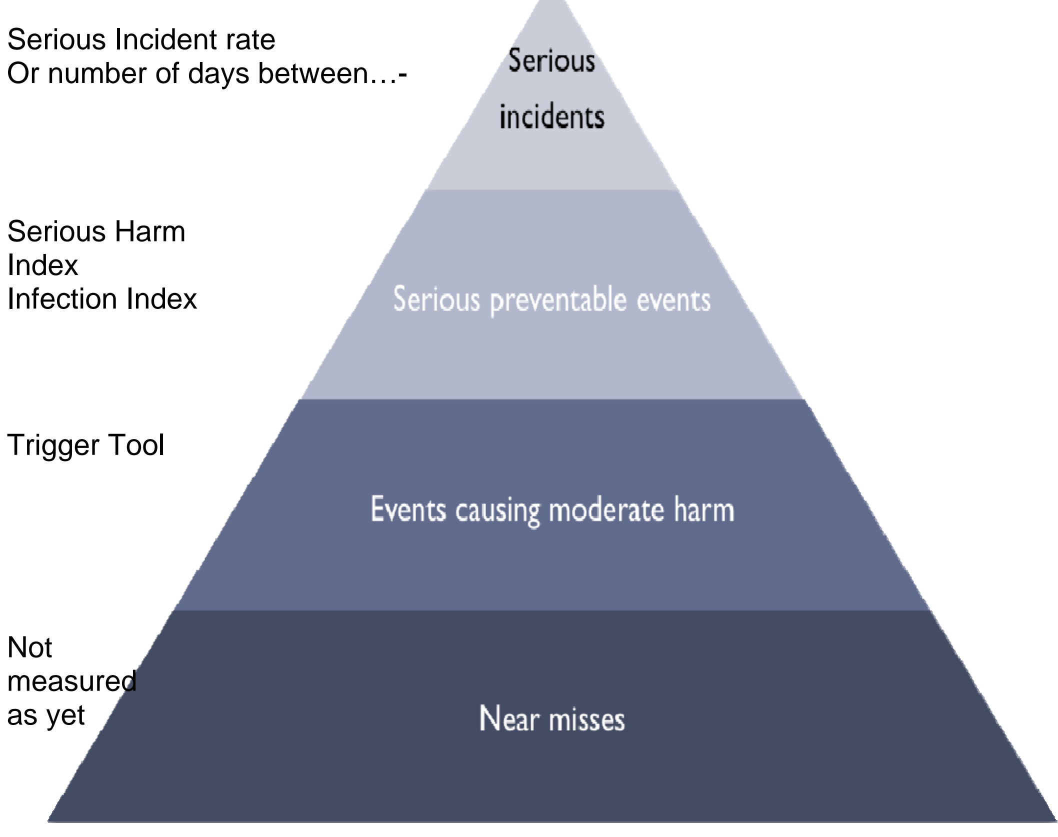
2. Patient Safety Officers PSO

The posts funded by the Trustees for 1 Professional Activity for a PSO in each Unit are now filled. This will provide support to the safety programmes in the Units. A key aim is the engagement of medical staff at all levels.

3. New Dashboard

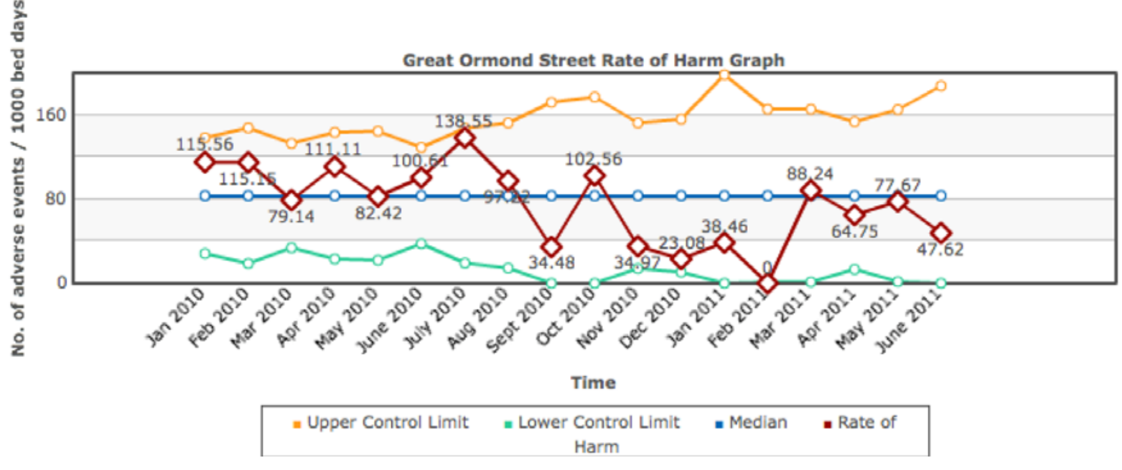
The Trust is developing a new dashboard. This requires verification of the measures and their source. We hope to have similar definitions to those in Cincinnati Children's Hospital to allow for some comparison. We also intend to develop this with the QIPP safety stream lead by Maxine Power. The current dashboard is given below.

Attachment M



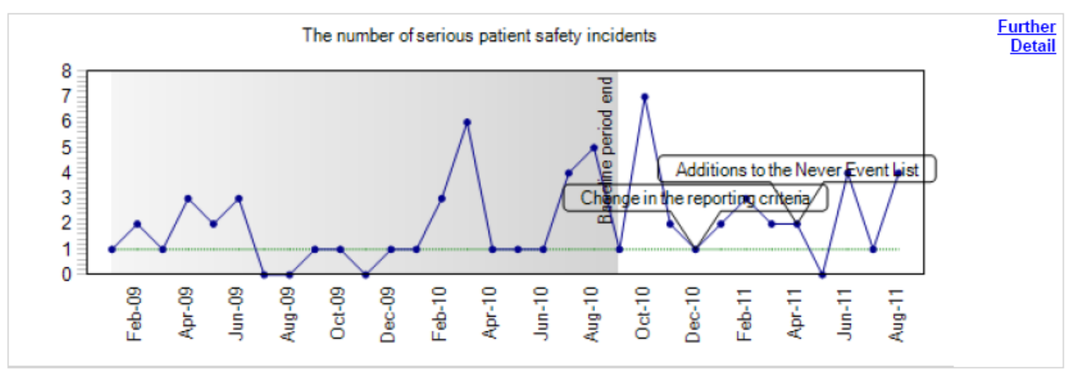
Trigger tool

This is continuing to indicate the moderate harm in the trust with the majority being in the reversible category.



Zero Harm Trust Dashboard

Serious Patient Safety Incidents

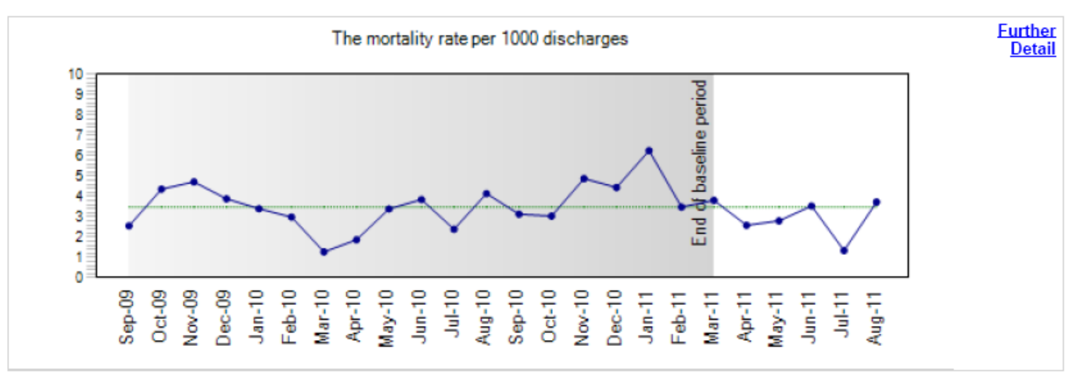


Definition: The number of serious patient safety incidents

Definition Source: Patient Safety

Data Source: Patient Safety

Mortality Rate

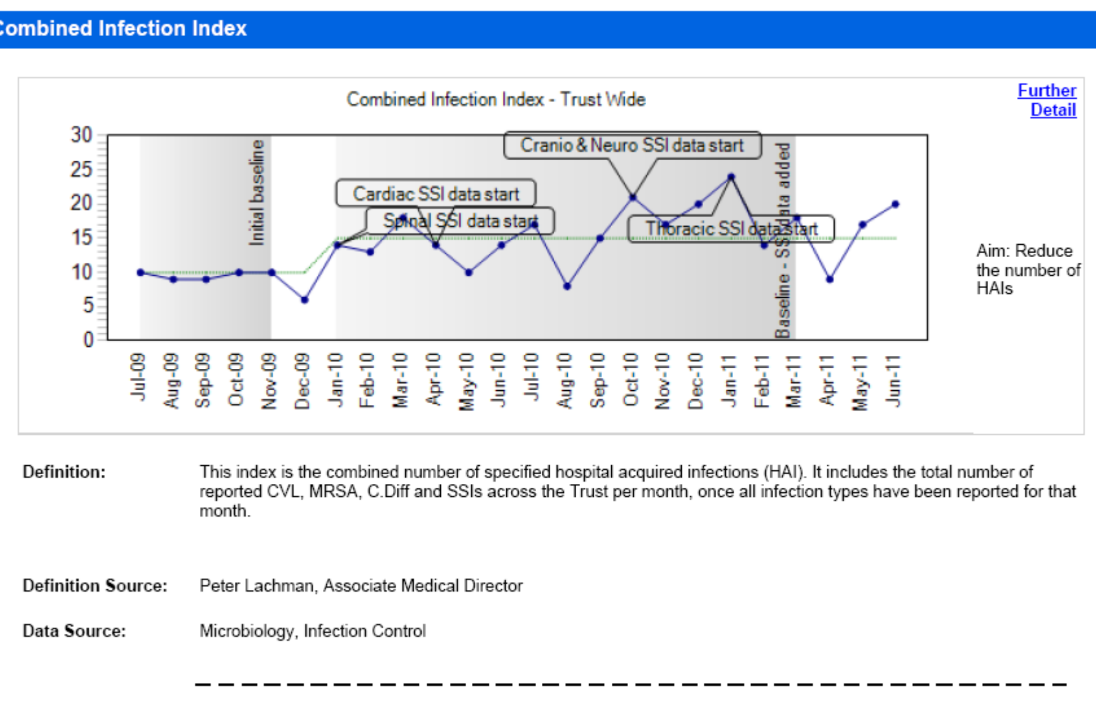


Definition: The mortality rate per 1000 discharges

Definition Source:

Data Source: PiMS

The combined infection is developing well and we hope to start using it, as the data is refined.

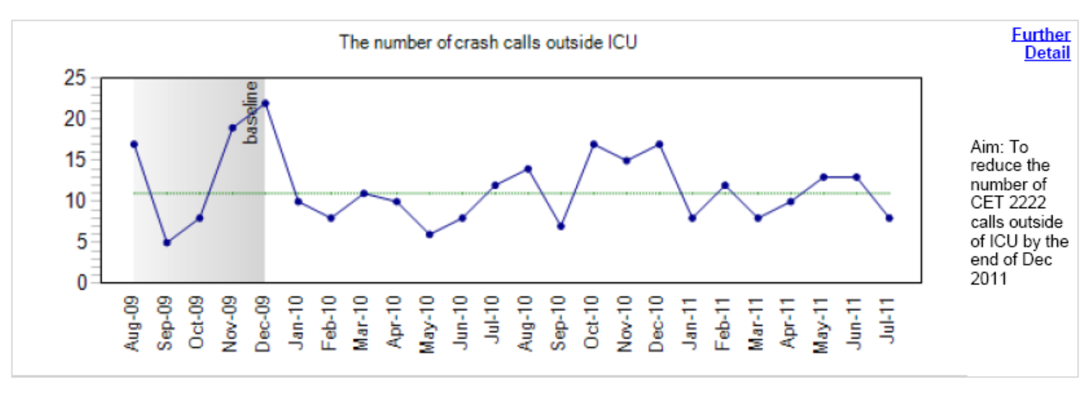


Definition: This index is the combined number of specified hospital acquired infections (HAI). It includes the total number of reported CVL, MRSA, C.Diff and SSIs across the Trust per month, once all infection types have been reported for that month.

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

There is some progress in responding to the deteriorating child as noted below

4. Central Line Infections

Good progress continues in the work on central line infections. We are using a baseline of 3.02 CVL infections per 1000 line days for the period of 11 months from Mar-09 to Jan-10.
Latest results show continuing progress to achieve the aim of a 50% reduction.

Current position:	**2.04 CVL infections per 1000 line days**
Current average per month:	**7.4 actual infections per month**
Aim for this year	**1.5 CVL infections per 1000 line days**
Analyst Comment:	A run of 7 points below the median starting in February 2011 has been identified. The step change has been added to the chart, giving a new current position of 2.04 CVL infections per 1000 line days. The end point has been left open until we are assured that the new process is sustained. In the meantime each following month's data will affect the current median giving the potential for the target to be reached by the end of the year.
Action needed	**The clinical teams need to continue to improve the bundle compliance. Standardisation of insertion of lines is planned.**

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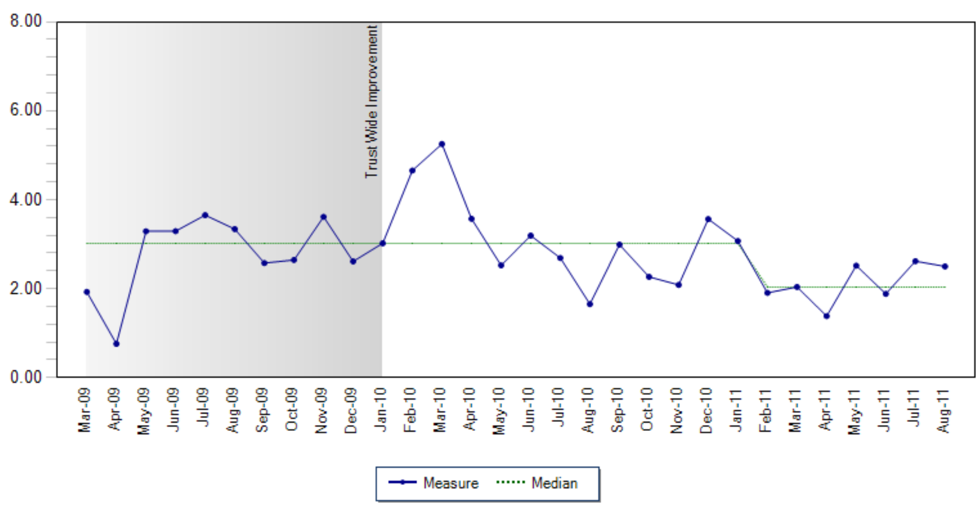
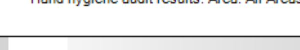
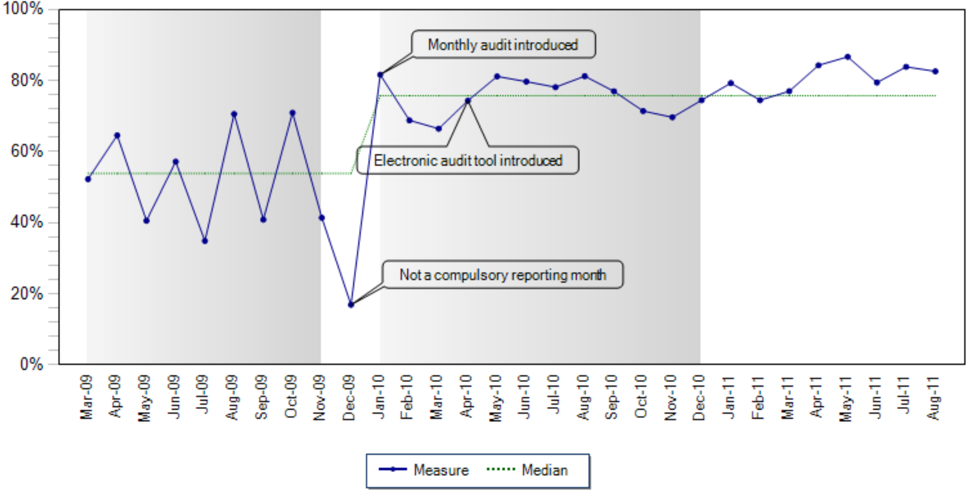
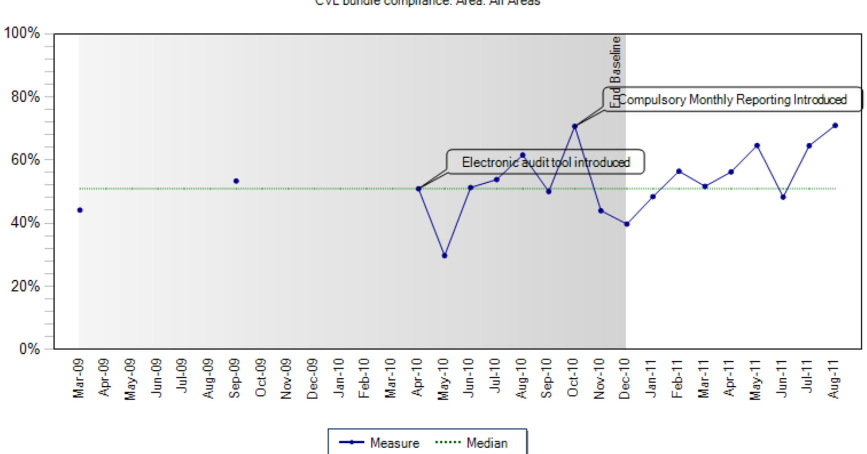








5. Medicine Management

Reducing medication errors is key to achieving the zero harm objectives. Clinical Units have identified work to be undertaken to achieve Zero Harm on a year on year basis. Project leads; Improvement Managers and Co-coordinators have been appointed at Clinical Unit Level, with an Executive Sponsor responsible for the programme. A post for a Medicines Management Improvement Specialist is due to start shortly.

Medicines management underwent a follow up audit by the London Audit Consortium in July 2011-09-01. Key conclusions are:

Control Objective/ Risk Area	Assurance Level	DOT	Recommendations by Priority		
			High	Med	Low
1. Medication administration policy	Reasonable	⇔	1		
2. Monitoring errors rates & EP	Reasonable	⇔		1	1
3. Medicines management	Reasonable	⇔		1	
4. Analysis of reported errors	Significant	⇔			1
5. Reporting to units & committee	Significant	⇔			
6. Inclusion on risk registers	Reasonable	⇩		1	
7. Operational reviews	Significant	⇔			

Overall Assessment	Reasonable	⟺	1	3	2

The overall reasonable assurance level was determined because controls are generally sound and operating effectively. However, there are defects in design or inconsistency of application, which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.

The Trust continues to play a pioneering role in developing improved controls over the prescribing, dispensing and administering of medicine, such as the use of Electronic Prescribing, the use of Commissioning for Quality and Innovation (CQUIN) schemes and Transformation Programmes.

The review noted that a number of key controls and processes are in place that includes:

a. Responsibilities have been clearly assigned by way of the Trust's Administration of Medicines Operational Policy and a comprehensive audit programme and related reviews are undertaken to obtain assurance regarding compliance with the policy;
b. Testing indicated ongoing usage of the Electronic Prescribing system, the roll-out of pilot studies and the monitoring of percentage errors rates;
c. We were satisfied that there is an effective medicines management programme with improvement plans including a number of dedicated medication error reduction projects across the Clinical Units, demonstrating considerable progress since the last audit;
d. Significant progress is being made in implementing recommendations made by the Chief Pharmacist in her paper 'Medicines Management at GOSH – Options for the Future'
e. Previously agreed actions regarding NHS Patient Safety First methodology and best practice have now been implemented;
f. The regular analysis of medication errors, reporting to relevant committees and feedback to clinical teams was evident;
g. With the exception of Surgery, medication errors continue to be included in Trust-wide and local risk registers to ensure monitoring.

However, there are a number of issues, which require management attention:

a. The Drug Analysis Toolkit is not consistently used by doctors increasing the risk that errors have occurred that have not been properly investigated;
b. Information from the Electronic Prescribing system is not made available to the Clinical Unit and Transformation Analyst Teams; and
c. The improvement work on different elements of the medication pathway, as part of the medicines management project, is fragmented.

The positive assurance identified by this audit contributes to the Trust Board Assurance Framework concerning Objective 1: Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world and Board Assurance Framework Risk 1A Children may be harmed through medication errors. The report does not contain

any findings that the Trust needs to consider as potential disclosures within its Statement on Internal Control or essential standards of quality and safety declaration, CQC Outcome 9 'Management of medicines and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The key recommendations will be implemented as part of the medicines management transformation programme.

The programme is based on the approach recommended by Patient Safety First. The methodology used is wide ranging ands aims to work on the different areas of the medicine pathway. Much work was done in assessing administration violations and improving the pathways on the wards. In addition double-checking assisted in decreasing harm. Dashboards are available for specific projects.

The Transformation Board have recommended the following targets in the outcome measures:

- **Medication Errors (except high risk drugs)– 25% reduction year on year**
- **Medication Errors (high risk drugs) – 100% reduction**

More specifically the aims are:

	Baseline	**Baseline Comment**	**Target**
Medication Errors - (except high risk drugs)			
CICU - Drug errors per prescription	0.05	21 weeks from 17-May-10 to 18-Oct-10	0.0375
PICU – Prescribing errors (clinical) per bed day	0.09	23 weeks from 27-Apr-09 to 28- Sep-09	0.0675
PICU – Prescribing errors (non-clinical) per bed day	0.22	23 weeks from 10-May-10 to 11-Oct-10	0.165
NICU	Awaiting data. Date unknown		
Haem/Onc – Prescribing errors per 100 items prescribed	7.6	15 weeks from 31-Oct-10 to 06-Feb-11	3.8
Medication Errors - High Risk Drug errors (days between drug errors for the following drugs)			
Morphine	7 days	21 errors from 07-Jan-09 to 25-Jul-09	Never
Insulin	22 days	12 errors from 07-Jan-09 to 19-Oct-09	Never
Heparin	21 days	15 errors from 10-Jan-10 to 10-Mar-10	Never
Amikacin and Vancomycin	21 days	19 errors from 28-Sep-09 -23-Sep-10	Never

6. Seriously Deteriorating Children

Work on early recognition and intervention for children who are deterioration is led by Sue Chapman and is part of a UCLP project across all the partner organisations. GOSH is leading in some areas.
Current successes are shown in the charts below

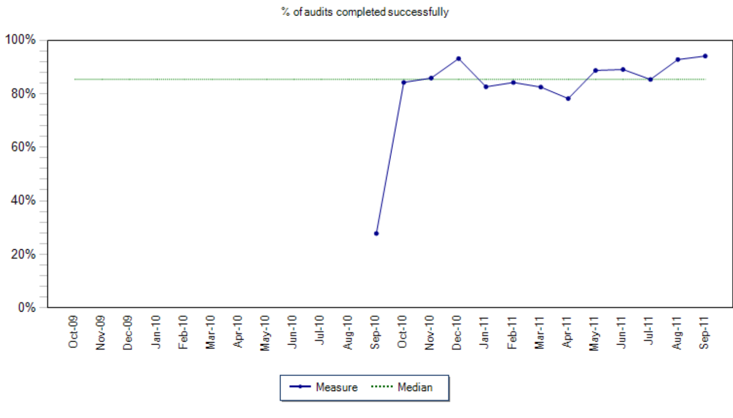
- Use of SBARD[1] and CEWS[2] is improving
- Early signs of better outcome
- Adoption of deteriorating patient as a cross-cutting Transformation theme

The challenge is to engage the medical staff in a more proactive way.

A new policy now sets out the standards for taking and recording children's observations for all children is in place. Work is underway to standardize monitoring equipment across all wards, particularly around recording blood pressure.

All clinical staff receive training on CEWS, SBARD and the role of the CSP, ICON and CET on induction. They are also given laminated credit card sized memory prompts to attach to their ID badge. eLearning is used to update staff on CEWS and SBARD and forms part of the clinical update programme. All clinical staff receive resuscitation training appropriate to their role. All members of the CET have advanced resuscitation skills. Simulation training is used to support clinical skill development for ward based staff. Together with the London Deanery we are developing a training programme for human factors for members of the hospital at night team. The programme has 3 modules based on building positive working relationships by managing the team, the environment and managing self. Human factors are also incorporated into CEWS and SBARD to raise situational awareness.

<u>Process</u> <u>CEWS recording</u>

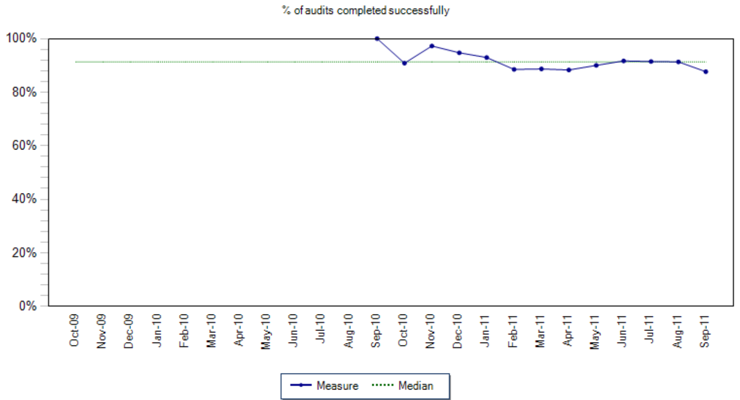


[1] <u>SBARD</u> is a tool to improve communication of safety critical information. SBARD is recommended for all calls about the deteriorating child and is the basis of the hospital at night handover. 'Flagged' patients

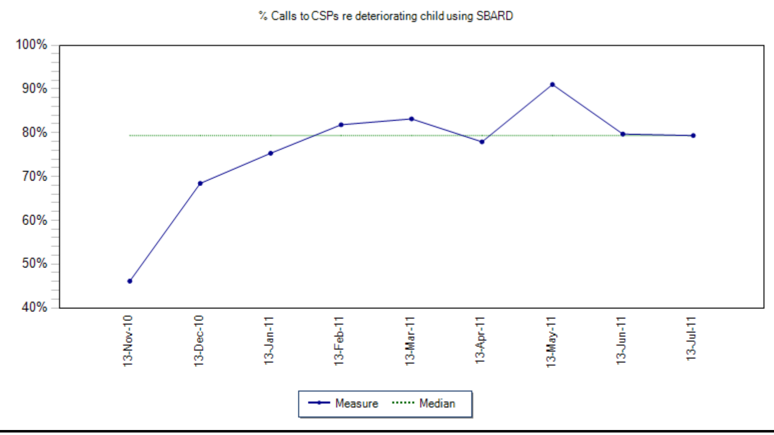
[2] <u>Children's Early Warning System (CEWS):</u> Linked to the patients observation chart, this system identifies when a child's vital signs are outside of the normal range and prompts staff to seek the appropriate level of senior clinical support. CEWS is now a nursing performance indicator

Attachment M

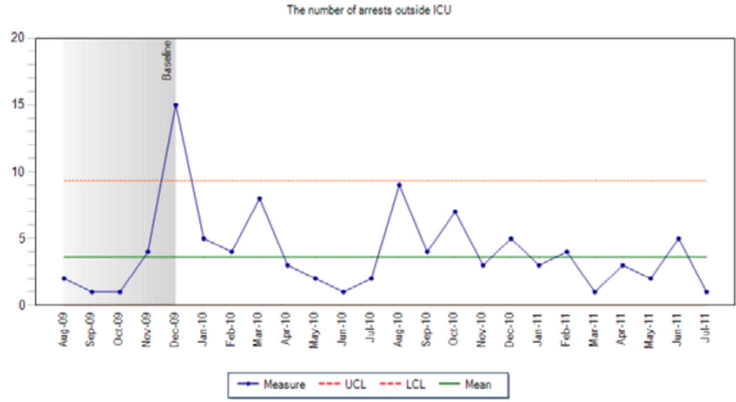
Process CEWS Correct



Process Use of SBARD for escalation to CSP



Outcome: Arrests outside the ICU – aim is to decrease and eliminate where possible



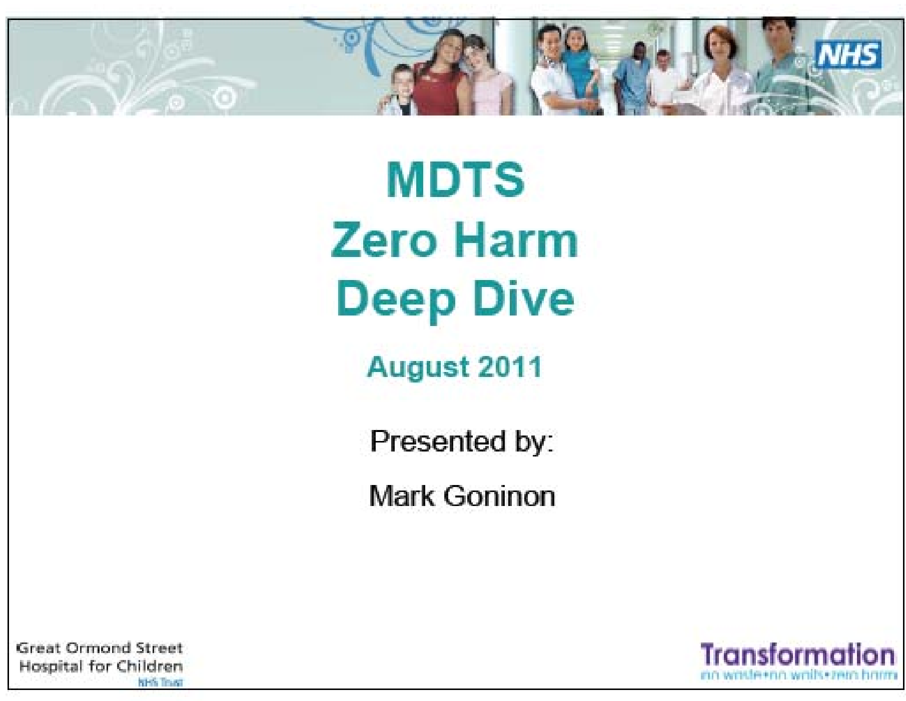
7. Patient Stories

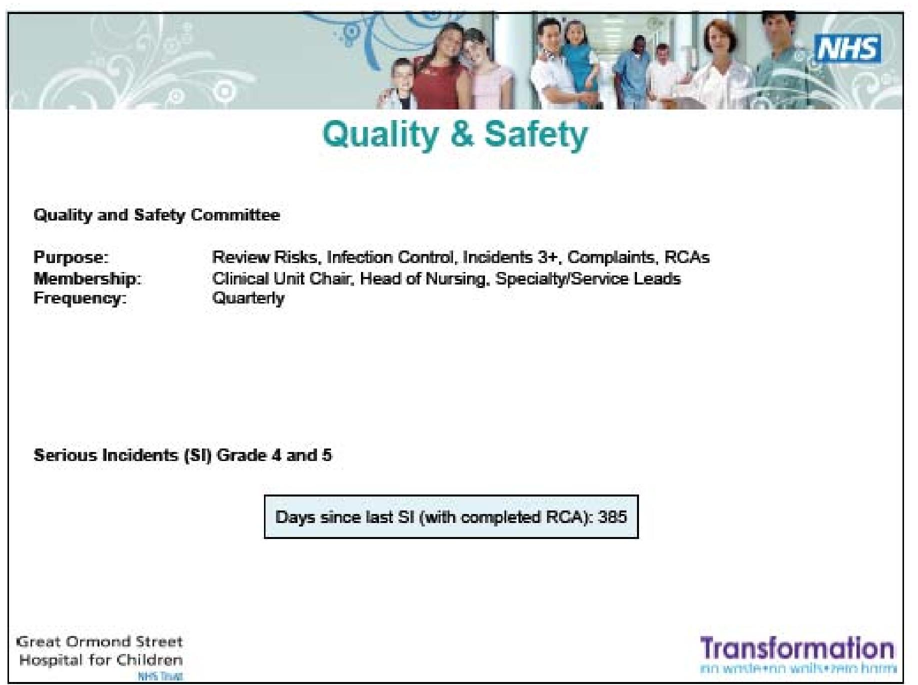
- The patient stories are being developed
- The transformation team has been testing bringing stories to the their meetings
- It is proposed that we trial the first one at the Board in October

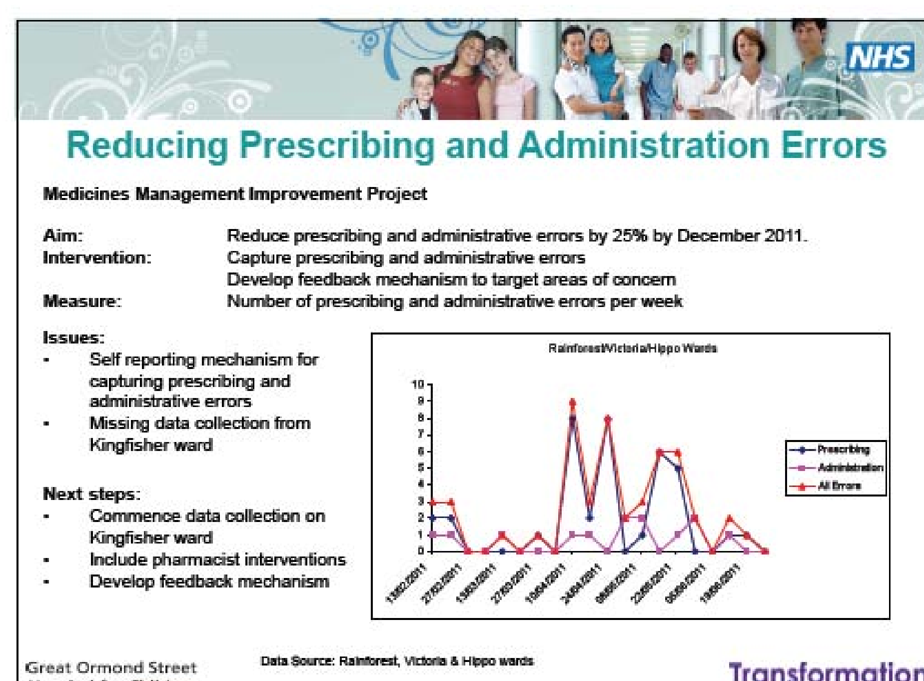
8. Unit report

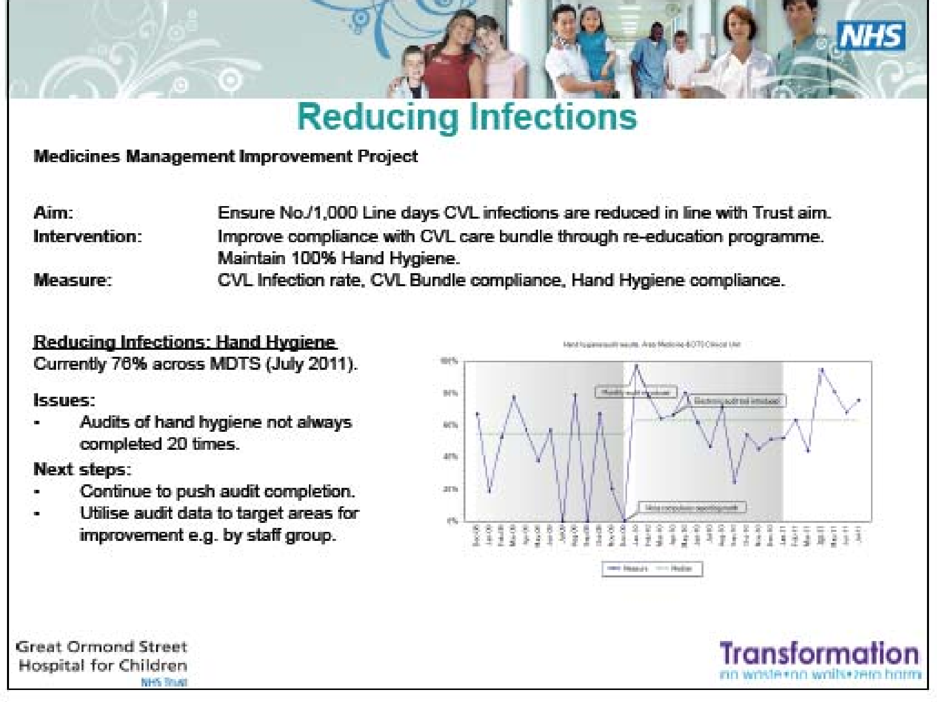
Unit Reports
Medicine presented their 6th monthly review of the Unit Zero Harm report at the September meeting of the Transformation Board. The presentation is attached

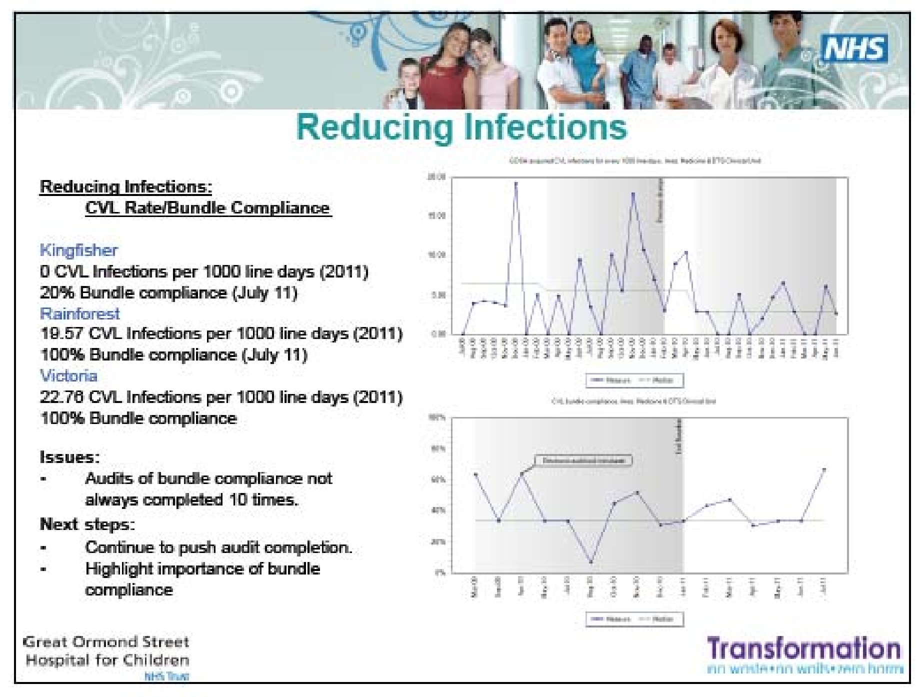
Peter Lachman
18th September 2011

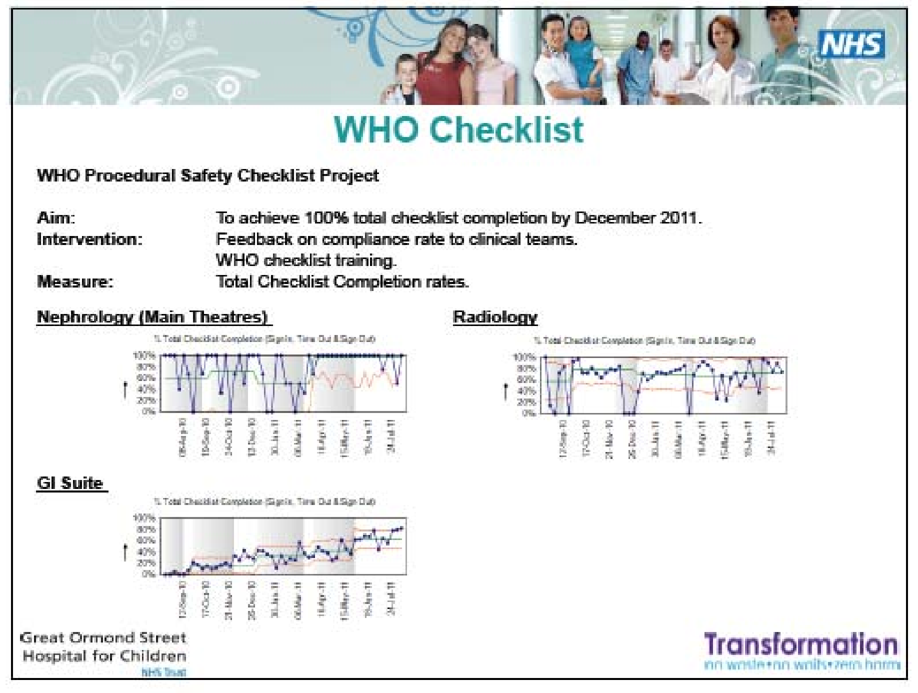

NHS
MDTS
Zero Harm
Deep Dive
August 2011
Presented by:
Mark Goninon
Great Ormond Street
Hospital for Children
NHS Trust
Transformation
no waste•no waits•zero harm

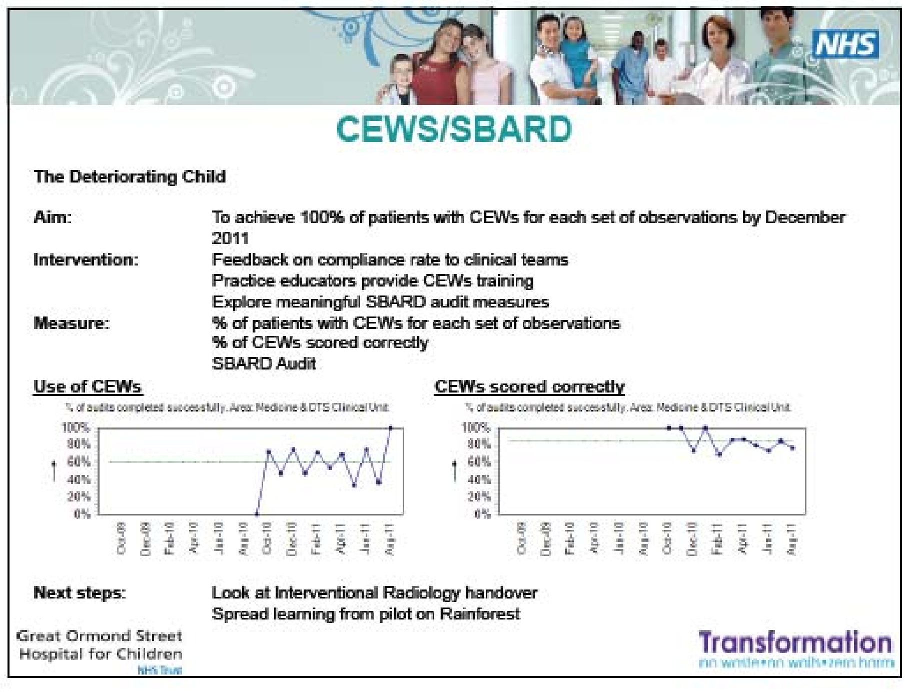

NHS
Quality & Safety
Quality and Safety Committee
Purpose: Review Risks, Infection Control, Incidents 3+, Complaints, RCAs
Membership: Clinical Unit Chair, Head of Nursing, Specialty/Service Leads
Frequency: Quarterly
Serious Incidents (SI) Grade 4 and 5
Days since last SI (with completed RCA): 385
Great Ormond Street
Hospital for Children
NHS Trust
Transformation
no waste•no waits•zero harm


NHS
Reducing Prescribing and Administration Errors
Medicines Management Improvement Project
Aim: Reduce prescribing and administrative errors by 25% by December 2011.
Intervention: Capture prescribing and administrative errors
Develop feedback mechanism to target areas of concern
Measure: Number of prescribing and administrative errors per week
Issues:
- Self reporting mechanism for capturing prescribing and administrative errors
- Missing data collection from Kingfisher ward
Next steps:
- Commence data collection on Kingfisher ward
- Include pharmacist interventions
- Develop feedback mechanism
Rainforest/Victoria/Hippo Wards
Prescribing
Administration
All Errors
Data Source: Rainforest, Victoria & Hippo wards
Great Ormond Street Hospital for Children NHS Trust
Transformation
no waste • no waits • zero harm


NHS
Reducing Infections
Medicines Management Improvement Project
Aim: Ensure No./1,000 Line days CVL infections are reduced in line with Trust aim.
Intervention: Improve compliance with CVL care bundle through re-education programme.
Maintain 100% Hand Hygiene.
Measure: CVL Infection rate, CVL Bundle compliance, Hand Hygiene compliance.
Reducing Infections: Hand Hygiene
Currently 76% across MDTS (July 2011).
Issues:
- Audits of hand hygiene not always completed 20 times.
Next steps:
- Continue to push audit completion.
- Utilise audit data to target areas for improvement e.g. by staff group.
Great Ormond Street Hospital for Children NHS Trust
Transformation
no waste • no waits • zero harm


NHS
Reducing Infections
Reducing Infections:
CVL Rate/Bundle Compliance
Kingfisher
0 CVL Infections per 1000 line days (2011)
20% Bundle compliance (July 11)
Rainforest
19.57 CVL Infections per 1000 line days (2011)
100% Bundle compliance (July 11)
Victoria
22.76 CVL Infections per 1000 line days (2011)
100% Bundle compliance
Issues:
Audits of bundle compliance not always completed 10 times.
Next steps:
Continue to push audit completion.
Highlight importance of bundle compliance
Great Ormond Street Hospital for Children
NHS Trust
Transformation


NHS
WHO Checklist
WHO Procedural Safety Checklist Project
Aim: To achieve 100% total checklist completion by December 2011.
Intervention: Feedback on compliance rate to clinical teams.
WHO checklist training.
Measure: Total Checklist Completion rates.
Nephrology (Main Theatres)
Radiology
GI Suite
Great Ormond Street Hospital for Children
NHS Trust
Transformation


NHS
CEWS/SBARD
The Deteriorating Child
Aim: To achieve 100% of patients with CEWs for each set of observations by December 2011
Intervention: Feedback on compliance rate to clinical teams
Practice educators provide CEWs training
Explore meaningful SBARD audit measures
Measure: % of patients with CEWs for each set of observations
% of CEWs scored correctly
SBARD Audit
Use of CEWs
CEWs scored correctly
Next steps: Look at Interventional Radiology handover
Spread learning from pilot on Rainforest
Great Ormond Street Hospital for Children
Transformation

NHS
Upcoming Projects
Improving the Quality of Medical Notes
Aim: To improve content and quality of medical notes. To achieve 80% compliance of the medical notes gold standard by July 2011 across MDTS.
Utilisation of Information for Improvement
Aim: To provide accurate real time information on key indicators by the end of December 2011. Ensure that key indicators are reviewed across MDTS and actions put in place as appropriate.
Admissions/Discharge Administration Restructure
Aim: To streamline the admissions and discharge process by providing a centralised admissions team and restructuring the administration support to the admitted patient pathway. Ensure processes and policies are put in place to facilitate this.
Structured consultant-led daily Ward Rounds on Rainforest
Aim: To improve communication on Rainforest ward, both across the medical and nursing teams, and to patients and their families.
Great Ormond Street Hospital for Children
Transformation

ATTACHMENT N

Trust Board Meeting **28th September 2011**	
Trust Board Terms of Reference **Submitted on behalf of** **Jane Collins, Chief Executive**	**Attachment N**
Aims / summary The Trust Board terms of reference have been reviewed in light of the Monitor's Code of Governance, the Trust's governance structure, amendments to the Standing Orders (as currently drafted) and draft Reservation and Delegation of Powers. The terms of reference were lasted approved in April 2010. Amendments include requirements of the Trust Board when authorised as a Foundation Trust and are included in brackets in red text. The document refers to increasing the number of Non Executive Directors (NEDs) from five to six. This has previously been approved by the Board and the sixth NED will be subject to consideration for full appointment following authorisation by Monitor as a Foundation Trust.	
Action required from the meeting To approve the revised terms of reference for the Trust Board.	
Contribution to the delivery of NHS / Trust strategies and plans Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation.	
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 applicable.	
Who needs to be told about any decision Not applicable.	
Who is responsible for implementing the proposals / project and anticipated timescales Not applicable.	
Who is accountable for the implementation of the proposal / project Chief Executive	
Author and date Anna Ferrant 16th September 2011	

DRAFT TRUST BOARD [BOARD OF DIRECTORS]
TERMS OF REFERENCE

1. Role

The role of the Great Ormond Street Hospital NHS Trust Board [Board of Directors] is:

- To provide leadership in establishing and promoting the values and standards of conduct for the Trust and its staff;

- To establish a clear strategic direction, by setting strategic objectives that are reflected in an explicit set of key deliverables and performance indicators;

- To scrutinise the quality of the Trust's services, focusing on effectiveness, patient safety and patient experience;

- To monitor the Trust's performance, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives; that systems are in place to minimise the risk of adverse performance; and, to take account of independent scrutiny of performance including from [councillors], regulators and other external stakeholders;

- To ensure the Trust develops and implements appropriate risk management strategies to deliver its Annual Plan and comply with its Care Quality Commission registration and [Monitor's Terms of Authorisation], systematically assessing and managing its clinical, financial and corporate risks.

- To ensure that strategic development proposals have been informed by open and accountable consultation and involvement processes with staff, patients, [councillors, members], the wider community and other key external stakeholders.

- To exercise financial stewardship, ensuring that the Trust is operating effectively, efficiently and economically and with probity in the use of resources;

- To demonstrate a commitment to openness and transparency in the Trust's relationship with staff, patients, the public, [councillors, members] and other stakeholders;

- To ensure that the Trust is operating within the law and in accordance with its statutory duties and the principles of good corporate governance.

2. Membership

The Trust Board [Board of Directors] shall comprise 10(11) directors excluding the chairman.

There shall be 5 (6) non-executive directors, one of whom shall be appointed by the Institute of Child Health, University College London.

There shall be 5 executive directors, currently:

- the Chief Executive
- Chief Finance Officer
- Chief Operating Officer/Deputy Chief Executive
- Co - Medical Directors (2)
- Chief Nurse and Director of Education.

3. Attendance at meetings

The Trust Board [Board of Directors] is committed to openness and transparency**.**

The main body of the meeting shall be held in public and representatives of the press and any other members of the public or staff shall be entitled to attend.

Members of the public and staff shall be excluded from the first part of the meeting due to the confidential nature of business to be transacted, or due to special reasons stated in the resolution and arising from the nature of the business of the proceedings.

In addition to Trust Board [Board of Directors] members, the following individuals shall be entitled to remain during confidential business:
- Director of Redevelopment
- Executive Director of Great Ormond Street Hospital Children's Charity
- Director of Research and Development
- Company Secretary.

Other senior members of staff may be required to attend the confidential session by invitation of the Chair.

4. Quorum

No business shall be transacted at a meeting unless at least five [six] directors are present including not less than two independent non-executive directors, one of whom must be the Chairman of the Trust or the Deputy Chairman of the Board; and not less than two executive directors, one of whom must be the Chief Executive or another executive director nominated by the Chief Executive.

An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

Participation in a meeting by telephone, video or computer link shall constitute presence in person at the meeting.

5. Frequency of meetings

The Trust Board [Board of Directors] shall normally hold formal meetings on the last Wednesday of the month except in February, August, October and December.

The Trust Board [Board of Directors] shall normally hold strategic review days in February and October of each year.

In addition to the above meetings, the Trust Board [Board of Directors] shall reserve the right to convene additional meetings as appropriate.

6. Performance evaluation

The Trust Board [Board of Directors] will undertake an evaluation of its own performance on an annual basis.

7. Secretariat

The Company Secretary shall act as Secretary to the Trust Board [Board of Directors].

The minutes of the proceedings of Trust Board [Board of Directors] meetings shall be drawn up for agreement and signature at the following meeting.

Signed minutes shall be maintained by the Secretariat

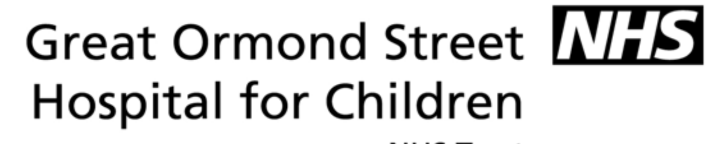
Agendas and papers for the public section of all Board meetings shall be placed on the Trust website two working days prior to the meeting.

8. Review of the terms of reference

These Terms of Reference shall be reviewed annually by the Trust Board [Board of Directors] or following amendments to the Trust's Standing Orders, Reservation and Delegation of Powers.

September 2011

ATTACHMENT N



<table>
<tr><td colspan="2">Trust Board Meeting
September 2011</td></tr>
<tr><td>Proposal to move from existing Dubai office

Submitted on behalf of:
Trevor Clarke, Director of International</td><td>Paper No: Attachment O</td></tr>
<tr><td colspan="2">Aims / summary
This proposal will provide International Division with an office in Dubai that is in line with its requirements, whilst making cost savings towards the CRES target</td></tr>
<tr><td colspan="2">Action required from the meeting
To note the report and approval further investigation</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
Cost reduction</td></tr>
<tr><td colspan="2">Financial implications
To reduce costs currently incurred, making a year on year saving.</td></tr>
<tr><td colspan="2">Legal issues
The Trust Board will need to approve the move as revised documentation (Power of attorney, etc) will need to be provided in Dubai.</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?
Discussions have occurred with Dubai office staff and with Finance for the estimated savings</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
International Division</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Joanne Lofthouse, General Manager, International</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Trevor Clarke, Director of International</td></tr>
<tr><td colspan="2">Author and date
Joanne Lofthouse, General Manager, International. 8th September 2011</td></tr>
</table>

Project background

The International Division opened the Dubai office in 2005. The Dubai office is a base for referrals to Great Ormond Street Hospital from the Middle East and liaises with local hospitals to ensure that all clinical information relating to the referral is available and co-ordinates the admission. The office also manages the overseas visiting programmes and develops relationships with local bodies. It also administers the practical arrangements for the provision of consultancy, training and education in Kuwait.
There are three staff based in Dubai (Nurse Advisor, Administrator and receptionist), although no clinical care is offered the office is visited by locals (potential patients) and is a good contact point for patients throughout the Middle East.
The current office is situated within Dubai Health Care City (DHCC) which is a "free zone" enabling GOSH a base within Dubai.

Aim and objectives

Property rental values in Dubai have decreased in recent years. Out current landlord is not reducing rents. Alternative office locations have been explored.
The International Division proposes to downsize the Dubai office, with the aim of achieving reduced rent and of providing the same services within a smaller floor space. This proposal will not affect the service provision or staff numbers, but will reduce costs.

The proposal works towards a transfer of offices by January 2012, which is when the existing rental contract expires.

There are no financing requirements as the one-off costs will be absorbed within the savings generated in year one, there will be a CRES in all years.

Strategic context

The gulf office provided GOSH with an increased exposure in the Middle East, which has aided the development of the GOSH brand and contributed towards the growth in International income. The current costs for the office rental could be reduced without impacting on our reputation or relationships.

Proposal

The International Division has identified the opportunity to downsize its existing Dubai office from 1647 square foot to approximately 800 square foot.
The proposal is to relocate within DHCC, this will reduce current rental costs whilst remaining within the free zone, although a re application process will be necessary GOSH are known to the licensing authorities. Two properties have been viewed within DHCC and both are available for occupation within the timescales required. The proposal submitted to the Trust will offer a rent free period, so there will be minimal duplicate rental charges and the future rental charges including all maintenance and service charges.

Contact has been made with the real estate agents who advised on the current office, they have also advised upon the rental charges of the prospective properties and they are appropriate and consistent with market conditions. Professional advice regarding the move will be obtained as necessary in Dubai to ensure a smooth transition from one property to another.

The proposal was approved at Management Board in July 2011 and requires approval from Trust Board to progress.

Attachment O

Timeframes

The plan is complete move prior to current rental expiry on 31 December 2011.

Table 1: Project plan

Milestone	Completion Date	Person Responsible
Approval at Management Board	21 July 2011	Joanne Lofthouse
Approval at Trust Board	28 September 2011	Trevor Clarke
Property Reserved	1 October 2011	Joanne Lofthouse
Power of Attorney issues resolved	15 October 2011	Jonathan Elwood / Sophie Pownall
Plan for Office move	31 August 2011	Gwyneth Reynolds
Agree heads of agreement for new office / Contract signing	9 September 2011	Trevor Clarke / Joanne Lofthouse
Issue notice on existing rental contract	16 September 2011	Gwyneth Reynolds
Move office	October 2011 to December 2011	Gwyneth Reynolds
Close existing office	31 December 2011	Gwyneth Reynolds

Risks

Table 2: Risks

	Risk	Description	Likelihood	Impact	Risk rating	Control
1	Licencing issues	License unable to be transferred as Power Of Attorney arrangements not in place.	3	4	12	Project plan to ensure appropriate approvals in place before committing to property rental. Liaison with Notary to ascertain issues.
2	Property availability	Property viewed and deemed as suitable no longer available.	3	3	9	Time scale of plan to be discussed with DMCC, ascertain amount of suitable property. Property in plentiful supply.
3	Continuity of service provision	Not able to transfer all office functions during the move.	3	3	9	Ensure planning of all services is within the transfer / move plan. Ensure an overlap of provision if possible, rent free period will facilitate this.
4	Moving outside the HealthCare City Zone into a commodities Free-zone	Perception in Middle East of the downsized offices could be misinterpreted. Downsizing to a non-health related free-zone could be perceived as a sign of weakness/failure.	2	4	8	Opportunity to achieve reduced rental levels in DHCC will be pursued. Dubai staff will continue to promote GOSH. Right message needs to be shared in terms of reasons for move
5	Size of office	Less space in new site for visitors to office.	2	2	4	Fit out will include child friendly meeting area. Staff will also prepare to meet families in a hospital setting.

Outcomes and performance management

The intended benefits to the division and the Trust will be:

- Delivering an excellent experience that exceeds expectations of service users by increased access to beds and no waits. Between one and ten patients per month on average are either refused or deferred admission when requested. The ability to admit more patients will encourage consultants to bring their private work to GOSH

Costs, income and savings

Existing rental and associated costs total £37,331 per annum. The proposed office will incur costs of £20,000 - £25,000 at current exchange rates.
There will be one-off costs associated with the move of £15,132. In addition there will be legal fees in the UK of approximately £2,000 to update or change licence documentation.

Supporting Analysis

Quality impact assessment

Consideration is given to the Trust wide guidelines on ensuring quality through corporate governance on safety, managing risk, complaints and financial impact

Patient Safety and Compliance	The proposed office move will have a minimal impact on patients, as the main role of the office is patient referrals and post referral experience. There may be minimal delays during the move period but these will be managed by a 2 month dual running period.
Staff recruitment and retention	No impact
Staff Training	No impact
Financial sustainability	Reduced costs will facilitate recurring CRES

Impact on other services and departments

The impact will be minimal, except within the International Division and potentially within the Legal Department, although both of these areas will be impacted based upon the corrective action that is required to ensure all documents required for the existing Dubai office continue to be of a legal form.

Space considerations

None, outside of those already mentioned within the paper.

Trust Board
28th September 2011

Key Performance Indicator (KPI) report **Submitted on behalf of.** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment P**

Aims / summary

The report monitors progress against the Trust's seven strategic objectives, providing traffic light analysis against each of the supporting work streams and progress against specific key performance indicators. Remedial actions to address performance and operational issues are undertaken by Management Board.

The report has been updated to include:
- Quarter 1 market share analysis
- Briefing of cases of possible C.difficile associated disease reported this year
- Briefing of actual cases of MRSA reported this year
- Analysis of waiting times.

The exception report includes progress against those indicators that are reported as 'red'. The October report will be updated to include clear written criteria for when KPIs are rated red, amber or green. The report will be additionally be updated to ensure that targets and trajectories are identified for all applicable indicators and benchmark data available where possible.

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

Remedial actions to address performance and operational issues are undertaken by Management Board.

Attachment P

Author and date
Alex Faulkes Head of Performance and Planning. September 2011

KPI Exception report

1. C. difficile and MRSA

In month the Trust reported 1 case of C. difficile. To date the Trust has reported 5 cases against a year-to-date trajectory of 3.75 (Appendix 1 for detail). 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 a trajectory of 0 (Appendix 2 for detail). It should be noted that where an NHS Foundation Trust has an annual MRSA objective of six cases or fewer (the de minimis limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's Compliance Framework.

2. NICE recommendations un-reviewed

The number of un-reviewed NICE recommendations increased from 8 in July to 11 August. Initial review by the Clinical Audit Team has been suggested that the majority of un-reviewed guidance relates to adult care. The position has been escalated to General Managers and Clinical Unit Chairs to ensure all guidance has been reviewed by no later than October.

3. Referral to Treatment waiting times.

The Trust continues to meet the existing 18week referral to treatment standards and the 95th Centile waiting time standards for both admitted and non-admitted patients. To date the Trust has not consistently met the standard for incomplete pathways, median admitted waiting times and 26week inpatient waiting times. (Appendix 3 for detail).

3.1 Incomplete pathways

A lack of validation over time has led to a high number of incomplete pathways across all specialties - most noticeably in Medicine and Surgery. Over the last month we have focused on resolving this issue, whilst implementing robust plans to ensure this standard continues to be met. Following this work the Trust is now achieving the median and 95th Centile standards for incomplete pathways for August.

3.2 Median admitted waits and 26week inpatient waits.

We have identified 5 specialities with the most significant adverse impact on the failed targets of median admitted waits and 26 week inpatient waits. These include: Maxillofacial Urology Spinal Orthopaedics Cardiac Surgery. Detailed recovery plans to address these areas of concern have been developed and were submitted to September Management Board for approval.

4. Clinic outcome form completeness

Performance continues to improve with an in-month position reported at 65%. This represents an improvement of 10% against the May position. The Referral to Treatment Pathway Group has recently completed an audit of the current clinic outcome form completion process and a range of recommendations are being implemented across all specialties. The Trust has set a target of achieving 95% by March 2012 and progress against trajectory will be monitored closely by Management Board.

5. Discharge summary completion rates

This indicator has previously been reported to Trust Board. Performance has plateaued at approximately 77% under the current paper based system. An electronic solution is required and is currently being discussed through the Technical Delivery Board.

6. Mandatory training

This is the first month of reporting mandatory training compliance. To date 62% of all staff are recorded as having undertaken mandatory training within the last 18 months. The Trust internal target of has been set at 80% by end of year. 15% of staff who have not undertaken training have a future date booked.

The Education and Training department continue to circulate performance reports to managers

to progress. Guidance on accessing and completing online training has also been made available to all staff. Progress will be monitored closely through Management Board.

7. Market Share Analysis (Appendix 4)

Several specialties, particularly, Cardiac Surgery, Neuro Surgery, General Surgery and Haem/Onc/BMT have shown market share gains in quarter 1 of 2011/12

Appendix 1 Briefing on cases of possible C. difficile associated disease reported this financial year at GOSH (to 19 Sept 2011)

Case 1 - haematology / oncology patient undergoing chemotherapy, receiving appropriate antibiotics for febrile neutropenia; experienced a self-limiting episode of diarrhoea. C. diff detected for the first time.
D.O.B. 04/03/2008, age at positive test 3.1 years
D.O.A 18/03/2011,
Sample 08/04/2011, 18th day of admission
Ribotype 20 – commonest ribotype in GOSH, seen 7 times, on 5 different wards. In 2011. Likley to be sporadic.
Co-incidental finding or mild disease. No evidence of cross infection.

Case 2 - haematology / oncology patient undergoing chemotherapy and on laxatives, receiving appropriate antibiotics for febrile neutropenia; no change in loose stool. C. diff detected for the first time, therefore treatment given.
D.O.B. 25/11/2003, age at positive test 7.4 years
D.O.A 10/04/2011
Sample 14/04/2011, 4th day of admission
Ribotype 5 - 3 of 5 ribotype 5s this calendar year were in children on this ward, so possible transmissions but may represent increased community activity as case 4 is also a ribotype 5 and is totally unrelated in time, ward and clinical service.
May be co-incidental finding or mild disease. Possible cross transmission on ward followed by re-enforcement of specific control measures.

Case 3 - haematology / oncology patient undergoing chemotherapy, receiving appropriate antibiotics for febrile neutropenia; no change in frequent liquid stool.
C. diff detected for the first time. **D.O.B. 29/12/2004, age at positive test 6.4 years**
D.O.A 26/04/2011
Sample 12/05/2011, 16th day of admission
Ribotype 81 – detected 3 times this calander year, the other two times on admission stools and on different wards to this child; so highly likely to be sporadic.
Co-incidental finding or mild disease. No evidence of cross infection.

All three of these cases had possible C.diff associated disease but equally there were other reasons present for loose stool. There was no evidence of serious infection; treatment was administered but there is uncertainty as to its need.
In summary, all three cases had possible C.difficile associated disease but equally there were other reasons for these children having diarrhoea.

Case 4 - Non-immunocompromised 12 year old child received co-amoxicalv prophylaxis for surgery, followed by co-amoxiclav for a post-operative respiratory infection. Developed abdominal pain, tenderness and diarrhoea, C.diff detected. Antibiotics were stopped; treated and resolved.
D.O.B. 14/11/1998, age at positive test 12.6 years
D.O.A. 06/06/2011
Sample 13/06/2011, 7th day of admission
Ribotype 5 – unrelated to the other 5s seen at GOSH; most likely prior colonisation and probable true case of C. difficile associated disease following surgery and antibiotic treatment. No evidence for hospital crossinfection.

This is the first probable case this year. While the antibiotic use was in accordance with protocol, we are aware of the switch in some areas of surgery from benzyl pencillin / amikacin and methronidazole to co -amoxicalv (this is to reduce the potential aminoglycoside toxicity) may potentially lead to an increase in Clostridium difficile associated diarrhoea. We are monitoring this.

Case 5 – Child being established on peritoneal dialysis, undergoing laxative treatment; had a chest infection treatment ending 2 weeks before a single day of diarrhoea, 6 loose stools. Self limiting, untreated. Stool was sent and positive.
D.O.B. 4/1/2003, age at positive test years. One other positive stool in August in a 0.9 year old.
D.O.A. 3/8/2011

Sample 28/8/2011, 25th day of admission
Ribotype – pending.
Co-incidental finding or mild disease two weeks after appropriate antibiotics. Source unknown.

Possible case, as no other cause found, although the intention is to keep the child's stool loose and clinical team were not concerned.

Appendix 2a Briefing on cases of MRSA: Case 1 Executive summary from formal investigation

Brief Incident Description
An 18 month old patient with acute lymphoblastic leukaemia was admitted to GOSH on the 18th January 2011. On the 30th January a blood culture was taken as the patient had developed febrile neutropaenia and this yielded MRSA.

Incident Date: 30th January 2011
Incident Type: MRSA Bacteraemia
Specialty: Haematology

Actual effect on patient and/or service:
Patient required removal of portacath (central venous line) and a replacement line (2 additional anaesthetics). Inpatient stay not prolonged as this period of admission required for treatment.

Actual severity of the incident: Severe (Level 4)

Level of investigation undertaken: A level 2 root cause analysis investigation was undertaken in line with guidance from the National Patient Safety Agency.

Involvement and Support of Patient, Family and Staff
Family fully informed of bacteraemia.
Staff involved in investigation and results fed back at relevant meetings

Key Care and Service Delivery Problems identified
- **Difficulties obtaining IV access**

Day after admission difficulties with peripheral IV access and need for early central line identified.
No routine slots available for IR insertion of central venous access within the required time frame.

Key Contributory Factors identified
- **Delay scanning catheter placement**

There was a 10 minute delay closing the portacath insertion site in theatre whilst awaiting the arrival of a Radiographer to confirm the portacath placement.
During this time the wound was open which increased the possibility of local transmission of infection from colonised skin.

- **Unfamiliar environment and support staff**

Port placement carried out in a theatre that the locum consultant would have been unfamiliar with as no space in routine IR areas. Assisted by a nurse not as familiar with IR techniques as staff normally working in IR areas

- **Awareness of Trust policy**

Locum Consultant who undertook the procedure had not read the IR policy on CVA device insertion, although he was aware of it. Policy not readily available on a central drive or intranet. However, his procedure fulfilled all the requirements of the policy (including appropriate skin prep with 2% chlorhexidine gluconate in 70% isopropyl alcohol).

Root Cause
Although it is difficult to identify if the infection occurred during the maintenance or insertion of the portacath it is felt it is more likely that this occurred during the insertion of the portacath.

In light of this it is probable that the cause of the infection was due to the delay in scanning the catheter placement in theatre. The wound was open for approx 10 minutes whilst waiting for a radiographer to attend.

Lessons Learned

- There is a need to review the processes (ie need for decolonisation) following a staph aureus bacteraemia to prevent future infections.
- Hand hygiene results need to be discussed and analysed more frequently within ICI-LM
- Recording of training for nurses (with reference to CVLs) needs to be reviewed to ensure that records of training are readily available and to facilitate update training being attended in a timely way.
- It is important that all Trust staff are aware of policies relevant to their work, but it is equally as important that all locum staff are advised of relevant Trust and Local policies. Induction of locum medical staff must be strengthened to ensure that this happens promptly (Trustwide Locums)
- The use of locums is known to pose a risk to patient safety, as they are more likely to be unfamiliar with locations, equipment and local policies. Where possible, the Trust should always aim to ensure that a locum member of staff is directly supported by a member of the team who is familiar with the environment, equipment, procedures and policies relevant to the locum.

Recommendations

- Review of recommendations for topical decolonisation for MRSA in patients who are or may become significantly immuno-compromised to be undertaken.
- An electronic white board system is being implemented by the Trust which should make information regarding a patient's infection history easier to access for all staff.
- Hand hygiene and CVL bundle compliance audit results to be added to ward meeting agenda to ensure they are discussed and analysed at each meeting.
- In addition to the centrally held education and training database training records should be held locally to ensure all nursing staff are trained and annual updates are attended.
- IR to review induction arrangements for locum medical staff and availability of key policies
- Although the significance of the delay in imaging cannot be fully determined, this should be included in the Transformation project looking at standardising insertion of CVLs.
- Information in this report to be used to support the case for increased capacity of IR line insertion which is being developed by MDTS
- The Trust wide arrangements for preparing temporary staff for their work at the Trust, including the need for them to be supported by staff familiar with relevant environments and policies, need to be reviewed.

Arrangements for Shared Learning

- Report to be shared with the Lion/Elephant ward teams by General Manager.
- Report to be discussed at the Haematology/Oncology monthly management meeting
- Report to be discussed at ICI-LM and Radiology risk action groups
- Report to be discussed at ICI-LM Unit Board Meeting
- Report to be submitted to the Trust Quality & Safety Meeting

Appendix 2b Briefing on cases of MRSA: Case 2 Executive summary from formal investigation

Brief Incident Description
Patient was admitted to the Trust on 29th March 2011 for resection of neuroblastoma on 30th March 2011. A blood culture was taken on 1st April and it was confirmed positive for MRSA bacteraemia on 3rd April 2011.

Incident Date
A blood culture was taken on 1st April and it was confirmed positive for MRSA bacteraemia on 3rd April 2011.
Incident Type
MRSA bacteraemia
Specialty
General Surgery / Anaesthetics

Actual effect on patient and/or service
Patient's Hickman line had to be removed
2 week course of IV antibiotics via long line
MRSA decolonisation protocol prior to insertion of new line

Actual severity of the incident
Severe

Level of investigation undertaken
Level 2 Investigation in line with NPSA guidance

Involvement and Support of Patient, Family and Staff
The family initially met with the PALS team on the 5th April 2011. The PALS Manager supported the family in making a formal complaint regarding their experiences on Woodland Ward. The PALS manager arranged for the family to meet with a member of the complaints team on the 5th April 2011.

The Complaints Assistant met with the family and documented their concerns. She discussed the complaints and infection control root cause analysis process with them. The family outlined a number of concerns that they had about the patient's care and treatment to be investigated as part of the Trust's review.

Key Care and Service Delivery Problems identified:
- Non-achievement of 100% compliance with Central Venous line care bundle

Key Contributory Factors identified:
- Not all staff who access CVCs currently undergo training and competency assessment
- The temporary ward environment was not to the expected standard
- The line was accessed a large number of times

Root Cause

The root cause of the patient's MRSA bacteraemia was a central venous catheter related infection.
Despite the investigation undertaken by the Trust
- it has not been possible to identify exactly how the patient acquired the central venous catheter related infection although we believe it is likely to have occurred due to non compliance with the central venous line care bundle.

- it has not been possible to identify the source of the MRSA, although it is likely to have been acquired after admission on 29 March. The investigation has enabled the Trust to learn some important lessons in relation to the consistent application of the central venous line bundle, which we hope will improve the safety of all patients with central venous lines in the Trust.

Lessons Learned
Beyond the root causes identified, some additional lessons have been learned. Often the analysis of an incident will flag up other key patient safety issues which did not in this instance materially contribute to the incident, but could potentially contribute to other patient safety incidents unless acted upon. They may relate to the incident itself, the investigation process or the implementation of recommendations or action plans.

- The investigation has identified that there are no data to support consistent application of the central venous line care bundle. We recognise that although many staff are compliant with the bundle, we need more robust checks in place to demonstrate that this is the case. This includes theatres as well as ward based areas.

- Trust documentation does not support staff in easily identifying which access points (when patient's have multiple access points) have been used as part of the care delivered to the patient while on the ward or in theatres.

- Need for high compliance with MRSA admission screening. The absence of an MRSA admission screen result did not contribute to this bacteraemia but contributes to the uncertainty of the MRSA reservoir.

- Incomplete MRSA screening of staff involved after the event is not a contributory factor to the patient acquiring the bacteraemia, but difficulty getting staff screened during the investigation was another issue demonstrated which impacts on our ability to reduce likelihood of other events

- Although not contributory to the CVC infection, the Trust is aware of variation in CVC insertion protocols and is working to standardise this.

Recommendations

- The Unit will review the training records of all relevant staff that access lines including anaesthetists. Where any gaps in training are identified, staff will undergo training on CVL care bundle and best practice as appropriate. This may include targeted training or workshops.
- The Unit will audit CVL bundle compliance in theatres and wards.
- Monitoring the compliance of theatre staff using the CVL Bundle should be added to the improvement plan Surgery.
- The Surgery Unit will ensure that the findings of this report in identifying point of access for treatment are escalated to the Electronic Prescribing (EP) Improvement Board.
- There should be a daily review by the medical team of whether a permanent line should remain in.
- The Unit will ensure compliance with the MRSA Screening policy.
- The Unit will work with Infection Control Team to look at the process for obtaining and processing swabs from staff. This work will be undertaken as part of our infection control work stream.
- Trust will ensure there is a managerial process in place to ensure follow up of staff members requiring screening during MRSA investigations.
- The unit will continue to work on the standardisation of insertion of lines – with one protocol and a checklist.

Appendix 3 Waiting times analysis

The performance measures for waiting times have altered over the past year and also vary between review bodies. The table below summarises what is measured, by whom and our performance in July 2011. These are all shown at a Trust wide level in the KPI report

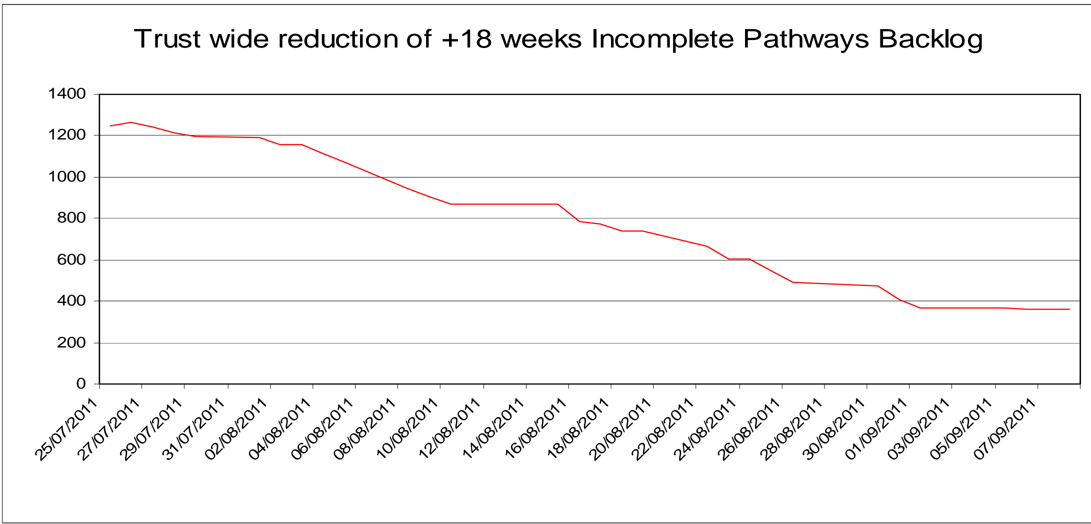
Target	Monitoring Organisation	Performance in July/August 2011	Key Reason(s) for Failure
% Patients within 18 weeks Admitted	Commissioners - Contractual	Achieved	
% Patients within 18 weeks Non Admitted	Commissioners - Contractual	Achieved	
18 week 95th Centile Admitted	Monitor & Commissioners	Achieved	
18 week 95th Centile Non Admitted	Monitor & Commissioners	Achieved	
18 week 95th Centile Incomplete Pathways	Commissioners	Not Achieved	
18 week Median Incomplete Pathways	Commissioners	Not Achieved	
18 week Median Admitted	Commissioners	Not Achieved	Cardiac & Surgery
18 week Median Non Admitted	Commissioners	Not Achieved	Medicine & Neuro
26 Week Inpatients	Internal	Not Achieved (163 patients)	Surgery, Maxfax, Spinal, Ortho & Urology

As can be seen the situation is complex, with different targets suggesting different problems. In summary the 3 issues of most concern are:

- Lack of validation leading to high numbers of incomplete pathways notably in Medicine and Surgery.
- Growing and lengthening inpatient waiting lists leading to 26 week and 18 week median admitted problems – key specialties are Cardiac Surgery, Urology, Orthopaedics, Dental & Maxfax and Spinal.
- Consistently longer average waiting times for non admitted patients in Medicine and Neuro (not a new problem)

For the last few weeks we have focused on the first issue and the graph below shows the reduction in over 18 week patients on incomplete pathways. We are now achieving the median and 95th Centile waits for incomplete pathways for August.

Attachment P



The second issue is the next area of focus. We have identified 5 specialities with the most significant adverse impact on the failed targets of median admitted waits and 26 week inpatient waiters. These include: Maxillofacial Urology Spinal Orthopaedics Cardiac Surgery Detailed recovery plans to address these areas of concern have been developed and were submitted to September Management Board for approval.

The latter issue is not a new problem for GOSH and is an outcome of the tertiary / quaternary nature of the GOSH case mix (inherited ticking clocks). This will be analysed in more detail shortly.

Key Performance Indicator Report

Trust Board

Aug-11

Key Performance Indicator Report

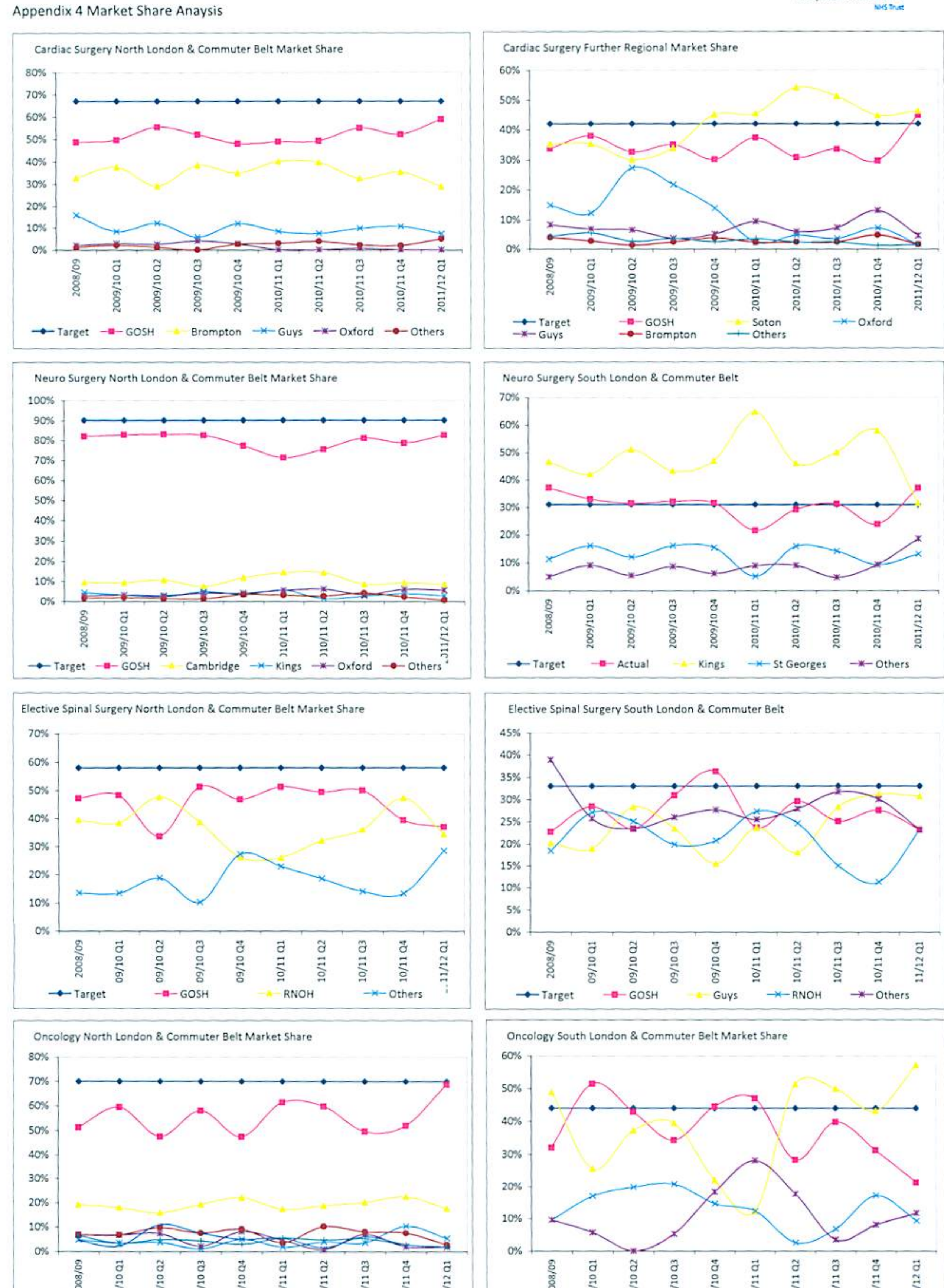
Great Ormond Street NHS Hospital for Children NHS Trust

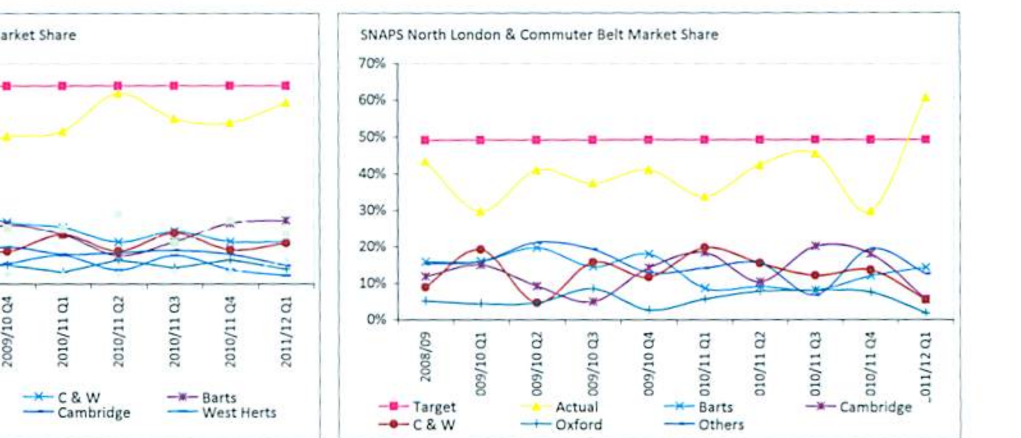
Dashboard

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	3.8	5	1	↓	Monthly	Red
Incidence of MRSA	0	2	0	↑	Monthly	Amber
Incidence of MSSA	Baseline TBC	4	0	↑	Monthly	-
Incidence of E-Coli	Baseline TBC	5	3	↓	Monthly	-
No. of NICE recommendations unreviewed	<3	-	11	↓	Monthly	Red
Serious incidents	Within tolerance	11	4	↓	Monthly	Green
Mortality figures	Within tolerance	26	11	↓	Monthly	Green
CVL related infections (per 1000 bed days)	1.5	2.25	2.5	↑	Monthly	Amber
SSI as a percentage of Urology operations - July	0.24%	0.39%	1.23%	↓	Monthly	Amber
SSI as a percentage of Cardiology operations - July	Baseline TBC	4.32	2	↑	Monthly	-
SSI as a percentage of Cranio operations - June	Baseline TBC	5.06	9.1	↓	Monthly	-
SSI as a percentage of Neurology operations - June	Baseline TBC	5.16	7.2	↓	Monthly	-
SSI as a percentage of Thoracic operations - July	Baseline TBC	7.4	11.8	↓	Monthly	-
Incidence of Ventilator-Associated Pneumonia	0	Data collection under review				
Surgical Checklist completed - Sign in (%)	100	90.9	89.5	↓	Monthly	Amber
Surgical Checklist completed - Time out (%)	100	85.4	86.3	↓	Monthly	Amber
Surgical Checklist completed - Sign out (%)	100	80.6	82.5	↓	Monthly	Amber
48 Hour readmissions to ITU	3	1.14	1.14	↔	Quarterly	Green
Prescribing errors Haemotology / Oncology	-	5.6	5.37	↑	Monthly	-
Accidental extubation	-	Data collection under review				
Medication errors reported (per 1000 bed days)	-	Data collection under review				
2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations						
18 week performance - Admitted (%)	90	92.6	92.4	↓	Monthly	Green
18 week performance - Non-Admitted (%)	95	97.03	96.76	↓	Monthly	Green
Inpatient waits >26wks	<5	-	163	↓	Monthly	Red
95th Centile RTT - Admitted	<23 weeks	-	21.45	↓	Monthly	Green
95th Centile RTT - Non-Admitted	<18.3 weeks	-	17.52	↓	Monthly	Green
Median Wait - Admitted	<11.1 weeks	-	11.25	↑	Monthly	Amber
Median Wait - Non-Admitted	<6.6 weeks	-	6.67	↑	Monthly	Amber
95th Centile RTT - Incomplete Pathways	<28 weeks	-	36.49	↑	Monthly	Red
Median Wait - Incomplete Pathways	<7.2 weeks	-	8.07	↑	Monthly	Amber
Clinic outcome form completeness (%)	95	59.62	64.8	↑	Monthly	Red
Valid coding for ethnic category - inpatient (%)	85	91.6	88.8	↓	Monthly	Green
Discharge summary completion (%)	95	75.79	77.7	↑	Monthly	Red
Did not attend - outpatients (%)	<10	6.35	7.7	↑	Monthly	Green
3. Successfully deliver our clinical growth strategy						
Theatre Utilisation - U4 (%)	70	-	67.2	↓	Monthly	Amber
Follow up to new ratio	4.18	4.33	4.6	↓	Monthly	Amber
Number of refused referrals	Baseline TBC	98	2	↑	Monthly	-
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 (£)	Baseline TBC	2,160,913	778,776	↑	Monthly	Green
Clinical trials - number recruited	Baseline TBC	340	148	↔	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 (£)	1,435,969	1,435,969	-	↔	Quarterly	Green
SIFT SLA Value (£)	15,036	15,036	-	↔	Quarterly	Green
MPET SLA Value (£)	264,594	264,594	-	↔	Quarterly	Green
6. Deliver a financially stable organisation						
CRES delivered - Released from budgets 11/12 (£m)	15.6	1.6	-	↑	Monthly	Amber
Bank and Agency Total expenditure (£000)	-	6,628	1,338	↑	Monthly	-
Monitor Risk Rating	3	-	4	↑	Monthly	Green
Charity fundraising target	19,224,903	20,398,474	4,283,031	↓	Monthly	Green
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation						
Sickness absence rate (%)*	TBC	-	3.28	↔	Monthly	-
No. of staff in post - Costs*	TBC	4,806,900	4,806,900	-	Quarterly	-
Vacancy rate (%)	TBC	-	6.77	↑	Monthly	-
Turnover rate (%)*	TBC	-	21.05	↓	Monthly	-
NHS Number completeness - FCE inpatient (%)	95	98.8	99	↓	Monthly	Green
NHS Number completeness - outpatient (%)	95	99.1	99.3	↑	Monthly	Green
Staff PDR completeness - clinical (%)	80	-	75.9	↓	Monthly	Amber
Staff PDR completeness - non clinical (%)	80	-	71.1	↓	Monthly	Amber
Mandatory Training Uptake	80	-	62	-	Monthly	Red
Staff trained on Information Governance by week (%)	90	-	86.00	↑	Monthly	Amber
Network Availability (%)	99.99	-	100	↔	Monthly	Green
Average Key Server Availability Monthly (%)	-	-	100	↔	Monthly	-
Monthly Key Application Availability	-	-	99	↓	Monthly	-

* Rolling 12 month position

Appendix 4 Market Share Anaysis




Gastro North London & Commuter Belt Market Share
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
2008/09
2009/10 Q1
2009/10 Q2
2009/10 Q3
2009/10 Q4
2010/11 Q1
2010/11 Q2
2010/11 Q3
2010/11 Q4
2011/12 Q1
Target
GOSH
C & W
Barts
Royal Free
NW London
Cambridge
West Herts
Oxford
Others
SNAPS North London & Commuter Belt Market Share
70%
60%
50%
40%
30%
20%
10%
0%
2008/09
009/10 Q1
009/10 Q2
009/10 Q3
009/10 Q4
010/11 Q1
010/11 Q2
010/11 Q3
010/11 Q4
011/12 Q1
Target
Actual
Barts
Cambridge
C & W
Oxford
Others

Trust Board 28th September 2011	
Update on achievement of C. difficile target **Submitted on behalf of** Director of Infection Prevention and Control, Dr John Hartley	**Paper No: Attachment Q**
Aims / summary To update Board since March 2011 report.	
Action required from the meeting None	
Contribution to the delivery of NHS / Trust strategies and plan None	
Financial implications Failure to meet target may harm Foundation application	
Legal issues	
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?	
Who needs to be told about any decision Trust Board	
Who is responsible for implementing the proposals / project and anticipated timescales	
Who is accountable for the implementation of the proposal / project Director of Infection Prevention and Control	
Author and date Dr John Hartley 19/09/2011	

C difficile infection in children at GOSH 19/09/2011 John Hartley

Update to report of 17/3/2011

The total number of detections of *C. difficile* in children of all ages at GOSH has increased slightly in 2011 compared to 2010, although, as previously, most detection occurs co-incidentally or in association with mild and self limiting disease. C. difficile infection remains an ever present but well managed risk at GOSH.

Of note this year, three children (two under the age of 2 and not included in national surveillance, where testing is not recommended) have developed probable C. difficile associated disease following use of co-amoxiclav for surgical prophylaxis and treatment. Disease was not serious but treatment was given. We must continue to monitor closely whether changes in antibiotic prophylaxis policy - shifting from aminoglycosides (to avoid oto- and renal toxicity) to co-amoxiclav – alters the epidemiology of C. difficile infection.

Additionally, a true case of community acquired C. difficile caused pseudomembraneous colitis with toxic megacolon (requiring resection), was seen in a child referred to GOSH for post operative ITU care.This is the first confirmed case of serious disease cared for at GOSH in the last12 years, with one other case suspected but managed medically in this time, and confirms severe disease can occur.

Extensive surveillance, including all children with loose stool of all ages and routine surveillance, continues to show cross-infection remains rare but isolated clusters may have occurred and there were three potentially linked cases in one ward over 4 months.

An update of the children aged 2 years and over with C. difficile detected in stools since the March report is attached (Appendix 2).The number reported under the national surveillance scheme is within our expectations and previous returns, but outside the current objective (which we believe is inappropriate).

C. difficile testing and surveillance in children varies between paediatric departments in general hospitals and paediatric hospitals, this may result in variable numbers of samples tested and therefore variable detection rates by admission data. The results of the Paediatric Microbiology Group (PMG) survey in 2009 are shown in Appendix 3. This survey is currently being repeated.

Following a presentation to the Paediatric Microbiology Group, a proposal for modification of the national *C. difficile* objective was produced (shown below Appendix 1). This was submitted to the DH advisory group on healthcare associated infection (ARHAI) for discussion with the DH. Feedback was sympathetic to the proposal and, while this year's objective can not be changed, it is hoped that next years will reflect the paediatric position.

Meanwhile, it is proposed that testing at GOSH should remain at its current level as the potential for disease remains, control is assisted and surveillance provides valuable audit of infection prevention and control activity across the age groups.

John Hartley 19/9/2011

Appendix 1
Proposal for surveillance of *C. difficile* infection in children.

From the Paediatric Microbiology Group Meeting 1/4/2011.
Co-ordinator: Dr Patricia Fenton, Sheffield Children's Hospital
Presenter: Dr John Hartley, Great Ormond Street Hospital

Discussion following review and presentation of data from GOSH

Aim: To develop a consensus proposal (from microbiologists with a special interest in paediatrics) for the surveillance of *C. difficile* infection (CDI) in children for inclusion in a National CDI Objective for children.

Rational: CDI may be serious, especially in adults. It is associated with a number of risk factors, especially prior antibiotic use, and cross infection in the health care setting. In response to an increase rate of detection of CDI in adults a successful national control programme was implemented in England with standardised protocols and improvement Targets (2008-11) and a new National Objective from April 2011.

C. difficile infection is not the same in children as adults. While it is imperative that surveillance is continued and any reduction in infection sought, a National Objective should be considered separately for paediatrics.

Infection with *C. difficile* has a different epidemiology and clinical course in children compared to adults.

- Asymptomatic infection (carriage) is higher in children (especially, but not limited to, the under 2 years old)
- There has been no increase in *C. difficile* detection in those aged 2 or over since 2003
- Intensive surveillance and ribotyping shows the majority of infection detected is sporadic, often associated with other causes of diarrhoea (or asymptomatic) and almost always self limiting. Specific treatment is rarely given.

However:

- serious disease has occasionally been proven
- monitoring for cross infection is useful to help audit infection prevention and control practice.
- there may be worse outcome of infection if potentially more virulent types (e.g. ribotype 027) were to become prevalent in children
- children may potentially be a reservoir leading to adult infection.

It is therefore imperative that surveillance is performed in children. However, a paediatric national objective should be adjusted for the paediatric situation.

National Paediatric *C. difficile* Objective Proposal: Taking into account the low absolute numbers, steady state, and sporadic nature of *C. difficile* detection in children, the objective should be to maintain this situation, with leeway included in the performance target to account for natural fluctuation around the mean.

Proposal for surveillance and objective
Age limit – because of the high rate of carriage in children, especially under 2 years, surveillance should be maintained in the 2 – 17 year olds
Testing algorithm – as currently, faecal samples should be tested when children have diarrhoea of a potentially infectious aetiology (CDR Weekly Vol 13 No 40 Oct 2003)

Ribotyping – in addition to current recommended typing for cases linked by location and time, all isolates should be tested, if local CDRN can offer this service, to ensure un-recognised transmission is not occurring.

Objective – for Trust assigned cases, (aged 2 and over, in for 3 or more days when tested) the objective control limit should be set as mean of last three years plus 50%.

J C Hartley 3/6/2011

Attachment Q

Appendix 2

Children aged 2 years and above with C. difficile toxin detected in stools since March Board Report (to Sept 2011)

Days in when tested	Ribotype	Ward	
Not in	126	0	4 year post gene therapy; worsening diarrhoea; positive at local; treating
Not in	N/A	0	5 weeks diarrhoea, cause unknown; from Middle East
Not in	15	0	Post heart transplant; diarrhoea with blood in stool 3 weeks and chronic diarrhoea
Not in	20	0	Patient was seen as a day patient; 5 days post surgical jejunostomy with co-amox prophylaxis; offensive stools. Possible case but outcome not known.
0	62	1	1 month post combined liver and renal transplant; routine admission, admission stool liquid therefore tested
0	N/A	2	Post chemotherapy loose stool; self limiting; no antibiotics; last tested last year.
1	139	3	Admitted post colectomy for toxic megacolon. 3 days into acute C pox diarrhoea June neg; resected colon definite pseudomembraneous colitis
1	29	4	Aplastic anaemia, awaiting BMT; bloody diarrhoea; C dif positive local, transferred on treatment, now vanc.
1	14	1	Post urethral valves, admitted with loose stools 19t, had diarrhoea with strong smell few days before; self limiting but not gone yet. Possible CDAD.
1	NT ref Cardiff	6	Positive 8 months ago and negative between; grade 8 stool, not too frequent; treatment given therefore notify
1	106	12	Admitted for chemotherapy; loose stool; GDH pos, VIDAS neg
1	pending	2	PNET, short admission for gastrostomy and chemo; routine admission stool was liquid therefore tested; diarrhoea not mentined as an issue in discharge notes;
2	106	2	Chemotherapy, developed loose stools the day after admission; oral MTZ given therefore report
2	20	3	Laryngotracheal repair, has had diarrhoea since admission to PICU; settled while on augmentin.
2	5	5	Admitted as chronic resp condition worse, loose stool was present; no recent antibiotics. Resolving when went home.
2	23	6	Admitted for chemotherapy; admission stool liquid and WBC +++; not a clinical issue
4	5	6	Undergoing chemotherapy, on laxatives. Antibiotics started on 13th; has gone from neg to pos; subsequently treating from 20th therefore clinically possible
4	14	2	AML; frequently has loose stool, as now; admitted with it, still has and not severe; change from neg to positive home or hospital acquisition. Not treated. Not CDAD.
4	2	7	Admitted for investigatin of fever, night sweats; large cell lymphoma diagnosed; routine stool sample, although loose stool. No need to treat currently
5	54	8	Diarrhoea and fever post reversal of ileostomy; but also was constipated and given laxatives +++, and settled as soon as went home. Not CDAD.
6	1	9	Sent for viral investigation for encephalitis; diarrhoea not an issue.
7	78	10	One loose stool noted by night staff after required enema in day; stool was recorded to be formed. No diarrhoea before or after. Was post op on PTAZ/AK. Not a case of CDAD
7	5	9	Post op fever, diarrhoea, abdo pain; noro on ward, but PCR negative. Treating
7	24	7	Routine sample while on Meropenem; no loose stools. No CDAD
7	14	11	Cyclical vomiting (no diarrhoea, on laxatives) Tested by protocol. No diarrhoea. No CDAD
16	81	12	Relapse ALL; neg to pos, following antibioitcs and previous admissions
18	20	12	AML; received chemotherapy end March, and febrile neutropenic antibiotics,; stool has gone neg to positive. Treated later therefore notify
29	20	6	HD chemo; expected diarrhoea with mucositis AND self limiting despite on antibiotics, NOT CDAD. (Although recent acquisition with change neg to pos)
70	14	4	SCID post BMT; weekly screen, no change in normally loose stool; is a recent acquisition but not a case of CDAD.
94	pending	13	Awaiting heart transplant on ventricular assist; previously toxigenic C difficile in stool but toxi negative, now toxin detected but no diarrhoea. Not CDAD.
Not notified			
Notified as case			
	NT ref Cardiff	not typable at London Reference Lab, sent to National Ref lab	
		Not isolated on culture therefore not available	
	pending	isolate sent to local Reference lab and result pending	

Appendix 3

Results of survey of C. difficile testing in 4 paediatric hospitals in 2009

	Number of samples tested					Number of patients tested					Number of patients positive			
	G	AH	B	S		G	AH	B	S		G	AH	B	S
Less than 1 month old	84	3	0	NT		71	3				0	0		
1 month -12 months	588	89	< 5	NT		309	65				21	2		
13 - 24 months	351	56	< 5	NT		152	31				16	1	1	
Greater or equal to 2 years	1069	304	317	700		419	165	N/A	N/A		24	9	4	10
Positive rate in >/= 2											5.7	5.5		
All Patients	2092	452	327	700		951	264	N/A	N/A		61	12	5	10

G = GOSH; AH = Alder Hey; B = Birmingham; S = Sheffield

Attachment: R

Great Ormond Street NHS
Hospital for Children
NHS Trust

<table>
<tr><td colspan="2">Trust Board
28th September 2011</td></tr>
<tr><td>Finance and Activity Report
FIVE months to 31 AUGUST 2011

Submitted on behalf of
Claire Newton, CFO</td><td>Paper No: Attachment R</td></tr>
<tr><td colspan="2">AIM
To summarise the Trust's financial performance for the FIVE months to 31 AUGUST 2011.</td></tr>
</table>

SUMMARY

Results year to date to end of period 5

- Net surplus **£5.1M**, which is £1.1M lower than plan. On the basis of the forecast, this adverse variance will reverse as expenditure in the plan has been weighted too heavily towards the remaining period of the year
- Normalised EBITDA margin is 8% (Plan 8.9%)

Forecast

The forecast out-turn remains in line with 'Plan' at **£7.1m** pre-impairment, although both income and expenditure are forecast to be higher than planned values. The impairment is in respect of the revaluation of Phase 2A from cost to MEA value.

Risks / Issues

The most significant risks in delivering the forecast are:

- achievement of the Trust's CRES plan;
- managing Phase 2A double running costs in line with Plan;
- managing commissioning contracts to ensure activity delivered is appropriately reimbursed;
- containing the higher than planned levels of agency staff although this is currently primarily to deliver planned activity;
- ensuring R&I income shortfall is made up from the new sources being pursued.

In addition the Trust's international income is currently very close to the private patient cap due to overperformance of International clinical income. Action is being taken to manage it going forward below the cap, pending any changes in the forthcoming legislation.

Activity

NHS & IPP activity is generally above plan and for the same period last year. Exceptions to this are some NCG services where the year to date adverse activity variances are likely to reverse, packages of care where activity is forecast to end the year below plan and overseas (EC etc) activity which can be very volatile as it is typically high value low volume.

Ratios (FT)

- Overall FT score of **4** for year to date (this has increased from 3 as the Trust is currently scoring higher on Operating Margin and ROA than previously although this is a temporary position
- Forecast score is **3**

BPCC performance (Non NHS – cumulative)

- Total payables – Value 86.4% (range in year to date 82-86.7)

- Total payables – Number 88% (87.3% previous month)

CRES 2011/12

- The target of £15.7M is fully met by schemes and the risk adjusted value of those schemes is in line with plan at £10.4M.

CRES 2012/13

- Schemes totalling £15.4M have been identified against a target of £16M: and the risk adjusted value is assessed to be sufficient if realised.

CRES 2013/14

- Schemes total £13.7M an increase of £1.9M since last month v Target of £16M

CRES 2014/15+2015/16

- A total of £24M of potential schemes have been identified over these two years

Capital

- Capital spend is £20.9M; £1.2M lower than plan YTD
- The Trust is £2M behind on donated capital spend, mainly redevelopment, and £0.8M ahead on owned capital

Statement of Financial Position (Balance sheet)

- Non Current Assets increased by £1.6M to £344.5M as a result of further asset additions net of depreciation
- Current assets decreased by £3.5M as a result normal cyclical receipts coupled with some clearance of long outstanding NHS debt
- Current liabilities decreased by £4.2M primarily normal cyclical reduction of deferred income and there was a £1m reduction in capital creditors (mainly redevelopment)
- Cash balances were approximately £1.6M lower than forecast at £21.7M affected by the higher than planned year to date Trust funded capital expenditure, the initiative to clear off old creditors and a slight lengthening of IPP debtor days

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 09 September 2011

PERIOD 5 - 2011/12 FINANCE REPORT

(1) Year to date (5 months)

The year to date surplus is £5.1M, £-1.1m below plan. Income is above Plan by £0.5M and expenditure below Plan by £1.6M but it is now believed that planned expenditure was weighted too heavily into the Plan for the remaining months of the financial year.

An analysis of the variance in net surplus to Plan is as follows:

	Core excl. Int	International	TOTAL
	£'M	£'M	£'M
Income	0.1	0.2	0.5
Expenditure	-0.9	-0.5	-1.6
Net variance	**-0.8**	**-0.3**	**-1.1**

(2) Forecast position

The forecast position has been arrived at by projecting forward the underlying performance in the 5 months to date, after adjusting for Haringey community services, and adding the estimated impact of recent service developments, future CRES realisation and the additional costs relating to 2A which are phased into the final quarter.

The adverse variance ytd is forecast to reverse as the non-pay expenditure budget was too heavily weighted into the second part of the year, even after taking into account Phase 2A costs.

(3) Variance summary

3.1 Expenditure overview

Pay is £1.6 higher than budget at £79.8M.
The overall pay variance taking employed and agency costs together arises primarily on junior doctors & nursing. The level of vacancies being covered by agency staff is higher than expected in these areas, although overall use of medical agency has reduced since last year due to the introduction of the Medical Bank.

Non Pay expenditure is £0.1 higher than budgeted at 46.3M higher than budget (excluding depreciation, PDC and interest).The principal variances are ;

- Lower drugs and blood costs, some of the latter relates to patients transferred to clinical trials and lower metabolic drug activity
- Under spend on clinical supplies related to spinal implants and devices, lower consultancy costs, lower premises costs associated with phase 2A and lower education and charity costs.

3.1.1 Pay

Pay expenditure totals £79.8M, £1.6M higher than plan and £3.3M higher than last year for the continuing business, ex Haringey staff. With pay increments an average of 2.5% due to

increments, this suggests that staff numbers have grown by almost 2%, most notably in the Cardiac and ICI/LM units to deliver planned growth in activity. There has also been growth in IT/Finance corporate staff numbers due to use of temporary staff to cover absences and non-recurring projects.

	11/12 YTD Budget £'M	11/12 YTD Actual £'M	*11/12 YTD Variance to Plan £'M*	10/11 YTD £'M	*Variance to 10/11 YTD £'M*
Consultants	-15.2	-15.0	*0.3*	-14.5	*-0.5*
Junior medical	-7.7	-8.7	*-0.9*	-8.3	*-0.4*
Nurses	-23.9	-25.0	*-1.1*	-23.2	*-1.8*
Sci/Therapeutic	-13.7	-13.8	*0.0*	-13.0	*-0.8*
Managers/admin	-14.7	-14.7	*0.0*	-13.9	*-0.8*
Other	-1.5	-1.2	*0.3*	-1.9	*0.7*
Core ex H	-76.8	-78.3	*-1.6*	-75.0	*-3.3*
Haringey	-1.5	-1.5	-	-4.6	3.1
Core ex Haringey	-78.3	-79.8	-1.6	-79.6	-0.2

- **Agency costs**

Junior doctors	£0.6M	
Nursing	£1.0M	
Sci, Ther, Tech	£0.75M	
Non-clinical	£1.9M	Total £4.3M (5.3% pay)

3.1.2 Non pay

Non-pay expenditure is £46.1M, in line with plan including the, as yet, unallocated non-pay CRES target of £4.3M. Items which include pass through (drugs, bloods and clinical supplies exclusions) are on aggregate £1.8M under plan of which c £0.9M is pass through expenditure.

Non-pay excluding pass through items is over Plan by £0.9M due in part to activity being over plan and in part due to the phasing of non pay planned expenditure being weighted disproportionately into the remaining periods of the financial year.

3.2 Revenue

3.2.1 Overview

Income is £0.5M lower than plan at £139.5M.

Category	Annual Budget £M	YTD Budget £M	YTD Actual £M	YTD Variance £M
NHS Revenue Activity	256.1	104.5	106.9	2.4
Activity Revenue Non Nhs	31.4	13.1	13.0	-0.1
Other Operating Revenue	51,5	21.5	19.6	-1.8
Grand Total	339.1	139.2	139.5	0.5

- NHS income is £2.4M above budgeted levels. Pass through income (drugs, blood & implants) are behind plan and if these are excluded NHS activity income is ahead of budget by c £3.3M although the majority of this will be assumed to contribute towards meeting budgeted CRES targets.
    - PBR income is ahead of plan with strong impatient activity across a number of units including high cardiac activity

- Non PBR income is ahead of plan with most bed day activity, consortium activity and outpatients ahead, whilst activity for bilateral cochlear activity and spinal income are below planned levels.
- IPP is ahead of plan by £0.4M
- Charity funding is £0.7M behind, a phasing difference only, and R&D funding is behind plan as the NIHR annual award on CLRN was lower than anticipated in the plan

3.2.2 NHS Revenue

PCT Tariff Income is £1.2M ahead of Plan & associated MFF £0.3M ahead of Plan

The variance includes £0.2M of income relating to 2010/11 activity. Current year inpatient activity remains £1M higher than plan. There are high than planned levels of cardiac surgery income, ICI - ahead in a number of areas, Neurosurgery and surgery. Outpatient activity is behind plan by £50K.

PCT Non-Tariff Income is 1.4M ahead of Plan
PCT and Consortium pass-through drugs usage is £0.8M below plan, this is due to low Factor 8 blood usage where patients switched on to clinical trials.

Inpatient activity is behind in respect of bilateral cochlear implant activity (although this is offset by positive variances on unilateral in PbR) as well as spinal activity and there are areas of Neurosciences and Medicine that are also contributing to the under-performance in this category

Other Bed-days activity is £0.7M ahead of plan and in month there was a marked increase reflecting high CICU and PICU activity in July and a higher estimate for August.

'Packages of care' income is £0.2M behind plan.
Overseas E112 income is £0.5M behind plan, mainly in Surgery and Cardiac.

3.2.3 Non NHS Revenue
Non NHS Clinical revenue is £0.1M behind plan. Non English activity is behind plan by £0.5M and this offsets the over performance under PCT revenue.
Private patient income is £0.4M ahead of plan.

3.2.4 Other operating revenue
Overall this income category is £1.9M behind plan. The principle variances are in respect or R+I income and charity income.

- R+I income is below budget but there should be new sources of income to offset part of this variance later in the year. Charity income is lower than expected but this will recover later in the year as expenditure is incurred and funded.
- There are also a variety of other areas with lower income levels including salary recharges and hospice income.

(4) CIP/CRES
4.1 Summary

Status	2011/12 £M	2012/13 £M	2013/14 £M
BLUE	1.60	0	0.00
GREEN	5.05	0.42	0.07
AMBER	9.40	6.77	0.38
RED	0.037	6.50	15.45
Total	**16.08***	**13.69**	**15.90**
Target	15.77	16.0	16.0
Variance	0.31	-2.31	-0.10

***The risk adjusted value is approximately 10.3M**
The Trust has also commenced the collection of CIP schemes for 2014/15 and 2015/16. For the two years combined these currently total £24.0M and as would be expected at this point, the majority are red schemes.

(5) CAPITAL PROGRAMME AND CRL

5.1 The Trust is expecting to meet its capital target (total capital expenditure excluding expenditure funded by donations) of £13.8M for the full year.

5.2 Overview

The Trust's capital plan including expenditure funded by donations is £55.9M with planned expenditure for the five months ending 31 August amounting to £22.1M. The total spend to date amounts to £20.9M representing an under spend to date of £1.2M.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Hospital Redevelopment	36.3	17.2	14.9	2.3
Estates Maintenance Projects	9.0	2.2	2.9	(0.7)
IT Related Projects	7.0	1.8	1.3	0.5
Medical Equipment Purchases	3.6	0.9	1.8	(0.9)
Total Additions in Year	**55.9**	**22.1**	**20.9**	**1.2**
Asset Disposals	0	0	0	0
Donated Funded Projects	(42.1)	(18.7)	(16.7)	(2.0)
Net capital plan	**13.8**	**3.4**	**4.2**	**(0.8)**

5.3 Redevelopment

Redevelopment projects are currently under spent by £2.3M, but cost estimates provided by Gardiner & Theobald indicate that the current budget will be utilised for the full year as planned.This includes a budget for Phase 2B enabling works for which there are no costs yet recorded

An additional £0.8M of phase 2B fees is not included above but is expected to be spent in this year, funded by donations.

(6) STATEMENT OF FINANCIAL POSITION (SOFP)

6.1 Non Current Assets

Non Current Assets at the end of August 2011 totalled £344.5M, a net increase of £1.6M; this increase was a combination of capital additions net of depreciation reductions. There were no disposals or impairments.

6.2 Current Assets (excluding Cash & Cash Equivalents) – decrease £3.5M in month

NHS Trade Receivables (£4.8M decrease)	This is mainly due to receipts relating to quarterly billed invoices to the SHA which includes NCG Income and also receipts from old debts.
Non NHS (International)	Substantially unchanged
Non NHS Capital Receivables (£0.2M increase)	This represents an increase in Redevelopment and medical equipment expenditure to be recharged to the Trustees.
Prepayment and Accrued Income (£0.8M increase)	This relates to IPP work in progress income, invoices paid in advance and income relating to NHS recharges and Trustees Research & Innovation to be invoiced in September.

6.3 Current Liabilities - decrease by £4.2M in month

NHS Trade Payables (£1.3 increase)	This mainly represents 3 invoices from UCLH NHS Foundation Trust and invoices from NHS Blood and Transplant and NHS Supplies which were received in month.
Deferred revenue (£2.8M decrease)	Representing quarterly income received in July which relates to the entire second quarter.
Capital Payables (£1.1 decrease)	This decrease is due to timely payment of invoices.
Other Payables (£0.5 increase)	This represents an additional month of PDC accrual.
Expenditure Accrual (£1.3M decrease)	This represents a decrease in the accrual of Pharmacy invoices as well as a decrease in Factor 8 Consortium accrual.

(7) WORKING CAPITAL MANAGEMENT

Payables – good improvement in BPCC, old outstanding balances are being cleared

Receivables:

- NHS debtor days – reduced back to 15 after a temporary issue last month was resolved
- IPP debtor days – increased from 98 to 101 (delays in payments due to Middle East public holidays)

Cash

The Trust had cash holdings of £21.7m at the close August 11, and had operating cash balances of between £22.2m and £43.6m throughout the month. Cumulative commercial bank account balances at £0.02M was in line with the DH target maximum holding of £0.05M.

(8) FINANCIAL RISK RATIOS

The current overall score is 4 and forecast score is 3. These are the required level of scores expected by MONITOR.

Month 5	Score
EBITDA Margin	4
EBITDA Achieved	4
ROA	4
I and E surplus margin	5
Liquidity days	3
Weighted average	3.7
Overall Score	**4**

The forecast score for the full year is 3.

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
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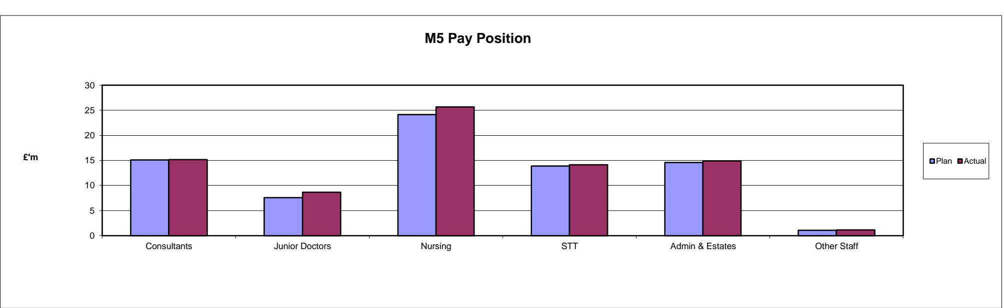
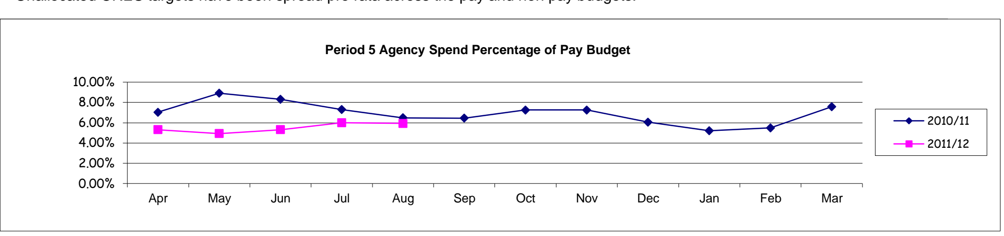
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Trust Summary

Statement of Comprehensive Income

	Current Month		YTD	
		Plan		Plan
	Actual	Variance	Actual	Variance
	£000	£000	£000	£000
Revenue				
Revenue from patient care activities	23,005	(627)	120,042	2,404
Other operating revenue	3,849	(442)	19,612	(1,895)
Operating expenses	(25,286)	184	(132,143)	(1,688)
Operating surplus	**1,568**	**(885)**	**7,511**	**(1,179)**
Investment revenue	5	2	31	16
Other gains and (losses)	0	0	0	0
Finance costs	(3)	(1)	(17)	(7)
Surplus for the financial year	**1,570**	**(884)**	**7,525**	**(1,170)**
Public dividend capital dividends payable	(480)	0	(2,402)	0
Retained surplus for the year	**1,090**	**(884)**	**5,123**	**(1,170)**
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	2,464	100	16,696	(1,959)
Reclassification adjustments:				
- Transfers from donated and government grant reserves	(519)	27	(2,540)	50
Total comprehensive income for the year	**3,035**	**(757)**	**19,279**	**(3,079)**



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



Staffing	**WTE**	**Maternity**	**Temp**	**Overtime**	**Total**	**Last yr, ytd**
Staff Numbers	**Paid**	**Paid**	**Paid**	**Paid**	**Paid**	**Paid**
Admin and Other Support	799	12	78	8	897	889
Clinical Support	668	28	37	4	737	757
Medical	471	17	40	0	528	493
Nursing	1,200	80	144	3	1,428	1,427
Total	**3,137**	**137**	**300**	**15**	**3,590**	**3,566**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 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	22,213	23,359	420	(12,398)	(13,748)	(1,040)	(620)
Surgery	26,529	26,737	(847)	(24,675)	(25,001)	(1,323)	(2,170)
DTS	531	515	(278)	(7,905)	(8,331)	(207)	(484)
ICI	23,186	23,584	(930)	(21,215)	(23,133)	(614)	(1,543)
International	9,634	12,808	288	(3,867)	(5,188)	(489)	(202)
Medicine	16,736	17,534	(1,016)	(15,814)	(15,858)	95	(921)
Neurosciences	10,934	11,250	207	(8,275)	(9,025)	(383)	(175)
Haringey	4,301	1,590	7	(4,350)	(1,519)	64	71
North Mid.	676	(3)	(3)	(677)	(29)	(29)	(31)
Total Clinical Units	**114,742**	**117,376**	**(2,151)**	**(99,176)**	**(101,832)**	**(3,925)**	**(6,076)**
Central Departments							
Operations & Facilities	837	608	(55)	(7,240)	(6,097)	(232)	(287)
Corporate Affairs	28	23	(14)	(560)	(614)	99	85
Estates	269	265	21	(5,164)	(4,881)	(305)	(284)
Finance & ICT	67	83	2	(4,130)	(4,662)	(210)	(208)
Human Resources	261	278	(25)	(1,134)	(1,097)	88	62
Medical Director	46	8	(56)	(1,642)	(1,663)	(32)	(88)
Nursing And Workforce Development	867	787	30	(2,280)	(2,140)	198	228
Research And Innovation	4,866	5,402	(813)	(2,278)	(2,188)	581	(231)
Redevelopment Revenue Costs	208	191	(181)	(208)	(191)	94	(87)
Total Central Departments	**7,449**	**7,645**	**(1,091)**	**(24,635)**	**(23,533)**	**280**	**(811)**
Depreciation & Dividends	3,137	2,540	50	(8,451)	(8,340)	(60)	(10)
Centrally held development reserves and cres funding	**10,497**	**12,093**	**3,700**	**(901)**	**(826)**	**2,026**	**5,727**
Net Position	**135,824**	**139,654**	**509**	**(133,163)**	**(134,531)**	**(1,679)**	**(1,170)**

* Cardiac, Surgery & Neuro expenditure variances have been adjusted to reflect centrally held growth funding to be transferred in M6.

CRES 2011/12		Analysis of CRES Scheme Deliverability					
	TARGET	Released from Budgets	Deliverable Schemes	Feasible Schemes	Potential Schemes	Scheme Above Target NET	Total Risk
CRES 2011/12 Target	15,773	1,607	5,057	9,408	37	-336	14,166
Status		Delivered	RISK	RISK	RISK	RISK	
Recurrent 2011/12		1,556	5,038	9,170	37		
Non recurrent 2011/12		51	19	238	0		
Expenditure		993	2,607	2,973	27		
Income		614	2,450	6,435	10		
CRES 2012/13	16,000	0	429	6,773	6,502	2,296	16,000
CRES 2013/14	16,000	0	71	382	15,450	97	16,000
CRES 2014/15	16,000	0	60	409	11,146	4,385	16,000
CRES 2015/16	16,000	0	0	623	11,805	3,572	16,000

Analysis	Month 5			*	Month 5 New CRES	Schemes in progress		Schemes to be Developed	
CLINICAL	Target	BLUE	Variance	Posts released	New BLUE	On target (Green)	Feasible (Amber)	Potential (Red)	Unidentified (if -tive overachieved)
Cardiac	2,073	0	-2,073	0.00	0	286	2,026	0	-239
ICI	2,164	366	-1,798	2.00	366	1,067	877	0	-146
IPP	664	231	-433	0.00	231	627	145	0	-339
MDTS	2,622	31	-2,591	1.20	0	1,210	1,484	0	-103
Neurosciences	1,418	57	-1,361	0.00	11	612	599	0	150
Surgery	3,357	31	-3,326	1.00	0	556	2,649	0	121
Total	**12,298**	**716**	**-11,582**	**4.20**	**608**	**4,358**	**7,780**	**0**	**-556**
CORPORATE									
Clinical Ops	154	48	-106	0.00	0	132	10	0	-36
Corporate Facilities	1,026	450	-576	11.10	0	95	337	20	124
Corporate Affairs	121	121	0	0.00	0	0	10	0	-10
Estates	783	57	-726	0.00	0	217	465	0	44
Finance	732	0	-732	0.00	0	142	510	0	80
Medical Director	151	0	-151	0.00	0	0	103	7	41
Nursing and Education	283	114	-169	0.58	32	113	96	0	-40
HR	192	100	-92	0.00	0	0	61	10	21
Reseach and Development	34	0	-34	0.00	0	0	35	0	-1
Total	**3,475**	**891**	**-2,586**	**11.68**	**32**	**699**	**1,628**	**37**	**220**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 05 2011/12
Revenue Statement

	11/12 Annual Budget £000	11/12 Mth 05 Actual £'000	11/12 Mth 05 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	**5,474**	-54	**27,807**	1,156	**2,598**
Primary Care Trusts Non Tariff	120,130	**9,432**	-165	**48,578**	1,418	**298**
Primary Care Trusts Mff	18,754	**1,595**	-16	**8,109**	342	**30**
Strategic Health Authorities	45,155	**3,183**	-579	**18,713**	-101	**1,165**
Nhs Trusts	874	**-10**	-83	**283**	-81	**-599**
Department Of Health	850	**45**	-26	**250**	-104	**-139**
Nhs Other	5,993	**369**	-1	**3,254**	-146	**-520**
Activity Revenue Nhs	**256,105**	**20,089**	**-925**	**106,993**	**2,483**	**2,832**
Local Authorities	168	**0**	0	**151**	-17	**-270**
Private Patients	27,669	**2,451**	152	**11,695**	231	**2,245**
Non Nhs Other	3,602	**289**	-31	**1,027**	-469	**-255**
Activity Revenue Non Nhs	**31,439**	**2,740**	**122**	**12,873**	**-255**	**1,720**
Patient Transport Services	1,216	**70**	-31	**448**	-59	**-98**
Education And Training	13,386	**1,071**	-47	**5,691**	26	**630**
Research And Development	13,364	**1,032**	-82	**5,074**	-495	**119**
Charitable & Other Contrib	5,278	**333**	-127	**1,492**	-682	**-699**
Depreciation Income Transfer	6,773	**519**	27	**2,540**	50	**-597**
Non Patient Care Services	3,631	**280**	-22	**1,551**	38	**308**
Revenue Generation	1,802	**131**	-19	**678**	-73	**135**
Other Revenue	6,088	**412**	-141	**2,138**	-701	**-695**
Other Operating Revenue	**51,538**	**3,849**	**-441**	**19,612**	**-1,895**	**-898**
Directors & Senior Managers	-8,721	**-705**	15	**-3,512**	164	**-261**
Consultants	-37,047	**-3,103**	-7	**-15,154**	257	**-296**
Junior Doctors	-18,612	**-1,544**	42	**-8,041**	-312	**-802**
Junior Doctors Agy	11	**-204**	-205	**-614**	-618	**817**
Administration & Estates	-25,993	**-1,904**	279	**-9,549**	1,397	**-533**
Administration & Estates Agy	-629	**-348**	-295	**-1,842**	-1,580	**414**
Healthcare Assist & Supp	-2,252	**-191**	-3	**-937**	1	**-47**
Healthcare Assist & Supp Agy	0	**-20**	-20	**-67**	-67	**106**
Nursing Staff	-58,010	**-4,809**	50	**-24,735**	-160	**-301**
Nursing Staff Agy	-21	**-184**	-183	**-987**	-978	**7**
Scientific Therap Tech	-32,949	**-2,565**	169	**-13,403**	689	**-126**
Scientific Therap Tech Agy	-53	**-178**	-174	**-752**	-730	**133**
Other Staff	-295	**-18**	7	**-116**	7	**-11**
Pay Reserves	-4,530	**-92**	280	**-112**	1,776	**632**
Cips And Cres Unidentified - P	3,383	**0**	-282	**0**	-1,410	**0**
Pay Costs	**-185,717**	**-15,865**	**-326**	**-79,821**	**-1,565**	**-267**
Drugs Costs	-34,709	**-2,104**	309	**-13,577**	837	**-1,119**
Blood Costs	-18,485	**-1,550**	96	**-6,996**	681	**338**
Supplies & Services - Clinical	-23,909	**-1,505**	542	**-9,938**	269	**-169**
Services From Nhs Organisation	-4,147	**-370**	-2	**-1,484**	238	**302**
Healthcare From Non-Nhs Bodies	-1,959	**-102**	65	**-738**	77	**-283**
Supplies & Services - General	-1,468	**-72**	52	**-648**	-37	**290**
Consultancy Services	-1,357	**-143**	-30	**-419**	147	**-21**
Clinical Negligence Costs	-1,950	**-162**	0	**-812**	0	**-98**
Establishment Costs	-2,800	**-165**	98	**-1,016**	160	**44**
Transport Costs	-2,883	**-247**	-8	**-1,078**	131	**12**
Premises Costs	-19,318	**-1,313**	314	**-7,680**	559	**-115**
Auditors Costs	-420	**-30**	5	**-148**	27	**-27**
Education And Research Costs	-2,293	**-101**	90	**-438**	522	**89**
Expenditure - Other	-4,581	**-151**	239	**-1,196**	723	**-247**
Non Pay Reserves	-13,809	**0**	-225	**0**	202	**0**
Cips And Cres Unidentified - N	10,754	**0**	-837	**0**	-4,481	**0**
Non Pay Costs	**-123,332**	**-8,016**	**708**	**-46,169**	**55**	**-1,004**
P & L On Disp Of Fixed Assets	0	**0**	0	**0**	0	**44**
Fixed Asset Impair & Reversals	-5,571	**0**	0	**0**	0	**228**
Depreciation & Amortisation	-17,164	**-1,221**	-34	**-5,937**	-61	**-199**
Interest Receivable	36	**5**	2	**31**	16	**10**
Other Revenue / Expenditure	-24	**-3**	-1	**-17**	-7	**-3**
Pdc Dividend Payable	-5,765	**-480**	0	**-2,402**	0	**39**
Corporation Tax	-234	**-8**	12	**-40**	58	**-40**
Other Revenue / Expenditure	**-28,723**	**-1,707**	**-21**	**-8,365**	**6**	**78**
Retained Surplus / (Deficit)	**1,309**	**1,090**	**-884**	**5,123**	**-1,170**	**2,462**

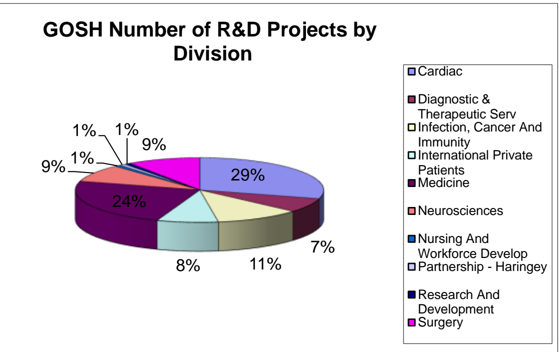
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Research and Development Activity

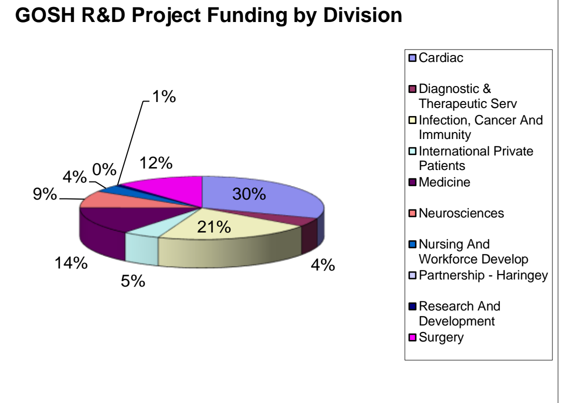
	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
Biomedical Research Centre including Clinical Research Facility				
- Income	(7,834)	(7,861)	(2,981)	(294)
- Income deferred from 10-11	(21)	(21)	(9)	0
- Commercial Trials Income	(295)	0	(64)	64
- Expenditure	2,812	2,811	905	267
	(5,339)	(5,070)	(2,149)	37
CLRN (PCRN) Income				
- Income CLR Activity Based (Non DH R&D)	(1,186)	(1,186)	(220)	(274)
- 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	(47)
- Expenditure CLR	100	198	100	(18)
	(1,269)	(1,100)	(144)	(315)
NIHR GRANTS				
- Income	(838)	(838)	(233)	(116)
- Expenditure	838	838	233	116
	0	0	(0)	0
R&D GOSH Charity Funded Projects				
- Income	(919)	(919)	(409)	(88)
- Expenditure	754	754	336	76
	(165)	(165)	(73)	(12)
R&D Development Office & Other Grants				
- Income Charitable Contribution	(600)	(770)	(67)	(178)
- Income non R&D	0	0	(5)	
- Income R&D including Flexibility and Sustainability	(2,504)	(2,479)	(1,024)	145
- Expenditure	1,133	1,354	244	164
	(1,971)	(1,895)	(852)	131
TOTAL RESEARCH & DEVELOPMENT DIRECTORATE				
- R&D Income	(12,545)	(13,247)	(4,898)	(622)
- R&D Income Deferred from 10-11	(21)	(21)	(9)	0
- R&D Charitable Contribution	(1,519)	(1,689)	(477)	(203)
- Non Research Income	(295)	(16)	(19)	12
- Expenditure	5,636	6,743	2,188	581
	(8,744)	(8,230)	(3,214)	(232)
- Expenditure in Clinical Areas	8,673	8,673	3,614	(0)
Total R&D Division	(71)	443	400	(232)
Devolved Income				
- DTS : From CLRN Service Support	(76)	(218)	(41)	(50)
- Medicine : Grants	(147)	(60)	(75)	50
- ICI : From CLRN Support / NIHR Felowships	(81)	(67)	(48)	20
- Surgery : From Charitable Donation	(3)	0	(2)	2
Total Centrally Held and Devolved Income	(307)	(345)	(166)	22
TOTAL R&D INCOME				
-R&D Income Excluding Hosted network	(12,872)	(12,497)	(4,855)	(599)
-Income Generation GOS / Direct Credits	0	248	0	104
Total Income	(12,872)	(12,248)	(4,855)	(496)
Local Research Network MCRN *				
- Income DH to fund Network	(629)	(629)	(219)	(106)
- 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)	0	(3)
- Expenditure LRN	788	788	219	(24)
	0	0	(0)	0

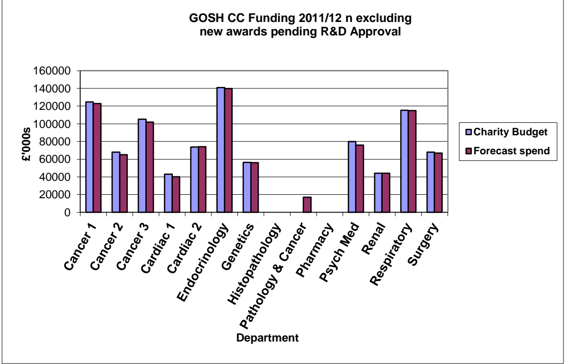
* GOSH is Hosting this service for Central and North East London

	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
TOTAL R&D INCOME (as per Board Report)				
- R&D Income	(13,643)	(13,364)	(5,074)	(495)

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 5 2011/12
Ratio Analysis

Provider Agency Rating	Target for FT Status	M5 11/12 Actual - FT	M04 11/12 Actual - FT	Forecast Outurn - FT	M5 FT Score
EBITDA Margin	5%	9.7%	9.5%	8.7%	4
EBITDA % Achieved	70%	92.0%	97.1%	100.0%	4
ROA	3%	5.2%	5.2%	3.8%	4
I&E Surplus margin	1%	3.7%	3.6%	2.0%	5
Liquidity Days	15.0	15	14	10	3
Weighted Average	3.0	4.0	3.7	3.2	4.0
Overall Rating	**3**	**4**	**3**	**3**	4
IPP Cap (Max 9.7%)	9.7%	9.6%	9.5%	9.4%	

Salary Overpayments		
Unit	**No.**	**Amount £'000**
MDTS	2	5.3
Cardiac	1	3.8
Nursing	1	0.3
TOTAL	4	9.4

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Statement of Financial Position

	Actual as at 1 April 2011 £000	Actual as at 31 July 2011 £000	Actual as at 31 August 2011 £000	Change in month £000
Non Current Assets :				
Property Plant & Equipment - Purchased	177,238	178,146	177,907	(239)
Property Plant & Equipment - Donated	141,526	153,790	155,693	1,903
Property Plant & Equipment - Gov Granted	363	342	337	(5)
Intangible Assets - Purchased	972	1,168	1,181	13
Intangible Assets - Donated	25	23	17	(6)
Trade & Other Receivables	9,505	9,358	9,319	(39)
Total Non Current Assets :	***329,629***	***342,827***	***344,454***	***1,627***
Current Assets :				
Inventories	5,156	5,555	5,520	(35)
NHS Trade Receivables	7,455	21,352	16,510	(4,842)
Non NHS Trade Receivables	10,360	9,142	9,231	89
Capital Receivables	6,571	6,912	7,152	240
Provision for Impairment of Receivables	(1,498)	(1,649)	(1,829)	(180)
Prepayments & Accrued Income	4,919	5,769	6,612	843
HMRC VAT	1,895	359	752	393
Other Receivables	807	815	764	(51)
Cash & Cash Equivalents	32,371	21,114	21,747	633
Total Current Assets :	***68,036***	***69,369***	***66,459***	***(2,910)***
Total Assets :	**397,665**	**412,196**	**410,913**	**(1,283)**
Current Liabilities :				
NHS Trade Payables	(7,722)	(3,411)	(4,738)	(1,327)
Non NHS Trade Payables	(2,519)	(3,110)	(2,669)	441
Capital Payables	(12,179)	(7,588)	(6,478)	1,110
Expenditure Accruals	(14,866)	(12,155)	(10,861)	1,294
Deferred Revenue	(6,280)	(13,376)	(10,542)	2,834
Tax & Social Security Costs	(4,022)	(3,921)	(3,939)	(18)
Other Payables	0	(1,922)	(2,402)	(480)
Payments on Account	(228)	(228)	(228)	0
Lease Incentives	(400)	(400)	(400)	0
Other Liabilities	(2,754)	(3,433)	(3,118)	315
Provisions for Liabilites & Charges	(2,867)	(2,700)	(2,635)	65
Total Current Liabilities :	***(53,837)***	***(52,244)***	***(48,010)***	***4,234***
Net Current Assets	**14,199**	**17,125**	**18,449**	**1,324**
Total Assets Less Current Liabilities :	**343,828**	**359,952**	**362,903**	**2,951**
Non Current Liabilities :				
Lease Incentives	(7,327)	(7,194)	(7,160)	34
Provisions for Liabilites & Charges	(1,250)	(1,234)	(1,237)	(3)
Total Non Current Liabilities :	***(8,577)***	***(8,428)***	***(8,397)***	***31***
Total Assets Employed :	**335,251**	**351,524**	**354,506**	**2,982**
Financed by Taxpayers' Equity :				
Public Dividend Capital	124,732	124,732	124,732	0
Retained Earnings	16,869	20,959	22,064	1,105
Revaluation Reserve	48,623	48,564	48,549	(15)
Donated Asset Reserve	141,551	153,813	155,710	1,897
Government Grant Reserve	363	342	337	(5)
Other Reserves	3,114	3,114	3,114	0
Total Taxpayers' Equity :	**335,251**	**351,524**	**354,506**	**2,982**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Statement of Cash Flow

Statement of Cash Flows	Actual For Month Ending 31 August 2011 £000	Actual For YTD Ending 31 August 2011 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	1,569	7,511
Depreciation and Amortisation	1,221	5,938
Transfer from Donated Asset Reserve	(514)	(2,514)
Transfer from the Government Grant Reserve	(5)	(26)
Decrease/(Increase) in Inventories	35	(364)
Decrease/(Increase) in Trade and Other Receivables	3,787	(7,915)
Decrease in Trade and Other Payables	(3,224)	(2,660)
(Decrease)/Increase in Other Current Liabilities	(349)	197
Decrease in Provisions	(66)	(262)
Net Cash Inflow/(Outflow) from Operating Activities :	***2,454***	***(95)***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	5	31
Payments for Property, Plant and Equipment	(3,941)	(26,463)
Payments for Intangible Assets	0	(212)
Net Cash Outflow from Investing Activities :	**(3,936)**	**(26,644)**
NET CASH OUTFLOW BEFORE FINANCING :	**(1,482)**	**(26,739)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Other Capital Receipts	2,115	16,115
Net Cash Inflow from Financing :	**2,115**	**16,115**
NET DECREASE IN CASH AND CASH EQUIVALENTS :	**633**	**(10,624)**

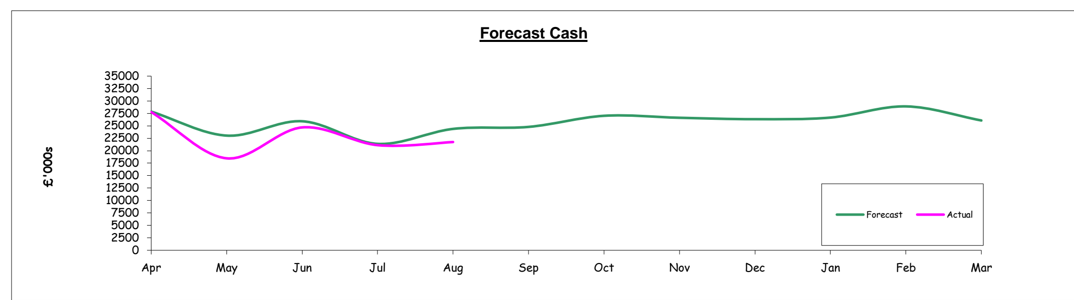
Cash and Cash Equivalents at the Beginning of the current period	**21,114**	**32,371**
Cash and Cash Equivalents at the End of the current period	**21,747**	**21,747**
Net Increase/ (Decrease) in Cash and Cash Equivalents per SOFP :	**633**	**(10,624)**

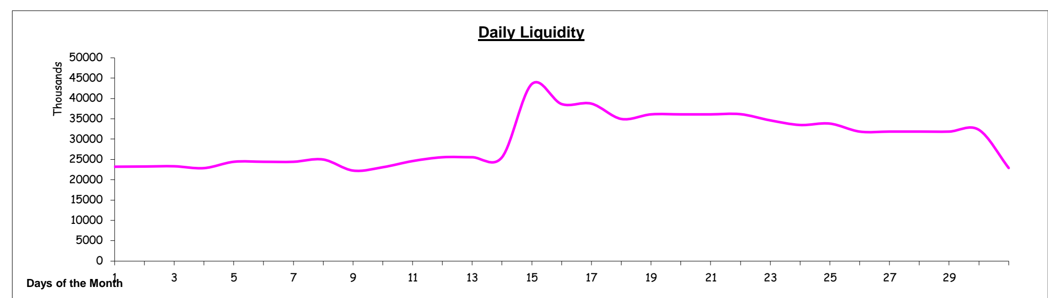
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report August 2011/2012
Activity

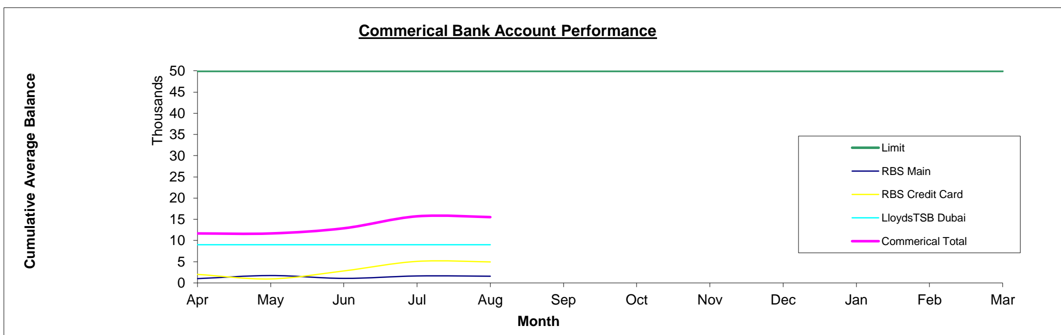
August activities are based on April to July

	April	May	June	July	August	September	October	November	December	January	February	March	YTD 11/12 Actual	YTD 11/12 Plan	YTD 11/12 Variance	YTD 10/11	Variance 11/12 to 10/11
Elective PBR	1,427	1,505	1,667	1,528	1,663								7,790	7,492	298	7,275	515
Elective Non PBR	106	151	160	138	151								706	953	-247	714	-8
Same Day PBR													0	0	0	0	0
Same Day Non PBR													0	0	0	0	0
TOTAL ELECTIVE	1,533	1,656	1,827	1,666	1,814	0	0	0	0	0	0	0	8,496	8,445	51	7,989	507
Non Elective PBR	298	203	219	306	261								1,287	750	537	880	407
Non Elective Non PBR	3	1	1	2	2								9	22	-13	14	-5
TOTAL NON ELECTIVE	301	204	220	308	263	0	0	0	0	0	0	0	1,296	772	524	894	402
Outpatients PBR	5,604	6,732	7,578	6,707	6,601								33,222	33,194	28	27,748	5,474
Outpatients Non PBR	4,282	4,842	5,077	4,920	4,439								23,560	23,333	227	25,020	-1,460
TOTAL OUTPATIENTS	9,886	11,574	12,655	11,627	11,040	0	0	0	0	0	0	0	56,782	56,527	255	52,768	4,014
POC (Non Consortium)	812	799	816	803	808								4,038	4,391	-353	4,586	-548
BEDDAYS (includes PICU Consortium)																	
Panda HDU (PBR HDU)	744	622	757	901	821								3,845	3,608	237	3,513	332
Transitional Care	140	176	139	164	157								776	625	151	625	151
Rheumatology Rehab	145	194	216	218	196								969	922	47	903	66
CAMHS	214	239	252	251	243								1,199	1,230	-31	1,141	58
Cardiac ECMO	17	6	19	0	11								53	39	14	40	13
Neurosurgery HDU (NC)	0	11	0	7	5								23	16	7	16	7
Neurosurgery (PICU Consortium-ITU & HDU)	2	51	100	94	63								310	323	-13	319	-9
Neurosurgery ITU (NC)	1	0	0	12	3								16	9	7	9	7
Cardiac HDU (NC)	33	28	42	54	40								197	171	26	165	32
Cardiac ITU (NC)	61	101	146	102	104								514	481	33	566	-52
Cardiac (PICU Consortium-ITU & HDU)	251	165	179	341	238								1,174	1,047	127	1,000	174
Paediatric ITU (NC)	48	68	71	44	59								290	347	-57	275	15
Paediatric ITU (PICU Consortium-ITU)	399	367	374	446	403								1,989	1,958	31	1,904	85
TOTAL BEDDAYS	2,055	2,028	2,295	2,634	2,343	0	0	0	0	0	0	0	11,355	10,776	579	10,478	877
HaemOnc Consortium*																	
PBR	50	55	53	56	58								272	266	6	221	51
NON PBR	134	142	145	144	153								718	706	12	653	65
Panda HDU (PBR HDU)	223	262	173	329	268								1,255	1,157	98	1,043	212
TOTAL HAEMONC	407	459	371	529	479	0	0	0	0	0	0	0	2,245	2,129	116	1,917	328

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Cash Management





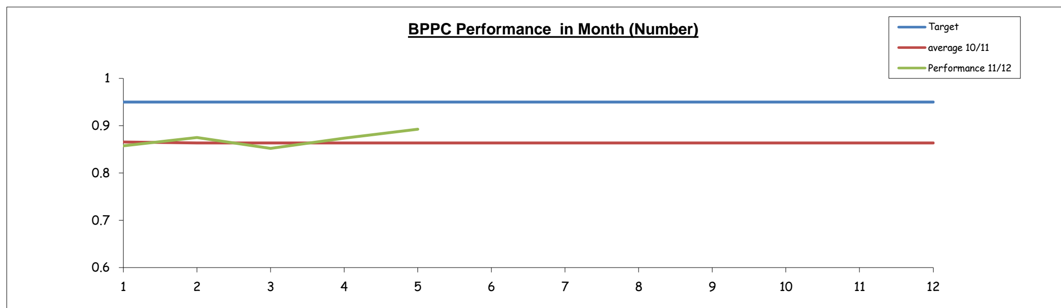


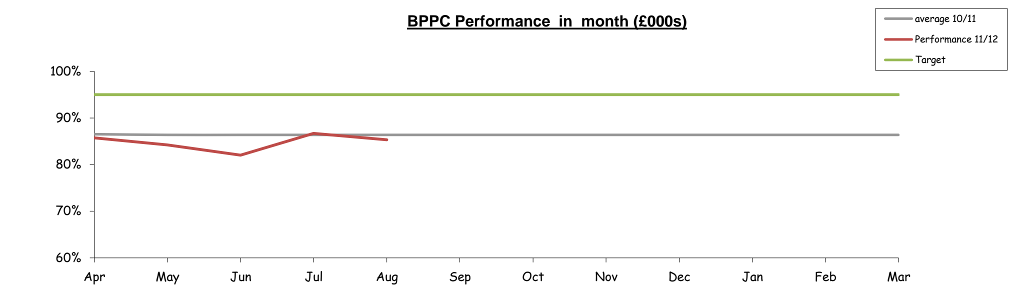
Payables Analysis

Days	Current Month	Previous Month	Movement in Month
	£000s	£000s	£000s
Not Yet Due	3,709	3,618	91
1-30	2,146	1,937	209
31-60	1,076	698	378
61-90	455	1,256	(801)
91-120	334	521	(187)
121-180	339	451	(112)
180-360	799	860	(61)
360+	1,194	1,368	(174)
	10,053	**10,709**	**(656)**

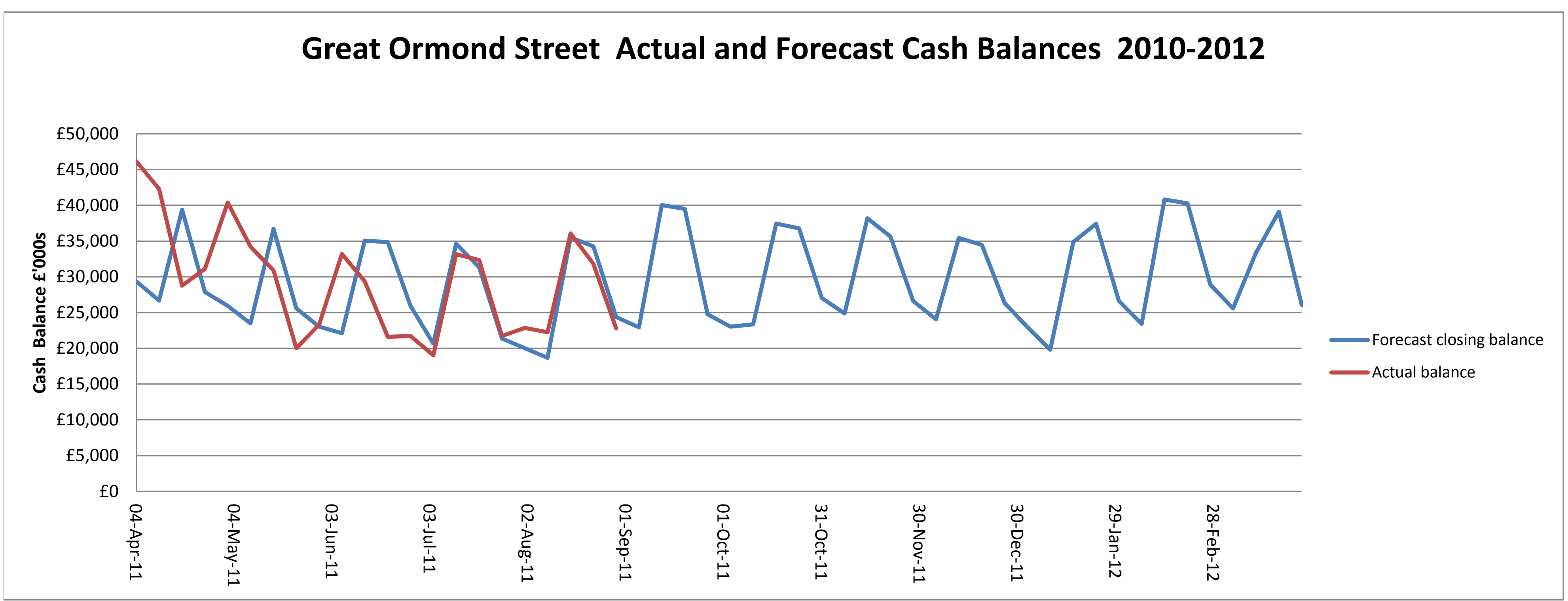
Better Payment Practice Code (BPPC)

	Number	£000s
Cumumlative Performance		
Total Payables		
% of Invoices paid within target	86.6%	84.1%
Non-NHS Payables		
Invoices paid in the year	32979	84,303
Invoices paid within target	29008	72,866
% of Invoices paid within target	88.0%	86.4%
NHS Payables		
Invoices paid in the year	1216	7,436
Invoices paid within target	613	4,285
% of Invoices paid within target	50.4%	57.6%





Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Cash Forecast



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	Overdue 31 - 60 Days	Overdue 61 - 90 Days	Overdue 91 - 120 Days	Overdue 121 - 180 Days	Overdue 181 - 360 Days	Overdue Over 360 Days
NHS	**11734**	-1002	5435	2696	3029	1061	364	97	41	14
NHS Credit Note Provision	-1108	0	0	0	0	-303	-144	-230	-62	-369
Specific NHS Debt Provisions										
NHS Net Receivables	**10627**	**-1002**	**5435**	**2696**	**3029**	**758**	**219**	**-133**	**-21**	**-354**
Non-NHS	**1610**	-21	479	166	89	159	62	248	245	185
Bad Debt Provision-Non NHS	-662	0	-67	-28	-11	-16	-17	-71	-246	-205
Specific Non-NHS Debt Provisions	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**948**	**-21**	**411**	**137**	**79**	**143**	**44**	**177**	**-1**	**-20**
International	**6935**	-1058	5107	900	491	150	71	337	268	669
Bad Debt Provision-International	-991	-15	-5	-1	-1	-0	-15	-69	-186	-699
International Net Receivables	**5944**	**-1073**	**5102**	**899**	**490**	**150**	**56**	**268**	**82**	**-30**
GOSH Charity Receivables	**340**	-1	188	26	102	20	2	3	-0	0
Specific Activity Provisions (IPP)	-176	0	0	0	0	0	0	0	0	0
Net Trust Receivables	**17682**	**-2097**	**11136**	**3758**	**3699**	**1070**	**322**	**315**	**59**	**-405**

Trust Receivables in £'000's	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	Overdue 31 - 60 Days	Overdue 61 - 90 Days	Overdue 91 - 120 Days	Overdue 121 - 180 Days	Overdue 181 - 360 Days	Overdue Over 360 Days
NHS	11734	-1002	5435	2696	3029	1061	364	97	41	14
Non-NHS	1610	-21	479	166	89	159	62	248	245	185
International	6935	-1058	5107	900	491	150	71	337	268	669
Gross Trading Receivables	**20279**	**-2081**	**11020**	**3761**	**3609**	**1370**	**496**	**682**	**554**	**868**
GOSH Charity Receivables	340	-1	188	26	102	20	2	3	-0	0
Total Trust Receivables	**20619**	**-2082**	**11208**	**3787**	**3711**	**1390**	**498**	**685**	**554**	**868**

Movement in £'000's	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	Overdue 31 - 60 Days	Overdue 61 - 90 Days	Overdue 91 - 120 Days	Overdue 121 - 180 Days	Overdue 181 - 360 Days	Overdue Over 360 Days
Gross Trading Receivables (as above)	20619	-2082	11208	3787	3711	1390	498	685	554	868
Gross Trading Receivables (last month)	25531	-2775	13370	9019	1862	626	1072	355	672	1330
Movement in Month	**-4912**	**693**	**-2161**	**-5231**	**1849**	**764**	**-573**	**330**	**-119**	**-463**
Gross Trading Receivables (year end 10/11)	15481	-1747	11317	1550	779	524	423	515	1385	734
Movement in Financial Year	**-5138**	**335**	**109**	**-2237**	**-2931**	**-866**	**-75**	**-169**	**831**	**-134**

Systems Schedule

Receivables in £'000's	Gross Receivables	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	Overdue 31 - 60 Days	Overdue 61 - 90 Days	Overdue 91 - 120 Days	Overdue 121 - 180 Days	Overdue 181 - 360 Days	Overdue Over 360 Days
eFinancial	13684	-1024	6102	2887	3220	1240	427	348	285	199
Compucare	6935	-1058	5107	900	491	150	71	337	268	669
Trust Receivables	**20619**	**-2082**	**11208**	**3787**	**3711**	**1390**	**498**	**685**	**554**	**868**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Capital Expenditure (£000s)

Capital Spend by Division	Annual Plan	Year To Date Plan	Actual (YTD)	Variance (YTD)
	Year to Date (YTD)			
Redevelopment Projects				
Donated Funded:				
Phase 1	26	12	(1)	13
Phase 2a	26,789	12,679	14,070	(1,390)
Phase 2b Enabling	6,271	2,968	0	2,968
Phase 2b	0	0	776	(776)
Phase 2 - Inhouse Resources	344	163	105	58
Unallocated	2,942	1,392	0	1,392
Total :	**36,372**	**17,215**	**14,950**	**2,265**
Estates Maintenance Projects				
Trust/DH Funded	7,702	1,925	2,923	(998)
Donated Funded	1,250	315	9	306
Total :	**8,952**	**2,240**	**2,932**	**(692)**
IT Projects				
Trust/DH Funded	6,000	1,500	1,300	200
Donated Funded	1,000	250	0	250
Total:	**7,000**	**1,750**	**1,300**	**450**
Medical Equipment Projects				
Trust/DH Funded	90	25	30	(5)
Donated Funded	3,500	875	1,736	(861)
Total:	**3,590**	**900**	**1,766**	**(866)**
Total Additions in Year	**55,914**	**22,105**	**20,949**	**1,156**
Asset Disposals	0	0	0	0
Donated Funded Projects	(42,122)	(18,655)	(16,696)	(1,959)
Charge Against CRL Target	**13,792**	**3,450**	**4,253**	**(803)**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2011/12
Staffing WTE

Permanent (Excludes Maternity Leave)					2010/11	
Unit	Period 1	Period 2	Period 3	Period 4	**Period 12**	Increase
Cardiac	350	354	348	354	**342**	13
Surgery	650	644	640	652	**646**	6
DTS	354	356	354	355	**349**	6
ICI	479	481	472	486	**460**	26
International	114	116	117	117	**115**	2
Medicine	280	284	275	280	**282**	-2
Neurosciences	261	264	254	258	**255**	3
Haringey	183	175	0	0	**183**	-183
North Mid.	2	2	2	2	**-**	2
Children's Population Health	7	8	8	7	**7**	0
Operations & Facilities	202	203	208	207	**208**	-1
Corporate Affairs	15	13	12	10	**13**	-3
Estates	46	45	45	44	**48**	-4
Finance & ICT	138	138	140	138	**134**	4
Human Resources	57	55	54	58	**57**	2
Medical Director	14	14	13	14	**15**	-1
Nursing And Workforce Development	80	78	75	76	**80**	-4
Research And Innovation	57	63	66	71	**77**	-6
Redevelopment Revenue Costs	7	7	7	8	**7**	0
TOTAL	3297	3300	3089	3,137	**3,279**	-141

Overtime					2010/11	
Unit	Period 1	Period 2	Period 3	Period 4	**Period 12**	Variance
Cardiac	6.3	2.4	1.0	1.6	**3**	-1
Surgery	3.3	2.4	1.8	1.8	**3**	-1
DTS	0.4	0.8	1.1	0.7	**1**	0
ICI	0.4	0.3	0.1	0.8	**1**	0
International	0.2	1.5	0.8	0.9	**2**	-1
Medicine	0.3	0.8	0.4	0.1	**0**	0
Neurosciences	0.9	0.6	0.7	0.5	**1**	0
Haringey	0.0	0.0	0.0	0.0	**-**	0
North Mid.	0.0	0.0	0.0	0.0	**-**	0
Children's Population Health	0.0	0.0	0.0	0.0	**-**	0
Operations & Facilities	3.6	4.0	4.3	4.9	**4**	1
Corporate Affairs	0.0	0.0	0.0	0.0	**-**	0
Estates	2.0	1.2	1.4	2.0	**2**	0
Finance & ICT	3.1	1.2	1.7	1.5	**1**	0
Human Resources	0.1	0.0	0.0	0.1	**-**	0
Medical Director	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**	0
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	**-**	0
TOTAL	20.6	15.7	13.8	15.0	**17**	-2.1

Agency/Locum/Bank					2010/11	
Unit	Period 1	Period 2	Period 3	Period 4	**Period 12**	Variance
Cardiac	38	31	41	41	**50**	-10
Surgery	61	67	68	71	**80**	-10
DTS	11	11	22	16	**19**	-3
ICI	42	36	41	50	**58**	-8
International	44	48	40	38	**35**	4
Medicine	29	23	23	16	**28**	-12
Neurosciences	27	19	22	19	**33**	-15
Haringey	5	6	1	0	**14**	-14
North Mid.	0	0	0	0	**-**	0
Children's Population Health	2	0	0	0	**-**	0
Operations & Facilities	9	18	17	17	**22**	-4
Corporate Affairs	0	1	0	2	**-**	2
Estates	5	15	7	4	**5**	-1
Finance & ICT	15	14	14	17	**14**	3
Human Resources	5	0	4	2	**8**	-6
Medical Director	2	2	1	1	**2**	0
Nursing And Workforce Development	3	2	3	1	**5**	-4
Research And Innovation	1	2	3	1	**5**	-3
Redevelopment Revenue Costs	0	0	3	3	**4**	-3
TOTAL	298	295	308	300	**383**	-84

TOTAL STAFFING (Excluding Maternity Leave)					2010/11	
Unit	Period 1	Period 2	Period 3	Period 4	**Period 12**	Variance
Cardiac	393	387	390	397	**395**	2
Surgery	714	713	709	724	**729**	-5
DTS	366	368	377	373	**369**	3
ICI	521	517	513	537	**519**	18
International	157	166	158	156	**151**	5
Medicine	310	307	298	296	**311**	-15
Neurosciences	289	284	276	277	**289**	-12
Haringey	188	181	1	0	**198**	-198
North Mid.	2	2	2	2	**-**	2
Children's Population Health	9	8	8	7	**7**	0
Operations & Facilities	214	225	228	229	**234**	-5
Corporate Affairs	15	14	12	13	**13**	0
Estates	53	61	54	50	**55**	-5
Finance & ICT	155	153	155	157	**149**	8
Human Resources	62	55	58	60	**65**	-4
Medical Director	17	16	14	15	**16**	-1
Nursing And Workforce Development	83	80	77	77	**85**	-8
Research And Innovation	58	66	69	72	**81**	-9
Redevelopment Revenue Costs	7	7	11	10	**12**	-1
TOTAL	3,615	3,610	3,411	3,453	**3,679**	-226

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

Trust Board
28th September 2011

Foundation Trust application update **Submitted on behalf of:** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment S**

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.

Monitor started their formal assessment on 3 August. Since then they have visited the hospital on 6 days for meetings with individual staff and groups. They have covered finance, clinical quality, education & training, audit, CRES, constitution, charity, research & innovation, IT, data quality, performance management, two tours of the hospital, and visits to wards.

The main themes emerging from these meetings are:

- A focus on risk, in terms of service quality, clinical and financial risks. In particular, the assessment of risks associated with the CRES programme and service developments.
- Contingency planning for the redevelopment programme ("what if phase 2B does not go ahead?")
- Board decision making and assurance.

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.

Key actions for the next month:

- Complete election process for the Members' Council.
- Continue with Monitor assessment process.

Action required from the meeting
To note the current position

Contribution to the delivery of NHS / Trust strategies and plans
Achievement of Trust objective to secure Foundation Trust status

Financial implications: None

Legal issues: None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Formal consultation has been completed (18 June 2010)
A set of commissioner meetings have been held with lead commissioners.

Who needs to be told about any decision Not required

Who is responsible for implementing the proposals / project and anticipated timescales
Sven Bunn, FT Programme Manager

Who is accountable for the implementation of the proposal / project
Jane Collins, Chief Executive

Author and date
Sven Bunn
19 September 2011

Foundation Trust application – September 2011 position

Assessment of current performance for Great Ormond Street Hospital against the seven domains of the Secretary of State assurance process (changes since July 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). • **Monitor have reviewed the constitution and will request some minor amendments.**	Green
The trust has carried out due consultation process	• Consultation commenced on 9 Feb 10 and was completed on 18 June 2010. • Consultation feedback was provided on 13 August 2010. • **Monitor asked for evidence of consultation in Beds, Herts, Essex and Sussex.**	Green
Membership is representative and sufficient to enable credible governor elections	• Currently ~**8,400** 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 in April 2011 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. • **Monitor have asked for further details on Phase 2A and 2B redevelopment plans, and on the CRES programme.**	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: Meeting all core standards (July 2011)** • HAI Performance (c. diff – 4 cases; MRSA – 2 cases). • 95th centile of admitted pathway waiting time **achieved since 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	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 • **Monitor have requested specific targets for some indicators, and further development of financial forecasts.**	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
19 September 2011

Trust Board 28th September 2011	
In-year review of Strategic Objectives and work-streams **Submitted on behalf of.** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment T**

Aims / summary

2011-12 is the final year of our 3-year Strategic Objectives, which include:

1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations
3. Successfully deliver our clinical growth strategy
4. With partners maintain and develop our position as the UK's top children's research organisation
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK
6. Deliver a financially stable organisation
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation

Work-streams for 2011-12

When the Trust Board agreed the Annual Plan, 34 actions needed to deliver the Workstreams that support our Strategic Objectives were identified along with 8 Key Deliverables (see attached appendices). These Actions are monitored regularly with progress reported through the various responsible committees. It was also agreed that there would be a regular review of all Work-stream at the CEO Executive meeting with a summary reported to the Trust Board.

Current progress

The Executive meeting at the beginning of September considered reports that detailed progress of actions and ensured that key risks were identified, owned and that appropriate mitigation plans had been established where appropriate.

Of the 34 Actions, 7 were rated Amber (Of concern) and the rest Green. At this time no Actions were rated Red. Of the 8 Key Deliverables, 1 is rated Amber and the rest Green.

At this time we are confident that all Amber rated Actions are recoverable and we are on course to complete all 34 Actions by the end of the year along with all 8 Key Deliverables.

The 7 Amber rated Actions include:

1. **Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)**

   This Action was rated Amber due to the restructure of the teams responsible taking longer than planned. The restructure has now been agreed and a draft process has been presented to Management Board in September.

2. **Ensure provision of safe services for the deteriorating and critically ill child.**

   This Action was rated Amber because the Executive Team feel that while good progress has been made there is still more work to do. A full paper on these issues has been presented to Clinical Governance Committee last week.

3. **Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.**

   This Action was rated Amber due to concerns around ownership of operational policy development and appreciation of the new floor layouts. Workforce plans for all of the new floors are due for completion by the end of September.

4. **Ensure that Information Governance (IG) processes are strengthened and the self assessment score in the IG toolkit is improved.**

   This Action was rated Amber due to the Training target of 95% staff by end of June being missed (we are currently at 86%). A series of lecture training sessions were held for staff that choose not to use online training. Departments with low compliance rates have been targeted.

5. **Improve Quality and Access to Critical Information**

   This Actionwas rated Amber due to the Draft Information Strategy document being delayed. This has now been presented to the September meeting of the Technical Delivery Board.

6. **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.**

   This Action was rated Amber due to Managed Services Tenders taking longer than hoped for leading to extended agency requirement to cover critical areas of ICT service.

7. **Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.**

This Action was rated Amber as there is still more work to do, in particular to support the Specialty Leads. Leadership opportunities have been created in UCLP and individual Specialty Leads are being interviewed to better understand their requirements.

The Key Deliverable rated Amber (Ensure the Morgan Stanley Clinical Building ready for occupation) is covered by 3 above.

At the Trust Board away day in October it will be important to consider our Strategic Objectives going forward and agree those for the next three years.

Action required from the meeting

- To note the progress in 2011-12 towards our Strategic Objectives so far
- To note that we are forecasting to complete all Actions and Key Deliverables this year.
- To note that the Strategic Objectives are up for review

Contribution to the delivery of NHS / Trust strategies and plans
To ensure that the Trust is working coherently and effectively towards our Strategic Objectives

Financial implications
None

Legal issues
None

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

Who needs to be told about any decision
Senior Management Team

Who is responsible for implementing the proposals / project and anticipated timescales
Work-stream leads

Who is accountable for the implementation of the proposal / project
Executive leads

Author and date
Daniel Dacre, Planning and Performance Manager
September 2011

Appendix 1: Work-Stream Actions for 2011-12

Strategic Objective	Work-stream	Refno	Action	Management Lead	Executive Sponsor	RAG
Deliver clinical outcomes	Maintain our focus on Zero Harm	2197	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.	Judith Cope	Jane Collins	Green
		2198	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.	John Hartley	Martin Elliott	Green
		2199	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	Sonia Jenkins	Liz Morgan	Green
		2200	Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)	Salina Parkyn	Martin Elliott	Amber
		2201	Ensure effective provision of nutritional care for all patients	Caroline Joyce	Liz Morgan	Green
		2202	Ensure provision of safe services for the deteriorating and critically ill child.	Sue Chapman	Martin Elliott	Amber
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	2203	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations	Lisa Davies	Martin Elliott	Green
		2204	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly	Nick Wright	Claire Newton	Green
Deliver an excellent experience	Continue to reduce waiting times further through our 'no waits' programme	2205	Continue to meet national and commissioning standards and improve the utilisation and efiiciency of our resources.	Robert Burns	Fiona Dalton	Green
	Improve the standard of customer service that we offer patients and families	2234	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	Caroline Joyce	Liz Morgan	Green
	Continue to improve our relationships with referrers in order to achieve our market share objective	2207	Continue to implement the actions for improvement following the results of the Referrer Survey including producing a directory, holding referrer days along	Robert Burns	Barbara Buckley	Green
		2208	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.	William McGill	William McGill	Green
		2209	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.	Natalie Robinson	Fiona Dalton	Amber
Deliver clinical growth	Deliver our planned in year growth	2210	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP)	Robert Burns	Fiona Dalton	Green
	Maintain IPP service growth	2211	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved	Joanne Lofthouse	Trevor Clarke	Green
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	2212	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.	Sarah Dobbing and Anne Layther	Fiona Dalton	Green
		2213	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.	Robert Burns	Fiona Dalton	Green
		2214	Renew and deliver the Biomedical Research Centre in paediatrics	Lorna Gibson	David Goldblatt	Green

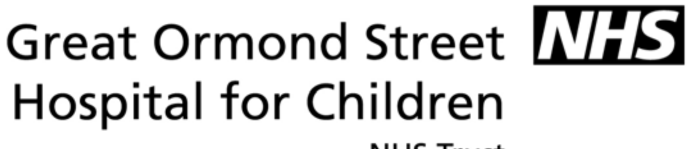
Appendix 1: Work-Stream Actions for 2011-12

Work-stream	Objective	Ref	Action	Lead	Executive	Status
Develop as research organisation	**Deliver the Research Strategy**	2215	Continue to develop partnership working with ICH, University College London Partners (UCLP) and UCL Business	Lorna Gibson	David Goldblatt	Green
		2216	Increase research activity and income for the Trust by 10%	Lorna Gibson	David Goldblatt	Green
	Continue to improve the mechanisms for the management of research within the Trust	2217	Continue to improve the mechanisms for the management of research within the Trust	Lorna Gibson	David Goldblatt	Green
Education & training	**Deliver the Education & Training Strategy**	2221	Implement the Trust's Education and Training Strategy through the delivery of an innovative and effective programme of blended learning using the on-line campus, classroom & work-based teaching and simulator learning.	Geoff Speed and Chris Caldwell	Liz Morgan	Green
Financial stability	**Agree achievable CRES plan and ensure delivery through robust project and performance management**	2222	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	Chris Skilbeck	Fiona Dalton	Green
		2223	Deliver surplus to plan.	Fiona Dalton	Fiona Dalton	Green
	Improve efficiency through our Transformation Programme	2224	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.	Katharine Goldthorpe	Fiona Dalton	Green
	Ensure appropriate funding for our clinical services from commissioners	2225	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.	Claire Newton	Claire Newton	Green
		2226	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.	Nick Wright	Claire Newton	Green
	Support the charity to raise targeted funds	2227	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met	Tim Johnson	Jane Collins	Green
Corporate support processes	**Make progress towards becoming a Foundation Trust**	2228	Complete monitor assessment, attain authorisation status and establish an effective members council.	Sven Bunn	Fiona Dalton	Green
		2229	Ensure that the Trust retains registered status with CQC.	Anna Ferrant	Jane Collins	Green
	Ensure that the Trust is compliant with regulatory requirements	2230	Ensure that Information Governance (IG) processes are strengthened and the self assessment score in the IG toolkit is improved.	Clare Reed	Claire Newton	Amber
		2231	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	Geoff Bassett	Martin Elliott	Amber
	Improve efficiency of business processes	2232	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.	Mark Large	Claire Newton	Amber
		2233	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.	Jane Collins	Jane Collins	Amber

Appendix 2: Key Deliverables for 2011-12

Strategic Objective	Key Deliverable	RAG
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	To achieve a 10% reduction in harm as defined by the global trigger tool	Green
	To double the number of speciaties that have clinical outcome measures published on our internet site	Green
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	Ensure the Morgan Stanley Clinical Building ready for occupation	Amber
3. Successfully deliver our clinical growth strategy	To meet our growth targets for both NHS and IPP activity	Green
4. With partners maintain and develop our position as the UK's top children's research organisation	To increase our research publications and income for the Trust by 10%	Green
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	To achieve excellent ratings in the Post Graduate Medical Education and Training Board and Quality Assurance Agency for higher education reviews	Green
6. Deliver a financially stable organisation	To meet our budget	Green
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	To attain authorisation as a Foundation Trust	Green

Trust Board Meeting 28 September 2011	
GOSH Child Protection Quarterly update April 2011 – September 2011 **Submitted on behalf of:** Liz Morgan, Chief Nurse and Director of Education	**Paper No: Attachment U** **Date considered by Clinical Governance Committee:** 22 September 2011
Aims / summary To provide an update regarding operational progression of the Trust Child Protection Action Plan 2011-2012 as well as relevant information impacting on Child Protection operational and strategic compliance of the Trust.	
Action required from the meeting To note the evidence of continued implementation of the Trust strategy to protect children.	
Contribution to the delivery of NHS / Trust strategies and plans Keeping children safe is a primary objective of the Trust.	
Financial implications All initiatives currently funded.	
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? Chief Nurse/Director of Education, Deputy Chief Nurse	
Who needs to be told about any decision Chief Nurse/Director of Education, Child Protection Co-Ordinating Manager, Named Professionals	
Who is responsible for implementing the proposals / project and anticipated timescales Child Protection Co-Ordinating Manager and named professionals.	
Who is accountable for the implementation of the proposal / project Chief Nurse/Director of Education	
Author and date Sonia Jenkins, September 2011	



GOSH Child Protection
Quarterly update April 2011 – September 2011

1. This report provides evidence of continued implementation of the Trust strategy to protect children. This report provides a brief overview of specific issues since the last quarter (Jan 2011 – March 2011) as an update for Board members. Due to a change in reporting dates, this report will cover a five month period rather than the normal three months.

2. Full details of Trust wide activity are outlined in the Trust Child Protection Action Plan (*see appendix 1a*) which demonstrates the level of ongoing development, and improved oversight of all services for which the Trust has safeguarding responsibility. Following the transfer of Haringey Children's Community Health Services to Whittington Health on 23 May 2011, the GOSH child protection reporting structure has been realigned to reflect the move.

3. Overall since April 2011 the Trust continues to make good progress against planned activity and goals and is working hard to embed strategic processes across the Trust to ensure good outcomes for children and young people.

   Highlights include:

4. Implementation of GOSH Safeguarding Scorecard

From April 2011, GOSH is now populating the balanced Scorecard (*see appendix 1b*) as detailed in the CP Annual report (2010-2011).

5 Staffing
See Scorecard dashboard domain 6

5.1 Child Protection Administrator post
This post is now vacant due to the resignation of the postholder and is currently on hold pending a review of the administration services across Safeguarding, Resuscitation, Nursing & Allied Health Research, PALS, and the CSP team.

6. Inspections and Audit

6.1 The Care Quality Commission visited GOSH on 9 June 2011 to carry out a planned review of the 16 registration outcomes. A number of areas in the hospital were visited. No concerns were highlighted in the initial feedback regarding Child Protection/Safeguarding standard (Outcome 7).

6.2 Laming Audit. The audit has been completed and a meeting has been held with the audit manager who is finalising the information and results for the report. The mean compliance for 2009/10 was 61% (below the previous year's audit (2008/09) of 70%). An action plan for improvement is being developed to address the areas of deficiency and will be reported on in the next quarter. A new records audit tool is now in place and has been undertaken quarterly instead of annually. This will enable regular monitoring of performance against the action plan. The first quarter audit was carried out in retrospect using the new tool. The results were 80% which meets our yearly target of 80%.

7. Serious Case Reviews
See Scorecard dashboard domain 4

7.1 GOSH has not been invited to report on any new SCR's since April 2011.

7.2 The Chief Nurse/Director of Education presented a report to the Clinical Governance Committee on 21 June on the themes arising from GOSH involvement in three Serious Case Reviews during the period April 2010 - April 2011. This report contained an update on the actions taken and how they were disseminated across the trust as well as showing that the recommendations in all three cases have now been achieved.

8. Social Care Referrals

8.1 Overall since April 2011 to date, the GOSH social care team received 214 referrals in total - 47 were child protection concerns and 167 were child in need referrals.

8.2 A three month pilot commenced in June on PICU, NICU, Tiger and IPP wards of the new electronic referral to social work system. The pilot has been extended for another month due to a delay with the start date because of ICT issues which have now been resolved.

9. Training
See Scorecard dashboard domain 5

9.1 The figures for the overall uptake of safeguarding training continue to rise. The percentage listed will therefore reflect number of places taken up on CP training.
LEVEL 1: % received training (full day/half day) - 89.7%
LEVEL 2: % received training - 62.1%
LEVEL 3: % received training - 22.8%

9.2 A programme of classroom based level 2 and 3 activity is now running. A series of half day level 2 workshops that provide greater depth of safeguarding knowledge for all Doctors, Nurses and Clinical Support Staff have been arranged. So far 43 staff have or are due to attend this learning. In addition the safeguarding training on our clinical update has been reviewed to ensure it meets level 2 standards.

We have a comprehensive package of Level 3 activity. This includes a series of modules designed to meet the safeguarding needs of all Doctors, Nurses and Clinical Support Staff. Staff are able to attend a full day session or mix and match modules. Topics covered include:

Challenges faced by Health Professionals
Assessing Risk
Referrals Multi Agency Meetings
Domestic Abuse
Record Keeping
Differential Diagnosis in Safeguarding
Domestic Abuse - Impact on Children
Legal Orders
Serious Case Reviews
Safeguarding Adolescents and Young People
Working with parents/carers in CP investigations
Safeguarding the Neonatal Baby
Locally delivered level 3 events

So far 144 places have been reserved on these modules.

In addition GOSH have worked with e-Learning for Healthcare to enable staff to access to their e-Learning package: Safeguarding Children (Level 3). We have first rolled this opportunity out to those staff that have completed their level 2 training. We should start to see the impact of this e-learning on the L3 training figures during Q3.

9.3 A Sexual Abuse Study Day was held on 6 June which 35 staff attended. The day provided information on the identification and management of sexual abuse and the various issues of child exploitation, and has been well received by those attending.

10. Case Conference attendance
See Scorecard dashboard domain 2

10.1 Overall since April 2011 to date, GOSH received 16 case conference requests. Ten of these were attended by appropriate GOSH professionals. For the other six requests, reports were submitted for four of these, one was a verbal report due to the lateness of receipt of the conference invitation and one request is awaiting clarification from the consultant as to whether they attended or sent a report. If this has been achieved GOSH will have achieved 100% compliance with this standard (April – June 2011 GOSH were 100% compliant).

11. Safeguarding Supervision
See Scorecard dashboard domain 4

11.1 Supervision sessions with the CSPs (Clinical Site Practitioners) are held regularly at six weekly intervals. An initial supervision session has been held with the CATS (Children's Acute Transport Service) team and will be continued on a 6-8 weekly basis. Supervision for MCU (Mildred Creak Unit) staff and CNSs (Clinical Nurse Specialists) has commenced within this quarter. Case consultation /supervision on complex cases has also been commenced with 3 other AHP groups (e.g. Social Communication, Parent and Child Team and Feeding and Eating Team).

11.2 Supervision drop-in clinics are held on the first Wednesday of each month for any member of staff to meet with the Named Nurse to discuss any safeguarding concerns they may have. Response for this remains slow despite further publicity. If uptake remains slow, this will need to be reviewed to see if targeting areas where there have child protection cases would be more beneficial. GOSH is therefore compliant with targets for this standard so far in this reporting period.

Sonia Jenkins
Child Protection Co-Ordinating Manager
September 2011

GOSH Child Protection Work Plan / Action Plan April 2011 – April 2012 (Appendix 1a)
(To be considered in conjunction with Safeguarding and Child Protection Strategy and Quarterly reports)

This live document:-

- Identifies from child protection reviews (single agency/ IMR's and SCR's), local and national reports key areas of activity, particularly structures and processes, that will improve the quality of child protection services provided by GOSH.
- Has been developed in partnership with health and social care colleagues from partner organisations and it is recognised that successful implementation is dependent upon shared ownership by the whole safeguarding team and a sharing of the GOSH vision ' the child first and always'
- This action plan will be constantly updated and reviewed to ensure it remains applicable in time and context.
- Areas for action are developed from this strategic plan and managed locally by Child Protection Management Group (CPMG) and implemented via Unit CPMGs (UCPMG) and Link Professionals groups.

The plan will be:

- Considered and formally updated monthly at CPMG meetings and quarterly at Strategic CPMG meetings.
- Presented and reviewed as part of Child Protection Trust assurance at quarterly Quality and Safety Meetings (Q&S) with recommendations to Management Board quarterly and Trust Board on an annual basis.
- Updated as requested by Management Board/Trust Board/Clinical Governance Committee

[ ] **= Completed task**

Task	Source	Lead	Plan	Timeframe	Progress (Latest update in bold)	Rating
1. CP supervision	**JAR AP** **IMR**	Jan Baker	CP Supervision for identified groups also: - *Named Nurse / Doctor* Paediatricians Doctors involved in CP case (on request and when required because involved in a case). All GOSH nursing staff (on request). Target: one supervision session per quarter per identified group	April 2011 – April 2012	The following groups of staff have been identified for group supervision sessions with Named Nurse: CSP's (Clinical Site Practitioners), CNS's (Clinical Nurse Specialists), CATs team (Children's Acute Transport Service), AHPs (Allied Health Professionals), Band 6's. Audit will take place in Quarter 3 GOSH is currently compliant with CP supervision for named professionals. Other staff groups have a minimum of one supervision session per quarter which have all been achieved 80% except for CNS's to begin in Q2.	AMBER

Task	Source	Lead	Plan	Timeframe	Progress	Rating
					JB expanding this and to review how it is done. Will be made wider so not just focussing on named groups. To get more flyers on wards advertising the supervision drop in clinics. **CP admin distributing laminated copies of flyers to CP links on 25/08/11 for advertising in their wards/areas.**	
2. CP medical audit to take place	**Request from Barbara Buckley**	Sonia Jenkins	Ensure CP medical notes compliant with CP practice. Audit to take place as part of Haringey transition arrangements in May 2011.	November 2011	SJ to carry out audit of CP notes. **New audit date to be negotiated with CP Admin at NMUH prior to w/e 10/10/11**	AMBER
3. Implement the new Child Protection Structure	**CPMG**	Madeline Ismach Sonia Jenkins	Local accountability and expectations of Unit CPMG's to be devised and circulated to each Unit lead.	September 2011	MI to rework/update accountability and expectations of clinical chairs/general managers by updating ToRs for Unit CPMG. **SJ to work something up for MI.**	AMBER
3.1 Representative from General Paediatrics team to sit on Unit CPMG	**CPMG**	Nick Lessof	NL to share with General Paediatricians and agree allocation of Units.	September 2011	NL to speak to General Paediatricians to agree allocation to clinical units and role in Unit CPMG's. SJ has agreed to attend with NL. **Jane Valente (JV) to discuss further with GP team at their September team meeting.**	AMBER
4. Devise plan to improve written referrals to Social Work	**CPMG**	Sonia Jenkins Marion Cullen	To consider implementation of electronic referral system.	September 2011	Three month pilot of the electronic referral system commenced in June on PICU, NICU, Tiger and IPP wards. **Pilot has been extended for another month due to delay with start date.** It was reported that no forms have been received electronically yet. Some staff have been printing off the forms, filling in by hand and then taking to social work! **Only one referral received so**	AMBER

Task	Source	Lead	Plan	Timeframe	Progress	Rating
					far. IPP are not completing or making any referrals. JV attending a meeting in IPP so agreed to discuss further with them then. **SJ to ask LM to send out email circular to unit leads of pilot areas to say that they need to be using electronic referral system. If paper referral made it needs to be followed up with an electronic referral. Discussed at Surgery and Neuro UCPMG.**	
5. CP webpage to be set up on GOSH internet to replace pre-existing page. To also consider an internal CP webpage on the GOSH intranet.	**CPMG**	Sonia Jenkins	To set up a webpage so staff can access information around CP. Dependent on CP Admin resource/priority.	December 2011	Trust is changing software for web development of intranet and will make new development tool available in July 2011 for launch in September 2011. **Meeting to be arranged to discuss content of page once new development tool available and pending availability of CP admin to work on webpage creation.**	AMBER
6. Safeguarding Scorecard Conclude thinking on board metrics	**SIT Recommendation January 2011**	Sonia Jenkins	Move towards performance indicator (evidence based measures) rather than narrative reports. To design a scorecard which reflects the performance indicator for safeguarding.	December 2011 Implement final version from quarter 3.	Draft scorecard created based on the Haringey model. **Scorecard submitted with CP quarterly report for quarter 1. Now in operation.**	GREEN
7. Domestic Violence Awareness	**CPMG**	Jan Baker	To plan a week of activities including an information stand, awareness training etc.	November 2011	DV module completed for Level 3 training. Policy for staff experiencing DV drafted and discussed at February CPMG. **Amended policy to be circulated. Aim is to launch the policy around the DV week in November in conjunction with**	AMBER

Task	Source	Lead	Plan	Timeframe	Progress	Rating
					the study day.	
8. Due to Trust requirement around case conference attendance, policy to be drafted.	**CPMG**	Jan Baker	Draft policy following current agreed flowchart.	November 2011	JB circulated amended draft at July CPMG which was agreed by group. Will now need to go to Quality and Safety for approval and Management Board for ratification. **There are some issues re 'unborns' and if they are covered in the policy. JB to discuss further at October CPMG due to absence at September meeting.**	AMBER
9. SCR Policy to be drafted	**CPMG**	Sonia Jenkins	Due to the complexity of the SCR pathway, an SCR policy now needs to be drafted.	March 2012	Draft to CPMG October 2010. **Following government response to Munro Review SCR position needs clarity before proceeding.**	AMBER
10. Produce criteria for the lead doctor role in safeguarding	**SIT Recommendation January 2011**	Nick Lessof	Identify an appropriate medical structure for safeguarding beyond named doctor role.	31 December 2011	**NL to meet with staff currently in 'CP lead consultant' roles + relevant unit general manager. Support and supervision for these consultants by named doctor considered and plan to absorb into CP Link group and also provide social work managerial support for these four members of staff who have taken up roles within specific areas.**	AMBER
11. Allied Health Professionals – SIT found a sense of them not feeling as well integrated across trust with	**SIT Recommendation January 2011**	Madeline Ismach Sonia Jenkins	a) MI to meet with Head of Physiotherapy to discuss further. b) To look at possibility of having a separate link group meeting for AHPs.	31 August 2011	MI met with Head of Physiotherapy. Letter sent to CP Links about splitting links into two groups – nursing and clinical support	GREEN GREEN

Task	Source	Lead	Plan	Timeframe	Progress	Rating
safeguarding as might be expected		Jan Baker	c) JB to look at the programme of CP link meetings to see whether there are any that would be suitable for AHPs to join. An assessment of what their needs are will need to be done.	October 2011	professionals. New structure in place for CP links meeting held on 19 July 2011. Appropriate support for nursing/AHP staff needs to be agreed as well as understanding professional responsibilities and threshold. **SJ/JB to go through programme of CP link meetings.** JB doing a review of CP links. To meet with Andrew Pearson regarding doing a survey of nursing and AHPs. **JB took a proposal to Heads of Nursing meeting in August re role of CP links. Awaiting comments back from them.**	GREEN AMBER
12. CP Policy and Procedures – on Parrot ward there was an out of date folder of CP material	**SIT Recommendation January 2011**	Jan Baker	a) Email to be sent to CP Links and ward sisters asking them to check that any copies of the policy held on their wards/units is the current version as per the document library. b) CP Links to undertake a regular spot-check within their wards/units.	30 September 2011	Following Neuro CPMG meeting on 1 March 2011, Patrick Dodds removed out of date folder from Parrot Ward. a) The issue was discussed within the wider feedback on SIT report to the CP Links. b) The checks are to be completed at the time of the CP Link Audit. **Audit now in progress – deadline for completion extended to 2 September due to summer leave.** **A review of CP link competencies taken to Heads of Nursing meeting in August.**	GREEN GREEN AMBER

Task	Source	Lead	Plan	Timeframe	Progress	Rating
13. Devise action plan to address inclusion of referrer information needed regarding Local Authority involvement and CP status of children to better address risk to inpatient/outpatient referrals.	**Post IMR training with outpatients units**	Sonia Jenkins	SJ to discuss with LM and MI	December 2011	SJ met with RB 14 June 2011 Clear plan to include in new referral packs to be launched end of September 2011. SJ and JR working on wording **JV said there is a 'Referrers day' to be held soon for all referrers to GOSH. GP team have a slot at the day and JV said MI is attending as well. SJ to talk to MI to ask if she bring this up then.**	GREEN AMBER
14. Audit coding of child maltreatment associated admissions.	**CPMG**	Nick Lessof	To agree outcomes and who should be involved. To meet with Ruth Gilbert and Clinical Coding manager to discuss further.	September 2012	Meeting held on 5 July. **Audit launched 11/09/11. First analysis Spring 2012.**	AMBER
15. IT issues	**CPMG**	SJ	Webcams Policy / E-Safety	January 2012	**SJ has amended policy to reflect link to CP procedures. To be linked in with CP Policy. Working group/if now decided to devise overarching policy for children and staff.**	AMBER

Great Ormond Street Hospital Safeguarding Dashboard 2011/12: Key measures of assurance

Great Ormond Street Hospital for Children NHS Trust

RAG status

- Meeting target and on track to achieve by end of year
- within 20% of target and on track to achieve by end of year
- more than 20% below target & not on track to achieve

Direction of Travel

- Increase from previous quarter
- Decrease from previous quarter
- No change from previous quarter

1. Quality of Record Keeping

This shows the results of the regular audit conducted by the Child Protection Managent Group (CPMG)

	Target	Q1 2011-12	Q2 2011-12	Q3 2011-12	Q4 2011-12	RAG	DOT
No of case files audited	5	5					
% of case files judged adequate or better across 10 domains	80%	80%					

Explanation of current performance:
Target 80% (10% increase over previous audit of 70%). Q1 target 72.5% - we are overtarget (4 out of 5 cases audited as one case was not auditable as did not fit criteria). Q2 audit in progress - to be completed by end of September.
Quality measure:
The quality of record keeping and note taking is assessed across all the 10 domains of the audit tool. However, an assessment of the child/family needs assessment as adequate or better is provided as a measure of data quality. Excellent = 9-10 domains/Good = 7-8 domains/Satisfactory = 5-6 domains/Inadequate = 0-4 domains
Proposed remedial action:
New audit tool to be compiled to reflect 10 domains. Approxiamately 110 CP referrals per year received by GOSH social work department. Audit from a sample of 25 cases per quarter. Quarter one will be audited in retrospect

2. Case Conferences

	Target	Q1	Q2	Q3	Q4	RAG	DOT
Case conference attended or report sent	100%	9	16				
% participation (attended or report sent)	100%	100%	100%				

Explanation of current performance:
Target 100% of attendance or reports sent to relevant case conferences by Nursing / Medical staff / AHPs as appropriate.
GOSH is currently compliant with this standard.
Quality measure:
National standard requires written reports sent or attendance at all invited/relevant case conferences.
Proposed remedial action:
None

3. Supervision (Named CP staff, Identified groups / Individuals)

NPs - Named professionals OSGs - Other staff groups	Target		Q1		Q2		Q3		Q4		RAG	DOT
	NPs	OSGs	NPs	OSGs	NPs	OSGs	NPs	OSGs	NPs	OSGs		
Named professionals												
Named nurse	100%		1		1							
Named doctor	100%		1		1							
Other staff groups												
CSP's				1		1						
CNS's				0		1						
AHP's				1		10						
Band 6's / Drop in session/ ad-hoc				1		3						
CATS				1		1						
% within timescale	100%	See over	100%	42%	100%	68.7%						

4. Individual management reviews (IMR's) / Serious Case Reviews (SCR's)

	Target	Q1	Q2	Q3	Q4	RAG	DOT
Average no. of reviews invited to respond	100%	0	0				
No. of reviews responded to within timescale	100%	0	0				
No. of reviews not responded to within timescale	100%	0	0				
No. of cases not applicable or medical report only	100%	0	0				

Explanation of current performance:

Target 100% Named Professionals are required to have regular CP supervision (individual or group).
GOSH is currently compliant with CP supervision for named professionals.
Other staff groups: Target 50% per year (2.5% per quarter increase over 4 quarters). Supervision/case discussion carried out on Child Protection/Child in Need cases across identified groups. Q1 target 27.5% - achieved 42%. Q2 target 35% - part results only. Progress so far have achieved 68.75% therefore over achieved.

Proposed remedial action:

N/A

5. Safeguarding Training (No. of staff whose training is current / total staff requiring level of training)

	Target	Q1	Q2	Q3	Q4	RAG	DOT
LEVEL 1: % received training (full day/half day)	80%	68.37%	89.7%				
LEVEL 2: % received training	80%	59.00%	62.1%				
LEVEL 3: % received training	40%	22.81%	22.8%				
Cumulative target	80%	88.41%	89.7%				

Explanation of current performance:

Target: The national (cumulative) target for level 1, 2 and 3 is 80% over three years (i.e . at GOSH 88.41% of staff have some form of CP training).

Level 3 - The target for 2011-2012 is 20%. Quarterly target is 5%. (the staggered target is based on the recognition that GOSH is a paediatric hospital and the numbers of staff required to have level 3 training will be higher than in a DGH setting. Q1 22.81%. Q2 remains unchanged so far.

Proposed remedial action:

The figures for safeguarding continue to rise. A programme of classroom based level 2 and 3 activity is now running. A series of half day level 2 workshops that provide greater depth of safeguarding knowledge for all Doctors, Nurses and Clinical Support Staff have been arranged. So far 43 staff have or are due to attend this learning. In addition the safeguarding training on our clinical update has been reviewed to ensure it meets level 2 standards.

We have a comprehensive package of Level 3 activity. This includes a series of modules designed to meet the safeguarding needs of all Doctors, Nurses and Clinical Support Staff. Staff are able to attend a full day session or mix and match modules.
In addition GOS have worked with e-Learning for Healthcare to enable access to their e-Learning package: Safeguarding Children (Level 3). We have first rolled this opportunity out to those staff that have completed their level 2 training. To save staff time we have centrally created a username and password for each staff member. We should start to see the impact of this e-learning on the L3 training figures during Q3

Explanation of current performance:

Target : The national target for compliance with SCRs is 100% (i.e we must respond to all SCRs we have been invited to report on by submitting an IMR within suggested timescales).
GOSH has not be invited to report on any SCRs in this quarter.

Proposed remedial action:

N/A

6. Staffing (People in post / total WTE posts available)

	Target	Q1	Q2	Q3	Q4	RAG	DOT
Named Doctor	0.4 WTE (100%)	1	1				
Named Nurse	1 WTE (100%)	1	1				
Board Lead	1 WTE (100%)	1	1				

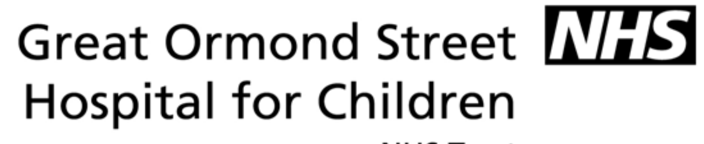
Explanation of current performance:

Target: CQC and London Child Protection procedures require all trusts to have named staff in place.

GOSH is compliant with this standard.

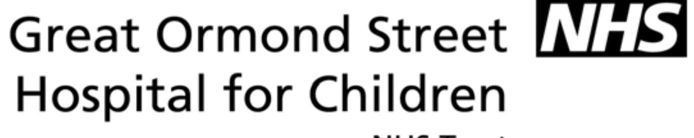
Proposed remedial action:

N/A



Trust Board Meeting **28th September 2011**	
Redevelopment Update **Submitted on behalf of Redevelopment Directorate**	**Paper No: Attachment V**
Aims / summary The purpose of this report is to update the Board on the progress of our Redevelopment Programme	
Action required from the meeting This paper is for information	
Contribution to the delivery of NHS / Trust strategies and plans The Redevelopment Programme is a Key Deliverable as part of our objective to provide the best equipment, technology and buildings to deliver care	
Financial implications The financial implications are included in the Business Case Documents	
Legal issues There are no legal issues	
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	
Who needs to be told about any decision The Special Trustees, Trust Executive Team, and the Redevelopment Committee	
Who is responsible for implementing the proposals / project and anticipated timescales The Redevelopment Board	
Who is accountable for the implementation of the proposal / project Director of Redevelopment	
Author and date William McGill Director of Redevelopment 28th September 2011	

Attachment V



Redevelopment Report
Trust Board 28th September 2011

1.0 Phase 2A New Clinical Building

1.1 Contract Details

- The Form of Contract is JCT 2005 Design and Build
- The contract period is agreed at 159 calendar weeks (including Advance Works)
- Commencement date (subsuming Advance Works) was 24th November 2008
- The revised Completion Date is 20th December 2011
- The current anticipated Completion forecast as 12th December 2011
- Planned building occupation by GOSH is Easter 2012
- The contract sum is £88,500,000

1.2 Summary

- The total extension of time granted to date is now 8 working days , all in respect of exceptionally inclement weather over the last three winters
- There have been no further requests for an extension of time
- At the Contractors progress meeting on 16th August 2011, BAM Construction assessed their progress as being five weeks in delay against their original contract construction programme (ie excluding the 8 days Extension of Time awarded to date) which is a recovery of one week from the position reported in July 2011
- This assessment is based on the status of the M&E commissioning activities
- BAM Construction continue to report that they are still planning to complete on the original contract Completion date (12th December 2011), although the revised Completion date is now 22nd December 2011
- BAM continue to monitor the critical path activities on the target recovery programme and any activity which is within two weeks of becoming critical . The critical path activities are currently the completion of the M&E systems, M&E commissioning and the completion of the level 2 restaurant fit out
- It should be noted that the target critical path programme still contains four weeks of float at the end of the critical path programme as Contractor Contingency on the main building and two weeks of float on the level 2 restaurant fit out
- 162 Employers Agent Instructions have been issued to date, 9 of which have been issued since the July 2011 report
- Of the 162 Employers Agent Instructions issued, 107 have been issued as a result of a Change to the Client Brief , the remainder consist of Provisional Sums (14no), unforeseen site conditions (16 no) and contractors alternative proposals resulting in costs savings
- Of the 162 Employers Agent Instructions issued, 121 no are anticipated to result in additional costs , the remainder are savings or nil cost
- The current anticipated Final Account is still estimated to be well within the approved contingency allowances

1.3 Principal Outstanding Risks (and actions to mitigate)

1. Changes to the Client Brief

A schedule of potential changes proposed by GOSH Estates has now been concluded

The only outstanding item concerns the Disney installations within the level 2 restaurant Our project Managers have presented Disney with a schedule of outstanding information and have requested a response from Disney by early September 2011

2.0 Phase 2B

Introduction
The Outline Business Case for both of these works was approved in December 2006 and reported to the Special Trustees in January 2007. The Special Trustees further approved the continuation and development of the Phase 2B design and Business case at their meeting on 20th October 2010. Due to delays in the design development for the Enabling Works and the intention to submit the FBC when the Trust is a fully constituted, Foundation Trust the programme dates have changed with regard to the FBC submissions but not for the construction programmes.

<u>Timetable</u>

Enabling works FBC submission	April 2011
Trust Board decision to commit to funding enabling works	April 2011
Demolition and Rebuild of Cardiac Wing FBC submission	January 2012
Trust Board decision to Approve FBC	January 2012
Enabling works programme commence	August 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

The clinical planning brief is now completed with the exception of level 1 (south west new build extension) . The remainder of level 1 remains as the current occupied areas of imaging (MRI and CT) to the south of the hospital street and nuclear medicine to the north of the hospital street

A more detailed Client Brief potentially changing the occupation at level 2 from an ambulatory care ward to a 10 bed cystic fibrosis ward north of the Hospital Street and a 14 bed respiratory ward south of the hospital street was issued on 4th August 2011 to enable the design team to commence feasibility studies in August 2011. A first draft of potential layouts will be issued by the end of August and further discussions will take place relating to this potential change in September 2011

The design team are also undertaking further studies in respect of the complex supply and extract ventilation that would be necessary if the level 1 theatre co-joined to the MRI 3T suite is confirmed as a further change to the brief

The 1:200 layouts at all levels (2 to 7 inclusive) have all been through reviews with the clinical planners and the end users and have all now been signed off

The design team issued the draft Scheme Design report to GOSH Estates , GOSH Clinical Planning and GTMS (based on the original ambulatory care Client Brief at level 2) on 30 June 2011.
A series of review meetings has taken place during July and August to consider architecture , clinical planning, structural engineering and M&E services and the final draft of the Scheme Design report has now been completed during September 2011

Whilst the previous report indicated that the design team had delivered the Scheme

Design Report one month earlier than programme, delivery of the final scheme design report will be two weeks ahead of schedule

Scheme design at level 1 (new build) is currently ‘on hold’ awaiting confirmation from GOSH whether the co-joined theatre forms part of the revised Client Brief .

Risks

The Trust have partially commented on the first draft of Phase 2B Client Brief issues which has been amended and issued to the design team
However, a number of GOSH response are urgently required before the Client Brief is concluded. This information is critical to the start of detail design in September 2011

Further meetings have taken place with the Trust to conclude the Client Briefing briefing documents to test for their validity (or amendments) for Phase 2B , These will be issued by mid September 2011

Phase 2B Risk Register

GTMS have produced the first draft of the Phase 2B Risk Register and a brainstorming session took place on 10th May 2011 to score each of the risks (input still required from GOSH on Clinical Risks)

The key risks which require further action are
* confirmation of the Client Brief at levels 1 and 2
* Phase 2B demolition
* Phase 2B new build over existing occupants
* air quality / supply & extract ventilation solutions
These will be the focus of attention in the next few months

There is a genuine desire to deliver a 3T MRI at the earliest opportunity, although a formal business case for this has not yet been presented.
The Operations and Redevelopment Teams have been tasked with looking at alternative solutions in delivering the MRI programme. A paper on the various options was submitted to Management Board in September 2011.

DCP 2010 / Phase 3 Schemes

The Phase 2B design team have completed a review of the 2010 Development Control Plan for the whole site and taking into account the purchase of the University of London Computer Centre at 20, Guilford Street.

This report was submitted to the November 2010 Trust Board, the January Trust Board and the Executive away day meeting on 2nd February 2011 and recommends the way forward for site development in the long term (10-20 years) and GOSH Redevelopment Phase 3 development and investment in the short term (2-10 years).

GOSH / ICH are currently reviewing the occupancy requirements of the ULCC site and a direction of travel paper has been submitted to the Management Board in September 2011

3. 0 Cardiac Wing Level 6&7 Report

Birth Defects Centre: The Project Status report at 08 August 2011 showed the project continuing to run to time and within identified budgets.

ICH Guildford Street works: noise and vibration parameters have been agreed with UCL/ICH and the Home Office and are now included in the Contract Conditions issued for Tender to the 5 short-listed Contractors on 24 January 2011 Keir have been

selected as the preferred contractor , contracts signed on 19th July 2011. Strip out has commenced and is on programme . A number of discovery items have been found during demolition , these are being managed from the project contingency.

Wolfson site development: the Contractor appointed for the project –including the enhanced works- is Peak Construction who took possession of the site 10 January 2011. The programme date achieved completion on 15th July 2011.

Portex Offices and GOS Relocations: These are part of the enabling works sequence for Phase 2B, the programme for which has now been confirmed. The location for Portex Offices has been established as Southwood L 4C and GOSH P21+ team are actively progressing the design

Risk summary

The risks around stoppages and unachievable noise constraints on 30 Guildford St previously rated as red –the latter being potentially mitigated by identifying a cost for contract termination - this work is now 50% completed with no significant delay. Other Guildford St risks remain amber. Enhanced Scheme related to funding are now rated green

William Mc Gill
Director of Redevelopment
28th September 2011

<table>
<tr><td colspan="2">Trust Board Meeting
28 September 2011</td></tr>
<tr><td rowspan="2">PALS (Patient Advice and Liaison Service) Annual Report 2010-11

Submitted on behalf of:
Liz Morgan, Chief Nurse and Director of Education</td><td>Paper No: Attachment W</td></tr>
<tr><td>Date considered by Clinical Governance Committee: June 2011</td></tr>
<tr><td colspan="2">Aims / summary
To provide the Trust Board with an overview of PALS activity during 2010-11.</td></tr>
<tr><td colspan="2">Action required from the meeting
To note the content of the report.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
STRATEGIC OBJECTIVE 2: Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations</td></tr>
<tr><td colspan="2">Financial implications
None.</td></tr>
<tr><td colspan="2">Legal issues
N/A</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Chief Nurse/Director of Education, Deputy Chief Nurse</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
Chief Nurse/Director of Education</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Grainne Morby, Head of Public and Patient Involvement</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Chief Nurse/Director of Education</td></tr>
<tr><td colspan="2">Author and date
Anna Ferrant, September 2011</td></tr>
</table>

The Pals (Patient Advice and Liaison Service) Annual Report 2010/2011

Summary of Report

1. Overall Volume of Activity –
2, 800 families assisted, 1111 cases opened, 1689 information enquiries/contacts. Casework has increased by 55% against last year's figure of 718.
1.1 Number of Pals cases by year
1.2 Number of Pals episodes per 1000 patients

2. Source of Referrals

3. Cases by Ethnicity

4. 872 Green Cases
4.1 872 Green Cases by Subject
4.2 872 Green Cases by Directorate

5. 204 Amber Cases
5.1 204 Amber cases by Subject
5.2 204 Amber cases by Directorate

6. 35 Red Cases

7. **Learning and Issues for Improvement - identified from Pals Cases**

- Current issues being worked on at year end include:
  Appointment Centre - parents experiencing difficulties in communication
  Gastroenterology - service issues.
- Care Co-ordination of complex children under multiple specialties
- Admission process on Kingfisher ward – ensuring families arrival known to nursing staff
- Information and planning of Neuromuscular OPA's to eliminate unnecessary cancellations and ensure that family knows about any booked physiotherapy.
- Provision of breast feeding support in Haringey
- Access to NHS treatment for children newly arrived in the UK
- Facilities on wards for increasing numbers of young patients with multiple disabilities/wheelchairs/hoists etc
- Confusion as to what is and what is not disclosable from third parties in medical notes.
- Disseminating good practice in postoperative and procedural pain management and waiting time for access to chronic pain management clinic.
- Communicating need for X-Rays prior to Orthopaedic outpatient clinic
- The scope and relevance of the 'Managing Conflict' policy in relation to patients in the community.

8. **Pals User Satisfaction**

9. Casework and Recording System

10. Pals Input to Staff Training and Development

11. Patient and Public Involvement

12. Appendix 1- Grading of Pals Cases

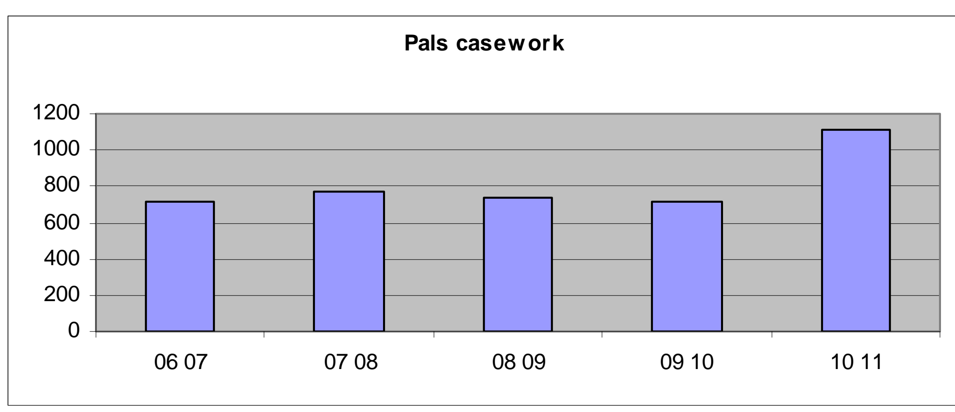
1. Overall Volume of Activity

Pals experienced a substantial increase in complex casework (Green and Amber cases) in 2010/2011 and a small decrease in straightforward information queries.

Pals helped over 2,800 families and patients during the course of the year.

Pals recorded 1111 cases of which 872 were Green, 204 Amber and 35 Red. In addition there were 1689 White information enquiries/contacts recorded. The number of Green cases increased by 51%, the number of Amber cases by 62% and overall casework increased by 55% against last year's figure of total cases of 718.
(Please see Appendix for detail on classification).

1.1 Number of Pals cases by year

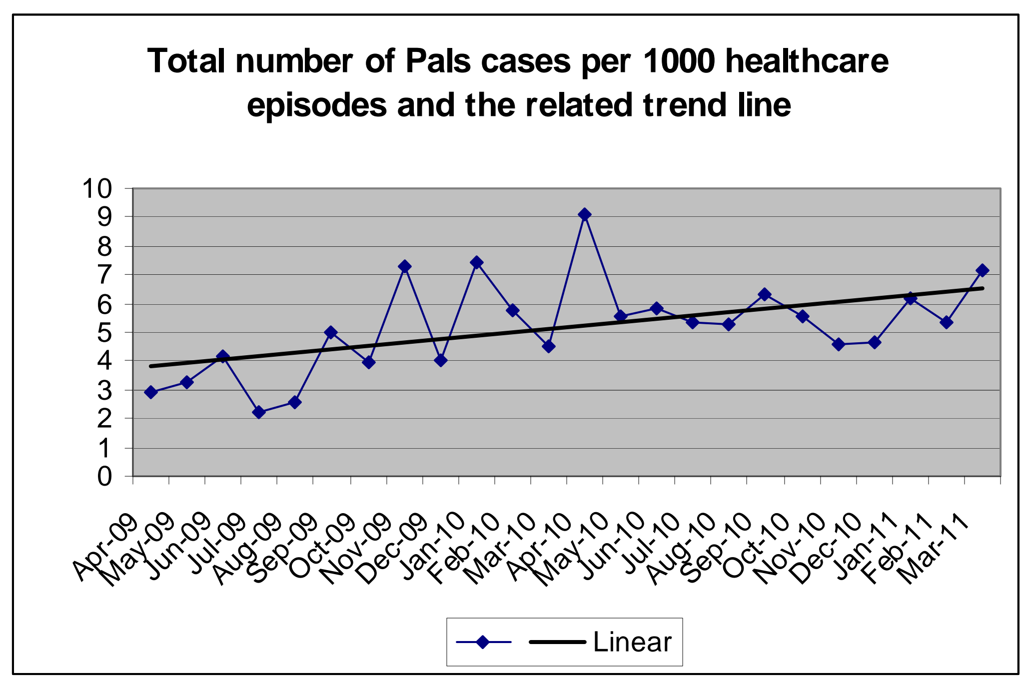


This graph illustrates the number of cases Pals has helped with over the past five years (Green, Amber and Red).

1.2 Number of Pals episodes per 1000 patient episodes

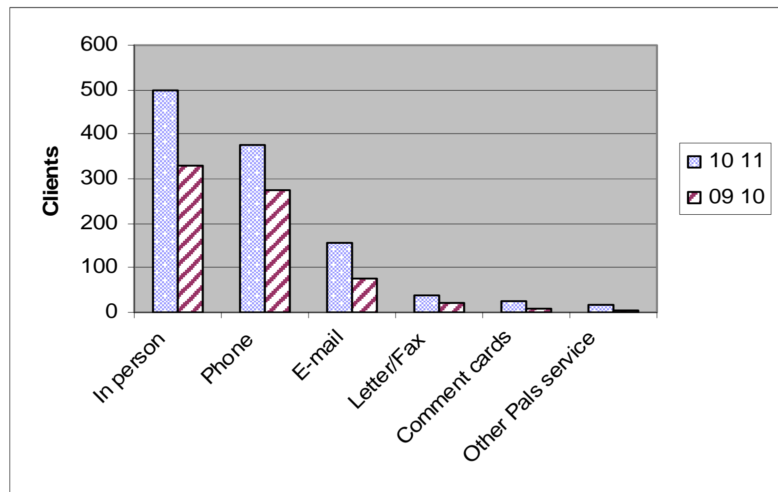
This figure shows the total number of Pals cases per 1000 healthcare episodes. This enables us to see whether the number of episodes influences the number of Pals cases the Trust receives.

- A flat line would indicate that the number of Pals cases is directionally proportional to the number of patient episodes in the Trust.
- An increasing trend line (as illustrated) indicates that Pals are helping with a proportionally higher number of issues and that Pals workload has increased.



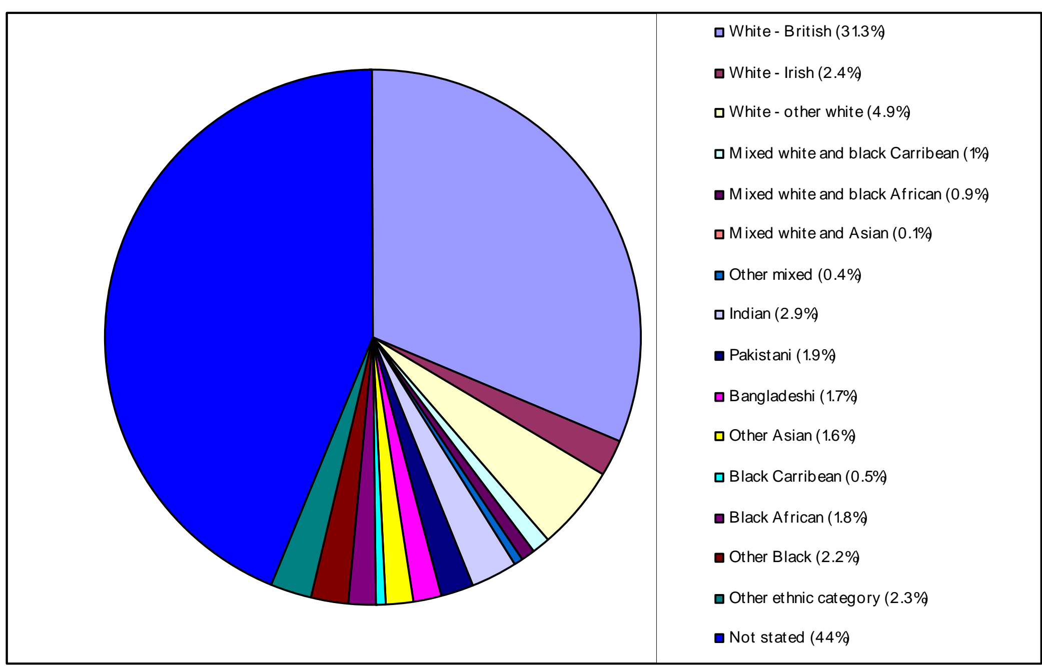
Healthcare episodes includes inpatients, daycases, and outpatients episodes

2. Source of Referrals



This graph illustrates how the quantity of Pals cases has increased from all referral sources during 2010/2011. Two years of data is presented so that comparisons can be made. A high proportion of clients come to Pals following recommendations from staff.

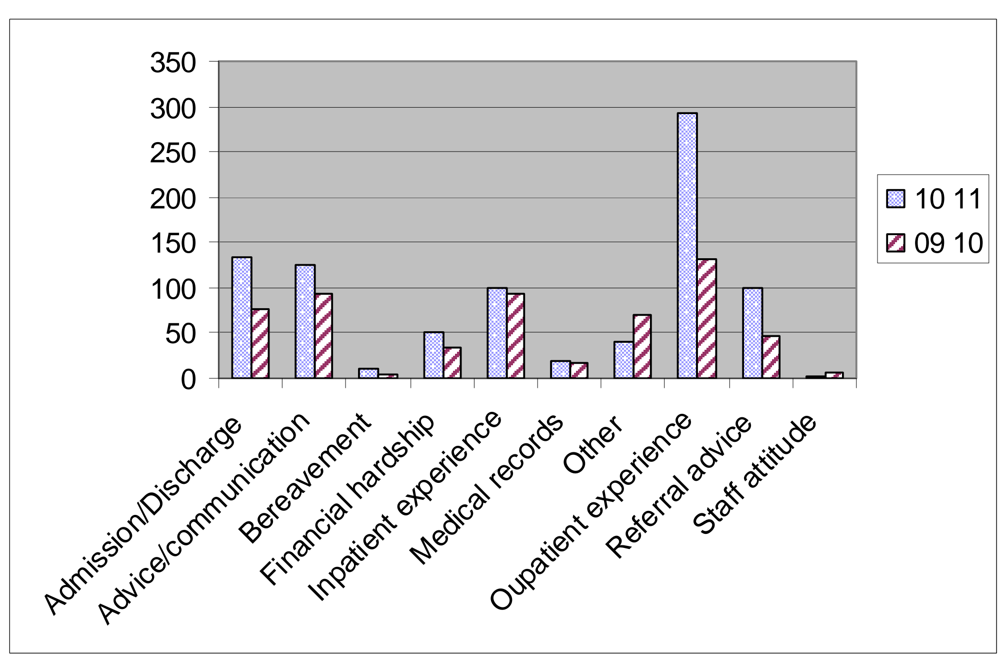
3. Cases by Ethnicity



This chart shows that Pals users reflect the overall ethnicity of GOSH patients.

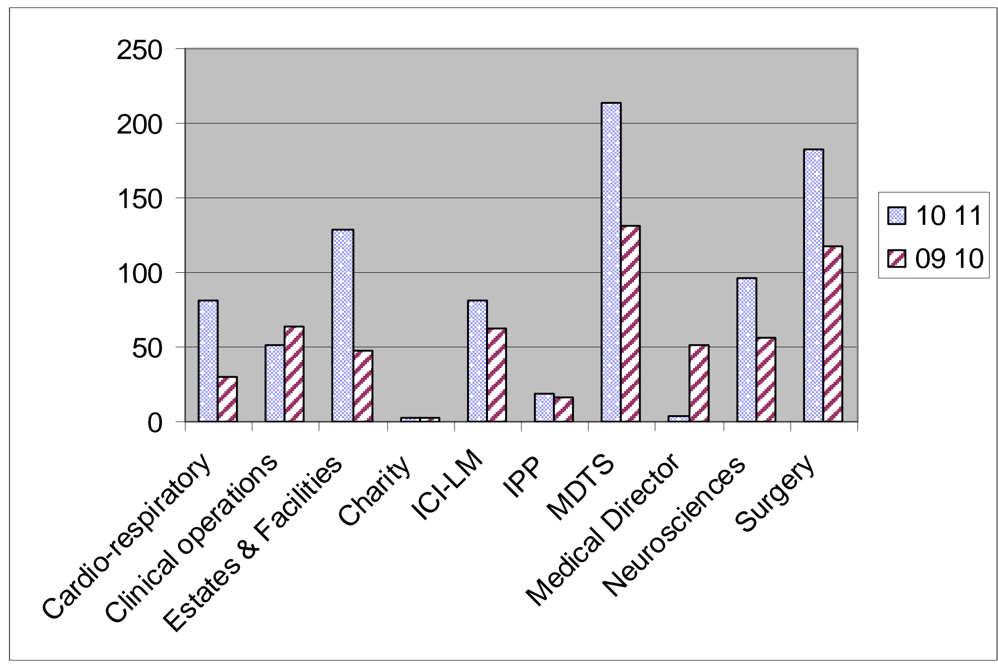
4. 872 Green Cases

4.1 872 Green Cases by Subject



This graph summarises the main issues presented with green cases over the past two years. Issues with the Outpatient experience have been raised frequently by parents, however these are usually dealt with quickly and escalation is avoided. [Overall Trust-wide outpatient activity has increased by 11% from 09/10 to 10/11]. Steep increases are seen with admission/discharge and referrals – Pals often offers intensive liaison work internally.

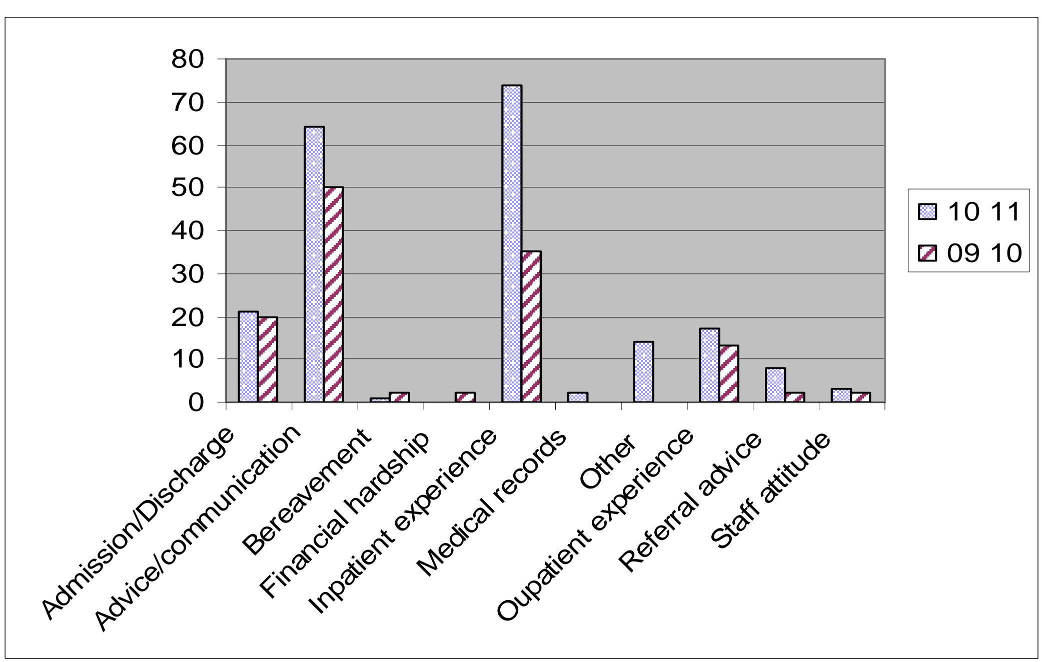
4.2 872 Green Cases by Directorate



This graph shows the number of Pals Green cases have increased for most Directorates compared to last year. Decreases are seen for the Directorates of Clinical Operations and the Medical Directors Office.

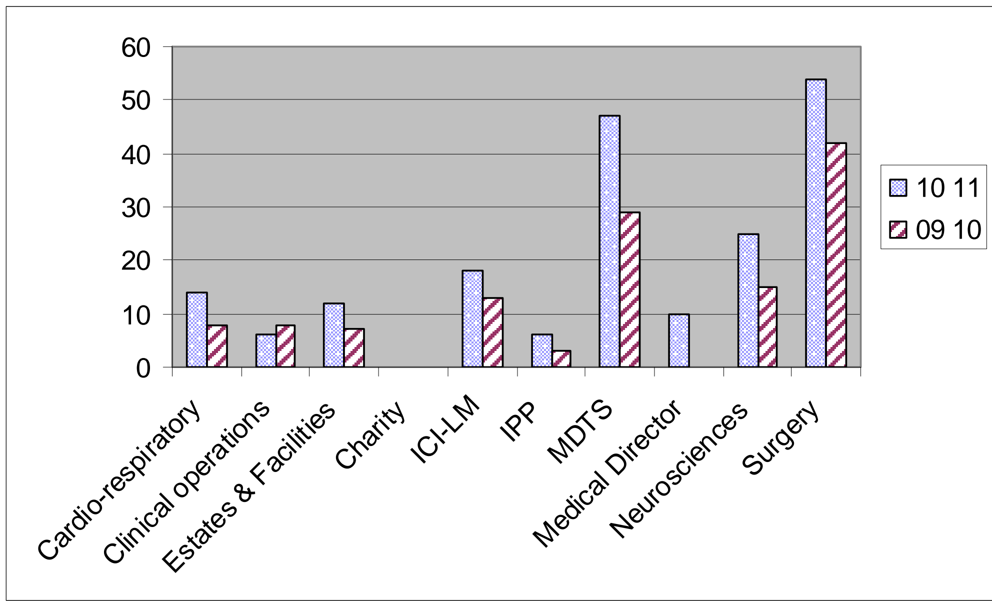
5. 204 Amber cases

5.1 204 Amber cases by Subject



The above graph illustrates that most of Pals complex and longer-term cases relate to the inpatient experience.

5.2 204 Amber Cases by Directorate



This graph shows that for Pals amber cases; most issues concerned the Directorates of Surgery and Medicine & DTS. Increases are in proportion to those seen in other Directorates. Pals is contributing to current Improvement work in Medicine and DTS (for gastroenterology).

Amber cases for Surgery for 10/11 were reviewed for this report, due to the number of cases received. The main issues were communication, admission and the inpatient/outpatient experience. Waiting times and cancellations were identified as themes however no significant trend was present.

6. 35 Red cases.

Thirty five cases were referred on to the Trust's CGST team; this is 3% of the total casework received. Red cases are cases that need rigorous investigation or where Pals has exhausted all possible options of local resolution.

7. Key Issues for Improvement identified by Pals in 2010/11

Current issues being worked on at year end include:

Appointment Centre - parents experiencing difficulties in communication
Gastroenterology - service issues.

The following issues were identified for the Trust by Pals in 2010/11 as needing action or improvement. An update of actions taken is included.

Care Co-ordination of complex children under multiple specialties
Update: Pals has met with General Paediatric team to share understanding of respective roles and referral protocol.

Admission process on Kingfisher ward – ensuring families arrival known to nursing staff
Update: Ticketing system introduced to ensure that arrival is flagged up to nursing station

Information and planning of Neuromuscular OPA's to eliminate unnecessary cancellations and ensure that family knows about any booked physiotherapy.

Update: Case discussed by OP Risk Group who agreed to work with the specialty to identify and implement any improvements.

Provision of breast feeding support in Haringey
Update: Following the concerns being raised the provision of breastfeeding support in the borough has been reviewed and a breastfeeding support group set up to offer local families more support.

Access to NHS treatment for children newly arrived in the UK
Update: GOSH Legal team waiting for updated advice from DH in order to provide further guidance to staff and parents.

Facilities on wards for increasing numbers of young patients with multiple disabilities/wheelchairs/hoists etc
Update: OT agreed to advise on equipment needed and AD Nursing to investigate for all wards. The issue of reviewing changing needs of young patients with multiple disabilities has been referred to the Equality and Diversity Committee.

Confusion as to what is and what is not disclosable from third parties in medical notes.
Update: Legal Department agreed to write guidance for the necessary amendments to GOSH policies.

Disseminating good practice in postoperative and procedural pain management and waiting time for access to chronic pain management clinic.
Update: Action plan to increase awareness of Pain Service in place.

Communicating to parents the need for X-Rays on main site prior to Orthopaedic outpatient clinics
Update: The Outpatients Manager introduced a new procedure whereby patients on the orthopaedics clinic list are telephoned in advance if they need to use X-ray machine on main site prior to clinic.

The scope and relevance of the 'Managing Conflict' policy in relation to patients in the community. Pals gave casework examples which highlighted that the sanctions in the Managing Conflict policy were not effective for out-patients or in relation to patients requiring home visits. The sanction in the current policy to a family not changing their behaviour is to limit or supervise access to their child whilst at GOSH as an in-patient.
Update: The Assistant Director of Nursing convened a working group which produced a separate policy for community services based on 'best practice' elsewhere.

8. Pals User Satisfaction

Satisfaction surveys were sent to Pals casework clients in 2010/2011. Questionnaires were returned by 88 families (Green and Amber cases). The results were encouraging – typical comments include 'Very helpful and resolved our problems', 'They action the problem quickly'.

Clients were asked why they had contacted Pals, how they heard about the service, whether they had been given clear information about access, whether they were concerned that they might be treated badly if they raised a concern, whether

relationships with staff improved after accessing Pals, whether their concerns were addressed in a timely manner, whether contact with Pals had led to change that resolved their concerns, what Pals had done well and what Pals could improve upon.

9. Casework and recording system

This report includes new comparative data charts. The Pals case recording and reporting system introduced in 2009/10 (details in Appendix 1) is now incorporated into Pals systems, enabling improvement in overall reporting and for more analysis of trends and themes to take place.

10. Pals Input to Staff Training and Development

Pals continued to support and deliver high-quality provision of Conflict Resolution Training to all staff members in the Trust. This has taken place on centrally-coordinated training sessions, as well as locally-delivered bespoke training solutions for 250 members of staff.

Pals also contributed to the delivery of GOSH's student nurse sign off mentorship programme. This programme provides teaching on relevant transitional issues for final placement students. For the past two programmes the Pals provided support and delivered sessions, teaching about the role of Pals within the NHS and conflict resolution within the workplace. These sessions have always evaluated very well by the student nurses involved. Pals also continued to contribute to induction training to raise awareness of local resolution and managing conflicts at GOSH.

11. PPI (Patient and Public Involvement) responsibilities

Pals continued to play a major role in PPI activity during the year, supporting the Chair, Members and activities of the Member’s Forum, recruitment of parent representatives and the development of a Patient Experience Action Plan which is part of Year 3 (2011/12) of the Trust’s PPI/Engagement strategy. A separate PPI Annual Report 2010/11 is in preparation.

12. Appendix 1- Grading of Pals Cases

White

Enquiries that can be responded to through the provision of verbal or written information are categorised as White Cases. Responses will be factual and will not be matters requiring complex judgement. White are inquiries for information, clinical and non-clinical, GOSH related and non-GOSH related. These information requests are analysed quarterly to identify potential unmet need for patient and public information, and reported to the Child and Family Information Group (CFIG), a sub-group of the Patient and Public Involvement and Experience Committee (PPIEC) which monitors whether GOSH needs to produce information for patients/public on the topics identified.

Green

A case is categorised as Green when it involves

- A distressed or angry person; or someone who presents as 'wishing to complain'
- dissatisfaction with a service, or an experience that is not directly related to clinical care
- dissatisfaction with a service or experience related to clinical care which can be resolved quickly, or is a single resolvable issue that has relatively minimal risk to the provision of clinical care.

Green cases are routine Pals cases which are dealt with by Pals, in liaison with other staff, within 24 hours or to a timetable agreed with the enquirer. They are reported on numerically, by Unit /specialty and by subject of enquiry to QSC quarterly. Any issues/learning/change from Green cases will be identified and monitored through reports to QSC.

Amber

A case is categorised as Amber when it involves

- A patient/family experience of a service that has fallen well below their expectations in several ways, but is unlikely to cause lasting problems.
- A patient/family experiencing confusion or distress about their care and requiring some level of on-going support in order to re-establish trust with clinicians, get their views heard, or to reshape or better understand care plans.
- Any case which involves a Pals officer agreeing to accompany a patient/family to a clinic consultation, to any meeting involving members of a clinical team, and to any case which involved Pals having been asked to attend an 'incident' involving angry or distressed patients or their families.

Amber cases take longer to resolve, are often complex and may involve differing expectations or perceptions of service. Issues/learning/change from Amber cases are also identified and monitored through reports to QSC and include a summary of the patient/family reported experience giving rise to the issue, and its originating Unit/specialty.

Red

A Pals enquiry is categorised as a Red case when it involves

- A significant issue regarding the quality of clinical care that involves clear risk management issues to the patient, possible litigation against the Trust and/or possible adverse publicity for the Trust.
- A serious issue that may appear to cause long term damage, such as grossly substandard care, professional misconduct or death.
- Complaints that appear to involve serious safety issues that require immediate and in-depth investigation in order to establish the facts and reassure the patient/family.
- Complete rejection by the enquirer of all forms of local resolution, and an insistence on the issue being escalated to the Chief Executive, the media etc.

Red cases are cases identified by Pals as high risk. They are referred within 24 hours to the Clinical Governance and Safety Team (CGST) and dealt with by CGST. Pals will report to QSC on the volume and nature of red cases referred to CGST to enable this referral rate to be monitored, over time.

Trust Board Meeting
28th September 2011

Annual Aggregated Analysis of Incidents, Complaints and Claims **Submitted on behalf of** Professor Martin Elliott, Co-Medical Director	**Attachment X**

Aims / summary

This report aims to give an overview of the main issues identified through an aggregated analysis of incidents, complaints and claims for 2010-11. A quarterly report is presented to the Clinical Governance Committee at each meeting.

The report includes:

- A comparison of serious incident and complaints rate
- an assessment of key themes and trends evident in incidents, complaints and claims across the organisation
- Update on risk issues identified in the previous report.
- Progress update on plan for improvement and expansion of the aggregated analysis report.

Action required from the meeting

Review the report and assess whether the Trust Board feels that sufficient steps are being taken to mitigate the risks identified through aggregated analysis of incidents, complaints and claims.

Contribution to the delivery of NHS / Trust strategies and plans

Through learning lessons and implementing risk mitigating actions following incidents, complaints and claims the Trust is working towards achieving its goal of zero harm, no waste and no waits

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

Roisin Mulvaney, Patient Safety Manager
21st September 2011

Annual Aggregated Incidents, Complaints and Claims Report
Clinical Governance Committee, September 2011
September 2010 – August 2011

This report aims to provide the Trust Board with an Aggregated Analysis of the Incidents, Complaints and Claims have arisen between September 2010 and August 2011.

Key risk themes in each area were analysed collectively by the Patient Safety Manager, Complaints Manager, Trust Solicitor and Legal Services Manager. Separate, more detailed, reports are available which look specifically at the trends in each area. The purpose of this report is to aggregate across the three departments to look for trends which may not have been as evident on a case by case basis. Through the aggregation of key concerns arising from these areas, the Trust Board is provided with information about the types of issues that have arisen which may affect its achievement of the 'No Waits, No Waste, Zero Harm' targets.

This report aims to give an overview of the main issues identified through an aggregated analysis of incidents, complaints and claims.
The report includes:

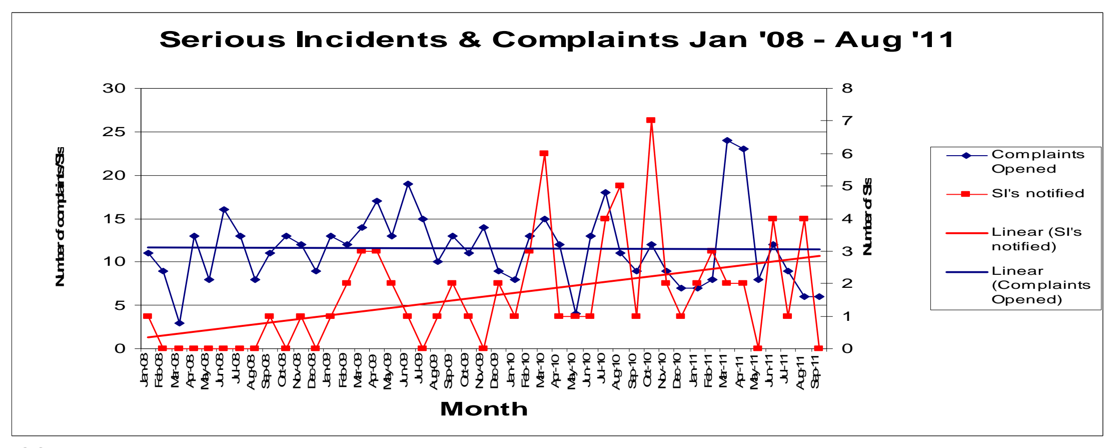
- A comparison of serious incident and complaints rate
- an assessment of key themes and trends evident in incidents, complaints and claims across the organisation
- Update on risk issues identified in the previous report.
- Progress update on plan for improvement and expansion of the aggregated analysis report.

Comparison of Serious Incident and Complaints Rates

This chart shows the relationship between the occurrence of complaints and the occurrence of Serious Incidents.

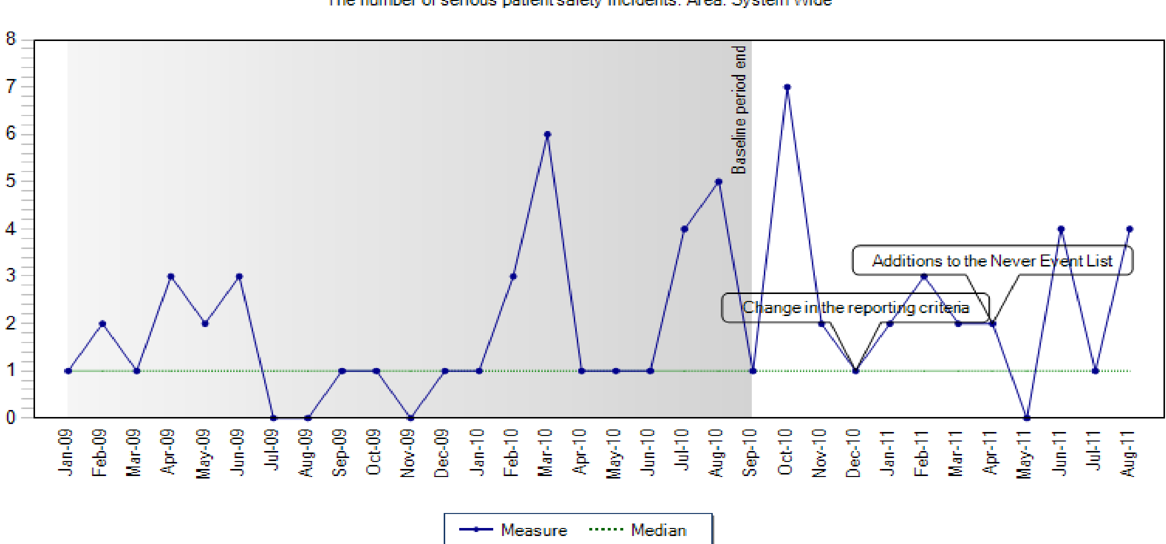
The trend in Complaints suggests that outside of a spike in complaints in March and April 2011, the figures suggest that there has been a decrease in the number of complaints seen each month. The spike noted in March-April 2011 coincided with an increase in PALS referrals in March 2011. Neither Team has been able to point to a clear cause of the increased numbers.

There has been a significant increase in the number of SIs which the Trust has reported over the last 3 years. The Trust recognises that this is due to a change in the reporting culture around Serious Incidents in the Trust, combined with changes in the expectations of external organisations (NPSA, NHS London) in relation to the types of incidents which should be reported. However, the chart below also suggests that we are starting to see a decrease in the numbers of SIs reported. We will continue to monitor these rates on a monthly basis to determine whether we are seeing a sustained decrease.



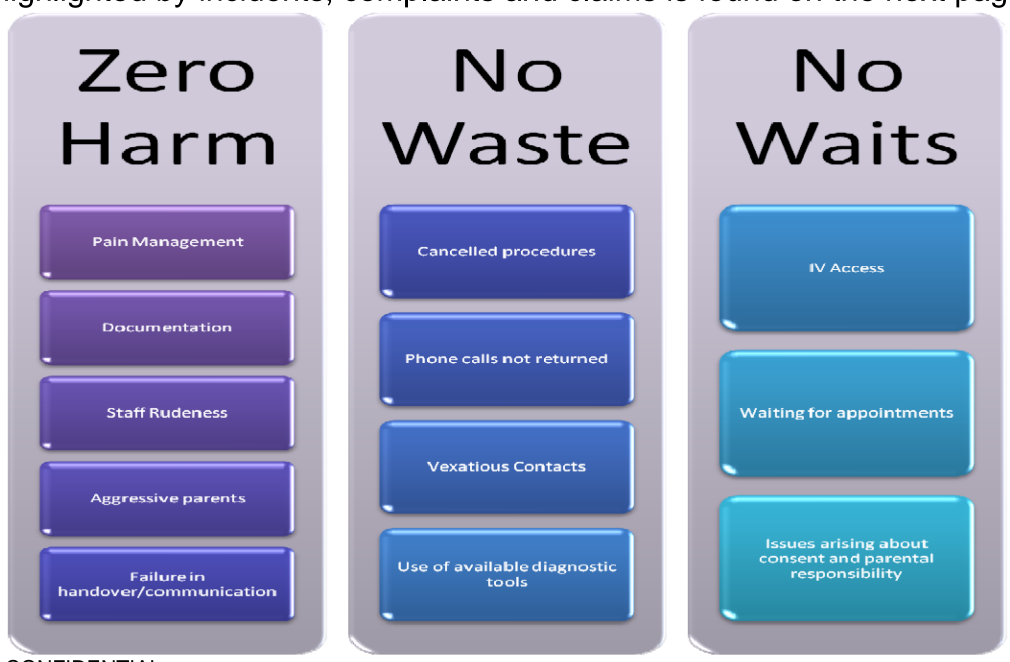
Further to a request from the Clinical Governance Committee at the June meeting, the Transformation team have undertaken an analysis of the SIs with specific reference as to the impact of the change in reporting criteria.

The Transformation team have provided the chart below, and indicated that, on the basis of the SI figures provided, they can draw no conclusion. When analysing data, they check for 7 successive data points either above or below the median. This is not evident currently, so they have advised that further measurement is required.



Comparison of Themes & Trends June– August 2011

The following section sets out the key issues identified through aggregated analysis which may affect the Trust's achievement of the 'No waits, No Waste, Zero Harm' targets. More detailed information on the specific issues highlighted by incidents, complaints and claims is found on the next page.



Complaints	Serious Incidents	Claims/Legal
Cancellation of procedure and patients having to **wait a long time to access care** at GOSH was highlighted in 28 complaints. One complaint related to a patient whose procedure was cancelled 3 times, and another related to an inpatient who was kept nil by mouth for 6 days in one week for a procedure which was repeatedly cancelled. Families reported significant delays in getting surgical dates, and subsequent follow up appointments. One family felt that their child had been '*neglected for 7 months'* and asked the Trust to understand the *'time, energy and emotional effort'* that the family had spent chasing the appointment rather than caring for their child. 15 complaints were made about **staff attitude,** including staff being rude, abrupt or inappropriate. Three complaints related to non clinical staff. Many of the complaints related to staff being dismissive at appointments. One family described how they were *'talked over'* by the doctor while on of the parents was crying. They were *'appalled'* by the '*lack of sympathy, poor communication skills and lack of professionalism'*. 5 families made complaints about what they perceived to be as inappropriate referrals to social services. 8 families reported **problems in contacting services**, or getting their calls or emails responded to. This includes clinicians and secretaries. In one complaint a family described *being 'appalled by the extent of stress'* that had been put though as a	There have been 26 serious incidents notified by the Trust between September 2010 and August 2011. 19 SIs have been fully investigated and closed. Three of these related to MRSA bacteraemias. These investigations highlights failures in **compliance with the central venous line care bundle** and the need for a **standardised approach to central line insertion** across the specialities which undertake the procedure. 7 SIs which occurred between January and August 2011 are currently open. Two of these are overdue. The current status of all open SI's is monitored weekly by the Executive team and monthly by the Quality and Safety Committee. SIs key themes which have been highlighted include: **Failures in the multi-disciplinary team working** in terms of pre-assessment and during the patient's admission. Areas for improvement in the **care of the deteriorating patient** were also highlighted. At least 6 SIs in the last year have identified failure of **handover/communication** processes as a significant contributory factor to the incident occurring. The incidents investigation included communication with families about the route of administration of contrast, the process for communicating about the type of post mortem consented for, the effectiveness of multi-disciplinary communication, clear communication with external referring hospitals about the equipment needs of patients. Failures in **handover processes** resulted in two incidents of staff being unaware of the actual procedure which a patient had undergone. Two incidents cited failure of the interventional radiology handover process as contributory factors. Patients are having to wait for significant period of time to have central lines inserted. The Trust had an SI and a claim regarding an incident of major delay in patient's getting appropriate **intravenous access**. In addition may incidents	There have been 5 new confirmed and 1 non confirmed clinical claims between September 2010 and August 2011. One of these claims relates to a patient who died following an accidental overdose of glucose on NICU. The incident was previously investigated by the Trust under the SI process. Key learning was identified in relation to the **process for administration of fluids and medications to neonates via a syringe pump**. Immediate action was taken by the Trust at the time of the incident (January 2008) and this learning has subsequently been made the subject of a National Patient Safety Agency Rapid Response Report. The 4 other matters were not reported as incidents at the time of occurrence. Learning will be identified from the ongoing claims investigation and reported accordingly. The NHSLA have highlighted to the Trust a potential risk management issue in relation to **patient confidentiality.**

result of leaving messages that were not being returned. The family stated that they were given the impression *'that some staff are not committed to their job'* and there was a '*profound gap in service*'. 10 complaints related to the **environment**. This included cleanliness and access to toys. There were also two complaints from the families of teenaged children who found the facilities inappropriate for their age. 9 families highlighted problems with **disorganised and disappointing patient admissions**. This included two families who specified that they felt there was a lack of coordination between specialities at GOSH. 20 complaints related to **poor communication** with families, including the accuracy of information being provided. Again many of these complaints noted a a perception of clinicians being dismissive of their concerns or not listening to them. **Misdiagnosis** was suggested by 7 complaint letters. Following the death of their child 4 families highlighted **concerns about the treatment the patient received**. The patients involved all died on PICU, and different specialties were involved in their care. In addition to this, 14 families highlighted concerns about the quality of care provided. 13 families highlighted problems with pain management. One parent described her child being left in severe pain for several hours during a	have been reported and a complaint has been made regarding patients having femoral lines removed when leaving PICU and the being added to waiting lists for re-insertion of central access on the ward. Work is being led by the chief nurse to explore the safety issues relating to the use of the femoral lines for intravenous access. Failure to fully implement/ intensively monitor the ongoing implementation of **national guidance** was identified in 4 SIs, two of which were Never Events (wrong site surgery and retained needle) post procedure. The other incidents included guidance on the use of appropriate imaging for the insertion of lines and chest drains in emergency situations. It was also identified that staff do not appear to be **fully using the resources which are available** to them to prevent/detect complications arising from treatment. The failure to use available images of equipment for imaging has been a common contributory factor in 5 of the serious incidents investigated in the last year: ♦ Ultrasound guidance not used to place a vascular line in the patient's neck ♦ Family to undertaken an xray in theatre to check for a needle noted to be missing during a procedure ♦ Failure to check imaging in theatre prior to incision on the wrong site ♦ Echo not undertaken following ECMO cannulation may have led to delay in detecting that it was in the wrong place ♦ Difficulties in interpreting images of a misplaced chest drain. 3 of the SIs investigated this year have identified the need for clearly defined escalation of concerns to consultants in appropriate circumstances. This is a lessons that all wards in the Trust can learn from and they should not wait for an incident to happen in their area for them to realise the importance of clearly defined escalation routes. The Quality and Safety Committee has already identified this issues and the COO is leading on ensuring that each area develops escalation algorithms with the support of their specialty consultants. **The key lessons which have been learned this year also include:**	In addition to claims, the legal team has also identified learning in relation to: Poor **documentation** which may result in the Trust being unable to defend a potential claim. Clinicians need to understand that poor documentation = poor care. Confusion/lack of clarity about **parental responsibility** The impact of complex and long running complaints/contacts with families on staff time within the legal team, the clinical governance and safety team and the PALS team.

weekend as nursing staff consistently bleeped the registrar but were ignored. Others reported harm their children had suffered through failure to remove stitches, multiple re-bleeds, misplaced cannulas, blocked ports and infections. 8 families drew attention to failure in **discharge planning.**	♦ Improving understanding and clarity about the radio-opacity of surgical needles to ensure that every step is taken to avoid a 'retained instrument' never event. ♦ Ensuring that staff are using the appropriate imaging equipment when inserting lines and chest drains. ♦ Introduction of frequent joint morbidity and mortality meetings between PICU and Neurosurgery ♦ Change in clinical practice regarding blood pressure targets and EVDS for patients with brain injuries. ♦ Re-development of the Trust's consent form ♦ Ensuring that staff are using all appropriate imaging to ensure that the correct site of the procedure is identified (to prevent against a wrong site surgery never event) ♦ The need to ensure that clerking happens consistently and robustly for each patient who is admitted to the Trust. ♦ Development of cumulative summary (Cusum) analysis charts for two high risk procedures (cerebal embollisations and craniotomies) which will help teams to track their complication rates and provide more up to date risk information to families during consent. ♦ Improved training and awareness about prevention of pressure sores, and how to grade and document information about pressure sores. ♦ Re-assessment of the sensitivity of the pressure sore assessment tool currently being used by the Trust. ♦ Implementation of a new formalised structure to ensure better MDT working for spinal patients	

Follow up on Lessons Learned in previous report

Over the last year, the following issues were highlighted through the aggregated analysis. This section provides an update on the actions that the Trust is taking to mitigate against other patients experiencing the same problems.

1. Pressure Sores	What is being done to minimise the risk of harm to patients?
Pressure sores (and other forms of tissue damage) have featured highly this quarter through incidents and complaints. As of 2011, pressure sores of grade 3 and 4 have had to be reported to the NPSA and SHA as Serious Incidents. Delays were noted in these incidents being reported. In order to try to prevent the occurrence of grade 3 and 4 pressure sores, the Trust is recommending that RCAs are undertaken at local level for all grade 2 pressure sores.	♦ The Tissue Viability guideline has been updated to reflect new guidance from the National Patient Safety Agency, including the importance of timely reporting ♦ The CGSTimes Safety Newsletter has included a section on pressure sores ♦ PICU/NICU have developed a new flow chart to help their assessment of risk to patients and choice of tools available to them ♦ PICU/NICU have launched an awareness raising campaign to ensure that their staff are aware of risk factors for pressure sores ♦ The Trust is reviewing whether it's risk assessment tool is sufficiently sensitive to help us ensure that all steps are taken to prevent pressure sores developing. ♦ The Trust continues to work on the development of the Trust wide tissue viability service to support local areas in the prevention and treatment of pressure sores.
2. Medication Errors	**What is being done to minimise the risk of harm to patients?**
Medication errors continue to take place in the Trust, but a moderate/high level of harm is generally not identified via incident reporting or complaints. One SI related to a medication error. This was in the context of a clinical study and was reported as a Serious Breach to the MHRA. The level of harm to the patient was unclear, but is considered to be low – moderate.	♦ The Trust continues to work on improving medication errors on a Trust wide level, as well as through local improvement projects. ♦ The risk of medication errors is included on many local risk registers. This ensures that local areas are frequently assessing the strength of their attempts to control the risk of medication errors causing harm to patients. ♦ Medication errors reported through the incident reporting system are included
3. Lack of coordination between specialties	**What is being done to minimise the risk of harm to patients?**
This was identified across several complaints. One family described it as feeling like each doctor only focussed on their specialty and no one was looking at the *'big picture.'* Another family described feeling the absence of a *'holistic approach'*. Several recent SIs, including the Spinal Review, have also highlighted gaps in the multi-disciplinary approach to pre-assessment.	♦ The Trust has introduced a team of General Paediatricians who started in April of this year. ♦ The action plan for the Spinal Review has a very strong focus on improving the MDT approach to pre-assessment.
4. Delays in families being able to access information	
There was no common directorate or specialty involved in all of these incidents unfortunately. The complaints team is continuing to monitor for evidence of a trend. The Pals team also reported a similar problem in their Q4 report	♦ Each issue has been investigated separately. Changes were made to the outpatients phone system however the problem seems to be much wider that outpatients or central bookings.

Trust Board
28 September 2011

Update on 6 day working **Submitted on behalf of** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment 1**

Aims / summary
To provide an update on the current status of 6 day working and extended working hours.

Current weekend provision
- 223 beds are open for patients needing to stay over the weekend and for emergency admissions.
- A staffed emergency theatre list is available 24 hours a day, for 7 days a week, with an additional on-call emergency list available if required.
- Laboratories and imaging are available for emergency and urgent diagnostic testing.
- No routine out-patient services are provided at weekends

Theatres
- Cardiac theatres run two all day lists as extended lists from 8.30am - 7pm. These shifts are covered by rostered staff.
- Overall theatre use by international and private patients has increased by over 70% since April 2011, with Saturday sessions increasing from an average of 4 sessions per Saturday, to over 5.5 in July 2011.
- A general surgery waiting list initiative list is being provided on the first Saturday of each month.

Next steps
A project plan will be developed in January 2012 (or post FT authorisation) which will cover the following actions:
- Planning and modelling to match staffing and other resources with demand.
- Financial modelling - ensure decrease in unit costs
- Role redesign and skill mix
- Plan for sustainability after implementation, particularly workload planning and organisational structures
- Outcome measures and audit before and after implementation

Action required from the meeting
To note the current position

Contribution to the delivery of NHS / Trust strategies and plans
Additional capacity would be required to meet upside case growth projections.

Financial implications
Additional costs, particularly in relation to higher staffing costs for weekend working, will be offset by increased income and greater utilisation of existing assets.

Legal issues
Existing contracts for consultants and other staff provide a specific framework for costs and hours of work. It may be necessary to set local terms and conditions to enable six day working consistently across the hospital.

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?
A full consultation process with staff will need to be completed.
Commissioners need to be informed of any significant change in hospital capacity.
Patients and families will be involved in the development of service models for Saturday working.

Who needs to be told about any decision
Staff
Commissioners
Patients and families

Who is responsible for implementing the proposals / project and anticipated timescales
Sven Bunn
FT Programme Manager

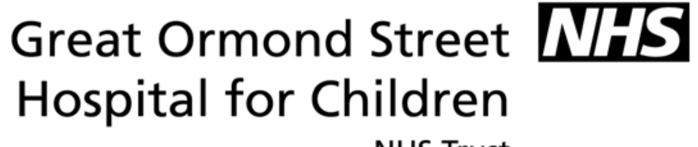
Implementation of additional capacity will be phased over a 2 year period to meet anticipated requirements.

Who is accountable for the implementation of the proposal / project
Fiona Dalton
Chief Operating Officer

Author and date
Sven Bunn
20 September 2011

ATTACHMENT 2

Attachment 2



FINAL MINUTES OF THE CLINICAL GOVERNANCE COMMITTEE

Held on 21 June 2011

Present:

Andrew Fane	Non Executive Director and Chair
Jane Collins	Chief Executive
Andrew Copp	Non Executive Director
Fiona Dalton	Deputy Chief Executive
Elizabeth Morgan	Chief Nurse and Director of Education
Mary MacLeod	Non Executive Director
Salina Parkyn	Acting Assistant Director, Clinical Governance and Safety
Aaron Shah	Assistant Director Audit, LAC

In attendance:

Mr Ray Conley	Head of Human Resources Operations
Mrs Angela MacLennen	Head of Patient Complaints
Mr Stephen Moxley	Record Manager
Mr Andrew Pearson	Clinical Audit Manager
Ms Caroline Joyce	Assistant Director of Nursing
Ms Judith Cope	Chief Pharmacist
Dr Anna Ferrant	Company Secretary (minutes)

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

1.	**Apologies for Absence**
1.1	There were no apologies for absence.
2.	**Minutes of the meeting held 16th February 2011**
2.1	The minutes of the meeting held on 16th February 2011 were received and **approved** as an accurate record, subject to the following amendments:
2.2	86.4: The sentence should read: "*He advised Committee Members that current decontamination techniques were not sufficient to remove the pathogen <u>from</u> surgical instruments used for patients <u>who were</u> at risk of infection.*"
2.3	88.3 – Removal of the repetition of 'number of complaints' in the third line.
2.4	90.2: To replace: "*She said that the Co-Medical Director (BB) had been asked to form a panel to aid future case selection. " with "The Co-Medical*

	Director, Dr Barbara Buckley had worked to develop the existing multi-disciplinary team into an integrated team. It was agreed that an update be provided on the outcome of the spinal surgery review in September 2011."
2.5	***Action**: The Co-Medical Director, Professor Martin Elliott to provide the Committee with an update on the outcome of the spinal surgery review in September 2011.*
2.6	92.5: The bullet point should read: The phrase 'Your work in Haringey
3.	**Matters Arising and Action Point Checklist**
3.1	The Committee received updates on the following actions:
3.2	86.7: The Chief Operating Officer stated that it was important to include reference to infection control in relevant job descriptions and agreed to carry this action forward.
3.3	91.5: Mrs Macleod, Non-Executive Director stated that a meeting of the Ethics Committee was planned to be held in the forthcoming weeks.
3.4	There were no other matters arising.
4.	**Self assessment of committee's effectiveness**
4.1	The Company Secretary, Dr Anna Ferrant presented the report. Upon reviewing attendance at the Committee throughout the year, the Chairman emphasised the importance of attendance by one of the medical directors.
4.2	The Committee noted the reference to the Ethics Committee report received earlier during the year. Mrs Mary MacLeod Non-Executive Director and newly appointed Chair of the Ethics Committee stated that revised terms of reference and committee membership would be presented to the Clinical Governance Committee in September. Mrs MacLeod stated that she was focused on ensuring that the reporting process was in place. Mr Fane asked that the Committee consider how it will report its outcomes through the organisation.
4.3	The Committee **approved** the review of effectiveness of the Committee for presentation at Trust Board in July.
5.	**Assurance Framework**
5.1	The Chief Operating Officer presented an overview of the assurance framework. Work was on-going to review the wording of risk 1E and determine whether additional risks were required to be presented on the Framework, in particular around the taking of consent.
5.2	It was noted that risk 1K had been assessed as amber assurance, the reason for this being that the trust had in place a zero target for the number of children being required to be rushed to ITU. The Chief

	Executive, Dr Jane Collins stated that a lot of work had been undertaken to control this risk, including implementation of CEWS, SBARD, the introduction of the ICON team and appointment of general paediatricians. A further review of the risk would be undertaken prior to the next Clinical Governance Committee in September.
5.3 5.4	The Committee agreed that risk 1K should be reviewed at the September meeting. **Action**: The Clinical Governance Committee to review risk 1K in September 2011.
5.5 5.6 5.7	The Co-Medical Director, Professor Elliott updated the Clinical Governance Committee on the progress with the ITU review and stated that the outcome of the review would provide additional assurances around the handling of deteriorating children. The Committee endorsed the review and supported the direction of travel taken by the management team to reduce riskland improve the patient experience. A report was expected later in the year. The Committee **noted** the report.
6.	**Risk 2A: We may not be able to measure, report and act on patients' experience**
6.1	The Chief Nurse and Director of Education presented the report. The committee was reminded that a PPI Strategy was in place and that a new patient experience officer would commence work in the next few months. A lot of work had been undertaken to collate parents' views and a shift was required to collect patient views and report this through to the Trust Board.
6.2	The recent in-patient and outpatient MORI surveys had provided positive assurance that work was underway to collate the patient experience.
6.3 6.4	The Chief Executive stated that more real time reporting would provide an up to date view of the patient's experience and that this would be implemented via the bedside system. The Committee requested an update on this bedside entertainment system at the next meeting in September. **Action** – The Head of Corporate Facilities to be asked to provide an update on implementation of the bedside entertainment system in September 2011.
6.5	The Chief Operating Officer asked how many local patient experience surveys had been undertaken at speciality level. The Chief Nurse stated that work was underway to collate this information and develop standards so as to ensure consistency. Further information on the number of surveys would be available for the next meeting.
6.6	The Chief Operating Officer asked why the overall risk score was 3. The Chief Nurse stated that severity of the risk was scored at 1, based on

	minimal harm to patients.
6.7	The Committee **noted** the report.
7.	**Risk 1I: We do not make sufficient progress in developing benchmarks and demonstrating world class clinical outcomes**
7.1	The Co-Medical Director presented the report and advised the Committee that in order to be one of the top five children's hospitals in the world, it was necessary to be able to benchmark performance and outcome data to prove that this was the case. Work was underway to create a sophisticated clinical unit outcome inventory, looking at five measures per speciality and identifying suitable bench marking sites. The Committee was informed that part of his work required an understanding of international parameters, for example Philadelphia and Cincinnati, to enable effective benchmarking. Progress was monitored via the Clinical Outcomes Committee. The Committee was reminded that the Quality Account had recently been published and presented some of this information.
7.2	Professor Copp, Non-Executive Director asked whether there were some specialties where it was difficult to access benchmarking data, for example, psychosocial services. Professor Elliott stated that measurements such as expected date of return to school or weight gain were some examples.
7.3	The Committee **noted** the report.
8.	**Risk 1J: Clinical outcomes and patients' experiences may suffer as a result of a lack of appropriate management focus"**
8.1	The Chief Operating Officer presented the report and stated that this was a real risk. The Trust has many potentially competing objectives and targets. These could result in the management of the Trust having a greater focus on certain objectives (e.g. financial) at the expense of quality and experience objectives.
8.2	The Trust had implemented robust systems and processes and unit and senior management structures. Recent events had shown that external distractions could have the potential to impact on these systems.
8.3	The Co-Medical Director queried whether the response to the risk was sufficiently broad. It was agreed that the controls and assurances should also relate to the prevention of losing clinical and patient focus as outlined in the Mid Staffordshire investigation report. It was important that the Trust had spare capacity to deal with one off events but at the same time, maintained focus on outcomes.
8.4	The Committee noted the range of assurance data available including audits of internal management processes such as SBARD; external assurances from regulators and the monthly zero harm reports at Management Board.
8.5	The Committee **noted** the report.

9.	**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**
9.1 9.2 9.3 9.4	The Chief Nurse and Director of Education presented the report. The Education Strategy was approved by the Trust Board in November 2010 and an action plan recently submitted outlining how the strategy would be implemented. This included plans for enhancing simulation training facilities. It was noted that a lack of space for providing these facilities was hampering implementation. It was suggested that the seminar rooms allocated in the Morgan Stanley building could be considered and the Chief nurse agreed to take this matter forward. **Action**: The Committee requested an update report on risk 5A at the December 2011 meeting. The Committee **noted** the report.
10.	**Update on Care Quality Commission (CQC) compliance**
10.1	A report on compliance with the Care Quality Commission Registration Standards was received from the Company Secretary. The committee was advised that the Trust had recently been visited by the Care Quality Commission as part of its planned review schedule. The visit had raised a few issues including staff following the uniform policy and high level dust had been found on one ward.
10.2	An action plan would be developed. The Chief Nurse had already taken action to emphasise the need for uniform for all nursing staff. The clinical audit team had also been asked to undertake an audit of 'bare below elbows'. The Chief Operating Officer stated that compliance with the uniform policy was an on-going theme arising from safety walkarounds with regards senior clinicians. Although the policy was aimed at staff, guidance was provided to parents and conflicts with religious beliefs had been raised.
10.3 10.4 10.5	Professor Copp requested that arrows no longer be used for the Quality Risk profile report and that statements such as 'better than previous month'; 'worse than previous month' or 'no change' be used. The Company Secretary agreed to consider different criteria. **Action**: Company Secretary to consider revised criteria for the monitoring of risk estimates as reported in the QRP. The Committee **noted** the report. *Caroline Joyce joined the meeting.*
11.	**Outcome 1: Respecting and involving people who use services**
11.1	The Assistant Director of Nursing, Ms Caroline Joyce presented the report and provided an overview of the evidence collated for outcome 1.

	The Committee was advised that the CQC had requested a copy of this evidence as part of its planned review of the Trust. No significant gaps were apparent and further work was underway to enhance the equalities agenda across the Trust.
11.2 11.3	Mrs MacLeod noted that no reference had been made to the Clinical Ethics Committee (CEC) in the report. It was agreed that the work of the Committee required re-integration with the Trust's governance structures. It was agreed that the CEC should report to Management Board and provide assurance to the CGC. The Committee **noted** the assurances evidenced in the report.
12.	**Outcome 5: Meeting nutritional needs**
12.1	The Assistant Director of Nursing, Ms Caroline Joyce presented the report and informed the Committee that nutritional screening for patients and protected mealtimes had been flagged as risks in the CQC's Quality Risk Profile.
12.2	The Trust had developed a nutrition handbook and a nutrition screening tool. A one year Clinical Site Practitioner had been appointed to oversee the implementation of the policy and flowchart and roll out the protected mealtimes. It was noted that the Care Quality Commission had observed mealtimes on the wards and did not raise any issues.
12.3 12.4 12.5	Clinical audit had also engaged two doctors to carry out a pre and post-operative fasting audit to ensure that the necessary controls are in place. The screening tool was a flow chart requiring children to be heighted and weighted and referred to dietician where required. The Co-Medical Director requested that checks for percentile nutrition should be added to the flowchart. **Action**: Checks for percentile nutrition should be added to the flowchart.
12.6 12.7 12.8	Research had recently been conducted and found that some children treated at the hospital were mal-nourished. The Chief Executive agreed to write to the author of the research to ask when this would be published. **Action**: The Chief Executive to write to the author of the research and enquire on its expected publication date. The Committee **noted** the assurances evidenced in the report. *Stephen Moxley joined the meeting.*
13.	**Outcome 21:Management of Records**
13.1	The Trust's Record Manager, Mr Stephen Moxley presented the report. He informed the Committee since collation of the papers, the Care Quality Commission had requested a copy of the Provider Compliance Assessment Tool for outcome 21, as part of their planned review of the

	Trust. The Committee noted the assurances evidenced in the report.
14.	**Internal audit report**
14.1	The Internal Audit Manager, Mr Aaron Shah presented the report. The internal audit on the management of the Care Quality Commission key standards found reasonable assurance of processes in place. Directors had access to the necessary information and officers were updating the documents.
14.2 14.3	Mr Shah informed the Committee that the audit on the assurance framework had found significant assurance of processes in place. The framework was viewed as fit for purpose, reported to Trust Board appropriately, and used to assess risks to delivery of the strategic objectives by both assurance committees. It had received an 'A' status award and was one of the better frameworks reviewed by the auditors. The Committee **noted** the assurances evidenced in the report.
15.	**Internal audit strategic plan 2012-2015**
15.1 15.2	The Internal Audit Manager, Mr Aaron Shah presented the report highlighting that it included more emphasis on CRES, performance monitoring and patient experience. The Co-Medical Director asked where clinical outcomes would be audited. The Committee agreed the need for audit focused on quality outcomes.
15.3	The Chairman asked if a limited assurance required the audit team to undertake an automatic additional audit at a later date. It was agreed that the role of the CGC was to raise concerns about audits where limited assurance of processes had been found and to determine whether there was a need for a further audit.
15.4 15.5 15.6	The Committee requested that an update on implementation of recommendations from internal audits with clinical focus and clinical audits should be presented at the CGC at every meeting. **Action**: Update on implementation of recommendations from internal audits with clinical focus and clinical audits to be presented at the CGC at every meeting. The Committee approved the internal audit strategic plan 2012-2015. *Jude Cope joined the meeting.*
16.	**Internal audit report – management of medical equipment**
16.1	The Internal Audit Manager, Mr Aaron Shah presented the report and

	advised the committee that the audit included a review of the processes for managing both medical equipment and devices.
16.2	Limited assurance of the processes in place had been found. However, it was noted that the Trust had a comprehensive policy in place, complied with acquisition rules, held an inventory of equipment, undertook necessary testing of equipment and training of staff.
16.3	The audit had found that planned preventative maintenance was not fully in place and that there was insufficient documentary evidence to confirm the disposal of equipment. Action had been taken immediately to rectify these matters. There was also a lack of evidence that reported incidents were being promptly addressed. The electronic reporting system would prevent this from occurring in the future.
16.4 16.5	Ms Cope stated that equipment was being electronically tagged, which enabled the BME department to know where the equipment was and to ensure that it was maintained in a timely manner. The Trust was only the second Trust in the country to tag its medical equipment. Mr Shah emphasised the importance of evidencing the maintenance of equipment for audit purposes. Mr Fane considered this to be an area of risk to the Trust and informed the Committee that he would escalate this matter to the next Trust Board meeting. *Andrew Pearson joined the meeting.*
16.6 16.7	Mr Pearson asked if the Trust monitored whether children had to wait for equipment and whether incident reports were completed to record this, as this matter had been drawn to this attention within the ICI unit. The Chief Operating Officer agreed to investigate. **Action**: Chief Operating Officer to investigate the access to equipment in the ICI Unit. *Lorna Gibson and Angela MacLennan joined the meeting*
17.	**Medical Equipment and Devices Annual Report**
17.1 17.2 17.3	The Chief Pharmacist and Head of Bio-Medical Engineering, Ms Jude Cope presented the report. The Co-Medical Director asked whether the BME Department had information available on those pieces of equipment that had higher failure rates and if so, whether such equipment was removed from the catalogue. Ms Cope stated that the Trust used very few providers and that careful assessment of equipment was undertaken as part of the tendering process, including maintenance requirements and ease of use. It was agreed that there should be less need for preventive maintenance where there was evidence that equipment was reliable. Ms Cope was asked to

17.4	provide an update on this at the next meeting. **Action**: The Head of BME to provide an update on the requirement for PPM versus the reliability of equipment purchased.
17.5	The Committee **noted** the report. *Ray Conley joined the meeting.* *Jude Cope left the meeting*
18.	**Annual Clinical Audit Report**
18.1	The Clinical Audit Manager, Mr Andrew Pearson presented the report and highlighted the findings from the various clinical audits, including the quality of medical records audit which had resulted in a significant improvement in the quality of written records and was being rolled out to all clinical units.
18.2	The Committee was advised that NICE guideline actions were monitored by the Clinical Audit Team.
18.3	Further assurance was being sought around doctors being knowledgeable of procedures to take valid consent.
18.4	The Co-Medical Director, Professor Elliott requested notice of when a department failed to respond to a national audit. The Clinical Audit Manager agreed to advise him should this ever occur..
18.5	The Committee **noted** the report. *Andrew Pearson left the meeting.*
19.	**Integrated Incident report**
19.1	The Acting Assistant Director of the Clinical Governance and Safety Team, Mrs Salina Parkyn presented the report, stating there had been an increase in serious incidents (Sis) reported and this was mainly due to the change in the SHA criteria for reporting Sis, including a greater number of incident types in the SI category. The increase also demonstrated a positive reporting culture.
19.2	The Chairman queried when the Trust would start to see a fall in such incidents. Mrs Salina Parkyn stated that analysis of incident themes had shown that the same incidents were not reoccurring.
19.3	Mrs Mary MacLeod stated that it would be helpful for the Committee to see an analysis of the reporting trends since the changes to the SHA reporting criteria.
19.4	**Action**: The Acting Assistant Director of the Clinical Governance and Safety Team, to request that the Transformation provide information on trend analysis since the change to the SHA reporting criteria.

19.5 19.6	Mr Fane noted the large number of incidents reported under the heading 'infrastructure'. Mrs Parkyn stated that each unit reported many such incidents relating to wards being too hot or cold or other such environmental matters. The figure looked distorted due to the number of criteria in the infrastructure section. The Committee requested further analysis of these incidents by theme. **Action**: Incidents reported under the 'infrastructure' heading to be analysed and reported to the next meeting of the Committee.
19.7 19.8	The Chief Operating Officer, Ms Fiona Dalton agreed to review the red risks to ensure that the appropriate management focus was applied. **Action**: The Chief Operating Officer to review the red risks to ensure that the appropriate management focus is applied.
19.9 19.10	The Committee expressed concern that the number of risks on the risk register (515) and wanted to be assured that local risks were being dealt with and eliminated. **Action**: The Acting Assistant Director of the Clinical Governance and Safety Team to demonstrate in the next report how local risks are being dealt with and eliminated.
19.11 19.12 19.13	Mrs MacLeod welcomed the aggregation of the information. She asked what action was taken when incidents were reported about staff rudeness and also pressure sores were found. It was agreed that an update would be included in the next report to the Committee. **Action**: An update on how the Trust has responded to staff rudeness incidents and pressure sore incidents to be included in the September 2011 Committee report. The Committee **noted** the report.
20.	**Annual PALS report 2010-11**
20.1	The Chief Nurse and Director of Education, Mrs Liz Morgan presented the report. There had been a significant increase in case work and a review was underway to understand if teams were referring to PALS rather than dealing with issues locally.
20.2 20.3	Professor Andrew Copp, Non-Executive Director asked why red cases did not include further analysis in the report. Mrs Morgan stated that these cases were sent directly to the Clinical Governance and Safety Team (CGST) to take forward. However, it was agreed that it would be helpful to know the issues raised and that this information should be included in future reports. **Action**: The PALS report to include information about red cases that have been referred to the CGST.
20.4	The Committee noted that the report included the actions taken following

	assessment of the enquiries and queries. The Co-Medical Director, Professor Martin Elliott asked for assurance that these actions had been put in place and disseminated widely. Mrs Morgan agreed to bring an update on this to the September 2011 Committee meeting.
20.5 20.6	**Action**: The Chief Nurse and Director of Education to provide a report to the September 2011 Committee meeting on assurances that actions stated in the PALS report have been implemented and disseminated across the Trust. The Committee **noted** the report and requested that a quarterly PALS report be presented at every meeting.
21.	**Annual Complaints Report 2010-11**
21.1	Angela MacLennan, the Head of Complaints presented the report. The Committee was informed that the Trust had received twice as many complaints in March and April 2011. No trends had been noted and the number of complaints had since fallen.
21.2	Mrs Mary MacLeod, Non-Executive Director suggested that a review should be undertaken to understand whether a fall in complaints was matched by a relative rise in PALs queries. The Acting Assistant Director of the Clinical Governance and Safety Team, Mrs Salina Parkyn stated that this would be easier to assess once the integrated report included PALs queries.
21.3 21.4	It was agreed the importance of disseminating the learning from complaints. The Committee was advised that the Clinical Units received individual reports. The CGST was considering how the Trust could hold learning set events to cascade the leaning from complaints, incidents and PALs queries. The Committee **noted** the report. *Angela MacLennan left the meeting*
22.	**IMRs and SCRs**
22.1 22.2	The Chief Nurse and Director of Education, Mrs Liz Morgan presented the report and informed the Committee that once a serious case review of individual management review was completed, each organisation was required to implement the necessary actions and disseminate learning. It was reported that briefing sessions had also been held with relevant staff. The Committee welcomed the report and requested that this be presented on an annual basis.
23.	**Employee relations report 2010-11**
23.1	Mr Ray Conley, Head of Human Resources Operations, presented the report.

23.2	There had been a decrease in the number of disciplinary and tribunal claims in 2010-11. This had been in part due to the promotional work around mediation and the review of recruitment processes to ensure that the appropriate skilled people were appointed.
23.3 23.4	Disappointment was expressed about the number of staff from a black, minority ethnic background subject to disciplinary procedures. This matter had recently been discussed at Trust Board and was subject to further review. The Committee **noted** the report.
24.	**Datix report**
24.1 24.2	The Acting Assistant Director of the Clinical Governance and Safety Team, Mrs Salina Parkyn presented the report and informed the Committee that the Datix reporting systems had now been rolled out across the Trust. There had been problems with the software and this had hampered the electronic reporting system but these had now been resolved. Analysis showed that incidents were being reported quicker and that there had been no drop in the number of incidents reported during the transition to electronic reporting. The Committee **noted** the report and congratulated the team on the work involved in training staff in the electronic reporting system.
25.	**Research governance Update**
25.1 25.2	The General Manager for the Research and Innovation Division, Ms Lorna Gibson presented the report. The Committee noted the report and agreed that future reports include updates on the research governance framework and any recommendations arising from external reviews. The Committee **noted** the report.
26.	**Trust Wide Risk Register, incorporating overview of risks arising from RAGs and benchmarking data**
26.1	It was noted that the Trust Wide Risk Register had been included for information. The Chairman asked if there were any questions or comments. There were none.
27.	**Annual Safeguarding Report 2010-11**
27.1	It was noted that the Annual Safeguarding Report had been included for information. The Chairman asked if there were any questions or comments. There were none.
28.	**Health and Safety Annual Report 2010-11**
28.1	It was noted that the Annual Health and Safety Report had been included for information. The Chairman asked if there were any questions or comments. There were none.

29.	**Freedom of Information Requests Update Quarter 4 (2010-11)**
29.1	It was noted that the Freedom if Information Update Report had been included for information. The Chairman asked if there were any questions or comments. There were none.
30.	**Risk, Assurance and Compliance Group Minutes**
30.1	It was noted that the minutes of the Risk Assurance and Compliance Group had been included for information. The Chairman asked if there were any questions or comments. There were none.
31.	**Quality and Safety Committee Minutes**
31.1	It was noted that the minutes of the Quality and Safety Committee had been included for information. The Chairman asked if there were any questions or comments. There were none.
32.	**Audit Committee Minutes:**
32.1	It was noted that the minutes of the April 2011 Audit Committee had been included for information. The Chairman asked if there were any questions or comments. There were none.
33.	**KPI Performance Report – Month 2**
33.1	It was noted that the KPI Performance Report had been included for information. The Chairman asked if there were any questions or comments. There were none.
34.	**Any Other Business**
34.1	There were not items of any other business.
35.	**Date of the Next Meeting**
35.1	The date of the next meeting was confirmed as Wednesday 22nd September 2011 at 8:30am.

Signed as a correct record of the Great Ormond Street Hospital for Children NHS Trust Clinical Governance Committee meeting held on 21st June 2011.

Chairman: ……………………………….

Date ……………………………….

ATTACHMENT 3

Great Ormond Street Hospital for Children NHS Trust

MANAGEMENT BOARD
Thursday 16th June 2011

FINAL MINUTES

Present:

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

In Attendance

Anna Ferrant (AF)	Company Secretary
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)

**Denotes meeting part attended*

Attachment 3

74	**Apologies**	
74.1 74.2	Apologies were received from Melanie Hiorns, CU Chair MDTS and Martin Elliott, Co-Medical Director. JC introduced and welcomed Carla Hobart as Interim General Manager ICI-LM to the Board. JC also asked the Board to note and congratulated Julie Bayliss for achieving Well Child Nurse of the Year Award 2011.	
75 75.1	**Minutes of Management Board meeting held on 19th May 2011** The minutes were approved as an accurate record with the following two amendments: EJ did not attend the Board and minute 51.5 should have read 'rates had <u>not</u> gone up significantly' as opposed to 'rates had gone up significantly'.	
76 76.1 76.2 76.3 76.4 76.5 76.6 76.7 76.8 76.9 76.10	**Action Log and other matters arising** The following updates were received on the documented actions: 45.6 It was agreed that subcommittees reporting to Management Board and the tool for evaluating effectiveness of a committee such as Management Board would be brought back to the October Management Board. 891.18 Bid for 4 additional PICU beds. CN stated that an additional business case would come to Management Board for approval. It was agreed that CN would proceed internally and then link with the Specialist Commissioners. 45.7 Honorary Contracts at GOSH. CL sent round a copy of the licence agreement to all Management Board members. 891.24 IV Access/Femoral Lines, It was agreed that this item would be kept on the action list for next month. 8.4 Issues with PIMS. It was decided that this item would be brought back to the July Management Board meeting. 48.2 Arrests outside ICU / Theatres. BB reported work was still on going. 60.3 Provision of employment legal services. FD clarified that Management Board members could go through HR to request employment related legal advice. JC reported that CQC had visited the hospital and the visit had gone well save for a few minor issues which will be addressed. JC gave thanks to all involved. JC also addressed some of the recent press surrounding allegations made by Lynne Featherstone, MP. JC reported that an extraordinary Board meeting had been called to review the allegations.	
	Clinical Unit and Zero Harm Reports	
77 77.1	**IPP** JL presented the IPP Zero Harm report. JL reported there had been no delayed or refused patients in the month and it had been 64 days since the last Serious Incident (SI). JL reported that the unit had received one complaint. A family was unhappy about timeliness of nursing care interventions on Bumblebee Ward.	

77.2	JL reported the top three risks were medication errors, recruitment and retention of nursing staff; and income may exceed the Private Patient's CAP. Discussions had taken place to ensure the Cap is not exceeded.	
77.3	JL also requested advice on whether the Bumblebee Business case needed to be re submitted to Management Board. At the design stage of the proposed ward upgrade it became apparent only 3 beds could be accommodated rather than 4, this would affect the income figures previously submitted. . JC asked JL to bring back a short paper updating the Board on amended financial elements of the case.	
77.4	**Action:** JL to bring a paper to the next Management Board updating the Board on the amended case.	**JL**
	Management Board **noted** the content of the report.	
78	**Cardio Respiratory**	
78.1	AG presented the report. AG reported it had been103 days since the last SI.	
78.2	AG reported medication errors, single consultant service and documentation in Medical Notes as the Unit's top 3 risks.	
78.3	AG updated the Board on Safe and Sustainable. AG reported that consultation would be completed at the end of June 2011.	
78.4	Management Board **noted** the content of the report.	
79	**Infection, Cancer and Immunity**	
79.1	CC presented the report. CC reported it had been 63 days since last SI. CC reported that one of the top three risks faced by the Unit were a lack of timely psychology support for dermatology patients; lack of and/or timely availability of medical equipment and patient beds/cots; and inadequate ambulatory care facility for rheumatology patients.	
79.2	RB raised concerns around 4 arrests in the Unit. CC reported that they were actually crash calls rather than arrests so the report was misleading but nonetheless the reasons needed addressing. The Board agreed that this should be changed in the template.	
79.3	**Action:** PL to request changes are made to the zero harm templates for the units to provide clarification around reported arrests.	**PL**
79.4	Management Board **noted** the content of the report.	
80	**MDTS**	
80.1	JA presented the paper. JA reported there had been 345 days since last SI. JA reported the top risks to the unit were CRES targets for 2012/13, nephrology staffing on Victoria Ward and interventional radiology, a business case had been approved to provide 3 additional interventional radiology lists and nurse vacancies would be advertised shortly.	
80.2	JA also reported that delayed emergency admission guidelines were currently being used to measure delayed admissions on Rainforest Ward.	

80.3 80.4	**Action:** JA to produce a short paper for next Management Board on what the plan will be around emergency on call. Management Board **noted** the content of the report.	**JA**
81 81.1 81.2 81.3 81.4 81.5 81.6 81.7 81.8 81.9 81.10	**NEUROSCIENCES** CDS presented the report. CDS reported that it was 199 days since the last SI occurred. CDS also reported no refusal or delays in Neurosurgery. CDS reported that one formal complaint had been received. CDS reported medication errors; inadequate IV access and lack of information sharing regarding child protection issues at handover as the Unit's top 3 risks CDS reported the RCA recommendations that came from the last SI, wrong site surgery. JC highlighted that sharing the story with other units was an important part of learning. The Board had a discussion around effective ways in which the Trust could learn from SIs such as this, including a proposed ½ day audit meeting across disciplines; monthly review meetings and a one sheet flyer for surgeons. EJ and RB was asked to take those ideas away. **Action:** EJ and RB to report back to the October Management Board on the progress of learning from SIs. Management Board **noted** the content of the report. CDS presented a presentation on Neuroscience deep dive into zero harm. CDS presented on the Unit's aims: provide accurate real time information on key harm indicators; use data for improvement and improve use of dashboard by clinicians. CDS also gave an overview of reducing hospital-acquired infections and outlined measures, progress and challenges of surgical site infections. CDS highlighted the General Paediatrician team's aims and progress on zero harm and raised concerns about medical note keeping. JC echoed concerns around how doctors are trained in medical note keeping and correspondence. BB was asked to feed through concerns to Professor Stephenson. **Action:** BB to contact Professor Stephenson regarding concerns over medical school's preparation of student's training on medical record keeping, preparing letters and reports etc. Management Board **noted** the content of the report.	 **EJ & RB** **BB**
82 82.1 82.2 82.3	**Surgery & Deep Dive** EJ presented the report. EL reported that the last SI had occurred 101 days ago. EL also reported 12 refusals and 6 complaints. EL identified the Unit's top three risks as complex patients and post-op ventilation; medication errors/ EP and hospital acquired infections. Management Board **noted** the content of the report.	
83	**R & I Divisional Report**	

83.1 83.2 83.3 83.4	LG presented the report, which included the current divisional activity and forthcoming work plan. Divisional current activity includes:- • The application for the BRC was submitted on Friday 10th June, for a total of £39,170,228 (which was renewal funding applied for 5 years ago and currently due to expire in March 2012). The application was based around the 3 current themes of "Novel Therapies for Childhood Diseases" (Mutoni), "Molecular Basis of Childhood Diseases" (Beales), "Gene Stem and Cellular Therapies" (Thrasher), with the addition of "Diagnostics and Imaging" (Sebire). This was accompanied by a 10 minute DVD outlining facilities available within GOSH/ICH. One more document of supplementary questions would be completed by the 24th June. The formal Department of Health interviews was taking place on 19th July 2011. LG anticipated hearing the outcome of the application in late August/ early September. JC gave thanks to all involved. • The Human Tissue Act inspection (for ICH's licence) was held on the 9th June with no significant findings. A formal report would be presented shortly. • The Divisional Board of Research and Innovation was to have its second meeting at the end of this month. • Arrangements for procurement of a new research database (Edge) to replace ReDA would be made at the July Management Board. LG highlighted some of the activity that the 3 Clinical Research Facilitators had been involved in since May 2011. LG also reported to the Board that there would be an article in the Newsletter about the role of the Clinical Research Facilitators. CC & JA said that they had worked with them and felt that it had worked very well. Management Board **noted** the content of the report.	
84 84.1 84.2 84.3 84.5	**Key Performance Report May 2011** RB – reported a few errors in the report. The Board had a discussion around potential decline in the Neuro market share. BB agreed to liaise with CDS and write a letter to Andy Mitchell and what would be happening with South London hospitals. JC asked that a meeting be set up to discuss how to support Neurosurgery for the Safe and Sustainable review. **Action:** BB to liaise with CDS and write a letter to Andy Mitchell to establish what would be happening with South London hospitals with regards Neurosurgery. **Action:** CL to set up meeting with JC, Dominic Thompson and unit team on the Safe and Sustainable Review for Neurosurgery. RB presented the report. The following was noted: The Key Performance Indicator (KPI) report had been considered in light of the annual plan and had revised Trust objective work streams. New Indicators included: 48 Hour readmission to ITU; prescribing errors Haematology/ Oncology; referral to treatment times; accidental extubation; CRES 2011/12 Trust Position; CRES 2012/13 trust position and Information Governance. Management Board **noted** the contents of the Key Performance Indicator Report for May 2011.	 **BB** **CL**
85 85.1	**Finance and Finance and Activity Report on Financial year 2010/11** CN presented the report and stated that at end of month 2, the Trust had a net	

	surplus £1.3M, which was £0.4M ahead of the 'phasing adjusted plan' and £2M ahead of the original plan.	
85.2	The Forecast out-turn remained in line with 'plan' and this was a net surplus of £7.1m pre-impairment charges for Phase 2A;	
85.3	Agency ratio to total pay was at 4.8% year to date (7.6% in same period last year) but management and administration spend remained high at 16.3% (2010/11 19.5%).	
85.4	Pay was £2.1M higher than budget. This reflected higher than budgeted net costs of junior doctors, including agency, mainly in the Medicine, ICI and Haringey service. It also included higher than budgeted net costs of nursing staff, including agency, across a number of units. The main reported cause was increased activity requiring increased levels of staffing as well as cover for maternity and sickness.	
85.5	Non Pay expenditure was £3.3M lower than budget, reflecting budget phasing. CN reported that non-pay expenditure was likely to be weighted towards second half of financial year	
85.6	A notable exception was the adverse variance on Premises costs which were higher than budget reflecting increased levels of maintenance related costs	
85.7	Income was £0.8M higher than budget.	
85.8	CRES 2011/12: A target of 15.8million had been set across the units. This was higher than the 4% factored into the plan, but after adjusting for risk, allowed the plan value to be achieved. Schemes currently exceeded this value by £0.3M. £4 million of CRES was categorised as GREEN or BLUE.	
85.9	The capital programme was £55.9M for the year and £0.8M behind plan at period 2 of which 0.5M was Trust capital and £0.3M donated capital.	
85.10	There were 2 salary overpayments totalling £7.4K.	
85.11	Management Board **noted** the contents of the report.	
86	**Foundation Trust Application Update May 2011**	
86.1	SB presented the paper that set 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.	
86.2	The "Evidence of meeting statutory targets" criteria had been rated amber (no change). Both hospital acquired infection indicators (c. diff – 2 cases; MRSA – 1 case) were above trajectory. It was also noted that the 95th centile of admitted pathway waiting time was over 23 weeks in Nov 10 and Feb 11. This indicator replaced the previous 18 week waiting time indicator.	
86.3	The overall "Financially viable" assessment was rated amber (no change). The main financial risks were CRES delivery and commissioner contract requirements. SB reported that to date the Trust had not received a decision from the Department of Health following their review of the application. The delay in receiving the response was likely to cause further delay to the whole programme. The earliest possible authorisation date now was 1 November 2011.	
86.4	Key actions for the next month:	

	• Complete DH assurance process • Commence election process for the Members' Council • Commence Monitor assessment process. Management Board **noted** the report.	
87	**Development of Neurodisability Service**	
87.1	SD reported that this was an opportunity to develop and expand the development of the following services - Developmental Epilepsy Service, Neuro-Metabolic Clinic, Neurodevelopmental Assessment Clinic and the Neurodisability Spinal Clinic.	
87.2	Management Board were asked to approve: • Additional funding to expand the service • Improve quality of service for children accessing the service • Shorter waiting times for assessment offering more responsive service • Shorter waiting times for those children who need monitoring • Increased activity to support the growth of Neuroscience Service	
87.3	Total recurring revenue expenditure was £363.3k (£354k pay), but this excluded occupancy.	
87.4	It was reported that space was available for Outpatient consulting rooms or additional rooms if needed. Activity growth continued so that activity levels were sustained beyond the existing need to reduce waiting times	
87.5	Management Board **approved** the Business Case.	
88	**Miffy Ward refurbishment proposal**	
88.1	FD presented the paper to May Management Board discussing the refurbishment of Miffy Ward. At that time it was undecided which physical option to pursue.	
88.2	It had now been confirmed that the proposal was to create a 10 bed ward. The proposed refurbishment would require the refurbishment of a new wing of Southwood (6B) for RANU. This would then enable 4C and D to be refurbished as an expanded Miffy ward.	
88.3	The intention was that this ward would be also used to care for transitioning patients who did not requiring acute care. Potential patient groups could be expanded to include those transitioning to parent led care (e.g. long term ventilated or training parenteral nutrition patients) or those on Berlin Hearts.	
88.4	Plans suggested that RANU could move to 6B by March 2012 and Miffy would move back into a refurbished ward by October 2012. Cardiac Critical Care in VCB could be used as decant space for Miffy during the works after the Morgan Stanley Clinical Building opened.	
88.5	The Friends Charity had been approached about funding the Miffy refurbishment and were arranging to visit the ward. The Trust would need to find additional capital of around £500K to refurbish 6B for RANU.	
88.6	This proposal had been discussed at the Capital and Space Planning Committee (CASP) and at the General Managers meeting.	
88.7	The Business Case was **approved** with adjustment for the Neuro unit to ensure that	

	they would have cross over space when leave they leave Koala. .	
89	**Scoping paper for 3T MRI**	
89.1	FD presented the Business Case, which proposed the replacement of the Trust's oldest Magnetic Resonance Imaging (MRI) scanner with a more powerful 3-Tesla MRI. This was an important and complex project that involved working across the Trust. Currently there was considerable pressure on MRI waiting times and any impact on our MRI capacity will need to be managed carefully. • MR1 had reached the end of it's useful life (this is a replacement project) • The project would be for a diagnostic rather than inter-operative facility • Decant options would need to be explored • A policy for demand management would need to be written • A robust business case would need to gain Trust Board approval	
89.2	Management Board **agreed** in Principal – to develop the business case. It was agreed to start the procurement process for replacement of the Trust' oldest Magnetic Resonance Imaging (MRI) scanner with a more powerful 3-Tesla MRI.	
90	**Expanding the role of Nurse Practitioners and Advanced Nurse Practitioners in ICI-LM**	
90.1	CC presented the paper on expanding the role of Nurse Practitioners and Advanced Nurse Practitioners in ICI-LM.	
90.2	The paper proposed to develop supernumerary trainee NP roles in ICI-LM to: • Increase their numbers to a viable cohort to enable closer integration into inpatient and day care areas 52 weeks a year, with additional weekend working where this would benefit the care of children and positively influence service delivery • Improve quality and safety of care for patients by providing increased senior nursing coverage of clinical areas • Increase the number of senior nurses directly involved in the delivery of patient care • Facilitate increased activity in BMT without the requirement for more senior medical staff • After 2 years, meet salary costs by decreasing junior medical staff workforce – also freeing up approximately £25,000 budget to facilitate creation of ANP roles • Provide a coherent career pathway for the NP role	
90.3	The Board had a discussion around setting a precedent around funding from the charity.	
90.4	Management Board **approved as a strategic direction of travel** but funding would need to be requested.	
91	**Mayors Cycling Strategy**	
91.1	PW presented the paper, which recommended steps to allow the Trust to continue to commit to the Mayor's Cycling strategy as part of its Sustainable Development Management Plan (SDMP) and its ongoing commitment to staff health & well being.	
91.2	To commit to the Mayors Cycling Strategy Stage 2, NHS Trusts are required to achieve the following :	
91.3	1. Hold a promotional event for staff (and patients/visitors where appropriate) focusing on raising the profile of cycling and providing practical advice and support to	

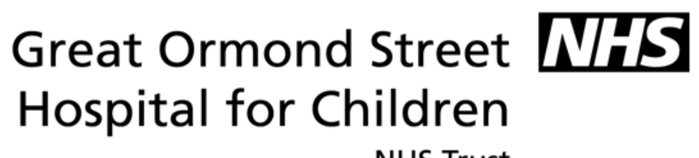
	interested parties (by November 2011). 2.Have an active Bicycle User Group (November 2011) 3.Participate in the London Cycle Challenge in June/July 2011 (by June 2011) 4.Provide cycle training to all interested members of staff (by November 2011)	
91.4	Management Board **approved** the report.	
92	**Support for Paediatric Haematology and Oncology in Kuwait – Progress Report**	
92.1	JL presented the paper. GOSH entered into a contract with Kuwait Ministry of Health in June 2010 to support clinicians in Kuwait in the improvement of haematology and oncology services for children and to undertake a number of service reviews in other specialties to inform the development of improvement plans in those services.	
92.2	The paper summarised progress to date, updated Management Board on the risk assessment undertaken at the outset of the work and provided an updated financial position.	
92.3	CC & CH agreed to add a criterion to the review to make sure the work does not impact upon NHS work. CN requested clarification of the extension.	
92.4	Management Board **approved** the report.	
93	**Patient Transfer Policy and Patient Discharge Policy**	
93.1	RB presented the paper which set out the Trust-wide Patient Transfer Policy and Patient Discharge Policy at Great Ormond Street Hospital (GOSH).	
93.2	Patient Transfer Policy The policy focused on both the transfer of children within GOSH and the transfer of GOSH patients to another healthcare setting. The policy did not cover transfers abroad (this is covered in the Discharge Policy: International and Private Patients Unit) and transfer of patients to theatre and radiology for general anaesthesia.	
93.3	Discharge Policy The policy was concerned with the discharge of children within GOSH. The policy applied to all inpatients and details staff responsibilities and discharge requirements including: Child protection concerns, prescribed special feeds and diets, equipment, end of life care and complex needs.	
93.4	The policy was not applicable to Day Care areas, e.g. Dinosaur, Island, Safari, and Cardiac Day Care, Haemodialysis and did not cover discharges abroad.	
93.5	It was noted that a number of key policies were quoted within both documents and would require updating. JC inquired how we were going to communicate these required changes. The Board agreed there should be some formal statement on how that happens.	
93.6	RB agreed to amend the policies and come back next month with additions and paper on how to add them and communicate them	
93.7	**Action:** RB to circulate to MB the revised policies including communication on how other policies that are affected should be notified.	**RB**
94	**End of Life Care Decision Making Policy (including DNAR Orders) For Children**	

94.1 94.2	LM presented the policy which delineated clearly the processes by which End of Life Decisions should be implemented. The aim was (i) to encourage earlier discussion and documentation of interventions (ii) to have clear documentation as to which interventions were appropriate. For example, sometimes there was confusion as to whether IV antibiotics were appropriate in a child with a 'DNR', or if bag and mask should be attempted if parents were not on the ward. The policy was **approved**.	
95 95.1 95.2 95.3	**Use of Cameras Policy** ML presented the policy, which aimed to provide all GOSH employees with the knowledge to ensure that cameras are used to the benefit of the Trust, whilst minimising risk to patients and their families, the Trust as an employer, or to the individual. A policy already existed (Policy for making and using illustrative clinical records of patients) regarding to the use of images including consent forms that are widely used. This new policy referred to the existing policy and proposed no change in the existing consent forms. This policy dealt with the issues and guidelines for camera usage. ML was asked to bring back the policy to the next Management Board.	**ML**
96 96.1 96.2	**Food Safety Policy and Operational Plan (Version 2)** PW presented the policy. This constituted the Formal Annual Update of the above named Policy. The specific change was the fuller account of the method by which standards were assured through a comprehensive four stage process of monitoring and audit. The policy was **approved**.	
97 97.1 97.2	**Recording and responding to physiological observations and CEWS** Early recognition and timely response to clinical deterioration is a key objective in delivering safe and effective care. The new policy set out the standards required when recording and responding to physiological observations and the Children's Early Warning Score (CEWS) at GOSH. The Policy contributed to reducing harm from unrecognised deterioration. The policy was **approved**.	
98 98.1 98.2	**Recognition Agreement** The Recognition Agreement outlined the terms of reference in regard to recognition of Trade Unions within Great Ormond Street Hospital for Children NHS Trust. It enabled the Trust to meet its legal obligations by ensuring recognised trade union representatives are treated lawfully. The policy was **approved**.	

99	**Time off and facilities for recognised staff representatives for trade union duties and activities**	
99.1	The Policy outlined the agreed arrangements and guidance on support available from the Trust to recognised staff representatives in respect of undertaking trade-union duties and activities.	
99.2	It enabled the Trust to meet its legal obligations by ensuring recognised trade union representatives are treated lawfully. The policy was **approved**.	
100	**Update on Referrer's Experience Improvement Programme**	
100.1	RB updated Management Board on the progress of the Referrer's Experience Improvement Programme.	
100.2	Referrers are the Trust's must important business customers and drive virtually all Trust clinical income.	
100.3	RB reported he would put together a guide by end June at specialty level	
100.4	Management Board **noted** the report.	
101	**CRES**	
101.1	Management Board **noted** the contents of the above document.	
102	**CASP**	
102.1	Management Board **noted** the contents of the above document.	
103	**Waivers**	
103.1	CN requested approval for waivers from the following suppliers: Laerdal, Perkinelmer Life Sciences, Ardmore Healthcare, UCL Business Services, MrG Surgical Instruments and Karl Storz.	
103.2	Management Board **approved** the waivers.	
104	**Any other business**	
104.1	There were no items of any other business.	

ATTACHMENT 4

Attachment 4



MANAGEMENT BOARD
Thursday 21st July 2011

FINAL MINUTES

Present:

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

In Attendance

Anna Ferrant (AF)	Company Secretary
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)
Andrew Taylor (AT)	Honorary Consultant, Cardiology
Janet Williss (JW)	Deputy Chief Nurse

**Denotes meeting part attended*

105	**Apologies**	
105.1	Apologies were received from Jacqueline Allan, General Manager, Medicine and DTS; Carla Hobart, Interim General Manager ICI-LM, Liz Morgan, Chief Nurse and Director of Education and Allan Goldman, CU Chair, Cardio-Respiratory.	
106 106.1	**Minutes of Management Board meeting held on 16th June 2011** The minutes were approved as an accurate record with the following amendments: • 81.3 and 81.4: EL should be replaced by EJ. • 84.1: The last sentence should have been removed (edit included by error). • 84.1 and 84.2: CC should be replaced with CDS. • 89.2: to add – 'it was agreed to start the procurement process for replacement of the Trust' oldest Magnetic Resonance Imaging (MRI) scanner with a more powerful 3-Tesla MRI'. • 94.1: The last sentence should also have been removed.	
107 107.1 107.2 107.3 107.4 107.5 107.6 107.7 107.8 107.9 107.10	**Action Log and other matters arising** The following updates were received on the documented actions: 857.5 The paper on Medication Errors was not included this month by error, therefore it was agreed the paper would be brought back to the August Management Board. **Action**: The paper on Medication Errors to be brought back to the August Management Board 48.2 and 79.3: PL reported that the way 'arrests' were being coded had been implemented to differentiate between cardiorespiratory arrests and unexpected deterioration where additional help was required but not an arrest. 81.9: BB gave the Board a verbal update on feedback to Professor Stephenson regarding concerns over medical school's preparation of student's training on medical record keeping, preparing letters and reports. On other matters arising, JC reported the Secretary of State had stated in a letter addressed to the Chair that it was not necessary for the trust to undergo an independent enquiry about the way the Trust released the Sibert report. This was good news as an inquiry would be time consuming and detract from what is important, the care of the children we treat. JC reiterated that there was however nothing to hide. JC highlighted concerns over internal communication and CDS reported that both consultants and other senior staff felt that internal communication in some areas could be improved. JC noted this and stated that work would be done to address these concerns. The work would commence with circulating 5/6 key points/decisions after Management Board, which would go out by internal email. **Action**: CL to circulate the top 5-6 main decisions agreed at Management Board. ML reported that ICT would be trailing a screensaver with a key message, which could be changed on a daily/ hourly basis. JC also reported that Monitor would visit next week to start the assessment process	 **CL** **CL**

	on the 1st August. JC reported it was good news that Monitor was commencing its review and that the Trust hoped to be authorised by 1st December 2011.	
	Clinical Unit and Zero Harm Reports	
108	**IPP**	
108.1	JL presented the IPP Zero Harm report. JL reported there had been no delayed or refused patients in the month and it had been 86 days since the last Serious Incident (SI). JL reported that the unit had received one complaint. A family was unhappy about timeliness of nursing care interventions on Bumblebee Ward.	
108.2	JL reported the top three risks were the Kuwait Health Authority refusing to use GOSH pharmacy for discharge medication; IT system and tariff for TTO drugs under review; and recruitment and retention of nursing staff.	
108.3	JL reported that a recruitment campaign was under way to address the recruitment of nursing staff. JL reported that they were confident regarding filling junior positions but that Band 6 recruitment had been unsuccessful and was continuing. Agency and bank staff usage was being monitored. JL reported that income could exceed CAP and to avoid this monthly income was being closely monitored in IPP and other Divisions., YTD was at 9.6% at month two (CAP 9.7%).	
108.4	Management Board **noted** the content of the report.	
109	**Cardio Respiratory**	
109.1	AL presented the report. AL reported it had been143 days since the last SI. There had been no refusals in respiratory or cardiac. AL reported that there had been one complaint, about short notice change in treatment plan and communication.	
109.2	AL reported that there had been an issue with outpatients getting appointments. Peter Lachman and the Unit were currently looking into a resolution to this.	
109.3	Management Board **noted** the content of the report.	
110	**Infection, Cancer and Immunity & Deep Dive**	
110.1	CC presented the report. CC reported it had been 27 days since last SI. CC reported that risks had not changed but some would be downgraded. The top three risks faced by the Unit were lack of timely psychology support for dermatology patients; lack of timely availability of medical equipment, beds/cots; and poor standard of clerking of patient's pre chemotherapy. CC stated a draft business case was being worked up with the psychology team to increase support for dermatology.	
110.2	Plans were in place to address clerking through review and update of paperwork and teaching. This would require an ongoing audit and review. A review of risks at the RAG indicated other high risks, such as accounts payable and ambulatory facilities for rheumatology were likely to be downgraded from 'high' to 'medium' in upcoming months.	
110.3	CC highlighted that the new Lab computer system should go on risk register as there were some issues around blood transfusion. There would be discussions today to resolve these .	
110.4	CC – presented deep dive on zero harm. CC gave a summary of zero harm	

	initiatives; reducing prescribing and administration errors, reducing infections, the WHO checklist, the risk reporting process review, medical records, upcoming projects and the lessons learnt. JC congratulated CC on 50% reduction in prescribing errors.	
110.5	CC reported that on Fox and Robin no line infections had been reported. One concern on medical records was chemotherapy delays. It was reported that an audit had been undertaken and the unit was looking at ways of improving the quality of records.	
110.6	**Action:** JC to write to two wards and congratulate the sisters of Fox and Robin for no line infections and see if other wards could learn.	**JC**
110.7	CC reported that the key thing was to engage the medical staff and make sure they took ownership of zero harm initiatives. JC reported that we would need to think about transformation devolution (in relation to debrief and root cause analysis). ML advised that if any management board member had an ICT risk, to get in contact with him so he could help.	
110.8	Management Board **noted** the content of the report.	
111	**MDTS**	
111.1	MH presented the paper. MH reported there had been 373 days since the last SI. MH reported the top risks to the unit were around CRES, Nephrology and Interventional Radiology.	
111.2	MH reported that CRES for 2011/12 had been identified; however there were major issues with work for 2012/13, which was in progress. Currently, approx £900k was identified.	
111.3	MH reported that on Victoria Ward, all new starters were in place with an education programme to address required competencies.	
111.4	A business case was approved to provide 3 additional interventional radiology lists and nurse vacancies would be advertised shortly.	
111.5	MH also reported that there had been an incident where abnormally high levels of sodium had been found in a feed. The child had not been harmed. The feed had been administered at home. As a result, all feeds were checked at GOSH but no problems had been found. The feed in question had not been prepared at GOSH and it was presently unclear how it had happened but all the right checks were currently in place.	
111.6	Management Board **noted** the content of the report.	
112	**NEUROSCIENCES**	
112.1	CDS presented the report. CDS reported that it was 234 days since the last SI. CDS also reported one refusal in Neurosurgery. CDS reported that one formal complaint had been received.	
112.2	CDS reported the three risks the Unit faced were medication errors, inadequate IV access and faulty feed pumps.	
112.3	CDS reported that there was a Medicines Management Group meeting on 15.07.11 to review trends in medication errors. This was an ongoing process for feeding back	

	to prescribers and completing the Drug Error Analysis Tool. CDS reported that inadequate IV access for children requiring long term IV therapy when discharged from ITU was been looked at. The new faulty feed pumps were also being looked at. JW would pick up also with the Heads of Nursing.	
112.4	**Action:** JW to pick up faulty feed pumps with the Heads of Nursing.	**JW**
112.5	CDS also reported that there had been some staff concerns around the move to the new building. JC stated that better communication was needed to relieve staff anxieties about the move.	
112.6	Management Board **noted** the content of the report.	
113	**Surgery**	
113.1	EJ presented the report. EJ reported that the last SI had occurred 256 days ago. EL also reported18 refusals, no delays and 3 complaints.	
113.2	EJ identified the Unit's top three risks as complex patients and post-op ventilation, Medication errors/ EP and hospital acquired infections.	
113.3	EJ reported that they were grateful to the team for improvements in WHO check list completion.	
113.4		
113.5	TS gave the Board an overview of the Scoliosis Surgery Review. The review was of 5 patients with Complex neurological problems requiring Scoliosis surgery who died in the Peri-operative and post operative period following Surgery to correct their spinal deformities in 2010 and 2011, with specific reference to identifying individual or system failures that may have contributed to their deaths.	
113.6	The review made 21 recommendations and TS highlighted the main ones:	
113.7	The report would be shared with the families concerned who would be contacted this week. TS stated that there was an action plan in place to address these recommendations. The waiting list would be reviewed where delays had arisen , offering families a transfer to another hospital.	
113.8	JC reminded the Board that these patients were at very end of the spectrum of complexity.	
113.9	The Board agreed lessons had been learnt from this process and one would be to inform the families prior to the review being undertaken and asking them to contribute if they wished.	
113.10	Management Board **noted** the content of the report.	
114	**R & I Divisional Report**	
114.1	LG presented the report, which included the current divisional activity and forthcoming work plan. Divisional current activity included: • Interviews for the BRC application were being held on the 19th July. They anticipated hearing the outcome in late August/ early September. • The formal MHRA inspection report was to be submitted on the 19th July 2011 which included detailed responses to the findings. • Analysis of the Human Tissue Act inspection report (for ICH's licence) and on going R&D support for the storage of Human Tissue was to be carried out later this month in collaboration with ICH. • The Divisional Board of Research and Innovation has had its second meeting,	

	the minutes of the first are appended for formal approval. • The "North West Exemplar project within GOSH" which was part of a Transformation project, had been launched, which examines the turnaround times and processes for commercially funded contracts. • They were liaising with the Charity with regards to branding and plans for a formal launch. • Details of the current Joint R&D Office structure and staff contact details had been widely circulated in GOSH and ICH. • The Senior Research Governance Co-ordinator who will lead the governance team had been appointed • Arrangements for procurement of a new research database (Edge) to replace ReDA had been delayed due to the need to ensure appropriate stakeholder input so an application would be made at the August Management Board. • Mechanisms of financial reporting research income via the Division of R&I were still being finalised with GOSH Management Accounts. • The Research Review for 2010 was being taken forward to print. • KPIs had been developed for research reporting. UCL Business' reports would be quarterly. • CRF activity, number of active studies was 48, number of studies in set-up was 11 and patient visits (per month) were 119. • MCRN activity: Number of participants recruited was 45, proportion of commercial studies achieving first participant recruited within 30 calendar days of NHS permission being issued was 3 out of 15 and the proportion of non-commercial studies achieving first participant recruited within 30 calendar days of NHS permission being issued was 2 out of 17. • Clinical Research Facilitator activity: The number of researchers engaged with was 58 in Medicine and Neurosciences, 60 in Infection, Cancer & Immunity, and 57 in DTS, Surgery and Cardiac. The number of research applications submitted – 14; 4 via GOSH (ICI, DTS, 2 Neurosciences) and 10 via ICH, totalling £3,629,857. The number of successful applications was yet to be confirmed.	
114.3	Management Board **noted** the content of the report.	
115	**Endocrine Business Case**	
115.1	MH presented the Endocrine Business case. The purpose of the Business case was to increase the Endocrinology clinical and research staffing resource as follows: • 10 PAs Paediatric Endocrinology Consultant: 5PAs GOSH Clinical, 5 PAs research funded by ICH • 1 WTE CNS band 7 for the Diabetes Service • 0.5 WTE A & C band 4 The objectives were to: • Support activity growth objectives set out in the IBP by ensuring that current and new activity was adequately and appropriately resourced. • Reduce risk across trust to ensure that adverse insulin events never happen • Implement an active education programme for all staff in the Trust on safe administration of insulin in line with NPSA guidance • Enable a positive impact on clinical outcomes for patients across trust • Ensure the timely collection of clinical outcome data	
115.2	CN stated that they had not been able to investigate with certainty the income status of the business case.	
115.3	Management Board **approved** the report subject to sign off from Finance. If approval from Finance was granted, the Chair would take Chairs action.	

115.4	**ACTION:** JC to take Chairs action on approving the Endocrine Business Case subject to sign off from Finance	
116	**Update on medicine management zero harm work**	
116.1	PL gave an update on medicine management zero harm work. The aim of the report was to bring clarity to the aims for the Zero Harm Agenda, with a defined method to determine whether the Transformation programme was delivering plans in line with Trust objectives.	
116.2	It was noted that there had not been a single set of aims agreed and approved by the Transformation Board when this work originally started. The recommendation to the Transformation Board was that by the end of 31st December 2011, the Trust would aim to reach the following targets for the outcome measures:	
116.3	Overall Measures of Harm – 50% reduction year on year Infection Prevention and Control – 50% reduction year on year. Medication Errors (except high risk drugs) – 25% reduction year on year Medication Errors (high risk drugs) – 100% reduction WHO procedure checklist – 100% completeness Deteriorating child – 50% reduction year on year	
116.4	Management Board **noted** the contents of the report. The targets had been agreed with the units at Transformation Board.	
117	**Key Performance Report June 2011**	
117.1	RB presented the Key Performance Indicator (KPI) report. It was noted that in preparation for operating as a Foundation Trust the report had additionally been updated to include a quarterly governance risk score against the revised Monitor governance framework.	
117.2	In month the Trust had reported 1 case of C. difficile. Year-to-date the Trust had reported 4 cases against a year-to-date trajectory of 2.25. The Trust trajectory for the year was 9 cases.	
117.3	The Department of Health (DH) had not yet agreed to a paediatric target different from adult. The DH advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) would be presenting our opinion on this again soon.	
117.4	The Trust had reported 2 cases of MRSA to date – against an annual target of 0 cases.	
117.5	Inpatients waiting list profile performance had improved with 64 patients reported as breaching the 26 week waiting standard against a previous month position of 73. Specific concerns had been identified across several specialties which were being investigated further.	
117.6	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.	
117.7	The Trust achieved the Median wait standard for admitted patient pathways in May. However, performance for non-admitted and incomplete pathways was reported over target. This was due to GOSH's role as a specialist acute trust with a high number of tertiary referrals as many patients arrive on an already ticking pathway. This position had been communicated to NHS London and lead commissioners.	

117.8	Overall performance for clinic outcome form completeness had 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 had been established to identify and resolve specific issues, which included a detailed review of the process for the recording of clinic outcomes and increased education and training in this area.	
117.9	In the last 13 months both clinical and non-clinical PDR rates had remained consistent at 75.9% and 73.0% respectively against a target of 80%. Services and departments were encouraged to continue to review staff currently identified as not receiving an appraisal.	
117.10	The Trust did not meet the June 95% target for staff achieving information governance training. Performance had reached a plateau at 84.7%.	
117.11	Mixed Sex Accommodation: There were no formal breaches last month.	
117.12	The Trust Monitor governance risk rating for quarter one was rated as 'amber-red'. This was due to underperformance against MRSA, C.diff and Referral to treatment non-admitted median waiting times.	
117.13	TS asked if graphs relating to refusals could be split between Surgical and Non-Surgical. RB stated that that would be done.	
117.14	**ACTION:** RB to split graphs relating to refusals by Surgical and Non-Surgical.	**RB**
117.15	**ACTION:** FD to send out a note to Trust Board clarifying the amber red on incomplete pathways.	**FD**
117.16	CC and TS raised the issue of overcomplicated clinical outcome forms for Outpatients. RB stated he would work out how to address this and report back to the Board.	
117.17	**ACTION:** RB to review overcomplicated clinical outcome forms for Outpatients and report back to Management Board.	**RB**
117.18	Management Board **noted** the contents of the Key Performance Indicator Report for June 2011.	
118	**Foundation Trust Application Update May 2011**	
118.1	SB presented the paper that set 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.	
118.2	On 24 June, the Trust received approval from the Secretary of State to submit the application to Monitor. A meeting had been held with Monitor to review the application for a "batching" decision. The outcome of the meeting would determine the overall timetable for the assessment, but the Trust was working towards a target authorisation date of 1 December 2011.	
118.3	The "Evidence of meeting statutory targets" criteria had been rated amber (no change). Both hospital acquired infection indicators (c. diff – 4 cases; MRSA – 2 cases) are above trajectory. It was also noted that the 95th centile of admitted pathway waiting time was over 23 weeks in Nov 10 and Feb 11. This indicator replaced the previous 18 week waiting time indicator in the Monitor compliance framework.	
118.4	The overall "Financially viable" assessment was now rated green (changed from	

	amber). Contracts had been agreed and the Trust was performing to target. There was a remaining risk to CRES delivery for 11/12, and CRES plans for 12/13 and 13/14, but these risks were being managed effectively by the CRES Steering Board.	
118.5	900 new members had been recruited in out-patient clinics over the last two months.	
118.6	Management Board **noted** the report.	
119	**Finance and Finance and Activity Report on Financial year 2010/11**	
119.1	CN presented the report and results year to date to end of period 3 Net surplus £2.6M, which was £0.05M lower than plan. Normalised EBITDA margin was 7.4% v Plan of 7.3%.	
119.2	The forecast out-turn remained in line with 'plan' and this was a net surplus of £6.9m pre-impairment charges for Phase 2A; normalised EBITDA margin 6.8%.	
119.3	There had been 12 staff overpayments totalling £9.9K – the common cause was late notification of changes to staff hours, pay, sickness etc.	
119.4	Pay was overall on budget. The improvement from period 2 was mainly the result of CRES and reserves being allocated to the appropriate income and expenditure categories.	
119.5	There were local pay overspends and agency costs exceeded plan. This related to: • Junior doctors, mainly in ICI, IPP and Surgery to cover rotas and reflecting high activity levels. • Higher than budgeted net costs of nursing staff, including agency, across a number of units but particularly IPP, cardiac and medicine. This was mainly to cover sickness, maternity and additional beds due to higher activity levels.	
119.6	Non Pay expenditure was £1.5M lower than budget. The principal issues were budget phasing benefit associated with activity planned later in the year; lower than planned drugs and blood costs, and lower non pay consumable costs across a range of areas	
119.7	CN highlighted an area of concern was the reduction in research income from Trustees because not enough research proposals had been put forward.	
119.8	LG added that there would be a cut of £500,000 this year from CLRN Activity Based Funding. Professor David Goldblatt and LG would have a discussion with the CLRN to see if they could take in to account the complexity of our patients (recognised in past years).	
119.9	Management Board **noted** the contents of the report.	
120	**Dubai Office move**	
120.1	JL gave an overview of the proposal to provide the International Division with a new office in Dubai, making cost savings towards the CRES target.	
120.2	JL requested the Board to note the report and approve further exploration.	
120.3	JL explained that property rental values in Dubai had decreased in recent years. However, our current landlord was not reducing rents. Alternative office locations had been explored.	
120.4	The International Division proposed to downsize the Dubai office, with the aim of achieving reduced rent and providing the same services within a smaller floor space.	

	This proposal would not affect the service provision or staff numbers, but would reduce costs.	
120.5	The proposal worked towards a transfer of offices by January 2012, which was when the existing rental contract expired.	
120.6	There were no financing requirements as the one-off costs would be absorbed within the savings generated in year one, there would be a CRES in all years.	
120.7	ML enquired if there were strong internet links in the proposed new offices and JL reported they were currently looking at this.	
120.8	Management Board **approved** further investigation into the office move.	
121	**GOSH Child Protection Quarterly Update April 2011-June 2011**	
121.1	JW presented the report on child protection. The report provided an update regarding operational progression of the Trust Child Protection Action Plan 2011-2012 as well as relevant information impacting on Child Protection operational and strategic compliance of the Trust.	
121.2	Full details of Trust wide activity were outlined in the Trust Child Protection Action Plan which demonstrated the level of ongoing development, and improved oversight of all services for which the Trust has safeguarding responsibility. Following the transfer of Haringey Children's Community Health Services to Whittington Health on 23 May 2011, the GOSH child protection reporting structure had been realigned to reflect the move.	
121.3	Overall, the Trust continued to make good progress against planned activity and goals and was working hard to embed strategic processes across the Trust to ensure good outcomes for children and young people.	
121.4	JW provided Management Board with an overview of the Trust's safeguarding training strategy for 2011-12. This strategy had been written to ensure the Trust continued to meet the safeguarding needs of staff and that the recommendations stemming from the 2011 SIT visit were addressed.	
121.5	This strategy was designed to support the Trust in ensuring all staff demonstrates the required level of knowledge and skills in relation to safeguarding. It had been informed by the January 2011 SIT visit, the 2010 Safeguarding Training Needs Analysis and discussion with all the Trusts safeguarding leads. It also underpinned the 'Zero Harm' pillar of the Trust strategy by enabling all staff to achieve the GOSH key objective of keeping children safe in hospital.	
121.6	JW stated that the dashboard (appendix 1b) outlined the strategy for training, which members of staff required. JC asked JW to check what other Trusts were doing. The Board was mindful of the balance between unnecessary training versus the need for staff to be properly trained. CDS highlighted that a lot of training does go on in the Trust but is not being captured. JW agreed to take comments back to the training department. JC asked JW to come back to the Board to present on training.	
121.7	**ACTION:** JW to come back to the Board to present on training in September.	**JW**
121.8	Management Board **noted** the contents of the report.	
122	**CRES programme update**	

122.1	FD updated Management Board on the development of the CRES Plans, in particular the latter years and high value schemes.	
122.2	FD requested the Board note and approve the work that had been undertaken to date and future developments.	
122.3	JC reported that there would be a different approach to CRES delivery in future which would involve bringing key people together each week to support the units along with appropriate executive challenge.	
122.4	Management Board **noted and approved** the report.	
123	**CSSD - Steam Sterilisation**	
123.1	PW presented the paper. The aim of the document was to ensure continued delivery of a compliant Decontamination Service to the Trust, in readiness for post December 2011. This was the timescale for when the steam boilers in the Trust Boiler House that feed the sterilisers in SSD were due to be decommissioned	
123.2	PW reported The Trust had three options : • Option 1: GOSH to invest capital funding to procure and install independent steam boilers • Option 2: GOSH to receive a sterilisation service from UCLH NHS Trust compliant Sterile Services Department or alternative NHS Trust • Option 3: GOSH to receive a sterilisation service from a compliant Commercial Provider for Decontamination Services	
123.3	The paper outlined the costs/benefits of each option.	
123.4	GOSH had previously had to have its service provided from UCLH with no material impact on service although the financial analysis showed this to be the most expensive option over a 5 year timescale.	
123.5	It was envisaged that the final business case for a UCLP Service would be ready to present at Management Board in August and would allow changes to the financial profile to reflect a partnership approach.	
123.6	PW requested approval for the following : • Delay Procurement of Replacement Steam Boilers at a saving of @ £370k in capital to allow time for final business case to be considered. • Agree Transfer of Service to UCLH as from December 2011 for an initial six month period (subject to revised costings) • Proceed to OJEU advert to allow option to consider commercial providers in medium term to mitigate Financial risk if required • Note the Cost pressure in year if an agreement cannot be reached as part of the UCLP Clinical and Corporate programme to offset the overheads in existing costings.	
123.7	The Board **agreed** to delay procurement of replacement steam boilers although WM highlighted that the Trust could not delay beyond this date because of the knock on effect to other areas. LJ agreed to the plan as long as a quality check was in place to ensure proper sterilisation of equipment.	
123.8	JC agreed to take to the UCLP Project Board a possible partnership with UCLP for CSSD in order to bring down costs.	
123.9	Management Board **approved** the report.	

124 124.1 124.2 124.3 124.4	**Update on Patient & Family Accommodation** PW gave an update on Patient and Family accommodation. In March 2010, Sue Connor produced a report on Great Ormond Street Hospital's parent accommodation. In the report, a number of recommendations were made following a review of the service. The paper gave an update on some of the actions and also highlighted options to ensure that both Patient and Family Accommodation requirements were met in the future. The Board was asked to note the recommendations and comment on any of the options being considered and to ensure that Clinical Units supported the work through appropriate representation at the User and Strategic level meetings The Board agreed to go ahead with the new booking system. FD provided clarification around who was entitled to use patient accommodation. PW would look at how this would be communicated to the Trust and would liaise with the different members of staff (PALS, Heads of Nursing) to ensure they were aware of entitlements and procedures for booking patient and family accommodation. Management Board **approved** the report.	
125 125.1 125.2 125.3 125.4	**Car Park Management Policy** PW presented the policy which documented the procedures and systems that related to the operation of Trust staff car parking arrangements. It was written in simple language to enable the document to be a practical guide that confirmed all procedures to user groups in an effective manner. The guidelines offered guidance and rules about the use by the car park owners (Brunswick NCP) and Great Ormond Street Hospital staff. PW requested approval from the Board for the change from the Camden Council facility (Bloomsbury Square) to the Brunswick NCP facility. This change would incur savings to operational costs for the Trust business car park spaces, and savings for individual staff. The policy was **approved.**	
126 126.1 126.2 126.3	**Managed Building & Engineering Service** WM presented the paper which proposed to provide a more efficient out-sourced Engineering Planned Maintenance Service to manage Critical Plant. WM requested approval to place an order for a five year period with Norland Managed Services for £716,694 (2011/12). The proposal contributed towards the Estates Strategy of improved planned maintenance regime of Critical Plant and provided a 24/7 service across the site. The financial implications had been analysed by the Finance Department and supported. The proposal also supported the Estates CRES Plan with potential savings of £110,302 in the first year and £254,370 by Year 3. The direction of travel of the paper was **approved**.	
127 127.1	**Bumble Bee Bed** JL presented the paper. The aim of the paper was to highlight an amendment to the original business plan (approved in April) which would increase the contribution of IPP makes to the Trust to £547k.	

127.2	JL requested the Board note the report and approve amendment. JL reported the beds would open on a phased basis; therefore there was no immediate change to capacity and funding. Once all 5 beds were open there would be a reduction in the total income of £325k, the contribution would be 27%.	
127.3	Management Board **approved** the amended figures – subject to approval by CASP.	
128	**Future of Systems at GOSH**	
128.1	ML presented the paper which described the problem of replacing PiMs and set out the next steps for how an Electronic Patient Record should be constructed. As part of this consideration, several other Trusts had been contacted to determine their direction of travel.	
128.2	ML requested approval for the direction of travel proposed – the creation of an electronic patient record for GOSH which currently had no financial implications for the Trust.	
128.3	JC queried what the clinical and business benefits were around having the UCL systems. ML stated that Geoff Basset was looking at this.	
128.4	The direction of travel of the paper was **approved**.	
129	**Business cases for new theatre covering paper and 5 draft business cases (cardiac surgery, neurosurgery, ENT, SNAPS, Urology)**	
129.1	FD presented the Business Cases. FD reported that the Trust's Integrated Business Plan (IBP) included the growth assumptions for individual specialties over the next few years. Growing surgical specialties increased the demand for theatre capacity. With the commissioning of the Morgan Stanley Clinical Building (MSCB) in May 2012 there would be a net increase from 10 to 11 theatres. Analysis of the activity and capacity model had been used to predict future theatre requirement. This would be met in the first instance by using existing theatre time better (supported by our ongoing improvement work in theatre utilisation) and then looking to extended hours working (this had already started with Cardiac working 2 extended days and planning more). Even with these factored in the model showed that some specialties needed more time. The suggested list for the division of extra theatre capacity available was as follows: • Cardiac surgery - 2 all day lists • Neurosurgery – 1 all day list • ENT – 1 all day list • SNAPS – 1 all day list	
129.2	This information had been discussed with clinical units and at the theatre management group.	
129.3	Urology had recently raised the issue that they felt that the growth figures in the IBP did not match their current demand and market assessment. They felt that there was a case for substantial growth which would also create demand for additional theatre capacity up to 1 all day list.	
129.4	Work was underway on the individual business cases to support this activity growth and initial stakeholder events had been held. Draft business cases were attached. Completed business cases would be presented to Management Board in September 2011.	
129.5	To be able to guarantee this, it was proposed that the Trust could open new theatre	

	sessions in May 2012. Recruitment would need to start immediately for additional theatre and anaesthetic staff.	
129.6	The new theatre would need equipping at a cost of approximately £1.5M which could potentially be funded by the GOSH Children's Charity (GOSHCC) if GOSHCC agreed to a proposal.	
129.7	Further work would be required to agree the finalised theatre schedule and similar work would be required to understand the demand for space in the new Hybrid Lab / Operating Theatre (also in MSCB) and would also be presented in September.	
129.8	FD requested that Management Board agree to the following: • Agree to start recruitment of additional theatre and anaesthetic staff • Agree the split of extra theatre capacity • Note progress of draft business cases that would be presented in September for approval • Agree that a capital bid to equip the additional theatre could go to the Capital and Space Planning Committee (CASP), and from there to GOSHCC. • Note that any specialties who believe that they have a case for requiring time in the new Hybrid Lab / Operating Theatre should contact Planning with the details of this by the end of August.	
129.9	JL queried if the cost of running a theatre (e.g. Staff paid) had been factored in as the costs seemed low FD reported she would take this away for further consideration. The Business cases were **approved**.	
130	**Intranet Project Update**	
130.1	CN updated the Board on the current status of this project and discussed the Content Editor role which would be required to oversee the intranet site.	
130.2	CN reported the development of the intranet would allow the Trust to take advantage of the latest technologies and allow staff to fully collate information and communicate and collaborate with colleagues effectively.	
130.3	The paper proposed the need for a dedicated resource. Work would be conducted to see if there was possible leverage of resources within existing teams already engaged in updating internal intranet or web pages.	
130.4	Management Board **approved** the post but not the funding.	
131	**Downside scenario**	
131.1	SB presented the report which set out the criteria that would trigger downside scenario management, the management plan, and the roles and responsibilities in a downside scenario.	
131.2	A downside scenario would be triggered as a result of a forecast FRR of 2 or less in any quarter, as a result of planning assumptions for income, activity or CRES savings not being met.	
131.3	The paper set out actions that needed to be implemented in preparation for a downside scenario and actions that would be implemented in a downside scenario situation.	
131.4	The paper also set out key roles and responsibilities for management of the downside scenario.	

131.5	SB requested the Boards approval for the following recommendations: • The trigger for downside scenario management: Forecast FRR of 2 or lower in any quarter. • Implementation of the pre-downside actions. • Actions and timescales in a downside scenario. • Roles and responsibilities in a downside scenario.	
131.6	SB stated a robust management plan for a downside scenario was required to achieve the Trust objective to secure Foundation Trust status.	
131.7	The paper was **approved** with the amendment that dates be shifted by one month earlier.	
132	**Business Continuity Plan**	
132.1	FD presented the policy which sought to build upon the experience gained and lessons learned from previous incidents. The aim was to provide an overarching corporate business continuity plan that supported service-level planning and provided structure and guidance to continue service delivery during large-scale incidents.	
132.2	The policy established organisational structures for effective decision making and improvement. There were no anticipated financial implications in the implementation of the plan.	
132.3	Management Board **approved** the policy pending any additions the Board may have that would be made to Tom Luckraft directly.	
133	**Service Line Reporting Project Plan**	
133.1	Management Board was briefed on the current status of SLR information and an action plan was proposed.	
133.2	SLR information had been completed each quarter during 2010/11 and had been accessible to clinical units for the third and fourth quarters. The costing information at patient level (PLICs) and activity as part of the review by KPMG of specialist childrens' hospitals' PbR activity costs was reviewed.	
133.3	There remained further development work to be done within finance to ensure all income (ie non PbR) was at patient level. There were also some specialties where costs appeared to be shared with other specialties and not apportioned correctly between those specialties.	
133.4	The plan set out in more detail the actions for the next 3-6 months, which included following up those specialties with significantly negative contributions and some benchmarking with other Trusts of both costing information and use of SLR.	
133.5	The Board was advised that SLR and PLICs information would continue to be produced and reported on a quarterly basis.	
133.6	Management Board **approved** the action plan.	
134	**Patient Transfer Policy & Patient Discharge Policy**	
134.1	RB presented the policies that set out the Trust-wide Patient Transfer Policy and Patient Discharge Policy at Great Ormond Street Hospital (GOSH). The policies had been further reviewed by Management Board members and Heads of Nursing.	

134.2	<u>Patient Transfer Policy</u> ▪ The policy focused on both the transfer of children within GOSH and the transfer of GOSH patients to another healthcare setting.	
134.3	<u>Discharge Policy</u> The policy was concerned with the discharge of children within GOSH. The policy applied to all inpatients and detailed staff responsibilities and discharge requirements including: Child protection concerns, prescribed special feeds and diets, equipment, end of life care and complex needs.	
134.4	It was noted that a number of key policies that were quoted within both documents would require updating.	
134.5	**ACTION:** RB to update key policies that were quoted within both the Patient Transfer and Patient Discharge Policies.	**RB**
134.6	SB requested Management Board approval of the policies. The policies provided a framework that underpinned the development, monitoring and delivery of the Trust's strategic plans and had no financial implications.	
134.7	The policies were not approved. Concerns over the areas the policies were not applicable to were raised. JL asked that IPP's policy on transferring patients be included in the appendix.	
134.8	**ACTION:** RB to come back to Management Board in August with an updated version of the Patient Transfer and Patient Discharge Policies.	**RB**
135	**Admission and Bed management Policy**	
135.1	RB presented the policy. A sub group of the Referrers Experience Improvement Group had been looking at a range of issues raised by GOSH referrers, including the GOSH admission process. One of the immediate priorities had been to review systems and processes to ensure they were fit for purpose and work.	
135.2	The Admission and Bed Management Policy underpinned practice; therefore the policy had been reviewed and circulated widely for comment. Useful feedback had been incorporated, and for the final stage of the consultation the Clinical Unit Chairs were invited to discuss at their Unit Boards to ensure all were in agreement with the policy and would adhere to it. The policy provided a robust framework for Bed Management and clearly described the roles and responsibilities of key individuals in this process. The importance of the Daily Operational Bed meeting was emphasised as the forum where admission and bed management issues were resolved and forward planning takes place.	
135.3	The process had required specialties to identify and agree specific admission criteria.	
135.4	SB requested the Board agree the policy and ensure that staff were informed and adhered to the policy, understanding how GOSH manages its bed pool.	
135.5	The policy would ensure a robust process was in place to expedite admissions and minimise refused admissions. The financial implication of the policy was increased income as a result of increasing admissions.	
135.6	There were concerns over criteria issues and communication raised. The policy was not approved. RB was asked to amend and bring it back to the Management Board in August for it to go on to the GMSC.	
135.7	**ACTION:** RB to come back to Management Board in August with an updated version	**RB**

	of the Admission and Bed management Policy.	
136	**Commercial Strategy**	
136.1	RB gave a verbal update on the Trust commercial strategy. RB reported there were currently discussions with KPMG in order to try to broaden our income base.	
136.2	JC stated that the Board could consider this strategy over the next few months.	
137	**UCLP Shared Services – Status report**	
137.1	CN provided an update on the review carried out on options for UCLP members to share services.	
137.2	UCLP commissioned Ernst and Young to coordinate 7 clinical/corporate support service workstreams (involving 7 UCLP members) and assess the potential benefits for each member of some form of shared services.	
137.3	The initial assessment of annual recurring cost savings for GOSH - if all workstreams were pursued by all participants - assumed an internal shared service structure based in London but with some activities outsourced to third parties. The assessment of recurring benefits was £4.9m (some not to be achieved for three years) although a large proportion of this saving related to two workstreams (pathology and estates & facilities). It was estimated that further development of the workstreams, set up and transition would cost GOSH £3.7m.	
137.4	The cost savings did not take into account other benefits of joint working, such as collaborating on new procurement leveraging activities, and changes in space needs. It was also believed that the capital requirements for standardising systems and processes had not been fully factored into the financial assessments and this would be addressed if the workstreams were approved for further development.	
137.5	Management Board **noted** the report.	
138	**Redevelopment Programme Steering Board**	
138.1	Management Board **noted** the contents of the above document.	
139	**Technical Delivery Board**	
139.1	Management Board **noted** the contents of the above document.	
140	**Research & Innovation Board**	
140.1	Management Board **noted** the contents of the above document.	
141	**Transformation Board**	
141.1	Management Board **noted** the contents of the above document.	
142	**Major Incident Planning Group**	
142.1	Management Board **noted** the contents of the above document.	
143	**CASP**	
143.1	Management Board **noted** the contents of the above document.	

144 144.1 144.2	**Waivers** CN requested approval for waivers from the following suppliers: Smiths Medical B Braun and ThinkShield Management Board **approved** the waivers.	
145	**Any other business**	
145.1	JW reported that a new Nurse Consultant, Julie Bayliss had been appointed.	

ATTACHMENT 5

Update: August 2011

Our collaborative discussions with Barts and The London, QM and other providers in North East London (NEL) on co-developing a single Academic Health Sciences System (AHSS) continue to progress positively, with the aim of enhancing health and healthcare for the 3m population of NCL and NEL, and gaining additional national and international competitiveness and relevance to wider populations.

In conjunction with the HIEC we have been designated the preferred supplier to assess the Olympic Health legacy. This work is being led by Rosalind Raine and Robyn Hudson.

The joint bid by NCL and NEL to co-create a single cancer provider network ("*London Cancer*" which is the agreed name of our integrated cancer system) was well received by the commissioners and we underwent a detailed assurance interview with an external panel on August 9th. The assurance interview was well attended by representatives from across all providers in NCL and NEL and similarly received excellent feedback. Thank you to everyone who gave their time and expertise to help create the bid, and jointly represent the plans to the commissioners. We are in discussion with the commissioners about resource allocation to enable the pace and scale of implementation that we would like to deliver.

UCLPartners is moving the company offices to the third floor of 170 Tottenham Court Road. We will space with The National Institute for Clinical Outcomes Research (NICOR) and prevention – in line with our focus on population health gain and clinical outcomes. This space should be ready for our use in early November 2011.

We are planning to hold a half day seminar for all our members on afternoon of November 21st (hopefully in 170 TCR!) on how the AHSS can better reduce the time from discovery to implementation in the community, update on our programmes, and report progress on the development of UCLPartners.

UCLPartners is participating in the NHS CEOs innovation review (see website for our response led by Dr Begley, UCLPartners Director of Innovation and Implementation), which we will continue to develop as part of the seminar on November 21st

UCLP has passed the PQQ stage of the next round of MDECs, and we are awaiting the invitation to tender document for the stage 2 bundles (13 topics). This will form a major focus of work for UCLP during September and October. Meanwhile we have commenced our formal lead provider role with the first year intake of junior doctors in the core specialities from Bundle 1.

Professor Chantler and myself formally welcomed City University to the UCLPartners Executive group at a signing ceremony with Professor Curran and Professor Newman on August 30th.

Congratulations to all of the BRCs and BRUs on their designation and funding by NIHR which secures the discovery pipeline that will drive patient and population health gain, and to Martin Rossor on the award of an MRC Centre of Excellence (COEN) in early dementia diagnosis.

David Fish

Managing Director